Regional Strategies to Address HIV/AIDS Among Mobile Populations – A Right to Health Approach

Sharuna Verghis

7th International Congress on AIDS in Asia Pacific
Plenary – Cross Border Approaches
July 3rd, 2005

The focus of my paper as suggested by the title is on regional strategies to address HIV/AIDS among mobile populations. However, in keeping with my own experience in the area of migration and the magnitude of the scope of issues with regards to the different sub-categories of mobile populations, this paper will focus on migrants and make links to trafficked people and refugees wherever possible, cognizant of the peculiarities of each group that demands uniqueness in responses to their separate needs.

Much of what I share comes from the collective experience and learning of my organization CARAM. In addition I have tried to explore the applicability of the Comments, Recommendations and Reports of the Committee on Economic, Social and Cultural Rights and the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, to migrants.

Many organizations contributed information to the development of this paper. I have gratefully acknowledged their valuable input at the end of this paper.

1. INTRODUCTION

The importance of mobility of people has been gaining prominence because of its intersections with a host of issues from development and health to terrorism, security and international relations.

UN estimates that there are between 185-192 million migrants globally – up from 175 million in 2000. Asia, which has traditionally represented the largest international migrant stock, saw an increase in the number of migrants from 28.1 million in 1970 to 43.8 million in 2000 with more and more Asians finding job opportunities within Asia itself[1]. According to the World Migration Report by 2005 IOM, the total amount of global international remittances in 2003 was USD 93 billion and more than USD 100 billion in 2004. Twice as much money is estimated to be sent through informal sources with South Asia accounting for 20% of the annual global remittances.

The significance of mobility as a co-factor of HIV infection in Asia Pacific catapulted from being a non issue in the mid '90s to almost a centre stage position currently, if the profiling of mobility in the ICAAPs is any indicator of the same.

The need for specific interventions for migrants at all times underscored the importance of a regional approach based on the rationale that both migration and HIV were transnational issues and effective protection for migrants against HIV required coordinated policy and program responses linking the different stages of migration that contributes to different types of vulnerability and problems for the migrant in the migration cycle[2]. Conceptual and programmatic frameworks and tools have also been suggested for an effective response by various organizations including CARAM, WHO, UNAIDS, UNDP, IOM, FHI and others. Some important principles underlying these frameworks include a rights based approach, consideration of vulnerability of migrants as opposed to risky behavior alone, development of an enabling environment, and a multi-sectoral approach and the need for migrant participation[3].

An attempt to map current regional HIV/AIDS responses with regards mobile populations for this presentation indicates that there are virtually any interventions currently in the region operating within a multilateral framework. Most responses are bilateral and multi-lateral to the extent of involving a limited group of countries within a sub-region, whereas, migratory flows of people within Asia currently is known to be taking place across sub-regions. The focus of most responses is on research and documentation with emphasis on information exchange, networking and advocacy. This observation in no way seeks to deny the significance and value they bring to the overall protection of health of mobile populations, but to point to the need for an enhanced response to the problem.

Is this state of affairs indication of a much larger global problem or is it peculiar to Asia?

2.. SOME MAJOR CHALLENGES TO REGIONAL STRATEGIES TO ADDRESS HIV AMONG MOBILE POPULATION

Existing literature indicates the following challenges to developing regional strategies:

- **Crossing Terminological Boundaries in Population Mobility –** Though there are internationally agreed definitions for a migrant worker, trafficked person and refugee[4], in reality it is difficult to distinguish between the types of populations mobility. Categorization of types of population mobility has been suggested to achieve conceptual clarity of differences and interlinkages between the kinds of population movement[5]. The criteria of 'consent' attempts to distinguish a migrant from a trafficked person and refugee, along anti-poles of a continuum of population mobility, on the basis of those who have a 'choice' as against those who are 'forced' to migrate. Other criteria includes the use of 'legal status' and 'authorized or unauthorized entry' and its the consequences of being 'regular' or 'irregular' as a way of making a distinction between regular or documented migrants visavis undocumented migrants. Here, trafficking is seen as a subset of migration[6].

