

# Discussion Paper

## HIV and refugee resettlement

The issue of mandatory HIV-testing for refugees and access to resettlement programmes is an important and at times contentious issue for governments, UNHCR and others working to protect and care for refugees. It raises important health management and human rights considerations but can be easily distorted in the media debates of refugee receiving countries.

It would be easy to get the impression there were scores of untested refugees bringing HIV and other diseases into western countries. In fact, there is mandatory HIV-testing for all refugees coming to Australia and New Zealand through resettlement programmes and concerns about medical costs and 'public interest' criteria already exclude vulnerable refugees who need a resettlement place on protection grounds. While waivers exist and are exercised in small numbers by Australia and New Zealand, UNHCR has for some time been concerned to promote informed discussion on the issue.

To get a range of perspectives, in this newsletter, UNHCR invited contributions on the issue from the Australian and New Zealand Governments and medical experts from the Centre for International Health, Burnet Institute in Melbourne. The Australian Government was unable to contribute a paper at this time. UNHCR's own paper is drawn from existing policy on the issue developed in consultation with UNAIDS and WHO and some 'real life' case studies from the field.

Group counselling on HIV/AIDS for refugee women attending antenatal classes in Mae La Camp, Thailand.

UNHCR/P. Spiegel

### HIV/AIDS in the New Zealand refugee resettlement programme by New Zealand Government

New Zealand has been accepting refugees for resettlement since the end of the Second World War. In 1987, the Government established a formal annual quota for the resettlement of refugees. Over time, New Zealand's refugee policy has evolved in response to changing global circumstances and needs. In recent years, a focus on refugees in need of protection – identified by the UNHCR – has resulted in the resettlement of a diverse range of nationalities and cultures who have added to the richness of New Zealand society.

As a signatory to the 1951 United Nations Convention Relating to the Status of Refugees and its 1967 Protocol New Zealand is committed to working with the international community to resolve refugee problems. The size and composition of the refugee resettlement quota is set annually by the Minister of Immigration and the Minister of Foreign Affairs, after consulting widely with relevant Government departments, the UNHCR, NGOs, existing refugee communities and other stakeholders.

Refugee Division of the Department of Labour works closely with the UNHCR, IOM and other governments to promote international responsibility sharing, co-

ordinated responses to refugee issues, capacity building, and the ongoing development of norms, policies and best practice in refugee protection.

Under its refugee resettlement programme New Zealand accepts 750 refugees (+/- 10%) who have been mandated by the UNHCR and referred by them for resettlement. Refugees referred by UNHCR are interviewed by Refugee Quota Branch officers in the country of asylum, before decisions are made on the cases. The Government aims to ensure that the resettlement quota remains targeted to refugees in greatest need of resettlement, while also balancing this with New Zealand's capacity to provide good

settlement outcomes to those accepted under the programme.

The 750 places are comprised of the following subcategories:

- Up to 75 places for Women-at-Risk refugees
- Up to 75 places for Medical/Disabled refugees
- UNHCR Priority Protection 600 (including up to 300 places for family reunification and up to 35 places for emergency referrals).

All subcategories within the refugee resettlement quota generally include the immediate family members (i.e. spouse and dependent children) of the principle applicant.

The Medical/Disabled subcategory provides for the resettlement of refugees with medical, physical or social disabilities which place them outside the normal criteria for acceptance by resettlement countries. Applicants under this category generally must have a medical condition that cannot be appropriately treated in their country of refuge, and resettlement to New Zealand would be life-saving or significantly enhance their medical condition and well-being. In all cases where there is an apparent physical or psychological condition, full medical reports must be provided by the UNHCR for assessment by the relevant health authorities in New Zealand. The full disclosure of the condition and its effects are essential for planning purposes.

Up until November 2005 New Zealand did not require refugees to complete any health screening offshore before acceptance into New Zealand. Up until then New Zealand had accepted people with medical conditions, including HIV/AIDS. Persons identified with medical conditions or disabilities were accepted

under the 75 places for Medical/Disabled refugees within the 750 quota.

On 4 April 2005 a new New Zealand immigration health screening policy came into force.<sup>1</sup> Under this policy, refugees who came under the refugee resettlement programme would now be required to complete health screening offshore for TB and HIV/AIDS. Those found to be TB positive would not be declined for resettlement, but their travel would be temporarily delayed while they received treatment to ensure they were fit to travel.<sup>2</sup>

For those found to have HIV/AIDS the policy set out that up to 20 places<sup>3</sup> within the refugee resettlement programme would be available. This policy was not however set in place with the primary aim of keeping refugees with HIV/AIDS out of the New Zealand. New Zealand's programme has always aimed to focus on providing protection to those most in need. As stated above, New Zealand accepts medical/disabled cases if that acceptance will mean that the person will be able to get treatment in New Zealand that will significantly improve their health status and enhance their chances of survival. In the case of refugees with HIV/AIDS this now appears to be possible with the introduction of antiretroviral treatment.

