Discrimination, Denial, and Deportation

Human Rights Abuses Affecting Migrants Living with HIV

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Introduction

The scale of global migration, defined by the World Health Organization (WHO) as the movement of people from one area to another for varying periods of time,[1] is vast and growing. The International Organization for Migration has estimated that 192 million people globally, or 3 percent of the world's population, live outside of their country of birth.[2] Worldwide, even more people migrate within their country than out of it.[3] According to the WHO, migration can often have serious health consequences for migrants because of challenges involving "discrimination, language and cultural barriers, legal status and other economic and social difficulties."[4] Indeed, the global financial crisis has particularly thrown into relief the plight of migrants as it has exacerbated health and social inequalities.[5]

Since the emergence of the HIV epidemic, migrant populations have received considerable recognition from the international community in the context of risk, spread, and prevention of HIV/AIDS.[6] However, despite the long recognition of migration's relationship to HIV vulnerability, states have largely failed to ensure that internal and international migrants have access to HIV treatment. Instead, many states have implemented discriminatory laws and policies that restrict the entry, stay or residence of persons living with HIV (PLHIV) and serve to limit the access of internal and international migrants to treatment services within the state. Furthermore, in many countries migrants are deported without adequate consideration of the availability of HIV treatment in the country of origin and without sufficient provision for continuity of care.

Given the global scale and frequency of migration worldwide, a rational public health strategy toward HIV/AIDS prevention and treatment cannot include any form of discrimination against migrants. Denying treatment to migrants will only serve to perpetuate transmission and frustrate efforts toward controlling the HIV/AIDS epidemic. Interruptions in HIV treatment occasioned by restrictions on entry, stay, or residence in a state, limits on movement within a state, barriers to access, or deportation can lead to illness, development of drug resistance, and death.[7]

This document provides a brief overview of some of the human rights challenges that HIV-positive migrants face and related public health consequences at every stage of the migration process, from restrictions on entry, stay, and residence, to official and unofficial barriers to accessing prevention and treatment services, to deportation and lack of continuity of treatment upon return to the country of origin. Despite recognition of the links between HIV and mobility and periodic pledges to deliver care, millions of migrants fail to

obtain or maintain access to the HIV treatment they need and risk needless illness, drug resistance, and premature death. Only with concerted global effort on the part of states, international agencies, non-governmental organizations (NGOs), and donors, will human rights violations against HIV-positive individuals be eliminated and migrants' rights to health be fully realized.

HIV-Related Restrictions on Entry, Stay and Residence

Scope of the Issue

As of September 2008, 66 of the 186 countries in the world for which data were available placed special entry, stay, or residence restrictions on PLHIV. These restrictions take two general forms. The first is an absolute ban on entry for PLHIV, and the second involves restrictions on longer term (generally greater than three months) residence. The most comprehensive database to track these restrictions has found that among countries for which information is available, 14 countries either categorically refuse entry of PLHIV or require disclosure of the status (likely leading to exclusion). The remainder of countries that impose restrictions require documentation of HIV sero-status for longer-term stays. In such cases, an HIV-positive result for an individual applying for a long-term student or work permit in a country usually will lead to refusal of entry or deportation.[8]

As the World Health Organization has declared, HIV-related restrictions on entry, stay, and residence are not beneficial from a public health standpoint.[9] The Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have also unequivocally stated that restrictions on the rights to liberty of movement and choice of residence based on HIV status alone cannot be justified by public health concerns,[10] since, while HIV is infectious, it cannot be transmitted through casual contact.[11] HIV-related restrictions on entry, stay, and residence may, in fact, negatively impact public health for several reasons. First, these restrictions contribute to and reinforce stigma and discrimination against migrant PLHIV by lending credence to the idea that non-nationals are a danger from which the national population must be protected, and by prejudicially implying that PLHIV will act irresponsibly in transmitting the infection. The restrictions make it difficult to discuss HIV issues in public, decreasing prevention, testing, and treatment opportunities and uptake, and further isolating and marginalizing PLHIV. Singling out HIV for entry restrictions and mandatory testing has also been criticized by experts on the grounds that it creates a false sense of security in a country's nationals that only migrants are at risk for HIV.

International Law

National restrictions on entry, stay, and residence that single out PLHIV broadly violate international human rights law provisions banning discrimination and upholding equality before the law.[12] Following the Universal Declaration of Human Rights, the International

Covenant on Civil and Political Rights (ICCPR) guarantees all persons the right to equal protection of the law without discrimination based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.[13] The UN Commission on Human Rights has interpreted this provision to include discrimination based on HIV status.[14] States must respect this right for all individuals within their territory and subject to their jurisdiction, regardless of citizenship. Indeed, the Human Rights Committee – the ICCPR's monitoring body – has noted that while a state has in principle the authority to determine whom to admit to its territory, in the context of discrimination considerations, aliens still enjoy the protection of the Covenant in relation to entry or residence.[15]

Restrictions against entry, stay, and residence based on HIV status also run contrary to related human rights principles. As UNAIDS has noted, the implementation of these restrictions has regularly violated the human rights principle of *non-refoulement* of refugees (which prohibits return to a place where life or freedom is threatened),[16] obligations to protect the family, protection of the best interests of the child, the right to privacy, the right to freedom of association, the right to information, and the rights of migrant workers.[17] These restrictions also affect the individual's rights to seek asylum and to work, as well as the rights to education, the highest attainable standard of health, dignity, and life.

According to international human rights law, as set out for example in the Siracusa Principles, to avoid being classified as impermissible discrimination, any difference in treatment that has a negative impact on a particular group – e.g. persons living with HIV or AIDS – has to be justified by being necessary to achieve a compelling purpose and be the least restrictive (meaning least discriminatory) means of achieving that purpose.[18] However, while preservation of public health is a compelling purpose that might justify some forms of restrictions, HIV-related distinctions in entry, stay, and residence do not actually protect public health, and are too broad and coercive to be the least restrictive means to achieve this end.[19]

Case Studies

Labor Migrants

UNAIDS has determined that the greatest impact of HIV-related entry, stay, and residence restrictions lies on labor migrants,[20] of whom there are approximately 86 million worldwide.[21] Frequently, unskilled or semi-skilled labor migrants are subject to mandatory HIV testing prior to departure, are unable to work overseas if found to be positive, and are subject to regular mandatory testing during residence overseas, with summary deportation resulting from a positive test. A 2005 study found that HIV-positive Filipino migrant workers in

numerous destination countries were deported without counseling or ability to claim unpaid wages or possessions, and were, in some cases, confined in a hospital pending deportation (in one case in Saudi Arabia for as long as 11 months).[22] Human Rights Watch has also documented pre-departure HIV testing without informed consent, confidentiality or access to test results of prospective migrant workers in Sri Lanka[23] and the deportation of migrants who test positive for HIV from Saudi Arabia.[24] These human rights violations are exacerbated by the fact that they take place with little or no effort to extend HIV prevention, treatment, support, or counseling geared specifically toward this population in either the home or destination countries.[25]