  However, there is unanimous acknowledgement even among those taking a stab at drawing these terminological boundaries that in reality these differences are often superfluous given the cyclical movements of people, overlaps in terms of identity and legal status within the same population movement continuum, and, differences in legal and administrative frameworks that lend themselves to diversity in the interpretation of the different terms in different countries and different contexts. Thus, a person might be a refugee, an undocumented migrant and a documented migrant in one migration cycle because the state may have failed to recognize her refugee identity leading to her taking on a migrant status to escape from persecution or conflict.

- **Quantifying the Invisible -** The absence of reliable data poses problems for the development of a comprehensive response and cooperation, especially for policy makers. This arises from the complexity of disentangling the different identities in the mixed and composite flows of mobile populations, and the ever increasing numbers of mobile people outside the 'regular' sphere of mobility. Internal conflicts, poverty and unemployment, state oppression, environmental catastrophes, violence and just the dream of a better life are among factors that have spurred the forced displacement and massive movement of people across national boundaries in recent times in Asia – most of them irregular. A related problem with putting a figure to the flows of mobile people is the operation of national and transnational crime which further keeps hidden people who are trafficked and smuggled.

- **Regulating Migration vs Protection of Migrant Rights** – There is also discussion about the absence of an international regime to regulate migration[7] - However, these discussions pose more questions than answers. The concerns arise from the emphasis on 'regulating migration' and the implications it has for guaranteeing the rights of migrants. The concern also arises from varied interests in the migration issue among existing agencies focusing on migration (ranging from the World Bank's interest in remittances to IOM's diverse activities from promoting rights based migration management frameworks to managing detention centres for asylum seekers for the Australian government in Nauru).

  The real problem lies in,

- **Weak Political Will** - in both origin and destination countries to deal with the issue. This is reflected in part in Bilateral Agreements and MoUs that lack the bite of human rights protections because they are developed on the basis of unequal negotiating strengths[8] between source and destination countries and motivated at both ends by pecuniary gains. Both sending and destination countries benefit from institutionalizing cheap migrant labor to maintain their competitive edge. The wider ensuing regional and global health impacts of these bilateral labor agreements have not been the consideration of the contracting State parties. Weak political will is also reflected in the consistent practice of inconsistent, incoherent, ad hoc, reactionary and ineffective policies for migrants in most destination countries over the past 30 years and the absence of efforts to deal with their incapacity. The resulting situation neither helps to achieve their objective of controlling migration flows nor meet the migrant's need for protection, wellbeing and dignity.

- **Human Rights: An Alien Language –** There is a lack of human rights vision and perspective in many countries regarding migrants, especially in destination countries. This is demonstrated by the inordinate time (13 years) it took for the International Convention on the Rights of Migrant Workers and Members of Their Families (1990) to get ratified. Receiving countries were reluctant to sign, and sending countries tried to protect their labor bargaining positions[9]. As against this, the two Protocols to the United Nations Against Transnational Organized Crime adopted in 2000[10] which clarifies the boundaries of trafficking, and, criminalizes smuggling and defines state responsibility to investigate and prosecute offenders respectively, saw more ratifications than ICMW[11].

  The absence of a human rights approach results in the absence of national policies, legislation, and mechanisms to distinguish between the different types of mobile populations. For example, this leads, to states blaming existing international protection regimes for refugees for their failure to address migration related challenges and prosecuting refugees and trafficked persons for immigration offences instead of offering them support.

  The weak orientation to human rights is also reflected in failure to recognize health as a right resulting in heath being seen as a privilege and tool for controlling migration[12].

  Unfortunately, the NGO sector is as guilty of this failure to integrate empowering approaches into programs for mobile populations. Welfare oriented measures like distribution of condoms and IEC materials (which have their undisputed value) predominate without other steps to make the environment enabling for the migrant.

- **Disconnects in Dialogue and Action** – The United Nations and IOM have played a key role in the last decade in facilitating various international conferences and global and regional consultative processes related to mobility and HIV. The Cairo Declaration recognized access to health for documented migrants and refugees. One of the 4 health related goals of the MDGs focuses on

HIV. The UNGASS went further with a time bound goal for the provision of prevention measures for migrants. The Bangkok Declaration on Irregular Migration was another landmark process that recognized health services for irregular migrants.

These international commitments have yet to translate into a positive response to AIDS with regards to mobile populations in the SAARC.

Similarly while the ASEAN took laudable steps in recognizing the need for a regional approach to reduce the HIV vulnerability of mobile populations[13], the integration of health in sub-regional and regional dialogues and consultative processes by the ASEAN on migration and labor issues is yet to take place.

