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A critical analysis of the right to health of failed asylum seekers and illegal migrants living with HIV and AIDS.

Ross Davies

Keele University

LLM Gender, Sexuality and Human Rights Law

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ABSTRACT

Failed asylum seekers and illegal migrants might remain in the UK for months and sometimes years before they can be repatriated, with no access to free treatment for HIV/AIDS. The issues of migration and HIV/AIDS both suffer from the fear of the alien 'other' which can inhibit the basic rights of those involved. It is at the intersection of these two matters where the issue of migrant health lingers.

Despite the internationally recognised right to health, HIV/AIDS has slipped down the domestic political agenda even as the Government has won plaudits internationally for its actions overseas. In February 2005, the Parliamentary Under Secretary of State for International Development, Gareth Thomas, MP stated that "the UK supports efforts to provide increased, and eventually universal, access to treatment and care for people with AIDS."[1] This Government commitment, however, is not matched at home where HIV/AIDS services are failing to meet the needs of African migrant communities in the UK, especially undocumented migrants.

Whilst measures such as the charges regulations might quieten public fears and demonstrate apparent Government action on HIV/AIDS, they are unlikely to have much effect on the progress of the HIV/AIDS epidemic in the UK. Not only is it inhumane to diagnose but not treat HIV/AIDS, it also undermines the Government's commitment to managing the spread and effects of HIV/AIDS worldwide. Everyone, irrespective of immigration status should be entitled to free medical care for HIV/AIDS while they are present in the UK.

[1] HC Deb February 2005 c792W

ABBREVIATIONS

A&E	Accident and Emergency Department
ACPO	Association of Chief Police Officers
AHPN	African HIV Policy Network
AIDS	Acquired Immune Deficiency Syndrome
APPGA	All-Party Parliamentary Group on AIDS
ART	Antiretroviral Therapy
BMA	British Medical Association
BMJ	British Medical Journal
CESCR	United Nations Committee on Economic, Social and Cultural Rights
DFID	Department for International Development
ECHR	European Convention on Human Rights
ECRI	European Commission against Racism and Intolerance
EU	European Union
G8	Group of 8 - The countries of Canada, France, Germany, Italy, Japan, Russia, the United Kingdom, and the United States.
GHT	George House Trust
GP	General Practitioner (UK doctor)
GUM	Genito-Urinary Medicine
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IOM	International Organisation for Migration
NAT	National AIDS Trust
NHS	National Health Service
OHCHR	Office of the United Nations High Commissioner for Human Rights
PCT	Primary Care Trust
STI	Sexually Transmitted Infection
TB	Tuberculosis
THT	Terrence Higgins Trust
UK	United Kingdom of Great Britain and Northern Ireland
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCHR	United Nations High Commissioner for Human Rights
UNICEF	United Nations United Nations Children's Fund
UNGASS	United National General Assembly Special Session on HIV/AIDS
US	United Stated of America

INTRODUCTION

Forced migrants, asylum seekers and refugees are arguably the most marginalised people in the world. Away from their homeland, often away from family and friends, they occupy a peculiar place in the law. They are often stateless and may not have legal recognition in the countries through which they pass or in their destination / host country. Those whose claims for asylum have been refused and illegal migrants may find themselves in a position where they have no legal status, no access to state benefits, no right to seek employment, no support network of family, friends or a wider community and are denied access to free health care, including treatment for HIV/AIDS.[2]

In 2005 the House of Lords ruled in *N v Secretary of State for the Home Department*[3] that failed asylum seekers with HIV/AIDS do not have the right to stay in the UK in order to receive treatment for their condition, and that deporting such a person to their country of origin would not constitute a breach of Article 3 of the European Convention on Human Rights (ECHR) which states that:

> No one shall be subjected to torture or to inhuman or degrading treatment or punishment.[4]

Whilst there has been a limited amount of critical analyses of this case which focus on the ethics of the expulsion of people with HIV/AIDS[5], they do not address the issue of

[2] In line with many academics and non-government organisations the composite "HIV/AIDS" will be used throughout this paper.
[3] [2005] UKHL 31
[4] Full text of the ECHR can be seen at: http://conventions.coe.int/treaty/en/Treaties/Html/005.htm (retrieved 18/04/06)
[5] See, for example, Sawyer, C. (2004) "Insufficiently Inhuman: removing AIDS patients from the UK", *Journal of Social Welfare and Family Law* 26(3) 281-288; Palmer, S. (2005) "AIDS, Expulsion and Article 3 of the European Convention on Human Rights" *EHRLR* 2005, 5, 533-540; Gill, P. (2006) Body

the access to treatment of failed asylum seekers who are still present in the UK. This dissertation will argue that while such people remain in the UK they should be entitled to receive free treatment for HIV/AIDS. This dissertation does not provide a detailed analysis of deportation case law, nor does it examine the application of Article 3 of the ECHR.

The inter-relationship between migration and HIV/AIDS has been addressed by many authors[6], but most comprehensively by Haour-Knipe and Rector.[7] Their book brings together the work of many different writers and explores a myriad of issues, including a chapter on asylum seekers and clandestine migrants.[8] The chapter, however, does not detail the difficulties faced by such populations in accessing healthcare or the human rights arguments for allowing them to do so.

Although there are many publications on the related issues of the HIV/AIDS and migration, including the testing and screening of migrants[9], the detention and dispersal of asylum seekers with HIV/AIDS[10], HIV/AIDS and human rights[11], high HIV/AIDS-

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Count: How they turned AIDS into a catastrophe, London, Profile Books; and Oder, J. (2005) "Living with HIV/AIDS not a bar to deportation" 15 *Interights Bulletin* 91

[6] There are too many to present a comprehensive list but see, for example, Williamson, K. (2004) AIDS, Gender and Refugee Protection Framework, Masters thesis, University of Oxford, Refugee Studies Centre, Working Paper 19, Oxford; UNAIDS and IOM, (1998) "Migration and AIDS", *International Migration* Vol. 36 (4) 1998 p. 445; AIDS Infoteque (2000) Migration and HIV/AIDS in Europe Sida Info Doc Suisse 5/00 p. 4-14; AVERT, HIV, Immigrants and Immigration at http://www.avert.org/hivmigrants.htm (retrieved 18/04/06); Weston, H. (2003) Safe Haven? Immigration, Asylum and HIV in the UK, Naz Project, London;

[7] Haour-Knipe, M. and Rector, R. (eds.) (1996) Crossing Borders: Migration, Ethnicity and AIDS London, Taylor and Francis

[8] Matteelli, A. El-Hamad, I. "Asylum Seekers and Clandestine Populations" in Haour-Knipe and Rector

[9] See All-Party Parliamentary Group on AIDS, (2003) Migration and HIV: Improving Lives in Britain – An Inquiry into the impact of the UK Nationality and Immigration System on People Living with HIV, London; National AIDS Trust, (2003)Mandatory HIV Testing of Migrants: NAT Discussion Paper, London

[10] See NAT, (2006) Dispersal of Asylum Seekers with HIV, London

[11] See Gostin, L. and Lazzarini, Z. (1997)Human Rights and Public Health in the AIDS Pandemic, Oxford, Oxford University Press; Creighton, S. *et al* (2004) "Dispersal of HIV positive asylum seekers: national survey of UK healthcare providers" *BMJ* 2004, 329: 322-3; NAM Immigration, migration and HIV for African communities at http://www.aidsmap.com/cms1008896.asp (retrieved: 13/01/06)

prevalence in migrant communities[12] and the prohibition of refoulement under Article 3 of the ECHR[13], research on the right to health of failed asylum seekers and illegal migrants with HIV is somewhat lacking.[14] This dissertation aims, to an extent, to fill that gap, taking a holistic approach to the concept of human rights for failed asylum seekers and illegal migrants. The aim of this paper is also to point the finger of blame at the Government[15] for failing to protect the health rights of failed asylum seekers and illegal migrants living in the UK, especially since the introduction of the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004 which prevent undocumented migrants from accessing free treatment for HIV/AIDS.

This dissertation is a theoretical exploration of how the Government justifies withholding treatment for HIV/AIDS for failed asylum seekers and illegal migrants and how this sits at odds with UK international development policy and universal declarations of human rights. Relevant theoretical literature, scholarly and news articles and declarations were examined. This exploration could have been further substantiated through holding interviews with medical practitioners, government officials and failed asylum seekers and illegal migrants but given the limitations of resources these were not conducted. Additionally the difficulty of contacting failed asylum seekers and illegal migrants would have to be addressed as many do not wish to be noticed, so obtaining their involvement in an academic study would be challenging. Although their

[12] See Weatherburn, P. *et* al, (2003) Project Nasah: An investigation into the HIV treatment information and other needs of African people with HIV resident in England London; Brady, R. (2006) Destitution, Vulnerability, Deprivation – the experience of Africans living with HIV in the UK? Crusaid, The National African HIV Conference, London 19 May 2006

[13] See Ovey, C. (2001) Prohibition of Refoulement: The meaning of Article 3 of the ECHR ELENA International Course on the European Convention on Human Rights in relation to Asylum, 26-28th January 2001, Strasbourg, http://www.ecre.org/elenahr/art3.pdf (retrieved 14/03/06); Cooper, J. (2003) Cruelty: An analysis of Article 3, London, Sweet and Maxwell

[14] For a wider examination of access to healthcare in the EU see Romero-Ortuño, R. (2004) "Access to healthcare for illegal immigrants in the EU: should we be concerned?" *European Journal of Health Law* 11:245-2752

[15] All references to the Government are to the UK Government.

voices would have added credence to this dissertation the author chose to focus on the broader legal issues.

While it has been argued by Kesby *et al* that the epidemiology of the recent rise in HIV cases in Britain highlights the needs for more research among the heterosexual African migrant population,[16] work especially needs to be undertaken to investigate the impact of domestic policy on failed asylum seekers and illegal migrants who remain a remarkably under-researched population subgroup.

Chapter 1 will provide background information on the internationally recognised right to health and will demonstrate how the Government is failing to protect this right by barring those without legally recognised residential status access to free healthcare, specifically treatment for HIV/AIDS. The Chapter will then explore how creative judicial interpretation could be used to protect the right to health. Chapter 2 will investigate the right to health of refugees and asylum seekers, especially failed asylum seekers and illegal migrants. It will demonstrate how the right to health is dependent upon legal presence in the state and will introduce the intersection of the issues of migrants' right to health and access to treatment for HIV/AIDS. Chapter 3 will further explore the intersection of migration and HIV/AIDS and will demonstrate how failed asylum seekers and illegal migrants have the least access to healthcare and deserve extra, not less support. It will then go on to explore the growing rates of HIV prevalence in African migrant communities in the UK and will examine how the Government are not adequately supporting these communities, especially those without

[16] Kesby, M *et al* (2003) "An agenda for future research on HIV and sexual behaviour among African migrant communities in the UK", *Social Science and Medicine* 57 (2003) 1573-1592

legal status. The chapter will introduce the concept of HIV/AIDS-related stigma and discrimination which will be further examined in the next Chapter. Chapter 4 will examine the discrimination, both institutional and non-institutional, that occurs when the issues of migration and HIV/AIDS collide. It will also examine the concept of 'health tourism' as a justification for refusing to treat failed asylum seekers and illegal migrants with HIV/AIDS. This dissertation will conclude by investigating the Government's waning domestic commitment to HIV/AIDS. It will be argued that despite the Government's proclamations that they are committed to combating the HIV/AIDS epidemic in the developing world, the same commitment is lacking at home where the Government policies that are denying access to healthcare are discriminatory and not only profoundly effect the health of the individual but also that of the general public. As will be demonstrated, the Government's decision to withdraw free services from failed asylum seekers and illegal migrants without the ability to pay for their care will add to the HIV/AIDS epidemic and amounts to a breach of human rights law.

CHAPTER 1: Human Rights - the right to health

This opening Chapter will look at the internationally recognised right to health and will demonstrate how the Government is violating this right by barring those without legally recognised residential status access to free healthcare, specifically treatment for HIV/AIDS. As will be shown below, the right to health is a fundamental human right which precludes discrimination in access to healthcare. The chapter will show how creative judicial interpretation can change domestic policy and respect the right to health, even when the right is not enshrined in constitutional law.

