EMPTY PROMISES

Holding the UK Government Accountable for its Commitments on HIV, Human Rights & Vulnerable Groups

Author

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We have also received submissions from individuals who have wished to remain anonymous.

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"The protection of human rights is essential to safeguard human dignity in the context of HIV and to ensure an effective, rights-based response to HIV and AIDS. An effective response requires the implementation of all human rights, civil and political, economic, social and cultural, and fundamental freedoms of all people, in accordance with existing international human rights standards."

International Guidelines on HIV/AIDS and Human Rights, 2006 Consolidated Version

FOREWORD by Professor Paul Hunt
UN Special Rapporteur on the Right to the Highest Attainable Standard of Health (2002-2008)

For many years, the United Nations has emphasised the vital importance of human rights in the context of HIV/AIDS. Consider, for example, the *International Guidelines on HIV/AIDS and Human Rights* (2006), as well as the *Declaration of Commitment on HIV/AIDS* (2001).

Enjoyment of the right to the highest attainable standard of health is a core HIV/AIDS issue. Individuals must be able to protect themselves from HIV, access treatment when living with the virus and benefit from adequate care and support. This fundamental human right is also closely related to the realisation of other rights and freedoms that are often violated in the context of HIV/AIDS. The pandemic is not only a health issue: its devastating impact also extends into the social, political and economic realms.

International human rights law places obligations on States. States have duties to respect, protect and fulfil the human rights of those within their borders. Action and accountability lie at the heart of human rights. Without accountability, States' human rights obligations can become little more than window-dressing.

Human rights require that accessible, transparent and effective mechanisms are in place to monitor, and hold States to account, in relation to their human rights duties in the context of HIV/AIDS. Civil society organisations have a critical role to play in the struggle for robust human rights accountability.

This report by the *UK AIDS and Human Rights Project* exemplifies what civil society organisations can do as "watchdogs" to check that Governments are fulfilling their human rights commitments on HIV/ AIDS.

This report focuses on specific groups that are particularly vulnerable to HIV/AIDS. It argues that the UK Government has failed to meet its human rights obligations in relation to HIV/AIDS and sex work, prisoners, asylum, immigration, children and young people. The report argues that, despite criticisms from United Nations monitoring bodies, as well as parliamentary committees, some UK laws and policies relating to HIV/AIDS remain inconsistent with international human rights law.

The *UK AIDS and Human Rights Project* deserves our support. And this important Report demands our attention.

Paul Hunt

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ACRONYMS

APPGA - All Party Parliamentary Group on AIDS
ARV – Antiretroviral treatment
ASBO - Anti-Social Behaviour Order
CAB - Citizens Advice Bureau
CAT - Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
CEHR – Commission for Equality and Human Rights
CEDAW - Convention for the Elimination of all forms of Discrimination Against Women
CERD - Convention against Racial Discrimination
CPT - European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
CRC- Convention on the Rights of Child
DCA – Department for Constitutional Affairs
DFID – Department for International Development
DH- Department of Health
ECHR - European Convention on Human Rights
ECtHR – European Court of Human Rights
GC – General Comment
HIV – Human Immunodeficiency Virus
HP - Humanitarian protection
HRA – Human Rights Act
HRC – Human Rights Committee
IAG - Independent Advisory Group on Sexual Health and HIV
ICCPR - International Covenant on Civil and Political Rights
ICESCR - International Covenant on Economic, Social and Cultural Rights
IND – Immigration and Nationality Directorate
JCHR - Joint Committee on Human Rights
NASS - National Asylum Support Service
NEP - Needle Exchange Programme
OAPA – Offences Against the Persons Act
OEM - Operational Enforcement Manual
PCT - Primary Care Trust
PSHE - Personal Social and Health Education
PSO – Prison Service Order
SHRC - Scottish Human Rights Commission
SOA – Sexual Offences Act
SPS - Scottish Prison Service
SRE - Sex and Relationship Education
STI – Sexually Transmitted Infection
UASC - Unaccompanied Asylum-Seeking Children
UDHR - Universal Declaration of Human Rights
UNHCR - UN High Commissioner for Refugees

EXECUTIVE SUMMARY

This report follows the 2001 inquiry of the All Party Parliamentary Group on AIDS (APPGA) into the UK government's compliance with and implementation of the *International Guidelines on HIV/AIDS and Human Rights*.[1] The inquiry concluded with the publication of a report making recommendations for government action until 2006.[2]

The specific aim of the report is to assess the UK government's compliance with international human rights law in the context of HIV. The report also considers the implementation of the APPGA's recommendations in specific areas and the impact of the Human Rights Act, which was not in force when the Group's report was published.

The report focuses on specific vulnerable groups and analyses the impact of current government policy and legislation on the rights of sex workers, adult asylum seekers, prisoners, asylum seeking children and young people, in the context of HIV. It also considers the means of redress for alleged violations of HIV-related rights in the UK.

These issues are considered in light of binding international human rights instruments and policy standards that provide a framework on the application of international human rights law in the context of HIV, in particular the *International Guidelines on HIV/AIDS and Human Rights.* The report gives a comprehensive account of specific issues from a human rights perspective and provides recommendations which aim to introduce a human rights based response to HIV in the country.

The overall conclusion is that the UK government is failing to fulfil its HIV-related obligations under international human rights law in relation to the vulnerable groups considered in the report. In some cases, current government policy leads to a breach of most fundamental rights and freedoms guaranteed under binding treaties that the UK is a party to. The government is also not doing enough for the promotion, monitoring and enforcement of HIV-related rights.

The key general findings of the report are that:

- Despite its commitment to taking action towards the realisation of fundamental rights and freedoms in the context of HIV the government has failed to turn its promises into action.
- Current policy and legislation impact on vulnerable groups' rights to access HIV prevention, treatment and care and to protect themselves against HIV.
- The government has failed to implement UN policy and legal HIV-specific standards which set out a rights based approach to HIV and has instead introduced and/or maintained policies which interfere with HIV-related rights.
- Despite criticisms from UN monitoring bodies and parliamentary bodies, the government has maintained or introduced policies and laws that flout international human rights law, particularly in relation to the treatment of asylum seekers.
- The lack of a cross-government framework on HIV and human rights leads to contradictory domestic policies between various government departments and between the government's international and domestic responses to HIV. It also results in conflicting and inconsistent policies within the Department of Health.
- None of the APPGA's recommendations have been implemented in relation to the issues considered. New issues of concerns have emerged since the Group's report was published. In some cases, the situation has worsened.

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[1] The Guidelines were first published in 1998 and revised Guideline 6 first published in 2002.

[2] APPGA, *The UK, HIV and Human Rights: recommendations for the next five years*, July 2001.

In relation to sex workers:

- The available evidence indicates that the UK is not fulfilling its obligations to guarantee sex workers' right to health or other fundamental human rights.
- The current legal and policy reform is based on a public nuisance framework. It has major implications for sex workers' access to HIV prevention and sexual health services. It also impacts on sex workers' ability to control their working conditions, making them more vulnerable to violence.
- Human rights must be the basis of any reform of sex work law and policy and legislation and legal reform must comply with the UK's human rights obligations.
- The government does not involve sex workers and sex workers' organisations in decision making on policy and legal reform.
- There are valuable lessons to be learnt from other jurisdictions' moves to decriminalise sex work or sex work related activities and the government should review the experiences of other countries in shaping legal and policy reform so as to ensure better protection of sex workers' rights.

In relation to asylum seekers:

- The government is currently failing to meet its obligations under international human rights law to guarantee asylum seekers' right to health and other fundamental rights and freedoms.
- Despite being criticised by UN monitoring bodies, NGOs and parliamentary groups, the government has not only failed to take necessary actions recommended, but it has actually introduced additional measures which have led to further violations of human rights.
- There is no evidence of so-called "health tourism" in the UK and current policy on access to NHS treatment and removal puts the lives of people with HIV in jeopardy or even amounts to a death sentence.
- Although there is guidance on the detention of asylum seekers, including specific provisions on healthcare for vulnerable people, research and case law show that there is a wide gap between theory and practice. Furthermore, despite concerns from the international community such as the Human Rights Committee and the UN High Commissioner for Refugees about the detention policy and extensive evidence of its detrimental impact particularly on vulnerable people, the government is blatantly disregarding the most fundamental principles that govern the treatment of asylum seekers in international law and policy.
- The lack of cross-departmental HIV and human rights strategy has a significant impact on Home Office policy and decisions and leads to incoherent policy regarding access to HIV treatment.

In relation to prisoners:

- The UK is currently failing to meet its obligation to develop and implement a policy on HIV in prison which is consistent with international human rights norms.
- The principle of equivalence, set out in international and domestic policy, is not translated into practice and prisoners receive "second class" standards in terms of HIV prevention, treatment and care. This leads to a breach of prisoners' most fundamental rights and freedoms.
- Current policy impacts on prisoners' ability to protect themselves against HIV transmission and the limited measures available are unequally implemented.
- Needle exchange programmes are not available across the country and condoms are not readily accessible to prisoners.
- There is evidence of prison officials' failure to provide adequate and appropriate healthcare to prisoners, including those living with HIV.

Children and young people:

- The current policy and legal framework on children is also not based on human rights. This has strong implications for children and young people's HIV-related rights. The most fundamental rights of the child, guaranteed not only by the Convention on the Rights of the Child (CRC) but also other human rights treaties are currently disregarded.

In the context of asylum:

- The UK's reservation to the CRC allows the government to exclude children who are subject to immigration control from the scope of its legal obligations under the treaty. This has major implications on asylum seeking children's HIV-related rights.
- The treatment of children seeking asylum conflicts with the government's *Every Child Matters* strategy and reflects incoherent policies between departments.
- Current policy on detention, dispersal and deportation interferes with children's rights set out in the CRC.
- There is an urgent need for the government to remove its reservation to the CRC. The government should also incorporate the CRC domestically. A framework based on the Convention would ensure the domestic implementation of the treaty and a human rights based response to asylum seeking children and HIV.

In the context of sex education:

- Despite strong evidence of a worrying level of ignorance and complacency about HIV among young people, sex education is still not compulsory in schools. This impact on young people's right to education and related entitlements set out in the CRC and subsequent General Comments as well as in other international human rights treaties.
- Despite the recognition of the rights of the child at international and domestic levels, education in schools remains a reserved matter to adults. The main evidence of the exclusion of young people from the decision making process is the fact that parents in the UK retain the statutory right to withdraw their children from Sex and Relationship Education lessons that fall outside of the national curriculum.

Promotion, monitoring and enforcement of HIV-related rights

- Lack of awareness and knowledge of human rights impacts on people's ability to seek redress for alleged HIV-related rights violations.
- Government's policy and legislation on HIV-related issues not only increase HIV-related stigma but also perpetuate myths that it is acceptable to violate the rights of people living with and/or vulnerable to HIV.
- There is currently a significant gap in the provision of human rights education, legal support and advice for people living with and/or affected by HIV. There is also a lack of HIV expertise amongst UK enforcement and monitoring bodies and legal professionals.
- Current means of redress for HIV-related violations of human rights are limited. The right to individual petition is not allowed under most human rights treaties. Reservations to international human rights treaties also significantly impact on HIV-related rights, particularly on asylum seeking children.
- Access to adequate legal representation is a significant issue for people seeking legal redress, in particular those who are vulnerable and in urgent need of help such as asylum seekers.

The overall recommendation of the report is that a human rights based and cross-governmental framework should be developed and implemented.

The framework should:

- Be based on and conform to the framework provided by the *International Guidelines on HIV/AIDS and Human Rights*;
- Be developed with representatives from relevant government departments, HIV and non-HIV organisations working with vulnerable and/or affected groups, as well as people living with HIV, and human rights experts;
- Be monitored and evaluated on a yearly basis through an “HIV and Human Rights Monitoring and Evaluation Body”.

1. INTRODUCTION

1.1. About the report

1.1.1. Background

This report follows the 2001 APPGA's inquiry into the UK's compliance and implementation of the *International Guidelines on HIV/AIDS and Human Rights*.[3] The inquiry concluded with the publication of a report setting out key recommendations for government action until 2006.[4]

On paper the place of human rights in the response to HIV is well-established.[5] In adopting the *Declaration of Commitment on HIV/AIDS*, governments, including the UK, committed to taking action towards the realisation of fundamental rights and freedoms. Yet, in practice, violations of the rights of people living with, affected by and/or vulnerable to HIV have continued or worsened through the introduction, aggravation and/or continuation of policies and legislation. The UK is no exception.

Since 2001, some progress has been made, most notably in relation to HIV-related discrimination. For example, people living with HIV are now legally protected against discrimination from the point of diagnosis. But one has to admit that positive changes remain the exception rather than the rule when it comes to HIV-related rights in the country.

There are also increasing examples of gaps in the domestic response to HIV and the lack of commitment by the government to keep promises made at international level. The *Declaration of Commitment on HIV/AIDS*, which was endorsed by the 189 UN Member States in June 2001, requires governments to submit progress reports on its implementation. In 2003, the UK government failed to submit its first progress report. In 2006, the Department of Health involved four HIV organisations in the initial draft. It then carried out a consultation whose outcome was never published. The final report failed to mention and incorporate any of the comments and recommendations made by the organisations that did respond to the consultation. It also did not provide a comprehensive and accurate account of the impact of governmental policies on HIV-related rights. It also contained inaccuracies.[6] In 2008, the government did not even consult with a wide range of civil society organisations, only getting feedback from selected HIV organisations and people. The progress report submitted to UNAIDS was an incomplete document which failed to acknowledge major HIV and human rights issues in the country. None of the groups examined in this report were mentioned in the report. [7]

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[3] OHCHR and UNAIDS, Consolidated version 2006.
[4] *Supra*, at 2.
[5] *Human Rights and HIV/AIDS: Now More than Ever*, Open Society Institute, 2007 (available at http://public.soros.org/initiatives/health/focus/law/articles_publications/publications/human_20071017)
[6] See UK AIDS and Human Rights Project's Shadow Report on UNGASS in the UK, March 2006 (available at www.aidsrightsproject.org.uk)
[7] The UK report is available on the UNAIDS website.

1.1.2. Aim and Scope of the Report

The aim of the report is to assess the UK's compliance with international human rights law and the impact of domestic human rights legislation in the context of HIV. The report does not intend to provide a catalogue of all HIV-related issues but to develop a comprehensive analysis of the situation of vulnerable groups and areas which have been neglected, have emerged or have worsened since the publication of the APPGA's report in 2001. It analyses the impact of current government policy and legislation on the rights of sex workers, adult asylum seekers, prisoners, asylum seeking children and young people in the context of HIV. It also addresses the means of redress for alleged violations of HIV-related rights in the UK.

The report considers the issues in light of binding international human rights instruments and policy standards that provide a framework on the application of international human rights law in the context of HIV. It also relies on the use of UN monitoring bodies and special procedures.

1.1.3. Evidence

The content of the report was informed by written evidence received from UK and international organisations and individuals and by discussions conducted with experts and professionals.

In addition to formal evidence, focus groups with former immigration detainees were conducted in London and Manchester in December 2006 and January 2007 with the help of Bail for Immigration Detainees, Medical Justice, African HIV Policy Network and Body&Soul. Those focus groups informed the report's section on the treatment of immigration detainees with healthcare needs.

1.1.4. Structure of the Report

Chapter 2 considers the situation of sex workers, in particular the impact of the current policy and legal prostitution framework on HIV prevention. Chapter 3 examines HIV-related issues within the context of asylum and immigration. It focuses on access to HIV treatment, detention, dispersal and removal. In Chapter 4, we consider current HIV-related policy and practice in UK prisons. Access to HIV prevention and the adequacy of medical care available to HIV-positive prisoners are examined. Chapter 5 deals with the issue of asylum seeking children in particular within the context of detention. It also considers sex education in schools and the impact of current policy on young people's ability to access information and protect themselves from HIV. The final Chapter examines the enforcement of HIV-related rights in the UK, in particular the central role of awareness and education and the potential and limitations of monitoring and enforcement of HIV-related rights.

1.2. Key Principles of International Human Rights Legal Framework

1.2.1. States' obligations

The international human rights legal framework rests on the postulate that human rights are universal and inalienable; indivisible; interdependent and interrelated.

Fundamental rights and freedoms are enshrined in international treaties and regional instruments which States can become party to and are accountable for.

States and State actors have binding obligations to *respect*, *protect*, and *fulfil* rights and freedoms set out in those legally binding standards.

This means that governments are responsible for:

- Not directly violating human rights;
- Preventing violations of human rights by non-state actors and providing legal means of redress; and
- Taking all appropriate measures towards fulfilment of human rights – including legislative, administrative, and budgetary measures.

These duties reflect States' "positive" and "negative" obligations. Positive obligations designate a protective duty of the State and address the question of the State as guarantor of human rights rather than violator. Negative obligations reflect the State's obligation to refrain from interference.

1.2.2. Justifications for States' Interferences with Human Rights

Under international human rights law, interferences with fundamental rights and freedoms that are "qualified" (as opposed to "absolute") may be justified when all of the following criteria are met:

(1) The restriction is provided for and carried out in accordance with the law;
(2) It serves the interest of a legitimate objective of general interest;
(3) Is strictly necessary to achieve this objective;
(4) Is the least intrusive and least restrictive means available; and
(5) Is not imposed arbitrarily or discriminatorily.

These criteria – although the wording may differ –are generally set out in human rights treaties.

1.3. The UK and International Human Rights Law

1.3.1. The UK as State Party to International Human Rights Treaties

The UK is party to the International Bill of Rights which comprises the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR); and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

It has also ratified the main international Conventions and instruments, such as the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), the Convention on the Rights of Child (CRC), the Convention for the Elimination of all forms of Discrimination Against Women (CEDAW) and its Optional Protocol, the Convention on the Rights of the Child (CRC), the Convention against Racial Discrimination (CERD), the 1951 Convention relating to the Status of Refugees and its 1967 Protocol, and regional standards such as the European Convention on Human Rights (ECHR).

The UK has made substantial reservations to some of the treaties and has not ratified a number of their subsequent protocols. In 2005, the Joint Committee on Human Rights (JCHR) published a review of international human rights instruments. The report provided an evaluation and recommendations of the government's reservations entered in respect of international treaties and its decisions on additional protocols.[8] The UK government has also refused to allow for individual petition under most treaties. Rights of individual petition are available under the ICCPR, CERD, CEDAW and the CAT. Individual petition permits anyone claiming to be a victim of a human rights violation under a treaty to bring their complaint before a monitoring/supervising body (Committee).[9]

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[8] Joint Committee on Human Rights, *Review of International Human Rights Instruments*, Seventeenth Report of Session 2004-05 (HL Paper 99, HC 264), March 2005.

[9] The treaty bodies include the Human Rights Committee (HRC) – which monitors the implementation of the ICCPR, the Committee on the Elimination of Discrimination Against Women – which supervises the implementation of CEDAW, and the Committee on Economic, Social and Cultural Rights – the supervisory committee of the ICESCR (note that there is no Optional Protocol to the Covenant on the right of individual petition).

1.3.2. The Human Rights Act 1998

The Human Rights Act (HRA) is designed to give further effect to the majority of the substantive rights and freedoms contained in the ECHR by making them directly enforceable in English courts.

The ECHR opened for signature on 4 November 1950 and entered into force in September 1953. The UK was among the first states to ratify the Convention but did not choose to incorporate the treaty into domestic law.

As a result, individuals who alleged a violation of their rights under the Convention had to bring a claim before the former European Commission and Court of Human Rights in Strasbourg.

The HRA received royal assent on 9 November 1998 and entered fully into force on 2 October 2000. The Convention under the HRA is not made part of English law, and thus is not directly justiciable in the courts. Instead the HRA gives further effect to most of the Convention rights by:

- Making it clear that as far as possible the courts in the country should interpret the law in a way that is compatible with Convention rights.
- Placing an obligation on public authorities to act compatibly with Convention rights.
- Making Convention rights directly enforceable in domestic courts.

Only an individual claimant can bring a case to court, and only public authorities and quasi-public bodies acting in a public capacity are liable under the Act. Liable authorities include government departments and bodies and local government.

Since coming into force, the HRA has been increasingly used to challenge government policies and legislation on HIV-related issues. Challenges tend to be through judicial review proceedings and based on assertions that government policy or legislation contravened one or more Convention rights.

1.4. HIV and Human Rights Policy Framework

There are no binding standards on the promotion and protection of HIV-related rights. There are however guidelines and declarations. Although non-binding, these provide crucial guidance on the translation of international human rights norms into practical observance in the context of HIV and AIDS.

1.4.1. International Guidelines on HIV/AIDS and Human Rights

HIV and AIDS are not explicitly mentioned in international human rights treaties. However, the United Nations has recognised the pertinence of human rights law in the context of HIV and AIDS. This is strongly reflected in the UNAIDS/OHCHR International Guidelines on HIV/AIDS and Human Rights (“International Guidelines”).[10] The *UNAIDS/Inter-Parliamentary Union Handbook for Legislators on HIV/AIDS, Law and Human Rights* (“the Handbook”) analyses each of the 12 International Guidelines and gives best practice examples of their implementation, in terms of content and/or process, at national and sometimes local and regional levels.

The International Guidelines are firmly anchored within a framework of existing human rights principles, norms and standards contained in various regional and international human rights instruments. They provide authoritative interpretations of human rights standards in the context of HIV and AIDS and aim to assist governments in translating human rights principles into practical observance.

[10] Supra, at 1.

The International Guidelines acknowledge the relationship between HIV and human rights by asserting that "[*t]he protection of human rights is essential to safeguard human dignity in the context of HIV and to ensure an effective, rights-based response to HIV and AIDS. An effective response requires the implementation of all human rights, civil and political, economic, social and cultural, and fundamental freedoms of all people, in accordance with existing international human rights standards (...)"*[11]

Although non-binding, the International Guidelines provide a powerful advocacy tool as governments are required to report on their implementation every two years. Furthermore, UN monitoring bodies such as the Committee on Economic, Social and Cultural Rights, have made reference to and recommended that States comply with the standards set out in the Guidelines.

The publication of the revised Guidelines in 2006 show that a decade after they were first published, they are still central to the promotion and protection of HIV-related rights.

1.4.2. UN Bodies Documents

UN human rights bodies, especially the former Commission on Human Rights, have made numerous statements on HIV and its implications for fundamental rights and freedoms guaranteed by international human rights standards. Some UN bodies have also published guidance and/or comments on specific HIV-related issues and their impact on States' legal obligations under international law.

For example, the UN High Commissioner for Refugees (UNHCR) published *"Note on HIV/AIDS and the Protection of Refugees, IDPs and Other Persons of Concern"*[12] ("Note on HIV/AIDS"). The document aims to inform governments of recognised standards in the field of HIV and AIDS and the protection of persons of UNHCR's concern. The Committee on the Rights of the Child published a General Comment (GC) on HIV and the rights of the child.[13] The GC aims, *inter alia*, to promote the realisation of the human rights of children in the context of HIV and AIDS and to identify measures and good practice to increase the level of implementation by States of children's HIV-related rights.

Finally, the *Declaration of Commitment on HIV/AIDS*[14] recognises the rhetorical value of human rights in the context of HIV and AIDS. Although the Declaration does not rest on a human rights legal and policy response to HIV, it does represent a strong commitment on behalf of leaders to promote and protect HIV-related rights.

[11] Ibid, p.16.
[12] Available at www.unhcr.org/publ/PUBL/444e20892.pdf
[13] *General Comment No 3 on HIV/AIDS and the rights of child"*, 2003 (available at www.unhchr.ch/html/menu2/6/crc/doc/comment/hiv.pdf)
[14] Available at http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf

2. SEX WORKERS

- ***The available evidence indicates that the UK is not fulfilling its obligations to guarantee sex workers' right to health or other fundamental human rights.***
- ***The current legal and policy reform is based on a public nuisance framework. It has major implications for sex workers' access to HIV prevention and sexual health services. It also impacts on sex workers' ability to control their working conditions, making them more vulnerable to violence.***
- ***Human rights must be the basis of any reform of sex work law and policy and legislation and legal reform must comply with the UK's human rights obligations.***
- ***The government does not involve sex workers and sex workers' organisations in decision making on policy and legal reform.***
- ***There are valuable lessons to be learnt from other jurisdictions' moves to decriminalise sex work or sex work related activities and the government should review the experiences of other countries in shaping legal and policy reform so as to ensure better protection of sex workers' rights.***

2.1. Introduction

Sex work is a large industry describing not only the street sex market but a variety of other areas such as massage parlours, strip clubs, phone lines, etc. Most of these activities are legal. In the UK, the proportion of men who reported paying for sex doubled in the decade from 1990 to 2000.[15] About 80,000 women in the UK sell sex and there are an estimated 164 million commercial sex transactions each year making an annual spend of £770 million pounds.[16]

2.2. UK Sex Work Policy and Legislation

2.1.2. Sex work legal framework in England and Wales

The main legislation relating to prostitution in England and Wales is contained in the Sexual Offences Act 1956, the Street Offences Act 1959 and the Sexual Offences Acts 1985 and 2003. The 1956 Act relates mainly to off street Prostitution, the 1959 and 1985 Acts to street prostitution and "kerb crawling". Although prostitution is not in itself an offence there are a wide range of sanctions for those who seek to encourage or exploit it.

Off-street prostitution

The main legislation referring to off-street prostitution is contained in the Sexual Offences Act (SOA) 1956. If a woman sells sex from her own home she does not necessarily commit an offence. However, if the premises can be categorised as a brothel, the offences of keeping or managing a brothel or allowing premises to be used as a brothel will be committed under the Act. Saunas and escort agencies are required to state that they are not offering sexual services in order to obtain a licence.

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[15] Ward H, Mercer C, Wellings K, *et al.* "Who pays for sex? An analysis of the increasing prevalence of female commercial sex contacts among men in Britain", *Sexual Transmission Infection,* 2005; 81:467–71.
[16] The Independent (2002).

Street Prostitution

Under the Street Offences Act 1959, soliciting is described as *"loitering in a street or public place for the purposes of prostitution".* A public place may include a balcony, a doorway or window, and no verbal exchange or disturbance is necessary for the prosecution to stand. The maximum penalty for soliciting or loitering is a fine.

Kerb-crawling (soliciting with persistence and in a manner likely to cause annoyance) is illegal under the Sexual Offences Act 1985. Soliciting need not be in words or action but the customer must indicate that he requires the services of a prostitute. Kerb crawling is an arrestable offence under the 2001 Criminal Justice and Police Act.

