

People on the Move - Forced Displacement and Migrant Populations

Statement to 24th UNAIDS Programme Coordination Board
(Monday 22 June 2009)

Check against delivery

Excellencies, colleagues, ladies and gentlemen,

It is an honour to address the 24th UNAIDS Programme Coordination Board meeting, the first since Michel Sidibé became Executive Director of UNAIDS. UNHCR is committed to working with Michel and all of you to achieve universal access for HIV prevention, treatment, care and support.

We strongly support Michel's dedication to protection and human rights issues relating to HIV. I am very pleased that this year's World AIDS Day campaign will be "Universal Access and Human Rights".

I would like to acknowledge with sincere thanks the tireless work of Dr. Peter Piot. Dr. Piot had led UNAIDS' since its creation and helped prepare us for the increasingly complex challenges of HIV and AIDS.

Ladies and gentlemen,

The theme of my remarks is *People on the move - forced displacement and migrant populations*. I suggested this topic last year, as chair of the Committee of Co-sponsoring Organisations. It is one of vital interest to me and the organization I lead.

Who are these people on the move? They are an estimated 200 million migrants all over the world that move to meet their needs or improve their opportunities. But a large and growing proportion is and will eventually be forcibly displaced. And the nature of this displacement is changing.

Conflict, climate change and extreme poverty are more and more inter-related. The food and energy crises of 2008 together with the global financial and economic crisis have compounded the push factors.

Confronted with a lack of security, food, education, health care, livelihoods or a sustainable environment, people are understandably opting or even forced to leave their usual place of residence and are being absorbed into broad migratory movements, destined primarily to cities.

Migrants and refugees are increasingly using the same routes, the same means of transport and the same smugglers. This has prompted many states to erect new barriers to their arrival. Refugees must be able to access the protection to which they are entitled but this does not mean that we should focus only on the rights of refugees and ignore the rights of migrants. HIV and AIDS make no such distinction.

Ladies and gentlemen,

Whatever their reason for moving, people on the move may be more vulnerable to HIV. People on the move, including refugees, internally displaced persons and migrants, are often accused of spreading diseases, such as HIV. In fact, in most refugee camps, refugees have lower HIV prevalence than surrounding host populations. Stigmatized or discriminated against for being different from those around them, some will engage in risky behaviours just to survive. This in turn may increase their likelihood of contracting HIV. Elevated levels of sexual and gender-based violence also increase the individual risk of people on the move contracting HIV.

It is the duty of all of us to ensure that the human rights of people on the move are respected. Ensuring that the needs of migrants and refugees for HIV prevention, treatment, care and support is essential to achieving universal access. This is probably the most important point I will make so I would like to repeat it: Meeting the needs of people on the move for HIV prevention, treatment, care and support is essential for achieving universal access.

Over the past approximately five years, much progress has been made in crafting appropriate HIV policies and interventions for persons affected by humanitarian emergencies. The revisions to the minimum standards set out in the 2003 IASC Guidelines on HIV Interventions in Emergency Settings are nearly complete.

Illustrating how quickly things change, the 2003 Guidelines did not mention anti-retro-viral therapy (ART), except for post-exposure prophylaxis. Emergency-affected populations were largely excluded from international discourse on ART since it was believed these required stability not always found in such settings. Today, thanks primarily to the efforts of Médecins Sans Frontières, it is now generally accepted that ART is feasible and affordable in emergency settings. Indeed, a recent study showed that compliance is similar to or higher than that in developing countries not in conflict.

UNHCR published its first anti-retro-viral medication policy for refugees in 2007. Access to anti-retro-virals by refugees has increased ever since. At present, approximately 75% of refugees have access to ART when they are available to surrounding host populations. Disturbingly, some countries explicitly exclude refugees from national anti-retro-viral medication programmes. We must work together to ensure refugees and migrants are included in national ART programmes.

Ladies and gentlemen,

The transition from minimum interventions to more comprehensive HIV and AIDS programmes in post-emergency, early recovery and return situations is problematic. Too often, minimum interventions remain in place when more comprehensive programmes are possible. This may be due to a lack of funding, concerns about stability or sustainability, the insufficiency of political will, or some combination of these factors.

