



Note on HIV/AIDS and the Protection of Refugees, IDPs and Other Persons of Concern

1. The impact of the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) on refugee protection continues to be an issue of concern to the United Nations High Commissioner for Refugees (UNHCR). This note provides an overview of how principles of refugee protection and human rights apply to persons of concern¹ to UNHCR who are vulnerable to HIV and its consequences and/or are living or suspected to be living with HIV and AIDS.

2. The Note serves to inform governments and UNHCR staff of recognized standards in the field of HIV and AIDS and the protection of persons of UNHCR's concern, and to assist UNHCR in its protection interventions and advocacy efforts.

A. Human rights basis for response

3. UNHCR's policy on HIV and AIDS and the protection of refugees, IDPs and other persons of concern is firmly embedded in an understanding that human rights underpin all aspects of UNHCR's international protection work. Human rights provide the basic normative framework governing UNHCR's protection and assistance activities in relation to persons of concern affected by HIV and AIDS. In its efforts to assure refugees, IDPs and other persons of concern, including those affected by HIV and AIDS, the widest possible exercise of fundamental human rights and freedoms, UNHCR promotes the full implementation by States of their obligations under international refugee and human rights law as provided for, *inter alia*, in the 1951 Convention relating to the Status of Refugees (hereinafter 1951 Convention), the International Covenant on Civil and Political Rights, the International Covenant on Social,

What are HIV and AIDS?

***HIV** (human immunodeficiency virus) is a virus that damages the defence system of the body. HIV infects cells of the immune system and destroys their function leading to "immune deficiency". A person infected with HIV may look and feel healthy for many years. However, the person is still able to pass on the virus.*

***AIDS** (acquired immune deficiency syndrome) is caused by infection with the HIV virus. Over time the immune system becomes seriously weakened so that the body loses its ability to fight off infection that it would normally have fought. The infected person develops a number of serious infections and illnesses which eventually leads to death. Once a person who has HIV gets one or more opportunistic infections, that person is said to have AIDS. Some people develop AIDS shortly after being infected with HIV, yet some live with HIV for ten or more years before developing AIDS.*

¹ The human rights standards examined in this Note are equally applicable to all individuals of UNHCR's concern, including refugees and asylum-seekers, persons displaced within their own countries (IDPs), returnees (refugees and IDPs who have returned to their countries/places of origin), and stateless persons.

Economic and Cultural Rights, the *Convention on the Elimination of All Forms of Discrimination against Women*, the *Convention on the Rights of the Child*, and related regional human rights instruments, as well as norms of customary international law.

4. UNHCR's policy is further informed by the expertise of specialized UN agencies,² as well as the interpretations of the UN human rights treaty bodies, while additional guidance can be found in UNHCR's Executive Committee Conclusion No. 102 (LVI) – 2005.³

5. This Note draws on existing United Nations guidance on human rights and HIV/AIDS, specifically the *HIV/AIDS and Human Rights: International Guidelines* and *Revised Guideline 6 on access to prevention, treatment, care and support*.⁴ These *International Guidelines* underline the fundamental importance of human rights protection in any effective programme or policy to combat HIV and AIDS. The principles set out in this Note show how this general human rights guidance applies in the context of providing protection to refugees and other persons of concern to UNHCR.

6. A human rights based approach is also in accordance with the *Declaration of Commitment on HIV/AIDS* adopted by the United Nations General Assembly during the Special Session on HIV/AIDS in 2001.⁵ The Commission on Human Rights has also emphasized the inextricable relationship between human rights and HIV and AIDS. While taking note of the critical intersection between the protection of human rights and an effective response to the epidemic, the Commission urged States, *inter alia*, to ensure that their laws, policies and practices on HIV and AIDS respect human rights.⁶

² For example, the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the Office of the High Commissioner for Human Rights (OHCHR).

³ See Executive Committee (ExCom) General Conclusion on International Protection No. 102 (LVI) – 2005 at paragraph (w) which “*Acknowledges* that access to HIV and AIDS prevention, care and treatment, as far as possible in a manner comparable with the services available to the local hosting community, is increasingly recognized by States as an essential component in the protection of refugees, returnees and other persons of concern; *encourages* UNHCR to pursue activities in this regard, in close collaboration with relevant partners, in particular in the implementation of the objectives agreed in the UNAIDS Unified Budget Work Plan, ensuring specific emphasis on the rights of refugee women and children affected by the pandemic; and *notes* the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors;”

⁴ OHCHR and the Joint United Nations Programme on HIV/AIDS, *HIV/AIDS and Human Rights: International Guidelines*, HR/PUB/98/1 (1998) (hereinafter “*HIV/AIDS and Human Rights: International Guidelines*”); OHCHR/UNAIDS, *HIV/AIDS and Human Rights: International Guidelines. Revised Guideline 6 on access to prevention, treatment, care and support*, HR/PUB/2002/1 (2002) (hereinafter “*HIV/AIDS and Human Rights: International Guidelines. Revised Guideline 6*”). In response to a request of the Commission on Human Rights, the *HIV/AIDS and Human Rights: International Guidelines* were finalized and adopted at the Second International Consultation on HIV/AIDS and Human Rights in 1996. Although the Guidelines do not constitute a binding instrument, they reflect and are consistent with international human rights law. They serve as a tool for States in designing, co-ordinating and implementing effective national HIV/AIDS policies and strategies in that they provide the framework for a rights-based response to the HIV/AIDS epidemic by outlining how human rights standards apply in the context of HIV/AIDS and translating them into practical measures that should be undertaken at the national level. In 2002, *Guideline 6* was revised to reflect new standards in HIV treatment and evolving international law on the right to health.