Short Term Travelers

The impact of restrictions on short-term entry, stay, or residence can be serious for affected individuals, including tourists, individuals seeking to visit family, and business travelers. When PLHIV are confronted with questions calling for HIV status disclosure on visa application forms, they must choose between either not disclosing their HIV status (potentially committing fraud and, if caught, risking future entry), and having to hide medication, or disclose their HIV status, and face refusal of entry.[26] Confronted with this dilemma, a 2006 study of HIV-positive travelers from the United Kingdom to the United States found that of the 239 patients taking antiretroviral therapy (ART) at the time of travel to the US, the majority travelled illegally without a waiver visa. Twenty-seven (11.3%) stopped ART during the period of travel, thus running the risk of developing drug resistance. Twenty-eight patients (11.7%) mailed their medication to the US in advance, but only 25% received mailed medication on time.[27] Overwhelmingly, individuals who stopped treatment reported doing so because of the US travel restrictions, fear of being searched, and discovery of their illness.[28]

Recommendations

An increasing awareness of the discriminatory nature and deleterious effects of HIV-related travel laws has begun to prompt change. International agencies, human rights and HIV/AIDS organizations must continue to demand that such restrictions be repealed immediately and entirely. In instances in which these laws and policies are not rescinded, at a minimum national governments need to reform testing practices so as to conform with basic human rights standards. Conducting voluntary testing, obtaining informed consent, and providing adequate pre- and post-test counseling are key to ensuring that the rights of involved individuals receive a minimum measure of respect. Confidentiality of test results should also be strictly maintained. Policies subjecting individuals to expulsion must always be coupled

with protection of that individual's right to challenge his or her deportation through due process of law.[29]

Regardless of a country's policies on HIV-related travel restrictions, provision of adequate HIV/AIDS prevention, care, and treatment services for migrants and citizens alike is essential. The experience of discrimination, dislocation and disruption in social networks around migration is closely linked to HIV risk. Legislative priority and government resources should be redirected from maintaining costly and discriminatory entry, stay, and residence restrictions on PLHIV, and refocused on providing prevention, care, and treatment programs that target and serve non-citizens and citizens. The creation and maintenance of such programs will be the truly effective long-term strategy in combating this pandemic from both a public health and a human rights perspective.

Additional Resources

Joseph J. Amon and Katherine Wiltenburg Todrys, "Fear of Foreigners: HIV-Related Restrictions on Entry, Stay, and Residence," *Journal of the International AIDS Society*, vol. 11, no. 8, 2008, http://www.jiasociety.org/content/11/1/8.

Access to HIV Prevention and Treatment for Internal Migrants

Scope of the Issue

Internal migrants – as opposed to international migrants – are those individuals who change residence from one civil division to another within their country of origin. Reasons for migration are varied, but typically stem from social, political, or financial causes, or natural disaster. Internal migration has increased in many countries throughout the world in recent years.[30]

Already marginalized and subject to stigma as a result of their migration status, migrants with HIV/AIDS are often doubly stigmatized and subject to neglect and exploitation. Gaps in internal migrants' access to HIV/AIDS services—either as a result of official restrictions or logistical, cultural and linguistic barriers—have significant consequences: individuals are less able to access care and are increasingly vulnerable to infection and death, states are less able to realize the goals of universal access to treatment and reduction of the AIDS epidemic, and the public health community may face the emergence of drug-resistant strains resulting from interruptions in treatment.[31] Barriers to access to HIV/AIDS-related services faced by internal migrants when they move from their place of origin include internal migration restrictions, and logistical, linguistic and cultural barriers to HIV/AIDS prevention and treatment. To successfully achieve global goals for reducing the burden of HIV and providing universal access to prevention and care, states must recognize the rights of internal migrants and their own obligations to eliminate barriers to care.

International Law

International law provides for the basic right to the highest attainable standard of health, and requires states parties to take steps individually and through international cooperation to progressively realize this right via the prevention, treatment, and control of epidemic diseases and the creation of conditions to assure medical service and attention to all.[32] International law also establishes the basic principles of non-discrimination and equality.[33] Taken together, these rights imply a right to access a core minimum set of health care services, including ART, without discrimination, including on the basis of social origin.

According to the UN Committee on Economic, Social and Cultural Rights, the Convention on Economic, Social and Cultural Rights' monitoring body, states must guarantee certain core obligations as part of the right to health, including ensuring non-discriminatory access to health facilities, particularly for vulnerable or marginalized groups. While the Committee, in

its General Comment 14, notes the progressive nature of the right to health, it also points to the fact that states must immediately take steps to realize the right to health, and must immediately guarantee the exercise of the right without discrimination of any kind. The right to health is thus centrally linked to the right to non-discrimination. Discrimination against internal migrants – who are in fact citizens of the state in question – is banned as explained by the Committee's Comments, which state that the Covenant prohibits discrimination based on "social origin." Thus, the Committee findings make clear that the Covenant prohibits discrimination against internal migrants in receiving health care, and are an immediate call on all states parties to eliminate discrimination.[34]

Case Studies

The People's Republic of China

While urban residents holding permits in China have long been entitled to state-sponsored social welfare benefits, individuals without *hukou* (a form of registration with local authorities that is often time-consuming, expensive, or difficult for internal migrants to obtain) are unable to access basic public services such as education and health care, and therefore are forced to pay all costs.[35] The vast majority of internal migrants are uninsured, and rarely visit doctors or hospitals.[36] Furthermore, lack of health care coverage for sick migrants has, in the past, been compounded by additional, harsh consequences: For example, internal migrant workers have been returned to their home province under armed guard after being found to be HIV-positive.[37]

HIV-positive internal migrants' access to treatment remains extremely limited, confounded in part by the effects of the *hukou* system. In 2003, the Chinese government announced a national HIV/AIDS treatment program – free to rural residents and poor urban residents. However, universal HIV/AIDS treatment is far from a reality among the general population.[38] Indeed, even when free treatment is ostensibly offered, delays in diagnosis and referral can create significant costs for the patient prior to the availability of free treatment, thus particularly disadvantaging migrants, who are not entitled to free basic health care.

The Russian Federation

Vestiges of an internal registration system also plague access to health care for internal migrants in Russia. While officially simplified and relaxed by the federal government, in practice, registration in cities including Moscow may be cumbersome and expensive, and lack of registration status may have serious official or unofficial consequences for internal migrants. Instances of unregistered migrants unable to legally marry, vote, send their

children to school, and receive public assistance, have all been reported.[39] Indeed, individuals who are legally in the country but lack local registration have also reportedly faced harsh consequences, such as detention or deportation.[40]

While the Russian government is constitutionally required to provide free medical care to all citizens and most HIV treatment is officially provided free of charge to citizens, in practice the implementation of this right is limited and major challenges exist in access to free health care.[41] Internal migrants especially face barriers, as registration is a precondition for entitlement to many free health services. Human Rights Watch research has documented that a migrant without registration is often denied both short-term (for purposes of Prevention of Mother to Child Transmission) and long-term antiretroviral treatment[42] and will typically be directed to his or her city of origin to receive the treatment.

