REGIONAL FRAMEWORK FOR MIGRANT HEALTH AND RIGHTS (R2H Framework) 2018

Abstract: This document sets out a roadmap for equitable and non-discriminatory access to health care services across the Caribbean for mobile and migrant populations regardless of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV and AIDS), sexual orientation, gender identity and civil, political, social or other status. The Framework responds to the findings of 2 multi-country studies conducted by PANCAP over the period 2011 – 2015 which highlighted the barriers to access HIV services by migrant and mobile populations. Following a participatory approach involving representation from Government, (Ministry of Health, Chief Medical officers, National AIDS Programmes, Immigration Officers) Civil Society (Migrant groups and other key population groups) and international and regional organisations including, PANCAP, UWI, IOM, UNHCR and UNAIDS at a regional forum in Trinidad and Tobago from the 26 -27 June 2018, the mandate was for the development of a more comprehensive roadmap for a right based framework for access to health by migrants and mobile populations. The Framework is rationalized with the vision of regionalism under

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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

The Vision of Regionalism

Vision of Regionalism: When the Governments of the Region adopted the Revised Treaty of Chaguaramus and brought into effect the CARICOM Single Market and Economy (CSME) the vision was for, among others, a single economic space where CARICOM nationals would be entitled to the full enjoyment as citizens of all Member States in respect of production and trade in goods, the provision of services, the movement or transfer of capital, the freedom to move, to seek work and compete for employment in any geographical part of the CSME. [1]

ARTICLE 46 (2) relating to Movement of Skilled Community Nationals provides that:

> 46 (2) Member States shall establish appropriate legislative, administrative and procedural arrangements to:
>
> (a) facilitate the movement of skills within the contemplation of this Article;
>
> (b) provide for movement of Community nationals into and within their jurisdictions without harassment or the imposition of impediments, including:
>
> (i) the elimination of the requirement for passports for Community nationals travelling to their jurisdictions;
>
> (ii) the elimination of the requirement for work permits for Community nationals seeking approved employment in their jurisdictions;
>
> (iii) establishment of mechanisms for certifying and establishing equivalency of degrees and for accrediting institutions;
>
> (iv) harmonisation and transferability of social security benefits.

Progressive realisation: Social Security: These requirements are being progressively realized in the region. In 1996, the Caribbean Community (CARICOM) Agreement on Social Security was established to harmonise the social security legislation of CARICOM Member States. Workers and their dependants who are registered in one of the ratifying Member States are entitled to benefits paid by the social security schemes in the countries in which they have contributed, but with some limitations. The benefits covered by the Agreement include contributory pensions for invalidity, disability, old age, and death and survivors' benefits. Maternity allowances or sickness benefits are not covered. The Agreement is seen as key in facilitating the free movement of labour within the CARICOM Single Market and Economy, as it applies to those who are moving to another country to work or have worked in two or more countries that have implemented the Agreement.[2]

Progressive realisation: Free Movement: 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. Several categories of CARICOM nationals have been eligible for free movement throughout the

[1] Text of the Agreement. Retrieved from http://www.caricom.org/jsp/single_market/single_market_index.jsp?menu=csme

[2] The CARICOM Agreement on Social Security is recognized as a good practice by the International labour Organisation (ILO). http://www.ilo.org/dyn/migpractice/migmain.showPractice?p_lang=en&p_practice_id=17

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.

CCJ expansion of freedom of movement: In the exercise of its original jurisdiction under the Revised Treaty of Chaguaramus, the Caribbean Court of Justice (CCJ) in its landmark decision in the case of ***Myrie v Barbados***[3] on the right of freedom of movement of CARICOM nationals, established that CARICOM member states were bound by the 2007 Decision of the Conference of Heads of Government 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 an 'undesirable person' or where it is believed the Community national seeking entry may become a 'charge on public funds'. This ruling further entrenches the notion of regionalism and the Caribbean as a single space. It should be noted however, the terms 'undesirable persons' and 'a charge on the public purse' are unclear and may be interpreted consistent with broad powers given to immigration officials.

Progressive realisation: Contingent Rights: The realisation of a single space was further advanced on 6th July 2018 when the Protocol on Contingent Rights was opened for signature at the 39th Regular Meeting of the Conference of Heads of Government of the Caribbean Community held in Montego Bay, Jamaica on 4-6 July 2018. It was signed by seven countries (Barbados, Grenada, Haiti, Jamaica, Saint Lucia, St. Vincent and the Grenadines and Suriname) but is not yet in force. The Protocol grants rights to CARICOM nationals exercising the right of establishment, provision of services, movement of capital or free movement of skills. Spouses and immediate dependants are also entitled to enjoy these rights. Unfortunately, the guarantee of access to primary health care is contained within the "built-in agenda" which will be applied as contingent rights at such time and on such terms and conditions as the Conference of Heads of Government may determine.[4]

Gap – Access to Health: As the region continues to advance to greater cooperation and movement of labour among other things, a clear gap is a consistent approach to the access to health by mobile and migrant populations in the region. This issue has been spurred by the findings of studies conducted by the Pan Caribbean Partnership Against HIV/AIDS under two (2) Global Fund grants during the period 2011 to 2015.

The PANCAP Studies: 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).

Outcome of Studies: The outcomes of the studies were consistent on two issues; (1) that the Caribbean is a multi-cultural, multi-lingual region with high levels of intra-regional migration and that; (2) it is

[3] Shanique Myrie and the State of Barbados and Jamaica [2013] CCJ 3 (OJ)
[4] Protocol on Contingent Rights Article II 2. (a)

necessary to tailor health programmes to particular migrant population groups and make them accessible to anyone regardless his/her legal migration status and his/her ability to pay for health services.

Filling the Gap towards realisation of regionalism:

- Securing access to health of migrants and mobile populations constitutes access, largely to CARICOM nationals who are moving and working in other CARICOM countries in a reciprocal and cyclical manner.
- It constitutes the acknowledgement of the principles of equal rights and treatment for all persons of Member States and non-discrimination based on nationality in Article 7 of the Revised Treaty of Chaguaramas which underpins the CSME.
- It acknowledges the commitments enshrined in Article XX of the Charter of Civil Society related to health which urges States to "use their best endeavours to provide a health care system that is: (a) sufficiently comprehensive to deal with all health challenges including epidemics; and (b) well administered, adequately equipped and accessible to all without discrimination".[5]
- It advances the commitments made under the Brazil Declaration "A Framework for Cooperation and Regional Solidarity to Strengthen the International Protection of Refugees, Displaced and Stateless Persons in Latin America and the Caribbean" 2014.
- It secures the commitment to universal health coverage made at the 52nd PAHO Directing Council (2013) expressed in the PAHO Strategic Plan 2014-2019, which recognizes universal health coverage as a key pillar, together with the social determinants of health and calls on States to 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.[6]
- It secures the realisation of the commitment to the Sustainable Development Goals to "Leave No One Behind" to which all Member States have committed. In particular to target 3.8 on Universal Health Coverage which the SDGs recognise as "intrinsically inclusive of the entirety of a population, including migrants".[7]
- It is necessary 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.[8]

  In 2018, there are an estimated 310,000 persons living with HIV in the region and although there have been successes, the region is falling short of achieving the global targets:
    - 73% of all people living with HIV know their HIV status.
    - 57% of all people with diagnosed HIV infection receive sustained antiretroviral therapy.
    - 40% of all people receiving antiretroviral therapy are virally suppressed.