Dialogues on mobility and HIV are also needed between the sub regional caucuses of the ASEAN, SAARC, GCC etc and in the other ongoing regional consultative processes.[14]

At the international level, the ICMW contains some ambiguities which could be misapplied on public-health grounds to restrict people's movement and turn health care into an instrument that can be used against migrants[15]. Further, the convention is not equipped to deal with the specific vulnerabilities of migrants to major epidemics like HIV. It only provides for access to emergency care for irregular migrants while we know that there is a critical need for marginalized groups like irregular migrants to be included in the whole spectrum of health services from prevention to treatment, care and support.

A major disconnect is the absence of NGO and migrant input in these regional and sub-regional dialogues related to migration. This peculiarity is also evidenced in the drafting of the ICMW 1990 which saw no NGO participation unlike the drafting of the other international conventions.[16] The same is true for regional consultative processes on migration.

Other disconnects are intra-organizational, as in international organizations with separate departments on migration and HIV. . For example, ILO had migration as the theme of its 2004 international labor conference and made concluding resolutions promoting health care access and HIV prevention measures for migrants[17]. Yet, ILO's report on 'HIV/AIDS and Work: Global Estimates, Impact and Response', released in the same year in conjunction with the XVth International AIDS Conference in Bangkok in 2004 was conspicuously silent on migrants[18].

3. Regional Strategies to Address HIV Among Mobile Populations – A Right to Health Approach

The policy framework guiding the development of health policies for migrants in almost all destination countries is based largely on considerations of sovereignty of states and their right to determine policies that safeguard the health of their local population, national security and escalating health expenditures by the state. These are all legitimate concerns. But in themselves they are ineffective to guarantee the health of their citizens or to enable a nation to fulfill its duties as a responsible member of the global community. Nevertheless these considerations often dictate the perspective and content of state led regional strategies and also sets the limitations to what NGOs can do to reduce the spread of HIV through interventions with mobile populations.

Complementing the public health perspective with a right to health approach for the development of regional strategies for mobile populations on HIV/AIDS has the added advantages[19] of,

- Bringing in the consideration of social justice along with medical, financial and technical resources to problem solving through the concern for equity

- Tapping on the pre-occupation of human rights with disadvantaged and marginalized groups.
- Policy and program response does not only address 'need' but also 'claims of rights' of people to 'freedoms' and 'entitlements.' Policy responses are not driven by benevolence on the part of state but their accountability to people within their jurisdictions and to the international community.

This paper attempts to integrate a right to health approach in regional strategies to address HIV among mobile populations at three levels – of norms, policy and program framework and roles and responsibilities of key players.

THE NORM

Health for All

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[20].

For mobile persons, 'this translates into the physical, mental and social wellbeing of mobile populations and communities affected by migration'[21].

The application of international standards to look at migrant health can also be interpreted through the articulation of the right to health in the International Covenant on Economic, Social and Cultural Rights which recognizes that**,**

> ***Every human being*** *is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity* (Art 12.1, ICESCR)

General Comment 14 (2000) by the Committee on ESC Rights (CESCR)[22] ,further affirms the principles of non discrimination and equal treatment in exercising the right to health (para 18). Thus, terminological inexactitudes regarding the identity and the status of the mobile person cannot be cited as barriers to the enjoyment of health and well being of the migrant.

International Cooperation - Healthy Relationships

With this underpinning norm to international cooperation many deficiencies of an uneven playing field in the current migration scenario and its health impacts can be averted.

Highlighting the importance of international policy development in the protection of health, the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health states that, …'States are obliged to respect the enjoyment of the right to health in other jurisdictions, to ensure that no international agreement or policy adversely impacts upon the right to health….[23].

This is also reflected in General Comment 14 … 'To comply with their international obligations in relation to article 12, States parties have to respect the enjoyment of the right to health in other countries...'[24]. This means that states must refrain from actions that violate the right to health in other countries.

A quick look at HIV prevalence in some of the low prevalence sending countries like Philippines and Sri Lanka where a major proportion of their HIV infections have been attributed to out-migration suggests that that migrants are more at risk of exposure to HIV infection through migration than of transmitting

the same. In the Philippines, according to the National Registry of the Department of Health (April 2005), Overseas Filipino Workers (OFWs) comprised 33% or 749 of HIV positive persons. In Sri Lanka as per existing statistics 50% of reported HIV persons are returned domestic workers from the Middle East[25].