⁵ United Nations General Assembly Special Session resolution on the “Declaration of Commitment on HIV/AIDS” (A/RES/S-26/2), Annex (adopted 27 June 2001) (hereinafter “UNGA Declaration of Commitment on HIV/AIDS”). This special session on HIV/AIDS, convened by the General Assembly from 25 to 27 June 2001, was in response to the alarming acceleration of the AIDS epidemic and its global impact.

⁶ Commission on Human Rights Resolution 2005/84, “The protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS)”, E/CN.4/RES/2005/84, 61st meeting (21 April 2005), (hereinafter “CHR Resolution on the protection of human rights in the context of HIV/AIDS”), preambular paragraph 12 and paragraph 5.

B. Protection Concerns arising from HIV/AIDS

7. UNHCR is concerned with a number of protection issues relating to refugees, IDPs and other persons of concern affected by HIV and AIDS. This Note addresses ten key protection concerns which can arise in the context of HIV and AIDS and highlights UNHCR's policy for each. Aspects of this policy may evolve as effective treatment for HIV and AIDS becomes more accessible. These ten issues and UNHCR's policy may be summarized as follows:

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, IDPs and other persons of concern to UNHCR who are living with HIV and AIDS should not be subject to discriminatory measures. Misconceptions about refugees, IDPs or other person of concern 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, IDPs and other persons of concern to UNHCR 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 would also 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 asylum-seekers, 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. In the context of **resettlement**, although UNHCR opposes HIV testing as a prerequisite for such, certain resettlement countries require pre-departure health-screening, including HIV testing. Where testing is done, human rights should be respected and **voluntary counselling and testing** standards should be met. 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, IDPs and other persons of concern, particularly with regard to HIV-related prevention and care information as well as information related to sexual and reproductive health.

8. UNHCR's policy for each of these issues is explained in more detail below with reference to the international legal principles upon which this policy is based.

B.1 Non-Discrimination

9. Persons of concern living with HIV and AIDS face discrimination in many ways, including in relation to employment, housing, and health care. This discrimination can be by government authorities, service providers, members of the host community as well as by other refugees. Persons living with HIV and AIDS are entitled to live their life in dignity, free from discrimination as non-discrimination is among the most fundamental principles of international human rights law.

10. According to the *International Covenant on Civil and Political Rights* (ICCPR) and the *International Covenant on Economic, Social and Cultural Rights* (ICESCR), the rights enunciated in those instruments are to be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. The Committee on Economic, Social and Cultural Rights as well as the Committee on the Rights of the Child have interpreted the term "other status" in the non-discrimination provisions in the relevant international human rights instruments to include health status, including HIV and AIDS.⁷ Discrimination on the basis of HIV or AIDS status, whether actual or presumed, is therefore prohibited by existing international human rights standards.

11. The principle of non-discrimination, however, would allow for the creation of specific strategies which differentiate among particular groups of persons. The criteria for any distinction must be reasonable and objective, the differentiation must be in pursuance of an aim

⁷ See the Committee on Economic, Social and Cultural Rights General Comment No. 14 (2000) on Article 12 of the International Covenant on Economic, Social and Cultural Rights, E/C.12/2000/4, (hereinafter "CESCR General Comment No. 14"), paragraphs 18-19 and the Committee on the Rights of the Child General Comment No. 3 (2003) on 'HIV/AIDS and the rights of the child', CRC/GC/2003/3, (hereinafter "CRC Committee General Comment No. 3"), paragraph 9. The Commission on Human Rights has also interpreted the term "other status" to include health status: see CHR Resolution on the protection of human rights in the context of HIV/AIDS, above footnote 6, preambular paragraph 16.

which is legitimate under human rights law, and the means used must be proportional to the achievement of that aim.⁸ Therefore providing privileged access to a particular HIV or AIDS health care programme for a marginalized or disadvantaged group in society or others with special needs, such as pregnant women who are infected with or affected by HIV and AIDS would not violate the principle of non-discrimination.

12. Moreover, misconceptions that refugees, IDPs or another person of concern are associated with an increased prevalence of HIV may lead to discriminatory practices and should be dispelled.⁹ Governments should actively promote non-discriminatory treatment through education and public information programmes which enable the public to understand better the nature of HIV and AIDS and should ensure that such programmes, as well as mass media reports, do not create negative stereotypes or stigmatize refugees, IDPs or other persons of concern. According to Guideline 9 of the *International Guidelines on HIV/AIDS and Human Rights*, States should, for example, promote the distribution of materials which are designed to change public attitudes of discrimination and stigmatization associated with HIV/AIDS.¹⁰

13. In light of these principles, refugees, IDPs and other persons of concern to UNHCR who are living with HIV and AIDS should not be subject to discriminatory measures based on the above-mentioned grounds, including, in particular, their health status.