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[5] Charter of Civil Society for the Caribbean Community 1997

[6] 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

[7] 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

[8] 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

Move from exclusion to inclusion: Securing the free movement of labour without securing the health of workers and other mobile and migrant populations will limit the vision of improving the quality of life for the people of the region. Addressing and achieving this vision requires a shift away from traditional approaches that are nationally based with a focus on exclusion, security and disease control to approaches which focus on inclusion, reduction of inequities, access to health and multi-country and inter-sectoral policy development. The second more modern approach echoes the ethos of the Caribbean integration movements both under the CSME and the OECS Economic Union.

As the region continues to advance to greater cooperation and movement of labour, the migration patterns presented below paint the picture of high emigration and high intra-regional migration.

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.[9]

High Emigration Rates

The United Nations 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.[10]

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.[11]

The 2017 International Organisation for Migration (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**

[9] 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.

[10] ibid

[11] Ibid

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.
- 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.
    (a) **Haiti i**s the Caribbean country most dependant on remittances. In 2014, 21.1 per cent 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.**
    (b) The ACP Observatory on Migration in 2014[12] found that **Guyana, Haiti, Jamaica, Grenada** and **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.[13]
- 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 other health care professionals. 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**.
- **Dominican, Saint Lucian** and **Haitian** nationals **work seasonally in Martinique and Guadeloupe.**
- **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.**

[12] ACP Observatory on Migration highlights South-South Migration and Development
[13] 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

- 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.

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.[14]

In a 2018 research paper on Gender Empowerment and Migration in the Caribbean commissioned by ECLAC, it 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.[15]

- 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.[16]
- 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. [17]
    (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,[18]

[14] 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

[15] ibid

[16] Ibid.

[17] 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.

[18] 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.

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 is not widely available, and evidence-based policy making is difficult.[19]

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:

- the high global demand for domestic servants, agricultural labourers, sex workers, and factory labour;
- political, social, or economic crises, as well as natural disasters;
- lingering machismo (chauvinistic attitudes and practices) that tends to lead to discrimination against women and girls;
- existence of established trafficking networks with sophisticated recruitment methods;
- public corruption, especially complicity between law enforcement and border agents with traffickers and smugglers;
- restrictive immigration policies in some destination countries that have limited the opportunities for regular pathways of migration flows to occur;
- government disinterest in the issue of human trafficking; and
- 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.

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.[20] Listed below is the profile of mobile and migrant populations identified by countries which were studied under the PANCAP GIZ Migrant Project.[21]

Table 1: Profile of Migrants in the Caribbean (Select Countries)

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

[19] UNDP. (2016). Caribbean Human Development Report. pp. 65 and 122 http://www.hdr.undp.org/sites/default/files/2016_human_development_report.pdf

[20] 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.

[21] 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 Bahamas	**Migrant workers**, **Persons seeking entry into the US**, **Creole speaking populations** **Inter-island movements**; (9.7% of population are migrants	Haiti, Cuba, Jamaica
Belize	**Migrant workers** - Seasonal Agricultural Workers, Construction workers) **Mobile populations** - Persons crossing 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 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 the Trends, Opportunities and Challenges for Migration in the Caribbean include: [22]

(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.

[22] 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.

(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. In many cases irregular migrants in the Caribbean are persons who move from regular to irregular status by over-staying visas or periods of stay. Irregular migration can be countered not only by increasing border security, but also by expanding regular migration opportunities to migrants who currently cannot enter or work legally, or face significant difficulties obtaining legal permits.

(d) **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.[23] Only, Antigua and Barbuda, Belize, Dominican Republic, Guyana, Haiti, and Trinidad and Tobago have specific anti-trafficking laws.[24]

(e) **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.

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* (being born in the territory) 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. They are arbitrarily considered to be '**in transit'** and fall within the exemption to the provision recognising citizenship in the 2010 Constitution.[25]

Through a systemic process of "denationalization" births of children are not registered since registration would ground a claim for citizenship. This situation has been further exacerbated by ***Judgment 168/13 of the Dominican Republic's Constitutional Court of September 23, 2013***

[23] 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.

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

[25] 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

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.

Status of Migrant Access to Health in the Caribbean

The two PANCAP studies were instrumental in achieving some successes in improving access to HIV prevention care and treatment among key populations including specific interventions targeting Men who have Sex with Men (MSM), sex workers, miners and loggers which 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.

In the majority of countries of the region with the notable exceptions of Barbados, Suriname and the Dominica Republic, foreign nationals or migrants can access medical services, at least at the primary level and HIV services in most countries as detailed below. Secondary and tertiary level care are accessible under the same terms as nationals.

Table 2: 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. - Some migrant populations limit access due to copayment requirements at the main
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	hospital, Mount St. John Medical Centre (MSJMC) in Antigua and Barbuda. - Persons with a valid Medical Benefits card and who are under sixteen and 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). -
The Bahamas	- access to HIV prevention, treatment and care is free	
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.	

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 programmes. Simultaneously, national contexts which vary based on legislation and policy imperatives, and national health requirements for access to health, level of availability of services and language limitations continue to pose challenges.

Vulnerability of Migrant and Mobile Populations

Migration is not per se a primary risk factor for disease or for the spread of HIV. Instead, **it is the conditions of migration and the lack of appropriate policy responses that exacerbate health risks and increase vulnerability in places of origin, transit and destination**.[26]

This finding was echoed in the most recent **2018 UNAIDS Global AIDS Monitoring Report (GAM). 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

[26] 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

and less able to cope with illness, including HIV-related illness.[27] 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.[28]

These findings are echoed in the findings under the two PANCAP projects which over the course of the studies identified the following barriers to accessing health services by mobile and migrant populations.

Barriers to Accessing Health Services in the Caribbean

- ***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:
  - fear of being deported;
  - fear of discrimination, especially if they are MSM or sex workers; and
  - lack of knowledge about availability and anonymous treatment.
- ***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.
- ***Lack of information among health care workers*** on health and rights of migrants.
- ***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.
- ***Poor working conditions and absence of social security, such as health insurance and housing challenges***
  - temporary workers 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.*** 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.
- ***Sexual exploitation and human trafficking.***
- ***Centralization of treatment sites.***
- ***Lack of confidentiality at health and social service facilities.***

[27] 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

[28] Ibid

- ***Lack of citizen rights, dependency and xenophobia in the host societies.***

Good Practice: Antigua and Barbuda

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.

The Imperative to Act

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.

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.

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.[29]

Rising Recognition for Attention to the Health of Migrants

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.[30]

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.[31]

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).[32]

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"[33] Among other things, this resolution calls for the promotion of migrant-sensitive health policies;

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[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/

[30] 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).

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

[32] 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

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

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 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*.[34]

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.[35]

***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.[36]

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".[37]

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

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[34] 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.