Existing MoUs between destination and origin countries focus on regulation of migrant flows rather than protective conditions for migrants, including protection of health. While it is true that the ICESCR and other international conventions have not been ratified by destination countries like Malaysia, Singapore and Saudi Arabia, these standards are internationally recognized, have the consensus of the international community and have been contributing to state practice. In addition, many of the sending countries are signatories to the ICESCR and have obligations to their citizens in guaranteeing the right to health. Many sending countries also have laws and policies which prohibit discriminatory practices like mandatory HIV testing. This fact needs to be recognized and respected by destination countries. Integrating a right to health approach in Bilateral Agreements and MoUs would mitigate the retrograde impact of HIV arising from mobility and help in long term planning in a strategic manner which would also control irregular migration.

States that have not yet ratified the various international instruments that offer protection to migrants must show their commitment and responsibility to the international community by ratifying these conventions. Destination countries must ratify immediately the ICMW 1990, ICESCR, CERD, CEDAW, the UN Convention against Transnational Organized Crime and its Protocol on Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children (2000), the 1951 Convention on Refugees and the ILO Conventions 97 and 143. It is also critical that governments that are party to GATS, Mode 4, ensure that the prevailing trade and profit perspectives in labor services agreements do not infringe upon the human and health rights of migrants.

International obligations with regards to right to health also extend to states that are outside the migration arrangements. Given the regional and global impact of engagements and agreements between two countries, the international community has the indisputable responsibility to take up on actions of states that spread HIV/AIDS and jeopardize the efforts of others fighting the epidemic.

In this context, I request your attention to the over 1 million migrants from Burma in Thailand, who had to leave Burma in order to survive. In recent months, large numbers of people are becoming victims of forced migration as the ceasefires break down and villagers in Shan state and other ethnic states become caught in the crossfire between the military regime's army and the ethnic resistance. There is no information available for migrants before they leave Burma, and most migrants arrive in Thailand in a very bad state of health, with little knowledge about health care, least of all about HIV. MAP Foundation, our CARAM partner is concerned that they are referring young Burmese people with heart disease to the hospital, and that Burmese mothers are giving birth to babies with birth defects including heart disease, spina bifada, cleft palate and other body deformities.

The SPDC has recently made it even more difficult for NGOs to work in the country, issuing restrictions on their movements and activities. Although humanitarian aid is desperately needed, it is clear that there is no political will to facilitate it. Only united international pressure can force the regime to make some changes. Despite there being over 30,000 Burmese citizens working in the areas affected by the Tsunami in Thailand, and at least 2,500 Burmese migrants being directly affected by the Tsunami in Thailand, there was absolutely no response from their government. No humanitarian assistance was offered by their government, no official ever went to visit the area. Effective community responses to HIV demand an enabling environment. The environment of fear and repression in Burma is completely

disabling. Translators and community motivators have been harassed for mobilising communities to increase harm reduction strategies.

We therefore call for all donors (governments, UN and INGOs) to protest against the restrictions and repressions.

Burma, is next in line to chair the ASEAN. If a military dictatorship is given this position in ASEAN human rights in the region will disappear. We cannot separate democracy from development, migration and HIV. To control AIDS, the international community must act so that democracy is restored in Burma and Burma is free from a military dictatorship which has no respect for the lives of its citizens.

THE FRAMEWORK

A framework for policy or intervention needs to be coherent, efficient, strategic, effective, humane and bringing about equity. Some important elements of the right to health can help to achieve these desired aims.

Intercepting Intersections through a Multisectoral Approach - According to General Comment 14 (2000) by the Committee on ESC Rights (CESCR) the right to health covers access to health care and the related socio-economic determinants of health including ….*'access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health'* (para 11). Thus mobility, development, HIV and human rights are seen as an integrated whole without separations.

The Chronic Poverty Report 2004-05 includes migrants, refugees and displaced people in the category of chronically poor on the bases of their experience of social marginalization, discrimination and disadvantage. This fact with demographic projections which indicate the increased mobility of people and an increasingly globalized world emphasizes the need for a multi-sectoral approach that is able to capture the intersectionality of issues and contribute to bridging the regional socio-economic divide. Disaster reduction needs to be integrated within this multisectoral developmental approach given its potential to displace people and exacerbate the existing HIV vulnerability of mobile populations.

