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Migrants and refugees and the fight against AIDS

Report[1]
Committee on Migration, Refugees and Displaced Persons
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Summary

Although precise data on migrants' health is generally lacking throughout Europe, many countries present strong evidence that migrants are disproportionately affected by HIV. Their high infection rate is due both to the epidemiological situation in their country of origin and to the problems that migrants face in accessing information and treatment for the virus in their host country.

Migrants living with HIV/AIDS suffer multiple forms of discrimination and stigmatisation, including denial of entry, or refusal to renew residence permits in some countries. The policies of several European countries, which require obligatory HIV testing, or testing without the consent of migrants, raise serious human rights concerns.

Migrants continue to face many barriers in accessing HIV prevention and treatment. Social and language barriers result in lack of awareness and stigma. Legal, administrative and financial barriers result in delayed diagnosis, fear of seeking treatment and higher HIV-related morbidity and mortality. Especially vulnerable subgroups of migrants include women, men having sex with men, sex workers, undocumented migrants and refugees.

Member States should adopt a human rights-based approach to fighting HIV/AIDS: they should ensure that all migrants, including undocumented migrants, asylum seekers and refugees, have full access to affordable HIV treatment and care and to adapted prevention strategies. Attention should be given to the notion of protection of seriously ill foreigners in the context of expulsions. Where appropriate health care is unavailable in the country to which the persons are to be returned, they should not be expelled.

1. Reference to committee: Doc. 12867, Reference 3858 of 23 April 2012.

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A. Draft resolution[2]

1. Migrants, including asylum seekers and refugees, are a particularly vulnerable group in relation to the HIV virus. Their high rate of infection is due to the epidemiological situation in their countries of origin and the problems that migrants face in accessing information and treatment for the virus once they are living in Europe.

2. The Parliamentary Assembly is concerned that migrants suffer multiple forms of discrimination and stigmatisation when tested positive for HIV/AIDS. Some countries go as far as denying them entry into the country or refusing them the renewal of their residence permits. The Assembly is also concerned about policies which require obligatory HIV testing, and testing which is carried out without consent of the migrants concerned.

3. Migrants are all too often deterred from accessing prevention and treatment services due to a range of factors. These may be linked to language, cultural and social barriers and difficulties in accessing the labour market, social services and housing. Financial barriers are also an important factor when States impose charges for testing and treatment for the HIV virus. Furthermore, irregular migrants face the additional problem linked to the fear of their immigration status being reported if they approach the health authorities.

4. The Assembly notes that in most European countries there is a lack of data and information about HIV transmission amongst migrants. There is also a lack of psychological support and insufficient information and education given to them about testing, treatment and safe-sex practices. This allows the virus to spread and represents a serious threat to public health.

5. The Assembly is convinced that every person, including regular and irregular migrants, living with HIV/AIDS in member States of the Council of Europe should have free access to treatment. The Assembly believes that such a measure is in the best interest of infected individuals and public health as a whole because it reduces the risk of passing the virus on to others and cuts down on the high costs of emergency and other treatment.

6. The Assembly considers that an infected migrant should never be expelled when it is clear that he or she will not receive adequate health care and assistance in the country to which he or she is being sent back. To do otherwise would amount to a death sentence for that person.

7. The Assembly considers that, in view of the number of migrants, including refugees and asylum seekers, living in Europe with HIV, and the particular problems they face, it is necessary to take a number of special measures concerning this vulnerable group.

8. The Assembly therefore calls on member States to ensure that HIV programmes and services for migrants are provided on an appropriate and sufficient scale, and more particularly to:

8.1. regarding legislative measures:

8.1.1. review and revise their legislation with the aim of removing discriminatory provisions and legal barriers which hamper preventative measures and treatment of migrants with HIV/AIDS;

8.1.2. remove provisions in domestic law which bar migrants with HIV from entering the country or which allow them to be expelled solely on account of their HIV status;

8.1.3. include in domestic law the notion of protection of seriously ill foreigners, providing for protection from expulsion where appropriate treatment is not available in the country to which they are due to be expelled;

8.1.4. provide that no person should be detained solely because of their HIV status;

8.1.5. adopt anti-discrimination provisions regarding all migrants with HIV and ensure the monitoring of the issue by specialised bodies;

8.2. regarding access to testing, treatment and preventative measures:

8.2.1. ensure that gender-specific HIV prevention and treatment policies are developed at national and international level;

8.2.2. guarantee that HIV testing is provided to migrants on a voluntary and anonymous basis;

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2. Draft resolution adopted by the committee on 20 November 2013.

8.2.3. ensure that all migrants, regular or irregular, have free and universal access to HIV testing and counselling, as well as to sex education and awareness-raising programmes on the prevention of HIV/AIDS;

8.2.4. ensure that vulnerable groups among migrants, in particular, women, children, men who have sex with men, and sex workers, who are particularly at risk of infection, receive special attention;

8.2.5. guarantee that the needs of refugees and asylum seekers are taken into account, in view of the traumas they may have faced and continue to face;

8.2.6. ensure that HIV drugs and treatment are affordable and available for all migrants with the virus, and that the private sector, including drugs companies, are fully involved in providing effective answers in the fight against the HIV epidemic;

8.3. regarding policy measures:

8.3.1. adopt or revise, as appropriate, national plans to fight HIV/AIDS, including in them a specific section on migrants. This should be done with input from those affected by the virus and in consultation with representatives of civil society;

8.3.2. increase the funding of HIV/AIDS services in low- and middle-income countries through member States' development and co-operation policies;

8.3.3. increase funding and support for representatives of civil society working with HIV/AIDS-infected migrants.

