Global Mobility and the Right to Health

An assessment of migrant health care in Norway

Master's thesis in Globalisation – Global Politics and Culture

Faculty of Social Sciences and Technology Management

Norwegian University of Science and Technology

Inger Beate Måren Sundseth

Trondheim, Sør-Trøndelag, Norway

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Abstract

In this Master's thesis I have studied to what degree primary- and moral duty bearers in Norway maintain accountability and fulfil their obligations towards migrants and the right to health, as stated in the International Convention on Economic, Social and Cultural Rights (ICESCR) of 1966.

Theoretical perspectives on global mobility and Rights-based approaches, an outline of the HIV/AIDS epidemic, as well as empirical data provides a basis for the discussion addressing how the Norwegian Government maintain accountability with regards to health care of migrants, and seeking to identify the role of other duty bearers in offering health care services to migrants.

The research methods applied in order to generate data are analysis of text and interviews. I have studied legislation, treaties and official publications. In addition, I have performed two key informant interviews; one with Siv Limstrand, project manager of the Church City Mission in Trondheim's project 'Living with HIV' ('Leve med hiv'), and another with nurse Tove Buchmann in Trondheim Municipality's refugee health team (flyktningehelseteamet).

The thesis concludes that there appears to be an embedded contradiction between legislation, policy and practice. Norway has stated a clear goal to protect, respect and fulfil human rights, both internationally and through the ratification and implementation of human rights treaties into Norwegian legislation. Based on this, they should to a larger extent fulfil their obligations and not restrict the access to medical attention on the part of asylum seekers and irregular migrants. On the part of the other duty bearers included in this thesis, namely the Church City Mission in Trondheim's project 'Living with HIV' and Trondheim Municipality's refugee health team, the thesis finds that they play a vital role in guiding and informing, as well as in administering health care services to migrants in Trondheim

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Abbreviations

ADB – Asian Development Bank

AIDS – acquired immune deficiency syndrome

HIV – human immunodeficiency virus

HRBA – Human Rights-based Approach

ICCPR – International Covenant on Civil and Political Rights

ICESCR – International Covenant on Economic, Social and Cultural Rights

IDU – injecting drug use

ILO – International Labour Organisation

IOM – International Organisation for Migration

MSM – men who have sex with men

NGO – Non-Governmental Organisation

OHCHR – Office of the High Commissioner for Human Rights

RBA – Rights-based Approach

UDHR – Universal Declaration of Human Rights

UN – United Nations

UNHCR – United Nations High Commissioner for Refugees/the UN Refugee Agency

UNAIDS – The Joint United Nations Programme on HIV/AIDS

UNDP – United Nations Development Programme

UNRTF – United Nations Regional Taskforce

WHO – World Health Organisation

1 Introduction

The globalised world is a world of flows, mixture, interconnectedness that transcend the traditional boundaries of the nation state. Processes of globalisation affect everyone, and numerous theories and approaches have been developed as a means of deconstructing and making sense of it all.

The character of population mobility and international migration has been altered and diversified by globalisation processes. Reshaping of economies, political systems and cultures, coupled with developments in communications systems and infrastructure has changed human activity (Gogia 2006: 359; Urry 2000: 62, in Munck 2008: 1229; Wickramasekara 2008: 1251).

Harvey (1989, in Inda and Rosaldo 2008: 8-9) and Giddens (1990, in Inda and Rosaldo 2008: 10-11) apply the concepts of 'time-space compression' and 'time-space distanciation' in order to explain how distance and time no longer seem to constrain human activity, and how the emergence of remote encounters has heightened interconnectedness between the local and the global. As a result, more people are mobile and leave their countries either as refugees or in search of a better life. One of the consequences of global population mobility is an increase in irregular migration, often sparked by economic inequality or social unrest in the migrant's country of origin, coupled with immigration restrictions in developed countries and multinational companies (MNCs) in search of cheap, flexible labour (Wickramasekara 2008).

International recognition and the scope of universal human rights are also connected to globalisation processes. The framework of Rights-based approaches (RBA) is based on international human rights treaties, the first of them being the Universal Declaration of Human Rights (UDHR) of 1948, and the covenants on economic, social and cultural rights (ICESCR) and civil and political rights (ICCPR) of 1966 (Mikkelsen 2005: 201; OHCHR n.d a). Further, the added value of RBA is connected to the concept of accountability, which aims to identify rights holder and duty bearers, as well their various entitlements and obligations (Yamin 2008: 1-2; UN and OHCHR n.d.).

RBA to health is critical in order to address global health inequalities, exclusion and marginalisation (London 2008: 65-6). In order to realise health for all, RBA provides a framework aimed at holding governments, as primary duty bearers, accountable so they fulfil their obligations towards human rights. Further, RBA is a framework for developing policies and programmes in order to operationalise human rights in development work, securing redress in case of human rights violations and mobilising moral duty bearers (London 2008: 70).

According to Ottesen (2008: 31), the increase in global mobility flows and the implications this has on human rights is a global reality we cannot distance ourselves from.

1.1 Background of the research

Globalisation and its implications on population mobility and the spread of infectious disease create a need for addressing the factors contributing to the heightened risk and vulnerability of mobile populations and how to redress these factors. "The link between mobility and HIV/AIDS is related to the conditions and structure of the migration process, poverty, exploitation, separation from families and partners and separation from the socio-cultural norms that guide behaviours in stable communities" (Redpath 2004: 297), in addition, migrants frequently come from parts of the world with a high HIV prevalence, so it is possible that they are already HIV positive (Den Norske Legeforening 2008: 48).

The development of universal human rights and frameworks such as RBA is one potential tool for holding duty bearers accountable to their obligation to respect, fulfil and respect human rights with regards to migrants and health care (Gready and Ensor 2005: 12; Mikkelsen 2005: 202-3; Seppänen 2005: 23, 25).

In concordance with the changing character of population mobility and growing international migration, official immigration statistics show that immigration flows into Norway have increased in recent years. Figures from the Norwegian Ministry of Labour and Social Inclusion (Arbeids- og inkluderingsdepartementet) (2008: 5) show that there were 44,300 registered non-Nordic immigrants to Norway in 2007, an increase from 29,500 in 2006. The majority of

immigration is related to work or non-Nordic family-related immigration. Further, net-immigration into Norway has risen from 25,000 in 2006, to 40,200 in 2007 (Norwegian Ministry of Labour and Social Inclusion 2007: 5; Norwegian Ministry of Labour and Social Inclusion 2008: 5).

There has also been an increase in the number of registered asylum seekers to Norway, from 6,530 asylum seekers in 2007 to 39,630 in 2008 (UNHCR 2009a: 5). The UN Refugee Agency (UNHCR) ranks Norway in 10th place on the overview of main receiving countries, a ranking based on the total number of asylum claims[1] (UNHCR 2009a: 7). However, Norway is in 6th place on the UNHCR ranking of number of asylum seekers per 1,000 inhabitants. This ranking shows that from 2004 - 2008 there were 8.2 asylum seekers per 1,000 inhabitants in Norway (UNHCR 2009a: 9).
Regarding estimates of the number of irregular migrants in Norway, it is impossible to present exact figures. However, estimates range from 5,000 – 10,000 (Den Norske Legeforening 2008: 53) to an estimate of 30,000 irregular migrants (Zhang 2008: 3).

A current issue in Norway regards the providing of health care services to irregular migrants. In 2008, the Church City Mission (Kirkens Bymisjon) published a report named ‘Undocumented migrants’ (‘Papirløse migranter’). One of the aims of the report was to explore the situation of people without legal residence in Norway. The report concludes that the Church City Mission should contribute in identifying the needs of irregular migrants in Norway, as well as initiate “humanitarian action” to meet those needs (Ottesen 2008: 34).

The Norwegian Medical Association (‘Den Norske Legeforening’) also addresses the issue of migrant health care in their health politics report which questions the equality in access to health care services (Den Norske Legeforening 2008). The health care of irregular migrants was also addressed in the Official Norwegian Report (NOU 2008: 14) ‘Coherent for development?’ (‘Samstemt for utvikling?’). The Committee’s initiative seven states that irregular migrants

[1] Figures from 2008

should be entitled to basic health services beyond acute medical attention, and that humanitarian aid to irregular migrants should be legalised (NOU 2008: 14: 145).

Norway has a strong commitment towards human rights. This commitment has been shown through the ratification of the ICERCS and the ICCPR, and the subsequent implementation of the Conventions into Norwegian legislation through the Human Rights Act (Menneskerettsloven 1999). This means that Norway has committed to securing "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (OHCHR n.d. b). However, in the Act on Rights of Patients (Pasientrettighetsloven 1999) §2-1, cf. §1-2, only the access to acute medical attention is mentioned. In addition, in the Guidelines for health care services for asylum seekers and refugees ('Helsetjenestetilbud til asylsøkere og flyktninger') published by the Norwegian Directorate of Health it is stated that asylum seekers are not to be put on long-lasting and comprehensive treatments while their asylum application is still being considered (Sosial- og helsedirektoratet 2005: 15).

My own motivation for studying the topic of global mobility, human rights and the HIV/AIDS epidemic stems from my internship at the Asian Institute of Technology (AIT) in Bangkok, Thailand. In the third semester of the Master of Science in Globalisation Programme all students undertake an internship in a global organisation, company or institution located abroad. During my stay at AIT I completed a report on mobility and the HIV/AIDS epidemic in the Mekong Region, which formed the basis for my choice of topic for the master's thesis. The choice to apply RBA as a means of addressing the topic was partly influenced by the current debate in Norway regarding irregular migrants and their human rights.

1.2 Aims and research questions

The thesis seeks to provide an overview of relevant theories and concepts regarding universal human rights and global mobility, and to outline how the theories and concepts relate to the spread of infectious diseases. More specifically I will explore to what degree primary- and moral duty bearers in Norway maintain accountability and fulfil their obligations towards regular and irregular migrants and the right to health as stated in the International Covenant on Economic,

Social and Cultural Rights (ICESCR) of 1966. With a distinct focus on duty bearers, examining the issue from the perspective of rights-holders is beyond the scope of this thesis.

Based on these aims, the thesis seeks insights into

What degree the Norwegian Government fulfils its obligations towards human rights with regards to health care of migrants

The overall research question addresses

How does the Norwegian Government apply these rights (maintain accountability) with regards to different types of migrants, both regular and irregular migrants?

Having outlined and assessed the human rights obligations and fulfilment of the Norwegian Government, I also see the need for identifying

What is the role of other duty bearers in offering health services to irregular migrants in Norway?

More specifically, by examining

How does the Norwegian Government at the municipal level manage migrant health care? – Case of the refugee health team (flyktningehelseteamet) in Trondheim

What is the role of voluntary organisations with regards to migrants, health care and rights? – Case of the project 'Living with HIV' ('Leve med hiv') in Trondheim?

The main part of the analysis will build on text as a means to get insight into Government law and practice. Key informants for the interviews have been selected among moral duty bearers because voluntary organisations seem to have made it their moral agenda to secure and fulfil migrant's right to health care.

To address the research questions I will apply qualitative methods as a means of generating data. More specifically, the methods will consist of analysis of text and semi-structured interviews of key informants.

1.3 Outline of study

The thesis consists of an introduction, three main parts regarding methods, analytical framework and analysis, before it is concluded by a thesis summary, conclusions and recommendations.

The first main part of the thesis regards research methods. First, qualitative methods and the concept of data are presented, before the thesis outlines the methods applied. After outlining the methods I will focus on the interview process, from the selection of informants to conducting the interviews. Further, a section on data analysis is included. Last, the ethical issues as well as the strengths and limitations of the methods applied will be reviewed.