Republic of India

HIV prevention in India is seriously hindered by the low awareness of the disease among internal migrants, particularly from rural areas,[43] as a result of the mobile nature of this population, language, and cultural barriers. Significant HIV/AIDS treatment gaps exist for all groups throughout the country, but migrants also face particular challenges in accessing health care.[44] Health care is administered on a state-by-state basis in India, and in some states significant uncertainty exists among government officials as to whether state authorities are responsible for social welfare services to temporarily resident workers and their families.[45] Furthermore, internal migrants are often unable to use the government-issued "ration cards" outside their local home authority in order to access social services, and migrants may face significant logistical challenges and delays in procuring a new ration card.[46] Absent a ration card, it can be difficult to access even programs designed to provide health care to the poor, as some such services specifically target ration card holders.[47] Indeed, some local authorities reportedly refuse to provide ART to individuals without ration cards.[48]

Recommendations

First of all, in countries that place formal or informal eligibility restrictions on access to health care, such restrictions based on social origin within different regions of the country need to be immediately eliminated. As noted above, the Economic, Social and Cultural Rights Committee directs that states have an immediate obligation to eliminate discrimination in health care provision, including discrimination based on "social origin." The obligation to ensure HIV/AIDS prevention and treatment to all individuals without

discrimination is all the more acute, as HIV/AIDS services are included as essential drugs in the core minimum of health care services nations have an obligation to provide.[49]

Second, states should reduce barriers to ART uptake for internal migrants. User fees constitute the main barrier to ART adherence, and free care at point of service leads to improved uptake of HIV-related services, especially among the poorest users.[50] Internal migrants are often subject to greater fees and indirect costs than non-migrants, and the resulting lack of access to treatment serves to push internal migrants toward self-medication or illegal clinics.[51]

Creating programs tailored specifically to internal migrants' needs is essential to ensure uptake even of free HIV prevention and treatment services. To remove barriers in access to HIV/AIDS services when free care is officially available, states and international agencies and donors need to formulate programs to specifically address internal migrants' needs. Cross-regional linkages need to be developed to facilitate the transition from one regional health authority's care to the next, where health care is not administered at a national level. Additional programs could include providing translators who could translate to the languages internal migrants to the region frequently speak, providing mobile outreach services or transport from areas where internal migrants live to health centers, educating health care providers as to migrants' particular needs and rights, or holding patient education sessions geared toward migrants.

Finally, national governments need to remove restrictions on movement that prevent or delay internal migrants from establishing residence in urban areas. The harsh consequences and rights violations of restrictions on internal migration in some countries can include detention or deportation. Fear of such consequences may lead internal migrants to avoid HIV-related services even when they are available.

Additional Resources

Katherine Wiltenburg Todrys and Joseph J. Amon, "Within but Without: Human Rights and Access to HIV Prevention and Treatment for Internal Migrants," 2009 (forthcoming).

Access to Antiretrovirals for International Migrants

Scope of the Issue

Since the emergence of the HIV epidemic in the 1980s, public health officials have recognized that migrant populations face special risk of HIV infection.[52] However, despite the long recognition of migration's relationship to HIV vulnerability and recent calls by international bodies to address migrant health needs,[53] states have largely failed to ensure that migrants have access to HIV treatment. Although governments have committed themselves to provide "universal access"[54] to HIV treatment and have specific obligations under international human rights law to ensure that HIV treatment (specifically, antiretroviral therapy or ART) is provided to migrants as part of their duty to realize the right to health without discrimination, access to ART for migrants remains largely unrealized. Few states have explicitly recognized ART as part of the core minimum of health services to be provided without discrimination, including as to citizenship, for migrants within their borders.

Given the global scale and frequency of migration worldwide, a public health strategy toward HIV/AIDS prevention and treatment cannot include discrimination against non-citizens in provision of ART, as denying such treatment will only serve to perpetuate transmission and – for those already infected – can lead to illness, the development of drug resistance, and death.[55] The development of HIV treatment systems geared toward migrants is necessary to achieve universal access to HIV treatment and to meet the needs of the world's significant and growing population of international migrants.

International Law

International law provides for the basic right to the highest attainable standard of health, and requires states parties to take steps individually and through international cooperation to progressively realize this right via the prevention, treatment, and control of epidemic diseases and the creation of conditions to assure medical service and attention to all.[56] International law also establishes the basic principles of non-discrimination and equality.[57] Taken together, these rights imply provision of a right to access a core minimum set of health care services, including ART, without citizenship-based discrimination.

According to the Economic, Social and Cultural Rights Committee, the Convention on Economic, Social and Cultural Rights' monitoring body, States must guarantee certain core obligations as part of the right to health, including ensuring non-discriminatory access to

health facilities – particularly for vulnerable or marginalized groups – and providing essential drugs. While the Committee notes the progressive nature of the right to health, it also points to the fact that states must immediately take steps to realize the right to health, and must immediately guarantee the exercise of the right without discrimination of any kind. The right to health is thus centrally linked to the right to non-discrimination. More specifically with respect to migrants, the Committee notes that "States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services."[58] Thus, a prohibition against discrimination against non-citizens in receiving health care, and an immediate and core obligation to eliminate discrimination, emerge from the Committee's findings.

Additionally, the Committee on the Elimination of Racial Discrimination has called on states to adopt measures including those that would remove obstacles that prevent the enjoyment of economic, social and cultural rights by non-citizens, notably in the areas of education, housing, employment and health; and those that would ensure that States parties respect the right of non-citizens to an adequate standard of physical and mental health by refraining from denying or limiting their access to preventive, curative and palliative health services.[59] The International Convention on the Rights of Migrant Workers also explicitly guarantees the rights of migrant workers and their families to emergency medical care, providing them with medical care "urgently required for the preservation of their life or the avoidance of irreparable harm to their health" on an equal basis as a state's nationals, without regard to irregularity of status. With respect to additional health services, the Convention guarantees migrant workers equality of treatment with nationals in access to social and health services if requirements for participation in those schemes have been met.[60]

Case Studies

South Africa

Under the South African Constitution, individuals with irregular legal status are accorded a wide range of human rights, including the rights to access to emergency and basic health care, and ART.[61] Asylum seekers and refugees are accorded free care if they are indigent, and assessed according to the same means test used to evaluate South African citizens if they are not. The Department of Health has issued memoranda clarifying that these rights apply equally whether the patient has documentation or not.