B. Explanatory memorandum by Ms Fiala, rapporteur

1. Introduction

1. Despite ongoing improvements in treatment, the human immunodeficiency virus (HIV) remains one of the most dangerous communicable diseases in Europe, associated with a considerable reduction in life expectancy and quality of life and high costs of treatment. Migrants are often accused of "spreading AIDS". But what are the facts? To what extent does migration impact on the overall HIV burden in Europe? What should member States and institutions do to gain a fuller understanding of the reality of the phenomenon and to deal with it more effectively? What mechanisms can be introduced to encourage counselling and voluntary testing among migrants – in particular among women, who are disproportionately affected by the virus – and to provide those who are HIV positive with non-discriminatory access to health care?

2. The aim of this report is to try to answer these questions and to assess whether the responses by Council of Europe member States and other countries are adequate and sufficiently co-ordinated. In this report, the term "migrants" refers to all migrant groups, including refugees, asylum seekers and undocumented migrants, unless stated otherwise.

3. This report was prepared with the assistance of Doctors of the World international network. I thank them for their valuable analysis. During the preparation of this report, I also carried out two fact-finding missions to Portugal and to Ukraine to look into the situation in the field. I would like to thank the parliamentary delegations and the authorities of these countries for their help and information provided during my visits.

2. General information on HIV/AIDS and migration in Europe

4. Generally speaking, information on migrants' health is lacking in most European countries. This limits the possibilities for monitoring and comparing inequalities in health, accessibility to health care, and evaluating which measures are most effective in improving migrant health.[3] Due to a lack of data and hard evidence on HIV prevalence among migrants in Europe, information presented here should be treated with caution. Cross-country comparisons are further complicated due to the fact that there is no common definition of the term "migrant" in epidemiological data collection. Nevertheless, evidence suggests that migrants from countries with a high HIV/AIDS prevalence, particularly in sub-Saharan Africa, are disproportionately affected by HIV.[4]

5. Because of the lack of precise data, a questionnaire was sent through the network of the European Centre for Parliamentary Research and Documentation (ECPRD) to all parliaments of the Council of Europe member States to get more detailed information on migrants and refugees and the fight against HIV/AIDS. Thirty member States of the Council of Europe answered the questionnaire and their answers served to illustrate with real facts and figures the main tendencies of the situation of HIV/AIDS-affected migrants in Europe.

2.1. Vulnerability factors specific to migrants

6. Migrants face numerous barriers in accessing HIV prevention and treatment services, which can be in law, policy or practice. For instance, in practice, language barriers can prevent migrants from accessing general information on HIV, and make communication with health professionals difficult. Furthermore, migrants' focus on employment often causes them to delay investing time or money in health care, particularly preventive health care.

7. A European review showed that African migrants' high perceptions of risk and fear of death and disease constitute a barrier for HIV testing, especially for those unable to access HIV treatment, either in their country of origin or in Europe.[5] In many countries of origin, HIV equals death because of the lack of available treatment and the common belief that HIV means the loss of procreative capacities. In many African contexts, not having children leads to social exclusion and marginalisation, as the societal role of men and even more so of women is often linked to their reproductive capacity.

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3. For example, see Rechel B., Mladovsky P., Deville W., Rijks B., Petrova-Benedict R. and McKee M., *Migration and health in the European Union,* Open University Press, World Health Organization 2011 on behalf of the European Observatory on Health Systems and Policies.

4. ECDC Evidence brief: Migrants. Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 progress report, Stockholm, 2013.

5. Fakoya I, Reynolds R, Caswell G, Shiripinda I., Barriers to HIV testing for migrant black Africans in Western Europe. HIV medicine, 2008;9:23-5.

8. The European Centre for Disease Prevention and Control (ECDC) has identified migrant women, migrant men who have sex with men, and heterosexual migrants who engage in high-risk behaviour (sex work, drug use, but also multiple partners) as well as prisoners, as those migrant groups most vulnerable to HIV infection.[6] During the last decade, there has been a feminisation of HIV infection in migrants. Women are more vulnerable to HIV both biologically and socially. Among the social reasons are reproductive pressures, exposure to sexual violence, pressure to have unsafe sex and not having access to gender-sensitive HIV prevention services. Concerning migrant men who have sex with men, this group is largely "invisible" because of the associated stigma.

9. As is the case for some other vulnerable groups, many migrants lack general knowledge about HIV and other sexually transmitted infections (STIs). They are insufficiently aware of the transmission modes and prevention strategies. Many do not know how to access the existing preventive and curative health-care services in their country of residence. Particularly among undocumented migrants there is little knowledge about available HIV services. An international survey by Doctors of the World (2008) showed that only 35.4% of all undocumented patients that were questioned knew about the possibility of a free HIV test. Moreover, 50.1% stated not knowing whether screening was free or not and 12.9% (erroneously) stated that one had to pay for a test.[7]

10. When a person tests positive for HIV, more detailed clinical exams can give some indication of the time that has passed between the time of infection and diagnosis. Delayed diagnoses are shown to have a direct impact on AIDS-related deaths. The majority of infections in migrants are diagnosed for the first time in Europe. In 2012, among migrants who attended Doctors of the World health-care centres in France, 67% were unaware of their serologic status.[8]

