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English Edition

ANUJ BHUWANIA

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HUMAN RIGHTS OF PEOPLE ON THE MOVE:

MIGRANTS AND REFUGEES

KATHARINE DERDERIAN AND LIESBETH SCHOCKAERT

Responding to “mixed” migration flows: A humanitarian perspective

JUAN CARLOS MURILLO

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JOSEPH AMON AND KATHERINE TODRYS

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CONTENTS

ANUJ BHUWANIA	7	“Very wicked children”: “Indian torture” and the Madras Torture Commission Report of 1855
DANIELA DE VITO, AISHA GILL AND DAMIEN SHORT	29	Rape characterised as genocide
CHRISTIAN COURTIS	53	Notes on the implementation by Latin American courts of the ILO Convention 169 on indigenous peoples
BENYAM D. MEZMUR	83	intercountry adoption as a measure of last resort in Africa: Advancing the rights of a child rather than a right to a child
Human Rights Of People On The Move: <i>Migrants And Refugees</i>		
KATHARINE DERDERIAN AND LIESBETH SCHOCKAERT	105	Responding to “mixed” migration flows: A humanitarian perspective
JUAN CARLOS MURILLO	117	The legitimate security interests of the State and international refugee protection
MANUELA TRINDADE VIANA	133	International cooperation and internal displacement in Colombia: Facing the challenges of the largest humanitarian crisis in South America
JOSEPH AMON AND KATHERINE TODRYS	155	Access to antiretroviral treatment for migrant populations in the Global South
PABLO CERIANI CERNADAS	179	European migration control in the African territory: The omission of the extraterritorial character of human rights obligations

PRESENTATION



As in recent issues of our Journal, in this tenth edition we highlight one theme, to which we dedicate five of nine total articles. This theme refers to the plight of the millions of migrants and refugees who find themselves in dire situations in many countries around the world. The article by Katharine Derderian and Liesbeth Schockaert of *Médecins sans Frontières* realistically portrays the terrible human tragedy of refugees and, from the point of view of human rights, discusses the concept of refugee, according to the criteria of the United Nations High Commissioner for Refugees (UNHCR), under whose guidance and with whose generous support we were able to organize this edition. The UNHCR criteria and the foundations of the protection system for refugees are explained in the article by Juan Carlos Murillo.

In addition to the articles mentioned above that address general problems, we published the following contributions, which focus on specific problems relating to the human rights of refugees and migrants:

International Cooperation and Internal Displacement in Colombia, by Manuela Trindade Viana, focuses on problems related to internal displacement in Colombia, a country that contains 25% of the world's internally displaced population (11.5 million).

Access to antiretroviral treatment for migrant populations in the Global South, by Joseph Amon and Katherine Todrys, of the *Human Rights Watch*, denounces the violation of laws that guarantee access to health resources for non-permanent populations of migrants and refugees.

European Migration Control on African Territory, by Pablo Ceriani Cernadas, analyses the inhuman immigration control policies adopted by European governments and EU organizations on the coast and in the waters of North African countries.

Our tenth edition is completed with the contributions by Anuj Bhuwania ("**Indian torture**" and the **Madras Torture Commission Report of 1855**), Daniela De Vito, Aisha Gill and Damien Short (**Rape Characterised as Genocide**), Christian Courtis (**Notes on the implementation by Latin American courts of the ILO Convention 169 on indigenous peoples**) and Benyam E. Mezmur (**Intercountry Adoption as a Measure of Last Resort in Africa**). Bhuwania argues that police torture in India is a legacy of colonialism, as illustrated by the "Madras Torture Commission Report of 1855". De Vito, Gill and Short discuss the theoretical consequences of defining rape as a

particular kind of genocide. Courtis presents emblematic cases of the application of the ILO 169 Convention on Indian and tribal populations in Latin America. Finally, Mezmur focuses on the problems associated with the policies for adoption of African children by families from other continents.

We hope that the articles presented in this edition will help to enrich the debate surrounding the growing number of problems associated with the displacement of vast human contingents, who were forced to leave their homes, not only due to wars, persecutions and political totalitarianism, but also due to various economic causes, whose detrimental consequences to the human rights of their victims are equally dramatic.