B.2 Access to HIV and AIDS Health Care

14. One of the most significant issues for any person living with HIV and AIDS is access to health care, including appropriate access to life-saving treatment such as antiretroviral therapy (ART).¹¹ Access to health care is one of the rights contained in the 1951 Convention¹² and has, as well, been recognized as a fundamental human right under the ICESCR which must be granted on a non-discriminatory basis.

15. As with other social rights, the right to the “highest attainable standard of physical and mental health” requires States parties to the ICESCR “to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the

⁸ See Human Rights Committee (HRC) General Comment No. 18 “Non-discrimination”, HRI/GEN/1/Rev.7 (10 November 1989) at paragraph 13; Committee on the Elimination of Racial Discrimination (CERD), General Recommendation No. 30 “Discrimination against non-citizens”, CERD/C/64/Misc.11/rev.3 (23 February-12 March 2004); CERD General Recommendation No. 14 “Definition of discrimination”, HRI/GEN/1/Rev.7 (22 March 1993).

⁹ Evidence suggests that the HIV prevalence among refugees is often lower than that among their surrounding host country population due to a number of factors, including reduced mobility and accessibility of the population, which may work to decrease HIV transmission. See PB Spiegel, “HIV/AIDS among conflict-affected and displaced populations: dispelling myths and taking action”, *Disaster*, 28(3), (2004), at 322-39.

¹⁰ See *HIV/AIDS and Human Rights: International Guidelines*, above footnote 4, paragraph 40. See also CESCR General Comment No. 14, above footnote 7, paragraph 36, as well as section B.10 below on *Access to HIV Information and Education*.

¹¹ ART is a combination of medications that interrupts HIV replication at various points in the viral replication cycle. ART is generally divided into three components: 1) post-exposure prophylaxis, usually a 28-day course of ART given to a rape survivor in order to reduce the chances of HIV transmission; 2) prevention of mother-to-child transmission, a short course of one or more antiretroviral medications provided to the pregnant women during labour and the newborn to reduce the chances of HIV transmission to the newborn; and 3) long-term ART, a lifelong combination of antiretroviral medications provided to persons living with HIV and AIDS who meet certain inclusion criteria.

¹² Under Article 23 of the *1951 Convention*, refugees lawfully staying in the host country are entitled to social and medical assistance on the same conditions as nationals.

*rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.*¹³

16. The right of access to health care flows from the obligation of State parties to the ICESCR to ensure that everyone within its jurisdiction has access, without discrimination, to the highest attainable standard of physical and mental health.¹⁴ An important component of this obligation is the creation of conditions which would assure *to all* non-discriminatory access to medical service and medical attention in the event of sickness as well as the treatment of epidemic diseases.¹⁵ The Committee on Economic, Social and Cultural Rights has interpreted the right to health to include an obligation on States to refrain from denying or limiting equal access for all persons, including asylum seekers and illegal migrants, to preventative, curative and palliative health services.¹⁶ Moreover, according to the Committee, it is a core obligation of States parties to ensure primary health care and to provide essential drugs.¹⁷

17. 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, and to move as quickly and effectively as possible, towards realizing access for all to HIV and AIDS prevention, treatment, care and support.¹⁸ This would necessarily include ART.

¹³ Art 2(1) ICESCR.

¹⁴ See Article 2(1) of the ICCPR and Article 12 of the ICESCR. See also, Human Rights Committee General Comment No. 31, “The Nature of the General Legal Obligation imposed on States Parties to the Covenant”, CCPR/C/21/Rev.1/Add.13 (29 March 2004), paragraph 10 and CESCR General Comment No. 14, above footnote 7, at paragraphs 12, 34 and 52. The exception under Article 2(3) of the ICESCR which allows for developing countries to distinguish between nationals and non-nationals is restricted to *economic* rights. Additionally, the right to health is recognized, *inter alia*, in Article 5 (e) (iv) of the *International Convention on the Elimination of All Forms of Racial Discrimination*, in Articles 11.1 (f) and 12 of the *Convention on the Elimination of All Forms of Discrimination against Women* and in Article 24 of the *Convention on the Rights of the Child*. Several regional human rights instruments also recognize the right to health, such as the *European Social Charter* as revised (Art. 11), the *African Charter on Human and Peoples' Rights* (Art. 16) and the *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights* (Art. 10).

¹⁵ With regard to the issue of *non-discriminatory access to health care*, according to the Committee on Economic, Social and Cultural Rights, the ICESCR “proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV and AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.”: See CESCR General Comment No. 14, above footnote 7, paragraph 18.

¹⁶ See CESCR General Comment No. 14, above footnote 7, paragraph 34.

¹⁷ See CESCR General Comment No. 14, above footnote 7, paragraph 43.

¹⁸ See *HIV/AIDS and Human Rights: International Guideline. Revised Guideline* 6, above footnote 4, paragraph b. at p.15. See also CESCR General Comment No. 14, above footnote 7, as well as the Commission on Human Rights resolution 2005/23, *Access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria*, E/CN.4/RES/2005/23, 61st meeting (15 April 2005) (hereinafter “CHR Resolution on Access to Medication in the context of HIV/AIDS”), paragraph 1, in which it was recognised that “access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria is one fundamental element for achieving progressively the full realisation of the right of everyone to the enjoyment of the highest attainable standard or physical and mental health.” The Commission also called upon States, at paragraph 3, to develop and implement national strategies in order to progressively realise “access to comprehensive treatment, care and support for all individuals infected by pandemics such as HIV/AIDS, tuberculosis and malaria,” and at paragraph 7(a) to refrain from taking measures which would deny or limit equal access for all persons to preventive, curative or palliative pharmaceutical products or medical technologies, ..., used to treat pandemics such as HIV/AIDS, tuberculosis, malaria or the most common opportunistic infections that accompany them.”