2.2. Epidemiological data on HIV and migration

11. Due to a lack of available data and methodological difficulties, determining the exact extent to which migration impacts the overall burden of HIV/AIDS in Europe is not entirely clear. Thirty member States answered the questionnaire elaborated for this report. Only 7 out of the 30 answered that they provided data on the estimated number of regular and irregular migrants living with HIV in their countries. However, it is clear that many countries present strong evidence that migrants from countries with generalised HIV epidemics, particularly from sub-Saharan Africa, are disproportionately affected by HIV as compared to the native population of the host countries. At the same time, when comparing migrants to the native population of their countries of origin (with high HIV/AIDS prevalence) the proportion of HIV/AIDS infection among migrants is usually lower, which can be explained by the "healthy immigrant effect" (see paragraph 73). In 2011, for eastern European countries and for some central European countries, this proportion of migrants among the HIV- infected population is below 10% of total infections. For most Northern countries, it is over 40%. For most countries in western Europe, the proportion of migrants among those infected by HIV is between 20% and 40%.[9]

12. The question whether migrants mostly contract HIV in their country of origin or after migration is a question that could fuel xenophobic discourse. On the other hand, the answer is important to determine what public health policies are likely to be most effective in fighting HIV/AIDS.

13. However, the current state of epidemiological research across Europe does not allow for a certain answer to this question. A recent review by the ECDC (2013)[10] showed great differences between destination countries in the proportion of post-migration infections: from 2% among Sub-Saharan Africans in Switzerland to 62% among black Caribbean men who have sex with men in the United Kingdom. According to the Swiss Aids Federation, about 62% of HIV-positive migrants from high-prevalence countries diagnosed in Switzerland declared they contracted HIV in their country of origin. Only approximately 11% of HIV-positive migrants said that they had become infected in Switzerland.[11]

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6. ECDC, Migrant health: HIV testing and counselling in migrant populations and ethnic minorities in EU/EEA/EFTA member States, Stockholm, 2011.
7. Chauvin P., Parizot I., Simonnot N., European observatory of access to health care, Doctors of the World, September 2009.
8. Personal communication, Dr Marie-Dominique Pauti, Doctors of the World France.
9. ECDC technical report, Migrant health: Epidemiology of HIV and AIDS in migrant communities and ethnic minorities in EU/EEA countries, Stockholm, 2010.
10. ECDC Technical report, Migrant health: Sexual transmission of HIV within migrant groups in the EU/EEA and implications for effective interventions, Stockholm, 2013.
11. Swiss Aids Federation, Migration and HIV in Switzerland.

14. Migrant workers living alone, away from their spouses or permanent sexual partners, may be open to greater risks of HIV exposure. This would be due to the fact that they may seek other partners of a casual nature, increasing their own risk of exposure to HIV and that of their sexual partners.

15. In conclusion, migrants are more affected by HIV/AIDS than the general population, especially in northern and western Europe, both due to the epidemiological patterns in the countries of origin and to their increased vulnerability in European destination countries.

3. Obstacles to HIV/AIDS prevention and treatment among migrants in Europe

16. Prevention and treatment services are not always adapted and accessible to migrants. Together with restrictive migration policies, migrants' vulnerabilities and barriers to services form a complex interplay that poses a threat to public health.

3.1. Restrictive national migration and health-care policies

17. As pointed out by many international expert actors such as UNAIDS (Joint United Nations Programme on HIV and AIDS), World Health Organization (WHO) Europe or the ECDC, restrictive legislation on access to health care for undocumented migrants hinders effective HIV/AIDS prevention and treatment. Furthermore, migration enforcement policies targeting undocumented migrants raise their fear of deportation or denunciation, thereby creating considerable additional barriers to health care. This can lead to more infections and later diagnoses posing a direct threat to public health. Furthermore, excluding migrants from antiretroviral treatment equates to a near certain death sentence. Other member States allow access to health care in theory, but have implemented complex administrative or financial barriers that lead to similar reverse consequences for undocumented migrants.

18. I regret to say that countries such as Germany, Greece, Sweden and my own country, Switzerland, offer the worst legislative conditions as regards access to health care for undocumented migrants. Although in each of these countries one can find health professionals who disregard these laws for humanitarian and ethical reasons, who cover the costly and long-term antiretroviral treatment without any State reimbursement.

19. In **Switzerland**, undocumented migrants have – just as nationals – the obligation to take out expensive private health insurance to be able to access basic health care (over €250 per month). Non-payment of premiums on time leads to a judicial complaint. Insurance requires proof of identity and residence. There is also a risk of immigration services being alerted when a migrant takes out health insurance. Generally, the health insurance policy in Switzerland with its complex system of monthly premiums, a franchise (an amount of money that an insured person elects to pay before claiming on his health policy) and a retention (a maximal amount an insured person must pay towards the cost of his health care) constitute a formidable barrier to access and, in practice, these barriers most often render treatment inaccessible.

20. In **Sweden**, undocumented migrants were explicitly excluded from health care (including emergency care) unless they paid the total cost. I welcome the fact that in July 2013, a new law was passed allowing adult undocumented migrants to have the same kind of access to health care as asylum seekers. Children of undocumented migrants will have the same rights as Swedish children. But asylum seekers only have access to "care that cannot be postponed" (meaning ante and post natal care, family planning, abortion, urgent dental care). For Swedish health professionals, it is not clear yet to what degree HIV prevention and treatment services will become available to undocumented migrants.

21. In the **Russian Federation**, undocumented migrants have no access to health care as it is based on the social insurance system.