[35] 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

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

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

protect their human rights, with a gender perspective, paying attention to women and other vulnerable groups in the migration cycle.[38]

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 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.[39]

***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.[40]

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 10** on reducing inequalities, **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. [41]

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[38] 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

[39] 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

[40] 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

[41] United Nations. (2016). The New York Declaration for Refugees and Migrants, A/RES/71/1 (2016). Retrieved from

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, among others; 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 Toward a Global Compact for Safe, Orderly and Regular Migration (GCM) took place in Trinidad from the 27-28 November 2017.[42]

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.[43]

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.* [44]

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http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/71/1

[42] 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

[43] 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

[44] 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/

Why is this Framework Important?

This Framework is advanced by PANCAP as an evidence-based approach based on assessments and research to advance the health of the region by setting a framework to guide countries in expanding access to essential health services within the commitments to universal health. While there appear to be few de jure restrictions specifically denying or excluding migrant access to health by most countries in the region, the lack of a cohesive and comprehensive policy correspondingly means that there is no policy of inclusion. The laissez-faire approach also means that the barriers described above are arbitrarily applied with no redress and result in no or limited access. There is human rights imperative, a public health imperative and an economic imperative to ensure a rights-based approach to secure access to health by migrant and mobile populations.

The Human Rights Imperative

- Adopting a human rights-based approach means that the rights of refugees, asylum seekers and migrants and the right to health are integral to all priorities and actions. A rights-based approach acknowledges migrant populations as rights holders with a corresponding obligation on duty bearers, States, including all countries involved in the migration process to respect, protect and fulfill the rights endowed by the international core human rights treaties and the rights recognised in national law as fundamental human rights of all persons within their jurisdiction including refugees, asylum seekers and migrants.

- The framework for the right to health is based on article 12 of the International Covenant on Economic, Social and Cultural Rights which recognizes the right of everyone to the enjoyment of the highest attainable standard of mental and physical health. Comment No. 14 also highlights that the right to health in all its forms and at all levels contains the interrelated and essential elements: availability, accessibility, acceptability, and quality.

- 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.[45]

- 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 and AIDS), sexual orientation, gender identity and civil, political, social or other status.[46]

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

[45] Committee on Economic, Social and Cultural Rights, General Comment no. 14, article 3.
[46] Committee on Economic, Social and Cultural Rights, General Comment no. 14, article 18 – 19.

"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.

- Migrants rights are contained and recognised in the following international instruments including the **Core Human Rights Treaties**, whose provisions apply universally, and thus protect mobile populations and migrants in particular. These include:
    a. **International Covenant on Civil and Political Rights 1966** [154 ratifications: 'ICCPR']:
    b. **International Covenant on Economic, Social and Cultural Rights 1966 [**151 ratifications 'ICESCR'
    c. **Convention to Eliminate all forms of Discrimination against Women 1979** [179 ratifications: 'CEDAW'];
    d. **Convention on the Rights of Child 1989** [192 ratifications: 'CRC']
    e. **The International Convention on the Protection of Migrant Workers and Members of Their Families 1990,** the most comprehensive instrument protecting the rights of migrants.
    f. **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.
    g. ***Migrant Workers (Supplementary Provisions) Convention 1975*** **(No. 143),** sets out the rights of irregular migrants, and rights to equal treatment with nationals.
    h. **Convention on the Status of Refugees (1951)** and the **1967 Protocol Relating to the Status of Refugees**.
    i. **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**

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.[47] 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 the principles of ***non-discrimination***, and ***equal treatment***.

- 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**.

[47] 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.

- **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 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.

- **The Basic Principle:** 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.[48]

It is a basic principle of human rights 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 Public Health Imperative

- From a public health perspective, opening health prevention programmes to migrants reduces health risks for the general population. 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.

- Given the high levels of intra-regional travel, a public health approach is necessary in order to align strategies, policy options and interventions for improving health outcomes among particular subgroups of migrants. Several basic principles influence the development of a public health approach for migrants.
    - The main public health goal is to avoid disparities in health status and access to health services between migrants and the host population.

[48] 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.

- The second, closely associated, principle is 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.
- The third principle is to put in place lifesaving interventions so as to reduce excess mortality and morbidity.
- The fourth principle is to minimize the negative impact of the migration process on migrants' health outcomes. Together, these four principles may be taken as the basis for a policy framework for defining public health strategies for migrants.[49]

- Excluding migrants from health provisions not only results in health risks for the individual, and violations of migrants' rights, but also poses risks for the broader attainment of public health objectives. Human mobility, whether resulting from voluntary or forced means, can be a critical factor in the spread of disease and or a challenge to controlling it.

- Disease eradication and successful prevention including reducing the spread and impact of HIV rests, fundamentally, on inclusive and non-discriminatory approaches. Delivering equitable access for migrants can reduce health and social costs, improve social cohesion and, most importantly, will protect public health and human rights.

The Economic Imperative

- Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

- Financing systems need to be specifically designed to:
  - provide all people with access to needed health services (including prevention, promotion, treatment and rehabilitation) of sufficient quality to be effective; [and to]
  - ensure that the use of these services does not expose the user to financial hardship [driven by reliance on out of pocket payments].

- Studies have shown that it is less expensive to offer preventive care than to pay for expensive emergency treatments. 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 demonstrate 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.[50]

[49] International Organisation for Migration. 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

[50] 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

- 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. One of the main arguments mentioned was cost effectiveness.[51] 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.

- Ensuring that migrants have access to basic primary and preventive care means that they can be treated before a catastrophic result occurs due to their lack of ability to seek earlier medical intervention and reduce the cost impact on the health sector by not requiring more expensive secondary or tertiary level care. A cost analysis will be important, taking account of the financing of the health system in the Caribbean will be relevant.

- At the Third LAC Forum *Third LAC Forum, November 2017: Road To Ending AIDS in LAC-Towards Sustainable Regional Fast Track Targets*, Governments and civil society organisations recognised that in achieving the goal of sustainability in the HIV response, the principles of human rights and universal health, and the core values of the right to health, equity, and solidarity with meaningful participation of people living with HIV, key populations (MSM, people who use drugs, people in prisons and other closed settings, sex workers and transgender) and most vulnerable populations (adolescents and youth, women and girls, orphans, people with disabilities, migrants and mobile workers and indigenous and African descendants) were required in securing sustainability.

A Pragmatic Approach – Scope of the Framework

- The pragmatic approach centers on the recognition of the reality that addressing the public health challenges currently facing the region and others, which may come in the future, cannot be addressed nationally or by closing national borders given the high levels of intra-regional migration. It acknowledges that protecting the health of the populace, correspondingly requires protecting the health of mobile and migrant populations. It acknowledges that restricting access based on cost considerations is counterproductive as we can save in the short term but will lose in the long term.

- This framework recognises the regions commitment to Universal Health Coverage and the move to National Health Insurance in the financing of the health sector. It is designed to allow countries to adopt human rights principles in addressing access to health by mobile and migrant populations in the design of their systems, taking account of public health and financial sustainability issues.

- The commitment to a rights-based approach entails providing access to high-quality

[51] 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

comprehensive health services for mobile and migrant populations in their territories of origin and destination, during transit, and upon return to their country of origin.

