Migration and HIV/AIDS:

Community Recommendations

Based on the European conference
"The Right to HIV/AIDS Prevention, Treatment, Care and Support for Migrants and Ethnic Minorities in Europe: The Community Perspective"
Lisbon, 7-8 June 2007

To be launched at the EU National AIDS Coordinators Meeting, "Translating Principles into Action" (12-13 October 2007, Lisbon, Portugal) and presented in other major events and occasions, including the Eastern European and Central Asian AIDS Conference (EECAAC) in 2008 in Moscow.

1. Background

Migration is a global reality and with increased globalization, there is greater mobility across borders. There are a variety of push and pull factors in countries of origin and in countries of destination respectively that promote and sustain migration. These include demand for skilled and unskilled labour, family reunification, social and economic imbalances, war, persecution, human rights abuses and poverty. Such dynamics can lead to the migration of individuals and also entire communities.

Global population mobility is a complex, heterogeneous and growing phenomenon. In 2005, 3% of the global population[1] were migrants. In the same year, 8.4 million refugees[2] and 23.7 million internally displaced people in 50 countries[3] were seeking shelter and safety. Due to various gender-related factors, the proportion of migrants who are women is increasing, with women now accounting for approximately half of the global migrant population. Migration routes have also changed. In addition to traditional destination countries such as Australia, Canada, New Zealand, the UK and the USA, new countries have emerged as popular destination or transit countries. In Europe these include Ireland, Italy, Norway and Portugal. Countries like Spain, Portugal and France that are linked historically or geographically to formerly colonised and/or neighbouring countries have emerged as common transit countries. Furthermore, labour migration within and from the regions of Central and Eastern Europe and Central Asia has increased and there is a notable increase in short-term circular migration. With the EU enlargements in 2004 and 2007, the freedom of settlement was extended and international agreements increasing opportunities for mobility were put in place.

Consequently, migrants in Europe are a diverse group with many interconnections. They may be men, women or children; they may come from within or from outside of the EU, Eastern Europe and Central Asia; they may belong to ethnic minorities or may be descendants of migrants who still face legal exclusion and discrimination.

Global migration today not only shapes, changes and enriches societies but forms an integral part of national economies worldwide. Remittances resulting from migration amount to more than 170 billion euros per year.[4] In addition to these financial resources, migrants bring new skills and experiences to their home countries. Migrants also make an important contribution to economic growth, development, cultural enrichment and diversity in their countries of destination.

Restrictive legislation, social exclusion and stigmatisation lead to instability and vulnerability for migrants and ethnic minorities. They are often confronted with policies which lead to marginalisation and which reinforce xenophobic and racist scapegoating resulting in a worrying level of exclusion. This affects not only their legal and socio-economic situation but also their access to health care and especially access to HIV prevention, treatment, care and support.

Migrants bear a heightened risk of HIV infection, which results from the condition and structure of the migration process. Marginalised groups[5], including undocumented migrants, sex workers, trafficked persons, ethnic minorities, injecting drug users (IDUs), men who have sex with men (MSM), incarcerated persons[6] and people living with HIV/AIDS (PLWHA) can experience exploitation, violence and exclusion. Factors leading to this can include their high level of mobility, legal status, language and cultural differences, lack of information, education and work, poor access to prevention, harm reduction and health care services, social exclusion, and gender related factors. Stigma further exacerbates their vulnerability. Travel restrictions, deportation and policies that make it illegal for HIV-positive migrants to stay in a country due to their HIV status may also threaten their lives and well-being as well as violate their human rights.[7]

European states have committed to ensure the right to health, which is considered a fundamental human right to which all people are entitled regardless of their status or citizenship.[8] To ensure that the right to health is upheld, access to HIV prevention, treatment, care and support must be universal. Furthermore, the European and Central Asian governments have made strong commitments regarding HIV, including some that specifically address HIV among ethnic minorities and migrants. These include the UNGASS Declaration of Commitment on HIV/AIDS (2001), the Dublin Declaration (2004), the Vilnius Declaration (2004), the UNGA Political Declaration on HIV/AIDS (2006), and the Bremen Declaration (2007). Approaches based on human rights and the principles of non-discrimination, equality and participation are considered crucial for addressing HIV/AIDS. Current policy and practice however do not always reflect these commitments. Health care services and HIV prevention, treatment and care programmes are too scarce and often do not meet the specific needs of migrants and ethnic minorities. In some cases the design of programs actually reinforces exclusion and marginalisation instead of ensuring universal access.

