



Returned to Risk

Deportation of HIV-Positive Migrants

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Summary

Andrea Mortlock was 15 in 1979 when she arrived in New York from Jamaica, leaving behind the abusive household where she had lived since her mother, years earlier, had left for work in the United States. In 1987, she was convicted of selling cocaine and served a year in prison. A legal permanent resident of the United States with a US-citizen daughter and son, Ms. Mortlock was ordered deported in absentia in 1995 based on her criminal conviction. However, Ms. Mortlock was HIV-positive, and required a complicated medical regime that was unavailable in Jamaica in order to survive. In 2005, despite US federal authorities' claims that her illness had no bearing on her immigration proceedings, Ms. Mortlock and her attorneys filed a petition with the Inter-American Commission on Human Rights in a last-ditch effort to halt her deportation. Ms. Mortlock argued that deporting her to Jamaica would be equivalent to a death sentence because of the absence of adequate AIDS treatment and because of the severe discrimination she would face in that country.

Recommending that the United States refrain from deporting Ms. Mortlock, the Inter-American Commission set out its test for prohibiting deportation of HIV-positive individuals. That test considers whether deportation would create extraordinary hardship to the deportee and his or her family based on two principal considerations: (1) the availability of medical care in the receiving country and (2) the availability of social services and support, in particular the presence of close relatives, in the receiving country. Again at the regional level, the European Court of Human Rights (ECtHR) has also grappled with the issue of deportation of people living with HIV and AIDS to places where anti-retroviral therapy (ART) and individual support networks are not readily available, developing case law that narrowly considers (1) the applicant's present medical condition, and whether it is at an advanced or terminal stage, (2) the availability of family and friend support in the country of origin, and (3) the availability of medical care in the country of origin.

The principle of *non-refoulement*, applied in the Inter-American Commission and ECtHR cases, has long been established in international human rights and refugee law. In human rights law it has created an absolute prohibition on the deportation of a person to another state where there are substantial grounds for believing that the person would be in danger of being subjected to torture or other cruel, inhuman, or degrading treatment or punishment. International refugee law prohibits the return of refugees to a territory where the refugee's life or freedom may be threatened. Additionally, in some states, a form of protection from removal known as "complementary" protection exists, which can govern categories of people who claim that they cannot be returned to their country of origin based on human

rights or humanitarian law principles but do not fit into traditional refugee definitions, according a wider range of eligibility.

National protections against *refoulement*, however, are often insufficient or underdeveloped to protect the rights of people living with HIV against unlawful return. Furthermore, from a policy perspective, post-deportation continuity of treatment mechanisms often are non-existent or grossly inadequate to protect deportees' health, and may lead to illness, premature death, or the development of drug resistance. In South Korea, as in many other countries with HIV-related restrictions on entry, stay, and residence, non-citizens are deported upon discovery of their illness because of their very HIV status, without consideration of the possibility of *refoulement*. In Gulf States including Saudi Arabia and the United Arab Emirates, individuals found to be HIV-positive are detained—sometimes for months on end—with no access to treatment, then summarily deported without any provision for continuity of care. South Africa, while having in place constitutional provisions and case law that could be used to prohibit *refoulement*, has not yet done so for people living with HIV facing lack of treatment in their country of origin, and has compromised the health of migrants by deporting individuals without any referral to treatment. The United States, despite having strict HIV-related restrictions on entry, stay and residence, has granted asylum to some HIV-positive individuals where the person faces persecution in his or her country of origin based on HIV status; however, when HIV-positive individuals are deported, adequate systems are often not in place to ensure that treatment is not interrupted or discontinued.

In order to meet international human rights law protections of detainees' and deportees' rights to life, health, and to be free from torture and cruel, inhuman and degrading treatment, states worldwide should begin or continue to provide ART to HIV-positive individuals in detention awaiting deportation and should reexamine deportation of HIV-positive individuals to countries where treatment and social support structures are inadequate.

As a matter of good practice, states should also make provision for continuing deportees' treatment when deportation does take place. Specifically, Human Rights Watch, Deutsche AIDS-Hilfe, the European AIDS Treatment Group, and the African HIV Policy Network recommend that states:

- Publish comprehensive information about HIV-positive individuals deported, including the numbers of individuals removed, grounds for removal, and countries to which they are deported.

- Review national standards on deportation of people living with HIV to ensure compliance with international prohibitions on *refoulement*.
- Where feasible, contact health authorities and anticipated providers in each deportee's country of origin, devise a plan for continuing to assure care without interruption, and possibly provide a temporary medication supply if necessary.
- Together with international agencies and donors, work to harmonize regional standards of care.

International agencies and donors, as well, have an opportunity to improve deportees' access to adequate treatment. Crucial steps toward improving the health of deportees may be made by international donors and organizations by:

- Supporting and supplementing states' efforts to provide cross-border continuity of care for individuals undergoing deportation, including ensuring the existence of confidential medical record transfer systems, cross-border health care registration, uniform regional standards of care, and local support networks in deportees' countries of origin.
- Placing the deportation of HIV-positive individuals on their research agenda, and collecting and providing better data on this practice, as well as more detailed, accurate, and up-to-date information on the availability of treatment in receiving countries.

Introduction

Since the emergence of the HIV epidemic in the 1980s, migrant populations have repeatedly been recognized by the international community as a vulnerable group in the risk, spread, and prevention of HIV/AIDS.¹ Some countries, embracing an anti-migrant approach, have even sought coercive measures to try to keep infected foreigners out of their borders, through HIV-related restrictions on entry, stay, and residence.² Either as a result of HIV-related restrictions on entry, stay, and residence, or as part of deportation proceedings commenced on unrelated grounds, HIV-positive migrants may be taken into custody and detained pending outcome of an immigration case or deportation. In such circumstances, international law has developed a framework that broadly protects the right to health of persons deprived of their liberty. States have an obligation to ensure medical care for detainees, including immigration detainees, at least equivalent to that available to the general population.³

Despite this obligation, however, adequate systems are not in place in many countries to ensure HIV/AIDS treatment for detainees pending deportation. In 2007, Human Rights Watch documented in its report *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States* the sub-standard policies, procedures and supervision governing

¹Ivan Wolffers, Sharuna Verghis and Malu Marin, "Migration, Human Rights, and Health," *The Lancet*, vol. 362, December 13, 2003, pp. 2019-20. See also Prerna Banati, "Risk Amplification: HIV in Migrant Communities," *Development Southern Africa*, vol. 24(1), March 2007, pp. 205-23. United Nations International Institute for the Advancement of Women (UN-INSTRAW) and South African Institute of International Affairs (SAIIA), "Gender, Remittances and Development: Preliminary Findings from Selected SADC Countries," 2007, <http://www.un-instraw.org/en/downloads/final-reports/index.php> (accessed July 20, 2009), p. 50. Joint United Nations Programme on HIV/AIDS (UNAIDS), "Population Mobility and AIDS: UNAIDS Technical Update," *UNAIDS Best Practice Collection*, February 2001, p. 4.

²While no single definitive source has addressed the existence of these laws, the most comprehensive database to track them has found that, as of September 2008, 66 of the 186 countries in the world for which data were available placed special entry, stay, or residence restrictions on people living with HIV. Deutsche AIDS-Hilfe e.V., "Quick Reference: Travel and Residence Regulations for People with HIV and AIDS - Information for Counsellors in AIDS Service Organizations - 2008/2009," Lemmen, Karl; Wiessner, Peter; 8th edition, Berlin, September 2008. See also "The Global Database on HIV Related Travel Restrictions," www.hivtravel.org (accessed July 20, 2009). An additional 22 countries may have special restrictions but contradictory and imprecise information only are available. Deutsche AIDS-Hilfe e.V., "Quick Reference." See also Joint United Nations Programme on HIV/AIDS, "HIV-Related Travel Restrictions," March 4, 2008, http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080304_HIVrelated_travel_restrictions.asp (accessed June 18, 2009). UNAIDS and International Organization for Migration (IOM), "UNAIDS/IOM Statement on HIV/AIDS-Related Travel Restrictions," 2004.

