

Report of the NGO Representative

PEOPLE ON THE MOVE—KEY TO ENDING AIDS'



Additional documents for this item: *none*

Action required at this meeting—the Programme Coordinating Board is invited to:

Recalling Article 25. 1 of the General Assembly Resolution 217 A - December 10, 1948: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”; and recalling decision from previous Programme Coordinating Board meetings related to HIV and people on the move as well as the 2014 UNAIDS Gap Report and the 12 population groups defined as people left behind including migrants and displaced populations:

1. *Welcome* and take note of the report;
2. *Encourage* the Joint Programme to adopt the International Organization of Migration’s (IOM) definition of ‘migrant’; to fully implement the General Cooperation Agreement between the Joint United Nations on Programme on HIV/AIDS (UNAIDS) and the International Organization for Migration (IOM) to promote access to HIV prevention, treatment, care and support services for migrants, mobile populations and people affected by humanitarian emergencies; and to strengthen the engagement of IOM in the AIDS response at global, regional and country level by developing a roadmap, including an action plan with timeline of implementation;
3. *Call* Member States in partnership with communities and civil society organizations and other partners to:
 - a. Strengthen international cooperation in ending AIDS by 2030 to ensure continuum of HIV care and services for migrant and mobile populations by establishing a common data framework, and by producing data on HIV and migration to improve the evidence base relative to the needs of mobile populations;
 - b. Review and remove laws, policies and practices that are barriers to and inhibit the free movement of people living with HIV as well as humanitarian-affected key populations as they seek life-saving healthcare services;
 - c. Strengthen technical support to ensure that national healthcare systems address HIV and co-morbidities among migrant and mobile populations and accelerate quality assured HIV, TB and viral hepatitis treatment and care services;
 - d. In collaboration with national healthcare systems, support communities and civil society organizations in the provision of life-saving and comprehensive HIV prevention, care and treatment services for migrant and mobile populations, including people living with HIV and ensure availability of financial and human resources.
4. *Request* the Joint Programme to report back to the 45th PCB meeting on progress in the implementation of the AIDS response for people on the move.

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1. EXECUTIVE SUMMARY

1. Discussion and dialogue around people on the move have occurred at the United Nations (UN) since at least 1951, when the *Convention Relating to the Status of Refugees* was adopted, and the forerunner of the International Organization for Migration (IOM), the Intergovernmental Committee for European Migration (ICEM) was established to help resettle people displaced by World War II. Fifty years later, the link between migration, population mobility and HIV surfaced in the 2001 *UN General Assembly Declaration of Commitment on HIV/AIDS*. In 2016, the IOM became a related organization of the UN. UNAIDS and IOM first entered into a Cooperation Framework in 1999, which was later revised in 2002 and in 2011. In 2017, IOM and UNAIDS renewed a General Cooperation Agreement to enhance dialogue and cooperation in order to combine and coordinate their efforts. A list of other relevant UN policy documents spanning the period through to 2018 is provided in Annex 3.
2. The 2018 NGO Report to PCB is intended to help renew and focus the dialogue around people on the move so that the 2030 target of ending AIDS as a public health threat can be achieved. It is the NGO Delegation's contribution to support Member States to ensure that mobile populations are covered for services across their origin, transit and destination countries.
3. This report builds on last year's 2017 NGO Report, which clearly showed that mobile populations are over-represented among people living with HIV who are undiagnosed, not on antiretroviral therapy (ART) not virally suppressed—even in countries that have achieved or exceeded the 90–90–90 targets.² Those insights were instrumental in deciding on people on the move as the theme for the 2018 NGO Report.
4. For the purposes of this report, and given the lack of international consensus about key terms like "mobile" or "migrant" populations, people on the move or human mobility is used as a comprehensive term that includes international migration, refugees, people experiencing internal or forced displacement, people moving because of climate change impacts, or labour migrants. This mirrors the definition developed by the International Organization for Migration (IOM), which uses the terms migration and migrant to refer to people moving across an international border as well as within states, and regardless of legal status, willingness, cause or length of stay.
5. This report explores certain key global trends: increasing diversity and complexity of human mobility, the increased prominence of women on the move, the shift in our health paradigm towards a more positive appreciation of development and people on the move, the growing acknowledgement that mobility is not only or even predominantly about crossing international borders but also about internal or in-country population movements, and the resurgence of attacks on human rights and international migration. These trends are having significant impacts in terms of the health and HIV vulnerability of people on the move.
6. It is difficult to ensure continuity of care during the current spike in population mobility. Increased population mobility is confounding traditional approaches to health-care financing, which are still based largely on stable residence, citizenship, occupational category or a family relationships. Mobility can increase exposure and vulnerability to HIV, tuberculosis (TB) and viral hepatitis. In addition, the various legal and regulatory challenges encountered in the process of moving can aggravate health conditions and increase treatment costs, with higher morbidity and mortality as possible outcomes. The

fact that there is a lack of international consensus about the definitions of key terms like migration and mobility only adds to the complexity of these issues.

7. The Delegation collected community experiences and self-reports illustrating key challenges related to mobility and HIV mainly via interviews with people on the move and stakeholders, as well as via survey responses. Interviews were conducted across all the regions represented on the Delegation: Africa, Asia-Pacific, Europe, Latin America and the Caribbean, and North America. The majority of survey participants were employed, with access to health care and with good knowledge of available services for HIV, TB and, to a lesser extent, viral hepatitis. About half self-identified within a key population group. They came from 28 different countries of origin, predominantly Colombia, India, Jamaica, Kenya, Nigeria, the Philippines, Poland, the United States of America (USA), Venezuela and Zambia. Brief quotes from people on the move and from stakeholders appear throughout the report to highlight the issues being discussed.
8. Interviewed people on the move pointed to a range of factors that may result in increased vulnerability to HIV and coinfections. They included language and cultural barriers, fear of requesting/accessing services and being reported to authorities, lack of access to targeted services for people on the move, lack of understanding about the health-care system, poor living conditions, risky behaviours and sexual practices, and lack of access to prevention services.
9. Stakeholders interviewed were engaged in a range of activities, including direct HIV services, policy making, legal support, advocacy and campaigning, research, capacity building, and language classes. The majority stated that they involved people on the move as peers in delivering their activities, including in leadership and management, frontline services, volunteering and research.
10. In general, stakeholders noted similar needs and challenges as those identified by people on the move, including absence of basic protections, difficulties acquiring documented status/legalization, lack of knowledge about HIV and coinfections, lack of awareness about and access to culturally and linguistically competent health-care and other services, difficulties obtaining employment, stigma and discrimination, isolation, poverty, lack of housing, mental health challenges, fear of violence, fear of criminalization/detention and deportation, and trauma.
11. The report indicates several avenues of good practice which, if implemented and scaled up, could give us a better chance of achieving the 2030 targets. These good practices include:
 - the meaningful involvement of people on the move;
 - legal and/or regulatory reforms;
 - capacity building for people on the move and related service providers;
 - development of national health systems and Universal Health Coverage (UHC) that are sensitive to and inclusive of people on the move;
 - ensuring continuity of care;
 - addressing stigma and discrimination;
 - protecting against economic exploitation; and
 - effective responses to the needs of undocumented migrants.

12. The report illustrates these good practices through 12 case studies from Brazil, Canada, China, Germany, India, Kyrgyzstan, Philippines, the Russian Federation, Thailand, USA and Viet Nam.

“Several community agencies and community health centres are doing great work. The most successful ones have staff that reflect the populations they serve.”

– Latino Commission on AIDS, New York City

13. The report notes the lack of data and evidence about links between population mobility and HIV in general and about the needs of specific sub-populations on the move. Without enhancing such an integrated population mobility and HIV evidence base, it is unlikely that lawmakers or health-care planning will become more sensitive and inclusive for people on the move.
14. The report recognizes that there are a significant number of people on the move who belong to key populations in the AIDS response because they are also gay men or other men who have sex with men, sex workers, transwomen and transmen or people who inject drugs. However, other people may have a claim to be considered as key populations, including people imprisoned and kept in closed settings such as detention centres or camps, people with "illegal" or undocumented status, or because a specific country may have so designated them internally based on the national epidemiological and social context.
15. Finally, the report presents recommendations based on the following conclusions:
- The relatively recent increase, acceleration and diversity of human mobility is aggravating the HIV vulnerability of people on the move;
 - Mobile populations face significant obstacles in accessing HIV and coinfection services;
 - Mobile populations, many of whom belong to key populations, are in danger of being left behind in the AIDS response; and
 - There is a range of innovative and scalable good practices for advancing HIV and related services among mobile communities.

2. INTRODUCTION

“I wish other countries would accept us without denying our basic right to health.”

– Carlos, MSM migrant, Venezuela

16. The NGO Delegation at the UNAIDS Programme Coordinating Board (PCB) prepares a report annually on some area of the AIDS response that needs a higher profile, a more focused policy perspective and a clearer sense of intention and agreement across the UN Joint Programme on HIV/AIDS. For 2018, the NGO Delegation’s report focuses on the HIV response specific to mobile populations as a key to achieving the 2030 target of ending the AIDS epidemic. The report aims to:
- **provide a better understanding** of (1.1) how population mobility is related to increased HIV vulnerabilities; and (1.2) how the HIV vulnerabilities of mobile populations are a serious threat to the global commitment to ending AIDS by 2030;
 - **illustrate good practices** in addressing HIV vulnerabilities related to population mobility; and
 - **recommend** how Member States and the Joint Programme can improve their approach in addressing the HIV vulnerabilities of people on the move.

17. The report builds on past decisions taken at the international and UN levels. Within five years of the constitution of the World Health Organization (WHO) and three years after the UN General Assembly adopted the *Universal Declaration of Human Rights*, Member States agreed one of the first international policy documents on population mobility and migration: *The Convention Relating to the Status of Refugees* (1951), followed by several other relevant conventions and General Assembly decisions. In 2008, the PCB issued its *Report of the International Task Team on HIV-related Travel Restrictions*. Since then, the PCB has continued to take other decisions on HIV and mobile populations. Annex 3 provides a brief overview of the existing policy framework among UN Member States.
18. This report surveys existing evidence and community perspectives on the issue to inspire an urgency for implementing concrete actions to address vulnerabilities. The situation is already too serious and desperate for far too many people on the move, especially those who are living with HIV or who belong to key populations. Only with urgent action will Member States be able to achieve the 2030 goals and targets of the Sustainable Development Goals (SDGs).

Methodology and limitations

19. The report is based on an extensive literature review of over 150 documents. The literature review is complemented by 27 interviews or personal testimonies from people on the move, many of whom were also engaged in service provision. In addition, there were 83 survey responses. The surveys were conducted in English and Spanish in various locations around the world.
20. Given the importance of the African context for the AIDS response, a separate focus group was conducted there involving 15 stakeholders. The report also collects 12 good practice case studies from Brazil, Canada, China, Germany, India, Kyrgyzstan, Philippines, the Russian Federation, Thailand, USA and Viet Nam. We hope these and other good practices can be replicated and scaled up elsewhere. The report then highlights key conclusions and recommendations.
21. The interviews, focus groups and surveys were used for gathering *qualitative* data. This methodological approach is commonly used to explore participant views, experiences, reasoning and motivations. The goal of this approach was to deepen the understanding of population mobility alongside descriptions available in the literature review.
22. The methods used in this report are not meant to provide *quantitative* data or to be predictive in any way. There is no intention to produce measurements or numerical data or statistical analysis. Nor does the report provide any quantification of attitudes, opinions and behaviours in order to generalize its results to a wider population of civil society or people on the move at large. Instead, this report is based on a literature review and qualitative data, as noted above.
23. This report is not an exhaustive study of the hugely diverse area of global human mobility. Nor is it meant to be a final statement in an area that is still swiftly evolving and which still requires further in-depth quantitative and qualitative research. Instead, the report, along with its conclusions and recommendations, is based on the work and priorities of many researchers, community activists, mobile people and other stakeholders from around the world. As such, it is an appropriate input from the NGO Delegation whose role is to bring the voice of communities at the HIV frontline to the PCB meeting.