In order to support and further stimulate action, the following Community Recommendations are put forward. They were developed at the European conference on “The Right to HIV/AIDS Prevention, Treatment, Care and Support for Migrants and Ethnic Minorities in Europe: The Community Perspective” (Lisbon, June 2007).

They summarize key issues of concern and aim to capture and convey the diverse voices of migrants and ethnic minorities. They embrace the expertise, knowledge and experience of experts from a wide range of perspectives working in the fields of HIV/AIDS, migration and ethnic and cultural minorities.[9]

The Community Recommendations are intended to provide relevant information to policy makers, National AIDS Coordinators and other stakeholders and to highlight the need for action. They will be used by organisations on national and international levels as guiding principles from the community perspective.

2. Basic Principles

Drawing on our experience as community organisations, we emphasize the following principles.

- **Basing Programmes on a Human Rights Framework**

Programmes that specifically target migrants as a "risk group" in particular need of HIV/AIDS-related services can further stigmatize groups that are already stigmatized. It is more appropriate to base programmes on principles that stress access to health services as a fundamental right for all. Article 12 of the Covenant on Economic, Social and Cultural Rights[10] states that the right to the highest attainable standard of health applies to everyone without distinction of race, religion, political belief and economic or social status. States are obliged under international human rights law to respect and protect human rights for everyone within their jurisdiction, without discrimination between citizens and aliens. They are obligated to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures to uphold human rights in general and the right to health in particular. It is necessary to call upon states to fulfil this obligation to uphold the rights of the most vulnerable and marginalized sections of the population.

- **Combining Human Rights and the Promotion of a Public Health Agenda**

Ensuring universal access to HIV/AIDS prevention, treatment and care is not only human rights issue. Ensuring access to health services and commodities is good for public health and is cost-effective. Harm reduction measures, including provision of sterile injecting equipment and condoms, outreach and peer education, opioid substitution therapy and other measures in both community and prison settings are effective and cost effective. Provision of access to antiretroviral drugs lowers the morbidity and mortality of people living with HIV. Moreover, this enables them to remain socially and economically active. Also, as antiretroviral treatment reduces viral load, transmission of the virus is less likely which is advantageous for public health and society at large.

- **Building Political Commitment**

Governmental support for community-based actions is necessary to develop effective intervention programmes. Programs that actively and meaningfully involve targeted populations in their design, implementation and evaluation should receive political commitment and funding. Several European and international partnerships as well as local institutions and ethnic and migrant groups have incorporated these objectives and play a crucial role in advocating for the rights of marginalized groups.

- **Comprehensive and Holistic Approaches: Sexual and Reproductive Health Rights**

Given that sexual transmission is one of the main means of HIV transmission in Europe, it is crucial to ensure that sexual and reproductive health services and HIV initiatives are integrated. Provision of prevention, treatment and care must go beyond the provision of HIV services and should include education and counselling programmes on safer sex, contraception, pregnancy and birth. Programmes should be designed to reach the greatest number of people possible. In this context, special attention should be paid to women, mothers

and young girls from migrant and ethnic communities, who are often extremely vulnerable and confronted with multiple sources of discrimination and exclusion.

- **Involvement Leads to Good Public Health**

Universal access to health services has a beneficial impact on the individual as well as on society at large, whereas exclusion exacerbates vulnerability, stigmatisation, and discrimination. Inclusion is of vital importance in making health messages more effective and in insuring that they are communicated widely and appropriately. The inclusion of marginalised groups such as migrants, ethnic minorities, PLWHA, drug users, MSM, incarcerated persons and sex workers in policy formulation and in service planning, delivery and evaluation is indispensable for improving both policies and the quality and accessibility of services.