We would like to thank the following professors and partners for their help with the selection of articles for this edition: Carina du Toit, Carlos Ivan Pacheco Sánchez, Florian Hoffmann, Gaim Kibreab, Glenda Mezarobba, Guilherme da Cunha, Iniyana Ilango, Jeremy Sarkin, José Francisco Sieber Luz Filho, Juan Amaya Castro, Laura Pautassi, Malak Poppovic, Paula Miraglia, Rajat Khosla Renata Reis, Roberto Garretón and Upendra Baxi.

As mentioned on our website, beginning with this edition, we have adopted new rules for citations and bibliographical references in order to facilitate the reader's experience. Because this is a recent change, we count on our readers' understanding in the case of any mistakes caused by such change. In this matter, we would like to thank the following individuals who contributed to the formatting of the articles: Clara Parra, Elaini Silva, Mila Dezan, Rebecca Dumas and Thiago Amparo.

We conclude by stressing once again the importance of the guidance and support provided to us by the UNHCR for the publication of this edition, which originated as a doctrinal investigation and development of the "Mexican Action Plan for the Strengthening of International Protection of Refugees in Latin America", geared towards cooperation with academic institutions that are dedicated to the research, promotion and instruction of international law related to refugees.

In particular, we would like to thank the offices of UNHCR in Argentina and Brazil, and the Legal Regional Unit for the Americas.

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ABSTRACT

While international human rights law establishes the right to health and non-discrimination, few countries have realized their obligations to provide HIV treatment to non-citizens—including refugees, long-term migrants with irregular status, and short-term migrants. Two countries, South Africa and Thailand, provide useful illustrations of how government policies and practices discriminate against non-citizens and deny them care. In South Africa, although individuals with irregular status are afforded a right to free health care including antiretroviral therapy (ART), non-South African citizens are frequently denied ART at public health care institutions. In Thailand, even among registered migrants, only pregnant women are entitled to ART. In order to meet international human rights law—which requires the provision of a core minimum of health services without discrimination—states in the Global South and worldwide must make essential ART drugs available and accessible to migrants on the same terms as citizens.

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KEYWORDS

Migrant – HIV/AIDS – Antiretroviral therapy – Human rights – Right to health.



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ACCESS TO ANTIRETROVIRAL TREATMENT FOR MIGRANT POPULATIONS IN THE GLOBAL SOUTH

Joseph Amon and Katherine Todrys

1. Introduction

The scale of global migration, defined by the World Health Organization (WHO) (2003) as the movement of people from one area to another for varying periods of time,¹ is vast and growing. The International Organization for Migration (IOM) (200-) has estimated that 192 million people worldwide, or 3 percent of the world's population, live outside of their place of birth.

In 2008, the Joint United Nations Programme on HIV/AIDS (UNAIDS) (2008a) estimated that 33 million people worldwide were living with HIV. According to the WHO, migration can often have serious health consequences for migrants because of challenges involving “discrimination, language and cultural barriers, legal status and other economic and social difficulties” (WHO, 2003, p. 4). Indeed, since the emergence of the HIV epidemic in the 1980s, public health officials have recognized that migrant populations face special risk of HIV infection (WOLFFERS; VERGHIS; MARIN, 2003, p. 2019-2020).

UNAIDS, IOM, and the International Labour Organization (ILO) (2008, p. 1) have together noted that social, economic, and political factors affecting international labor migrants in origin and destination countries—including separation from spouses and unfamiliar cultural norms, substandard living and working conditions, and language unfamiliarity, compounded by lack of access to HIV-related information and services—can increase the risk of HIV infection. Public health research has repeatedly shown the vulnerability of migrants and their families to HIV (HERNÁNDEZ-ROSETE et al, 2008; WELZ et al, 2007; FORD; CHAMRATHRITHIRONG, 2007, BANDYOPADHYAY; THOMAS, 2002; BROCKERHOFF; BIDDLECOM, 1999), and recent studies have further demonstrated the unique health needs of

Notes to this text start on page 176.

mobile populations and the impact of changes in social and cultural practices on health (BANATI, 2007, p. 210-214). The 2001 Declaration of Commitment on HIV/AIDS explicitly commits governments of the world to “develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers” (para. 50).