1.1 Human rights discourse and the right to health in international law

Human rights discourse is based on principles of equality, on the premise that all humans possess the same equal worth which should be respected.[17] To emphasise this point, Higgins states that human rights are not necessarily legal rights, but are "rights which all persons hold by virtue of the human condition. They are thus not dependent upon grant or permission of the state and they cannot be withdrawn by fiat of the state."[18]

The United Nations Committee on Economic, Social and Cultural Rights (CESCR) has stated that health is a fundamental human right indispensable from the exercise of other human rights.[19] CESCR's General Comment 14 states that the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and

[17] Williamson, op. cit., p. 17
[18] Higgins, R. (1997/8) International Protection of Human Rights, LLM Course Materials, Vol. 1 Part 1. London School of Economics, quoted in Kuper, J, (2004) Law as a Tool: The Challenge of HIV/AIDS, Crisis States Research Centre, London School of Economics p. 24
[19] Committee on Economic, Social and Cultural Rights, General Comment No. 14 (2000), para. 1

conditions necessary for the realisation of the highest attainable standard of health.[20] The International Covenant on Economic, Social and Cultural Rights (ICESCR), ratified by the UK in 1976, provides the most comprehensive article on the right to health in international human rights law. Article 12.1 of ICESCR specifically addresses the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including access to medical services.[21]

Paragraph 1 of the World Health Organisation and UNICEF Declaration of Alma Ata in 1978 reaffirms that:

> health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.[22]

While it is recognised that "a state of complete physical, mental and social wellbeing" is an unrealistic goal to set states, the state does possess the power to ensure the conditions under which people can be healthy.[23] It is this power that is being abused in the UK through the denial of free HIV/AIDS treatment to failed asylum seekers and illegal migrants in the UK, thereby denying them the opportunity to live a healthy life.

1.2 Human Rights, the right to health and HIV/AIDS

Respect for human rights is essential for effective responses to HIV/AIDS as infringements of human rights lie at the heart of marginalisation and the creation and

[20] Ibid, para 9
[21] The full text of the ICESCR can be seen at: http://www.unhchr.ch/html/menu3/b/a_cescr.htm (retrieved 12/03/06)
[22] WHO and UNICEF (1978) Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, para. 1
[23] Gostin and Lazzarini, op. cit., p. 29

continuation of vulnerability.[24] UNAIDS has accepted the importance of human rights in the battle against HIV/AIDS and has declared that it "has adopted a rights-based approach in its policies, programmes and activities" and "works to mainstream HIV/AIDS into human rights and vice versa".[25]

Although there are no binding international human rights treaties that specifically focus on HIV/AIDS, existing international treaties contain numerous principles relevant to the issue, including, but certainly not limited to, the right to life, to liberty, to security, to health, to education, to freedom from torture and inhuman treatment, to freedom from discrimination. Many Governments have made political commitments regarding HIV/AIDS in UN resolutions and declarations. The Office of the United Nations High Commissioner for Human Rights (OHCHR) has stated that "the protection and promotion of human rights are… essential in preventing the spread of HIV and to mitigating the social and economic impact of the pandemic" and that "an effective international response to the pandemic there must be grounded in respect for all civil, cultural, economic, political and social rights.[26]

The International Guidelines on HIV/AIDS and Human Rights were developed in 1996 at the second International Consultation on HIV/AIDS and Human Rights, convened jointly by the OHCHR and UNAIDS. They provide explicit benchmarks to implement and measure performance in developing an effective rights-based response to the epidemic and clarify obligations in existing human rights instruments. Many of these

[24] UNAIDS, (2001) Fighting HIV-related Intolerance: Exposing the links between Racism, Stigma and Discrimination The World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance, Durban, South Africa, p. 13
[25] UNAIDS, UNAIDS activities in HIV/AIDS, Human Rights and Law, at http://data.unaids.org/UNA-docs/UNAIDS-Activities-Human-Rights-Law_en.pdf (retrieved 12/03/06)
[26] OHCHR, Introduction to HIV/AIDS and Human Rights at http://www.ohchr.org/english/issues/hiv/introhiv.htm (retrieved 12/01/06)

instruments use the term "or other status" which the OHCHR has resolved "should be interpreted to include health status, including HIV/AIDS."[27] Human rights instruments can therefore offer protection to people with HIV/AIDS from discrimination. In emphasising the relationship between human rights and HIV/AIDS, Piot and Ayala-Lasso have stated that "people cannot fully enjoy and exercise their human rights if they are not healthy, and people cannot remain healthy if they are deprived of their rights."[28]

1.3 State responsibility for protecting the right to health

According to Kuper, every country in the world is party to at least one human rights treaty that calls for the provision of health-related rights.[29] The international human rights treaties thus provide a legal framework for defining state obligations in protecting HIV/AIDS-related human rights and a resource for implementing human rights protections through legal proceedings in the national arena.[30]

By virtue of article 2.2 and article 3, the International Covenant on Economic, Social and Cultural Rights (ICESCR)

> proscribes any discrimination in access to healthcare and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of … health status (including HIV/AIDS) ….which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.[31]

[27] Cited in All-Party Parliamentary Group on AIDS (2001) The UK, HIV and Human Rights: Recommendations for the next five years, London p. 10
[28] Piot, P. and Ayala-Lasso, J. Foreword, in Gostin, L. and Lazzarini, Z. (1997) Human Rights and Public Health in the AIDS Pandemic, Oxford, Oxford University Press, p. vii
[29] Kuper, op. cit., p. 27
[30] MacNaughton, G. (2004) Women's Human Rights related to health care services in the context of HIV/AIDS, Health and Human Rights Working Paper Series No 5, London, The International Centre for the Legal Protection of Human Rights p. 15
[31] CESCR, General Comment No. 14 (2000), para. 18

The ICESCR therefore acknowledges the responsibility of the state and society for health within that society.[32] The CESCR's General Comment No. 14 asserts that under the ICESCR

> 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 preventative, curative and palliative health services; abstaining from enforcing discriminatory practices as a state policy; and abstaining from imposing discriminatory practices relating to women's health status and needs.[33]

The UK is failing in this obligation by overtly discriminating against certain categories of migrants in denying them access to medical treatment and by singling out HIV/AIDS from the exemptions from charges the Government is directly discriminating against those with HIV/AIDS. In its General Comment 9, CESCR has emphasised that it is up to states how they give effect to the rights contained in the International Covenant, including the right to health, but whatever arrangements they choose they must be effective.[34]

Despite these affirmations of the right to health, however, almost all international human rights rules are subject to limitations, and it is important to note that this body of law is also subject to the concept of a 'margin of discretion'.[35] According to this concept, countries are allowed leeway as to how they interpret or apply particular human rights provisions. As the right to health, like other economic and social rights, is not codified in domestic law, it is subject to interpretation, adjudication and enforcement by courts.

[32] Feldman, D. (2005) The Contribution of Human Rights to Improving Public Health a lecture delivered at the London School of Hygiene and Tropical Medicine, London
[33] CESCR, General Comment No. 14, para. 34. original emphasis
[34] Committee on Economic, Social and Cultural Rights, (1998) General Comment 9, para. 1 and 2
[35] Kuper, op. cit., p. 27

1.4 Judicial interpretation and the right to health

Byrne illustrates how the innovative applications of international human rights law in commonwealth and other courts has helped develop the right to health for people with HIV/AIDS. [36] He shows how non-codification of the right to health in domestic law is not necessarily a bar to both consideration and enforcement by the courts of healthcare and treatment issues.[37] Byrne's paper illustrates the contradiction in the application of the right to health between developed economies in the Commonwealth which do not explicitly recognise health rights and developing countries of the Commonwealth that do.[38] He states that in the absence of constitutional protection for health rights "much will depend upon how far courts will be prepared to go in offering creative but legitimate approaches which do not exceed the scope of judicial powers."[39]

One of the ways that Byrne demonstrated how courts protect health rights is through

> adopting expansive definitions of civil rights some of which tend to be widely if not universally guaranteed under domestic law, e.g. rights to life or not be subjected to cruel, inhuman or degrading treatment.[40]

This approach has been sanctioned by the UN Human Rights Committee in its General Comment No. 6 para. 5 on the right to life where it stated that

> the right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to … increase life expectancy, especially in adopting measures to eliminate … epidemics.[41]

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[36] Byrne, I. Making the Right to Health a Reality: Legal Strategies for Effective Implementation, Commonwealth Law Conference, London, September, 2005. p. 2
[37] Ibid, p. 1
[38] Ibid. p. 6
[39] Ibid. p. 14
[40] Ibid.
[41] UN Human Rights Committee, General Comment No. 06: The right to life (art. 6):30/04/82. CCPR General Comment No. 6. (General Comments) para. 5

Byrne acknowledges that in the UK, where health rights are not entrenched, this is still an emerging area of law which has a mixed record of success.[42] The judges in the case of *N v Secretary of State for the Home Department,* for example, could have used their skills of legal interpretation to realize the right to health of a failed asylum seeker with HIV, following the earlier European case of *D v UK*[43] where the UK was prevented from deporting a man who was dying from an AIDS-related illness to a country where treatment and care would not be available to him. The Law Lords accepted that N's plight was indeed desperate and expressed sympathy toward her situation. However, they refused to grant her permission to appeal to stay in the UK, effectively deporting her to Uganda to die since treatment for her condition was not readily available to her.[44]

Cover once wrote that "legal interpretation takes place on a field of pain and death."[45] He argues that the judiciary has a special, active role in protecting minorities and that "against hysterical politics it is necessary to offer protection, make amends, award compensation."[46] Such protection was not offered to N. Using the example of slavery in the United States, Cover demonstrated that judges there could have used available legal materials to argue for the abolition of slavery.[47] The puzzle that Cover poses is why they did not do so. The judges in *N* were also entangled in a moral struggle, here between the Government's argument for the expulsion of N and humanitarian arguments for allowing her to stay. Unfortunately for N, the Law Lords lacked the conviction to allow her to remain. Exhibiting what Cover called the "judicial can't"[48],

[42] Byrne, op. cit., p. 20
[43] *D v UK* (30240/96) (1997) 24 EHRR 423 (ECtHR)
[44] See *N* for the facts of the case
[45] Cover, R. (1986) "Violence and the Word" 95 *Yale Law Review* 1601
[46] Cover, R. (1982) "The origins of judicial activism in the protection of minorities" 91 *Yale Law Journal* 1287-1316
[47] Cover, R. (1975) Justice Accused: Antislavery and the judicial process Yale University Press, New Haven
[48] Cover, R. Ibid. p. 119

the judges "revealed and then shaped their own characters as obedient servants rather than leaders."[49] Minow has written that Cover suggests that most judges would "respond to the plural dimensions of normative argument by selecting the most rigid thread and, at the same time, denying their own responsibility for that choice."[50] This is certainly evidenced in the case of *N* where, although all of the Law Lords expressed sympathy for N, Hope LJ stated that "judges must examine the law in a way that suppresses emotion of all kinds".[51] As FitzGibbon states, however,

> the issue in N's case does not really have anything to do with emotions: it is whether knowingly sending a person to a preventable death amounts to inhuman or degrading treatment. Either it does or it doesn't. To say it does is not a judgment based on inappropriate - or indeed on any – emotion.[52]

1.5 Chapter conclusion

As this Chapter has shown, the UK Government and judiciary have been reluctant to extend the fundamental human right to health to failed asylum seekers and illegal migrants who have HIV/AIDS. Creative judicial interpretation displayed elsewhere in the world has, with regards to the right to health failed asylum seekers and illegal migrants, been absent in the UK. Despite ratifying the ICESCR in 1976, the UK does not fully recognise or apply the international right to health enshrined in it. As will be shown below, the Government's insistence that illegal migrants are abusing the National Health Service has led them to derogate from the right to health.

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[49] Minow, M. "Introduction" to Minow *et al* (eds.) (2004) Narrative, Violence and the Law: the essays of Robert Cover, Ann Arbor, The University of Michigan Press, p. 5
[50] Ibid.
[51] *N v Secretary of State for the Home Department* [2005] UKHL 31, Hope LJ, para. 20
[52] See FitzGibbon, F. (2005) The case of N for an analysis of this case www.doughtystreet.co.uk/news/news_detail.cfm?iNewsID=120 (retrieved 07/08/06)

In the case of *N* the Law Lords effectively closed the door on the argument that HIV/AIDS sufferers can rely on Article 3 to prevent their removal from the UK and demonstrates that a restricted reading of the ECHR can protect states from obligations to non-nationals. With the development of treatment for HIV/AIDS in the UK it is rare that a sufferer will be at death's door in the UK. Ironically, sufferers who do not commence anti-retroviral therapy in the UK would, according to Walsh and Brander, have much better chance of succeeding in relying on Article 3 to prevent their removal, but at a very high cost[53]

[53] Walsh, J. and Brander, R. (2005) "Public Law Update" *NLJ* 155.7183 (1005)

CHAPTER 2: Health rights of failed asylum seekers and illegal migrants

This Chapter will demonstrate how the right to health is dependent upon ones legal presence in the state. Those without proper authority to be in the country cannot rely on international human rights instruments such as the 1951 Convention relating to the Status of Refugees. This means that because of their very nature as failed asylum seekers and illegal migrants, many people in the UK are therefore denied the right to access publicly funded healthcare. As will be shown below and in subsequent chapters, in the context of HIV/AIDS this is ethically indefensible, unlawful from a human rights perspective and extremely damaging to individual and public health.