*In the early years of the epidemic the rise in numbers of AIDS diagnoses was mirrored by a similar rise in deaths a year or so later, a reflection of the survival of people with AIDS then being around 18 months. In recent years the number of deaths has remained well below the number of AIDS notifications indicating dramatic success in treatment of HIV infection which has allowed prolonged survival in many people with AIDS.<sup>4</sup>*

New Zealand completes full medical screening onshore and prior to the offshore screening policy coming into force, historically New Zealand had found approximately 1% of its 750 quota to have HIV/AIDS. Therefore when the new policy cap was set at 20 it was highly unlikely to result in actual declines on the basis of HIV/AIDS status. What the policy does do is provides an effective early warning process whereby health authorities in New Zealand are prepared before a refugee arrives in New Zealand with HIV/AIDS, so appropriate and necessary treatment and support can be given to them as soon as possible.

While New Zealand has no obligation to automatically accept every refugee referred to it for consideration by UNHCR, having the cap of 20 HIV/AIDS cases does provide New Zealand with an additional level of control, in the event the programme focuses on an area where there are significant numbers of refugees with HIV/AIDS.

The Department of Labour is aware of some of the extreme challenges that refugees living with HIV/AIDS face. For example where HIV/AIDS positive family members are separated from the family through a number of means (for example by leaving of their own choice, divorce or suicide), as they believe that having a family member with HIV/AIDS will prevent them from being accepted into a country through their refugee resettlement programme. The Department of Labour therefore ensures the offshore HIV/AIDS screening process also includes both pre and post screening counselling so that refugees know that HIV/AIDS will not automatically mean non-acceptance into the New Zealand refugee resettlement programme.



UNHCR/C. Schwetz

Myanmar Maternal and Child Welfare Association (MMCWA) demonstration of HIV transmission methods to trainee community education volunteers, many of whom are returnees.

Where a refugee is found to have HIV/AIDS an assessment is then completed whereby many factors are considered, including existing family connections in New Zealand, the cost of health care and the potential contribution to New Zealand that refugee and their family could make.

There was initial concern that the HIV/AIDS subcategory could be used or seen as a potential pull factor. The concern was that where New Zealand had approximately six refugees with HIV/AIDS coming to New Zealand per year under the refugee resettlement programme prior to the new HIV/AIDS policy, now 20 refugees each year with HIV/AIDS would come to New Zealand under the refugee resettlement programme. However the New Zealand refugee HIV/AIDS subcategory is not such that UNHCR submits 20 refugees to New Zealand for consideration under that subcategory. The HIV/AIDS status is taken into consideration during the assessment process, not as the catalyst to it. In fact, since New Zealand started its offshore screening for refugees for HIV/AIDS in November 2005 only three

refugees have been found to be positive and have arrived in New Zealand.

Confidentiality of refugees' HIV/AIDS status is of course paramount. New Zealand has processes in place to ensure that only those that need to know the HIV/AIDS status of quota refugees are informed. Those who need to know in the first instance are the team of medical officials at the Mangere Refugee Reception Centre where all quota refugees spend their first six weeks in New Zealand. The Auckland Regional Public Health Service operate a medical clinic (including dentistry) at the Mangere Refugee Reception Centre. They medically assess all refugees during their stay and treat or refer to health specialists, as appropriate. This service is essential to those found to have HIV/AIDS to ensure they are set up with ongoing treatment and support as early as possible. Health funding authorities also support refugee-specific mental health counselling services, for survivors of torture and trauma, through non-government agencies. In addition, some refugee specific community education and health programmes

(including HIV/AIDS prevention) are funded by the Government, as well as community liaison and co-ordinator positions that assist refugees with gaining access to health services in the community.

In summary, while accepting people who have any medical condition within New Zealand's refugee resettlement programme presents challenges, the establishment of a subcategory for those with HIV/AIDS has not presented New Zealand with unmanageable risks or stresses on its health system. As a resettlement country New Zealand believes it must aim to provide protection to those most in need. The current policy on HIV/AIDS in its resettlement programme assists New Zealand in doing this.

1. Due to the processing time between offshore screening and arrival in New Zealand, the first refugees who arrived in New Zealand who were screened for TB and HIV/AIDS under this policy arrived in November 2005.  
 2. Usually approximately eight weeks.  
 3. Unlike with the other subcategories, immediate family members (i.e. spouse and dependant children, or parents and their dependant children if the refugee with HIV/AIDS is a child) are accepted in addition to the 20 places.  
 4. AIDS – New Zealand, Issue 57 – February 2006, ISSN 1170-2656, AIDS Epidemiology Group, Department of Preventive and Social Medicine, University of Otago Medical School, Dunedin, New Zealand.