Transit routes have long been recognized as facilitating both population and disease spread. National highways such as the Golden Quadrilateral in India have been called a “conduit of the virus” (WALDMAN, 2005) and since early in the epidemic, the M1 highway running from Egypt to South Africa has been called the “AIDS Highway.” Billboards along major transit routes and at borders throughout southern Africa carry AIDS-related messages and caution individuals on the move to use condoms. The main highway linking Abidjan, Côte d'Ivoire to Lagos, Nigeria, travelled by 47 million people a year, also includes AIDS awareness messages and is the focus of a travelling HIV/AIDS awareness campaign (IRIN PLUS NEWS, 2008b).

However, despite the longtime recognition of the relationship between migration and vulnerability to HIV infection, donors and states have largely failed to ensure that migrants have access to HIV treatment. Although governments have committed themselves to provide “universal access” (UN POLITICAL DECLARATION ON HIV/AIDS, 2006, para. 20) to HIV treatment and have specific obligations under international human rights law to ensure that HIV treatment (specifically, antiretroviral therapy or ART) is provided to migrants as part of their duty to realize the right to health without discrimination, access to ART for migrants remains largely unrealized.

The World Health Assembly (WHO, 2008) has called on member states to promote migrant-sensitive health policies, promote equitable access to disease prevention and care for migrants, document and share information on best practices for meeting migrants' health needs, train health professionals to deal with mobility-related health issues, and cooperate with other countries involved in the migratory process on migrants' health issues. However, few states have explicitly recognized antiretroviral therapy as part of the core minimum of health services to be provided without discrimination as to citizenship for migrants within their borders.

The development of HIV treatment systems for migrants is necessary to achieve universal access to HIV treatment and to meet the needs of the world's significant and growing population of migrants, particularly in the Global South. The expansion of HIV treatment in the Global South has been uneven; while previously, HIV positive migrants were unable to access care both in low and middle income countries of origin and destination, in recent years national governments in some countries of the Global South, with the assistance of international donors, have been for the first time able to provide such treatment at low cost or free of charge (GARRET, 2007).

In addition to unequal resources between various countries in the Global South, unequal access to and utilization of donor resources has created a vast disparity amongst low and middle income countries in their ability to provide ART, a disparity that may persist. Currently, 15 countries worldwide enjoy the status and special aid directed at HIV treatment as “focus countries” of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program (THE UNITED STATES, 200-). Money from the Global

Fund to Fight AIDS, Tuberculosis and Malaria is also unevenly distributed (more than 1/5 of monies expended by 2007 had been given to only four countries) (GARRET, 2007). Further complicating matters, in some low and middle income countries corruption is common and significant portions of donor funding never reach their intended health targets; war, poor leadership, and lack of health infrastructure hamper access to drugs in others.

Given the global scale and frequency of migration worldwide, a rational public health strategy toward HIV/AIDS prevention and treatment cannot include discrimination against non-citizens in provision of ART. From a prevention standpoint, denying such treatment to migrants will only serve to perpetuate transmission and frustrate efforts toward controlling the HIV/AIDS epidemic. From the perspective of adequately caring for those already infected, interruptions in HIV treatment can lead to illness, development of drug resistance, and death, which ultimately may present public health programs with greater social welfare costs (BURNS; FENTON, 2006).

It should be noted that such poor access to care and discrimination also exists for migrants to high income countries. Human Rights Watch has examined instances of South-to-North migration, and consequent challenges facing migrants in accessing ART in their new homes, elsewhere (HUMAN RIGHTS WATCH [HRW], 2009). This article will examine migrants' access to ART in two middle income countries—South Africa and Thailand—in the context of relevant international law, and provide general recommendations for realizing the goal of universal access to HIV treatment for all.

2. Populations

Three broad categories of migrants may be defined for the purposes of this article: refugees, long-term migrants with irregular status, and short-term migrants.

