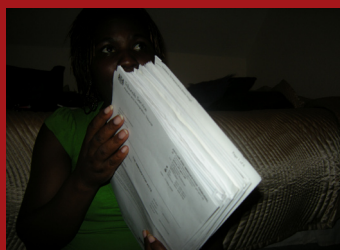


# FROM A DESTINATION UNKNOWN

## TO A SAFE PLACE

IMMIGRATION CONTROL AND PEOPLE LIVING WITH HIV: NEW POLICY PERSPECTIVES



**From a Destination Unknown to a Safe Place:** Immigration control and people living with HIV: new policy perspectives

An African HIV Policy Network position paper <sup>1</sup>  
2009

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We would like to thank all those individuals and organisations that have offered their support, help and expertise by contributing to this paper through a public consultation process involving our member organisations.

We would like to extend a special thank you to the following people for their extensive feedback and help: Dr. Catherine Dodds - SIGMA Research, Neil Gerrard - MP/Chair for APPGR, Joe Murray - NAT, Veronica Oakeshott - APPGA, Mel Steel - THT

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<sup>1</sup> This paper is based on a draft commissioned by the African HIV Policy Network from Richard Stanton. Note that *italic font* in this paper indicates direct quotation from documents, or their titles.

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## ***From a Destination Unknown to a Safe Place***

Immigration control and people living with HIV: new policy perspectives

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# Part A: Introduction and context

## 1. Introduction

People can live with HIV for a lifetime as active and productive members of society, given the right framework of treatment and support. This includes timely access to antiretroviral (ARV) drug therapy, tailored to their body's needs; stable living conditions; and regular healthcare to safeguard them against HIV-related illness. Interrupting HIV treatment exposes them to serious risks, as they may become resistant to their ARV drugs. Removing them from it altogether may mean early death, with life expectancy no more than 11 years – as a world-wide average – for HIV-positive people without ARV therapy.

The framework of treatment and support needed by people living with HIV is usually available to them in the UK, once they are diagnosed. In many parts of the world it remains available only to a minority of those who need it, and in some countries to hardly any.

For a decade from the mid-1990s, informal Home Office policy allowed a foreign national being treated for HIV to stay when their application to live in the UK was rejected - if, because of HIV and AIDS, their removal from the UK would have substantially shortened their lives.<sup>1</sup> The number of removals of people living with HIV from the UK was relatively low. But it was a fragile policy relying on ministers' discretion. In 2005 the House of Lords ruled (*N v Secretary of State for the Home Department* [2005] UKHL 31) that these migrants were not in general protected from removal by the European Convention on Human Rights, transposed into UK law by the Human Rights Act 1998.<sup>2</sup> Removals increased, with potentially serious consequences for individuals and communities.

In spring 2008 the African HIV Policy Network (AHPN) - a strategic umbrella organisation representing African communities UK-wide affected by HIV - launched a national campaign entitled *Destination Unknown*, calling on the Home Office to *delay the deportation of people living with HIV from the United Kingdom until antiretroviral treatment becomes more widely available and accessible*. In the light of major developments during 2008 in law and policy bearing on the debate about immigration controls and HIV status, this paper aims to

- explore key current issues in this policy area
- inform AHPN's decisions about how best to continue pursuit of its *Destination Unknown* objective.

The paper's main concern is not with people currently applying to stay in the UK - for example to get asylum, join family, study or work - nor with the issue of fees for HIV treatment which the NHS now charges to some migrants. The latter issue, though closely linked to this paper's theme, is separate from it.

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<sup>1</sup> For consistency with current legal definitions, *removal* is used generally in this paper to denote the forced return of a migrant to country of origin after failure of an application for leave to remain in the UK. Since 2000, *administrative removal* has been the Home Office term for this standard return procedure. *Deportation* has been reserved for cases where the returnee's presence in the UK is considered against the public interest (and/or they have been convicted of an offence punishable by imprisonment). Unlike removal, a deportation order bans them from re-entering the UK. The draft Immigration and Citizenship Bill before Parliament in 2008/09 reverts to a single term - *expulsion* - for both categories.

<sup>2</sup> *Migrant* means here a long-term international migrant as defined by UN and ONS: that is, anyone moving to a country other than that of his or her usual residence for 12 months or longer. The term thus includes asylum seekers and refugees.

Our focus here is on what happens to migrants living with HIV and accessing treatment, when their application to stay in the UK is found by the Home Office not to meet current criteria for 'leave to remain', and they have exhausted all appeal rights. Rejection of their claim does not necessarily mean they have been dishonest or done anything illegal. It means only that, in the eyes of UK authorities when they reached their decision, a positive outcome was not justified by the facts of that person's claim (including conditions in their country of origin) looked at in terms of prevailing law and judicial interpretation<sup>3</sup>.

Accepting that the Government has a duty to operate immigration controls within this current legal framework, the paper asks: are there legal obligations on the UK state that should override its immigration duties, where HIV-positive migrants face removal to countries of origin? Even if there is no countervailing obligation in law, are there other compelling reasons why the Home Secretary should use discretion in these cases to make sure no-one on HIV treatment has to undergo the trauma and risks of forced removal?

The next section outlines parallel trends in migration, UK immigration controls and the HIV and AIDS epidemic that have set the context for this debate. Section 3 summarises what is known about the number of people whose treatment, or removal, may be at issue. Then in Part B, sections 4 to 7 look at the policy framework for these aspects of the debate:

- public health, development and HIV at global level
- HIV strategy in the UK: Government aims
- immigration control: new phase
- HIV and Home Office removal policy: alternative perspectives

Part C of the paper concludes that the AHPN campaign can reconcile Government policy with its aims by promoting a scheme of *agreed, safe and sustainable resettlement (ASSURE)* in country of origin for HIV-positive migrants without regular status who opt for it - based on informed consent, doctors' judgement and dialogue between NHS clinicians and counterparts in the country to which the migrant returns. It is now vital to stop using force as a means of applying immigration rules to migrants living with HIV, not only to safeguard the health and wellbeing of people living with HIV but UK-wide public health as such.

## 2. Context: migration, UK controls and the HIV epidemic

**Migration:** For the UK as for countries world-wide, the past two decades have seen a steady rise in the number of migrants living within its borders. From 1991 to 2001 the UK's foreign-born population grew by almost 1.1 million, far more than in any previous decade.<sup>4</sup> Official estimates suggest that in the UK by 2007/08

- people born abroad numbered 6.4 million, over one in ten of all UK residents
- nearly four million or 60% of these migrants were born in poorer countries of the world
- around one million had been born in Africa, mostly south of the Sahara (including a large minority of white migrants).<sup>5</sup>

These trends are driven by a mix of powerful factors affecting all regions of the world: globalisation of social relationships, economic activity and communications, together with political instability and growing international inequality. Reasons why migrants come to the UK are accordingly diverse: to seek protection from danger and persecution as refugees, join family, study or find work – often to support families they left behind.

<sup>3</sup> On the debate about conditions in countries of origin, see African HIV Policy Network, *Completing the Picture: an examination of the Home Office's country reports on the availability of HIV treatment in Zambia, Malawi, Uganda, South Africa, Nigeria and Zimbabwe* (2008) and discussion in Section 7.2 below.

<sup>4</sup> Office for National Statistics (ONS), *Focus on People and Migration* December 2005.

<sup>5</sup> Estimates drawn from ONS *Population by country of birth and nationality* (2008). See Annex A at the end of this report for further detail of these estimates. ONS source is at <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15147>

**Controls:** Successive governments have sought to curb the rise in international migration to the UK. Responding to vocal public concern, they have since the early 1990s steadily tightened controls in a sustained effort to stem flows of immigrants including asylum seekers.<sup>6</sup> The attempt to combat a long-term migratory trend with increasingly tough controls has - on available evidence - resulted in a sharp rise in the number of *irregular migrants* who find themselves in breach of immigration rules.

**HIV epidemic:** Through the same two decades which saw major global change in the movement of people between countries, the world has also witnessed an epidemic of unprecedented scale and severity – that of HIV and AIDS. World-wide since 1990, on UNAIDS estimates, the number of people living with HIV has risen more than four-fold to reach 33 million in 2007.

Sub-Saharan Africa bears the brunt of this massive challenge. In 2007 some 22 million of its residents lived with HIV, two-thirds of the global total.<sup>7</sup> HIV prevalence among adults in 2007 ranged from below 2% in some West and Central African countries and in the Horn of Africa, to more than 15% in seven countries of southern Africa.<sup>8</sup>

**Outcome:** Over the past 20 years there has been strong growth in immigration to the UK and a tightening of immigration rules. There has also been a rise in the numbers of people living with HIV globally. This has left some migrants with HIV caught between the law and health needs of the utmost urgency. Though their numbers are small, this paper suggests, forcible removal of HIV-positive migrants with no assurance of continued therapy puts at risk not only their own well-being and dignity - and ultimately their lives - but also much wider goals of public health and development.

### 3. UK immigration and HIV: the question of scale

By 2007 - on best available estimates by the Health Protection Agency (HPA) - 77,000 people were living with HIV in the UK. For more than a quarter it was undiagnosed, while 57,000 people in whom it had been diagnosed were accessing HIV-related care.<sup>9</sup>

Estimated rates of HIV prevalence and diagnosis in 2007 are not available by any migrant category, at the time of writing. Such rates have however been published for people born in Sub-Saharan Africa, for 2006. If we assume that rates for this regional category relate to rates for total HIV-positive population in the same way in each year, we can infer an approximate number of Sub-Saharan African migrants living with HIV in the UK in 2007. On this basis, they would have numbered over 26,000 in that year. Applying HPA estimates that generally the condition is undiagnosed in over a quarter of cases, roughly 19,000 UK residents born in Sub-Saharan Africa might have been diagnosed as HIV-positive by 2007.<sup>10</sup>

Allowing also for possible HIV prevalence among people from other ethnic groups or regions of birth, we can reasonably infer that the total number of migrants living in the UK with diagnosed HIV in 2007 was probably between 20,000 and 25,000.

It is difficult to know how many migrants who are living with HIV are liable for removal from the UK, since we have no information at all on the country's undocumented migrant population. Any estimate must be mostly guesswork. It is nevertheless worth suggesting a plausible range for it, to understand what order of magnitude is under discussion when Government frames its policy on the issue.

6 Among the few exceptions to this long-term policy trend, was the decision to admit EU Accession State nationals to the UK labour market in 2004.

