Vulnerable mobile populations overlooked

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Many countries have been seemingly overwhelmed by the speed with which the HIV epidemic has spread and its impact on forced migrants and other mobile populations.

Millennium Development Goal 6 (MDG 6) seeks improved access to HIV prevention services and AIDS treatment, care and support, and halting and reversing the spread of the HIV epidemic by 2015. Universal access to HIV/AIDS services can only be achieved if the global effort to scale up HIV prevention, care and treatment includes such highly vulnerable populations as the estimated 200 million people affected annually by humanitarian crises (and, frequently, by the ensuing displacement), the approximately 50 million uniformed services personnel, and regular and irregular migrants. UNAIDS has created a new Outcome Framework to galvanise support for key objectives which include reducing sexual transmission of HIV, improving access to treatment, social protection, empowering young people and combating gender-based violence. UNAIDS is promoting the strong partnerships that can deliver results on the ground.

Meeting MDG 6 will not be easy for a variety of reasons. At the end of 2008, only 42% of people in need of treatment were receiving anti-retroviral therapy. While this represents a significant increase over the previous year’s coverage of 33%, reaching all those still in need of antiretrovirals will require a major reallocation of human, financial and logistical resources. Countries will need to take a more comprehensive view of demographic realities in order to ensure inclusion of IDPs, refugees and migrants.

Mobile populations

Among those who have traditionally not been reached by HIV (as well as other health) interventions, mobile populations rank especially high. These vulnerable groups are growing in both number and diversity and comprise a varied mix of people forced to move as a result of war and natural disasters and people who move in search of work and economic opportunities. Differences between refugees and IDPs are not only limited to legal status, but also to living conditions and socioeconomic opportunities, depending, for example, on whether people are living in camps or not, which can in turn affect their ability to integrate into the host community.

There are also millions of people who are typically referred to as economic migrants, but who also vary widely in terms of their status, how they move and how they are received. Some move officially, and are known as regular or documented migrants; they have a type and degree of access to health care that unofficial or irregular migrants, who are not documented, and are often smuggled or otherwise travel under difficult conditions, do not benefit from.

In coming years, changing climatic patterns and environmental conditions are expected to displace many more people, and this will add massively to the demographic, social and cultural complexities confronting health planners and those responsible for designing HIV programmes.

What all of these forms of human movement have in common is that the backgrounds people come from, the conditions under which they move, and the ways in which they are received and resettled (even for temporary periods) can influence both their physical health and their psychosocial well-being, and can affect patterns of incidence of HIV, TB and other diseases. If the gap between rich and poor countries, and between rich and poor people, continues to grow and as transportation and information options improve, the speed with which people move will increase – and this in turn will impose on governments an ever greater need for pro-active planning, flexibility in health policy and rapid response capacities.

Due to the circumstances of their movements, forcibly displaced populations, as well as migrants, can be at a higher risk of gender-based violence, including rape, which in turn can increase the risk of HIV infections. Combating sexual violence which is a serious violation of human rights in itself, is therefore also a key priority in order to prevent HIV transmission and to protect the rights of mobile populations, especially – but not only – in conflict settings. It is crucial that uniformed services, such as militaries and peacekeepers, are targeted not only with HIV services (as they are highly mobile groups themselves) but also as agents of change, to combat gender-based violence and the spread of HIV.

The health and human security of migrants and refugees, however, are also a function of the extent to which migrants have access to, and are able to use, health and social services in the countries they pass through and settle in. In some cases this is influenced by legal and administrative requirements, while in others it may be more a function of social, cultural and linguistic factors. In most situations it is a mix of all of these factors and more.

In principle, the right of refugees and asylum seekers to health care and to HIV services is protected by international conventions, and documented migrants are also likely to be assured of access to the same health care as nationals. The extent to which undocumented migrants are able to or feel free to access services, including for HIV, in the countries where they live and work varies considerably. In general, undocumented migrants have come to constitute a particularly marginalised group in most parts of the world, and have far more limited
Forced migration and HIV/AIDS in Asia: some observations

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Although most of Asia has not suffered from a generalised HIV epidemic, there is reason to be concerned about how forced migration and economic crisis-related migration may increase the risks.

A thorough discussion of how and why forced migration can increase risks of HIV transmission in the region would require reviewing a myriad of social, cultural, economic and even physiological dynamics. So I will focus on a few issues of particular relevance – HIV in humanitarian settings, security-related programme developments, and the special needs of the millions of Asians who, out of desperation, find themselves exploited and unprotected as labourers in foreign lands.

In my capacity as Special Envoy, I have advocated for stronger prevention, better care, and destigmatisation of HIV/AIDS throughout the region. I have also worked for the recognition that migration within and outside the region plays an important epidemiological role and that there must be much greater attention paid to the rights, needs and protection of migrants. Over the past decade, there has been significant progress in HIV awareness and adoption of ever more progressive and effective policies and programmes by many governments. A good example of recent change is the lifting of immigration restrictions based on HIV status by China, setting a good example for other countries.

But there remains much room for improvement when it comes to widespread establishment of effective, rights-based policies and programmes for HIV prevention and care. There are particular needs for more attention to those at risk due to being displaced. There are millions of Asians who have left their homes and areas of origin and are living, often without their families or other social support, in new communities. Many are facing circumstances which make them more vulnerable to contracting HIV while at the same time they have lost access to information and means of prevention.

Over the past decade there has been a great deal of conflict-related displacement in the region. Civil war or insurgencies in Afghanistan, Nepal, Myanmar, Sri Lanka, Indonesia, Pakistan, India and the Philippines and across Central Asia have created large numbers of refugees and IDPs who have required humanitarian support. Although HIV prevention, as a part of the minimum package of reproductive health services, was adopted as a critical component of humanitarian response in 1994, resource constraints and social and cultural factors have impeded universal access to information and means of prevention among these populations. (It should also be pointed out that for some people the first information they ever received on HIV was from humanitarian agencies.)

Some types of conflict or displacement have brought much more particular risks of HIV infection. For example, long years of refugee...