Access to Equity – Reducing regional health inequalities demands reducing health inequities. Access to health services and information to mobile populations in all stages of migration is a critical element to reducing their vulnerability to HIV and providing them increased control over health outcomes.

The essential elements comprising **'accessibility'** with regards to the right to health include[26] non discrimination in terms of accessibility of health facilities, physical accessibility, economic accessibility and information accessibility. Economic accessibility is defined on the basis of the equity principle.

Denial of entitlements of access to health services for migrant workers is inconsistent with international standards for the treatment of workers and migrant workers. It also reflects discrimination which the Committee on ESC Rights asserts, should be got rid of because *'most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications'* (para 18).
Improving access to health services for mobile populations includes,

- Making budgetary provisions for them
- Including their right to health in National AIDS Action Plans

- Evolving equitable health financing provisions
- Provision of special support for HIV positive migrants (counseling, referrals, access to treatment and monetary compensation measures)

Empowering through Participation - The right to health vests the State with a **core obligation** to undertake national public health strategies in a **participatory** manner that is also consistent with **attention to marginalized and vulnerable groups**[27]. Participation of mobile populations is not a choice for the State to exercise within a right to health approach but an obligation. Participation must increase the migrant's empowerment and control over her health. However, the experience of CARAM and other NGOs especially in destination countries consistently indicates that migrants, especially in destination countries are preoccupied with more urgent problems of survival related to their jobs, documents, living and working conditions, violence and exploitation. This also diverts the resources of NGOs struggling to address the threats of the pandemic and trying to meet the needs of the community at the same time. Thus, to discharge its obligations of enabling the participation of migrants in health strategies, the state needs to make migration safe.

Participation of mobile populations should include GIPA. This involves creating an enabling environment for the meaningful participation of mobile persons with HIV/AIDS by abolishing mandatory HIV testing and deportation, recognition of the right to work of HIV positive migrants, facilitating access to treatment, and policy backing for workplace initiatives to raise AIDS awareness and address discrimination. Above all it must facilitate the involvement of HIV positive migrants in all strategies and stages of decision making – planning, implementation, and M&E in AIDS and mobility related initiatives.

The 'Unknown' and the 'Critical' – The X Factor and Factor X in the Struggle against AIDS – Irregular migrants are the unknown element (X factor in Math) in Asia and also the critical Factor X of the economies of sending and receiving countries as well as in the struggle against AIDS.

The right to health states that *'In particular, States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities,* ***asylum seekers and illegal immigrants, to preventive, curative and palliative health services****; abstaining from enforcing discriminatory practices as a State policy;'* (Gen Comment 14, para 34). These are strong words stating that state must refrain from actions that hinder the right to health for refugees and undocumented migrants. This provision augurs well with good public health praxis which emphasizes holism in strategy and emphasizes the inclusion of marginalized and unreachable populations such as undocumented workers in AIDS combating strategies.

It is not their fault that poverty, unemployment, conflict and environmental disasters, institutional deficiencies and lack of an enabling policy environment bring about irregularity in their movement. Being undocumented does not mean that they do not exist. As long as they exist, they have to be counted as human beings and should be *entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.* The other human rights based reasons to recognize the right to health of undocumented migrants include,

- the pre-occupation of human rights with the marginalized groups like undocumented migrants
- vesting of obligations of assistance and protection to the international community, of persons that the State is unwilling or unable to support and protect[28]
- adequacy of provisions in the international system to deal with issues like smuggling, trafficking and transnational crime (the reasons usually used by states to deny the rights of undocumented migrants) without taking away their right to health
- undocumented migrant workers, though often portrayed as criminals and scapegoated in the so called war against terrorism are workers and often the backbone of their home country and

destination economies. They should not be denied the treatment, benefits and health rights accorded to workers because states are incapable and unwilling to grasp their tremendous real and monetary contribution because of the limitations of legal and policy perspectives and frameworks.

Today the irregular movements of people far exceed regular migration. If States choose to ignore the health/HIV dimensions of this problem and fail to see the broader human security issues because of their immediate national security concerns, we will be confronted with a bigger problem with HIV which would in fact give rise to new and varied types of security concerns. Recognizing the health rights of undocumented migrants and including them in HIV strategies is imperative to mitigating the health, economic and security fallout of an AIDS pandemic.