A word about definitions

24. There is no internationally agreed definition for the terms "mobility" or "migration" or "migrant". Mobility is sometimes seen as the general process of human travel in pursuit of a better life while migration is regarded as a legal or administrative term referring to the crossing of geographic boundaries or borders. Until relatively recently, migration referred to the process of leaving one's country of origin or birth to go to another country for a new life or livelihood.
25. For example, UNHCR notes that refugees are people fleeing armed conflict or persecution, and that this group is defined and protected in international law; UNHCR also sees migrants as people who choose to move not because of any direct threats, but mainly to improve their lives.³ Drawing on these UNHCR definitions, for example, a gay man living with HIV moving from Hungary to Germany within the European Union in the course of finding a job would seem to qualify as a migrant even though that person left Hungary because he felt unsafe within the current political climate in Hungary, and his quality of life and safety would deteriorate substantially if he returned—is this person a refugee or a migrant?
26. Population mobility occurs within countries for many of the same reasons as cross-border mobility, for example to seek work, escape conflict or avoid prejudice. However, as with international migration, the extent of in-country mobility has increased significantly in the recent past, and it sometimes overlaps with cross-border mobility. As a result, while there may have been clearer distinctions between international migration and in-country mobility, the situation is no longer simple and traditional definitions may not easily fit the contemporary reality. In effect, strict adherence to our traditional definitions runs the risk of leaving certain people behind.
27. The IOM has produced a definition of migration that is more comprehensive than the traditional definitions. Covering both international and in-country movement, it refers to a migrant as:
"any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is".⁴

The NGO Delegation sees this IOM definition as an example of the kind of inclusive rethinking that we urgently need.
28. This NGO Report does not presume to resolve these definitional conflicts. Nevertheless, for the purposes of this report, and given the lack of consensus about many key terms, people on the move or human mobility are seen as a comprehensive concept that includes international migration, refugees, people experiencing internal or forced displacement, people moving because of climate change impacts, or labour migrants. This mirrors the IOM definition, which uses the terms migration and migrant to refer both to people moving across international borders as well as within states, regardless of legal status, willingness, cause or length of stay. It also builds upon the language of the 2017 General Cooperation Agreement signed between IOM and UNAIDS.
29. **This report therefore uses people on the move or mobility as generic terms, referring to the all-encompassing phenomenon of human movement.** It also discusses subgroups of mobile populations, using more specific terms such as international or internal or cross-border migrant, refugee, asylum seeker, IDP, etc.

2017 General Cooperation Agreement between the Joint United Nations on Programme on HIV/AIDS (UNAIDS) and the International Organization for Migration (IOM)

Common Goals:

- To pursue the continuity of HIV prevention, treatment, care and support and to providing a package of care for people living with HIV, tuberculosis and/or malaria in humanitarian emergencies and conflict settings, as displaced people and people affected by humanitarian emergencies face multiple challenges, including heightened HIV vulnerability, risk of treatment interruption and limited access to quality health care and nutritious food
- To promote the development of and access to tailored comprehensive HIV prevention services for all women and adolescent girls, migrants and key populations
- To encourage States to address the vulnerabilities to HIV and the specific health-care needs experienced by migrant and mobile populations, as well as by refugees and crisis-affected populations, and to take steps to reduce stigma, discrimination and violence, as well as to review policies related to restrictions on entry based on HIV status, with a view to eliminating such restrictions and the return of people on the basis of their HIV status, and to support their access to HIV prevention, treatment, care and support.
- To combat sexual and gender-based violence to the greatest extent possible, by, inter alia, providing access to sexual and reproductive health-care services and tackling the multiple and intersecting forms of discrimination against refugee and migrant women and girls.

The concrete areas for dialogue and cooperation of the agreement are:

- *Advocacy and Policy Advice*: to promote integration of human rights and the needs of migrants and displaced persons into national and regional HIV responses and strategies, to promote universal access of migrants to HIV prevention, treatment, care and support; to enhance social protection for migrants affected by HIV by promoting a range of social services to protect vulnerable migrants, and to stop violence against migrant women and girls; to remove punitive laws, policies, practices, stigma and discrimination related to HIV and population mobility that block effective responses to AIDS; to ensure HIV/AIDS and health-related priorities for migrants and refugees are well addressed in global health, migration, sustainable development and foreign policy processes.
- *Capacity-Building and Programmatic Support*: to provide guidance to strengthen relevant technical support at the global, regional and country levels for appropriate national AIDS responses which facilitate and promote equitable migrant access to comprehensive HIV services, regardless of migration status; to assist in building capacity of governments, regional institutions and civil society to reduce HIV vulnerability among mobile and migrant populations, including addressing social determinants of health.
- *Research and Dissemination of Best Practice*: to strengthen understanding of HIV and population mobility to inform and mobilize governments and stakeholders to promote the health of migrants and host communities; to improve country-by-country strategic information

generation, analysis and use of data on the health of migrants and displaced persons to ensure evidence-informed HIV policies and programmes; to produce strategic analyses of HIV programmes which include mobile populations to improve results-based implementation, and to identify, document and promote best practice.

3. LITERATURE REVIEW

Global trends in population mobility

30. There are strong indications that mobility can increase vulnerability to HIV and its coinfections, both for people on the move and their partners. There is evidence that areas of high mobility such as high-volume transportation routes and border regions correlate with higher rates of infection.⁵
31. About 1 billion people are on the move globally, roughly a quarter billion of them internationally and three times as many internally within states. This mobility is not unidirectional: people move back and forth, and they move from South to North and from South to South. For the sake of comparison, there were almost as many mobile people globally in 2017 as the entire population of India (1.3 billion). It is impossible to predict the extent or patterns of mobility 5-10 years from now. But population mobility is clearly a very significant phenomenon: such massive movements of people have wide-ranging consequences, not least for their health.
32. This report identifies five major trends in population mobility:
 - increasing diversity and complexity of human mobility;
 - "feminization of migration";
 - new health paradigm;
 - new approaches to thinking about mobility; and
 - challenges to globalization.
33. The report then explores the consequences or impact of these trends on HIV and coinfection vulnerabilities.

Trend 1: Increasing speed, volume, diversity and complexity of human mobility

34. Population mobility is as old as the human race and it continues to this day. Mobility is a fundamental and enduring aspect of who we are as humans, central to the human desire to choose how and where to live, and it has been essential for commerce and development. The study of human history shows how humans moved from Africa to populate the rest of the earth. The earliest population movements of *homo erectus* from Africa could have started as early as 2 million years ago, continuing to about 30 000 years ago.⁶ Ancient texts provide evidence of human mobility throughout human history, as people fled persecution, disasters or oppression or to seek food security.
35. In recent history, infection control quarantine and travel restrictions were already in use as disease prevention as early as the 14th century in Italian seaports. The infamous slave trade from Africa was an example of what today may be termed "human trafficking", though on a massive scale. The 19th and 20th centuries provided several examples of recent colonisers and settlers scattered across many parts of the globe.
36. In addition to common reasons for moving, such as seeking professional and economic opportunities or family reunification, people increasingly are being forced to move to escape conflict or because of climate change or dwindling natural resources, violence,

persecution, political oppression, economic collapse, environmental and human-induced disasters, food insecurity or famine.

37. Recent examples include people fleeing the conflict in eastern Ukraine, now in its fifth year, or crossing the Mediterranean and to reach Europe. In South America, there is significant movement internally within the region: Argentina, Brazil and Chile attract the majority of such people on the move. Large numbers of people are fleeing Venezuela and moving to neighbouring countries such as Brazil and Colombia.
38. In 2017, there were 30.6 million new population displacements as a result of conflict and disasters across 143 countries and territories. The ten most affected countries were China, the Philippines, Syria, the Democratic Republic of the Congo (DRC), Cuba, the United States, India, Iraq, Somalia and Ethiopia, each accounting for more than one million new displacements.⁷
39. There were complex humanitarian emergencies in the DRC, Somalia, South Sudan, Yemen and Venezuela, with significant societal and economic breakdown. In Myanmar, over 1 million Rohingya were displaced. Long-term political unrest at national borders has created difficulties for large numbers of people such as in Kashmir at the India-Pakistan border, or the Tibet-China border, or the Israel-Palestine border. Colombia faces a major displacement crisis with over 7 million registered internally displaced people while an additional 350 000 Colombian refugees are in Costa Rica, Ecuador and Panama. The number of asylum applications from El Salvador, Guatemala and Honduras in 2017 was 1,500% higher than in 2011. Mexico's drug cartel violence is also resulting in significant internal and external displacement.⁸
40. In such situations, there is little space for discussing people's health. Specific to the topic of HIV, there are people on the move because of their HIV or TB status or sexual orientation, who are fleeing stigma and discrimination or moving to where they may access better HIV or related health-care services. Examples abound, including in the Middle East and North Africa, which is experiencing enormous social and political unrest and which includes 3 of the 10 countries most affected by population displacements (Iraq, Somalia and Syria).⁹ A majority of the countries in that region criminalize same-sex relations, with 7 of them allowing for the death penalty. Yet there is an emerging concentrated epidemic among MSM in the region, most obviously in Lebanon where an estimated 50% of HIV infections are associated with MSM activity. Countries such as Lebanon have become something of a haven for lesbian, gay, bisexual and transgender refugees from Algeria, Syria and other states in the region.¹⁰

"The only reason I decided to move to Brazil was not about accessing a new job or way of life – I knew the economic situation at that time was bad for Brazilians too – but there I could access my ARV medicines."

– Jose, MSM migrant, Haiti

41. Human mobility is an historical constant. But it is now happening more quickly, in greater numbers and including more diverse populations. Management of population mobility has become much more complex. We are witnessing an interaction of many forces, especially globalization and forced internal or international migration. Our existing migration systems and regulations seem unable to keep pace effectively with these challenges.

Trend 2: "Feminization of migration"

42. Although widely in use, the concept of the "feminization of migration" can be misleading since it may imply that women and girls now outnumber men and boys among migrating populations. This may be so for certain regions and countries, as it has historically in some places.¹¹ Such feminization is evident visible in southern Africa currently, where over two thirds of cross-border traders between South Africa and Mozambique or Zimbabwe are women. In Australia and North America, women for decades have outnumbered men among people on the move.¹²
43. At the global level, however, the proportion of people on the move who are women has stayed relatively stable in the past several decades, at a little 50%. The UN's *International migration report 2017* notes that 48% of international migrants were women, though they outnumbered male migrants in many regions (though not in Africa and Asia). Women make up slightly more than half of the migrants in high-income countries and slightly less than half in low- and middle-income countries. So the feminization of migration at the global level does mean women constitute a growing proportion of people on the move. Rather it refers to ways in which women move independently of men and the related new challenges they encounter, including vulnerability due to lack of recognition of domestic work and sex work, the pressure of being the breadwinner, isolation and separation from their children and families.¹³
44. With the feminization of poverty, women in less rich countries are under increasing pressure to provide for their families and to enter the wage-earning labour force as breadwinners. At the same time, there is a growing demand in many labour markets (particularly in high-income countries) for caregivers, especially female caregivers. Governments in high-income countries have responded by making it easier for women from abroad to obtain entry visas on their own to work as domestic workers, maids, entertainers, nannies and day-care workers for the young and the elderly.
45. There are currently about 11.5 million people on the move globally who work as domestic workers, an estimated 73% of whom are women. Male domestic workers, mostly in the Arab states and parts of southern Asia, they tend to work as gardeners, drivers and security guards. However, some 80% of domestic workers globally are concentrated in high-income regions, especially the Arab states, North America and western Europe. In the Middle East and North Africa, significant numbers of people move from north-eastern Africa to Gulf states as migrant labourers. In Qatar and the United Arab Emirates, migrants make up 90% of the labour force. The trafficking of women is also increasing in the Middle East and North Africa, including in Sudan, Syria and Yemen.¹⁴ It is worth noting, however, that only 25 countries have ratified the ILO's "Convention C189 – Domestic Workers Convention", none from North America or the Arab states.
46. Remittances from females on the move are vital for financing and supporting local development in their places of origin. Women tend to remit larger proportions of their earnings and do so more frequently and sustainably than men. This reinforces the changing role of women as family breadwinners even though their caregiving occurs abroad.
47. Women also move for non-economic reasons, for example to seek greater personal freedom and opportunity. They may be fleeing abusive relationships and/or domestic violence, or trying to escape the cultural or patriarchal obligations that are imposed on married or unmarried women, single mothers or widows. Women, children and the elderly comprise about 80% of asylum seekers and refugees fleeing persecution or violence.¹⁵ Gender-related causes are seldom accepted as valid grounds for the granting of refugee status.

48. Women on the move encounter persistent forms of gender inequality. Certain female-dominated occupations are excluded from visa schemes and there may be prohibitions on employment of migrant women in certain male-dominated occupations. Accepted definitions of what constitutes work may result in excluding these women from legal protections. There are examples of sex-discriminatory mandatory testing for pregnancy, HIV or other infections, without consent. Women fall prey to gender-based violence. They may also have inadequate access to healthcare in the destination countries.
49. Mobile women are especially prevalent in domestic/care work and the entertainment sectors. This reinforces traditional sexual divisions of labour, with women working as predominantly as caregivers or serving the entertainment needs of men. As a result, one of the main opportunities for women on the move is the largely unprotected and unregulated field of "private sector" domestic work, which can involve significant exploitation. In addition, it can produce a "care drain" in countries of origin where skills associated with domestic work may not be valued or remunerated to the extent as in high-income countries that have ageing populations which depend on such skills.
50. Mobility provides different opportunities and challenges to women as distinct from men, including specific human rights abuses, exploitation and health risks. Females on the move face unique vulnerabilities and risks of abuse and sexual violence, including rape. Population mobility is not gender-neutral. Yet migration law and policy continue to be cast in outdated male categories, even though women are increasingly visible and major components of population movements.