## HIV and refugees: improved responses and attendant dilemmas

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More than twenty years into the human immunodeficiency virus (HIV) pandemic, the international community is reaching consensus on the need for interventions for HIV at all stages of the response for refugees (and displaced populations).

These interventions are becoming standardised and as circumstances allow, increasingly sophisticated. However, a number of important problems remain to be solved before efforts to address HIV can be maximised. False beliefs that refugees are

dangerous reservoirs of HIV infection are held by governments, humanitarian agencies and host populations. There are programmatic, coordination and funding difficulties associated with the medical relief and health development paradigms. Some countries accepting refugees for resettlement have inappropriate HIV testing policies. And there are challenges implementing new developments in responses to HIV in refugee settings including the latest effective HIV preventive measure, male circumcision.<sup>1, 2, 3</sup>

### Are refugees “importers of HIV”?

According to some of Australia's political leaders, we live in a xenophobic world where foreigners threaten our security and health. In recent months, they have cast asylum seekers as terrorists or “medical

tourists”, justifying our ‘processing’ of them, our checks on their story, their accent and our testing to exclude infections of public health importance, including HIV. After all, refugees do encounter circumstances that could increase their vulnerability to HIV: conflict and rape; displacement with loss of food security, income and resources; social fragmentation; and collapse of health services. Indeed, rapid increases in HIV infection appear to have followed conflicts characterised by extensive sexual violence such as the Ugandan civil war during the 1970s<sup>4</sup> and eastern Democratic Republic of Congo more recently<sup>5</sup> It has also been suggested that the greater increase in risk of death for adults compared with under five year olds observed during many conflicts may be due in part to previously unrecognised HIV-related mortality.<sup>6</sup>

However, these patterns are not uniform for all refugees and conflict affected populations. In Angola, Sierra Leone and Sudan, all countries that have endured years of war, HIV-prevalence is much lower than their neighbours.<sup>7, 8, 9</sup> And although limited, assessments of the HIV burden in refugee camps across Africa have generally shown lower HIV-prevalence among refugees than among local host populations.<sup>5</sup> The reasons why HIV transmission may be slowed during conflict are not well understood. Protracted conflict may impede mobility, lessening sexual networking. ‘Closed’ refugee camps may have the same effect. Organised camps frequently provide refugees with better security, health and education services than they had before they were displaced and compared to host communities. Conflict is associated with poverty perhaps restricting opportunities for men to pay for sex.



UNHCR/A. Burton

UNHCR Community Services staff discuss HIV/AIDS with Bhutanese refugees in Beldangi extension, Nepal.

Neither conflict nor refugee populations then can simply be said to increase the spread of HIV. Transmission of the virus amongst refugees is contingent on many tangled factors including the existing prevalence of HIV and sexually transmitted infections in both host and original populations, the level of interaction of host and refugee communities, sexual behaviours such as condom use, numbers of partners and the frequency of rape, the number of sexually active men who are circumcised and the amount of drug use in the population.

### **Moving toward HIV programs comprehensive in content and coverage**

Given that the HIV risk for refugees is context-specific, how should we respond to HIV in an emergency? In 2001, the UN General Assembly advised relief agencies to “incorporate as a matter of urgency HIV/AIDS prevention, care and awareness elements into their plans and programmes”.<sup>10</sup> Refugees are not separate groups; instead they are linked to the wider host and relief communities through complex behavioural networks. Excluding them may limit the success of national (and regional) programs. Consequently, we now consider the same range of interventions for refugees as used in national responses although insecurity, lack of access and limited resources necessitate a “focused, hierarchical approach”.<sup>11</sup> Such interventions always begin with urgent preventive measures. Procuring and distributing condoms and health education materials and prevention of sexual violence and treatment of sexually transmitted infections are vital elements of emergency sexual and reproductive health programs. Training

healthcare workers in the practice of universal precautions and screening donor blood ensure that health systems do not spread HIV during emergencies.<sup>11</sup> Technical developments have also made care and treatment interventions feasible in resource-poor settings and are now advocated for the “earliest possible stages of an emergency response”.<sup>12</sup>