The next part of the thesis concerns the analytical framework. First, theory on global mobility is outlined and conceptualised. Second, rights-based approaches (RBA) are explored and conceptualised. Thirdly, the HIV/AIDS epidemic is sketched out and the connections between global mobility and the HIV/AIDS epidemic are summarised. Last, the chapter is concluded by 'my analytical approach', where I connect the various theories and concepts of the analytical framework chapter and present my model for analysis.

The third of the thesis' main parts consist of the analysis, and it is divided into two sections. The first section concerns empirical data presentation; from the International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966, Norwegian legislation on human rights, and Norwegian policy on providing health care to asylum seekers and refugees. In the second section the research questions are discussed, based on the model for analysis and empirical findings.

Last, the main aspects of the thesis are summarised, and the thesis conclusions and recommendations are presented.

The thesis concludes that there appears to be an embedded contradiction between legislation, policy and practice. Norway has stated a clear goal to protect, respect and fulfil human rights, both internationally and through the ratification and implementation of human rights treaties into Norwegian legislation. Based on this, they should to a larger extent fulfil their obligations and not restrict the access to medical attention on the part of asylum seekers and irregular migrants. On the part of the other duty bearers included in this thesis, namely the Church City Mission in Trondheim's project 'Living with HIV' and Trondheim Municipality's refugee health team, the thesis finds that they play a vital role in guiding and informing, as well as in administering health care services to migrants in Trondheim

2 Methods

The purpose of this chapter is to outline the methods I have chosen to gather information and data in order to best answer the research questions, and the various decisions I have made throughout the process of completing the thesis. First, I will briefly outline the nature of qualitative methods and why I chose to apply qualitative methods in the research for this thesis. Second, I will explore the concept of data. The third part of the chapter regards the methods of data collection used to generate data for the thesis, namely analysis of text and interviews. Fourth, I have outlined some of the issues regarding analysis of the data generated, and fifth, I consider the ethical issues of the methods applied. Last, I will attempt to investigate the strengths and limitations of the methods used in the research for this thesis.

2.1 Qualitative methods

Qualitative methods are flexible, which means the researcher can work with the different parts of the research process simultaneously. The essential qualities of qualitative methods are the focus on process and meaning, analysis of text as opposed to data, the close relationship between the researcher and the informants, and small samples which allow the researcher to go in depth (Thagaard 2002: 27).

The process is divided into different phases: the formulation of the research questions, the data generation process and analysis and interpretation of the data generated. However, the researcher can go back and forth between the different phases. For instance, qualitative methods allow the researcher to modify the research questions throughout the whole process. In addition, the researcher can initiate the data analysis at an early stage, and not only towards the end of the research process (Thagaard 2002: 27).

My decision to apply qualitative methods in this thesis has its basis in the research questions. Analysis of text is the main method, but throughout my work on the thesis I decided to apply interviews as a complement to the analysis of documents. This was done in order to get additional information and data.

2.2 Data

Lindsay (1997: 21) states that "data are the materials from which academic work is built", and that they have two universal characteristics: Data are both selected and shaped with the purpose of the research in mind. From a researcher's point of view, it is important to be aware of both the conscious and the unconscious elements of data generation. We cannot view data as absolute and objective truths that are available for researchers to harvest and apply as they wish, but rather as something created within a certain context and whose validity needs scrutinising.

As a means of classifying and assessing it is useful to divide data into categories of primary, secondary and tertiary data (Lindsay 1997: 22-3). Primary data generation, for instance through interviews, are collected directly by the researcher and for a specific purpose. Secondary and tertiary data are sometimes hard to distinguish. However, they both provide a context for interpreting and handling the primary data. Secondary data are for instance research papers containing primary data, while tertiary data often discuss secondary data.

2.3 Analysis of text

As O'Leary (2004: 66) points out, "the production of new knowledge is fundamentally dependent on past knowledge". To work with literature is an essential part of any research process, from the formulation of the research questions and the background and aims of the study to the discussion and conclusions. In order to find the appropriate literature and make it work for your research purposes, you have to attain knowledge on where to find the literature, what to search for, and how to classify and treat it. Throughout this thesis I have followed a four stage process of finding literature, managing the literature, using the literature and reviewing the literature (O'Leary 2004: 67).

During the first stage of the process I searched for literature in the available search engines and library databases using broad terms and key words associated with the field of research I was to write my thesis. Having done a broad literature study on a similar topic during my internship the

previous semester, I had a general idea of where to search for literature and what key words to use in order to generate the highest number of relevant hits. When doing this I also made sure to read the references of the texts I located in order to further widen my scope.

The second stage deals with managing the literature found, and throughout this stage I read the various texts found and after doing so I classified them and started writing up my references in order to keep track of them.

The third and the fourth stage somewhat overlap. However, during these stages I further developed my research questions as well as attempting to ensure that I had sufficient coverage in the literature I had found and applied. At the same time, I conducted the interviews, these two methods of generating and handling data became to some degree intertwined.

Throughout the process of generating and applying texts in research, the researcher has to consider the propriety and quality of the data generated. To ensure this, I have assessed the texts based on their type. O'Leary (2004: 67-8) divides literature into discipline-based reference materials, subject specific books, journal articles, grey literature, official publications and writing aids. In this thesis I have mostly applied subject-specific books, journal articles, grey literature and official publications.

Subject-specific books are good for background and context. However, the most contemporary research is not likely to be found in books as they take a long time to edit and print. In this thesis I have applied various anthologies and research reports, as well as introductory and advanced texts to form a foundation for theory and methods.

Journal articles often present research that is current and up to date, and I have particularly used journal articles in order to get an overview over the recent developments in the relevant fields of research.

The grey literature I have applied are mainly reports, working papers, theses, government documents, fact sheets and the like, and have mostly been downloaded from the internet. The

major part of the grey literature has been accessed from the websites of various United Nations (UN) institutions, the World Health Organisation (WHO) website, as well as websites of the Norwegian Government and the central government administration.

Last, I have employed several official publications such as the UN's 1951 Convention Relating to the Status of Refugees and the ICESCR of 1966.

2.4 Interviews

O'Leary (2004: 162) defines interviewing as "a method of data collection that involves researchers asking respondents basically open-ended questions". A research interview is characterised by the researcher always being conscious about the manner the questions are asked and the interaction between the researcher and the informants, as well as a critical though towards the data generated through the interview (Kvale 2001: 31). Further, interviews are reproductions of previous events, and the interview is thus influenced by the informant's understanding of those particular events (Thagaard 2002: 83). The data generated through interviews are both regarded as a representation of the outside world and the way in which the informant understands his/her experiences.

I chose to perform key informant interviews to complement the analysis of text. I wanted to generate primary data as a means of exploring how aspects related to my analytical approach and research questions are perceived by stakeholders.

As a researcher, you have to make a decision of what type of interview best suits the research questions. In structured interviews the researcher has prepared a set of pre-established questions that are in a set order. Semi-structured interviews are more flexible than structured interviews and as the name suggests the questions are planned, however, the researcher is open to pursue interesting chains of thought brought up by the informants. A researcher conducting an unstructured interview will have laid out the theme of the interview without presenting the informant with any planned questions (Thagaard 2002: 84-5; O'Leary 2004: 164).

My initial thought when planning the interviews was to conduct semi-structured interviews where I would make an interview guide in order to have some structure to the interview[2]. Also, I wanted to be as prepared as possible in order to appear professional as a means of putting my informants at ease and to best inform them about the research I was conducting and their role within it. However, in retrospect, I see that the interviews were actually more structured in style. The questions were asked in their initial order, although I had room for follow-up questions if the informants mentioned issues I wanted to pursue further. Also, I noticed that the number of questions I had planned in the interview guide contributed to the more structured style of the interview. It appeared to me during the interviews that my informants expected me to ask them the questions as opposed to me simply suggesting over arching subjects for them to discuss. The result was that I feel I became more involved in the interview. Last, the interviews ending up more structured is perhaps also a result of my inexperience with interviewing as a method for data generation.

2.5 The interview process

The interview process consists of a number of steps where the ultimate goal is to generate data the researcher can make use of as primary data in order to help answer the research questions. In chapter 2.5.1 and 2.5.2 I will explore the interview process with regards to this thesis, from the selection of informants, via contacting the informants, and finally to the conducting of the interviews.

2.5.1 Selecting the informants

In order to select informants for the research conducted in this thesis, I used my research questions as a starting point for identifying key informants. I wished to interview persons who represent expertise within the concept of duty bearers, as I apply the concept in the thesis. According to O'Leary (2004: 109), strategic selection of key informants[3] has been viewed as

[2] See appendix 1 and 2 for interview guides

[3] O'Leary (2004: 109) refers to this as non-random sampling

inferior because they cannot be statistically assessed for representativeness. However, to be able to have the results of data generation statistically assessed is not always the goal in research, particularly not in qualitative research. It can be just as credible depending on the purpose for which the data is to be used. In the case of this thesis, the purpose of the interviews conducted was to get access to complementary data (in addition to the literature already found) and thus I chose to interview key informants who are also professionals in their field.

During the data generation process I have attempted not to choose my informants by means of what I believe their opinions are, and instead opted to select informants on the basis of their position as duty bearers as related to the theory I am applying in the thesis. However, I do recognise that my informants may be more positive towards migrants and/or marginalised persons in comparison to others, because of their professions and the fact that they work closely with migrants and marginalised groups on a daily basis.

When deciding on key informants I used my research questions as a starting point and ended up interviewing informants from the refugee health team (flyktningehelseteamet) in Trondheim Municipality and the Church City Mission in Trondheim's project 'Living with HIV' ('Leve med hiv') as they are important stakeholders when it comes to the topic of this thesis, which is global migration and health (in this case the HIV/AIDS epidemic).

I used snowballing as a means of getting in touch with my second informant (Thaagard 2002: 54; O'Leary 2004: 110). I asked my informant early if she knew of persons working in Trondheim Municipality, and within the field of immigration and/or health. She then gave me the name and number of my second informant, who works as a nurse providing health care to refugees coming to Trondheim.

To try and ensure that I would not select an informant based on unwitting bias, that is when the researcher unwittingly acts in a manner confirming what the researcher suspects will be the conclusion of the study (O'Leary 2004: 109), I held firm on the notion that I was to interview persons with expertise on the field I was researching. In addition, when a researcher applies

snowballing it is important to consider the potential bias on the part of the first informant, and that they will refer you to someone who shares the same views and opinions as they do.

The first informant I contacted was the project ‘Living with HIV’ run by the Church City Mission in Trondheim. After first having sent an e-mail outlining the topic of the thesis and informing her that I would later contact her by phone, I called the project manager Siv Limstrand, and asked her if she was available for an interview. The interview was set for 18 March 2009 in the offices of ‘Living with HIV’.

Siv Limstrand informed me about the background of ‘Living with HIV’ during the interview, and in addition she gave me a pamphlet written by the project to provide me with further information. In 2003, the Church City Mission in Trondheim initiated a seminar in order to uncover and discuss the situation of people living with HIV in Trondheim and the greater region. Through the allocation of funds from the national fundraising-campaign (‘TV-aksjonen’) in 2004, the Church City Mission established the project ‘Living with HIV’. The vision of ‘Living with HIV’ is to help, support and guide all that are affected by HIV through prevention, communication, work against stigma, and by acting as a meeting place.