7 UNAIDS 2008 Report on the Global AIDS Epidemic (2008) p.32.

8 The seven higher-prevalence states are Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe. Source: UNAIDS (2008) op.cit. p.39

9 Health Protection Agency, *HIV in the United Kingdom: 2008 report* (November 2008) p. Note that HPA estimates of prevalence and rates of HIV diagnosis, cited in this section, are subject to wide margins of error.

10 Ibid: November 2009

The only official attempt at assessing the size of the UK '*unauthorised migrant population*' was a notional estimate for 2001 by the Home Office. Rolling this forward in line with growth in reported migrant population, a tentative best guess would be that roughly 12% of all UK migrants were here in 2007 without current permission. (See Annex A.) There are no grounds for supposing those living with HIV differ in this respect from other migrants.

The implication is that in 2007 between 2,400 and 3,000 UK residents, born abroad and diagnosed HIV-positive, might have faced the risk of removal from the UK because the Home Office had decided that they had no valid case for remaining here. Applying the standard assumption on typical unit cost of HIV treatment, the implied total cost to the NHS of helping them to stay well as UK residents was somewhere between £31m and £47m per year. The upper figure would have been 0.06% of its £72.5 billion net operating costs for 2007/08 – that is, just over half of one-thousandth of the Service's total net spending.<sup>11</sup>

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<sup>11</sup> See Annex A. NHS operating cost from Department of Health *Resource Accounts 2007-08* (Oct. 2008) p.43.

# Part B: Policy framework

## 4. Public health, development and HIV at global level

### 4.1 Millennium Development Goals

Drawn from a declaration endorsed by a large proportion of the UN's member states at its Millennium Summit in 2000, the Millennium Development Goals (MDGs) focus international effort on achieving major development milestones in poorer countries of the world by 2015, in particular to help eradicate poverty, hunger and disease. The UK Government has pledged this country to work with the UN for these Goals.

Among them is the commitment to *Combat HIV and AIDS, malaria and other diseases*. Three targets were agreed to implement it, both for HIV and AIDS and for other major diseases (malaria and TB). The second - Target 6b of the Millennium Development Goals - is to *Achieve, by 2010, universal access to treatment for HIV and AIDS for all those who need it*. To measure progress towards this goal, the following indicator was adopted: *Proportion of population with advanced HIV infection with access to antiretroviral drugs*.<sup>12</sup>

In 2005 at Gleneagles, G8 leaders agreed a UK proposal to reaffirm the MDG target of universal access to treatment for HIV and AIDS. The following year its definition was broadened beyond the issue of treatment by a UN General Assembly High Level Meeting, so that in 2008 the UK Department for International Development (DFID) declares the UK's commitment, *along with the entire international community, to intensify our work towards achieving the goal of Universal Access to comprehensive HIV prevention programmes, treatment, care and support by 2010*.<sup>13</sup>

But how far can the Millennium Development Goal commitment to universal access be used to challenge Home Office policy on removing irregular migrants who are being treated for HIV in the UK? It has of course to be recognised that:

- MDGs and their targets are political pledges with no statutory force
- at both UN and national level, it has always been clear that these are goals for securing change in developing countries - as indicated for instance by the title of DFID's 2008 strategy on achieving the HIV and AIDS universal access objective (see footnote 12).

Nevertheless the universal access principle would seem to imply responsibility for treatment and care of those living with HIV within the jurisdiction of an MDG signatory state. Thus the African HIV Policy Network *believes that there is a clear contradiction between the UK's policy aim of universal access to HIV treatment for all those who need it by 2010 and the deportation of people living with HIV who are on treatment to countries where treatment is not readily available or affordable*.

Whether Home Office policy on removals can be reconciled with the UK's commitment to universal access has also been questioned by the House of Commons International Development Committee, scrutinising UK action globally on HIV and AIDS. Voicing concern in 2005 at lack of coherence between Government departments in this field, the Committee called for DFID to be given a role in helping to shape UK policy on the removal of irregular migrants, especially rejected asylum seekers: *We were concerned to hear that the Home Office only "occasionally" consults DFID and the FCO regarding the availability of ARVs in countries to which they propose to deport individuals living with HIV*.<sup>14</sup>

<sup>12</sup> See <http://www.undp.org/mdg/goal6.shtml>. Source document's terminology ('HIV/AIDS') is amended here in line with current good practice.

<sup>13</sup> DFID, *Achieving Universal Access – the UK's strategy for halting and reversing the spread of HIV in the developing world* (2008), p.13

<sup>14</sup> House of Commons Select Committee on International Development, First Report of Session 2005-06, *Delivering the goods: HIV/AIDS and the provision of*

Again in 2006, referring to the universal access goal, the Committee challenged Home Office policy towards rejected asylum seekers who need HIV treatment.<sup>15</sup> Though its comments here were mostly about charges for NHS treatment within the UK, its closing recommendation adds a reference to removal: *We believe that DFID should play a role in ensuring that asylum seekers living with HIV are not returned to countries where access to ARVs is not practical.*

Equally significant was the Committee's broader view that work with marginalised groups plays a key part in global strategy to tackle HIV and AIDS: *To combat epidemics effectively, the rights and needs of those most at risk must be as central to strategies as are treatment and prevention.*

## 4.2 International treaty obligations

The UK was among the first signatories of the International Covenant on Economic, Social and Cultural Rights, which came into force in 1976.<sup>16</sup> Its Article 12 (1) requires states to *recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. This broad principle was given more concrete interpretation in 2000, in a striking commentary by the UN Committee on Economic, Social and Cultural Rights. Article 12(1) means, it said, that *States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services.*<sup>17</sup>

The Covenant has never (so far as is known) played any effective part in the adjudication of immigration cases in the UK, and its limitations have to be recognised:

- many signatories have entered wide-ranging reservations to their endorsement of it
- the UN Committee notes that it allows for *progressive realization and acknowledges the constraints due to the limits of available resources*, making clear that it is in part a set of aspirations towards long-term goals.<sup>18</sup>

Nevertheless the Covenant, as interpreted by the UN, does inscribe in international law the far-reaching principle that states should be working to ensure that all social groups - including migrants without regular status - have equal access to health prevention and care services. The principle was pursued in 2008 by UNAIDS, representing all UN agencies involved in action to tackle HIV and AIDS, in a briefing issued jointly with the International Labour Organisation (ILO) and International Organisation for Migration (IOM).<sup>19</sup> Asking how the Millennium Development Goal can be realised for labour migrants living with HIV and referring to the International Covenant, these key global institutions comment:

*International labour migrants have the same human rights as everyone else ... To maintain productivity and reduce risk of HIV transmission they need access to culturally and linguistically appropriate HIV programmes in origin, transit and destination countries ... prior to departure, on arrival, during stay in the destination country, and upon return and reintegration into the countries of origin. States retain the sovereign right to determine who enters their country.... Yet international labour migrants, whether in regular or irregular status, should have the same human right to health as nationals.*

*anti-retrovirals* (November 2005) para.10. <http://www.parliament.the-stationery-office.co.uk/pa/cm200506/cmselect/cmintdev/708/70805.htm#a5>

<sup>15</sup> House of Commons International Development Committee, Second Report of Session 2006-07 Vol.I, *HIV and AIDS: Marginalised groups and emerging epidemics* (November 2006). Following quotes from pp.17 and 3 respectively. <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmintdev/46/4602.htm>

<sup>16</sup> Text of the Covenant is at <http://www2.ohchr.org/english/law/cescr.htm>

<sup>17</sup> UN Economic and Social Council / UN Committee on Economic, Social and Cultural Rights, *The right to the highest attainable standard of health : 11/08/2000. E/C.12/2000/4, CESCR General comment 14* (Geneva), para.34

<sup>18</sup> Ibid

<sup>19</sup> UNAIDS Policy Brief [with ILO/IOM] *HIV and International Labour Migration* (Aug.2008). Following quotes are from pp.3-4. See [http://data.unaids.org/pub/Manual/2008/jc1513a\\_policybrief\\_en.pdf](http://data.unaids.org/pub/Manual/2008/jc1513a_policybrief_en.pdf)

Among migrants living with HIV in the UK and at risk of removal, many have come to find work. Particularly significant for our analysis of UK Government options in handling such cases, therefore, is the strong message to governments from UNAIDS, the ILO and the IOM that responsibility to these HIV-positive migrants must extend through the successive stages of migration. Governments, they urge, should *Integrate HIV prevention, treatment, care and support programmes into pre-departure, postarrival and return and reintegration processes.*

The Millennium Development Goal of universal access to programmes of HIV prevention, treatment, care and support is thus powerfully underpinned by the UK's commitment – over more than three decades – to an International Covenant which calls for integrated action to promote better health, across borders and for migrants regardless of legal status.

### 4.3 UK policy at global level: health, development and HIV

In line with this principle of the International Covenant, the Government published in 2008 a five-year cross-departmental Strategy aimed at enhancing the UK contribution to *improving health around the world* through a clear, coherent and coordinated approach to the many issues that influence global health.<sup>20</sup> Key themes in this Strategy, **Health is Global**, are as follows:

- better health should be a priority aim for UK work on international development
- it links with other basic development objectives like poverty reduction, trade and security
- joint work in Government and internationally is vital to make the most of such linkages.

The last point is spelt out in particularly clear terms by the Strategy, itself published as a cross-departmental statement by the Government:

*A globalised, interdependent world, characterised by the increasing movement of individuals and populations – and where disease recognises no borders – means that health has become a global issue. ... improving health around the world requires co-operative actions and solutions. This means creative, joined-up partnership both between UK government departments, and between the UK Government and a host of other partners ...*

*To be most effective in our work on global health, and to make the most of opportunities to improve UK health, we need a consistent and joined-up approach across government. A more coherent approach can also raise awareness of any unintended adverse effects of UK government policy, and highlight policies that conflict with efforts to improve global health. ... To help reduce policy conflicts, the Department of Health (DH) will support other departments in preparing global health impact assessments, which describe the global health impact of their foreign and domestic policies.*

This call for coordinated action on global health has clear implications for the Home Office approach to migrants living with HIV. Already in 2005 and 2006 the link had been made by the House of Commons **International Development Committee** (see sec.5.1), scrutinising the UK's international response to HIV and AIDS. In 2006 for example, after addressing the removal from the UK of asylum seekers living with HIV, the Committee went on to argue that promoting the goal of universal access was not a task for DFID alone but must be put explicitly on the agenda of other Government departments - including the Home Office:

*We are concerned that [the 2004 document] Taking Action, although billed as the UK strategy on HIV/AIDS in the developing world, is in reality only the strategy of DFID. We recommend that DFID work closely with other Departments, particularly the FCO [Foreign and Commonwealth Office] and the Home Office, to develop a truly integrated strategy for the UK's action on HIV/AIDS internationally. This should draw ... the Home Office into broader UK advocacy of the international goals on HIV/AIDS, such as universal access to treatment.*

<sup>20</sup> HM Government, *Health is global: a UK Government strategy 2008-13* (2008). Quotes from pp.7, 15, 17. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_088702](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702)

The same linkage between Government objectives - development, health and better coordination by public authorities - emerges also from a major report commissioned by the Prime Minister from Lord Nigel Crisp in 2007 to consider *how the UK's experience and expertise in health could be used to best effect to support developing countries*.<sup>21</sup> Responding to this **Crisp report**, the DH and DFID agreed that a Framework should be developed that includes not only the NHS, but also all departments of health in the UK, arm's length bodies, and UK healthcare training institutions ... [It will include] Government recognition that NHS and other participation in international development is legitimate and part of the UK Government's overall commitment to scaling up international development.