The imperative for HIV interventions in emergency settings to include preventive, and treatment elements has also been defended on moral grounds, with communicable disease control evidence that shows that “prevention and treatment are mutually reinforcing components of controlling AIDS”<sup>13</sup>, and through studies of the long-term cost-effectiveness of expanding treatment programs.<sup>14</sup> As a

result, the provision of an expanding range of interventions for HIV during the emergency phase is challenging the dichotomy of medical relief with brief, expensive, palliative measures<sup>15</sup> “driven by the humanitarian imperative”<sup>16</sup> and health development based on health as a human right and aiming for effective, financially viable healthcare systems. A (semantic) middle ground of *developmental relief* and “emergency development”<sup>17</sup> now infers a continuum of support for refugees from flight to repatriation and acknowledges the links between the level of development and the scale of humanitarian emergencies.<sup>17</sup> Nonetheless, this ideal of providing the full range of HIV prevention and treatment programs for refugees must be considered carefully. Costs and benefits and



UNHCR/B. Heger

UNHCR's Kitty McKinsey and Kisut Gebre talk with Somali women about health and AIDS problems at Aisha refugee camp in Ethiopia.

sustainability factors need to be assessed. We should also consider whether the objectives of humanitarian relief might be compromised by attempts to meet broader human development needs through providing universal access to prevention and treatment.

Clear mechanisms for supporting comprehensive responses for refugees from displacement to repatriation or resettlement are not yet established. Lack of cooperation, coordination and funding, have always been impediments to successful relief and development operations and are especially pertinent for an infection requiring lifelong pharmacotherapy and laboratory and clinical monitoring.

For example, there are dilemmas in coordinating funding for HIV treatments. Many refugees come from poor countries that have under-financed health systems

incapable of providing treatment for people with HIV. But even wealthier countries may not be able to provide free treatment because they cannot always access cheaper generic drugs. What happens, then, when a refugee provided with HIV treatment by relief agencies either returns to their home country or is resettled in a third country? Who pays for the necessary ongoing healthcare? Some regional responses to the epidemic are finding it difficult to weigh up the costs of providing HIV medicines to mobile populations migrating for economic reasons, let alone examine the more complex issues of treating asylum seekers.\* And what about the opportunity cost of providing HIV treatment? If the same amount of funding was used for HIV prevention programs in refugees' countries of origin this could ensure that even the most marginalised

people in those countries would be less likely to become infected with HIV in the first place. In considering the implications of *developmental relief*, broader questions about effective prioritisation are relevant.

HIV programs are tailored to address the epidemic (or epidemics) occurring within a country. Refugees crossing borders may therefore move from an area experiencing one type of epidemic with a particular health, educational and social response into an area undergoing a different pattern of HIV spread with a different local response in place. Relief agencies must be aware of these variations and donors will be required to assist programs incorporating both relief and development elements. Success will need to be demonstrated in practice and models adapted to specific circumstances. UNHCR anticipates that treatment components of national HIV programs in host countries and in refugees' countries of origin would be simultaneously strengthened. Perhaps the acceptance of morally contentious preventive measures in development programs such as male condom distribution – a mainstay of the initial response during an emergency – will also be positively influenced by this intermingling of development and relief responses to HIV.

### **The controversy of screening asylum seekers for HIV**

UNHCR has developed strict guidelines for HIV testing to minimise discrimination and ensure appropriate counselling and education for those offered testing.<sup>5</sup> Contrary to these recommendations however, many governments, including Australia, continue mandatory HIV testing as part of off-shore health screening of asylum seekers. Not only does this threaten



UNHCR/B. Gonzalez

A World Refugee Day Anti-Sida (anti-AIDS) performance by Burundian refugees from Kigeme camp, Rwanda.

the success of HIV programs for refugees and slow resettlement processing, but Australian doctors have questioned the quality and timing of these health checks in light of cases of missed infections.<sup>18, 19</sup> A UK All-Parliamentary group echoed the concerns of UNHCR finding that mandatory testing of asylum seekers would not only “be in breach of international obligations and human rights, but there was no evidence that the policy would be effective in protecting public health.”<sup>20</sup> In this light, pre-departure screening of refugees for HIV appears to be a mechanism for estimating prospective costs of treatment upon resettlement. According to UNHCR, “concerns about costs of resettled refugee health support do, in practice, exclude other refugees including people with HIV/AIDS [from Australia].”<sup>21</sup>

### **Incorporating the latest preventive measure?**

HIV prevention strategies, treatments and care programs continue to rapidly evolve. Novel advances have sometimes proved difficult to incorporate in refugee and post-conflict settings. The inclusion of a new HIV preventive strategy, male circumcision, is a case in point: it has yet to be extensively discussed for stable, resource-poor settings let alone emergencies. There are already reports of discrimination of young men in Africa because they retain their foreskin<sup>22</sup>, but also reports of *increased* transmission associated with unhygienic circumcision<sup>23</sup>; so how will this promising means of reducing the risk of HIV transmission for men transpose to refugee contexts? For instance: what effect will beliefs about male circumcision have on the reception of refugees by host populations and relief workers in future? Will circumcision have any impact at all in relatively small refugee

populations where HIV prevalence may be low? How will ethical research on this intervention be conducted in refugee settings? If it is found to be effective, how will a *surgical* public health measure be safely and sensitively incorporated into the international community’s increasingly holistic, graded HIV response for refugees? Will men have the right to decline circumcision when they are dependent on relief organisations for their livelihoods? And what impact will this have on the resettlement policies of countries like Australia who accept refugees – will governments consider screening asylum seekers not just for infection but for a physical state that influences HIV transmission risk?