3. Recommendations

In order to ensure universal access to health in general, and the right of migrants and ethnic minorities to HIV/AIDS prevention, treatment and care in particular, the undersigned organisations urge the implementation of the following recommendations:

- **General recommendations:**

1. All relevant actors should recognize the right to health as a fundamental human right and should ensure universal access care. Special effort should be made to ensure access by vulnerable and marginalized groups such as members of ethnic minorities, undocumented migrants, migrant sex workers, incarcerated migrants, migrant people living with HIV and migrant injecting drug users.

2. We stress the need for the meaningful involvement and representation of migrant and ethnic community members including PLWHA, IDUs, migrant women and transgendered people, men who have sex with men, sex workers and trafficked persons in all phases of development, implementation and evaluation of intervention programmes.

3. We urge decision makers to adopt approaches that are sensitive to culture, religion and language and that recognise the diverse backgrounds and the intersecting needs of migrants and ethnic minorities.

4. We request an end to harmful practices, such as deportation connected with HIV status. It is unacceptable to deport people to places where treatment and care are not guaranteed. Furthermore we request an end to repression, criminalisation and "illegalisation" of marginalized and stigmatized groups as these practices pose serious obstacles to accessing HIV/AIDS prevention, treatment and care.

5. An European-wide mechanism for awareness-raising, advocacy, knowledge-sharing, training and information exchange concerning issues of migration and HIV is essential and should be supported.

- **Recommendations to policy makers:**

1. Policy makers need to recognize the problem of inadequate access to health services by migrant populations and ethnic

minorities and address it at the highest political levels.

2. Strategies to address the health needs of marginalised groups including undocumented migrants, migrant IDUs, migrant transgendered people, migrant PLWHA, migrant sex workers and incarcerated migrants should be integrated into public health strategies and action plans at local, national and international levels.

3. Policies should support universal access to prevention, treatment, care and support as a core element of health promotion and should avoid deportation and repression, which exacerbate vulnerability and hinder progress toward universal access to prevention, treatment, care and support.

4. Politicians and societies need to recognize the manifold benefits their countries gain from migration and cease to consider migrants a social and economic burden.

5. European and national legislation should counter discrimination and protect the rights of vulnerable groups.

6. All countries should support international co-operation and networking among all stakeholders to reinforce awareness and commitments concerning migration health issues at the national and European level.

7. Regulatory restrictions on access to health care which currently restrict the freedom of movement of European citizens, residents and visitors should be removed.

8. Public health authorities should work in close collaboration with community representatives at all levels and should ensure an appropriate distribution of services and funding.

9. An essential part of a comprehensive strategy to prevent HIV transmission among incarcerated migrants is the reduction of prison populations. Overcrowding in prisons is detrimental to health and promotes the spread of HIV infection. Therefore alternatives to detention have to be strengthened and immigration-related detention should be used only as a last resort. Furthermore the responsibility for delivering health services in prisons and places of detention should be transferred to the Ministry of Health and not remain with the Ministries of Justice or Interior.

- **Recommendations to the health care sector:**

1. Holistic treatment has to be emphasized, taking into account that health is more than the absence of diseases. The issue of HIV has to be addressed in relation to sexual and reproductive health in general. It is essential to link services, involving social workers, psychologists and community workers to provide holistic and comprehensive treatment. Health services need sufficient funding and should be made accessible to all, including undocumented migrants and incarcerated persons.

2. To ensure universal access to health services, health authorities and workers are strongly encouraged to actively advocate for the adaptation of appropriate health systems. This includes structural changes and the appointment of bilingual or multilingual staff and cultural mediators. Furthermore, special attention should be given to increasing the knowledge and skills of staff at all levels of service provision.

3. All HIV testing, including testing in prisons and detention centres, must be voluntary and be accompanied by appropriate pre- and post-test counselling. Test results must be kept confidential. Mandatory HIV testing is unethical, increases HIV-related stigma, and undermines HIV education and prevention efforts.

4. National AIDS committees should involve members of migrant groups and of ethnic minorities as community delegates.

5. Given that prevention is cost effective, resources should be invested into culturally sensitive prevention programmes.