Evidence Based - Following his mission to the WTO, the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health highlights the need and right of nations to undertake health impact assessments of policies[29]. Health impact assessments for MoUs, Bilateral and Multi-lateral agreements related to mobility would be very useful in the development of evidence based strategies.

Women Sensitive – Given the increased numbers of out migration of women in recent times and their employment in informal and unprotected sectors of work like domestic work, a perspective addressing the feminization of poverty and migration and paying attention to the special health needs of women migrants is crucial and urgent in regional strategies for mobile populations. Right to health for all women including migrants is upheld by various instruments including the ICESCR and CEDAW which among other health rights guarantee the right to continuity of employment and health care during pregnancy as against current practice to terminate employment and deport pregnant women migrants.[30]

ROLES AND RESPONSIBILITIES

The participation of every player is crucial in the fight against AIDS. However, given limitations of time, the roles and responsibilities of only some will be highlighted in this presentation.

Dual Loyalty – Health personnel play an important role in the enjoyment of the right to health by mobile populations. There are increasing situations of **dual loyalty –** *or conflict between professional duties to a patient and perceived or real obligations to the interest of a third party*[31]. Health personnel are under pressure from the state and/or the employers and insurance private sector to undertake actions that breach their professional code of ethics that demands '*first consideration of the health of the patient'*… and …'*full technical and moral independence'*[32]. Participation in mandatory HIV testing and deportation without providing the migrant pre and post counseling, referral and access to treatment as is the current practice is an example of dual loyalty including breach of confidentiality, violation of UN guidelines on HIV testing, and participation in the denial of access to treatment. Other examples include denial of access to treatment for undocumented migrants, disclosure of the migrant's health problems to the company's panel doctors, limiting and/or denying medical treatment and leave because of pressure from the employer, and, failure to report abuse, torture or dehumanizing and inhumane treatment of migrants in detention centers. Though it is the obligation of the State to *'provide an environment which facilitates the discharge of these responsibilities*[33]*',* health professionals cannot blame the compromise of their professional integrity on State policy. They are obliged to maintain professional independence and speak up against these violations.

Role of Donors and International Assistance – The right to health enunciates that international assistance focus on the 'core obligations' of states[34] including non discrimination of marginalized and vulnerable groups in accessing health services and participating in the adoption and implementation of public health strategies[35]. International assistance to governments should include time bound goals with clear right to health indicators to create an enabling environment. Given the unwillingness of governments to work with migrants, especially undocumented migrants, NGOs working with migrants deserve assistance.

Role of NGOs – NGOs have three unique responsibilities. 1) Though there are some good examples of migrant participation these are few by far. We NGOs need to deal with our internal organizational contradictions on this front. 2) Notwithstanding the criticalness of dialogue with other stakeholders, especially policy makers we NGOs cannot compromise on our responsibility of monitoring the violation of migrant rights. In monitoring the obligations of conduct and obligations of result of the state with regards to mobile populations, and, the progress of global commitments like UNGASS and the MDGs, we need to explore more fully the potential of engagements with the mechanisms of the UN Special Rapporteurs on migrants, trafficking and health, the treaty bodies that receive the periodic reports of the state on the right to health and national human rights institutions, through the development of alternate reports and other mechanisms. 3) Lastly we need to strengthen our linkages with each other and synergize. Currently there is very little networking and cooperation between NGOs and migrant organizations working on health. We need to resolve our internal struggles for turf, territory and visibility, because a united a coordinated response is far more effective.

Role of the State – Internally, States have the responsibility to facilitate the development of a political, legal and policy framework that is critical to developing an enabling environment. Externally, States also have an obligation to the international community on common commitments. Like all human rights, in this context it needs to respect, protect and fulfill the right to health[36], including the right to health and the rights of migrants, trafficked persons and refugees. This means that it has to refrain directly and indirectly from infringing on the right to health of mobile populations, protect mobile populations from third parties who violate their rights and take all steps to promote their right to health through the adoption of legal, administrative, budgetary and other means. While 'progressive realization' of the right to health by States is allowed, States have an 'immediate obligation' to reduce discrimination (Gen Comment 14 - para 30) which requires minimum resources (Gen Comment 14- para 18).