Trend 3: New health paradigm—linking development and people on the move

51. A recognition of the linkage between human mobility and development has been growing for over four decades, at least since the World Population Conference in Bucharest in 1974. That event and subsequent conferences have noted the contributions of migrants to development and highlighted the need to respect the human rights of international migrants and uphold labour standards for migrant workers, and the impact of the "brain drain". These discussions continued at the 1994 International Conference on Population and Development held in Cairo, the 2006 High-Level Dialogue on International Migration and Development (the first UN summit to focus on international migration), and the 2013 High-Level Dialogue (in effect the second UN migration summit). A third summit is planned for 2019.
52. Despite these discussions, there was limited direct reference to migration or mobility in the Millennium Development Goals (MDGs). Nevertheless, many elements of the MDGs had strong links with the wider discussion about the relationship between development and mobile populations: for example, Goal 1 on poverty reduction; Goal 3 on gender equality; Goal 6 on prevention of HIV/AIDS, malaria and other diseases; Goal 7 on environmental sustainability; and Goal 8 on global partnership for development.
53. Population mobility features more prominently in SDGs and its targets, for example in relation to retaining the health workforce in developing countries, eradicating human trafficking, protecting labour rights of workers on the move, reducing transaction costs of remittances, and disaggregating data by migration status.
54. The SDGs not only recognize rights and vulnerabilities of people on the move, they also recognize their contributions and the social benefits of population mobility. The SDGs exhibit the paradigm shift in our understandings of the links across mobility and development. As a result, the need to normalize and manage human mobility as a constant and for the benefit of all—not simply as a threat to origin and destination countries—has moved to the fore. People movement becomes a positive means to

ensure sustainable development. This shift is perhaps most sharply stated in SDG 10.7, which calls on Member States to "facilitate orderly, safe regular and responsible migration". That call is at the root of the emerging Global Compact on Migration to be adopted by the UN General Assembly later in 2018.

55. In the New York Declaration for Refugees and Migrants in 2016, UN Member States committed to developing a compact for safe, orderly and regular migration. This Global Compact on Migration is still in development: a "zero draft" was produced in February 2018 and the final document is to be adopted at a High-Level Meeting in the Middle East and North Africa region (Morocco) in December 2018. It is expected that the final document will reinforce the paradigm shift of recognizing that population mobility can benefit states and people on the move.
56. While the Global Compact will not be legally binding, the preamble of the "zero draft" reinforces relevant international norms and laws, including those addressing human rights, against organized crime and trafficking, ILO conventions on decent work and labour mobility, and the SDGs. The Compact is also expected to include actionable commitments on a range of topics, such as disaggregated data gathering, reducing migration vulnerabilities, combating trafficking, and creating conditions for migrants to fully contribute to sustainable development. It is hoped that the Compact will follow the "zero draft" by specifying the need to provide information to all migrants, regardless of their status, on their right to health and how to access basic social and health services.
57. It is not clear whether there will be a clear commitment to extend UHC to people on the move or ensure their access to reproductive health services, including for STIs such as HIV. One limitation in the proposed Compact seems very likely: it will only address migration in the narrow sense of legal or documented *international* migration. Wider discussions of mobility and internal migration will very probably not be addressed in this Global Compact on Migration.

Trend 4: New approaches to thinking about mobility

58. As noted, the lack of shared definitions of mobility poses a challenge for understanding and addressing the links between mobility and HIV risk. Different studies are based on different definitions and yield ambivalent or even contradictory conclusions.¹⁶ This variation is also visible in how we understand the variety of people on the move; Annex 4 (below) provides descriptions of 14 different categories or modalities of people on the move.
59. It is difficult to provide robust statistical public health evidence or consistent correlations linking population mobility and HIV risk or infection. Recent thinking suggests that the study of this area, especially regarding links between mobility and HIV vulnerability, should involve collaboration and use of research methodologies associated both with public health and with mobility and migration studies. These methods need to address specific behavioural patterns and reasons for moving, specific kinds of mobility, and specific contexts or locations, including the background HIV prevalence rates and extent of overlap in sexual networks. New thinking on population movement and HIV risk will need to be more specific and inclusive of several key strands: who is moving, how they are moving, why they are moving and the origins or destinations of their movements.

Trend 5: Challenges to globalization

60. In Trend 1, we noted that globalization is a key driver of the recent expansion in population movement. However, as challenges to globalization continue, international migration is also facing growing opposition. Immigration is again being seen in an

increasingly negative light by growing numbers of people, who believe it undermines national identity, increases competition among citizens and exacerbates pressures on existing state resources and capacities. It is as if a backlash has occurred against the late-20th century ideal of "thinking globally, acting locally" by pitting the local against the global.¹⁷ This is fuelling new waves of populist nationalism in contemporary politics, a key element of which is anti-immigrant. This backlash is accompanied by a distrust of political and economic authorities and experts that had promoted globalization, including national political parties, the International Monetary Fund, the World Bank, the G7 nations, and more.

61. The anti-globalization perspective emphasizes the role of the state in maximizing the welfare of its own citizens. However, the movement sees the growth of international finance and free trade precisely as a danger to the welfare of its citizens. There has been a pre-existing tension between the internal legitimacy of states based on their citizens versus the need for states to more and more look externally to meet the needs of those very citizens. In this context, there is little room to address concerns about people on the move who are not citizens, their health or their HIV vulnerability.
62. The benefits of globalization are distributed very unevenly and have been shadowed by numerous setbacks.¹⁸ Disadvantages have included job losses, depressed wages, increased "brain drain", aggravated racial and cultural tensions, intensified competition for skilled migrants, tensions between local and international workers or other people on the move, farmers pushed off their lands, and rollback of the welfare state. All these factors also function as drivers of further internal and international mobility. Debates around globalization have not yet been effective in producing policies that include and support people on the move.
63. The anti-globalization and anti-immigrant currents—and their local/global dichotomy—reinvigorated in many parts of the world. However, it is unclear whether this constitutes a watershed leading to a long-term retreat from "thinking globally" and towards enduring and rigid nationalism and protectionism. If so, it will add further negative consequences for people on the move, including even more restrictive migration policies, arrests and deportations, often in violation of human rights and international norms.

"In Italy, the migrant issue is now considered an "emergency" and there are many movements against their presence in the country. There have been quite a few episodes of physical offence (also with guns) towards migrants and black people, real episodes of racism. The law is quite protective of their rights, but in reality things work out differently."
– LILA Milano

Key health impacts and HIV vulnerabilities

64. The links between human mobility and HIV vulnerability are complex. Mobility can impact health and HIV vulnerability. Some people may move precisely to ensure for themselves better HIV care and support or to escape stigma and prejudice: they may move away from their families and communities to be closer to HIV specialists elsewhere, or they may move closer to their families to ensure better care and support. On the other hand, some move to flee conflict, persecution or poverty only to then face conditions that place them at increased risk of contracting HIV. They may lack access to HIV prevention information, tools and services; they may have unprotected sex with partners from countries with a high prevalence of HIV infection; or they may be exposed to sexual violence.

65. This report now groups the major impacts of mobility on health and HIV vulnerability under four headings: continuity of care (the care continuum); financing health care; HIV and coinfection risk environments; and stages of the mobility process itself.

Impacts on continuity of care

66. The HIV care continuum refers to a process spanning HIV testing and diagnosis, engaged in treatment and care services, initiating ART, and achieving and sustaining viral suppression. Being on the move can significantly affect this continuum, by facilitating or undermining any of the four main stages of the continuum.
67. All the standard issues related to continuity of care for HIV and its coinfections are similar but more challenging and complex for mobile populations. In the southern African region, which has the highest HIV and TB prevalence in the world, an estimated 10 million people are on the move, not including undocumented migrants.¹⁹ Such levels of mobility pose challenges. For people living with HIV, especially those receiving ART, there are often obstacles to maintaining effective engagement with the health-care system or accessing a stable supply of antiretroviral drugs. People who have not acquired HIV may not know how to access prevention information and tools, or HIV prevention and testing services. Being on the move may result in delays in accessing HIV testing and diagnosis, no longer having the same level of medical insurance or service that was provided in one's home country, and new cultural and language barriers.
68. Mobility can also complicate access to a new health-care system if the system is not inclusive of or sensitive to people on the move or is not based on the principles of UHC. It has not been built in a way that integrates and provides sustainable service provision for people on the move and it does not have service-providers and structures that are inter-culturally and linguistically competent. Examples include health services that people on the move do not understand or cannot navigate on their own; discrimination against mobile populations, including those from key populations and/or people living with HIV; and fear of disclosure of HIV status. When people on the move are unfamiliar with local languages, they may be less likely to seek help to manage a medical condition, which puts their health at risk.

"We face violence, being homeless, stigma and discrimination, and HIV. Migrants should have somewhere they can go to get help like food or a place to stay and access to healthcare. Government, civil society/NGOs should put systems in place to help migrants."

– Lorenzo, MSM and migrant living with HIV, Jamaica

69. Access to documentation is one of the biggest challenges for mobile people, particularly those who are of irregular status. Government services typically require proof of identity or residence before providing services; access to services for people without the necessary documentation therefore is poor. Many people will therefore avoid going to services because they fear that their failure to produce requested documentation could result in them being detained or deported.
70. People living with HIV and/or a coinfection face specific challenges to avoid interrupting their HIV or other treatment. Evidence indicates that the more one is on the move, the higher the chances of not adhering to a treatment regime, usually due to barriers in accessing treatment or other services in a new health system or health-care setting. Treatment initiated in one country or location needs to be continued while on the move or

in another location. In India, research indicates that internal migration is linked to one quarter of all people being lost to TB treatment and follow-up.²⁰

71. Various vulnerable populations face specific challenges when trying to remain in treatment and care. For example, nomadic pastoralists experience particular TB risks associated with their traditional lifestyles, for example animal husbandry, drinking unpasteurised milk or living in poorly ventilated or over-crowded conditions. Similarly, the living and working conditions of refugees and internally displaced persons (IDPs) aggravate their health risks. HIV stigma in health-care systems is known to undermine continuity of care. HIV stigma as a barrier to continuous health care was observed in Thailand where a health-care provider survey revealed that some health-care providers explicitly stated they would prefer not to provide services to migrants.²¹
72. Barriers to negotiating the care continuum can contribute to people on the move presenting with advanced health problems, achieving poor treatment outcomes, experiencing high morbidity and mortality rates, and involving high costs to health-care systems. Chronic health conditions such as TB and HIV require optimal treatment adherence to reduce the risk of transmission and drug resistance. Access to and continuity of care for mobile populations are crucial if HIV and coinfection vulnerabilities are to be effectively addressed. Possible solutions that have been identified include mobile clinics, community health centres, and networks of health volunteers who are themselves from mobile populations.

Impacts on financing of health care

73. Accurate, disaggregated data are essential for effectively planning and financing public health interventions for HIV, hepatitis B and C, and TB, as well as for ensuring adequate medical supplies and equipment are available. The information needs to be gathered from a variety of sources and should cast light on migration flows, the extent of access to services for people on the move, structural discrimination against mobile populations, burdens of HIV and coinfections among specific mobile populations, and the wider benefits of addressing the health needs of people on the move.
74. Turkey, for example, hosts almost four million refugees from Syria, as well as from Iran (Islamic Republic of), Iraq, Somalia and Afghanistan.²² Up to 40% of the capacity of hospitals along the Turkish-Syrian border is devoted serving refugees and health services in some wards are severely strained. Female refugees have been noted to receive poor antenatal care. A recent study of HIV risk among refugees in Turkey noted a need to improve resources in several key areas, including housing, shelter and security; basic needs support; cash assistance; and livelihood opportunities. Nevertheless, even though there is increasing population mobility and health-related information, there is simultaneous acknowledgement of significant limitations and gaps in funding.²³
75. In order to plan and finance the response to the health-care concerns of the large variety of at-risk people on the move, there needs to be models for estimating the sizes of various sub-populations. Without such information, it would be impossible to accurately determine how many HIV rapid tests should be provided how many clean needles should be available, or how many workers should be deployed to reach specific groups. However, representative data gathering and analysis—and service provision—can be very complicated.²⁴
76. There are several approaches for gathering more accurate data on the wide variation in movement patterns and groups. One involves not simply relying on a single method of acquiring the data, but using a combination of methods for assessing sub-population

size. Human mobility and the HIV epidemic are in constant flux. Size estimations should be done quickly to tally people while they are in one location while ensuring they are not double-counted in different locations. Sex workers may only work in certain locations at specific times, or they may regularly cross borders to work in one location and return home. In such cases, estimates could mistakenly count the same sex workers twice, thus yielding inaccurate data. A good understanding of sex work is needed therefore to achieve an accurate count.