2.1 Lack of health rights for failed asylum seekers and illegal migrants

Under Article 23 of the 1951 Convention relating to the Status of Refugees, states parties shall accord to refugees *lawfully staying* in their territory the same treatment with respect to public relief and assistance as is accorded to their nationals, including medical care.[54] Countries of asylum are therefore responsible for ensuring equal and non-discriminatory access to healthcare service, including treatment for HIV/AIDS, for refugees and asylum seekers whose claims are being processed.[55] Should an individual's claim for asylum fail before they are diagnosed with HIV, however, they are not entitled to free treatment in the UK.[56]

[54] Full text of the Convention is available at: http://www.unhchr.ch/html/menu3/b/o_c_ref.htm (retrieved 18/04/06) Emphasis added
[55] UNAIDS, (2005) Strategies to support the HIV-related needs of refugees and host populations, Geneva p. 9
[56] See discussion below on the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004

The right to health in the UK is, under the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004, dependent upon legal presence in the country. It is unethical to refuse to treat people who are without such authority and goes against the *raison d'être* of the National Health Service and the General Medical Council's Duties of a Doctor.[57] This is especially true of those with HIV/AIDS since their presence in the UK without treatment is a great risk to both their personal and public health. In relation to access to treatment for undocumented migrants with HIV/AIDS in the UK, it is clear that, despite healthcare being regarded as a fundamental human right, the "supremacy of *human rights of persons over social rights of citizens* becomes less evident."[58]

Neil Gerrard MP, Chair of the All-Party Parliamentary Group on AIDS, has accepted the importance of the right to health by highlighting the statement in the UNAIDS document Migrants Right to Health that "as long as any segment of the population (whether or not they are present legally) is neglected in public health terms, then the global response to AIDS will be limited and there will be concomitant cost and suffering."[59]

As stated by Romero-Ortuño, "national legislations and implementation practices need to be upgraded in order to grant illegal immigrants effective access to healthcare, as mandated by human rights law."[60] The fact that no EU Member State, including the UK, has ratified the Convention on the Protection of the Rights of All Migrant Workers

[57] General Medical Council, Duties of a Doctor, at http://www.gmc-uk.org/guidance/library/duties_of_a_doctor.asp (retrieved 20/01/06)
[58] Romero-Ortuño, R (2004), op. cit., p. 249 original emphasis
[59] APPGA (2003), op. cit., p. 2
[60] Romero-Ortuño, R. (2004) op. cit., p. 245

and Members of their Families[61] symbolises what Taran calls "a broader general resistance to recognition of application of human rights standards to migrants, particularly undocumented migrants."[62] Van Krieken also notes that this "virtual exclusion of illegals would appear to confirm that the present state of human rights focuses on citizens, and tries to be accommodating to non-nations, as long as they are lawfully present."[63] The European Commission has acted to remind Member States that "illegal immigrants are protected by universal human rights standards and should enjoy the same *basic* rights e.g. *emergency* healthcare."[64] Whilst the European Convention on Human Rights would appear to guarantee rights to everyone within a state's jurisdiction, no protection is offered to foreign nationals within the territory who are liable to expulsion. The rights are therefore not as universal as they would appear, but are instead dependent on nationality or immigration status.[65]

2.2 Chapter conclusion

Despite the ethical duties of medical professionals and the serious health implications for undocumented migrants, the UK is reluctant to extend full healthcare coverage to undocumented migrants. What is needed is a health service that does not actively discriminate against failed asylum seekers and illegal migrants, especially those with HIV/AIDS: everyone, irrespective of immigration status should be entitled to free

[61] Full text of the convention can be seen at: http://www.ohchr.org/english/law/cmw.htm (retrieved 18/04/06)
[62] Taran, P.A. (2000) "Human Rights of Migrants: challenges of the new decade", *International Migration* 38 (6), p. 18
[63] Van Krieken, P. (2000) "Health and continued residence: reason or pretext", *European Journal of Health Law* 7 (1), p. 35, cited in Romero-Ortuño, op. cit., p. 249
[64] European Commission (2003) Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions on immigration, integration and employment [COM (2003) 336 final] Brussels: Commission of the European Communities, p. 26. Cited in Romero-Ortuño, op. cit., p. 250 emphasis added
[65] See Sawyer, C. on human rights and territoriality op. cit.

medical care for HIV/AIDS while they are present in the UK. Migrants, especially those from countries of high HIV-prevalence such as sub-Saharan Africa, are in need of extra care and support, not the complete denial of it. To refuse care on the basis of immigration status is to deny the human rights of those affected.

CHAPTER 3: The intersection of migration and HIV/AIDS – African communities in the UK

This Chapter will explore the relationship between migration and HIV/AIDS and will demonstrate how both concepts are engulfed in fear and stigmatisation of the alien 'other'. The intersection of migration and HIV/AIDS create a double burden on those affected. This Chapter will explore how the factors that drive migration are the same as those behind the HIV/AIDS epidemic and will highlight how risk behaviours and social inequalities can add to the HIV/AIDS epidemic. Having examined international declarations and legal requirements in Chapter 1 these will now be contextualised through focusing on African migrant communities in the UK. These communities are of special interest because their HIV-prevalence rate is higher than the UK national average and because they have a relative high number of failed asylum seekers and illegal migrants with HIV/AIDS. This Chapter will illustrate the growing prevalence of HIV/AIDS in African communities in the UK and will demonstrate how Government policies are failing to tackle the problem. The Government has not matched its international strategy and funding commitments in the UK, leaving African migrants especially vulnerable. The Chapter identifies HIV/AIDS-specific problems for African migrant communities in the UK, including undiagnosed infections, deterrents to testing and late presentation. The Chapter concludes with an examination of HIV/AIDS-related stigma within African communities. Stigma is a barrier to accessing treatment and can lead to inept Government policies which compound stigma toward African communities and those with HIV/AIDS. This will enable us to then consider issue of HIV- and AIDS-related stigma and discrimination.

3.1 Migration and HIV/AIDS

Haour-Knipe and Rector claim that HIV/AIDS and migration are two of the greatest social issues facing the world today.[66] People with HIV/AIDS and migrants both experience marginalisation from resources and lack of respect for human rights.[67] Haour-Knipe succinctly highlighted the link between HIV/AIDS and migration when she stated that

> HIV thrives in situations of powerlessness, poverty, exploitation and social exclusion. The factors that drive migration are the same as those behind the AIDS epidemic: social inequalities, economic imbalances and non-respect of rights—factors that push people to migrate also make migrants vulnerable to HIV.[68]

The very process of forced migration makes migrants and those who seek asylum at increased risk of infection. They may be exposed to the increased danger of HIV infection in all stages of their refugee experience: during conflict in their country of origin, in transit, their settlement, and even during their repatriation. At each stage of the refugee experience poor living conditions, inadequate access to healthcare and lack of employment all increase their risk of infection.[69] Being a migrant is in itself not a risk factor for infection with HIV/AIDS, it is the risk behaviours and social inequalities which are experienced during the migration process that lead to increased risk. This is a view shared by Haour-Knipe when she states that "it is the situations encountered and the activities undertaken during the migration process that are the risk factors."[70] The

[66] Haour-Knipe, M. and Rector, R. Crossing Borders: Migration, Ethnicity and AIDS, London, Taylor & Francis, 1996, p.1
[67] Williamson, op. cit., p.11
[68] APPGA (2003), Migration and HIV op. cit., inside cover of publication.
[69] Williamson, op. cit., p.13
[70] Haour-Knipe, M. Migration and HIV/AIDS in Europe, AIDS Infotheque. Sida Info Doc Suisse. 5/00 October 2000, p. 3

main risk factors involved in migration are social and include poverty, powerlessness and social instability.

Of the migrant groups, it is undocumented migrants and those whose applications for asylum have failed that have the least access to healthcare since seeking help or treatment will make them increasingly visible to the authorities and may result in detention or deportation, a risk which few may be willing to take. The fact that they may therefore be driven further underground and further marginalised negates any public health response to combat HIV/AIDS.[71] It is therefore important that such migrant groups require focused attention from Governmental policies. If the needs of these groups continue to be ignored, the HIV epidemic will continue to grow amongst poor immigrant communities and will present a further drain on health and financial resources as these individuals become increasingly ill.

The denial of medical treatment to such vulnerable people is contrary to the values of a humanitarian society and breaches human rights standards. The denial of treatment for illegal migrants with HIV/AIDS has a potentially devastating effect on African migrant communities in the UK where prevalence rates are rising significantly.

3.2 HIV/AIDS in African communities in the UK – the facts[72]

African migrants move to UK for a variety of reasons. Some move for the purpose of career development or study, while others have done so as a result of persecution,

[71] UNAIDS/IOM (1998) Migration and AIDS International Migration Vol.36 (4) p. 451

[72] For information on the sexual attitudes and lifestyles of African communities in England see the Mayisha II study findings at: http://www.ahpn.org/downloads/publications/Mayisha_II.pdf#search=%22mayisha%22 (retrieved 20/08/06)

illness, civil conflict, insecurity, genocide and poverty. So for many there is no real option to return 'home' and most describe their existence in the UK as one of necessity rather than choice.[73] According to the British Medical Association, "healthcare for asylum seekers in Britain is patchy, belated and often inappropriate" with problems including difficulty in finding a GP, language barriers, lack of cultural sensitivity, high levels of mental health difficulties, and disrupted social support.[74]

In their submission to the House of Commons Health Select Committee inquiry into developments in HIV/AIDS and Sexual Health Policy in 2005, the African HIV Policy Network (AHPN) state that there are estimated to be more than 8,000 African people living with diagnosed infection in the UK.[75] In addition several thousand more African people living in the UK have undiagnosed HIV infection since studies have shown that roughly two-thirds of African people in the UK have never tested for HIV.[76] HIV-prevalence is many times higher among African people in the UK than among the White British majority. In 2004, 4.4% of black Africans aged 16 to 44 in England, Wales and Northern Ireland were living with HIV/AIDS compared to 0.07% of those of white ethnicity.[77] Compared to UK born men and women attending GUM clinics (each of whom have an HIV-prevalence of 0.2%), 7.7% of African born women and 4.8% of African born men who attend GUM clinics are infected with HIV.[78] [79]

[73] NAM, Immigration, migration and HIV for African communities op. cit.
[74] BMA and the Medical Foundation for the Care of Victims of Torture, (2001) Asylum seekers and health, at http://www.bma.org.uk/ap.nsf/Content/Asylumseekershealthdossier (retrieved 12/10/2005)
[75] AHPN, House of Commons Health Select Committee, New Developments in Sexual Health and HIV/AIDS Policy, Third Report of Session 2004-05 – Volume II – HC 252-1 Oral and written evidence, p. 17
[76] Ibid.
[77] National AIDS Trust,(2006) HIV in the United Kingdom: A Progress Report 2006, London
[78] Memorandum of AHPN, Volume II, op. cit., p. 17
[79] See also, data from the Health Protection Agency document Mapping the Issues: HIV and other STIs in the UK: 2005 at: http://www.hpa.org.uk/publications/2005/hiv_sti_2005/pdf/MtI_FC_Part_1_HIV.pdf (retrieved 16/03/06)

Undiagnosed infection and late presentation for testing and treatment are particular problems in African communities in the UK. Black Africans in the UK are consistently diagnosed late in the course of their infection compared to their white counterparts, thus increasing the likelihood of requiring antiretroviral therapy(ART) soon after diagnosis. The Project Nasah research found that African people tend to be diagnosed with more advanced HIV disease and as a result, their general health and prognosis may be poorer than other groups of people with HIV.[80]

Although black Africans living in Britain represent barely 1% of the population, in 2004 they accounted for 42% of new HIV/AIDS diagnosis. [81] As part of its continued investigation into the HIV/AIDS epidemic, in 2005 The Guardian newspaper looked at the impact of HIV/AIDS on African communities in the UK and stated the following shocking conclusions:

> If you are black, African and living in the UK you are 50 times more likely to be HIV positive than any other ethnic group…….. In 1999 for the first time the number of black Africans diagnosed with HIV outstripped those among gay and bisexual men. Epidemiologists were shocked to find that one in 18 African women and one in 28 African men attending STI clinics were testing HIV positive…..But, of the Department of Health's annual HIV prevention budget of £53.4 million for 1999, only £75,000 was allocated to African groups. [82]

This spending works out at a miniscule 0.14%. This pales into insignificance when compared to the £1.5 billion pledged to the disease between 2005 and 2008.[83] It would appear that the Government is only willing to support Africans with HIV/AIDS when they stay in Africa.

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[80] Weatherburn, P. *et al*, (2003) Project Nasah: An investigation into the HIV treatment information and other needs of African people with HIV resident in England London p. 1
[81] The Guardian online, Where it's really hurting 10 September 2005, www.guardian.co.uk/aids/story/0,,1566472,00.htm (retrieved 10/09/05)
[82] Ibid
[83] See below re: the Government's international commitment

3.3 Social exclusion and discrimination within African communities

It is likely that a significant proportion of African people with HIV in the UK are, or have been in the past, refugees or asylum seekers, a group already significantly socially excluded.[84] Exclusion associated with being HIV positive may be significantly compounded by pre-existing social exclusion and social need associated with being an African refugee or asylum seeker.[85] Compared to other people with HIV in the UK, African people with HIV are 10 times more likely to report problems associated with their income, seven times more likely to report problems with their living conditions, and three times more likely to report problems with discrimination.[86]

Despite a relatively long history of the epidemic in sub-Saharan Africa, HIV/AIDS remains stigmatised among African communities in the UK and globally.[87] A study by Dodds *et al* has highlighted the importance of expatriate African networks for survival of African migrants in the UK. However, the same study shows how disclosure of an HIV-positive identity often leads to the withdrawal of vital community support. [88] Thus, African people with HIV in the UK may be less able to disclose to and draw support from their family and expatriate communities.