- In addition, it recognizes the contributions of previous strategies or mandates from the Region that deal with this issue, and is aligned with other related strategies and commitments, including the Sustainable Development Goals. The Framework corresponds to the PANCAP's Justice for All program which establishes human rights as a priority of the regional response to reduce stigma, eliminating discrimination and strengthening rights-based legislative frameworks.

- This Framework acknowledges that laws, regulations and policies governing access to health services and financial protection for health by migrants and mobile populations vary across countries and are determined by national laws, policies and priorities.

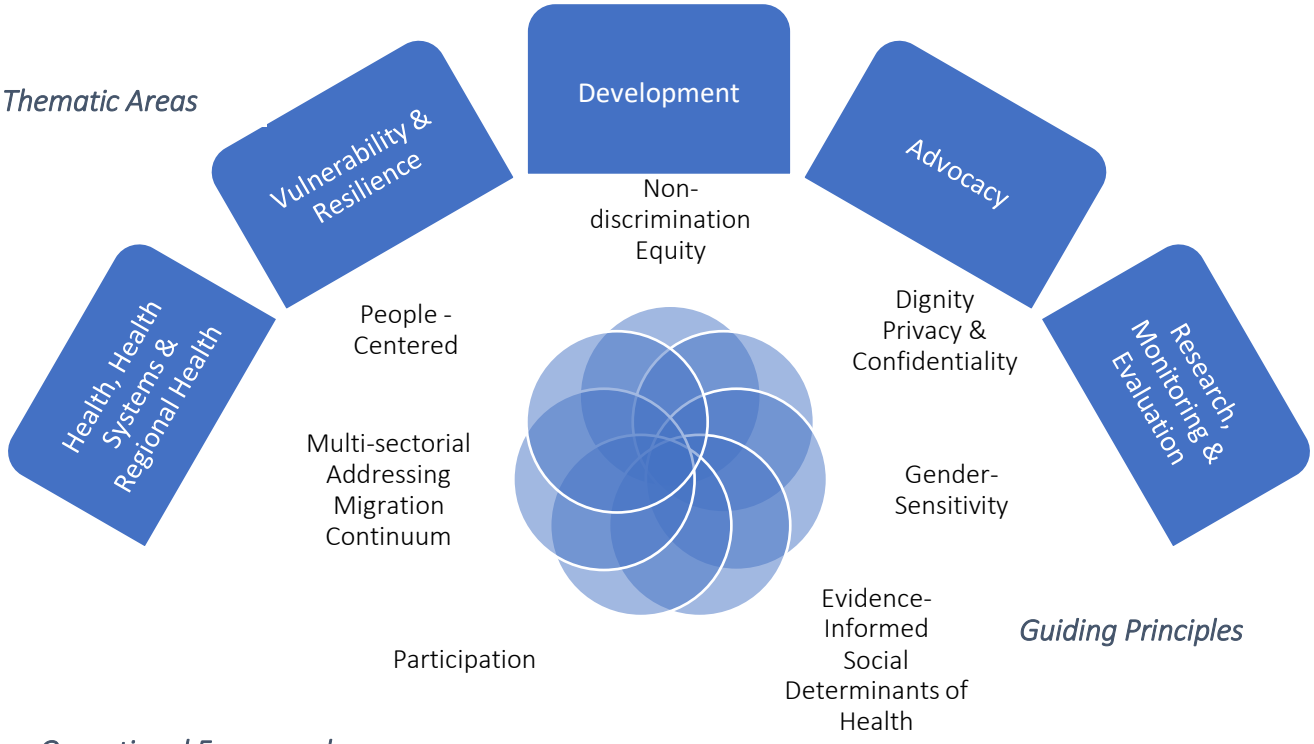
- The objective of the Framework is to:
  establish a roadmap for equitable and non-discriminatory access to health care services across the Caribbean for mobile and migrant populations regardless of age, race, colour, sex, language, religion, political or other opinion, national or social origin, sexual orientation, gender identity, property, birth real or perceived HIV status, economic or other status.

- In achieving this objective, the collection of accurate data and having regard to country national security interests are relevant. The collection of accurate and disaggregated data as a basis for evidence-informed policies for decision makers and service providers not only to inform policy but also to inform the public and the tension between balancing of national security interests and migrant rights will be an ongoing challenge.

- This Framework was developed thorough a participatory approach involving representation from Government, (Ministry of Health, Chief Medical officers, National AIDS Programmes, Immigration Officers) Civil Society (Migrant groups and other key population groups) and international and regional organisations including, PANCAP, UWI, IOM, UNHCR and UNAIDS. The elements of the Framework were developed at a regional consultation held in Trinidad and Tobago from 26 -27 June 2018 with participation of the above-mentioned representatives and distilled into the Framework document presented below.

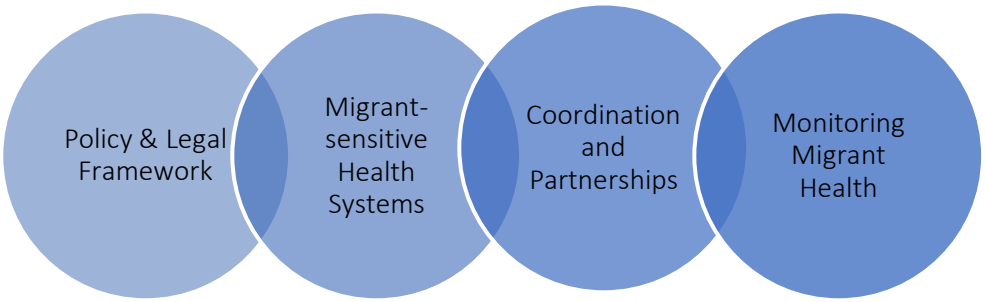
FRAMEWORK:
A PRAGMATIC APPROACH TO MIGRANT RIGHTS AND HEALTH WHICH RECOGNISES THAT A NON-DISCRIMINATORY STRATEGY FOR PUBLIC HEALTH BENEFITS THE ENTIRE POPULATION.

Thematic areas **prioritized for the Framework** ***Principles*** **of the Framework**



Operational Framework

Primary components identified from the 2010 IOM Operational Framework revised in 2017, which were applied to this Framework include the following four (4) components contained below. The Framework is designed to address regional and national level activities in line with these four (4) components and the key elements of the Right to Health including Accessibility (including Economic Accessibility), Availability, Acceptability and Quality.