DH and DFID go on to commit the Government to creating as soon as possible a UK International Health Links Centre, to act as a 'one-stop-shop' to act as an information and knowledge manager for UK and developing country organisations.<sup>22</sup>

From Millennium Development Goals to the Crisp report and *Health is Global* strategy, none of these statements about world development and health – including HIV – will in themselves override UK immigration policy. It is striking for instance that *Health is Global* (unlike the Chief Medical Adviser's consultation document which preceded it) hardly mentions the health of asylum seekers or other migrants.<sup>23</sup> But two principles emerge from them which bear directly on the treatment of HIV-positive migrants. The first is that the UK has an interest in taking responsibility, within available resources, for promoting the health of developing-country citizens as a key element of international development. The second is that this aim can be achieved if only all branches of Government pursue it together.

## 5. Policy framework: HIV and public health in the UK

### 5.1 HIV strategy in the UK – Government aims

The UK's relative success so far in addressing the HIV and AIDS epidemic has been achieved by combining clinical expertise with systematic work to address the wider context in which people acquire and live with HIV. In its current ten-year *National Strategy for Sexual Health and HIV*, running to 2011, the Department of Health focuses on work at behavioural, social and institutional levels.<sup>24</sup> It sets four main goals:

- reduce **onward transmission** of HIV, recognising its heavy long-run cost to individuals, public services and society
- reduce the prevalence of **undiagnosed HIV** by increasing takeup of HIV testing - both to lessen risks of onward transmission, and to get treatment started as soon as possible after infection which means lower mortality; better prospects of successful antiretroviral (ARV) therapy; and thus lower cost to health services<sup>25</sup>
- improve overall **health and social care** for people living with HIV, including
  - regular contact with primary care services
  - steps to promote their social inclusion, recognising that social links and stable living conditions help them to maintain complex drug regimens and good nutrition; deal with HIV's psychological impact; and play a positive role at work or in communities
- tackle **stigma** attached to HIV infection - a key to success in achieving the other goals.

In line with this holistic approach, the National Strategy also lays emphasis on

- targeting **groups and communities** at greatest risk, or with poorest access to services

<sup>21</sup> Lord Crisp, *Global Health Partnerships: The UK contribution to health in developing countries* (DH 2007) [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh\\_065374](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_065374)

<sup>22</sup> Department of Health and Department for International Development, *Global health partnerships: the UK contribution to health in developing countries - the Government response* (March 2008), pp. 15-16.

<sup>23</sup> HM Government, *Health is global* (op.cit 2008). It mentions migrants only in very brief references to 'managing' their health, and to possible health screening for new arrivals.

<sup>24</sup> Department of Health, *Better Prevention, Better Services, Better Sexual Health: the National Strategy for Sexual Health and HIV* (2001)

<sup>25</sup> British HIV Association, British Association for Sexual Health & HIV, British Infection Society, *UK National Guidelines for HIV Testing* (2008)

- partnerships that include **third sector bodies** linked to 'priority population groups', to help the NHS plan and commission HIV services and increase take-up of testing.<sup>26</sup>

Progress in carrying out this Strategy is monitored by the Independent Advisory Group on Sexual Health and HIV. Its in-depth progress report in 2008 reaffirms the Strategy's vision of *holistic sexual health and integrated care, based on patient need*,<sup>27</sup> and its core aims for HIV work (above). But the Group recommends adding a fifth goal: to improve sexual health and well-being, which again is about addressing perceptions, relations within communities and with services. The Group calls also for *a holistic approach ... to meet the needs of those vulnerable to multiple negative health outcomes, including people seeking asylum and other migrants*.<sup>28</sup>

From strategic work by the DH and its advisory body, a key policy message thus emerges: the UK's continued progress in tackling HIV will depend on people in high-prevalence groups feeling able to connect readily and consistently with the NHS and other health promotion agencies, including local authority and third sector services. This relationship with agencies must not only engage individuals - living with HIV or not, diagnosed or otherwise. Crucially it should extend also to community groups and networks around them, which are a major source of guidance on living with HIV and play a vital part in overcoming stigma and discrimination.

## 5.2 Key challenges

Despite some striking progress, the UK effort to tackle HIV still falls well short of National Strategy goals. Health Protection Agency (HPA) data show that

- the number of newly-diagnosed cases of infection continues to rise year on year
- HIV remains undiagnosed in a large minority of people living with the infection.

How far the UK's migrant communities generally are affected by HIV cannot be established from available data. But Black African communities, and especially people born in Sub-Saharan Africa, are clearly far more affected by HIV and its effects than any other major UK population group except men who have sex with men.<sup>29</sup> In the great majority of cases, it is reported to have been acquired by heterosexual contact in Africa. HPA estimates suggest

- people born in Sub-Saharan Africa make up 34% of all those living with HIV in the UK
- among heterosexuals attending sexual health clinics in 2006, the rate of previously undiagnosed HIV stood at 2.6% for those born in Sub-Saharan Africa or one in 40, which was 15 times higher than the rate observed for attendees born in the UK
- among women giving birth in the UK in 2007, HIV prevalence was one in 40 for those born in Sub-Saharan Africa, compared with fewer than one per 1000 for the UK-born
- new infections in these communities from heterosexual contact in the UK appear to be rising sharply, though absolute numbers are still low
- 42% of black Africans with HIV in the UK are diagnosed late (as indicated by CD4 count, a standard measure of loss of immunity).

The Department of Health and Health Protection Agency make clear that, together with men who have sex with men, black Africans - and especially migrants from Sub-Saharan Africa - are now the priority

<sup>26</sup> See for instance Department of Health (2001) paras. 4.45, 4.47, 4.67, 4.70, 5.3.

<sup>27</sup> Independent Advisory Group on Sexual Health and HIV, *Review of the National Strategy for Sexual Health and HIV* (by Medical Foundation for Aids and Sexual Health, July 2008), p.6

<sup>28</sup> Independent Advisory Group on Sexual Health and HIV (2008) pp.47-48

<sup>29</sup> Following points drawn from: UK Collaborative Group for HIV and STI Surveillance, *Testing Times: HIV and other Sexually Transmitted Infections in the United Kingdom: 2007*, (London: Health Protection Agency, Centre for Infections, November 2007); and Health Protection Agency, *Sexually Transmitted Infections in black African and black Caribbean communities in the UK: 2008 report* (November 2008). The HPA does not define 'black African' but appears to have adopted the term from the Census, where - like all ethnicity categories - it refers to the way people opt to identify themselves and may therefore include UK-born residents as well as migrants. For this reason, quite apart from broader geographical coverage, the number counted as 'black African' may vary considerably from Sub-Saharan migrant population.

for HIV prevention work in the UK. Reversing the advance of HIV in the UK will mean a determined effort to follow through the holistic approach of the Government's National Strategy (5.1 above) with this vulnerable population. Without it, there is little prospect of building awareness and confidence as urged, for instance, by the Head of the HPA's HIV Unit in response to new evidence of late diagnosis: *HIV is a serious infection and the fact that such a high percentage of black Africans are getting diagnosed late highlights the need for raised awareness in this community. People need to know that testing for HIV and all sexually transmitted infections is both free and confidential at Genitourinary Medicine clinics ... across the UK*<sup>30</sup>

### 5.3 HIV strategy and immigration control

As HIV prevention work with African migrants has moved up the national agenda, its connection to their experience of immigration control has become increasingly clear.

Among the earliest surveys of the needs of African-born people living with HIV in the UK was **Project Nasah**, commissioned by a consortium of agencies including the AHPN in 2002-03 (when the immigration regime was more tolerant in HIV cases than it is today). In interviews with 435 of these people in London, Manchester and Leeds/Bradford, the Project Nasah team asked them to indicate 'problem areas' in their lives over the preceding year. Among the top five issues, three related to psychological life: anxiety and depression, sleeping and self-confidence. But the practical or material difficulty which respondents identified most frequently - after lack of money - was immigration status, cited as a problem by 55% of them. Referring to the salience of immigration status in their lives, the report concludes that *The impact of migration on HIV-related need is pervasive, and especially common among those African people with HIV that have been resident in the UK for the shortest period of time.*<sup>31</sup>

The same message emerges from the **BASS Line project** in 2007, the largest survey to date of HIV prevention needs of people in England identifying themselves as African.<sup>32</sup> Conducted with partner agencies in the National African HIV Prevention Programme<sup>33</sup>, it covered more than 4100 people with both positive and negative HIV status, 90% born in Africa. In exploring information needs, respondents were asked for their reaction to the statement *'Africans are NOT deported from the UK solely because they have HIV'*. Almost two in five (37%) said they had not known this or were unsure if it was true.<sup>34</sup> The report adds: *Our collaborators felt that a major impediment to uptake of HIV testing was the false belief that Africans are deported from the UK if they are found to have HIV... Where individuals know or think they have HIV, misinterpretations such as these are likely to affect their judgement about discussing HIV openly and accessing HIV-related services.*

Still more vividly, recent **testimony to the AHPN** by African women and men living with HIV in the UK illustrates the potential impact of immigration control – and perceptions of it – on migrants' efforts to manage the infection and build successful lives with it.<sup>35</sup> Given as sworn affidavits, their testimony includes the following comments:

- Woman, aged 44, Rwanda: *I moved from Manchester because I am scared and I can't sleep in my accommodation. I went to friends. Last time I was like that I ended up in crisis, I lost my head. I felt paranoid that everyone was looking for me. I fear for my health because of my immigration status, and it affects my doctor. If you are HIV people it has a negative impact. What is life, living on medication, what if I abandon everything? What happens if I return and my health will deteriorate? Some people may*

30 Dr Barry Evans, Consultant Epidemiologist - quoted HPA Press Release 4 Nov 2008.

31 P.Weatherburn, W.Ssanyu-Sseruma, F.Hickson, S.McLean, D.Reid *Project Nasah: an investigation into the HIV treatment information and other needs of African people with HIV resident in the UK* (Sigma Research / NAM / NAT / AHPN, February 2003), pp.21, 42

32 Sigma Research *Bass Line 2007 survey: Assessing the sexual HIV prevention needs of African people in England* (Portsmouth, 2008). At <http://www.sigmaresearch.org.uk/go.php/reports/2008b>. This study, like the Census, reports ethnicity as self-identified by respondents. Some 8% of them were UK-born, and 2% white.

