The Burden of Medical Proof for HIV Positive Asylum Seekers to the European Union

Between 2007 and 2012, migrants represented 39% of reported HIV cases in the EU/EEA. HIV care and treatment is associated with viral suppression, improved health outcomes, and reductions in transmission risks (Nielsen). Though continuous medical care in arrival EU countries is tenuous, treatment needs in their countries of origin would almost certainly not be met for these migrants. This fact serves as the cornerstone of many asylum applications in the European Union (Palattiyil and Sidhva 57-61). Though some of these HIV positive asylum seekers may have left their country of origin for a “well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion,” or due to poverty and the possibility for economic advancement, others leave their country due to the lack of available medical care for their condition (UNHCR). In this essay, I thus focus on the uncomfortable category of medical migrants, who occupy a space between asylum seekers as tightly defined by the 1951 Refugee Convention and asylum seekers migrating for economic reasons. Within this essay, I seek to explore the unique legal and human rights contours of this vulnerable group, utilizing a series of questions as a framework for inquiry: how do HIV positive asylum seekers confuse the original, and limited definitions of “refugee”? How does public sympathy for medical asylum seekers shift when asylum seekers actually reach European land? How do physicians and Non-Governmental Organizations facilitate a prioritization of expert evidence over witness testimony in medical asylum cases? And lastly, how does bodily evidence of HIV status function simultaneously as a mechanism to enter a state, as well as a potential barrier?
Background

Today, more than 65 million people are forcibly displaced, operating at the outskirts of societal and legal protection. In 2015, over 1 million people, including refugees, displaced persons, and other migrants arrived in the European Union (Refugee Crisis in Europe, European Commission). Driven by the destabilization of the Middle East and the rise of various extremist political regimes, immigrants from countries such as Syria, Iraq, Afghanistan, Iran, and Pakistan have joined the more constant flow of refugees from West Africa (primarily Nigeria, Mali, Ghana, and Morocco) and the Horn of Africa (primarily Eritrea and Somalia). Many of these migrants arrive in the European Union after dangerous land or sea journeys, and are in need of basic humanitarian aid and assistance. Of these individuals who arrive in Europe, many are fleeing violent conflicts or natural disasters. However, a number of these migrants are fleeing due to a lack of available medical care to manage their HIV status (Palattiyil and Sidhva 57).

For many of these HIV positive migrants, seeking treatment in their country of origin would serve to identify themselves as members of a certain targeted group, and would gravely endanger their safety and ability to function within a society. These targeted groups are primarily men who have sex with men, women who have experienced sexual violence, or women who are employed as sex workers (AMFAR 2). To further complicate matters, other migrants to the European Union may have originally left their country of origin due to conflict or natural disaster, but also have a positive HIV status which then forms the basis of their asylum application, augmenting their underlying persecution. Regardless of impetus, the existence of medical opportunity for HIV care in the European Union generally far exceeds the possibility of treatment in their countries of origin.
In North Africa, only 11% of individuals living with HIV currently receive antiretroviral therapy, and in Western and Central Africa the number hovers slightly higher, at around 21% (UNAIDS 6-9). Therefore, of the 21.2 million people in Africa who would benefit from antiretroviral therapy under 2013 World Health Organization guidelines, only 7.6 million people are receiving treatment. There are various explanations for this discrepancy, including a lack of medical infrastructure, stigma and loss of privacy, and the criminalization of HIV transmission. For many migrants to the EU, disclosure of their HIV status in their country of origin would not necessarily grant them access to treatment, but would likely jeopardize their economic and social stability. As a note, criminalization of HIV transmission in many African countries disproportionately affects HIV positive mothers, who are at risk of transmitting the disease to their fetus. To grant an example: there are no laws against marital rape in Sierra Leone (Davies 17-20). If a woman has a husband who engages in risky extra-marital activities and refuses to wear condoms, his behavior cannot be challenged either domestically or in a legal sphere. Because abortion is illegal and access to antiretroviral treatment or information about vertical transmission of the disease is inaccessible, this woman will become HIV positive mother of an HIV positive child, for which she can be persecuted. Additionally, as is noted in the UNAIDS 2013 Global Report, national programs which place legal obstacles to practicing homosexuality are complicit in the disproportionate burden of disease shared by men who have sex with men. Homosexuality is punishable by death in 12 countries, (including some Middle Eastern countries that are providing large numbers of refugees in the current crisis), and is illegal in many African countries as well. Although the 1951 Refugee Convention does not mention lack of opportunity for medical treatment as a qualifier for refugee definition, I believe the fear of death or imprisonment for being diagnosed with HIV due to homosexual acts or by the inadvertent
transmission of the virus from mother to child would fall well within confines of a “well-founded fear” of being persecuted due to membership of a particular social group, as is required by the convention.