HIV/AIDS-infected migrants within the UK are often stigmatised in their own communities as well as within host country communities. HIV/AIDS is a highly stigmatised disease within African communities in the UK despite the comparatively

[84] The Guardian, (2005) Where it's really hurting op. cit.
[85] Ibid.
[86] Memorandum of AHPN, Volume II, op.cit., p. 18
[87] Ibid.
[88] Dodds, C. *et al* (2004) Outsider Status, London, Sigma research, pp. 19-25

high HIV/AIDS incidence and prevalence.[89] Stigma can act as a powerful barrier to accessing services, to disclosure of HIV/AIDS status in personal and social settings and to enjoying the same rights and freedoms as those who are not infected with the disease. HIV/AIDS-related stigma and discrimination remains an enormous barrier to effectively fighting the HIV/AIDS epidemic in African communities. Fear from discrimination often prevents people from getting tested, seeking treatment and/or from admitting their status publicly.

Most African respondents to the Sigma report on stigma and discrimination experienced by Africans with HIV/AIDS in 2004 discussed racism and discrimination as a matter of routine.[90] They felt that in the majority of public settings Africans can expect hostile and discriminatory reactions. Sigma concluded in its report that HIV/AIDS-related stigma reinforces racial prejudices characterising African people as irresponsible and a threat to public health.[91] Government policy which refuses HIV/AIDS treatment to illegal African migrants adds to the stigma suffered by the group.

3.4 Government strategic failings

The Government's National Strategy for Sexual Health and HIV, backed by £47.5 million, was published in 2001. Although black Africans at that time accounted for 60% of heterosexual diagnoses, they were only referred to five times in a 53-page

[89] Weatherburn, P. *et al* (2003) op. cit., p. 3
[90] Dodds, C. *et al* (2004), op. cit., p. 9
[91] Ibid

report that made them appear incidental rather than central.[92] This is further evidence of the Government's lack of initiative in tackling HIV/AIDS in African communities.

In 2005 the Department of Health finally published the framework it commissioned back in 2001 for treating and preventing HIV/AIDS among black Africans living in the UK.[93] The authors of that report told The Guardian newspaper that "by the time this report came out it was four years out of date, had been completely watered down and 7,000 more Africans had been diagnosed with HIV in the UK."[94] In a community where diagnoses are disproportionately high, it is contemptible that it should take so long to produce the framework. It seems rather hypocritical to establish a framework for African communities whilst denying treatment to a sizable number of that population. The lack of Government commitment to domestic HIV/AIDS policies is again evident, with the most vulnerable and prevailing community suffering.

In relation to those migrants living with HIV/AIDS, the most pressing issue should be how the UK can ensure that the immigration system does not compromise but respect their right to the highest attainable standard of health, as laid down in the ICESCR.[95] NAT has stated, however, that "the Government has failed to look comprehensively at how the immigration system is affecting those living with HIV/AIDS in the UK. This is an inevitable consequence of the lack of a multi-sectoral response to the epidemic."[96] The HIV/AIDS epidemic amongst Africans living the UK could not be addressed without tackling the context within which many Africans live in the UK, particularly

[92] Ibid
[93] Department of Health (2005) HIV and AIDS in African Communities: A Framework for better prevention and care, London
[94] The Guardian online, Where it's really hurting op. cit
[95] NAT, HIV in the UK, op. cit. p. 10
[96] Ibid.

the experience of asylum seekers, failed asylum seekers and illegal migrants. African migrants in the UK suffer from social exclusion that is directly consequential upon their immigration status. Denied the ability to work and often destitute such migrants are multi-burdened before their HIV status is even considered. For example, in their submission to the APPGA inquiry into HIV and Human Rights in the UK, AHPN pointed out that

> African communities affected by HIV are so overwhelmed with social exclusion issues such as housing, unemployment, poverty isolation, anxiety about family reunion and deprivation that they are not always able to prioritise HIV/AIDS.[97]

3.5 Chapter conclusion

It is at the intersection of migration and HIV/AIDS where the matter of migrant health lingers and where such people deserve extra care and support. The increase in the prevalence of HIV/AIDS is an issue that is having a devastating effect on African communities in the UK. The statistics highlighted above prove the importance of tackling the disease in these communities and the need to grant access to treatment to as many people as possible. African migrants with HIV/AIDS, whether in the UK legally or not, are in need of focussed attention, not restrictive, discriminatory Government policies. Failure to do so will result in creating a stigmatised and marginalised group of illegal migrants carrying a potentially fatal infection. African people with HIV/AIDS in the UK who have uncertain immigration status are faced with a media and a range of Government policies broadly hostile to their residence in the UK.[98] The issues of media

[97] Ibid.
[98] Weatherburn *et al* (2003) op. cit., p. 2

stigmatisation and an ineffective Government will be further explored in the subsequent Chapters.

CHAPTER 4: Blame and stigmatisation – when being positive can be a negative

Chapter 4 will look at the nature of stigmatisation and discrimination as a means of social control. It will look at the hostile media portrayal of migrants with HIV/AIDS. It will examine how the Government is failing to protect the human rights of undocumented migrants with HIV/AIDS by actively discriminating against them. This will then lead onto a discussion of how the notion of 'health tourism' is an illusory concept, perpetuated by the UK media and Government. It will be shown how the culture of fear that has been developed around 'health tourists' has led to reactionary policy-making which has in turn had a damaging effect on the health rights of failed asylum seekers and illegal migrants. The Chapter will highlight evidence which suggests that 'health tourism' does not exist and that infected migrants are actually accessing treatment at a late stage of infection.

4.1 HIV/AIDS-related stigma and discrimination

Freedom from discrimination is a fundamental human right founded on principles of natural justice and enshrined in international and regional human rights instruments. These instruments prohibit discrimination based on race; colour; sex; language; religion; political or other opinion; national, ethnic, or social origin; property; disability; fortune; birth; or other status. The United Nations Commission on Human Rights has declared that "the term 'or other status' in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including

HIV/AIDS."[99] It has also stated that "discrimination on the basis of HIV/AIDS status, actual or presumed, is prohibited by existing human rights standards."[100]

However, stigma and discrimination are powerful tools of social control.[101] Dodds *et al*. state that stigma and discrimination "are functional practices within a cultural system which aims to maintain the boundaries between those with power, and those without."[102] They can be used to marginalise, exclude and exercise power over individuals who do not match social expectations of normality. Goffman outlines the three most common characteristics that define stigmatised groups: abominations of the body, blemishes on individual character and the tribal stigma of race, nationality or religion.[103] He claims that such individuals are subjected to the judgements of others and are often blamed for their own misfortune.[104] Since migrants with HIV/AIDS fulfil all three of these categories it is not surprising that stigmatisation has surrounded them.

Throughout history marginalised populations have been blamed for social problems including economic decline, cultural decay and importing disease, most recently HIV/AIDS. Sabatier has written that the process of attributing blame does not always require evidence and tends to focus on people who are considered outsiders, those who are on the margins of society, such as migrants.[105] HIV/AIDS especially has been linked to deviant behaviour and like migration can stigmatise and problematise those affected.

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[99] UNCHR, The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) Commission on Human Rights resolution 1999/49
[100] UNCHR, The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) Commission on Human Rights resolution 2001/51
[101] Avert, HIV/AIDS Stigma and Discrimination at www.avert.org/aidsstigma.htm (retrieved 18/04/06)
[102] Dodds, C *et al*.(2004) op. cit., p. 1
[103] Goffman, E. (1963) Stigma: Notes on the Management of Spoiled Identity, New York, Prentice-Hall, cited in Haour-Knipe and Rector, op. cit., p. 88
[104] Goffman, cited in Dodds, *et al* op. cit., p 1
[105] Sabatier, R. (1990) Blaming Others: Prejudice, race and worldwide AIDS London, Panos, p.2

The arrival of HIV/AIDS has almost inevitably been accompanied by the need to point the finger at somebody. Initially, as it was in their community that HIV/AIDS first became an identifiable problem, it was men who have sex with men who suffered from the stigmatisation attached to blame. It was considered to be their conceived lack of sexual morality that had led to their infection by the 'gay plague'. This same moralistic tone has spread to other groups who are considered in some way to be deviant or responsible for their own infection and of that of the community; intravenous drug users, commercial sex workers, and, to an extent, migrants. Discrimination already suffered by such groups is compounded by HIV/AIDS and combine to create multiple burdens on them.

The UNAIDS epidemic update for 2005 recognises that stigma can fuel the desire to blame certain people or groups and can lead to discriminatory practices. [106] It taps into existing prejudices and patterns of exclusion and further marginalizes people who might already be more vulnerable to HIV infection. Stigma and prejudice are therefore experienced by "the most marginal of the marginal."[107] Such 'outsider' groups are often blamed for bringing HIV/AIDS into a country[108], and discrimination can be experienced by such groups when they are denied access to the services and treatment they need.[109] HIV/AIDS-related discrimination has been described by UNAIDS as:

> action that results from stigma. It occurs when a distinction is made against a person that results in their being treated unfairly and unjustly on the basis of their actual or perceived HIV status or their belonging, or being perceived to belong to a particular group. It results in rejection, denial and discrediting,

[106] UNAIDS (2006) AIDS Epidemic Update 2005, Geneva
[107] Haout-Knipe, Migration and HIV/AIDS in Europe p. 10
[108] For information on discriminatory HIV/AIDS-related travel restrictions, see UNAIDS and IOM, (2004) UNAIDS/IOM statement on HIV/AIDS-related travel restrictions, UNAIDS, Geneva
[109] Avert, HIV/AIDS Stigma and Discrimination

> and consequently leads to discrimination, which inevitably leads to the violation of human rights.[110]

Mann has identified three phases of the HIV/AIDS epidemic in society – the silent epidemic of HIV infection, the epidemic of HIV-related diseases that emerges later, and the epidemic of stigma and discrimination that characterises society's response to HIV/AIDS. Such discrimination can take many forms: institutional and state sanctioned through legislation and Government policies which actively discriminate against those who are infected; non-institutional, operating in the spheres outside Government policies and regulation; and structural, where issues of inequality such as gender, race or socio-economic status negatively impact upon people with HIV/AIDS. [111]

Stigma and discrimination toward people with HIV/AIDS and vulnerable populations creates the conditions for the epidemics of HIV infection and HIV-related diseases to continue or flourish. Vulnerable populations are less able to protect themselves from HIV infection because of cultural norms, laws, policies, and practices that place them at a disadvantage.[112]

4.2 Stigma and discrimination in the UK

Successive waves of immigration to the UK have frequently been accompanied by hostility and prejudice from the host population. A report published by the Association of Chief Police Officers found that "racist expressions towards asylum seekers appear

[110] UNAIDS, Regional Consultation Meeting on Stigma and HIV/AIDS in Africa, 4-6 June 2001, Tanzania, cited in Usdin, S. The No-nonsense guide to HIV/AIDS, New Internationalist, Oxford 2003 p. 58

[111] Mann, J. at an informal briefing on AIDS to the 42nd Session of the United National General Assembly, 20 October 1987, cited in de Bruyn, T. (2002) "HIV-Related Stigma and Discrimination – The Epidemic Continues" *Can. HIV/AIDS Policy Law Rev.* 2002 Jul;7(1):8-14.

[112] Ibid.

to have become common currency and 'acceptable' in a way which would never be tolerated towards any other minority group."[113] They concluded that "paradoxically, it is not unusual for those seeking asylum in this country, as a safe haven, to experience racial discrimination and harassment".[114] The European Commission against Racism and Intolerance (ECRI) went further and found that some British leaders were not doing enough to combat anti-immigrant discourses and that some were, in fact exacerbating the problem:

> Regrettably, many politicians have contributed to or at least not adequately prevented, public debate taking on an increasingly intolerant line with at times racist and xenophobic overtones. Public statements have tended to depict asylum seekers and 'economic migrants', explicitly or by reference, as a threat to security, economic stability and social peace… ECRI urges the British authorities to take these concerns into account.[115]

This is indeed damning criticism. As this paper will illustrate later, the Government has not taken heed of this concern and has continued to exacerbate racial tensions, especially with regard to the ability of asylum seekers to access healthcare, especially for treatment for HIV/AIDS.