33 The survey was conducted in with 96 collaborating agencies, including NAHIP partners

34 Derived from data in Sigma Research (2008) op.cit p.33. Excludes the small proportion who said they did not understand the question.

35 These cases will be available in African HIV Policy Network, [forthcoming publication], 2009

*think that taking ARVs is like taking normal pain-killers, I know what is involved – the monitoring and the access issues. My health choices are already limiting me in the UK, I don't want to think about what would happen in Rwanda. My support network of organisations and people who have become like my family here. I don't know where to go in Rwanda. Here I have a counsellor, support groups that I hold and attend, and my church. I belong to a community that supports me. They support me and I also support them.*

- *Woman, aged 40, South Africa: I do not know as the Home Office told me to go back as there is treatment in my home country. I know people back home are dying, Home Office is difficult to deal with. I am very afraid of removal. I cannot sleep if I hear someone has been detained. I sometimes do not sleep in my house in case Home Office comes for me. I am concerned that if I am returned to South Africa ... I will need HIV treatment in future which I will not afford. It means I will die.*
- *Man, aged 37, Zimbabwe: I take antiretroviral drugs and I am able to live a reasonably normal life but maybe the government could change its mind because of my immigration status. ... The immigration process has had a very negative impact on my confidence as a person. I cannot do what I am capable of doing – teaching mathematics or physics or working for an insurance company. This is all hindered by my immigration status. My feeling is that my health status could have a negative effect on the decision-making process at the Home Office. They think I am a health tourist ... I am concerned about removal. I have heard of people who have been detained; they are unable to take their medication. I have heard of abuse such as being handcuffed like criminals or terrorists. I feel criminals are not treated like that.*

This growing body of evidence confirms a direct conflict between the Government's plans for forcible action to apply the UK immigration regime, and key elements of its National Strategy to tackle one of the country's most serious public health risks - the continuing advance of HIV. To bring into focus the way this conflict may affect work on HIV among African communities, it is helpful to draw a comparison with equally vital work with the UK's other priority prevention group.

Until the 1960s homosexual activity was a criminal offence in the UK. The holistic approach of the current DH National Strategy on HIV (5.1 above) would clearly have little chance of success among men who have sex with men if they still felt today that by disclosing this identity they risked being arrested and punished as criminals, in the way the man from Zimbabwe and fears the outcome of immigration control. The Strategy's failure would be certain if these men felt they must sleep away from home to escape public authorities like the woman from South Africa and Rwanda.

As the Home Office unveils still more powerful instruments to enforce immigration rules, it becomes urgently necessary to examine the trade-off between that high-profile aim and Government's stated commitment to public health in the UK.

## 6. Immigration control: a new phase

### 6.1 Core objectives of immigration policy

The past decade has seen intense Government activity in the immigration and asylum policy area with six new laws on immigration and asylum since 1999, including the current draft Borders, Citizenship and Immigration Bill.<sup>36</sup> One strand of this activity may favour some immigration: reforms to create a simplified 'managed migration' system to admit workers with skills considered to benefit Britain. Otherwise, on its own account, the Government's core objectives appear to have been broadly as follows<sup>37</sup>:

- respond to perceived **public resentment** towards migration and most migrants
- make it **harder to enter** Britain, for most non-EU migrants ('protect our borders'), targeting both individual migrants and groups that assist clandestine entry
- reduce migrants' **rights and entitlements**, especially if their status is irregular, to reduce the UK's appeal as destination country ('pull factor'); to deny any benefit to people in the country whose claims it has rejected ('rewarding abuse'); and/or to induce them to leave
- **catch and expel** as many as possible of those migrants who have no regular status.

Of these objectives, the first usefully indicates Government's sense of its political constraints in this policy area. The second is essentially the traditional aim of curbing movement across UK external borders seen in successive immigration laws of the 20<sup>th</sup> century, albeit backed now by vastly greater powers and resources than ever before.

But the last two goals together signal a historic move over this decade to bring immigration control right into **UK domestic society**, so that it penetrates substantial areas of UK public services and public data systems - from schools and hospital wards to police records and vehicle licensing - plus the work of many private sector organisations. Prospects for HIV-positive migrants whose immigration status is insecure or irregular will be shaped by this Government drive to 'domesticate' the control regime.

### 6.2 Control becomes domestic

A milestone in this basic policy shift was Section 129 of the Nationality Immigration and Asylum Act 2002, under which '*The [Home Secretary] may require a local authority to supply information for the purpose of establishing where a person is ...*' suspected of being an irregular migrant who lives (or has lived) in that authority's area.<sup>38</sup>

Its full scope emerged however in 2007 when the Home Secretary issued a new strategy for enforcing immigration rules.<sup>39</sup> Stating that *It's not uncivilised to treat our own nationals differently from overseas citizens*, he went on to offer a *new approach, which tackles the root causes of the resentment about immigration, as well as making life in this country ever more uncomfortable and constrained for those who come here illegally*. In acting against migrants 'illegally' in the UK, the document said, the Home Office's priority would be to remove the minority causing serious harm. But for others, the pledge to make life uncomfortable was spelt out: *where swift removal is less likely, we will deploy a range of sanctions and penalties against illegal migrants, in order to make their ongoing stay here increasingly frustrating and difficult, to encourage them to leave*.

The strategy announced a new instrument to exert such pressure on 'illegal immigrants': **immigration crime partnerships** at local level in which the Home Office - via its immigration arm, now called the

36 Those to date are: Immigration and Asylum Act 1999; Nationality, Immigration and Asylum Act 2002; Asylum and Immigration (Treatment of Claimants, etc.) Act 2004; Immigration, Asylum and Nationality Act 2006; UK Borders Act 2007.

37 See for instance Home Office, *Enforcing the Rules: A Strategy to Ensure and Enforce Compliance with our Immigration Laws* (March 2007), Foreword by J.Reid, Home Secretary; Home Office, *Enforcing the Deal: Our Plans for Enforcing the Immigration Laws in the UK's Communities* (June 2008), Foreword by J.Smith, Home Secretary; and Home Office *Departmental Report 2008* (August 2008). More recent policy measures, in particular the draft Immigration and Citizenship Bill (2008), introduce a fourth major aim - to limit migrants' access to British citizenship. But its main effects will be longer-term, and not so relevant to migrants at risk of removal.

38 At [http://www.opsi.gov.uk/acts/acts2002/ukpga\\_20020041\\_en\\_10#pt6-pb6-11g129](http://www.opsi.gov.uk/acts/acts2002/ukpga_20020041_en_10#pt6-pb6-11g129)

39 Home Office, *Enforcing the Rules* (2007) op.cit. Following references are to pp.2-3 and 18; pp.19 and 24.

UK Border Agency (UKBA) - would work *with local authorities, police, primary care trusts, government departments and agencies* and other stakeholders, *to increase the impact of our enforcement effort.*

The idea of taking such partnership into healthcare was elaborated with reference to the ongoing Government review of rules on NHS access for foreign nationals. The Home Office would ... *run a pilot in three NHS trusts to test how access [rules], provision of data from the Border and Immigration Agency [now UKBA] and mechanisms for securing payment from overseas visitors can be combined together to collect revenue from those individuals who are not entitled to access these healthcare services.*

In 2008 the Home Office followed up this strategy with an implementation plan aimed explicitly at enforcing controls 'in the UK's communities'.<sup>40</sup> It confirms the key role of UKBA's immigration crime partnerships, feeding into the work of Local Immigration Teams which the Agency will set up across the UK to police 'illegal immigration' more effectively. Though structures are not defined, the 2008 plan says UKBA now envisages several types of immigration crime partnership to support its local teams. Two are especially significant for the debate about action against people living with HIV<sup>41</sup>:

- Partnership with **local authorities**: UKBA will work with councils *to protect communities from the harm caused by illegal immigration*, aiming to have such partnerships in place UK-wide by end 2008/09. A key purpose is to tackle *pressure on local services due to illegal claims for benefits and services or unfounded applications for safety net support.*
- Partnership with **health services**: The 2008 plan confirms UKBA's partnership pilots with three NHS Trusts during the preceding year to *improve data sharing and collection of revenue from un-entitled individuals* and to inform the DH review of rules on access to free NHS care for foreign nationals. Partners were Leeds Hospital NHS Trust, Luton and Dunstable Hospital NHS Trust, and West Middlesex NHS Trust.

Exchange of information on individual migrants is, this document indicates, what UKBA's partnerships are for. Data sharing should, in the Home Office view, help councils and NHS Trusts to *deny the privileges of the UK to those here illegally* – that is, exclude them from services in line with the Home Secretary's strategic aim of making their lives *uncomfortable ... frustrating and difficult*. For UKBA, it will help to steer action to seek their removal.

From this outline of evolving policy on immigration control, two critical points emerge. Firstly, UKBA's accelerating effort to bring immigration enforcement into wide areas of UK domestic public life sharply raises the tension (5.3 above) between this function and Government's public health goals. If migrants in African communities - regardless of their own HIV or immigration status - perceive even the risk of a link between engaging with healthcare or support agencies and Home Office action against them, the DH's National Strategy on HIV may already be compromised. If the perception becomes fact, with UKBA and local service providers systematically sharing data about migrants through formal partnerships to help identify 'offenders', then prospects of implementing the National HIV Strategy successfully within African communities may indeed be bleak.