22. In **Greece**, undocumented migrants have no access at all to health care except to emergency care and only until the condition is stabilised. Although HIV is considered an emergency, it is unclear what "stabilisation" means in this context. Whether or not an undocumented migrant has continuous access to antiretroviral therapy depends on the individual decision of the health professional. Refugees and asylum seekers have access to treatment, but applying for asylum in Greece is very difficult. Furthermore, the Greek health system is under enormous strain due to the economic and financial crisis. Greek health professionals and civil society organisations report that, in practice, migrants no longer have any access to public health-care services.

23. In **Germany**, screening for HIV and hepatitis is usually available for all and is anonymous (*de jure* and *de facto),* most communal health departments have screening clinics. However, for any medical treatment other than emergency treatment, including HIV treatment, undocumented migrants have to apply for a

Krankenschein (illness certificate) in order to be eligible for public subsidies from the social welfare office. The obligation of the welfare offices to report undocumented migrants to immigration police, however, effectively prevents access to health care.

24. Some European countries have specific HIV testing arrangements for foreigners entering the country. These arrangements are not mandatory, but systematically proposed in the following circumstances: voluntary HIV testing proposed during the medical examination of foreigners applying for a residence permit (Luxembourg), voluntary HIV testing proposed to asylum seekers and refugees depending on the country of origin (Finland). These kinds of arrangements have to be dealt with cautiously as they could create barriers to accessing legal status depending on the way they are implemented.

3.2. Social and administrative obstacles

25. For migrants, difficult access to housing or the labour market are further obstacles to coping with an HIV diagnosis, the associated stigma and completing the medical treatment. Some HIV-positive migrants also have to deal with psychological trauma or other mental health problems (for example refugees who were infected with HIV through rape). Asylum seekers in reception centres often have difficulties safely storing and/or taking antiretroviral medication without others noticing (stigma). Migrants living with HIV/AIDS often lack social support and psychosocial interventions that take into account the social and cultural specificities of migrant communities are rare. Finally, very few European studies exist on the living conditions of migrants with HIV/AIDS.

26. An overview of national responses to HIV/AIDS in Europe confirms that language is an important barrier to HIV prevention and access to health care for migrants. Relatively few adapted campaigns exist that encourage migrants to attend screening services or sex education programmes (for example material in other languages, visual material accessible to people unable to read or write, intercultural mediators that are part of the community or other community-based programs). Furthermore, HIV/AIDS is still considered a taboo topic by some health-care professionals, which is exacerbated by the fact that social determinants of health and barriers to health care are not part of any professional training.

3.3. Financial constraints

27. When legal restrictions do not apply, the main barrier is often financial in nature. In some European countries HIV health-care services are not free for migrants, even with a residence permit. Switzerland provides free access to treatment for HIV and sexually transmitted infections only when it is considered “urgent”, otherwise, testing has to be paid for or will need to be covered by a health insurance scheme.

28. As already outlined, different barriers deter migrants from getting tested. Consequently, they remain unaware of their serological status and do not get treatment in due time. This leads to a higher prevalence of HIV in the population, which leads to more expensive health-care costs both for patients and for national health-care systems.

4. Human rights concerns for migrants with HIV/AIDS

29. Human rights are inextricably linked with the spread and impact of HIV. The main human rights concerns as regards the protection issues related to migrants were pointed out by the Office of the United Nations High Commissioner for Refugees (UNHCR) in its Strategic Plan for HIV and AIDS 2008-2012 and other related documents.[12]

4.1. Discrimination and legal measures to tackle discrimination

30. Migrants often experience discrimination and stigmatisation. health care is often less available to migrants than to the native population. As rightly stated by the former Council of Europe Commissioner for Human Rights: “Denial of essential treatment can breach the right to life as provided for in the ECHR; in the extreme context of terminal illness, e.g. AIDS, deportation to a country where treatment is not available, could breach the right to be protected from inhuman and degrading treatment. Similarly, where access to antenatal care is normally free, but made dependant on payment in the case of irregular migrants, issues of discrimination in the enjoyment of the right to life, to protection from inhuman treatment, and to family life arise.”[13]

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

31. People living with HIV often also experience discrimination and stigmatisation when it comes to housing, the labour market or access and quality of health care. As such, HIV-positive migrants are often the victim of double discrimination. As outlined above, some vulnerable migrant groups can even experience multiple exclusion: not having a residence permit, being a woman, a sex worker, men that have sex with men, etc.

32. According to the United Nations High Commissioner for Human Rights:[14] "Where an open and supportive environment exists for those infected with HIV; where they are protected from discrimination, treated with dignity, and provided with access to treatment, care and support; and where AIDS is de-stigmatized; individuals are more likely to seek testing in order to know their status. In turn, those people who are HIV positive may deal with their status more effectively, by seeking and receiving treatment and psychosocial support, and by taking measures to prevent transmission to others, thus reducing the impact of HIV on themselves and on others in society."

4.2. Laws and regulations regarding entry and stay in Europe

33. Beyond constituting an intentional human rights violation (including jurisprudence of the European Court of Human Rights), there is a consensus among international experts that HIV-related travel restrictions are neither efficient nor effective. On the contrary, they are harmful to the public health of the host country, by compelling migrants to avoid HIV screening for fear of expulsion and by lulling the local population into a false sense of security suggesting that HIV/AIDS is a "foreign problem".

34. Although 41 member States of the Council of Europe have no restrictions on entry, stay and residence based on HIV status, a few still do.[15] Some member States still impose mandatory HIV testing for foreign nationals when applying for long-term residence permits.