6. To guarantee continuous access to treatment and care, access must be monitored and evaluated in countries of destination as well as countries of origin.

- **Recommendations to social and other service providers:**

1. Culture and gender sensitive approaches which take the needs and vulnerability of marginalised groups into account should be supported. This is especially necessary when dealing with delicate issues such as sexual and reproductive health or drug education.

2. Approaches that engage only the majority populations should be avoided. Migrants and people from other marginalised groups should be involved in supporting their communities.

3. In order to promote access, service providers should develop partnerships with migrant and ethnic minority communities and should endeavour to develop sustainable drug related harm reduction programmes.

4. Targeted outreach work should be carried out to respond to the needs of migrants and ethnic minorities. Peer education and cultural mediation should be employed as means of reaching out to and supporting members of vulnerable communities.

5. Service providers are recommended to train, inform and sensitize their personnel to meet the specific needs of vulnerable groups and ensure non-discriminatory approaches.

- **Recommendations to community groups:**

1. In order to influence and shape decision making and policy development on migration and HIV, it is important that members of various minority communities including the Black and African Diaspora community, Roma and Sinti and Eastern Europeans outside their countries participate in decision making processes at the international, national and regional levels. All members of their communities should be involved, including women and young people.

2. Community representatives should engage in the policy making process, promote their community agendas to higher political levels, contribute to research efforts and promote non-discriminatory coverage in the media.

3. Co-operation with various organisations and the development of partnerships should be strengthened as this increases capacity and improves the promotion of information, education and communication within the communities.

- **Recommendations to researchers and academia:**

1. Data concerning migration should be included in epidemiological monitoring. Specific studies concerning migration should be conducted on a regular basis and harmonized between countries.

2. Complementary, cross-cutting studies should be designed and carried out by experts from different scientific fields in order to provide greater insights and to broaden our understanding of issues related to migrant health.

3. Researchers and academia are urged to involve advisors from minority groups into the entire process of their research.

- **Recommendations to the media:**

1. The media carries great responsibility with regard to influencing public opinion, awareness and understanding. Thus, when reporting on issues of marginalised groups such as (undocumented) migrants, sex workers, IDUs, MSM, PLWHA or incarcerated persons, it is essential to avoid discriminatory and stigmatizing language or images.

2. Media representatives should try to develop a sensitized understanding of the vulnerability of these population groups and must uphold their right to confidentiality.

3. In order to provide comprehensive and accurate coverage, the media should bear in mind that migrant and ethnic groups can serve as valuable sources of information.

References:

1 United Nations Department of Economic and Social Affairs/Population Division: Trends in Total Migrant Stock: The 2005 Revision, http://www.un.org/esa/population/publications/migration/UN_Migrant_Stock_Documentation_2005.pdf
International Labour Organization: HIV/AIDS and Work in a Globalizing World, http://www.ilo.org/public/english/protection/trav/aids/publ/globalizing.pdf

2 UNHCR: 2005 Global Refugee Trends. Statistical Overview of Populations of Refugees, Asylum-Seekers, Internally Displaced Persons, Stateless Persons, and Other Persons of Concern to UNHCR, http://www.unhcr.org/cgi-bin/texis/vtx/events/opendoc.pdf?tbl=STATISTICS&id=4486ceb12

3 UNHCR (2006): Internally Displaced People, http://www.unhcr.org/cgi-bin/texis/vtx/basics/opendoc.pdf?tbl=BASICS&id=405ef8c64

4 United Nations Department of Economic and Social Affairs/Population Division: Trends in Total Migrant Stock: The 2005 Revision, http://www.un.org/esa/population/migration/hld/Text/Migration_factsheet.pdf

5 The following groups are not to be understood as exclusive categories. Although focus is put on different groups and communities, individuals often belong to several communities at a time and may experience multiple and intersecting forms of discrimination.

6 When referring to incarcerated persons, we refer to both migrants imprisoned for criminal charges and migrants in detention who have not been charged, whose allegations are being investigated or who are held for migration-related reasons.

