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Asylum Seekers and HIV/AIDS: Legal Issues, Well-Being and Fundamental Rights

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Abstract Migrants, including asylum seekers, are a key population to focus on, according to the European Action Plan for HIV/AIDS 2012–2015. In general, data on the prevalence of HIV/AIDS among asylum seekers are scarce, but some receiving states have already noted a high HIV prevalence among asylum seekers who give birth. While there are many challenges in ensuring asylum seekers living with HIV/AIDS have access to adequate health services, it seems that protection of rejected asylum seekers (and other irregularly staying migrants) living with HIV/AIDS will be at the forefront of their struggle for adequate protection of their human rights.

KEYWORDS: asylum • international protection • HIV • non-refoulement • fundamental rights

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1 Introduction

According to official statistics of the UN High Commissioner for Refugees (UNHCR), there are an unprecedented 65.3 million displaced people in the world (UNHCR, 2016). In 2015 alone, 1.3 million persons filed an asylum application in the EU member states. In the same year, over 245,000 persons were granted refugee status in the EU, over 60,000 subsidiary protection status, and over 26,000 authorisation to stay for humanitarian reasons (Eurostat, 2016). Many of them are coming from sub-Saharan Africa where human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) prevalence among the adult population is 4.7 per cent on average, and where 70 per cent of world new infections occur (Avert, 2016; see also Allan & Clarke, 2005; Chadwick, 2003; Clark & Mytton, 2007: 420; NAT, 2008: 3; Palattiyil & Sidhva, 2011: 9). HIV/AIDS epidemics vary significantly from country to country and range from 0.5 per cent of the population in Senegal to 27.4 per cent of the population in Swaziland (Avert, 2016). Migrants are a key population to focus on, according to the European Action Plan for HIV/AIDS 2012–2015 (WHO, 2011). In general, the data on the prevalence of HIV among asylum seekers are scarce, but some receiving states, such as The Netherlands, have already noted a high HIV prevalence among asylum seekers who give birth (Goosen et al., 2015: 1).

Accordingly, the issue of HIV/AIDS raises a need for specific attention within asylum and migration management systems. The asylum-related areas where HIV/AIDS should be taken into consideration are the right to access to the asylum procedure and possible entry bans for HIV-positive asylum seekers; the refugee status determination procedure in terms of whether HIV-positive status can be considered as grounds for granting international protection; reception and detention conditions adapted to asylum seekers living with HIV/AIDS; access to healthcare and life-saving anti-retroviral treatment in both the receiving country and the country of origin; and, most importantly, implications of removal. A granted international protection status can significantly improve a person's access to HIV/AIDS treatment in the receiving country, their health situation and their life expectancy. Arguably, in dealing with HIV-positive asylum seekers and refugees, the states are obliged to exercise specific treatment which should be in line with fundamental rights standards, enshrined in the Charter of Fundamental Rights (CFR) and the European Convention on the Protection of Human Rights and Fundamental Freedoms (ECHR), in particular prohibition of torture and inhuman and degrading treatment or punishment (Article 4, CFR; Article 3, ECHR). The purpose of this article is to identify and map the legal issues that should impact the design of laws and policies adapted to asylum seekers and refugees living with HIV, by drawing lessons from the experiences of countries such as the United States, the United Kingdom, Germany and the Netherlands who are already receiving higher numbers of asylum seekers from HIV high-prevalence countries. The methodological research approach of this article is

based on an academic literature review, the collection of data gathered by governmental, international and non-governmental organisations dealing with asylum, migration and HIV/AIDS, and legal analysis of international and EU law in the field of asylum as well as case law of the relevant international forums. The manuscript was completed and submitted in September 2016.

2 Access to territory

Access of asylum seekers to territory, which is a basic right stemming from the prohibition of penalising asylum seekers who cross the border unlawfully as defined in Article 31 of the 1951 Convention relating to the Status of Refugees (hereinafter: Geneva Convention), can be severely impeded if a receiving country imposes a general entry ban for foreigners living with HIV/AIDS. This measure was in place in the United States from 1987 to January 4, 2010, meaning that in this period of time the persons were, first on the basis of a policy and since 1993 on the basis of law, automatically denied short-term visas or applications for lawful permanent residence simply because of their HIV/AIDS status (Ford, 2005: 298; Immigration Equality, 2014; The Global Database, 2016). Other countries which reportedly have an HIV entry ban in place are Brunei, Equatorial Guinea, Iran, Iraq, Jordan, Papua New Guinea, Qatar, Russia, Singapore, the Solomon Islands, Sudan, the United Arab Emirates and Yemen (The Global Database, 2016), while there are at least 66 countries in the world that have imposed certain restrictions in the field of immigration and HIV/AIDS (Amon and Todrys, 2008: 1). An entry ban usually entails mandatory HIV testing for immigration examination purposes. Mandatory HIV testing is no longer in place in the US; however, within the medical examination which is still used for immigration purposes, information obtained by physicians may lead to suspicion of HIV/AIDS status (Immigration Equality, 2014).