Thematic Areas

Health, Health Systems & Regional Health	Vulnerability & Resilience	Development	Advocacy	Research, Monitoring & Evaluation
•**To promote preventive and curative health approaches to reduce disease burden for migrants and host communities** Guided by Universal Health Coverage (UHC), Primary Health Care (PHC), and Health System Strengthening (HSS) concepts	•**To reduce vulnerability and enhance resilience of migrants, communities and systems** Guided by the Social Determinants of Health (SDH) and equity in migrant health	•**To ensure health of migrants and mobile populations are made an integral part of human and sustainable economic development** Guided by the Sustainable Development Goals (SDGs)	•**Advocacy for conducive, cross-sector Policy and Legal Framework Development**	•**Increase data collection for trends and outcomes through appropriate disaggregation and analysis** Monitor national and regional level progress

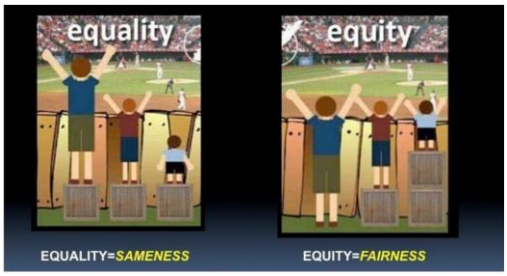
Guiding Principles

1. **Overarching Rights Framework:** The principle that all persons, including migrants and mobile populations, should be able to access a minimum standard of medical treatment, may be located under a number of internationally recognized human rights principles. These include:
   - The right to health: Every person has 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, States should do all in their power to ensure the health of those persons within their jurisdictions, especially in situations where its citizens and general population may be placed at risk because of related health issues;
   - 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 migrants.
   - The principle of equality and non-discrimination is accepted as a fundamental principle of international and domestic human rights law. An effective response requires that the rights to equality before the law and freedom from discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV and AIDS), sexual orientation, gender identity and civil, political, social or other status are respected, protected and fulfilled.
   - The duty not to discriminate: As stated above, 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.[52]

- Dignity: Human dignity is inviolable. This principle has not changed since 1948 when it was formulated by the United Nations in the Universal Declaration of Human Rights. It does not stop at national borders and applies to everyone regardless of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV and AIDS), sexual orientation, gender identity and civil, political, social or other status.
- This framework aims for the highest attainable standard of health irrespective of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV and AIDS), sexual orientation, gender identity and civil, political, social or other status or ability to pay.

2. **Equitable access to health services:** Equity is essentially about fairness. Equity in health is about ensuring equal access to health services for people with equal need, irrespective of personal characteristics such as gender, cultural background, sexual orientation, or other status. Equity in health implies that ideally everyone should have a fair opportunity to attain their full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. The aim for equity and health is not to eliminate all health differences so that everyone has the same level of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair. The health of migrants and mobile populations should not be considered separately from the health of the overall population. Where appropriate, it should be considered to include refugees and migrants into existing national health systems, plans and policies, with the aim of reducing health inequities.



3. **People-centred, migrant sensitive health systems**: Health systems should be migrant, and gender sensitive, and people-centred, with the aim of delivering culturally, linguistically and gender and **age** responsive services.[53]

4. **Gender sensitive health systems:** Health systems need to take account of gender norms, structural conditions that create vulnerabilities, and 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, sex workers and lesbian, gay, bisexual, transgender and intersex persons and women's lack of decision-making power all of which have particular consequences for female migrants, sex workers and lesbian, gay, bisexual, transgender and intersex persons. Delivery of services should be non-discriminatory and recognise the particular needs of women and girls and other vulnerable groups based on gender identity.

[52] 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

[53] International Organisation for Migration. 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

5. **Evidence-informed approaches**. Policy development and decision making need to be based on the best available data and the collection and disseminating of good practices. There is a need to enhance the monitoring of migrant health, such as the inclusion of migration variables in existing census, national statistics and targeted health surveys as well as in the SDGs and financial protection in health progress monitoring efforts.
   - 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 policymakers who, with the aim of reducing irregular migration, seek to create a hostile environment for irregular residence.[54]
   - 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. Monitoring migrant health is necessary to promote evidence-informed policymaking on migration and migrants' rights. It will facilitate better analysis of the impacts of migration and develop policies on the outcomes of migrants, their families, and their societies of origin, transit, and destination.[55]

6. **Multi-sectoral and Multi-country response:** The management of migrant health is a shared responsibility and requires close cooperation and collaboration among countries, as well as among sectors. Ensuring cross-border continuity of care for migrants with health needs requires harmonized health care protocols, confidential sharing of health data, and other forms of partnership that enhance surveillance along mobility pathways and effective regional response in the event of public health emergencies.

7. **Address health vulnerabilities of each stage of the migration continuum**: 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. 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, a mufti-country response is essential to address the health challenges over the migration continuum.

8. **Participation and social inclusion of mobile and migrant populations**: Health policies, strategies and plans and interventions across the migration cycle and in countries of origin, transit, and destination should be participatory, so that refugees, migrants and mobile populations are involved and engaged in relevant decision-making processes. Participation in the design, implementation and monitoring of policies, strategies and plans should not be token. All partners must be respected and given the opportunity for full participation by providing adequate, notice, materials and information for informed contributions.

[54] 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

[55] ibid

9. **Privacy and confidentiality**: Health care services should respect and deliver services in a private and confidential manner. Confidentiality is at the heart of reducing stigma and discrimination against persons living with HIV in particular. It is the breach of confidentiality which typically leads to stigmatization or discrimination. Health services have a duty to respect, protect and fulfill the right of migrants and mobile populations to the privacy and confidentiality of their information subject to such exceptions as are allowed by law, court proceedings and where the patient has given consent.

10. **Social determinants of health:** Addressing the social determinants of health that generate inequalities is essential to meet the immediate health requirements of migrant and mobile populations, particularly as migration is itself considered a social determinant of health. It is essential in considering the longer-term provision of health care and public health strategies which will also protect, without discrimination, the public health of the country.

These guiding principles are encapsulated within the definition of **"ACCESS"** and **"UNIVERSAL ACCESS"** by the Pan American Health Organisation and which are adopted here: [56]

- **Access is the capacity to use comprehensive, appropriate, timely, quality health services when they are needed. Comprehensive, appropriate, timely, quality health services are actions directed at populations and/or individuals that are culturally, ethnically, and linguistically appropriate, with a gender approach, and that take into account differentiated needs in order to promote health, prevent diseases, provide care for disease (diagnosis, treatment, palliative care, and rehabilitation), and offer the necessary short-, medium-, and long-term care.**
- **Universal access is defined as the absence of geographical, economic, sociocultural, organizational, or gender barriers. Universal access is achieved through the progressive elimination of barriers that prevent all people from having equitable use of comprehensive health services determined at the national level.**

Recommended Strategies

This framework is designed to set out some key strategies for governments, civil society and at the regional level for ensuring that migrant's rights to health are protected and delivered in a manner that is culturally, ethnically, and linguistically appropriate, with a gender approach, and that takes into account differentiated needs in order to promote health, prevent diseases and provide care for diseases.

POLICIES AND LEGAL FRAMEWORK AFFECTING MIGRANT HEALTH PRIORITIES

Member States to:

1. **Reinforce, review or amend national policies and legal frameworks to ensure that:**
   - measures are adopted to remove formal and practical obstacles that hinder or prevent the enjoyment of the right to health, such as requiring a residence permit, or additional

[56] 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

fees based on nationality or migration or residence status, and reporting migrants in irregular status to migration authorities.