35. In **Andorra**, foreigners living with HIV applying for long-term stays will not be granted a visa.

36. In **Cyprus**, foreigners applying for a residence permit in order to work or to study must undergo a medical examination by the Health Ministry in order to exclude an infection with HIV. The authorities will not grant a residence permit if the test result is positive. Tests for refugees and asylum are the same, but if their results are positive they are entitled to free treatment and counselling.

37. In **Bavaria, in Germany**, foreigners intending to stay for more than 180 days can be requested to undergo an HIV test. Asylum seekers are systematically tested for HIV, but they are only informed of the test when the result is positive.

38. In the **Republic of Moldova**, HIV testing is mandatory for residence permits beyond three months. People with AIDS will not receive a residence permit and can be deported.

39. In the **Russian Federation**, a negative HIV-test result is required for long-term stays (more than three months), for students and for foreign employees. Moreover, according to the Federal Law on prevention of spreading in the Russian Federation of the disease caused by HIV-infection, foreigners registered as having the HIV infection should be deported from the Russian Federation.[16]

40. In the **Slovak Republic**, foreigners applying for a residence permit are required to present a certificate stating that they are not suffering from a communicable disease. A residence permit will not be granted to persons with HIV/AIDS.

4.3. Access to information and education on HIV treatment and prevention

41. As already mentioned, it is important to develop effective, migrant-specific approaches to HIV prevention. To develop successful HIV prevention programmes targeting migrants, community involvement will be essential.

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13. CommDH/IssuePaper(2007)1, 17 December 2007.
14. www.ohchr.org/EN/Issues/HIV/Pages/HIVIndex.aspx.
15. The Global Database on HIV related travel restrictions: www.hivtravel.org.
16. Federal Law N 38-FZ of 30 March 1995. Reply to the questionnaire provided by the Analytical Department of the Council of Federal Assembly of the Russian Federation.

4.4. Access to voluntary and anonymous testing and health care

42. Despite a high rate of HIV testing in Europe, a large number of HIV-positive patients start their treatment with delays and many of them are unaware of their HIV infection at the time of diagnosis. According to the ECDC,[17] "there is strong evidence that an early diagnosis of an HIV infection and subsequent treatment can result in a markedly improved prognosis for the individual who can expect low morbidity, a good quality of life, and a near normal life expectancy".

43. International experts agree that testing should always be voluntary. Testing is not only an epidemiological tool to monitor the spread of HIV, it is also a prevention tool in itself, which allows a health-care professional to discuss risk behaviours during a pre-test and post-test counselling session. Obtaining a reduction in harmful behaviour necessitates a relationship of trust which cannot be established when a test is mandatory. Furthermore, mandatory tests in "high-risk groups" (migrants but also drug users, sex workers, men having sex with men) are stigmatising, making those that are targeted turn away from testing and giving a false sense of security to the rest of the population. In reality, everyone should be aware of HIV risks and transmission.

4.5. Access to asylum procedures

44. Asylum seekers are considered particularly vulnerable to HIV for three main reasons: they may have experienced situations of risk in areas of high HIV prevalence; their migration may have been triggered by such experiences as detention, beatings, torture, rape, sexual assault and harassment; and the experience of becoming an asylum seeker or refugee may involve poor living conditions, malnutrition, lack of protection and depression, which may leave them vulnerable to sexual exploitation.

4.6. Protecting seriously ill migrants from expulsion

45. Although people living with HIV can achieve a high quality of life, they require specialist medical care (including regular blood tests requiring advanced laboratory technology) and, in most cases, antiretroviral treatment for the rest of their lives. Furthermore, it is common for patients to require supplementary medication during the course of their treatment (for example to treat additional pathologies to which HIV patients are particularly vulnerable). Stopping medication or even taking medication on an irregular basis almost always leads to a serious aggravation of their medical condition implicating a risk of immediate death or a strong diminution of life expectancy, as well as the development of HIV drug resistances.

46. In some countries, refugees and asylum seekers may be at risk of expulsion or *refoulement* despite their HIV status. For example, in my country, Switzerland, the HIV-positive status in itself is not regarded as sufficient grounds for expulsion to be deemed unreasonable. In addition to being confirmed as HIV-positive, the person who has been denied asylum must already be receiving antiretroviral HIV therapy in Switzerland. They must also provide that it is not possible for them to receive therapy in their country of origin. Very often, it is impossible to provide such evidence, as the health ministries of the countries of origin present the situation as more positive than it actually is.[18]

47. Some undocumented migrants who are seriously ill or who have children that are seriously ill refuse to go to hospital for treatment, as they are afraid of being sent back to their countries because of their status. Expelling an HIV-positive person to a country where he or she cannot access effective care can indeed be compared to a death sentence, out of sight, decided by administrative bodies!

48. The protection standards for seriously ill migrants are far from coherent and vary significantly throughout member States, despite the fact that they are all Parties to the European Convention on Human Rights (ETS No. 5, "the Convention") and that expulsion of HIV-positive migrants can amount to inhumane or degrading treatment, thus raising an issue under Article 3 of the Convention. In some member States, legislation exists to protect from detention and expulsion seriously ill foreigners who do not have access to health care in their country of origin. Yet in practice, civil society organisations across Europe[19] have found that treatment and care are often esteemed "accessible" based only on partial evidence. But the fact that some antiretroviral treatment is only available at a very high price and limited to a particular part of a country of origin does not mean HIV care is available to all.

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17. ECDC, HIV testing: Increasing uptake and effectiveness in the European Union, Stockholm, 2010.
18. Migration and HIV in Switzerland, Swiss Aids Federation.
19. For instance, see the Platform for International Cooperation on Undocumented Migrants (PICUM), Undocumented and seriously ill: residence permits for medical reasons in Europe (2008).

