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DESK REVIEW
DEVELOPMENT OF A REGIONAL RIGHTS-BASED FRAMEWORK TO INCREASE THE ACCESS OF MIGRANTS AND MOBILE POPULATIONS TO HIV PREVENTION, CARE, SUPPORT AND TREATMENT

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All human beings are born free and equal in dignity and rights. Everyone has the right to recognition everywhere as a person before the law. We recall that our obligations under international law prohibit discrimination of any kind on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Yet in many parts of the world we are witnessing, with great concern, increasingly xenophobic and racist responses to refugees and migrants.

UN Resolution RES/71/1 on Refugees and Migrants "The New York Declaration 2016"

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BVI	British Virgin Islands
CARICOM	Caribbean Community
CEDAW	Convention on the Elimination of All Forms Discrimination Against Women
CCJ	Caribbean Court of Justice
CJ	Chief Justice
CRC	Convention on the Rights of the Child
CRN+	Caribbean Network of Persons Living with HIV
CRSF	Caribbean Regional Strategic Framework
CSME	Caribbean Single Market and Economy
CVC	Caribbean Vulnerabilities Communities Coalition
CSO	Civil Society Organisation
COHSOD	Council for Human and Social Development
DR	Dominican Republic
ECLAC	UN Economic Commission of Latin America and the Caribbean
EU	European Union
GAM	Global AIDS Monitoring Report
GCM	Global Compacts for Migration
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit (GIZ) GmbH
GDP	Gross Domestic Product
HCP	Health Care Professional
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families
IDP	Internally displaced person
IECSR	International Covenant on Economic, Social and Cultural Rights
ILO	International Labour Organisation
IOM	International Organization for Migration
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MSM	Men who have Sex with Men
MIPEX	Migration Integration Policy Index
MOSCTHA	El Movimiento Socio-Cultural de los Trabajadores Haitianos
NAP	National AIDS Programme
NCD	Non-communicable Diseases
NGO	Non-Governmental Organisation
OECS	Organisation of Eastern Caribbean States
OHCHR	Office of the High Commissioner for Human Rights
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PLHIV	People Living With HIV
SDH	Social Determinants of Health
SDG	Sustainable Development Goals
STI	Sexually transmitted infection
TIP	Trafficking in Persons
TB	Tuberculosis
UHC	Universal Health Care
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNHCR	United Nations High Commissioner for Refugees
US	United States
UWI	University of the West Indies
WHO	World Health Organisation

INTRODUCTION

Rationale for Development of a Framework for Migrant Health

While the first reported case of HIV in the Caribbean region occurred in 1981, it was only within the second version of the Caribbean Regional Strategic Framework (CRSF) on HIV and AIDS 2008-2012 (CRSF 2008-2012) that programmatic concentration shifted from general populations to more focused interventions on most-at-risk or key populations including mobile and migrant populations.

Under a Round 9 Global Fund Grant, The Pan Caribbean Partnership Against HIV/AIDS (PANCAP) in 2012, commissioned research into the vulnerabilities of migrant workers in the informal economy in four Caribbean countries including, Antigua and Barbuda, Barbados, Belize and Trinidad and Tobago. Following this project, the PANCAP/ Deutsche Gesellschaft für Internationale Zusammenarbeit (German Society for International Cooperation) (GIZ) or PANCAP/GIZ Migrant Project ***"Improving Access of Mobile Populations to HIV Services in the Caribbean"*** worked to integrate migrant-specific interventions into the national HIV response and improve inclusion of migrants on regional and national HIV bodies in order to advocate for equal access to health care in Antigua and Barbuda, Sint Maarten, Suriname, Guyana, Trinidad and Tobago, Dominican Republic and Haiti (border region).

Key population-specific interventions targeting Men who have Sex with Men (MSM), sex workers, miners and loggers were implemented in Guyana, Jamaica, Belize, Suriname and Haiti. Under the GIZ Project, migrant-friendly HIV services were developed or strengthened in the following countries: two (2) in Antigua and Barbuda, three (3) in the Dominican Republic and Haiti, one (1) in Trinidad, two (2) in Guyana and one (1) in Suriname. NGOs in Suriname continue to provide migrant friendly services for both HIV and malaria. The work of NGOs in the Dominican Republic, for example, El Movimiento Socio-Cultural de los Trabajadores Haitianos (MOTSCHA, its Spanish acronym) which has a long history (over 30 years) of providing services including HIV services to Haitian migrants in the Dominica Republic was strengthened.

Notwithstanding the gains achieved by these projects, migrants continue to face challenges in accessing health services which impact HIV coverage by reducing testing, linkage and retention in HIV care and treatment programs. For example, sex workers are an identified mobile population in this region and are particularly vulnerable to higher rates of HIV due to stigma and discrimination which limits their access to HIV care and treatment services. Simultaneously, national contexts which vary based on legislation and policy imperatives, social security and national health requirements for access to health, level of availability of services and language limitations continue to pose challenges. There is no policy approach at the regional level to establish basic guidance on access to health by migrants in a region where intra-regional migration is high.

Given these challenges, PANCAP intends to develop a rights-based framework for migrant access to health to increase coverage of HIV care and treatment as the countries of the region strive to fulfill their commitment to achieve the 90-90-90 global targets. By 2020:

- 90% of all people living with HIV will know their HIV status.
- 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
- 90% of all people receiving antiretroviral therapy will have viral suppression.[1]

[1] UNAIDS. (2014). 90-90-90 An ambitious treatment target to help end the AIDS epidemic. Joint United Nations Programme on HIV/AIDS (UNAIDS). Geneva, Switzerland. Retrieved from: http://www.unaids.org/sites/default/files/media_asset/90-90-90_en.pdf

Methodology

The report is a comprehensive desk review of existing legislation, policy, international law principles and emerging health and migration policy initiatives on the access to health by migrant and mobile populations including barriers limiting the access to health and specifically HIV services for migrants in the Caribbean. Key informant interviews were also conducted with the consultants on the PANCAP/GIZ Project and immigration officials from two countries (Antigua and Barbuda and Guyana).

Structure of the report

At its inception, this desk review provides a brief outline of the current climate related to international migration which is shaping some of the more negative perceptions of migration in general, the myriad vulnerabilities experienced by migrants particularly irregular or undocumented migrants and the growing international policy framework which recognises that migrants right to health is a critical omission of international and regional discourse which have focused on security and the protection of borders in the absence of an understanding that migrants are people entitled to basic fundamental rights.

The following section situates the Caribbean as a region with high rates of emigration and relatively low rates of immigration. In contrast with ongoing international mass movements, the situation in the Caribbean is characterised by a cyclical and constant flow of formal and informal workers and other classes of migrants within and among Caribbean States. The section also reviews the profile of migrants as identified by countries included in the PANCAP/GIZ Project, the gender dimensions of migration in the region, the situation of Haitian migrants in The Bahamas and in the Dominican Republic and ends with the governance challenges related to migration in the Caribbean.

The legal barriers limiting a rights-based application of migration in the Caribbean is presented in the following section, including the opportunities for the expansion of non-discrimination based on the recent case law from Belize, Trinidad and Tobago and the Caribbean Court of Justice. The following section centres on international law human rights principles relating to migrant rights, particularly the right to health and the barriers and conditions of vulnerability impacting migrants access to health. The barriers and challenges in accessing HIV services, identified by the Caribbean research are thereafter presented with striking similarity to findings on the barriers and conditions of vulnerability presented in the previous section.

The report finally considers key policy imperatives in addressing the health of migrants and recommendations from the research and other policy frameworks on priorities for inclusion in a rights-based framework to increase access of migrant and mobile populations to health and specifically HIV prevention, treatment and care services in the Caribbean.

Getting it Right - Definitions

Theories and definitions of migration are diverse and include temporary and more permanent forms of human mobility that can occur for different purposes over long and short distances. Statistics on global migration are imprecise because of the diversity in definitions and due to the difficulty of counting irregular or undocumented migrants. A list of definitions for some key concepts including mobility, migration, undocumented migrant, asylum seeker, refugee, among others are contained in **Annex 1**. This list is supplemented by **Annex 2** which lists the United Nations (UN), United Nations Joint Programme on HIV/AIDS (UNAIDS), International Labour Organisation (ILO), World Health Organisation (WHO) and key international convention definitions.

THE CURRENT CLIMATE RELATED TO MIGRATION AND MOBILITY

1 billion people in the world today are on the move. There are an estimated 244 million international migrants (3·3% of the world's population)—an increase from 155 million in 2000. Internal migration is most prevalent, with more than 740 million people who have migrated within their own country of birth. In 2015, almost half (48 percent) of the 244 million international migrants were women.[2] According to the International Organisation for Migration (IOM), the UN migration agency:

> "We are facing the highest levels of forced displacement globally recorded since World War 2, with a dramatic increase in the number of refugees, asylum seekers, and internally displaced people across various regions of the world. But this so-called migrant crisis is not a crisis of numbers, it is a crisis of policies—of policies not keeping pace with today's challenges".[3]

An Increasingly Challenging Landscape

Human migration is not a new phenomenon, but it has changed significantly in number and nature with the growth of globalization, including the ease of international transport and communication, the push and pull factors of shifting capital, effects of climate change, and periodic political upheaval, including armed conflict. As a result, migrant networks that facilitate mobility and circular migration, in particular, have expanded in unprecedented ways.

Box 1

"Do we want migration to be a source of prosperity and international solidarity, or a byword for inhumanity and social friction?"

Antonio Guterres, UN Secretary General
World Congress on Migration, Ethnicity, Race and Health
May 17–19, 2018, in Edinburgh, UK

The words of the Secretary-General of the United Nations, Antonio Guterres quoted here, is critical in considering the global situation of migration today. Forced displacement due to the wars in Syria, Afghanistan, Iraq, Yemen, unrest and economic strife in some countries in Northern and Western Africa and displacement due to persecution, conflict, generalized violence, and human rights violations in Latin America have triggered an unprecedented wave of mass migration giving rise to **hardening attitudes globally**, including a **rise of ultra-nationalistic populist sentiments, xenophobia, restrictive immigration policies and practices, and the rise of criminal networks increasing the vulnerability of migrants to exploitation including forced labour, sexual exploitation and trafficking**.[4]

Contrary to public perception, while millions have attempted to reach Europe, with thousands dying at sea, more than 40,000 since 2000, millions more remain in border states. The top hosting countries for migrants include countries in the developing world - **Jordan** (664,100), **Ethiopia** (736,100), **Iran** (979,400),

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[2] UN DESA (United Nations Department of Economic and Social Affairs, Population Division) (2016). International Migration Report 2015 Highlights. ST/ESA/SER.A/375. p. 1. Retrieved from http://www.un.org/en/development/desa/population/migration/publications/migrationreport/docs/MigrationReport2015_Highlights.pdf.

[3] Lancet. (2018). No public health without migrant health. World Congress on Migration, Ethnicity, Race and Health May 17–19, 2018, Edinburgh, UK. Retrieved from https://www.thelancet.com/pdfs/journals/lanpub/PIIS2468-2667(18)30101-4.pdf

[4] International Organisation for Migration. (2017, February 23-27). Address by David Mosca, Director of Health and Migration Division to the 2nd Global Consultation on Migrant Health 2017: Resetting the Agenda, Colombo, Sri Lanka. Retrieved from http://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/2GC%20Colombo%202017%20Setting%20the%20Scene4.pdf

Lebanon (1.1m), **Pakistan** (1.6m) and **Turkey** (2.5m).[5] Some 86 percent of displaced persons are hosted in developing countries, making refugees less of a burden on developed countries.[6]

The Caribbean is not immune. The ongoing political and economic crisis in Venezuela has triggered an influx of Venezuelan migrants in countries of South and Central America, Trinidad and Tobago and Guyana. The effects of climate change, natural disasters, including the unprecedented violent hurricanes in 2017, forced the temporary migration of nationals from Dominica, British Virgins Islands (BVI) and other affected countries to bordering states and the temporary relocation of prisoners from the British Virgin Islands to other countries in the Organisation of Eastern Caribbean States.

In April 2018, the United Nations refugee agency, the United Nations High Commissioner for Refugees (UNHCR) reported the forced deportation of 82 Venezuelan **asylum seekers** contrary to the principle of **non-*refoulement***,[7] which the Government of Trinidad and Tobago reported was voluntary. UNHCR also reported that persons were being held in detention without the agency being given access to them.[8]

Box 2

T&T Newspaper Newsday

"A looming crisis"

"There are costs that must be borne by the State - the cost of health care and education are just two that arise.

The type of jobs they engage in, what are the effects on the labour market, will local workers be displaced?

We have to assess the social, cultural and economic impact of the arrival of **these people**? **As citizens**, we just need a better understanding of what is taking place".

A looming Crisis // Sept 2017
http://newsday.co.tt/2017/09/14/a-looming-crisis/

Vulnerability of Mobile and Migrant Populations

Migration and mobility within a receiving country is often framed as a ''threat''. Throughout the world, migrants face daily and systematic violations of their human rights. The UN Human Rights Council has stressed the particular vulnerability of migrants to discrimination, exploitation, and abuse, and has repeatedly underscored the importance of the international human rights regime for protecting migrants.[9]

Yet, migrants' "right to have rights" is continuously called into question, particularly when their residence or migration status is irregular, and migrants are subject to systematic discrimination and human rights violations. **In the context of migration control**, migrants:

[5] Ibid, citing source - UNHCR 2016

[6] United Nations Development Program. (2013). Human Development Report, p. 35. Retrieved from http://hdr.undp.org/sites/default/files/reports/14/hdr2013_en_complete.pdf

[7] The right to be protected against "refoulement" (expulsion or return) is the cornerstone of international refugee law. The principle of "non-refoulement", enshrined in Article 33 (1) of the 1951 Convention, prohibits Member States from returning a refugee to a country "where his life, or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion".

[8] Reuters. (2018, April). U.N. says Trinidad forcibly deported Venezuelan refugees //April 2018. Retrieved from https://www.reuters.com/article/us-trinidad-venezuela/u-n-says-trinidad-forcibly-deported-venezuelan-refugees-idUSKBN1HU2RN

See also, Newsday. (2017, September). A looming Crisis // Sept 2017. Retrieved from http://newsday.co.tt/2017/09/14/a-looming-crisis/

Blomberg. (2018, March). Venezuelans, Go Home: Xenophobia Haunts Refugees // March 2018. Retrieved from https://www.bloomberg.com/news/features/2018-03-05/venezuelans-go-home-xenophobia-spreads-as-refugees-flee-crisis

[9] Office of the High Commissioner for Human Rights. (2012). Migration and Human Rights - Improving Human rights-based Governance of International Migration Report on Global Governance. Geneva, Switzerland. Retrieved from http://www.ohchr.org/Documents/Issues/Migration/MigrationHR_improvingHR_Report.pdf

- can be imprisoned, deported and detained in conditions which may breach an array of civil, cultural, economic, political, and social rights, including the prohibition of inhuman and degrading treatment and the right to freedom from arbitrary deprivation of liberty;[10]
- are systematically detained for immigration purposes in all regions of the world;
- may face family separation (including children from their parents) due to detention, deportation, and discrimination;
- have limited opportunities for family migration;
- right to life is at times threatened by, for example, border control practices and immigration enforcement practices that can endanger lives and limit or refuse access to justice for violence, whether by police, border or immigration detention officials, traffickers, employers, landlords, or partners;
- face, xenophobia, discrimination, sexual violence (women and children in particular) and other rights violations;
- exercise of social rights linked to access to services, including education, shelter, social protection and health, is restricted in many countries according to migration or residence status.[11]

Migrants who have no official status or who are otherwise irregular;

- have problems accessing education, health care, housing and any other forms of official assistance,
- in the case of domestic workers, may be sexually or emotionally abused with impunity, while workers in the informal sector, with no support from trade unions or the wider community, may be fired without reason or simply not paid;
- as a migrant worker, 'easily fall prey' to extortion and are highly vulnerable to abuse and exploitation by employers, migration agents, corrupt bureaucrats and criminal gangs.
- in the case of women, are doubly vulnerable owing to the high risk of sexual exploitation. Victims of smuggling and trafficking may find themselves both irregular in legal terms, and in situations of exploitation at the hands of the traffickers or smugglers.

Box 3

Five common myths about refugees

Refugees are a European problem
Europe is home to only 6% of global refugees; 86% are in developing countries. The six richest nations host only 9% of refugees worldwide.

Refugees are not desperate—they Are choosing to migrate
By definition refugees are people who flee across borders to escape violent conflict or persecution.

Most refugees are young, able-bodied men
Worldwide nearly 50 million children have migrated or been forcibly displaced. These children may be refugees, internally displaced persons or migrants.

Refugees and migrants bring terrorism
Over the past few years the deadliest terrorist attacks around the world have been perpetrated by citizens born in the targeted countries.

Developed countries are overcrowded and cannot take any more people
The size of the population in most developed countries is actually declining, and the demographic dividend in these countries is being exhausted. Migration can be crucial in addressing this issue.

UNDP, 2016 Human Development Report

[10] See, for example, reports of the UN Special Rapporteur on the human rights of migrants, including, Report of the Special Rapporteur on the Human Rights of Migrants. For relevant judgments relating to immigration detention by the European Court of Human Rights at http://www.detention-in-europe.org/index.php?option=com_content&view=article&id=316&Itemid=214

[11] Ceriani Cernadas, P., LeVoy, M. and Keith, L. (2015). Human Rights Indicators for Migrants and their Families. Global Knowledge Partnership on Migration and Development (KNOMAD). Retrieved from https://www.ohchr.org/Documents/Issues/Migration/Indicators/WP5_en.pdf

The more 'illegal' a migrant, the greater is the danger of the journey, or of being exploited, or even enslaved by traffickers and unscrupulous employers. Vulnerability to abuse and exploitation sharply increases due to the disassociation between nationality and physical presence.

Impact of Non-Human Rights-based Approaches

Discussions on global migration governance have been shaped by **two predominant narratives**, namely

- **the perceived economic, political and security interests of states**, which lean towards the closing of borders and the screening of migrants and asylum seekers outside of their borders; and
- **the protection of refugee and migrants' rights**.

While some States are striving to achieve a balance, the global trend towards the securitisation of migration is threatening to jeopardise the protection and rights of migrants. Internationally, **policy-making on migration has generally been conducted from policy sector ''silos''** (for example, security, immigration enforcement, trade, and labor) that rarely include the health sector, and which often have different, if not incompatible goals with little consideration for the recognition of migrants as persons and holders of fundamental rights.[12]

The International Labour Organisation (ILO) in its 2016 Framework for Action on Migrant Health and HIV, highlighted the **negative impacts and barriers created where the policy focus is on immigration enforcement rather than on a human rights-based approach** (that is, an approach which recognizes migrants' fundamental human rights, their special vulnerability to, for example, interpersonal and occupational hazards, social exclusion, and discrimination, and the importance of universal access and culturally competent health care and other key services including social protection services)**.** These negative impacts and barriers include:

- failure to recognize migrants as individuals equal before the law;
- lack of recognition and protection of migrants' human rights;
- characterizing migrants as merely economic actors or merely "development actors";
- criminalization of migrants;
- increasing xenophobic hostility and violence against migrants;
- systematic/structural discrimination and exploitation of migrant women;
- suppression of migrant organizations and participation, particularly as workers;
- lack of health care, including explicit denial of access to care and of health-related rights;
- challenges in access to social protection and social security for many migrants;
- failure to respect migrants' right to family unity.[13]

Although often framed as a ''threat'', human mobility is not inherently risk-laden. **It is poor policy coordination and contradictory policy goals,** (such as increasing foreign labor requirements while maintaining restrictive rights for migrants), which can exacerbate risk conditions related to migration and pose health challenges.[14]

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[12] Zimmerman, C., Ligia Kiss, and Mazeda Hossain. (2011). "Migration and Health: A Framework for 21st Century Policy-Making." *PLoS Medicine* 8.5: e1001034. *PMC*. Web. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3101201/

[13] International Labour Organisation. (2016). Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Geneva, Switzerland, International Labour Office, p. 7. Retrieved from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/Right-based-Approach-to-Migration-Health-and-HIV-AIDS.pdf

[14] Fortier, JP. (2010). Migrant-sensitive Health Systems - Health of Migrants - The Way Forward, Report of a Global Consultation. World Health Organization, Madrid, referred to in (Zimmerman, C., et al., 2011).

Rising Recognition for Attention to the Health of Migrants

Increasingly prompted by the public health challenges related to HIV and AIDS, TB and other infectious and communicable diseases, it has become evident that migration represents significant challenges for public health, not because migrants pose a public health risk, but because the risks that the process of migration can impose on migrants may threaten their right to health and other health-related fundamental rights with corresponding implications for the health of the rest of the population. The growing trend of migration, therefore, demands a reorientation of health policies to better protect migrants' health. This fact is reflected by the content of a number of high-level, health-related international commitments and activities on the rights and health of migrants.