18. According to the Committee on the Rights of the Child it is now widely recognized that comprehensive treatment and care for HIV includes ART.¹⁹ Further strengthening the Committee's finding is the fact that ART is considered to be a life-saving essential medication and is contained in the World Health Organization (WHO) List of Essential Medicines. Finally, the international community has recognized that access to medication in the context of HIV and AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.²⁰

19. With regard to children and the right to health, States parties to the Convention on the Rights of the Child (CRC) are obliged, *inter alia*, to ensure the provision of necessary medical assistance and health care to all children on their territory and to ensure appropriate pre-natal and post-natal health care for mothers.²¹ Thus, for example, the Committee on the Rights of the Child has noted that in order to prevent mother-to-child transmission of HIV, "States parties must take steps, including the provision of essential drugs, e.g. antiretroviral drugs, appropriate antenatal, delivery and post-partum care, and making HIV voluntary counselling and testing services available to pregnant women and their partners."²²

20. Based on the international refugee and human rights principles described above, and given that equal and non-discriminatory access to ART is a vital component of ensuring the right to the highest attainable standard of physical and mental health, host governments which are parties to the above-mentioned instruments should ensure that refugees, IDPs and other persons of concern have access, on an equal and non-discriminatory basis, to existing national health and HIV programmes or their equivalent. This includes access to national ART programmes, or their equivalent, and access to other essential drugs which are available to the host population.

21. Moreover, it should be recognized that ART embodies a public health function in that it helps to prevent the spread of the virus.²³ This is particularly the case in preventing mother-to-child transmission (PMTCT) as well as post-exposure prophylaxis (PEP).²⁴ ART also performs the public health functions of keeping people alive and healthy and acting as an incentive for people to avail themselves of VCT programmes which entail HIV-related prevention and care services.

22. UNHCR promotes the full and non-discriminatory access of refugees, IDPs and other persons of concern to governmental health schemes and advocates for their inclusion in international assistance programs and capacity building measures.²⁵

¹⁹ CRC Committee General Comment No. 3 (2003), above footnote 7, paragraph 28.

²⁰ UNGA Declaration of Commitment on HIV/AIDS, above footnote 5, Articles 15 and 23.

²¹ See Article 24 of the CRC. The Committee on the Rights of the Child has interpreted that the obligations of States parties under the CRC extend to ensuring that children have sustained and equal access to comprehensive treatment and care, including necessary HIV-related drugs, goods and services on a non-discriminatory basis; CRC Committee General Comment No. 3, above footnote 7.

²² CRC Committee General Comment No. 3, above footnote 7, paragraph 26.

²³ According to medical research, it "has been estimated by an analysis of longitudinal cohort data that antiretroviral therapy reduces per-partnership infectivity by as much as 60%." See Porco TC, Martin JN, Page-Shafer KA, Cheng A, Charlebois E, Grant RM, Osmond DH, "Decline in HIV infectivity following the introduction of highly active antiretroviral therapy" *AIDS* Vol. 18 (2 January 2004) at 81-88.

²⁴ See above footnote 11.

²⁵ For further information, please see UNHCR's Policy on Antiretroviral Therapy (forthcoming).

B.3 Access to Asylum Procedures and Protection from Expulsion and Refoulement

23. Refugees and asylum-seekers living or suspected to be living with HIV and AIDS may be at risk of expulsion or *refoulement* from their countries of asylum due to their HIV status or, as asylum-seekers, may be barred from access to asylum procedures. The health or HIV status of an asylum-seeker would not be a legitimate reason for denying the person access to asylum procedures. Moreover, 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.

24. Under the *1951 Convention*, as well as under customary international law, States are prohibited from returning a refugee to a country where his or her life or freedom would be threatened on account of his or her race, religion, nationality, membership of a particular social group or political opinion. Although certain provisions of the *1951 Convention* exceptionally allow for the expulsion to a third country (Article 32) or *refoulement* of refugees (Article 33(2)), these actions, if carried out solely on the basis of HIV and AIDS, would amount to contraventions of the *1951 Convention* and/or to the *non-refoulement* obligation under customary international law.

25. The grounds to the exception to the principle of *non-refoulement* as provided for in Article 33(2) of the *1951 Convention* are limited and must be interpreted restrictively and applied with great caution. This exception applies only to a refugee for whom there are reasonable grounds for regarding him or her as a danger to the security of the country in which s/he is, or who, having been convicted by a final judgment of a particularly serious crime, constitutes a danger to the community of the country. Article 32 of the *1951 Convention*, on the other hand, sets out the exceptional grounds of national security or public order upon which a refugee who is lawfully in the territory may be expelled to a third country where he or she will not be at risk of persecution.