I contacted my second informant, health nurse Tove Buchmann in Trondheim Municipality’s refugee health team, via telephone and told her that Siv Limstrand had referred me to her as a possible informant. First, I briefly outlined the topic of my thesis to her, and second, I asked her if it was possible to set up an interview. We agreed to for me to come and interview her 26 March 2009 in the offices of the refugee health team.

Tove Buchmann summarised the background of the refugee health team, saying that it dates back to 1988, when large groups of refugees arrived Trondheim. In order to provide necessary health services, Trondheim Municipality decided to start a health team specifically aimed at newly arrived refugees and already resident refugees. The refugee health team’s primary responsibility is to carry out health examinations based on Guidelines (‘veileder’) published by the Norwegian Directorate of Health (Sosial- og helsedirektoratet 2005). I will further outline the Guidelines in chapter 4.1.3.

2.5.2 Conducting the interviews

When conducting interviews, the researcher has to make a choice of how to record what is being said in the interviews. The researcher can apply for instance a tape recorder, a videotape recorder, write notes by hand or simply memorise the interview. During the pre-interview preparations, I decided on note taking, tape recording or a combination of both in order to record the interviews.

Thagaard (2002: 97) outlines the positive and negative aspects of taking notes during the interview versus applying a tape recorder. A tape recorder gives the interview a sense of formality and the interviewer ensures that everything the informant says is stored. The amount of data that the use of a tape recorder leads to can be viewed as being both positive and negative. Positive in the sense that you get rich data for your analysis, and negative because the amount of data accumulated can seem insurmountable to the researcher. Further, a tape recorder cannot store the visual aspects of the interview, such as facial expressions or the body language of the informant, and in addition, informants may be hesitant towards responding to certain questions when a tape recorder is used (Kvale 2001: 101; Oliver 2008: 117). In the case of note taking, Thagaard (2002: 97) states that the amount of data accumulated during the interview is reduced, and in addition, the interviewer performs part of the analysis while taking notes by deciding what to write down and what to leave out. On the other hand, note taking may lead to less rich data, and it can be a challenge to keep focus during the interview when writing, listening, posing questions and observing all at the same time.

After having considered these aspects, I decided to apply both tape recording and note taking as a means of recording the interviews. I wanted to take notes as to start the data analysis process and reduce the amount of data, and the tape recorder would ensure that I would not miss anything the informant said during the interview. In addition, having recorded the interview would make it easier to use direct quotes when writing the analysis. Before starting each interview, I asked the informants if they had any objections towards me using a tape recorder

during the interview. After considering my question for a couple of seconds, the informants told me they accepted the tape recording.

During the process of transcribing the interviews I combined the notes I had taken during the interview with the tape recordings. In order to minimise the amount I had to transcribe, I used the notes to write down what I regard as the essentials of the interview. Throughout the interviews I had not only made notes of what the informants said, I noted down the point in time of important information I could later use as quotes. This was a means for me to easily find the answers I deemed most interesting when it was time to transcribe the interviews.

2.6 Data analysis

Text analysis is my main method of analysis. During the literature search and literature study I read and classified the literature I had procured. I spent a large amount of time interpreting legislation and other empirical data, and trying to assure that my understanding and interpretation, and later the application of the literature in the thesis, would be as correct as possible. As the analysis of texts advanced, I decided to interview key informants as a means of strengthening the data.

An additional note regarding the data analysis concerns translation of interviews and texts. A source of potential bias when translating text and speech from one language to another, as I have done during my work on this thesis, is the risk of altering or losing some of the meaning in the text and/or speech. Regarding the interviews I have submitted some of the translated data to the informants for approval of the translation, as for the texts I spent time ensuring the quality of the translations. In addition, references and links to the original texts are to be found in the reference list.

2.7 Ethical issues

The relationship between researcher and informant is important in qualitative research, and it is therefore crucial that there are ethical guidelines in place who define this relationship (Thagaard

2002: 21). The researcher gets access to personal and often sensitive information about the informant and the researcher thus has certain responsibilities towards the informants. The concept of informed consent is such a responsibility. Informed consent obligates the researcher to ensure that the informants are made fully aware of the nature of the research and their role within it (Silverman 2005: 258; Oliver 2008: 115-6).

My informants were made aware of the research questions and the principal aim of the thesis, and I told them that they at any time could withdraw from the research if they should choose so. In addition, I informed them that I would be writing the thesis in English, and that I would submit any direct quotes I wished to use in the thesis for them to approve.

In addition to informed consent, anonymity and confidentiality is an important aspect a researcher has to consider when applying qualitative methods. Anonymity refers to the informant not wanting his/her name to be revealed in the final research publication. Confidentiality is a question of who has access to the data provided by the informant (Oliver 2008: 116). In the case of anonymity and confidentiality it is vital to make the informant aware of the concepts, so that he/she can make a decision on for instance whether or not they wish to have their name revealed in the final research thesis.

Before each interview I informed the informants of their right to remain anonymous. Siv Limstrand, the project manager of the Church City Mission project ‘Living with HIV’, agreed before the interview to have her name and position released in this thesis, while Tove Buchmann, nurse in the refugee health team in Trondheim, agreed to have her name released after having discussed this with her colleagues. Both of the informants wished to approve direct quotes attributed to them in the final thesis.

Regarding the issue of confidentiality, both informants were made aware that I was writing a master’s thesis at NTNU and that the research thus would be published.

2.8 Assessing the strengths and limitations of the methods applied

At some point in the thesis, it is important to review the overall success of the research design and of the applied strategy of research: “We tend to select the methodology on a number of grounds, including the nature of the aims and our judgement about the extent to which data of a certain kind may be available” (Oliver 2008: 118). As a researcher I also have to reflect on the ways in which the methods chosen could have been amended or altered.

First, what I would have done differently with the methods I applied, and knowing what I know now? The thing that comes to mind when considering this question is that I would have included more questions in the interview guides as a means to generate more data, and on the other hand, there are other parts of the interview guides I would have shortened. Also, I see that I would have gotten more information without extending the time of the interviews if I had kept the interviews tighter and had been better at keeping the informants on track. I see that I occasionally let them talk too much outside what was the topic of the interview, and my lack of experience in interviewing was the main reason for that.

Second, what would I have done if I were to start all over again? This is a hypothetical question and my answer is that I would have performed more interviews and perhaps chosen to interview duty bearers outside Trondheim. As for the methods applied, I am unsure if I would have opted for other methods, as I find them suitable for a thesis of this scope, length and objective.

In order to expand on what I would have done if I were to start again, I could have had more informants if the time and means had allowed for it. In that case I would have travelled to Oslo to interview the Church City Mission there (and other organisations operating within the scope of the thesis) and the Oslo equivalent to the refugee health team.

I acknowledge that Trondheim is a smaller city than Oslo, with fewer migrants and fewer people living with HIV, however, it was interesting to explore the situation in Trondheim with regards

to my research topic. Also, Trondheim is a large city in Norway, and thus the research done here may be applicable for instance to other Norwegian cities.

3 Analytical framework

In this chapter I will outline the analytical framework for the thesis. The chapter starts with a short conceptualisation of globalisation, followed by a part on global mobility where the various theories and concepts are explored. Second, I will investigate Rights-based Approaches, focusing on the background, concepts and basis of the approach. The third part of the analytical framework deals with the connections between global mobility and the HIV/AIDS epidemic. Last, the chapter is concluded by my analytical approach, where I connect the various theories and approaches outlined throughout the chapter in order to form a basis for the chapter on analysis.

3.1 Globalisation – tying it all together

Globalisation is a multi-faceted concept which has sparked an array of theories and approaches aiming at deconstructing and making sense of processes that are taking place in the world today. A globalised world is a world full of flows and mixture, contact and linkages, a world where processes operating at a global scale transcends national boundaries and connect cultures and communities (Inda and Rosaldo 2008: 4, 6). These linkages and flows are "making the world in reality and in experience more interconnected" (Hall 1996: 619, in Inda and Rosaldo 2008: 6).

3.2 Global mobility

Globalisation has affected the character of population mobility and international migration: the processes of globalisation reshape economies, political systems and cultural parameters, resulting in "massive, hard-to-categorise, contemporary migration, often with oscillatory flows between unexpected locations (...) [a series] of turbulent waves, with a hierarchy of eddies and vortices" (Urry 2000: 62, in Munck 2008: 1229). Further, communications systems and infrastructure development enables people to commute between home countries and destination countries, or within countries, without pressure for settlement. In addition to this, there is a diversification in mobility flows, with individuals crossing borders for work, leisure, safety and security (Gogia 2006: 359; Wickramasekara 2008: 1251). As Munck (2008: 1229) puts it, in an era of

globalisation, the mobile individual becomes the symbol of fluidity, impermanence and complexity.

The UN estimates regarding the number of people living outside their country of origin ranges from 120 – 190 million. The International Labour Organisation (ILO) estimate that there are 70 – 80 million labour migrants in the world today (ILO n.d: 1; Munck 2008: 1229; Wickramasekara 2008: 1248). Further, UNHCR state that the world refugee population amounted to 11.4 million people in early 2008. Last, the number of people of concern[4] to UNHCR totalled 31.7 million in 2008 (UNHCR 2009b: 30).

Harvey (1989, in Inda and Rosaldo 2008: 8-9) and Giddens (1990, in Inda and Rosaldo 2008: 10-11) have theorised this increased interconnectedness as it relates to changing notions of time and space coupled with alterations in human activity.

Harvey coined the term “time-space compression” to explain what he argues is a manifestation of the changing experience of time and space: distance and time no longer seem to constrain human activity. Shrinking of space coupled with a shortening of time, both in economic and social life, has reduced the once set links between time and space.

Giddens has what is viewed as both a complementing and contradicting argument to Harvey’s time-space compression. Giddens’ notion “time-space distanciation” concerns the stretching of social life across time and space. Face to face contact, manifested as interaction in bounded local spaces, is now increasingly being replaced by remote encounters. Giddens attributes these remote encounters as being enabled by global transport and communications systems, and he argues that social relations now are disembedded from local contexts of interaction and rearranged across extensive spans of time-space. Globalisation accelerates this disembedding, and the result is heightened interconnectedness between the local and the global because what happens in one part of the globe increasingly is a result of occurrences in a different part of the globe.

[4] ‘People of concern’ include refugees, internally displaced people (IDPs), stateless people, returned refugees and IDPs, asylum seekers and ‘others of concern’ to UNHCR (UNHCR 2009b: 30)

As a result of this, physical distance becomes less significant for deciding where to go and where to live (Harvey 1990, in Frändberg and Vilhelmson 2003: 1756). Frändberg and Vilhelmson (2003: 1754) link the theories of Harvey and Giddens to growth in long distance mobility, and Amin (2002: 385) explains place and space as being associated with raised global connectivity. Amin argues that flows of people, goods, ideas and information are results of rapid communications and infrastructure development.

Globalisation has forced a change in theories on global mobility and migration: traditional migration theories were largely economistic and the main approach for explaining migration was the push-pull theory. The push-pull theory is based on neoclassical, reductionist notions of the rational individual that migrate from one place to another for economic reasons (Munck 2008). This theory has been criticised for being one-dimensional and fail to grasp the complexity and often contradictory nature of human migration. Munck (2008: 1230) argues that push-pull theories are inadequate in explaining why people migrate for reasons beside economic ones, as well as why some countries experience more emigration than others.