In 2001 and 2006, **Declaration of Commitment on HIV and AIDS (2001)** and the **Political Declaration on HIV and AIDS** emphasized the multifaceted approach necessary to address HIV, including considerations of human rights, workers' rights, gender equality, stigmatization, discrimination, social protection and the various needs of different groups of persons affected by HIV, including children. In addition, these resolutions and declarations have focused specifically on migrant and mobile populations.[15]

In 2006, the United Nations General Assembly (UNGA) Global Commission on International Migration and the high-level dialogue called for a more collaborative and cohesive global response to the challenges of migration.[16]

In 2008, on 25th January 2008 the 122nd Session of Executive Board of the World Health Organisation (WHO) recommended the adoption of a Resolution on Health of Migrants (EB122.R5, 2008).[17]

In 2008**, on May 24th, 2008, Resolution WHA61.17** ***on the Health of Migrants*** was adopted by the 61st World Health Assembly and called upon Member States to devise mechanisms for improving the health of all populations, including immigrants, in particular through identifying and filling gaps in health service delivery, promote equitable access to health promotion and care for migrants and to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migration process"[18] Among other things, this resolution calls for the promotion of migrant-sensitive health policies; the establishment of health information systems containing disaggregated data to support analysis of migrant health needs; and the documentation and sharing of information and best practices for meeting the health needs of migrants in countries of origin, return, transit, or destination.

In 2009, the **Program Coordination Board (PCB)** of the Joint United Nations Programme on HIV/AIDS (UNAIDS) held its 24th meeting in Geneva, *highlighting HIV-related needs for people on the move*. The Board also articulated that the improvement of HIV information and services for migrants would buttress

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[15] United Nations. (2001). Declaration of Commitment on HIV and AIDS, A/RES/S-26/2 (2001); United Nations. (2006). Political Declaration on HIV and AIDS, A/RES/60/262 (2006).

[16] See all documents and Summary Report at http://www.un.org/esa/population/migration/hld/

[17] World Health Organisation. (2008). WHR61.17 - 122nd Session of Executive Board of the World Health Organisation on the Health of Migrants. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/23533/A61_R17-en.pdf;jsessionid=C56852C5A82B84053FDEA1CA412F558B?sequence=1

[18] Ibid at Articles, 1, 3 and 5 respectively.

the development and implementation of international healthcare strategies. *The issue of the health of migrants has expanded from disease-specific care to health promotion and disease prevention*.[19]

In 2010, the **1st International Organisation for Migration (IOM) Global Consultation on Health of Migrants** produced an Operational Framework for Migrant Health centered on four (4) pillars, (1) monitoring migrant health, (2) policy and legal frameworks, (3) migrant sensitive health systems and (4) establish partnerships and multi-country frameworks.[20]

***In 2011,* The Political Declaration on HIV and AIDS**: Intensifying Our Efforts to Eliminate HIV and AIDS established a set of targets and commitments to be achieved by 2015. It specifically notes that States should address, through national legislation, the needs of migrants and mobile populations and their vulnerability to HIV infection, as well as their lack of access to HIV prevention, treatment, care and support.[21]

In 2011, 19th – 21 October 2011 in Rio de Janeiro **the World Conference on the Social Determinants of Health** reaffirmed the essential value of equity in health and recognized that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".[22]

In 2013, the **Montevideo Consensus on Population and Development**, Member States expressed concern at the evident and systematic human rights violations suffered by migrants in the region as a result of racism, xenophobia and homophobia, as well as the lack of guarantee of due process and specific problems, such as discrimination, abuse, trafficking in persons, exploitation and violence, that affect different groups, especially women, girls, boys and adolescents. It recommended a series of measures to protect their human rights, with a gender perspective, paying attention to women and other vulnerable groups in the migration cycle.[23]

In 2013, the **second UN General Assembly High-level Dialogues on International Migration and Development**, (the first in 2006) reinforced the importance of global cooperation and global approaches to migration governance. The 2013 High-level Dialogue achieved agreement on a Declaration "Making Migration Work" that reiterated a general consensus on eight (8) normative and policy priorities: (1) Protect the human rights of all migrants, (2) Reduce the costs of labour migration; (3) Eliminate migrant

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[19] UNAIDS. (2009, 22-24 June). 24th Meeting of the UNAIDS Programme Coordinating Board. Joint United Nations Programme on HIV/AIDS Geneva, Switzerland. Retrieved from http://files.unaids.org/en/media/unaids/contentassets/dataimport/pub/informationnote/2009/20090603_pcb_24_decisions_en.pdf.

[20] IOM. WHO. (2010, 3-5 March). Health of Migrants: The Way Forward - Report of a Global Consultation. Madrid, Spain. International Organisation for Migration, World Health Organisation, p. 9. Retrieved from http://www.who.int/migrants/publications/mh-way-forward_consultation-report.pdf

[21] United Nations. (2011). Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, A/RES/65/277 (2011).

[22] See all documents and Summary Report http://www.who.int/sdhconference/resources/wcsdh_report/en/

[23] UN ECLAC. (2013, 12-15 August). Montevideo Consensus on Population and Development. Montevideo. United Nations Economic Commission for Latin America and the Caribbean. pp. 23-28. Retrieved from https://repositorio.cepal.org/bitstream/handle/11362/21860/15/S20131039_en.pdf

exploitation, including human trafficking; (4) Address the plight of stranded migrants; (5) Improve public perceptions of migrants; (6) Integrate migration into the development agenda; (7) Strengthen the migration evidence base; and (8) Enhance migration partnerships and cooperation.[24]

***In 2015*, the United Nations 2030 Agenda for Sustainable Development – "LEAVE NO ONE BEHIND"** Migration, health and HIV feature explicitly and implicitly throughout the Resolution adopted by the UN General Assembly. There are explicit references to migration in six of its 17 goals, mainstreaming migration into global development policy. The SDGs identify migrants, refugees and internally displaced people as vulnerable populations that 'must be empowered.[25]

In relation to migration, **Target 10.7** aims "to facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies". Furthermore, migration and migrant rights are relevant to several Goals, such as **Goal 8** on growth and decent work, **Goal 16** on peaceful and inclusive societies and access to justice for all, and **Goal 17** on global partnership on sustainable development, which includes improving data.

In 2016, migrants were also highlighted across the **New Urban Agenda adopted at Habitat III in Quito** in October 2016. The Agenda emphasized the importance of extending health care to all in cities and urban settlements worldwide, with specific attention to HIV and AIDS.

In 2016, the United Nations adopted the **New York Declaration for Refugees and Migrants,** which expresses the political will of world leaders to save lives, protect rights and share responsibility on a global scale. The New York Declaration contains bold commitments both to address the present issues and to prepare the world for future challenges. In the Declaration, UN Member States committed to negotiating the **Global Compact on Safe, Orderly and Regular Migration** and the **Global Compact on Refugees**, over the next two years. [26]

In 2017, the process to develop the **Global Compacts on Safe, Orderly and Regular Migration** commenced. The ongoing process has included: Thematic sessions; UN Regional Economic Commissions; Regional Consultative Processes; Multi-stakeholder consultations; Global Forum on Migration and Development; IOM International Dialogue on Migration; Preparatory stocktaking meeting; other meetings; distribution of documents; negotiations are expected to culminate at the end of 2018. The global compact for migration will be the first, intergovernmental negotiated agreement, prepared under the auspices of the United Nations, to cover all dimensions of international migration in a holistic and comprehensive manner. The Sub-Regional Caribbean Consultation

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[24] United Nations. (2013, 3-4 October). 2nd High Level Dialogue on International Migration and Development. United Nations. Retrieved from http://www.un.org/en/ga/68/meetings/migration/pdf/migration_8points_en.pdf

[25] United Nations. (2015). UN Resolution on Sustainable Development Goals, A/RES/70/1 (2015). Article 23. Retrieved from http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

[26] United Nations. (2016). The New York Declaration for Refugees and Migrants, A/RES/71/1 (2016). Retrieved from http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/71/1

Toward a Global Compact for Safe, Orderly and Regular Migration (GCM) took place in Trinidad from the 27-28 November 2017.[27]

In 2017, the **2nd International Organisation for Migration (IOM) Global Consultation on Health of Migrants, "resetting the Agenda"** was convened in Colombo Sri Lanka, 21st – 23rd February 2017 as a follow-up to the 1st Global Consultation on Migrant Health, held in 2010, in response to the renewed international attention to the health needs of migrants through agenda-setting on the 2030 Sustainable Development Goals, Universal Health Coverage, and other global health priorities. The Operational Framework was revised based on three thematic areas: Health, Health Systems and Global Health, Vulnerability and Resilience, and Development.[28]

In 2018, **The Edinburgh Declaration on Migration, Ethnicity, Race and Health 2018**, promulgated at the First World Congress on Migration, Ethnicity, Race and Health May 17–19, 2018, in Edinburgh, UK attended by over 700 participants from 50 countries. The Declaration recognized among other things, *that investment in migrant and ethnic minority health and health care provides many benefits, including those going beyond health itself, and exceeds the costs incurred.* [29]

While awareness of the need to respond to the health of migrants is increasing, the necessary global technical and policy instruments are still scarce, however, there has been movement on the regional and sector level. For example, the International Labour Organisation (ILO) 2016 Framework for Action on Migrant Health and HIV;[30] the Revised Migration Policy Framework for Africa and Plan of Action (2018 – 2027) (Draft);[31] Strategy and action plan for refugee and migrant health in the World Health Organisation (WHO) European Region.[32] Also, the International Organisation for Migration (IOM), Unifying Agenda on an Operational Framework for addressing migrant health and the outcome of the negotiations Global Compact on Safe, Orderly and Regular Migration will provide useful governance frameworks.

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[27] International Organisation for Migration. (2018, 5 February). Global Compact for Safe, Orderly and Regular Migration, Zero Draft. Retrieved from https://refugeesmigrants.un.org/sites/default/files/180205_gcm_zero_draft_final.pdf
IOM. (2017, 27-28 November). Sub-Regional Caribbean Consultation Toward a Global Compact for Safe, Orderly and Regular Migration (GCM) - Report on Results for the Preparatory Process for the Global Compact on Migration. Trinidad and Tobago Retrieved from http://rosanjose.iom.int/site/en/report-results-sub-regional-caribbean-consultations-toward-global-compact-safe-orderly-and-regular

[28] International Organisation for Migration. (2017). Report of 2nd Global Consultation on Migrant Health: Health of Migrants - Resetting the Agenda. Colombo, Sri Lanka. Retrieved from https://www.iom.int/migration-health/second-global-consultation

[29] The 1st World Congress on Migration, Ethnicity, Race and Health with over 700 participants from over 50 countries, is a landmark in the field of Health, bringing together different disciplines across the globe with the aim of fostering unity and cross fertilisation of ideas through an integrated dialogue on issues related to migration, ethnicity, race, indigenous and Roma populations. Retrieved from: http://www.merhcongress.com/welcome/edinburgh-declaration/

[30] International Labour Organisation. (2016). Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Geneva, Switzerland, International Labour Office. Retrieved from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/Right-based-Approach-to-Migration-Health-and-HIV-AIDS.pdf

[31] African Union. (2018). The Revised Migration Policy Framework for Africa and Plan of Action (2018 – 2027) (Draft). Retrieved from https://au.int/sites/default/files/newsevents/workingdocuments/32718-wd-english_revised_au_migration_policy_framework_for_africa.pdf

[32] World Health Organisation (2016, 12-15 September). Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region. Regional Committee for Europe 66th Session, EUR/RC66/Conf.Doc./4. Copenhagen, Denmark. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0004/314725/66wd08e_MigrantHealthStrategyActionPlan_160424.pdf

PROFILE OF MIGRATION IN THE CARIBBEAN – "A People on the Move"

The Caribbean is both a region of origin, transit, and destination of extra-regional and intra-regional migration flows, and experiences considerable return migration. Furthermore, as it is situated between North and South America, the Caribbean serves as a transit point for irregular migrants from South America and elsewhere trying to reach the United States which consistently attracts large numbers of Caribbean migrants – both regular and irregular – from most of its different islands and territories. In short, migration in the region is anything but linear, rather characterised by complex, reciprocal flows.[33]

High Emigration Rates

The UN Economic Commission for Latin America and the Caribbean (UN ECLAC) estimates that in 2015, a total of **7,773,471 Caribbean people were living in a national territory other than where they were born,** in some cases in a territory within the same sub-region. On the other hand, there were **1,367,407 international immigrants, living in Caribbean countries** and dependencies. **Immigration** in the Caribbean can therefore be **rated as middle-low,** as 3.2% of inhabitants were born outside their country or dependency of residence. Also, in relative terms, **emigration** may be **considered high**, as emigrants account for almost 16% of the native-born population in this region.[34]

Historically there have been several waves of emigration throughout the history of the Caribbean. Three (3) distinct periods can be identified:

- in the 1930s, to Central America to work on the construction of the Panama Canal;
- the 1950s to the United Kingdom to work mainly as nurses and in public transportation;
- most recently to the United States and, to a lesser extent, Canada.

It is estimated that in the last 50 years, **at least 5 million people** have emigrated from the Caribbean, a region currently home to 37 million people. This makes the Caribbean one of the heaviest emigration areas of the world.[35]

The 2017 IOM Report on the Trends, Opportunities and Challenges for Migration in the Caribbean indicates:

- **Guyana** and **Saint Vincent and the Grenadines** show the **strongest emigration movements**: 9.65 and 9.6 per 1000 people respectively were emigrating in 2013. The only confirmed **net recipients of migrants** are **Antigua and Barbuda** and **Suriname**, with immigration rates of 2.23 and 0.57 per 1,000 respectively for 2013.
- **Guyana** and **Haiti** are, **in absolute terms, the primary countries of origin of intra-regional migrants**. In relative terms, **Guyana** and **Saint Vincent and the Grenadines** have the most emigrants. Respectively, the emigrant population is 58.2 per cent and 55.5 per cent of the size of the population living at home.

[33] International Organisation for Migration. (2017). Migration in The Caribbean: Current Trends, Opportunities and Challenges. San Jose, Costa Rica. p. 7 citing United Nations Department of Economic and Social Affairs (UNDESA) (2015). Trends in International Migrant Stock: The 2015 revision (United Nations database, POP/DB/MIG/Stock/Rev.2015). The countries covered in the Report include: Antigua and Barbuda, The Bahamas, Belize, Cuba, Dominican Republic, Guyana, Haiti, Jamaica, St. Vincent and the Grenadines, Suriname and Trinidad and Tobago.

[34] ibid

[35] Ibid

- The vast majority of migrants, cross international borders as migrant workers and contribute to the productivity and growth of destination countries as well as their communities of origin.
    - **Haiti i**s the Caribbean country most dependant on remittances. In 2014, 21.1 percent of its GDP was derived from remittances. **Jamaica** (15%) and **Guyana** (11%) follow. In absolute amounts, the **Dominican Republic** receives most remittances: USD 4.65 billion in 2014. The **Dominican Republic** is followed by **Jamaica** (USD 2.26 billion), and **Haiti** (USD 1.95 billion). **Antigua and Barbuda, Belize**, and **Trinidad and Tobago are net senders of remittances.**
    - The ACP Observatory on Migration in 2014 found that **Guyana, Haiti, Jamaica, Grenada** and **the Dominican Republic** rank among the **top 30 remittances receiving countries worldwide in relative terms**. The 2013 UNDP Human Development Report found that nearly half of remittances sent home by emigrants from the South come from workers living in other developing countries.[36]
- One serious problem related to the migratory outflows to countries outside of the Caribbean is the departure of professionals, also known as **"brain drain."** The loss of professionals to developed countries has been identified as a major challenge for the Caribbean particularly in recent times with the loss of teachers, nurses, and persons recruited into the British Army. In the Caribbean, at least **Guyana, Jamaica**, and **Trinidad and Tobago** are negatively affected by the emigration of nurses, and **Haiti** by skilled emigration in general.

Strong Intra-regional Movements

In terms of movements, a 2013 International Organisation for Migration (IOM) Report identified that:

- **Barbados** is a **major final destination for** migrants from **Guyana, Trinidad and Tobago**, and Member States of **the OECS**. Workforce shortages in that country's health sector have led to a high intake of trained nurses from Saint Vincent and the Grenadines for example.
- **Trinidad and Tobago** has historically **received migrant workers** from other parts of the Caribbean, **Venezuela** and more recently, **Colombia**. Based on data from the World Bank in 2010, Trinidad and Tobago's immigrant population stock was 34,000 or 2.6 percent of the population.
- **Dominican, Saint Lucian** and **Haitian** nationals **work seasonally in Martinique and Guadeloupe** in the harvesting of the sugar cane crop in the French Antilles.
- **Vincentian, Grenadian** and **Guyanese higglers** sell their agricultural produce in **Trinidad.**
- There has also been an influx of migrants **from the Dominican Republic** to **the Eastern Caribbean** and to **the Dutch territories**.
- **Haitians** are present in significant numbers in the **Dominican Republic, the Bahamas, Turks and Caicos** and **Dominica.**
- In addition to economic migration, **student mobility** is evident in the Caribbean, not least due to the existence of principal campuses of the University of West Indies in Barbados, Jamaica, and Trinidad and Tobago.
- Migrants also move with dependents that are enrolled in primary and secondary schools in the Caribbean destination countries.

Free Movement of Labour and Capital

[36] United Nations Development Program. (2013). Human Development Report. p. 107. Retrieved from http://hdr.undp.org/sites/default/files/reports/14/hdr2013_en_complete.pdf

Efforts have been made at the regional level to facilitate intra-regional travel to expand access to labour and markets within the region. Economic integration is a key pathway to development and demands labour mobility and other forms of economic engagement that necessitate the movement of persons. In the Caribbean, two key regimes fostering the free flow of labour and capital are the CARICOM Single Market and Economy and The OECS Economic Union.

Caribbean Single Market and Economy (CSME)

The CSME was established in 1989 by the Heads of Government of CARICOM through the Grand Anse Declaration. One of the main pillars of the CSME is the commitment to liberalize the movement of labour and to abolish the need for work permits for nationals from CSME participating countries. To facilitate its implementation, this free movement initiative was modified several times since its adoption to reach an agreement on a phased implementation.

Several categories of CARICOM nationals have been eligible for free movement throughout the CSME without the need for work permits. With a Certificate of CARICOM Skills Qualification these include, University Graduates, Media Workers, Artistes, Musicians, Sportspersons, Managers, Technical and Supervisory Staff attached to a company and Self-Employed Persons/Service Providers. However, contingent rights to spouses and dependents have not been implemented and now being considered by CARICOM Heads of Government. CARICOM nationals also have the right to transfer social security benefits from one CARICOM state to another. However, these aims have not been fully realized at this time.

CARICOM nationals are entitled to definite entry for six months. Separate lines identified for CARICOM and Non-CARICOM Nationals at ports of entry are in place for 13 members and the introduction of a CARICOM Passport and Standardized Entry/Departure Forms are in place. [37]

OECS Economic Union

The decision to establish an economic union was taken by OECS Heads of Government at the 34th meeting of the Authority held in Dominica in July 2001. At the 35th meeting of the Authority in Anguilla in January 2002, the main elements of an economic union implementation project were endorsed. The Treaty was signed on June 18, 2010, in Saint Lucia, during the 51st Meeting of the Authority of Heads of Government of OECS Member States. The provisions of the OECS Economic Union Treaty include the free circulation of goods and trade in services within the OECS, free movement of labour by December 2007, free movement of capital, a regional Assembly of Parliamentarians and a common external tariff.