77. Estimating population sizes and gauging the health-care needs of other highly mobile groups such as nomads, undocumented migrants or Roma can involve even greater challenges. It is therefore often necessary to use proxy definitions for groups of vulnerable people on the move based on specific group characteristics that may be linked to HIV risk (e.g. occupations or frequently visited entertainment sites or accommodation).
78. When it comes to financing health-care, there is an assumption that people on the move, especially asylum seekers, place heavy economic burdens on countries, including on their health systems. However, a recent study on the "migrant crisis" across 15 European countries has shown that any additional public expenditure is more than compensated for by an increase in tax revenues as asylum seekers become residents.²⁵ There are certainly significant challenges in coping with large inflows of people to Europe, at national and regional levels. However, acknowledgement that the so-called "migrant crisis" may actually turn out to be an economic opportunity, could facilitate a more positive political approach to addressing these problems. An earlier report by the European Union Agency for Fundamental Rights made similar findings. It noted that: "providing access to healthcare to migrants in an irregular situation would not only contribute to the fulfilment of the right of everyone to enjoy the highest attainable standard of physical and mental health, but would also be economically sound. Obligations deriving from an inclusive interpretation of international human rights law would thus be supported by economic arguments."²⁶
79. The research specifically focused on access to hypertension and prenatal services, so further research would be needed on the financial implications of providing treatment to people on the move for other conditions. Early detection and treatment are certainly cost-effective, so addressing the health-care needs of mobile populations sooner than later makes good economic and political sense.
80. A diversity of approaches exist for financing health-care services for people on the move and their families, e.g. based on residence, citizenship, occupational category, family relationship to someone with health insurance, etc. In China, Hukou, access to government services is linked to residential registration at a specific location. However, with increasing population mobility in China, millions of rural-to-urban internal migrants do not qualify for public medical insurance and assistance programmes at their new location where they do not have registered resident status. Botswana has among the highest levels of HIV viral suppression in the world, with free ART for all citizens living with HIV. However, non-citizens are not eligible for ART coverage.²⁷
81. On the other hand, there are also several examples where countries provide care and treatment in medical emergencies and/or for communicable diseases regardless of legal status or having medical insurance. Most countries in the European Union provide TB treatment for the benefit of the public health; in the United Kingdom there is free HIV care and treatment for anyone regardless of their legal status in the country. In Brazil, the frontier is open to mobile populations, including people living with HIV, with clear guidelines around confidentiality, care, treatment and support.

82. Concerns about HIV and international migration have a long history in south-eastern Asia (Indonesia, Malaysia, Philippines, Singapore and Thailand), especially with respect to the movement of workers (e.g. entering Thailand or returning to the Philippines). In Thailand, these migrants comprise less than 10% of the population, whereas in Singapore they make up almost half of the population. As a result, these five countries have health schemes that cover such mobile populations in different ways, with Thailand having gone the farthest in not only realizing UHC for its citizens but also for documented migrants.²⁸
83. Thailand has a health financing model that is primarily tax-based: employed individuals are covered via payroll taxes, while the rest of the population is covered through general taxation. Thailand's Compulsory Migrant Health Insurance scheme (2001) is administered by the Ministry of Public Health and is available to all international migrants; it previously included undocumented migrants, but no longer does so. The system is not perfect and could be improved to allow more people on the move to enter it (e.g. increased portability within the country, payments by instalment or relaxed identity checks at hospitals).
84. It seems clear that if we are to develop effective response to the HIV and coinfection vulnerabilities of people on the move, we need to develop more effective methodologies for studying them. In addition, we cannot continue thinking about health finances based on assumptions that populations remain stable. We need to appreciate the reality of increasing human mobility and develop systems of health financing that respond to that reality.

Impacts resulting from risk disparities

85. Risk disparities can be grouped into three categories: those resulting from belonging to one or several key populations, those resulting from moving across different zones of HIV prevalence, and those related to the varieties of health systems encountered.
86. Key populations are at higher risk of contracting HIV. This vulnerability can be further increased when on the move. Mobility may result in criminalization, economic precarity, and social isolation and marginalization. That in turn may restrict key population members' access to prevention commodities and services and increase their vulnerability to sexual violence, coercion and pressures to engage in risky sexual and injecting behaviour.
87. At east African cross-border sites, certain mobile populations are at particular risk of acquiring HIV, particularly female sex workers, gay and other men who have sex with men (MSM), people who inject drugs, young women, and truck drivers. In some but not all situations, the most effective HIV prevention activities among these groups target the venues where behaviours associated with high HIV prevalence are common (e.g. sex work locations or where alcohol is consumed).²⁹ Nevertheless, significant gaps exist in accessing and using condoms and lubricants, or seeking treatment for symptoms of sexually transmitted infections. These gaps need to be addressed.
88. In the Caribbean, population movement has been constant for at least two centuries. People move for the usual reasons, including poverty or to seek employment, and they tend to move from lower- to higher-income countries in the region, with or without documentation. In addition to the usually identified key populations, cross-cutting HIV risks link youth with mobility. Young, undocumented people on the move, with limited livelihood options, may engage in sex work under exploitative work conditions and face barriers to asserting safe sex practices. MSM move across the region to secure

anonymity and safety which can result both in higher self-esteem as well as increased sexual risk-taking.

"In our settings, adolescent girls and young women, are like sex toys in internally displaced camps or shelters. Young men and boys as well survive as sex objects to sugar mummies and other men in the neighbourhood"

– Uganda Youth Coalition on Adolescent Sexual and Reproductive Health Rights and HIV

89. Among people who inject drugs, mobility may result from several factors, including drug availability, legality, price and quality. In Tijuana, Mexico, which lies on the border with the USA, "drug tourism" from the USA to the city seems common.³⁰ There is a high potential for cross-border transmission of HIV, highlighting the need for strengthening HIV services on both sides of the Mexico-USA border.
90. The HIV epidemic among people on the move from other parts of Europe and elsewhere to the European Union/European Economic Area is largely driven by ongoing HIV transmission among MSM, mostly acquired after arrival.³¹ For example, HIV-positive people who have moved from Latin America and the Caribbean make up a growing proportion of HIV cases in the European Union/European Economic Area region. Among those from Latin America and the Caribbean, it is estimated that more than half (53%) of the HIV cases were MSM. MSM also made up 84% of reported HIV cases among people coming from South America and 46% from those coming from the Caribbean.
91. MSM often move to larger urban areas in pursuit of more acceptance, more opportunities to find sexual partners, and an identifiable gay community. Such movement may mean heightened HIV risk. Taking New York City as an example of one such attractive destination for MSM, a recent study suggests that more recently-arrived MSM (within the previous 2–5 years) are at higher risk of unprotected sex and heavy alcohol use.³² Another study by CARAM Asia noted that MSM on the move in the region are vulnerable to rape and gang rape, which they are often afraid to report since it would entail an admission of engaging in homosexual acts. It is extremely problematic to access services at home if returning to a conservative religious country like Pakistan, Bangladesh, Sri Lanka, or the Philippines.³³
92. Another study assessed HIV risk for mobile transwomen living in Lima, Peru, but born elsewhere. It found that the transwomen, especially younger ones, exhibited many high-risk behaviours for HIV and rectal STIs.³⁴
93. In a 2018 briefing paper of the Global Network of Sex Work Projects, three key reasons were identified for sex worker mobility: escaping punitive laws, escaping stigma and prejudice, and pursuing better incomes and living standards.³⁵ The vast majority of mobile sex workers interviewed for the report in Spain (90%) reported moving there for a better life. Many of them regularly sent money home to support their children. Due to criminalization and stigma, sex workers in many countries are vulnerable to abuse and violence, including at the hands of police and their clients. This situation is aggravated for mobile sex workers, whether documented or undocumented, who may also face the added risks of not being entitled to access health services and of deportation. A recent study from the Middle East and North Africa on Syrian sex workers in Turkey noted that this group was largely "invisible" and had little awareness of the existence of health-care centres that offered anonymous testing and counselling.³⁶
94. While various populations experience HIV risk differently depending on their key population status, there are also clear risks associated with moving between locations

that vary in HIV prevalence. Global disparities in prevalence will continue to impact both source and destination countries regardless of their separate national health programmes and policies, but may burden source countries more when mobile people are deported home because of HIV or TB infection. The Global Fund represents an attempt to address this challenge in an integrated way across TB, malaria and HIV, while taking into account the variety of challenging operating environments.³⁷

95. People on the move are recognized as a key affected population with respect to TB, with increased TB morbidity and mortality in part due to late-stage treatment and incidence of drug resistance. In countries with a low or moderate burden of TB, prevalence among international migrants is often high. People who move in or from high-burden countries face numerous factors which contribute to increased vulnerability to TB and pose significant obstacles to accessing services and treatment. Mobile people who are undocumented, lodged in detention centres, trapped in conditions of forced labour or trafficking or forcibly displaced are particularly vulnerable to TB infection.
96. According to the WHO, up to 500 million people may be living with viral hepatitis, which claims more than one million lives a year. Between 8 million and 16 million hepatitis B virus infections per year probably result from sharing contaminated drug injecting equipment. Population mobility, especially mass movements of people, from, through or to nations of high prevalence are a challenge to their respective health systems.
97. Being on the move can export and import epidemiological risks, including those related to chronic infections such as TB, hepatitis B and C, HIV and other sexually transmitted infections. A narrow focus on domestic epidemiology in order to make health-care projections about disease volume or burden will fail if mobile populations are not taken into account. In addition, there is mounting evidence that more effective outcomes could be obtained by increased disease control interventions in source nations through increased testing and treatment, rather than through the use of screening mechanisms such as mandatory health testing at destination sites.
98. In general, health systems have not sufficiently adapted to the expanding challenges associated with the size, speed and disparity of modern patterns of human mobility. Access and use of health-care services vary across countries, as do the services themselves. Insurance systems are often rigid and limited in catering for people on the move. UHC would seem to be the most appropriate approach to ensure full coverage of mobile populations.

“Canada’s health-care system is not good at addressing the needs for racialized trans people. They need a safe place to come, to help them connect to services. But when they do connect, they experience a lot of trans-phobia from healthcare providers. Education, legal remedies, policies and practices for helping this populations would be helpful.”

– Alliance for South Asian AIDS Prevention, Toronto

99. In Europe, mobile populations are overrepresented in the HIV epidemic. Research indicates that opportunities for HIV prevention among people on the move in Europe are being missed, including expanded community-based testing, increased provider-initiated or indicator condition testing in primary care, pre-exposure prophylaxis and "treatment as prevention" among MSM.
100. It is not uncommon for MSM who initially test HIV negative in a receiving European country to acquire HIV subsequently.³⁸ Similarly, chronic hepatitis B is an important public health policy issue in Europe. The disease disproportionately affects people on the

move from medium- to high-prevalence areas. However, screening for chronic hepatitis B is not systematically offered to people on the move across Europe; as a result, testing and treatment is suboptimal.³⁹ Other missed opportunities include limited or no access to public health care for undocumented migrants in most countries and mandatory reporting requirements to immigration authorities.

101. Stigma and discrimination against people living with HIV and key populations within the health-care system is a particular aspect of HIV vulnerability related to health system disparities. This discrimination refers to “unfair and unjust treatment (by act or omission) of an individual based on their real or perceived HIV status, or the fact that they belong to a segment of the population that is perceived to be at greater risk of, or more vulnerable to, HIV infection.”⁴⁰ The discrimination can be directed at key populations and vulnerable groups (e.g. sex workers, people who inject drugs, MSM, transwomen and transmen, indigenous peoples, and people on the move). People may encounter such stigma and discrimination at any stage of the mobility process, and it may cause those populations to move.
102. The skills needed by health workers to meet the needs of the wide variety of people on the move are still lacking globally. Health outcomes are relative to the individual’s own level of general health as well as to the social, educational, economic, medical and cultural aspects of the location through which the individual travels, from pre-departure to arrival. People who have been most compromised along that process are the most vulnerable.
103. Populations that are less able to control their mobility experience face particular risks, especially refugees, displaced populations, trafficked people or undocumented migrants. Depending on the situation, women, the elderly and children also face significant risks. Sometimes regularized migration can lead to loss of control over circumstances, such as among domestic workers who find themselves isolated in their employer’s homes where they may be subjected to abuse, including sexual abuse. People on the move may not be familiar with the host language and may have different cultural assumptions about health than those of the host country or location. These varied experiences and circumstances, especially in the context of large movements of people, poses an enormous health-care skills challenge. It also highlights the pressing need for capacity building and increased investment, for example to confront stigma and negative attitudes, and to address language barriers.⁴¹

Impacts from the mobility process itself

104. Population movement is a human constant. Many nations, especially more industrialized ones with low birth rates and ageing populations, depend on international migrants for their long-term growth. However, such migration may generate many changes, including shifts in racial and cultural composition, and may lead to the emergence of new political constituencies with their own demands. One response to the currently heightened human mobility is a backlash, with some states instituting or reverting to hardline immigration laws and procedures. These reactions are aggravating the health and HIV vulnerabilities which people on the move are being exposed to.
105. Each phase of the process of being on the move has its own unique effects and HIV vulnerabilities. A person starts from the existing health environment in his/her own country, possibly with specific medical conditions. This pre-departure phase would be ideal for doing collaborative health promotion activities between origin and destination countries, but this is rare. The main exception to this is in regards to countries involved in significant higher-skilled labour migration where there are a few examples of pre-departure education on health risks and rights to service, even including multilateral

social insurance schemes. During movement, people may then experience a series of health challenges associated with exposure, deprivation, hunger, isolation, trauma, abuse and even torture.