Individual government responses to HIV throughout the world have varied in scope and quality and are frequently subject to the constraints of conditional aid. In contrast, HIV interventions for emergency settings have long been based on pragmatic, life-saving measures, skirting the (moral) controversy associated with some strategies due to the short-term humanitarian imperative. These recent evolutions in HIV responses for refugees during flight and continuing after repatriation or resettlement necessitate discussions of comprehensive HIV strategies, coordinated across countries and supported by donors. Hopefully, these discussions will advance local and international responses to the daily HIV emergency occurring in many of the world’s least developed countries.

+ See, for example, the Strategic Framework for the Third ASEAN Work Programme on HIV and AIDS (2006-2010). ASEAN Secretariat, 2006

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## **HIV and refugees: the case for a principled approach**

**by UNHCR Regional Office  
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UNHCR's mandate to provide international protection to refugees includes the responsibility to ensure that their human rights and well-being are promoted and protected. HIV and AIDS prevention and impact mitigation are essential components in the overall protection of refugees and other displaced people. While refugees do not necessarily have high HIV prevalence rates, they are often disproportionately vulnerable to HIV due to the environment in which they find themselves.<sup>1</sup> This is especially so in the case of women, young people and children. Refugees and other persons of concern to UNHCR are some of the most vulnerable people worldwide, uprooted from their homes and separated from traditional support structures, including family and healthcare.

Having signed a Cooperation Framework with UNAIDS in 1998, UNHCR became a

UNAIDS Co-sponsor in June 2004. The fundamental principles of international protection and durable solutions for refugees as well as the universally recognized human rights standards form the core framework for UNHCR's policies with regard to HIV and AIDS which cover: the need to address HIV and AIDS in the earliest stage of an emergency situation and throughout the stabilization period; efforts to expand and improve prevention programmes for refugees and their host community as a refugee situation stabilizes as well as to provide comprehensive care services for people with HIV and AIDS; promoting HIV testing in refugee situations; and ensuring international standards of HIV testing for resettlement applicants.

The willingness of resettlement countries to adopt a principled approach towards those living with HIV and AIDS improves the lot of all those affected, both directly and indirectly, by the disease.

### **Human rights basis for response**

UNHCR has adopted a rights-based approach to its HIV policies and

programmes. Such an approach is consistent with international refugee and human rights law as well as the global consensus expressed through the United Nations General Assembly in its 2001 *Declaration of Commitment on HIV/AIDS* and the *International Guidelines on HIV/AIDS and Human Rights*.<sup>2</sup>

The linkage between the protection of refugee and human rights and effective HIV programmes is apparent as people will not seek HIV-related voluntary counselling and testing (VCT), treatment and care if there is lack of confidentiality or discrimination, risk of refoulement, restrictions on freedom of movement or other negative consequences exist.

### **Non-discrimination**

Persons living with HIV and AIDS are entitled to live in dignity, free from discrimination and stigmatization. UNHCR does not support policies and practices by host and resettlement governments that negatively affect refugees based on HIV status.

## **A young woman comes under family pressure when her HIV-status is revealed in the context of resettlement medical screening**

### **Case study from UNHCR Pretoria**

A family of five refugees fled the Democratic Republic of Congo in the early 1990s after the father was badly tortured. They lived in a refugee camp for many years and were referred by UNHCR for resettlement in early 2006, with the father as the principal applicant.

The family were provisionally accepted but the father later reported to UNHCR he had received a letter from the government of the resettlement country saying their application was rejected because the 19-year-old daughter was HIV positive. Neither the father nor daughter knew of her status prior to resettlement medical screening.

Within the family, the daughter now bears the brunt of the rejection decision. Initially, the father asks that the family be re-submitted without the daughter. He is advised that the entire family can be submitted to another country where they would all be accepted. However, to date, there is still no agreement about the next

steps and pressure continues to mount within the family. UNHCR continues to counsel the whole family and is extremely concerned about the well-being of the daughter, for whom they also facilitate HIV-related counselling.

This family, focused on getting a resettlement place, was clearly not prepared for the HIV results. This might go some way to explain the seemingly harsh reaction of the father who suggested leaving his daughter behind. Experience from non-refugee related HIV testing programmes indicates such reactions are less likely when families are better prepared for the possibility of HIV-positive results.