Profile of Mobile and Migrant Populations in the Caribbean

Although there is little data with regard to the specific characteristics of migrants, in particular relating to gender, ethnicity, socioeconomic background and educational levels, among other things, it is evident from the preceding paragraphs that migrant workers make up the majority of intra-regional and international migrants.[38] Listed below is the profile of mobile and migrant populations identified by

[37] Text of the Agreement is available at http://www.caricom.org/jsp/single_market/single_market_index.jsp?menu=csme

[38] Kairi Consultants Ltd. (2013). Human Mobility in the Caribbean: Circulation of Skills and Immigration from the South, Research Report, ACPOBS/2013/PUB16. p. 11 Retrieved from http://publications.iom.int/system/files/pdf/human_mobility.pdf.

countries which were studied under the PANCAP GIZ Migrant Project.[39]

Table1: Profile of Migrants in the Caribbean

Country	*Profile:*	Sending Countries
Antigua & Barbuda	**Migrant workers**, - Aviation industry, Teachers, Housekeepers, Doctors, Nurses, Waitresses, **Exotic dancers**, **Sex workers** from the Dominican Republic (at least 15% of the population are migrants)	Jamaica, Guyana, Dominican Republic, Dominica and the USA
The Bahamas	**Migrant workers**, **Persons seeking entry into the US**, **Creole-speaking populations** **Inter-island movements**; (9.7% of the population are migrants	Haiti, Cuba, Jamaica
Belize	**Migrant workers** - Seasonal Agricultural Workers, Construction workers) **Mobile populations** - Persons crossing the border on a daily or regular basis - bus drivers and conductors, Utility Workers, Salesmen and Trainees, Government Workers, Students in Primary and High Schools, **Sex workers**, **Street vendors**	Guatemala, Honduras, El Salvador and Colombia
Dominican Republic	**Migrant workers** - Agricultural workers (cane cutters), Housekeepers, Hotel workers, Construction workers, Seasonal workers **Haitians,** other undocumented 'Dominico-Haitians, **Sex workers**	Haiti
Guyana	**Migrant workers** - Miners, Loggers, **Mobile populations** – Seafarers, Army (two bases in Region 1 and 1 base in Region 9), Transport workers, Indigenous population, Traders- expansion of trading and other economic activities to the hinterland regions especially by the Chinese; **Sex workers**	Brazil, Venezuela, China and the Caribbean Region
Sint Maarten	**Migrant workers** - construction, hotel, other migrant workers, **Adult entertainers,** **Sex workers** (82% of the population are migrants from approximately 105 countries)	The Netherlands, Dominican Republic, Guadeloupe, India, Guyana, Haiti
Suriname	**Gold miners** **Sex workers**	Brazil, China, Netherlands, Guyana
Trinidad and Tobago	**Migrant workers** – mainly from the Eastern Caribbean and Guyana, **Male and Female sex workers**, **Refugees and other displaced persons** from Venezuela	Eastern Caribbean Countries, Guyana, Columbia and Venezuela

Populations of Migrants which pose challenges for the Caribbean identified in the 2017 IOM Report on

[39] Cenac, V. (2011). Access by Mobile and Migrant Populations to HIV Services in the Caribbean, A legal and Policy Analysis. EPOS Health Management. Pp. 47-49. Information compiled from country national strategic plans, UNGASS reports and population census data.

the Trends, Opportunities and Challenges for Migration in the Caribbean include:[40]

(a) **Deported and returned migrants**. The United States, Caribbean countries and others, deport convicted criminal irregular migrants, and others in irregular status, back to their country of origin. These returnees often find themselves with no social network in the country they left years prior, increasing the risk of repetition of criminal behaviour.
(b) **Environmentally induced migration**. Several Caribbean islands are especially vulnerable to climate and environmental risks, both extreme weather events and the depletion of local natural resources. This may spur internal displacement, and ultimately, international migration.
(c) **irregular migration**. Irregular migration facilitated by porous borders and advanced smuggling networks, has negative implications for both the migrant as well as the recipient country: the migrant is vulnerable to exploitation, the recipient country's laws are violated, and due taxes may not be collected. Irregular migration can be countered not only by increasing border security, but also by expanding regular migration opportunities to migrants that currently cannot enter or work legally, or face significant difficulties obtaining legal permits.
(a) **Trafficked persons.** There is great concern for the trafficking of especially minors and young women to islands with a large tourism industry, domestic workers and women and young women involved in sex work. Women in an irregular status are doubly vulnerable owing to the high risk of sexual exploitation. Victims of smuggling and trafficking may find themselves both irregular in legal terms and in situations of exploitation at the hands of the traffickers or smugglers. In the Caribbean, survivors of human trafficking are often victimized and stigmatized as sex workers.
    - In the 2017 Trafficking in Persons Report (TIP) compared to the 2016 report, only Belize remained on the Tier 3 list; Haiti and Suriname moved to Tier 2 Watch List, with Antigua and Barbuda; and Barbados, Curacao, Jamaica, Saint Lucia, Saint Vincent and the Grenadines, Trinidad and Tobago continue on the Tier 2 list as well as the Bahamas and St. Maarten on the Tier 1 list.[41] Only, Antigua and Barbuda, Belize, Dominican Republic, Guyana, Haiti, and Trinidad and Tobago have specific anti-trafficking laws.[42]

(b) **The Special case of Haitian Migrants**

Haitian migrants in the Bahamas face arbitrary deportation and discrimination. If born in the Bahamas they are only entitled to apply for citizenship at age 18. In practice, this means that many children born in the Bahamas to Haitian parents are effectively stateless until they are 18. Even then, the applicant has only a year to complete the formalities. There are allegations of deliberate delays and the rules are not widely known.

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[40] International Organisation for Migration. (2017). Migration in The Caribbean: Current Trends, Opportunities and Challenges. San Jose, Costa Rica. referencing Thomas-Hope, E. (2005). Current Trends and Issues in Caribbean Migration. Document Presented at the Expert Group Meeting on Migration, Human Rights and Development in the Caribbean. Port of Spain, Trinidad and Tobago. 14-15 September 2005.

[41] Countries on Tier 3 list are those whose governments do not fully meet the minimum standards and are not making significant efforts to do so. Tier 2 Watch List countries are those whose governments do not fully meet minimum standards but are making significant efforts to meet those standards, and the absolute number of victims of severe forms of trafficking is very significant or is significantly increasing. Countries on the Tier 2 list are those whose governments do not fully meet the minimum standards but are making significant efforts to meet those standards. Tier 1 countries are those whose governments fully meet the U.S. Trafficking Victims Protection Act's (TVPA) minimum standards.
United States. (2017). Trafficking in Persons Report. US Department of State, Washington, DC. Retrieved from https://www.state.gov/documents/organization/271339.pdf.

[42] International Organisation for Migration. (2017). Migration in The Caribbean: Current Trends, Opportunities and Challenges. San Jose, Costa Rica.

In the Dominica Republic, it is estimated that there are close to 280,000 persons born in the Dominican Republic of Haitian parentage. These 'Dominico- Haitians' are said to live in a state of 'permanent illegality' Although the Constitution of the Dominican Republic recognises the principle of *jus soli* (right of soli) or place of birth as one of the basis for citizenship, Haitians are discriminated against on the ground that they are arbitrarily considered to be '**in transit'** and fall within the exemption to the provision recognising citizenship.[43]

Under the 2010 Constitution of the Dominican Republic, children of migrants who are "illegally" in the country are not eligible for citizenship. The Constitution provides:

> *S. 18 - Dominicans are:*
> *(3) All persons born in the territory of the Republic, with the exception of the legitimate children of foreigners residing in the country's diplomatic representatives or who are **in transit.***

Haitians are granted neither citizenship nor permanent resident status even where they have been born there and have lived there for years or in some cases all their lives. Through a systemic process of "denationalization" births of children are not registered since registration would ground a claim for citizenship. **Without proof of identity Haitian migrants in the Dominican Republic**

- face reduced access to education and health facilities,
- can take no part in political or other organized activity,
- have no civil rights, and, most significantly,
- can be repatriated arbitrarily and without appeal, to a country they have never seen.

This situation has been further exacerbated by ***Judgment 168/13 of the Dominican Republic's Constitutional Court of September 23, 2013*** against a backlash of international and regional condemnation, which ruled that only persons born in the Dominican Republic to Dominican parents or legal residents are considered citizens. This interpretation was applied retroactively to all persons born between 1929 and 2010: arbitrarily depriving hundreds of thousands of people of Haitian descent, of their Dominican nationality, and creating a situation of statelessness of a magnitude never before seen in the Americas.

Gender and Migration in the Caribbean

Gender inequality shapes livelihoods and opportunities for women and men, including when they move within their country, or across international borders. Socially constructed norms and power relations between genders exist at various levels, including couple and family relations, parenting, community and institutions, such as the school or labour market, and extend internationally to define both patterns of migration and its consequences for migrants, their families and communities at origin and destination.[44]

In a research paper on Gender Empowerment and Migration in the Caribbean commissioned by ECLAC, it

[43] Ferguson, J. (2003). Migration in the Caribbean: Haiti, the Dominican Republic and Beyond. Minority Rights Group International. Retrieved from http://www.oas.org/atip/regional%20reports/migrationinthecaribbean.pdf

[44] Platonova A., Gény, L. R. (2018). Women's Empowerment and Migration in the Caribbean. UN Economic Commissions for Latin America and the Caribbean, ECLAC sub regional headquarters for the Caribbean. Santiago. Retrieved from https://repositorio.cepal.org/bitstream/handle/11362/42491/1/S1700980_en.pdf

was recognised that while mobility and employment abroad create opportunities for female migrants, gender norms (and other structural conditions) also create vulnerabilities, as do institutional failures to address gender inequality and discrimination. Gender norms, prevalent in all countries, are a root cause of the gendered division of labour, violence against women and girls, and women's lack of decision-making power all of which have particular consequences for female migrants.[45]

- In **Antigua and Barbuda, Barbados, Belize, Grenada, Saint Lucia, Saint Vincent and the Grenadines**, and **Trinidad and Tobago**, **females account for more than 50 per cent of migrants**, and women make up more than 60 per cent of the migrant population in **Barbados**. Male migrants tend to outnumber females in the Dominican Republic and Cuba. Over half of total Caribbean migrants to the US, Europe, and Canada are women.[46]
- For many women, the decision to migrate is often caused by fundamental concerns about **poverty** and done in an attempt to ensure household survival by maximizing and diversifying the household income through remittances.
- Discrimination and violence in the private and public sphere can act as important motivation for migration. For example:
    (a) Fleeing from violence is a strong push factor. The UNDP Caribbean Human Development Report (2016) revealed that between 20 and 35 per cent of women in the Caribbean are subjected to different types of violence, including physical, sexual, psychological or a combination of them. [47]
    (b) prejudice and violence against certain categories of persons including lesbian, gay, bisexual, transgender and intersex (LGBTI) individuals also acts as a push factor. Nine (9) countries in the English-speaking Caribbean still criminalize same sex relations,[48] however, even in countries where LGBTI people are not considered criminals, their prospects are limited by discrimination in their social and economic life. Unlike other minorities they are often hidden and may not disclose their identity for fear of legal punishment, social abuse, hostility and discrimination by society or by close friends and family members. Because differences in sexual orientation are not openly recognized in many societies, data on discrimination are not widely available, and evidence-based policy making is difficult.[49]
- Women in the Caribbean are particularly at risk of becoming victims of trafficking both to North America and within the sub region due to several factors. These include:
    (a) the high global demand for domestic servants, agricultural labourers, sex workers, and factory labour;
    (b) political, social, or economic crises, as well as natural disasters;
    (c) lingering machismo (chauvinistic attitudes and practices) that tends to lead to discrimination against women and girls;
    (d) existence of established trafficking networks with sophisticated recruitment methods;
    (e) public corruption, especially complicity between law enforcement and border agents with traffickers and smugglers;

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[45] ibid
[46] Ibid.
[47] UNDP. (2016). Caribbean Human Development Report. p. 62. Retrieved from http://www.bb.undp.org/content/barbados/en/home/presscenter/articles/2016/09 /13/caribbean-human-development-report-2016-launched.html.
[48] Countries which criminalize include: Antigua and Barbuda, Jamaica, Saint Lucia, Grenada, St. Vincent and the Grenadines, Barbados, St. Kitts and Nevis, Dominica, and Guyana. Countries which do not criminalize include: The Dutch territories, UK Overseas Territories, Bahamas, Cuba, Dominican Republic and Suriname and more recently Belize and Trinidad and Tobago.
[49] UNDP. (2016). Caribbean Human Development Report. pp. 65 and 122 http://www.hdr.undp.org/sites/default/files/2016_human_development_report.pdf

(f) restrictive immigration policies in some destination countries that have limited the opportunities for regular pathways of migration flows to occur;
(g) government disinterest in the issue of human trafficking; and
(h) limited economic opportunities for women in the sub region.

- On arrival in the country of destination, violence and discrimination continue to be part of lives of many migrant women.

Sex Workers

Mobility throughout the region by sex workers is common, both within individual countries and to other islands and countries, usually for a limited period. This is an important group to consider in addressing mobility and health in the Caribbean and is of particular concern in relation to HIV as sex workers are among the key populations with higher risk and higher rates of HIV. Migrant sex workers are vulnerable to HIV because the illegality of aspects of their work and their undocumented status keeps them from accessing their rights to basic education, legal services, and public health-care systems, both in their own countries and abroad. The stigmatization they face as sex workers is compounded by xenophobia and discrimination based on nationality, which further limits their ability to access even the most basic services in many places.[50]

Among the important sub-populations in many Caribbean nations are non-identifying sex workers (both women and men) and MSM sex workers who do and do not identify as gay. Progress has been made in much of the Caribbean in reducing HIV prevalence among certain specific sex worker subpopulations, in particular female, establishment-based, self-identifying sex workers in the Dominican Republic. However, other sub-populations (for example, transgender sex workers) have received comparatively little, if any, attention or resources.[51]

The recent United Nations (UN) New York Declaration for Refugees and Migrants (2016) urges the UN Member States to ensure that the "**responses to large movements of refugees and migrants mainstream a gender perspective, promote gender equality and the empowerment of all women and girls, and fully respect and protect the human rights of women and girls**"[52] Gender equality and the empowerment of women is also recognised as a catalyst for accelerating the achievement of the **2030 Agenda on the Sustainable Development Goals.**

Identified Governance Challenges Related to Migration in the Caribbean

The Sub-Regional Caribbean Consultation Toward a Global Compact for Safe, Orderly and Regular Migration (GCM) took place in Trinidad from the 27-28 November 2017 identified the following challenges, among others: [53]

[50] Caribbean Vulnerable Communities Coalition (CVC) and El Centro de Orientación e Investigación Integral (COIN). (2012, March). From Tolerance to Rights: HIV and Sex Work Programs in the Caribbean - Effective Models and Opportunities for Scale Up. Pan Caribbean Partnership Against HIV/AIDS. Georgetown Guyana. p. 12

[51] Ibid

[52] United Nations. (2016). The New York Declaration for Refugees and Migrants, A/RES/71/1 (2016). p. 5. Retrieved from http://www.un.org/pga/70/wp-content/uploads/sites/10/2015/08/HLM-on-addressing-large-movements-of-refugees-and-migrants-Draft-Declaration-5-August-2016.pdf.

[53] International Organisation for Migration. (2017, 27-28 November). Sub-Regional Caribbean Consultation Toward a Global Compact for Safe, Orderly and Regular Migration (GCM) Report on Results for the Preparatory Process for the Global Compact on Migration. Trinidad and Tobago Retrieved from http://rosanjose.iom.int/site/en/report-results-sub-regional-caribbean-consultations-toward-global-compact-safe-orderly-and-regular

- **lack of will in some countries to effectively protect the human rights and fundamental freedoms of migrants**, including women and children, regardless of their migratory status and in the different stages of the migratory process. Evidenced by a lack of compliance with existing migration conventions, treaties and standards by some countries and cultural perceptions and specific norms in relation to women, children and other vulnerable groups that increase their risks.
- **lack of disaggregated data to develop differentiated treatment or options** appropriate for women and other vulnerable migrants - **Identified access to basic services for migrants including health, and gender responsive services as a priority for the region**.
- **combating racism, xenophobia, discrimination and intolerance** towards all migrants.
- **promotion on cultural diversity, social cohesion and accurate data** on the situation of and contribution of migrants.
- **migration because of climate change, natural disasters and human-made crises** – countries should strengthen the attention and assistance to populations affected by migration caused by climate change, with priority for the most vulnerable.
- **lack of regional cooperation and governance on migration** in all its dimensions, including at borders, in transit, entry, return, readmission, integration and reintegration.
- **lack of participatory, inclusive and cross sectoral approach t**owards migration at the national, regional and international level
- **harnessing the contribution of diasporas** and strengthening links with countries of origin and host.
- **trafficking in persons and smuggling of migrants - lack of funding to sufficiently address the situation (investigations, assistance), and lack of awareness and sensitization** at different levels of the judicial and legislative branches, that deny or underestimate the real situation.
- **irregular migration** – Irregular migrants are often unable or unwilling to access essential services such as education and health systems. **Identified reducing vulnerability through access to information on regularization processes**, that **migratory status should not be a barrier to access to essential services**, relevant to the capacity of the destination state and r**egistration for social, law enforcement and judicial services should not threaten current or future migration status.** Prioritize the regularization of migratory status of children and their access to basic rights, considering the right to family unit.

Legal Barriers related to Migration and Mobility in the Caribbean

Inapplicability of Certain Constitutional Protections to "non-citizens"

In relation to the countries considered in the PANCAP GIZ Project, all Constitutions provide for the protection of various rights. In relation to the English-speaking Caribbean countries, these are generally limited to civil and political rights with some exceptions, most notably Guyana. Suriname, Haiti, Dominican Republic, Sint Maarten and Guyana provide guarantees to economic social and cultural rights including the right to health and the right to work.

In the Caribbean, **the right to health** is constitutionally protected only in the **Dominican Republic, Cuba, Guyana, Haiti, Suriname** and **Sint Maarten**. The **right to work** is constitutionally protected in **Guyana, Haiti, Suriname, the Dominican Republic** and **Sint Maarten**. In **Belize**, the Constitution protects an individual from being denied the right to gain a living by work that he freely chooses or accepts.

Within the structure of a Constitutional framework, some rights are generally restricted to all classes of persons where it is "reasonably required" in the interest of defence, public safety, public order, public morality or public health in a democratic society. Exceptions to these exclusions include the right against torture, inhuman and degrading punishment or treatment and slavery. There are, however, clear restrictions in relation to non-citizens.

The gap between:

"citizen"
and
"non-citizen"

In many situations there is a gap between the rights which migrants, both regular and irregular, enjoy under international law, and the difficulties they experience in the countries where they live, work, and across which they travel. **This gap between the principles agreed by governments, and the reality of individual lives, underscores the vulnerability of migrants in terms of dignity and human rights. The special vulnerability of migrants stems from the fact that they are not citizens of the country in which they live**, they have crossed an international border and – **unlike citizens that they may generally enter and live in another country only with the express consent of its authorities**.[54]

In relation to migrants, even when States recognize the rights of certain foreign nationals to remain in their territory, concerns about national security often trump any exercise of migrant rights. Of concern are rights related to non-discrimination and freedom of movement. The term "migrants" are referred to here as the status of being a non-citizen/non-national upon which distinctions are made under Constitutional law.

Non-Discrimination - Exception in relation to Non-nationals or Migrants

Of the countries reviewed under the PANCAP GIZ Project, all provide for non–discrimination in limited circumstances principally on the grounds of **sex, race, place of origin, political opinions, colour or creed.**

- **Antigua and Barbuda** on the grounds of race, place of origin, political opinions or affiliations, colour, creed, or sex;
- **Bahamas** on the grounds of race, place of origin political opinions colour or creed;
- **Belize** on the grounds of sex, race, place of origin, political opinions, colour or creed;
- **Dominican Republic** on the grounds of gender, colour, age, disability, national origin, familial ties, language, religion, political or philosophical, social or personal condition;[55]
- **Guyana** on the grounds of race, place of origin, political opinion, colour, creed, age, disability, marital status, sex, gender, language, birth, social class, pregnancy, religion, conscience, belief or culture (s. 149(2));
- **Sint Maarten** on the grounds of religion, belief, political persuasion, race, colour of skin, sex, language, national or social origins, membership of a national minority, wealth, birth or and any other ground whatsoever is prohibited;
- **Suriname** on the grounds of birth, sex, race, language, religion, education, political opinion, economic position or **any other status;**
- **Trinidad and Tobago** on the grounds of race, origin, colour, religion or sex.

Discrimination on the grounds indicated do not extend to persons who are not citizens. See for example, Section 14 subsections (1) and (4) (b) of the **Antigua and Barbuda** Constitution:[56]

> *14. (1) Subject to the provisions of subsection (4), (5) and (7) of this section, no law shall make any provision that is discriminatory either of itself or in its effect.*

[54] International Organisation for Migration. (2004). HIV/AIDS and Mobile Populations in the Caribbean: A Baseline Assessment. Santo Domingo, Dominican Republic. Retrieved from http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/published_docs/books/hiv_mobile_carribbean.pdf

[55] 2010 Constitution, Article 39: the right to equality.

[56] Constitution of Antigua and Barbuda, 1981. Retrieved from http://laws.gov.ag/acts/chapters/cap-23.pdf

> *(3) In this section, the expression "discriminatory" means affording different treatment to different persons attributable wholly or mainly to their respective descriptions by race, place of origin, political opinions or affiliations, colour, creed, or sex whereby persons of one such description are subjected to disabilities or restrictions to which persons of another such description are not made subject or are accorded privileges or advantages that are not accorded to persons of another such description.*
>
> *(4) Subsection (1) of this section shall not apply to any law so far as the law makes provision-*
> *a. ……*
> *b.* ***with respect to persons who are not citizens****; or ...."*

In ***Honourable Gaston Browne v The Attorney General of Antigua and Barbuda, (2013)*** **(HC) *Judgment delivered on 18 December 2013,*** the inapplicability of Section 14 to non-citizens was confirmed. Cottle J stated at paragraph 11, that the general prescription against discrimination is not absolute. Subsection (4) restricts the applicability of subsection (1) in so far as it deals with legislation which makes provision with respect to persons who are not citizens of Antigua and Barbuda, "**the very section of the Constitution that provides for non-discrimination, expressly allows for different treatment to be meted out to non-citizens".**

Commonwealth Constitutions have generally been restrictively interpreted to exclude any ground of discrimination which is not expressly stated in the non-discrimination provision. In ***Nielson v Barker (1982) 32 WIR by 254*** which was approved in ***Baldwin v The Attorney General of Antigua and Barbuda et al*** (1982) (CA) Massiah J.A. at 280 stated the position;

> "…It is a misconception to think that the Constitution is panacean in character, capacitated for the eventual solution of all legal problems. This process of magnification has led to attempts being made to fit a variety of rights into the framework of fundamental rights and freedoms, although the former often lacked the attributes essential for such categorisation. It is to be profoundly in error to think that there has been a contravention of a person's fundamental rights under [the discrimination article] where the alleged discrimination is based on some ground other than those referred to above, no matter how reprehensible such grounds may appear to be".

A Less Restrictive Approach?

This restrictive or strict interpretation of Constitutional rights by Caribbean courts appear to be thawing with the application of a more purposive approach.[57] This is evident in the recent decisions in ***Caleb Orozco v The Attorney General of Belize 688 of 2010, Judgment delivered on 10 August 2016***[58] and ***Jason Jones v The Attorney General and Equal Opportunities Commission***.