³See, e.g., International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, arts. 12(1) and 2.2. International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, arts. 6, 7 and 10. For a comprehensive discussion of the international legal instruments, resolutions, and model standards related to detainee health, see Rick Lines, "The Right to Health of Prisoners in International Human Rights Law," *International Journal of Prisoner Mental Health*, vol. 4(1), 2008, pp. 3-53. Rick Lines, "From Equivalence of Standards to Equivalence of Objectives: The Entitlement of Prisoners to Health Care Standards Higher than Those Outside Prisons," *International Journal of Prisoner Health*, vol. 2(4), 2006, pp. 1-12.

HIV/AIDS care for migrants detained in US custody, leading to treatment that was delayed, interrupted, and inconsistent to an extent that endangered the health and lives of the detainees.⁴ Human Rights Watch has further reported in *Bad Dreams: Exploitation and Abuse of Migrant Workers in Saudi Arabia* the detention of migrant workers in Saudi Arabia under poor conditions with inadequate medical care.⁵

Building on *Chronic Indifference* and *Bad Dreams*, this report considers the deportation of HIV-positive migrants from countries worldwide. Under certain circumstances, international law prohibits deportation or permits protection from deportation of persons living with HIV. National governments need to broadly reconsider the deportation of HIV-positive individuals under the international law principle of *non-refoulement* and additional human rights and humanitarian law provisions to ensure that HIV-positive individuals are not returned to circumstances where treatment and social support are inadequate, the return to which would put them at risk of inhuman or degrading treatment. Furthermore, Human Rights Watch, Deutsche AIDS-Hilfe, the European AIDS Treatment Group, and the African HIV Policy Network urge states to ensure deportees' continuous access to treatment as a matter of good practice.

⁴ Human Rights Watch, *United States – Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States*, vol. 19, no. 5(G), December 2007, p. 2.

⁵ Human Rights Watch, *Saudi Arabia – Bad Dreams: Exploitation and Abuse of Migrant Workers in Saudi Arabia*, vol. 16, no. 5(E), July 2004.

International Law

Prohibitions on Deportation: The Principle of Non-Refoulement

Under international law, states have the right to control their borders and decide whom to admit or to deport, following appropriate procedures and limited by considerations of non-discrimination, prohibition of inhuman treatment, respect for family life, and other human rights and refugee law protections.⁶ Chief among these limitations are international law protections against *refoulement*.

The principle of *non-refoulement*, articulated in international refugee and human rights law instruments, establishes an absolute prohibition on the forced departure of a person to another state where there are substantial grounds for believing that the person would be in danger of being subjected to torture or other cruel, inhuman or degrading treatment or punishment.⁷

Under international human rights law, states have an obligation to refrain from *refoulement* of all individuals. The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), Article 3, absolutely prohibits states from sending individuals to a country in which there is a risk of torture⁸; the International Covenant on

⁶ UN Human Rights Committee, General Comment 15, The Position of Aliens Under the Covenant (Twenty-seventh session, 1986), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc. HRI/GEN/1/Rev.1, p. 18 (1994), para. 5. For a discussion of the right to raise defenses to deportation, the principle of proportionality, the right to family unity, and the right to protection from return to persecution in the context of U.S. immigration law, see Human Rights Watch, *United States – Forced Apart: Families Separated and Immigrants Harmed by United States Deportation Policy*, vol. 19, no. 3(G), July 2007, http://www.hrw.org/sites/default/files/reports/uso707_web.pdf. Children, especially, have additional protections under international law which must be considered in deportation procedures. For a discussion of limitations on deporting children under international law, see, e.g., Human Rights Watch, *Left to Survive: Systematic Failure to Protect Unaccompanied Migrant Children in Greece*, 1-56432-418-4, December 2008, http://www.hrw.org/sites/default/files/reports/greece1208web_o.pdf. Human Rights Watch, *Spain – Unwelcome Responsibilities: Spain's Failure to Protect the Rights of Unaccompanied Migrant Children in the Canary Islands*, vol. 19, no. 4(D), July 2007, <http://www.hrw.org/sites/default/files/reports/spain0707webwcover.pdf>. See also UN Committee on the Rights of the Child, General Comment No. 6, Treatment of Unaccompanied and Separated Children Outside their Country of Origin, U.N. Doc. CRC/GC/2005/6 (2005).

⁷ Convention relating to the Status of Refugees, 189 U.N.T.S. 150, entered into force April 22, 1954, art. 33. See also Protocol Relating to the Status of Refugees, 606 U.N.T.S. 267, entered into force October 4, 1967. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention Against Torture), adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (no. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, art. 3. ICCPR, art. 7. UN Human Rights Committee (UN HRC), General Comment 20, Replaces General Comment 7 Concerning Prohibition of Torture and Cruel Treatment or Punishment (Forty-Fourth Session, 1992), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.6 at 151 (2003).

⁸ Ruma Mandal, "Protection Mechanisms Outside of the 1951 Convention ("Complementary Protection")," UNHCR Legal and Protection Policy Research Series, June 2005, <http://www.unhcr.org/refworld/pdfid/435e198d4.pdf> (accessed December 17, 2008), p. 21.

Civil and Political Rights (ICCPR), Article 7, has been interpreted to prohibit deportation of a person to a country where he faces a real risk of torture or “cruel, inhuman or degrading treatment or punishment.”⁹ Furthermore, the prohibition on returning an individual to torture, cruel or inhuman degrading treatment or punishment has been deemed to rise to the level of customary international law.¹⁰ Regional human rights instruments also include the non-derogable prohibition on torture, cruel, inhuman or degrading punishment and treatment, which extends to situations in which the forced removal of an individual would place them at risk of such prohibited treatment.¹¹

At the regional level, the European Court of Human Rights (ECtHR) and the Inter-American Commission on Human Rights have each established case law laying out when deportation of people living with HIV is prohibited on human rights grounds. Article 3 of the European Convention on the Protection of Human Rights and Fundamental Freedoms (ECHR) declares that “[n]o one shall be subjected to torture or to inhuman or degrading treatment or punishment.”¹² In a landmark 1997 case, *D v. United Kingdom*, a St. Kitts native argued that his removal from the United Kingdom would violate Article 3 of the ECHR and subject him to inhuman and degrading treatment. The court prohibited his deportation, finding that the combination of the advanced stage of the applicant’s HIV/AIDS, lack of available treatment in St. Kitts, and lack of any family to care for him was decisive and formative of “exceptional circumstances” such that removal would amount to inhuman treatment.¹³

However, this standard has since been narrowly interpreted, and the ECtHR has not found on the facts that any other deportation of a person living with HIV constituted a violation of the ECHR because of lack of treatment or support in the country to which the person was being

⁹ UN Human Rights Committee (UN HRC), General Comment 31: Nature of the Legal Obligation on States Parties to the Covenant, U.N. Doc. CCPR/C/21/Rev.1/Add.13 (2004). See also UN HRC, General Comment 20, para. 9.

¹⁰ See, e.g., UN HRC, General Comment 20, para. 9.

¹¹ African [Banjul] Charter on Human and Peoples’ Rights, adopted June 27, 1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force October 21, 1986, art. 5. American Convention on Human Rights (“Pact of San José, Costa Rica”), adopted November 22, 1969, O.A.S. Treaty Series No. 36, 1144 U.N.T.S. 123, entered into force July 18, 1978, reprinted in Basic Documents Pertaining to Human Rights in the InterAmerican System, OEA/Ser.L.V/II.82 doc. 6 at 25 (1992), arts. 5 and 22 (further noting that “[i]n no case may an alien be deported or returned to a country, regardless of whether or not it is his country of origin, if in that country his right to life or personal freedom is in danger of being violated because of his race, nationality, religion, social status, or political opinions.”). European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), 213 U.N.T.S. 222, entered into force September 3, 1953, as amended by Protocols Nos 3, 5, 8, and 11 which entered into force on September 21, 1970, December 20, 1971, January 1, 1990, and November 1, 1998, respectively, art. 3. Article 3 of the European Convention has been interpreted as an absolute prohibition on the return of a person to a territory where he or she faces a real risk of harm. European Court of Human Rights, *Soering v. United Kingdom*, Judgment of July 7, 1989, Series A no. 161. *Chahal v. United Kingdom*, 70/1995/576/662, Judgment of November 15, 1996.

¹² ECHR, art. 3.