Police, local authorities and magistrates now also have the power to use Anti-Social Behaviour Orders (ASBOs) against sex workers and clients. ASBOs were created by the Crime and Disorder Act 1998 to enable the police or local council to apply to magistrates for an order to control "anti-social" behaviour, defined as *"a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household"*. ASBOs typically ban the subject of the order from an area, which may include the sex worker's home, as well as the premises of agencies sex workers need to access for health and welfare services. Some ASBOs ban the sex worker for soliciting anywhere in the country. If the ASBO is breached, this can result in a prison sentence of up to five years, even though soliciting is not an imprisonable offence.

As stated by Dr Sanders, Senior Lecturer in Sociology of Crime and Deviance at Leeds University, there seems to be a trend to use ASBOs in preference to prosecuting under the soliciting laws. Recent orders have included demands that the person not go to a particular area; not associate with particular people; and even not to purchase more than twelve condoms at a time.

"One particular case (…) is that of a sex worker in Manchester who was given an ASBO that included a condition not to carry condoms in the excluded areas. The excluded area was also where the drug clinic was located and which provided free condoms and a harm reduction service. The sex worker breached the Order and was put on probation."[17]

Prostitution Strategy

In January 2006, the Home Office published *A Co-ordinated Prostitution Strategy* for England and Wales. The document is the outcome of a 2004 public consultation on the *Paying the Price* White Paper and the first substantial review/overhaul of the laws on, and attitudes towards, prostitution in nearly 50 years.[18]

The Strategy aims to challenge the view that prostitution is inevitable and to achieve an overall reduction in the prevalence of street prostitution in particular and also commercial sexual exploitation. It also seeks to improve the safety of communities affected by prostitution, including the lives of women involved in street sex markets. The government plans to address prostitution through five strands of work – prevention, tackling demand, developing routes out, ensuring justice and tackling off street prostitution.

The Strategy tackles demand through criminalising the purchase of sexual services, whilst decriminalising sex work itself and offering welfare support for women. It does not provide concrete measures and only lists possibilities. The only tangible proposal is the crackdown on clients which has been criticised by sex workers' organisations for its emphasis on criminalisation and its effect on sex workers' safety and violence.

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[17] Dr Teela Sanders (Written evidence received).

[18] The last significant overhaul being the report of the Wolfenden Committee (1957). Other reviews include The Criminal Law Revision Committee, Sixteenth Report, Prostitution in the Street, Cmnd. 9329 (1984), para. 17 and the Sexual Offences Bill 1990 which never received Royal Assent. In addition, the Sexual Offences Act 2003 has also affected this area of the law.

The Strategy also states:

"There (…) needs to be a clear understanding that the purpose of the projects (i.e. outreach projects) is to develop routes out of prostitution as it has been reported that communities can have the perception that services for women on the street can attract prostitution or create a "comfort" zone."

As stated by UK Network of Sex Work Project, this statement is counter to many sex work projects' original purpose, which emphasised health needs while working in the sex industry, and not forcing sex workers to exit.[19] Also, until recently, many projects had no funding for exiting initiatives. This also worrisomely allows the prejudices of "communities" to override health priorities. The Strategy's measure that has received the most media attention has been the proposed reform of the legal definition of a brothel to allow two (or three) individuals to work together, which would be in line with the advice that women should not work alone in the interest of safety. However this proposal seems to conflict with the increase in sentencing for brothel-keeping from six months to seven years, making it a much more serious offence.[20]

2.1.3. Sex work legal framework in Scotland

Prostitution itself is not illegal. However most activities relating to it are criminal offences. Loitering, soliciting or importuning in a public place for purposes of prostitution are prohibited under the Civic Government (Scotland) Act 1982.

Although these offences are not imprisonable but subject to a fine, many women end up in prison for non-payment of fines. Prostitution is classed as a "crime of indecency", a sex-offence in the same category as sexual assault. Running brothels and "living off immoral earnings" are criminal offences. Under the Criminal Law (Consolidation) (Scotland) Act 1995 a man persistently soliciting or importuning for immoral purposes may be imprisoned for 6 months on summary conviction or 2 years on indictment. Under the Prostitution (Public Places) (Scotland) Act 2007 kerb crawling is now an offence in Scotland.

ASBOs have been introduced by the Antisocial Behaviour etc (Scotland) Act 2004 and are also used to tackle prostitution in Scotland. A breach of ASBO results in 6 months' imprisonment on summary conviction and/or a fine on indictment to 5 years' imprisonment and/or a fine.

2.3. HIV and Sex Work

Despite the lack of epidemiological evidence on HIV transmission from sex workers to clients, the stigma of "vector" of HIV transmission is still attached to sex workers. This unjustified and misconceived assumption adds to the existing stigma and discrimination faced by sex workers on the basis of their profession.

The government's *Paying the Price* contained multiple ill-conceived and stigmatising references that carried out the message of sex workers are spreading HIV. In particular, Section 7.22 of the document stated:

"Every effort must be made to deter men from this activity, sending a clear message that it is seriously anti-social, that it fuels exploitation and problematic drug use, and that going to prostitutes contributes to the spread of HIV/AIDS and STIs."

[19] Submission on the strategy consultation document *Paying the Price*.
[20] SOA 2003.

Kinnell cited comments by the police which exacerbate the perception of sex workers as vectors of HIV transmission:

"In 2003, Reading police (…) descended to using this tactic, claiming a local sex worker "had AIDS", to try to scare clients away[21] .In 2001, Wolverhampton police even used the arrest of a multiple rapist to raise fears about HIV: A police force today warned men about the possibility of contracting HIV from prostitutes after a man with the condition was charged with rape.[22"23]

The recent worrying increase in HIV and other STIs in the general population contrasts with a reduced HIV prevalence in sex workers.

Various studies have highlighted the high levels of reported condom use during commercial sexual activities[24] but they also acknowledge that some factors such as coercion, lack of knowledge, drug use, trafficking and economic hardship can influence the decision of not using condoms with clients.

As noted by Sanders, compliance with the discourses of safer sex is higher in indoor markers. Behind doors clients are more willing to accept the "house rules". In the street, sex workers are more likely to accept to have sex without condoms and men willing to pay higher prices in exchange for non-condom use because they are desperate for drugs.[25]

A survey carried out in 2004 in England and Wales found that all the areas surveyed reported extremely high levels of drug addiction amongst street sex workers.[26]

2.4. Impact of Law and Policy on Sex Workers in the context of HIV

2.4.1. Violence and Vulnerability to HIV

It is estimated that about six sex workers are murdered each year in the UK. It can be more. In December 2006, five young women involved in street prostitution were murdered in Ipswich.

Client violence against sex workers has been well reported. A study conducted in 1999 in Glasgow, Edinburgh and Leeds[27] reported that half of prostitutes working in the street and over a quarter of those working indoors reported some form of violence by clients in the past six months. High level of violence has also been found in Birmingham[28] and Nottingham.[29]

In 2002, a multi-centre survey of street workers conducted for Channel 4 *Dispatches* documentary showed that violence against street sex workers was significant.[30] Over 100 street sex workers were interviewed in 18 towns and cities across Britain. Three quarters of street prostitutes (73 per cent) reported being attacked by clients in the previous 12 months – 42 per cent on more than 3 occasions. Sixty per cent said they had either been badly

[21] *Police AIDS 'witch-hunt' criticized*, BBC News Online, Berkshire, 2/07/2003.
[22] *HIV warning to men using prostitutes*, PA News, 27.4.01.
[23] H. Kinnell, "Murder made easy: the final solution to prostitution", in *Sex Work Now*, eds. Rosie Campbell and Maggie O'Neill, Willan Publishing 2006.
[24] H.Ward et al., *"Declining prevalence of STI in the London sex industry, 1985 to 2002",* Sexually Transmitted Infections, 2004: 80, pp. 373-376. See also H. Ward et al., *"Risky business: health and safety in the sex industry over a 9 year period"*, Sexually Transmitted Infections (1999): 75, pp. 340-343.
[25] T. Sanders, *"A continuum of risk? The management of health, physical and emotional risks by female sex workers",* Sociology of Health and Illness (2004): 26(5), pp. 557-574.
[26] R. Matthews, *"Policing Prostitution – Ten years on"*, British Journal of Criminology (2005): 45, pp. 877-895.
[27] S. Church, et al., "*Violence by clients towards female prostitutes in different work settings",* British Medical Journal (2001): 322 (3 March).
[28] H. Kinnell, "*Prostitutes' exposure to rape: Implications for HIV prevention and for legal reform*", paper presented to the VII Social Aspects of AIDS Conference, South Bank University, London, June 1993.
[29] C. Benson (ed.), *"Health, Migration and Sex Work: The Experience of Tampep*", Amsterdam: Tampep International Foundation.
[30] Source: www.channel4.com/news/microsites/D/Dispatches/prostitution/ (last accessed Saturday 28 June 2008).

beaten up or raped in the previous 12 months. Forty-four per cent had been strangled (men had squeezed their throats).

Twenty seven per cent had been stabbed or threatened with knives; 8 women had been threatened with guns. Seventeen per cent said they had been kidnapped – taken somewhere in a car against their will. Fifty five per cent said men had refused to pay them for their services.

The main "triggers" for client violence have been identified as:

- Sex workers' refusal to do the type of sexual services asked by the client;
- Clients' refusal to pay;
- Time of transaction over before the client could ejaculate;
- Clients being unable to get an erection or ejaculate; and
- Sex workers' insistence on using condoms.

Legislation and policy on kerb crawling and policing activities impacts on sex workers' ability to control their working conditions. It also heightens their potential exposure to sexual violence and HIV: kerb crawling increases the pressure on sex workers to take risks in terms of condom use and other safer sex practices. It interferes with the process of negotiation between sex workers and clients by making interactions hurried and furtive, thus undermining the practice of safer sex and exposes sex workers to physical and sexual violence. It also pushes sex workers to work in isolated areas and disrupts their contact with regular clients regarded by them as an important safety strategy. Equally important it reduces contact between sex workers and outreach projects decreasing information access about violent incidents and clients.

The Channel 4 survey found that 87 per cent of women interviewed had experienced a police crackdown in their town or city in the previous 3 months. As a result of the police crackdown: 65 per cent said they worked longer hours; 40 per cent worked 'a lot more' hours; 71 per cent worked later into the night than usual, to avoid the police; and 24 per cent agreed to sexual services that they would normally refuse – like sex without a condom or anal sex. Only 1 per cent (2 women) said they stopped street sex work altogether as a result of police activity.

2.4.2. Access to HIV Prevention and Sexual Health Services

Current legislation and policies have major implications for sex workers' access to HIV prevention and sexual health services. The UK Network of Sex Work Projects' submission on *Paying the Price* highlights obvious conflicts between law enforcement and sexual health:

- Police interference with and harassment of health workers. It has been reported that police have threatened those who supply condoms and health advice, at both street and indoor venues, with charges of "controlling prostitution".
- The use of ASBOs and raids on indoor premises undermines the effectiveness of sexual health promotion. For example, possession of condoms has been judged as evidence for the granting of ASBOs and for proving breach leading to custodial sentence.
- Sex workers have to move to other areas where they may not have access to sexual health services.
- Condoms and sex worker-specific literature are still used as criminal evidence by some police forces. As a direct result, some sex workers are reluctant to take more than a small number of condoms from outreach workers.
- Police vehicles or officers on foot locating themselves very close to outreach vehicles or drop-in premises, thus deterring sex workers from accessing services and safer sex supplies.

Cusick and Boynton also noted:

"Outreach services and health researchers have noted increased fears among sex workers regarding the safety and confidentiality of [sexual health] services. Specialist healthcare services in red light areas face an uncertain future. Outreach work, provision of condoms, needle exchange schemes, and primary care for a population rarely registered with a general practitioner could be compromised if the [prostitution] *strategy is enforced and sex workers become reluctant to seek help. Without access to specialist fast track services for sexual health, sex workers may face delays in receiving treatment for sexually transmitted infections, which could have profound consequences both for sex workers and the wider population (…) Sex workers have a responsible approach to managing the risk of sexually transmitted infections, with a high prevalence of condom use for commercial vaginal sex (98%)."* [31]

2.5. Sex Workers, HIV and Human Rights

2.5.1. Sex Work and International Human Rights

Prostitution-specific instruments do not address the rights of sex workers who engage in prostitution by choice – even if a choice is made as a result of limited range of options. However, non-specific human rights treaties provide for the respect, protection and fulfilment of sex workers' rights.

As argued by Betteridge, at the most fundamental level, sex workers have the right to be treated with dignity and to enjoy the fundamental rights and freedoms guaranteed to all people in treaties.[32] As a party to both the ICCPR and ICESCR, the UK has obligations to guarantee sex workers' rights set out in those treaties.

These include the right to health protected under Art.12 ICESCR and defined by the Committee on Economic, Social and Cultural Rights' General Comment 14. GC 14 states that Governments *"are under the obligation to respect the right to health by (…) refraining from denying or limiting equal access for all persons (…)to preventive (…) health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs (…)* States should [also] *refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health (…)"* (at para. 34)

Current legislation and policy on prostitution interferes with sex workers' ability to access HIV prevention and sexual health services. It also exposes them to increased risk of violence and HIV infection from clients.

Interference with the right to health can be justified (Art.4 and Art.5 (1) ICESCR) under the test of proportionality. It is submitted that the government's interference with the right to health does not meet the criteria of the justification test. There is no evidence of less sex work or less crime associated with sex work. On the contrary, there has been a significant increase in men who buy sex over the past 10 years meaning that the current policy and legal framework does not effectively address the "public nuisance" it aims to target. It also exposes sex workers to serious risks for their health and welfare which outweigh the purported benefits to the community.

The government has also failed to look at the experience of other jurisdictions where cities with successful managed areas have seen the removal of street work from residential area whilst the availability of sexual health services onsite have enabled sex workers to access health services.

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[31] L. Cusick and P. Boynton, *Sex workers to pay the price*, British Medical Journal (2006): 332:190-191.

[32] Canadian HIV/AIDS Legal Network, "*Sex,work, rights: reforming Canadian criminal laws on prostitution*", July 2005.

2.5.2. Sex Work, HIV and Human Rights

The detrimental impact of punitive legislation and policy on sex workers' rights has been highlighted in the International Guidelines. Guideline 4 on criminal laws and correctional systems states that criminal law prohibiting sexual acts including sex work *"should be reviewed with the aim of repeal"*. The Guidelines also provide that *"with regard to adult sex work that involves no victimization, criminal law should be reviewed with the aim of de-criminalizing, then legally regulating occupational health and safety conditions to protect sex workers and their clients, including support for safe sex during sex work. Criminal law should not impede provision of HIV prevention and care services to sex workers and their clients".*[33]

The *Handbook* contains a section on criminal law and sex work. It acknowledges that the criminalisation of sex work impedes the provision of HIV prevention and care by driving people engaged in the industry underground. It further states that if sex work is treated as a personal service industry regulated by laws focusing on management responsibilities and ensuring occupational health and safety conditions for sex workers and their clients, public health objectives are more likely to be achieved:

"By recognizing the industry through regulation, some of the stigma associated with sex work would be removed. This would (…) alleviate the fear of public identification which ironically makes it more difficult to leave the profession. In improving working conditions, a culture of safer sex can be promoted in the industry and responsible behaviour by workers, clients and management can be encouraged."[34]

2.6. Conclusion

The 2001 APPGA report only made a minor recommendation on sex work which did not rest propose any options for reform of sex law which do not undermine human rights.

The available evidence indicates that the UK is not fulfilling its obligations to guarantee sex workers' right to health or other fundamental human rights. Sex workers face unsafe working conditions including violence, in many instances as a result of the criminalisation of sex work. Human rights must be the basis of any reform of sex work law and policy and legislation and legal reform must comply with the UK's human rights obligations.

The following principles should form the basis for legal and policy reform:

- It should ensure compliance with sex workers' rights as guaranteed by international human rights treaties.
- It should be based on and conform to the framework provided by the International Guidelines and the Handbook for Legislators on HIV/AIDS, Law and Human Rights. It should not be based on a public nuisance framework and should recognise sex work as an occupation.
- The government should actively involve sex workers and sex workers' organisations in decision making on policy and legal reform.
- There are valuable lessons to be learnt from other jurisdictions' moves to decriminalise sex work/sex work related activities and the government should review the experiences of other countries in shaping legal and policy reform so as to ensure better protection of sex workers' rights.

[33] At paras 21(b) and (c).
[34] Ibid, at page 56.

3. ASYLUM SEEKERS

- ***The government is currently failing to meet its obligations under international human rights law to guarantee asylum seekers' right to health and other fundamental rights and freedoms.***
- ***Despite being criticised by UN monitoring bodies, NGOs and parliamentary groups, the government has not only failed to take necessary actions recommended, but it has actually introduced additional measures which have led to further violations of human rights.***
- ***There is no evidence of so-called "health tourism" in the UK and current policy on access to NHS treatment and removal puts the lives of people with HIV in jeopardy or even amounts to a death sentence.***
- ***Although there is government guidance on the detention of asylum seekers, including specific provisions on healthcare for vulnerable people, research and case law show that there is a wide gap between theory and practice. Furthermore, despite concerns from the international community such as the HRC and the UNHCR about the UK's detention policy and extensive evidence of its detrimental impact particularly on vulnerable people, the government is blatantly disregarding the most fundamental principles that govern the treatment of asylum seekers in international law and policy.***
- ***The lack of cross-departmental HIV and human rights strategy has a significant impact on Home Office policy and decisions and leads to incoherent domestic and international policies regarding access to HIV treatment.***

3.1. Introduction

Since the 9/11 attacks in New York, the "war on terror" has led to an erosion of human rights in the UK, including the right to asylum. It only but added to existing public concerns about "the asylum issue" which has gained momentum since the 1990s. Over the last few years the government's approach to migration has overwhelmingly relied on the assumption that asylum seekers are not fleeing torture and persecution but are health or economic migrants. Changes in policy and legislation on asylum have had a significant impact on asylum seekers' rights, including in the context of health and HIV.

Concerns have been raised both in the UK and internationally. Numerous reports have highlighted the consequences of policy and legislation on those seeking asylum. Most recently, the Joint Committee on Human Rights (JCHR) conducted an Inquiry into the Treatment of Asylum Seekers. The Inquiry's report concludes that the treatment of asylum seekers in a number of cases reaches the human rights threshold of "inhuman and degrading treatment".[35]

This chapter of the report does not intend to duplicate existing publications on the UK asylum policy and legal framework and the treatment of asylum seekers. It provides an overview of the current issues and then examines the implications of current policy on asylum seekers living with HIV.

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[35] JCHR, Tenth Report, The Treatment of Asylum Seekers, March 2007 (available at www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/81/8102.htm).

3.2. Asylum Seekers' Access to HIV Treatment and Care[36]

3.2.1. Healthcare Needs of Asylum Seekers

The healthcare needs of asylum seekers have been examined in numerous reports. The common themes and issues that have been raised are:

- Most asylum seekers' health problems are not specific to their status and are shared with other deprived or excluded groups. Health problems that are specific to asylum seekers originate from the physical or mental torture, or other harsh conditions from which they have escaped.
- Some asylum seekers come from countries where access to healthcare is difficult due to conflict and lack of resources and as a result, they tend not to have received the appropriate immunisations and vaccinations and are susceptible to infectious diseases when held together for several months with other asylum seekers.
- It is estimated that over 50% of women refugee and asylum seekers in the UK, the majority of whom come from Africa, are fleeing rape - mostly perpetrated by soldiers, police or agents of the state.[37]

Common healthcare needs that have been identified include:

Physical Needs:
- Communicable diseases (TB, HIV, Hepatitis A, B and C, parasitic diseases);
- Physical effects of war/conflict/torture;
- Maternal care; and
- Sexual health care (for example as a result of rape and/or sexual violence).

Psychological Needs:
- Symptoms of psychological distress, depression, anxiety;
- Post-traumatic stress.

3.2.2. Policy and Legislation on Asylum: Access to HIV-related Healthcare and Treatment

Access to Primary Care

The current policy on entitlement to primary care is unclear. Asylum seekers have a right to free primary care until their claim is decided. NHS Circular 1999/018 Overseas Visitors' Eligibility to Receive Free Primary Care states that refused asylum seekers should not be registered with a GP. However, GPs have discretion as to whether or not to accept anyone onto their list, including a refused asylum seeker or anyone who is not ordinarily resident or is unlawfully in the UK.

A GP has three options if a refused asylum seeker applies to join their list: accept them as a permanent patient; treat them as a temporary patient; or refuse to accept them on their list and charge for treatment as a private client.[38] A GP must provide emergency treatment or immediately necessary treatment for a maximum of 14 days to a temporary patient. Registration with a GP does not provide entitlement to referral for hospital care. There is evidence of problems with registration especially because of the burden of documentation (e.g. proof of address and ID) required on registration and the confusion about entitlement to primary care.

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[36] This section is based on the UK AIDS and Human Rights Project's Response to the Joint Committee on Human Rights' Inquiry into the treatment of asylum seekers.
[37] Women's Resource Centre, *WhyWomen?*, 2006.
[38] See NHS (General Medical Services) Regulations 1992 as amended and Circular 1999/018.

In August 2004 the government completed a consultation on *"Proposals to exclude overseas visitors from eligibility to free NHS primary medical services"*.[39] Under the new proposals GP practices would have no discretion to register overseas visitors, refused asylum seekers, people who overstay their visas, and those without official papers, although the provision for emergency and immediately necessary treatment would remain. The consultation's conclusions have not been published.

Access to Secondary Care

In England, provisions on access to secondary for asylum seekers are set out in the National Health Service (Charges to Overseas Visitors) Amendment Regulations 2004 which amended the 1989 National Health Service (Charges to Overseas Visitors) Regulations 1989. The amended Regulations came into force in April 2004 and have been implemented through the Department of Health Guidance for NHS Trust Hospitals ("*Implementing the Overseas Visitors Hospital Charging Regulations*").[40]

According to the 2004 Guidance, asylum seekers have access to free secondary care until their claim is decided. Refused asylum seekers and undocumented migrants are not entitled to free hospital healthcare (except in an A&E department) and free HIV treatment and care on the NHS. Treatment for TB remains free. Only HIV testing and the associated counselling are available free of charge. NHS Trusts and Primary Care Trusts have to identify people who are not ordinarily resident or otherwise exempt from charges for hospital treatment and to charge them for treatment.

The implementation guidance was quickly deemed inadequate and misleading in its interpretation of the concept of "ordinarily resident" (i.e. "a person not ordinarily resident in the UK"). An overseas visitor who is ordinarily resident is entitled to free NHS treatment, whilst only unlawful residence disqualifies a person from becoming ordinarily resident in the UK, and therefore liable to NHS charging. The Guidance also stated that refused asylum seekers did not become exempt from charges after 12 months. It was therefore misleading and wrong as it failed to distinguish refused asylum seekers who are lawfully present in the UK and those who are unlawfully present. The Guidance was also criticised for failing to make it clear that refused asylum seekers who cannot reasonably be expected to leave the UK, for example because they have made a further application for Leave to Remain on ECHR grounds that is not manifestly unfounded, are entitled to free NHS Care.[41]

The Guidance was challenged before the High Court in the test case *R (A) v. Secretary of State for Health and West Middlesex University Hospital NHS Trust*.[42]

"A" was a refused asylum seeker who suffered from chronic liver disease with several consequential illnesses. His condition deteriorated and he was admitted to West Middlesex University Hospital through A&E. The treating clinicians suspected that he had lymphatic cancer but because of his immigration status and that he could not pay for his treatment, they refused to carry out tests and sent him home. "A" applied for judicial review of the government's guidance. The court decided that the Guidance was wrong in failing to recognise that refused asylum seekers may still be entitled to free treatment despite the 2004 Regulations. The judge therefore decided that all refused asylum seekers who have been granted temporary admission should be considered "ordinarily resident" in the UK, and should not be charged for treatment. They can demonstrate their "ordinarily resident" status by showing the hospital an IS96 form (which everyone receives when they first make a claim if they are not being detained or when they leave detention).

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[39] Department of Health, *Proposals to exclude overseas visitors from eligibility to free NHS primary medical services: a consultation*, 2004.
[40] Guidance available at www.dh.gov.uk/assetRoot/04/10/60/24/04106024.pdf
[41] See *R (Binomugisha v. Southwark LBC* [2006] EWHC 2254 Admin and *R (JB) v. Haringey LBC and Secretary of State* [2006] EWHC 2255.
[42] [2008] EWHC 855 (Admin).

However, people who have overstayed their visas and not made any further application that led to them getting an IS96 form (temporary admission), and people who are completely undocumented (i.e.; who have never presented themselves to the immigration authorities or made any application for leave to remain) are charged for hospital treatment. The Department of Health is to appeal the decision. It may be many months before that appeal is heard and resolved. However, any decision on the appeal may cause the guidance to be changed again. The Home Office and Department of Health intend to publish a joint consultation in Summer 2008 on access to healthcare for foreign nationals in the UK.[43]

Following the judgment, the Department of Health issued a new guidance explaining how the 2004 guidance should now be applied. The new guidance does not mean that all refused asylum-seekers will necessarily receive free hospital treatment. This may still depend on whether it is thought the person meets the ordinarily resident test. However, a refused asylum-seeker who has been in the UK for more than 6 months and can show a current IS96 form granting temporary admission is now likely to receive free treatment. Others may also receive free treatment.

The changes made in England were also made in Wales where a very similar guidance was issued. However, the Welsh Assembly Government decided not to follow the Department of Health in issuing further guidance and announced in May 2008 that healthcare treatment will be available free to all refused asylum-seekers. The situation in Northern Ireland and Scotland has been very similar although changes were not made in the same way as in England and Wales in 2004.[44]

3.2.3. Policy and Legislation on Asylum: Access to Support Services and Housing

Reports by NGOs and the recent findings of the JCHR's inquiry into the treatment of asylum seekers leave little doubt as to the negative consequences of current policy on health related determinants. These include accommodation, access to food and other means of support.

Home Office Policy

Asylum seekers are entitled to free health and social care services in addition to the housing and subsistence support from National Asylum Support Service (NASS).[45] Those refused asylum are entitled to virtually no welfare, health or social care services and are left destitute.