The general principle was stated in ***AG of the Gambia v Jobe***[59] where Lord Diplock said:

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[57] See also the decision in Trinidad and Tobago ***Jason Jones v The Attorney General and Equal Opportunities Commission***. For the full decision see; http://www.u-rap.org/web2/index.php/component/k2/item/71-jasonjonesandagttandeoc . See also ***AG of Gambia v Jobe [1984] AC 689 at 700***, ***Home Affairs v. Fisher [1980] AC 319 at 328 and Reyes v R. [2002] UKPV 11 at para 26***

[58] For the full decision see; http://www.u-rap.org/web2/index.php/component/k2/item/52-judgement-of-orozco-v-ag-of-belize

[59] ***AG of Gambia v Jobe [1984] AC 689 at 700***

> "A constitution and in particular that part of it which protects and entrenches fundamental rights and freedoms to which all persons in the state are to be entitled, is to be given a generous and purposive construction."

In ***Orozco*** the Court held unconstitutional section 53 of the Criminal Code which deemed same sex sexual activity a crime. Among other grounds, Benjamin CJ found that the word 'sex' in section 16(3) of the Belize Constitution was to be interpreted to extend to "sexual orientation". Taking account of section 65 of the Interpretation Act, which provides that more than one interpretation is reasonably possible, "a construction which is consistent with the international obligations of the Government of Belize is to be preferred to construction which is not". He stated that:

> [58] It have been judicially pronounced that the Constitution is a 'living instrument' (See: ***Boyce v R (2004) 64 WIR 37(para 24) and R v Lewis (2007) 70 WIR 75 (at para. 74).*** The Belize Constitution owes its provenance to the European Convention on Human Rights which in turn was influenced by the UN Declaration on Human Rights. As such, decisions in relation to human rights issues have been informed by developments in international law (See: Bovce. per Lord Hoffman (at para. 27). Indeed, the final appellate court of Belize, the Caribbean Court of Justice has acknowledged the application of the jurisprudence from international bodies to domestic law **(S*ee: AG v Jeffery Joseph et al —CCJ Appeal No. CV2 of 2005 (at para. 106).***

In ***Jason Jones*** the Court held that sections 13 and 16 of the Sexual Offences Act Chapter 11:28 were unconstitutional, illegal, null, void, invalid and are of no effect to the extent that these laws criminalise any acts constituting consensual sexual conduct between adults.

Freedom of Movement - Exception in relation to Non-nationals or Migrants

Generally, states have broad authority to exclude foreign nationals from entering their territory and expel or deport persons already in their countries. This is clearly permissible within the Constitutional frameworks supported by various pieces of legislation relating to immigration. By way of example, s.10(1) the 2017 Constitution of Belize guarantees the right to free movement but non-citizens are specifically excluded (understandably so) by subsection (3)(d);

> *10. (1) A person shall not be deprived of his freedom of movement, that is to say, the right to move freely throughout Belize, the right to reside in any part of Belize, the right to enter Belize, the right to leave Belize and immunity from expulsion from Belize.*
>
> *(3) Nothing contained in or done under the authority of any law shall be held to be inconsistent with or in contravention of this section to the extent that the law in question makes reasonable provision-*
>
> *(d) for the imposition of restrictions on the freedom of movement of any person who is not a citizen of Belize.*

Restrictive Immigration laws

Restrictions on Entry – Prohibited Immigrants

In conformity with the Constitution as indicated above, countries possess broad authority to regulate the movement of foreign nationals across their borders. Although this power is not absolute, in that the

human rights of migrants must be protected, States are generally able to exercise their sovereign powers to determine who will be admitted and for what period.

Every country places additional restraints on the entry of foreigners. All countries forbid the entry to a range of persons.

- Persons who are 'paupers' or 'disabled' and are likely to be a drain on the resources of the state or charge on public funds - **All countries**
- Prostitutes, homosexuals - **in the case of Trinidad and Tobago and Belize, prostitutes and *homosexuals* expressly mentioned.** Entry is not restricted in **Sint Maarten** or **Suriname**. A Work permit and an HIV test is required for workers in brothels in **Sint Maarten**.
- Persons entering to engage in immoral acts,
- Persons suffering from a communicable or contagious or infectious disease – **All countries** – **Trinidad and Tobago and the Bahamas** define HIV as an infectious disease.
- Persons addicted to drugs – **Trinidad and Tobago**

The immigration law of **Trinidad and Tobago** is most extensive in this respect and determines that the following persons **may be deemed prohibited immigrants.** [60]

- *persons who will be charge on public funds due to insanity, physical handicap, pauper; suffering from an infectious disease; convicted of offence for which penalty one-year imprisonment or more; prostitutes; homosexuals; procuring one for prostitution or homosexual acts; beggars and vagrants; alcoholics; drug addict; drug trafficker; engaging in sedition, subversion or treasonable activities; person deemed an undesirable migrant by Minister*.

In all cases, definitions are lacking. It is the immigration officer's task to determine who might be a prostitute, beggar, homosexual, or drug dealer which is difficult or impossible to determine on sight. This arbitrary exercise of discretion on the part of immigration officers may lead to abuse and in cases where persons fall within the category of behaviours which are criminalized as described below, to further discrimination and possible deportations.

In ***Tomlinson v Belize, Trinidad & Tobago***[61] a consolidated case challenging the immigration laws of Trinidad and Tobago and Belize on the restriction relating to homosexuals before the Caribbean Court of Justice in its original jurisdiction. The Caribbean Court of Justice (CCJ) relied on its landmark decision on the right of freedom of movement of CARICOM nationals in the case of ***Myrie v Barbados*.** The CCJ's ruling, in that case, established definitively that CARICOM member states were bound by the 2007 Decision of the Conference of Heads of Government of CARICOM to allow all CARICOM nationals hassle-free entry into their territories and a stay of six months upon arrival. The only exceptions for refusing entry are where the Member State deems a person to be 'undesirable person' or where it is believed the Community national seeking entry may become a 'charge on public funds'.

In its decision, the Court considered the state practice in Belize and Trinidad & Tobago in finding that the mere existence of the challenged statutory provisions did not constitute a breach. Although the claim failed, the Court stated definitively that "the practice or policy of admitting homosexual nationals from other CARICOM States (not falling under the two exceptions mentioned in the 2007 Conference Decision) is not a matter of discretion but is *legally required* based on Article 9 of the Revised Treaty of Chaguaramas

[60] Immigration Act Cap 18:01 Section 8 (1) (a) – (q)

[61] See the full decision at http://www.caribbeancourtofjustice.org/news/judgment-gay-rights-activist-receives-ccj-decision-in-immigration-matter

as this is an appropriate measure within the meaning of that provision". Therefore, States cannot as a matter of practice deny entry of homosexuals into their territories.

Following the decision of the Twenty-Seventh Meeting of the Conference of Heads of Government of CARICOM wherein it was agreed that the right of entry granted to CARICOM nationals is subject only to the rights of Member States to refuse entry on the basis of CARICOM nationals being deemed to be 'undesirable persons' or persons deemed to become 'charges on the public purse', as applied by the CCJ in the two cases mentioned above, CARICOM nationals may only be excluded on these two grounds and not on the range of grounds currently contained in Immigration laws. However, the terms 'undesirable persons' and 'a charge on the public purse' are unclear and are interpreted broadly, consistent with broad powers given to immigration officials. It should also be noted that the two grounds apply only to CARICOM nationals and therefore migrants from other countries will continue to be subject to exclusion on the grounds contained in the various Acts.

Irregular Status and Deportations

In the Dominican Republic, regular large-scale deportation exercises target anybody of 'Haitian appearance' (i.e. black) or whose accent betrays Haitian origins.[62] Undocumented status means the **continual threat of deportation**, although this is more likely in territories such as the French Overseas Departments and the Netherland Antilles. Irregular status applies to those migrants who have entered the country irregularly, have overstayed their permitted period of stay, or have committed acts that render them a prohibited migrant (e.g. prostitution, drug trade, homosexual behaviour). Irregular status is considered an offence under all migration laws.

Every state retains the right to deport irregular, "unwanted" or "prohibited migrants". In Antigua and Barbuda, the Bahamas and Guyana, all migrants facing a deportation order have the right to appeal. In the Dominican Republic only 'legal foreigners' may appeal; in Suriname, only those claiming to be a refugee. In Belize and Jamaica, no appeals can be made.[63]

De Jure Restrictions on Entry of Persons Living with HIV

In many countries, HIV or AIDS is **not** defined in Public Health law as a notifiable or infectious or communicable disease. However, where **it is so defined as in the case of the Bahamas, and Trinidad and Tobago as an "infectious disease"** a person living with HIV may be prevented the entering the State.

Notwithstanding the legal position, there has been no policy or practice giving effect to these provisions in any of the countries. Although **Belize** defines HIV as an infectious disease in public health law, an Immigration Officer may restrict entry to someone suffering from a 'communicable' disease, not an infectious disease.

Victimizing the Victim – Anti-Trafficking Laws in the Caribbean*

Antigua and Barbuda, Belize, the Dominican Republic, Guyana and Trinidad and Tobago have anti-trafficking laws. In these laws, trafficking is punished regardless of whether the country is the source,

[62] Ferguson, J. (2003). Migration in the Caribbean: Haiti, the Dominican Republic and Beyond. Minority Rights Group International. Retrieved from http://www.oas.org/atip/regional%20reports/migrationinthecaribbean.pdf

[63] International Organisation for Migration. (2017, 27-28 November). Sub-Regional Caribbean Consultation Toward a Global Compact for Safe, Orderly and Regular Migration (GCM) Report on Results for the Preparatory Process for the Global Compact on Migration. Trinidad and Tobago. p. 68. Retrieved from http://rosanjose.iom.int/site/en/report-results-sub-regional-caribbean-consultations-toward-global-compact-safe-orderly-and-regular

transit, or destination country, regardless of the consent and background of the victim, and trafficking victims are offered measures of protection.[64]

The anti-trafficking law of **Trinidad and Tobago** does not grant to trafficking victims, immunity from crimes committed as part of their trafficked status, and in the **Dominican Republic,** trafficking victims may only be granted immunity if he/she is willing to provide sufficient information to the authorities. Under the **Belize Trafficking in Persons (Prohibition) Act 2003** victims and their dependent children are entitled to **temporary residency status** for the duration of criminal proceedings, provided they are willing to assist in investigation and prosecution. Victims are also given immunity **from prosecution for any immigration-related offence or other criminal offence, including a prostitution offence**, that is a direct result of the trafficking.

However, in **Guyana** the **Combating of Trafficking in Persons Act 2005** makes provision for witness protection for victims, provides that **victims may be eligible to work and to receive social benefits** and that they **ought not to be housed in prisons or detention facilities except in exigent circumstances**. Further, that trafficked persons **may be eligible to apply for residence in Guyana.** Returned victims to Guyana are to have access to education and training programmes provided by the government or others without being differentiated from other participants because they were trafficked. In Guyana, trafficking victims are housed by the Non-governmental organisation, Help and Shelter with State resources. The organisation also runs a shelter and offers services for women who are victims of domestic violence and other forms of abuse.

Under all migration laws, irregular border crossing is criminalized a priori – this implies that the weight of punishment lies with the irregular migrant – not on the individual that smuggles or traffics this person. Victims of human trafficking may therefore also be punished by the judicial system.

Absence of Laws or Procedures related to Refugees

Generally, while 11 countries have acceded to the 1951 Convention on the Status of Refugees and the 1967 Protocol, most have failed to enact enabling legislation or include procedures to guide refugee claims for asylum seekers in immigration or other laws or policies. The situation in Trinidad and Tobago is reflective of the norm. The last UNHCR Report for Trinidad and Tobago submitted in 2011 notes, The Republic of Trinidad and Tobago acceded to the 1951 Convention on the Status of Refugees and its 1967 Protocol (hereinafter referred to jointly as the 1951 Convention) in November 2000. The country has not

* **Addendum**: The following Countries have Anti-Trafficking Legislation - 1. Saint Lucia - Counter Trafficking Act, Cap. 3.17
2. Grenada - Prevention of Trafficking in Persons Act, No 34 of 2014
3. Bahamas - Trafficking in Persons (Prevention & Suppression) Act Ch. 106
4. Antigua and Barbuda (already included) - Trafficking in Persons (Prevention) Act 12/2010
5.Jamaica - The Trafficking in Persons (Prevention, Suppression and Punishment) Act.pdf
6.Belize (already included) - Trafficking in Persons (Prohibition) Act 2/2013
7. St. Kits and Nevis - Trafficking in Persons (Prevention) Act (Cap..4.40) 2002 Rev
8. Barbados - Trafficking in Persons Prevention Act 9/2016
9. St. Vincent and the Grenadines - Prevention of trafficking in persons Act, 2011
10. Trinidad and Tobago (already included) - Trafficking in Persons Act 2011 14/2011
11. Dominican Republic (already included)
12. Guyana (already included) - Combating of Trafficking in Persons Act 2/2005

[64] Ibid at pp.69-70

yet passed any implementing legislation or administrative regulations on asylum or refugee status, nor established a national refugee status determination procedure. [65]

The Report noted that recognized refugees in Trinidad and Tobago do not receive refugee documentation, nor are they entitled to any form of legal status or documentation that would entitle them to work legally. They are placed under Orders of Supervision by the Immigration Department, which provides a measure of security against refoulement. Yet, due to the lack of temporary residency rights and/or work permits, refugees may face detention, prosecution for illegal work, increased vulnerability to labour exploitation, difficulties achieving self-sufficiency, obstacles to accessing social services, prolonged situations of family separation, and uncertainty about their future. This lack of legal rights has tended to lead to depression, anxiety, and secondary trauma amongst some of the more vulnerable refugees in Trinidad and Tobago.

The only countries that have clauses in their Constitution or immigration laws are Cuba, Haiti and Suriname. In Suriname, national immigration laws have incorporated provisions that permit the entry and residence of people who have a well-founded fear of persecution for racial, religious, or political grounds.

Laws Criminalizing Certain Behaviours

The following criminal laws exacerbate the vulnerability of mobile people and migrants who fall within the categories listed below exposing them to heightened discrimination, exploitation, and abuse,

- buggery or sodomy laws;[66]
- laws criminalizing prostitution (and a range of associated activities);[67]
- laws criminalizing drug use;

as criminalization contributes to suppression, marginalization, stigma and discrimination manifested by varying levels of disapproval, exclusion, and even persecution of persons and groups associated with these identities, orientations and behaviours. For example, a migrant sex worker is at heightened risk for violence and abuse and may be unwilling to access health services for fear of deportation. The high rates of sexual violence in the region as well as virulent transphobia and homophobia combined with persistent stigma, limit the ability of 'criminalized" populations to access healthcare and other social services, including voluntary testing, counseling and treatment for HIV. If they are migrants and not citizens of a country in which they reside, these conditions of vulnerability are exacerbated.

Absence of Broad Anti-Discrimination Laws

In **Guyana, t**here is a substantial body of anti-discrimination legislation in Guyana, contained in both the Constitution and in specific statutes that seek to promote equality between the sexes and prevent discrimination. **The Prevention of Discrimination Act (1977)** prohibits discrimination on grounds including race, sex, religion, colour, ethnic origin, indigenous population, national extraction, social origin, economic status, disability, family responsibilities, pregnancy, marital status and age (s.4) Prohibited areas of discrimination include recruitment, employment, training and membership of professional bodies.

[65] Universal Periodic Review Trinidad and Tobago. (2011, March). Submission by the United Nations High Commissioner for Refugees for the Office of the High Commissioner for Human Rights' Compilation Report on the Situation of Refugees in Trinidad and Tobago. Retrieved from http://www.refworld.org/type,COUNTRYREP,UNHCR,TTO,4d886a9f2,0.html

[66] Countries which criminalize include: Antigua and Barbuda, Jamaica, Saint Lucia, Grenada, St. Vincent and the Grenadines, Barbados, St. Kitts and Nevis, Dominica, and Guyana. Countries which do not criminalize include: The Dutch territories, UK Overseas Territories, Bahamas, Cuba, Dominican Republic and Suriname and more recently Belize and Trinidad and Tobago.

[67] With the exception of the Dutch Territories sex work is largely criminalized.

In **The Bahamas**, t**he Employment Act (2001)** prohibits discrimination in public or private employment, except the disciplined forces (armed forces, police & prison services). The Act prohibits discrimination on the grounds of race, creed, sex, marital status, political opinion, age, **HIV and AIDS status**, or disability (subject to reasonable accommodation). Prohibited discrimination is defined as refusal to offer employment, not affording access to opportunities for promotion or training or other benefits, dismissal of the employee, subjecting the employee to other detriment. The Act also expressly prohibits the pre-screening of an employee for HIV and AIDS.

In the area of employment, **Saint Lucia** and **Grenada** have broad Labour Acts which include prohibited grounds of discrimination related to race, colour, sex, religion, national extraction, social origin, ethnic origin, political opinion or affiliation, age, disability, serious family responsibility, pregnancy, marital status or HIV and AIDS, in respect of recruitment, training, work facilities or service, promotion, terms and conditions of employment or benefit arising out of the employment relationship.

General protections for non-discrimination and equality with the exception of Guyana are still contained in the relevant national Constitutions, which as indicated above, exclude its applicability to non-citizens or migrants. Otherwise, protections exist with respect to the labour law in the Bahamas, Saint Lucia and Grenada. The GIZ Migrants project proposed an amendment to **the PANCAP Model Anti-discrimination Legislation** which was endorsed by the COHSOD in 2012 (but has not as yet been adopted by any country) to include a specific reference to migration but this was not approved by the COHSOD.[68]

Lack of Compliance with Existing Migration Conventions, Treaties and Standards

Lack of accession or ratification of many international human rights instruments

The right to health is protected in only five (5) countries in the region as indicated above.[69] The 1990 International Convention on the Protection of Migrant Workers and Members of Their Families, the most comprehensive instrument protecting the rights of migrants has only been ratified by **Belize, Guyana, Jamaica** and **St. Vincent and the Grenadines**. The Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10) has only been signed by **Haiti** and the **Dominican Republic**. Only **Cuba**, **Haiti**, and **Suriname** have clauses in their legal framework that allow for the asylum of refugees. Only**, Antigua and Barbuda**, **Belize**, **Dominican Republic**, **Guyana, Haiti**, and **Trinidad and Tobago** have specific anti-trafficking laws some of which victimize, survivors of human trafficking.

Dualist as opposed to Monist traditions

Even where states have ratified international human right conventions (see Table 2 below), the application of international law is dependent on whether a country has adopted a ***monist*** or a ***dualist*** system relating to the application of international law. In a dualist system, treaties and other international instruments signed and/or ratified by a country require passage through Parliament to be enforceable. In a ***monist*** system treaties and other international instruments signed and/or ratified become part of the law of the land and where the instrument is self-executing, it ranks as part of and above national law. The majority of the countries of the Caribbean as dualist states, **Antigua and Barbuda**, **Bahamas, Belize, Dominica, Grenada, Guyana, Jamaica, St. Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines and Trinidad and Tobago.** The following countries have a monist system **Dominican Republic, Suriname and Sint Maarten, Haiti**. However, even in a monist state, there may be limitations. For example, national Constitutions may require the approval of the Legislature or passage of an implementing law.

[68] CVC/COIN PANCAP Baseline Assessment 2016

[69] For ease of reference - Dominican Republic, Cuba, Guyana, Haiti, Suriname and Sint Maarteen

Table 2: Status of Ratifications of key International Human Rights Instruments by Caribbean Countries

Country	Right to Health	ICCPR 1976	ICESCR 1976	Convention on the Status of Refugees 1951	Protocol Relating to the Status of Refugees 1967	International Convention on the Protection of Migrant Workers and Members of Their Families 1990	CEDAW 1981	Convention on the Rights of the Child 1990	Convention for the Elimination of All Forms of Racial Discrimination 1969	Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
Antigua and Barbuda	No	No	No	**1995 a**	1995	No	**1989**/2006	**1993**/2002	**1988**	1993
Bahamas	No	**2008**	**2008**	**1993 a**	1993 a	No	**1993**	**1991**/2010	**1975**	2018
Barbados	No	**1973**/1976	**1973**	No	No	No	**1980**	**1990**	**1972**	No
Belize	No	**1996**	**2015**	**1990**	1990	2001	**1990**/2002	**1990**/2003	**2001**	1986
Dominica	No	**1993**	**1993**	**1994 a**	1994 a	No	**1980**	**1991**/2002	**No**	No
Dominican Republic	**Yes**	**1978**	**1978**	**1978 a**	1978 a	No	**1982**/2001	**1991**/2014/2006	**1983**	2012
Grenada	No	**1991**	**1991**	No	No	No	**1990**	**1990/**2012	**2013**	No
Guyana	**Yes**	**1977**/1999	**1977**	No	No	2010	**1980**	**2012**/1991/2010	**1977**	1988
Haiti	**Yes**	**1991**	**2013**	**1984 a**	1984 a	Signed 2013 – not ratified	**1981**	**1995**/2014	**1972**	No
Jamaica	No	**1975**	**1975**	**1964 d**	1980 a	2008	**1984**	**1991**/2002/2011	**1971**	No
Saint Kitts and Nevis	No	No	No	**2002 a**	No	No	**1985**/2000	**1990**	**2006**	No
Saint Lucia	No	No	No	No	No	No	**1982**	**1993**/2014/2013	**1990**	No
Saint Vincent and the Grenadines	No	**1981**	**1981**	**1993 a**	2003 a	2005	**1981**	**1993**/2001/2005	**1981**	2001
Suriname	**Yes**	**1976**	**1976**	**1978 d**	1978 d	No	**1993**	**1993**/2012	**1984**	No
Trinidad and Tobago	No	**1978**	**1978**	**2000**	2000	No	**1990**	**1991**	**1973**	

MIGRANTS RIGHTS AND HEALTH

International Law on Migration

To some degree**,** migrants are protected under an amalgam of general international law, human rights law, labour law, and international criminal law**. This area of law has been described as** an unassembled juridical jigsaw**. Unlike refugees or children, whose rights are set out in one treaty,** there is not yet a legal text for migrants which brings together all the different elements, and which is accepted as legally binding and authoritative by a majority of states**.**

The international instruments referred to below establish both general and specific principles that provide a foundation for the development of effective national legal and policy frameworks to regulate migration from a rights-based perspective while ensuring health protection and services. See **Annex 3** for a comprehensive list of international legal instruments.