49. I am convinced that migrants with HIV status should be guaranteed legal protection against expulsion by international and national legislation. In this context, accessibility to health care in the country of origin should be evaluated based on geographical and financial availability of treatment for the individual concerned in that particular State. Special attention should be given to the accessibility of continuous treatment and of specialised follow-up care (for example sufficient qualitative and quantitative availability of physicians and care structures that specialise in HIV as well as necessary blood tests and other equipment). The absence or presence of treatment also needs to be evaluated in light of the specific state of health of the individual applicant (progression of the illness, complications).

4.7. Protection from arbitrary detention

50. The detention of a person due to their HIV status is arbitrary and unlawful even for people who are unlawfully present in the country. International institutions, including UNAIDS, WHO and the Office of the United Nations High Commissioner for Human Rights, have all opposed forcible HIV testing and the isolation of people with HIV as incompatible with human rights standards.

51. To my knowledge, Greece is the only European country to have put in place such detention specifically aimed at HIV-positive persons. Health Regulation No. GY/39A "Amendments That Concern the Restriction of the Transmission of Infectious Diseases", states that mandatory health examinations will be required, as well as isolation and compulsory treatment, for diseases of public health importance. This regulation specifies certain groups as a priority for testing, including undocumented migrants coming from countries where such diseases are endemic.

4.8. Protection of vulnerable groups

52. Vulnerable groups among migrants require specific attention regarding access to prevention, HIV testing and HIV services. Women are more at risk of HIV infection because they more frequently face sexual violence and exploitation. Gender inequalities also concern HIV-positive women who may be more susceptible to violence by their partners or families. Protection of children affected by HIV (directly or through a family member) might also be reinforced to ensure access to education and health care and to prevent violence. Sex workers – especially in countries where their activity is criminalised or where local policies hinder their access to law enforcement – need particular protection because of their high risk of being victims of sexual violence, their high risk of being pressured to have unsafe sex and subsequent HIV infection or other STIs. Migrant men who have sex with men and migrant drug users are often invisible due to the high stigma associated with these high risk behaviours. Prisoners often do not have access to HIV prevention and treatment services – prisoners with a migrant background are extremely vulnerable.

5. European response to HIV/AIDS prevention and treatment among the migrant population

5.1. HIV testing: positive and negative practices

53. In general, information about HIV and HIV testing is provided to migrants on their arrival in the country (Germany, Italy, Lithuania, Montenegro, Poland, Romania, Slovenia, Spain and Switzerland). Information on HIV testing is also given during medical visits for migrants and asylum seekers (Norway, Serbia, Sweden and Switzerland). In this regard, a Swiss preventive information campaign promoting voluntary HIV testing for migrants could be a good model for other countries. In Switzerland, the border medical services organisation provides audiovisual tools in 28 languages to support the provision of information and advice to asylum seekers. These tools cover the health-care system in Switzerland, tuberculosis, and the option of various vaccinations. Asylum seekers view a 12-minute video about HIV, AIDS and safe behaviour. This video is available in16 languages.

54. In Ukraine, according to the Law on combating the spread of diseases caused by HIV and the legal and social protection of people living with HIV, migrants, refugees and asylum seekers are entitled to free HIV/ AIDS testing. During the first six months of 2013, 1 818 foreign citizens took HIV tests, among which 18 tests were positive. Non-governmental organisations (NGOs), such as the International HIV/AIDS Alliance in Ukraine, provide voluntary testing for migrants and have undertaken an assessment of behaviour of migrants, monitoring HIV prevalence among Ukrainian migrant workers.

55. Even if most countries identify migrant and ethnic minority populations as being more at risk to HIV infection, not all countries explicitly recommend voluntary HIV testing for these populations.[20]

56. In Iceland and Poland, HIV testing is offered to all migrants prior to entry as part of a general health screening. In Denmark, it is recommended that HIV testing be offered to migrants on first contact with health services whatever the reason for recourse. In France, official recommendations are annual testing for people originating from sub-Saharan countries or the Caribbean.

57. In some countries, testing is mandatory for a special category of migrants (Cyprus, Russia and the Slovak Republic.) In Cyprus, for example, testing is mandatory for migrants coming from countries where there is a high prevalence of HIV. In Russia, testing is mandatory for migrant workers, who have to provide a medical certificate stating they do not have HIV in order to get a temporary or permanent residence permit. In the Slovak Republic, third-country nationals are obliged to undergo a medical examination.

58. There is no mandatory testing in Switzerland. Compulsory testing and/or testing without the person's consent conflicts with Switzerland's prevention strategy in this area.

59. It is worth noting that women have more frequent access to HIV testing because of pre-natal examinations. HIV testing is systematically proposed to pregnant women (migrant or not) in order to avoid mother-to-child transmission. This results in more frequent HIV testing in women. In certain circumstances migrant women are not aware that they have been tested for HIV because of a lack of information from doctors or language barriers. This situation is not acceptable, as testing should not be carried out without women’s consent.

5.2. Best practices of HIV/AIDS prevention and treatment of migrants in European countries

60. As regards access to health care for regular migrants, several European countries offer free HIV treatment, as well as free STI treatment. In Latvia, free HIV testing and HIV treatment are only offered to European Union citizens.