But secondly it is clear that this evolution of UK immigration controls is driven by powerful, long-established policy aims. Recognising its strong commitment to these goals, we now ask what alternative arguments and perspectives might be put to the Home Office to create scope for negotiating an approach to UKBA enforcement which offers a safer future for migrants living with HIV and a better outlook for UK public health.

<sup>40</sup> Home Office, *Enforcing the Deal: Our Plans for Enforcing the Immigration Laws in the UK's Communities* (2008)

<sup>41</sup> Home Office, *Enforcing the Deal* (2008) op.cit pp.16 and 17, and (re NHS Trust pilots) Appendices A and B

## 7. HIV and Home Office removal policy: alternative perspectives

### 7.1 Recent challenges

Counter-arguments deployed in recent years to challenge Home Office policy on removing HIV-positive migrants have mostly been of three types: debate over an alleged NHS 'pull factor'; commitments at global level on HIV prevention and other healthcare rights; and obligations under the European Convention on Human Rights. We now briefly consider how far any of these lines of argument is likely, in the current policy environment, to alter the Home Office stance on migrants living with HIV.

#### (a) Debating the 'pull factor'

When in 2004 the Government amended NHS charging rules to restrict access to free secondary care for migrants without regular status - for most health conditions including HIV - it said its main motive was not to collect money but to make sure people were not drawn to the UK just to get free NHS treatment. As a minister told a House of Commons Health Committee enquiry into charges for 'overseas visitors' for HIV and AIDS treatment in 2005: *What is clear is that if people think they can come in and, under any circumstances, remain here for free treatment, we would become such a magnet, and that was what we were concerned to deal with. We are a national health service; we are not a global health service.*<sup>42</sup>

The charging policy was thus justified publicly as a way of eliminating a supposed 'pull factor' for migrants. By implication the same argument applies to the Home Office policy on removal of HIV-positive migrants, although here ministers give it much less emphasis.<sup>43</sup>

Analysis showing repeatedly that claims about the pull factor lack an evidence base might, therefore, be expected to prompt the Government to reconsider policies both on charging and on removal. In fact it shows little interest in objectively testing its own claims. This suggests that both these measures may in fact be targeted primarily at the first core objective of recent immigration policy (see 6.1 above): responding to public resentment about immigration. If so, it will matter less to the Government whether they also help achieve its second core objective: regulating and restricting entry to the UK.

Challenged to produce evidence that the 'magnet' of free NHS treatment was attracting HIV-positive migrants on any significant scale, in the 2005 Select Committee enquiry and subsequently, the Government has never done so.<sup>44</sup> In October 2008 the NAT (National AIDS Trust) published a briefing which set out key tests of the hypothesis that this has been a pull factor for people living with HIV, such as the time lapse between migrants' arrival in the UK and their first request for HIV diagnosis and/or care.<sup>45</sup> The NAT analysis conclusively disposes of the hypothesis as applied to migrants living with HIV in the UK.

Yet on its recent record, the Government is unlikely to respond by dropping either its rules on NHS fees for HIV-positive irregular migrants or its aim of removing them from the UK.

#### (b) UK's global commitments

Successive Governments have strongly committed the UK to promote internationally the right to conditions enabling people to live healthy lives, and in particular to work for universal access to HIV prevention, treatment, care and support. Section 4 above outlines the far-reaching nature of these commitments via the International Covenant on Economic, Social and Cultural Rights, Millennium

<sup>42</sup> House of Commons Health Committee, *New Developments in Sexual Health and HIV and AIDS Policy*, Third Report of Session 2004-05, March 2005), evidence given Feb.2005.

<sup>43</sup> See for example letter from Tony McNulty MP, Minister of State for Borders and Immigration, to Neil Gerrard MP, 20 February 2006; and response by Home Secretary Jacqui Smith MP to Joint Committee on Human Rights, *Human Rights Issues Relating to the Home Office*, 28 October 2008 (Uncorrected Transcript of Oral Evidence) at <http://www.publications.parliament.uk/pa/jt200708/jtselect/jtrights/uc1142-i/uc114201.htm>

<sup>44</sup> Secretary of State for Health, *Government Response to the Health Select Committee's Third Report of Session 2004-05: New Developments in Sexual Health and HIV and AIDS Policy*, Cmd 6649 (July 2005), pp.19-20

<sup>45</sup> NAT, *The Myth of HIV Health Tourism* (October 2008)

Development Goals and the DH policy 'Health is Global'. But they are in themselves very unlikely, as indicated, to overturn current Home Office policy on removal from the UK of irregular migrants living with HIV.

These international commitments may nonetheless make an important contribution to the debate.<sup>46</sup> While they apparently present no decisive legal or political barriers to current Home Office policy, they may - more positively - point towards an alternative approach that offers better prospects of securing not only public health and the well-being of HIV-positive migrants, but also UK international development goals.

### (c) Human rights – the European Convention

The strongest challenge to Home Office moves to expel migrants from the UK when receiving HIV treatment, over the past decade, has come in appeals to the European Convention on Human Rights (ECHR), incorporated into UK law by the Human Rights Act. These challenges have been mostly on grounds of the Convention's Article 3, requiring that no one be subjected to inhuman and degrading treatment; or Article 8, guaranteeing respect for the right to private and family life. We now briefly assess the scope for using these ECHR provisions to protect people with HIV from removal.

**ECHR Article 3 - inhuman and degrading treatment:** In the 1990s with HIV therapy much less developed, high mortality and negligible provision of HIV treatment in many sending countries, Article 3 had obvious potential for challenging the removal of people living with HIV. But the case of D in 1997 already suggested narrow limits on its application. The Lords agreed that it would breach D's Article 3 rights to return him, terminally ill with AIDS, to St Kitts where he would die with no therapy or care at all. Their verdict implied however that in general Article 3 was unlikely to protect the migrant unless

- consequences of return for them would be quite 'exceptional', involving hardship or suffering much worse than that generally experienced in the country of origin
- conditions there did not just weaken Article 3 rights but 'nullified' them – so that, for instance, HIV treatment services were not just inadequate but non-existent.

A decade later, appeals against removal from the UK could similarly be won from time to time by a migrant living with HIV where their specific circumstances convinced immigration judges that they would face a truly exceptional risk of 'inhuman and degrading treatment' in their country of origin.

In 2007 for instance the Asylum and Immigration Tribunal agreed that Ms A, an Indian migrant suffering from serious HIV-related illness, should be allowed to stay in the UK on Article 3 grounds after her husband died as a result of AIDS.<sup>47</sup> It identified several factors in her case which combined to meet the Article 3 test, as set by higher courts. These included gender discrimination in India, with especially severe stigma for women living with HIV; the likelihood that she would be blamed for her husband's death; and the resulting prospect that in India she would be shunned by her family, get no material or social support and thus be unable to maintain the ARV treatment regime needed to control her HIV infection.

Again, the themes of D's case were echoed in 2008 by the Asylum and Immigration Tribunal's decision in the case of O & O, a mother and son who were both HIV-positive.<sup>48</sup> In agreeing that Article 3 ruled out returning them to Kenya, the judge emphasised that this ECHR right would not be engaged just by the greater difficulty she might face in getting HIV treatment there. The critical factor was that her child had a 'one in a million' blood condition which meant he could not be monitored and treated at all without special equipment which could not be found anywhere in Kenya.

<sup>46</sup> UK AIDS and Human Rights Project, *Empty Promises: Holding the UK Government Accountable for its Commitments on HIV, Human Rights & Vulnerable Groups* (July 2008)

<sup>47</sup> See Asylum and Immigration Tribunal (Senior Immigration Judge Jarvis), Determination issued 4 June 2007. It is at <http://www.ait.gov.uk/Public/Unreported/HR00562%202006.doc>

<sup>48</sup> Heard by Senior Immigration Judge Nicholls, AIT March 2008 – details from Immigration Law Practitioners Association (personal communication)

But most decisively, Article 3's limitations as a general defence against enforcement action have been confirmed by the landmark case of *N*, heard by the House of Lords in 2005. This Ugandan woman with an HIV-defining illness appealed against removal under Article 3 on the grounds that her condition - stabilised by therapy in the UK - would rapidly deteriorate if she was sent back to Uganda, effectively condemning her to an early death. When the Lords rejected her case, *N* took it to the European Court of Human Rights.

Its decision in May 2008, again refusing her appeal, makes clear why the ECHR's Article 3 will not offer general protection against forced return of irregular migrants even if they are seriously affected by HIV infection. The following passage from the European Court's judgment spells out the core argument, reflected also in UK rulings:

*Advances in medical science, together with social and economic differences between countries, entail that the level of treatment available in the Contracting State and the country of origin may vary considerably. While it is necessary ... for the court to retain a degree of flexibility to prevent expulsion in very exceptional cases, article 3 does not place an obligation on the Contracting State to alleviate such disparities through the provision of free and unlimited health care to all aliens without a right to stay within its jurisdiction. A finding to the contrary would place too great a burden on the Contracting States.*<sup>49</sup>

**ECHR Article 8 - private and family life:** As interpreted by UK and European judges Article 8 opens up the decision about enforcing control to a wide range of issues, from the interests of the child to the nature of family relations, and the impact of removal on those relationships. The result is that there seems now to be considerable scope for a successful Article 8 challenge to Home Office removal, where the irregular migrant is a parent with a child (or children) also in the UK, and either or both are being treated for HIV.

This possibility was illustrated by the 2005 case of mother and son *O* and *W* from Nigeria, both HIV-positive and in the son's case seriously disabled as a result. The Asylum and Immigration Tribunal found that to return them to Nigeria would breach Article 8 because the mother would inevitably have to watch her son die in distressing circumstances.<sup>50</sup>

The scope for invoking Article 8 to protect migrants from removal is confirmed by a series of judgments in 2008 by the House of Lords. They related to a man born in Sierra Leone whose family links were in the UK; a young Kosovan man who formed a relationship here while awaiting a delayed Home Office decision; a woman from Zimbabwe with child and partner in the UK; and a mother and child threatened with return to Lebanon where prevailing law would effectively have separated them.<sup>51</sup> While none of them involved people living with HIV, it seems possible that – given otherwise comparable circumstances – they would have been all the more likely to succeed if HIV had also been a factor.

In all instances where UKBA seeks removal of a migrant living with HIV, good-quality legal advice remains vital to establish whether they have grounds for resisting it on ECHR or other grounds. But an Article 8 appeal now has clearly a better chance of success than an Article 3 case. Indeed it would appear that UKBA has adopted a tacit policy of refraining from removal action against families living with HIV, possibly in response to the trend in court judgments just mentioned, though this has not yet been officially confirmed.