Migrants have rights under five (5) sets of international instruments:

(1) The **Core Human Rights Treaties**, whose provisions apply universally, and thus protect mobile populations and in particular migrants. These include:
   - **a. International Covenant on Civil and Political Rights** [154 ratifications: 'ICCPR']:
   - **b. International Covenant on Economic, Social and Cultural Rights [**151 ratifications 'ICESCR'
   - **c. Convention to Eliminate all forms of Discrimination against Women** [179 ratifications: 'CEDAW'];
   - **d. Convention on the Rights of Child** [192 ratifications: 'CRC']

(2) Specific migrant and worker protection International Instruments.
   - **a. The International Convention on the Protection of Migrant Workers and Members of Their Families 1990,** the most comprehensive instrument protecting the rights of migrants.
   - **b. Migration for Employment (Revised) 1949 (No. 97)** sets out the rights of migrants in relation to remuneration, social security, taxation, access to trade unions, and transfer of personal belongings.
   - **c.** ***Migrant Workers (Supplementary Provisions) Convention 1975*** **(No. 143),** sets out the rights of irregular migrants, and rights to equal treatment with nationals.

   These three (3) international instruments can be seen as comprising an "international charter" for the protection of international migrant workers. These instruments establish a normative framework for the protection of migrant workers, addressing their access to health services and treatment and calling for inter-state cooperation in this regard.

Other relevant ILO Conventions and Recommendations including:

(3) **Other ILO Conventions related to migrants:**
   - **a.** ***Domestic Workers Convention*** **(No. 189)** and **Domestic Workers Recommendation (2011) (No. 201)** also stipulate certain health protections specifically for migrant workers. These include standards with regard to medical examinations; care and hygiene before

the migration journey, during the journey, and on arrival; equality of opportunity with regard to social security; weekly rest periods; and protection from abuse. Paragraph 3(c) of the Domestic Workers Recommendation makes specific reference to the protection of domestic workers from mandatory HIV testing practices.

b. **ILO Social Security (Minimum Standards) Convention, 1952 (No. 102),** the **ILO Equality of Treatment (Social Security) Convention, 1962 (No. 118)**, and the **ILO Recommendation concerning National Floors of Social Protection, (No. 202)**. These two Conventions and the Recommendation govern the right to social protection.
c. **ILO Recommendation 200 on HIV and the World of Work 2010** provides for safeguards of confidentiality and recommends access to HIV, care and treatment for migrants.

(4) **International Criminal Law and International Humanitarian Law** – protect migrants' rights in the most extreme situations for example, war, genocide or crimes against humanity.

(5) **Special Rapporteurs on the Human Rights of Migrants** under the **United Nations** and **Inter-American System.**

The 1990 International Convention on the Protection of Migrant Workers and Members of Their Families:
The Convention is the most comprehensive instrument protecting the rights of migrants. Building on other core human rights treaties, the Convention came into force in 2003, however, in the Caribbean, it has only been ratified by **Belize, Guyana, Jamaica** and **St. Vincent and the Grenadines**.

This Convention recognizes migrant workers as a group vulnerable to rights' violations and sets out a framework for "equitable and humane conditions of international migration".[70] It recognizes the importance of providing migrant workers with access to social security, emergency medical care,[71] and health and social services,[72] and stipulates that migrant workers should have access to the same treatment as nationals of the state of employment in respect to working conditions.[73]

Instruments relating to Refugees and Asylum Seekers

International law related to refugees is contained in the **Convention on the Status of Refugees (1951)** and the **1967 Protocol Relating to the Status of Refugees**.

In accordance with Article 2 of the Convention, a refugee is a person:

> owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

[70] International Convention on the Protection of Rights of All Migrant Workers and Members of Their Families, p. 9.
[71] Ibid., article 28.
[72] Ibid., articles 43 and 45.
[73] Ibid., article 25.

This regime established in 1951 predates the human rights treaty system. **Refugees are distinguished from migrants by their lack of protection by their own governments,** and it is for this reason that a special protection 'regime' was created, which defines them by reference to their 'well-founded' fear of persecution at home, **protects them from *refoulement*, (right of return)** recognises their civil, social, economic and cultural rights, and places them under the protection of individual states and of the United Nations High Commissioner for Refugees (UNHCR).

The right of "non-refoulement" enshrined in Article 33 (1) of the 1951 Convention, right to be protected against "refoulement" (expulsion or return) is the cornerstone of international refugee law. Such principle prohibits Member States from returning a refugee to a country "where his life, or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion". This principle now constitutes a norm of customary international law and must be respected for all individuals, including all migrants, regardless of their status.

Instruments Related to Trafficking in Persons

In addressing trafficking on persons, the legal frameworks and initiatives in most cases include three core components targeted at dealing with the human trafficking problem, that is, prevention, prosecution and protection. The key international instruments include, the **UN Convention against Transnational Organized Crime (2000)**; **Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children**; **Protocol against the Smuggling of Migrants by Land, Sea and Air.**

The **Protocol to Prevent, Suppress and Punish Trafficking in Persons especially Women and Children**, supplementing the **UN Convention against Transnational Organised Crime, 2000** was adopted by the United Nations specifically to deal with trafficking of human beings of both gender and provided an omnibus definition of trafficking in persons (including the act, the means and the purpose) for the first time in international law.

Section II of the Convention obliges State Parties to adopt "legislative or other appropriate measures" necessary for the actualisation of the remedies for victims of trafficking therein contained. The remedial framework provided for under Articles 6 – 8 and which are aimed at the physical, psychological and social recovery of victims include the right to legal assistance, rehabilitation, recovery, and a safe repatriation and reintegration into either the state of origin or residence.

States have an obligation to:

- identify, recognise and treat trafficking victims as victims and not as illegal/irregular migrants and criminals that should be repatriated to home countries;
- create an enabling environment and relevant mechanisms to assist victims to access justice, either by helping them help the state to prosecute and punish their traffickers and help victims to recover compensation for damages suffered. This implies adequate legal and administrative frameworks for enforcement of the right to access justice.
- protect the physical, psychological, economic, legal, and social well-being of victims by adopting measures that help to rehabilitate and reintegrate them into society and prevent re-victimisation.

In a report by the UN Special Rapporteur on on Trafficking in Persons, especially Women and Children it was found that a critical analysis of these legal frameworks and initiatives at the regional and international levels reveals a heavy emphasis on the prosecution (law enforcement) component of the frameworks,

with little or no attention to the prevention and more importantly, victim protection components.[74] This finding echoes the situation of the Caribbean referenced at pages 24 -25 in relation to trafficking in persons legislation.

Human Rights Principles Underlying the Rights of Migrants

The principle which unifies and underlies the treaty 'regime' is ***universality***. 'Everyone' is protected, and human rights are linked not to citizenship but to a common humanity. Human rights encompass civil, cultural, economic, political and social rights, and are ***indivisible***, meaning these different sets of rights are interdependent and cannot be separated.[75] Human rights are also ***inalienable*****,** and thus cannot be taken away, regardless of immigration status or HIV status.

Addressing the rights of migrants and mobile populations are centered on the principles of ***non-discrimination***, and ***equal treatment***.

The principle of **equality** was underscored in a case brought against the British Government by foreign nationals in ***A(FC) and others (FC) (Appellants) v. SSHD (Respondent)*** **[2004] UKHL 56** who had been detained on grounds of national security, and who challenged legislation allowing their indefinite detention without trial, on the ground that it applied to foreign, but not to British nationals. The House of Lords held that, while the rights of these two groups might differ in an immigration context, international human rights law – in this case, the European Convention on Human Rights - does not permit discrimination between citizens and aliens in their rights to liberty. It was not therefore permissible for the State to discriminate between aliens and its own nationals as regards their **right to liberty**.

There is no hierarchy between human rights; all rights are universal, inalienable, indivisible, interdependent and of equal importance. The international human rights framework is similarly clear that every person without **discrimination** is entitled to consideration of his or her unique circumstances as a matter of human rights principles. **Simply put, all human beings have all human rights**.

Distinctions between citizens and non-citizens may be made, but since they are exceptions to this principle, **they must serve a legitimate state objective and be proportionate:** in other words, the means used must not exceed the goals pursued. Thus, states may limit free movement and political participation, **but they must not draw distinctions between citizens and non-citizens in relation to fundamental rights,** such as those contained in the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.

Beyond this, certain legal protection regimes have been created for groups of non-nationals, including refugees, trafficked persons and migrant workers, to address particular situations and specific vulnerabilities. In applying such regimes, however, care must be taken to avoid creating hierarchies of vulnerability based on categorisation. Fragmentation or compartmentalization of different categories of migrants may be counterproductive to the purpose of ensuring the human rights of all migrants. The "categorisation" approach to the human rights of migrants is complicated by the cross-cutting nature of these categories; For example, migrant workers, refugees, trafficked persons and smuggled migrants can

[74] United Nations. (2013, 21 November). Special Rapporteur on Trafficking in Persons, especially Women and Children - Paper presented at the Regional Consultation on the Right to an Effective Remedy for Trafficked Persons. Abuja, Nigeria.

[75] World Conference on Human Rights. (1993, 25 June). Vienna Declaration and Programme of Action. Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx.

also be migrants with disability, children, pregnant women and women who have suffered sexual and other forms of gender-based violence, migrants, stateless persons, minorities and indigenous migrants, persons with HIV or AIDS, lesbian, gay, bisexual and transgender migrants, and victims of torture. Many migrants will be or may become vulnerable on more than one ground and may have suffered abuse of more than one type. Those who are victims of violence and trauma, in an irregular as well as in a situation of poverty, are more likely to be vulnerable to discrimination and exclusion. Migrants will pass through varying legal categories during their journey, particularly when migratory journeys are long and hazardous. States must affirm the human rights of **all migrants** while at the same time recognising more specific protection needs as these arise.[76]

Human rights law thus provides that every person, without discrimination, must have access to his or her human rights. States are obliged to ensure that any differences of treatment between national and non-nationals or between different groups of non-nationals are enshrined in national legislation, serve a legitimate objective, and that any course of action taken to achieve such an objective must itself be proportionate and reasonable. States, committed by legal obligations, have the duty to respect, protect and fulfil the human rights of all migrants.[77]

The basic principle of human rights is that entering a country in violation of immigration laws does not deprive an irregular migrant of his or her most fundamental human rights, nor does it erase the obligation of the host state to protect these individuals. Differences in treatment must be;

- enshrined in national legislation,
- serve a legitimate objective, and
- that any course of action taken to achieve such an objective must itself be proportionate and reasonable.

Otherwise States may not draw distinctions between citizens and non-citizens in relation to fundamental rights.

The Right to Health

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease." It is influenced by a broad range of factors, including income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology, gender, and culture.[78] The WHO states that;

[76] Office of the High Commissioner for Human Rights (OHCHR). (2012). Migration and Human Rights - Improving Human rights-based Governance of International Migration Report on Global Governance. Geneva, Switzerland. P. 19. Retrieved from http://www.ohchr.org/Documents/Issues/Migration/MigrationHR_improvingHR_Report.pdf

[77] Ibid at page 16 – referencing the Committee on the Elimination of Racial Discrimination which has advised that differences of treatment based on citizenship or immigration status will constitute discrimination if the criteria for different treatment, judged in the light of the objectives and purposes of the Convention, are not applied in pursuit of a legitimate aim or are not proportional to its achievement. CERD, General Recommendation No. 30: Discrimination against Non-Citizens, October 2004, para. 4.

[78] Preamble to the Constitution of the WHO as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 states (Official Records of the World Health Organization, no. 2, p. 100).

"the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

Article 12 of the 1966 United Nations (UN) **International Covenant on Economic, Social and Cultural Rights (ICESCR)** provides **the most comprehensive article on the right to health** in international human rights law.

Article 12.1 prescribes the "***right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*** and;

Article 12.2 enumerates, by way of illustration, a number of ***"****steps to be taken by the States parties ... to achieve the full realization of this right".* It includes specific provisions for child and maternal health; environmental and industrial hygiene; medical access and attention for all; and prevention, treatment, and control of diseases.[79]

The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.[80]

A definition of the 'right to health' encompasses a similarly broad range of factors. It is not simply the right to be healthy or the right to health care. The right to health, as defined in article 12.1, extends not only to timely and appropriate health care **but also to the underlying determinants of health** such as:

- access to safe and potable water and adequate sanitation;
- an adequate supply of safe food;
- nutrition and housing;
- healthy occupational and environmental conditions;
- access to health-related education and information, including on sexual and reproductive health; and
- the participation of the population in all health-related decision-making at the community, national and international levels. [81]

The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:[82]

(a) ***Availability.*** Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and

[79] International Covenant on Economic, Social and Cultural Rights (ICESCR), article 12.

[80] Committee on Economic, Social and Cultural Rights, General Comment no. 14, article 3.

[81] Committee on Economic, Social and Cultural Rights, General Comment no. 14, article 11.

[82] Committee on Economic, Social and Cultural Rights, General Comment no. 14, article 12.

other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs;

(b) ***Accessibility.*** Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

i. *Non-discrimination:* health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds;

ii. *Physical accessibility*: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities;

iii. Economic accessibility **(*affordability*):** health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households;

iv. Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality;

(c) ***Acceptability***. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned;

(d) ***Quality.*** As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

Core obligations of the Right to Health Include:[83]

(a) ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

(b) ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

[83] Committee on Economic, Social and Cultural Rights, General Comment no. 14, article 43 and 44.

(d) provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
(e) ensure equitable distribution of all health facilities, goods and services;
(f) adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population, adopting a participatory and transparent process;

Of comparable priority are:

(a) ensure reproductive, maternal (prenatal as well as post-natal) and child health care;
(b) provide immunization against the major infectious diseases occurring in the community;
(c) take measures to prevent, treat and control epidemic and endemic diseases;
(d) provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
(e) provide appropriate training for health personnel, including education on health and human rights.

Moreover, the Committee's General Comment No. 3, on the nature of states parties' obligations, provides that every state has a minimum core obligation to ensure the satisfaction, at the very least minimum essential levels, of each of the rights, including the right to health.[84] Embedded in the right to health are the principles of **equality** and **non-discrimination** on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status.[85]

Mapping the Right to Health for Migrants in International Law

In relation to migrants, Article 34 of General Comment 14 on the Right to Health **expressly states;**

> "States are under the obligation to ***respect*** **the right to health** by, inter alia, **refraining from denying or limiting equal access for all persons, including** prisoners or detainees, minorities, **asylum-seekers and illegal immigrants**, to preventive, curative and palliative health services.

Mapping the Right to Health for Migrants in International Law[86]

Table 3: Mapping the Right to Health for Migrants in International Law

Convention	Relevant Articles and Comments	Right to Health Protections
International Covenant on Economic, Social and Cultural Rights (ICESCR)	ICESCR Article 7	The right to safe and healthy working conditions
	ICESCR Article 9	The right to social security, including social insurance.
	ICESCR Article 12	The right to the enjoyment of the highest attainable standard of physical and mental health.
	CESC General Comment 14	Expands on right to the highest attainable standard of physical and mental health.

[84] Committee on Economic, Social and Cultural Rights, General Comment No. 3, 1990, contained in document E/1991/23, para.10. The Committee further explains that "*a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant*."

[85] Committee on Economic, Social and Cultural Rights, General Comment no. 14, article 18 – 19.

[86] UNDP (2015). The Right to Health. United Nations Development Programme, Bangkok Regional Hub Bangkok, Thailand.

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	CEDAW Article 11 (1) f	The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction, on a basis of gender equality.
	CEDAW Article 12 and CEDAW Article 14 (2) b	The right to access health-care facilities, including information, counselling, and services in family planning, on a basis of gender equality.
	CEDAW General Comment 24	Expands on women's right to access health care, including reproductive health.
International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)	Article 5 (e) iv	The right of everyone to public health, medical care, social security, and social services, without distinction as to race, colour, or national or ethnic origin.
Convention on the Rights of the Child (CRC)	Article 24	The right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.
Specific Migrant Protections to Health		
International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICMW)	Article 28	The right to receive emergency medical care.
	Article 43 (1) e	The right to access social and health services, provided that the requirements for participation in the respective schemes are met.
	Article 45 (c)	The right for families of migrant workers to access social and health services provided that requirements for participation in the respective schemes are met.
Migration for Employment Convention (ILO No. 97)	Article 5 (b)	Member Parties to ensure that migrants for employment and members of their families enjoy adequate medical attention and good hygienic conditions at the time of departure, during the journey, and on arrival in the destination country.
Migrant Workers (Supplementary Provisions) Convention (ILO No. 143)	Article 9	Member Parties to ensure equal treatment for migrant workers with regard to social security.
Domestic Workers Convention (ILO No. 189)	Article 13	Member Parties to ensure the right to a safe and healthy working environment for domestic workers.
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	CEDAW General Recommendation 26	Expands on the rights of women migrant workers, including recommendations relating to safe migration and access to health services, including reproductive health care.
ILO, HIV and AIDS Recommendation, 2010	Paras. 25, 27-28	That migrant workers should not be subjected to compulsory HIV testing, nor should they be required to disclose HIV–related information or be excluded from migrating based on their real or perceived HIV status at any stage of the migration process.
	Para 47	Calls for international cooperation among countries of origin, of transit, and of destination to ensure migrants' access to HIV prevention, treatment, care and support.

The Committee on Migrant Workers (CMW), the treaty body for the **International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICMW)**, in its elucidation of Article 28's parameters, has stated that:

- access to urgent medical care must be ensured to all migrant workers on the basis of equality of treatment with nationals and thus on a non-discriminatory basis;
- states parties should prohibit the charging of excessive fees from migrant workers in an irregular situation;
- states parties should ensure that migrant workers and members of their families are provided with information on the medical care provided and information about their health rights.[87]

Despite the ICESCR's comprehensive standards for right to health, and their specific application to migrant workers in the conventions and approaches described above, migrant workers as well as other migrants can face a broad range of potentially serious health challenges throughout the migration cycle.

Tackling Migration and Health

Challenges concerning the health of migrants cannot be tackled straightforwardly since the issue is highly dynamic and complicated, involving various stages of migration, from pre-departure to early and late migratory status. Furthermore, this matter is tightly intertwined with several social determinants, which are related not only to migrants' characteristics (such as, different gender roles, cultural diversity, migration experiences, and precarious legal status), but also the contextual environment of migrant destination countries (such as, idiosyncratic health systems and cultural values).[88]

A growing body of research addresses some of the connections between health and migration and the range of health vulnerabilities of each stage of the migration continuum.[89] Contemporary mobility is a much more complex process, more accurately viewed as a multistage cycle that can be entered into multiple times, in various ways, and may occur within or across national borders. The migratory process model has five phases: (1) **pre-departure,** (2) **travel**, (3) **destination**, (4) **interception** (affecting a minority of migrants), and (5) **return**. At each stage there are varying health concerns and vulnerabilities:

[87] International Labour Organisation. (2016). Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Geneva, Switzerland, International Labour Office, p. 52. Retrieved from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/Right-based-Approach-to-Migration-Health-and-HIV-AIDS.pdf
See also Committee on Migrant Workers, General Comment No. 2.

[88] Suphanchaimat, R., et al. (2015). Challenges in the Provision of Healthcare Services for Migrants: A Systematic Review through Providers' Lens. *BMC Health Services Research* 15: 390. *PMC*. Web.