This uncomfortable and forced placement of medically motivated migrants under the definition of refugee is not just for legal semantics. It is a tactic that that Non-Governmental Organizations are increasingly utilizing in response to a negative shift in public sympathy towards migrants since the Paris attacks. This ‘shifting’ of who and what experience qualifies for refugee status can be drawn into conversation with the statement made in late January by European Commissioner for Home Affairs and Migration Dimitris Avramopoulos. He stated, “Europe will provide protection for those who need it, but those who have no right to be here have to be returned” (Cook). With this claim, he creates two groups of migrants: one legitimate (official refugees) and one illegitimate (other migrants). This approach universally favors one group over another without nuance, making “migrant” a dirty word and “refugee” a sacred one.

It also provides European countries with the ability to absolve themselves of moral or legal responsibility for these migrants. For this reason, there is an increase in the discussion of removing North African migrants from Europe by classifying countries such as Algeria and Tunisia as "safe third countries.” However, this would have devastating effects on migrants living with HIV, as Algeria and Tunisia have no recognition of same-sex relationships, and same-sex sexual behavior has been illegal since 1966 in Algeria and since 1913 in Tunisia due to Islamic Sharia Law (OutRight). As many migrants with HIV are members of the LGBT community, their care and treatment will almost certainly be harmed. This violates the principle of non-refoulement, articulated in international refugee and human rights law. This principal prohibits the forced departure of a person to another state where there are substantial grounds for
believing that the person would be in danger of being subjected to torture or other cruel, inhuman or degrading treatment or punishment.

**Legal Situation for the Asylum Seekers the European Union**

Before we delve into case studies, a brief delineation of the legal situation for asylum seekers to the European Union would be helpful. The creation of the Office of the High Commissioner for Refugees, followed by the ratification of the Geneva Convention and the drafting of various national legal frameworks across European Countries, has formed a framework for European navigation of asylum claims. In addition, the 1984 UN Convention against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment (UNCAT), the 1950 Convention for the Protection of human Rights and Fundamental Freedoms (ECHR), and the 1948 Universal Declaration of Human Rights are also critical in this development of migrant rights. Lastly, the right to “equitable access to health care” is enshrined in Article 3 of the European Convention on Human Rights and Biomedicine drafted by the Council of Europe.

Pan-European guidelines are not sufficient to define the scope of migrant rights, but the Treaty of Amsterdam, which came into force in 1999, was a powerful tool for the European community to work collectively in the realm of immigration and asylum law. Before this point, European power was mostly limited to aspects of visa policy and matters concerning citizens and their family members, beginning in 1986. This remained true even with the establishment of the European Union in November 1993, and the development of the Schengen Agreement in 1995. The Schengen Agreement was a system agreed among most member states to provide an integrated system of extremal border controls and common rules on short-term visas. However, between 1993 and 1999, member states were reluctant to agree to any binding measures on immigration and asylum, and created instead largely non-binding measures such as Resolutions
and Recommendations. The Treaty of Amsterdam integrated the Schengen rules into the EU legal framework. All this said, there is still considerable discretion afforded to member states regarding the acceptance of asylum claims.

Didier Fassin astutely notes, “The logic of universal protection and human rights clashes and competes with the logic of national sovereignty” (43). This can be vividly seen in the fact that out of 10 million refugees in 2010, only 200,000 were in France and 265,000 in the United States. In other words, while the total number of refugees has multiplied by six worldwide, it has diminished by one-fifth and by half respectively in these countries (UNHCR 2011). This decrease has likely occurred at the cost of protecting or providing basic human rights for these individuals. Unfortunately, there is increasing bureaucratic and subjective control exerted on those trying to cross borders to the expense of the universal promise of human rights. This control is rooted in the increasingly suspicious view of stateless peoples and a concentrated European resistance to fulfilling human rights obligations.