As far as we can tell without relevant population data, however, those with close family in the country

<sup>49</sup> Decision of Grand Chamber in case of *N*, May 2008, para. 44 – cited by Hope of Craighead LJ in *EM (Lebanon) (FC) v Secretary of State for the Home Department (Respondent)* [2008] UKHL 64 [22Oct 08]

<sup>50</sup> Case cited by Wesley Gryk, *British immigration law as it relates to foreign families in the United Kingdom affected by HIV* (unpubl. note), March 2006

<sup>51</sup> See *Beoku-Betts (FC) (Appellant) v Secretary of State for the Home Department (Respondent)* [2008] UKHL 39; *EB Kosovo (FC) (Appellant) v Secretary of State for the Home Department (Respondent)* UKHL 41; *Chikwamba (FC) (Appellant) v Secretary of State for the Home Department (Respondent)* [2008] UKHL 40; and *EM (Lebanon) (FC) v Secretary of State for the Home Department (Respondent)* [2008] UKHL 64 at <http://www.publications.parliament.uk/pa/ld200708/ldjudgmt/jd081022/leban-1.htm>

are probably a minority of the UK's total of HIV-positive migrants. For most, human rights legislation now offers little protection against forced removal and the pervasive fear and anxiety which this engenders at both individual and community level.

An effective response to this Home Office policy will not emerge either, we have suggested, just through argument about an alleged NHS pull factor or by appealing to the UK's international commitments on health and HIV. All these areas of debate and analysis have an important part to play in shaping policy on HIV and immigration. But to secure real change in immigration enforcement policy towards people living with HIV, the Home Office has now to be offered an alternative way of delivering its departmental objectives that also fits with the needs of migrants, communities and wider public policy.

## 7.2 Immigration control - forcible removal or agreed resettlement?

The UK's population of migrants will, for the foreseeable future, include people living here with HIV but without current permission to be in the country. If national strategy to tackle HIV is to remain viable, as Section 5 has shown, the UK urgently needs an approach to immigration control that will foster trust and engagement between these migrants, their communities and public service providers, rather than fear and suspicion.

Agreed resettlement in country of origin for irregular migrants receiving HIV treatment, through a scheme reflecting their interests as well as the aims of immigration policy, could offer this alternative. It would build on the existing policy consensus that states should give priority to voluntary repatriation over forcible return, when migrants' claims to stay have failed. This principle is now widely accepted across public authorities and sectors in the UK and EU-wide.<sup>52</sup>

**Existing UK schemes:** The UK Government endorses this principle and runs two voluntary return schemes in conjunction with NGOs and the International Organisation for Migration (IOM).<sup>53</sup> Advice on their operation is given by a Voluntary Return Steering Group, convened by the Home Office, which includes representatives from other Government departments, such as DFID, as well as the Refugee Council and other NGOs.

The first, long-established scheme is the Voluntary Assisted Return and Reintegration Programme (VARRP), geared to asylum seekers and others with temporary status in the UK *who wish to return voluntarily and permanently to their country of origin or to a third country to which they are admissible*. This is now complemented by the Assisted Voluntary Return of Irregular Migrants (AVRIM) programme *for those who are in the United Kingdom illegally (including those originally in UK on valid permission, but having breached conditions of leave) and wish to return to their home country*.

Voluntary returns arranged through both programmes totalled 4,155 in 2007, compared with 6,200 the previous year. For 2007, this was 15% of all migrants who left the UK (forced and voluntary) after being notified that they had no permission to stay. Roughly two-thirds of voluntary returnees in 2007 had been asylum seekers, and one-third were non-asylum cases.<sup>54</sup>

It appears in practice that asylum seekers are defined very strictly within the VARRP as those who have made an application under the Refugee Convention, anyone whose application is solely based on Article 3 or Article 8 under the ECHR would therefore not be included. This means that they would only qualify for the AVRIM programme and thereby not receive the whole return and reintegration package..

<sup>52</sup> See for instance European Parliament and Council, Directive on common standards and procedures in Member States for returning illegally staying third-country nationals, 2005/0167 (COD), p.5, at <http://register.consilium.europa.eu/pdf/en/08/st10/st10737.en08.pdf>; European Council for Refugees and Exile (ECRE) <http://www.ecre.org/topics/return/>; Council of Europe Guidelines on Forced Return of Illegal Residents (Strasbourg May 2005); Independent Asylum Commission, *Safe Return: Second Report of Conclusions and Recommendations* (2008)

<sup>53</sup> <http://www.ind.homeoffice.gov.uk/aboutus/workingwithus/workingwithasylum/assistedvoluntaryreturn/>

<sup>54</sup> Home Office (Research Development & Statistics), *Control of Immigration Statistics 2007* p.33

Those taking up these schemes are in principle advised by IOM officers for a period after leaving the UK, and take with them a Home Office cash subsidy to help them resettle in their country of origin (for example, £3000 per family member in one current scheme). The Home Office is able to offset this expenditure by savings per returnee compared with the much higher cost of forcible removal from the UK.

Anecdotal evidence from some NGOs and migrant returnees suggests that existing Home Office/IOM schemes may not always deliver in practice the post-return support which they are supposed to offer. If people with support needs as complex as those living with HIV are to make such a transition, their programme of return and resettlement must be planned, piloted and above all monitored independently.

**HIV-positive migrants and agreed return:** Even five years ago, few if any migrants receiving treatment for HIV in the UK would conceivably have agreed to resettle in countries of origin, especially in Sub-Saharan Africa. Why might a programme enabling them to do that, adapted to meet their needs from existing schemes, now be a realistic way for the Home Office to fulfil its immigration control duties towards such migrants?

- **Access to HIV treatment** in many areas of origin – notably in Sub-Saharan Africa - has expanded dramatically in recent years. However, AHPN's detailed scrutiny of information on HIV treatment and care in selected African countries shows the need for caution in interpreting aggregate reports of provision in individual countries, underlining the difference between availability and real access.<sup>55</sup> Even where correct drug therapy itself is assured, obstacles to successful management of HIV may still arise for instance from fees for the overall process of treatment, monitoring and support; cost of transport to clinics; or shortage of primary care to deal with risks of opportunistic illness.

Nonetheless, vigorous local and national initiatives backed by a large-scale international effort through this decade, including UK investment guided by DFID, clearly have transformed the scale of treatment available in a number of countries with high HIV prevalence in Africa and elsewhere. UNAIDS global report for 2008 notes that *In only six years, the number of people receiving antiretroviral drugs in low- and middle-income countries has increased more than 10-fold.* At end-2007, the number of people receiving antiretroviral drugs in low- and middle-income countries was 45% more than the previous year and (at three million) was just under one-third of all those needing such treatment in those countries. Individual countries vary widely in their degree of progress but some – several of them in Africa - have made major advances in just three years 2004 to 2007.<sup>56</sup>

- Some HIV-positive migrants have **opted to leave the UK** after diagnosis here. No data are available on which countries they went to, but some may be in Africa. The HPA notes that over recent years, the total number of people diagnosed with HIV in the UK consistently exceeds the number starting HIV treatment by about 2,500, or roughly half of the latter new caseload. It adds: *The excess of approximately 2,500 newly diagnosed persons compared to additional numbers seen for HIV-related care each year is due to persons being lost to clinical follow-up and may indicate substantial emigration of HIV-infected persons (mortality is low).*<sup>57</sup>
- Migration in the 21<sup>st</sup> century is often a circular process, and a substantial proportion of the UK's HIV-positive migrants may originally have **planned to go back**. Of course many came as refugees, driven to this country by real fear of conflict or persecution at home (but these people should not be facing removal anyway, given good legal advice and a fair Home Office determination process). Many others

<sup>55</sup> African HIV Policy Network, *Completing the Picture* (op.cit. 2008)

<sup>56</sup> UNAIDS 2008 *Global report* (op.cit. 2008) pp.131, 135

<sup>57</sup> UK Collaborative Group for HIV and STI Surveillance, *Testing Time: ...2007.* (op.cit. 2007)

now living here without authority will have come to the UK to work or study for a limited period, until visas expired and their HIV diagnosis intervened, in effect trapping them in the UK. Often they have left close family in their country of origin.

The result may be the ambivalence voiced for instance by African women and men living with HIV in the UK, in testimony to the AHPN as cited earlier (sec. 5.3 above)<sup>58</sup>:

- Woman, aged 44, Zimbabwe: *I would go back to Zimbabwe if I could get the treatment. I would really love to. But you wouldn't want to die in shambles, in a dirty place because of lack of medication, lack of services, health care.*

- **Practitioners** report working with migrants who recently chose to go back voluntarily to country of origin. Examples include a senior HIV clinician who arranged the transfer of HIV treatment and care for patients returning to Uganda and to Cameroon, liaising directly by phone and email with medical counterparts in those countries; and a support organisation for African families with HIV which has found some service users interested in discussing possible return.<sup>59</sup>
- Where a migrant living with HIV decides to go home, a structured programme ensuring guidance, liaison between clinicians and continuity of HIV care will clearly offer huge **advantages for them and the country of return**. Like forced removal from the UK by the Home Office, an unsupported independent move back to country of origin with no provision for continued HIV treatment will almost certainly jeopardise the migrant's own health and may risk onward HIV transmission in that country. In some cases this could directly undermine DFID-led prevention work funded by the UK.
- Examples from **other destination countries** including Sweden, Canada and Australia show how a well-structured programme of support for irregular migrants (in these cases rejected asylum seekers), with regular caseworker guidance, can help a high proportion of them to return voluntarily with sustainable resettlement in their country of origin.<sup>60</sup>
- Since it has to be founded on liaison between HIV practitioners in the UK and in countries of origin, a UK programme of agreed return and resettlement has the potential to strengthen **professional and practical links** between clinicians at both ends of this relationship. It could thus become an important channel for joint work between them, bringing together the Government's health and international development objectives in line with its 'Health is Global' agenda.<sup>61</sup>
- Arrangements for UK clinicians and their overseas counterparts to share experience and ensure continuity of care, as HIV cases are transferred between them, could for instance be set up via the proposed UK International Health Links Centre. The Government would thus be putting into effect, in the critically important area of HIV treatment, its 2008 pledge to support the NHS in forging **global health partnerships**.