- migrant and mobile populations access health services on the same terms and conditions as nationals with full respect for confidentiality of all users.
- migrant and mobile populations have non-discriminatory access to HIV, STI and TB prevention, treatment and care, health services for pregnancy and other communicable diseases including hepatitis.
- legislation does not oblige health workers and civil servants to detect migration or residence status to provide goods and services and report irregular migrants to migration authorities.
- legal provisions or policies exist to protect the right to adequate housing, including access to water and sanitation services, without discrimination based on nationality and migration or residence status.
- legislation on occupational safety and health, including workers' rights and protections, apply to all workers regardless of migration status.
- legal provisions or policies exist to protect migrants' right to sexual and reproductive health services, that is, regardless of nationality and migration or residence status, equal to nationals.
- legal provisions or policies exist to protect children's right to health, regardless of their migrant status or their parents' migrant status and legal recognition of the right to birth registration, regardless of the migration or residence status of parent.
- legal provisions or policies exist for equal access to justice, legal aid and effective remedies by victims of discrimination, without repercussions on grounds of their residence status.
- the principle of non-discrimination is included in immigration laws.

2. **Reinforce national policies and legal frameworks to ensure that** migrant rights are protected by incorporating into domestic law key legal instruments on migrant rights and human rights and for those countries that have not yet done so, to consider accession or ratification, as appropriate, to:
    - the 1951 Convention relating to the Status of Refugees and its 1967 Protocol, the 1954 Convention relating to the Status of Stateless Persons, the 1961 Convention on the Reduction of Statelessness,
    - International Covenant on Civil and Political Rights 1966 (ICCPR),
    - International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR)**,**
    - 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families,
    - the 2000 United Nations Convention against Transnational Organized Crime and its Protocols to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, and Against the Smuggling of Migrants by Land, Sea and Air (Palermo Protocols), and other relevant instruments;

    and to foster the progressive development of the interpretation of these instruments.

3. **Ensure that migrants who are detained by public authorities, are treated humanely and fairly** regardless of their immigration status, nationality, gender, ethnicity, race, or others, and are afforded all applicable legal protection, including where appropriate the assistance of counsel, competent, and gender-responsive interpreter services, access to their consulates, access to

health needs while in detention and protection against arbitrary detention, in accordance with international law, norms and standards.

4. **Ensure that all migrants have access to the courts, lawyers, judicial system,** relevant government agencies and refugee determination procedures where requested, including the opportunity to contest removal procedures in a manner consistent with international law, standards and norms.

5. **Provide migrants with adequate and free administrative support** with regard to government services and national laws in a language they understand.

6. **Promote, develop and conduct gender-sensitive human rights training** (inclusive of issues on gender identity and sexual orientation) for public officials, including personnel in the administration of justice, particularly law enforcement, and correctional institutions, as well as among health-care providers, schools and migration authorities**.**

7. Strengthen responses to the particular needs of migrant women and girls, particularly ensuring that their health needs, labour rights and human rights are respected. A gender perspective should be integrated in all national and regional migration management policies, strategies and programmes, recognising the agency of women in migration, promotes their empowerment and leadership.

8. **Reduce negative perceptions and discrimination** perpetrated by healthcare personnel, immigration officers, other public officers (including police and labour) and the media by;
   - continued sensitization and training in Human Rights among these duty bearers.
   - educate media on responsible reporting and positive impacts of migration.
   - advocate for evidenced-based media reporting and public education.
   - train immigration officers, coast guard, customs officers on appropriate referrals, customer service and human rights.

9. **Promote the integration of migrants into host societies,** including through public information and education campaigns, in order to prevent negative perceptions, foster mutual cultural acceptance and ensure that the rights of migrants are respected and protected.

10. **Promote coherence among the policies of the various sectors, other than health,** that may affect the ability of migrant and mobile populations to access health services, for example, by involving ministries of finance, home affairs, social services, gender foreign affairs, immigration as appropriate.

MIGRANT SENSITIVE HEALTH SYSTEMS

1. **Promote continuity and quality of care delivered by public and private institutions and providers,** and other service providers for migrants and mobile populations in particular for persons with disabilities, pregnant women, people living with HIV, tuberculosis, malaria, mental health and other chronic health conditions as well as those with physical trauma and injury.

2. **Ensure the minimal healthcare service package for refugees and displaced persons, including prevention, treatment and health education, with special regard for the needs of vulnerable**

groups, and mobilise resources needed, by inter alia enhancing collaboration with UNHCR, IOM, WHO, UNFPA, UNAIDS, and other relevant agencies.

3. **Increase the availability of health services by address geographic and other issues of availability including, d**evelop mobile outreach services to reach migrants in border regions and other remote areas; implementing extended, alternative hours or shift systems for health service delivery to accommodate migrant workers who may be unable to access services during normal working hours and promote the decentralization of services.

4. **Provide cultural and linguistical appropriate services by** building the capacity of health care workers in basic foreign language skills and recruit staff who are bilingual where possible. Conduct cultural sensitivity training for health care providers and migrants.

5. **Secure the meaningful participation of migrant and mobile populations in policy and strategy development.** Ensure the inclusion of migrant representatives in the development and implementation of public health policy and programming.

6. **Leverage the comparative advantages of CSOs to deliver services to migrants** by collaborating with civil society to engage in delivery of services using a social contacting model.

7. **Mobilise resources to fund migrant health responses within national healthcare schemes by**
   - Improving cost effectiveness at the country/ regional level
   - purchasing/ accessing approved generic medication
   - Increasing domestic funding ('sin' taxes e.g. alcohol and tobacco, taxing sectors that migrants tend to work in, development/labour opportunities for migrants in host countries and reaching out to diaspora)

8. **Scaling up low-cost high-volume health care services to increase available**, affordable services accessible to migrants

9. **Develop guidance manuals/ tools/ training sessions to explain entitlements to migrants** and Health care Providers to address the lack of clarity pertaining to existing entitlements per sub-group of migrants.

MONITORING MIGRANT HEALTH

1. **Foster the exchange of best practices and lessons learned** on the health of refugees and migrants among relevant actors.

2. **Strengthen research and data collection initiatives on the relationship between health** and migration and enhancing co-operation between countries and relevant agencies including WHO, UNAIDS, IOM, UNFPA and ILO.

3. **Conduct research on the cost of non-inclusion; cost of current needs** within migrant response; impact studies, Ethical issues and net migration, and co-morbidity and public health implications.

4. **Conduct robust gender-responsive research and enhance data collection, acquisition**, analysis and accountability measures at all stages of migration, including at borders and upon return, in order to highlight the contributions made by women in migration, the gendered drivers of migration, and the situation and realities of migrant women in every phase of the migration process, including violations of migrant women's rights, exploitation and trafficking.

5. **Harmonise the collection of migration data, including definitions of migration,** data collection tool and methods at the regional level so that data are comparable across countries and the region.

PARTNERSHIPS NETWORKS AND MULTI COUNTRY FRAMEWORKS

PANCAP to:

1. **Review existing regional strategies, for example, the Caribbean Cooperation in Health** IV, the Justice for All Roadmap, the Regional Advocacy Strategy and other relevant regional policies and strategies for coherence with the Framework.

2. **Enhance cross-border cooperation and partnerships to harmonize policies and practices** and ensure continuity of care and health responses to emerging needs linked to human mobility, including in health and border management.

3. **Ensure the mainstreaming of migration health issues in bilateral, regional and multiregional** dialogues on health, migration, development, labour, and foreign policy; enhance cooperation among countries of origin, transit and destination.