**Popular Depictions of Irregular Migrants**

This phenomenon of surface-level sympathy coupled with underlying distrust and subsequent refusal can be traced in a comparison of the public reception to the image of Alan Kurdi versus the public sentiment facing migrants when they actually reach European shores. There is a simultaneous embrace of migrants on a theoretical level, while still demanding “unequivocal individual proof” of their hardship as well as “inquisition into the person’s past and speculation about his or her future” (Didier 45), that leaves so many HIV positive migrants mistrusted, silenced, and ultimately placed in bodily harm.

Alan Kurdi’s death made international headlines when Turkish journalist Nilüfer Demir shot the image of him lying face down in the sand, looking jarringly peaceful, yet unquestionably
lifeless. Kurdi and his family were aboard a small inflatable boat, attempting to reach the Greek island of Kos after departing from Bodrum, Turkey in the early hours of September 2, 2015 (Kinsley). Five minutes after leaving Bodrum, the boat capsized. The details of the story have slowly emerged through time, but the photograph was largely disseminated with minimal background information. It is because of this lack of information that the photograph depicting Alan Kurdi holds so much power. The photograph asks more questions than it answers, and from these questions the story materializes. The child is alone, seemingly abandoned by both his parents and the other migrants. Why have they left him? Have they also been consumed by the passage? How long has he been lying there? How close did he get to his destination? Why was his family fleeing? But of all these inquiries, the greatest implicit question is: who has the power to change his situation? But because the child is alone in the picture and his death is “presented as if it existed free of local people and local worlds,” the implicit extension would be that there is nothing to turn to, except towards the observer (Kleinman and Kleinman 7). But how can we help Alan? The system has already failed him.

The photograph attached international attention and caused global outrage. Both French President François Hollande and British Prime Minister David Cameron were deeply moved by the image, and Hollande stated that the picture was to be a reminder of the world’s responsibility towards migrants. However, as Didier Fassin shrewdly notes, “France is more generous when the cost is minimal” (Fassin and D’Halluin 599). Indeed, we can be generous with our support and sympathy for Alain Kurdi, as the cost is nothing. He is a child and thus he is presumed innocent. More importantly, he is dead, and thus he holds no immigration or national identity threat. He is simply a tragedy who has never reached his destination, stripped of any national obligation.

Portraying suffering is not an easy task, and Paul Farmer acknowledges the difficulty of it when
he writes, “The experience of suffering, it’s often noted, is not effectively conveyed by statistics or graphs. In fact, the suffering of the world’s poor intrudes only rarely into the consciousness of the affluent” (31). But it seems that when suffering does finally invade our consciousness, we only are able to offer compassion and sympathy when the suffering does not threaten our national order and sense of who is deserving of asylum status.

Due to the persistence of media and presence of photographers, the arduous journeys many migrants undergo to reach European shores has been well documented, arousing surface-level sympathy and support for migrants. However, once a migrant reaches European shores and has the audacity to demand basic human rights, the right to health amongst them, the sympathetic winds shift. According to a Pew Research poll conducted in September of this year, 59% of Europeans believe refugees will “increase the likelihood of terrorism” in their respective country. Furthermore, in no country surveyed did more than 4 in 10 individuals say that having an increased number of people from many different races, ethnic groups and nationalities made their country a better place to live (Poushter). In October 2, 2016, 98% of Hungarian voters backed the government’s opposition to the EU refugee acceptance quotas, even though Hungary would only need to accept a little over a thousand of the 160,000 refugees taken into consideration of the plan (Rotsky). In France, more than 20 French mayors have refused to lift their bans on the “Burkini,” a full body swimsuit worn mainly by (immigrant, refugee) Muslim women even though the national court system has ruled the ban as unconstitutional.

Perhaps playing into this phenomenon is that the main origin myths and myths of identity in Europe have generally not included the myth of being accepting of migrants, as opposed to the myth of identity in the United States (though this is quickly being revised). Therefore, immigrants perceived as being different from the national identity inadvertently cause widespread concern
and create a sense that they are ‘taking advantage of a host country’s hospitality. Additionally, there is an increasing sense that migrants are lying; whether about age, country of origin, or history of persecution to gain recognition as a refugee.