Home Office support (or "section 4")[46] enables refused asylum seekers who are no longer able to receive full NASS support to apply for reduced provision of accommodation and food or voucher but no cash. Section 55 of the Nationality, Immigration and Asylum Act 2002 which provided for the withdrawal of welfare support for childless adults who did not apply for asylum *"as soon as reasonably practicable"* after arriving in the UK was challenged in courts with the final reaching the House of Lords in November 2005 (post-HRA)[47] with the Lords finding a breach of human rights. Yet, section 55 continues to be used in subsistence-only support (i.e. support without accommodation).[48]

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43 ILPA Information Sheet, Access to Healthcare, May 2008.
44 Ibid.
45 The National Asylum Support Service (NASS) was set up under the Immigration and Asylum Act 1999 to provide support and accommodation for destitute asylum seekers.
46 Section 4 of the 1999 Act, as amended by the Nationality, Immigration and Asylum Act 2002 and Section 10 of the Asylum and Immigration (Treatment of Claimants, etc.) Act 2004.
47 *R v. SSHD ex parte Adam/Limbuela/Tesema (conjoined appeals)* [2005] UKHL 66.
48 There is no formal appeal mechanism against negative decisions under Section 55. Asylum seekers may apply to be reassessed in circumstances of extreme poverty, or where a doctor or hospital can testify to physical or mental health problems, particularly when these can be shown to arise from their living conditions.

Local Government Policy

Under section 21(1) of the National Assistance Act 1948 local authorities must provide destitute asylum seekers with special needs not related to their destitution with residential accommodation and associated assistance. All asylum seekers with special needs have the right to a community care assessment carried out by the social services.

There is no clear guidance on local authority responsibilities towards asylum seekers with healthcare needs.[49] In Scotland, the responsibility for caring for asylum seekers with healthcare needs falls under the IND. There is evidence that assessments are not carried out even when requested and that there are significant delays often caused by a dispute between NASS and the local authority over who should provide the services. This has led to a series of court cases which resulted in the local authority having to provide support.[50] However, some asylum seekers in desperate need of services can end up being denied them completely because a dispute is never resolved.[51]

3.2.4. Impact of Government Legislation and Policy on Asylum Seekers' Rights in the context of HIV

Access to treatment and care

The effects of the 2004 Regulations on secondary care have been highlighted in various pieces of research and organisations working on the ground.

The Refugee Council's report *First do no harm: denying healthcare to people whose asylum claims have failed*[52] has highlighted the case of 37 patients denied treatment as a result of the 2004 regulations. The report mentions the case of two refused asylum seekers who were denied HIV treatment as a result of the regulations:

"N is an Eritrean man who tested positive for HIV after his appeal rights were exhausted. His trust has refused to prescribe him anti-retroviral therapies unless he is able to pay (…) O is a Zimbabwean woman with cancer and possible HIV infection from her husband who died of AIDS. Her Trust denied her cancer care, and offered to test her but not treat her, for HIV".

The report emphasises that asylum seekers whose claims have been turned down may remain in this country for various genuine reasons - for example, appealing against the decision - but will have little or no income. Many are presented with bills, even for a few hundred pounds, which effectively prevent them from accessing care, whilst others are "chased" by debt collection firms.[53]

Numerous organisations have also highlighted the confusion about entitlement to primary and secondary care which results in people entitled to free healthcare being turned away from surgeries, refused healthcare or charged for it:

"This has occurred because medical staff may not have sufficient understanding of the (now relatively complex) rules governing entitlement, people have been mistaken for failed asylum seekers or because they have not been given the right documents. It is unrealistic to expect frontline NHS staff (i.e. GP receptionists) accurately to assess people's immigration status and eligibility for NHS treatment."[54]

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[49] JCHR Report, supra at 35, at para. 113.
[50] Ibid.
[51] Refugee Council, *A Study of Asylum Seekers with Special Needs*, April 2005.
[52] June 2006 (available at www.refugeecouncil.org.uk/policy/position/2006/healthcare.htm)
[53] Ibid.
[54] Liberty's submission to the JCHR's Inquiry, available at www.liberty-human-rights.org.uk/pdfs/policy06/treatment-of-asylum-seekers.pdf

The confusion about entitlement to primary care and the variation in practices, and the detrimental impact of the measures imposed to stop so-called health tourism were highlighted in Médecins du Monde UK first year report of Project London published in July 2007.[55]

The detrimental impact of the regulations on HIV treatment and testing has also been widely highlighted in the submissions we received:

"Many of our African clients are concerned about their entitlement to HIV treatment. They are fearful that if their immigration status is not settled, they may have to pay for their HIV treatment. This situation clearly deters African people who might want to test for HIV but are concerned that they may not be able to access HIV treatment if they test HIV positive."[56]

"Many of the sex workers in South London do not know their HIV status because they have not tested for HIV. Some feel that there are limited benefits in testing for HIV because if they test positive, they would not be able to access HIV treatment for free in the UK because of their uncertain immigration status. Others are fearful of testing positive, of being deported and then not accessing treatment in their home countries."[57]

"We are concerned that the way NHS treatment charging is perceived among migrants at risk of HIV, means that fewer people come forward for testing, leading to more, avoidable, transmissions and to people presenting for testing and treatment at a late, acute stage of HIV illness. Late presentation increases costs that will be borne by the NHS because crisis treatment is then "urgent" or "immediately necessary" and must be provided under the regulations. Treatment charging is a deterrent to HIV testing among one of the two groups in the population who are most at risk of HIV."[58]

Access to adequate housing and means of support

- Inadequacy of NASS Support

The impact of the NASS support system on HIV-positive asylum seekers' health has also been reported. Lack of cash support, inability to access social services and inadequate accommodation are some of the key problems that have been raised.

A study of organisations working with refugees and asylum seekers found that 85 per cent of the organisations interviewed reported that their service users experienced hunger; 95 per cent said that their service users could not afford shoes or clothes; and 80 per cent reported that their service users were unable to maintain good health.[59] Although not specific to HIV-related needs, all those facts are relevant in the context of this report. A person living with HIV needs to eat healthily and protect themselves against potential infections which they are more prone to because of their weakened immune system.

The Refugee Council's report on the needs of asylum seekers[60] states that asylum seekers living with HIV are not automatically entitled to social services. The criteria are tight and they will only qualify for social services support if they are unable to care for themselves and have no other friends or immediate family members to help them.

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[55] Report available at www.medecinsdumonde.org.uk/doclib/155511-plartwork.pdf
[56] Written Evidence by Positive East.
[57] Written Evidence by African Culture Promotions.
[58] Written Evidence from George House Trust.
[59] J. Penrose, *Poverty and asylum in the UK*, London: Refugee Council and Oxfam, 2002..
[60] Supra, at 51.

The report mentions the case of people living with HIV who used the small amount of cash provided by NASS for food and the money left for emergency travels to hospital:

"*Khalid is HIV-positive. He has a loaf of bread, a liter of milk and jam in the fridge for his meals and saves his remaining money for hospital travel and a phone card to speak to his mother in Africa."*

The Refugee Council's report also addresses the issue of accommodation, in particular the common use of shared accommodation and its implications for people experiencing HIV treatment side-effects and the lack of privacy to deal with a new HIV diagnosis.

Body & Soul and George House Trust have provided evidence on the housing situation for HIV-positive asylum seekers:

"We shared one bathroom, one toilet and one kitchen with eight other men. I was so sick at the time. We lived among rats and cockroaches. The rats were just walking around the house, even in daylight. Michael would wake up screaming because a rat had jumped onto his face. That's what he would wake up to—a rat on his face. He would scream and cling to me every time he saw one and scream in his sleep because he always felt them on him. We lived there for two years before the council finally got us a two bedroom house with a garden." (Body & Soul)

"We have one memorable woman who has caught numerous mice in her property. Another person's 1 year old son has fallen downstairs twice because of a faulty safety gate. We have had an example of one subcontracted provider telling a client of someone else's HIV status. Often providers do not understand HIV at all and some basic level of knowledge / awareness should be required.

We have many people accommodated in shared accommodation. The storage of HIV medication (i.e. in a fridge) often necessitates single accommodation if confidentiality is to be maintained. We then have to make the case for single accommodation. There frequently seems to be no real will to work towards solutions or good quality housing / support for people. There is a clear argument that all HIV-positive people should have their own single accommodation. Shared houses are not appropriate accommodation.

I have never seen a house that has a secure place to store information and papers meaning that confidentiality around HIV status is easily breached. We have worked with people whose HIV status has become known in this way." (George House Trust)

- Destitution

The large majority of refused asylum seekers are denied support under Section 4 and are left destitute. They have to rely on charities and families to live. A report by Citizens Advice Bureau (CAB) found that thousands of asylum seekers and refused asylum seekers entitled to support are being left destitute because of regular failures by NASS and its accommodation providers.[61]

[61] Citizens Advice Bureau, *"Shaming destitution – NASS Section 4 Support for Failed Asylum Seekers who are temporarily unable to leave the UK",* June 2006, available at www.citizensadvice.org.uk/shaming_destitution (last accessed Saturday 28 June 2008).

Case study (Positively Women):

"Ruth came to the UK in May 2002, aged 61 years old, and was diagnosed HIV positive in August 2002. On arrival in this country she immediately applied for asylum on seeking protection from persecution grounds. During the application process Ruth started suffering from severe mental illness, requiring support from Social Services and regular sessions with a psychiatrist. However when Ruth's appeal for asylum was finally turned down, she found that both support from NASS and Social Services were automatically withdrawn. Despite her mental illness Ruth was left destitute and homeless. A friend was able to take Ruth in, however that friend in turn became ill, was admitted to hospital and Ruth again became homeless. Finally Social Services agreed to provide Ruth with temporary accommodation; however she receives no NASS support and relies on charity to survive."

Case study (Body & Soul)

"I was raped in Zimbabwe and subsequently tested positive for HIV. I came to the UK with the aim of seeking asylum. I went to the clinic and had my blood tested once more. When I called for my results, they said I was completely fine. What I didn't know at the time was that the HIV test was not included with the other STIs. I did not think to ask about HIV and they did not tell me that it was not included. So I assumed I was ok and that my test in Zimbabwe was wrong. At my Home Office interview, they said that my case was not strong enough—that because I was healthy, I could go back to Zimbabwe and find work. I began to get ill shortly after and went back to the GP. They tested again and found me to be HIV positive. I started medication right away. Upon return to the Home Office, however, they said that I had waited too long to make an asylum application. The GP did nothing to support me or explain the mistake made earlier. The Home Office refused my right to appeal. I now live without any benefits from government and without the right to work. I rely on friends and my partner to support me completely—even in paying my travel costs so I can sign in at the Home Office once a month."

Research has shown that destitution is characterised by a number of recurring consequences, including: lack of shelter and sleeping rough; unsanitary and vermin infected accommodation, lack of privacy in accommodation, inability to feed and cloth oneself, and a reliance on informal support structures:

"Many vulnerable people, including pregnant women, families with children, and people with long term or even potentially fatal health conditions, have not been able to get any support from Section 4 or social services. They are often left in perilous circumstances, literally on the streets, depending on solidarity or in circumstances that may be dangerous."[62]

Destitution has a major impact on refused asylum seekers' health, even more so if they have special healthcare related needs. The Refugee Council reported that the anxiety caused by Section 4 and loss of support may create or aggravate ill health.[63]

"I worry about HIV-positive women being forced to turn to sex work in order to support themselves. I am concerned for other HIV positive women obliged to remain in difficult or violent situations. Many people are forced by destitution to work illegally, but have no legal right to work. What else can people be expected to do? This irregular / illegal working leaves them highly vulnerable to abuse and exploitation at the hands of the people who are prepared to employ them."

[62] Refugee Action, *The Destitution Trap*, 2006, available at www.refugee-action.org.uk/campaigns/destitution/NewDestitutionReport.aspx
[63] Ibid.

“People with HIV are often living in the most tenuous of situations, outstaying their welcome with friends who are not aware of their HIV status. The essential minimum 95% level of compliance with HIV drug treatment regimes can be impossible in these situations too.”[64]

In the specific context of HIV, the lack of access, to adequate food and accommodation will have a significant impact on a person’s health and will undoubtedly lead to a worsening in their condition.

3.3. Detention of HIV-Positive Asylum Seekers

3.3.1. Overview of UK Law and Policy on Detention

Under Immigration Act powers, it is the executive which authorises the detention of people who have sought asylum. No judicial authorisation is required and there is no prompt and automatic judicial oversight of the decision to detain, nor are there automatic judicial reviews of the continuance of detention.

Stated UK policy allows for detention to be used to prevent absconding; to establish identity; to remove people from the UK at the end of their asylum or immigration case; and for the purposes of making a decision on a claim for asylum deemed to be straightforward and capable of being decided quickly. There is no upper or lower age for being detained as asylum-seekers or immigrants.

There are nine immigration removal centres in England and one in Scotland. Of these ten centres, six detain men only and the other four are mixed centres. Children in families are detained at Tinsley House, Yarl's Wood or Dungavel House.

Operation of seven out of the ten centres is sub-contracted by the Home Office to private profit-making companies, most of them to the multi-national GSL (Global Solutions Ltd). They in turn sub-contract healthcare to a second private profit-making company. The Home Office, with whom ultimate responsibility lies, does not employ any doctor to advise it on healthcare in immigration detention. The other three centres are converted criminal prisons run by the Prison Service and healthcare responsibility lies with the NHS. In April 2007, Serco Group Plc took over the running of Yarl’s Wood from GLS.

Asylum seekers can be detained at any stage of their application for asylum or their claim to remain in the UK. The use of detention is also not restricted to people who face removal shortly. Detention is increasingly used for “fast track” cases that the government considers can be decided quickly.[65]

There are guidelines for immigration detention contained in the Home Office instructions, the Operational Enforcement Manual (OEM), and the statutory Detention Centre Rules.

The OEM states that detention must be used sparingly, and for the shortest period necessary. It also includes a section on factors that influence a decision to detain (excluding pre-decision fast track cases):

- There is a presumption in favour of temporary admission or temporary release.
- There must be strong grounds for believing that a person will not comply with conditions of temporary admission or temporary release for detention to be justified.
- All reasonable alternatives to detention must be considered before detention is authorised.

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[64] Written Evidence by George House Trust.
[65] Bail for Immigration Detainees, Briefing, *Immigration Detention in the UK - Key facts and figures*, June 2007.

- Once detention has been authorised, it must be kept under close review to ensure that it continues to be justified.
- Each case must be considered on its individual merits.

The manual lists people who are "normally considered suitable for detention in only very exceptional circumstances, whether in dedicated IS detention accommodation or elsewhere". These include people suffering from serious medical conditions or the mentally ill and those where there is independent evidence that they have been tortured. The manual does not provide a definition of "very exceptional circumstances" and there is evidence that very often, those groups are detained.

The Detention Centre Rules 2001 also contain guidance on the treatment of people with special illnesses and conditions. In particular Rule 35(1) states:

"The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention."

Finally the Detention Services Operating Standards introduced in 2002 provide information on the standard of healthcare in detention centres.

3.3.2. Impact of Detention of Asylum Seekers' Health

The UNHCR has emitted serious concerns about the detention of asylum seekers in the UK:

"*UNHCR understands that under current legislation any asylum seeker, including minors and other vulnerable persons, may be detained at any stage of their asylum claim, that there is no maximum period an individual may spend in detention, and that continued detention of any one individual is subject to internal administrative review conducted by IND caseworkers and immigration officers only (…) UNHCR further notes the continued practice of detaining vulnerable individuals."*[66]

Several reports have provided medical evidence on the inadequacy of conditions of detention for asylum seekers with healthcare needs, including in the context of HIV. These include:

- *"The Health and Medical Needs of Immigration Detainees in the UK: MSF's Experiences"* published by Médecins Sans Frontières (MSF) in November 2004.
- "*Fit to be detained? Challenging the detention of asylum seekers with health needs"* published by Bail for Immigration Detainees (BID) in May 2005.
- *"Migration and HIV: Improving Lives in Britain*" published by the All Party Parliamentary Group on AIDS in 2003.
- Several reports by the HM Inspectorate of Prisons have included evidence of the failure of detention facilities to meet the healthcare needs of detainees, that it be for short or longer periods.[67]

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[66] UNHCR London 2005.

[67] For example, the publication of the report on the "*Inquiry into the quality of healthcare at Yarl's Wood immigration removal centre"* by the HM Inspector of Prisons in October 2006 revealed the appalling conditions in the centre and concluded that the centre's healthcare service was not geared to meet the needs of those with serious health problems or the significant number of detainees held for longer periods for whom prolonged and uncertain detention was itself likely to be detrimental to their well being; weak clinical governance systems; inadequate staff training; insufficiently detailed policies and protocols, and the lack of mental health care provision. Issues like the lack of routine professional check ups soon after arrival leaving some health problems undetected, the use of handcuffs, the lack of contracted healthcare input for local GPs or nurses, healthcare professionals only called in an emergency with staff required to make a judgement on what constituted an emergency themselves were mentioned in the *"Report on four STHFs (Luton, Waterside Court, Portsmouth, Stansted) May 2005 - January 2006"*. The lack of communication between detention centres and community healthcare professionals, the absence of specialised care, the lack of shared medical records between the different centres and GPs, the removal of medication on arrival as blanket policy, and the reluctance to use interpreters or language line making it difficult for detainees to discuss their health concerns and reveal

UK AIDS and Human Rights Project, with the support of Bail for Immigration Detainees, Medical Justice, Body&Soul and AHPN, organised focus groups with former immigration detainees. One meeting took place in December 2006 and one in Manchester in January 2007. One woman who attended the focus group in London was HIV-positive. The eight women who participated to the focus group in Manchester were all HIV-positive. The purpose of the focus groups was to bring together people who had first hand experience of immigration detention in the UK, to discuss the issue of health treatment in detention particularly in relation to HIV.

The main issues raised by the participants included:

- No time to prepare before being taken to detention

The former detainees of the London focus group described being given a very short time (often 30 minutes) to pack up their things before being taken to detention. One HIV-positive woman described how officers came to detain her while she was in the shower. She was given so little time that she did not even get to rinse off the conditioner in her hair and was shocked and became disoriented. She had very little time to pack her things up but managed to pack her HIV medication in one of her bags. However, when she arrived at the police station, officers said they did not bring the bag, which led this woman to not receive her medication for three days. For those who arrive at a removal centre after the fixed supper time, no evening meal is available, and they must wait until morning to be fed. One woman was only offered a banana and some water. This meant she couldn't take her medication with food as directed.

- Getting access to medication and health treatment is very difficult in detention

Accessing medication was a significant issue. Participants explained that it was not often available and took time to be delivered. The HIV-positive participant of the London focus group was refused her normal medication and offered a substitute. The nurse suggested she took an overdose as the substitute has lower dosage than her normal medication. The detainee knew that she would develop resistance and would get the side-effect of tingly eyes if she followed the nurse's advice. Furthermore, if she were to take the double dosage as the nurse had suggested, the medication would have run out.

A woman attending the focus group in Manchester recalled her arrival at Oakington detention centre where she was asked what her medication was for. When she said her records say she was HIV-positive, she was told: *"You don't look sick so you don't need medication".* She did not receive her medication for 3 months. This meant her body developed a resistance to the drugs, which led to her having to start her treatment all over again with a new, more expensive cocktail of medication.

Another participant in Manchester mentioned that when people request medication when it ran out, it can even take one week to get it. She also reported that there are delays in taking detainees to the hospital "*because there is no doctor for HIV in the detention centres".*

Most of the ex-detainees from the Manchester focus group said that after their release, they told their consultants that they had not had access to treatment in the centres, but the consultants would not speak up or say anything about it.

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health issues that were relevant to their asylum claims, were issues reported in *"Tinsley House, Haslar, Oakington, Campsfield House and Lindholme (an Inspection of five IRCs)".*

A woman was interviewed by the Home Office, and then arrested. She did not speak any English. She said she had to see a doctor because of what she went through in her country:

"At Yarl's Wood they didn't give me a doctor or anything because I wasn't able to speak English… I didn't eat. I went to the airport; I resisted. I said 'My life is in danger'. I resist, they were trying to push me, I resist. They put me in a room. I want to see a doctor. I'm not feeling well. I'm sick all the time. I can't eat I can't sleep. In that time I don't have any solicitor I don't have anybody. I started to ask how I can go to healthcare. I have to go to do a blood test 'cause of what I've been through. I take paracetamol for one month. I wasn't able to eat; I wasn't able to sleep. I was like 'I'm going to die'… A guard asked 'What's happened to you?' 'I need to see a doctor I need to do a blood test, I'm sick, it's not normal' so I had a blood test and they said 'you are HIV positive.' I was ashamed to take it in front of my friends 'cause I don't know how they're gonna react…"

The lady got two weeks worth of medication and was told by the doctor that she was expected to start getting sick and that she needed to come back when the medication ran out. The personnel at the centre later told her there was no appointment for six weeks.

- The liaison process with GPs and doctors regarding patients' care and treatment is extremely poor

Manchester focus group's participants said that there was no evidence at all of any attempt being made to create any kind of connection between people in the detention centre and doctors outside in relation to patient care and treatment. None of the participants ever saw medical notes inside the detention centre. They saw personnel note down when the detainees were in and out of the centre but nothing concerning medical history or treatment. No one was ever told what they could do if they needed help with their health.

- Confidentiality is not respected as people are being given HIV medications in front of other detainees

For those who do receive medication, a few detainees from the London focus group explained the problems associated with collecting it. Detainees cannot keep medication on them and so all medicine is located in the health care centre. This means that individuals have to walk to the centre up to four times a day to collect their drugs escorted by guards, and some find this humiliating, embarrassing, or fear stigma. One woman talked of the complete lack of confidentiality within the process of receiving medication. This situation meant that many people in detention, including her room mate found out that she was HIV-positive when she did not want anyone to know. She stated: *'however much I am sick I don't want my issues, whatever my problems are, to be discussed'*.

Some participants in Manchester reported that when they were given access to their medication, it was in an entirely unprofessional manner. Medications were given in front of the other detainees so everyone knew who was HIV-positive and who was not.

"They don't need to ask – the person's name is on the bag with the medication. 'They just want to feel you ashamed, to show you are HIV, to let you know, to everybody.' 'To embarrass you – there's a bad connotation to it. They just want to make the worst out of the situation for you."

- Lack of medical staff with specific knowledge of HIV in the detention centre and lack of understanding of HIV amongst some nurses at hospitals

A participant in Manchester recalled: *"It's painful to be in detention with HIV. You don't find any consultant or doctor for HIV. They have those people training to be nurses or doctors. When I came back [to Yarl's Wood] from the airport, I went to the doctor and said 'I'm HIV positive and I need my medication' and the doctor said 'Don't call it HIV, its AIDS, and the solution for that, you have to die'… 10 months with no treatment."*

Another participant who was taken to a hospital in Birmingham said: *"Some of the nurses, they don't understand this HIV, or how is it being transmitted … There are other people in the side room. When they go to give them their food they don't wear gloves, but when they come to me, they wear gloves – they wear everything, something over their mouth – whatever!"*

- There is no access to adequate food for people on ARVs

Participants in London explained that meal times were at strict times which often did not coincide with the times people are supposed to take their medicine. A participant explained that she was given sandwiches for her night dosage of ARVs. However, she raised concern because sandwiches and in fact, all the meals in detention, are not nutritious enough for HIV positive individuals who need specific dietary requirements for ARVs to work effectively.

One woman attending the group in Manchester needed to take her medication at a specific time on a full stomach. It was agreed she could have a sandwich at that time, but every day the guards grabbed it off her. Every day she had to explain that she was allowed it. When another detainee said that it was ridiculous that every day this woman had to fight for a sandwich she had to eat to take her medication, she was told that it was none of her business. There was no mechanism, no continuity. Every day there were different people on the wing. The detainees were told not to expect the guards to know their situations.

3.4. Removal of HIV-Positive Asylum Seekers

3.4.1. Overview of UK Law and Policy on Removal

A person is granted refugee status only if they meet the criteria laid down by the 1951 Refugee Convention and their asylum claim has been accepted by the Home Office. If the asylum application is successful, the refugee will only be granted limited leave, initially for five years, after which their case will be reviewed.[68]

Humanitarian protection (HP)[69] is leave to remain granted to a person who does not meet all the criteria to enable them to receive refugee status but would, if removed, face in the country of return a serious risk to life or person arising from a death penalty, unlawful killing, or torture or inhuman or degrading treatment or punishment. HP normally allows the asylum seeker leave to stay in the UK for five years maximum. Shortly before this five year period expires, a person is theoretically able to apply for indefinite leave to remain in the UK. If someone does not qualify for humanitarian protection, they may still be allowed to stay under "discretionary leave". This is only granted in special circumstances – especially for unaccompanied asylum-seeking children (UASC) who cannot be returned to their country of origin.[70]

Under UK immigration law, asylum applicants whose applications have been rejected and who have no appeal outstanding have no legal right to remain in the UK. Refused applicants are expected to leave the UK voluntarily or be subject to removal action.[71]

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[68] This applies only to those who have received refugee status since September 2005. Those receiving refugee status prior to this are allowed remain indefinitely.
[69] The main categories for being awarded Leave to Remain on human rights grounds changed slightly with the introduction of 'Council Directive 2004/83/EC' in October 2006. This Directive was transposed into UK law on 9th October 2006. Applicants can now simply apply for either refugee status or 'subsidiary protection'. Paragraph 339C of the Immigration Rules sets out how a person can qualify for 'humanitarian protection' (HP). This is what the UK government has decided to call the subsidiary protection available under the Directive so there is no real change apart from which rules one would apply under. The qualifications within the Immigration Rules for an award of HP are largely the same as they were before. One important advance, however, at para. 339C (iv), is the recognition of civil war type conditions as sufficient to constitute 'serious harm' for the purposes of the rule.
[70] The issue of asylum seeking children is examined in Chapter 5 of this report.
[71] Immigration Rule 395(B).

The Statement of Changes in Immigration Rules (HC 1337)[72] outlines the changes in the rules laid down regarding the practice to be followed in the administration of the Immigration Act 1971 for regulating entry into and the stay of persons in the UK. It amends the Immigration Rules to make it clear that where a person is liable to deportation then the presumption shall be that the public interest requires deportation and that it will only be in exceptional circumstances that the public interest in deportation will be outweighed in a case where it would not be contrary to the ECHR and the Refugee Convention to deport.

3.4.2. UK Policy on the Removal of Refused HIV-Positive Asylum Seekers

The Home Office has used the ECtHR's judgment in *D v. UK*[73] to define its policy on the removal of refused asylum seekers living with HIV.