61. Moreover, several countries provide HIV testing for undocumented migrants. According to the replies to our questionnaire, in some countries HIV testing and HIV treatment are free (Belgium, Croatia, France, Italy, Lithuania, Estonia, Poland, Spain and Russia), even if they often have to face the administrative barriers cited above. The main problem is that irregular migrants have no access to health-care insurance. In fact, in some countries testing and treatment for HIV depend on the access to health care more generally (Finland, Latvia, Netherlands, Romania and Switzerland).

62. Portugal has a very well developed legislation as regards non-discrimination of migrants and their access to health care. The parliament pays special attention to the problem of HIV; a Permanent Working Group for Problems of HIV/AIDS has been established in the Portuguese Parliament to tackle this problem. Antiretroviral drugs are considered so important that they are immediately available to everyone, including to undocumented migrants.

63. In 2012, after evaluating the costs over eight years of restricting treatment, the British Government decided to make HIV treatment free to anyone diagnosed with the HIV virus in England, regardless of their eligibility for National Health Service care.

64. In Ukraine, a State Programme on Prevention of HIV infection, treatment, care and support of HIV/AIDS patients for 2009-2013 was elaborated. Migrants are included as one of the vulnerable groups in the main tasks of this programme. As a result of its implementation, 92% of people living with HIV/AIDS receive State support in treatment and medical care. Nevertheless, more resources should be provided by the government on preventive measures and social support to vulnerable groups.

65. Civil society organisations play an important role in mobilising resources for treatment of people with HIV/AIDS across Europe. Many initiatives are taken, some small some large, but all contribute in their own way. In this respect, I would like to welcome, as an example, the initiative of the Ukrainian migrant organisation in Italy “Women for Peace, Culture and Development”, which collected €2 200 for the treatment of children with HIV during a charity concert in Rome.

66. In summary, policies concerning the prevention and treatment of HIV in migrants are very different depending on the countries. Although many countries have set up interventions and good practice specifically addressing the needs of migrants, more could be done to guarantee universal access to prevention and treatment.

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20. ECDC Technical report, Migrant health: HIV testing and counselling in migrant populations and ethnic minorities in EU/EEA/EFTA member States, Stockholm, 2009.

5.3. HIV/AIDS prevention and treatment programmes by international organisations in Europe

67. Several international organisations joined their efforts in the humanitarian response to the danger of the proliferation of HIV/AIDS in Europe. UNAIDS, WHO, the UNHCR, the International Organization for Migration (IOM), the International Labour Organization (ILO) and UNESCO have elaborated strategic plans and different co-operation programmes for migrants and their access to HIV protection, prevention, treatment, care and support.

68. The UNHCR, for example, developed a Strategic Plan for HIV and AIDS 2008-2012,[21] which outlined the overall objectives and main strategies to address HIV and AIDS within the UNHCR's mandate to protect refugees, internally displaced persons (IDPs) and other persons of concern. In co-operation with UNAIDS, this organisation also developed activities encouraging countries to remove travel restrictions based on HIV status.[22] The organisation also supports the capacity of national counterparts to ensure the integration of HIV into preparedness plans in disaster-prone areas. It is done through training and awareness-raising campaigns on the principles of HIV programming in emergency settings, in co-operation with national AIDS commissions, government disaster-management units and NGOs.

69. WHO has adopted the European Action Plan for HIV/AIDS 2012-2015, where one of the objectives is "to reduce the number of new HIV infections acquired through sexual transmission by 50%, including among men who have sex with men, in the context of sex work and among migrants".[23]

70. The European Commission also implemented an Action plan to combat HIV/AIDS for the period 2009-2013, in which it defined eastern European countries that are subject of the European Neighbourhood Policy as priority areas, and migrants from countries with a high rate of HIV-infected people as one of the three most affected groups. In the framework of this plan, a series of five reports was produced covering the epidemiology of HIV and AIDS; access to HIV prevention, treatment and care and HIV testing and counselling for migrants; issues related to infectious diseases, including HIV and migrants; and improving data comparability and definitions of migrants used within the EU/EEA/EFTA.[24]

71. Concerning EU/EEA countries, the EU European Centre for Disease Prevention and Control recently issued the "Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 progress report" which calls for improved availability of data on HIV prevalence among migrant communities, sufficient HIV programmes and services for migrant communities particularly affected by HIV, and additional steps to address the obstacles and difficulties that prevent migrants (in particular undocumented migrants) from accessing HIV services.

5.4. International development policy

72. There has been a huge increase in access to Anti-Retroviral Therapy (ART) in low- and middle-income countries, especially in Sub-Saharan African countries, since around the year 2000: ART coverage rates rose from 0% to 50% according to UNAIDS. ART are increasingly accessible and affordable in those countries. However, it also means that around 50% of people who are in need of treatment still cannot access ART, leading to 1.6 million deaths due to AIDS in 2012!

73. This huge progress has been made possible thanks to funds from high-income countries – including most of the Council of Europe member States. HIV/AIDS international funding mechanisms have to be considered as an efficient tool to promote universal access to HIV/AIDS treatment in low-income countries. Due to the burden of the epidemic in some of those countries – especially, in Sub-Saharan African countries – fighting HIV/AIDS is also an efficient way to alleviate economic and social inequalities which is a main pull factor for migration.

74. In this regard, it has to be said that the average yearly cost of ART treatment in developing countries is estimated at around US$100 per person. Even if there are partial or total patient fees, this yearly cost is less than the cost of a flight ticket to Europe.

75. Member States should increase funding for HIV/AIDS services in low- and middle-income countries in order to ensure effective universal access to treatment for those infected with HIV in those countries.