<sup>58</sup> To be published in: African HIV Policy Network, [forthcoming publication], 2009

<sup>59</sup> Personal communications

<sup>60</sup> Analysed in: John Bercow MP, Lord Dubs, Evan Harris MP, *Alternatives to immigration detention of families and children* (Discussion paper for All Party Parliamentary Groups on Children and Refugees, July 2006), available at [http://www.biduk.org/pdf/res\\_reports/alternatives\\_to\\_detention\\_july\\_2006.pdf](http://www.biduk.org/pdf/res_reports/alternatives_to_detention_july_2006.pdf)

<sup>61</sup> Department of Health, *Global health partnerships* (op.cit 2008)

# Part C: Conclusion

This paper has examined the policy environment of Home Office efforts to enforce immigration controls on asylum seekers and other migrants living with HIV in the UK. In the light of that policy review - and recognising the Home Office's duty to operate the system of immigration control established by Parliament - we have explored options for pursuing the aim of the *Destination Unknown* campaign. This is to ensure that migrants with HIV are safeguarded from forcible removal to countries where continued antiretroviral treatment is not yet widely available and accessible.

Though only a minority of people living with HIV are at risk of removal, and the cost of their UK treatment is a minute fraction of the NHS budget, we have seen that the threat of forcible removal is likely itself to pose a profound risk to the viability of the Department of Health's *National Strategy for Sexual Health and HIV*. This has wide implications for NHS expenditure and public health in the UK.

The risk arises from the way Home Office enforcement of immigration rules, and community perceptions of it, may corrode the relationship between migrant communities and official agencies or their third sector partners. Relationships of trust and engagement between them are crucial for the holistic approach underpinning the DH National Strategy. Growing evidence that Home Office removals policy undermines those relationships with the UK's African communities (Sec.5) therefore has particularly serious implications for the National Strategy, since these are - alongside men who have sex with men - the groups within UK population most affected by HIV.

Reviewing the UK's global commitments to health promotion - including the Millennium Development Goal target of universal access to HIV treatment - we found (Sec.4) that these would not in themselves override the strong policy aims that drive Home Office policy on forced returns. But what emerges from them is the principle of UK global responsibility which if applied consistently across the fields of international development, health and migration - including immigration control - could strengthen UK action in all of them.

A closer look at recent evolution of Home Office immigration enforcement policy (Sec.6) showed that, so far from aligning itself with wider Government goals, it may put them increasingly in jeopardy. In particular, risks it poses to the UK's HIV strategy seem to be getting steadily more severe as a tight nexus is established between UKBA enforcement operations and agencies that play a key part in tackling HIV, including NHS Trusts and local authorities.

Finally (Sec.7) the paper turned to alternative perspectives. For some migrants with HIV, human rights law may offer protection against removal if they are parents with a child or children in the UK. It has also overturned removal decisions for a few single adult migrants living with HIV, where their illness and/or social exclusion are so severe as to persuade the courts that they are truly 'exceptional' cases.

Appeals on this case-by-case basis, referring to specific features of each one, are clearly profoundly important for the individuals concerned. What they cannot achieve is the general shift in communities' experience of immigration control which the UK needs (above, sec.5) to clear the way for successful implementation of its national HIV strategy. Current Home Office policy, focused on forcible removal, seems immune to any such general challenge whether on the grounds that it lacks a firm evidence base, or conflicts with international health commitments or with human rights principles.

We instead propose that other Government departments and partner agencies now work positively with the Home Office to shape ASSURE - a dedicated programme of Agreed, Safe and Sustainable Resettlement for migrants living with HIV who have no regular status. Lifting the fear of forced removal from their communities, such a programme (see box below) should enable the Home Office to implement immigration control decisions in a way that fits with the Government's wider goals for UK public health, global health and development.

For migrants living in the UK with HIV and its challenges, the ASSURE programme would offer a guarantee of continued treatment here unless and until they and their doctor agree that it is time for them to return to their country of origin. At the same time it would

- meet the Home Office requirement for an orderly method of applying its immigration decisions, building on long-established policy of the UK Government and its EU partners to give priority to voluntary return over forced removal;
- give practical expression to wider UK aims of development and health promotion at global level, spelt out by the Government in key policy statements from the Millennium Development Goals to its 2008 strategy *Health is Global*;
- lift from African communities the fear and distrust engendered by campaigns of forced expulsion; and hence
- open the way for successful implementation of the DH National Strategy by the target date of 2011, yielding major long-term benefits for public health in the UK

#### **ASSURE: towards a programme of Agreed, Safe and Sustainable Resettlement**

To work effectively, the ASSURE programme will need the following key features:

- (a) **Genuinely voluntary:** The proposed ASSURE scheme can succeed only if migrants living with HIV participate in it by their own informed choice, free of threat or sanctions. Crucially it requires a policy commitment that, until they make this decision, HIV treatment and care will be available to them free of charge.
- (b) **Country-specific:** Scope for agreed resettlement must be assessed country by country.
- (c) **Key role for clinicians:** Resettlement must be agreed and overseen by the NHS clinician(s) responsible for UK treatment, in liaison with treatment services in countries of return and with DFID officers engaged locally with HIV treatment and prevention. NHS resources have to be assigned to cover costs of this vital liaison work by clinicians.
- (d) **Legal advice:** Before deciding whether to enter the agreed resettlement programme, migrants must have the opportunity to explore other options – such as appeal against refusal of their asylum or immigration claim – in depth with a competent legal advisor.
- (e) **Collaborative approach:** To build in the required range of expertise and maintain balance between policy goals, the programme must be designed and managed by a multi-agency team, convened by the Home Office with representation (as a minimum) from DH, DFID and the Foreign & Commonwealth Office together with key NGOs offering relevant experience in this field.
- (f) **Link to development effort:** The programme should tie into DFID programmes to extend access to HIV treatment in developing countries, especially Africa – so that the scope for migrant returns will reflect UK success in building HIV treatment there.

The AHPN would like to collaborate with key government departments, immigration and health experts as well as other important partners to develop the ASSURE programme and thereby facilitate a feasible voluntary return programme for people living with HIV who are on treatment and wish to return to their countries of origin.

An external and independent evaluation of the proposed programme is imperative. An evaluation panel would monitor the transparency and success of the programme and consist of various external organisations with key knowledge and expertise. The UK is not unique in hosting migrants living with HIV and it would therefore be beneficial to establish an EU-wide monitoring system that ensures fair policies and practice.

For the ASSURE programme to become successful there needs to be great clarity in the operation and options available within the programme. Government officials, front-desk staff and people going through the asylum process must be able to get a clear understanding of the programme and be confident in the policies and guidance applied within its structure. Any applicant should be allowed to withdraw their application at any time of the process.

In order to link the UK's committed efforts towards global development with its domestic strategy, participants deciding to join the programme should have an opportunity to be skilled-up prior to returning to their country-of-origin to assure appropriate transfer of skills that can benefit the communities they are returning to. Feasible voluntary return programmes offer a value-for-money model of international development for DfID. Following up with returnees lies at the heart of building trust and exchanging information between the UK Government, asylum seekers living with HIV and the ASSURE programme.

The AHPN and its member organisations are keen to offer assistance and guidance to develop the ASSURE programme. With a strong network of African-led community based organisation in the UK, the AHPN is able to facilitate the sign-posting of services and organisations. The proposed collaboration would strengthen cooperative partnerships across European and African countries. The UK would be in a unique position to guide this partnership.

We hereby welcome the opportunity to initiate the development of the ASSURE model and pursue a dialogue with the UK government and key institutions to bring about an agreed, safe and sustainable resettlement alternative for people living with HIV. The experiences of people affected by HIV remains our priority and their health and rights must remain core to any future policies on return to countries of origin.



## Bibliography

African HIV Policy Network, *Completing the Picture: an examination of the Home Office's country reports on the availability of HIV treatment in Zambia, Malawi, Uganda, South Africa, Nigeria and Zimbabwe* (2008)

British HIV Association, British Association for Sexual Health & HIV and British Infection Society, *UK National Guidelines for HIV Testing* (2008)

Bercow J. MP, Lord Dubs, E. Harris MP, *Alternatives to immigration detention of families and children* (Discussion paper for All Party Parliamentary Groups on Children and Refugees, 2006) at [http://www.biduk.org/pdf/res\\_reports/alternatives\\_to\\_detention\\_july\\_2006.pdf](http://www.biduk.org/pdf/res_reports/alternatives_to_detention_july_2006.pdf)

Department of Health, *Better Prevention, Better Services, Better Sexual Health: the National Strategy for Sexual Health and HIV* (2001)

Department of Health *Resource Accounts 2007-08* (2008)

Department of Health and Department for International Development, *Global health partnerships: the UK contribution to health in developing countries - the Government response* (March 2008), pp. 15-16. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_083509](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083509)

Department for International Development, *Achieving Universal Access – the UK's strategy for halting and reversing the spread of HIV in the developing world* (2008)

Gryk W., *British immigration law as it relates to foreign families in the United Kingdom affected by HIV* (unpublished note), March 2006

Health Protection Agency, *HIV in the United Kingdom: 2008 report* (Nov. 2008)

Health Protection Agency, *Sexually Transmitted Infections in black African and black Caribbean communities in the UK: 2008 report* (November 2008)

HM Government, *Health is global: a UK Government strategy 2008-13* (2008) at [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_088702](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702)

Home Office, *Enforcing the Rules: A Strategy to Ensure and Enforce Compliance with our Immigration Laws* (March 2007)

Home Office, *Enforcing the Deal: Our Plans for Enforcing the Immigration Laws in the UK's Communities* (June 2008)

Home Office *Departmental Report 2008* (August 2008)

Home Office (Research Development & Statistics), *Control of Immigration Statistics 2007*

House of Commons Health Committee, *New Developments in Sexual Health and HIV and AIDS Policy, Third Report of Session 2004-05* (March 2005) at <http://www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/252/25202.htm>

House of Commons Select Committee on International Development, *First Report of Session 2005-06, Delivering the goods: HIV/AIDS and the provision of anti-retrovirals* (Nov. 2005) at <http://www.parliament.the-stationery-office.co.uk/pa/cm200506/cmselect/cmintdev/708/70802.htm>

House of Commons International Development Committee, Second Report of Session 2006-07 Vol.I, *HIV and AIDS: Marginalised groups and emerging epidemics* (Nov. 2006) at <http://www.publications.parliament.uk/pa/cm200607/cmselect/cmintdev/46/4602.htm>

Independent Advisory Group on Sexual Health and HIV, *Review of the National Strategy for Sexual Health and HIV* (by Medical Foundation for Aids and Sexual Health, July 2008)