In this landmark decision, the ECtHR ruled that the deportation of a person living with AIDS to a country where no adequate facilities necessary to his condition, no accommodation, no money and no access to social support, would be available would be contrary to the ECHR. It found that the abrupt withdrawal of medical treatment caused by the deportation would amount to a violation of Art3. It also made it clear that everyone, irrespective of conduct (e.g. refused asylum seeker, prisoner) is protected under Art.3 and that States are bound to protect individuals within their jurisdiction from ill-treatment (e.g. lack of medical facilities) even if that ill-treatment is likely to take place outside the Contracting State.

The Home Office policy on the removal of refused HIV-positive asylum seekers was introduced in 2001. It is set out in Chapter 36 of the IND Operation Enforcement Manual dealing with *"extenuating circumstances"* in relation to deportation orders.

The policy states that the UK's obligations under Art.3 are engaged in medical cases where the following requirements are satisfied: (1) the UK can be regarded as having assumed responsibility for a person's care; (2) there is credible medical evidence that return, due to a complete absence of medical treatment in the country concerned, would significantly reduce the applicant's life expectancy and (3) subject them to acute physical and mental suffering. The policy further distinguishes between "availability" and "affordability" of treatment. It also does not mention the availability of family support but states that every application should be considered on a case by case basis.

The Home Office was sympathetic to Art.3 cases in the past. However, there has been a significant shift in policy which has coincided with a harshening of government's asylum policy, the debate surrounding "imported infections" and the alleged draining of NHS resources. The introduction of mandatory of HIV testing for immigrants was considered by the government in 2004.[74]

A doctor who submitted evidence for this report highlighted another important element of the UK government's current approach to removal cases on ground of HIV status:

"What my patients do not know, but what solicitors have told me is the following: In HIV immigration cases the Home Office purposely waits some time before processing the case yet continues to ask for medical reports. They wait until they see that the patient's CD4 count rises over the 200-300 level, the level at which they are seen medically as 'out of immediate danger' as long as they are on medication. Doctors notice that they get letters repeatedly for such cases – and only these cases- asking for only this information. When the patient's CD4 count is above this level they allow the case to be processed, knowing they would have a case against the patient in light

[72] Document available at www.ind.homeoffice.gov.uk/aboutus/newsarchive/hc1337
[73] (1997) 24 EHRR 425.
[74] See for example : http://news.bbc.co.uk/1/hi/health/2756849.stm

of the cases D and N (i.e. they would be 'less dying' than D or N) and that several judges would favour the Home office presentation in the current political climate."[75]

The Home Office's new policy on Art.3 has been widely condemned by the NGO community, legal experts and human rights bodies. Criticisms culminated following the House of Lords' judgment in *N v. Secretary of State for the Home Department*.[76]

N" was a 24-year-old woman from Uganda who had entered the UK by using a false name and a false passport. She did not know she had AIDS and did not come in the UK for medical treatment, but as a refugee. After arriving in the UK, she was diagnosed as having two "AIDS defining illnesses". She had been kidnapped and held captive by the Lord's Resistance Army for two years, then by another rebel group. She had been severely mistreated and repeatedly raped.

N applied for asylum under the 1951 Refugee Convention and under Art.3 ECHR. In April 2001 the Home Office refused N's application for asylum. Her appeal under the Refugee Convention was dismissed but her Art.3 claim was upheld by the Adjudicator and the Immigration Tribunal Appeal (now abolished). The Court of Appeal reversed the decision saying that her case stretched Art.3 too far.

The case went to the House of Lords which upheld the Court of Appeal's decision and ruled that there was no violation of Art.3 by the UK in returning an immigrant suffering from AIDS to her country of origin where she would not be able to obtain the necessary medicines and treatments to prolong her life and maintain her relative good health, and where she also does not have any family support.

The Lords argued that an Art.3 claim would only succeed where *"the applicant's medical condition has reached such a critical state, that there are compelling humanitarian grounds for not removing him or her to a place which lacks the medical and social services which he or she would need to prevent acute suffering"*.

The ruling was described as appalling evidence of what has become an over-restrictive interpretation of "exceptional circumstances" as first stated by the ECtHR in *D v. UK*. The case was subsequently taken to Strasbourg.[77]

The ruling and more generally the Home Office's policy on removals emphasises the lack of policy coherence in relation to access to HIV treatment across Whitehall which was actually highlighted in the International Development Committee's report on the provision of ARVs *"Delivering the goods: HIV/AIDS and the provision of anti-retrovirals"*.[78] The Committee noted:

"We were told (…) of a lack of coherence between the Home Office, the Foreign and Commonwealth Office (FCO) and DFID in relation to the provision of free ARV treatment to individuals who have failed in their asylum applications, and the deportation of those living with HIV who have no right to reside in the UK. 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."

[75] Written Evidence (name is kept anonymous).
[76] (2003) EWCA Civ 1369, [2005] UKHL 31.
[77] More details available in section 3.5.4.
[78] HC 708-I (2005).

3.5. Asylum Seekers, HIV and Human Rights

3.5.1. Asylum Seekers under International Law

The 1951 Refugee Convention does not contain specific provisions on the treatment of asylum seekers. It nevertheless remains an important starting point for considering standards of treatment for the reception of asylum seekers, not least because asylum seekers may be refugees.[79] Important elements of the Convention, notably the *non-refoulement* provision in Art.33 and the prohibition on punishment for illegal entry in Art.31, are applicable to refugees before a formal recognition of their status. At a minimum, the 1951 Convention provisions that are not linked to lawful stay or residence would apply to asylum seekers in so far as they relate to humane treatment and respect for basic rights.[80]

International human rights law is also relevant in the context of defining adequate reception standards for asylum seekers. International law recognises the right of States to control entry to their territories. However, international and regional human rights treaties provide core rights to people seeking asylum regardless of their status. Discrimination on grounds of nationality is prohibited under the ICESCR, ICCPR, the CERD and ECHR.

The UK is bound by a number of human rights obligations relating to immigration. In particular, Art.12 (4) ICCPR[81] protects nationals of a State by prohibiting States from arbitrarily depriving anyone of the right to enter his own country.

The UK has entered a reservation to Art.12(4) reserving its *"right to continue to apply such immigration legislation governing entry into, stay in and departure from the UK as they may deem necessary from time to time"*. The operation of Art.12(4) therefore does not prevent legislation from restricting the right *"as regards persons not at the time having the right under the law of the UK to enter and remain in the UK"*, but this must not permit arbitrary deprivation of the right, as this would contravene one of the purposes of Art.12(4).

3.5.2. Right to Access HIV Treatment, Care and Support

Right to health, HIV treatment and Public Health

Asylum seekers' right to equal access to health is guaranteed by Art.12 ICESCR and GC14 which state that States have specific legal obligations *"to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including (…) asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health status and needs (…)* [and to] *ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups."* (paras. 34 and 43(a))

GC14 emphasises the principle of equality of access to healthcare and health services. It states that governments *"have a special obligation to (…) prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health"*. (para. 19)

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[79] See UNHCR, Handbook on Procedures and Criteria for Determining Refugee Status, 1992, para. 28.
[80] See Articles 3 (non-discrimination), 4 (religion), 5 (rights granted apart from this Convention), 7 (exemption from reciprocity), 8 (exemption from exceptional measures), 12 (personal status), 16 (access to courts), 20 (rationing), 22 (public education), 31 (refugees unlawfully in the country), and 33 (non-refoulement principle).
[81] Article 12(4) ICCPR 1966 reads "No-one shall be arbitrarily deprived of the right to enter his own country".

The right to be free from discrimination is at the cornerstone of international human rights law and its implications for health have been well explained by WHO:

"*The observance of human rights is permeated and characterized by the principle of freedom from discrimination. Governmental responsibility for non discrimination includes ensuring equal protection and opportunity under the law, as well as de facto enjoyment of rights such as the right to public health, medical care, social security and social services."*[82]

Guideline 6 on HIV treatment, care and support provide:

"States should also ensure that their laws, policies, programmes and practices do not exclude, stigmatize or discriminate against people living with HIV or their families, either on the basis of their HIV status or on other grounds contrary to international or domestic human rights norms, with respect to their entitlement or access to health-care goods, services and information." (para. 30)

<u>*Justify the charging policy*</u>

The right to health is not absolute and is limited on grounds of *"promoting the general welfare in a democratic society"*[83] provided that they comply with the principle of proportionality.[84]

The government's rationale for introducing charging for refused asylum seekers and other undocumented migrants has been in the public interest. Justifications for denying medical treatment have relied on allegations of "health tourism" and the assumption that the new charging regime would save the NHS significant funds which could be spent instead on those legally resident.

The flaws and lack of basis of the government's arguments have been highlighted in 2005 the Health Select Committee's Third Report on *New Development in Sexual Health and HIV/AIDS Policy* and more recently in the JCHR's report on the treatment of asylum seekers. Refuting arguments have emphasised that:

- The Department of Health's original consultation did not contain any specific examples of people migrating to the UK as "health tourists" to use NHS services for HIV or for any other chronic condition.[85]
- There is extensive evidence that NHS services are overstretched due to prolonged under-funding not because of asylum seekers or other migrants abusing the system. In the particular context of HIV, treatment provision represents less than 0.1% of the total NHS budget.[86]
- There is no evidence that HIV-positive asylum seekers (or other migrants) are coming to the UK to access free healthcare, with the majority ignoring their HIV status when entering the country and only getting tested months later.[87]

The potential impact of charging refused asylum seekers for HIV treatment on the ground of public health has been emphasised in the Health Select Committee's report:

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[82] WHO, Health and Human Rights Publication Series, *Health and Freedom from Discrimination*, Issue 2, August 2001.
[83] Art.4 ICESCR.
[84] General Comment 14.
[85] This was highlighted in the Health Select Committee's Third Report on *New Developments in Sexual Health and HIV/AIDS Policy* (2005).
[86] The NHS spends £3.8 billion per year on alcohol related illnesses as opposed to £279 million on HIV treatment and prevention. Indeed the NHS expenditure on heart disease is £7 billion a year.
[87] This was illustrated in various NGO submissions to the Health Select Committee inquiry into new developments in sexual health and HIV.

“[I]ntroducing charges for HIV treatment may in fact contribute to onward transmission, both because charges may act as a deterrent to testing for people who cannot afford treatment in the event of a positive result, and because untreated individuals are more infectious than those on treatment whose viral load is controlled. In its cost-benefit analysis of the changes to regulations governing access to free NHS treatment for overseas visitors, the Department must also take into account the potential costs associated with increased onward transmission of HIV (…)Coupled with increasing confusion regarding eligibility for HIV treatment even amongst those who are eligible, and fear amongst migrant communities that if, in future, they attend health services they will be questioned about their immigration status, this strongly suggests that the introduction of charges for HIV treatment will increase the number of HIV+ people living in this country who are unaware of their infection, in direct contradiction of the Government's target to reduce the number of undiagnosed HIV infections. An increase in the numbers of people who are unaware of their HIV+ status will pose a serious and escalating threat to public health.” (paras. 134-52)

It is noteworthy that the government’s policy was criticised by the Committee on Economic, Social and Cultural Rights in its 2002 monitoring report on the UK, two years prior to the introduction of the revised NHS charging system.

The Committee noted "*de facto discrimination in relation to some marginalised and vulnerable groups"* and asked the UK to ensure that its *“obligations under the covenant were taken into account in national legislation and policy on health and education.*”[88]

In July 2006, the Chair of Doctors for Human Rights UK, Peter Hall was unequivocal about the impact of the charging policy in an article in the British Medical Journal:[89]

“In restricting their access to free secondary health care the British government is violating the right of failed asylum seekers to the highest attainable standard of health, guaranteed by the International Covenant on Economic, Social and Cultural Rights (…) Although not yet justiciable (liable to court trial or legal decision) in the UK, the International Covenant on Economic, Social and Cultural Rights is no less binding on governments than international law that has been incorporated in domestic legislation, such as the Convention against Torture or the European Convention on Human Rights. The Committee on Economic, Social and Cultural Rights, which monitors states’ compliance with the covenant, found no factors that might prevent full implementation of the covenant at its last review of the UK in 2004.”

Medical care and ill treatment

Art.3 ECHR jurisprudence provides a useful insight into the link between medical care and ill treatment; which pertains to the issue of access to HIV treatment and care for refused asylum seekers and those in detention. In particular, the ECtHR has held that a refusal to provide access to essential healthcare may exceptionally lead to “treatment” which is so severe that it may violate Art.3 ECHR. The test of “severity” is high and was outlined in *Pretty v. UK*:[90]

“As regards the types of ‘treatment’ which fall within the scope of article 3 of the Convention, the Court’s case law refers to “ill-treatment” that attains a minimum level of severity and involves actual bodily injury or intense physical or mental suffering. Where treatment humiliates or debases an individual showing lack of respect for, or diminishing, his or her human dignity or arouses feelings or fear, anguish or inferiority capable of breaking an individual’s moral and physical resistance, it may be characterised as degrading and also fall within the

[88] United Nations. *Concluding observations of the Committee on Economic, Social and Cultural Rights: United Kingdom*. Geneva: UN, 2002..
[89] P. Hall, “*Failed ayslum seekers and health care: current regulations flout international law”,* British Medical Journal 333: 109-10, 2006.
[90] [2002] 35 EHRR 1.

prohibition of article 3. The suffering which flows from naturally occurring illness, physical or mental, may be covered by article 3, where it is, or risks being exacerbated by treatment, whether flowing from conditions of detention, expulsion or other measures, for which the authorities can be held responsible."

There is evidence that a majority of asylum seekers only find out about their HIV status after they arrived in the UK and many already present advanced symptoms. Refused asylum seekers who are entitled to free counselling and HIV-testing may be left with a devastating diagnosis and the emotional and psychological implications it implies. This means copying and dealing with the diagnosis but also facing stigma and discrimination including within their own community, and the further burden of having to cope and live with the mental and physical trauma of violence, assaults and torture in their country of origin. The government's policy on HIV treatment also means that people who are diagnosed with HIV may not be given access to life saving treatment that would enable them to remain in good health for several years. As a result, the feeling of anguish, fear and distress caused by a diagnosis is likely to increase significantly because they are denied HIV treatment and care.

Article 3 may also be at stake in the case of pregnant HIV-positive women who cannot afford drugs which significantly reduce chances of vertical transmission of HIV from mother to child. Knowing that she may infect her unborn baby with HIV will cause stress and significant emotional and psychological effects on the mother-to-be and arguably, will also impact on her physical health and well being. The consequence might also be extremely grave with the birth an HIV-positive baby when access to adequate drugs would have considerably reduced the risk of transmission. A complete course of treatment can cut the risk of transmission to below 2 per cent.

States parties to the Convention are under an absolute obligation not to take steps which would expose people to the risk of Art.3 ill-treatment (i.e. a negative obligation). They are also under a positive obligation to take reasonable steps to protect people against serious harm.[91]

The ECtHR has made it clear that States' obligations under Art.3 apply to all individuals within their jurisdiction, regardless of the *"reprehensible nature of the conduct of the person in question"*.[92] It is argued that by charging refused asylum seekers for HIV treatment and care, government policy amounts to a violation of Art.3. This argument is compounded by the increase in the suffering and distress that occur following an HIV diagnosis and its psychological and emotional implications as well as personal and social consequences.

Medical care in detention

Under international law, the fundamental principle underlying the detention or imprisonment of a person is that they shall be treated in a humane manner and with respect for the inherent dignity of the human person.

Jurisprudence on Art.3 has reiterated States' obligation to treat detained people with dignity. In *McGlinchey and Others v. UK*[93] the ECtHR held that *"[t]he state must ensure that a person is detained in conditions that are compatible respect for human dignity, that the manner and method of the detention do not subject her to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, her health and well-being are adequately secured by, among other things, providing her with requisite medical assistance (…)"*.[94]

[91] See for example, A v United Kingdom (1998) 27 EHRR 611; Z v United Kingdom [2001] 2 FLR 612 at 631, para. 73.
[92] *D v UK, Supra at 73.*
[93] [2003] 37 EHRR 41.
[94] States' duty of care for detainees had been previously acknowledged by the ECtHR on several occasions, including in *Algur v. Turkey*.

Art.10 ICCPR states that "*all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person"*. This implies not only the right not to be subjected to inhuman or degrading treatment, but also that people deprived of their liberty should be kept in conditions that take into account their status and needs. General Comment 21 on Art.10 further provides that *"[p]ersons deprived of their liberty enjoy all the rights set forth in the Covenant, subject to the restrictions that are unavoidable in a closed environment"*. (para. 3)

General Comment No. 15 on the position of aliens under the ICCPR further states that *"if lawfully deprived of their liberty, [aliens] shall be treated with humanity and with respect for the inherent dignity of their person".*

In *Steve Shaw v. Jamaica*[95] and *Desmond Taylor v. Jamaica*[96] the HRC found that the treatment of detainees, which included a lack of provision for healthcare and medical care and medical facilities, constituted a breach of Art.10(1) ICCPR.

Although non-binding, the UNHCR Detention Guidelines are regarded as authoritative in the field of refugee rights. They condemn the use of detention of asylum seekers and emphasise the case of those with healthcare needs.

They also state that *all* detained asylum seekers must have *"the opportunity to receive appropriate medical treatment and psychological counselling where appropriate"*[97] and call for *"regular follow-up and support by a relevant skilled professional" for those detained, and "access to services, hospitalization, medication, counselling, etc., should it become necessary".*[98]

Principle 24 of the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment further provides that:

"A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary (…)

International law also recognises that health professionals who provide care for detainees are bound by significant ethical obligations. These professionals *"have a duty"* to protect detainees' *"physical and mental health"* and to provide *"treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained*".[99]

Commenting on the detention of asylum seekers in the UK, the UNHCR has stated:

"Victims of torture, persons with a mental or physical disability, unaccompanied elderly persons, families with children, and other individuals with similarly vulnerable backgrounds and characteristics are also of concern to UNHCR in the context of detention. In the event that individuals falling within these categories are detained, UNHCR's view is that this should only be on the certification of a qualified medical practitioner that detention will not further adversely affect their health and well-being."[100]

[95] Communication No. 704/1996.
[96] Communication No. 705/1996.
[97] Guideline 10(v),
[98] Principle 24.
[99] Principles of Medical Ethics relevant to the Role of Health Personnel particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, In human or Degrading Treatment or Punishment (Adopted as UN General Assembly Resolution 37/194, 18 December 1982), Principle 1.
[100] UNHCR Comments on the 2005 Immigration and Nationality Bill.

There has been extensive domestic case law on the treatment of asylum seekers in detention centres. Recently in *D & K v. Secretary of State for the Home Department*[101] the High Court found a *"persistent and sustained failure to give effect to important aspects of the Detention Centre Rules and publicly to highlight a departure from published policy"* by the Home Office to abide by the legal requirement to ensure that detainees in immigration detention centres are medically examined within 24 hours of their detention. This failure led to the unlawful detention of two asylum seekers at Oakington Removal Centre in May 2005, who should have been assessed as unsuitable for detention as there was medical evidence that they had been tortured in their countries of origin.

It is argued that the government's policy on detention of asylum seekers is not in line with international and regional law and standards. Although there are domestic guidance on the detention of asylum seekers, including specific provisions on healthcare for vulnerable people, research findings and case law show that there is a wide gap between theory and practice. Furthermore, despite concerns from the international community such as the HRC and the UNHCR about the detention policy and extensive evidence of its detrimental impact particularly on vulnerable people, such as children, women and those with healthcare needs, the government is blatantly disregarding the most fundamental principles that govern the treatment of asylum seekers in international law and policy.

3.5.4. Deportation of HIV-Positive Asylum Seekers and Human Rights

The principle of *non-refoulement* is codified in its best-known form in the Refugee Convention. Major UN human rights treaties also prohibit the forcible return of persons to countries where they may be exposed to torture or cruel, inhuman or degrading treatment or punishment.

The ICCPR and the ECHR do not contain any explicit provisions on the deportation of asylum seekers. However, the HRC and the ECtHR have both interpreted the ban on *refoulement* as being inherent in Art.7 ICCPR and Art.3 ECHR.[102]

Since *D v. UK*, the ECtHR has considered the deportation of HIV-positive asylum seekers on several occasions, ruling in most cases that although HIV treatment may only be in principle available - yet at a considerable cost, the existence of family support to assist the appellant in accessing treatment was sufficient to rule in favour of the State. The ECtHR's recent ruling in *N v. UK*[103] was a huge disappointment for HIV and rights advocates as the Grand Chamber ruled that the removal of N to Uganda did not violate Art. 3 ECHR:

"*The fact that the applicant's circumstances, including her life expectancy, would be significantly reduced if he were to be removed from the Contracting State is not sufficient in itself to give rise to breach of Article 3. The decision to remove an alien who is suffering from a serious mental or physical illness to a country where the facilities for the treatment of that illness are inferior to those available in the Contracting State may raise an issue under Article 3, but only in a very exceptional case, where the humanitarian grounds against the removal are compelling (…) The Court accepts that the quality of the applicant's life, and her life expectancy, would be affected if she were returned to Uganda. The applicant is not, however, at the present time critically ill. The rapidity of the deterioration which she would suffer and the extent to which she would be able to obtain access to medical treatment, support and care, including help from relatives, must involve a certain degree of speculation, particularly in view of the constantly evolving situation as regards the treatment of HIV and AIDS worldwide. In the Court's view, the applicant's (…) does not disclose very exceptional circumstances, such as in D. v. the United Kingdom (…).* (paras. 42-51)

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[101] [2006] EWHC 980 (Admin).
[102] International Commission of Jurists, *Terrorism and Human Rights*, p. 246.
[103] Application no. 26565/05 (27 May 2008).

The Chamber's judgment echoes the House of Lords' decision which set out a two-stage test for Art.3 claims in the context of HIV and other mental or physical illnesses. This test was explained by Bettinson and Jones[104] as follows:

(1) *The seriousness of the applicant's medical condition:* the applicant's condition must be "terminal" (i.e. the applicant is dying). N was at the "advanced" stage of HIV but not at a "terminal" stage, and therefore her case failed the first stage as a result of medical advances in the treatment of HIV and her getting treatment in the UK.
(2) *The lack of treatment or support that would hasten the applicant's death and cause suffering:* this requires convincible evidence of a lack of care, a lack of moral or social support, the applicant would die significantly earlier and this would be accompanied by significant mental and physical suffering.

Three Grand Chamber's judges disagreed with the Court's findings, arguing:

- That the so-called "Pretty threshold" should be equally apply where the harm stems from a naturally occurring illness and a lack of adequate resources to deal with it in the receiving country, if the minimum level of severity, in the given circumstances, is attained.
- That the Court's statement that the ECHR is essentially directed at the protection of civil and political rights was incomplete; it ignored the social dimension of the integrated approach adopted by the Court previously;
- That the Court's use of the balancing exercise "between the demands of the general interest of the community and the requirements of the protection of the individual's fundamental rights" in the context of Art. 3 was wrong as it was clearly rejected by the Court in February 2008 and previously in 1996;
- That the allegation that finding a violation of Art.3 in the present case would "open up the floodgates to medical immigration and make Europe vulnerable to becoming the "sick-bay" of the world" was wrong.

Despite the compelling facts in *N v. UK*, the Court's ruling that there was no violation of Art.3 means that the UK can now "legitimately" carry on with its removal policy, despite its obvious conflict with its commitment and actions on access to HIV treatment internationally through DFID.

3.6. Conclusion

The APPGA only made one recommendation in relation to asylum seekers in its 2001 report. It recommended that "*the Home Office should specifically investigate the impact that they asylum system, in particular dispersal and vouchers, is having on asylum seekers with HIV".* However the Group subsequently published a report on HIV and migration in the UK which made numerous recommendations on this issue.

In seven years, asylum and immigration related issues in the context of HIV have become a major cause of concern and have led to strong condemnation and criticisms by national NGOs and experts and the international community of the government's policy. It is extremely worrying that despite being criticised by UN monitoring bodies, the government has not only failed to take the necessary actions recommended by the UN, but it has actually introduced additional measures which have led to further violations of human rights.

The government is currently failing to meet its obligations under international human rights law to guarantee asylum seekers' right to health and other fundamental rights and freedoms at all stages of the asylum seeking process.

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[104] V. Bettinson and A. Jones, *"Is Inadequate Medical Care Insufficient to Resist Removal? The Return of Foreign Nationals with HIV/AIDS and Article 3 ECHR",* Journal of Social Welfare and Family Law, 2006:28(1); and "The *Future of Claims to Resist Removal by Non-Nationals Suffering from HIV/AIDS"*, Liverpool Law Review (2007) 28: 183-213.

Key international human rights treaties are not incorporated domestically and the government has refused to allow for individual petition under the Covenants. As a result, means of redress are limited and complainants have to rely on the Human Rights Act.

HIV-related asylum policy must comply with international human rights law and rely on evidence and effective implementation of domestic and international guidelines. The lack of coherence between policies on access to HIV treatment provides one of the best arguments for a cross-department framework on HIV which rests on the government's duties to protect, respect and fulfil asylum seekers' rights.

- The UK government should develop and implement a cross-departmental HIV and human rights strategy to remedy incoherent policies regarding access to HIV treatment.
- A monitoring system should be developed to ensure that policy on the detention of HIV-positive asylum seekers is implemented.
- There is no evidence of so-called "health tourism" in the UK and current policy on access to NHS treatment and removal puts the lives of people with HIV in jeopardy or even amounts to a death sentence. Current policy should be revised and based on a human rights approach to healthcare, including accessibility and affordability, and the non-discrimination principle.
- The Home Office should consult DFID and the FCO regarding the availability of ARVs in countries to which they propose to deport individuals living with HIV.
- Plans to introduce charging for primary care should be officially dropped by the government.