106. The majority of health policy activity has addressed the arrival phase at a new destination. This phase can be particularly risky if it involves interception and temporary detention as may be the case for asylum seekers, displaced persons, refugees, or undocumented workers. In the European context, the European Commission has encouraged scaling up detention and deportation and tends to limit human rights concerns to saving lives.⁴² For example, asylum seekers arriving on Greek islands are required to wait at registration centres or camps until decisions are taken for their transfer to the mainland. Asylum seekers may have to live there for up to a year, often in squalid and desperate conditions with inadequate access to health-care services.
107. During the phase of temporary or permanent return to a country of origin, there may be additional health risks, especially for children. For example, people returning to rural communities who are not provided proper VCCT or access to services may transmit HIV unknowingly to partners or TB to family members.
108. One of the biggest health impacts associated with from the process of mobility relates to the increasing attempts to exclude border regions from human rights law and obligations, in effect ignoring the human rights of mobile populations. As a result, borders are increasingly dangerous, especially for undocumented migrants. Individuals may be subjected to travel restrictions based on HIV status, mandatory HIV testing, inadequate access to health services such as HIV and hepatitis screening, overcrowding and withholding of passports.
109. For example, there is clear evidence of human rights abuses at the Lindela deportation centre in South Africa, which has experienced high numbers of deaths in detention, and where health-care access and infection control are poor, with many individuals detained for months.⁴³ Mobile people may also be subject to forcible return, even to countries where they may face persecution—even though international law prohibits such *refoulement*. Deportation of mobile people living with HIV used to include quarantine in some countries. The premature return home coupled with a lack of counselling or referral leaves such mobile people and their partners at risk of transmission.
110. People may also face challenges with various legal systems as they move to other countries. MSM are criminalized in some countries, and drug use and sex work are criminalized in the vast majority of countries. Many countries prohibit the participation of migrants in their domestic sex industry or prohibit individuals who are "known" sex workers from immigrating. This turns the vast majority of mobile sex workers globally into undocumented migrants. It denies mobile sex workers labour protection and civil entitlements and it increases their vulnerability to labour exploitation and unsafe work conditions. Crossing into such a country puts a person on the move at increased risk in terms of barring access to healthcare and increasing HIV vulnerability.

“With the current draft revision of the book of penal code in Indonesia that will include condoms, as a contraceptive tool, that can be considered as evidence under the penal code—the draft of the revision will include criminalization of unauthorized personnel (non-medical staff) conducting preventative promotion using contraceptive tools. This means that NGO workers, peer sex workers will not be allowed to promote the use of condoms in prevention efforts. Additionally, due to forced closure of brothels, many sex worker focal points are lost to contact and therefore Organisasi Perubahan Sosial Indonesia cannot intervene in ensuring condom use (by customers) which has usually been done through the focal points.”

– Organisasi Perubahan Sosial Indonesia (Network of Sex Workers in Indonesia)

111. A recent legal difficulty involves efforts to criminalize certain types of humanitarian aid. For example, the US Bureau of Land Management has issued charges of littering against individuals who leave water bottles for people illegally crossing from Mexico through the Arizona desert, despite the fact that thousands of people have died during such crossings.⁴⁴ Hungary recently criminalized some forms of humanitarian aid as part of its "Stop Soros" package, citing a need to stop migration, secure its borders and protect national security.⁴⁵
112. Such developments highlight the challenge involved in humanely addressing the needs and rights of all people on the move and ensuring that humanitarian aid is not treated as a criminal offence. Human rights do not cease to exist when people move or arrive at international borders: the management of immigration and borders has to be human rights compliant.
113. The more barriers to health inserted into the process of human mobility, the more severe the resulting health conditions. This means higher treatment costs, and higher mortality. Health needs to be an integral part of domestic and global population mobility and foreign policy discussions and planning.

Summary

114. The literature review highlights five geopolitical trends in contemporary population mobility. These trends are having a major impact on the AIDS response among mobile populations. If we do not adequately addressing these realities, the human costs will continue to be unacceptably high and we will not be able to achieve our 2030 targets.

“Most of the existing NGOs focus on services: consulting, test and treat—but nothing more. No empowerment programmes for migrants, no diversity trainings for social workers, limited support when it comes to the asylum seeker procedure or legalizing people without papers.”

– Deutsche AIDS-Hilfe e.V., Berlin

115. The review also indicates several avenues of good practice that, if implemented and scaled up, could give us a better chance of achieving our 2030 targets. These good practices include:
- Meaningful involvement of people on the move as well as civil society, especially those who are from key populations;
 - Effective law and/or regulatory reform, such as decriminalization of certain behaviours of key populations (MSM, PWID, sex workers) and ending discrimination in immigration law against certain female-dominated forms of work;

- Capacity building for people on the move, health-care workers, key population-led organizations and community service providers to ensure they are culture and language competent can provide safe safe services;
- National health systems that are sensitive to and inclusive of people on the move, including UHC as well as effective monitoring and financing of healthcare services;
- Continuity of care across the pre-departure, transit, arrival, detention and return phases, including medical passport systems, meaningful pre-departure and post-arrival training, health interventions, accessible locations for services, community referral systems;
- Addressing stigma and discrimination through public education about the social and economic value of population mobility;
- Protecting people on the move, including children, against economic exploitation; and
- Effective responses to reduce the HIV and coinfection vulnerabilities of undocumented migrants.

4. COMMUNITY VOICES

Interviews, surveys and focus groups

116. The Delegation collected community experiences and self-reports that illustrate key challenges related to people's experiences of mobility and HIV. This was done mainly via interviews with people on the move and stakeholders, as well as via survey responses. Interviews were conducted across all the regions represented on the Delegation: Africa, Asia-Pacific, Europe, Latin America and the Caribbean, and North America. Quotes from people on the move as well as stakeholders appear throughout the report.

"I migrated because of the violent situation in Venezuela and the scarce supply of food. I wanted a better life for myself. The government should make provision for migrants, Civil Society should have a network to be able to know where migrants are and migrants should form an organization to bring their issues to the national level. I do not have access to healthcare. I do have formal steady employment and I am not documented as a migrant."

– Jessica, transgender sex worker, Venezuela

117. The majority of survey participants were employed, with access to health care and good knowledge of available services for HIV, TB and, to a lesser extent, hepatitis. About half of the participants self-identified within a key population group. They came from 28 different countries of origin, predominantly Colombia, India, Jamaica, Kenya, Nigeria, the Philippines, Poland, USA, Venezuela and Zambia. A notable observation is the impact of population movement from Venezuela on neighbouring Latin American countries where most people on the move in the region are reported to be males who have been on the move for less than a year.

118. People on the move identified a range of factors that may result in increased vulnerability to HIV and coinfections. The factors include language and cultural barriers, fear of requesting/accessing services and being reported to authorities, lack of access to targeted services for people on the move, lack of understanding about the health-care system, poor living conditions, risky behaviours and sexual practices, and lack of access to prevention services. The following are three interview summaries of people on the move that illustrate the relevant issues.

"I come from a very remote area in Subang, West Java where there is very little opportunity of employment. Plus, I am a woman, this means I have even smaller opportunity compared to men. Therefore, I decided to join an agency and work in another country. I have lived in different countries (mostly middle-eastern countries) and cities with my current job. Though, since I first found out my HIV status, I have not returned to my agency to work in another country as there is a medical check-up before leaving the country and it includes an HIV test. By working in middle-eastern countries, I was able to save a lot of money to help my family back home.

I still have to get my monthly ARV back home and it is not possible for me to return home every month. Therefore, I need someone to get my ARV every month and send it to where I am right now. But I still have to be present every 3 months. Luckily, I am working with a family who understands the situation so I am allowed to go home every 3 months. I know other people who in the end have to stop their ARV because the family they are working with do not know about their HIV status and do not allow them to go home regularly.

All my administrative registrations are based in my home town. So it is difficult for me to access services in another city. The way national insurance works in Indonesia is based on residential location. I have not had CD4 or viral load test in the last 2.5 years, and if I have to pay, it will be too expensive. I have lost employment opportunity because of my HIV status, despite now having another job."

– Nani, heterosexual women and internal migrant living with HIV, Indonesia

"You do not have access to anything, no access to healthcare, you cannot work. You cannot own anything in your name. You do not have ID, working papers, social insurance number that can help you. When you begin to work on ID papers, then you begin to have access. It is also very difficult if you want to move around. The need for documents is paramount. You need papers for banking, for working, for safety. It can take years to get papers. If you get sick, you just have to walk around to find a hospital that will accept you and treat you. You are separated from things that define you as a person. You leave your country, your culture, your identification behind. Believe me it is not easy

The government and NGOs need to develop a support system to reach out to people in my situation and help with basic information and needs. We need basic information on how best to access ID/apply for legal status without jeopardizing your stay. There is a need for sensitization of the migrant situation. People get sick, need healthcare. NGOs could have volunteer programmes for migrants to help them develop skills and improve language skills. It is important to learn to work in the new country.

Being a refugee or migrant you can be in very vulnerable situations—you can end up doing things you ordinarily would not do, or even consider doing.

I just think that being a refugee/immigrant is a tough decision. You do not know what it is really like until you are in the situation. It comes with its own challenges that you are unaware of until you do it. I have been lucky. I have a place to stay, and family here. And yet it is still very tough. It is very challenging – you do not know what will happen next. It is really tough. People will still do it. They think coming to a new place will be better."

– Pelagia, heterosexual women and international migrant, Zimbabwe

“I had a very terrifying incident with police in Mexico and was attacked, left beat up in a ditch, naked in the middle of the night. It was then that I realized I had to get out of Mexico. I walked, walked and a family invited me to San Francisco.

We need language justice and a commitment to language accessibility. There is a complete lack of appreciation about this issue. It goes way beyond translation. People do not have knowledge and experience in technical English. Life as a non-native language speaker is extremely difficult.

What needs to happen is an international commitment to racial justice. There needs to be meaningful involvement of migrants and refugees in local communities and it is a real challenge. We need jobs for migrants with HIV.

The HIV community needs to accept a racial justice agenda. The Migration community needs to address HIV. The two worlds need to come together. By default, I will confront many barriers, gay, Latinx, HIV positive, migrant—it can be overwhelming. We need to create welcoming centres and places where migrants can give back to the community and to each other. I am an informed HIV advocate and I have had a tough time getting the care I need, culturally relevant and competent care—for who I am.”

– Marco, MSM living with HIV, on the move, Mexico

119. In addition, the Delegation collected input from stakeholders and service providers in the AIDS response across the five regions. These stakeholders are engaged with a range of activities, including direct HIV services, policy making, legal support, advocacy and campaigning, research, capacity building and language classes. The majority stated that they involved people on the move as peers in delivering their activities, for example in leadership and management, frontline services, volunteering and research.

120. In general, the stakeholders noted needs and challenges similar to those identified by people on the move, including absence of basic protections, difficulty acquiring documented status/legalization, lack of knowledge about HIV and coinfections, lack of awareness about and access to culturally and linguistically competent health-care and other services, seeking employment, stigma and discrimination, isolation, poverty, lack of housing, mental health challenges, fear of violence, fear of criminalization/detention and deportation, loss of identity, trauma.

121. Brief quotes from stakeholders are dispersed throughout the report.

GOOD PRACTICE CASE STUDIES

This section presents examples of good practices which may be replicated and/or scaled up to improve the AIDS response and support achievement of 2030 target of ending AIDS as a public health threat.

1. MAP Foundation, Chiang Mai, Thailand

Thailand has over 2 million documented migrant workers from the neighbouring countries of Cambodia, Lao PDR and Myanmar, as well as an unknown number of undocumented migrants. Migrants who are properly registered are meant to have either migrant health insurance or social security. However, there are numerous cases of migrant workers who lack health coverage due to the neglect of brokers or employers. A policy which has allowed undocumented migrants to purchase health insurance was dropped due to hospitals' reluctance to participate in the move. Documented migrants without proper health coverage and undocumented migrants now have to pay out-of-pocket for all health and HIV services.

Migrants with health insurance have access to free ART, but voluntary HIV testing is not covered. Language barriers, a lack of trust and constraints related to the location and timing of service provision are among other obstacles migrants face in accessing HIV counselling and testing from Thai public health facilities. As a result, migrants living with HIV infection often are diagnosed with advanced HIV.

MAP Foundation, a local NGO working to promote and protect migrant workers' rights in Northern Thailand, is a sub-recipient of the Global Fund project "STAR – Stop TB and AIDS through RRTTR." In order to increase migrants' access to HIV testing, MAP has opened its own health testing centre in a migrant community. The centre encourages migrants to test for HIV, for example by adding syphilis and hepatitis B and C tests to the package of free testing.

Trained MAP staff, themselves migrants, assist in providing counselling in migrants' languages and coordinate with the migrant community, while medical clinicians provide the counselling and administer the tests. Through a partnership with an international research organization and local university, the centre has some of the most advanced testing equipment available and provides rapid, accurate test results. All cases of HIV or other health conditions are then referred for confirmatory testing and treatment.

In the past two years, MAP Foundation has provided testing and counselling to over 315 migrants through the centre, and referred 11 migrant workers living with HIV for treatment. However, Global Fund support for Thailand is scheduled to end in 2020. The Thai Government, meanwhile, cannot use public funds to support services for non-Thais. It is important for migrant workers that community health centres such as MAP are recognized and supported as channels for providing HIV services.

This good practice demonstrates the meaningful involvement and capacity building of people on the move, collaboration with local health-care providers and integrating HIV testing into other community-based voluntary health testing services to reduce stigmatization.

2. Valley AIDS Services, Lower Rio Grande Valley, USA

Texas has a border of almost 3,200 kilometres with Mexico, much of it impassable. The border along the Lower Rio Grande Valley is more accessible and includes an easily traversable river, many cross-border agricultural towns and a number of official entry points. Consequently, some 30 000 immigrants cross into the USA annually along this section of the border without official authorization. Many are fleeing gang violence in Mexico and Central America, others are fleeing poverty and domestic abuse, and some are fleeing discrimination based on sexual orientation or gender identity. Some people who know they are living with HIV also cross the border in order to seek care that they cannot obtain where they live.