## Mandatory HIV testing

UNHCR is not in favour of mandatory HIV testing of refugees as this is at variance with relevant human rights standards.<sup>3</sup>

The World Health Organization and UNAIDS believe no public health justification exists for mandatory HIV screening as it does not prevent the introduction or spread of the disease.<sup>4</sup> UNHCR believes public health interests are best served by promoting VCT in an environment where confidentiality and privacy are maintained.

UNHCR's opposition to mandatory HIV testing includes opposition to testing as a pre-requisite for resettlement eligibility. However, certain resettlement countries require an HIV test as part of a pre-departure health screening. Where such testing is done, basic human rights of privacy, security and non-discrimination should be upheld and the provision of effective counselling and referral to appropriate follow-up services should be ensured. Most resettlement applicants

undergo HIV testing not because they are interested in knowing their HIV status, but because it is a requirement of the resettlement process. Because of this, many are not adequately prepared for a positive test result; very serious consequences, including suicide and child abandonment, have occurred. For this reason, particular care must be given to the manner in which the results of HIV testing are provided to allow individuals and families to come to terms with possible adverse news in their own way. While the requirement of resettlement countries to be informed of potentially costly health conditions of resettled refugees is understandable, mandatory testing has the potential to violate the right to liberty and security of the person or the right to non-discrimination. Allowing for a medical waiver for HIV-positive refugees contributes to international responsibility sharing as well as meeting protection concerns and basic human rights principles.

## Counselling

Mandatory testing is even less desirable given the lack of, or minimal, counselling services available. In situations where resettlement countries require mandatory screening, doctors or counsellors are expected to provide pre-and post-HIV test counselling. However, it has been known for only two counsellors to be available to provide assistance to between 400 to 600 refugees in two to three weeks. Given that proper counselling requires at least 45 minutes, its absence puts individuals at risk. Appropriate pre- and post-test counselling, in a language the refugee understands, ensures that applicants are familiar with the disease and are aware of measures to avoid its spread. Counselling on the nature of the illness itself, as well as the effect of HIV status on resettlement opportunities, is important but currently inadequate.

## The right to health

Consistent with its protection mandate and in accordance with other human rights instruments, UNHCR seeks to ensure that refugees, asylum-seekers and other persons of concern who are affected by HIV and AIDS can live in dignity, free from discrimination, and that their human rights are respected, including their non-discriminatory enjoyment of the highest attainable standard of physical and mental health.<sup>5</sup> Antiretroviral medications (ARVs) have been included on the WHO's model list of Essential Medicines, indicating their use reflects such a standard.<sup>6</sup>

Since the introduction of antiretroviral drugs in 1996, the quality and longevity of the life of people with AIDS have improved, while the cost of such drugs has dropped. HIV is no longer a death

## Impact of HIV test results leads to family separation

### Case study from UNHCR Pretoria

A 47-year-old Congolese widow alongside her three adult and two minor children were submitted for resettlement on similar grounds. The three adult children were accepted, but the widow received a letter from the government of the resettlement country stating she and her dependents were rejected "because X did not meet the health requirement defined in public

interest criterion XXXX because the applicant is a person with HIV infection."

The mother and her children only learned of her HIV-status through the resettlement medical screening. The adult children were then placed in a situation of deciding between staying with their mother to care for her as she becomes sicker, or having a new life in Australia. Eventually, the mother convinced them to leave her behind but is herself left in the camp, caring for minors, without the support of her adult children. She becomes a classic 'women at risk' case.



UNHCR/G.M.B. Akash

A Rohingya woman addresses fellow camp-dwellers about AIDS, Nayapara camp, Cox's Bazaar, Bangladesh.

sentence. As treatment becomes available to more and more people, median survival times for persons diagnosed with HIV increased from 17 months in 1995 to 45 months in 2001.<sup>7</sup> A recent study focusing on labour participation of AIDS patients in sub-Saharan Africa found that within six months of beginning treatment, the likelihood of the patient participating in the labour force increased by 20 per cent and weekly hours worked by 35 per cent.

## Conclusion

The current practice of mandatory HIV testing and the effective exclusion on medical grounds of HIV-positive refugees from a resettlement programme are at variance with human rights principles. As shown in the case studies from UNHCR HIV officers in the field, they have a very real impact on the lives of already vulnerable refugees. These personal stories demonstrate that while resettlement is intended as a protection tool, the linkage of resettlement to HIV-status can lead to the separation of families and even the creation of additional protection problems.

UNHCR appreciates that some resettlement countries don't discriminate against HIV-positive refugees and that mandatory testing sits alongside other health management procedures. For those

countries that do limit access to resettlement to HIV-positive refugees, the introduction of quotas and discretionary use of waiver provisions can be seen as steps in the right direction. Ultimately, however, the underlying principles of non-discrimination against HIV-positive refugees should apply in all cases.