26. A person living with HIV and AIDS does not fall within the national security exceptions provided for in Articles 32 and 33(2) of the *1951 Convention*.²⁶ Moreover, it should be noted that the *travaux préparatoires* of the *1951 Convention* show that the drafters did not intend the public order exception provided for in its Article 32 to permit the expulsion of refugees on social grounds, such as indigence, mental or physical illness or disability. Reasons of morality would also not be a valid basis for invoking Article 32 of the *1951 Convention*.²⁷

B.4 Protection from Arbitrary Detention and Unlawful Restrictions on Freedom of Movement

27. The right to liberty and security of the person, as well as the right to freedom from arbitrary detention, are fundamental norms which should not be interfered with solely on the

²⁶ These articles are applicable only to those cases where a person represents a very serious future danger to the security of the country of refuge, and where the *refoulement* or expulsion of the refugee is necessary to eliminate the danger and is used as a mechanism of last resort, in keeping with the principle of proportionality. See *Factum of the Intervenor United Nations High Commissioner for Refugees, Suresh v. Minister of Citizenship and Immigration*, SCC No. 27790 (Can) as well as UNHCR *Advisory Opinion regarding the scope of the "danger to the security of the country" exception under Article 33(2) of the 1951 Convention relating to the Status of Refugees, letter to Paul Engelmayer Esq.* (6 Jan. 2006). See also, E. Lauterpacht and D. Bethlehem, 'The scope and content of the principle of non-refoulement: Opinion', in E. Feller, V. Türk and F. Nicholson (eds.), *Refugee Protection in International Law: UNHCR's Global Consultations on International Protection*, Cambridge University Press 2003, at 87-177, in particular paragraphs 162-179 and Atle Grahl-Madsen, *Commentary on the Refugee Convention 1951*, (1963), at 201-204 and 232-236.

²⁷ *1951 Convention, Travaux préparatoires*; see Paul Weis, *The Refugee Convention, 1951* Cambridge University Press, Cambridge (1995), at 305-324.

basis of a person's HIV status.²⁸ These rights apply to anyone within the jurisdiction of a State, even those who are unlawfully present.

28. With regard to the right to freedom of movement and the right to choose one's place of residence, these are restricted to those who are lawfully on the territory. Thus, refugees, asylum-seekers and other persons of concern lawfully on the territory of a host state who are infected with HIV or affected by AIDS should not be subject to restrictions on their freedom of movement.²⁹ Although certain restrictions on freedom of movement are permissible under Article 12(3) of the ICCPR, such as public health, this exception would seldom be a legitimate basis for such a restriction in the context of HIV and AIDS and would likely infringe on the principle of non-discrimination.³⁰

29. According to the *HIV/AIDS and Human Rights: International Guidelines*, there is no public health justification for deprivation of liberty (whether quarantine, detention in special colonies or centres, or isolation) based on a person's HIV status.³¹ Moreover, any restrictions of the right to liberty and security of the person or the right to freedom of movement based on suspected or real HIV status alone are discriminatory and cannot be justified by public health concerns.³² HIV and AIDS is not a disease that can be transmitted through everyday life activities and transmission may be prevented by less restrictive means, such as through public education and awareness as well as through VCT programmes which promote safe behaviour.

30. Refugees, IDPs and other persons of concern should therefore not be detained nor have restrictions imposed on their freedom of movement based solely on their HIV status.

B.5 Respect for Confidentiality and Privacy

31. Another critical protection issue facing persons of concern living with HIV or AIDS relates to the confidentiality and privacy of their health status which if violated can put them at risk. In principle, personal data is confidential and should not be shared without the prior consent of the individual concerned; this includes data on the health status of the person.

32. The right to privacy as provided for in Article 17 of the ICCPR includes privacy of information about a person's health status, including HIV status. Thus, persons who have access to the health status of persons of concern, such as health professionals, counsellors, UNHCR staff or those of implementing partners, must ensure that they take appropriate measures to maintain its confidential nature. A decision whether to record HIV status should be guided by the protection considerations for the individual ((e.g., to administer specific

²⁸ See Article 9 of the ICCPR. This right is also guaranteed in a number of regional human rights instruments, such as Article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, Article 6 of the African Charter on Human and Peoples' Rights, Article 7 of the American Convention on Human Rights.

²⁹ See Article 26 of the *1951 Convention* as well as Article 12 of the ICCPR.

³⁰ In order for a restriction on a human right to be legitimate, the State must establish that the restriction is provided for and carried out in accordance law, is for a legitimate objective, is necessary, and the means employed to achieve the objective must be proportionate to the aim pursued; that is, they must constitute the least restrictive means available. Moreover, any restriction must be consistent with the other rights, such as the right of non-discrimination. Although public health has been cited by States as a basis for restricting human rights in the context of HIV and AIDS, measures taken by them may not be the least restrictive ones possible and may be imposed on discriminatory basis, and therefore would not be legitimate; see *HIV/AIDS and Human Rights: International Guidelines*, above footnote 4, paragraphs 82-83.

³¹ *HIV/AIDS and Human Rights: International Guidelines*, above footnote 4, paragraphs 110-113.