The US Government began a programme of zero tolerance for undocumented immigrants, including massive deportation efforts, under the Obama Administration. These efforts have become dramatically harsher in the past two years. When immigrants are taken into custody by border officials, they are placed in detention, which may last for months or years if the persons detained seek to appeal their deportation. The circumstances in these detention centres are at least as harsh as in prisons. Physical and sexual abuse is common, and people with chronic conditions are often deprived of medical care.

Valley AIDS Services is a nongovernmental organization established in 1987 to serve people living with HIV in the Lower Rio Grande Valley. The only AIDS service organization in the region, it provides a range of prevention and treatment services. It has located one of its HIV

prevention venues two blocks from the largest border crossing in Brownsville. It also conducts targeted prevention and testing outreach among immigrant MSM and provides PrEP irrespective of a person's ability to pay, along with primary care that emphasizes health for LGBTI persons.

For people living with HIV, Valley AIDS Services provides comprehensive HIV-centered healthcare, case management, and peer support. The case management services include referrals to legal counsel to address issues having to do with legal status. In addition, Valley AIDS Services provides transportation in its own vehicles to overcome fear by consumers that they might be stopped and detained by the authorities. Support groups are conducted in a discrete manner. When clients are arrested, the Valley AIDS Council continues to provide them with medical care while in jail or pre-deportation detention. Because of its welcoming approach, about one quarter of all people in care are immigrants who are undocumented.

This good practice illustrates meaningful involvement of people on the move as well as effective legal and health responses to the HIV and coinfection vulnerabilities of undocumented migrants.

3. ARK-Antiaids and ECUO, southern Russia (Rostov-on-Don region)

Due to its geopolitical situation, this region is experiencing intensive migration flows as people cross from the Caucasian and Central Asian region or from Ukraine. Migrants living with HIV are unable to obtain registration in the Russian Federation since they face deportation based on their HIV status. They are left therefore without medical support and have to interrupt their ART when in Russia due to many reasons.

The local organization of people living with HIV (ARK-Antiaids), together with its partner in Ukraine, the European and Central Asian Union of People Living with HIV, developed an algorithm for getting ARVs to Ukrainian migrants, people who have escaped from the Donetsk People Republics and people who had been living in the annexed Crimea territory.

Through a partnership with a local HIV medical centre, these organizations ensure that clients from Ukraine get their HIV tests (viral load and CD4 cells) done and receive a document indicating that they need ART. The scanned copies are sent to Kyiv ECUO office and/or partners in the Donetsk People's Republic where they can collect their medications and then send them via post or with people who travel to the Russian Federation.

The scheme has arranged treatment for more than 100 people in the Russian Federation who had been unable to initiate or continue their treatment. However, the situation requires a more strategic approach and there is an urgent need to work in partnership with central Asian countries, Georgia, Lithuania and other countries along migration routes. A recent initiative is IMMIGRANIADA, a project that aims to bring together community organizations serving people living with HIV in eastern Europe and central Asia (in partnership with ECUO) to build effective structures to serve undocumented migrants with HIV.

This good practice illustrates continuity of care/care continuum across national borders and effective responses to HIV and coinfection vulnerabilities of undocumented migrants living with HIV.

4. Catholic church-related and other faith-based organization responses to people on the move living with and affected by HIV and coinfections

In April 2016, more than 100 professionals from across the world and who are engaged in the faith-based response to people living with and affected by HIV gathered to share good

practices and experiences related to children living with or at risk of HIV infection. They were joined by other stakeholders, including representatives from national governments. The following examples highlight good practices to provide HIV care and attention to people on the move.

The Mai Tam (Centre of Hope) Program, located in Ho Chi Minh City, Viet Nam, was started by local priests in response to women and children living with HIV who had been abandoned by their families and often found themselves living on the streets or in hospital wards. Many of the women had migrated to the city from rural areas and were victimized by sex traffickers and/or dependent on drugs. Since most of the mothers were internal migrants without an exit permit from their home cities, they could not access health care services.

Mothers were trained in job skills and encouraged to start their own businesses. Some of the women work in the sewing industry and others have built a successful flower arrangement business. With the help of early funding by PEPFAR, mothers and children were provided with ART. The programme now serves 87 children at three centres and more than 200 children in community-based support to support treatment adherence. While many of the internal migrant mothers are encouraged to consider returning to their home cities, most prefer to stay in Ho Chi Minh City due to discrimination toward people living with HIV in their places of origin.

The International Catholic Migration Commission is a network of Catholic Church-related organizations engaged in serving people on the move, especially involuntary migrants. It operates field programmes that include humanitarian assistance and protection for refugees and forced migrants. Among them are nine primary health-care clinics in camps for Afghan refugees along the border to Pakistan, where clinical personnel are attentive to HIV vulnerability and promote HIV testing, especially among pregnant women. The organization also provides access to maternal and new-born health-care in the Damascus area of Syria, and mental health and social services for refugee survivors of sexual and gender-based violence in Jordan, Malaysia, and Pakistan. The Commission also works closely with UNAIDS, WHO and IOM to promote attention to migration and health in the Global Compact on Migration and on Refugees.

This good practice illustrates the meaningful involvement of civil society as well as protecting people on the move against economic exploitation.

5. Deutsche AIDS-Hilfe e.V., Berlin



Evidence shows that queer refugees in Germany lack equal access to the health system, information, counselling, HIV/STI testing and treatment, and are seldom involved in HIV/STI prevention. The community-based participatory health approach is a valuable tool for building capacity and enabling queer refugees and service providers to strengthen knowledge and develop appropriate prevention tools and services for the heterogeneous queer community.

“Your health, your rights” (2017–2018) is a two-year community-based participatory health project to improve the involvement of queer refugees in HIV/STI prevention, as well as create appropriate HIV/STI prevention media collaboratively. It is run by the national association of community-based AIDS service organizations (Deutsche AIDS-Hilfe e.V.) with Berlin-based partners from various immigrant organizations, queer refugee activists, AIDS service organizations and MSM projects. The project components include a multilingual participatory needs assessment workshop, a series of capacity building methodological workshops, a community-led art-based project and a participatory evaluation.

Twelve queer refugees (transwomen, transmen, gay and lesbians) and members of queer migrant organizations chose to take part in the project and have been educated and supported to document their lived experiences and needs using methods such as community mapping and story-telling. Key topics and needs connected to sexual health have been identified jointly. Based on these results and in the framework of an art-based workshop, participants created a concept and design of a multilingual website for queer refugees which delivers helpful information on the legal situation in Germany, the German health system, HIV and other sexually transmitted diseases and safer sex. Moreover, it features the addresses of organizations which offer counselling, HIV/STI testing and support.⁴⁶ The evaluation shows the web site is used frequently.

The project shows that greater involvement of queer refugees and migrant groups is possible if it is enabled. This takes resources, trained and committed staff, and an understanding and practice of participation that includes the provision of decision-making power to the refugee participants. The interactive approach and the use of supportive performative prevention and media development methods have provided opportunities for participation even for highly traumatized refugees who may struggle to verbally express their thoughts and feelings. It has also enabled communication between participants who do not share the same language.

Migrant participation in the project has positive effects on several levels: the persons directly involved improve their competencies (empowerment); service providers tailor their media and services better to the needs and living environments of queer refugees and migrants; and the resources of participating communities are identified and mobilized and community building processes are supported.

This good practice illustrates the meaningful involvement of key populations on the move—MSM, transwomen and transmen—as well as capacity building for both mobile populations and service providers.

6. The Canadian HIV/AIDS Black, African and Caribbean Network, Ottawa, Canada

The Canadian HIV/AIDS Black, African and Caribbean Network is a national network of organizations, individuals and other stakeholders who are dedicated to responding to issues related to HIV in Canada’s African, Caribbean and Black communities. Formed in 2010, the network aims to complement activities related to the Federal Initiative to Address HIV/AIDS in Canada, specifically among people from countries where HIV is endemic in Africa and the Caribbean.

In 2018, the network was funded by the Public Health Agency of Canada under the HIV and Hep C Community Action Fund for a project titled “Canadian HIV/AIDS Black African Caribbean Network (CHABAC): Mobilizing across regions to build an effective HIV response in ACB communities”.

Through this project, the network is developing a programme science model for HIV prevention services which has been systematically evaluated, is grounded in scientific evidence, and is specifically designed for African, Caribbean and Black communities. The project provides training on this model to at least 80 service providers in Alberta, Ontario, New Brunswick and Nova Scotia so they can adapt their existing interventions and adopt new ones. Through webinars, fact sheets and conference presentations, network will broadly share its programme science model and lessons learned from implementation.

The initiative is intended to be a best practice model and can help mobilize African, Caribbean and Black communities in other countries to consider developing a similar regional hub model to engage these communities for country-level impacts funded by their national government.

This good practice illustrates the importance of meaningfully involving and building the capacities of people on the move and civil society organizations, and of addressing stigma and discrimination through public education.

7. AIDS Care China, Ruili

Ruili City of Dehong prefecture, in Yunnan province, is located near the opium-producing areas of the Golden Triangle and is the starting point of major drug trafficking routes in China. The first HIV infections were detected here among people who inject drugs in 1989.

An estimated 50 000 people from Myanmar live in Jiegao district in Ruili. AIDS Care China, the Alliance Linking Organisation, partners with the Ruili government to operate the "Better Clinic". The "Better Clinic" offers one-stop services for people living with HIV and people who inject drugs, either from nearby villages in Ruili or from across the border in Myanmar. The services include needle exchange, methadone maintenance treatment extension, HIV testing and counselling and ART. Most of the clients are migrants from Myanmar and include truck drivers, people who inject drugs and sex workers.

Owing to these effective strategies in Ruili among people living with HIV eligible for antiretroviral therapy, the mortality rate has decreased by 95% compared to 2005. There were zero new HIV infections reported among people who used drugs and attended methadone maintenance treatment clinics from 2008 to 2014, and no babies born to pregnant women living with HIV have been reported to be HIV-positive since 2008.

This good practice illustrates effective regulatory reform as well as sensitive and inclusive local health systems relative to people who inject drugs and people living with HIV who are on the move.

8. Brazil: Responding to Venezuela, a major crisis for the Latin American region

Due to serious political and economic crises, a major migration of Venezuelans out of that country started in 2015 and has increased significantly. From January to June 2018, nearly 130 000 Venezuelans entered Brazil and around 60 000 requested regularization of migration. The Brazilian government has agreed to receive the Venezuelans, but the growing influx has posed major challenges to public health services in the Northern region.

The decision of the Brazilian government to receive Venezuelans is based on a new Migration Law (No. 13,445), which provides access to public health and social welfare services and social security irrespective of nationality and migratory status. The Brazilian Unified Health System (which offers universal and free access to health) also guarantees access to comprehensive health care for migrants.

In this context, an Integrated Plan of Action for Health was elaborated to guide and organize a timely response to the migratory flow in the state of Roraima, involving actions among the Federal Government, the Government of the State of Roraima, and the Municipalities of Boa Vista, Pacaraima and other municipalities affected by migration flow. In order to accommodate thousands of Venezuelans, 10 shelters were built in the state capital (Boa Vista), where vaccination and health promotion services are also being provided.

Regarding HIV prevention and care, the plan already promoted capacity building for more than 100 health professionals (medical doctors, nurses and pharmacists) for diagnosing and clinically managing HIV and other STIs, with a focus on avoiding stigma and discrimination. The plan also promoted the restructuring of the HIV-related health services, with an emphasis on decentralization. It is important to emphasize that screening for HIV and other STIs is not compulsory; the services are offered in health facilities and shelters on a voluntary basis.

HIV treatment is guaranteed to all people living with HIV in Brazil, whether they have Brazilian nationality or not. According to the public ARV dispensation system, the number of new Venezuelan patients in ART increased 5.5-fold between 2016 (16 new patients) and June 2018 (104 new patients).

Brazil's support to the Venezuelans extends beyond the borders of the country. Aware that Colombia also received a large contingent of migrants, Brazil recently donated first-line regimen drugs (tenofovir/lamivudine + dolutegravir) to treat 500 Venezuelans in that country.

This good practice illustrates effective law and/or regulatory reform, capacity building of healthcare workers, and development of national health systems that are sensitive to the needs of people on the move.

9. Kyrgyz Indigo—services for MSM on the move in Kyrgyzstan

Kyrgyz Indigo is a public association that supports the lesbian, gay, bisexual, transgender and intersex (LGBTI) community in Kyrgyzstan. Its activities are aimed at promoting healthy lifestyles, strengthening psychological health, providing capacity development, providing shelters in Bishkek and support in Osh city and advocating for LGBTI rights.

Kyrgyz Indigo was founded in 2009. The organization provides legal protection, reacts to human right violations, conducts research, advocates for inclusive prevention and sustainable health-care interventions, and brings state and international institutions together to promote non-discrimination. It has also conducted trainings on leadership and activism, rights and gender, HIV, STIs, hepatitis, TB and living a healthy lifestyle.