¹³ European Court of Human Rights, *D v. the United Kingdom*, no. 30240/96, Judgment of May 5, 1997, ECHR 1997-III no. 37.

deported.¹⁴ More recent cases have re-iterated the ECtHR's position that the fact that an individual's circumstances in the receiving country would be less favorable than those he or she currently enjoys in the host country is not sufficient to constitute a violation.¹⁵ Instead it has narrowly interpreted the "exceptional" standard set out in *D*, excluding cases in which the deterioration in the applicant's (physical or mental) health condition is considered speculative.¹⁶ The Court has repeatedly found that if treatment is in principle available in the receiving country, and the disease has not yet reached a terminal stage, removal would not constitute inhuman or degrading treatment.¹⁷ Over time, this body of case law has left the ECtHR with a three-fold test that narrowly considers (1) the applicant's present medical condition and whether it is at an advanced or terminal stage, (2) the availability of family and friend support in the country of origin, and (3) the availability of medical care in the country of origin.

In 2008, the Inter-American Commission on Human Rights held that deporting a person living with HIV to a country with substandard health care for persons with HIV would violate the American Declaration's protection against "cruel, infamous, or unusual punishment."¹⁸ Andrea Mortlock was 15 in 1979 when she arrived in New York from Jamaica, leaving behind the abusive household where she had lived since her mother, years earlier, had left for work in the United States. In 1987, she was convicted of selling cocaine and served a year in

¹⁴ While a similar outcome was reached by the European Commission for Human Rights in the case of *B.B. v. France*, prior to European Court consideration of the referred case the French Government guaranteed that the individual in question would not be deported and so the case was not heard. European Commission for Human Rights, *B.B. v. France*, no. 30930/96, Judgment of 7 September 1998, Reports 1998-VI. Subsequent ECtHR cases have failed to find violations of Article 3, narrowly interpreting the "exceptional" standard set out in *D*. See, *Karara v Finland*, Decision of May 29, 1998 (deportation of an HIV-positive Ugandan national to Uganda was permitted on the basis that his illness had not yet reached an advanced stage and treatment was available in Uganda). *S.C.C. v. Sweden*, no. 46553/99, Decision of February 15, 2000 (Zambian national could be deported to Zambia on grounds that his HIV treatment had only recently been commenced, AIDS treatment was available in Zambia, and his children and other family members lived in Zambia). *Bensaid v. the United Kingdom*, no. 44599/98, Judgment of February 6, 2001, ECHR 2001-I (an Algerian national suffering from schizophrenia could be deported because the risk of deterioration of his condition was to a large extent speculative, and medical treatment was ostensibly available to him in Algeria, where he had family). *Arcila Henao v. the Netherlands*, no. 12699/03, Decision of June 24, 2003 (a Colombian HIV-positive national could be deported as his illness had not achieved an advanced or terminal stage, treatment was in principle available in Colombia, and his father and siblings resided there). *Ndangoya v. Sweden*, no. 17868/03, Decision of June 22, 2004 (deportation to Tanzania was permitted as, although the applicant was HIV-positive, his illness had not reached an advanced or terminal stage, treatment was available in Tanzania albeit at considerable expense and not widely, and he did have some family support and relatives in Tanzania). *Armegnigan v. the Netherlands*, no. 25629/04, Decision of November 25, 2004 (deportation of a Togolese HIV-positive national was permitted as his illness had not attained an advanced or terminal stage, adequate treatment was in principle available in Togo, albeit at a considerable cost, and he had family support in Togo). *N. v. United Kingdom*, no. 26565/05, Judgment of May 27, 2008, (HIV-positive Ugandan in stable condition while receiving treatment could be deported given the availability of medication in principle in Uganda, and the existence of the applicant's family members in Uganda). All decisions and judgments are available at www.echr.coe.int.

¹⁵ *Bensaid v. the United Kingdom*, para. 38; *Arcila Henao v. the Netherlands*, p. 8. *Ndangoya v. Sweden*, p. 13. *Armegnigan v. the Netherlands*, p. 9. *N v. United Kingdom*, para. 42.

¹⁶ See, e.g., *Bensaid v. the United Kingdom*, para. 39.

¹⁷ *Arcila Henao v. the Netherlands*, p. 8. *Ndangoya v. Sweden*, p. 13. *Armegnigan v. the Netherlands*, p. 9. *N v. United Kingdom*, paras. 42 and 43.

¹⁸ Inter-American Commission on Human Rights, *Andrea Mortlock Case*, Judgment of July 25, 2008, report no. 63/08, case 12.534. The Commission does not separately define the terms "cruel," "infamous" and "unusual" in its opinion. *Ibid*.

prison. A legal permanent resident of the United States with a US-citizen daughter and son, Ms. Mortlock was ordered deported in absentia in 1995 based on her criminal conviction. However, Ms. Mortlock was HIV-positive, and required a complicated medical regime that was unavailable in Jamaica in order to survive. In 2005, despite US federal authorities' claims that her illness had no bearing on her immigration proceedings, Ms. Mortlock and her attorneys filed a petition with the Inter-American Commission on Human Rights in a last-ditch effort to halt her deportation.¹⁹ Ms. Mortlock argued that deporting her to Jamaica would be equivalent to a death sentence because of the absence of adequate AIDS treatment and because of the severe discrimination she would face in that country.²⁰ In its determination, the Commission noted that Andrea Mortlock was in the advanced stages of a terminal and incurable illness. It determined that the standard was whether the deportation would create "an extraordinary hardship" that could amount to a death sentence given two principal considerations: "(1) the availability of medical care in the receiving country and (2) the availability of social services and support, in particular the presence of close relatives."²¹ Based on this test, and given Ms. Mortlock's particular circumstances, the Commission recommended that the United States refrain from deporting Ms. Mortlock.²²

Regional Tests for Deportation of People Living with HIV

European Court of Human Rights

- The deportee's present medical condition, and whether it is at an advanced or terminal stage,
- The availability of family and friend support in the receiving country, and
- The availability of medical care in the receiving country.

Inter-American Commission on Human Rights

- Whether an extraordinary hardship would be created given
- The availability of medical care in the receiving country and
- The availability of social services and support, in particular the presence of close relatives.

Following the principle of *non-refoulement*, states are also prohibited from removing individuals protected by the 1951 Convention Relating to the Status of Refugees and its 1967 Protocol. In international law, a refugee is defined as a person who, "owing to well-founded

¹⁹ Nina Bernstein, "Rights Agency Urges U.S. Not to Deport AIDS Patient," *The New York Times*, August 27, 2005.

²⁰ Inter-American Commission on Human Rights, *Andrea Mortlock Case*, para. 21.

²¹ *Ibid.*, para. 91.

²² *Ibid.*, para. 103.

fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.”²³ The Convention prohibits the return of refugees to a territory where the refugee’s life or freedom may be threatened: “No Contracting State shall expel or return (“refouler”) a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion.”²⁴

Refugee law can, in some jurisdictions and depending on the facts of the particular case, be used as a basis for prohibiting the removal of individuals who are HIV-positive. Claims for refugee or asylum status under the Convention and its Protocol alleging fear of persecution based on HIV/AIDS status have occasionally been accepted in some status determination tribunals throughout the world. Some jurisdictions have held that HIV status can form the basis of membership in a particular social group for the purposes of a claim based on the Convention.²⁵

Additional Human Rights and Humanitarian Protections from Removal

Many states also provide for additional forms of protection (known generally as “complementary” protection), which supplement the protection framework discussed above with an extended concept of *non-refoulement* based on additional human rights and humanitarian law obligations.²⁶ Distinct from temporary protection offered in emergency situations, complementary protection mechanisms are a feature of most western legal

²³ Convention relating to the Status of Refugees, art. 1(A)(2). Protocol Relating to the Status of Refugees.

²⁴ *Ibid.*

²⁵ In the United States, for example, the Board of Immigration Appeals has ruled in a non-precedent decision (*In Re Oscar Alberto Argueta*, BIA, November 14, 2003) that people living with HIV/AIDS can comprise a social group. The then-Immigration and Naturalization Service Office of the General Counsel has also recommended that the category of persons living with HIV be recognized as a social group for asylum purposes. Memorandum from INS Office of the General Counsel, David A. Martin, General Counsel, to all Regional Counsel, Legal Opinion: Seropositivity for HIV and Relief from Deportation (Feb. 16, 1996), reported in 73 Interpreter Releases 901 (July 8, 1996). See also *Matter of []*, (I) December 20, 2000, reported in 78 Interpreter Releases 233, January 15, 2001. *Matter of []*, A71-498-940 (I) October 31, 1995, reported in 73 Interpreter Releases 901, July 8, 1996.