More recent theories cover several aspects of the migration process, and it thus becomes clear that one can no longer rely on one grand theory of migration. Migration networks, family and household theory, and an increase in focus on flows and cultural hybridity are characteristics of today's attempts to theorise human mobility. Migration networks refer to the contact between migrants and those left behind, and it is argued that this information network builds social capital and that it drives further migration (Munck 2008: 1230). This notion is intimately linked to Giddens' and Harvey's notions of time-space distanciation and time-space compression. Migration networks are manifestations of remote encounters, as well as a shrinking of time and space. The household is the main decision-making unit in family and household theory, thus it distances itself from the rational individual migrant of the push-pull theory (Munck 2008: 1230). Family and household theory views migration as a means of diversifying income and spreading risk. This can be viewed as a result of processes of globalisation as one household seldom can rely solely on subsistence agriculture for their survival, and subsequently the need to diversify household income occurs.

With globalisation, there has emerged a body of theory engaged with the effects of heightened global mobility, as opposed to earlier theories whose main focus was on the reasons for migrating. Diasporas and the complexity of migrants have become important fields of study, and they show that migrants are not a homogeneous group and migrant flows become increasingly diversified. Gender, class and ethnic differences between migrants and mobile populations add to the complexity of global migration. For instance, female migrants are more likely to work in the informal sector, which often leads to difficulty in gaining language skills and accessing social networks which are vital in achieving social inclusion (Munck 2008: 1233). Munck (2008: 1234) points out that migration restructure traditional gender divisions of labour, households and communities. The sense of belonging and the process of identity formation are radically altered through heightened global mobility: shifting places lead to new, complex forms of gender- and ethnic identity.

3.2.1 Conceptualising mobility and migration

Generally, the concept of mobility is wider than the concept of migration. According to ILO, migrants are a sub-set of mobile people, and they suggest using duration of stay, patterns of movement, sector of employment, skill levels and legal status as a means to categorise migrants (ILO n.d: 1). The UN recommendations on migration statistics suggest to define a migrant as someone who lives at least one year outside their usual country of residence, whereas short-term migrants are defined as those living at least three months outside their usual country of residence. This means that the UN recommendation does not cover other flows of mobile people such as frontier workers, people who enter a country for a shorter period of time than three months, and seamen (ILO n.d).

However, the UN does not operate with one definition of migration: the 1990 UN Convention on the Protection of the Rights of all Migrant Workers and Members of Their Families laid out a broader definition than that of the UN recommendations on migration statistics. The 1990 Convention includes all people who cross borders, more specifically “a person who is to be engaged, is engaged, or has been engaged in remunerated activity in a State of which he or she is not a national” (ILO n.d: 2). The problem with this definition is that it does not include mobile

people who are internal migrants or stateless, and it is inadequate with regards to migrants who are engaged in the informal sector or criminal activity.

In addition, refugees need to be included in a discussion on the concept of mobility. The term *refugee* was internationally established by the UN's 1951 Convention Relating to the Status of Refugees, which states that a refugee is a person currently outside their country of nationality as a result of persecution for race, religion, nationality, membership in a particular social group or political opinion (UNAIDS and IOM 1998: 447; UNHCR 2009b: 4).

UNAIDS define mobile people as "those who move from one place to another temporarily, seasonally or permanently for a host of voluntary or involuntary reasons" (ADB n.d: 8). This definition is further specified by Hannam et al. (2006: 1, in Gough 2008: 244) who divide between large-scale movements of people, goods, capital and information across the globe, and local processes of daily mobility and movement through public space. In addition, UNAIDS and IOM (1998: 446) build on the concept of migration, and suggest that voluntary, economic migrants, refugees, displaced people, as well as individuals who move for other compelling reasons should be labelled migrants[5].

3.2.2 Irregular migration

Irregular migration is a concern with regards to global mobility (Wickramasekara 2008). There are several factors contributing to the increase in irregular migration, and these factors render a complex and unclear picture. Immigration restrictions on low-skilled and un-skilled workers when there is strong demand for such labour results in irregular migration, and the effect of this are abuse and human rights violations.

Globalisation further complicates the picture, with multinational companies being forced to bend rules and employ cheap flexible labour in the face of tough international competition. According

[5] When applying these definitions mobility and migration become close to synonyms, therefore these concepts may sometimes be used interchangeably. However, the author point out that mobility is used as a wider term than migration in this thesis.

to Sutcliffe (1998: 331-3, in Munck 2008: 1239), “human rights are at their weakest in the vicinity of frontiers (...) Injustices gather like vultures around frontiers”. The UN High Commissioner for Human Rights elaborates on this claim, saying that irregular migrant’s human rights are endangered in all stages of the mobility system (Wickramasekara 2008). In addition, global economic inequality, refugees who are not granted status as asylum seekers and human trafficking are all factors that inspire and contribute to irregular migration.

Researchers apply different concepts when attempting to explain irregular migration, for instance ‘illegal migration’, ‘unauthorised migration’, ‘clandestine migrant’ and ‘undocumented migration’. These concepts are interrelated, however, they are distinguishable.

PICUM (Platform for International Cooperation on Undocumented Migrants) lists three reasons why irregular migrants should not be labelled ‘illegal’ (PICUM n.d.). First, referring to illegality suggests that a criminal offense has taken place. PICUM states that being in a country without papers is not a criminal offense in most countries. Second, no person is illegal, and applying the term ‘illegal’ can thus be regarded as denying people their humanity. Third, PICUM states that asylum seekers may have their asylum claims jeopardised when they are being referred to as ‘illegal’ because the political climate in the relevant country will become more intolerant.

The concepts ‘unauthorised’ and ‘clandestine’ both signify something unlawful and disguised, which arguably puts them in the same category as the concept ‘illegal’ in that their meanings are both value laden and connotative.

‘Undocumented migrant’ is a concept which suggests that a person is staying in a country without a residence permit or a visa. PICUM (n.d) states that a person is an ‘undocumented migrant’ if he/she has been unsuccessful in the asylum procedure, overstayed his/her visa or entered the country irregularly. Ottesen (2008: 6) elaborates on this concept by including people whose residence permit has expired and people who have obtained a visa or a residence permit falsely.

Düvell (2006: 15-6) operates with six categories of irregular migrants, who in a more satisfactory way uncover and explain the complexities of irregular migration. First, migrants are considered irregular if they are working without a work permit, although they have entered the country regularly and hold a valid residence permit. Second, a migrant is irregular if he/she has entered a country regularly, but is staying without a valid work- and/or residence permit. Third, migrants who have entered a country regularly, is economically inactive and who does not qualify for family reunification are classified as irregular. The fourth category of irregular migrants is those who have entered a country irregularly, who have no residence permit and work without a work permit. The fifth category includes migrants entering a country irregularly, staying without a residence permit, but who is economically inactive. Last, a migrant is irregular when he/she has entered a country irregularly and works without a work permit, but who has obtained a residence permit.

In this thesis, the concept ‘irregular migrant’ is applied. When the concept ‘undocumented migrant’ is defined as broadly as mentioned in the previous paragraph I find it more useful to apply the concept ‘irregular migrant’. The reason for this is the broad and more academic nature of the concept ‘irregular’, as it does not refer to something value laden to the same degree as the concepts ‘illegal’, ‘unauthorised’ or ‘clandestine’ suggests, or potentially confusing or misleading, as the concept ‘undocumented’ implies.

3.3 Rights-based Approaches

Rights-based approaches (RBA) are founded on the principle that all people have both moral and legal entitlements to human rights, and that they serve as social and political guarantees from infringement of those rights on the behalf of modern states and modern markets (Mikkelsen 2005).

The Office of the High Commissioner for Human Rights (OHCHR) define RBA as a “conceptual framework for the process of human development that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights” (Seppänen 2005: 21; UN and OHCHR n.d).

3.3.1 Background of the approach

RBA is considered a novel approach among development policies. However, the approach has historical analogies. The notion of human rights has their roots in the colonial era, and the first concrete documents referring to natural law and rights of people were the US Declaration of Independence of 1776 and the French Declaration of the Rights of Man and the Citizen of 1789 (Gready and Ensor 2005: 10-5; Seppänen 2005: 2). These declarations were the first step towards a claim that all human beings are free and equal, and subsequently, this claim laid the basis for a change in the relationship between the individual and the state that earlier had been characterised by the rights of the ruler and the duties of the subjects.

In the aftermath of World War II, the stage was set for what Gready and Ensor refer to as 'the second human rights revolution' (Gready and Ensor 2005: 5). This human rights revolution was marked by the establishment of the UN and the adoption of the Universal Declaration of Human Rights in 1948.

The processes of globalisation have largely contributed to this wide acceptance and spread of human rights. First, the Enlightenment notion of natural law and rights of people is preserved, for instance through global human rights institutions such as the UN. Second, through globalisation we have seen the growth of inter-governmental bodies (IGBs), non-governmental organisations (NGOs), multinational corporations (MNCs) and supra-national institutions that compete and cooperate with nation states on the international stage (Gready and Ensor 2005: 5). As Darcy (2004: 120, in Gready and Ensor 2005: 8) argues, there is now a 'globalising of responsibility' towards human rights.

The post- Cold War period's resurgence of democracies, civil conflicts, war, genocide and civil society again brought human rights to the forefront. This change in political context coupled with the failings of structural adjustment programmes for development form the basis of the emergence of RBA in the late 1980s (Gready and Ensor 2005: 20; Mikkelsen 2005: 200).

From the 1990s steps were taken to mainstream human rights in international development cooperation, with the UN in the forefront. Several large NGOs departed from their traditional needs-based and service driven approach in favour of an approach where human rights issues were increasingly incorporated into their day-to-day work (Molyneux and Lazar 2003: 6, in Gready and Ensor 2005: 20). These mainstreaming efforts were embodied in the Vienna Declaration of 1993, which would serve as a basis for cooperation between international organisations and national institutions in the promotion of human rights (OHCHR 1995).

3.3.2 Central documents and monitoring instruments

The central documents of RBA comprise the previously mentioned Universal Declaration of Human Rights (UDHR) of 1948, the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) of 1966 and its two Optional Protocols. Together these documents are known as the International Bill of Rights (Mikkelsen 2005: 201; OHCHR n.d. a). The ICESCR will be outlined further in chapter 4.1.1 of the thesis.

Several monitoring instruments have been set up by the UN in order to oversee the implementation of the International Bill of Rights by nation states and attempt to hinder human rights violations (Smith 2007: 49). The main global monitoring instruments are the Human Rights Commission, the ILO, the OHCHR and the UNHCR. In addition, the Human Rights Committee and the Committee on Economic, Social and Cultural Rights have been set up by specific treaties.

3.3.3 Concepts and agents

As Seppänen (2005: 15) states, there is no universally accepted definition of concepts in RBA. Perhaps the most fundamental discussion revolves around what is the appropriate name of the approach. The literature on the field somewhat interchangeably applies the terms ‘Human Rights-based Approach’ (HRBA) and ‘Rights-based Approach’ (RBA).

It is arguable that using the concept ‘Rights-based approach’ means including a wider spectrum of rights into the discourse. RBA suggests that the universal human rights incorporated in various treaties, as well as additional rights such as property rights and intellectual property rights are fundamental to development and development policies and therefore need to be incorporated into the approach. HRBA, on the other hand, holds a more sole focus on universal human rights and the implementation of a normative framework for development work (Seppänen 2005: 16-8).

However, the OHCHR applies the concept RBA much like the way Seppänen (2005) defines HRBA. As mentioned in chapter 3.3, the OHCHR (UN and OHCHR n.d.) define RBA as “normatively based on international human rights standards”, and those ‘international human rights standards’ must then be the International Bill of Rights and the following treaties.

In adding to the conceptual inconformity, the OHCHR (UN and OHCHR 2002) applies the term Human Rights Approach (HRA) in its Draft Guidelines for poverty reduction strategies. In the Draft Guidelines the OHCHR state that “the essential idea underlying the adoption of a human rights approach to poverty reduction is that policies and institutions for poverty reduction should be based explicitly on the norms and values set out in the international law of human rights” (UN and OHCHR 2002: chapter 1, point 3).