Kyrgyzstan experiences both internal and external migration. Gay and other men who have sex with men migrate mainly to pursue education opportunities or for work. International migration occurs mainly in search of higher earnings and/or greater freedom, or to avoid psychological oppression or cultural violence, including forced marriage. Migration and work relieve financial dependence on relatives and the emotional pressure to demonstrate masculinity through marrying and having children.

Kyrgyzstan is a country that provides specific opportunities for internal and external migrants. Internal MSM migrants can receive free HIV counseling and testing from nongovernmental organizations or government institutions. They can also make use of a dispensary in the capital, even if they lack a residence permit in the city. HIV treatment is free of charge for everyone, including foreign citizens,.

Kyrgyz Indigo operates in the capital of the city, which provides widely advertised rapid testing and social support. The organization also operates a shelter, which provides temporary safe space, hot meals, social, psychological and legal services for victims of violence and for migrants.

This good practice shows that inclusive and sensitive MSM mobile and key population health-care services can be provided, and that stigma and discrimination can be avoided.

10. Action for Health Initiatives (ACHIEVE, Inc.), Philippines

The incidence of HIV infection among overseas Filipino workers has increased steadily over the years. The HIV/AIDS and ART Registry of the Philippines reported that 10% (5,889) of Filipinos diagnosed with HIV from 1984 to June 2018 (56,275) were overseas Filipino workers. Seventy-one percent (4,181) of the overseas Filipino workers diagnosed with HIV were males and an estimated 86% of them had acquired HIV through unprotected sex with other men. In response, Action for Health Initiatives (ACHIEVE) combined community mobilization, institutional capacity building and advocacy grounded in participatory action research.

ACHIEVE conducted numerous studies on the linkages between migration and HIV and used the results to develop a training programme aimed at strengthening the HIV response for overseas Filipino workers in destination countries. Working closely with the Foreign Service Institute, the School for Diplomacy of the Department of Foreign Affairs, for the past 14 years, ACHIEVE has trained 14 intakes of Foreign Service Officers on handling HIV-related needs and concerns of Filipinos in destination countries. The Foreign Service Officers are trained to be career diplomats and future Ambassadors.

The trainings include awareness-raising on HIV and migration realities; stigma reduction through talk shows with overseas Filipino workers living with HIV; and skills-building on sensitive interviewing and counselling. The training was supplemented by a guidebook for handling HIV-related issues of overseas Filipino workers in destination countries, which ACHIEVE also published and disseminated to all Philippine Post abroad.

ACHIEVE had to make sure this programme would be sustainable. It advocated for the inclusion of the HIV and migration training module in the curriculum of the Foreign Service Institute for all foreign service officers and other personnel. Those involved in the training programme of the FSI championed this advocacy within the Department, which led to its institutionalization.

What makes this training programme successful is the involvement of overseas Filipino workers living with HIV. The development of this programme was influenced by an overseas Filipino worker who had been diagnosed with HIV. The involvement of these workers living with HIV as speakers had a lasting impression on the training participants. ACHIEVE ensured that the involvement of this community was meaningful and effective by developing a capacity building programme that enhanced their understanding of HIV, gender, sexuality, human rights and migration issues, as well as building practical skills such as public speaking, training facilitation and advocacy.

This good practice illustrates meaningful involvement of people on the move who are living with HIV in the capacity building of key stakeholders.

11. Wajood: Empowering transgenders and hijras to access sexual health and human rights in India



Transgender and hijra communities are among the most marginalized populations in India. They have the second highest HIV prevalence in India at 7.2% (NACO 2017), and globally have a 49 times higher possibility of contracting HIV. In 2016, the Indian government finally granted them legal status. However, they remain marginalized with limited access to services including health, education, social entitlements as well as livelihood options. Violence and specifically gender-based violence against transgender and hijra from within and outside the community is significant and common: from police, clients and even regular partners. Because most transgender and hijra members are either thrown out from or leave their homes, they are often migrants or mobile with no documentation.

Wajood is designed for and led by transgender and hijra. The project's uniqueness is that it demonstrates models to scale up comprehensive, need-based and sensitive services for transgender and hijra. It is being implemented in five states and six sites: Delhi (NCR), Gujrat (Vadodara), Karnataka (Kholar and Chikbalapura), Andhra Pradesh (Eluru) and Telangana (Hyderabad). Serving 7,000 transgender and hijras, all three core staff and 32 field level staff are from trans or hijra backgrounds.

Since the communities are not homogenous, it was important to ensure that Wajood reach the wide diversity of transgender and hijra. At each site, two to three community members with leadership qualities were trained as "agents of change" and equipped to respond to three specific areas of need—work on access to safe feminization, support against violence faced by the community, and help in social protection and support—with counselling support and HIV testing and continuum of care as the basic service. The agents of change were from varied transgender and hijra groups, including those who were extremely traditional and

living in community homes, those with strong religious affiliations, and those from sex worker groups in modern bath houses (high-density sex work sites).

Before going to the communities, the outreach workers and the agents of change mapped the gatekeepers and supporters and developed systems such as crisis response teams with advocates and doctors in the team along with transgender and hijra leaders. They also mapped community friendly doctors for feminization services and sensitized the social justice department and police. Then they started contacting the wider transgender and hijra groups, educating and spreading awareness and linking the people who needed services, e.g. enrolling in educational institutions, accessing social entitlements like identify cards, and negotiating job opportunities. As a result, the uptake of HIV services also increased.

This good practice illustrates capacity building of key populations who are on the move internally—specifically trans, and including sex workers—as well as of service providers, and addressing stigma through public education.

12. Welcoming America—building a nation of neighbours, USA

(<https://www.welcomingamerica.org/>)

The Welcoming America programme assumes that cultural diversity enriches communities with unique perspectives and variety of thought. It is a nationwide network of non-profit and local government partners that recognizes that being welcoming leads to prosperity. All people, including immigrants, are valued contributors who are vital to the success of communities and their shared future. Launched in 2009, Welcoming America has spurred a growing movement across the USA, with one in eight residents living in a Welcoming Community: these places show it is possible to go beyond fear and even tolerance for a bright future for all. This award-winning social entrepreneurship model is beginning to scale up elsewhere.

The movement encompasses a wide range of participants in each local area: corporate partners and economic development agencies, including financial institutions; civic partners like YMCAs and educational institutions; public sector partners, including not only local government but police chiefs and school boards; local philanthropic organizations and community foundations; and representatives of many faith communities.

Welcoming communities foster a culture and policy environment that makes it possible for newcomers of all backgrounds to feel valued and to participate fully alongside their neighbours in the social, civic and economic fabric of their adopted hometowns. These communities agree to ensure that all relevant sectors, such as government, business and non-profits, work together to create a welcoming community climate that supports long-term integration.

Municipalities commit to institutionalizing strategies that ensure the ongoing inclusion and long-term economic and social integration of newcomers. Messages of unity and shared values permeate the community through the media, through the voices of leaders, and among residents. Furthermore, policies and practices are set in place to ensure interactions between new and long-time residents remain positive and the community's economic vitality remains strong.

One example of such a welcoming community is Iowa City.⁴⁷ This local approach involves going beyond a single programme or service to work with institutions across the community to reduce the barriers that immigrants face and build bridges between newcomers and long-time residents. Strong impetus has come from the Iowa City Area Development Group, formed in 1984, which is committed to enhancing the economic vitality of the area, fostering

a strong business climate and promoting employment opportunities. A website was developed to help immigrants connect to all the resources and events needed to settle into the area. Finally, a series of welcoming banners have been displayed throughout the city to promote good relations and a positive view of immigrants.



This good practice illustrates how stigma and discrimination can be addressed through local collaborative action and education about the social and economic value of migration, and how people on the move can be protected against the exploitation.

5. CONCLUSIONS AND RECOMMENDATIONS

“Bilingual and welcoming spaces need to be established. There is a need to welcome you to the new place. A welcoming centre. And if possible the people at such a centre can help to get you plugged into the systems. It would be great if there were a peer navigator system—you need help with all of this. It would be much less intimidating—a bunch of things can happen then. It is really difficult and takes incredible resources and internal resources to get healthcare when you have basic needs to meet. I am not finding an easy way to do it.”

– Laurel, lesbian living with HIV, migrant worker, USA

122. This report emphasizes the links across population mobility and HIV as being key for achieving our global 2030 goals and targets, and for leaving no one behind. Four main conclusions can be drawn:

The relatively recent increase, speeding up and diversity of human mobility is aggravating the HIV vulnerability of people on the move.

123. This report explores several relevant global trends, including:

- increasing diversity and complexity of human mobility;
- the emerging differentiated role of women on the move;
- the shift in our health paradigm towards a more positive appreciation of development and people on the move;
- the appreciation that mobility is not only or even predominantly about crossing international borders, but also about internal or in-country population movements; and
- the emergence of anti-globalization with a return to more negative views on human rights and international migration.

124. These trends are having significant impacts on HIV health care. It is difficult to ensure continuity of HIV care during the current spike in population mobility, e.g. from rural to urban areas or across international borders. Health-care financing and access has usually been based on residence, citizenship, occupational category or family relationship to someone with health insurance. However, increased population mobility confounds these traditional approaches. Mobility and migration status can increase exposure and vulnerability to HIV, TB and hepatitis.

125. The various legal and regulatory challenges and barriers encountered in the process of moving can aggravate health conditions, with discriminatory policies resulting in higher costs, limited access to services and treatment, and increased morbidity and mortality. The fact that there is a lack of international consensus about the definitions of key terms such as migration and mobility only adds to the complexity of the current context.

Significant obstacles and gaps face mobile populations as far as accessing HIV and coinfection services

126. There are significant obstacles as well as gaps in HIV and coinfection advocacy, policy, programming and funding for mobile communities. In far too many cases, borders are being increasingly treated as rights-free zones, where human rights are illegally assumed to be suspended and protection from discrimination is incorrectly seen as based on regular status in a host location.

127. Health-care settings continue to be one of the main sources of discriminatory practices for people on the move. Health-care services and law enforcement may even appear to overlap, with inadequate training or capacity building for these personnel relative to the experience of people on the move and a lack of firewalls to ensure access to health services regardless of migration status.

128. There is a lack of facilities and training to enable people on the move to address barriers, e.g. legal aid support, ombudsmen or other redress mechanisms. Insufficient regard may be paid to effective linguistic and culturally sensitive communication and healthcare information. An individual on the move may also be exposed to various levels of HIV-related or key population-related stigma and may be criminalized, detained or deported.

“I decided to move because my drug use and family harassment. In general, major challenges I now face include access to food, shelter, work, and health services. Sometimes I face police harassment. Since I am a person living with HIV, I need to be on regular treatment; I also need treatment for Hep C. The governments could have a migrant centre to guide people who come from home, a system where immigrants can get support to get papers or identification. I wish there were no borders.”

– Rachi, male heterosexual, injecting drug user living with HIV and migrant, Myanmar

129. Underlying these barriers is a lack of data and evidence about links between population mobility and HIV in general and about the needs of specific sub-populations on the move. Without enhancing such an integrated population mobility and HIV evidence base, it is unlikely that lawmakers or health-care planning will become more sensitive to and inclusive of people on the move.

Mobile populations are in danger of being left behind in the AIDS response; a significant number of them belong to key populations

130. Significant numbers of people on the move belong to key populations. These mobile sub-populations experience reduced access to services and are at greater HIV risk than people who are not on the move, partly due to the fact they are marginalized, face restrictions on movement and may also be criminalized. Empowering and engaging mobile populations, especially those who belong to key populations, is a key strategy for achieving the 2030 targets.

“I left home because of fights with my family; I had the support of my guru (senior hijra). And I moved to my present location because I found a new hijra family there and a guru. Currently, my major concerns relate to high blood pressure, need to for sexual health services, and hormone therapy. I also struggle because of lack of regular water, working in areas that are not clean, and I sometimes face police harassment. People don’t realise the problems of transgender people: we need to be accepted and given opportunities.”

– Payal, hijra/transwoman, internal migrant, India

There are a range of innovative and scalable good practices for advancing HIV and related services among mobile communities

131. This report features a variety of good practices that address a wide range of issues, including meaningful involvement of mobile populations, capacity building of both people on the move and health-care workers, to ensure culture- and language-competent services, mobile population-sensitive health services, continuity of care/care continuum

across the movement process (including medical passport systems and accessible service locations) and responses to HIV and coinfection vulnerabilities of undocumented migrants. However, the good practices do not exhaust the range of innovative responses that are possible. There are examples of many NGOs who provide HIV and coinfection services, including for uninsured or undocumented migrants. Addressing the health needs of people on the move is crucial for ending the AIDS epidemic by 2030. Governments, NGOs and the private sector can collaborate to replicate or scale up the many good practices available.