³² *HIV/AIDS and Human Rights: International Guidelines*, above footnote 4, paragraphs 104-105.

assistance or prioritize cases), and if recorded, then maintained in secure conditions with restricted access.³³

33. If, for a specific purpose, information concerning an individual's health status needs to be disclosed to a third party, the prior informed consent of the person concerned needs to be obtained. Informed consent entails proper counselling as to the reasons for sharing and with whom the information will be shared, as well as the consequences of denying consent. Not only would breaches of confidentiality be an infringement on a person's right to privacy, but may also cause other protection problems for the person concerned; such as refoulement, rejection by family members or the community, violence or threats of violence, or discriminatory treatment in accessing services. Maintaining privacy is also in the best interest of public health so that more people will feel safe and comfortable in using public health measures, such as HIV/AIDS prevention and care services.³⁴

34. The right to privacy is also applicable to families, including children. Therefore, family members (including spouses or parents) should not be informed of a relative's HIV status without the consent of the individual concerned. The individual, however, should be actively counselled to inform his or her spouse as well as other sexual partners.

35. The CRC reiterates the obligation that children also enjoy the right to privacy, including within the health setting.³⁵ Counselling and testing services would, however, have to pay due attention to the evolving capacities of children and normally the consent of the parents would be required, subject to the best interests of the child and with due regard to applicable national legislation. Although information on the HIV status of children should not be disclosed to third parties, including parents, without the child's consent, this, of course, is subject to the age and maturity of the child as well as to a determination of his or her best interests.³⁶

36. Innovative mechanisms may need to be put in place to ensure that the provision of services for persons living with HIV and AIDS, particularly in refugee and IDP settings, do not jeopardize confidentiality (e.g., ensure home-based care or supplemental feeding is provided to all persons with chronic diseases who fit the criteria and not solely for persons with HIV and AIDS). Moreover, those providing health services to refugees, IDPs and other persons of concern should be enabled to protect confidentiality and privacy by receiving clear guidance and training on how to do so.

B.6 Provision of Voluntary Counselling and Testing

37. The provision of voluntary HIV testing and counselling (VCT) programmes plays an important role in preventing HIV transmission by providing people with accurate information about the virus. However, if proper standards are not in place, there may be breaches of confidentiality resulting in other protection problems (see above) or the person concerned may not receive the proper counselling they need in order to understand the consequences of living with the virus and the programmes and/or treatment available for them and their families.

38. Thus, for VCT to meet acceptable standards, testing of individuals must be **confidential**, be accompanied by pre- and post-test **counselling** and only be conducted with

³³ See UNHCR Handbook for Registration.

³⁴ *HIV/AIDS and Human Rights: International Guidelines*, above footnote 4, paragraphs 97-98.

³⁵ See Article 16, CRC. See also CRC Committee General Comment No. 3, above footnote 7, paragraphs 22-24.

³⁶ CRC Committee General Comment No. 3, above footnote 7, paragraphs 22-24.

consent, meaning that it is both informed and voluntary.³⁷ Pre- and post-test counselling should be performed by **qualified** and **professional** staff. During the pre-test counselling session, the informed consent of the patient must be obtained. Post-test counselling should be conducted regardless of the results of the test: counselling on HIV prevention is relevant for those who test negative as well as positive. Counselling on the availability of referral and support programmes, including on the availability of ART programmes, is necessary for those testing positive.

39. UNAIDS and WHO recommend that where effective prevention and treatment services that include ART are assured, health care providers should make routine offers of HIV testing during or as part of medical checks to certain categories of patients.³⁸ For example, in situations where PMTCT is available, medical practitioners should offer an HIV test to pregnant women which would be undertaken unless there is a specific objection. The basic conditions of confidentiality and informed consent apply in such situations.

40. UNHCR encourages the use of VCT programmes as long as the above-mentioned standards are met. UNHCR actively promotes equal access for persons of its concern to existing VCT programmes or the establishment of such programmes in cooperation with governments and partners.

B.7 Freedom from Mandatory Testing

41. Mandatory HIV-testing imposed by States may result in serious protection consequences for refugees, IDPs and other persons of concern, such as *refoulement*, detention or the denial of other fundamental rights.

42. UNHCR strictly opposes mandatory HIV-testing of refugees, IDPs and other persons of concern as this is at variance with relevant human rights standards. The right to privacy, as provided for in Article 17 of the ICCPR, for example, encompasses obligations to respect privacy of information and physical privacy; the latter term referring to the security of the person. Mandatory testing may, thus, violate or lead to a violation of, for example, the right to liberty and security of the person or the right to non-discrimination.³⁹ The Committee on the Rights of the Child has explicitly stated that “States parties must refrain from imposing mandatory HIV/AIDS testing of children in all circumstances and to ensure protection against it.”⁴⁰

43. WHO and UNAIDS have concluded that there is no public health justification for mandatory HIV screening as it does not prevent the introduction or spread of HIV and that HIV testing carried out on a voluntary basis and with appropriate pre- and post-test counselling is

³⁷ According to UNAIDS/WHO, the minimum amount of information that patients require in order to be able to provide informed consent is: (i) the clinical benefit and the prevention benefits of testing; (ii) the right to refuse; (iii) the follow-up services which will be offered and; (iv) in the event of a positive test result, the importance of anticipating the need to inform anyone at ongoing risk who would otherwise not suspect they were being exposed to HIV infection. See *UNAIDS/WHO Policy Statement on HIV Testing*, June 2004.

³⁸ According to UNAIDS/WHO, a routine offer of HIV testing should be made by health care providers in the following situations: (1) patients who are being assessed for sexually transmitted infections; (2) in the context of pregnancy if antiretroviral prevention of mother-to-child transmission therapy is available; (3) patients being seen in clinical and community-based health service settings where HIV is prevalent and antiretroviral treatment is available. See *UNAIDS/WHO Policy Statement on HIV Testing*, above footnote 37.