²⁶ Jane McAdam, “Complementary Protection and Beyond: How States Deal with Human Rights Protection,” UNHCR Working Paper No. 118, August 2005, <http://www.unhcr.org/research/RESEARCH/42fb1fo45.pdf> (accessed July 20, 2009), p. 1. Mandal, “Protection Mechanisms Outside of the 1951 Convention (“Complementary Protection”),” p. ix. Indeed, states have varying names for sorts of protection that are included in “complementary” protection, including “subsidiary protection”, “humanitarian protection”, and “temporary asylum.” *Ibid.* See also Jane McAdam, *Complementary Protection in International Refugee Law* (Oxford, UK: Oxford University Press, 2007), p. 2. Volker Türk and Frances Nicholson, “Refugee Protection in International Law: An Overall Perspective in Refugee Protection,” in Erika Feller et al., eds., *International Law: UNHCR’s Global Consultations on International Protection* (Cambridge, UK: Cambridge University Press, 2003), pp. 3 and 6.

systems.²⁷ While no definition of complementary protection exists in international law, when, in 2005, the Executive Committee of the UNHCR adopted the first international Conclusion particularly on “complementary forms of protection,” it suggested that the term included individuals not covered by the 1951 Convention and its protocol, and referred to regional instruments that define refugees as people who cannot return to their countries due to indiscriminate threats resulting from situations such as generalized violence, armed conflict, or events seriously disturbing public order.²⁸

Depending on the law of the state involved, an individual may make a claim for protection based on a variety of eligibility criteria grounded in international human rights and humanitarian law obligations to non-citizens.²⁹ From a human rights law perspective, such protections may include those set out in the Convention on the Rights of the Child, particularly the “best interests of the child” principle.³⁰ Deportation may also be prohibited or withheld based on humanitarian principles. In such cases, an applicant may qualify if, returned to his or her country of origin, he or she would face a threat to his or her life, safety or freedom as a result of generalized violence, external aggression, occupation, internal conflicts, foreign domination, or other events or circumstances seriously disturbing public order in either part or the whole of the country of origin.³¹ Several international humanitarian law obligations also explicitly prohibit removal of an individual from a country, though these are limited in their scope and apply only to parties to an international armed conflict and often individuals in their country of origin.³² Additionally, further international humanitarian

²⁷ McAdam, *Complementary Protection in International Refugee Law*, p. 3.

²⁸ *Ibid.*, p. 40. See also UNHCR Executive Committee, “Conclusion No. 103: Conclusion on the Provision on International Protection Including Through Complementary Forms of Protection,” 2005. The Executive Committee did note that this term included individuals encompassed by regional protection mechanisms, the Organization of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa, the Cartagena Declaration on Refugees, and asylum legislation adopted by the European Union.

²⁹ McAdam, *Complementary Protection in International Refugee Law*, p. 9.

³⁰ Convention on the Rights of the Child (CRC), adopted November 20, 1989, G.A. Res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force September 2, 1990, art. 3. For an example of how this principle may be applied in the national deportation context, see, e.g., Swedish Aliens Act, amended, March 31, 2006, chapter 1, s. 10. *Baker v. Canada*, 2 SCR 817, 1999. See also Committee on the Rights of the Child, General Comment No. 6. McAdam, *Complementary Protection in International Refugee Law*, pp. 173-96.

³¹ The basis for this type of protection is refugee definitions in the 1969 Convention Governing Specific Aspects of Refugee Problems in Africa (OAU Convention), the 1984 Cartagena Declaration on Refugees and the 2001 Bangkok Principles on the Status and Treatment of Refugees. African States which are parties to the OAU Convention, Latin American States that have signed the Cartagena Declaration and Asian and African States that have signed the Bangkok Principles must recognize individuals falling under this category as refugees and not as individuals with a claim for complementary protection.

³² Geneva Convention relative to the Protection of Civilian Persons in Time of War, adopted August 12, 1949, 75 U.N.T.S. 287, entered into force October 21, 1950, art. 49. Protocol Additional to the Geneva Conventions of 12 August 1949, and Relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), 1125 U.N.T.S. 609, entered into force December 7, 1978, art. 17.

law provisions not amounting to prohibitions on removal may influence states in their decision to deport.³³

³³ Geneva Convention relative to the Protection of Civilian Persons in Time of War, art. 3.

National Laws and Procedures in Place for Migrants Engaged in Deportation Proceedings

People living with HIV may be subject to deportation for the same reasons as other non-citizens or, in some countries, based on their HIV status itself. Available information from some migrant-rich countries in the world suggests an emerging but incomplete consideration of the international and regional prohibition on *refoulement* in national immigration laws that could be better developed and applied to people living with HIV, as well as a pervasive failure to ensure that treatment is continued upon deportation. Below, Human Rights Watch, Deutsche AIDS-Hilfe, the European AIDS Treatment Group, and the African HIV Policy Network have chosen to highlight case studies from South Korea, Saudi Arabia and the United Arab Emirates, South Africa, and the United States, as they demonstrate the broad range of issues involved and challenges remaining in deportation of HIV-positive individuals across diverse geographic regions and cultures.

Republic of Korea (South)

South Korea places strict limits on the entry, stay and residence of people living with HIV, and is one of 30 countries in the world that force HIV-positive foreigners to leave their borders.³⁴ The country has a significant population of migrant workers: In 2007, South Korea had 468,000 registered migrant workers.³⁵ Many migrant workers are required to submit for HIV testing.³⁶ Since November 2007, Korean national policy has mandated that E-2 Teaching Visa holders submit a health certificate, including an HIV test, when applying to extend their residence in Korea, and new applicants for the E-2 visa must submit a health certificate including an HIV test when applying for alien registration.³⁷ Upon testing positive, a non-citizen is detained and, after confirmation of the test result, the individual's employer is notified and the individual is held in a detention center until being deported to his or her country of origin, typically within a week.³⁸ The Joint United Nations Programme on HIV/AIDS

³⁴ Korea's Immigration Control Act stipulates that immigration officers have a right to deny entry to or to deport those who are carrying a communicable disease. Ministry of Legislation, "Immigration and Control Act (Republic of Korea)," <http://unpan1.un.org/intradoc/groups/public/documents/APCITY/UNPAN011498.pdf> (accessed July, 20, 2009). See also Deutsche AIDS-Hilfe e.V., "Quick Reference," p. 4. "The Global Database on HIV Related Travel Restrictions."

³⁵ CARAM Asia, "State of Health of Migrants 2007: Mandatory Testing," 2007, p. xiii.

³⁶ *Ibid.*, p. 153.

³⁷ Ministry of Justice, Republic of Korea, Residence Policy Division, "New Changes on the E2 Teaching Visa Holders in Korea," December 10, 2007, http://home.windstream.net/ssheiko/e2_changes_en.pdf (accessed June 17, 2009).

³⁸ CARAM Asia, "State of Health of Migrants 2007," p. 156.

(UNAIDS) estimated that in 2007 there were 13,000 adults living with HIV in Korea.³⁹ In 2008, the Korea Center for Disease Control and Prevention reported that 521 of the 647 foreigners diagnosed with HIV to date had been “forced to leave the country.”⁴⁰ While there is no information as to which of the non-citizens may have subsequently suffered inhuman and degrading treatment as a result of their forced removal, no steps were taken by the South Korean authorities to ensure they were not put at that risk. Indeed, Thai migrant workers have reported that, for those migrants deported from South Korea because of their HIV-positive status, “[t]here’s nothing they can do but die if they go back to Thailand,” and they have called for counseling, medical education, and health care for those found to be infected.⁴¹ South Korea is a party to the core international treaties prohibiting *refoulement*, the ICCPR and CAT.⁴²

Case Study: “Heo”

In March 2007, “Heo,” a Chinese citizen of Korean descent, arrived in South Korea on an ethnic Korean visitor visa at his (Korean citizen) mother’s invitation, and subsequently received a work visa from the Seoul Immigration Office. During a health check required for the job training program under his visa category, Heo was found to be HIV-positive, and his HIV status was reported to the Seoul Immigration Office on May 3, 2007. That same day, Heo was detained in a foreign internment camp, and a departure order directing him to leave by May 21, 2007 was issued on the next day. Heo was released upon his mother and stepfather signing a memorandum of understanding that they would leave the country voluntarily. Monitoring of his health at that time suggested that antiretroviral therapy would likely be required after four years.⁴³

Heo challenged his deportation in proceedings before the Seoul Administrative Court. The National Human Rights Commission of Korea submitted an opinion supporting Heo, noting that “[i]n light of international human rights standards and foreign cases, it is the opinion of the Commission that ordering a foreigner who has been staying in Korea to leave the country solely because he or she is infected with HIV is extreme. Considering all of the circumstances of the plaintiff, the presence of an HIV-positive person is not likely to pose

³⁹ World Health Organization, UNAIDS and UNICEF, “Epidemiological Fact Sheet on HIV and AIDS: Core Data on Epidemiology and Response: Republic of Korea,” December 2008, http://apps.who.int/globalatlas/predefinedReports/EF52008/full/EF52008_KR.pdf (accessed June 1, 2009).