4. PRISONERS

- ***The UK is currently failing to meet its obligation to develop and implement a policy on HIV in prison which is consistent with international human rights norms.***
- ***The principle of equivalence, set out in international and domestic policy, is not translated into practice and prisoners receive "second class" standards in terms of HIV prevention, treatment and care. This leads to a breach of prisoners' most fundamental rights and freedoms.***
- ***Current policy impacts on prisoners' ability to protect themselves against HIV transmission and the limited measures available are unequally implemented.***
- ***Needle exchange programmes are still not available across the country and condoms are not readily accessible to prisoners.***
- ***There is evidence of prison officials' failure to provide adequate and appropriate healthcare to prisoners, including those living with HIV.***

4.1. Introduction

Worldwide, the rates of HIV are significantly higher in prison than in the general community. Overcrowding, the nature of the prison population and activities behind bars have significant implications for the transmission of HIV behind bars. In the UK, overcrowding is endemic and a significant proportion of the prison population is made up of men and women belonging to groups mostly affected by and/or vulnerable to HIV, particularly Black Africans[105] and injecting drug users.[106]

Prisoners' social environment also impact on their ability to access to health education and increase their risk of becoming infected with HIV. High risk activities such as drug use,[107] consensual or coerced sex, and tattooing[108] expose prisoners to HIV and other blood borne viruses.

The last serosurveys of HIV prevalence in prisons in England/Wales[109] and Scotland[110] date from 1997. They found a prevalence of 0.3 per cent amongst adult male prisoners in England/Wales and Scotland and 1.2 (England and Wales) and 0.6 (Scotland) per cent amongst adult female prisoners. Yet, the increase in newly

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[105] Black Africans are one of the two main groups overwhelmingly affected by HIV in the UK. Over 90% of heterosexually acquired HIV infections diagnosed in the UK during 2004 were probably acquired in high prevalence countries of origin, mainly sub-Saharan Africa, and while relatively low, the number of black and minority ethnic (BME) adults acquiring HIV through sexual contact in the UK is rising steadily. Over three-quarters of the foreign national prison population are from a BME group. The number of Black prisoners has risen by almost 60% since 1997 and the imprisonment rate of Black men is almost ten times as high as white men. In 2000, the population of white prisoners represented 188 per 100,000 in the general population and 1,615 per 100,000 for Black prisoners with Black Africans incarcerated at a rate of 1,704 per 100,000. (Source: Prison Reform Trust/NAT, "HIV and hepatitis in prisons- addressing prisoners' healthcare needs", 2005).

[106] In October 2006 and November 2007, the Health Protection Agency published reports which highlighted a continuing increase in HIV prevalence amongst IDUs.

[107] A report published in 2003 by the Home Office stated that 2% of prisoners inject drugs but highlights the likelihood of significant under-reporting because of the illegality of drug use in prison and the stigma attached to drugs. In Scotland, the most recent figures show that 82% of the prisoner population had used an illegal drug in the twelve months prior to imprisonment, of which 56% reported having used heroin. Overall, 27% of prisoners with a history of drug use in Scotland in 2004 reported having been in drug treatment prior to imprisonment. (source: Scottish Prison Survey, 2004). A 2004 study among prisoners in Northern Ireland found that 11 per cent injected drugs. (see Department of Health, Social Services and Public Safety, Hepatitis C, Hepatitis B and HIV in Northern Ireland Prisons:A cross-sectional survey, Northern Ireland, 2004) It also found that one in five injectors started injecting while in prison. Almost 10 per cent of the injectors also reported sharing equipment while in prison.

[108] Despite being prohibited, tattooing is a very common activity in prison and sharing of tattooing equipment is extremely frequent. There is no study available on the extent of tattooing in UK prisons but there is extensive evidence that tattooing is a widespread activity in prisons. For example, a study found that almost half of the prisoners surveyed were tattooed with nearly 15% of those having been tattooed whilst in prison in Ireland. In Canada, 45% of federal prisoners have reported having had a tattoo done in prison.

[109] *Prevalence of HIV in England and Wales 1997*, para.33 Department of Health 1998; see also Weild, Gill et al. *Prevalence of HIV, hepatitis B, and hepatitis C antibodies in prisoners in England and Wales: a national survey,* Communicable Disease and Public Health Vol. 3 No 2 June 2000.

[110] Scottish Prison Service Nursing Service Review 2003 section 2.6.

diagnosed cases of HIV since 1997[111] and the fact that a quarter of people living with HIV in the UK are unaware of their status, strongly suggest the number of prisoners living with HIV may be significantly higher than the estimates.

4.2. Overview of UK Prison Service and Healthcare

4.2.1. Prison Establishments

There are three separate official bodies in charge of prisons across the UK. The HM Prison Service deals with prison establishments in England and Wales; the Scottish Prison Service (SPS) manages prisons within Scotland and is an executive agency of the Scottish Executive; and the Northern Ireland Prison Service is responsible for providing prison services Northern Ireland establishments and is an executive agency of the Northern Ireland Office.

There are 135 prison establishments in England and Wales, 17 in Scotland and 3 in Northern Ireland. Each Prison Service agency is responsible for prison-related policies and matters as prison is a devolved area.

4.2.2. Healthcare Provision

The Department of Health is responsible for prisons' healthcare, and since April 2006 Primary Care Trusts (PCTs) have held responsibility for healthcare provision in all English publicly run prisons.

PCTs are assessed on their commissioning by the Healthcare Commission. The assessment of the actual services themselves is undertaken by HM Inspectorate of Prisons via a memorandum of understanding (MOU). The MOU sets out the working relationship between HCC and HMIP (Inspectorate of Prisons for England and Wales); it details how HMIP continues to inspect and report on the health outcomes for prisoners within the prison while the Healthcare Commission assesses the arrangements for, and effectiveness of, the PCTs' commissioning arrangements generally.

Prison Health has introduced a new Prison Service Performance Standard which sets out a prison's new and continuing responsibilities in relation to prisoners' health and health services. The draft Prison Service Order (PSO) on "Governors Responsibilities for Prisoners' Health and Health Services" has been issued.

Healthcare services in Wales' four prisons are funded by the National Assembly for Wales, and are commissioned by the four local health boards in which the prisons are located: Cardiff, Swansea, Bridgend and Monmouthshire. In Scotland, the responsibility for healthcare in prisons remains with the SPS. Healthcare services in Northern Ireland's three prisons are jointly funded and commissioned by the Department of Health, Social Services & Public Safety and the Northern Ireland Prison Service. Commissioning of health services in Northern Ireland prisons is through a range of contracts with Health Service provider.

4.3. Policy on HIV Prevention in Prisons

4.3.1. Condoms Availability

Condoms are not readily available in prisons across the UK. In England and Wales, condoms are available "on prescription". The most up to date policy guidance on condom provision is set out in a Clinical Practice Letter issued in July 2006 and which *"seeks to restate guidance originally issued in Dear Doctor Letter DDL (95)10 and*

[111] Newly diagnosed cases of HIV increased by 20 per cent between 2002 and 2003 and again by 20 per cent between 2003 and 2004.

clarify the current position in relation to this policy". Thus, the guidance does not modify the condoms "on prescription" previously set out in the DDL. The maim points of the guidance are as follows:

- Sexual activity between prisoners carries with it known public health risks. Prison doctors must therefore make condoms, dental dams and water-based lubricants available to any prisoner, irrespective of age, who requests them if, in their clinical judgement, there is a risk of the transmission of HIV, or any other sexually transmitted disease.
- Governors must ensure that their establishment has a protocol setting out the arrangements under which condoms, dental dams and water-based lubricants will be made available to prisoners, on application, in accordance with the general provisions set out in this letter.
- The protocol should ensure that prisoners who may be at risk are provided with advice about the policy and procedures for making condoms and dental dams available to them. It should also specify the arrangements for the disposal of condoms, including via the clinical waste disposal contract. Governors must allow prisoners to whom condoms, dental dams and water-based lubricants have been issued to retain them in their possession.
- Subject to the agreement of the governor and of the staff concerned, the establishment's protocol may provide for doctors to delegate responsibility for providing these items to other members of the health care centre's clinical team.
- Since any penetrative sexual activity without a condom is unsafe, and oral sexual contact may also be unsafe, there is no requirement to ascertain whether a prisoner is HIV positive, or has AIDS or any other communicable disease, before providing a condom or a dental dam. Under no circumstances should a prisoner be required to be tested for HIV or any other blood borne virus before a condom or dental dam is issued.
- Before issuing a prisoner with a condom or dental dam, the member of staff should provide appropriate information and guidance on sexual health education, together with any necessary counselling.

The scope of this guidance is unclear and the document raises significant questions in relation to the provision of condoms. UK AIDS and Human Rights Project contacted Prison Health and asked for clarification on specific points. Here are the list of questions asked and Prison Health's responses:

Doctor's clinical judgment -what conditions/criteria will ensure that a prisoner can access condoms? Under what circumstances a prisoner would not be given condoms?

> *"We cannot be prescriptive about a doctors' clinical judgement although any prisoner who is sexually active is potentially at risk of STIs, and the guidance makes it clear that doctors must make condoms, dental dams and water-based lubricants available to any prisoner…if, in their judgement, there is a risk of the transmission of HIV or any other sexually transmitted disease. A prisoner only has to ask the doctor."*

How will the implementation of the clinical guidance be monitored? There is evidence that the DDL was not implemented in several prisons in England and Wales.

> *"The requirement for governors to have a protocol will be in the new Governors' Responsibilities for Prisoners' Health and Healthcare Standard. This will be monitored by Standards Audit Unit (SAU)."*

Two years ago, the Prison Service said that a Prison Service Order (PSO) on condom provision would be published. What is the rationale for issuing a Note (clinical guidance) which prison governors are "free" to disregard, instead of a PSO?

> *"This guidance will go into a wider PSO, governing Governor's Responsibilities for Prisoners' Health and Healthcare. Whilst this is being developed, it was felt that guidance in some form should be issued in the meantime to support staff working in prisons."*

Identification of "prisoners who may be at risk": how can prisoners at risk of contracting HIV or another STI be identified? Isn't there a risk of prisoners being stigmatised? Wouldn't it more efficient to ensure that all prisoners are aware of the clinical guidance?

> *"It is the policy to make sure that all prisoners are aware of the risk of STIs and are aware of ways of reducing the risk."*

How many condoms does a prisoner get?

> *"This is down to the reasonable judgement of the doctor. This matter would be approached in a similar way as it would be in the community but bearing in mind the security risks."*

Is the provision of condoms recorded in the prisoners' medical notes?

> *"[t]here is no prescription for this. If it is, the notes are confidential anyway, and it can be a useful way of auditing how the process is working."*

Would a prisoner have to get information and guidance on sexual health each time he requests condoms?

> *"The doctor would use their judgement; if they are seeing the same prisoners regularly, it would not be necessary to give them the same information each time. This requirement is really to make sure that all prisoners that receive a condom or a dental dam receive appropriate information and guidance."*

Will prison staff receive training on HIV and counselling? There is evidence that some prison healthcare staff have little knowledge of HIV.

> *"There is ongoing education of prison healthcare staff, in the same way as there is for healthcare staff in the community, such as CPD. Prison Health is developing a number of initiatives in relation to this over 2007. There will be a new DVD which sets out the risks of blood borne viruses, including HIV and hepatitis C. There will be a leaflet aimed at prisoners on HIV and sexual health programmes. Training for staff will be picked up by the local PCTs."*

Who could be given the responsibility of providing prisoners with condoms when the doctor delegates this responsibility?

> *"The guidance note makes it clear that this will be a member of the healthcare centre's clinical team; it will be for the doctor to decide who is appropriate within the team."*

Those responses remain vague and emphasise the doctor's clinical judgment in issuing condoms, including the quantity, and therefore the absence of a consistent application of the guidance. The response on the number of condoms to be issued also raises concerns as to what could be used as the argument to hand out only one condom; that is security concerns.

There is evidence of breach of prisoners' right to privacy in the context of healthcare.[112] Yet, Prison Health fails to acknowledge the risk of stigma if a prisoner's medical notes are disclosed to an unauthorised party or his access to condoms were discussed between staff members and overheard by other prisoners.

In relation to HIV education, there is also evidence that healthcare professional lack adequate knowledge about HIV.[113] It is therefore crucial that any healthcare staff member who may be responsible for issuing condoms receive comprehensive training on HIV and sexual health, including on the issue of stigma and discrimination.

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[112] Prison Reform Trust/NAT, *supra* at 105.
[113] *Ibid.*

Finally, because the guidance is not a PSO, it is unlikely that it will be implemented consistently. Research has showed that the former DDL was not or inadequately implemented (e.g. prisoners not able to access condoms in a confidential manner and/or whenever they need them).

In a 2005 survey, although 64 per cent of prisons in England and Wales said that condoms were available, testimonies from prisoners and ex-prisoners has highlighted the discrepancies between the official figures and the actual number of prisons providing condoms.[114]

In 2004, the JCHR highlighted the issue of condom provision in prisons in England and Wales and made a recommendation which has not been taken forward by the Prison Service:

"At present, any prisoner who wants access to condoms has to get them from healthcare. The Prison Service confirmed that they had no plans to make condoms available to prisoners other than through healthcare professionals. However, prisoners may be concerned about implications of going to see a healthcare professional for condoms and may therefore be more likely to engage in unsafe sex. The Prison Service should commission an independent review into whether its current policy on the availability of condoms is doing enough to prevent the spread of HIV/AIDS amongst the prison population and therefore to protect the right to life."[115]

Despite announcing in 2005 that free condoms and dental dams would be made available in every Scottish prison, no change has happened so far.[116] Condoms are also not available in prisons in Northern Ireland.

4.3.2. Sterile Needles Provision

At least 99 per cent of health authorities provide needle exchange programmes (NEPs) to injecting drug users in the general community. The Department of Health committed to providing prisoners with healthcare related services equivalent to those available in the community (i.e. principle of equivalence). Yet, sterile needles, which are the safest means of preventing the transmission of blood-borne viruses through drug injection, are not currently available in prisons in England and Wales. Similarly, NEPs are not available in prisons Northern Ireland and Scotland.

The SPS has been piloting a needle replacement scheme at reception in several prisons to support the schemes now existing in many police custody suites in Scotland. The scheme involves offering sterile needles to known injectors when they leave prison. A further pilot is currently underway in HMP Aberdeen, where prisoners can also access injecting paraphernalia and support upon release. It was expected that this initiative at HMP Aberdeen would be expanded late 2007 to incorporate a pilot in-prison needle exchange scheme.

The announcement of an in-prison NEP followed an SPS's report[117]which made the case for such programs. The report recommended that *"the distribution of sterile injecting equipment be introduced as part of an integrated and expanded Health Care Standard 10"*. It further stated that the SPS *"has a responsibility to safeguard the wellbeing of prisoners and their families including the specific task of tackling the spread of HIV and HCV in the prison system. The evidence is overwhelming that injecting equipment provision is successful at reducing the incident of BBV transmission and that injecting equipment provision in prison poses no significant risk or will interfere with the security of prisons"*. Refuting all arguments against NEPs in prisons, the SPS noted: *"[i]T could be argued that refusal to make sterile equipment available to prisoners is actually condoning the spread of HIV and HCV among prisoners, and, indirectly, to the community at large".* [original emphasis]

[114] *Ibid.*
[115] JCHR, Third Report, December 2004, at para 185.
[116] *Respect and Responsibility: Strategy and Action Plan for Improving Sexual Health,* Scottish Executive (2005).
[117] *The Direction of Harm Reduction in the SPS: from chaotic drug use to abstinence* July 2005 (unpublished).

However the pilot did not go ahead mainly because of resistance from the Scottish Prison Officers Association, which regarded the scheme as a health and safety matter for its members.

In England and Wales, Prison Service Instruction 53/2003 provides that tablets for disinfecting shared needles and syringes were to be made available to prisoners from 1 April 2004. More than 4 years later, disinfecting tablets are still not available in all establishments[116]. There is also evidence that disinfecting tablets are not fully effective in destroying all blood-borne viruses present in used needles; this was acknowledged by the Department of Health. Disinfecting tablets have been introduced in Scottish prisons in December 1993 but are not available in Northern Ireland.

4.3.3. Preventing HIV in Prisons: International Evidence

Condoms

Condom availability in prisons varies significantly worldwide. The Canadian HIV/AIDS Legal Network has however highlighted that no system that has adopted a policy of making condoms available in prisons has reversed the policy; the number of systems that make condoms available has continued to grow every year. For example, in a number of surveys undertaken in Europe, the proportion of prison systems that declared having made condoms available rose from 53 percent in 1989 to 75 percent in 1992 and 81 percent in 1997. In the most recent survey, condoms were available in all but four systems.[117]

Available evaluations of condom provision programmes in prisons have dispelled assumptions that introducing condoms would lead to unintended incidents.[118]

Recently, an evaluation of the condom distribution programme in Australia (New South Wales) concluded that is was feasible to distribute condoms to prisoners. There were several indicators for this: (1) the majority of prisoners supported the provision of condoms; (2) most prisoners were of the opinion that the condom vending machines were in accessible locations; (3) the reported level of harassment of prisoners using the machines was relatively low; (4) most importantly, prisoners were using condoms when having anal sex. Overall, there were no indicators of negative consequences as a result of the condom distribution program. Minor incidents of misuse such as water balloons, water fights and littering were recorded but these did not compromise prison safety or security. [119]

Needle Exchange Programmes (NEPs)

There is extensive international evidence of the benefits of NEPs which have been introduced in an increasing number of prisons in various countries, including those with limited resources: Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus.

International experiences have highlighted that the assumptions and fears about the implications of NEPs on prison security and injecting drug use were unjustified.

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[116] UK AIDS and Human Rights Project contacted the Department of Health's focal person on disinfecting tablets several times in order to get an update on the implementation of the Instruction but they never responded to our query.
[117] Canadian HIV/AIDS Legal Network, HIV/AIDS in Prisons Fact Sheet 4 (2005).
[118] For example, in 1999, the Correctional Service Canada evaluated HIV harm reduction measures in the Canadian federal prison system. The evaluation found that, in general, prisoners had easy and discreet access to both condoms and lubricant; and that although some unintended usage has been identified for condoms, there is no evidence that condoms have been used as weapons. Management and line staff interviewed at 18 prisons could not recall any incident where condoms had been used as weapons. A search of the federal prison system's incident database found 20 incidents involving the unintended uses of condoms. All incidents relating to condoms were associated with smuggling drugs.
[119] K. Dolan, D. Lowe, J. Shearer, Evaluation of the condom distribution program in New South Wales prisons, Australia. *Journal of Law, Medicine & Ethics*, 2004, 32: 124-128.

The Canadian HIV/AIDS Legal Network published the most comprehensive study of existing NEPs and the analysis of evidence makes the following points:

- Prison needle exchange programs are safe with no reported of cases of needles being used as weapons against prison staff or other prisoners since the beginning of the first prison NEP in 1992;
- Prison needle exchange programs do not lead to increased drug use;
- Prison needle exchange programs do not condone illegal drug use and should be introduced as one of the components of a more comprehensive harm-minimisation approach;
- Prison needle exchange programs can be successful in various prison environments including poor resources prison systems;
- Prison needle exchange programs reduce risk behaviour and effectively prevent the transmission of blood-borne viruses;
- Prison needle exchange programs are most effective when supported by prison administration, staff, and prisoners; and
- Prison needle exchange programs are best introduced as pilot projects[120].

The Canadian HIV/AIDS Legal Network's updated report on NEPs acknowledges the increasing introduction of NEPs in other jurisdictions, including the pilot in local Scottish prisons.

The increasing introduction of NEPs in prisons and the very positive results of programmes evaluations contrast with what the UK government told the JCHR when questioned over the absence of NEPs in prisons:

"[The Parliamentary Under Secretary of State at the Department of Health (Minister for Community] told the Committee that he was open minded about the idea of needle exchanges, though previous experience had not been particularly successful. The Director General of the Prison Service (…) stated that needles were rarely used in prisons and that the introduction of needle exchanges could do more harm than good, though he added that the Prison Service was committed to monitoring developments both at home and abroad, including existing practice in the community, policy and practice in custodial settings and the effectiveness of needle exchanges over other harm minimisation measures."[121]

4.4. HIV Treatment in UK Prisons

4.4.1. Healthcare in UK prisons: Principle of Equivalence

UK prison healthcare policy rests on the principle of equivalence which calls for prisoners to receive healthcare at least equivalent to that available for the outside population.

The principle of equivalence in prisons in England and Wales is stated in numerous Prison Service policy documents. It was also endorsed in a report from the HM Inspectorate of Prisons for England and Wales[122] and reiterated by the Department of Health when it took over the administration of healthcare in English prisons.

The principle of equivalence in Scottish prisons is stated in the Scottish Prison Service Health Care Standards. However, the SPS is independent from the Scottish Government and thus, health care is not provided by the health service.

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[120] *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience,* Second Edition, 2006.
[121] *Supra*, at 115, at para. 183.
[122] Department of Health, *Patient or Prisoner: A new strategy for health care in prisons*, 1996.

In Northern Ireland, prison healthcare is also provided under the principle of equivalence. Primary care is by health professionals employed by the Department of Health, Social Services and Public Health.

4.4.2. Prisoners' Access to HIV treatment

There is no UK wide policy on HIV in prisons. HIV treatment and care therefore varies greatly between prison establishments.

Prisoners' problems in accessing adequate and appropriate healthcare, including HIV treatment, in UK prisons have been highlighted in a study[123] which stressed healthcare staff's lack of awareness of the number of prisoners with HIV as well as the sub-standards of care afforded to prisoners in particular a "paracetamol policy" which consists of providing paracetamol for most of health-related requests by prisoners; lack of healthcare facilities; delay in accessing HIV treatment; and problems in adhering to HIV treatment because of prison regime and/or lack of trained staff.

Positively Women (PW) provided us with the following case study:

"Martine is 38 years old, a single mother and is serving a 24-month prison sentence for grievous bodily harm. Martine was diagnosed HIV positive a couple of years ago and was placed on medications prior to her arrest. While in detention Martine has been transferred between prisons. Her medication was left behind at her previous detention centre and she was left without any medications now for 2 weeks. As a result Martine has now grown resistant to her combination therapy."

One step in the direction of improved services for women in prisons is the establishment of Women's Health Clinics which provide care and advice on sexual health and can facilitate visits from sexual health and HIV organisations.[124]

4.5. International Legal and Policy Framework on Prisoners' Rights and HIV

4.5.1. Prisoners have Rights

The rights of prisoners are guaranteed under international human rights law. Prisoners do not surrender their rights upon imprisonment; they retain all rights *"subject to restrictions that are unavailable in a closed environment."*[125]

Several international documents flesh out prisoners' rights and provide guidance as to how governments may comply with their international legal obligations. The most comprehensive guidelines are the *United Nations Standard Minimum Rules for the Treatment of Prisoners* (thereafter "the Standard Minimum Rules"). Other documents relevant to prisoners' rights include the *Body of Principles for the Protection of All Persons Under Any Form of Detention or Imprisonment*, the *Basic Principles for the Treatment of Prisoners*, and, with regard to juvenile prisoners, the *United Nations Standard Minimum Rules for the Administration of Juvenile Justice*.

Although non-binding, these documents clearly reaffirm the tenet that prisoners retain fundamental human rights and provide authoritative guidance on prisoners' rights within the context of international human rights treaties.

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[123] Prison Reform Trust and NAT, *supra* at 105.

[124] Positively Women (PW) has a *Drugs and Prison Project* run by women who have personal experience of addiction, living with HIV and being in prison. At present the project works mainly with HIV-positive women prisoners of HMP Holloway. In 2004, Holloway prison commenced a programme of day-release to allow those nearing the end of their sentence to attend group support sessions at Positively Women.

[125] *General Comment No. 21 on the humane treatment of persons deprived of liberty (Art.10).*

The most comprehensive policy framework on HIV in prisons is the UNODC, WHO and UNAIDS *Framework for HIV and AIDS prevention, care, treatment and support in prison settings* ("the UNODC Framework") published in 2006. The UNODC states *respect for human rights and international law* as a key principle:

"Respecting the rights of those at risk of or living with HIV/AIDS is good public health policy and good human rights practice. Therefore States have an obligation to develop and implement prison legislation, policies, and programmes consistent with international human rights norms."

The document provides a framework *"for mounting an effective national response to HIV/AIDS in prisons that meets international health and human rights standards".* It is a tool to assist governments meet their international obligations on human rights, prison conditions and public health; it represents the most comprehensive policy document that provides governments with a comprehensive action plan to implement a response to HIV and AIDS in prisons based on recognised international standards and guidelines.

4.5.2. Prisoners' Right to Health

The link between health and inhuman and degrading treatment in prison was highlighted by the ECtHR in *Pantea v. Romania*.[126] The Court held that Art. 3 ECHR *"compels the authorities not only to refrain from provoking [inhuman or degrading treatment on people in detention]"*, but also *"to take the practical preventive measures necessary to protect the physical integrity and the health of persons who have been deprived of their liberty*".[127]

The UNAIDS Guidelines assert States' obligations in the specific context of HIV:

"Imprisonment is punishment by deprivation of liberty but should not result in the loss of human rights or dignity. In particular, the State, through prison authorities, owes a duty of care to prisoners, including the duty to protect the rights to life and to health of all persons in custody. Denial to prisoners of access to HIV-related information, education and means of prevention (bleach, condoms, clean injection equipment), voluntary testing and counselling, confidentiality and HIV-related health care and access to and voluntary participation in treatment trials, could constitute cruel, inhuman or degrading treatment or punishment (…)" (para. 152)

The Legislators' Handbook further states:

"Loss of liberty does not entail loss of human rights, including health. The often closed, overcrowded, violent and unsafe environment in prisons creates a special responsibility for prison authorities to protect the health of prisoners (…)." (p. 61)

4.5.3. HIV Prevention and Prisoners' Rights

Prevention of HIV Transmission under International Human Rights Law

Under international human rights law, States have a duty to take the necessary steps to prevent HIV transmission and provide HIV treatment in prison. Prisoners' right to access HIV preventive measures is guaranteed under Art.12 ICESCR and GC14.

[126] (2005) 40 EHRR 26.
[127] Ibid, at para. 189.