A critical element of this role of the state is related to its relationship with and engagement with NGOs. NGOs are best placed to deal with vulnerability issues of migrants, especially undocumented migrants and states have a serious obligation to *'respect, protect, facilitate and promote the* ***work of human rights advocates*** *and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health'*[37]. For various reasons the state is often unable or is unwilling to work directly with migrants. The least it can do in such a situation is to refrain from harassing NGOs especially those that work with undocumented workers and refugees in countries where the latter are not recognized as such. Providing financial support and involving NGOs (because of the richness of their potential contribution arising from their proximity to migrants) in developing and implementing policies and programs are positive steps that governments can take in the discharge of their right to health obligations. In recent times we have also seen defenders of human rights of migrants coming under extreme pressure. This needs to change.

I'd like to end by taking up a point Dr. Prasada Rao, UNAIDS Director, Regional Support Team, made in yesterday's plenary when he said that – No impact can be reached without reaching the critical threshold, which includes 60% behavior change of vulnerable communities. Goals like this are

redundant if there are no concomitant goals to make the environment enabling. What we need is right to health indicators which will help us monitor the commitment of states to make the environment enabling. The questions we should also be asking are:

- How many destination countries have abolished mandatory HIV testing?
- How many MoUs and Bilateral Agreements have right to health protection provisions?
- Are mobile populations included in national AIDS strategies?
- Are mobile populations included in national health budgets? What percentage of the health budget is devoted to migrants in sending and receiving countries?
- How many states have policy and program provisions to provide accurate and timely information to migrants before departure?

And as Peter Piot stated on the first day, we need context specific data or disaggregated data to monitor where the real vulnerabilities exist.

Conclusion

Recognition of the right to health of mobile populations will empower them against HIV/AIDS, lead to better health outcomes in home and destination countries, and contribute effectively to the fight against AIDS.

Acknowledgements and Thanks to:

- My partners in CARAM, especially Bernard D'Sami and Jacqueline Pollock for their feedback and contribution to this paper; Pravina Gurung/NIDS, David Soyza/MSC, Musarrat P/LHRLA, ACHIEVE for information
- Partner organizations for generously sharing information and facilitating contacts. While I was able to incorporate some of the information directly in this paper, because of limitations of time for the oral presentation and the varied nature of the information, a lot of the information unavoidably became background material – though very valuable – and which helped to establish the status of interventions and realities with regards to mobility and HIV.
    - The contacts of these partner organizations are given here for whoever might wish to know more their projects: Bandana Pattnaik/GAATW (bandana@gaatw.org); Meera Mishra/UNDP (meera.mishra@undp.org), Himani Sethi/SARDI (sardi@del6.vsnl.net.in); Bounpheng Philavong/ASEAN secretariat (b.philavong@aseansec.org); Shahidul Haque, Umbareen Kuddus, Lucy Riffat Hossain, IOM Dhaka (SHAQUE@iom.int) and Greg Irving, IOM Bangkok (girving@iom.int); Bitra George and Nigoon Jitthai of FHI (bgeorge@fhiindia.org), Sornchai Looareesuwan and Sandra Tempongko, SEAMEO Tropmed Network (fnvpn@diamond.mahidol.ac.th); Rex Varona, Mekong Migration Network (amc@pacific.net.hk); Migrant Forum in Asia (mfa@pacific.hk.net), Sue Carey (sue@csearhap.org) and David Patterson (david.patterson@videotron.ca) of CSEARHAP; Lotte Kejser and William Pang of ILO (pang@ilojkt.or.id); Maria José of CIDEHUM (cidehum@hotmail.com)
- Titi Soentoro for information on Aceh (euron@indo.net.id) and Nesathurai for support in sourcing information on development and poverty
- Tashia Peterson and Elaine Tan
- IFFHRO, for their support to explore the strength of the right to health approach in advocacy with/for migrants

Endnotes

[1] Too Many Myths And Not Enough Reality On Migration Issues, Says IOM's World Migration Report 2005, No. 882 - 22 June 2005
[2] CARAM Asia , The Forgotten Spaces, Mobility and HIV Vulnerability in the Asia Pacific, 2002
[3] Ibid 1, 2002
[4] The term "migrant worker" refers to a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national. (International Convention on the Rights of Migrants Workers and Members of Their Families 1990)