I apply the term RBA in this thesis, since it is viewed as being a wider term than both HRBA and HRA. Arguably, the OHCHR use the three terms somewhat interchangeably, however, I lean towards Seppänen’s (2005) argument that RBA encompasses human rights together with the notions of empowerment, accountability, participation, non-discrimination and attention to vulnerable groups.

Accountability is part of what is referred to as the ‘added value’ of RBA (Yamin 2008: 1-2). There are several types of accountability: administrative, professional, financial, social, political and legal. All of these types of accountability require transparency and monitoring in order for them to be realised. In addition, there is also a need for mechanisms for redress in order to ensure accountability. One way of approaching this issue is to identify ‘rights holders’ and their

entitlements, and ‘duty bearers’ and their obligations (UN and OHCHR n.d.). Gready and Ensor (2005: 12) claim that globalisation has imposed changes to the human rights regime, and that the current idea is “that there are rights in search of duties and rights holders in search of duty bearers”.

All individuals are rights holders, and every person holds these rights equally and they are inalienable. The concept of duty bearers can be divided into categories of primary duty bearers and moral duty bearers. There also exists a sub-division of moral duty bearers.

Nation states are the primary duty bearers as they sign human rights treaties, and because of the social contract between governments and people (Darcy 2004, in Gready and Ensor 2005: 8; Mikkelsen 2005: 202-3). Nation states have a duty to respect, protect and fulfil human rights, which means they are obliged to refrain from violating human rights at the same time as they are to prevent violations by others. Also, nation states are to take active measures in order to fulfil human rights obligations (Gready and Ensor 2005: 12; Mikkelsen 2005: 202-3; Seppänen 2005: 23, 25).

Organisations and individuals are identified as moral duty bearers. Organisations, such as NGOs, private sector organisations, MNCs, regional organisations and the UN, together with individuals hold a moral obligation towards respecting, protecting and fulfilling human rights. Mikkelsen (2005: 202-3) argue that globalisation contributes to greater obligations for moral duty bearers. This can be connected to organisations becoming more influential and the increased scale and complexity of global human rights needs and violations.

Last, RBA operates with a sub-division of moral duty bearers that is opposite of the top-down structure of primary versus moral duty bearers (Mikkelsen 2005: 202-3). The primary duty bearer in this respect is for instance a doctor for his/her patients. Secondary duty bearers are community organisations, hospital administrations and such. NGOs and private sector organisations are classified as tertiary duty bearers, and last are the external duty bearers, such as countries, institutions, and the UN.

The relationship between duty bearers and rights holders, as well as the added value of RBA is illustrated in Figure 1 (adapted from Mikkelsen 2005: 206). Rights-based approaches seek to strengthen accountability of duty bearers and support rights holders. Universalism, inalienability and indivisibility create a normative basis for rights holders to claim their stated human rights, and international law and human rights treaties are measures to strengthen accountability of duty bearers (Mikkelsen 2005: 206-210). Further in Figure 1 we see changes in structures as a result of duty bearers fulfilling their obligations, and the subsequent consequence is participation and enjoyment of human rights for all persons. And as Mikkelsen (2005: 206) points out, "in a dynamic world there will be feedback from democratic processes and poverty reduction to continuous rights-based efforts".

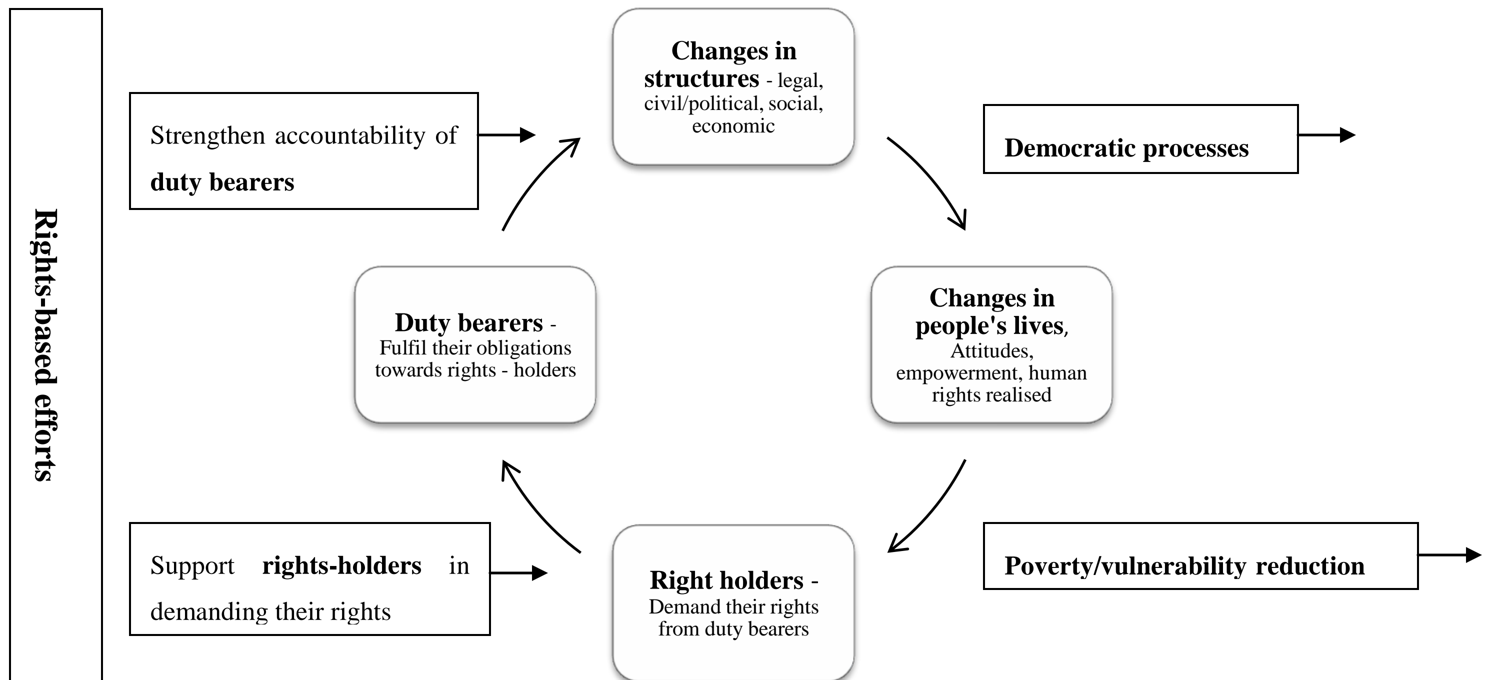

Figure 1: Rights-based Approaches (adapted from Mikkelsen 2005: 206)

As a note to Figure 1, the entire model will not be applied in this thesis. Based on the research questions the focus will be on the accountability of duty bearers. Mikkelsen (2005: 206) states that "an exclusive focus on either rights holders or duty bearers may be necessary and useful in the short term". However, in the long term a more holistic approach will prove more useful.

3.4 Global mobility and the HIV/AIDS epidemic

The first case of acquired immune deficiency syndrome (AIDS) was recorded in the United States in 1981. Ever since 1981, we have witnessed an epidemic of global proportions with more than 65 million infected and 25 million deaths. UNAIDS (2006, in WHO 2007) estimates that 39.5 million people worldwide are currently living with the human immunodeficiency virus (HIV), among these are 18 million women and 2.3 million are children. According to UNAIDS, 11,000 people are infected every day, and these new HIV infections are in many parts of the world concentrated among young people between 15 and 24 years (WHO 2007).

Further, of the estimated 4.3 million getting infected in 2006, 95% of these live in low and middle income countries. This is just one of the markers documenting the relationship between global economic inequality and health. People living in high income countries are generally more nourished, the morbidity and mortality among the population is lower, and they have better access to health care than people living in lower income countries. Also in the case of the global HIV/AIDS epidemic, the developing world is more affected and the impact is more severe. However, as UNAIDS (2008: 89) points out, the relationship between economic inequality and health needs to be put in context, and the picture is often more nuanced than what is generally perceived. UNAIDS therefore puts focus on “the importance of prevention strategies that target all socioeconomic strata” (UNAIDS 2008: 89).

3.4.1 Modes of transmission, risk and vulnerability

There are several modes of transmission of the virus. UNAIDS (2008) and WHO (2007) identify the modes of transmission as injecting drug use (IDU), unprotected paid sex, unprotected heterosexual intercourse, men who have unprotected sex with men (MSM), blood transfusions and mother-to-child transmission. However, the HIV/AIDS epidemic cannot be looked at as something purely medical: socioeconomic conditions, such as discrimination and stigma, and how they affect risk and vulnerability are crucial to understanding the spread of the virus.

Risk is based on the assumption that some individuals or groups adopt certain behaviours that create, increase and sustain the risk of them contracting the HIV virus. Unprotected sex and IDU are risk factors that make it more likely for someone to get infected. *Vulnerability* is determined by factors that an individual or a group themselves are not in control of. These factors include lack of knowledge and skills needed in order to mitigate risk of contracting HIV, insufficient health services, and societal factors that are disempowering certain populations. Individuals or groups may be subject to one or a combination of these factors of vulnerability (UNAIDS 2008: 65).

UNAIDS (2007: 9) define stigma as "...a process of devaluation of people either living with or associated with HIV and AIDS". Stigma towards people with HIV/AIDS or those associated with the disease is based on the negative connotations connected to the disease, as well as a general fear of getting infected. Discrimination, on the other hand, is a result of stigma, and occurs within both social networks and public institutions. Stigma and discrimination exacerbate HIV risk as such actions and sentiments make people hesitant about for instance HIV-testing, attaining information and knowledge about mitigating vulnerability and condom use (Nyblade et al. 2003, Ford et al. 2004, Wolfe et al. 2006, Ma et al. 2007, Pulerwitz & Barker 2008 in UNAIDS 2008: 76-7). Further, stigma and discrimination may prevent people living with HIV from seeking medical attention and treatment for the disease which in effect leads to more people dying and more people left behind. Last, people living with HIV become reluctant to inform their sexual partners of their disease when such stigma is attached to it (White and Carr 2005, Lui et al. 2006, Mills 2006, in UNAIDS 2008: 77).

3.4.2 Connecting global mobility and the HIV/AIDS epidemic

Chantavanich, Beesey and Paul (2000) argue that HIV moves with mobile populations because they pass through various risk situations that often lead to unprotected sex or IDU, as well as the heightened vulnerability of mobile people throughout the different stages of the mobility system.

It is important to notice that as the virus spreads it is more the behaviour of individual migrants that determine their risk and vulnerability towards contracting and spreading the virus. Thus, it is

not mobility itself that is to blame for the HIV/AIDS epidemic, rather than the environment surrounding mobile populations (Chantavanich, Beesey and Paul 2000).

There are several factors that contribute to the heightened vulnerability and risk taking of mobile populations with regards to HIV/AIDS. The most important factors are loneliness, separation from regular partners, higher and more disposable income, influence of peers and peer cultures, freedom from the norms and rules of the family and society, limited access to health and reproductive services, occupational factors and limited access to education (UNDP 2003: 15-6; Family Health International (FHI) 2006: 2). Limited access to health and reproductive services are a result of language barriers, cultural barriers, unfamiliarity with the area, unavailability of services in the area and irregular migration (FHI 2006: 2; UNRTF 2008: 11). As Redpath (2004: 297) states: "the link between mobility and HIV/AIDS is related to the conditions and structure of the migration process, poverty, exploitation, separation from families and partners and separation from the socio-cultural norms that guide behaviours in stable communities".