One of the ways in which hostility towards immigrants and asylum seekers has been expressed is through the perception that migrants bring disease and infection to the community. In 2003, the APPGA recognised that issues surrounding migration and public health have received increasing attention due to what they identify as "the persistence of anti-immigrant sentiments and recent HIV statistics indicating the extent to which new cases of heterosexually acquired HIV originate overseas or in people of

[113] Association of Chief Police Officers Asylum Seekers Policing Guide (3) available at: http://www.acpo.police.uk/asp/policies/Data/Asylum_Guide3.doc (retrieved 12/05/06)
[114] Ibid
[115] ECRI Second Report on the United Kingdom, 16 June 2000, Strasbourg p.18 http://www.coe.int/t/e/human_rights/ecri/5-archives/1-ecri%27s_work/5-cbc_second_reports/CBC2%20UK.pdf (retrieved 12/05/06)

African descent."[116] Connections are being made in the media between the increase in HIV infections, the level of migration to the UK, and the growing pressure on the NHS and extent to which migrants are able to access healthcare within the UK. These concerns are leading to more stringent measures being proposed to protect the public health and public purse, such as mandatory health testing of immigrants and greater restrictions on migrants' access to healthcare in the UK.[117]

Prejudice and discrimination against migrants are being perpetuated in the media by associating them with an increasing range of social problems including, but certainly not limited to, declining standards in education, fears of terrorist attacks in the UK, and the abuse of social benefits. The most recent issues to be presented as immigration problems surround non-UK citizens' access to healthcare in the UK and so-called 'health tourism' or 'treatment tourism', the public cost of treating migrants' and non-UK citizens' medical conditions, and the effect that immigration is having on public health in the UK.

The fear of the foreign disease-bringing 'other' is often played out in the British media, certain sections of which obsess about the alleged incoming hoards of 'health tourists'. The following headline from the Daily Telegraph back in 1986 is indicative of the prejudices that both migration and HIV/AIDS can evoke and could just as easily have appeared in a newspaper today:

"African Aids 'deadly threat to Britain'"[118]

[116] APPGA (2003) op. cit., p. 15
[117] Ibid
[118] Cited in Sabatier, R. Blaming Others, op. cit., p. 3

The Spectator has accused "foreigners [of] bringing death to our land" and The Sun published an article warning that immigrants were "polluting us with disease."[119] As Weston writes, a large proportion of the media and public attitude towards migrants is generally negative and asylum seekers and refugees are regularly stereotyped in the media as "bogus", "scroungers", "terrorists" and "disease carriers."[120]

The 2003 APPGA report states that

> a culture of blame also frequently accompanies HIV. People who have HIV/AIDS are sometimes viewed as responsible for their own infection, and therefore less deserving of sympathy and support. Headlines such as *Where Britain's New Hetero AIDS Cases Began* reinforce the perception that responsibility for the spread of HIV/AIDS lies with particular social groups rather than individuals within society as a whole. They encourage entire groups to be viewed with suspicion as carriers of HIV.[121]

Other articles highlighted by the report have used pejorative descriptions for people living with HIV/AIDS such as "polluted with…disease" and a "threat to British lives."[122] In the eyes of certain parts of the UK press, the issues of migration and HIV/AIDS co-exist to form a devastating threat to the country. However, it is not illegal migrants with HIV/AIDS that are threatening the public health but the refusal of the Government to provide them with free treatment.

4.3 Government action to tackle stigma and discrimination

The Government identified the need for action to tackle the stigma associated with HIV in the National Strategy for Sexual Health and HIV back in 2001. In yet another example of the Government dragging it's feet, however, it was not until December

[119] Ibid
[120] Weston, (2003) op. cit., p. 2
[121] APPGA (2003) op. cit., pp. 17-18
[122] Ibid, p.18

2005 that a consultation document was launched on the development of an action plan.[123] In a remarkable statement of sheer hypocrisy, the document states that:

> Research shows that healthcare is one of the areas where people living with HIV are more likely to encounter discrimination. This is unacceptable.

This is the same Government that is refusing to provide free treatment for HIV/AIDS to failed asylum seekers and illegal migrants on no other ground than their lack of legal presence in the country. Surely this too is 'unacceptable'? It is apparently only 'unacceptable' when those facing discrimination are legally present in the country. The human rights of those who are not lawfully present are brushed aside. While the Government is claiming to be an exemplar in outlawing discrimination and providing treatment, both home and abroad, the reality is quite different. It is indeed telling that no reference whatsoever is made failed asylum seekers and illegal migrants in the Government's action plan, presumably because of the Government sanctioned discrimination evident in this field.

4.4 HIV/AIDS and 'Health tourism' – fact or fallacy?

The UK media has used the increasing HIV-prevalence rates in African communities to deepen prejudices and exacerbate stigma. The media association between Africans and HIV/AIDS has worsened discrimination against Africans and particularly refugees from Africa.[124] There appears to be an assumption in certain sections of the media that all African migrants bring disease and are coming to the UK as 'health tourists'. There are, however, no figures available for the prevalence of HIV or any other disease among asylum seekers in the UK.

[123] Department for Health (2005) Action Plan: HIV related stigma and discrimination, London p. 2
[124] Refugee Council (1992) Refugees and HIV/AIDS, London, p. 1

In March 2005 the House of Commons Health Select Committee produced a report on sexual health and HIV/AIDS policy in the UK.[125] As part of its remit the report looked at whether there was any evidence that 'health tourism' exists. 'Health tourism' is a phenomenon that appears to have been created by the British media, without any hard evidence that it presents a problem for the NHS. The concept involves people entering the UK to make use of free NHS treatment, whether for a single procedure or course of treatment or, in the case of migrants infected with HIV/AIDS, management of a longer term chronic problem. The then Minister of State for Health, John Hutton, MP stated that the issue is a serious problem and that the UK would become a magnet for 'health tourists'. He went on to emphasise that "we are a national health service; we are not a global health service."[126] In their submission to the Committee, Migrationwatch UK, an independent body established to monitor what they see as the unacceptable influx of migrants to the UK, argued that "the sexual health crisis in the UK is being exacerbated by the unnecessary and avoidable importation of cases of HIV."[127] We can see here another example of the stigma that is faced by migrants with HIV/AIDS.

The Committee, however, refuted the claim that 'health tourism' is a serious problem and stressed that there is no empirical evidence to support the suggestion that it is. It states that while the current high levels of HIV/AIDS infection now seen in the UK are in part attributable to increased migration of people from countries of high prevalence, there is "little evidence that HIV sufferers are commonly health tourists" and claims

[125] House of Commons, Health Select Committee, New Developments in Sexual Health and HIV/AIDS Policy, Third Report of Session 2004-05 – Volume I – HC 252-1
[126] Ibid. p. 35
[127] Ibid pp. 34-35

made to the contrary are "difficult to substantiate."[128] Despite the Minister's assertion that "there is a significant amount of abuse going on"[129] the Committee emphasised that no evidence exists to quantify the scale of abuse, either in relation to HIV/AIDS or more generally.[130]

4.4.1 Late Presentation within migrant communities

Countering accusations of 'health tourism' by people with HIV/AIDS, Max Sesay, Chief Executive of the AHPN, has stated that it would be difficult for people in the developing world to know how the "incredibly complex" health system operates in the UK. [131] Similarly, written and oral evidence presented to the Health Select Committee showed that migrants are not coming to the UK to access free treatment for HIV/AIDS. The Terrence Higgins Trust (THT), the British Medical Association (BMA) and the AHPN, amongst others, argued that people with HIV/AIDS who were infected outside the UK typically sought access to medical treatment at a late stage instead of trying to access treatment upon arrival.[132] Evidence suggests that people coming to the UK from higher HIV prevalence countries come to the NHS in late-stages of HIV requiring complex treatment for opportunistic infections as well as the on-set of AIDS.[133] Data from the Health Protection Agency and from a British HIV Association audit reveal that a high proportion of late presenters are from African backgrounds.[134] Such late

[128] Ibid, p. 34
[129] Ibid, p. 36
[130] Ibid.
[131] APPGA (2003),op. cit., p. 31
[132] House of Commons Health Select Committee, New Developments in HIV/AIDS and Sexual Health Policy Third report of Session 2004-05 Volume II, Oral and written evidence – HC252-II,
[133] APPGA (2003) p. 8
[134] Memorandum by Dr. Jane Anderson, Volume II, op. cit., p. 101

presentation means that it is often too late to get the best benefits from HIV/AIDS treatment, and leads to unnecessary deaths.[135]

In its submission to the Committee the BMA contended that if "people arriving into the UK from Africa with HIV were treatment tourists, they would access treatment earlier rather than turning up as emergencies in A&E with undiagnosed infection as is currently the case."[136] Such evidence clearly contradicts the suggestion that migrants are entering the UK to access healthcare services.

4.4.2 Evidence to counter claims of 'health tourism'

In 2003 THT conducted a small piece of research on a population of 60 HIV-positive African migrants who were recent users of THT and George House Trust services. The research highlights the fact that late diagnosis is a serious problem amongst African migrant communities. Approximately 3% had been diagnosed prior to entering the UK. Only 8% were diagnosed with HIV within three months of entry to the UK. In all, at least 75% waited more than 9 months after entering the UK before having an HIV test. One third of people in the cases examined did not have a test until more than eighteen months after entry.[137]

The research supports the NAT's view that if migrants with HIV/AIDS had come to the UK for treatment it is unlikely they would have waited until they were severely unwell

[135] NAT, (2004) The UK Response to the HIV Epidemic: An Assessment of the UK's Compliance with the UNGASS Declaration of Commitment on AIDS, London p. 29
[136] Memorandum by AHPN, Volume II, op. cit., p. 20
[137] Ibid, p. 30

before seeking treatment.[138] While it is appreciated that the survey is by no means extensive, it is the only research on the issue of migrants with HIV/AIDS and the concept of "health tourism" and demonstrates that such migrants are not entering the UK for treatment.

4.5 Chapter conclusion

Despite being condemned in international law, HIV/AIDS-related stigma and discrimination are commonplace within certain spheres of the UK media and are enshrined in areas of UK domestic policy. Although the Government cannot produce any evidence to support their claims of the existence of 'health tourism', they are insistent that it is a threat to the country. The Government's claim that 'health tourism' is a serious problem is unfounded. No evidence exists to suggest that it is a burden on the resources of the NHS. Although HIV was repeatedly named in the media as an example of treatment tourism, the only piece of extant research indicated that the reverse was true. Most migrants were unlikely to be aware of their status until they had been in the UK for more than nine months. The report of the Health Select Committee recognised and accepted that the majority of overseas visitors infected with HIV do not access NHS help until the later stages of their condition when they are seriously ill.[139] It is unlikely that this would be the behaviour of health tourists entering the country solely to access free services.

By citing 'health tourism' as a serious issue the Government clearly falls into reactionary policy making which is far from the reality as exposed by academic studies.

[138] Ibid, p. 26
[139] Health Select Committee Report (2005) Volume I, op. cit., p. 36

Furthermore it supports the media in communicating false messages, which in turn contribute to the increasing stigmatisation and marginalisation of failed asylum seekers and illegal migrants with HIV/AIDS. Given the higher than national average HIV-prevalence rates in migrant communities this action by the Government is foolish, blasé and worthy of a national outcry.

As Ashcroft states: "It is shaming to live in country which not only mistreats migrants but even sees political parties appeal for votes on the basis that the public actively support them in doing so."[140] The Government and media are both guilty of maintaining HIV/AIDS-related stigmatisation by transmitting false information which ultimately endangers the lives of immigrants and UK residents. This has important ramifications for the future as HIV/AIDS rates may continue to rise and this, as will be evidenced in the next Chapter, is directly attributable to current ineffective and discriminatory UK policy.

[140] Ashcroft, R. (2005) "Standing up for the medical rights of asylum seekers" *J Med Ethics* 2005;31:125-126

CHAPTER 5: Government Commitment to HIV/AIDS: International promises *v.* waning domestic commitment

This Chapter will investigate the waning domestic commitment of the Government to tackling HIV/AIDS. It will use the Government's proclamations of universal access to treatment to illustrate the hypocrisy of Government action. The Chapter will show how the Government fails to give HIV/AIDS the strategic and funding priority status that they demand.

This Chapter will examine in detail the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004. These Regulations prohibit failed asylum seekers who have been diagnosed with HIV after losing their appeal for asylum and other migrants without legal status from accessing free treatment for HIV/AIDS. It is argued that while there are exceptions to the charges for sexually transmitted infections and infections that risk public health if left untreated, to exclude HIV/AIDS from these exceptions is unethical, illogical and discriminatory. As stated above, to discriminate against someone because of their HIV status is a breach of human rights law. To reserve treatment for HIV/AIDS only for to those who are legally present in the country is unethical.

This Chapter will consider the risks that the regulations pose to public health and will explore how the regulations are acting as a deterrent to testing. It will also focus on the exemption of allowing treatment for 'immediately necessary treatment' and the issue of cost-effectiveness.