[89] IOM, WHO, and OHCHR. (2013). International Migration, Health and Human Rights. International Organization for Migration, World Health Organisation and Office of the High Commissioner for Human Rights, Geneva, Switzerland. p. 29; Zimmerman, C., Ligia Kiss, and Mazeda Hossain. (2011). "Migration and Health: A Framework for 21st Century Policy-Making." PLoS Medicine 8.5: e1001034. PMC. Web. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3101201/;
PAHO. (2016, 22 – 30 September). 55th Directing Council 68th Session of the Regional Committee of WHO for the Americas. Washington, D.C., USA. Retrieved from https://www.paho.org/hq/dmdocuments/2016/CD55-11-e.pdf

The Migratory Process and Health Impacts[90]

Table 4: The Migratory process and health impacts

Stages	Health Impacts	Key Vulnerable Pop	Responses
Pre-Departure – Time before individuals leave from their place of origin	Biological characteristics, local chronic disease patterns and pathogens, environmental factors, human rights violations e.g. violence	Forced migrants are particularly likely to have experienced traumatic events at this stage, which may affect their psychological and physical health status throughout their journey	Collaboration between countries of origin and destination is necessary but there is little evidence of this.
Travel - Period when individuals are between their place of origin and a destination or an interception location.	Pathogens may be carried across different zones of disease prevalence and initiate changes in international and local transmissible disease epidemiology.	Especially for irregular migrants, health influences during this time are closely related to the mode of transport and circumstances of travel, such as journeys via flimsy boats or closed containers. In cases of human trafficking, this phase is generally the time when criminal acts begin, such as illegal border crossings, kidnapping, and, for women and children, sexual violence.	Health promotion programs at border or transit locations for migrants
Destination – Period when individuals settle either temporarily or long-term in their intended location.	Mental health outcomes often appear worse for migrants, displaced populations, and refugees than for native-born populations Migrant women may be at greater risk of reproductive health problems and poor pregnancy outcomes, such as pregnancy complications, neonatal morbidity, and infant mortality Asylum-seekers with temporary protection tend to have poorer mental health than refugees who have permanent residency Similarly, low-skilled migrant laborers, especially those with irregular status, are at high risk of injury and illness. Many may not have access to health services	Displaced populations, refugees, women, asylum seekers, low skilled Irregular migrant workers	Greater attention is required for non-communicable diseases, mental health, and socioeconomic influences on health.

[90] Zimmerman, C., Ligia Kiss, and Mazeda Hossain. (2011). "Migration and Health: A Framework for 21st Century Policy-Making." PLoS Medicine 8.5: e1001034. PMC. Web. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3101201/

Interception – Situations of temporary detention or interim residence.	Immigration detention centers or refugee camps often have deleterious effects on mental or physical health and are commonly sites of human rights abuses.	Forced migrants (e.g., asylum-seekers, refugees, displaced populations, trafficked persons) or irregular migrants, such as undocumented workers.	
Return - Period when individuals go back to their place of origin, either temporarily or to resettle indefinitely or permanently.	Migrants may experience the cumulative toll that migration exposures have taken on their physical and psychological wellbeing. Individuals returning to low-resource settings with life-threatening, disabling, or chronic health concerns that require ongoing or high-tech treatment, such as cancer, diabetes, or HIV, may have difficulty identifying or paying for adequate care. Many labor migrants, however, may return with reasonable remuneration and remittances that help them afford a healthier lifestyle and better health care for themselves and their family.	Trafficked persons or war affected Refugees, deportees	There is a need for bilateral or regional agreements to support the portability of health care benefits, especially when healthy migrants contribute to wealthy countries and return unwell or to retire and require significant care from their home country's health system

The Pan American Health Organisation in support of this evidence also cites in its Directive on the Health of Migrants, at paragraph 10 "the association between migration and adverse **health outcomes varies** by **migrant subgroup** and by **vulnerable conditions, ethnicity**, **gender**, and **region of origin** and **destination**". **Psychosocial factors** may also play a role in the deterioration of health after migration.[91]

Barriers or Conditions of Vulnerability Impacting the Health of Migrants

The factors which impact on the health of migrants include:[92]

Poverty

The circumstances surrounding migration often put many migrants in precarious living and working conditions that increase their vulnerability to adverse health outcomes. Migrants frequently find themselves concentrated in marginal neighbourhoods with poor access to public transport, education and healthcare services. Significant numbers of migrant workers live and work in geographically isolated areas, such as construction sites, mining facilities, or in rural agricultural areas, where health care facilities and services are limited, inaccessible or non-existent.[93]

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[91] IOM. WHO. (2010, 3-5 March). Health of Migrants: The Way Forward - Report of a Global Consultation. Madrid, Spain. International Organisation for Migration, World Health Organisation, p. 9. Retrieved from http://www.who.int/migrants/publications/mh-way-forward_consultation-report.pdf
See also, PAHO. (2016, 22 – 30 September). 55th Directing Council 68th Session of the Regional Committee of WHO for the Americas. Washington, D.C., USA. Retrieved from https://www.paho.org/hq/dmdocuments/2016/CD55-11-e.pdf

[92] Ibid paragraphs 10 - 14

[93] International Labour Organisation. (2016). Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Geneva, Switzerland, International Labour Office, p. 21. Retrieved from

Precarious living and working conditions affect migrants in irregular or undocumented situations even more acutely than other migrants. Migrants in irregular situations tend to accept jobs with dangerous working conditions or work in the informal economy, where low wages and an absence of occupational safety and health protections are common. Migrants in irregular situations often live in substandard conditions for multiple reasons, including a lack of formal employment that generates consistent income, or a reluctance to raise concerns about housing conditions due to fear of deportation

Irregular as opposed to regular status

From a public health policy perspective, an important dichotomy is between 'documented' versus 'irregular' migrants. Individuals who travel via legal channels with required documentation, for example, high-skilled workers, are likely to encounter fewer health risks and have better service access than irregular migrants.[94] For example, the Report on migrant construction workers in Trinidad and Tobago found that, most of the migrants who entered the country on a work permit were provided with health care and accommodations by the Employer, which most deemed as satisfactory. For irregular migrants, health care, insurance and other benefits were not provided.[95]

Conditions surrounding the migration process can increase vulnerability to ill health. This is particularly true for people who migrate involuntarily, flee natural or man-made disasters and human rights violations; and for those who find themselves in an irregular situation, such as those who migrate through clandestine means or have no documents. Referencing a series of studies, the International Labour Organisation (ILO) further states that, in addition to facing legal barriers, undocumented migrants often lack sufficient financial resources to cover healthcare services. It is especially problematic in cases where states oblige undocumented migrants to cover all their healthcare costs, as is the practice in Sweden. In the United States, healthcare services received by undocumented migrants are often not covered by any insurance. Undocumented migrants remain the largest uninsured group in the country and poverty levels among the group are accelerating.[96]

- ***Fear of deportation***

Without legal status, irregular migrants often living and working in substandard conditions and pay are reluctant to raise concerns about working and housing conditions due to fear of deportation. Living in such conditions, they also often face considerable difficulty in accessing healthcare and in many cases will refrain from accessing care for fear of deportation.

Xenophobia, stigma and discrimination

Migrants' status as non-nationals often leaves them less protected under national law. Additionally, because they are less familiar with the local language and with the legal and social support systems in the

https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/Right-based-Approach-to-Migration-Health-and-HIV-AIDS.pdf

[94]UNAIDS. (2009). Background Paper: People on the Move – Forced Displacement and Migrant Populations. 24th Programme Coordinating Board Thematic Segment. United Nations Joint Programme on HIV/AIDS, Geneva, Switzerland.

[95] Noguera-Ramkissoon, A. (2011, December). HIV Vulnerabilities of Migrant Construction Workers in Trinidad and Tobago, ABNR Consultants on behalf of the Pan Caribbean Partnership Against HIV/AIDS (PANCAP).

[96] International Labour Organisation. (2016). Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Geneva, Switzerland, International Labour Office, p. 13. Retrieved from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/Right-based-Approach-to-Migration-Health-and-HIV-AIDS.pdf

new country, and in many cases are visible minorities, they are particularly at risk of discrimination. Other differences from local populations, such as race, ethnicity or religion, are also often factors in the discrimination to which they may be subjected. The 'otherness' of migrants often creates xenophobia, isolation and hostility by the host community.

Widespread racist and xenophobic hostility directed against migrants, refugees, immigrants and immigrant origin populations, particularly those whose appearances and backgrounds are visibly different from the 'norm' of the host society, are reported worldwide. These represent especially virulent manifestations of discrimination. The negative effects of xenophobia and racism, which manifest through political and popular discourse as well as through physical violence, including murder, cannot be underestimated. Not only have such incidents occurred in every region of the world, evidence suggests they are increasing in intensity. Frequent attacks against migrants by individuals or groups, police round-ups, mass detention and even killings of migrants take place with alarming regularity.[97]

Discrimination and conditions in which exclusion of migrants or hostility and violence against them thrive lead to direct and indirect negative health consequences, which can be severe. These range from high levels of stress, to psychological problems, to physical illness, as well as injury resulting from direct violence. Migrants also fear accessing services including health services for fear of being targeted and also deported if they are in an irregular situation.

Gender Inequality

A person's gender identity, gender expression, sexual orientation, or ethnicity, among other factors, can be associated with specific risks to health and differential vulnerability before, during, and after migration. Gender and ethnicity, among other factors, can affect the reasons for migrating, as well as the social networks migrants use to move in host communities, their experiences during transit, integration experiences at destination, and relations with the country of origin. For example, women are more often affected by violence, abuse, and rape. Moreover, there is substantial evidence of inequities in both the state of health of members of ethnic groups and the accessibility and quality of health services available to them due to social exclusion.[98]

Social Exclusion

In most countries of destination, immigrants become minorities, excluded from full participation and integration in society, and this may extend to their offspring. Social exclusion is higher in countries where belonging to the nation is strongly rooted in membership of a specific ethnic group and ethnic and cultural diversity are seen as a threat to national culture.[99]

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[97] International Labour Organisation. (2016). Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Geneva, Switzerland, International Labour Office, pp. 16-17. Retrieved from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/Right-based-Approach-to-Migration-Health-and-HIV-AIDS.pdf

[98] PAHO. (2016, 22 – 30 September). 55th Directing Council 68th Session of the Regional Committee of WHO for the Americas. Washington, D.C., USA. paragraph 12, citing: World Health Organization, Regional Office for Europe. (2010). How Health Systems can Address Health Inequities linked to Migration and Ethnicity. Copenhagen, Denmark; and Urquia, ML, et al. (2010). International Migration and Adverse Birth Outcomes: Role of Ethnicity, Region of Origin and Destination. Journal of Epidemiology and Community Health. Retrieved from https://www.paho.org/hq/dmdocuments/2016/CD55-11-e.pdf

[99] PAHO. (2016, 22 – 30 September). 55th Directing Council 68th Session of the Regional Committee of WHO for the Americas. Washington, D.C., USA. paragraph 13. Retrieved from https://www.paho.org/hq/dmdocuments/2016/CD55-11-e.pdf

Separation from family and socio-cultural norms

Removed from their original environment, migrants may have little or no social support, making it difficult to communicate about the stress engendered by challenging living and working conditions and being separated from a supportive home environment. Being away from family, a regular partner and social networks can lead to migrants being more likely to engage in high-risk sexual behaviours involving multiple partners, including with sex workers.

Language and cultural differences

In many migration situations, cultural norms and constraints on behaviour differ between origin and destination countries. Language and cultural barriers often contribute to inadequate access to health including HIV prevention information, confidential voluntary testing opportunities and treatment and support services. Being unable to speak and understand the local language poses challenges for basic daily activities, including use of social and healthcare services. Migrant workers and their families might be unfamiliar with the local health system and might have difficulties in communicating their concerns to healthcare providers. When health services are available to migrants, these may not be culturally, linguistically and socially sensitive, leading to delayed or ineffective treatment. They might also face uncooperative attitudes from local health personnel that are exacerbated by miscommunication due to the language barrier.

- ***Health Care Provider Challenges***

In a 2015 study, a systematic review of literature was conducted to investigate the perceptions and practices of healthcare providers in managing care for migrants, as well as the challenges and barriers that health personnel faced. The study concluded, that the perceptions, attitudes and practices of practitioners in the provision of healthcare services for migrants were mainly influenced by:

- diverse cultural beliefs and language differences;
- limited institutional capacity, in terms of time and/or resource constraints;
- the contradiction between professional ethics and laws that limited migrants' right to health care.

Nevertheless, healthcare providers addressed such problems by partially ignoring the immigrants' precarious legal status, and using numerous tactics, including seeking help from civil society groups, to support their clinical practice.[100]

Psychosocial factors

Psychosocial factors may also play a role in the deterioration of health after migration. The mismatch between immigrants' educational credentials and their occupational achievements in the host country, for example, may constitute a source of stress, as well as the creation of a new social support network.[101]

Lack of social security and protection

Although migrants make many contributions to economies and societies in countries of origin and destination, they are routinely excluded from even the most basic coverage by social protection instruments and schemes. This exclusion is experienced by migrants whose status is regular as well as irregular but is particularly acute among undocumented migrant workers. Upon leaving their countries of origin, migrant workers risk losing entitlements to social security benefits in their country of origin due to

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[100] Suphanchaimat, R., et al. (2015). Challenges in the Provision of Healthcare Services for Migrants: A Systematic Review through Providers' Lens. *BMC Health Services Research* 15: 390. *PMC*. Web.

[101] PAHO. (2016, 22 – 30 September). 55th Directing Council 68th Session of the Regional Committee of WHO for the Americas. Washington, D.C., USA. paragraph 10. Retrieved from https://www.paho.org/hq/dmdocuments/2016/CD55-11-e.pdf

their absence and may at the same time encounter restrictive conditions under the social security system of the host country. This is despite the important contributions they make to social security schemes, either in their home countries or countries of destination.

In the host country, social security schemes may also have long residency requirements, making it difficult for migrants to claim their benefits if engaged in temporary or informal work. High-skilled migrant workers also suffer from low portability of social security. Even when they are entitled to social security benefits in their countries of destination, they often lose what they have accumulated in their countries of origin. Inadequate or no access to social protection exacerbates health risks and vulnerabilities by leaving migrants with little or no means to obtain essential health services. Lack of social protection undermines or denies access to minimum income for those in need to support, basic nutrition and housing essential to maintain healthy living conditions. This is often the case for women who are not economically active, as well as children, migrants with disabilities, and migrants who retire from employment, whether they remain in countries of employment or return to origin countries.[102]

These factors place migrants at a higher risk for occupational injury, sexual abuse, violence, drug abuse, psychological disorders, and contracting infectious diseases such as sexual transmitted diseases, HIV, tuberculosis, and hepatitis. These risks are exacerbated by limited access to social benefits and health services within territories of origin or return, transit, and destination. Lack of social security and limited access to health services can lead to excessive costs for migrants who may pay out-of-pocket, and to the exacerbation of health conditions, which could have been prevented if lower-cost services had been available.[103]

Challenges and Barriers Limiting Access to Health and HIV Services in the Caribbean

Effective protection of the human rights of migrant populations contributes to lowering the risk of HIV transmission and improving access to HIV services. If the rights of persons with HIV to live in dignity without discrimination or stigmatization are respected, they will neither be afraid to learn their status, nor to disclose it, which in turn facilitates prevention efforts. Stigma and discrimination not only place a heavier burden on persons living with or affected by HIV, they also impede HIV prevention efforts. Respect for the human rights of people living with HIV is a basis for ensuring universal access to HIV prevention, treatment, care and support.[104]

Migration is not per se a primary risk factor for disease or for propagation of HIV. Instead, **it is the conditions of migration and the lack of appropriate policy responses that exacerbate health risks and**

[102] International Labour Organisation. (2016). Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Geneva, Switzerland, International Labour Office, p. 20. Retrieved from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/Right-based-Approach-to-Migration-Health-and-HIV-AIDS.pdf

[103] PAHO. (2016, 22 – 30 September). 55th Directing Council 68th Session of the Regional Committee of WHO for the Americas. Washington, D.C., USA. paragraph 11. Retrieved from https://www.paho.org/hq/dmdocuments/2016/CD55-11-e.pdf

[104] International Labour Organisation. (2016). Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Geneva, Switzerland, International Labour Office, p. 43. Retrieved from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/Right-based-Approach-to-Migration-Health-and-HIV-AIDS.pdf

increase vulnerability in places of origin, transit and destination.[105]

This finding was echoed in the most recent **2018 UNAIDS Global AIDS Monitoring Report. Migration in and of itself does not put people at risk of negative health outcomes**. **Rather, the circumstances in which people migrate,** notably **social determinants of health** such as their living and working conditions, and particularly their migration status, can leave them more vulnerable to health risks and less able to cope with illness, including HIV-related illness. The GAM Report referencing studies conducted in Europe and Africa found that migrants are prevented from accessing the health services they need due to; (a) irregular immigration status; (b) language and cultural barriers; (3) user fees; (4) a lack of migrant-inclusive health policies; and (5) inaccessible services.[106]

As early as 2002 an IOM study on barriers to access to HIV services found that, despite *stereotypes and common assumptions,* **it is neither migrants nor migration per se that increases the risks of HIV transmission. It is the trying conditions and hardships that many face throughout the migration experience that makes them more vulnerable to infection**. These conditions were described as follows:

- separation from family and spouses, isolation and loneliness, can encourage people to engage in high-risk sexual relations;
- mobility itself makes it harder to reach migrants with prevention information, condoms, counselling and testing services or care;
- migrant communities are often socially, culturally, economically and linguistically marginalized, which, in turn, throws up barriers to health-care access;
- the legal status and occupation of an individual migrant will also influence to what degree he or she risks exposure to the virus. Undocumented migrants may fear deportation if they approach health-care providers or may be unable to afford care in the first place;
- women migrants who are smuggled; stranded in transit; travelling alone; trafficked; unemployed and left with no recourse but to engage in survival sex or sex work, face heightened risks of exploitation, violence and, by extension, HIV infection;
- migrants often know little about HIV and have negligible prior experience with health services in their countries of origin. Seasonal or return migration can also increase the risks of transmission to partners and spouses.[107]

These findings are echoed in the findings under the two PANCAP projects which addressed access by mobile and migrant populations and are in keeping with the conditions of vulnerability which limit migrants access to health in general as outlined in the previous section.

As stated in the introduction to this review, the need to focus on access to HIV services by migrant populations was identified by PANCAP which in 2012, commissioned research into the vulnerabilities of migrant workers in the informal economy in four Caribbean countries including, Antigua and Barbuda, Barbados, Belize and Trinidad and Tobago. Following this project, the PANCAP/GIZ Migrant Project

[105] International Labour Organisation. (2016). Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Geneva, Switzerland, International Labour Office, p. 9. Retrieved from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/Right-based-Approach-to-Migration-Health-and-HIV-AIDS.pdf

[106] UNAIDS. (2018). Global AIDS Monitoring Report - Miles to Go, Closing Gaps Breaking Barriers Righting Injustices. United Nations Joint Programme on HIV/AIDS. Geneva, Switzerland. p. 15. Retrieved from http://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf

[107] Haour-Knipe, M. (2002). Sexual Health of Mobile and Migrant Populations. Sexual Health Exchange. International Organisation for Migration. Geneva, Switzerland. p.1.

worked to integrate migrant-specific interventions into the national HIV response and improve inclusion of migrants on regional and national HIV bodies in order to advocate for equal access to health care in Antigua and Barbuda, Sint Maarten, Suriname, Guyana, Trinidad and Tobago, Dominican Republic and Haiti (border region).

Table 5: Access to HIV Prevention Treatment and Care in Select Caribbean Countries

Country	Policy Position on Access to Treatment	Practice
Trinidad and Tobago	- no requirement for national or other legal status to be proved before access is granted. - no national health insurance scheme and anyone, regardless of nationality, may be legally treated in a public hospital, not simply for HIV, but for other illnesses free of charge.	In all countries, discrimination and limitations in access have been reported. - Reports of isolated incidents where officials from public healthcare facilities refused to treat non-nationals and more particularly, to perform surgery. - Persons in Immigration Detention Centres reportedly had little or no access to HIV services. - For privacy reasons persons living with HIV from other countries access care in Trinidad - Lack of policy may result in arbitrary conduct by individual health or administrative personnel, as indicated above.[108] - Some migrant populations limit access due to copayment requirements at the main hospital, Mount St. John Medical Centre (MSJMC) in Antigua and Barbuda.[109] - Persons with a valid Medical Benefits card and who are under sixteen and
Antigua and Barbuda	- access to HIV prevention, treatment and care is free - medical care covered by the Medical Benefits Scheme. To access, migrants must have legal documented resident status, but HIV services are free - no requirement to declare immigration status to access health services - Antiretroviral medication and treatment for opportunistic infections is free regardless of nationality, immigration status or whether or not the person is a holder of the medical benefit card.	
Belize	- access to HIV prevention, treatment and care at public clinics is free	

[108] Antoine, Rose-Marie Belle. (2012). HIV, Migrant Policy and Status in Trinidad and Tobago;
Noguera-Ramkissoon, A. (2011, December). HIV Vulnerabilities of Migrant Construction Workers in Trinidad and Tobago, ABNR Consultants on behalf of the Pan Caribbean Partnership Against HIV/AIDS (PANCAP);
Norton, K. (2012, September). A Mapping Study on Access to HIV Services for Mobile and Migrant Populations in Antigua – Component 4. Pan Caribbean Partnership Against HIV/AIDS (PANCAP)/ GIZ Project;
Taylor, N. (2013, March). Migrant Friendly Health Services - Trinidad and Tobago. Component 4. Pan Caribbean Partnership Against HIV/AIDS (PANCAP)/ GIZ Project;
Thomas, M. (2012). Improving Access to HIV Services for Migrants in Trinidad. – Component 3. Pan Caribbean Partnership Against HIV/AIDS (PANCAP)/ GIZ Project;
Middleton-Kerr, S. (2011, December). Assessing the HIV Vulnerabilities of Migrant Workers in the Informal Economy (Agriculture Sector) in Belize on behalf of the Pan Caribbean Partnership Against HIV/AIDS (PANCAP)
Boxill, Ian et al, (2011) Improving Universal Access to HIV, Prevention, Treatment, care and Support- Consultancy on the Study of the HIV Vulnerabilities of Migrant Workers in the Informal Economy among Migrant Workers from CARICOM Countries in Antigua and Barbuda and Barbados
Carto, M. (2014). Guyana Reports on Access to HIV Services by Migrant and Mobile Populations. Pan Caribbean Partnership Against HIV/AIDS (PANCAP)/ GIZ Project.