³⁹ See *HIV/AIDS and Human Rights: International Guidelines*, above footnote 4, paragraph 97.

⁴⁰ CRC Committee General Comment No. 3, above footnote 7, paragraph 23.

more likely to promote behaviour change than mandatory testing.⁴¹ Furthermore, mandatory testing measures could be counter-productive as they may drive those at high risk of HIV infection underground, as a result of which such persons may not have access to education and counselling programmes. Public health interests are thus best served by promoting voluntary counselling and testing in an environment where confidentiality and privacy are maintained.⁴² Public health interests do, however, require HIV screening in cases where blood or another human product, rather than the person, is tested before use on another person.

44. In this context, UNHCR opposes mandatory testing in situations where such testing is a prerequisite to according rights and benefits to refugees, IDPs or other persons of concern, such as admission to the territory, access to asylum procedures or to residence permits.

B.8 Access to Durable Solutions

45. Part of UNHCR's international protection mandate requires it, in cooperation with States, to seek durable solutions for refugees. The attainment of a durable solution should not be jeopardized by the HIV-status of a refugee or of a family member, particularly in cases where this would lead to a violation of fundamental human rights or in cases where it would cause undue hardship or exacerbate other protection problems. The health status of an individual may also call for the prioritization of the case.

46. Concerning **voluntary repatriation**, the right to return to one's country is enshrined without restriction in Article 12(4) of the ICCPR and Article 13(2) of the Universal Declaration of Human Rights and may not be denied on the basis of HIV status. Moreover, any mandatory HIV testing that specifically targets returnees because they are repatriating or returning from a refugee or IDP situation may amount to discrimination and/or be in violation of other human rights (see above under section B.7 *Freedom from Mandatory Testing*). Confidential VCT programmes for returnees, as well as other persons in the areas of return, however, should be made available, whenever possible. Furthermore, a State's obligations to ensure the **re-integration** of returnees and to respect their civil, political, economic, social and cultural rights are not affected by the HIV-status of the individuals concerned.

47. When refugees are receiving ART in the country of asylum, phased return may be necessary in order to ensure continuity of treatment in the country of asylum if it is not yet available in the country of origin. Family unity should be respected and maintained in such situations. Measures to extend coverage to the areas of return should be undertaken by governments with the support of donors, NGOs and UNHCR in coordination and cooperation with the HIV UN Theme Group.⁴³

48. Similarly, with respect to **local integration**, as stated above, 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. Integration of HIV and AIDS-related programmes among persons of concern to UNHCR and surrounding host communities is strongly encouraged.

⁴¹ See UNAIDS/WHO Policy Statement on HIV Testing, above footnote 37. See also World Health Assembly Resolution 45.35, Forty-fifth World Health Assembly (14 May 1992) which recognized that "there is no public health rationale for any measures that limit the rights of the individual, notably measures establishing mandatory screening". Moreover, according to the *HIV/AIDS and Human Rights: International Guidelines on HIV/AIDS*: "Compulsory HIV testing can constitute a deprivation of liberty and a violation of the right to security of the person... There is no public health justification for such compulsory HIV testing."; see above footnote 4, paragraphs 98 and 113.

⁴² See UNAIDS/IOM Statement on HIV/AIDS-related travel restrictions, June 2004.

⁴³ For further information, see UNHCR's Policy on ART (forthcoming).

49. UNHCR, in principle, opposes HIV testing as a prerequisite for **resettlement** eligibility. However, certain resettlement countries require pre-departure health-screening, including HIV testing. Where testing is done, basic human rights of privacy, security, non-discrimination, as well as the principles of autonomy, informed consent and confidentiality must be respected, in particular to ensure that the mechanisms in place for testing and notification of results do not expose refugees to stigmatization or other protection problems. With regard to counselling, it is of utmost importance that the person concerned fully understands the reasons and possible consequences of the test. Moreover, at a minimum, the standards mentioned above in Section B.6 *Provision of Voluntary Counselling and Testing* should be met.

50. With regard to the notification of results, in cases where an individual has tested positive for HIV, the conveyance of the results must be made in a sensitive way which ensures privacy and comprehensive information on the consequences and options available. Procedures to ensure that these standards are met should be in place and supported by States. Where States may deny entry to individuals who are HIV-positive or AIDS, automatic waivers should be given for resettlement cases.

B.9 HIV-related Protection Needs of Women, Girls and Boys

51. Women and girls are disproportionately affected by the epidemic in that they comprise an increasing proportion of the people infected. Gender inequality also plays a significant role in the protection problems faced by women, and studies show that not only does violence against women and girls increase their risk of HIV infection, but that women who are HIV-positive may be more susceptible to violence or the threat of violence by their partners and/or families.⁴⁴

52. In situations of forced displacement, the risk of being exposed to physical or sexual violence may be exacerbated and thus States, UNHCR and its partners must ensure that appropriate measures are taken to protect women, girls and boys from sexual violence or exploitation, including the adequate provision of sufficient assistance to enable them to avoid transactional sex for food, shelter and other necessities. Other measures to prevent infection, such as information campaigns, should be carried out in such a manner as to reach women and children. The protection needs of women and children who are HIV positive or otherwise made vulnerable by HIV and AIDS must also be monitored, including a possible exposed risk of domestic violence, barriers to women's access to care and treatment, stigma and discrimination, possible abandonment by their families or additional family care responsibilities, particularly for children or older women.