In its 3rd General Report (1992), the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) also noted:

"The task of prison health care services should not be limited to treating sick patients. They should also be entrusted with responsibility for social and preventive medicine (…) A prison health care service should ensure that information about transmittable diseases (in particular hepatitis, AIDS, tuberculosis, dermatological infections) is regularly circulated, both to prisoners and to prison staff. Where appropriate, medical control of those with whom a particular prisoner has regular contact (fellow prisoners, prison staff, frequent visitors) should be carried out." (paras. 52-54)

International HIV policy guidelines are unequivocal about States' duty to provide prisoners with means to protect themselves against HIV transmission. The International Guidelines state that *"[p]rison authorities should take all necessary measures, including adequate staffing, effective surveillance and appropriate disciplinary measures, to protect prisoners from rape, sexual violence and coercion. Prison authorities should also provide prisoners (and prison staff, as appropriate), with access to (…) means of prevention (condoms, bleach and clean injection equipment…)"* (para. 21(e)). *"[D]enial to prisoners (…) means of prevention (…) could constitute cruel, inhuman or degrading treatment or punishment."* (para. 152)

The Legislators' Handbook further states:

"Prisoners are condemned to imprisonment for their crimes, but they are not condemned to HIV transmission, and prison authorities have a legal duty of care to ensure that this does not occur." (p. 61)

The UNODC Framework recommends the following action by governments:

"Ensure the measures available outside of prisons to prevent transmission of HIV through the exchange of bodily fluids are also available in prisons. This should include providing access to the full range of prevention commodities to prevent HIV transmission through unsafe sex, needle sharing, unsafe tattooing, and joint use of razors in those countries where these measures are available in the outside community, e.g., condoms, sterile needles and syringes, razor blades and sterile tattooing equipment. HIV prevention measures should be accessible in a confidential and non-discriminatory fashion. Provide prisoners with access to HIV prevention measures prior to any form of leave or release." (paras. 60 and 61)

Duty to prevent HIV transmission under Article 3 ECHR

The ECHR does not contain an explicit right to health but the ECtHR has recognised that prisoners' right to health can be engaged under Art.3 of the Convention.

Lines has considered the use of Art.3 ECHR to advocate in favour of prison needle exchange programmes.[128] Numerous arguments used in the context of NEPs can also be applied to sexual HIV transmission.

The ECtHR has asserted States' duty to *"do everything that could reasonably [be] expected (…) to prevent the occurrence of a definite and immediate risk to [a prisoner's] physical integrity, of which [the authorities] knew or should have known".*[129]

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[128] R. Lines, "*Injecting Reason: Prison Syringe Exchange and Article 3 of the European Convention on Human Rights*", European Human Rights Law Review, 2007(1).
[129] *Supra*, at 126.

It has also recognised that a person's vulnerability heightens a State's obligation to provide adequate conditions of imprisonment in order to prevent ill-treatment.[130] This obligation is specifically heavy in the context of prisoners as by detaining them, States restrict their ability to protect their own health.

The risk of HIV transmission in prison has been universally accepted and UK prisons are no exception to this risk. High risk activities (sexual intercourse, injecting drug use) may be considered "illegal" but governments are aware of them taking place. As highlighted by Lines, the illegal nature of the activities does not reduce States' obligations.

The ECtHR has further ruled that States must take "*all measures within their powers which, given reasonable consideration, would have avoided"* the ill-treatment of a prisoner.[131] It has found that prison conditions that lead to the spread of diseases can contribute to circumstances amounting to a violation of Art.3.[132]

In *Alver v. Estonia*, [133] although the Court did not find that acquiring TB in prison was insufficient to constitute a violation of Art.3, the transmission of HIV involves factors and consequences that may meet the minimum level of severity set by the ECtHR:[134]

- Although treatable HIV is still incurable and may lead to death even if treated;
- The treatment of HIV requires a strict treatment regime which has to be taken for the rest of a person's life;
- HIV treatment has side effects such as diarrhoea which prison conditions may make difficult to cope with;
- HIV increases the risk of other infections which is also heightened by inadequate prison conditions (e.g. overcrowding);
- HIV transmission may lead to stigma and discrimination especially within the prison setting where breaches of confidentiality are common;
- HIV transmission can be prevented;
- Knowledge of the risk of transmission without being able to be able to protect oneself brings feeling of fear and anguish; and
- In the case of HIV transmission acquired as a result of coerced sex, degrading treatment will result from the feeling of fear and anguish and the physical and emotional consequences of the act will be heightened by a positive HIV diagnosis.

As noted by Lines, the fact that only a small number of European countries provide NEPs in prisons illustrates the *"existence of little common ground between the Contracting States"* on this issue – and arguably on condom provision- which is very often seen as a "pre-requisite" when arguing an Art.3 violation. But he also argues that the right of prisoners to access healthcare services equivalent to those available in the community without discrimination is recognised throughout Europe and internationally. The ECtHR has actually held that Convention violations may arise when a State has *"put an individual's life at risk through the denial of health care which they have undertaken to make available to the population generally*".[135]

[130] *Supra*, at 128.
[131] *Pantea v. Romania* (2005) 40 EHRR 26, para. 190 (as quoted in Lines, supra at 128).
[132] See *Kalashnikov v. Russia* (2003) 36 EHRR 34, at para. 98.
[133] See *Alver v. Estonia*, Application N. 64812/01 (Judgment of 8 November 2005), at para. 54.
[134] Lines, *supra* at 128.
[135] *Cyprus v. Turkey* (2002) 23 EHRR 244, para. 219.

Lines concludes:

"[t]he failure of the State to provide prisoners with access to syringe exchange programmes, and the human rights issues engaged by this failure, should be considered in this wider context. [Furthermore when] assessing whether ill-treatment constitutes a violation of Article 3, the Court has stated that it 'cannot but be influenced by the developments and commonly accepted standards in the penal policy of the members States of the Council of Europe[136]'".[137]

Furthermore, as argued by the Canadian HIV/AIDS Legal Network and Irish Prison Reform Trust in their submission to the ECtHR in *Shelley v. UK*:[138]

"Prison authorities often suggest that the issue of PNEO is one of domestic policy, and that the lack of consistent state practice in this regard means that it is a matter falling within the state's margin of appreciation. However this position contradicts the broad international consensus on prisoners' equal right to health and the positive obligations of states [under international human rights law]."[139]

It is note worthy that over the past few years, the ECtHR has considered human rights reports and guidelines from international expert agencies such as WHO and the International Guidelines in its deliberations.

Using Art.3 under HRA

The only case brought under the HRA which included an alleged violation of Art.3 ECHR in relation to HIV prevention in prisons is John Shelley's.[140]

Shelley is a prisoner who has been arguing that the failure to introduce a trial of needle exchanges into English and Welsh prisons violated articles 2, 3 and 8 of the ECHR. His application followed the introduction of Prison Service Instruction 53/2003 on the provision of disinfecting tablets.

The High Court refused Shelley's renewed application for permission to apply for judicial review. The judge was satisfied that the Home Office had showed that they had considered the issues and that it was within their discretion to consider that needle exchanges should not be introduced. The judge placed significant weight on security concerns (i.e. the risk that inmates would use needles to assault other inmates or prison officers) despite the fact that the Home Office produced no evidence for this and did not refer to the matter in its arguments. The renewed application to the Court of Appeal was also dismissed.

The government's arguments did not rest on any solid evidence in particular the claim that there were strong security considerations in the decision not to introduce NEPs in prisons.

The failure of the application for judicial review therefore strongly suggests that judges consider that issues such as those of NEPs are within the Home Office's discretion and they are not willing to contradict government policy on controversial and sensitive issues.

Shelley launched application before the ECtHR arguing that the UK government violated its obligations under the ECHR. The Court considered the case under Arts. 3, 8 and 14 but the Court only considered Art. 8 and Art. 14.

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[136] *Tyrer v. UK* (19780 2 EHRR 1, para 31. See also *Őcalan v. Turkey* (2003) 37 EHRR 10, para. 194.
[137] Supra, at 128.
[138] Application 23800/06.
[139] At para. 34 (submission available at www.aidslaw.ca).
[140] *John Shelley v. The Secretary of State for the Home Department* (2005), Case No. CO/5613/2004.

HIV Prevention and Privacy

The ECtHR has adopted a broad definition of privacy under Art.8 ECHR. Privacy encompasses physical/bodily and psychological integrity of a person.[141] A person's body also concerns the most intimate aspect of private life.

The Court has held that Art.8 ECHR imposes positive obligations on States. These obligations *"may involve the adoption of measures designed to secure respect for private life even in the sphere of the relations of individuals between themselves".[142]* It therefore stated that the scope of Art.8 ECHR includes a negative right to be "left alone" in a physical sense and a positive obligation to ensure that bodily/physical integrity is not infringed by other individuals.[143]

States have a duty to prevent the violation of the physical integrity of a prisoner whose confinement impacts on their ability to protect themselves against HIV. It is argued that States' failure to provide condoms and clean needles amounts to a breach of a prisoner's right to privacy.

HIV transmission impedes on a prisoner's physical/bodily integrity. The lack of access to HIV preventive measures and the knowledge that they may get HIV when having sex or/and injecting drugs also have implications for a prisoner's psychological integrity.

The current policy of condoms in England and Wales "on prescription" also impedes on prisoners' informational private interests. Prisoners have to ask for a condom to a healthcare professional, therefore having to reveal extremely private and intimate information. In the case of straight men deciding to engage in sex or forced into having sex, this may cause stigma, shame and embarrassment. It is argued that having to "disclose" one's sexual activity because condoms are not readily available may amount to a "forced" disclosure.

In *Z v. Finland*[144] ECtHR recognised that the respect for medical confidentiality was a "*vital principle*" crucial to the right to privacy, in particular in relation to a person's HIV status. The Court stated that*"[t]he protection of personal data, not least medical data, is of fundamental importance to a person's enjoyment of his or her right to respect for private and family life as guaranteed by Article 8 of the Convention (…) It is crucial not only to respect the sense of privacy of a patient but also to preserve his or her confidence in the medical profession and in the health services in general. Without such protection, those in need of medical assistance may be deterred from revealing such information of a personal and intimate nature as may be necessary in order to receive appropriate treatment and, even, from seeking such assistance, thereby endangering their own health and, in the case of transmissible diseases, that of the community (…)"* (para 95)

The ECtHR has not dealt with a claim relating to the provision of condoms in prisons but one case was brought by a prisoner in the UK (pre-HRA). In *R v. Secretary of State for the Home Department ex p. Fielding*[145] a former prisoner sought judicial review of the government's policy on condoms which were only issued to prisoners already infected with HIV and those deemed to be at risk by doctors. The Court upheld the government's "condoms on prescription" policy.

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[141] *X and Y v. The Netherlands* (1985)
[142] *Ibid*, at paras. 22-23.
[143] See for example the protection of children from sexual abuse: *A v. UK* (1998) 2 FLR 959.
[144] [1997] ECHR 10, 25 February 1997. This case dealt with the manner in which evidence was taken by the police in the course of criminal proceedings instituted against the applicant's husband on suspicion that he had knowingly contaminated other women with HIV. As a result of the measures taken by the authorities the applicant's HIV status was disclosed.
[145] High Court of Justice, Queen's Bench Division, 1999.

The High Court's decision in *R (Hunter) v. Ashworth Hospital*[146] (post-HRA) provides guidance on how UK courts may interpret Art. 8 ECHR in the context of condom provision and NEPs in prisons. In his judgment, Justice Bellamy said:

"I would have thought that, to become infected with a sexually transmissible disease such as hepatitis C, was a violation of a person's physical integrity, which is in principle protected by Article 8. Further support for the proposition that failure to protect a person's health may be a breach of Article 8 is found in two cases on environmental pollution decided by the European Court of Human Rights which have been drawn to my attention, even though in those cases the issue was a wider one than purely health (…)"[147]

It has been recognised by the ECtHR and then by the judge in *R (Hint)* that the test to be applied in the case of an allegation that the State has failed to protect a person's physical integrity is in principle the same test as that to be applied to an allegation that the State has breached Art.2 ECHR (i.e. right to life).

In order to succeed under Art.8 ECHR, the claimant would have to show that there was *"a real and immediate"* risk to his health from which the defendant has failed to protect him, and that the defendant had not taken such steps as were *"reasonably to be expected"* of it to obviate that risk.

There are numerous serious factors that would support this argument, in particular prisons' endemic overcrowding, evidence of sexual activity and/or injecting drug use and the nature of the prisoners' population and the ongoing increase in new HIV diagnosed cases in the general community. Yet, the decision of the ECtHR in Shelley (in the context of NEPs) was a disappointing example of the Court's reluctance in getting involved in these sensitive matters.

The Court examined Art. 8 and Art. 14 and declared the complaint inadmissible in January 2008.[148] The Court puts strong emphasis on the State's margin of appreciation in this matter and the limitations of States' positive obligations under Art. 8 in the context of preventive health:

"[T]here is no authority that places any obligation under Article 8 on a Contracting State to pursue any particular preventive health policy (…) While it is not excluded that a positive obligation might arise to eradicate or prevent the spread of a particular disease or infection, the Court is not persuaded that any potential threat to health that fell short of the standards of Articles 2 or 3 would necessarily impose a duty on the State to take specific preventive steps. Matters of health care policy, in particular as regards general preventive measures, are in principle within the margin of appreciation of the domestic authorities (…) While it is true that there is no evidence from the studies so far that the provision of needles either increases needlestick injuries or drugs use within the prison, the Court considers that the authorities are entitled to give careful consideration to extending such schemes in such a context and to proceed with requisite caution as concerns their implementation."

The government has so far refused to hear and acknowledge evidence about the benefits of introducing NEPs and the absence of negative consequences following the introduction of condoms. It has also disregarded extensive guidelines and authoritative recommendations from UN expert bodies on an adequate response to HIV in prisons.

[146] 2001 EWHC Admin 872 (30 October 2001)
[147] *Ibid*, at para. 124.
[148] Application 23800/06.

4.5.4. HIV Treatment and Prisoners' Rights

Provision of HIV Treatment under International Human Rights Law

Prisoners' right to health is based on the principle of equivalence. States' obligation to provide healthcare treatment under the principle of equivalence has been emphasised in key international guidelines on prison health and prisoners' rights such as the Basic Principles for the Treatment of Prisoners, the 1993 WHO Guidelines on HIV Infection and AIDS in Prisons and the UNODC Framework.

For example, Principle 9 of the Basic Principles for the Treatment of Prisoners states that *"[p]risoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."*

Prison healthcare was specifically addressed in the CPT's 3rd Annual General Report which noted that *"[a] prison health care service should be able to provide medical treatment and nursing care(…) in conditions comparable to those enjoyed by patients in the outside community."* (para. 38)

Prisoners' right to HIV treatment has been stated in international HIV policy instruments.[149] The UNODC Framework recommends that governments *"[e]nsure that all necessary health care is provided to prisoners free of charge and without discrimination at a level equivalent to that in the community, including referral and access to community health services when necessary. This should include (…) HIV/AIDS treatment (including antiretroviral treatments) and care, mental health services, palliative care interventions, and measures to prevent mother to child transmission of HIV".* (para. 41)

Failure to provide adequate medical treatment under Article 3 ECHR

Prisoners' right to medical care under Art.3 ECHR has been extensively examined by the ECtHR. The Court has made it clear that States must ensure that the health and well-being of detainees are adequately secured by, among other things, administrating them with the required medical assistance[150] and care;[151] monitoring of the prisoner's condition[152] including HIV and chronic diseases,[153] and taking effective steps to treat a prisoner's condition (e.g. hospitalisation).[154]

In *Farbtuhs* v. *Latvia*[155] the ECtHR noted that if the authorities decide to place and maintain a seriously ill person in detention, they should demonstrate special care in guaranteeing such conditions of detention that correspond to his special needs resulting from his disability.

Both the existing UK and Strasbourg case law on prisoners' right to health under Art. 3 and the evidence available on the provision of HIV treatment -and more generally healthcare in some UK prisons- provide a strong argument that the delay in providing prisoners with their HIV treatment and the lack of practical arrangements aiming to secure adherence to the treatment may amount to a breach of Art.3 ECHR.

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[149] See for example the WHO Guidelines on HIV Infection and AIDS in Prisons which state that *"[a]ll prisoners have the right to receive health care (…) equivalent to that available in the community without discrimination…with respect to their legal status."*

[150] see *Kudła v. Poland* [GC], Application No. 30210/96, para. 94, ECHR November 2000; see also *Hurtado v. Switzerland*, [1994] ECHR 1, § 79; and *Kalashnikov v. Russia*, Application No. 47095/99, Paras. 95 and 100, ECHR June 2002.

[151] *Mouisel v. France* [2002] ECHR 740.

[152] *Keenan v.UK* [2004] ECHR 663.

[153] *Kudhobin v. Russia*, Application No *59696/00* (Final judgment of 26th January 2007).

[154] *McGlinchey v* UK [2001] 33 EHRR.

[155] [2004] ECHR 663.

4.6. Conclusion

In its 2001 Report, the APPGA made significant recommendations in relation to HIV in prisons. It recommended that:

- The evaluation of pilot provision of cleansing tablets in prisons should be published and, if evaluated as successful, expanded throughout England and Wales;
- In principle, needles exchange schemes should operate inside prisons on the same basis as outside, in parallel to other health promotion measures and work which aims to reduce the incidence of drug use and treat drug addiction, and therefore should be piloted;
- A Prison Service Instruction should be issued to ensure that all prison staff know that they have a duty to provide condoms in an effective and confidential way and not merely through medical officers; and
- The Home Office in conjunction with the Department of Health develop clear guidelines and implementation mechanisms across the prison service, to ensure that, as far as is possible, the treatment of people with HIV in the prison system reflects practice outside and works towards equivalence.

None of these recommendations have been fully implemented.

- The introduction of cleansing tablets across prisons in England and Wales has been extensively delayed and has not currently been fully implemented.
- The introduction of pilot needle exchange schemes in England and Wales has been rejected by the government. The pilot did not go ahead in Scotland.
- The new guidance on condom provision in England and Wales still relies on medical staff issuing condoms and prisoners identifying themselves, and because it is up to each individual prison to implement the guidance, will undoubtedly lead to various policies across prisons. In Scotland the SPS has announced that condoms will be made available but nothing has been put in place yet.
- Finally, there is evidence that the medical treatment of HIV does not reflect outside practice with prisoners being denied HIV treatment or the delay in ensuring that they access their treatment as required.

In addition, the principle of equivalence, set out in international and domestic policy is not translated into practice and prisoners receive “second class” standards in terms of HIV prevention, treatment and care.

The UNODC framework provides a comprehensive human rights based approach to HIV in prison. The government should implement the framework as appropriate and ensure adequate monitoring of its implementation. The government should also look at the experience in other jurisprudences in revising their policy on HIV preventive measures in prison.

5. ASYLUM SEEKING CHILDREN AND YOUNG PEOPLE

Children and young people:

- ***The current policy and legal framework on children is also not based on human rights. This has strong implications for children and young people's HIV-related rights. The most fundamental rights of the child, guaranteed not only by the Convention on the Rights of the Child (CRC) but also other human rights treaties are currently disregarded.***

In the context of asylum:

- ***The UK's reservation to the CRC allows the government to exclude children who are subject to immigration control from the scope of its legal obligations under the treaty. This has major implications on asylum seeking children's HIV-related rights.***
- ***The treatment of children seeking asylum conflicts with the government's Every Child Matters strategy and reflects incoherent policies between departments.***
- ***Current policy on detention, dispersal and deportation interferes with children's rights set out in the CRC.***
- ***There is an urgent need for the government to remove its reservation on the CRC. The government should also incorporate the CRC domestically. A framework based on the Convention would ensure the domestic implementation of the treaty and a human rights based response to asylum seeking children and HIV.***

In the context of sex education:

- ***Despite strong evidence of a worrying level of ignorance and complacency about HIV among young people, sex education is still not compulsory in schools. This impact on young people's right to education and related entitlements set out in the CRC and subsequent General Comments.***
- ***Despite the recognition of the rights of the child at international and domestic levels, education in schools remains a reserved matter to adults. The main evidence of the exclusion of young people from the decision making process is the fact that parents in the UK retain the statutory right to withdraw their children from SRE lessons that fall outside of the national curriculum.***

5.1. Introduction

A total of 6,388 children born in the UK to HIV-positive mothers had been reported by the end of June 2006. Of these, 730 had been diagnosed with HIV. Including children born in other countries, there have been 1,429 UK diagnoses of HIV in people who were infected with HIV from their mothers. The proportion of HIV-positive babies has fallen sharply since the widespread introduction of antiretroviral therapy and other interventions, which can dramatically cut the chances of HIV transmission from mother to child.[156] There are approximately 1,200 children being seen in HIV paediatric services in the UK. Half of them were born abroad[157]. Surveillance of children recognised as born to HIV-positive women relies on confidential voluntary reports from paediatricians and obstetricians.

[156] Source: AVERT.
[157] The National Study of HIV in Pregnancy and Childhood (NSHPC), February 2007.

Young people account for about 11 per cent of HIV diagnoses each year. By the end of 2005, a total of 10396 young people aged between16 to 24 had been diagnosed with HIV since 1981. In the same time period, 938 young people aged 16-24 had been diagnosed with AIDS and 481 had died.[158]

5.2. UK Legal and Policy Framework on Children's Rights

The UK is party to the Convention on the Rights of the Child but has not implemented it into UK law. The Convention's rights are therefore not justiciable (i.e. liable to court trial or legal decision) in the UK.

The current policy and legal framework on children is also not based on a human rights based approach. This considerably weakens the impact of the CRC in the UK.

Children's related matters are dealt with the *Children Act 1989* which came into force in England and Wales in 1991. The Act rests on the belief that children are generally best looked after within the family, with both parents playing a full part and without resort to legal proceedings. The welfare of the children is the paramount consideration.

The *Children Act 2004* forms the legislative framework for England and Wales. The Act establishes the direction for a programme of change in the delivery of services that support children, young people and their families set out in the cross-government policy framework *Every Child Matters: Change for Children.*[159]

The framework's main outcomes are that every child should have the support they need to: be healthy; stay safe; enjoy and achieve; make a positive contribution; and achieve economic well-being. *The National Service Framework for Children, Young People and Maternity Services*[160] sets out a ten-year programme to stimulate long-term and sustained improvement in children's health and wellbeing.

The child-related heath aim of the framework ("be healthy") includes enjoying a healthy lifestyle, having self-esteem, choosing not to take drugs, being physically, mentally, emotionally and sexually healthy, and being well-nourished and active.

Section 11 of the 2004 Act relates to children's services in England and sets out a duty on specific authorities to make arrangements to safeguard and promote the welfare of children. This duty does not apply to NASS, immigration removal centres or Chief Immigration Officers at a port of entry. These exemptions are justified, in the government's words, by the fact that such a duty *"could severely compromise our ability to maintain an effective asylum system and strong immigration control*".[161]

The Act 2004 also establishes a Children's Commissioner for each nation whose remit is to promote awareness of views and interests of children rather than promote and safeguard rights, which may affect the ability of the Commissioner to ensure that children's rights are upheld. The Children's Commissioner for England has responsibility for reserved issues, e.g. immigration and asylum.

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[158] Health Protection Agency, *A Complex Picture HIV and other Sexually Transmitted Infections in the United Kingdom: 2006,* November 2006 (available at www.hpa.org.uk/publications/2006/hiv_sti_2006/default.htm) . See also HPA, *Sexually Transmitted Infections in young people in the United Kingdom: 2008 Report*, available at http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1216022460726?p=1158945066450

[159] (2004) Document available at www.everychildmatters.gov.uk/_files/F9E3F941DC8D4580539EE4C743E9371D.pdf

[160] Department of Health & Department for Education and Skills, 2004, (available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4089100)

[161] Hansard (2004) *House of Lords Official Report, Vol. 662, No.100.* London: Crown Copyright.

The Children (Scotland) Act 1995 and t*he Children (Northern Ireland) Order 1995* are the child welfare legislation for Scotland and Northern Ireland respectively. The Acts set out key rights of children in the nations and the responsibilities of adults and public organisations to care for and protect them. The Acts do not refer to nor do they acknowledge the CRC.

The current policy framework on children's welfare has developed extensively and quickly over the past few years. Yet, the government does not approach children's policy and service development from a human rights or anti-discriminatory perspective.

Furthermore, the lack of emphasis on the implementation of the CRC and the government's failure to implement recommendations from UN monitoring bodies, NGOs and parliamentary committees means that children's HIV related rights have been several compromised in several areas.

5.3. HIV and Asylum Seeking Children

5.3.1. Detention

Policy on the Detention of Asylum Seeking Children[162]

In 2001, the government's policy of only detaining the children in families immediately prior to removal and for no more than a few days was changed to allow indefinite detention of those families whose circumstances provided justification.[163] This policy was reiterated in the 2002 Government White Paper on immigration and asylum.

In December 2003, following strong criticism, the Home Office announced that any detention of a child beyond 28 days would take place only after ministerial authorisation. In December 2007, the Immigration Minister Liam Byrne was asked in Parliament whether limits could be introduced on the amount of time children may be held in detention. He replied: "…Where family detention is prolonged it is often because parents seek to frustrate the removal process. To introduce a time limit on detention would reward such behaviour and that would be unacceptable."[164] Yet, the immigration minister admitted to the JCHR that the child's welfare is not the primary consideration in the ministerial authorisation process.[165]

Children are held with their families in Yarl's Wood, Tinsley House and Dungavel House in Scotland. Those centres are all run on behalf of the Home Office by private companies. They can be detained with their parents at any time during the asylum process. Research indicates that in practice children and their families are detained even when they have complied with immigration conditions and there is no reason to believe they would not continue to do so. Research has also found that detention is used when removal is not imminent and in some cases even before a claim for asylum has finally been decided.

In August 2007, statistics published by the Home Office revealed that, of the 1,235 children who left immigration detention in the nine months from January to September 2006, 7% (86 children) had been detained for 30 or more days.[166] A Save the Children study of 32 cases of child and family detention found the length of detention varied from seven to 268 days.[167]

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[162] This section is based on Save the Children's report "*No Place for a Child: Children in UK immigration detention: impacts, alternatives and safeguards",* 2005.
[163] Letter from Kevan Brewer, Director of Immigration Detention Services, to Bail for Immigration Detainees, September 25 2001
[164] House of Commons written answer to Parliamentary question, December 17 2007: Hansard Column 963W.
[165] Supra, at 35.
[166] Home Office (August 2007), *Statistical bulletin: Asylum statistics UK 2006.*
[167] Save the Children (2005), *supra, at 162.*

Impact of Detention on Children's Health

Some reports have focused on the impact of detention on the health of children, particularly Save the Children's *"No place for a child"* and the National Children's Bureau's report on HIV-positive affected children with insecure immigration status.[168]

The participants of the London focus group raised the issue of the treatment of children. A woman remembered that milk was not available for her children. The room allocated to her was too small and the cot had to squeeze between the two beds. Another woman explained how her children suffered vomiting and diarrhoea owing to the food in detention. She warned that this situation is very common for children in Yarl's Wood. This, coupled with the repetitive menus, led her children to refuse to eat. As a result, her children became sick, with her son being taken to hospital on reaching a temperature of 39 degrees Celsius. Her daughter suffered weight loss, which was recorded in her health appointments. She expressed concern that if her child's illness got worse, the centre would not have the equipment necessary to treat him. Interestingly, the doctor blamed the mother for this situation rather than the situation of detention - this culture of blame appears consistent with other detainees' accounts of detention.