⁴⁰ Bae Ji-Sook, “Deportation of HIV Positive Violates Human Rights,” *Korea Times*, March 3, 2008.

⁴¹ CARAM Asia, “State of Health of Migrants 2007,” p. 157.

⁴² South Korea acceded to the ICCPR on April 10, 1990 and to CAT on January 9, 1995.

⁴³ Seoul High Court, “*Heo Case*” (on file with Human Rights Watch).

a grave risk to public health, whereas the order would be an irreversible violation of the plaintiff's basic human rights."⁴⁴ The Seoul High Court (upholding the Seoul Administrative Court) prevented Heo's deportation in November 2008, finding that public health goals must be balanced against the rights to privacy and to receive medical treatment, and that early detection and treatment rather than deportation are the most effective means of curbing the spread of HIV. Furthermore, the Court noted that the deportation constituted a violation of Heo's human rights.⁴⁵

South Korea's practice of deporting HIV-positive non-citizens was challenged in November 2008, when the Seoul High Court (upholding the Seoul Administrative Court) prevented the deportation of "Heo," an HIV-positive Chinese citizen of Korean descent visiting his mother in Korea, finding that the deportation was contrary to public health and violated Heo's human rights.⁴⁶ However, despite this ruling, the Korean government introduced a parliament bill in December 2008 that would expand requirements under the Ministry of Justice's E-2 visa policy (which largely affects foreigners seeking to teach English). Under the measure, immigration officials could require drug and HIV testing of any foreigner seeking a work visa.⁴⁷

Gulf States: The Kingdom of Saudi Arabia and the United Arab Emirates

In Saudi Arabia, HIV testing is required for applications for long-term work permits, prior to entry, as well as on a routine basis for renewal of the two-year residency permit.⁴⁸ Far from being eligible for consideration for protection from removal as a result of their HIV status (though Saudi Arabia is a party to the CAT), individuals testing positive are deported as a result of their HIV status itself.⁴⁹

Reports describe migrants jailed upon discovery of HIV status, held, and deported from Saudi Arabia, often without any explanation or discussion of their condition.⁵⁰ In 2005, press

⁴⁴ "Deportation of an HIV-Infected Foreigner is Extreme," National Human Rights Commission of Korea press release, March 31, 2008.

⁴⁵ Seoul High Court, "*Heo Case*." See The Law Times, November 14, 2008, <http://www.lawtimes.co.kr/LawNews/News/NewsContents.aspx?kind=AA&serial=43571&page=1%ED%AF%80%ED%Bo%81%00%00> (accessed June 2, 2009).

⁴⁶ Ibid.

⁴⁷ See Bill No. 3356, introduced December 30, 2008. See also Joseph Amon, "Blaming Foreigners," *Korea Times*, March 12, 2009.

⁴⁸ Human Rights Watch, *Saudi Arabia – Bad Dreams*. See also Saudi Arabia Ministry of Health, "MOH News: The World Celebrates the World AIDS Day," November 28, 2007, <http://www.moh.gov.sa/en/modules/news/article.php?storyid=305> (accessed May 29, 2009).

⁴⁹ Deutsche AIDS-Hilfe e.V., "Quick Reference," p. 35.

⁵⁰ CARAM Asia, "State of Health of Migrants 2007."

reports highlighted the case of an HIV-positive Palestinian migrant to Saudi Arabia, jailed in a “crowded cage” at the King Saud Hospital for Infectious Diseases for three months—along with two HIV-positive cellmates, awaiting deportation.⁵¹ The detainee reported that he and other HIV-positive migrants are treated “like animals,” and noted the deportation of one among their number to Burma after being kept locked up for a year without any access to medications.⁵² Indeed, one doctor admitted that many individuals die in detention, with doctors prohibited from giving them treatment or care.⁵³ In 2005, CARAM Asia reported the case of a Filipino migrant worker in Jeddah, Saudi Arabia, who, upon testing positive for HIV, was confined in the hospital with other HIV-positive migrants for 11 months, unable to leave, deprived of income, and without any information on the progress of his case.⁵⁴ CARAM reports that, in the cases of deported Filipino migrants such as this one, psychological trauma, job loss, and lack of sustainable access to adequate health care (including antiretrovirals) are major issues.⁵⁵

Severe stigma and discrimination face many migrants returned from Saudi Arabia. In 2007, CARAM Asia documented the devastating consequences of deportation from Saudi Arabia for HIV-positive migrants, including one male worker who became an alcoholic and suicidal upon deportation, and was ostracized by his family.⁵⁶

Case Study: “Harjeet”

In 2008, the International AIDS Society compiled a series of narratives related to the personal effects of HIV-related restrictions on entry, stay, and residence, for UNAIDS’ International Task Team on HIV-Related Travel Restrictions. One of the cases it documented was that of “Harjeet,” an Indian migrant worker deported from Saudi Arabia because of his HIV status. Prior to departure for Saudi Arabia, an agent and doctor informed Harjeet that there was “something wrong” with his blood test results, offering to change the test results for a fee and assuring him that his visitor’s visa would easily be converted to a work visa upon arrival in Saudi Arabia. Arriving in Saudi Arabia, however, Harjeet was left destitute and unable to convert his visa, after the in-country medical tests required for the conversion found him to be HIV-positive. Detained and treated as a “stray dog,” Harjeet was sent back to India with a new stamp in his passport: “Deported.”

⁵¹ Mark MacKinnon, “Saudis Jail, Deport Foreigners with HIV,” *The Globe and Mail (Canada)*, August 9, 2005.

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ Action for Health Initiatives Inc. (ACHIEVE Inc.) and Coordination of Action Research on AIDS and Mobility (CARAM-Philippines), “Health at Stake: Access to Health of Overseas Filipino Workers: 2005 Report,” 2005, p. 39.

⁵⁵ *Ibid.*, p. 43.

⁵⁶ CARAM Asia, “State of Health of Migrants 2007,” p. 50.

Harjeet did not tell his family about his HIV status, and became depressed and an alcoholic. When he developed tuberculosis, his family took him to a hospital and learned that he was HIV-positive, which led to his wife leaving him, his two children being taken away from him, and his being ostracized by his family. Placed in a care center, Harjeet stopped taking his tuberculosis medication and began having seizures, one of which left him paralyzed on one side of his body. Fortunately, with the support of the care center, Harjeet recovered from the tuberculosis and paralysis, and now works with people living with HIV.⁵⁷

The United Arab Emirates (UAE) engages in similar practices. Workers testing positive for HIV are reportedly jailed and deported without any treatment or provision for care. Domestic workers comprise five percent of the UAE population and the number of migrant domestic workers in the country has grown rapidly in recent decades.⁵⁸ Migrant workers applying for a work or residence permit must undergo medical testing (including HIV testing) within the first three months of residence, conducted almost universally without counseling or consent. Those testing positive may be deported.⁵⁹ In 2008, the United States State Department Report on human rights in the UAE noted that the government deported 1,518 noncitizen residents infected with HIV, hepatitis types B and C, and tuberculosis that year.⁶⁰ Despite some reports that national policy on mandatory HIV testing and deportation of HIV-positive non-citizens was under review,⁶¹ a May 12, 2009 press report quoted the head of the National AIDS Programme as saying the policy was not currently under review and any changes would have to be discussed with other Gulf countries.⁶²

Migrants suffer serious hardships under the UAE deportation regime. Those migrant workers who test positive are generally reported to be detained in jail-like hospital cells, without treatment, and then returned to their country of origin, with a lifetime ban stamp in their passport preventing return.⁶³ No formal referral system for treatment exists.⁶⁴ One migrant to

⁵⁷ Joint United Nations Programme on HIV/AIDS (UNAIDS), "The Impact of HIV-Related Restrictions on Entry, Stay and Residence: Personal Narratives," May 2009, pp. 10-11.