Entry bans and residence restrictions are believed to be among 'the earliest and the most enduring responses to the HIV/AIDS epidemic' (Amon & Todrys, 2008: 1). Dire consequences have been documented for individuals who have been refused entry and status based only on their HIV positive status (Amon & Todrys, 2008: 3). From the fundamental rights perspective, blanket entry bans have been marked as disproportionate, contrary to the requirement for the minimum intrusion necessary for addressing public health consideration, and therefore discriminatory. The UN Commission on Human Rights has interpreted prohibition from discrimination as defined in Article 26 of the International Covenant on Civil and Political Rights to include discrimination based on HIV status (Amon & Todrys, 2008; Commission on Human Rights, 1995; UN Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, 1985). The European Court of Human Rights (ECtHR) also confirmed that laws regulating entry and residence should not be discriminatory (*Abdulaziz, Cabales and Balkandali v. UK*). Furthermore, entry bans were also

declared ineffective due to the fact that HIV/AIDS cannot be transmitted through casual contact (Amon &Todrys, 2008: 2; Thompson, 2005: 166; UNHCHR and UNAIDS, 2006). Entry bans as measures of prevention have been criticised as ineffective because they create a false impression that migrants only can be the source of infection and that infection can be prevented with border control instead of with other measures such as prevention, testing and treatment (Amon & Todrys, 2008: 2; Thompson, 2005: 165). Entry ban policies are based on the 'microbial public health model', which is unsuitable for HIV/AIDS (Gostin, Burris & Lazzarini, 1999: 75). Instead, the response should be based on the 'ecological public health model', which takes into account health risks such as social institutions, inequalities and economic activities (ibid.). More specifically, for asylum seekers, an entry ban may also hinder the enjoyment of their right to access some territory where they could seek protection from persecution on the grounds defined by the Geneva Convention. As discrimination is prohibited in relation to entry and residence rules adopted by receiving states, prohibition of entry of asylum seekers would clearly violate Article 3 of the Geneva Convention.

3 Reception conditions and detention

Due to the strict regime to be followed in the course of antiretroviral treatment, there is a clear need to take the HIV/AIDS status of a person into account when providing reception conditions while awaiting a decision on the asylum application. In line with Article 21 of the EU Reception Conditions Directive 2013/33/EU, the EU member states, while providing reception conditions, have to take into account the specific situation of 'vulnerable persons'. Asylum seekers living with HIV/AIDS are not explicitly mentioned in the definition of vulnerable persons, but the provision does mention 'persons with serious illnesses', which should include people living with HIV/AIDS. In order to establish the special needs of vulnerable groups, the member states are obliged to carry out an assessment procedure (Article 22 of the Directive). This provision should not be interpreted as including mandatory HIV/AIDS testing, as this would be intrusive towards individuals; however, testing should be offered in order to be able to address their specific medical treatment needs. The Directive further states that the support provided to asylum seekers with special reception needs should last throughout the duration of the asylum procedure. In terms of access to health services, people living with HIV/AIDS are in need not only of antiretroviral treatment, but also of access to healthcare for HIV-related illnesses such as tuberculosis. In addition, there is a need to consider providing support in taking the medicine due to the strict regime that is required, which might be incompatible with the sense of time and schedules in certain cultures. Activities to raise awareness and the preparation of protocols to facilitate such support should complement the actual access to healthcare services. The issue that is specifically important in the process of support and education about the treatment is the problem if treatment is interrupted due to drug resistance, which may occur. These

concerns are present also in the context of the right to housing and accommodation that is guaranteed under the Article 17 of the Reception Conditions Directive which regulates 'material reception conditions'. In cases of private accommodation, it needs to be taken into account that asylum seekers living with HIV/AIDS have such support which might otherwise be more easily available in collective housing facilities (asylum or accommodation centres). Of particular concern are situations where inadequate housing is provided to asylum seekers (with the lack of basic means of subsistence), as in such cases it is likely that there will be no attention paid to the required strict treatment regimes. On the other hand, in shared accommodation facilities, other problems might occur, such as the lack of a private fridge needed for storing antiretroviral medicine. In cases of dispersal of asylum seekers across the country and into smaller remote towns, difficulties with providing such support might also occur (NAT, 2006; Palattiyil & Sidhva, 2011: 39).