As stated by Conway, children living with HIV have complex clinical and psycho-social support needs that are exacerbated by their detention, with staff unprepared and untrained to respond to those needs. HIV-positive children require specialist paediatric care that is not available in detention centres. Children affected by HIV may also have to bear the detrimental consequences of detention if their parent or relative are not provided with ARVs and are subject to psychological, emotional and physical strain due to detention. Children may end up watching them deteriorate, feeling hopeless and caring for them when they are struggling and experiencing mental and physical health difficulties themselves.

5.3.2. Children and Dispersal[169]

Policy on Dispersal of Children

The current policy on the dispersal of asylum seekers has been examined in Section X of this report and is relevant to children. NASS Policy Bulletin 85 refers to children:

"Extra care should be taken when finding accommodation for families with children infected with HIV. Caseworkers will need to satisfy themselves that any accommodation is located where there are appropriate facilities for treating children with HIV/AIDS. The NASS medical advisor should be asked to provide advice about specific locations." (at para. 9.5)

Impact of the NASS Guidance

NCB's research was conducted 8 months after the revised guidance on the dispersal of HIV-positive asylum seekers was introduced. The findings show that the guidance has not translated into practice:

"Of the approximately 120 HIV infected children with insecure immigration status represented in the health questionnaires, in the six months prior to the NASS policy change, seven had been reported as being moved through dispersal (an additional child and family had been moved back to London as they had complex health needs and needed to access a hub centre for treatment). In the six months after the change, a further seven

[168] M. Conway, Children, HIV, Asylum & Immigration- An overview of the current situation for children living with HIV and insecure immigration status, December 2006.
[169] This section is based on NCB's report on HIV, children and asylum, supra at 168.

were reported as being dispersed into an area, although this number would have been nine, had it not been for the intervention and lobbying of health workers to stop two of these moves. Of families living with HIV represented in the support service questions, twelve were moved during the six months prior to the NASS policy change, and nine in the six months after. In addition to these moves out of an area, frequent moves within areas were noted, and the disrupting effect these have on families:

'There have been lots of moves because of housing providers losing contracts so although NASS guidelines are clear we make sure that they are adhered to (telling people to refuse to move if all else fails). The NASS system can still shuttle people about. One person with a young child has been moved several times in a week.'"
Healthcare providers said that the introduction of NASS guidance had no impact on the treatment and care of children. Seventy-five per cent that dispersal had either a "negative" or "very negative" impact on the children they treat or support both psychologically (mental and well being) and on the parent/child relationship. The research also highlighted further problems resulting from dispersal in particular the increasing needs of families either financial and/or legal. In relation to HIV-positive children, healthcare providers reported the issue of children not being treated locally and the cost and stress resulting from having to travel for hospital appointments.

The situation of HIV-positive pregnant women was also considered. NCB's report states that between 2002 and 2005, over 3500 women living with HIV gave birth. Approximately 80-90 per cent of the women were diagnosed before they delivered, and approximately 100 babies were HIV-positive. Two-third of women were undiagnosed and only a third was diagnosed during pregnancy. Three-quarters of these women were also from African countries with high HIV prevalence.

Preliminary findings from a recent audit of cases where there had been mother-to-baby transmission in England suggest that a majority of these women had serious problems concerning their immigration status or housing, or had major mental health or social problems.

As NCB noted:
"There will always be undiagnosed pregnant women, as you cannot make a woman take an HIV test. Hospitals who have HIV specialist teams and significant clinical experience of treating women from migrant communities are more likely to recognise the women who are a higher risk of being HIV positive, and as such can provide the kind of interventions which may be necessary to support women in accepting their need for an HIV test. As it stands a system which disperses vulnerable pregnant women from migrant communities with high HIV prevalence to areas without expertise in this area, potentially creates a greater risk that babies will be born HIV positive."

5.3.3. Deportation

The UK's reservation on children in immigration related matters means that unaccompanied children can be deported. Those with family can also be deported if one or more members of the family are being sent back to their country. This is however contrary to the guiding principles of the government's *Every Child Matters* strategy.

The threshold for an HIV-positive asylum seeker to be allowed to remain in the UK on Art. 3 is extremely high, and a recent judgment made it clear that the Home Office's policy applies equally to both adults and children:

"A woman and her 14 year old son who are HIV-positive face imminent deportation to Malawi. Jane came to Britain from Malawi in November 2002 to look after her ill sister, who died within five months of her arrival. Jane applied to stay as a student and this was allowed, until September 2003. She had four children still in Malawi, including Michael who, it was believed, had typhoid.

Three of them sought to join their mother in October 2003. Two were refused and were returned to Malawi. But Michael was granted temporary entry because he was so unwell. He was quickly diagnosed with HIV. Since their arrival, Jane and Michael have received treatment from the NHS and the health of both has improved and they can be expected to survive decades if they continue to receive HIV treatment available in the UK. Her application to remain on health grounds has been refused, and so has her son's. His appeal to an asylum and immigration tribunal, has been rejected too."[170]

As highlighted by Positive Parenting and Children (PPC), the government's policy on deportation has implications for children which are compounded by the lack of joined-up thinking around child welfare and immigration policies and the fact that immigration policy is taking prevalence over child welfare. PPC provided the following case study:

"Two young boys and their mother were placed in Yarl's Wood Detention Centre. After they were temporarily released, the mother placed the children in hiding, as she suspected she might be returned to the detention centre and deported. The mother was returned to the detention centre as she feared. She was deported to her home country shortly after, without her children. PPC do not know where the children are or who is caring for them."

It is worth noting the case of *O and W* decided in November 2005. "O" was a young single Nigerian woman. She arrived in the UK with false travel documents in October 2003. She was pregnant at the time. She gave birth to a boy ("W") and they subsequently both tested positive for HIV. The boy suffered from brain encephalopathy which resulted in development damage. "O" applied for political asylum and on health grounds in June 2005. The Home Office refused the application on both grounds but on appeal the judge stated that "O" differed from "N". The judge found that the focus of concerns was "W" and that if he were returned to Nigeria, his mother would have to watch him deteriorate and die as multi-disciplinary treatment required for the child's HIV and encephalopathy was not available in Nigeria. This amounted to an exceptional circumstance with "compelling humanitarian grounds" which would result in a breach of Art. 3. Yet, the Tribunal stated that the mother's Article 3 claim would not be successful in its own right. Whether the child's claim would have been successful if he had no suffered a brain condition is also uncertain – and unlikely.

In April 2007, Barnardo's Chief Executive said that about 20 children were due to be deported despite having or being suspected to be HIV-positive.[171] It is during that month that the deportation of a 7 year old boy and his HIV-positive parents was postponed. The boy would have had to face the prospect of dying alone after watching his sick parents die first.[172]

5.3.4. International Legal and Policy Framework on Asylum Seeking Children

<u>Asylum seeking children and the CRC</u>

The CRC is the most comprehensive international human rights binding treaty addressing children's issues. The Convention applies to all children under 18 years (unless under the law applicable to the child, majority is attained earlier) without exception or discrimination of any kind.

Article 3 CRC is unequivocal on the protection of the best interests of the child which must be given *"primary consideration"* in *"all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies".*

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[170] Source: George House Trust (February 2007).
[171] The Independent, 4 April 2007. See also: www.guardian.co.uk/uk_news/story/0,,2049502,00.html
[172] Source: www.barnardos.org.uk/news_and_events/media_centre/press_releases.htm?ref=28348

Children's right to health is guaranteed in Art.24 CRC which asserts:

"(1) State Parties recognise the rights of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States parties shall strive to ensure that no child is deprived of his or her right of access to such healthcare services. (2) States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures (..) (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care (…);(d)To ensure appropriate pre-natal and post-natal health care for mothers (…)."

Children's right to liberty is set out in Art.37 of the Convention:

"States Parties shall ensure that (…) (b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time; (c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age (…)"

The Committee on the Rights of the Child's General Comment 6 deals with the *"Treatment of Unaccompanied and Separated Children outside their Country of Origin"*.

On the detention of children, GC6 states:

"In application of article 37 of the Convention and the principle of the best interests of the child, unaccompanied or separated children should not, as a general rule, be detained. Detention cannot be justified solely on the basis of the child being unaccompanied or separated, or on their migratory or residence status, or lack thereof. Where detention is exceptionally justified for other reasons, it shall be conducted in accordance with article 37 (b) of the Convention that requires detention to conform to the law of the relevant country and only to be used as a measure of last resort and for the shortest appropriate period of time. In consequence, all efforts, including acceleration of relevant processes, should be made to allow for the immediate release of unaccompanied or separated children from detention and their placement in other forms of appropriate accommodation (…)(at paras. 61-62)

Children, HIV and Asylum

One of the objectives of GC3 on *"HIV/AIDS and the Rights of the Child"* includes promoting the realisation of the human rights of children in the context of HIV and AIDS, as guaranteed under the CRC. GC 3 states:

"The issue of children and HIV/AIDS is perceived as mainly a medical or health problem, although in reality it involves a much wider range of issues. In this regard, the right to health (article 24 of the Convention) is, however, central. But HIV/AIDS impacts so heavily on the lives of all children that it affects all their rights - civil, political, economic, social and cultural. The rights embodied in the general principles of the Convention - the right to non-discrimination (art. 2), the right of the child to have his/her interest as a primary consideration (art. 3), the right to life, survival and development (art. 6) and the right to have his/her views respected (art. 12) - should therefore be the guiding themes in the consideration of HIV/AIDS at all levels of prevention, treatment, care and support." (para. 5)

In relation to Art.3 CRC (best interests of the child), GC3 notes that *"[t]he obligations attached to this right are fundamental to guiding the action of States in relation to HIV/AIDS"*.

Paragraph 28 further states that *"[t]he obligations of States parties under the Convention extend to ensuring that children have sustained and equal access to comprehensive treatment and care, including necessary HIV-related drugs, goods and services on a basis of non-discrimination".*

The document acknowledges the needs of vulnerable children including *"children in detention"* and *"migrant"* children".

Finally of relevance to this section, GC3 states that *"[f]or children from families affected by HIV/AIDS, the stigmatization and social isolation they experience may be accentuated by the neglect or violation of their rights, in particular discrimination resulting in a decrease or loss of access education, health and social services. The Committee wishes to underline the necessity of providing legal, economic and social protection to affected children to ensure their access to (…) health and social services (…) In this respect, States parties are reminded that these measures are critical to the realization of the rights of children and to giving them the skills and support necessary to reduce their vulnerability and risk of becoming infected".*

5.3.5. The UK's Reservation

The UK has entered a reservation to Art. 22 CRC, which states:

"The United Kingdom reserves the right to apply such legislation, in so far as it relates to the entry into, stay in and departure from the United Kingdom on those who do not have the right under the law of the United Kingdom to enter and remain in the United Kingdom, and to the acquisition and possession of citizenship, as it may deem necessary from time to time."

This reservation therefore allows the government to exclude children who are subject to immigration control from the scope of its legal obligations under the CRC. The government's argument for entering and maintaining the Reservation is that it is necessary in order to maintain the integrity of UK immigration control. The government has however stated that the reservation does not prevent the UK from having regard to the Convention in its care and treatment of children.[173] It has also argued that, in practice *"the interests of asylum seeking children and young people are fully respected"* in particular under the Human Rights Act 1998 and that *"notwithstanding the Reservation, there are sufficient social and legal mechanisms in place to ensure that children receive a generous level of protection and care whilst they are in the UK".*[174]

The UK's reservation to the CRC has been widely criticised, in particular by the UN Committee on the Rights of the Child and the UK Joint Committee on Human Rights. The latter stated:

"The reservation is justified by the Government as necessary to prevent the Convention affecting immigration status. As we have made clear in previous reports, we consider the government's anxiety on this point to be unfounded (…) Evidence (…) testifies to the unequal protection of the rights of asylum seeking children under domestic law and practice (…) It is regrettable that such unequal treatment is legitimised by the continuance in force of the reservation to the CRC. The reservation has been subject to considerable criticism, including from the UN Committee on the Rights of the Child, and in reports of our own."[175]

[173] Government evidence to the JCHR inquiry into the UN Convention on the Rights of the Child, and the Home Office response to our questions on the Nationality, Immigration and Asylum Bill, was to similar effect: Tenth Report of Session 2002-03, op cit., HL Paper 117, HC 81, paras. 81-87; Seventeenth Report of Session 2001-02, *Nationality, Immigration and Asylum Bill*, HL Paper 132, HC 961, Ev 1.
[174] *Supra,* at 8, Appendix 6, p. 27.
[175] JCHR Seventh Report, at para. 48-49.

The Committee on the Rights of the Child also made a significant statement saying that a reservation to an obligation to apply rights on a non-discriminatory basis is inadmissible because it undermines the universality of the rights of children and the overall purpose of the Convention itself.[176]
The Committee has characterised the broad nature of the Reservation as one of its principal subjects of concern, expressing anxiety about the compatibility of the Reservation with the object and purpose of the CRC itself.

In his 2005 report,[177] the Commissioner for Human Rights was unequivocal about his concerns in relation to the government's asylum related policy and legislation, including the increasing use of detention, the use of fast-track asylum procedures, the length and conditions of detentions, and the detention of children. He stressed that the UNHCR Detention Guidelines are clear about the *"inherent undesirability of detaining children in relation to asylum proceedings"*.[178]

The promotion and protection of the rights of the child are not limited to the CRC. Both the ICCPR and the ICESCR set out States' obligations that apply to children. This includes the right to health (Art.12 ICESCR; GC14), the right to be free from inhuman and degrading treatment (Art.7 ICCPR), the right to liberty and security (Art.9 ICCPR) and the right of people deprived of their liberty to be treated with humanity and with respect for the inherent dignity of the human person (Art.10 ICCPR).

As examined above, domestic asylum and immigration law and policy impact on the rights guaranteed under the ECHR, and the arguments set out in the section of this report on the treatment of adult asylum seekers are applicable to children. However, the current government policy on the deportation of adult asylum seekers and children also has implications under Art.8 ECHR – the right to private and family life.

5.3.6. Conclusion

The issue of asylum seeking children was not addressed in the APPGA's report but changes in asylum policy over the past few years have attracted criticisms and condemnation from UK NGOs and parliamentary bodies as well as the UN. From our research we also conclude that:

- The treatment of children seeking asylum conflicts with the government's *Every Child Matters* strategy and provides another example of incoherent policies between departments.
- The most fundamental rights of the child, guaranteed not only by the CRC but also other human rights treaties are currently disregarded.
- There is also a gap between theory and practice as NASS guidance on the dispersal of children with HIV is not being implemented.
- There is an urgent need for the government to remove its reservation to the CRC. The government should also incorporate the CRC domestically. A framework based on the Convention would ensure the domestic implementation of the treaty and a human rights based response to asylum seeking children and HIV.

[176] N. Blake and S. Drew, *In the Matter of the United Kingdom Reservation to the UN Convention on the Rights of the Child*, 2001, legal opinion commissioned by Save the Children, available at www.segregation.org.uk/legalopinion.pdf
[177] Ibid.
[178] The UNHCR Detention Guidelines and its guidelines on unaccompanied asylum-seeking children state that *"minors who are asylum-seekers should not be detained"*. They further state that unaccompanied children should be released into the care of family members who already have residency, and where this is not possible, alternative care arrangements should be made with the appropriate childcare authorities. The guidance explicitly states that *"all appropriate alternatives to detention should be considered in the case of children accompanying their parents"*.

5.4. HIV-Related Education in Schools

5.4.1. HIV, STIs and Young People

The latest Health Protection Agency's report on HIV and sexual health in the UK reported that young adults are disproportionately affected by STIs, accounting for 65 per cent of all Chlamydia, 55 per cent of all genital warts and 48 per cent of gonorrhoea diagnoses in genitourinary medicine (GUM) clinics across the UK in 2006.[179] The report also stated that there were 745 new diagnoses of HIV in young adults in 2006 (11 per cent of all new HIV diagnoses), contributing to a total of 2,228 HIV-infected young adults accessing care in 2006.

Recent reports have highlighted evidence about young people's lack of knowledge and misconceptions about HIV and its ways of transmission. A 2005 Ipsos MORI survey[180] found that a quarter of young people aged 15-24 stop using condoms when they or their partner is on the pill. The survey also found that public awareness of how HIV is transmitted has seriously declined over the last five years.

A recent survey conducted by the British Broadcasting Corporation (BBC) has found a worrying level of ignorance and complacency about HIV among young people in the UK.

The survey of 1,500 people aged 16 to 64 was conducted online in May 2007. The survey found that among 16 to 24 year old, nine out of ten rarely or never thought about HIV when making decisions about their sex lives. Seventy-four per cent demonstrated incorrect knowledge about HIV when asked, with 55 per cent thinking HIV could be spread through kissing, and just under half believing that you could get HIV from a toilet seat. Yet many didn't realise their own level of ignorance about the disease – just 26 per cent of the young people surveyed said they did not feel sufficiently informed about the transmission and prevention of HIV.[181]

Those findings do not reveal new trends as a 2005 survey had already revealed that young people lacked knowledge about HIV.[182]

5.4.2. Sexual Health Education in Schools

Current laws regarding Sex and Relationship Education (SRE) and Personal Social and Health Education (PSHE) are confusing. The basic biology of sex and relationship education is part of the statutory science element of the National Curriculum. Learning about sexuality, relationships, choice, delay, safer sex, risks and pregnancy choices are recommended to be taught within PSHE and are outlined in the Sex and Relationship Education Guidance, but are not a statutory requirement.

This non-statutory curriculum for PSHE which includes SRE has not been enough to encourage all schools to deliver more than the very biological basics, which, although vitally important, are insufficient. This in turn results in children and young people across the country having unequal access to SRE.

Schools across the UK are required to develop their own SRE policy after consultation between governors, head teachers and parents to ensure that it will reflect parents' wishes and the culture of the community they serve. The school policy must:

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[179] *Testing Times - HIV and other Sexually Transmitted Infections in the United Kingdom,* 2007 (available at http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/publications/AnnualReport/2007/default.htm)
[180] See www.ipsos-mori.com/polls/2005/nat.shtml
[181] Source: http://news.bbc.co.uk/1/hi/health/7022497.stm
[182] Centre for Sexual Health Research at the University of Southampton, *The Choreography of condom use: how, not just if, young people use condoms.*

- Define sex and relationship education;
- Describe how sex and relationship education is provided and who is responsible for providing it;
- Say how sex and relationship education is monitored and evaluated; and
- Include information about parents' right to withdrawal.

Scotland

Sex education (like all subjects) is not mandatory in Scotland. Education authorities and schools make their own decision about what is taught and at what age. Personal and social education is encompassed by "Health Education".[183]

England and Wales

Sex education in England and Wales is only statutory in Science lessons. In England, the only aspects of SRE which have a compulsory statutory basis are biology-related issues. The broader framework, including social and emotional aspects of SRE is not statutory and therefore not compulsory.

Facts about HIV are taught from a medical perspective and HIV is not included in relevant subjects such as science, citizenship, geography and PSHE. Despite government guidance, Ofsted, the inspectorate for schools in England, has reported that provision is extremely patchy. PSHE is under-resourced and is delivered in many schools by non-specialist and/or poorly prepared teachers.[184]

The findings of an fpa survey published in February 2007 highlighted the current failures of sex education provision at school.[185] When respondents were asked to judge sex education at school, only 4 per cent said it was excellent. Most respondents answered negatively: a combined 39 per cent said it was either poor or extremely poor, whilst 25 per cent said it was adequate and 18 per cent said they never had any.

5.4.3. Calls for Sexual Health Education Reform

The Health Select Committee criticised the current policy on sexual health education in its 2003[186] and 2005[187] reports on sexual health. In 2003, the Committee recommended in particular:

- Renewed emphasis on the "relationships" aspect of sex and relationships education;
- Location of SRE within the National Curriculum to ensure it received adequate priority;
- Use of specialist teachers to teach SRE; and
- Young people's health services to be integrated within schools.

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[183] According to the National Guidelines from the Scottish Executive, Health Education should aim to enable young people to explore and clarify their beliefs, attitudes and values, develop personal and interpersonal skills, and increase their knowledge and understanding of a range of health issues. In Scotland, National Guidelines for 5 to 14 year olds are set by Learning and Teaching Scotland but they are not set by law, placing responsibility on local authorities and schools (which allows variation in teaching).
[184] SRE is included on a statutory basis within the Northern Ireland Curriculum through the health education cross-curricular theme as well as the science programme of study. Health Education is taught mainly through the medium of science, with important contributions coming from physical education, English, home economics, personal and social education and religious education.
[185] The survey was conducted by Gfk NOP which interviewed 495 adults aged over 18 during December 2006 (7th-12th December) across Great Britain. Weighting was applied to the data to bring it into line with national profiles.
[186] Third Report, *New Developments in Sexual Health and HIV/AIDS Policy*.
[187] Ibid.

The Committee emphasised the wrong focus of sexual health education:

"Many of the young people who gave evidence to us (…) felt that they and their peers were not receiving important messages about sexual health. A common problem not addressed by sex education was that for many young women, concern about pregnancy takes precedence over concern about STIs: A number of people are aware of the pill and think that, if you are on the pill, you are protected against STIs (…) Sarah (…) described a similar lack of emphasis given to the most common STIs amongst young people: 'I remember the only lesson we had on sexual health, there was nothing about Chlamydia or syphilis or anything like that, but it was a leaflet passed around the class about AIDS and HIV which then got taken back to the form teacher at the end of the lesson to use in next week's lesson with a different group'." (paras. 293-294)

The Independent Advisory Group on Sexual Health and HIV (IAG) has also repeatedly criticised the current curriculum framework. In November 2005, the IAG, with the Independent Advisory Group on Teenage Pregnancy, published a report[188] to support their continued recommendation to make PSHE a statutory foundation subject in the National Curriculum at all key stages. Numerous organisations have also called the Government to make SRE and PSHE, including HIV-related issues, statutory. Some charities have produced toolkits and packs but their use remains at the discretion of schools and does not ensure a uniform and coherent teaching programme across the UK.

5.4.4. HIV and Young People's Rights to Education and Information

One of the main issues raised by the debate on compulsory sex education is that of parental responsibilities. As noted by Cumper, the principle of parental choice in the field of education has been widely recognised as a fundamental right.[189] Yet, children's right to education is clearly articulated in the CRC and specific General Comments of the Committee on the Rights of the Child.

The right to sex education

There is no right to sex education per se under international human rights law. It is however arguable that the right to sex education can be implied.

Article 12 CRC provides for children's right to express their views freely in all matters affecting them and their views to be given due weight in accordance with their age and maturity. Article 17 CRC further guarantees children's right to have access to information and materials from various sources, **"***especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health".* This article can be read in conjunction with Art.24 CRC which provides for young people's right to health and imposes on States an obligation to develop *"preventive health care, guidance for parents and family planning education and services"*.

Article 29 on the right to education insists upon a holistic approach to education which ensures that the educational opportunities made available reflect an appropriate balance between promoting the physical, mental, spiritual and emotional aspects of education, the intellectual, social and practical dimensions, and the childhood and lifelong aspects. The overall objective of education is to maximize the child's ability and opportunity to participate fully and responsibly in a free society.

Paragraph 8 of the 2001 Committee's GC 1on the *Aims of Education* states that *"efforts to promote the enjoyment of other rights must not be undermined, and should be reinforced, by the values imparted in the*

[188] *Personal, Social and Health Education (PSHE) in schools: Time for Action.*
[189] P. Cumper, *"'Let's talk about sex': balancing children's rights and parental responsibilities"*, Legal Studies, Vol. 26, No. 1, March 2006, pp. 88-108.

educational process. This includes not only the content of the curriculum but also the educational processes, the pedagogical methods and the environment within which education takes place, whether it be the home, school, or elsewhere. Children do not lose their human rights by virtue of passing through the school gates. Thus, for example, education must be provided in a way that respects the inherent dignity of the child and enables the child to express his or her views freely in accordance with article 12 (1) and to participate in school life."

The Committee's GC4 on *Adolescent Health and development in the context of the Convention on the Rights of the Child* states:

"Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours. This should include information on (…) safe and respectful social and sexual behaviours (…) States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs)." (paras. 26 and 28)

The Committee's GC3 on *HIV/AIDS and the rights of the child* states the nature of States' obligations in the context of adolescent health and development. These include:

- Ensuring that adolescents have access to the information that is essential for their health and development and that they have opportunities to participate in decisions affecting their health (notably through informed consent and the right of confidentiality), to acquire life skills, to obtain adequate and age-appropriate information, and to make appropriate health behaviour choices; and
- Ensuring that adolescent girls and boys have the opportunity to participate actively in planning and programming for their own health and development.

GC3 further states:

"Consistent with the obligations of States parties in relation to the rights to health and information (arts. 24, 13 and 17), children should have the right to access adequate information related to HIV/AIDS prevention and care (…) Education plays a critical role in providing children with relevant and appropriate information on HIV/AIDS, which can contribute to increased awareness and better understanding of this pandemic and prevent negative attitudes towards victims of HIV/AIDS (see also the Committee's General Comment No. 1 on the aims of education). Furthermore, education can and should empower children to protect themselves from the risk of HIV infection (…)" (paras 16 and 18)

<u>Compulsory sex education in schools: parents' responsibility v. children's rights</u>

Despite the recognition of the rights of the child at international and domestic level[190] education in schools remains a reserved matter to adults. The main evidence of the exclusion of young people from the decision making process is the fact that parents in the UK retain the statutory right to withdraw their children from SRE lessons that fall outside of the national curriculum.[191] Yet, as examined above, children's right to sex (including HIV) education is unequivocally recognised in the CRC and related General Comments.

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[190] *Gillick v. West Norfolk and Wisbeach Area Health Authority,* [1986] AC 112.

[191] P. Cumper, *"'Let's talk about sex': balancing children's rights and parental responsibilities"*, Legal Studies, Vol. 26, No. 1, March 2006, pp. 88-108.

The ECtHR jurisprudence provides a further argument for the provision of compulsory sex education in UK schools.