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21. UNHCR's Strategic Plan for HIV and AIDS 2008-2012.
22. HIV/AIDS and refugees, Executive Committee of the High Commissioner's Programme, 5 June 2012, EC/63/SC/CRP.16.
23. European Action Plan for HIV/AIDS 2012-2015, WHO, 2011.
24. Special Report, Monitoring implementation of the European Commission Communication and Action Plan for combating HIV/AIDS in the European Union and neighbouring countries, 2009-2013, ECDP, 2012.

6. Tackling fears and prejudices of society towards HIV/AIDS and migrants

6.1. The myth of health tourism

76. Some policy makers and health professionals intuitively believe that restrictive health policies might help enforce restrictive migration policies, even though all sociological evidence suggests the opposite. This belief is strongly linked to the idea of "medical tourism" (travelling across international borders to obtain highly specialised or less costly planned health care). Fearing that greater access to health care would represent a pull factor for migration, the issue of HIV/AIDS is sometimes used in this discussion.

77. Several studies show that the number of "medical refugees" – people that leave their country of origin because health care is not available – is very small.[25] Only 1.6% of respondents to a 2012 Doctors of the World survey in seven European Union countries cited health as one of their reasons for migration.[26] Furthermore, as we know, one of the main barriers to health care for migrants in host countries is the lack of knowledge about the health and insurance system. One can then assume that migrants coming from developing countries do not take into account the degree of available health care in a particular region; the migration decision-making process is complex, guided by the local informal economy (for example job availability) and the presence of members of the same community (social capital and processes of chain migration), amongst other considerations. For many migrants their final destination is unknown when they start their journey.

78. In other words, when looking at these data, access to health care clearly does not present a pull factor. Restrictions on accessing care do not impact on a migrant's decision on where to settle. Furthermore, the levels of HIV amongst migrants to Europe are in general significantly below HIV levels in their countries of origin. This can be explained by what migration specialists call the "healthy migrant effect" – a process of self-selection where only the healthiest in a society migrate.

79. In conclusion, one can say that there is no evidence to support claims of HIV "health tourism". Furthermore, providing free access to health services for migrants and refugees does not appear to lead to this phenomenon of "health tourism".

6.2. Consequences of the global financial crisis

80. Europe is facing one of the deepest financial crises of its history. The burden of public debt and budget constraints are felt most strongly in southern European countries. This situation leads to scarcer resources in general and cutbacks in national budgets, including for health-care systems. We face the risk that some great achievements in the global fight against HIV/AIDS in Europe over the past ten years could be reversed by short-term cost-saving policies.

7. Conclusions

81. Although precise epidemiological data on migrants' health is generally lacking throughout Europe, evidence in many countries suggests that migrants are disproportionately affected by HIV. This is either due to the high HIV prevalence in their country of origin or the lack of accessible prevention, testing and treatment for HIV in their host countries. Member States of the Council of Europe can directly improve the high infection rate in migrant communities in Europe through specific legislative, political and social measures.

82. First of all, European countries should improve the availability of quantitative and qualitative data on HIV among migrant communities through partnerships with international institutions such as WHO Europe, the ECDC and UNAIDS. More information is needed on particularly vulnerable migrant groups including women and children, (male and female) sex workers, men having sex with men, drug users, prisoners and finally migrants with a precarious or irregular residence status (asylum seekers, undocumented migrants and refugees).

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25. For instance, for an overview see T. Faist (1997), The Crucial Meso-Level. In T. Hammar, G. Brochmann, K. Tamas and T. Faist (Eds.), *International Migration, Immobility and Development. Multidisciplinary perspectives* (pp. 187-218). Oxford, Berg. Accessible online via Google Books. Furthermore, travel from industrialised to less-developed nations is much more common – see Nicolas P. Terry, Under-regulated health care phenomena in a flat world: medical tourism and outsourcing. 29 W. New Eng. L. Rev. 421 (2007), http://digitalcommons.law.wne.edu/lawreview/vol29/iss2/6.

26. Access to health care in Europe in times of crisis and xenophobia, April 2013, Chauvin P., Simonnot N. and Vanbiervliet F., Doctors of the World.

83. Secondly, it is important to ensure that HIV prevention and treatment services are sufficiently provided for migrants and are affordable, especially for particularly vulnerable migrant groups. Special mention needs to be made of undocumented migrants living with HIV/AIDS who do not have effective access to health care in their country of origin and/or in their country of residence. They should have free access to treatment in Europe and be guaranteed the legal protection against expulsion and detention, which constitute serious human rights violations. European countries should revise their legislation with the aim to alleviate all legal and administrative provisions which hamper effective HIV/AIDS prevention and treatment among migrants (including asylum seekers and undocumented migrants). Steps should also be taken to address linguistic, social and financial obstacles to services. Voluntary and anonymous HIV testing, counselling, affordable treatment, as well as sex-education and awareness-raising programmes should be universally accessible.

84. Furthermore, member States should ban all remaining entry and residence restrictions as well as detention practices specifically related to HIV: they are considered inefficient, ineffective and even dangerous to public health by international experts and they constitute a serious human rights violation.

85. Specific measures can be undertaken to protect migrants living with HIV/AIDS from discrimination and stigma. Member States can introduce measures to guarantee effective access to the labour market, to housing, education and health care for migrants living with HIV (and their families).

86. Member States should consider the necessity to have a national plan (strategic framework) to fight HIV/AIDS with a specific section on migrants and the vulnerable migrant groups cited above, with input from migrants living with HIV/AIDS and civil society organisations.

87. Finally, European countries can contribute to improving substandard antiretroviral treatment coverage in developing countries through international funding programmes as a long-term strategy.