5.1 UK international policy

The United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS of 2001 calls for the highest levels of leadership and political commitment in responding to HIV/AIDS.[141] The declaration provides a framework for a response to the epidemic by providing a comprehensive set of principles, goals and targets to be achieved by member states. In her statement on the adoption of the Declaration of Commitment in June 2001, the then Secretary of State for International Development Clare Short, MP outlined the Government's commitment to tackling the HIV/AIDS epidemic and recognised the need for action when she said:

> My hope… is that this meeting will spur us all into action. We know what needs to be done. The lessons of best practice are summarised in the declaration. We must go home and implement. There have been enough conferences and declarations."[142]

The Government has begun to implement its plan to combat HIV/AIDS in the developing world and is now one of the leading benefactors of HIV/AIDS causes. In the Foreword to the 2004 Department for International Development's HIV/AIDS Treatment and Care Policy the Secretary of State for International Development Hilary Benn, MP states that the UK is committed to providing "increased, and eventually universal, access to treatment and care for people with HIV/AIDS."[143] The Government was also instrumental in the development of the G8 summit commitment of "developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by

[141] United Nations General Assembly Special Session on HIV/AIDS (2001), Declaration of Commitment on HIV/AIDS, para. 1
[142] UK AIDS and Human Rights Project UNGASS 2006: Has the Government kept the promise? March 2006, p. 1 at: http://www.aidsrightsproject.org.uk/pdfs/UKPROJECTUNGASSSHADOWREPORTFINAL.doc (retrieved 1 June 2006)
[143] DFID, (2004) HIV/AIDS Treatment and Care Policy, London, p. iii

2010 for all those who need it."[144] The UK is the second largest bilateral donor to HIV/AIDS (after the US) and has pledged to provide £1.5 billion for HIV/AIDS work between 2005 and 2008.[145] These are certainly impressive international targets.

5.2 UK domestic policy

While the Government's record in the international effort to combat HIV/AIDS can be applauded, however, the same cannot be said for domestic policy in the UK where such commitment is distinctly lacking. A recent NAT report claims that there has been a decline in political focus and concern for HIV/AIDS in the UK and for the needs of the most affected communities, especially vulnerable migrant populations. HIV in the United Kingdom: A progress report 2006 presents an overview of the UK's domestic record on tacking HIV/AIDS and highlights the following worrying findings:

- there is currently a lack of political focus and commitment to tackle HIV/AIDS in the UK; and
- there are policies and practices which ignore the human rights of many of the most vulnerable members of society to HIV infection, such as migrants from high prevalence countries.[146]

NAT claim that while early interventions by the Government to tackle HIV/AIDS initially led to a relatively successful containment of HIV/AIDS in the UK, "an obvious complacency has let to the 'de-prioritisation' of HIV on the agenda over the last decade."[147] As will be evidenced below, the current Government's inadequate response

[144] Cited in AVERT AIDS Treatment Targets and Results at http://www.avert.org/aidstarget.htm (retrieved 20/04/06)
[145] DFID, (2006) G8 Gleneagles: One Year On: Turning Talk into Action London, Chapter 8
[146] NAT, (2006) HIV in the United Kingdom: A Progress Report 2006 , London
[147] NAT, (2004) The UK Response to the HIV Epidemic: An Assessment of the UK's Compliance with the UNGASS Declaration of Commitment on HIV/AIDS London p.8

to the epidemic in the UK is failing to meet the needs of people, especially migrants, living with HIV/AIDS or protect their human rights.

The NAT report also lists further failures including the following: HIV was not discussed in the Public Health White Paper Choosing Health, published November 2004, which failed to address the particular challenges around HIV, including stigma and discrimination; there is no Government target for the Department of Health specifically related to HIV; and given the rising rate of HIV prevalence in the UK it is surprising that there has not in the last two years been a single high-level speech by the Prime Minister or any Cabinet Minister focussing on HIV in the UK.[148]

The Department of Health published the Action Plan on HIV-related stigma and discrimination, a whole five years after HIV stigma and discrimination was identified as a priority in the National Strategy for Sexual and HIV. The Action Plan fails to provide a comprehensive and cross-departmental response to HIV-related stigma and discrimination and does not address the issue of HIV-related rights.[149] The UK AIDS and Human Rights Project note that the publication of the Action Plan on HIV-related stigma and discrimination could have been an opportunity for much needed political support but its publication was hardly acknowledged and no statement was made by Ministers.[150]

[148]NAT (2006) HIV in the United Kingdom: A Progress Report 2006, op. cit., p. 4
[149] UK AIDS and Human Rights Project (2006) op. cit., p. 4
[150] Ibid. p. 7

Key policy documents have not been prioritised, with extended delays to their finalisation and publication.[151] Examples listed in the NAT report include the African HIV Framework. Although work began on the framework in May 2000, it was not published until January 2005. [152] This clearly demonstrates the lack of political will, resources and capacity to implement Government commitments.

5.2.1 National Strategy for HIV

In 2001, the National Strategy for Sexual Health and HIV[153] was published to, *inter alia*, modernise HIV/AIDS services in the UK, to reduce HIV/AIDS-related discrimination and to reduce the transmission and prevalence of HIV. However, the strategy has not been updated, reviewed or refreshed since its inception, and this despite the fact that the context of NHS service delivery has changed radically and climbing new diagnoses have swiftly rendered the strategy's goals unattainable.[154]

The NAT is critical of the lack of commitment shown by the Government, and identifies a number of strategic failures. For example, while the UNGASS Declaration calls for a genuinely multi-sectoral national strategy[155], this has not materialised in the UK. The trust states that:

> given the fact that HIV in the UK mainly affects groups with significant experience of discrimination and that for migrants there are additionally a host of challenges relating to social exclusion and immigration processes, it is clear that such a multi-sectoral approach is particularly important in the UK. But the national strategy is not truly multi-sectoral – it does not, for example, involve the Home Office - and the recently published draft Action

[151] NAT (2006) HIV in the United Kingdom: A Progress Report 2006, op. cit., p. 4
[152] Ibid.
[153] Department of Health, (2001) The National Strategy for Sexual Health and HIV, London
[154] NAT (2006) op. cit., p. 4
[155] UNGASS, op. cit., para. 37

> Plan on HIV-related stigma and discrimination again limits actions to the Department of Health.[156]

The UK AIDS and Human Rights Project agree that the lack of a multi-sectoral, UK-wide HIV/AIDS specific strategy has prevented the development of a comprehensive and effective response to HIV/AIDS in the UK.[157] Such a cross-departmental approach is needed in order to address the social context of the disease, since without understanding the context the Government cannot understand the epidemiology of the disease. Such a strategy would ensure a consistent human right-based response to HIV/AIDS in the UK, abide by international HIV/AIDS standards, and monitor and challenge the impact of government's policies on HIV/AIDS-related rights. Without the development of a multi-sectoral approach, to include the problems faced by legal and illegal migrants, it is difficult to see how the Government can effectively tackle HIV/AIDS in the UK.

5.2.2 Funding

Funds available for HIV prevention in the UK have stagnated or declined since the late 1990s whilst the number of those living with HIV has more than doubled.[158] HIV prevention funding is no longer ring-fenced but instead allocated by Primary Care Trusts (PCTs) from local NHS budgets. This means that as the funding now forms part of mainstream NHS funding, healthcare commissioners are no longer compelled to actually spend the money on HIV prevention. Agencies seeking funding for HIV prevention work with vulnerable groups such as asylum seekers and refugees now have

[156] NAT (2006) op. cit., p. 4
[157] UK AIDS and Human Rights Project, op. cit., p. 4
[158] NAT (2006) op. cit., p. 5

to compete directly with other more mainstream health needs.[159] The Government is also failing to centrally collect any information on local HIV prevention expenditure despite an earlier commitment to do so.[160] This is yet another example of the Government failing to match its actions to its words.

Reports for the financial year 2005-06 from PCTs across the country attest that in many cases funds which should were earmarked to sexual health have simply been used to help plug existing financial deficits.[161] A recent review of PCT Local Delivery Plans 2005-08 revealed that despite the extra funds theoretically allocated, only 30 per cent of surveyed PCTs made any mention of planned investment in sexual health, despite the Government's additional £250 million local funding for 2006/07 and 2007/08.[162] The NAT conclude that what is disturbing is that only a minority of Local Delivery Plans made any mention of HIV, and amongst those that did references were often cursory.[163] The Government's response to claims that monies destined for sexual health services are not reaching the frontline is that "it is up to local NHS organisations to decide how to manage their budgets to deliver services."[164] Instead of avoiding the responsibility the Government should be demonstrating effective leadership and insisting that funding reaching sexual health services. The HIV/AIDS epidemic is therefore not being given the priority status that it demands.

[159] Weston, (2003) op. cit., p. 4
[160] NAT (2006) op. cit., p. 5
[161] Ibid.
[162] Brook, fpa, MedFASH, NAT, THT (2006) Review of Primary Care Trust Local Delivery Plans 2005-08 at http://www.medfash.org.uk/publications/documents/LDP_Report_Jan06_FINAL_web.pdf#search=%22Review%20of%20Primary%20Care%20Trust%20Local%20Delivery%20Plans%202005-08%20%22 (retrieved 27/03/06)
[163] Ibid.
[164] BBC online, Sex health funds 'pay NHS debts' at http://news.bbc.co.uk/1/hi/health/5234938.stm (retrieved 02/08/06)

5.3 Charges for those not legally resident in the UK – an abuse of human rights?

Prior to April 2004, the 12-month residency exemption ensured that anyone who was a long stay resident of the UK would receive the health treatment they needed. The Regulations governing NHS charging, and a number of key exemptions to them, were enshrined in the NHS Act 1977 and the NHS (Charges to Overseas Visitors) Regulations 1989. [165] The exemptions ensured free treatment for a range of conditions on public health grounds, including TB and all sexually transmitted infections, except for HIV/AIDS. For HIV/AIDS, even though there was a theoretical 12 month wait to access free NHS services, the Terrence Higgins Trust state that many HIV/AIDS clinicians were willing to treat people who had been in the UK for shorter periods yet were clearly settling here.[166]

In April 2004, in an effort to prevent the alleged growing threat of 'health tourism', the Government introduced controversial changes to regulations concerning HIV/AIDS treatment for overseas visitors to the UK. Previously, NHS treatment for all conditions was free for anyone who could prove that they had lived in the UK for at least 12 months, as well as anyone applying for asylum or the right to remain in the country.[167] This allowed the majority of overseas visitors who required medication to obtain it without charge. The new changes, brought in by the National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2004, dictate that only those residing in the UK legally have access to HIV treatment without charge.

[165] Memorandum by Terrence Higgins Trust, Volume II, op. cit., p. 14
[166] Ibid.
[167] Avert, HIV, Immigrants and Immigration, op. cit.,

The new changes mean that whilst asylum seekers' claims are being decided, they are entitled to free NHS care. Once they have exhausted their appeal rights, they remain entitled to continue any treatment they were already receiving, but all other secondary care is chargeable. This means that those residing in the UK 'without proper authority' are now excluded from free treatment following a positive HIV diagnosis. Refusing treatment to such people, however, sends out the wrong message on how serious the Government is on tackling and preventing HIV/AIDS and raises important moral questions.

The House of Commons Health Select Committee concluded in their report into the effect of charges for overseas visitors for HIV/AIDS treatment that given the high HIV-prevalence in people born in Africa who are now living in the UK, there is concern that the regulations will have a disproportionate impact on African communities in the UK.[168] This is clearly an example of the institutional and state sanctioned discrimination that occurs through legislation and Government policies which actively discriminate against those who are infected identified by Mann above.[169]

According to the Department of Health's memorandum to the Health Select Committee inquiry, the 2004 Regulations attempted to tighten up the 12-month residency rule:

> One of the amendments to the 2004 Regulations was to tighten the 12 months residency exemption, which covers those overseas visitors who do not meet any of the other exemption conditions, providing exemption from charges once they have been living in the UK for 12 months. This exemption now specifies that in order to qualify for the exemption the person must have been living in the UK legally for that period. This means that illegal immigrants, failed asylum seekers, visa overstayers and others living here without proper authority cannot now take advantage of free NHS

[168] Health Select Committee Report (2005) Volume I, op. cit., p. 4
[169] See Chapter 6

> hospital treatment. In order to do so a person must be able to show that they had been living here legally.[170]

Although the Department argued that "the 2004 amendment Regulations made no changes to the existing rules on charging overseas visitors for HIV treatment", as the NAT pointed out to the Committee, "the end of the twelve-month rule effectively introduces a charge for a significant number of people".[171]

There are three instances under which illegal immigrants, failed asylum seekers, visa overstayers and others living in the UK without proper authority will not be charged for NHS treatment. These are:

- If they have a serious communicable disease which is exempt on public health grounds. These include TB and all sexually transmitted infections *apart from HIV*, for which only the initial diagnostic test and associated counselling is free;
- If they seek treatment in an A&E department; treatment, however, ceases to be free if a patient is admitted to an inpatient ward, or referred to an outpatient service. Where treatment is considered "immediately necessary", the PCT is not obliged to check whether the patient can afford to pay before they provide treatment, but they must seek to recover the costs after the fact.
- If they require compulsory mental health treatment.