However, Human Rights Watch research, as well as NGO and media reports, have described a striking gap between South Africa's inclusive policies and the reality of access to health care for refugees, asylum seekers, and especially undocumented migrants. Some public clinics demand a South African identification document before offering health care, denying treatment for those without identification papers.[62] Asylum seekers have experienced continuing difficulties accessing ART.[63] Human rights organizations and journalists have documented verbal abuse, sub-standard treatment, insensitivity by providers, unusually long wait times, and outright denial of services facing migrants seeking health care.[64] Others are illegally charged prohibitive fees for treatment or medication, or told they must carry a green South African citizenship card in order to receive basic services. Undocumented Zimbabweans in need of health care have overwhelmed South African charities and churches, and been turned away from government clinics when unable to present citizenship papers.[65] Basotho mineworkers, infected with HIV and multi-drug resistant tuberculosis (MDR-TB) have faced deportation and been left at the border of their home country without any treatment or referral to local health services for treatment.[66]

Thailand

The Thai government has developed a program to register migrants and regularize their status. Registration allows migrants access to basic health care services through the national health plan. However, ART is not considered part of the package of public health care involved in registration, except for pregnant women.[67] Antiretrovirals are distributed to Thais through a separate scheme than registered migrants' coverage, effectively barring non-Thais.[68]

Additionally, registration is problematic for migrants because of steep registration fees, the fact that migrants cannot change employers once registered, and migrants are not able to move outside the province in which they are registered.[69] Registration eligibility changes annually and restrictions stemming from a lack of coverage of typical migrant job categories, and linkage of registration to specific places of employment keep many from accessing the registration program.[70] Further, while migrants themselves are entitled to have possession of their registration, work permit, and health insurance documents, employers often hold these documents and migrants find copies of the documents insufficient for actually obtaining care.[71] A 2004 Physicians for Human Rights Report dealing with Burmese migrants in Thailand called for HIV care and treatment for migrants on equal terms as Thai citizens, as "discriminatory denial of care and treatment virtually condemns them to living with (and quickly dying of) AIDS."[72]

Recommendations

In order to realize the requirements of international human rights law to provide a core minimum of health services without discrimination, states worldwide must provide essential ART drugs to migrants on the same terms as to citizens. In order to realize this commitment, and to ensure the availability of ART in practice, states should immediately offer free or low-cost ART to non-citizens on the same terms as to citizens. This includes providing free or low-cost ART for Prevention of Mother-to-Child Transmission (PMTCT) to non-citizen HIV-positive pregnant women and removing all barriers to their enrollment in such programs. Furthermore, states should work to establish cross-border treatment mechanisms and improve continuity of care by taking steps to standardize health passports across borders, coordinate treatment regimes in neighboring countries, create an international registry of patients, and review ART guidelines to ensure lack of bias against mobile populations. States also need to eliminate barriers facing refugees and other migrants officially granted access to care in receiving services, including through health provider education on patients' rights. To implement these policies, states must allocate sufficient funding for provision of ART to migrant populations.

International donors, as well, have the capacity to improve migrants' access to ART. Crucial steps toward improving access may be made by international donors through conditioning funding for ART drugs for the general population on the equal availability of these drugs to both citizens and non-citizens, including non-citizens with irregular or undocumented status. International donors may also support and supplement states' efforts to provide cross-border continuity of care by assisting with every aspect of the development of cross-border systems noted above, and additionally aiding in the development of a confidential international patient registry system, providing translators and transportation for migrants, and providing counseling and information for migrants on health centers at other locations.

Furthermore, international agencies and NGOs have a significant role to play in increasing migrants' access to ART by writing equal access for migrants into international ART policies and guidance documents, and assisting state governments in doing so for national policies. As with international donors, international agencies and NGOs may also supplement national efforts toward creating cross-border and migrant-friendly treatment. Furthermore, international agencies and NGOs may push for the establishment of health care centers serving migrants in geographic areas frequented by migrants.

Additional Resources

Joseph J. Amon and Katherine Wiltenburg Todrys, "Access to Antiretroviral Treatment for Migrant Populations in the Global South," *Sur – International Journal on Human Rights*, vol. 10, 2009.

Deportation and Treatment for HIV-Positive Migrants

Scope of the Issue

HIV-positive individuals may undergo deportation for a host of immigration-related violations, or, in some countries, as a consequence of their HIV-positive status itself. States have an obligation to ensure medical care for immigration detainees at least equivalent to that available to the general population.[73] However, when, either as a consequence of HIV-related restrictions on entry, stay, and residence, or as part of deportation proceedings commenced on unrelated grounds, HIV-positive immigrants are taken into custody and detained pending outcome of an immigration case or deportation, adequate systems are not in place in many countries to ensure HIV/AIDS treatment.[74]

Under certain circumstances, international law prohibits deportation or permits withholding of deportation of persons living with HIV. The deportation of HIV-positive individuals needs to be broadly reconsidered by states under the international law principle of *non-refoulement* and additional human rights and humanitarian law provisions to ensure that HIV-positive individuals are not sent or returned to circumstances where treatment and family support are grossly inadequate. Furthermore, from a public health perspective, ensuring and coordinating continuity of treatment when HIV-positive individuals are deported to their countries of origin is imperative.

International Law

The principle of *non-refoulement* applies in international human rights and refugee law. In human rights law it has established an absolute prohibition on the deportation of a person to another state where there are substantial grounds for believing that the person would be in danger of being subjected to torture or other cruel, inhuman, or degrading treatment or punishment.[75] International refugee law prohibits the return of refugees to a territory where the refugee's life or freedom may be threatened: "No Contracting State shall expel or return ("refouler") a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion."[76] Some domestic courts have held that HIV status can form the basis of membership in a particular social group for purposes of an asylum analysis under the principle of *non-refoulement*.[77]

In some states, a form of protection from removal known as "complementary" protection exists. This often sets out the protection from *non-refoulement* based on human rights

principles. Complementary protection can govern categories of people who claim that they cannot be returned to their country of origin based on human rights law or humanitarian principles but do not fit into traditional refugee definitions,[78] according a wider range of eligibility.

Case Studies

South Korea

South Korea is one of the 30 countries in the world that force HIV-positive foreigners to leave their borders.[79] Work migrants are tested for HIV and are detained and deported upon testing positive.[80] In 2008, the Korea Center for Disease Control and Prevention reported that 521 of the 647 foreigners diagnosed with HIV to date had been "forced to leave the country," as the government routinely deported individuals who were found to be HIV-positive.[81]

South Korea's practice of deporting HIV-positive non-citizens was challenged in November 2008, when the Seoul High Court (upholding the Seoul Administrative Court) prevented the deportation of "Heo," a Chinese citizen of Korean descent visiting his mother in Korea, who was tested for HIV during a required health check, found to be positive, detained and ordered deported. The court found that public health goals must be balanced against the rights to privacy and to receive medical treatment, and that detection and treatment rather than deportation are the most effective means of curbing the spread of HIV. However, notwithstanding this ruling, the Korean government introduced a parliament bill in December that would expand requirements under the Ministry of Justice's E-2 visa policy (which largely affects foreigners seeking to teach English). Under the measure, immigration officials could require drug and HIV testing of any foreigner seeking a work visa.[82]