**Medico-Legal Reports in Response to this Distrust**

With the voices of those claiming asylum increasing distrusted and illegitimated, the development of medical expertise to back a migrant’s claim has become meaningful. It is simply not enough for an asylum seeker to claim torture or medical necessity; it must be validated by a more trusted (native) individual. This disregard for autobiographical accounts is viscerally and tragically recounted in “Brother, I’m Dying” by Edwidge Danticat. In the memoir, Danticat recounts the story of her Uncle Joseph, who has throat cancer and received a radical laryngectomy to remove the tumor, leaving him with an electronic voice box. In October 2004, after a clash between United Nations peacekeepers and Haitian gangs takes place in his church compound, Uncle Joseph is forced to flee Haiti for the United States where he is detained and sent to a Miami immigration detention center. There, his medication is taken away, leading to him becoming gravely ill during his interview. Even though Joseph is vomiting and almost comatose, the medic states “I think he is faking” (233). The visual proof of his illness is still no match for a medic’s words. Finally, Joseph is transferred to a hospital, where he passes away a few hours later.

The medic in this story is clearly the villain. However, many NGOs have attempted to subvert the status quo of migrant distrust and silencing as highlighted by Danticat’s memoir by providing medico-legal reports (MLR) for asylum seekers in Europe. MLRs are used in support of an asylum claim in a variety of ways. A MLR may establish the evidence that past persecution, either alleged torture or ill-treatment, consistent with testimony, did in fact occur. A
MLR can also be used explain a client’s inability to provide complete testimony as a result of torture or trauma, resulting in associated mental health symptoms. Lastly, a MLR can be used to prove the negative impact of return to the country of origin for the asylum seeker. It may detail the treatment that the claimant had in the country of origin as well as ongoing treatment needs that cannot be met in the original country. Currently, these cases most often relate to HIV or dialysis (Wilson-Shaw). It is in this way that the migrant’s body, mediated through official accounts, rather than their voice, becomes a primary factor in asylum applications.

In Miriam Ticktin’s ethnographic research on the role of biology in the politics of immigration, she argues that biological evidence of “illness, of torture; of immunity levels—are used as key measurements of suffering” (139). Thus, immigrant bodies, rather than their voices, are markers of truth and legitimacy. However, this depreciation of the asylum seeker’s word is obviously problematic, not the least when physicians are not able to speak to the facts, as in the case of sexual violence where the physical evidence quickly fades, or when a sexual identity that would place the individual at risk cannot be physically proven.

The importance of medico-legal reports also distorts the therapeutic physician-patient relationship. One of the primary promises of medical care—confidentiality—is disrupted when a patient visit is seen as a means to create a report, rather than a step to care or healing. These reports are sent to government bodies, as a part of an asylum application package. Though these hearings are often done behind closed doors, the level of security is far below a locked electronic medical record. For somebody with a positive HIV status, the inadvertent disclosure of this condition to their family or the public could be traumatic. The traditional format of a medical visit is to listen to the patient, and thus develop a differential diagnosis based entirely on a patient’s story and physical indications. However, as physicians compile testimonies of
traumatized people, their subjective narratives become enmeshed in the diagnostic reports. In trying to raise awareness on issues or assist an asylum seeker, the physician may dramatize certain situations or get emotionally involved, and become new voice of the conflict.

Unfortunately, NGOs are caught in a bind. If they were to stop issuing these certificates, HIV positive asylum seekers would be disadvantaged. With a lack of third party assistance, asylum seekers may turn to governmental physicians who “might charge more for their services and who might be less personally inclined to help clients” (Fassin and D’Halluin 603). The only solution is to ease the suspicion of asylum seekers by the public and governmental organizations. After all, in the mid-1970s, 19 of 20 asylum seekers in France obtained refugee status. Now the acceptance rate hovers at 3 of 20, a decrease of 80% (Fassin and D’Halluin 600). The status of refugee has become an almost unattainable goal.

**Inclusion/Exclusion due to HIV status**

The production of a MLR is not a guarantee for the success of an asylum seeker’s application. However, in the case of D v. United Kingdom (1997), the claimant’s HIV status was a critical feature in his application, and ultimately allowed him to stay in the UK to receive care. The case involved a national of St. Kitts, who was arrested upon arrival at Gatwick Airport for the possession of cocaine. Already, this is an exceptional case—Mr. D arrived via plane, and was arrested for something other than simply migrating illegally. This was in 1993—during his six-year prison sentence in the UK, he was diagnosed with advanced AIDS. He was released on parole three years early, with the immigration authorities dictating that he be removed to St. Kitts. A MLR was created, documenting Mr. D’s prognosis if returned St. Kitts. The physician noted that Mr. D’s prognosis was extremely poor and that St. Kitts did not have the facilities to provide Mr. D with the medical treatment he required to survive. Regardless of whether he
entered the UK in a legal sense, he was still physically present in the country, and thus under the jurisdiction of the European Convention on Human Rights. The court thus concluded that Mr. D’s refoulement to St. Kitts would amount to inhuman treatment as understood by the prohibition of torture enshrined by Article 3 of the European Convention on Human Rights. In this case, Mr. D’s HIV status served as a mechanism to gain refugee status.