Mobile people, and especially irregular migrants, are frequently discriminated against, exploited, harassed and marginalised. These human rights violations occur in various stages of the mobility system, and are often the result of a lack of social and legal protection as well as little participation in host communities (FHI 2006). Such hardships may result in higher frequency of sex for money, sex for survival and rape, and thus increased risk of HIV transmission (UNRTF 2008: 10).

Throughout the stages of the migration system, national health services and HIV interventions do little to prevent transmission among mobile populations by means of education, or provide treatment and care for migrants who are already infected. The need for services that specifically address the vulnerabilities and needs of mobile populations is evident (UNRTF 2008).

The precarious situation of irregular migrants needs to be addressed. Irregular migrants are largely a product of the processes of globalisation, and they are frequently subject to more stigma and discrimination than regular migrants. Vulnerability increases with low education and language barriers, coupled with scarce preparation for life as a migrant, a life often including

increased individual freedom (Chantavanich et al. 2000: 102). Migrants often lack full access to health services and education, however, the situation is even worse for irregular migrants, and this makes it difficult for non-profit organisations to reach them and provide them with such services that national governments often refuse them (UNRTF 2008: 17). In addition, both irregular and regular migrants who are already HIV positive may refrain from seeking treatment and care, and often do not disclose their HIV status to sex partners for fear of discrimination, stigma and deportation (UNRTF 2008: 12)

3.5 My analytical approach

The flows, linkages and interconnectedness that characterise globalisation processes make it important not only to focus on development in developing countries, but also to include developed countries. To some extent, universal human rights are also a 'child of globalisation' and represent a means to redress the inequalities that often exist between migrants and inhabitants of a nation state. RBA is important in this regard, as global mobility has implications on human rights, and in today's globalised world (with increased interconnectedness and mobility) nation states have a new set of rules, regulations and moral responsibilities which themselves have their basis in globalisation. Human rights obligations represent one of these new sets of rules and responsibilities.

RBA has traditionally been a means of explaining changes in development policies and development work. However, new ways of applying RBA has emerged. Two such approaches are RBA to health and RBA to HIV (London 2008; UNAIDS 2008).

The RBA to health is critical to address growing global health inequalities (London 2008: 65). The HIV/AIDS epidemic is partially a result of global inequality and exclusion, subsequently, the practice of public health needs to rethink population approaches to health by integrating human rights into public health (London 2008: 66). In order to realise health for all, the integration of an RBA to health is invaluable.

The core of the RBA to HIV is bringing human rights standards and principles into both HIV programming and the process of increasing empowerment, especially among vulnerable and marginalised groups. In addition, an RBA to HIV seeks to ensure that primary- and moral duty bearers are held accountable and uphold their obligations towards human rights (UNAIDS 2008: 66).

In this thesis global mobility is seen as a driving force for inequality and marginalisation, particularly due the increase in irregular migration, which in turn heightens vulnerability and risk among mobile populations.

In order to operationalise the theories and approaches outlined in chapter 3, I have developed Figure 2[6] to better illustrate the relationship and connections between the various theories and approaches. The model is based on the research questions presented in chapter 1.4. Also, Figure 2 outlines the role of the right to health (which will be further outlined in chapter 4.1.1) with regards to the theories and approaches.

[6] See next page

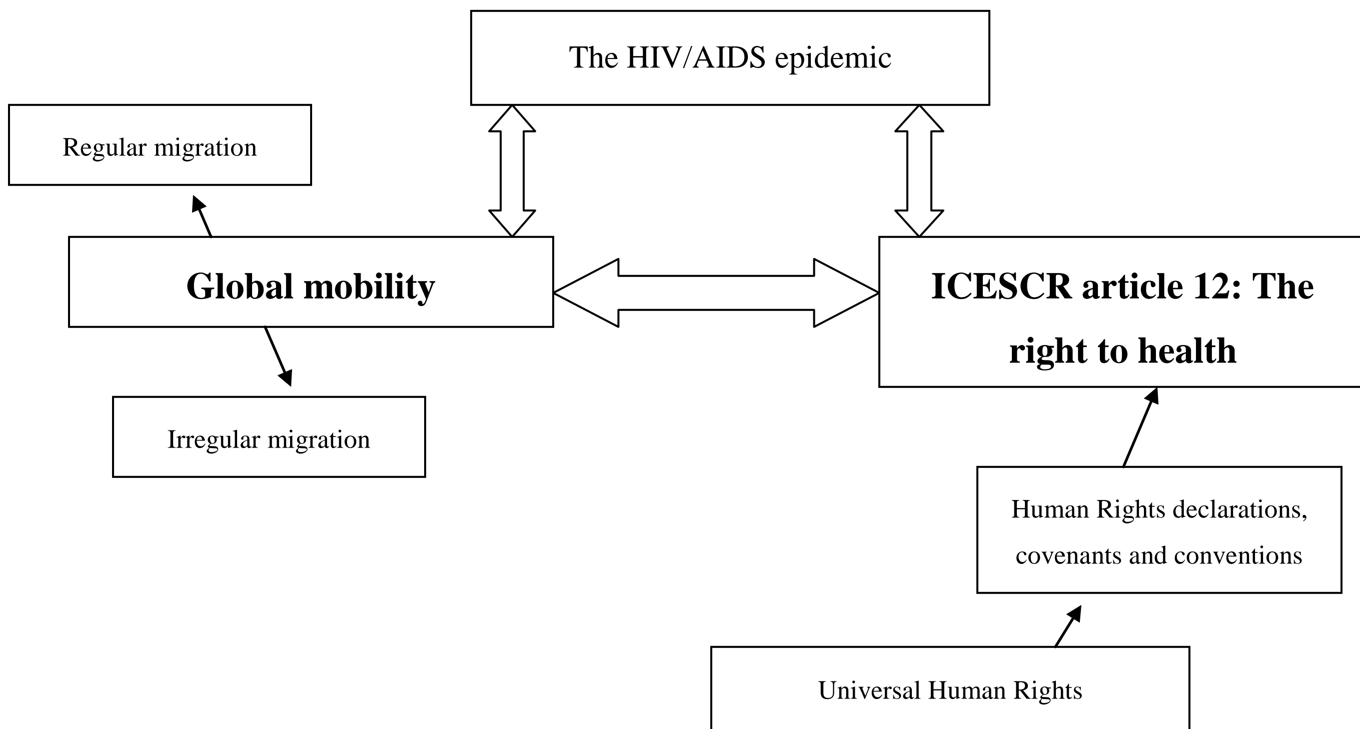

Figure 2: Illustrating the connection between global mobility, the right to health and the HIV/AIDS epidemic

4 Analysis

In this chapter I will first present the empirical data generated through the methods of text analysis and the interviewing of key informants. The empirical data outlined are the International Covenant on Economic, Social and Political Rights (ICESCR) of 1966, Norwegian legislation on human rights as well as Norwegian policy on providing health care to asylum seekers and refugees. In the second part of this chapter I will revisit the model for analysis presented in chapter 3.5 and apply it as a basis for the discussion.

4.1 Empirical data

In this chapter I will briefly summarise the empirical data from the text analysis and interviews, as they relate to the research questions. Presenting the empirical data is essential in forming a basis for the discussion of the research questions and my analytical model (Figure 2), which will be performed in chapter 4.2.

4.1.1 A Right to Health – the International Covenant on Economic, Social and Cultural Rights (ICESC) of 1966

The right to health is declared in article 12 of the ICESC of 1966, and it states that "the States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"[7] (OHCHR n.d. b; UN Economic and Social Council 2000). Further, point 2 c) and d) of article 12 refer to the steps to be taken by States Parties to the present Covenant in order to achieve the right to health. These include the prevention, treatment and control of epidemic disease and the creation of conditions to assure

[7] There are several other international human rights treaties recognising the right to health, for instance the 1965 International Convention on the Elimination of All Forms of Racial Discrimination art. 5 (e) (iv) and the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families art. 28, 43 (e) and 45 (c) (see OHCHR and WHO n.d.: 9 for more information). However, the ICESCR is considered to be the central document, as well as being more all-encompassing. Based on this I chose to outline the ICESCR in this thesis.

medical service and medical attention in the event of sickness (OHCHR n.d. b). As of 1 December 2007 157 States have ratified the ICESCR (OHCHR and WHO n.d: 3).

However, the right to health is not to be understood as a right to be healthy, and States cannot be expected to provide protection against every cause of ill health. The important aspect is that article 12 of the ICESCR states the right of access to good quality facilities and services in order to attain the highest attainable standard of health. Further, the ICESCR secures the principle of non-discrimination and equal treatment (UN Economic and Social Council 2000, part I; OHCHR and WHO n.d: 7-8).

The importance of the right to health is that it is vital in breaking the 'cycle of poverty' – that ill health creates poverty and poverty creates ill health (UN and OHCHR 2002). The OHCHR (2002, part D) identify accessibility as a key feature for realising the right to health, and focuses specifically on tailor-made services for vulnerable groups, for instance irregular migrants and asylum seekers, and the identification of diseases that have a particular impact on the poor, such as HIV/AIDS.

States are legally obligated to respect the right to health, which includes refraining from limiting equal access for all persons, including asylum seekers and irregular immigrants. Second, the obligation to protect refers to the duty of States to adopt legislation in order to secure the principle of non-discrimination and equal treatment. Last, the fulfilment of the right to health represents the obligation of States in enabling individuals to enjoy the highest attainable standard of health (UN Economic and Social Council 2000, part II).

4.1.2 Norwegian legislation and promotion of human rights

Norway has ratified the ICESCR and incorporated it in Norwegian law through the Human Rights Act §2 (Menneskerettsloven 1999; UNDP 2000: 50). The ICESCR applies as Norwegian law insofar as it is binding on Norway.

The purpose of the Act is to strengthen the position of human rights in Norwegian court, and §3 of the human rights law state that the provisions in the Conventions and Protocols that are mentioned in §2 of the Act shall prevail over provisions in other legislation.

In addition to the Human Rights Act, the Norwegian Government has incorporated human rights in the Constitution (amended 15 July 1994). Article 110c in the Norwegian Constitution states that "it is the responsibility of the authorities of the State to respect and secure human rights". Specific provisions concerning the implementation of treaties pertaining thereto shall be laid down by law" (UN Economic and Social Council 2004: 3).

In the Fourth Periodic Report submitted to the UN Economic and Social Council, the Norwegian Government outlines its strategies towards promoting human rights in development cooperation (UN Economic and Social Council 2004: 5). First, Norwegian development cooperation seeks to improve the economic, social and political situation of the population in developing countries, and the focus is on reducing poverty. Second, the promotion of rights of minorities and weak groups is a priority. Last, human rights obligations form the basis for discussions on development programmes and projects, and the aim is to strengthen the recipient country's ability to promote and protect human rights. Support for human rights and sanctions against violations are common in development cooperation, and Norway is one of the countries that have human rights as an explicit aim for aid policy (Smith 2007: 50).

4.1.3 Norwegian legislation and policy on providing health care to asylum seekers and refugees

According to the Fourth Periodic Report on the implementation of the ICSECR in Norway (UN Economic and Social Council 2004: 49-50), the Norwegian Government bases its national health policy on respect for human life and dignity. Also, the Government states a goal to construct a coherent health policy and equal provision of health services.