Saudi Arabia

Saudi Arabia relies on migrant laborers, many from South Asia, and these laborers constitute a significant proportion of the country's population and an even greater percentage of HIV cases in the country. HIV testing is required of non-citizens for long term work permits, with visa denial and likely deportation if HIV test results are positive.[83] Reports describe migrants jailed upon discovery of HIV status, held, and deported from Saudi Arabia, often without any explanation or discussion of their condition. In one instance in 1994, 80 non-citizens were hastily deported after medical tests for the purpose of resident permits led public health officials to conclude that the individuals were HIV-positive.[84] In 2005, press reports highlighted the case of one HIV-positive Palestinian migrant to Saudi Arabia, jailed in a cell (described by newspaper reports as a "crowded cage") at the King Saud Hospital for

Infectious Diseases for three months—along with two HIV-positive cellmates—receiving no medication except basic painkillers and anti-allergy medication.[85] In 2005, CARAM Asia reported a case of a Filipino migrant worker in Jeddah, Saudi Arabia who, upon testing positive for HIV, was confined for 11 months in the hospital without any information on the progress of his case. Psychological trauma, job loss, and lack of adequate health care face migrants upon return.[86]

United States

When HIV-positive individuals are faced with deportation from the United States—on the basis of HIV-positive status or other grounds—US law provides several legal avenues that individuals seeking to avoid deportation could theoretically pursue. HIV-positive individuals could try to qualify for official status along the lines of the 1951 Refugee Convention[87] by obtaining status as a refugee based on membership in a persecuted social group.[88] In addition to the asylum procedure, all applications involved in asylum proceedings are considered in light of the prohibitions on *refoulement* both in the domestic Immigration and Nationality Act, and in the Convention Against Torture.[89]

Deportees often face harsh conditions and lack of access to health care upon return from the United States to their countries of origin. Receiving country governments have complained about the effects of US immigrant deportation, especially when individuals with criminal convictions are deported without adequate notification or possibility of rehabilitation. In Guyana, legislation has authorized surveillance of some American deportees. In Haiti, criminal deportees are taken immediately to jail and held indefinitely under miserable conditions, where no medical treatment is provided for diseases including HIV/AIDS. Some deportees do not survive such detention.[90] In El Salvador and Honduras, some deportees are subject to discrimination and violence and risk being hunted by vigilante squads.[91] A study on injecting drug users in Mexico, for example, suggests recent deportees have less access to health services than other drug users in the country.[92]

Recommendations

In order to meet the requirements of international human rights law treatment to detainees and deportees, states worldwide should begin or continue to provide ART drugs to individuals in detention awaiting deportation on at least the same basis as that offered to the general population. As noted above, national governments have an obligation under international law to provide non-citizens in detention with medical treatment at least equivalent to that available to the general population. Instances of individuals held in

detention, especially for months at a time, without access to medication must not be repeated.

Furthermore, states should reexamine deportation of HIV-positive individuals to countries where treatment and social support structures are inadequate, in accordance with international and regional law *non-refoulement* prohibitions on deportation and additional complementary bases of protection. In determining a standard for when an individual should not be removed, national governments could consider regional case law: The Inter-American Commission for Human Rights recently found in a decision on the *Andrea Mortlock* case that the petitioner should not be returned by the United States to Jamaica and would face extraordinary hardship upon deportation, even amounting to a death sentence, under a two-part test considering 1) the availability of medical care in the country of removal and 2) the availability of social services and support, especially the presence of close relatives.[93] The European Court of Human Rights had previously set a similar test, but has subsequently interpreted its standard very narrowly.

As a matter of good practice, states—in cooperation with international agencies and donors—should attempt to make provision for continuity of treatment when deportation does take place. Prior to deportation, health officials in countries of deportation may work to coordinate action with health services in countries of removal to ascertain the availability of care, enroll deportees prior to deportation so as to make sure that waiting lists do not prevent continuity of care, and confidentially transfer medical records to a patient's new physician. Providing a temporary supply of ART medication for self- or government-administration may be strongly recommended for PLHIV who are deported to countries in which anti-retroviral medication is not immediately accessible to newly arrived deportees. Immigration and health officials in deporting countries should consider the situation facing each deportee on a case-by-case basis with detailed communication and understanding of the HIV treatment situation in the country of removal.

Finally, information from governments on the number of HIV-positive individuals who are deported needs to be made available, and further research undertaken on this issue by international agencies.

Additional Resources

Human Rights Watch, Deutsche AIDS Hilfe e.V., European AIDS Treatment Group and African HIV Policy Network, "Deportation of HIV-Positive Migrants," 2009 (forthcoming).

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Notes from Introduction

[1] World Health Organization (WHO), "International Migration, Health & Human Rights," *Health & Human Rights Publication Series*, Issue 4, December 2003. Note, however, that there is no internationally agreed-upon definition of "migrant," and scholars, NGOs, and countries have taken varying approaches. Joint United Nations Programme on HIV/AIDS (UNAIDS) and the International Organization for Migration (IOM), "Migrants' Right to Health," *UNAIDS Best Practice Collection*, March 2001, p. 1.

[2] International Organization for Migration, "About Migration," undated.

[3] International Organization for Migration, "Internal Migration and Development: A Global Perspective," 2005.

[4] WHO, "International Migration, Health & Human Rights," *Health & Human Rights Publication Series*, p. 4.

[5] The World Bank, "Averting a Human Crisis During the Global Downturn: Policy Options from the World Bank's Human Development Network: Conference Edition," 2009. Andy Guise et al., "Engaging the Health Community in Global Economic Reform," *The Lancet*, vol. 373, 2009, pp. 987-88.

[6] Ivan Wolffers, Sharuna Verghis and Malu Marin, "Migration, Human Rights, and Health," *The Lancet*, vol. 362, December 13, 2003, pp. 2019-20. See also Prerna Banati, "Risk Amplification: HIV in Migrant Communities," *Development Southern Africa*, vol. 24(1), March 2007, pp. 205-23. United Nations International Institute for the Advancement of Women (UN-INSTRAW) and South African Institute of International Affairs (SAIIA), "Gender, Remittances and Development: Preliminary Findings from Selected SADC Countries," 2007, http://www.un-instraw.org/en/downloads/final-reports/index.php (accessed December 7, 2008), p. 50. Joint United Nations Programme on HIV/AIDS (UNAIDS), "Population Mobility and AIDS: UNAIDS Technical Update," *UNAIDS Best Practice Collection*, February 2001, p. 4.

[7] Fiona Burns and Kevin A. Fenton, "Access to HIV Care Among Migrant Africans in Britain. What Are the Issues?" *Psychology, Health & Medicine*, vol. 11(1), February 2006, pp. 117-25.