1. See PB Spiegel, "HIV/AIDS conflict affected and displaced populations: dispelling myths and taking

action", *Disaster*, 28 (3), (2004), at 322-39.

2. Office of the High Commissioner for Human Rights and The Joint United Nations Programme on HIV/AIDS. *HIV/AIDS and Human Rights: International Guidelines*. Geneva: OHCHR, UNAIDS, 2002.

3. International Covenant on Civil and Political Rights, Article 17; Committee on the Rights of the Child General Comment No. 3, paragraph 23.

4. UNHCR/WHO *Policy Statement on HIV Testing*, June 2004

5. International Covenant on Economic, Social and Cultural Rights (1966), Article 12; UNHCR, *Refugees, HIV and AIDS: UNHCR's Strategic Plan 2005-2007*, 2005, Protection Objective (1).

6. UNHCR, *Antiretroviral Medication Policy for Refugees*, 2007.

7. UNAIDS, *Epidemic Update*, 2006, p 62

8. UNAIDS, above footnote 3, p 180

9. UNHCR, *Note on HIV/AIDS and the Protection of Refugees, IDPs and Other Persons of Concern*, 5 April 2006, p 3-4.

## HIV-positive refugee denied opportunity to be cared for by his extended family.

### Case study from UNHCR Bangkok

A man in his forties spent most of the 1990s in South-East Asia having fled his country of origin. In early 2002, he became ill and was found to be HIV-positive. Too ill to support his family, he approached UNHCR for protection and assistance. As it was not possible for him to be locally integrated into the country of asylum and repatriation was not an option, resettlement was the only viable solution.

The applicant had numerous close relatives in a particular resettlement country, including his parents, siblings and children from a previous marriage

who were all citizens and willing to provide care and financial and emotional support. Importantly, they were also willing to care for his younger children in the event of his death. The relatives applied to sponsor the man to join them under family sponsorship arrangements.

But despite compelling reasons he be resettled and the family sponsorship request, the application was refused on 'medical grounds'. Desperate to find a solution for the refugee who was now in need of urgent medical care, UNHCR submitted the applicant to another country. He was accepted and promptly resettled. While the man is extremely grateful for the assistance provided to him and his family by his new country, he and his family are now living in a place with few communal ties and no other family support.

# 10 Key Points on HIV/AIDS and the Protection of Refugees, IDPs and Other Persons of Concern

**1) Non-Discrimination:** Persons living with HIV and AIDS are entitled to live their life in dignity, free from discrimination and stigmatization. Refugees who are living with HIV and AIDS should not be subject to discriminatory measures. Misconceptions about those being associated with an increased prevalence of HIV and AIDS may lead to discriminatory practices and should be dispelled.

**2) Access to HIV and AIDS Health Care:** Refugees benefit as any other individual from the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health." This right entails non-discriminatory access to services which are equivalent to those available to surrounding host communities. In terms of HIV and AIDS, in order to respect and fulfil the right to the highest attainable standard of physical and mental health, states must take steps towards realizing access for all to HIV and AIDS prevention, treatment, care and support. This would necessarily include antiretroviral therapy (ART).

**3) Access to Asylum Procedures and Protection from Expulsion and Refoulement:** The HIV status of an asylum-seeker does not constitute a bar to accessing asylum procedures. The right to be protected against *refoulement* is the cornerstone of international refugee law and HIV status is not a ground for any exception to this principle. HIV status does not fall within the permitted grounds for expulsion to a third country.

**4) Protection from Arbitrary Detention and Unlawful Restrictions on Freedom of Movement:** Detention or restrictions on the freedom of movement of persons living with HIV and AIDS would be in violation of the fundamental rights to liberty and security of

the person, as well as the right to freedom of movement, if carried out solely on the basis of a person's actual or suspected HIV status. There is no public health justification for restrictions of these rights due to a person's HIV status alone. Moreover such restrictions would be discriminatory.

**5) Respect for Confidentiality and Privacy:** In principle, personal data is confidential and should not be shared without the consent of the individual concerned; this includes data on the health status of the person. Those who have access to the health status of persons of concern must take appropriate measures to maintain its confidential nature.

**6) Provision of Voluntary Counselling and Testing (VCT):** VCT programmes play an important role in preventing HIV transmission by providing people with accurate information about the virus. Without proper standards, however, there may be breaches of confidentiality resulting in other protection problems. UNHCR supports the use of VCT programmes as long as international standards are met and promotes equal access for persons of its concern to existing VCT programmes, or the establishment of such programmes in cooperation with governments and partners.