In order to develop further on the providing of health care to asylum seekers and refugees it is necessary to state the definitions applied by the Norwegian Government. The Norwegian

Directorate for Immigration (UDI) define a refugee as someone who is persecuted in their country of origin, and an asylum seeker is someone who arrives Norway on their own initiative and asks the Government for protection against persecution (UDI 2007). An individual has the right to asylum if he/she fulfils the criteria of what constitutes a refugee in the UN 1951 Convention Relating to the Status of Refugees[8] (UNAIDS and IOM 1998: 447; UNHCR 2009b: 4).

Tove Buchmann[9] in the refugee health team summarised the various categories of people they have as clients: resettlement refugees (previously called 'UN-refugees' as they are selected in cooperation with the UNHCR), refugees who have arrived in Norway on the basis of family reunification, asylum seekers, victims of trafficking, those who are staying without a residence permit (cf. irregular migrants), and church asylum seekers.

UDI clearly states that economic under-development in country of origin does not constitute grounds for asylum. However, the individual may be granted a residence permit on humanitarian grounds, for instance because of serious health problems (UDI 2007). The claims of UDI regarding the granting of residence permit on the basis of serious health problems are disputed by Ottesen (2008: 16), who states that being HIV-positive does not automatically give you a residence permit. In addition, it is neither customary to obtain a residence permit after treatment has commenced.

With regards to irregular migrants the picture is somewhat similar to that of asylum seekers, as the Act concerning protection against infectious diseases guarantees that all persons residing in Norway are entitled to treatment of infectious diseases (Smittevernloven 1994; Ottesen 2008: 16). In the case of infectious diseases, globalisation and global mobility can contribute to a higher prevalence in Norway than what is the situation at present. Vulnerable groups, such as IDUs and immigrants have a higher risk of contracting serious infectious diseases (UN Economic and Social Council 2004: 59). Besides the entitlement to treatment for HIV/AIDS,

[8] As mentioned in chapter 3.2.1

[9] Nurse in the refugee health team in Trondheim, interview performed 26 March 2009

irregular migrants only have access to acute medical attention[10] (Ottesen 2008: 15). This in effect means that irregular migrants themselves will have to pay for any medical attention besides what is considered acute (Den Norske Legeforening 2008: 54). According to Buchmann, there are several definitions of what constitute acute medical attention, and the refugee health team is open about the fact that they do not refuse anyone medical attention. As they see it, it is a question of human rights and the ethics of medical professionals.

The central document for public health care workers are the 'Guidelines' ('veileder') for 'Health care services for asylum seekers and refugees' ('Helsetjenestetilbud til asylsøkere og flyktninger') published by the Norwegian Directorate of Health (Sosial- og helsedirektoratet (2005)). According to Buchmann, the Guidelines serve as basis for the health examinations received by all asylum seekers who arrive in Trondheim. She stated further that all are offered the same health examination, regardless of status.

It is established by law that all persons who enter Norway and who come from a country with a high tuberculosis-prevalence are to be examined for possible infection of tuberculosis[11], and Buchmann confirms that the refugee health team notify the police if a person does not attend the examination (Sosial- og helsedirektoratet 2005: 11). While HIV-testing is voluntary, Buchmann states that "I have worked here for seven years, and I have seen (...) maybe five, less than five that have refused the HIV-test".

Asylum seekers are not to be put on long-lasting and comprehensive treatments while they are still awaiting the result of their asylum application, and issues regarding the health care services of irregular migrants is not even mentioned in the Guidelines (Sosial- og helsedirektoratet 2005: 15). Buchmann confirms this by informing that asylum seekers only get surgery when it is extremely necessary, however, procedures regarding this issue depends on the person making the judgement. In many cases this is a grey area, and according to Buchmann there are many definitions of what constitutes necessary medical attention. She adds that to some extent, one can

[10] See §2-1, cf. §1-2 in the Act on Rights of Patients (Pasientrettighetsloven 1999)

[11] See §3-1 in the Act on protection against infectious disease (Smittevernloven 1994)

claim that even asylum seekers fall within the category of individuals that only have access to necessary medical attention. Thus, asylum seekers have limited access to health care services in Norway.

4.2 Discussion

In this chapter I will revisit the model presented in chapter 3.5[12]. The model will form a basis for the discussion of the empirical data presented in the previous chapter as they relate to the theories, approaches and concepts outlined in chapter 3. The discussion will then serve as a foundation for drawing conclusions regarding the research questions.

4.2.1 Health care of migrants – the Norwegian Government as a duty bearer

The discussion regarding health care of migrants and the obligations of the Norwegian Government as a primary duty bearer consists of two main arguments. First, providing health care to both regular and irregular migrants concerns the fulfilment of basic human rights. The Norwegian Government has ratified the ICESCR and implemented it in Norwegian legislation through the Human Rights Act. In addition, human rights are mentioned in the Norwegian Constitution. Second, it is a question of health economics and the prevention of infectious disease, which is a societal concern.

As seen in Figure 2, universal human rights and global mobility are linked, and they mutually influence each other. The development and implementation of universal human rights and the increase in global mobility are both processes of globalisation. Global mobility creates new challenges and implications for human rights, exemplified by the right to health in this thesis. Since immigration into Norway is increasing one can assume that the issue of migrant health care will continue to grow.

[12] See page 36

In Figure 2, the connection between the HIV/AIDS epidemic and global mobility, plus the link between universal human rights and the HIV/AIDS epidemic is laid out. First, migrants often come from parts of the world with a high HIV prevalence[13]. This would suggest that a number of migrants are already infected with HIV, and thus need treatment in their country of residence. Second, as mentioned in chapter 3.4.2, there are several factors contributing to the heightened vulnerability and risk taking of migrants towards HIV, and limited access to health care services is one main factor in this regard. Additionally, irregular migrants are in a particularly vulnerable situation as they are frequently discriminated against and marginalised. These factors would suggest that the protection of migrant's human rights should be placed at the top of the agenda for nation states. As mentioned in paragraph one of this chapter, the fulfilment of the right to health for all people living in a country is both a question of health economics and preventing the spread of infectious disease, *as well as* a question regarding a country's stated obligation towards fulfilling and respecting human rights.

When applying the concept of accountability of duty bearers, particularly primary duty bearers, in the discussion of health care of migrants, the question is how are they to be held accountable? Who can sue who and where? In Norway, as the ICESCR is incorporated into Norwegian law via the Human Rights Act migrants can hold the State accountable if the migrants' human rights are not fulfilled. The problem arises when one considers how migrants, who often are marginalised and with few means, are to act on the injustice against them. How can one even know that migrants know of their human rights? It can be argued that the situation for irregular migrants is more precarious, as they often fear contact with the Government, and even health care workers, for fear that they will be discovered and deported.

Siv Limstrand[14] mentioned fear and trust as factors that influence migrant's access to health care. This can be seen as one of the arguments for a regularising and institutionalising of health care for all, either organised by the Government or voluntary organisations, as this is the way of making irregular migrants as rights holders confident that they will have their human rights

[13] cf. chapter 1.1

[14] Project manager in 'Living with HIV', interview performed 18 March 2009

fulfilled. Thus, in order for the Norwegian Government to fulfil its obligations, as stated in the ratification of the ICESCR and implementation of the Human Rights Act, the fulfilment of human rights needs to be systematised and regularised for all individuals staying in Norway.

This inconsistency between law and practice is one of the challenges of implementing RBA to health. Mikkelsen (2005: 213-5) argues that this inconsistency is based in the inadequacy of legal apparatuses and a general lack of awareness of human rights. I agree that such inconsistencies may occur in developing countries who's judicial- and political system are not fully developed, and where advocacy for human rights in civil society is weak. However, in a developed country such as Norway, with a strong judicial- and political system and where human rights awareness is widespread, there are no excuses for the inability to fulfil human rights. The Norwegian Government's strong commitment towards human rights and 'humanitarianism'[15] also adds to the embedded contradiction of what the Government is obligated and claim to do (after ratification and implementation into legislation), contra what they do in practice.

The widespread violations of human rights are seen as a common problem, despite every nation-state having ratified at least one of the numerous human rights treaties. When considering that the Norwegian Government has implemented the ICESCR in the Human Rights Act and that the obligation to respect and secure human rights is incorporated into the Norwegian Constitution, one can assume that Norway's commitment towards respecting, fulfilling and securing human rights is strong. What has been discovered, on the other hand, is that there exists a double standard in access to health care services in Norway. Asylum seekers are guaranteed access to health care, but no long-lasting and comprehensive treatments are to be started (see chapter 4.1.3). In the case of irregular migrants, they only have access to acute medical attention, besides being entitled to treatment for infectious diseases such as HIV/AIDS.

However, it is important to include the fact that all registered asylum seekers who come to Trondheim receive a health examination conducted by the refugee health team. The procedure for the health examination is laid out in the Guidelines for health care services for asylum

[15] A concept employed by Tove Buchmann at one point in the interview

seekers and refugees (Sosial- og helsedirektoratet 2005). For instance, the guidelines state that testing of tuberculosis is mandatory for all asylum seekers and refugees arriving Norway.

4.2.2 Other duty bearers – maintaining accountability

In this thesis I have sought to examine the role of other duty bearers in maintaining accountability towards human rights obligations. As a means of addressing the research questions I have explored the manner in which other duty bearers, such as the project 'Living with HIV' and the refugee health team maintain accountability with regards to migrants and their right to health. Also, I have attempted to outline their role as duty bearers.

First, when considering Figure 2, the project 'Living with HIV' plays a role with regards to migrants, health care and rights as their vision is to help, support and guide all that are affected by HIV, regardless of immigration status. Further, the project's aim is to contribute in the prevention of the spread of HIV by focusing on communication and anti-stigma. According to Siv Limstrand, between 15 and 20 immigrants are clients of 'Living with HIV', and she states that the project can act as a problem-solver and raise awareness. In order to maintain accountability, the project can both make migrants aware of their rights, as well as hold the Government accountable in fulfilling human rights. However, Limstrand says that one cannot expect migrants to go via 'regular channels' as there are issues regarding trust and scepticism towards the 'system' involved.

Secondly, regarding the refugee health team, it appears that individual health care workers do more than the 'bare minimum'. Buchmann referred to the importance of professional ethics of health care workers, which can be connected to the sub-division of moral duty bearers where a doctor is seen as a primary duty bearer for the patients[16]. When referring to Figure 2, the role of the refugee health team involves the factors global mobility, the right to health, as well as the HIV/AIDS epidemic. The refugee health team follow the Guidelines published by the Norwegian Directorate of Health (Sosial- og helsedirektoratet 2005) when examining the health of asylum

[16] Se chapter 3.3.3

seekers arriving in Trondheim, however, they do not ask for ID-papers or other documents if a person contacts them. As mentioned in chapter 4.1.3, Buchmann says that HIV-testing is voluntary, but only a handful of clients have refused to undergo testing during the seven years she has been working on the team. Buchmann states the complexity of immigration and the ambiguous nature of the concept ‘necessary medical attention’ as two reasons why they do not deny anyone health examinations. In addition, she states that one cannot work in the refugee health team without being affected by human rights.

Both Limstrand and Buchmann commented on the communication between ‘Living with HIV’ and the Municipality, as well as communication within the Municipality. This communication can be viewed as a way in which other duty bearers maintain accountability. Limstrand comments that the communication between ‘Living with HIV’ and the Municipality is good, they have several years of experience in communicating openly. Meetings are both formal and informal. For instance, Limstrand mentioned that if she by chance meets someone who works in the Municipality, they may discuss issues regarding their collaboration. On the other hand, meetings are also formal, for instance during conferences or planned meetings. Buchmann pointed out that the multidisciplinary and inter-departmental collaboration within the Municipality is particularly important.

