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)[1] 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[2] 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.[3]

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 socio-economic 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,[4] 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

access to health care services than other types of people on the move.

Many countries have not had the time or the insight to develop the policies and programmes needed to reach newcomers adequately. Others have simply chosen to neglect the question of HIV and mobile populations, in some cases assuming or hoping that people will not stay for long, or that the needs of newcomers will prove to be no different from those of their host populations. As a result, migrants and refugees are being overlooked everywhere, even though they may be made all the more vulnerable to HIV because of the work they do and the type of lives they are forced to live

Today the question of how to achieve greater and better access to prevention, care and treatment for HIV looms large. It is unlikely that MDG 6 will be met without far more outreach to all forms of displaced populations and migrants, regardless of their status, and to the uniformed services that in many cases interact with them. Specially tailored programmes to ensure universal access to vulnerable groups must become an integral part of national HIV policies and strategies, and a key item on the agenda of the international community.

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1. To combat HIV/AIDS, malaria and other diseases. http://tinyurl.com/MDG6-disease

2. Joint action for results: UNAIDS Outcome Framework, 2009-2011, available at: http://tinyurl.com/UNAIDS-OutcomeFramework

3. Partnerships especially with WHO, UNHCR, UNFPA, WFP, UNICEF, UNDP, UNODC, ILO, IOM, and ICMHD.

4. See FMR 31, Climate change and displacement at http://www.fmreview.org/climatechange.htm and in particular 'Health challenges' by Manuel Carballo, Chelsea B Smith and Karen Pettersson at http://www.fmreview.org/FMRpdfs/FMR31/32-33.pdf