⁵⁸ UNDP Regional Centre in Colombo, "HIV Vulnerabilities of Migrant Women: from Asia to the Arab States," October 2008, http://www2.undprcc.lk/resource_centre/pub_pdfs/P1105.pdf (accessed June 2, 2009), p. 95.

⁵⁹ The UAE Ministry of Health website confirms that, under national law, "expatriates with HIV are deported." United Arab Emirates Ministry of Health, "Sale of Drugs to Cut HIV Infection Allowed," November 5, 2008, <http://www.moh.gov.ae/en/NewsDetails434.aspx> (accessed June 2, 2009). "The Global Database on HIV Related Travel Restrictions." CARAM Asia, "State of Health of Migrants 2007," p. 125.

⁶⁰ United States Department of State Bureau of Democracy, Human Rights, and Labor, "2008 Human Rights Report: United Arab Emirates," February 25, 2009, <http://www.state.gov/g/drl/rls/hrrpt/2008/nea/119129.htm> (accessed June 2, 2009).

⁶¹ See, e.g., James Reinl and Mitya Underwood, "Aids Deportation Policy Under Federal Review," June 11, 2008, <http://www.thenational.ae/article/20080611/NATIONAL/342799182/1040/BUSINESS> (accessed June 2, 2009).

⁶² James Reinl and Mitya Underwood, "Ministry of Health Stands By HIV Policy," May 12, 2009, <http://www.thenational.ae/article/20090512/NATIONAL/705119804/1010/FRONTPAGE> (accessed June 2, 2009).

⁶³ CARAM Asia, "State of Health of Migrants 2007," p. 132.

the United Arab Emirates reported no counseling upon testing HIV-positive, and immediately being sent back to his country of origin.⁶⁵ Far from receiving any official referral for treatment, a deported Cambodian worker noted that, upon testing positive and being jailed in Dubai, the posters on the wall of Dubai jail actually included advertisements “of a notorious quack in Kerala who used to claim he could cure AIDS.”⁶⁶ One HIV-positive Pakistani worker was deported directly from the Dubai jail with a 104-degree fever. The local Pakistani doctor his wife procured for him first informed his wife that the government would give him a poison injection if they discovered the disease, then publicized the family’s address in a newspaper.⁶⁷

The Republic of South Africa

In addition to being home to the largest number of individuals infected with HIV in the world—in 2007, UNAIDS and the World Health Organization estimated that 5.7 million adults were living with HIV in South Africa⁶⁸—South Africa is also home to a large number of migrants, many of them undocumented and many of them from countries with grossly inadequate medical treatment and care. Identifying the number of migrants in South Africa is itself controversial. Estimates vary widely, and rise as high as six million non-citizen migrants in the country in 2008,⁶⁹ compared with an overall population of 47 million.⁷⁰ Most of these migrants come from other countries in the Southern African Development Community. In particular, as a result of the political and economic crisis in neighboring Zimbabwe, migrants have come to South Africa in large numbers.⁷¹

South Africa does not currently have HIV-related restrictions on entry, stay, and residence.⁷² However, deportation on unrelated grounds of individuals who are HIV-positive raises the

⁶⁴ Ibid., p. 135.

⁶⁵ Ibid. p. 37.

⁶⁶ Ibid., p. 51.

⁶⁷ New Light AIDS Control Society, “Voices of People Living with HIV/AIDS,” undated, <http://www.fhi.org/NR/rdonlyres/ebsd553amdo33nqmsdlsm3kfsufgm5ug3efjmgowv7sknutndbzxvln7vhmbe4mtxnri72jez24k/CaseStudiesNewLight1enhv.pdf> (accessed July 20, 2008), p. 7.

⁶⁸ World Health Organization, UNAIDS and UNICEF, “Epidemiological Fact Sheet on HIV and AIDS: Core Data on Epidemiology and Response: South Africa,” December 2008, http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_ZA.pdf (accessed June 1, 2009).

⁶⁹ Parliament of the Republic of South Africa, “Background Research Report Compiled by the Research Unit for the Task Team of Members of Parliament Probing Violence and Attacks on Foreign Nationals,” http://www.parliament.gov.za/content/BACKGROUND_RESEARCH_REPORT.pdf (accessed July 20, 2008), p.1, citing Statistics South Africa, “Migration and Tourism September 2007- February 2008”.

⁷⁰ Federation International des Droits de L’Homme (FIDH), “Surplus People? Undocumented and Other Vulnerable Migrants in South Africa,” January 2008, <http://www.fidh.org/spip.php?article5166> (accessed December 7, 2008), p. 8.

⁷¹ UNAIDS, “RST-ESA Position Paper: HIV in the Context of Zimbabwean Migrant Populations,” July 28, 2008, p. 1.

⁷² Deutsche AIDS-Hilfe e.V., “Quick Reference,” p. 37. In past years, however, newspaper reports document South Africa’s deportation of migrant workers found to have AIDS, deporting as many as 1,000 coal and gold miners, primarily to the

issue of when *non-refoulement* prohibitions or additional complementary protection provisions may be invoked to prevent deportation of persons living with HIV to places where treatment is not available. South Africa is a party to the core international treaties dealing with *non-refoulement* including the ICCPR and the CAT.⁷³

The South African Constitutional Court has spoken explicitly of obligations to individuals claiming protection based on the argument that they would suffer inhuman and degrading treatment in their country of origin. South Africa's Constitution provides that "everyone has the right to freedom and security of the person which includes the right not to be treated or punished in a cruel, inhuman or degrading way."⁷⁴ In 2001, the Constitutional Court held that the South African authorities could not deport a person to a country where that person would be executed because South African law considers the death penalty to be "cruel, inhuman and degrading punishment."⁷⁵ This judgment may have important implications for prohibiting the deportation of individuals who are HIV-positive to places where adequate treatment or social support is not in place, and so, where a deportee would experience such suffering as to amount to inhuman or degrading treatment.

When individuals are deported, however, post-deportation treatment and continuity of care remain a challenge. Non-governmental organizations have documented that migrant workers, including Basotho in South Africa, infected with multi-drug resistant tuberculosis and often with HIV, have faced deportation and have been left at the border of their home country without any treatment or referral, either by the employer (often a mining company) or the South African government. Such conduct can amount to a death sentence.⁷⁶ Human Rights Watch has also reported the deportation of hundreds of thousands of Zimbabwean migrants from South Africa to Zimbabwe, despite the fact that medical care available to persons living with HIV in Zimbabwe falls far short of needs.⁷⁷

countries Malawi, Zimbabwe, Zambia, and Uganda. Adrian Croft, "South Africa to Deport Workers with AIDS Virus: Migrant Black Workers Near End of their Contracts Will Be Sent Home," *The Guardian (London)*, February 9, 1988.

⁷³ South Africa ratified both the ICCPR and the CAT on December 10, 1998.

⁷⁴ Constitution of the Republic of South Africa, art. 12(1)(e). This Article is one of many rights in South Africa's Bill of Rights that belong to everyone, regardless of their legal status in South Africa. These rights are in sections 9-25, 27(3) and 28-35 of the Bill of Rights.

⁷⁵ *Mohamed v. President of the Republic of South Africa*, (CCT 17/01) [2001] ZACC 18, <http://www.saflii.org/za/cases/ZACC/2001/18.html>.

⁷⁶ Theo Smart, "Migrants with MDR-TB in Southern Africa Being Dumped Off at Borders Without Referrals to Care," *Aidsmap*, October 31, 2008, <http://www.aidsmap.com/en/news/F776AAFE-AB53-42B7-81BA-85C3E6426171.asp> (accessed July 20, 2009).

⁷⁷ Human Rights Watch, *South Africa — Neighbors in Need: Zimbabweans Seeking Refuge in South Africa*, 1-56432-343-9, June 2008, <http://www.hrw.org/sites/default/files/reports/southafrica0608webwcover.pdf>.

United States

In 2007, the UN estimated that 1.1 million adults were living with HIV in the United States.⁷⁸ The US has particularly restrictive policies on entry, stay, and residence for people living with HIV.⁷⁹ When HIV-positive individuals are faced with deportation, US law provides several legal avenues that individuals seeking to avoid deportation could theoretically pursue.