7 More than 100 countries have implemented restrictive entry regulations targeting PLWHA, as a study from the German Aids Federation demonstrates. Relevant data concerning these regulations can be downloaded at http://www.eatg.org/hivtravel/

8 Article 25 of the Universal Declaration of Human Rights (1948)
Article 2 of the International Covenant on Civil and Political Rights (1976)
Article 12 of the International Covenant on Economic, Social and Cultural Rights (1976)
Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination (1969)
Article 12 of the International Convention on the Elimination of All Forms of Discrimination Against Women (1981)
Article 24 of the International Convention on the Rights of the Child (1990)
Article 11 and 13 of the (Revised) European Social Charter (1999)
Article 35 of the European Union Charter of Fundamental Rights (2000)

9 The list of organisations and institutions that endorsed these recommendations appears at the bottom of this document.

10 cf. Committee on Economic, Social and Cultural Rights (2000): General Comment No. 14: The right to the highest sustainable health (Article 12): “By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.”
http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument

List of initial signatories

African Health Project, Waverley Care Trust, UK

African HIV Policy Network, UK

AIDES, France

AIDS Action Europe, Netherlands & Lithuania

Aids Coalition To Unleash Power - ACT UP-DRASE-HELLAS, Greece

Aids Fonds and STI AIDS, Netherlands

Aids-Hilfe Schweiz (Swiss Aids Federation), Switzerland

AIDSi Tugikeskus, Estonia

Amnesty for Women e.V., Germany

Arbeitsgemeinschaft Aids & Haft in Bayern, Germany

Associação de Apoio a Pessoas com VIH/SIDA (ABRAÇO), Portugal

Association Against AIDS (JAZAS), Serbia

Augsburger Aids-Hilfe e.V., Germany

Center for Democratic Development and Initiatives, Former Yugoslav Republic of Macedonia

Correlation Network, Netherlands

Deutsche AIDS-Hilfe e.V., Germany

DIA+LOGS, Latvia

Estonian Network of People Living with HIV, Estonia

Eurasian Harm Reduction Network (EHRN) *(formerly the Central and Eastern European Harm Reduction Network – CEEHRN)*, Lithuania

European AIDS Treatment Group (EATG), Belgium

European Youth Network for Sexual and Reproductive Health and Rights (YouAct), Portugal

Foundation of Social Education, Poland

Global Network of People living with HIV/AIDS (GNP+), Netherlands

Grupo Português de Activistas sobre Tratamentos de VIH/SIDA - Pedro Santos (G.A.T.), Portugal

Health and Social Development Foundation, Bulgaria

HIV-Sweden, Sweden

Humanitarian Action Fund, Russia

Hungarian Civil Liberties Union, Hungary

Initiative for Health Foundation, Bulgaria

International Community of Women Living with HIV/AIDS (ICW), UK

International Foundation and the European Network for HIV/STI Prevention and Health promotion among Migrant Sex Workers (TAMPEP), Netherlands

International Parenthood Planning Federation (IPPF), Belgium

International Treatment Preparedness Coalition (ITPC) in Eastern Europe and Central Asia, Russia

Lega Italiana per la Lotta contro l'AIDS (Italian League for Fighting AIDS), Italy

Movimento de Apoio à Problemática da Sida (MAPS), Portugal

Münchner Aids-Hilfe e.V., Germany

National Institute for Health Development, Estonia

National Union of the PLWHA Organisations (UNOPA), Romania

Notts County DAAT, UK

Odessa Charity Fund THE WAY HOME, Ukraine

Odyseus, Slovak Republic

Platform For International Cooperation on Undocumented Migrants (PICUM), Belgium

Project for AIDS Prevention & Care, for Surinam, the Antilles & Aruba (PASAA), Netherlands

Pro-tukipiste ry (Prostitute Counselling Centre), Finland

Sensoa, Flemish Centre for Services and Expertise with Regard to Sexual Health and HIV/AIDS, Belgium

Social AIDS Committee, Poland

Terre des Hommes Foundation, Switzerland

The Finnish Aids Council, Finland

The Unit for National Co-ordination of HIV/STI-Prevention, National Board of Health and Welfare, Sweden

For further information, see: www.eatg.org
To sign your organization on, contact: peter@eatg.org