**7. Freedom from Mandatory Testing:** UNHCR strictly opposes mandatory HIV testing of asylumseekers, refugees, IDPs and other persons of concern as this is at variance with relevant human rights standards. WHO and UNAIDS have asserted that there is no public health justification for mandatory HIV screening as it does not prevent the introduction or spread of HIV. Public health interests are best served by promoting voluntary counselling and testing in an environment

where confidentiality and privacy are maintained.

**8. Access to Durable Solutions:** The attainment of a durable solution should not be jeopardized by the HIV-status of a refugee or a family member. Concerning voluntary repatriation, the right to return to one's country may not be denied on the basis of HIV status. With respect to local integration, ensuring access to local health and HIV- and AIDS-related services on an equitable basis with nationals in the host country is critical to protecting the basic rights of refugees. Where States deny entry to individuals who are HIV-positive or AIDS, automatic waivers should be given for resettlement cases.

**9. HIV-related protection needs of women, girls and boys:** Women and girls are disproportionately affected by HIV and AIDS and gender inequality can play a significant role in the protection problems they face, including increased exposure to violence. Appropriate measures need to be taken to ensure their protection against sexual or physical violence and exploitation. Special attention must also be paid to children affected by HIV, including those orphaned or otherwise made vulnerable by HIV.

**10. Access to HIV information and education:** The right to health includes access not only to HIV treatment, but also to HIV-related education. States and UNHCR should ensure the widespread provision of information about HIV and AIDS to refugees particularly with regard to HIV-related prevention and care information as well as information related to sexual and reproductive health.

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UNHCR, Note on HIV/AIDS and the Protection of Refugees, IDPs and Other Persons of Concern, 5 April 2006

## Refworld goes online

The leading source of information for refugee status decision makers is now available online. *Refworld* contains a vast collection of reports relating to situations in countries of origin, policy documents and positions, and documents relating to international and national legal frameworks. The information has been carefully selected and compiled from UNHCR's global network of field offices, governments, international, regional and non-governmental organisations, academic institutions and judicial bodies.

You can now access this state-of-the-art tool at [refworld.org](http://refworld.org) or through our local portals [unhcr.org.au](http://unhcr.org.au) or [unhcr.org.nz](http://unhcr.org.nz)

The new website launched in June, is a unique and easily accessible system with vastly improved search functionality, navigation and browsing options, topic guides and special features on core issues. The complete contents of Refworld – including country reports, national legislation and case law and all public-domain UNHCR protection policies and guidelines – are now, for the first time, freely accessible to all.

### In a nutshell, Refworld features:

- More than 76,000 documents relating to countries of origin and asylum and to key protection issues;
- Daily document updates;
- Documents available in full-text, based on information-sharing agreements with strategic information partners;
- Documents such as UNHCR country and thematic positions, third-party country reports, case law from both international and national courts, national legislation, research papers, and training manuals;
- Excellent and user-friendly browsing and searching facilities.

## UNHCR submissions to Australian Parliamentary Committees

UNHCR in April submitted comments to the Parliamentary Joint Committee on Intelligence and Security on the operation, effectiveness and implications of the power to make regulations proscribing organizations as terrorist organizations. While recognizing that States must take robust steps to combat terrorism, UNHCR argued that such steps must be taken in full respect for the rule of law and human rights, including fundamental principles of refugee protection.

In July 2007 UNHCR submitted comments to the Senate Legal and Constitutional Legislation Committee Inquiry into the Australian Citizenship Amendment (Citizenship Testing) Bill 2007. UNHCR was particularly concerned to ensure that any

Australian citizenship test take into account Australia's international obligations under the 1951 Refugee Convention and the 1954 Statelessness Convention to facilitate the assimilation and naturalization of refugees and stateless people. UNHCR urged the Committee to consider the impact on refugees and stateless persons of the proposed bill; to recommend that any exemption for persons with special needs be extended to refugees and stateless persons; and to recommend that the proposed required residency period of four years include any period spent by a refugee as an asylum-seeker or on a temporary protection visa in Australia.

Further details on UNHCR parliamentary submissions may be found at [unhcr.org.au/subinq](http://unhcr.org.au/subinq)

## 2007 ExCom preview

The 58th plenary session of the Executive Committee of the High Commissioner's Programme (ExCom) will take place in Geneva from 1 to 5 October to review and approve the agency's programmes and budgets and to advise on protection matters. It will be preceded by the Annual Consultations with Non-Governmental Organizations on 26 to 28 September. ExCom is this year expected to

adopt a conclusion on international protection on children at risk which is currently being negotiated by Member States. The conclusion is intended to bring together standards developed over the last ten years into an operational framework to enhance the protection of refugee, internally displaced and returnee children.

Further details on ExCom and the Annual Consultations with NGOs can be found on UNHCR's global website at [unhcr.org](http://unhcr.org)