Individuals who are unlawfully in the US may seek protection against deportation on three basic grounds. First, an individual may try to qualify for asylum. To do so, the individual must establish that he or she is unable or unwilling to return to his or her country of nationality because of persecution or a well-founded fear of persecution on the basis of race, religion, nationality, membership in a particular social group, or political opinion.⁸⁰ Some immigration judges have held that HIV status can form the basis of membership in a particular social group for the purposes of an asylum claim.⁸¹ Furthermore, on rare occasions HIV-positive individuals have succeeded in obtaining refugee status based on their likelihood of persecution based on HIV status by adherents to a religious practice fostering discrimination against people living with HIV.⁸²

Second, an individual may try to seek so-called “withholding of deportation” under US law or apply to prevent his or her deportation based on the Convention Against Torture⁸³ prohibitions on *refoulement*. An individual may qualify for “withholding of removal” under the US Immigration and Nationality Act to prevent his or her removal to a country if he or she can establish that it is more likely than not that his or her life or freedom would be threatened on account of race, religion, nationality, membership in a particular social group, or political opinion in the proposed country of removal.⁸⁴

For a US court to grant suspension of removal on the grounds that it would violate CAT, the individual must show that he or she will “more likely than not” be tortured in the country to

⁷⁸ World Health Organization, UNAIDS and UNICEF, “Epidemiological Fact Sheet on HIV and AIDS: Core Data on Epidemiology and Response: United States of America,” December 2008, http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_US.pdf (accessed June 1, 2009).

⁷⁹ Deutsche AIDS-Hilfe e.V., “Quick Reference,” p. 41.

⁸⁰ Immigration and Nationality Act, sec. 208. See also Department of Homeland Security and U.S. Department of Justice, “I-589, Application for Asylum and Withholding of Removal,” OMB No. 1615-0067, April 7, 2009, http://www.uscis.gov/files/form/I-589_Inst.pdf (accessed July 19, 2009).

⁸¹ See note 25 above.

⁸² *In Re C-J*, No. A72-560-459 (U.S. Department of Justice, Executive Office for Immigration Review, Sept. 1, 2004). Lynda L. Ford, “HIV Afflicted Haitians: New Hope When seeking Asylum,” *The University of Miami Inter-American Law Review*, vol. 36, Winter-Spring 2005.

⁸³ The U.S. ratified the Convention Against Torture on October 21, 1994.

⁸⁴ Immigration and Nationality Act, section 241(3)(b). See also Department of Homeland Security and U.S. Department of Justice, “I-589, Application for Asylum and Withholding of Removal.”

which he or she is removed.⁸⁵ Individuals who are ineligible for withholding of removal because they persecuted others, committed particularly serious crimes, or represent a danger to the United States remain eligible for deferral of removal under the Convention Against Torture.⁸⁶ However, immigration judges have been reluctant to find CAT violations in removing HIV-positive individuals from the US, even when the petitioner would be removed to deplorable circumstances with practically nonexistent health care.⁸⁷

Some commendable initiatives to ensure continuous cross-border HIV treatment to deportees exist in the United States.⁸⁸ However, deportees often face harsh conditions and lack of access to health care upon return from the US to their countries of origin. Receiving country governments have complained about the procedures and effects of US non-citizen deportation, especially when individuals with criminal convictions are deported without adequate notification or possibility of rehabilitation. In Guyana, legislation has authorized police surveillance of some deportees.⁸⁹ In Haiti, criminal deportees are taken immediately to jail and held indefinitely under miserable conditions, where no medical treatment is provided for diseases including for HIV/AIDS. Some criminal deportees do not survive such detention.⁹⁰ A study on injecting drug users in Mexico also suggests recent deportees have less access to health services than their peers.⁹¹

⁸⁵ 8 C.F.R. § 208. Because the Convention is not self-executing, a petitioner raising a CAT claim is actually seeking relief under the Convention's implementing legislation, Foreign Affairs Reform and Restructuring Act of 1998, Pub. L. No. 105-277, § 2242, 112 Stat. 2681 (codified at 8 U.S.C. § 1231).

⁸⁶ 8 C.F.R. §§ 208.17(a), 1208.17(a). See also Department of Homeland Security and U.S. Department of Justice, "I-589, Application for Asylum and Withholding of Removal."

⁸⁷ See, e.g., *Lavira v. Attorney General of the United States*, 478 F.3d 158 (3d Cir. 2007), overruled in part by *Paul Pierre v. Attorney General of the United States*, 528 F.3d 180 (3d Cir. 2008). But see also *Jean-Pierre v. Attorney General of the United States*, 500 F.3d 1315 (11th Cir. 2007).

⁸⁸ "U.S.-Mexico Border AETC Steering Team," undated, <http://www.aidsetc.org/aidsetc?page=ab-01-10> (accessed June 29, 2009).

⁸⁹ United States Bureau of Citizenship and Immigration Services, "Guyana: Information on the Treatment of Criminal Deportees," February 12, 2004, <http://www.unhcr.org/refworld/docid/414ef10d4.html> (accessed June 29, 2009). Government Information Agency (GINA), "Monitoring of Deportees," June 30, 2003, <http://www.gina.gov.gy/archive/features/fo30630.html> (accessed June 29, 2009).

⁹⁰ *Auguste v. Ridge*, 395 F.3d 123 (3d Cir. 2005). *Paul Pierre v. Attorney General of the United States*.

⁹¹ K.C. Brouwer et al., "Deportation Along the U.S.-Mexico Border: Its Relation to Drug Use Patterns and Accessing Care," *Journal of Immigrant and Minority Health*, February 5, 2008.

Recommendations and Conclusion

States have an obligation to provide detainees with medical care at least equivalent to that available to the general population. In order to meet the requirements of international human rights law regarding the treatment of detainees, states worldwide should begin or continue to provide ART drugs to HIV-positive individuals in detention awaiting deportation on at least the same basis as that offered to the general population. Individuals should not be held in detention, especially for months at a time, without access to medication. Human Rights Watch has argued elsewhere the necessity of providing ART in detention.⁹²

Given the legal framework and national case studies discussed in this report, Human Rights Watch, Deutsche AIDS-Hilfe, the European AIDS Treatment Group, and the African HIV Policy Network have several recommendations for national governments and international agencies and donors aimed at realizing national obligations of *non-refoulement* and, as a policy matter, ensuring that treatment is not interrupted or discontinued when individuals are deported.

Recommendations for National Governments

Publish comprehensive information on the number of forcible removals of HIV-positive individuals including the number of individuals removed, grounds for removal, and countries to which they are removed

Existing sources of information on the number of HIV-positive individuals forcibly removed, legal *non-refoulement* protections potentially available to them, and provision—if any—made for their continuing treatment after removal are often inadequate.⁹³ Information from governments particularly on the number of HIV-positive individuals who are removed and the grounds for their removal needs to be published so that advocates, organizations serving migrants and deportees, and international agencies are able to enrich their understanding of these removals and better design programs aimed at improving the lives of HIV-positive migrants.

⁹² See, e.g., Human Rights Watch, *United States – Chronic Indifference*. Joe Amon and Megan McLemore, “Curb HIV Infection Rates in Texas Prisons,” *The Austin American Statesman*, May 10, 2007, <http://www.hrw.org/en/news/2007/05/10/curb-hiv-infection-rates-texas-prisons>.

⁹³ Human Rights Watch has previously documented the inadequate records that national governments keep of individuals deported from their borders. See, e.g., Human Rights Watch, *United States – Forced Apart (By the Numbers): Non-Citizens Deported Mostly for Nonviolent Offenses*, 1-56432-268-0, April 2009, <http://www.hrw.org/sites/default/files/reports/uso409web.pdf>.

Ensure national laws that permit deportation of people living with HIV meet “non-refoulement” obligations

The European AIDS Treatment Group has previously called on governments to end “harmful practices, such as deportation, connected with HIV status. It is unacceptable to deport people to places where treatment and care are not guaranteed.”⁹⁴ Human Rights Watch, Deutsche AIDS Hilfe e.V., the European AIDS Treatment Group and the African HIV Policy Network call on governments to reexamine deportation of HIV-positive individuals to countries where treatment and social support are inadequate, in accordance with *non-refoulement* prohibitions on deportation, and to offer additional complementary bases of protection. In determining a standard for when an individual should not be removed, national governments should consider regional case law, and in particular the Inter-American Commission on Human Rights’ recent decision in the *Mortlock* case.