4. **Maintain commitments and advocate globally to ensure that regional perspectives** are reflected in global dialogues and instruments.

5. **Promote the development of an operational plan in conjunction with CDEMA** and other regional disaster management entities to activate a regional response for the resettlement and other assistance including provision of essential medications including ARVs for persons displaced by natural disasters in the region.

6. **Strengthen partnerships, intersectoral, intercountry and interagency coordination** and collaboration mechanisms to achieve synergies and efficiency, including within the United Nations system, with IOM and UNHCR in particular, and with other stakeholders working towards improving the health migrant and mobile populations.

7. **Mobilise resources to enable countries and communities to respond t**o both the immediate and the medium/longer-term health needs of refugees and migrants; identify gaps and innovative financing to ensure a more effective use of resources.

8. **Lobby and advocate for regional support for the Global Compact on Safe and Orderly Migratio**n and universal access to health

Action Plan for Increasing Access to Migrant Health

	THEMATIC AREAS				
	Health, Health Systems & Regional Health	**Vulnerability & Resilience**	**Development**	**Advocacy**	**Research, Monitoring & Evaluation**
GOAL	**To promote preventive and curative health approaches to reduce disease burden for migrants and host communities** Guided by Universal Health Coverage (UHC), Primary Health Care (PHC), and Health System Strengthening (HSS) concepts	**To reduce vulnerability and enhance resilience of migrants, communities and systems** Guided by the Social Determinants of Health (SDH) and equity in migrant health	**To ensure health of migrants and mobile populations are made an integral part of human and sustainable economic development** Guided by the Sustainable Development Goals (SDGs)	**Advocacy for conducive, cross-sector Policy and Legal Framework Development**	**Increase data collection for trends and outcomes through appropriate disaggregation and analysis** Monitor national and regional level progress
AREAS **FOR** ACTION	Regional Health goals • Universal Health care	Contextual factors • Economy, employment livelihood, housing, cost of health care	Migration health & SDGs • reduce inequalities	Legal Framework • National health policies that incorporate a public health approach to the health of migrants	Define and agree on key terminology • Common definitions, migrant-specific ethical guidelines
	Cross Border Health • Data sharing to ensure continuity of care	Structural and policy factors • Availability of critical data for policy change	Technological & social innovation • Surveillance	Human Rights • Equal access to health services for migrants, regardless of their status.	Data collection • Accurate information on status and impact of migration • Negative perceptions towards migrants
	People centered health Systems- • Organising health services with consideration of migrant needs	Societal and systemic factors • access to migrant sensitive health systems, availability, accessibility, acceptability and affordability	Healthy migrants for development • Remittances • Investing in health for development		Research • Research and quantify the costs of not responding to the health needs of migrants • Capacity development, and adequate, long-term funding commitments.
	Health Needs of Migrants • Communication and sensitivity to different culture and language backgrounds	Individual factors • Language and cultural barriers, gender norms	Socioeconomic impact of health on migrants and families • Continuity of care across borders and health systems		

Strategic Objectives	Strategic Actions	Responsible Entity	Expected Outcome
MIGRANT SENSITIVE HEALTH SYSTEMS			
- To ensure health services are culturally, linguistically and epidemiologically appropriate. - To ensure continuity and quality of care in all settings. - To enhance the capacity of the health and relevant non-health workforce to address the health issues associated with migration - Adopt measures to improve the ability of health systems to deliver migrant inclusive services and programmes in a comprehensive, coordinated, and financially sustainable way.	**1. Address geographic and other issues of availability** • Develop mobile outreach services to reach migrant in border regions and other remote areas. • Implement extended, alternative hours or shift systems for health service delivery to accommodate migrant workers who may be unable to access services during normal working hours. • Decentralization of services **2. Provide cultural and linguistical appropriate services** • Capacity building of health care workers in basic foreign language skills & offer incentives. • Conduct cultural sensitivity training for health care providers and migrants. • Recruit staff in health facilities who are bilingual. • Adopt best practices from different countries. **Language Assistance** • Beneficial to use an in-house translator or a provider who speaks the same language as the patient (e.g. Utility of bilingual HCPs trained in Cuba) • Improve migrant patients' command of the national language (e.g. Experience of NAP in Antigua under the last PANCAP/GTZ project)	Government (Central and local), Migrants (to confirm the needs); NGOs and CSOs Ministry of Health Migrants and CSOs/FBOs that work with migrant organizations;	**Increase in uptake of health services by migrants** **Increase availability and affordability of migrant health services via public, private and CSO providers** **Increased communication between government, CSO and key populations** **Increased resources funding sources to institute**

Strategic Objectives	Strategic Actions	Responsible Entity	Expected Outcome
	▪ Provision of materials and information in migrants' native language		**comprehensive migrant health response**
	3. Secure the meaningful participation of migrant and mobile populations in policy and strategy development ▪ Inclusion of migrants in the development and implementation of public health policy and programmes	Ministry of Health Migrants and CSOs/FBOs that work with migrant organizations	**Migrants, HCPs and CSOs well informed about existing migrant entitlements to health and social services**
	4. Leverage the comparative advantages of CSOs to deliver services to migrants ▪ Collaborate with civil society to engage in delivery of services using a social contacting model.		
	5. Mobilise resources to fund migrant health response within national healthcare schemes ▪ International Funding Mechanism ▪ Improving cost effectiveness at the country/ Regional level (PAHO strategic Fund; purchasing/ accessing approved generic medication)	Governments; International Donors; IOM; Development Agencies (incl. UNHCR, PAHO)	
	6. Increase Domestic Funding ('sin' taxes e.g. alcohol and tobacco, taxing sectors that migrants tend to work in, development/labour opportunities for migrants in host countries and reaching out to diaspora)	Ministries of Finance, Ministries of Health Ministries of Labour Caribbean Diaspora/ CSO working with migrants/ Migrant Reps	
	7. Address lack of Information by migrant populations on availability of services ▪ Develop IEC materials with information on availability of services in various languages ▪ Engage media and migrant groups migrant groups/associations to sensitize them on the services available. ▪ Production of information and on social media, radio, television in various languages	Public Officials/Service Providers Media/Private sector	
	8. Strengthen legal, policy and operational systems to secure patient confidentiality in the health sector.	Ministry of Health Migrants and CSOs/FBOs Medical and Nurses Associations	