In their response to the Health Select Committee's report on New Developments in Sexual Health and HIV/AIDS Policy, the Government attempted to justify the rationale behind the regulations, arguing that:

[170] Health Select Committee Report, Volume I, op. cit., p. 32
[171] Memorandum by the National AIDS Trust (2005) Volume II, op. cit., p. 24

> What changed [in 2004] was that people who are here illegally, for whatever reason, stopped being able to abuse the hospitality of the UK by getting free hospital treatment to which they were not entitled simply by managing to stay here for a year.
> …
> *The only people who have anything to fear from that change are those who are abusing the system and shouldn't be here*. The fact that they have managed to stay here for a long period of time simply cannot be allowed to be an excuse for getting free treatment without question.[172]

This was confirmed in a letter from the Parliamentary Clerk, Department of Health to the Clerk of Health Select Committee when it was stated that the underlying rationale for the changes was not only to save the NHS money, "but also to protect free access to the NHS for all those who are entitled to it."[173] This statement confirms that the regulations are explicitly concerned with the exclusion of some of the most vulnerable people in our society.

The suggestion is that the new restrictions that were introduced in April 2004 were in response to fears that people were coming to the UK to access NHS services. They were introduced after a period of consultation but without any research or evidence base. As demonstrated in previous Chapters, there is no evidence to suggest that asylum seekers are 'health tourists'. However, because of the persistence of the fear of immigrants overrunning the already overburdened NHS the Government has introduced these regulations which deny those who have failed in their asylum application or who are otherwise without legal residency status their human right to the best possible standard of physical and mental health as identified above. Such reactionary policy making, where the Government is pandering to the scare-mongering of the certain parts of the media, is an affront to a civilised democratic state.

[172] Government response to the Health Select Committee's Third Report of Session 2004–2005 on New Developments in Sexual Health and HIV/AIDS Policy, CM 6649, July 2005, p. 25. Emphasis added
[173] Memorandum of Parliamentary Clerk, Department of Health to Clerk of the Health Select Committee inquiry, Volume II, op. cit., p. 135

The new restrictions ensure that long stay visitors, anyone in the UK without documentation, and anyone refused asylum or leave to remain, but not removed from the UK are liable to be charged for any NHS services other than those provided in an emergency or those outlined in the 1989 exemptions. Since such people are not permitted to work, and may be receiving no other benefits, it is difficult to see how they could meet the costs of medical treatment. Ashcroft points to the official guidance to NHS Trusts which states that to avoid claims of race discrimination, everyone should be asked the same questions about where they have lived for the past 12 months, and whether they can show the right to live here.[174] He states that it is absurd that it is more important to appear non-discriminatory than actually to be non-discriminatory.[175]

The new changes are directly contradictory to other areas of Government policy.[176] The effects of these changes to NHS entitlement will work against, or in contradiction to, the following areas of Government policy and strategy:

- Denying treatment to people living with HIV in the UK is in stark contrast to the Department for International Development's HIV/AIDS strategy for the developing world which states that "many vulnerable people cannot access the services they need because of cost. This is why the Government is committed to ensuring that affordability is never a barrier to accessing health and education, or to services such as HIV testing and contraception."[177] Such a contradictory, hypocritical view is astonishing,

[174] Ashcroft, R. (2005) op. cit.,
[175] Department of Health, Implementing the overseas visitors hospital charging regulations: Guidance for NHS Trust Hospitals in England. London, 2004
[176] Memorandum by Médicins du Monde UK, Volume II, op. cit., p. 124
[177] DFID, (2004)Taking Action: The UK's strategy for tackling HIV/AIDS in the developing world, , p. 48

especially considering the Government's refusal to provide treatment to people within their own national boundaries.

- The fact that vulnerable groups will be unable to access healthcare as a result of these changes may seriously undermine the Government's programme of action to tackle health inequalities launched in 2003;[178]
- Similarly, refusing to treat people before they become emergency cases will consequently put more strain on A&E services which are already stretched to the limits. Such a workload within the A&E services may impact on the quality of care and the waiting time that is already very lengthy. It will consequently go against the Government's efforts to reduce pressure on A&E services.
- The measures are also likely to have a divisive effect on social cohesion and could lead to further exclusion of already marginalised groups thus undermining efforts to tackle social exclusion. Specifically in relation to HIV, this could undo a great deal of progress made in this area. As DFID itself has recognised, "in the UK, early intervention that specifically focused on the needs of marginalised groups prevented the higher rates of HIV infection experienced by many other countries".[179]

5.3.1 Treatment for HIV/AIDS is singled out

While the regulations prevent those residing in the country illegally from gaining access to HIV medication, treatment for other communicable diseases and sexually transmitted infections (STIs) remains free to everyone. HIV/AIDS has been singled out

[178] Department of Health, (2003)Tackling Health Inequalities: op. cit.,
[179] Department for International Development, (2004) Taking Action: op. cit., p. 48

as an exception to the provision of services for STIs and infectious diseases. One possible reason for this is that compared to other STIs, which are generally curable, a course of treatment for an HIV patient is longer and more costly to the NHS. There is also the fear that, made available to everyone, free treatment will bring an influx of people from countries where none is available, putting the NHS under strain and public health at risk. People coinfected with HIV and other STIs will be able to access free treatment for gonorrhoea or chlamydia, but not for HIV, which is the more serious, and potentially fatal, condition transmissible by the same route.

Similarly, individuals coinfected with TB and HIV (a relatively common combination for African people with HIV/AIDS in the UK) will be told that, while their TB treatment is free, the HIV treatment necessary to ensure that their TB treatment is effective will be charged for.[180] There have been a number of cases where patients have left the hospital before the end of their course of TB treatment, risking the development of multi-drug resistant tuberculosis (which is transmissible) and returning to the community still able to transmit TB.[181] AHPN state that a number of pregnant women have been told they will be charged, and thus effectively refused, for temporary HIV treatment to prevent transmission of HIV to their unborn child.[182] The humanitarian and ethical repercussions of such refusals are extraordinary.

[180] AHPN Campaign on Access to HIV Services for All Migrants to the UK at http://www.ahpn.org/campaigns/index.php?camp_id=3 (retrieved 17/01/06)
[181] Ibid.
[182] Ibid.

5.3.2 Risks to public health and deterrent to testing

Preventing people from accessing appropriate treatment and care is inhumane, unjust and poses significant risks to wider public health. The introduction of the regulations pose a risk to public health since it is now accepted that the provision of antiretroviral treatment for HIV/AIDS not only saves and preserves life but is also an important component of effective HIV/AIDS prevention.[183] Allowing HIV/AIDS to go untreated undermines public health since there is a greater risk of HIV being transmitted by untreated individuals. People with HIV/AIDS who are unable to access antiretroviral treatment (ART) and associated services will remain in the community and will be more infectious that if they were in receipt of treatment. As the THT have stated,

> HIV treatment contributes to decreased infectivity of an individual. Failure to treat will also mean that people who would otherwise encounter a range of services in a clinical setting will be lost to interventions, such as counselling and group work, designed to support people in maintaining safer sex and preventing behaviour likely to contribute to onward transmission.[184]

The British Association for Sexual Health and HIV put the public health position very simply when they stated that "HIV positive patients in the UK irrespective of immigration status are of public health concern."[185] This was a view support by the NAT: "there are very good grounds to believe that the charges introduced are causing, and will continue to cause, harm to public health in the UK."[186] The Health Protection Agency, the Government agency charged with providing advice on protection against

[183] NAT, (2006) HIV in the United Kingdom op. cit., p. 11
[184] Ibid.
[185] Memorandum by the British Association for Sexual Health and HIV, Volume II, op. cit., p. 76
[186] Memorandum by the NAT, Volume II, op. cit., p.27

infectious diseases and other dangers to health, also supported this view:

> We are concerned that the new and proposed changes may impact on the clinical and public health management of HIV infection in overseas born individuals diagnosed with HIV in the UK.[187]

There are a number of public health concerns identified by the Health Select Committee in their report. First, the availability of treatment encourages people to have an HIV test. Second, the treatment actually reduces the infectiousness of the person living with HIV, decreasing the likelihood of infecting others. Third, there are also serious health and ethical risks from denying free maternity care since the ante-natal screen has been an immensely important intervention in diagnosing HIV amongst African women and reducing mother-to-child transmission. Finally, the potential impact on TB transmission rates.

In its report, the Committee was critical of the fact that no public health impact assessment had been carried out prior to the introduction of the new regulations.

The Committee concluded that:

> We agree with the Minister that it is appropriate to provide a national health service, not a global one. However, a crucial part of the Government's responsibility to provide a national health service is to protect the health of the population. Untreated HIV+ people living in this country present a serious public health threat, and we therefore recommend that all HIV-positive people, regardless of their immigration status, receive free treatment to reduce the likelihood of the onward transmission of HIV, of mother-to-child transmission of HIV, and of the onward transmission of TB.[188]

There are both individual and public health concerns regarding the willingness to test for HIV/AIDS if no treatment is available. If some individuals from the migrant communities most affected by HIV in the UK do not have access to medical care and

[187] Health Select Committee (2005) Volume I, op. cit., p. 46
[188] Ibid. p. 54

social support, those communities may be less receptive to prevention messages, less willing to seek HIV testing, and more likely to engage in activities which transmit HIV.[189] International evidence suggests that people are much more likely to get themselves tested for HIV where treatment is available than where there is no access to treatment.[190] The knowledge that they are not allowed treatment might stop immigrants from getting screened for HIV, posing a further possible risk to public health, as more cases of HIV are likely to go undiagnosed.

The THT presented evidence to the Health Select Committee that:

> People from one of the communities of highest prevalence for HIV in the UK have begun to ask why they should test for HIV if they may not be able to obtain treatment for it. While we believe there is almost always good reason to know one's diagnosis and thus be able to make informed decisions about both health and sexual behaviour, this view is gaining currency amongst migrant communities and is impacting on testing campaigns targeting them.[191]

The fact that the introduction of charges has resulted in a deterrent to testing is another example of how the Government contradicts itself regarding HIV/AIDS policy. DFID, in its document HIV/AIDS Treatment and Care Policy, recognised the important link between testing and the availability of treatment. It states:

> There is now an international consensus that treatment and care are essential parts of an effective and comprehensive response to AIDS. As well as the direct benefits for people receiving it, access to treatment and care can help prevention efforts and programmes designed to minimise the impact of AIDS. Availability of ART in particular gives people a reason to seek testing, and it might reduce the level of transmission in a population.[192]

Although one of the aims of the Government's National Strategy for Sexual Health and HIV is to reduce the number of those with HIV who are undiagnosed, there is a

[189] Memorandum by the Medical Foundation for AIDS and Sexual Health, Volume II, op. cit., p. 111
[190] AVERT, HIV Immigrants and Immigration, op. cit.
[191] Memorandum by the THT, Volume II, op. cit., p. 15
[192] Department for International Development (2004) HIV/AIDS Treatment and Care Policy, op. cit., p. 2

particularly high proportion of undiagnosed persons, and of late diagnosis, in African communities. [193] But, as DFID themselves make clear, to offer testing, with all its challenges and trauma, without the opportunity for treatment is to remove one of the main incentives to test. Failure to test will result in continuing and increasing late diagnosis, at which stage ART can be much less effective and death more likely. The result is an increase in avoidable mortality and also providing an increased length of time where people can unknowingly transmit HIV thereby further fuelling the pandemic.[194] The NAT conclude that

> Whether diagnosed or not, the refusal to provide ART will mean that individuals will remain much more infectious than they would otherwise be if on the treatment. Such high infectivity, joined with an absence of ongoing counselling and considerable personal trauma, is likely to result in an increase in onward transmission of the virus.[195]

A policy where patients can be tested, but not treated, for HIV/AIDS is not an ethical, safe (in terms of public health) or logical one as without knowledge of their HIV status people may not make changes in behaviour which would prevent onward transmission.[196] Of the main population groups in the UK affected by HIV, people from sub-Saharan Africa are least likely to have had their infection diagnosed. There may be little perceived advantage in taking up the option of being diagnosed with a progressive, fatal and highly stigmatised disease if there is no opportunity, or no perceived opportunity, to obtain the treatment which would radically improve quality and length of life.[197]

[193] Memorandum of the NAT, Volume II, op. cit., p. 27
[194] Ibid.
[195] Ibid.
[196] Memorandum of the Medical Foundation for the Care of Victims of Torture, Volume II, op. cit., p. 73
[197] Memorandum of the Medical Foundation for AIDS and Sexual Health, Volume II, op. cit., p. 111

Early detection of HIV/AIDS is important so that an infected individual can have treatment to prevent their condition worsening, so that they can take action to prevent transmission to others and also so that they can alter their lifestyle to minimise the risks of deterioration in their health. It is estimated that 33-50% of patients eventually diagnosed with HIV/AIDS have had previous contact with the medical profession over health problems associated with HIV/AIDS. [198] If patients were diagnosed earlier their treatment prospects would be better and the risk of them infecting other people would have been greatly reduced. In order to aid the early detection of HIV/AIDS, people must have an incentive to test. If no treatment or care is available, there is no such incentive. Although provision of voluntary HIV testing and counselling is to remain freely available to everyone, including those whose presence in the UK is not legally recognised, this policy will be seriously undermined if people know they will not be able to get free treatment after that.