4 HIV status as a ground for international protection?

In addition to the type of HIV/AIDS treatment that is available in the receiving country, the key question for the future legal status of the asylum seeker will be whether the receiving country grants international protection to persons based on their HIV/AIDS status. In the area of the Council of Europe, including all EU member states, the response is far from affirmative. Normally, HIV/AIDS status as such will not be sufficient for granting refugee status.

In line with Article 1.A.1. of the Geneva Convention, a refugee is a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, unwilling to avail himself of the protection of that country. The usual personal grounds that HIV positive persons invoke while claiming refugee status is 'membership of a particular social group'.[1] The wording of the Geneva Convention does not preclude the authorities from considering people living with HIV/AIDS from a certain country as belonging to a particular social group (US Office of the General Counsel, 1995).

The key document relevant for the purpose of defining a 'particular social group' on the EU level is the Council Directive 2004/83/EC of 29 April 2004 on minimum standards for the qualification and status of third country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted (Qualification Directive). The provision of Article 10.1(d) of this Directive defines at length the general meaning of 'membership of a particular social group' as a group whose members 'share an innate characteristic' or have 'a common background that cannot be changed'. Furthermore, they might also 'share a characteristic or belief that is so

fundamental to identity or conscience that a person should not be forced to renounce it', meaning that it is unalterable for reasons other than innateness. Another condition that has to be fulfilled is 'a distinct identity' of that group in the country that the asylum seeker is fleeing, and because of this identity the group is 'perceived as being different by the surrounding society'. The Directive continues with a definition to include specifically the notions of sexual orientation and gender identity (the latter added later, in 2011), as characteristics that the society might perceive as different. This is crucial for HIV-positive persons being recognised as members of particular social group: it is not just their characteristic that makes them different from the rest of the society, but it is also about whether the society perceives them as being different.

In addition to proving that they are persons living with HIV/AIDS, asylum seekers would have to show that they were *persecuted* in relation to their HIV/AIDS status. Having HIV/AIDS therefore does not suffice for being granted a refugee status: there has to be an element of *persecution* that is taking place because they have HIV/AIDS—they are facing disproportionate and persistent restrictions or discrimination based on their HIV/AIDS status, or they are claiming their rights are denied to them as HIV/AIDS patients (Immigration Equality). In these procedures, asylum seekers have to prove persecution and not merely hardship to qualify for asylum (Neilson, 2004). At the same time, they have to meet all other standards and demands usually imposed on asylum seekers by the asylum authorities, such as being able to support their claim with evidence or a credible statement and meeting the threshold that is required for certain state or non-state actors' actions to be considered persecution.

In the United Kingdom, for example, asylum has not yet been granted due to fear of persecution based on HIV/AIDS status, but there are instances of granting asylum to people who risked imprisonment following their campaigning against a government HIV/AIDS policy (NAM, 2014). There are also instances of people being granted asylum in the United States if the asylum authorities established that they would risk restrictions based on their HIV/AIDS status. The cases reported in this context involve a married Indian female asylum seeker who could be subject to imprisonment if returned to the country of origin, and a Haitian man with a criminal record who, upon return, would undoubtedly be imprisoned in an overcrowded unsanitary jail, which would be a death sentence for him (Neilson, 2004: 48–49).

5 Potential implications of removal and the European court of human rights

The key question the legal theory has been revolving around in recent decades is whether HIV/AIDS-positive asylum seekers should be protected from removal in case of lack of treatment in the country of origin. The ECHR provision relevant in

such a case is Article 3, which prohibits inhuman and degrading treatment or punishment. According to ECtHR case law, a prediction that, after return, a person will live for one more year does not constitute inhuman and degrading treatment (*N. v. United Kingdom* [GC] 2008), while a prediction that a person will die almost immediately due to medical and social reasons does constitute inhuman and degrading treatment (*D. v. United Kingdom*, 1997). The case of *D. v. United Kingdom* involved an applicant suffering from AIDS who challenged his removal to St. Kitts, a Caribbean island, where the lack of available treatment and the lack of family members who would care for him would hasten his death. The Court examined the gravity of the situation by stating that:

> 'the applicant is in the advanced stages of a terminal and incurable illness. At the date of the hearing, it was observed that there had been a marked decline in his condition and he had to be transferred to a hospital. His condition was giving rise to concern ... The limited quality of life he now enjoys results from the availability of sophisticated treatment and medication in the United Kingdom and the care and kindness administered by a charitable organisation. He has been counselled on how to approach death and has formed bonds with his carers … The abrupt withdrawal of these facilities will entail the most dramatic consequences for him. It is not disputed that his removal will hasten his death. There is a serious danger that the conditions of adversity which await him in St Kitts will further reduce his already limited life expectancy and subject him to acute mental and physical suffering. Any medical treatment which he might hope to receive there could not contend with the infections which he may possibly contract on account of his lack of shelter and of a proper diet as well as exposure to the health and sanitation problems which beset the population of St Kitts ... In view of these exceptional circumstances and bearing in mind the critical stage now reached in the applicant's fatal illness, the implementation of the decision to remove him to St Kitts would amount to inhuman treatment by the respondent State in violation of Article 3' (paras. 51–53).

Note that the court found the circumstances of this case to be exceptional, consequently narrowing the 'implications of this judgment' (Danisi, 2015: 69), as well as setting very high standards that require such a grave violation of Article 3 that it almost amounts to a violation of Article 2 of the ECHR.[2] Hence, under the ECHR case law, only imminent death that is expected to occur after extreme suffering following the return to the country of origin may amount to a breach of Article 3, while a significantly reduced life expectancy does not.

This was further clarified in cases of *Arcila Henao v. the Netherlands* (No. 13669/03; 24 June 2003), *Ndangoya v. Sweden* (No. 17868/03; 22 June 2004), *Amegnigan v. the Netherlands* (No. 25629/04; 25 November 2004) and *N. v. United Kingdom* (No. 26565/05; 27 May 2008). These cases were all initiated by

HIV-positive persons who were receiving antiretroviral treatment in the receiving state had not yet developed full blown AIDS and were all declared inadmissible even though it has been established in the court procedure that antiretroviral treatment was less accessible in their countries of origin and that, in case of interruption of treatment, their medical conditions would deteriorate fast. The most recent case of *N. v. United Kingdom* involved an asylum seeker from Uganda with two AIDS-defining illnesses who was receiving antiretroviral treatment in the United Kingdom where she had lived for nine years. After examining her situation based on the previous case law as well as against the standards set with the *D. v. the United Kingdom* case, the court reiterated that

> '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' (para. 42).

Finally, the case was declared inadmissible by finding 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' (para. 50).

This argument shows that the court was not ready to accept responsibility for granting protection to HIV/AIDS-afflicted individuals who were not under imminent threat of their life. With the term 'speculation', it apparently tried to point out the uncertainty of the pace and gravity of the development of the illness. The court also did not find the applicant's situation to be exceptional enough to find a violation. However, three judges who signed under a dissenting opinion in this case were of a different opinion. They emphasised that the majority of judges in fact agreed that the applicant, upon returning to Uganda, would face an early death, which clearly raises the responsibility of the expelling state (para. 23 of the dissenting opinion). However, for the Court majority, this finding was not sufficient as, according to the standard set in *D.*, protection of Article 3 applies only to those who are in the final stages of terminal illness. Using disanalogy, the Court majority found that the facts in the *N.* case did not sufficiently resemble the facts in the *D. v. UK* case (Harrington, 2008: 317). However, terminal AIDS complications are no longer an unavoidable destiny for those patients on antiretroviral treatment (Harrington, 2008). It seems that the current case law, described also as an 'extremely restrictive interpretation of the prohibition of

refoulement' (Danisi, 2015: 67), offers to patients two difficult options: either enjoyment of protection of Article 3 if their illness becomes mortal for them in the receiving state, or staying in relatively good health in the receiving state and deteriorating fast after returning to their country of origin. What is also striking is that in this case the court justified its decision by the need for 'carefully balancing' the general 'interests of community' and the 'interests of an individual' (para. 44), which is not what the Court usually does in the context of Article 3, which contains an absolute prohibition. In this context, the court's argument seems to be related to a concern that a significant financial burden would be placed on states (para. 44) if all aliens without the right of stay were provided with unlimited healthcare, unless the case was really exceptional.