Notes from HIV-Related Restrictions on Entry, Stay and Residence

[8] Deutsche AIDS-Hilfe e.V., "Quick Reference: Travel and Residence Regulations for People with HIV and AIDS –Information for Counsellors in AIDS Service Organizations—2008/2009, Karl Lemmen & Peter Wiessner, 8th edition, September 2008. See also "The Global Database on HIV Related Travel Restrictions," available at www.hivtravel.org (accessed May 21, 2009).

[9] World Health Organization, "Statement on Screening of International Travelers for Infection with Human Immunodeficiency Virus," WHO/GPA/INF/88.3, 1988.

[10] Office of the United Nations High Commissioner for Human Rights (OHCHR) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), "International Guidelines on HIV/AIDS and Human Rights," 2006.

[11] UNAIDS and International Organization for Migration (IOM), "UNAIDS/IOM Statement on HIV/AIDS-Related Travel Restrictions," 2004. UNAIDS, "Statement of the UNAIDS Secretariat to the Sixty-First World Health Assembly: Agenda Item 11.9 – Health of Migrants," 2008.

[12] Universal Declaration of Human Rights, G.A. Res. 217A, U.N. GAOR, 3d Sess. 1st plen. mtg. U.N. Doc A/810. 1048, art. 7(1). International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. No. 16 at 52, U.N. Doc. A/6316, 1966, art. 26. Convention on the Rights of the Child, G.A. Res. 44/25, Annex. 44, U.N. GAOR Supp. No. 49 at 167, U.N. Doc. A/44/49, 1989, art. 2. Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, 34. U.N. GAOR Supp. No. 46 at 193. U.N. Doc. A/34/46, 1981. International Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106 (XX), Annex. 20 U.N. GAOR Supp. No. 14 at 47, U.N. Doc. A/6014, 1966.

[13] International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. No. 16 at 52, U.N. Doc. A/6316, art. 26, 1966.

[14] Commission on Human Rights, "The Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)," Resolution 1995/44, March 3, 1995.

[15] Human Rights Committee, "General Comment No. 18: Non-Discrimination," 1989. Human Rights Committee, "General Comment No. 15: The Position of Aliens Under the Covenant," 1986.

[16] OHCHR & UNAIDS, "International Guidelines on HIV/AIDS and Human Rights."

[17] UNAIDS & IOM, "UNAIDS/IOM Statement on HIV/AIDS-Related Travel Restrictions."

[18] United Nations, Economic and Social Council, U.N. Sub-Commission on Prevention of Discrimination and Protection of Minorities, "Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights. UN Doc E/CN.4/1984/4, 1984. UNAIDS & IOM, "UNAIDS/IOM Statement on HIV/AIDS-Related Travel Restrictions."

[19] UNAIDS & IOM, "UNAIDS/IOM Statement on HIV/AIDS-Related Travel Restrictions." S. Schloenhardt, "From Black Death to Bird Flu: Infectious Diseases and Immigration Restrictions in Asia," *New England Journal of International and Comparative Law*, vol. 12, no. 2, 2006, pp. 33-64.

[20] UNAIDS, "Statement of the UNAIDS Secretariat to the Sixty-First World Health Assembly."

[21] UNAIDS, "Policy brief: HIV and International Labor Migration," 2008.

[22] ACHIEVE & CARAM, "Health at Stake: Report on Access to Health for Philippines Overseas Workers," 2005.

[23] Human Rights Watch, Exported and Exposed: Abuses Against Sri Lankan Domestic Workers in Kuwait, Lebanon, and the United Arab Emirates, vol. 19, no. 16(C), 2007, pp. 1-131.

[24] Human Rights Watch, Bad Dreams: Exploitation and Abuse of Migrant Workers in Saudi Arabia, vol. 16, no. 5(E), 2004, pp. 1-135.

[25] UNAIDS, "Statement of the UNAIDS Secretariat to the Sixty-First World Health Assembly."

[26] Deutsche AIDS-Hilfe e.V., "Quick Reference."

[27] Alana Klein, HIV/AIDS and Immigration: Final Report (Toronto: Canadian HIV/AIDS Legal Network, 2001).

[28] M. Mahto et al., "Knowledge, Attitudes and health Outcomes in HIV-infected Travellers to the USA," HIV Medicine, vol. 7, 2006, pp. 201-04.

[29] UNAIDS & IOM, "UNAIDS/IOM Statement on HIV/AIDS-Related Travel Restrictions." Klein, HIV/AIDS and Immigration.

Notes from Access to HIV Prevention and Treatment for Internal Migrants

[30] International Organization for Migration, "Internal Migration and Development: A Global Perspective," 2005.

[31] Joint United Nations Programme on HIV/AIDS (UNAIDS), "Migrants and HIV: 'Far Away from Home' Club," January 5, 2009.

[32] International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted 16 Dec. 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316,1966, 993 U.N.T.S. 3, entered into force 3 Jan. 1976, art. 12.

[33] Universal Declaration of Human Rights (UDHR), adopted December 10, 1948, G.A. Res. 217A(III), U.N. Doc. A/810 at 71 (1948), arts. 2, 7 and 26. UN Human Rights Committee, General Comment 18, Non-discrimination (Thirty-seventh session, 1989), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc. HRI\GEN\1\Rev.1,1994, para. 1.

[34] UN Committee on Economic, Social and Cultural Rights (UNCESCR), "Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights," General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, 2000.

[35] Zhan Shaokang, Sun Zhenwei, and Eric Blas, "Economic Transition and Maternal Health Care for Internal Migrants in Shanghai, China," *Health Policy and Planning*, vol. 17(Suppl.1), 2002, pp. 47-48.
Human Rights Watch, *China – "One Year of My Blood": Exploitation of Migrant Construction Workers in Beijing*, vol. 20, no. 3(C), March 2008. Xiaojiang Hu, Sarah Cook, and Miguel A. Salazar, "Internal Migration and Health in China," *The Lancet*, vol. 372(9651), November 15, 2008, p. 1717.

[36] Amnesty Internal, "People's Republic of China: Internal Migrants: Discrimination and Abuse: The Human Cost of an Economic 'Miracle'," AI Index: ASA 17/008/2007, March 2007. Human Rights Watch, *China – One Year of My Blood*.

[37] Human Rights Watch, *Locked Doors: The Human Rights of People Living with HIV/AIDS in China*, vol. 15, no. 7(C), 2003.

[38] World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS) and UNICEF, Epidemiological Fact Sheet on HIV and AIDS: Core Data on Epidemiology and Response: China: 2008 Update," 2008.

[39] Damian S. Schaible, "Life in Russia's "Closed City": Moscow's Movement Restrictions and the Rule of Law," *New York University Law Review*, vol. 76, April 2001, pp. 344-73.

[40] Ibid. Elina Leviyeva, "The Changing Face of Russian Democracy: Racism and Xenophobia in Russia—Foreign Students Under Attack in Russia and US," *Rutgers Race and the Law Review*, vol. 7, 2005, pp. 229-88. Human Rights Watch, *Russian Federation – Moscow: Open Season, Closed City*, 1997.