Where feasible, establish pre-deportation service enrollment and temporary medication supply

As a matter of good practice, states—in cooperation with international agencies and donors—should attempt to assist people living with HIV to continue treatment for their illness when they are deported.⁹⁵ Initiatives to provide cross-border treatment between the United States and Mexico could serve as an example in this regard.⁹⁶ Programs such as the US-Mexico Border AIDS Steering Team—a hybrid federal and academic program that provides support to HIV-positive detainees returning to Mexico from detention centers in the US Southwest—serve as a model for how treatment can be coordinated for deportees across borders and should be expanded where feasible.⁹⁷ Prior to deportation, health officials in the deporting country could contact the health authorities and anticipated health provider in the deportee’s country of origin and discuss how continuous access to treatment will be ensured, to make sure that waiting lists do not prevent registration for health services in the

⁹⁴ “Migration and HIV/AIDS: Community Recommendations: Based on the European Conference ‘The Right to HIV/AIDS Prevention, Treatment, Care and Support for Migrants and Ethnic Minorities in Europe: The Community Perspective,’ Lisbon, 7-8 June 2007,” <http://www.eatg.org/eatg/Press-Publications/Other-Reports-and-Publications/HIV-AIDS-and-Migration-Community-Recommendations> (accessed May 26, 2009).

⁹⁵ For a discussion of the need for cross-border initiatives in the British context, see, e.g., African HIV Policy Network, “From a Destination Unknown to a Safe Place: Immigration Control and People Living with HIV,” 2009, [http://www.ahpn.org/downloads/publications/From_a_Destination_Unknown_to_a_Safe_Place\(AHPN\).pdf](http://www.ahpn.org/downloads/publications/From_a_Destination_Unknown_to_a_Safe_Place(AHPN).pdf) (accessed July 28, 2009).

⁹⁶ “U.S.-Mexico Border AETC Steering Team.” Cross-border tuberculosis treatment initiatives could also prove informative. Philip A. LoBue and Kathleen S. Moser, “Screening of Immigrants and Refugees for Pulmonary Tuberculosis in San Diego County, California,” *Chest*, vol. 126, no. 6, December 2004, pp. 1777-82. Todd Harlow, “Notes from the Field: TB Net Tracking Network Provides Continuity of Care for Mobile TB Patients,” *American Journal of Public Health*, vol. 89(10), October 1999, pp. 1581-82, 1581. Nora Martinez, “TBNET: TB and Public Health,” undated, <http://www.migrantclinician.org/services/tbnet.html> (accessed December 8, 2008).

⁹⁷ “U.S.-Mexico Border AETC Steering Team.”

country of origin, the deportee has selected and is aware of a new provider, and medical records are confidentially transferred to a individual's new physician. These actions will both allow the immigration authorities in the departing country to provide deportees with adequate information about the steps needed to obtain services upon deportation, as well as ensure that care is planned as much as possible in advance. Crucial to this advance arrangement is not only the securing of a guarantee that services will be provided, but coordination with the country of origin's National HIV/AIDS Program so that an official will meet the deportee at the airport or other point of entry in order to review planned treatment.

Providing a temporary supply of ART medication for self- or health provider-administration may be strongly recommended for people living with HIV who are deported to countries in which anti-retroviral medication is not immediately accessible to newly arrived deportees. The US government has shown that it is possible to provide a longer-term supply of medication when an individual still requires a course of treatment and the medication is not readily available in the country of origin in the context of TB treatment.⁹⁸ Even if ART is available in principle in a country, regional unavailability, lack of understanding of the health system, language barriers, lack of community ties, waiting lists, lack of second- or third-line drugs, or medication shortages can all conspire to keep individuals living with HIV from accessing treatment upon deportation. Immigration and health officials in departing countries should consider the situation facing each deportee on a case-by-case basis with detailed communication and understanding of the HIV treatment options in the country of origin. Such coordination is especially important in order to avoid treatment interruption and the development of drug resistance, after which a patient requires drugs which are increasingly expensive and difficult to obtain.⁹⁹

Create regional standards of care

In addition to coordinating access to treatment services by deportees in their country of origin upon deportation, national governments should also ensure that the guidelines governing HIV treatment themselves are coordinated and standardized across countries. UNAIDS has called for a "regional protocol for the standardization of HIV treatment, as well as a regional system and means to secure such treatment by affected individual."¹⁰⁰ National governments should participate with regional organizations and neighboring countries in joint efforts to create the regional standards of care necessary to facilitate deportees'

⁹⁸ Centers for Disease Control and Prevention, "Deportation of Tuberculosis Patients Complicated by a Medication Shortage—Honduras, May-August 2006," *MMWR*, vol. 56, 2007, p. 655.

⁹⁹ All-Party Parliamentary Group on AIDS, "The Treatment Timebomb: Report of the Inquiry of The All Party Parliamentary Group on AIDS into long-term access to HIV medicines in the developing world," July 2009, (accessed July 28, 2009), p. 12.

¹⁰⁰ UNAIDS, "RST-ESA Position Paper: HIV in the Context of Zimbabwean Migrant Populations," p. 6.

smooth transition to services upon deportation. A broad-based, multi-country initiative is necessary to harmonize care and treatment standards and to ensure consistency in approach to treatment across borders. Recent efforts in the Southern African Development Community to advocate for harmonized communicable disease treatment mechanisms and management guidelines across the region are a commendable step in this direction.¹⁰¹

Recommendations for International Agencies and Donors

Aid states in establishing cross-border treatment

International agencies and donors have a history of supporting cross-border HIV/AIDS initiatives, particularly in the context of HIV/AIDS prevention efforts along transit corridors.¹⁰² Such expertise, coupled with multi-national reach and influence, make these individuals and organizations essential players in supplementing cross-border treatment initiatives for individuals with HIV/AIDS who are deported. Together with state governments, international agencies and donors could play a role in making sure that confidential medical records are transferred in a timely manner, ensuring information is available in deporting countries about how to register deportees for treatment in their countries of origin, developing regional standards of care, and ensuring that local support is in place in the country of origin, providing translation services if necessary. UNAIDS has also recommended the development of reception centers in each country providing information for migrants, including referrals for health care.¹⁰³ International agencies and donors could be instrumental in implementing such services in coordination with national governments.

Place the issue of deportation of HIV-positive individuals on the research and documentation agenda

As noted above, there is a dire need for governments to publish complete and accurate information on HIV-positive deportees, including the number of HIV-positive individuals deported, the grounds for their deportation, and measures (if any) to ensure appropriate care (including continuity of ART) in relevant receiving countries. Research into and analysis of HIV-related deportation policies and practices, as well as detailed, accurate, and up-to-date information on the realistic availability of HIV treatment in both rural and urban settings in receiving countries, by international agencies and donors is also essential to best understand, and therefore address, the particular needs of HIV-positive deportees.

¹⁰¹ Directorate for Social and Human Development and Special Programs, Southern African Development Community Secretariat, "Policy Framework for Population Mobility and Communicable Diseases in the SADC Region," April 2009, http://www.arasa.info/files/pub_SADC%20Policy_Framework_FINAL.pdf (accessed June 29, 2009).

¹⁰² "Uganda: Africa Gets Another AIDS Loan," *The Monitor*, February 14, 2002.

¹⁰³ UNAIDS, "RST-ESA Position Paper: HIV in the Context of Zimbabwean Migrant Populations," p. 6.

International donors and agencies should add this issue to their research agenda so that the legal and public health communities may better understand the challenges facing this population pre- and post-deportation.

The international community has a two-fold opportunity to improve the life-chances of people living with HIV/AIDS, both through meeting international obligations of *non-refoulement*, and, as a policy matter, through improved coordination with local authorities in the country of removal to minimize interruptions in treatment. Ultimately, however, if countries continue to deport HIV-positive migrants, for the benefit of these deportees and for individuals living in countries of removal, HIV/AIDS treatment systems in countries throughout the world must continue to be strengthened with the assistance of developed nations, especially the systems of those countries to which individuals are regularly deported. Assisting countries of origin, and others in the world, to improve health systems to the point where HIV/AIDS treatment, care, and support are freely available to all individuals in the population is an essential and pressing public health challenge that the international community must embrace on behalf of returning migrants and all people living with HIV/AIDS.

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