Art. 2 of the First Protocol to the ECHR states that *"no person shall be denied the right to education. In the exercise of any functions which it assumes in relation to education and to teaching, the State shall respect the right of parents to ensure such education and teaching in conformity with their own religions and philosophical convictions".*[192]

In *Kjeldsen, Busk Madsen and Pedersen v. Denmark*[193] the ECtHR accepted that compulsory sex education was compatible with Art.2 (2) Protocol 1 ECHR provided that the information is not conveyed with any particular moral attitude to sexual relations. In the absence of such attitude, a pupil will not have the right to be exempted from sex education.

This ruling was given in 1975, fourteen years before the CRC; and years before AIDS which became the epidemic we know.

It is argued that if the government was to make SRE compulsory and thus removing the "parental veto", it is unlikely that UK court would find it the policy incompatible with the HRA.

As argued by Cumper it is hard to believe that SRE in schools would be deemed to constitute "indoctrination" by a court. Furthermore, UK statistics show that young people are vulnerable to HIV and failure to provide them with sex education has significant implications on their right to health. It is therefore very unlikely that the courts would object to compulsory SRE given unequivocal evidence of the inadequacy of current information on sexual health and HIV, which is reflected in rates of STIs amongst young people and the teenage rate of pregnancy in the UK.

5.4.5. Conclusion

In 2001, the APPGA recommended that HIV education in schools should prioritise addressing stigma and discrimination, both towards HIV itself and vulnerable groups, and this should be encouraged through Department of Education and Skills guidance, Ofsted inspections and National Healthy Schools Standard assessments.

This recommendation has not been implemented and there have been increasing calls and campaigns towards the introduction of compulsory sex and relationship education in schools, which have not led to any actions by the government.

- There is compelling evidence that sex education should be made compulsory in schools. Although not expressly set out, there is a strong argument that the right to sex education is implied under international human rights law. Several CRC's General Comments support calls for the introduction of compulsory sex education in schools.
- As HIV prevalence continues to increase and 32 per cent living unknowingly with HIV, HIV education in school must be a priority.
- As HIV stigma and discrimination remains a significant issue, schools also have a crucial role in educating young people about the "social HIV epidemic".

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[192] Art. 2 is subject to a reservation entered by the UK to the effect that the second sentence is accepted only in so far as it is compatible with the provision of efficient instruction and training and with the avoidance of unreasonable public expenditure.
[193] (1979-80) 1 EHRR 711. This case dealt with the introduction of a compulsory sex education programme in primary schools for children aged from 9 to 11. A group of Christian parents challenged the legislation alleging that it failed to respect their parental, religious and philosophical convictions guaranteed under Art. 2 Protocol 1 ECHR.

6. SEEKING REDRESS FOR VIOLATIONS OF HIV RIGHTS

- ***Lack of awareness and knowledge of human rights impacts on people's ability to seek redress for alleged HIV-related rights violations; it also impacts on initiatives aimed at challenging and addressing HIV stigma and discrimination.***
- ***Government's policy and legislation on HIV-related issues not only increase stigma but also perpetuate myths that it is acceptable to violate the rights of people living with and/or vulnerable to HIV.***
- ***There is currently a significant gap in the provision of human rights education, legal support and advice for people living with and/or affected by HIV. There is also a lack of HIV and human rights expertise amongst UK enforcement and monitoring bodies and legal professionals.***
- ***Current means of redress for HIV-related violations of human rights are limited. The right to individual petition is not allowed under most human rights treaties. Reservations to international human rights treaties also significantly impact on people's ability to seek redress for alleged violations of HIV-related rights***
- ***Access to adequate legal representation is a significant issue for people seeking legal redress, in particular for those who are vulnerable and in urgent need of help such as asylum seekers.***

6.1. Introduction: Lack of Awareness and Understanding of Human Rights in the UK

There is strong evidence that the public lack knowledge of human rights, including how to use the Human Rights Act (HRA), when seeking redress for allegation of human rights violations. Public authorities also lack awareness on how to implement their duties under the Act.

A survey carried out for the Disability Rights Commission (DRC) in 2006 revealed that seven out of ten Britons cannot name any of their human rights. Over one third (36 per cent) of people felt they had no information about how the Human Rights Act effected their privacy and family life and only 10 per cent felt sufficiently informed about how the Act provides access to health and social care. JUSTICE's Human Rights Insight Project also highlighted the general public's limited awareness and understanding of human rights and of the HRA.[194] A 2006 Amnesty International report[195] on human rights awareness of public authorities across Scotland found that 65.5 per cent of those surveyed either did not understand their duties under the HRA or could not provide evidence of steps taken to comply with those duties. The survey also demonstrated a startling lack of awareness of the Act in public authorities as well as their failure to revisit their policies and practices since the Act came into force in 2000.

An important review of the Human Rights Act by the Department for Constitutional Affairs (DCA) highlighted significant concerns on the public's misunderstanding and misconceptions about the impact of the legislation and its purpose. The Joint Committee on Human Rights' Report on *The Human Rights Act: the DCA and Home Office Reviews* emphasised the impact of myths about the HRA:

[194] The report of the findings of the Project is available at www.justice.gov.uk/docs/human-rights-insight-full.pdf
[195] *Delivering Human Rights in Scotland: A report on Scottish public authorities*, September 2006, available at www.amnesty.org.uk/uploads/documents/doc_17149.pdf

"[i]t seems to us that there clearly exists a widely held public perception that the Human Rights Act protects only the undeserving, such as criminals and terrorists, at the expense of the law-abiding majority. Views differ as to whether responsibility for this perception rests with certain sections of the media, for inciting hostility to a statute to which they are opposed for reasons of self-interest; with our politicians for failing to provide the leadership necessary to demonstrate the benefits or potential benefits of the Human Rights Act to everyone; with lawyers and judges for appearing to suppose that the meaning and content of human rights are for exclusively legal rather than political decision; or with public authorities for failing to embrace the change of culture which the Act intended." (at para. 71)

The former Prime Minister Tony Blair was one of the politicians who raised concerns about the impact of the HRA and considered a radical overhaul of the legislation including the power to override court rulings. In 2003, the government considered opting out of Art.3 ECHR, which is a cornerstone of protection in the majority of human rights treaties, following a High Court ruling regarding asylum seekers' access to welfare benefits. These suggestions of "opting out" of various human rights obligations send out the wrong message to the public that human rights are not fundamental but optional.

6.2. Knowledge and Awareness of HIV-Related rights

Lack of awareness and understanding around human rights impact on initiatives aimed at challenging and addressing HIV stigma and discrimination. Any educational HIV prevention initiatives need to be supplemented by awareness-raising and educational initiatives about HIV and human rights. There are currently only limited activities carried out by some charities. Furthermore, government policies and legislation on HIV-related issues not only increase HIV-related stigma but also perpetuate myths that it is acceptable to violate the rights of people living with and/or vulnerable to HIV.

The effective realisation of HIV-related human rights also requires States' agents and legal professionals to have a comprehensive understanding and expertise on HIV-related legal issues. This includes knowledge of key references in relation to HIV and human rights, in particular the International Guidelines. It is the government's duty to ensure that adequate resources on HIV and human rights be developed and available to States' actors, legal professionals and staff providing legal and social services.

The AHPN has highlighted the issue of lack of knowledge and awareness of human rights amongst Africans affected by HIV facing immigration legal problems:

"[t]here is a general lack of awareness of human rights amongst African communities in the UK, and within broader society. Many people feel that the issue of human rights do not apply to them. This is particularly the case for people with an uncertain immigration status. Unless people are or feel entitled to services, they are not aware of their rights. They also do not consider their human rights unless they are going through a legal process. Young people have little knowledge of their rights; and those who have some understanding, do not feel it is for them. The issue of rights is regarded by young people as a theoretical concept, which is not applicable in their daily lives.Often African people in the UK are not empowered to learn about their human rights. The issue of rights is viewed in legalistic terms and associated with solicitors. In particular, newly-arrived African people do not feel it is their place to learn about their rights or to challenge the system. This would represent a shift in culture, whereby issues to do with 'rights' are left to lawyers. People also do not have the expertise to exercise their human rights. Consequently, they have to rely on solicitors to explain it to them, to take on their cases and to provide them with good representation."[196]

[196] Written Evidence.

The lack of awareness was also highlighted in Naz's submission:

"Most of our clients do not discuss their human rights. They view it in legalistic terms. They do not consider it to have relevance to their everyday lives."

The International Guidelines state that governments "*should implement and support legal support services that will educate people affected by HIV about their rights and provide free legal services to enforce those rights (…)*

The only HIV legal centre in the UK, The Terrence Higgins Trust's Specialist Advice Centre closed at the end of April 2006 as a result of funding cuts. The centre provided advanced casework advice, including tribunals and appeals for immigration, housing, welfare benefits and social care cases. The closure of the centre, which since 2001 had supported about 600 people a year with complex immigration and welfare rights cases, involved the redundancy of 10 solicitors and welfare experts. South Londoners UKC was subsequently commissioned by the South London HIV partnership to offer information, advice, and casework service for people living with HIV who lived in, or attended clinics in south London only, but the contract ended at the end of March 2007. THT's helpline, which recently broadened its services to include face to face meetings, remains the main source of advice for people living with HIV.

There is insufficient HIV specific legal advice and support available. The closure of the THT's centre because of funding cuts highlights the lack of resources enabling people living with HIV to challenge alleged human rights abuses and understand their rights and entitlements. Yet this was one of the key action recommendations contained in the Department of Health's 2006 consultation on an action plan on HIV related stigma and discrimination.[197] The Department's document stated that "*[i]t is important that those involved in supporting people with HIV are aware of the relevant legal framework and that people with HIV themselves understand their legal rights"* and that it will *"support the provision"* of a *"comprehensive and regularly updated guide to rights and entitlements of people with HIV".* This will require funding for production and dissemination, which seems to contrast with current budget cuts. The new Commission for Equality and Human Rights (CEHR)[198] has a key role to play in ensuring that people living with and other vulnerable groups are given appropriate resources on their rights and it is important that the Department of Health liaise with the Commission and discuss the best way forward for the development and dissemination of materials. It is crucial that relevant non-governmental organisations, including human rights organisations, and vulnerable groups, be actively involved in the process.

6.3. Legal Representation

Access to adequate legal representation is a significant issue for people seeking legal redress, in particular those who are vulnerable and in urgent need of help such as asylum seekers.

Problems that have been raised in asylum cases include solicitors' inability to explain the procedures and process clearly, language barriers, lack of information to the client, and clients' lack of control:

"For example: I have not yet met a solicitor who is really able to explain the case to the patient so that they really grasp it. Usually they lack the skills to deal with people whose English is poor. Should they have taken the trouble to engage an interpreter, they place the whole burden of transmitting the understanding of the content, procedures and process of the case to the interpreter. Yet it is not the words which are difficult to understand, it is the legal context. Often both the solicitor and the translator cut corners and resort to reassuring the patient because they find the job difficult. This is often not productive for the patient's mental health, because in the current political climate they frequently fail in their application and they lose trust in those who are supposed to

[197] See www.dh.gov.uk
[198] See below.

aid in enforcing their human rights and seeking redress. Bland reassurance reduces their sense of empowerment (…) If the patient speaks enough English, the solicitor seems still incapable of explaining the procedures and process. It is very common that a [client's] solicitor leaves a firm or another caseworker takes over the case and the patient is not even notified. Both my two other colleagues working with HIV patients repeatedly experience this – it's the norm (…) A diminished sense of control also leads the patient to believe that the solicitor is 'in charge of' the case. I have never met a case where a patient understands s/he is expected to instruct the solicitor. And the solicitor continues to leave the patient unknowing how to act. When once the patient does understand that the solicitor is to be instructed, they have difficulty grasping where the boundary of instruction lies. If a solicitor is unwilling to take a case further the patient does not understand there to be any point in instructing. They also feel that they are then deprived of what they imagine as their right to be heard, let alone that this 'legal specialist' can help them to 'enforce their human rights and seek redress for human rights infringements'. They are given no access to this understanding either."[199]

In their submission, George House Trust commended the work of a large number of lawyers from the non-profit sector. But they also highlighted numerous examples of bad representation by unscrupulous lawyers:

"There are countless examples of poor legal work (mainly lawyers in the private practice), for example:
- *Making promises to clients (often around obtaining student or work visas), taking payment for this and then not delivering on these promises*
- *Taking a case and dropping it after only the first refusal*
- *Giving bad advice e.g. telling someone an application is worthwhile when it is not / will certainly be refused (e.g. refusal is predictable for someone who is not on any HIV treatments and is in good health)*
- *Not seeking and including specialist reports on a variety of issues where it would seem appropriate, e.g. sexuality, female genital mutilation, rape, torture, HIV, inevitably weakening the applicant's case*
- *Not wanting to take on any case involving HIV because of the perceived (and indeed real) complexity of the case*
- *Not detailing / explaining advice to clients."*

Positive East also raised the issue of bad legal advice and representation and provided the following case study:

"P is 44 years old woman from Zimbabwe. She came to the UK in November 2002, on a visitor's visa to see her son. Soon after arrival, she was admitted to King Georges' Hospital with serious chest pain and while there, was diagnosed HIV+. Her CD4 count was below 200 and viral load was over 1 million. She was put on drugs to prevent opportunistic infections until she made an application to the Home Office on health grounds. Her application was rejected, and an appeal hearing was scheduled in June 05. Two weeks prior to the hearing her Solicitors withdrew representation on the grounds that 'N' case had reduced her chances of success to below 50%. Her options were to attend without representation, request the hearing on papers without anyone attending or to find herself a new Solicitor willing to grant her Controlled Legal Representation and attend court with her. P went to her local MP who referred her to another firm of Solicitors. P reports that this firm did nothing for her and used her papers inappropriately. Out of desperation she went back to the original firm who agreed to represent her provided that she paid for their services. P is under the care of Social Services for accomodation and subsistence in form of vouchers. She has no income to pay for representation. Positive East recently found another sympathetic solicitor who agreed to take on her case under Controlled Legal Representation. P's former solicitors have asked for £70 to release her file to the new firm which she has been asked to pay (...)"

[199] Written evidence (kept anonymous).

Other groups such as sex workers may also face difficulty in accessing legal advice and representation:

"Client is charged with loitering based on flimsy evidence and denies the charge. She is refused free legal representation under the legal aid scheme because there is no risk of custody as a result of the charge. She cannot afford to pay for representation. Nonetheless, the client decides to plead not guilty and argues her case on her own behalf, with the support of detailed written arguments by Release. The charges are dropped."[200]

6.4. Monitoring and Enforcement Human Rights Mechanisms

6.4.1. Human Rights Bodies

The main UK human rights body is the Commission for Equality and Human Rights (CEHR) launched in October 2007.

The CEHR has responsibility for the promotion and protection of human rights in England, Wales and Scotland. However, it only operates in relation to reserved human rights matters in Scotland which will have a Scottish Human Rights Commission (SCHR).[201] The CEHR is a Non-Departmental Public Body (NDPB) whose purpose is to reduce inequality, eliminate discrimination, strengthen good relations between people and protect human rights. It also promotes awareness and understanding of human rights and encourages good practice by public authorities in meeting their obligations under the HRA. The CEHR also has powers to take human rights cases.

In April 2008, the Commission launched an inquiry to find out how human rights work in Britain, which will aim to inform its human rights agenda. This inquiry is a positive development and shows that the CEHR is keen to develop its human rights remit. However the Terms of References of the inquiry are broad and it is hoped that HIV rights are given the visibility they need both in the responses to the consultation and in the final inquiry's report.

It is also important that the CEHR establishes dialogue with relevant government departments in particular, the Department of Health and the Home Office and discuss, with the input of civil society organisations, an agenda for actions on HIV-related rights, including campaigns aimed at informing and educating the public about human rights law and targeted campaigns at vulnerable groups.

6.4.2. Lack of Expertise on HIV and Human Rights

The main issue that arises in relation to human rights bodies is their lack of expertise and knowledge of the international legal and policy framework on HIV, for example the International Guidelines which provide a comprehensive model for the promotion and protection of HIV related rights.

The International Guideline 11 recommends that *"States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV, their families and communities."*

In order for the rights of people living with and affected by HIV to be adequately enforced and promoted, training and resources must be provided to bodies that have a crucial role in developing awareness of human rights and responding to human rights violations in the context of HIV.

[200] Release, Annual Report 2004-2005.

[201] Following a consultation exercise, the Scottish Executive announced on 10 December 2001 that it would establish an independent and statutory Scottish Human Rights Commission. The 2003 Partnership agreement confirmed the intention to legislate to establish such a Commission.

In the absence of a dedicated body, the CEHR should be monitoring and enforcing HIV-related rights. In order to do so, relevant training and expertise on HIV-related issues are essential.

6.4.3. Judicial Enforcement of Human Rights

Human Rights Act

Following the introduction of the HRA, most Convention rights are now justiciable and people who believe that their Convention rights have been violated by the government (e.g. Home Office, Department of Health) can apply directly to a domestic court or tribunal for the determination of alleged breaches of their Convention rights. Prior to the HRA, they could only bring a claim in Strasbourg for such a determination.

Judicial review has increasingly been used to challenge government's policy in the context of asylum and immigration and health related issues in prisons. This includes the removal of HIV-positive asylum seekers, the detention of asylum seekers, including children, and prisoners' access to clean needles.

Unfortunately, so far sensitive cases brought under the HRA have been unsuccessful. The current policy on deportation of HIV-positive refused asylum seekers to countries where they face certain death has been challenged several times, unsuccessfully. The courts have also been unwilling to support a stronger harm reduction approach in prisons such as the introduction of NEPs, despite international evidence that NEPs do work. In some cases, challenges have been successful, for example in relation to the detention of asylum seekers and prisoners' related healthcare. However, it is argued that the limited number of HIV-related cases reflect the lack of adequate HIV-related rights information, counselling and legal advice, which impact on people's ability to seek redress for alleged HIV-related abuses. Furthermore, as mentioned above, the problem of inadequate legal representation and lack of legal expertise on HIV also affect the number of cases and their outcome.

Taking a case to Strasbourg

The HRA does not remove the right of individual petition to the ECtHR and recourse to Strasbourg is available, including to challenge UK courts' interpretation of the Convention: (1) in the absence of remedial action with retrospective effect as UK courts cannot override legislation which is incompatible with the ECHR; and (2) if Parliament or the government has failed to provide legislative protection for Convention rights and to remedy the restrictive scope of the HRA which does not cover actions by private parties and quasi-public bodies (when acting within the scope of their private activities).

It may take years for a case to be considered in Strasbourg and recent HIV case law shows that the European Court has refused to go against the UK government's policy on issues that are politically sensitive or seen as "domestic issues", emphasising the margin of appreciation of the government.

6.4.4. Reservations and Individual Petition

The UK has made substantial reservations to some of the treaties and did not ratify some of their subsequent protocols. As highlighted by JUSTICE, the main theme running through the majority of the UK's reservations to international human rights instruments is based on the government's wish to protect itself from unwanted immigration.[202]

[202] http://www.justice.org.uk/images/pdfs/ICCPR.pdf

One of the current reservations which significantly impacts on HIV-related rights is that of the government to the CRC. The rights protected by the CRC apply to all children within the jurisdiction, irrespective of nationality. The UK has entered a general reservation to the CRC as regards the entry, stay in and departure from the country, of those children subject to immigration control, and the acquisition and possession of citizenship.

The government justifies this reservation as necessary in the interests of effective immigration control but has stated that the reservation does not prevent the UK from having regard to the Convention in its care and treatment of children.[203] However, evidence shows that there is a lack of adequate of protection and care for children, including those living with and affected by HIV in detention.

This reservation has been criticised by the UN Committee on the Rights of Child and the Joint Committee on Human Rights, the latter stating:

"The reservation has been subject to considerable criticism, including from the UN Committee on the Rights of the Child, and in reports of our own. In their concluding observations of 2002, the UN Committee expressed its concern that the UK did not intend to withdraw the reservation to Article 22, noting that the reservation was against the object and purpose of the Convention. In our report on the Convention, we supported the conclusion of the UN Committee, which is a particularly significant one, since reservations which are incompatible with the object and purpose of a treaty are impermissible and therefore invalid in international law."[204]

The UK government has consulted on whether it should withdraw its wide-ranging immigration reservation to the CRC but no decision has yet been taken. As highlighted by Children's Rights Alliance in their submission to the HRC in May 2008, "many aspects of current policy and practice toward immigrant and asylum seeking children breach both the UNCRC and the ICCPR (…) and failure to provide standards of care as provided to other children under the Children Act 1989 and the Children Act 2004 – the reservations have served to justify and perpetuate the discriminatory treatment of immigrant and refugee children, and often in matters which have no direct bearing on immigration or asylum determination".[205]

The government has also consistently refused to allow for individual petition under significant international human rights treaties such as the ICCPR; which impedes individuals' ability to enforce their human rights. This approach has been widely criticised both domestically and internationally.

The right of individual petition under the Optional Protocol to the ICCPR has been widely accepted, including by all EU Member States besides the UK. Ratification of the Protocol is particularly important in light of the fact that all of the rights guaranteed in the ICCPR are not incorporated into domestic law. This means that there are some ICCPR rights which individuals cannot directly enforce either in the domestic courts, or at the ECtHR. Some of these rights are particularly relevant in the context of HIV, and the availability of individual petition under the ICCPR would provide a means of enforcement to vulnerable groups in respect of these rights.

At the Briefing Session held by the Office of the High Commissioner for Human Rights, one of the participants stressed the importance of bringing individual complaints regarding discrimination in the context of HIV/AIDS to the HRC; this would ensure jurisprudence could benefit individuals in future similar cases.[206]

[203] Supra, at 8, Appendix 6.
[204] JCHR Seventeenth Report, 2005.
[205] Submission available at www2.ohchr.org/english/bodies/hrc/docs/ngos/CRAE_**UK**93.doc (May 2008).
[206] http://www.unhchr.ch/html/menu2/7/b/briefaids.htm

In its 2005 Seventeenth Report the Joint Committee on Human Rights noted:

"The right of individual petition under the Optional Protocol to the ICCPR has been widely accepted, including by all EU Member States besides the United Kingdom (…)Individual petition under Article 22 of CAT has been accepted by the majority of EU Member States and by Australia, Canada, New Zealand and South Africa. The right of individual petition under Article 14 of CERD has been accepted by the majority of European States. The relevant UN treaty bodies—the Human Rights Committee, the Committee on the Elimination of Racial Discrimination and the Committee Against Torture—have repeatedly called on the UK to accept rights of individual petition available under the treaties. ***In light of the widespread acceptance of the right of individual petition by comparable States, and the avowed acceptance by the UK of the standards in the UN human rights Conventions, there is a strong onus on the government to justify its refusal to accept individual petition (…) In our view (…), it is unfortunate that rights of individual petition are to be made available in respect of gender equality only, and excluded in respect of CERD and the general equality right under the ICCPR."*** (original emphasis)[207]

The Committee also recommended that two years following the coming into force of the Optional Protocol to CEDAW – which the government on 22 July 2004 that it intended to accede - there should be a review by government of the merits of accepting individual petition under the ICCPR, CERD and CAT.

6.5. Conclusion

There is currently a significant gap in the provision of human rights education and legal support for people living with HIV. In 2001, the APPGA recommended that people living with HIV, their families or communities should be able to access specialist legal advice in order to enforce their rights or challenge violations. Since then, the only HIV legal centre closed down due to funding cut and there is now no HIV specific legal service available.

There is also a lack of HIV and human rights expertise amongst UK enforcement and monitoring bodies and legal professionals. There is a need for the staff of the Commission for Equality and Human Rights to be trained on the policy and legal framework on HIV and human rights and to initiate campaigns aimed at informing and educating the public about human rights law. Policy makers and legal professionals should also become knowledgeable about HIV and human rights frameworks, particularly the International Guidelines.

Current means of redress for HIV-related violations of human rights are limited. The right to individual petition is not allowed under most human rights treaties. Reservations on international human rights treaties also significantly impact on HIV related rights. Those issues have been highlighted several times by NGOs, parliamentary bodies and the UN. Yet so far, the government has disregarded calls for changes.

[207] Report available at www.publications.parliament.uk/pa/jt200405/jtselect/jtrights/99/9902.htm

7. CONCLUSION AND RECOMMENDATIONS

The UK government is failing to fulfil its HIV-related obligations under international human rights law in relation to the vulnerable groups considered in this report. In some cases, government policy leads to a breach of most fundamental rights and freedoms guaranteed under binding treaties that the UK is a party to.

The government is also not doing enough for the promotion and enforcement of HIV-related rights.

The key general findings of the report are that:

- Despite its commitment to taking action towards the realisation of fundamental rights and freedoms in the context of HIV the government has failed to turn its promises into action.
- Current policy and legislation impact on vulnerable groups' rights to access to HIV prevention, treatment and care and to protect themselves against HIV.
- The government has failed to implement UN policy and legal HIV-specific standards which set out a rights based approach to HIV and has instead introduced and/or maintained policies which interfere with HIV-related rights.
- Despite criticisms from UN monitoring bodies and parliamentary bodies, the government has maintained or introduced policies and laws that flout international human rights law, particularly in relation to the treatment of asylum seekers.
- The lack of a cross-government framework on HIV and human rights leads to contradictory domestic policies between various government departments and between the government's international and domestic responses to HIV. It also results in conflicting and inconsistent policies within the Department of Health.
- None of the APPGA's recommendations have been implemented in relation to the issues considered. New issues of concerns have emerged since the Group's report was published. In some cases, the situation has worsened.

The overall recommendation of the report is that a human rights based and cross-governmental framework should be developed and implemented.

The framework should:

- Be based on and conform to the framework provided by the *International Guidelines on HIV/AIDS and Human Rights*;
- Be developed with representatives from relevant government departments, HIV and non-HIV organisations working with vulnerable and/or affected groups, as well as people living with HIV, and human rights experts;
- Be monitored and evaluated on a yearly basis through an "HIV and Human Rights Monitoring and Evaluation Body".

UK AIDS and Human Rights Project has endorsed the Declaration "Human Rights and HIV/AIDS: Now More Than Ever"

To endorse the Declaration, go to: www.soros.org/initiatives/health/focus/law/articles_publications/publications/human_20071017

UK AIDS and Human Rights Project has been established to promote and protect the rights of people living with, affected by, and vulnerable to HIV and AIDS in the UK. We aim to make the UK government accountable for violations of HIV-related human rights in the UK.
www.aidsrightsproject.org.uk