[41] Transatlantic Partners Against AIDS, "Federal law "On Prevention of Spreading in the Russian Federation of Disease Caused by the Human Immunodeficiency Virus (HIV infection)": Background, Content, and Perspectives," 2004, available at http://hivpolicy.net/upload/File/RelatedFiles/publication/209/839.pdf (accessed May 20, 2009). World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS) & UNICEF, Epidemiological Fact Sheet on HIV and AIDS: Core Data on Epidemiology and Response: Russian Federation: 2008 Update," 2008.

[42] Human Rights Watch, *Positively Abandoned: Stigma and Discrimination Against HIV-Positive Mothers and Their Children in Russia*, vol. 17, no. 4(D), 2005.

[43] The World Bank, "HIV/AIDS in India: The State of the Epidemic," August 2007. National AIDS Control Organization (NACO), Government of India, "UNGASS Country Progress Report 2008: India," reporting period January 2006-December 2007.

[44] World Health Organization (WHO), Joint United Nations Programme on HIV/AIDS (UNAIDS) and UNICEF, Epidemiological Fact Sheet on HIV and AIDS: Core Data on Epidemiology and Response: India: 2008 Update," 2008. AVERT, "Overview of HIV and AIDS in India," undated.

[45] Ben Rogaly et al., "Seasonal Migration and Welfare/Illfare in Eastern India: A Social Analysis," *Journal of Development Studies*, vol. 38, 2002, pp. 89-114.

[46] Kate Bird and Priya Deshingkar, "Circular Migration in India: Policy Brief No. 4," *ODI World Development Report*, 2009. Actionaid India, "We Are Citizens Too," Say India's marginalized groups," 2007.

[47] International Labour Organization Subregional Office for South Asia, "India: State Government Sponsored Community Health Insurance Scheme," undated.

[48] Preetu Nair, "No Aid for HIV Positive 'Outsiders'," *Gomantak Times Weekender*, February 12, 2006.

[49] World Health Organization, "WHO Model List of Essential Medicines," 2007.

[50] World Health Organization, "WHO Discussion Paper: The Practice of Charging User Fees at the Point of Service Delivery for HIV/AIDS Treatment and Care," 2005.

[51] Joseph J. Amon, "Dangerous Medicines: Unproven AIDS Cures and Counterfeit Antiretroviral Drugs," *Globalization and Health*, vol. 4, 2008.

Notes from Access to Antiretrovirals for International Migrants

[52] International Labor Organization (ILO), International Organization for Migration (IOM) and Joint United Nations Programme on HIV/AIDS (UNAIDS), "Policy Brief: HIV and International Labor Migration," June 2008, p. 1. Ivan Wolffers, Sharuna Verghis and Malu Marin, "Migration, Human Rights, and Health," *The Lancet*, vol. 362, December 13, 2003, pp. 2019-20. See also Prerna Banati, "Risk Amplification: HIV in Migrant Communities," *Development Southern Africa*, vol. 24(1), March 2007, pp. 205-23. United Nations International Institute for the Advancement of Women (UN-INSTRAW) and South African Institute of International Affairs (SAIIA), "Gender, Remittances and Development: Preliminary Findings from Selected SADC Countries," 2007, p. 50. Joint United Nations Programme on HIV/AIDS (UNAIDS), "Population Mobility and AIDS: UNAIDS Technical Update," *UNAIDS Best Practice Collection*, February 2001, p. 4.

[53] "Health of Migrants," Sixty-First World Health Assembly, Agenda Item 11.9, May 24, 2008. UN-INSTRAW and SAIIA, "Gender, Remittances and Development," p. 52.

[54] UN Political Declaration on HIV/AIDS, June 15, 2006, G.A. Res. 60/262, U.N. Doc. A/RES/60/262, para. 20.

[55] Fiona Burns and Kevin A. Fenton, "Access to HIV Care Among Migrant Africans in Britain. What Are the Issues?" *Psychology, Health & Medicine*, vol. 11(1), February 2006, pp. 117-25.

[56] International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted 16 Dec. 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316,1966, 993 U.N.T.S. 3, entered into force 3 Jan. 1976, art. 12.

[57] Universal Declaration of Human Rights (UDHR), adopted December 10, 1948, G.A. Res. 217A(III), U.N. Doc. A/810 at 71 (1948), arts, 2, 7 & 26. UN Human Rights Committee, General Comment 18, Non-discrimination (Thirty-seventh session, 1989), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc. HRI\GEN\1\Rev.1,1994, para. 1.

[58] UN Committee on Economic, Social and Cultural Rights (UNCESCR), "Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights," General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000), paras. 18-19, 30 and 34.

[59] UN Committee on the Elimination of Racial Discrimination, General Recommendation No.30: Discrimination Against Non Citizens (2004), paras. 2, 29 and 36.

[60] International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Migrant Workers Convention), adopted 18 Dec. 1990, G.A. Res. 45/158, annex, 45 U.N. GAOR Supp. (No. 49A) at 262, U.N. Doc. A/45/49,1990, entered into force 1 July 2003, arts. 28 and 43(1)(e).

[61] Constitution of the Republic of South Africa, No. 108 of 1996, s. 7(1) and 27. "Revenue Directive by Department of Health to all Provincial Health Managers and HIV/AIDS Directorates," September 19, 2007, on file with Human Rights Watch.

[62] "Q & A: Denying Antiretrovirals to Migrants Hurts Us All: Interview with Joanna Vearey, Forced Migration Project, Univ. of Witwatersrand," Inter-Press Service, July 15, 2008, http://ipsnews.net/news.asp?idnews=43191 (accessed December 8, 2008). See also Treatment Action Campaign, "Welcome to South Africa?" *Equal Treatment*, June 2008. "South Africa-Zimbabwe: No Documents? No Treatment," IRIN PlusNews, March 28 2008.

[63] Consortium for Refugees and Migrants in South Africa, "Protecting Refugees, Asylum Seekers, and Immigrants in South Africa," June 18, 2008. See also "Joint Submission to the S. African Nat'l Aids Council (SANAC) Plenary, Vulnerable Groups: Refugees, Asylum Seekers, and Undocumented Persons—the Health Situation of Vulnerable Groups in S. Africa," March 4, 2008, pp. 7-8.

[64] Federation International des Droits de L'Homme (FIDH), "Surplus People? Undocumented and Other Vulnerable Migrants in South Africa," January 2008, p. 31.

[65] Human Rights Watch, *Neighbors in Need: Zimbabweans Seeking Refuge in South Africa*, June 2008, p. 23. Treatment Action Campaign, "Welcome to South Africa?" *Equal Treatment*, pp. 10-11.

[66] Theo Smart, "Migrants with MDR-TB in Southern Africa Being Dumped Off at Borders Without Referrals to Care," *Aidsmap*, October 31, 2008.