Although in line with its previous case law (Derckx, 2006), the judgment in *N. v. the UK* was met by severe criticism in that the application of the tests defined by the court was inadequate (Buyse, 2008) and that the court in fact confirmed a 'death sentence' issued to the applicants by the House of Lords (Yeo, 2008). Asylum seekers with HIV are believed to be coming to the United Kingdom as 'treatment tourists' to access health services (Attawell, 2009; Bowes et al., 2009; Cherfas, 2006, cited in Palattiyil & Sidhva, 2011: 44); however, there is no evidence that suggests this. On the other hand, asylum seekers have little choice in their country of destination, as this is usually determined by others (Crawley, 2010, cited in Palattiyil & Sidhva, 2011). Also, the notion of 'treatment tourists' is rebutted by data which indicate that very few migrants and asylum seekers have been tested before immigrating and that most have learnt they were HIV positive only after fleeing their countries of origin (Cherfas, 2006: 7; Harrington, 2008: 317). This fact puts the case of *N. v. UK* in a different perspective, as it is clearly not the intention of asylum seekers to impose a financial burden on states, but it is in their interest to resist HIV/AIDS-related health complications for as long as possible. As Harrington (2008: 325), analysing the decision of the House of Lords in the same case, points out, the part of the ECtHR reasoning referring to financial burden reflects a concern for the financial resources of the contracting states, and therefore their resources that are primarily available for 'us' and not for 'the Other'. With this wording, the Court also reiterated the development of another 'pull factor' should the courts recognise the duty of states to enable HIV/AIDS-inflicted patients to access antiretroviral treatment in contracting states.

A different decision was issued by the Inter-American Commission on Human Rights in the case of *Andrea Mortlock*, in which the Commission found in favour of the applicant. It established that a removal of the Jamaican national who was residing in the U.S. and was receiving HIV/AIDS medication would decrease her access to treatment and that the loss of treatment would be fatal. Her removal would therefore violate the prohibition of cruel, infamous and unusual punishment clause in Article XXVI of the American Declaration of Rights and Duties of Man (Mitchell, 2011: 1643). This decision is clearly in contrast with the ECtHR

decision in *N. v. UK*: even though in both cases the person facing return was not in the critical stages of AIDS, treatment was in principle available in their host countries, but did not respond to the level that they needed. In both cases, the applicants had lived in their host countries for a long time, the Jamaican national for several decades and the Ugandan national for nine years. The findings of competent institutions in their respective cases were, however, detrimentally different.

6 Other potential implications of removal

Taking into account that the sole fact of being HIV positive and the lack of appropriate treatment or access to it in the country of origin does not suffice for refugee status or even to be protected from expulsion, this means that a significant proportion of these individuals will be exposed to return and removal procedures (Wojcik, 2007). However, due to the undoubted vulnerability of asylum seekers living with HIV/AIDS, special care needs to be taken in these procedures and additional attention needs to be exercised in relation to the possible implications of removal. The first consequence of the denial of an asylum request and imposition of a removal procedure on a person means that in most systems people with HIV/AIDS by law no longer have access to free healthcare, with the exception of urgent medical services in imminent life-threatening conditions, which does not include antiretroviral treatment (cf. Clark and Mytton, 2007: 426). If such treatment comes at a charge, it is highly questionable whether it will still be accessible for rejected asylum seekers.

On 23 May 2014, the Parliamentary Assembly of the Council of Europe passed Resolution 1997 (2014) titled 'Migrants and refugees and the fight against AIDS', in which it stated that 'an HIV positive migrant should never be expelled when it is clear that he will not receive adequate health care and assistance in the country to which he is being sent back. To do otherwise would amount to a death sentence for that person' (CoE Resolution 1997, 2014). Clearly, this resolution is not reflected in the binding normative framework governing Council of Europe and European Union member states. Individual states may have additional protection mechanisms (humanitarian statuses, toleration statuses, etc.) available for persons who do not qualify for asylum but are in need of medical treatment that is not available in their countries of origin. However, these mechanisms are outside the protection provided by international law, which means that the destination countries are free to choose whether or not they will provide such mechanisms. For now, they are not bound to provide for them either from the perspective of the Geneva Convention or from the perspective of the ECtHR.

However, there are some other issues that the destination country has to examine when deciding on the removal of an HIV-positive individual whose asylum application was refused. The same issues are also relevant for foreigners who have

not applied for asylum but have entered and/or lived in the country of destination irregularly. The first aspect to be considered is the situation in the host country, which includes not only the availability and practical and financial accessibility of treatment (as has been shown, this information on its own is not relevant for removal cases), but also the state policies and practices affecting persons with HIV/AIDS, their possible discriminatory nature, or even restrictive policies such as incarceration of persons due to their HIV/AIDS status if certain conditions are met. In such cases, the authorities of the destination country have to examine the proportionality of restrictions imposed and, in case of threat of incarceration, the proportionality of such treatment along with prison conditions from the perspective of possible overcrowding, sanitary conditions, privacy and security, as well as the accessibility of treatment in the prison itself.