[109] Norton, K. (2012, September). A Mapping Study on Access to HIV Services for Mobile and Migrant Populations in Antigua – Component 4. Pan Caribbean Partnership Against HIV/AIDS (PANCAP)/ GIZ Project.

The Bahamas	- access to HIV prevention, treatment and care is free	over 60 have some services free or with a co-payment. Migrants who are undocumented are not - eligible to participate and must pay for services (with exceptions including HIV). - Lack of privacy and confidentiality in public clinics - scarcity of culturally and linguistically appropriate HIV educational materials and prevention messages designed specifically for migrant workers - Limited access to condoms - Fear of deportation for migrants in irregular situation limits their access - Limited knowledge about where to go obtain an HIV test or to access HIV treatment, if positive, particularly for non-English speaking migrants. - In Guyana, language barriers, particularly for Brazilians who access services in region 7 of Guyana limit their uptake of services (since Portuguese is not known by many of the Guyanese population).
Dominican Republic	- a medical card is required to access some public health services including HIV treatment.	
Guyana	- HIV testing and treatment including the provision of ARVs is free of cost to all persons regardless of resident status.	
Sint Maarten	- treatment is not free, one must be registered and have a health card or have health insurance	
Suriname	- medical insurance is required	
Barbados	- HIV prevention services and certain levels of care are free regardless of immigration status in the public system. - citizens and permanent residents can access ARVs for free. - other migrants must undergo a means test to access free ARVs if they cannot afford to pay.	
OECS with the exception of Antigua and Barbuda	- HIV testing and treatment including the provision of ARVs is free of cost to all persons regardless of resident status	

Over the course of the two projects the finding reveal that access to prevention, care and treatment is limited, primarily to the following barriers.[110]

Barriers to Accessing Health Services

Lack of data: There is a lack of adequate, or reliable data or statistics on mobile and migrant populations and key populations including MSM and sex workers. There is limited understanding of the profile of the epidemic among migrant workers or the factors that increase this population's vulnerability to HIV.

No effective access for irregular or undocumented migrants: Despite the open access to health care policy in many of the countries, undocumented migrants appear to be driven underground because of:

- (a) fear of being deported;
- (b) fear of discrimination, especially if they are MSM or sex workers; and
- (c) lack of knowledge about availability and anonymous treatment.[111]

Lack of knowledge or awareness by migrants of their rights to information and right to health due to legal status, stigma, and socio-economic and cultural alienation.

[110] See Antoine, Rose-Marie Belle (2012) HIV, Migrant Policy and Status in Trinidad and Tobago;
[111] Antoine, Rose-Marie Belle (2012) HIV, Migrant Policy and Status in Trinidad and Tobago

Lack of information on health rights of migrants in an irregular situation among both healthcare users and health providers is a major barrier to accessing healthcare.

Language barriers and other cultural challenges, very few migrants reported knowledge about where to go obtain an HIV test or to access HIV treatment, if positive, particularly non-English speaking migrants.

Lack of knowledge of a host country's health system amongst many migrant populations. Such difficulties critically impeded effective communication between migrants and providers.

- Lack of knowledge or awareness of where to access basic prevention information and products, as well as where and how to take advantage of services that migrants are not excluded from.
- Lack of familiarity with the institutions and discourse in the host country.
- Not being exposed to the relevant HIV education and information.

A lack of diversity in the ethnic backgrounds of healthcare staff was considered another key hurdle in the provision of cross-cultural care. A key solution to solve this problem is finding healthcare staff who are able to serve as 'cultural brokers', or community or family representatives (who may know the language of the host country) bridging between the needs of migrants and the understanding of healthcare providers.

Poor working conditions and absence of social security, such as health insurance and housing challenges

- in terms of migrant workers, little support is provided by the employer in respect to overall health and reducing the impact of HIV and in most countries, they are not eligible for health insurance and benefits otherwise than through an employer.
- many irregular migrants reside in unstable accommodations

Homophobia and punitive legislative frameworks. For example, migration for sex work is one of many factors increasing the vulnerability of female sex workers. It implies loss of family support, difficulties accessing services, and increased stigma and discrimination. Discrimination against foreign sex workers is considered worse than that experienced by sex workers living with HIV. Migrant and undocumented sex workers, such as Hispanic sex workers in Trinidad identify immigration status and language as barriers to accessing HIV services.

Limited family support. Reports found that many migrants travel without their families and have little support in the host country.

Other barriers include:

- ***Sexual exploitation and human trafficking.***
- ***Centralization of treatment sites***
- ***Lack of confidentiality at health and social service facilities***
- ***Lack of citizen rights, dependency and xenophobia in the host societies.***

Other Findings

- there is no comprehensive policy on migrant labour within CARICOM or on access to services including health. However, in most countries nationality and HIV services are available free of cost except in Barbados and Suriname and the Dominican Republic.
- where there is no policy precluding migrants, the lack of a policy also means that there is no policy of inclusion. Rather it is a laissez- faire approach, which in some ways, is more harmful that a structured exclusive one.

    - For example, the no policy route means that there are no proactive schemes to target migrant populations which may be at high risk, or present high risks to others. This must be of concern to policy makers who are keen to reduce the impact of HIV in the country.
- Under the Caribbean Single Market and Economy (CSME) CARICOM migrants are not allowed to move freely with their spouses and dependents, that is there are no contingent rights.
- Gaps in data collection and information exist regarding systematic recording and reporting on migrants and migration in the region.
- MSM and sex workers continue to experience discrimination in accessing services due to lack of documentation, nationality, sexual orientation, language barriers, etc.
- The lack of gender-specific interventions acts as a factor constraining the effective execution of programmes and influences poor attendance at clinics.
- Migrant workers are uninformed (and not readily provided with information) regarding where to receive HIV testing and services.
- Migrant workers in Belize are constantly listed among the most vulnerable populations owing to, among other factors; their legal status, lack of access to information and services, language barriers and poverty. However, to date no comprehensive strategies exist to address HIV prevention among this vulnerable population.

Strategies that work

Following the implementation of the two projects in Antigua and Barbuda and through strategic partnerships with civil society organisations, the country has instituted some key strategies to increase the access of mobile and migrant populations to HIV prevention, care and treatment. Strategies include:

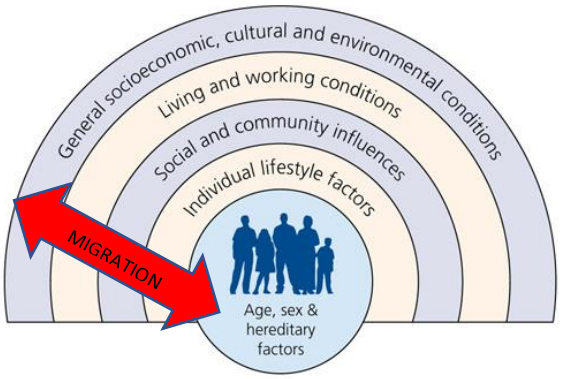
- The inclusion of bi-lingual health care providers (Spanish/English) clinics and National AIDS Programme. This has partly been due to the number of Cuban trained doctors, both local and Cuban in Antigua and Barbuda.
- Two (2) Spanish bi-lingual animators are utilized and paid by the National AIDS Programme for various interventions and media appearances.
- The development of Information Education and Communication (IEC) materials and public service announcements in multiple languages targeting migrants.
- Collaborating with brothel owners to provide their workers with HIV prevention activities. This is led by the 3 H Foundation, a civil society partner.
- Under the OECS Global Fund Grant a package of services for HIV prevention was developed for sex workers and are provided to them.
- Training of service providers in cultural diversity, working with vulnerable populations to improve the experiences of migrants when accessing health related services is continuous and ongoing.
- Civil society organisations under the OECS Global Fund Grant are being trained rapid testing to extend testing services to key populations, including migrants. Migrant sex workers have also been trained. Safe spaces are provided by civil society organisations and the National AIDS Programme provides the testing equipment. This has allowed three additional civil society organisations to provide HIV prevention services.

Key Policy Imperatives to Address the Health of Migrants

Many of these conditions and policy choices can be improved, and modifying them can have very beneficial consequences, including improved migrant health, reduction of HIV and improved public health in the host country. Key policy imperatives include:

Migration as a Social Determinant of Health

For these reasons the International Organisation for Migration (IOM) recognises migration as a social determinant for health. **Migration is, in and of itself, not a risk to health**.[112]



International Organisation for Migration 2017

However, the migration process can expose migrants to health risks, such as perilous journeys, psychosocial stressors and abuses, nutritional deficiencies and changes in lifestyle, exposure to infectious diseases, limited access to prevention and quality health care, or interrupted care. Migrants in irregular situations, those forced to move, the low skilled or low educated, and other vulnerable or disadvantaged migrants are more likely to suffer from a compromised health status as compared to others.[113]

Migrants often experience social conditions linked to poor health, such as poor living and working conditions, which place them at further disadvantage.[114] Difficult conditions of migration coupled with policies that do not contain any specific public health measures render migrants more susceptible to higher health risks, especially when they are combined with a lack of preventative health education, detection and treatment. As a result, health risks for migrant populations become exacerbated, as do those for host populations. Notable consequences of policy gaps or insufficiencies include diminished or no access to health care or to HIV preventative measures, including detection and treatment.[115]

Improving access to needed health services is not the only consideration in achieving positive health outcomes for migrants. **Policies and practices related to education, gender, labour, development and migration governance are essential** in reducing the causes of negative health outcomes and promote healthy lives for migrants and communities.[116]

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[112] International Organisation for Migration. (2017). Report of 2nd Global Consultation on Migrant Health: Health of Migrants - Resetting the Agenda. Colombo, Sri Lanka. p. 14. Retrieved from https://www.iom.int/migration-health/second-global-consultation

[113] ibid

[114] International Organisation for Migration. (2017). The Health of Migrants: A Core Cross-Cutting Theme. Global Compact Thematic Paper on the Health of Migrants.

[115] International Labour Organisation. (2016). Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Geneva, Switzerland, International Labour Office, p. 1. Retrieved from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/Right-based-Approach-to-Migration-Health-and-HIV-AIDS.pdf

[116] Ibid.

Migration and Sustainable Development Targets

Migrant and diaspora populations collectively contribute towards sustainable development in countries of origin, transit and destination. These populations bring transformative change, bridging developed and developing economies, importing and exporting sustainable technologies, and collaborating on innovations rooted in local contexts that can be adapted to the global context in which we live.

The Sustainable Development Goals at article 23 of the UN Resolution expressly includes migrants and persons living with HIV as vulnerable populations;

> *"People who are vulnerable must be empowered. Those whose needs are reflected in the Agenda include all children, youth, persons with disabilities (of whom more than 80 per cent live in poverty),* ***people living with HIV/AIDS****, older persons, indigenous peoples,* ***refugees and internally displaced persons and migrants****. We resolve to take further effective measures and actions, in conformity with international law, to remove obstacles and constraints, strengthen support and meet the special needs of people living in areas affected by complex humanitarian emergencies and in areas affected by terrorism.*[117]

The 2030 Agenda and Universal Health Coverage

The 2030 Agenda promotes migrant health on the principle to **"LEAVE NO ONE BEHIND".** The achievement of the sustainable development goals and in particular the overarching health target 3.8 Universal Health Coverage, requires evidence-based inclusive policies that facilitate access to equitable and quality health services, balancing the costs and benefits of promoting 'health for all' from a public health and sustainable development perspective.

Additionally, determinants of migrants' and refugees' health should be addressed using a Social Determinant of Health approach and through the implementation of multiple and relevant SDG goals and targets, including but not limited to target **10.7** facilitating orderly, safe and responsible migration and mobility of people by means of well managed migration policies which are sensitive to health issues.[118]

Target 3.8 'Achieve universal health coverage, including financial risk protection, access to essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all'.

Not only is this a target in itself, but it will be a contributory factor in the achievement of all the other targets in SDG 3. **Universal Health Coverage is intrinsically inclusive of the entirety of a population, including migrants.** It is expected to cover all the promotive, preventive, curative, rehabilitative and palliative health services people need, with affordable services being understood as not exposing the user to financial hardship. Providing Universal Health Coverage is a major financial undertaking, it can be **politically contentious and technically complex,** particularly in developing countries that may already struggle to provide basic health services for the wider host population. However, **it is essential to tackling the question of migration and health outcomes**, at both individual and national level.[119]

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[117] United Nations. (2015). UN Resolution on Sustainable Development Goals, A/RES/70/1 (2015). Article 23. Retrieved from http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E

[118] International Organisation for Migration. (2017). Report of 2nd Global Consultation on Migrant Health: Health of Migrants - Resetting the Agenda. Colombo, Sri Lanka. Retrieved from https://www.iom.int/migration-health/second-global-consultation

[119] Tulloch, O., Machingura, F. and Melamed, Claire. (2016, July) Health, Migration and the 2030 Agenda for Sustainable Development Retrieved from https://www.odi.org/sites/odi.org.uk/files/resource-documents/10759.pdf

Migration and Commitments to Universal Health Coverage

In addition to the clear imperatives for inclusion of access to migrants within the framework of universal health to which governments committed as part of the Sustainable Development Goals, the countries of the region reaffirmed their commitment to universal health coverage at the 52nd PAHO Directing Council (2013) by giving the Pan American Sanitary Bureau the mandate to prepare a strategy to be presented to the 53rd Directing Council (2014). This commitment by Member States is expressed in the PAHO Strategic Plan 2014-2019, which recognizes universal health coverage as a key pillar, together with the social determinants of health.

The 2014 Regional Strategy for Universal Access to Health and Universal Health Coverage (Universal Health),[120] which constitutes the overarching framework for the health system's actions to protect the health and well-being of migrants, adopted the right to health, equity, and solidarity as core values. The right to the highest attainable standard of health should be promoted and protected without distinction of age, ethnicity, sex, gender, sexual orientation, language, national origin, place of birth, or any other condition."

The Universal Health Strategy is based on four simultaneous, interdependent strategic lines of action:

- expanding equitable access to comprehensive, quality, people and community-centered health services;
- strengthening stewardship and governance;
- increasing and improving financing with equity and efficiency, and advancing towards the elimination of direct payments that constitute a barrier to access at the point of service;
- strengthening multi-sectoral coordination to address the social determinants of health that ensure the sustainability of universal coverage.

Financial protection, as established in the Strategy is a means to **"advance toward the elimination of direct payment [...] that constitutes a barrier to access at the point of service, avoiding impoverishment and exposure to catastrophic expenditures".**

Universal Health imply that all people and communities have access, without any kind of discrimination, to comprehensive, appropriate and timely, quality health services **determined at the national level according to needs**, as well as access to safe, effective, and affordable quality medicines, while ensuring that the use of such services does not expose users to financial difficulties, especially groups in conditions of vulnerability. Universal access to health and universal health coverage require determining and implementing policies and actions with a multisectoral approach to address the social determinants of health and promote a society-wide commitment to fostering health and well-being. Increasing financial protection will reduce inequity in the access to health services.

Under the Strategy, states should advance towards providing migrants with access to the same level of financial protection and of comprehensive, quality, progressively expanded health services that other people living in the same territory enjoy, regardless of their migratory status, **as appropriate to national context, priorities, and institutional and legal frameworks**.

[120] PAHO. 2014 Regional Strategy for Universal Access to Health and Universal Health Coverage (Universal Health) Regional Office for the Americas of the World Health Organization. Washington DC. Retrieved from https://www.paho.org/hq/index.php?option=com_content&view=article&id=9392&Itemid=2072

Key International and Regional Policies on the Health of Migrants

The 61st World Health Assembly held in Geneva in May 2008 adopted Resolution WHA61.17 on the health of immigrants, called on Member States to "devise mechanisms for improving the health of all populations, including immigrants, in particular through identifying and filling gaps in health service delivery".[121] This Resolution was the catalyst for action on an agenda for migrant health. The four basic principles for a public health approach to address the health of migrants and host communities were outlined in the Resolution and include:

- **to avoid disparities in health status and access to health services** between migrants and the host population;
- **to ensure migrants' health rights**. This entails limiting discrimination or stigmatization and removing impediments to migrants' access to preventive and curative interventions, which are the basic health entitlements of the host population.
- **to put in place lifesaving interventions so as to reduce excess mortality and morbidity** among migrant populations. This is of particular relevance in situations of forced migration resulting from disasters or conflict.
- **to minimize the negative impact of the migration process on migrants' health outcomes**.

International Organisation for Migration – Operational Framework

The WHO Resolution paved the way for the 1st Global Consultation on Migrant Health in Madrid in 2010, which proposed an operational framework to guide implementation of the Resolution by Member States and stakeholders.[122] It reaffirmed the need to adopt a rights-based, equity-driven, health system strengthening, and multisectoral approach. It identified four priority areas for action:

(a) **Monitoring Migrant Health -** developing systems and sharing good practices related to monitoring migrant health;
(b) **Policy-legal frameworks -** implementing supportive policy frameworks across sectors and across countries, including financial models;
(c) **Migrant sensitive health systems -** creating migrant-sensitive, inclusive health systems supported by appropriate professional competencies;
(d) **Partnerships, multi-country framework -** organizing partnerships and mainstreaming migration health within relevant multidisciplinary frameworks.

At the 2nd International Organisation for Migration (IOM) Global Consultation on Health of Migrants, "Resetting the Agenda" convened in Colombo Sri Lanka, 21st – 23rd February 2017 the Operational Framework was revised based on three thematic areas: [123]

1. **Health, Health Systems and Global Health** - action can be taken to address the health needs of migrants within the changing contexts and priorities of disease control, access to services through UHC, developing people-centred health systems management of cross-border health, and advancing migrant health as a global health goal.

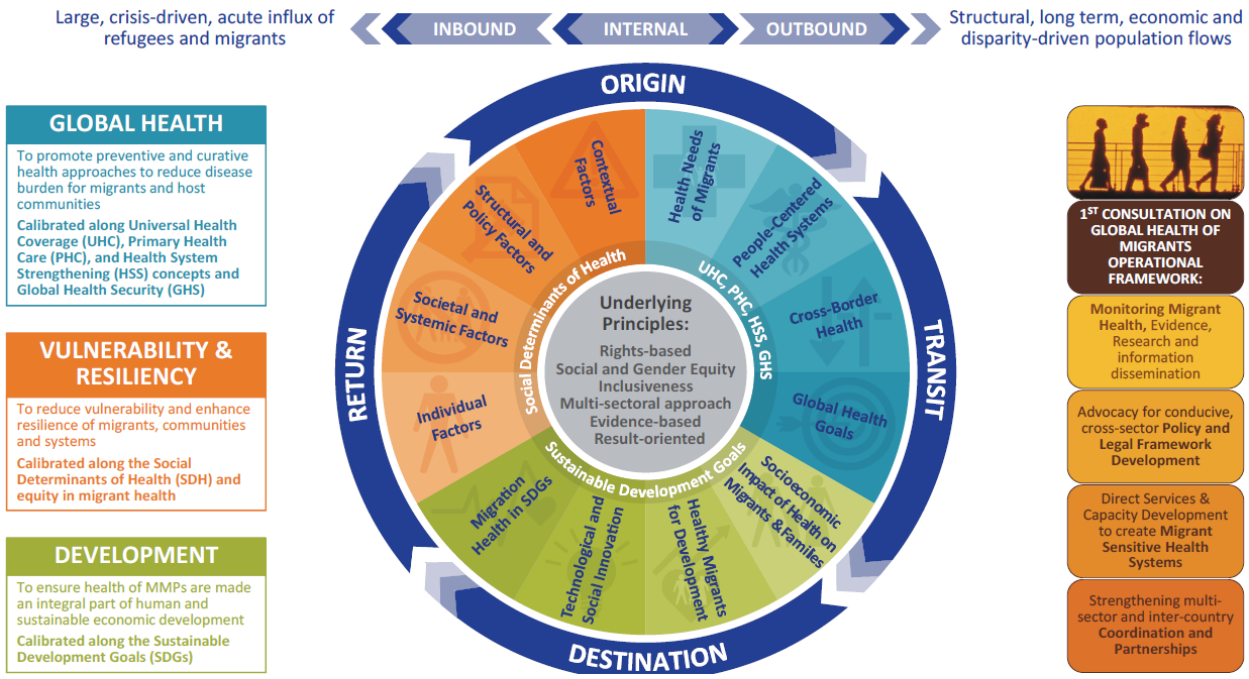
[121] World Health Organisation. (2008). WHR61.17 - 122nd Session of Executive Board of the World Health Organisation on the Health of Migrants. Retrieved from http://apps.who.int/iris/bitstream/handle/10665/23533/A61_R17-en.pdf;jsessionid=C56852C5A82B84053FDEA1CA412F558B?sequence=1

[122] World Health Organisation. (2010, 3-5 March). Health of Migrants: The Way Forward - Report of a Global Consultation. Madrid, Spain. Retrieved from http://www.who.int/migrants/publications/mh-way-forward_consultation-report.pdf

[123] International Organisation for Migration. (2017). Report of 2nd Global Consultation on Migrant Health: Health of Migrants - Resetting the Agenda. Colombo, Sri Lanka. Retrieved from https://www.iom.int/migration-health/second-global-consultation

2. **Vulnerability and Resilience** – based on the SDH model, requires responding to individual aspects of vulnerability, societal and system factors, structural and policy forces, and contextual elements such as security, economics, and environmental concerns. [124]
3. **Development** – migration health in a Development context involves looking at the socio-economic impact of health on migrants and families, the contributions of healthy migrants to development, the need for social protection, the role of technological and social innovation, and the place of migrant health in the SDGs at large.