[67] "Thailand: Burmese Migrants Excluded from AIDS Treatment," IRIN PlusNews, January 15, 2007. Physicians for Human Rights, "No Status: Migration, Trafficking & Exploitation of Women in Thailand," June 2004, p. 45.

[68] Physicians for Human Rights, "No Status," pp. 45-46.

[69] Bryant Yuan Fu Yang, "Life and Death Away from the Golden Land: The Plight of Burmese Migrant Workers in Thailand," *University of Hawaii Asian-Pacific Law & Policy Journal*, vol. 8, Spring 2007, pp. 485-535.

[70] Physicians for Human Rights, "No Status," p. 2.

[71] Simen Tellemann Saether et al., "Migrants' Access to Antiretroviral Therapy in Thailand," *Tropical Medicine and International Health*, vol. 12(8), August 2007, pp. 999-1008, 1004-05.

[72] Physicians for Human Rights, "No Status," pp. 1-4.

Notes from Deportation and Treatment for HIV-Positive Migrants

[73] See, e.g., International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, arts. 12(1) & 2.2. Rick Lines, "The Right to Health of Prisoners in International Human Rights Law," International Journal of Prisoner Mental Health, vol. 4(1), 2008, pp. 3-53. Rick Lines, "From Equivalence of Standards to Equivalence of Objectives: The Entitlement of Prisoners to Health Care Standards Higher than Those Outside Prisons," International Journal of Prisoner Health, vol. 2(4), 2006, pp. 1-12.

[74] Human Rights Watch, United States – Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States, vol. 19, no. 5(G), December 2007, p. 2. Human Rights Watch, Saudi Arabia – Bad Dreams: Exploitation and Abuse of Migrant Workers in Saudi Arabia, vol. 16, no. 5(E), July 2004.

[75] European Convention for the Protection of Human Rights and Fundamental Freedoms, 213 U.N.T.S. 222, entered into force September 3, 1953, as amended by Protocols Nos 3, 5, 8, and 11 which entered into force on September 21, 1970, December 20, 1971, January 1, 1990, and November 1, 1998, respectively, art. 3. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention Against Torture), adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (no. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, art. 3. International Covenant on Civil

and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, art. 7.

[76] Convention relating to the Status of Refugees, 189 U.N.T.S. 150, entered into force April 22, 1954, art. 33. See also Protocol Relating to the Status of Refugees, 606 U.N.T.S. 267, entered into force October 4, 1967.

[77] Immigration Equality and Midwest Immigrant & Human Rights Center, "Winning Asylum, Witholding and CAT Cases Based on Sexual Orientation, Transgender Identity and/or HIV Positive Status," undated. Lynda L. Ford, "HIV Afflicted Haitians: New Hope When Seeking Asylum," The University of Miami Inter-American Law Review, vol. 36, Winter-Spring 2005.

[78] Volker Türk and Frances Nicholson, "Refugee Protection in International Law: An Overall Perspective in Refugee Protection," in Erika Feller et al., eds., International Law: UNHCR's Global Consultations on International Protection (Cambridge, UK: Cambridge University Press, 2003), pp. 3, 6.

[79] Deutsche AIDS-Hilfe e.V., "Quick Reference: Travel and Residence Regulations for People with HIV and AIDS –Information for Counsellors in AIDS Service Organizations—2008/2009, Karl Lemmen & Peter Wiessner, 8th edition, September 2008, p. 4. Ministry of Legislation, "Immigration and Control Act (Republic of Korea)." See also "The Global Database on HIV Related Travel Restrictions," www.hivtravel.org.

[80] CARAM Asia, "State of Health of Migrants 2007: Mandatory Testing," 2007, p. 156.

[81] Bae Ji-Sook, "Deportation of HIV Positive Violates Human Rights," Korea Times, March 3, 2008.

[82] See, e.g., Joseph Amon, "Blaming Foreigners," Korea Times, March 12, 2009.

[83] Deutsche AIDS-Hilfe e.V., "Quick Reference," p. 35.

[84] "Eighty AIDS Virus-Carrier Expatriates Deported from Saudi Arabia," Arab News, March 21, 1994.

[85] Mark MacKinnon, "Saudis Jail, Deport Foreigners with HIV," The Globe and Mail (Canada), August 9, 2005.

[86] Action for Health Initiatives Inc. (ACHIEVE Inc.) and Coordination of Action Research on AIDS and Mobility (CARAM-Philippines), "Health at Stake: Access to Health of Overseas Filipino Workers: 2005 Report," 2005.

[87] Immigration and Nationality Act, sec. 101(a)(42). See also Ford, "HIV Afflicted Haitians," The University of Miami Inter-American Law Review, pp. 299-301.

[88] Immigration Equality and Midwest Immigrant & Human Rights Center, "Winning Asylum, Witholding and CAT Cases Based on Sexual Orientation, Transgender Identity and/or HIV Positive Status." Ford, "HIV Afflicted Haitians," The University of Miami Inter-American Law Review, pp. 293-94.

[89] Ruma Mandal, "Protection Mechanisms Outside of the 1951 Convention ("Complementary Protection")," UNHCR Legal and Protection Policy Research Series, June 2005, pp. 88-90.

[90] August v. Ridge, 395 F.3d 123 (3d Cir. 2005). Paul Pierre v. Attorney General of the United States, 528 F.3d 180 (3d Cir. 2008).

[91] Brian Lonegan, "American Diaspora: The Deportation of Lawful Residents from the United States and the Destruction of their Families," New York University Review of Law and Social Change, vol. 32, p. 76.

[92] K.C. Brouwer et al., "Deportation Along the U.S.-Mexico Border: Its Relation to Drug Use Patterns and Accessing Casre," Journal of Immigrant and Minority Health, February 5, 2008.

[93] Inter-American Commission on Human Rights, Andrea Mortlock Case, Judgment of July 25, 2008, report no. 63/08, case 12.534.

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Discrimination, Denial, and Deportation

Human Rights Abuses Affecting Migrants Living with HIV

Hundreds of millions of people cross borders annually, traveling and migrating for work or school, for family reasons, or to flee persecution or natural disasters. Migrants often face discrimination, language and cultural barriers, and other obstacles to health care, but those who are living with HIV face even greater problems: they can be denied legal entry, turned away from care, and deported because of their infection.

Discrimination, Denial, and Deportation: Human Rights Abuses Affecting Migrants Living with HIV identifies how violations of international law threaten both the lives of HIV-positive migrants and their families, and the goals of universal access to prevention and treatment that governments have pledged.

Governments worldwide should immediately eliminate HIV-related restrictions on entry, stay and residence, and remove discriminatory barriers to access to HIV prevention and treatment services for internal and international migrants. Individuals in detention awaiting deportation need to be provided with access to care and treatment. Governments must ensure that individuals previously receiving antiretroviral therapy are able to maintain access to treatment in detention and take steps to facilitate continuity of treatment upon deportation.

Migrant workers attend an event promoting HIV/AIDS knowledge among migrants in southwest China.