The same concerns needs to be considered in relation to detention imposed on the person with the purpose of removal—for example, under the national provisions that are transposing Directive 2008/115/EC of the European Parliament and the Council of 16 December 2008 on Common Standards and Procedures in Member States for Returning Illegally Staying Third-Country Nationals (Return Directive). From the moment when a final decision is issued in the asylum procedure and the person is processed in line with the Return Directive, the provisions of this directive dealing with vulnerable persons, and their special healthcare needs apply. The questions that need to be addressed are: Is the person going to have access to treatment in removal detention? Are the conditions in detention allowing the person to continue with treatment (e.g. is there a fridge available for the medicine and sufficient privacy, as well as safety from ill treatment from other inmates?)

The second issue to consider in removal is the conditions of the removal process itself: Will the person have access to treatment during the removal procedure (e.g. while waiting for removal at the airport, while on the plane or in the police van, and while surrendered to the authorities of another country (of transit or origin)? These concerns are important to consider, not only because of resistance that can be developed by a human body to antiretroviral treatment if interrupted or if not taken properly and under an exact time schedule, but also because return might seriously undermine the persons' health or even be fatal (NAT, 2008: 13–14). To address these concerns, the person should be provided with a supply of medicine and advice on where to access treatment upon return to the country of origin (NAT, 2008: 13–14).

7 Conclusions

A number of concerns have been identified, even in countries such as the US, the UK, Belgium, Germany and the Netherlands, with sizeable asylum seeker populations. Several reports have outlined a number of recommendations for the improvement of policies and access to adequate testing, treatment and protection

(Allan & Clarke, 2005; NAT, 2008; Palattiyil & Sidhva 2011). These countries have established certain mechanisms to enable adequate healthcare and treatment for persons living with HIV/AIDS; however, there are still several deficiencies in these systems. The lessons learned in these countries could assist countries with lower numbers of asylum applications that have already set up their asylum systems but have not yet exercised sufficient focus on persons with HIV/AIDS as a vulnerable group (Goosen et al., 2015). At the same time, there is a lack of studies available (at least in the English language) on the treatment of asylum seekers living with HIV/AIDS in other countries that are also receiving high numbers of asylum applications. In order to obtain more information on how these systems are working and possibly some good practices, more studies and research are needed, to be shared among academics and professionals working in this field. The most basic measures that need to be in place in each refugee-receiving country are compiling data on HIV prevalence among the migrant population; providing opportunities for testing; recognising asylum seekers living with HIV/AIDS as a vulnerable group; offering HIV treatment to asylum seekers and those who were rejected free of charge (also to those in detention); taking access to treatment into account when designing accommodation and dispersal plans for asylum seekers; providing education for asylum seekers on sexual health; considering HIV positive status in return procedures; providing advice for rejected asylum seekers on access to treatment in countries of origin; and taking accessibility of treatment in the countries of origin into account in deciding on the removal of rejected asylum seekers. In future, adjudication on cases aimed at resisting removals should serve as guidance—not only the ECtHR case law, but also the case law of other international forums such as the Inter-American Commission on Human Rights. The interpretation of the anti-torture and anti-inhuman and degrading treatment provisions in the decision in the case of *Andrea Mortlock* is certainly closer to basic human rights standards safeguarded by the absolute nature of the principle of non-refoulement than the 'balancing approach' taken by the ECtHR. While there are many challenges in ensuring asylum seekers living with HIV/AIDS have adequate health services, it seems that protection of rejected asylum seekers (and other irregularly staying migrants) living with HIV/AIDS will be at the forefront of their struggle for adequate protection of their human rights.

Notes

[1] However, there are also cases reported when HIV positive asylum seekers obtained protection based on 'reverse' religious prosecution, or even reverse religious prosecution. This means that the asylum seeker was not persecuted for his religion, but was persecuted because of the attitudes of those practising religion towards him. See, for example, the case of a Haitian asylum seeker who was persecuted because of 'superstition and fears promulgated by the voodoo religion towards those afflicted with HIV' (Ford, 2005: 304).

[2] The Court explicitly stated that, having found a violation of Article 3, there was no need to examine the applicant's complaint under Article 2.

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