53. Special attention must also be paid to children affected by HIV, including those orphaned or otherwise made vulnerable by HIV. Special attention is required in order to ensure that a child's HIV status, or that of a family member, does not create additional protection problems, such as isolation, lack of access to education, and the protection needs of child-headed households.⁴⁵

⁴⁴ The UNGA Declaration of Commitment on HIV/AIDS, above footnote , explicitly notes the gender dimensions of the epidemic in Article 14 by stressing that "gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS." In Article 47, Member States of the United Nations committed themselves to "intensify efforts to...challenge gender stereotypes and attitudes, and gender inequality in relation to HIV/AIDS, encouraging the active involvement of men and boys." See, also, UNAIDS, UNFPA and UNIFEM, *Women and HIV/AIDS: Confronting the Crisis*, (2004); as well as The Global Coalition on Women and AIDS, *Stop Violence against Women: Fight AIDS*, Issue #2, available at: <http://womenandaids.unaids.org>.

⁴⁵ See Articles 13, 17 and 24 of the CRC as well as the CRC Committee General Comment No. 3, above footnote 7, paragraphs 16-17.

54. As noted above in section B.2 *Access to HIV and AIDS Healthcare*, the provision of post-exposure prophylaxis (PEP) to rape survivors and PMTCT to pregnant mothers is vital in order to reduce the risks of transmission of the virus and would therefore be a priority activity. Health workers should be trained to recognize signs of gender-based violence and to provide medical care as well as counselling and referral services.

B.10 Access to HIV Information and Education

55. The right to health includes access not only to HIV treatment, but also to HIV-related education.⁴⁶ States and UNHCR should ensure the widespread provision of information about HIV and AIDS to refugees, IDPs and other persons of concern, particularly with regard to HIV-related prevention and care information as well as information related to sexual and reproductive health.

56. Consistent with the rights to health and information contained in the CRC, States parties should ensure that children have the right to access to adequate information on HIV/AIDS prevention and care. Such information should be relevant, appropriate and timely as well as presented in a manner which recognizes the differing levels of understanding among children.⁴⁷

C. Other

For information on strategic planning and HIV/AIDS programming, please refer to *Refugees, HIV and AIDS: UNHCR's Strategic Plan 2005-2007. 2007 and UNHCR's HIV and AIDS websites* (www.unhcr.org/hiv-aids (English) and www.unhcr.fr/cgi-bin/texis/vtx/protect?id=401915744 (French)).

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⁴⁶ The CESCR has interpreted that information accessibility, including the right to seek, receive and impart information and ideas concerning health issues, is a component of the right to health. The CESCR has also informed that the right contained in Article 12(2)(c) of the ICESCR – that States Parties must take steps necessary for the prevention, treatment and control of diseases – “requires the establishment of prevention and education programmes for behaviour-related health concerns such as sexually transmitted diseases, in particular HIV/AIDS”; see CESCR General Comment No. 14, above footnote 7, paragraphs 12 and 16. Additionally, the right of everyone to education is recognised in the Universal Declaration of Human Rights, which in Article 26 states that: “Education shall be directed to the full development of the human personality and to the strengthening of human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship...”

⁴⁷ For more guidance, see CRC Committee General Comment No. 3, above footnote 7, paragraphs 16-17.

Suggested Further Reading:

- Refugees, HIV and AIDS: UNHCR's Strategic Plan 2005-2007.
- Strategies to support the HIV-related needs of refugees and host populations. UNAIDS, UNHCR Best Practice Collection, 2005.
- UNAIDS/WHO Policy Statement on HIV Testing, June 2004.
- Committee on the Rights of the Child (CRC), *General Comment No. 3* (2003) on 'HIV/AIDS and the rights of the child'.
- Inter-Agency Standing Committee (IASC). Guidelines for HIV/AIDS interventions in emergency settings. Geneva: IASC reference group; 2003.
- OHCHR/UNAIDS, *HIV/AIDS and Human Rights: International Guidelines. Revised Guideline 6 on access to prevention, treatment, care and support*, HR/PUB/2002/1 (2002) and OHCHR and the Joint United Nations Programme on HIV/AIDS, *HIV/AIDS and Human Rights: International Guidelines*, HR/PUB/98/1 (1998).
- Refugees and HIV/AIDS, Executive Committee of the High Commissioner's Programme, Standing Committee, 20th mtg., U.N. Doc. EC/51/SC/CRP.7 (15 Feb. 2001).
- Committee on Economic, Social and Cultural Rights, *General Comment No. 14* (2000) on the right to the highest attainable standard of health (Article 12 of the International Covenant on Economic, Social and Cultural Rights).
- UNHCR Policy Regarding Refugees and Acquired Immune Deficiency Syndrome (AIDS), UNHCR/IOM/78/98, UNHCR/FOM/84/98 (1 Dec. 1998).
- UNHCR Policy and Guidelines Regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS), UNHCR/IOM/82/92, UNHCR/FOM/81/92 (12 Nov. 1992).
- UNHCR Policy and Guidelines regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS), UNHCR/IOM/70/88, UNHCR/FOM/63/88 (6 May 1988).