Recommendations

132. This report speaks broadly to a range of stakeholders, community-based as well as others. However, these Recommendations are specifically provided as a resource for the development of Decisions Points to be by the NGO Delegation to the PCB meeting in December 2018. This report recommends the following actions in order to more effectively address HIV and coinfection vulnerabilities among mobile populations and to achieve the 2030 targets. It calls on UNAIDS to

- *adopt* the IOM definition of migrant; and to fully implement the cooperation agreement between UNAIDS and IOM to promote access to HIV prevention, treatment, care and support services for migrants, mobile populations and people affected by humanitarian emergencies;
- *increase* its efforts to address and remove all legal and regulatory barriers that undermine the human and health rights of mobile populations, including travel restrictions, criminalization of key populations, criminalization of HIV transmission, and lack of service provision and access, including to harm reduction services;
- *develop and promote* a basic package of nonjudgmental, confidential, and culturally and linguistically competent primary healthcare services that will be made available to people on the move as part of UHC and in recognition of their right to the highest attainable standard of health, regardless of migration status, free of charge, and including speedy access to quality and culturally competent HIV, TB and hepatitis diagnostics, treatment and care services, mental health services as needed, sexual and reproductive health services for women and girls, and ensuring continuity of care;⁴⁸
- *request* that the Office of the United Nations High Commissioner for Human Rights prepare a report on the state of respect for the human and health rights of mobile populations, including those living with and at risk of HIV, as well as those belonging to key populations, and any laws that allow for travel and work restrictions, deportation or confinement on the basis of sexual orientation and social nonconforming behaviours as well as HIV, TB or hepatitis status;
- *develop* a policy brief on the meaningful involvement of mobile populations aligned with the GIPA principle of "nothing about us without us" with recommendations for governments, civil society and international donors on how to increase, improve and support their involvement as peers in the development, delivery and evaluation of global, regional and country AIDS responses;
- *offer* technical support to ensure that national health-care systems and HIV plans urgently address the needs of people on the move, including provision of mobile clinics and other forms of community-based HIV testing, alternatives to detention, medical/health passports or other patient-held clinical record cards that ensure continuity of health care, establishing a common data framework and improving the

evidence base on HIV in relation to mobile populations, training of health-care personnel in rights-based sensitive/inclusive and interculturally competent or safe health care for mobile populations, protections against labour exploitation and sexual violence, and strengthened international cooperation on the health of mobile populations;

- *call* for the explicitly including in the AIDS response targeting key populations those people on the move who belong to key populations, namely people on the move who are also gay men and other men who have sex with men, sex workers, transgender people, people who inject drugs, and people on the move held in closed settings such as detention centres or camps; as well as particularly vulnerable groups such as undocumented migrants, people who may have been forced to move against their will or who have been trafficked, and mobile populations that may be designated as key populations by specific countries based on the national epidemiological and social context.

6. ANNEXES

Annex 1. Acknowledgements and participants

The NGO Delegation to the PCB is grateful to all the individuals and organizations, including the 83 survey respondents, who contributed their time, experience and insights to make this report possible. Your voices, experiences and stories are crucial for ensuring that urgent and relevant actions are taken at the PCB to address the issues and concerns of people on the move in the context of a global AIDS epidemic.

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Annex 2: Abbreviations and acronyms

ACHIEVE	Action for Health Initiatives
AIDS	acquired immune deficiency syndrome
ART	antiretroviral treatment
CHABAC	Canadian HIV/AIDS Black, African and Caribbean Network
DRC	Democratic Republic of Congo
HIV	human immunodeficiency virus
IDP	internally displaced persons
IOM	International Organization for Migration
LAC	Latin America and the Caribbean
LGBTI	lesbian, gay, bisexual, transgender and intersex
MDG	Millennium Development Goals
MSM	Men who have sex with men
OFW	Overseas Filipino Workers
PCB	Programme Coordinating Board
people living with HIV	People living with HIV
PrEP	pre-exposure prophylaxis
PWID	people who injects drugs
SDG	Sustainable Development Goals
TB	Tuberculosis
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS

Annex 3. UN Member States' existing policy framework

Key documents	Selected references
<p>2018. 38th Session UN Human Rights Council, Agenda item 3: Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development</p>	<p>19. Urges States to address the multiple and intersecting forms of discrimination and the specific health-care needs experienced by migrant and mobile populations, and by refugees and crisis-affected populations, in the context of HIV and to eliminate stigma, discrimination and violence, as well as to review policies related to restrictions on entry on the basis of HIV status with a view to eliminating such restrictions and the return of people on the basis of their HIV status, and to support their access to HIV prevention, diagnosis, treatment, care and support;</p>
<p>2017. 35th Session UN Human Rights Council, Agenda item 3: The right of everyone to the enjoyment to the highest attainable standard of physical and mental health</p>	<p>2) Calls upon States to respect, protect and fulfil the right of everyone to the highest available standard of physical and mental health, with special attention to groups in vulnerable situations;</p>
<p>2017. 70th World Health Assembly Agenda item 13.7: Promoting the health of refugees and migrants</p>	<p>2. URGES Member States, in accordance with their national context, priorities, and legal frameworks:</p> <p>(1) to consider promoting the framework of priorities and guiding principles, as appropriate, at global, regional and country levels including using it to inform discussions among Member States and partners engaged in the development of the global compact on refugees and the global compact for safe, orderly and regular migration;</p> <p>(2) to identify and collect evidence-based information, best practices and lessons learned in addressing the health needs of refugees and migrants in order to contribute to the development of a draft global action plan on promoting the health of refugees and migrants;</p> <p>(3) to strengthen international cooperation on the health of refugees and migrants in line with paragraphs 11 and 68 and other relevant paragraphs of the New York Declaration for Refugees and Migrants;</p> <p>(4) to consider providing necessary health-related assistance through bilateral and international cooperation to those countries hosting and receiving large populations of refugees and migrants;</p>
<p>2017. PCB Agenda item 1.4; Report of the NGO Representative</p>	<p>4.4 Requests UNAIDS and member states in partnership with civil society organizations and all other relevant stakeholders to:</p> <p>a. Develop and apply country-level, community-participatory evidence gathering methodologies to identify barriers and measure the level and quality of access to services for all at risk populations so as to leave no one behind;</p> <p>4.5 Requests the Joint Programme to facilitate partnerships between member states and community-based organizations to help ensure effective action to meet HIV prevention, early diagnosis and treatment needs so as to leave no one behind;</p>
<p>2016. UN General Assembly New York Declaration on Refugees and Migrants</p>	<p>30. We encourage States to address the vulnerabilities to HIV and the specific health-care needs experienced by migrant and mobile populations, as well as by refugees and crisis-affected populations, and to take steps to reduce stigma, discrimination and violence, as</p>

	<p>well as to review policies related to restrictions on entry based on HIV status, with a view to eliminating such restrictions and the return of people on the basis of their HIV status, and to support their access to HIV prevention, treatment, care and support.</p>
<p>2016. UN General Assembly Political Declaration on HIV/AIDS</p>	<p>42. Note with alarm the slow progress in reducing new infections and the limited scale of combination prevention programmes, emphasizing that each country should define the specific populations that are key to its epidemic and response, based on the local epidemiological context, and note with grave concern that women and adolescent girls, in particular in sub-Saharan Africa, are more than twice as likely to become HIV-positive than boys of the same age, and noting also that many national HIV prevention, testing and treatment programmes provide insufficient access to services for women and adolescent girls, migrants and key populations that epidemiological evidence shows are globally at higher risk of HIV, specifically people who inject drugs, who are 24 times more likely to acquire HIV than adults in the general population, sex workers, who are 10 times more likely to acquire HIV, men who have sex with men, who are 24 times more likely to acquire HIV, transgender people, who are 49 times more likely to be living with HIV, and prisoners, who are 5 times more likely to be living with HIV than adults in the general population;</p> <p>62 (e). Promote the development of and access to tailored comprehensive HIV prevention services for all women and adolescent girls, migrants and key populations;</p>
<p>2016. UN General Assembly Sustainable Development Goals</p>	<p>Goal 10.7 Facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies.</p>
<p>2015. PCB Agenda item 6: HIV in prisons and other closed settings</p>	<p>8.5 Encourages the Joint Programme to</p> <p>a. Undertake initiatives to ensure that appropriate HIV interventions are routinely incorporated in all humanitarian emergency preparedness and response programmes;</p> <p>c. Prioritize actions to address gender-based violence against people affected by humanitarian emergencies, including women, young people, and other key populations [...];</p> <p>d. Promote cross-border and regional collaboration, as well as national and community collaboration, to ensure access to essential HIV prevention, care, treatment and support services for refugees and other displaced populations;</p> <p>e. Strengthen strategic HIV information, including age- and sex-disaggregated data, in humanitarian emergencies [...]</p>
<p>2008. UN Committee on the elimination of discrimination against women (CEDAW): General recommendation No. 26 on women migrant workers</p>	<p>23 (a) Formulating a comprehensive gender-sensitive and rights-based policy: States parties should use the Convention and the general recommendations to formulate a gender-sensitive, rights-based policy on the basis of equality and non-discrimination to regulate and administer all aspects and stages of migration, to facilitate access of women migrant workers to work opportunities abroad, promoting safe migration and ensuring the protection of the rights of women migrant workers (articles 2 (a) and 3);</p> <p>23 (b) Active involvement of women migrant workers and relevant non-governmental organizations: States parties should seek the</p>

	active involvement of women migrant workers and relevant nongovernmental organizations in policy formulation, implementation, monitoring and evaluation (article 7 (b));
2008, PCB Agenda item 3: Report of the International Task Team on HIV-related Travel Restrictions	6.1 Strongly encourages all countries to eliminate HIV-specific restrictions on entry, stay and residence and ensure that people living with HIV are no longer excluded, detained or deported on the basis of HIV status;
2008. Sixty-First World Health Assembly Agenda item 11.9: Health of Migrants	<p>Calls upon Member States:</p> <p>(1) to promote migrant-sensitive health policies;</p> <p>(2) to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race;</p> <p>(3) to establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;</p> <p>(6) to raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;</p>
2001. UN General Assembly Declaration of Commitment on HIV/AIDS	50. By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services.
1990. International Convention on the rights of all migrant workers and their families	<p>Article 70</p> <p>States Parties shall take measures not less favourable than those applied to nationals to ensure that working and living conditions of migrant workers and members of their families in a regular situation are in keeping with the standards of fitness, safety, health and principles of human dignity.</p>
1966. International Covenant on Economic, Social and Cultural Rights	<p>Article 12</p> <p>1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.</p> <p>2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:</p> <p>(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;</p> <p>(b) The improvement of all aspects of environmental and industrial hygiene;</p> <p>(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;</p> <p>(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.</p>
1951. Convention Relating to the Status of Refugees	<p>Article 33 (1)</p> <p>No Contracting State shall expel or return ("refouler") a refugee in any</p>

	manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion.
1948. UN General Assembly Universal Declaration of Human Rights.	Article 25 (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services [...] (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.
1946. Constitution of the World Health Organization.	The enjoyment of the highest available standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

Annex 4: Varieties of people on the move

Specific mobile population	Description
Asylum seeker	<ul style="list-style-type: none"> - Person who flees his/her home country and requests asylum or protection in another country - Any claim for refugee status has not yet been determined
Cross-border or circular migrant	<ul style="list-style-type: none"> - Person who works in one country but resides in another, moving repetitively back and forth across international borders, e.g. the China/Viet Nam, Switzerland/France or Myanmar/Thailand frontiers
Internal migrant	<ul style="list-style-type: none"> - Person who moves from his/her usual place of residence but remains within the borders of his/her own country - Usually involves crossing regional, district, or municipal boundaries (e.g. urban to rural, or vice versa) for educational or employment purposes or a better livelihood
Internally displaced person	<ul style="list-style-type: none"> - Persons who have been forced to leave where they live as a result of or in order to avoid the effects of armed conflict, generalized violence, violations of human rights, or natural or man-made disasters - Unlike refugees, they are on the run at home and have not crossed an international border
International labour migrant	<ul style="list-style-type: none"> - Person performing a remunerated activity in a country where s/he is not a national - Usually under special time-limited work permit or visa
International migrant	<ul style="list-style-type: none"> - Person who crosses an international state boundary and stays in the destination country for some time, usually at least one year
International student	<ul style="list-style-type: none"> - Person who has crossed a national border for the purpose of education and is now enrolled outside their country of origin - Usually under special time-limited student permit or visa
Nomad	<ul style="list-style-type: none"> - Person that moves from place to place and has no permanent home - May involve seasonal movement to find fresh pasture for his/her animals, as in the case of pastoralists
Refugee	<ul style="list-style-type: none"> - Person who has been forced to flee his/her country because of persecution, war or violence - Has well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group - Most likely, cannot safely return home or are afraid to do so.
Rom (Roma)	<ul style="list-style-type: none"> - Person belonging to the this ethnic group of traditionally itinerant people who originated in northern India but live nowadays around the world, mainly in Europe - Plural Roma, also called Romany or Gypsies (considered pejorative)
Stateless persons	<ul style="list-style-type: none"> - Person who is not legally considered as a citizen by any state
Tourist	<ul style="list-style-type: none"> - Person who visits places away from their usual environment mainly for the purposes of pleasure and interest
Trafficked person	<ul style="list-style-type: none"> - Person who is recruited, transported, or harboured by means of threat, force, fraud, deception, or abuse of power, for the purpose of exploitation

	<ul style="list-style-type: none">- Exploitation may involve forced labour, sexual violence, slavery, or even organ removal- May occur in home country or involve crossing an international border
Undocumented migrant	<ul style="list-style-type: none">- Person who enters or stays in a country without the documents needed to be within the country legally

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