Figure 1: Migration Health: A Unifying Agenda



Source: International Organisation for Migration 2017, Report of 2nd Global Consultation on Migrant Health: Health of Migrants -Resetting the Agenda. Colombo, Sri Lanka

[124] Ibid at p. 23 -24. Vulnerability is defined as the health risks and pathologies migrants and refugees face resulting not from their own characteristics but from social, economic, environmental and experiential impacts, many of which must be resolved by legal, policy and practical measures.

Recommendations for a Proposed Framework

Proposed Overarching Rights Framework

Effective protection of the human rights of migrant populations contributes to lowering the risk of HIV transmission and improving access to HIV services. If the rights of persons with HIV to live in dignity without discrimination or stigmatization are respected, they will neither be afraid to learn their status, nor to disclose it, which in turn facilitates prevention efforts. Stigma and discrimination not only place a heavier burden on persons living with or affected by HIV, they also impede HIV prevention efforts. Respect for the human rights of people living with HIV is a basis for ensuring universal access to HIV prevention, treatment, care and support.[125]

As evidenced in the preceding section on legal barriers in the Caribbean, the Constitutions of the region offer little assistance in formulating an appropriate legislative response to the access of migrants to health and to HIV services in particular. In a report on HIV, Migrant Policy and Status in Trinidad and Tobago, Professor Rose-Marie Belle Antoine argued that Constitution "may be positively counterproductive" and recommended the adoption some human rights principles given the weak legal framework supporting access to HIV services for migrants. [126]

The principle that all persons, including migrants and mobile populations, should be able to access a minimum standard of medical treatment for HIV, may be located under a number of internationally recognized human rights principles. These include:

1. Every person has a right to health, an economic and cultural right which is derived from the broader right to life. While it is recognized that states have a margin of appreciation in determining how to translate this right in monetary terms, at minimum, a state should do all in its power to ensure the health of those persons within its jurisdiction, especially in situations where its citizens and general population may be placed at risk because of related health issues;

2. The right to life: Every person has a right to life and to the protection of his or her life. In recent times, international human rights law has recognised that this right extends to protecting non-resident 'aliens' and other non-citizens where their lives are threatened for lack of access to HIV treatment. This is seen in recent asylum cases across regions where persons on the basis of their HIV status were able to successfully seek asylum. This principle is broad enough to encompass migrant and mobile populations.

3. The principle of equality and non-discrimination is accepted as a fundamental principle of international and domestic human rights law. While constitutions may make exceptions in certain circumstances with regard to citizens, where a person resides in a state, pays taxes

[125] International Labour Organisation. (2016). Promoting a Rights-based Approach to Migration, Health, and HIV and AIDS: A Framework for Action. Geneva, Switzerland, International Labour Office, p. 43. Retrieved from https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/Right-based-Approach-to-Migration-Health-and-HIV-AIDS.pdf

[126] Antoine, Rose-Marie Belle. (2012). HIV, Migrant Policy and Status in Trinidad and Tobago. p. 2-3

and contributes to a national health insurance scheme, there is no legitimate basis to apply this exception and the principle of equality in its absolute sense must stand. As such, every migrant person who contributes to taxes and national insurance should have EQUAL access to HIV treatment.

A fourth principle linked to the principle of equality and non-discrimination in a broader sense relating to both regular and irregular migrants is:

4. The Duty Not to Discriminate
   Health is intrinsically linked to the right to life, survival, and development, and to the enjoyment of all other rights. The International Covenant on Economic, Social and Cultural Rights recognizes that many states lack the capacity to provide sufficient health services to enable all individuals under their jurisdiction to enjoy the highest attainable standards of health, and that states may need to progressively develop health policies and services. However, in doing so **they have a duty not to discriminate**, since that is innate to the core of the right; whatever services are available must be made accessible to all without discrimination.[127]

Importance of Accurate Data for Evidence-Based Migration Policies

Migration and public policies are frequently developed on the basis of general, and often flawed, assumptions about migration. Common misperception is that ensuring the human rights of *all* migrants is impractical and would lead to a dramatic increase in the number of migrants with irregular status. This is at times linked to misperceptions about the number of migrants and how many are in irregular situations, the reasons why people migrate, and migrants' use of public services. The systematic restrictions of rights are at times favored by policy-makers who, with the aim of reducing irregular migration, seek to create a hostile environment for irregular residence.[128] Lack of accurate data has been highlighted in various studies and in the PANCAP reports on migration and health in the region.

Inadequate attention has been paid to systematically collecting quantitative and qualitative information to measure the social and human impacts of migration and migration policies, and the links between the human rights and the human development of migrants, their families, and their societies of origin, transit, and destination. Furthermore, the available information is not being adequately used by governments in either policy making, or to challenge common misperceptions and raise awareness about the positive impacts of migration and migrants, not least on local development outcomes. Monitoring migrant health will promote evidence-based policy-making on migration and migrants' rights. It will facilitate better analysis of the impacts of migration and public policies on the outcomes of migrants, their families, and their societies of origin, transit, and destination.

Public health considerations, cost effectiveness and human rights.

[127] Ceriani Cernadas, P., LeVoy, M. and Keith, L. (2015). Human Rights Indicators for Migrants and their Families. Global Knowledge Partnership on Migration and Development (KNOMAD). p. 3 Retrieved from https://www.ohchr.org/Documents/Issues/Migration/Indicators/WP5_en.pdf

[128] Ceriani Cernadas, P., LeVoy, M. and Keith, L. (2015). Human Rights Indicators for Migrants and their Families. Global Knowledge Partnership on Migration and Development (KNOMAD). P. 3. Retrieved from https://www.ohchr.org/Documents/Issues/Migration/Indicators/WP5_en.pdf

In an EU Report reviewing the access of migrants in an irregular situation to healthcare in 10 European Union Member States in 2011, public authority officers interviewed for the report gave manifold reasons why cities should be active in supporting access to healthcare for migrants in an irregular situation. The three main arguments mentioned were public health considerations, cost effectiveness and human rights.[129]

- One of the strongest arguments favouring health provision to migrants in an irregular situation that was put forward by public officials in almost all of the countries studied was disease prevention. In addressing the risk of certain diseases such as HIV and AIDS, TB, from a public health perspective, opening health prevention programmes to migrants in an irregular situation reduces health risks for the general population.

- Another argument in favour of opening healthcare services to migrants in an irregular situation is related to the costs of treatment. Officials in France and Ireland, for example, said that it is less expensive to offer preventive care than to pay for expensive emergency treatments. Fear of being detected based on real or perceived exchange of data between healthcare providers and immigration enforcement bodies means that migrants in an irregular situation delay seeking healthcare until an emergency arises. This has negative consequences for the health of the individual and results in more expensive interventions. In countries that grant migrants in an irregular situation access cost-free to emergency care only, migrants often have to wait until a health concern becomes a crisis before seeking healthcare.

    - In support of this finding is a study on the cost -benefit analysis of providing care. In a study by Ursula Trummer, from the Center for Health and Migration (Austria), conducted in collaboration with IOM and four European Union (EU) member states, using hypothetical cases, primary data, register data, desk research and expert opinion. Results from the study demonstrated that in the conditions and settings studied, timely treatment in a primary health-care setting is always cost-saving when compared to treatment in a hospital setting. This is true for the direct medical and non-medical costs, as well as the indirect costs.[130]

- The duty of states to 'fulfil' the rights of persons to health as stipulated in the human rights framework, is another argument mentioned by officials in Germany, Greece and Spain for enabling access of migrants in an irregular situation to healthcare, including on a local level. In Spain, an official underlined that given their human rights obligations, local governments should not be concerned about a person's legal status with regard to access to basic health services.

Other Emerging recommendations

- Migrants in an irregular situation should, at a minimum, be entitled by law to access necessary healthcare. Such healthcare provisions should not be limited to emergency care only, but should

[129] Migrants in an irregular situation: access to healthcare in 10 European Union Member States at page 33 http://www.lse.ac.uk/lse-health/assets/documents/eurohealth/issues/eurohealth-v16n1.pdf

[130] International Organisation for Migration. (2017). Report of 2nd Global Consultation on Migrant Health: Health of Migrants - Resetting the Agenda. Colombo, Sri Lanka. p. 28. Retrieved from https://www.iom.int/migration-health/second-global-consultation

also include other forms of essential healthcare, such as the possibility to see a doctor or to receive necessary medicines.

- States should disconnect healthcare from immigration control policies and should not impose a duty to report migrants in an irregular situation upon healthcare providers or authorities in charge of healthcare administration.

- Policies that respond to the diversity of migrant groups and their differential health risks and service access must be developed and implemented. Moreover, to make real advances in the protection of both individual and public health, interventions must target each stage of the migration process and reach across borders. Services should be based on human rights principles that foster available and accessible care for individual migrants.

- Ensure that migrants have adequate access to health care services by granting access to national healthcare systems and programmes ensuring that cultural and/or linguistic barriers do not prevent migrants from seeking and/or obtaining care, especially in relation to pregnancies, communicable diseases such as Sexually Transmitted Infections (STIs), tuberculosis and HIV and hepatitis.

- Provide migrants' access to social services, and the nutritional needs of infants and children of migrants in line with international law, standards and norms, ensuring such access is not restricted on the basis of migration status. Provide access to such service in a culturally and linguistically appropriate way without stigma and through advocacy and the provision of cultural mediators.

- Advocate for the inclusion of migrants and mobile population health issues into national and regional health programmes and strategies.

- Ensure that healthcare personnel in high migrant receiving areas are trained to provide healthcare needs of migrants.

Strategies that Work

- A basic rule is that interventions for HIV and AIDS prevention and care for migrants and mobile people at source must be offered in the appropriate language and tailored to the cultural context of the target group. It is often possible to share materials and messages between source and destination communities.

- Members of the mobile or migrant community should be involved to help design and implement the interventions. Such community input will ensure that the interventions are relevant, and they will also help find ways to overcome barriers to HIV and AIDS prevention.

- Culturally and linguistically appropriate HIV and AIDS information may be provided through media campaigns, street theatre, small group discussions sessions and peer education (those who returned from destination).

Conclusion

Migration is essential for some societies to compensate for demographic trends and skill shortages and to assist home communities with remittances. Migration can improve the health status of migrants and their families by helping them escape from persecution and violence, by improving socioeconomic status, by offering better education opportunities, and by increasing purchasing power for health services for family members in origin countries through remittances. [131]

However, exercise of social rights linked to access to services, including education, health, shelter, and social protection is restricted for migrants in many countries, according to migration or residence status. In general, the provision of universal services is threatened by political and economic models that qualify the right to access services according to criteria such as financial contributions (taxes, health, and social security schemes; direct payments for services), health insurance status, and citizenship and residence status. The portability of rights, and social rights in particular, is often limited. As a result, migrants with dependent statuses, in low-wage employment, and those who are in an irregular or undocumented situation face the most significant restrictions, in law, policy, and practice.[132]

The health of migrants is a public health issue that takes social equity and development into account. The benefits of including migrants in public health strategies have been seen in Thailand where the Ministry of Public Health, in partnership with the International Organization for Migration, has introduced the concept of migrant-friendliness in health service delivery with an overarching theme of 'Healthy Migrants, Healthy Thailand'. This helps to improve the health literacy of migrants and thus their access to basic public health services.[133]

At a minimum the policy framework to address the health needs of migrants and the local population requires the establishment and monitoring of comprehensive national migrant health policies that are:

- rights-based,
- multi-sectoral and coordinated across sectors,
- participatory for migrants, civil society, private sector, and other key actors
- within a whole-of-society and whole-of-Government approach.
- based on the extension of Universal Health Coverage (UHC) and Social Protection Floors to all migrants, irrespective of their migratory status.

Political Persuasion

The greatest task in moving forward in relation to improving access to health for the migrant populations is political persuasion. Professor Rose-Marie Belle Antoine recommended that regional actors must use all moral, intellectual, scientific and medical resources to persuade the political directorate that it is in the national and regional interest of all countries to continue to provide access to treatment for all migrants

[131] International Organisation for Migration. (2017). Report of 2nd Global Consultation on Migrant Health: Health of Migrants - Resetting the Agenda. Colombo, Sri Lanka. p. 14. Retrieved from https://www.iom.int/migration-health/second-global-consultation

[132] Ceriani Cernadas, P., LeVoy, M. and Keith, L. (2015). Human Rights Indicators for Migrants and their Families. Global Knowledge Partnership on Migration and Development (KNOMAD) p. 2. Retrieved from https://www.ohchr.org/Documents/Issues/Migration/Indicators/WP5_en.pdf

[133] International Organisation for Migration. (2009). Healthy Migrants, Healthy Thailand. Bangkok: IOM. Retrieved from https://publications.iom.int/system/files/pdf/healthy_migrants_healthy_thailand.pdf

with protections against eroding this in future health policies.[134] A Pragmatic Approach, as recommended by Professor Belle Antoine should be utilized to convince officials that migrants must be treated in order to protect the general population. The World Health Organisation explains this clearly.

Policies should provide health care services irrespective of migrants' legal status, as rapid access to health care can result in cure, and therefore avoid the spread of diseases. It is in the interests of both migrants and the receiving country to ensure that the resident population is not unnecessarily exposed to the importation of infectious agents. Likewise, diagnosis and treatment of NCDs such as diabetes and hypertension can prevent these conditions from worsening and becoming life-threatening. Each refugee and migrant should have full, uninterrupted access to a hospitable environment and, when needed, to high-quality health care, without discrimination on the basis of gender, age, religion, nationality or race.[135]

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135 http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues#292936

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ANNEX 1 – Definitions of Key Migration Concepts

Mobility covers all issues related to the movement of persons, including internal and external movements, voluntary or forced movement, short term or long-term movement.

Mobile populations can be described broadly as people who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons.

Migration requires movement across a national border. One is either an immigrant – entering another country or emigrant – leaving country of origin.

Migrants are mobile people who take up residence or who remain for an extended stay in another country, (immigrant) or leaving country of origin to take up residence or remain for an extended stay in another country (emigrant). A migrant must have crossed a border. The minimum length of time a person must have resided in a country in order to be regarded as a resident rather than a visitor (that is, the lower boundary) varies according to national legislation. According to United Nations terminology migrants staying for less than a year are classified as 'short-term' and those staying (or having permission to stay) for a longer period are 'long-term'.

Migrant worker is a sub-category of mobile people and can be defined as a person engaged in a remunerated activity in a State in which he/she is not a national. Migrant workers can be classified as "external" - moving from country to country or "internal", moving from their home to another site or location within the same country.

Regular migrants (documented) people whose entry, residence and, where relevant, employment in a host or transit country has been recognized and authorized by official State authorities.

Undocumented migrant (sometimes referred to inappropriately as "illegal" migrants /immigrants). This refers to migrants who lack authorisation to reside in the country where they are living. Unauthorised residence can result either from unauthorised entry, or (more frequently) from infringement of the conditions on which residence was authorised (e.g. overstaying a visitor's visa or violating conditions regarding work). The term has the same meaning as 'migrant in an irregular situation' (often abbreviated to '**irregular migrant'**).

Involuntary Migrant any person who has migrated to a country because they have been displaced from their home country, have an established and well-founded fear of persecution or have been moved by deception or coercion. Persons who may be refugees and internally displaced people (those displaced by conflicts) as well as people displaced by natural or environmental disasters, war, famine or persecution.

Refugee is a person who because of a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion resides outside the country of his or her nationality.

Asylum Seeker: An asylum seeker is a person who has applied for international protection and has not yet received a final decision on their claim. Persons still involved in appeal procedures but denied permission to await the outcome in the receiving country count as 'undocumented migrants'.

Internally Displaced Persons (IDPs) persons who have been forced to flee their homes. They differ from refugees in that they have not crossed an internationally recognized state border.

ANNEX 2 - United Nations (UN), UNAIDS, ILO, WHO and key international conventions definitions.

Agency or Instrument	Term	Definition	Example
UN[136]	**Long Term Migrant**	a person who moves to a country other than his origin or residence for a duration of more than 12 months	
	Short Term Migrant	is a person who migrates for between three and 12 months	
UNAIDS	**Mobile People**	people who move from one place to another, either temporarily or permanently, for a host of voluntary or involuntary reasons.	Transport workers such as truckers, train workers and bus drivers as well as itinerant traders, airline personnel, seafarers, agricultural workers, uniformed services, sex trade workers, and people employed in the tourism and hospitality industries
	Migrant worker	is a sub-category of mobile people and can be defined as a person engaged in a remunerated activity in a State in which he/she is not a national. Migrant workers can be classified as “external" - moving from country to country or “internal", moving from their home to another site or location within the same country.	Examples of migrant workers include individuals travelling to obtain employment such as miners or agricultural labourers, loggers, and health care professionals seeking better salaries and conditions in developed countries.
	Internally displaced persons (IDPs)	persons who have been forced to flee their homes	They differ from refugees in that they have not crossed an internationally recognized state border
WHO	**Regular (Documented)**	people whose entry, residence and, where relevant, employment in a host or transit country has been recognized and authorized by official State authorities	Visitors, tourists, foreign students or temporary contract workers
	Irregular (Undocumented)	(sometimes referred to inappropriately as “illegal” migrants /immigrants). People who have entered a host country without legal	

[136] UN ECLAC. (2005). Migration in the Caribbean – What Do We Know? An overview of data, policies and programmes at the international and regional levels to address critical issues. United Nations Economic Commission for Latin America and the Caribbean. Port of Spain, Trinidad and Tobago, LC/CAR/L.54 17 October 2005 Retrieved from http://www.un.org/esa/population/meetings/IttMigLAC/P09_ECLAC(Port%20of%20Spain).pdf

Agency or Instrument	Term	Definition	Example
		authorization and/or overstay authorized entry	
	Voluntary	people who have decided to migrate of their own accord (although there may also be strong economic and other pressures on them to move	labour migrants, family members being reunified with relatives and foreign students
	Forced	movements of refugees and internally displaced people (those displaced by conflicts) as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects"[137]	
The International Convention on the Protection of Migrant Workers and Members of Their Families 1990	**Irregular**	Irregularities in migration arising at various points – departure, transit, entry and return – they may be committed against or by the migrant	
	Regular	workers as those who are authorised to enter, stay and to engage in a remunerated activity in the State of employment. *Art 5(1)*	
Convention on the Status of refugees (1951) and the 1967 Protocol Relating to the Status of Refugees	**Refugee**	a person who because of a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group, or political opinion resides outside the country of his or her nationality.	

[137] WHO. (2003). International Migration, Health and Human Rights. (Health and Human Rights publication series) World Health Organization. ISBN 92 4 156253 6 p. 9. Retrieved from http://www.who.int/hhr/activities/en/intl_migration_hhr.pdf

ANNEX 3 - International Legal Instruments Relevant to Migration and Human Rights

Universal Declaration of Human Rights (1948)

Core international human rights treaties

- International Covenant on Civil and Political Rights (1966)
- International Covenant on Economic, Social and Cultural Rights (1966)
- International Convention on the Elimination of All Forms of Racial Discrimination (1965)
- Convention on the Elimination of All Forms of Discrimination against Women (1979)
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984)
- Convention on the Rights of the Child (1989)
- International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)
- Convention on the Rights of Persons with Disabilities (2006)
- International Convention for the Protection of All Persons from Enforced Disappearance (2006)

Relevant ILO conventions

- Forced Labour Convention, 1930 (No. 29)
- Labour Inspection Convention, 1947 (No. 81)
- Freedom of Association and Protection of the Right to Organise Convention, 1948 (No. 87)
- Right to Organise and Collective Bargaining Convention, 1949 (No. 98)
- Equal Remuneration Convention, 1951 (No. 100)
- Abolition of Forced Labour Convention, 1957 (No. 105)
- Discrimination (Employment and Occupation) Convention, 1958 (No. 111)
- Minimum Age Convention, 1973 (No. 138)
- Private Employment Agencies Convention, 1997 (No. 181)
- Worst Forms of Child Labour Convention, 1999 (No. 182)
- Domestic Workers Convention, 2011 (No. 189)
- Migration for Employment Convention (Revised), 1949 (No. 97)
- Migrations in Abusive Conditions and the Promotion of Equality of Opportunity and Treatment of Migrant Workers, 1975 (No. 143)

Convention relating to the Status of Refugees (1951) and the Protocol relating to the Status of Refugees (1967)

Convention relating to the Status of Stateless Persons (1954)

Convention on the Reduction of Statelessness (1961)

Convention against Transnational Organized Crime (2000); Protocol to Prevent, Suppress and Punish Trafficking in Persons, especially Women and Children; Protocol against the Smuggling of Migrants by Land, Sea and Air

Instruments of general relevance to migration

- International humanitarian law: Geneva Conventions (1949)
- Convention on Consular Relations (1963)
- International Convention for the Safety of Life at Sea (1974); International Convention on Maritime Search and Rescue (1979)
- Convention on the Law of the Sea (1982)
- Rome Statute of the International Criminal Court (1998)