5 Thesis summary

The aim of this thesis has been to provide an overview of relevant theories and concepts regarding universal human rights and global mobility, and to outline how the theories and concepts relate to the HIV/AIDS epidemic. More specifically, the focus has been on primary- and moral duty bearers in Norway, and how they maintain accountability and fulfil their obligations towards migrants and the right to health.

My decision to apply qualitative methods in this thesis has its basis in the research questions. Analysis of text is the main method, but throughout my work on the thesis I decided to perform key informant interviews as a complement to the analysis of documents. This was because I wanted to generate primary data as a means of exploring how aspects related to my analytical approach and research questions are perceived by stakeholders. My key informants were Siv Limstrand, project manager in the Church City Mission in Trondheim's project 'Living with HIV', and Tove Buchmann, nurse in Trondheim Municipality's refugee health team.

Further, the analytical framework of the thesis was presented. The theorising on global mobility builds on Harvey and Gidden's notions of "time-space compression" and "time-space distanciation" (1989, 1990, in Inda and Rosaldo 2008: 8-11) where shortening of time, shrinking of space and remote encounters between the global and the local are explored. Then the thesis sought to develop the concepts of mobility and irregular migration as they relate to the thesis, before presenting the Rights-based approaches (RBA). RBA provides a framework aimed at holding primary- and moral duty bearers accountable so they fulfil their obligations towards human rights. Further, RBA is a framework for developing policies and programmes in order to operationalise human rights in development work, securing redress in case of human rights violations and mobilising moral duty bearers (London 2008: 70). The section on RBA was followed by an outlining of global mobility as it relates to the HIV/AIDS epidemic. As Redpath 2004: 297) states, "the link between mobility and HIV/AIDS is related to the conditions and structure of the migration process, poverty, exploitation, separation from families and partners

and separation from the socio-cultural norms that guide behaviours in stable communities". The chapter was concluded with the presentation of my analytical framework.

The analysis chapter started with an outlining of the empirical data generated throughout the research for this thesis. The empirical data consisted of the International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1966, where the right to health is stated in article 12. Second, Norwegian legislation and promotion of human rights was explored. And third, Norwegian legislation and policy on providing health care to asylum seekers and refugees was outlined.

The second part of the analysis chapter consisted of a discussion, where I applied the model presented in chapter 3.5 on 'my analytical approach' as well as the empirical data presented in chapter 4.1 in order to address how the Norwegian Government as a primary duty bearer fulfils its obligations towards human rights with regards to health care of migrants. Further, I have sought to examine the role of other duty bearers in maintaining accountability towards human rights obligations. As a means of addressing the research questions I have explored the manner in which other duty bearers, such as the project 'Living with HIV' and the refugee health team maintain accountability with regards to migrants and their right to health. Also, I have attempted to outline their role as duty bearers.

6 Conclusions

The Norwegian Government has ratified the Human Rights Instruments, and implemented the ICESCR and other treaties in the Human Rights Act. Also, human rights are included in article 110c of the Norwegian Constitution.

Regarding how the Norwegian Government maintains accountability, the Norwegian Government as a primary duty bearer has restricted the access to health care for asylum seekers (cf. 'Guidelines' from the Norwegian Directorate of Health, outlined in chapter 4.1.3) and irregular migrants (only access to acute medical attention and treatment for infectious diseases such as HIV).

Other duty bearers such as health care workers in Trondheim Municipality and organisations and projects such as the Church City Mission and 'Living with HIV' to a large degree fulfil their obligations towards respecting, fulfilling and securing human rights. Although migrant's access to health care has been restricted by the Norwegian Government, public health workers to a large extent follow their professional ethics when refraining from denying health care. Organisations play a role in providing information, contributing to prevention and as a neutral meeting ground for immigrants (both regular and irregular – they do not ask questions regarding status).

Regarding the two research questions, the thesis concludes that there appears to be an embedded contradiction between legislation, policy and practice.

On the one hand, Norway has stated a clear goal to protect, respect and fulfil human rights, both internationally and through the ratification and implementation of human rights treaties into Norwegian legislation. Based on this, they should to a larger extent fulfil their obligations and not restrict the access to medical attention on the part of asylum seekers and irregular migrants. However, it is another question how the administration of health care should be organised and funded. In this regard, the thesis concludes that the Church City Mission in Oslo's plans to open a clinic where all migrants, regardless of status, will receive medical attention could be part of a solution. Meanwhile, the administration of health care to all by voluntary organisations such as

the Church City Mission, and subsequent attempt to fulfil the right to the highest attainable standard of health, as stated in article 12 of the ICESCR, will not release the obligation of the Norwegian Government as primary duty bearer.

On the part of the other duty bearers included in this thesis, namely the Church City Mission in Trondheim's project 'Living with HIV' and Trondheim Municipality's refugee health team, the thesis finds that they play a vital role in guiding and informing, as well as in administering health care services to migrants in Trondheim. 'Living with HIV' plays a role in working on anti-stigma of the HIV-positive, information to their clients as well as support and guidance for the HIV-positive and next of kin. The refugee health team base their work in guidelines from the Government, however, they are open about the fact that they do not refuse anyone medical attention. As they see it, it is a question of human rights and the ethics of medical professionals.

7 Recommendations for further studies

For further studies on this issue I recommend applying the entire model presented by Mikkelsen (2005: 206), and seeking insight into the dynamics between rights holders and duty bearers. As Mikkelsen mentions, a more holistic approach and focus on the model will prove more useful in the long term. Implicit in this recommendation is the need for more fieldwork. More stakeholders need to be interviewed in order to outline the broad picture of how global mobility affects the development and fulfilment of human rights. In addition, further research can study the implications of global mobility on the fulfilment of other human rights, for instance the right to education. It is also viable to investigate the situation in both developing- and developed countries.

Last, further studies can go more in-depth, and apply a comparative approach. For instance by exploring the situation in other countries and how governments and civil society act in comparison to the situation in Norway. This is partly done in the Church City Mission report on undocumented migrants (Ottesen 2008). However, I believe a larger study focusing on specific subjects will prove useful for further policy development and legislation.

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Buchmann, Tove (nurse in the Refugee Health Team, Trondheim) Interview, offices/clinic of the Refugee Health Team, Trondheim. 26.03.09

Limstrand, Siv (project manager of ‘Living with HIV’, the Church City Mission, Trondheim) Interview, offices of the project ‘Living with HIV’, Trondheim. 18.03.09

Appendix 1

Intervjuguide til intervju med prosjektleder i "Leve med hiv" i Trondheim

I. Introduksjon av meg selv og min bakgrunn
II. Informert samtykke
   a. Masteroppgavens overordnede mål/tema
   b. Prosjektplanens hovedtrekk
      i. Jeg vil påpeke at dette til dels er en eksplorerende studie, og at jeg kan komme til å endre problemstillingene
   c. Fordeler/ulemper ved å delta i prosjektet
   d. Informere om at informanten deltar på frivillig basis og kan trekke seg når som helst
   e. Spørre om informanten vil være anonym eller om navn kan bli brukt (evt. godkjenning av direkte sitat)
   f. Oppgaven vil bli skrevet på engelsk, om du ønsker kan oversettelsen av eventuelle sitat forhåndsgodkjennes på e-post
III. Har informanten noen spørsmål før intervjuet begynner?
IV. Stillingstittel, utdanning, alder på informanten
V. Begrepsavklaring: *migrant(er)*
VI. Kan du fortelle meg om prosjektet "Leve med hiv"?
   a. Oppstart
   b. Bakgrunn
   c. Tanke bak/mål
   d. Hva konkret gjør dere?
   e. Hvem er deres målgruppe?
      i. Hvordan identifiserer dere målgruppen?
   f. Hvordan tar folk kontakt med dere?
   g. Hva slags aktiviteter organiserer dere
      i. Hvem deltar i disse aktivitetene?
VII. Noe jeg vil ta tak i fra det svaret?
   a. Kan du beskrive nærmere arbeidet dere gjør?

VIII. Kirkens Bymisjon har vist engasjement i (irregulære) immigranters rett til helsehjelp, har du noen tanker om immigranters tilgang til helsehjelp i Norge?
   a. Er det mange immigranter blant deres klienter?
   b. Hvor kommer de fra og hva slags bakgrunn har de?

IX. Hvilken rolle mener du Kirkens Bymisjon og prosjekter som ”Leve med hiv” kan bidra når det gjelder irregulære immigranter, deres rettigheter og helsetilbud?
   a. Hvordan tror du irregulære (papirløse) immigranter oppfatter Kirkens Bymisjon og ”Leve med hiv”-prosjektet?

X. Samarbeider dere med myndighetene (Trondheim kommune) på noe plan?
   a. Hvis ja, på hvilken måte? Er samarbeidet fruktbart og positivt?
   b. Hvis nei, har du noen tanker om hvorfor dere ikke samarbeider?

XI. Kan jeg ta kontakt med deg igjen om jeg har tilleggsspørsmål/noe er uklart?

XII. Har dere dokumenter/brosjyrer e.l. du ser kan være relevant i forhold til intervjuets tema, og som jeg kan få innsikt i?

Appendix 2

Intervjuguide til intervju med Flyktningehelseteamet (FHT) Trondheim

1. Introduksjon av meg selv og min bakgrunn
2. Informert samtykke:
    a. Masteroppgavens overordnede mål
    b. Til dels eksplorerende studie så jeg kan komme til å endre på problemstillingene
    c. Fordeler/ulemper ved å delta: Viktig tema, håper at noe positivt kan komme ut av å belyse problemstillingen
    d. Informanten deltar på frivillig basis og kan trekke seg når som helst
    e. Vil informanten være anonym eller kan navn bli brukt?
    f. Vil informanten godkjenne direkte sitat? Oppgaven vil bli skrevet på engelsk
3. Har informanten noen spørsmål før intervjuet?
4. Stillingstittel, utdanning og alder på informanten
5. Begrepsavklaring: migrant
    a. Hvordan ville du forklart begrepet 'migrant'?
6. Bakgrunn for FHT
    a. Historien
    b. Hva går deres arbeid ut på?
    c. Hvem kommer til dere?
        i. Blir de henvist?
        ii. Kommer noen på eget initiativ?
        iii. Spør dere etter identifikasjon?
7. Hvilke rutiner har dere for HIV-testing?
    a. Hvem kommer for HIV-test?
    b. Hvor mange prosent tar HIV-test?
    c. Mørketall?
8. Hva er dine tanker rundt migranters tilgang til helsehjelp i Norge?
    a. Regulære
    b. Irregulære
9. Hvordan mener du FHT kan bidra med hensyn til irregulære migranter, deres rettigheter og helsetilbud?

   a. Kunnskap og kompetanse?
   b. Informasjon til migranter?
   c. Tilby helsehjelp til alle uansett status?
10. Hva tror du er grunnen til at myndighetene ikke følger menneskerettighetene når det gjelder irregulære migranters tilgang til helsehjelp?
11. Hvordan samarbeider dere med andre aktører i Trondheim? (koble inn nasjonale myndigheter?)
   a. 'Leve med hiv' og Kirkens Bymisjon, andre instanser i kommunen osv.
   b. Sentrale myndigheter?
12. Hvordan mener du andre aktører (som 'Leve med hiv') kan bidra i denne sammenhengen?
13. Kan jeg ta kontakt med deg igjen om jeg har tilleggsspørsmål/noe er uklart?
14. Har dere dokumenter/brosjyrer e.l. du ser kan være relevant i forhold til intervjuets tema, og som jeg kan få innsikt i?