UNHCR also frequently encounters the situation where refugees and IDPs return to areas with less infrastructure and fewer resources than those from where they came. This is the case presently in parts of Liberia, Southern Sudan and the Democratic Republic of Congo. It is a major problem. Ensuring the continuity of HIV and AIDS

prevention, treatment and care programmes in early recovery and transition settings is a priority challenge for governments, UN agencies and civil society.

Ladies and gentlemen,

The achievement of meaningful protection is inextricably linked to the adequacy of our HIV and AIDS efforts. Sexual and gender-based violence among people on the move not only increases the risk of HIV transmission but is a violation of human rights. Responding to SGBV is priority throughout UNHCR. Some of the measures which have reduced SGBV for refugees would likely also work in broader migratory movements: participation in the distribution of assistance, provision of sanitary materials, victim-sensitive reporting systems, support for the prosecution of abuses and safe learning initiatives. The discussion of and action upon sensitive issues cannot be swept under the carpet. Differences in cultures and values often used to explain away unacceptable behaviour can no longer be accepted.

Programmes aiming to reduce the stigma and discrimination faced by refugees, IDPs, and migrants need to be implemented at all levels. At the national level, they need to be included in HIV/AIDS National Strategic Plans, policies and funding proposals. Results presently are discouraging. Inclusion of refugees in HIV National Strategic Plans has actually decreased since 2006.

Last year, of 46 countries with refugee populations in excess of 5,000, 32 had National Strategic Plans available for review. Only 9 included specific activities for refugees. Another 9 mentioned refugees but 14 did not. That is to say, nearly 44% of the reviewable National Strategic Plans did not even mention refugees.

A recent examination of Global Fund HIV-approved proposals for countries with more than 5,000 refugees or internally displaced people was equally discouraging. Approximately 68% of the approved HIV proposals made no mention of refugees. Nearly 73% of the approved HIV proposals did not mention internally displaced people.

Clearly, we must do better to ensure that forcibly displaced persons and migrants are included in National HIV Strategic Plans and proposals.

Ladies and gentlemen,

In order to tailor our interventions to HIV vulnerability and risk, we need to “know our epidemic” among different mobile populations. We need better data on HIV vulnerabilities and risk among mobile populations. While this information can be difficult to obtain, innovative efforts have been made and need to be replicated.

In some settings, behavioural surveillance surveys have been adapted to conflict situations and have examined the interactions between displaced persons and their host populations. Some countries have adopted refugee sites as part of their national sentinel surveillance systems.

Multi-sectoral and multi-agency rapid HIV assessments among internally displaced people have taken place in a number of countries, including Nepal, Sri Lanka, Côte d’Ivoire and the Central African Republic. These have led to a better understanding of HIV vulnerabilities and risks among these groups and, consequently, to more targeted and appropriate interventions. These joint, rapid assessments are a first step towards improved HIV coordination and response for internally displaced people. Much however remains to be done.

Ladies and gentlemen,

Shortly after the establishment of the UNAIDS Division of Labour, humanitarian reform led to the creation of the so-called clusters. The clusters were intended to improve the predictability, accountability and inclusiveness of humanitarian response. HIV was characterized as a cross-cutting issue, relevant to all sectors.

One practical result of the creation of UNAIDS and the clusters is that UN actors are simultaneously involved in two processes – two processes that do not speak sufficiently with one another.

Recent missions by UNAIDS and UNHCR to Eastern DRC highlighted gaps in the HIV response in both the UNAIDS Division of Labour and the cluster processes. UNHCR would urge that a clearer structure needs to be agreed upon by UNAIDS co-

sponsors and the Inter Agency Standing Committee to ensure that HIV is adequately addressed in all areas of humanitarian response. Enhanced coordination, communication and technical advice are needed to ensure that IDPs have universal access to HIV prevention, treatment, care and support.

In light of the current global financial crisis, especial efforts will be required by the PCB and UNAIDS to ensure that HIV and AIDS response remain a priority on the global agenda. I am personally very concerned about the negative impact the crisis may have on AIDS response, particularly for women and children and most particularly, for women and children in mobile populations.

Ladies and Gentlemen,

In conclusion, I would like to refer to comments of Michel Sidibé recently in New York. He said that *“Achieving universal access to prevention, treatment, care and support is a human rights imperative.”* This necessarily includes people on the move and I couldn’t agree more.

Thank you very much.