"Trafficking in persons shall mean the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat of use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs" (article 3 of the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention against Transnational Organized Crime)

A refugee has been defined as a person who…'owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; (1951 Convention relating to the Status of Refugees. In addition extended definitions of this term also consider internal strife, conflict or natural disasters that drives people across national borders

[5] Md. Shahidul Haque, Ambiguities and Confusions in the Migration-Trafficking Nexus: A Development Challenge
[6] Ibid
[7] Ibid
[8] Hameeda Hosaain, Overview of Asian Women Migrant Workers: Current Trends in Institutional and Social Problems, Legal Protetcion for Asian Women Migrant Workers, Strategies for Action, 8-12- 197, Manila, Iawasia, Ateneo Human Rights Cenmter, Canadian Human Rights Foundation
[9] Piper N, Iredale R. Identification of the obstacles to the signing and ratification of the UN convention on the protection of the rights of all migrants 1990--the Asia Pacific perspective. UNESCO, 2003.
[10] the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (Assembly resolution 55/25, annex II), and the Protocol against the Smuggling of Migrants by Land, Sea and Air, supplementing the United Nations Convention against Transnational Organized Crime, (Assembly resolution 55/25, annex III)
[11] World Economic and Social Survey 2004, Department of Economic and Social Affairs, /2004/75/Rev.1/Add.1, ST/ESA/291/Add.1
[12] Ibid 1
[13] 7th ASEAN Summit Declaration on HIV/AIDS , 5 November 2001, Brunei Darussalam, ASEAN Work Program me HIV/AIDS I and II
[14] Like the Inter-governmental Asia Pacific Consultation on Refugees, Displaced People and Migrants (APC), the Bali and the Manila Processes etc
[15] Wolffers Ivan, Verghis Sharuna, Marin Malu, Migration Human Rights and Health' The Lancet, Dec 2003
[16] Ibid 9
[17] Resolution concerning a fair deal for migrant workers in a global economy, INTERNATIONAL LABOUR CONFERENCE, Ninety-second Session, Geneva, 2004
[18] CARAM News, Daily Review of Mobility Events of the XVth International AIDS Conference, 2004
[19] Judith Asher, The Right to Health: A resource Manual for NGOs, AAAS Science and Human Rights Program with HURIDOCS, and the Commonwealth Medical Trust (Commat), 2004

---

[20] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
[21]Migrant Health for the Benefit of All, IOM, Eighty-eighth session, 8 November 2004, MC/INF/275, (http://www.iom.int/DOCUMENTS/GOVERNING/EN/MC_INF_275.PDF - on 03 June 2005)
[22] SUBSTANTIVE ISSUES ARISING IN THE IMPLEMENTATION OF THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS - General Comment No. 14 (2000) - The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) CESCR - COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, Twenty-second session, Geneva, 25 April-12 May 2000, Agenda item 3
[23] Report of the Special Rapporteur The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt,, Paul Hunt, submitted in accordance with Commission resolution 2002/31, COMMISSION ON HUMAN RIGHTS, Fifty-ninth session, Item 10 of the provisional agenda, E/CN.4/2003/58, 13 February 2003
[24] Para 39, General Comment 14
[25] UNDP, Regional Update - Sri Lanka, http://www.hivanddevelopment.org/regionalupdate/srilanka/index.asp, as on 06 June 2005
[26] Para 12 (b) of General Comment 14 (2000)
[27] General Comment 14 – 43 f
[28] Muntarbhorn Vitit, Migration and Forced Displacement: The Nation State, Asia and Globalization
[29] Report of the Special Rapporteur on The right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Addendum, Mission to the World Trade Organization, COMMISSION ON HUMAN RIGHTS, Sixtieth session, Item 10 of the provisional agenda, E/CN.4/2004/49/Add.1, 1 March 2004
[30] International Convention on the Elimination of All Forms of Discrimination Against Women – Art 11.1, 12.1 and 12.2, and 14.2.b and h
[31] Dual Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms**,** A Collaborative Initiative of Physicians for Human Rights and the School of Public Health and Primary Health Care University of Cape Town, Health Sciences Faculty, 2003
[32] World Medical Association, *International Code of Medical Ethics*.
[33] General Comment 14, para 42
[34] General Comment 14, 45,
[35] General Comment 14, para 43
[36] General Comment 14, para 33
[37] General Comment 14, Para 62