By bowing to pressure from anti-immigration lobbies and to an increasingly hostile media, the Government has clearly demonstrated that it is incapable of effectively tackling the HIV/AIDS epidemic and the health of failed asylum seekers and illegal migrants. By discriminating against such people with HIV/AIDS, and though the enforcement of the charging regulations the Government is effectively putting public health at risk. As Power states, in relation to illegal immigrants with HIV/AIDS, "public health comes second to populism."[199]

[198] Asylum and Migration: a review of Home Office statistics. Report by the Comptroller and Auditor General, HC625 Session 2003-04: 25 May 2004, p. 3 cited in Treat with Respect op. cit., p. 6
[199] Power, L. (2004) "HIV and Sexual health in the UK: politics and public health", *The Lancet* Vol. 364,p. 108

5.3.3 'Immediately necessary treatment' and cost-effectiveness

The provision of treatment for people with HIV/AIDS should be recognised under the exemption of 'immediately necessary treatment' since untreated HIV/AIDS is a life-threatening condition. Treatment would not only improve the health of the individual concerned but would also decrease the infectiousness of the individual thereby helping to protect public health. 'Immediately necessary treatment' refers to the fact that if, in the judgement of a clinician, treatment is immediately necessary either to save life or prevent a condition becoming life-threatening, treatment must be provided in advance of any investigation of entitlement to free treatment or ability to pay. This means that chargeable overseas visitors will subsequently have to pay for any treatment that they receive. Most of these people are destitute and the mere prospect of a bill will be enough to deter them from accessing care.[200]

The denial of treatment to people with HIV/AIDS would result in repeated hospitalisation for opportunistic infections, e.g. pneumonia, without accessing treatment for the underlying cause of HIV/AIDS. Ongoing treatment might be less expensive than repeated, prolonged stays in hospital, both to the public purse and to public health. It is more humane and, as will be shown below, more cost effective to provide ART than to allow a person's health to periodically deteriorate resulting in repeated hospitalisation. Timely investment in treatment prevents expensive management of acute illness and repeated emergencies in those infected.

[200] THT and NAT, (2006) Note on access to treatment for undocumented migrants and those refused leave to remain, p. 2 http://www.nat.org.uk/document/109 (retrieved 12/03/06)

A person may present to an A&E department with a serious HIV/AIDS-related illness or with complications resulting from opportunistic infections associated with HIV/AIDS. If their immigration status is unclear or undecided, or if they have been refused asylum, they are only entitled to be treated for the infections but not for the underlying cause of their illness, HIV. This means that individuals will only be treated to become well enough until they acquire another opportunistic infection caused by HIV/AIDS.[201] The THT have stated that people with progressive HIV/AIDS-related immune deterioration will access emergency services multiple times, with increasing frequency and severity of need, resulting in many cases in far higher incident costs than a simple ongoing prescription for antiretrovirals.[202]

The annual cost of combination therapy is now under £10,000 per patient per year, but one week's stay in intensive care can cost almost as much, and this could be repeated many times in year through opportunistic/secondary infections relating to HIV/AIDS.[203] In their report, the Health Select Committee recognised that as one day in a hospital bed can cost about £500 it would take only a few days a month in a hospital bed to equal, if not exceed the cost of ART for that person.[204] The Medical Foundation for AIDS and Sexual Health has argued that an average inpatient stay for someone with HIV disease would usually last about 10 days, at a likely cost to the NHS of about £7,500–10,000, and that the average patient with severe HIV disease might be expected to spend a month in hospital during a 12-month period—i.e. two to three such

[201] APPGA (2003) op. cit., p. 49
[202] Memorandum of the THT, Volume II, op. cit., p. 16
[203] Ibid.
[204] Health Select Committee Report, Volume I, op. cit., p. 44

inpatient stays.[205] It is therefore more cost-effective to provide rather than deny treatment to people without legal status who have HIV/AIDS.

The Health Select Committee also acknowledged that the financial benefit of preventing further transmission of HIV is immense.[206] The Department of Health's own estimates suggest that preventing a single onward transmission of HIV saves between £500,000 and £1million in terms of individual health benefits and treatment costs.[207] The introduction of charges which act as a deterrent to testing is therefore a false economy. The Medical Foundation for AIDS and Sexual Health argue that access to antiretroviral treatment avoids the cost of expensive emergency care, supports HIV prevention interventions both among those who are infected and in the wider community, encourages uptake of HIV testing thus reducing rates of undiagnosed infection, and can radically reduce rates of mother-to-child transmission of HIV.[208]

In the same way that 'health tourism' can be discounted as a rationale for the introduction of the regulations, such financial arguments undermine the case for charges as a cost benefit to the NHS. With the Government's two main justifications therefore defeated, it is difficult to understand the need for the introduction of charges.

5.4 Chapter conclusion

It would appear that when the eyes of the world are watching, as they were at the G8 Gleneagles summit, the Government is keen to flex its humanitarian and philanthropic

[205] Memorandum of the Medical Foundation for AIDS and Sexual Health, Volume II, op. cit., p. 110
[206] Health Select Committee Report, Volume I, op. cit., p. 45
[207] Department of Health, (2001) Better prevention, better services, better sexual health: The National Strategy for Sexual Health and HIV, London p. 11
[208] Memorandum of the Medical Foundation for AIDS and Sexual Health, Volume II, op. cit., p. 110

muscles, with very impressive results. Despite early Government responses which addressed HIV/AIDS, however, the commitment has clearly been waning to the extent that no minister has even mentioned HIV/AIDS in the UK in the past two years. This is surprising given the rising toll of the pandemic globally and the rising infection rates in the UK. There are numerous examples where the Government has not given HIV/AIDS the attention the pandemic deserves. As identified above, HIV/AIDS has slipped down the political agenda and only resurfaces periodically when the fear of infected hordes of immigrants arises.

As evidenced above the Government's claim that 'health tourism' represents a serious problem in the UK is without merit. The 2004 charging regulations were introduced to combat this alleged concern but constitute little more than overt HIV/AIDS-related discrimination. The fact that HIV/AIDS is not included in the exceptions to charges is not only illogical but is in violation of international human rights law which proscribes discrimination against people with HIV/AIDS.

Chapter 6: Conclusion

Increasing levels of migration and the HIV/AIDS epidemic have heightened the need to explore the link between the human right to health and the needs of infected migrants. This dissertation set out to analyse the access to treatment for HIV/AIDS in the context of failed asylum seekers and illegal migrants resident in the UK. To do this it has explored the disappointing direction in which the UK has taken the right to health of asylum seekers and illegal immigrants. The Government and judiciary have proven reluctant to extend the fundamental human right to health to failed asylum seekers and illegal migrants who have HIV/AIDS.

Through the introduction of the 2004 charging regulations the Government has blocked access to free NHS hospital care for failed asylum seekers and illegal migrants. Since failed asylum seekers are not allowed to work and earn money, denial of access to free secondary health care is, de facto, denial of access.[209] The Government is hereby violating the right to health of failed asylum seekers to the highest attainable standard of health, as guaranteed by ICESCR. Destitute undocumented migrants are being refused hospital treatment and are being hounded by debt collectors if they have received emergency care.[210] In the UK it is the legal status of the migrant that defines their ability to access health care.

Through the enactment of the charging regulations, the Government is actively discriminating against migrants who do not have legal status by denying them access to free healthcare. The regulations provide a list of circumstances where payment is not

[209] Hall, P. (2006) "Failed asylum seekers and health care", *BMJ* Vol 333, p. 109
[210] Kelly, N. and Stevenson, J. (2006) First do no harm: denying healthcare to people whose asylum claims have failed London, Refugee Council and Oxfam

demanded such as treatment for all sexually transmitted infections and communicable disease, *except* HIV/AIDS. It is both unethical and illogical to exclude HIV/AIDS from free treatment and amounts to nothing more than HIV/AIDS-related discrimination.

The recent change in the profile of HIV/AIDS in the UK, with significant numbers in African communities affected, many of them at some stage within the immigration system, poses real challenges for the UK.[211] It is vital to ensure that the immigration system does not compromise their health and care but rather respects their right to the highest attainable standard of health. The statistics highlighted in this paper prove the importance of tackling the disease in African migrant communities and the need to grant access to treatment to as many people as possible. The AHPN's claim that the current social, legal and policy environment in the UK is not geared toward maximising the health of African people in the UK is difficult to refute.[212] Charges are especially discriminatory to African communities since it is these communities which are experiencing the highest prevalence of HIV/AIDS.

Despite being condemned in international law, HIV/AIDS-related stigma and discrimination are commonplace within parts of the UK media and are enshrined in areas of UK domestic policy. Although the Government cannot produce any evidence to support their claims of the existence of 'health tourism', they are insistent that it is a problem. As demonstrated throughout this dissertation, such reactionary policy making is extremely damaging to the health of failed asylum seekers and illegal migrants with HIV/AIDS in the UK, particularly those in African migrants communities. As Ashcroft states, "It is shaming to live in country which not only mistreats migrants but even sees

[211] NAT, (2006) HIV in the United Kingdom op. cit.
[212] Memorandum of AHPN, Volume II, op. cit., p. 32

political parties appeal for votes on the basis that the public actively support them in doing so."[213] Good governance should be evidence based and proportionate, not based on conjecture and stigmatisation.

Not only is it hugely irresponsible of the Government to deport the epidemic to the developing world where conditions are inferior to those here, as in the case of *N*, it is also evidence of the appalling hypocrisy of the Government extending, on the one hand, monetary aid to Africa whilst simultaneously throwing out individuals who have no hope of medical treatment in their home countries and are therefore being sent home to die.

Figures presented by the Scottish Legal Action Group show that HIV/AIDS treatment represents less than 0.1% of the total NHS budget including all of those who are not removable e.g. British citizens.[214] Where the continued expenditure by the expelling state is well within its means and the potential damage to the individual are horrendous there must arise an issue of proportionality.[215] There is no good economic, public health of moral argument for refusing treatment to those with HIV/AIDS. Instead of restricting care the Government should allow access to free NHS care for persons of uncertain residential status because healthcare professionals have a moral duty of care regardless of whether the harm occurs tomorrow or whether it occurs at any given point in the future and that any cost treatment incurred in the short-term will, in all likelihood, be a lot less than any incurred in the long-term.[216] Pollard and Savulescu argue that the "NHS has a duty of rescue to treat such people, whenever a delay in

[213] Ashcroft, R. (2005), op. cit., p. 125
[214] Scottish Legal Action Group, "Case Report" *SCOLAG Journal* August 2005. pp175-6
[215] Ibid
[216] Pollard and Savulescu (2004) "Eligibility of overseas visitors and people of uncertain residential status for NHS treatment", *BMJ* 2004; 329: 346-9

treatment would have serious effects".[217] The cost incurred by the NHS of treating these individuals is small in comparison to the considerable benefit to the individual. By treating someone with HIV/AIDS there is actually a saving to the NHS, since treatment would diminish the need for emergency care later on which may prove long and costly. Whatever the legal status of a foreign visitor to the UK, they should not be in a position where they are allowed to die or suffer serious harm if, through treatment on the NHS, this could be prevented.[218] This is not the creation of an 'international health service' but is a domestic service for those already in the country and would be a contribution to UK's obligation to treat HIV at a global level.

Two solutions to the problem of denying failed asylum seekers and illegal migrants with HIV/AIDS can now be highlighted. First, the government can either reclassify HIV as either an STI, a move that would entitle individuals of any status to receive appropriate care, or as any other blood-borne virus that poses a significant risk to public health. The public health reasons why other STIs are exempt apply equally to HIV/AIDS. The fact that HIV/AIDS is even more serious that other STIs, possibly life-threatening and at present incurable, adds urgency to the argument to use treatment as a key intervention to reduce onward transmission.[219]

Secondly, since a disparity in medical facilities between the expelling state and the receiving state will not entitle the HIV/AIDS-sufferer to remain in the UK in order to continue to receive treatment, the answer lies in confronting the unacceptable disparity of medical facilities across the world. A temporary amnesty on undocumented migrants with HIV/AIDS would allow them to remain in the UK to receive treatment until it is

[217] Ibid
[218] Kelly, R. *et al* (2005) Migration and Health in the UK: an IPPR FactFile, London, IPPR
[219] THT and NAT(2006) Note access to treatment op. cit.

available in their country of origin. Given the Government's commitment to making treatment accessible to all by 2010 this would only mean a few years of treatment before their repatriation. Such an amnesty would only have a small impact on NHS budgets and would have a huge impact upon the health of individuals, saving their lives. Until universal care is available the UK has a responsibility to treat those who are in the UK, whether legally present or not.

Regarding treatment for HIV/AIDS, the legal changes are neither humane nor cost effective and they have been widely condemned by the medical community. It would appear that public health and the right to health come second to populism. The strong political response to migrant use of NHS facilities would suggest that the Government is acting strongly to protect the sexual health of the nation. However, the reality is that these high-profile measures contribute little, if anything, to the sexual health of the UK and the health rights of failed asylum seekers and illegal migrants with HIV/AIDS.

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