However, Mr. D’s case is not typical. Even if asylum seekers have a medico-legal report documenting their HIV status and the treat of bodily harm should they be returned to their country of origin, they are not assured refugee status. Even more alarmingly, their HIV status may in fact harm their application. This reality is highlighted by UK Impendence Party leader Nigel Farage suggesting that his party would stop migrants with HIV from entering Britain. In April of 2015 Farage stated: “You can come into Britain from anywhere in the world and get diagnosed with HIV and get the [anti]-retroviral drugs, that cost up to £25,000 a year per patient…I know there are some horrible things happening in many parts of the world, but what we need to do is put the National Health Service there for British people and families who in many cases have paid into this system for decades” (Butler). In other words, Farage is suggesting the health service is being ripped off by refugee health tourists. At the time of the statements Farage could perhaps be simply seen as a right-wing outpost of anti-migrant sentiment. However, given the rise of far-right movements across Europe, Brexit, and the election of Donald Trump in the United States, his statement has a renewed poignancy.

10 years before Farage’s statements, the case of N v. Secretary of State of the Home Department highlights the underlying tension between the preservation of state resources and the obligation to comply with human rights law, notably the right to health care for HIV/AIDS sufferers. In the case, Ms. N, a Ugandan national, entered the UK in March 1998. At the time of
her entry, she was diagnosed as HIV positive. She sought asylum in the United Kingdom but was rejected. This case was her appeal to remain in the United Kingdom in order to continue to receive the necessary life-sustaining antiretroviral treatment. For this case, a physician prepared a MLR documenting that without regular antiretroviral treatment and monitoring, the applicant's life expectancy would be less than one year. However, she would survive several years with continued, proper anti-retroviral therapy, as provided by the National Health Service. If she was returned to Uganda, she would not very likely receive treatment and would likely die in a few months.

It was unclear why the plaintiff had left Uganda for the United Kingdom—likely it was a blend of economic desperation and health requirements. The Secretary of State rejected Ms. N’s asylum application. The main reason given for this rejection was that the case did not fall under the projection of Articles 3 (prohibition of torture) of the European Convention on Human Rights. However, in the judgement, Lord Hope claimed that granting Ms. N asylum would “risk drawing into the United Kingdom large numbers of people already suffering from HIV in the hope that they too could remain here indefinitely so that they could take the benefit of the medical resources that are available in this country” (Hand 28). Many following the case at the time believed that dismissal of the claim lay in the fear the United Kingdom’s resources would have been stretched to capacity if placed under an obligation to provide medical treatment to overseas patients suffering from serious illnesses. In other words, Ms. N’s HIV status served to harm her application for asylum due to a thinly-veiled floodgate argument. Even though Ms. N had the bodily evidence of her trauma, the MLR to prove it, and would not receive care in her home country, she was deported to Uganda after the appeal.
The right to protection afforded to asylum seekers by European human rights documents are in tension with the ambivalence of hospitality and the increasing distrust of the migrant motivations and claims. Although public support is maintained when migrants remain at a distance, migrants are often regarded with a mixture of suspicion and distaste once they reach European shores. Unlike previous images of the ‘noble refugee’, today’s migrants do not elicit admiration or compassion, and their autobiographical claims are carefully scrutinized. Thus, NGOs that provide Medico-Legal Reports have the uncomfortable task of legitimizing claims through expert opinion, while being complicit in the apparatus that distrusts and silences the migrants. European countries have the infrastructure to provide compassionate care for individuals living with HIV, whereas the majority of countries from which these asylum seekers arrive do not offer this care, nor the protections from persecution that are necessary for this particular vulnerable group. This forms the basis of many asylum claims, yet its success is by no means guaranteed, as is seen in the cases of D v. United Kingdom and N v. Secretary of State of the Home Department. As the refugee crisis in Europe is far from over, perhaps the tangled connections between hospitality, health, migration, and HIV discrimination will slowly be elucidated. For now, the path to refugee status is uncertain and tenuous, especially as a HIV positive asylum seeker.
Citations