Independent Asylum Commission, *Safe Return: Second Report of Conclusions and Recommendations* (2008)

Lord Crisp, *Global Health Partnerships: The UK contribution to health in developing countries* (Department of Health 2007) [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh\\_065374](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_065374)

NAT, *HIV and the UK Asylum Pathway* (2008)

NAT, *The Myth of HIV Health Tourism* (2008)

Office for National Statistics, *Focus on People and Migration - December 2005*

Office for National Statistics, *Population by country of birth and nationality* (2008) at <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15147>

Secretary of State for Health, Government Response to the Health Select Committee's Third Report of Session 2004-05: New Developments in Sexual Health and HIV and AIDS Policy, Cmd 6649 (July 2005)

Sigma Research *Bass Line 2007 survey: Assessing the sexual HIV prevention needs of African people in England* (Portsmouth, 2008) at <http://www.sigmaresearch.org.uk/go.php/reports/2008b>

UK AIDS and Human Rights Project, *Empty Promises: Holding the UK Government Accountable for its Commitments on HIV, Human Rights & Vulnerable Groups* (July 2008)

UK Collaborative Group for HIV and STI Surveillance, *Testing Times: HIV and other Sexually Transmitted Infections in the United Kingdom: 2007*, (London: Health Protection Agency, Centre for Infections. November 2007)

UNAIDS with International Labour Organisation and International Organisation for Migration, *Policy Brief - HIV and International Labour Migration* (August 2008) at [http://data.unaids.org/pub/Manual/2008/jc1513a\\_policybrief\\_en.pdf](http://data.unaids.org/pub/Manual/2008/jc1513a_policybrief_en.pdf)

UNAIDS *2008 Report on the Global AIDS Epidemic* (July 2008) at [http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008\\_Global\\_report.asp](http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp)

UN Economic and Social Council / UN Committee on Economic, Social and Cultural Rights, *The right to the highest attainable standard of health : 11/08/2000. E/C.12/2000/4, CESCR General comment 14* (Geneva 2000)

Weatherburn P., W.Ssanyu-Sseruma, F.Hickson, S.McLean, D.Reid *Project Nasah: an investigation into the HIV treatment information and other needs of African people with HIV resident in the UK* (Sigma Research / NAM / NAT / AHPN, February 2003)

Woodbridge J., *Sizing the unauthorised (illegal) migrant population in the United Kingdom in 2001* (Home Office Online Report 29/05, 2005) <http://rds.homeoffice.gov.uk/rds/pdfs05/rdsolr2905.pdf>

## Migrant population in the UK, HIV and NHS costs 2007/08

### Source

The most up-to-date guide to the UK's migrant population - so far as it can be identified in official data - is Office of National Statistics, *Population by country of birth and nationality 2008*.<sup>62</sup> This source presents estimates based on returns from the Annual Population Survey (APS) over the year to March 2008, subject to a margin of possible error since this is a sample survey. In this period 2007/08, according to its estimates

- total UK resident population was 60.1 million
- migrants, ie. residents born outside UK, numbered 6.4 m = 10.6% of the UK total
- migrants born outside EU (27 member states) numbered 4.4 m = 7.3% of UK total.

Apart from giving aggregate figures for those from within the EU, this source identifies where migrants were born only for those from the 'top 60' countries of birth - ie those for which migrant population in the UK reaches 20,000 or more. Except for people born within the EU, therefore, any estimate of migrant numbers by world region will be incomplete because some countries in it will fall outside the 'top 60'.

A partial figure for the UK's migrants from Africa can, for instance, be calculated by adding up the estimated number from major sending countries on that list. But inevitably it will miss significant numbers of people in smaller communities (such as more recent arrivals from Francophone states). Similarly for attempts to classify migrants' countries of origin in economic terms such as developing or developed, those who belong to the larger country-of-origin communities can be assigned to one of these categories but others cannot.

With this caveat, it is nevertheless useful here to distinguish migrants – in the UK's major migrant communities - who are from poorer or developing countries, and also those from African states .

### Migrants born in poorer countries

Migrants in the UK who came from the **world's poorer countries** are defined as follows:

- *rich-country* migrants are those from the 26 other EU states plus USA, Canada, Australia, New Zealand, Russia, Singapore, Japan.
- *poor-country* migrants are residents not born in the UK, less the rich-country group.

In 2007, with the rich-country group accounting for 40% of the UK total, **poor-country migrants** are estimated to make up **60% or 3.8 m of the UK total** of non-UK-born residents.

The estimate of **African migrant population** in the UK for 2007 is the sum of figures for all African states in the 'top 60' countries (ie. from which at least 20,000 people were living in the UK). It shows 13 Africa countries within this list, accounting for total migrant population of 963,000 in the UK that year (of all ethnicities, thus including many white migrants). Again it is emphasised that people in smaller migrant communities, not available at time of writing, would have to be added to arrive at a complete estimate of the UK's total African-born population.

### Migrants living with HIV 2007 – Sub-Saharan Africa

The Health Protection Agency (HPA) does not give an HIV prevalence rate for the UK's migrant population as a whole. It does however give estimated HIV prevalence and diagnosis rates for 2006 by certain major regions including Sub-Saharan Africa, in the report *Testing Times* on HIV and sexually transmitted

<sup>62</sup> At <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=15147>

infections which it published late-2007.

At time of writing, corresponding rates by world region for 2007 have not yet been published. The HPA's summary report on HIV for 2008, published November 2008, gives aggregate rates with no breakdown by region of origin. The only way to get a reasonably up-to-date picture of the likely number of African migrants living with HIV in the UK, therefore, is to assume that their share in the UK's total of HIV cases - diagnosed and undiagnosed - remained constant between 2006 and 2007.

By 2007, on HPA estimates, some 77,000 people were living with HIV in the UK. In more than a quarter of these cases it was undiagnosed, while 57,000 people in whom it had been diagnosed were accessing HIV-related care.<sup>63</sup>

The Agency's *Testing Times* report the previous year suggested that about 34% of all UK residents living with HIV in the UK in 2006 were born in Sub-Saharan Africa, of whom about two-thirds had had the condition diagnosed. In 2007, assuming the same ratios still applied, roughly **26,000 migrants from Sub-Saharan Africa would have been living with HIV** in the UK and about 19,000 of them would have had it diagnosed.

### How many HIV-positive migrants might be 'irregular'?

Any answer to this question will be to some extent a guess. Its starting point is the sole official attempt to estimate the UK's *unauthorised (illegal) migrant population*, carried out by the Home Office in 2005 using the 'residual method'. Referring back to Census data, this study produced a notional estimate of 430,000 irregular migrants living in the UK in April 2001 (central estimate within a possible range), or 0.7% of total UK population at that time.<sup>64</sup>

The only way of rolling this estimate forward to 2007, to relate it to recent information on HIV prevalence, is to assume that the number of migrants without regular status grew over that period in line with the UK's overall recorded migrant population. Total foreign-born population, recorded at 4.897 m in 2001, rose 31 % to an estimated figure of 6.414 m in 2007.<sup>65</sup> (The latter estimate is based on Annual Population Survey returns over the 12 months to year to March 2008). Applying this growth rate to the Home Office notional figure for the UK's unauthorised migrants in 2001, above, the most plausible 'guesstimate' is that they may have numbered [430\*31.0%] or **560,000 in 2007**.

In that year, the estimated total for UK residents born outside the EU was 4.375 m. Two alternative simplifying assumptions can then be made, about how our guesstimate of irregular migrant numbers relates to this non-EU-born population as estimated by ONS from its Annual Population Survey:

- (a) all those with irregular status are included in the APS-based estimate
- (b) all of them are outside it (because survey methods fail to record them).

Accordingly we have two possible figures for the proportion of non-EU migrants who might have been irregular in 2007:

- (a) irregular proportion =  $[0.56/4.375] = 12.8\%$
- (b) irregular proportion =  $[0.56/(4.375+0.56)] = 11.3\%$

This implies a 'central guesstimate' that in 2007 **about 12.0% of UK migrants were irregular**.

<sup>63</sup> Health Protection Agency, *Testing Times* ... (op.cit 2007) pp, 3, 28. It is emphasised that HPA estimates of prevalence and rates of HIV diagnosis, cited in this section, are subject to wide margins of error.

<sup>64</sup> Jo Woodbridge, *Sizing the unauthorised (illegal) migrant population in the United Kingdom in 2001* (Home Office Online Report 29/05, 2005) p1 <http://rds.homeoffice.gov.uk/rds/pdfs05/rdsolr2905.pdf>. 'The Residual Method takes as its starting point the foreign-born population recorded in the UK census .. in April 2001 and then deducts an estimate of the foreign-born population here legally. The difference is an estimate of the number of unauthorised migrants in the UK.'

<sup>65</sup> For 2001 see <http://www.statistics.gov.uk/StatBase/Product.asp?vlnk=12899> (ONS, *Focus on People and Migration archive data June 2004*). For 2007 see ONS *Population by country of birth and nationality 2008* - fn.56 above.

### Irregular migrants and NHS care costs

For 2007 the estimated number of migrants from Sub-Saharan Africa living with HIV was about 26,000 (above). Assuming the proportion of them without leave to remain in the UK is the same as for total non-EU migrant population, then the number of irregular migrants living with HIV among UK's Sub-Saharan African population would be  $[26,000 * 12\%]$  or 3,100. On standard assumptions about 'typical' cost of HIV treatment per patient, the likely annual cost of treating all of them would be **from £31 m to £47 m**.<sup>66</sup>

Actual cost would currently be only around two-thirds of these figures, given the proportion of HIV-positive people in the UK's African communities (as estimated by the HPA) who have not yet had the condition diagnosed. But on the stated assumptions, £47m appears to be the maximum annual cost if all of them were eventually to get this diagnosis and the consequent NHS care, in line with DH strategy.

For financial year 2007/08, net operating cost for the NHS is reported at £72.5 bn.<sup>67</sup> **As a proportion of total net expenditure on the NHS in 2007/08, therefore, the maximum cost of treating HIV-positive migrants from Sub-Saharan Africa who are living in the UK without regular status would have been  $[47/72500]$  or about 0.06%.**

<sup>66</sup> i.e. assumed annual cost per patient may range from £10,000 as minimum, to £15,000 as maximum.

<sup>67</sup> From: DH *Resource Accounts 2007-08* (published October 2008) p.43 'Consolidated Statement of Operating Costs by Departmental Aim and Objectives for the year ended 31 March 2008'



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