Strategic Objectives	Strategic Actions	Responsible Entity	Expected Outcome
	9. Develop guidelines and manuals for health care and other service providers to understand and address the health and social issues associated with migration. ***10.*** **Formalise collaborations with social services, CBOs and families to allow for sharing of information and connecting migrant patients to the wider community** (FBOs, health and non-health focused CBOs, e.g. women, children, rights-based CBOs) • Secure partnerships with language learning centres • Collaboration with CBOs, families and social services is especially important in delivery of mental health services to migrants • Engage patient advocates		
POLICIES AND LEGAL FRAMEWORK AFFECTING MIGRANT HEALTH PRIORITIES			
- To implement international standards that protect migrants right to health and monitor the implementation of relevant national policies, regulations and legislation responding to the health needs of migrants	**1. Conduct advocacy and public education efforts to build support among the public, government and other stakeholders for migrant-inclusive health policies and adoption of key international instruments.** • Advocate to policy makers (with migrants) on the need to ratify and/or implement the Convention on Refugees; • Sensitivity training for Policy Makers to inform policy regarding migrants •	Ministry of Health and National AIDS Programmes PANCAP propose to the Heads of Government Parliamentarians.	**Fulfillment of national and international obligations;** **Compliance with International Human Rights Conventions and Agreements.**
- To develop and implement policies that promote equal access to health services for all migrants.	**2. Conduct a legal environment assessment (including desk review) to inform legislative Reform**; • Laws need to be updated to reflect international, and regional treaties and policies	Ministries of Health Legal Affairs Ministries	**Realization of the right to the highest**

Strategic Objectives	Strategic Actions	Responsible Entity	Expected Outcome
- To extend social protection in health and improve social security for all migrants and family members. - To promote coherence among policies of different sectors that may affect migrants' ability to access health services.	**3. Convene national consultations with technocrats, policy makers, health care providers immigration officials, etc., to arrive at consensus with regard to providing an acceptable service and for coherence on the right to migrants across sectoral policies.** Sensitization of these groups with regard to what acceptability requires with the full participation of migrant representatives. **4. Advocate for a gender sensitive approach inclusive of sexual orientation and gender identity in policy review or development relating to migrants**. **5. Address Stigma and Discrimination perpetrated by healthcare personnel, immigration officers, other Public Officers (including Police and labour) and the media** Continue sensitization and training in Human Rights among these duty bearers Educate media on responsible reporting and positive impacts of of migration Train immigration officers, coast guard, customs officers on appropriate referrals, customer service and human rights Sensitize migrants on their rights and responsibilities **6. Address labelling and stereotyping of migrant populations** Sensitization and engagement of the populace to negate negative perceptions of migrants.	Migrants; Civil Society, First Responders, Healthcare providers, NGOs. Labour, Health, Security, Immigration Ministries Gender Ministries, Ministry of Labour, Key population NGOs, CSOs Labour, Health, Security, Immigration Ministries Migrants; Civil Society, Healthcare providers, NGOs.	**attainable standard of health.** **Continuity of care across borders** **Increased communication between government, CSO and key populations**
PARTNERSHIPS NETWORKS AND MULTI-COUNTRY FRAMEWORKS			
- To establish and support ongoing migration health dialogues and cooperation across sectors and across countries of origin, transit and destination. - To address migrant health matters in global and regional consultative migration, economic and development processes (e.g., The	**1. Develop Collaborative Interventions with Civil Society** Peer approach and collaborative interventions, public and community sector. **2. Create a multi-sectoral body inclusive of government, civil society, media and migrant groups where possible at the national level to advise on and inform policies and actions related to migrant access to health.**	Migrant organisations, other CSOs and NGOs Labour, Health, Security, Immigration Ministries Migrants; Civil Society, Healthcare providers, NGOs.	**The voices of migrant populations are at the table.** **Migrant issues incorporated into regional health and other strategies**

Strategic Objectives	Strategic Actions	Responsible Entity	Expected Outcome
Caribbean Consultations on Migration, United Nations High Level Dialogue on International Migration and Development). - To develop an information clearing house of good practices.	3. **Review existing regional strategies, for example, the Caribbean Cooperation in Health** IV, the Justice for All Roadmap, the Regional Advocacy Strategy and other relevant regional policies and strategies for coherence with the Framework. 4. **Enhance cross-border cooperation and partnerships to harmonize policies and practices** and ensure continuity of care and health responses to emerging needs linked to human mobility, including in health and border management. 5. **Ensure the mainstreaming of migration health issues in bilateral, regional and multiregional** dialogues on health, migration, development, labour, and foreign policy; enhance cooperation among countries of origin, transit and destination. 6. **Maintain commitments and advocate globally to ensure that regional perspectives** are reflected in global dialogues and instruments. 7. **Promote the development of an operational plan in conjunction with CDEMA** and other regional disaster management entities to activate a regional response for the resettlement and other assistance including provision of essential medications including ARVs for persons displaced by natural disasters in the region. 8. **Strengthen partnerships, intersectoral, intercountry and interagency coordination** and collaboration mechanisms to achieve synergies and efficiency, including within the United Nations system, with IOM and UNHCR in particular, and with other stakeholders working towards improving the health migrant and mobile populations. 9. **Mobilise resources to enable countries and communities to respond t**o both the immediate and the medium/longer-term health needs of refugees and migrants; identify gaps and innovative financing to ensure a more effective use of resources. 10. **Lobby and advocate for regional support for the Global Compact on Safe and Orderly Migratio**n and universal access to health	PANCAP PANCAP PANCAP PANCAP PANCAP PANCAP PANCAP PANCAP, National Agencies – Immigration, Labour, Health	**Rights of Migrants included in regional agenda on development and labour** **Interruption of treatment for persons with chronic illnesses during natural disasters mitigated** **Common Policy Framework on migration and universal access to health based on global framework signed off on by local Caribbean governments**

Strategic Objectives	Strategic Actions	Responsible Entity	Expected Outcome
MONITORING MIGRANT HEALTH			
- To ensure the standardization and comparability of data on migrant health - To increase and support a better understanding of trends and outcomes through the appropriate disaggregation and analysis of migrant health information in ways that account for the diversity of migrant populations. - To identify and map: 1) good practices in monitoring migrant health; 2) policy models that facilitate equitable access to health for migrants; and 3) migrant-inclusive health systems models and practices.	6. **Foster the exchange of best practices and lessons learned** on the health of refugees and migrants among relevant actors. 7. **Strengthen research and data collection initiatives on the relationship between health** and migration and enhancing co-operation between countries and relevant agencies including WHO, UNAIDS, IOM, UNFPA and ILO. 8. **Conduct research on the cost of non-inclusion; cost of current needs** within migrant response; impact studies, Ethical issues and net migration, and co-morbidity and public health implications. 9. **Conduct gender-responsive research and enhance data collection, acquisition**, analysis and accountability measures at all stages of migration, including at borders and upon return, in order to highlight the contributions made by women in migration, the gendered drivers of migration, and the situation and realities of migrant women in every phase of the migration process, including violations of migrant women's rights, exploitation and trafficking. 10. **Harmonise the collection of migration data, including definitions of migration,** data collection tool and methods at the regional level so that data are comparable across countries and the region. 11. **Identify and Map Good Practices. Identify and assess** best practices from different countries to determine applicability to regional context. (Regional best practice: Guyana's practice with miners and loggers with HIV. Approach focused on HIV, sexual reproductive health and migration health vulnerabilities. This resulted in improved health outcomes of sex workers, miners, loggers, mobile populations and affected individuals and communities in Guyana.	PANCAP, National Programmes PANCAP, regional partners PANCAP, UWI-HEU, Research institutions, Development agencies PANCAP, UWI-HEU, UN Women	**More accurate data on migration generated to inform policy development** **Cost analysis on inclusion conducted** **Strategic information about cost/benefits of provision of health care to migrants**

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