2.1 Refugees

A refugee is defined as a person who,

owing to 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, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it. (UN CONVENTION RELATING TO THE STATUS OF REFUGEES, 1954, art. 1(A)(2); UN PROTOCOL RELATING TO THE STATUS OF REFUGEES, 1967).

Refugees are granted special protection under international law. According to the 1951 Convention relating to the Status of Refugees and its 1966 Protocol, refugees are afforded treatment at least as favorable as that of a host country's nationals with respect to a variety of rights, including public relief and assistance and social security (which includes sickness, maternity, or other contingencies covered by social security

under national law or regulation) (UNITED NATIONS HIGH COMMISSIONER FOR HUMAN RIGHTS [UNHCHR], 2006, p. 28-29). With the exception of the right to public education, the rights in this Convention are limited to those refugees lawfully resident in the host country, a provision which has occasioned disagreement as to whether asylum seekers are or are not covered (CHOLEWINSKI, 2000, p. 710-712). Individuals who have an application for refugee status pending - asylum seekers - do have some special protections under international law as well (UNHCHR, 2006, p. 28-29), though these protections do not specifically address the right to health care.

Affording refugees access to ART is supported by UN agencies. The UN High Commissioner for Refugees (UNHCR) (2008, p. 5) considers it a strategic objective to ensure that “access to timely, quality and effective care, support and treatment services including access to antiretroviral therapy [is provided to refugees] at a level similar to that of the surrounding host populations.” Indeed, among the groups discussed in this article, refugees are provided with the broadest access to free ART.

2.2 Long-Term Migrants with Irregular Status

A long-term migrant has been unofficially defined as “[a] person who moves to a country other than that of his or her usual residence for a period of at least a year (12 months), so that the country of destination effectively becomes his or her new country of usual residence” (HEALTH PROTECTION AGENCY, 2006, p. 5). This group could include individuals who have been unsuccessful in an application for asylum but have chosen to remain in the country nonetheless, individuals who entered the country on a visa and have overstayed that visa without obtaining an extension, or individuals who have entered a country without legal status and have remained without status. Government laws and policies on providing health care—especially ART—to long-term migrants with irregular status are often very restrictive.

2.3 Short-Term Migrant Populations

A short-term migrant has been defined as a “person who moves to a country other than that of his or her usual residence for a period of at least 3 months but less than a year” (HEALTH PROTECTION AGENCY, 2006, p. 5). These mobile populations - also defined as “people who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons” (UNAIDS, 2001, p. 3) - face particular challenges in accessing care. UNAIDS and IOM (2001, p. 10) have noted that increasingly individuals are bi- or multi-local.

Migration may take a circular path, or individuals may use certain countries as “stepping stones” in the migration process (JACOBSEN, 2007, p. 206-208). Short-term migrant populations face many of the same challenges as long-term migrants with irregular status, including lack of access to free or low-cost medications, but also face particular challenges—including differing treatment regimens in various locations, differential prescription systems across borders, lack of continuity of care, and lack of conformity to ART guidelines that are designed for stationary populations.

3. Case Studies from Two Countries in the Global South

Despite international recognition of the vulnerability of migrant populations and specific human rights protections, the experience of migrants in accessing HIV treatment varies widely. South Africa and Thailand provide two instructive and differing examples of migrants' legal rights and reality of access to ART in the Global South.

3.1 South Africa

South Africa is home to the largest number of individuals infected with HIV in the world, an estimated 5.7 million people in 2007 (UNAIDS, 2008a, p. 40). Providing antiretroviral treatment to individuals who require it is a central and pressing issue of national concern.

Between member states of the Southern African Development Community (SADC), migration is frequent, and 46 percent of South Africans live in rural communities where employment-based circular migration is common (WELZ et al, 2007, p. 1471). HIV prevalence throughout the region is high, and one study of HIV prevalence in KwaZulu-Natal, South Africa, where migration is common found that HIV prevalence among migrant women aged 25-29 years old was 63 percent (WELZ. et al, 2007, p. 1469).

Identifying the number of migrants in South Africa, though, is itself controversial. Estimates vary widely, and rise as high as six million non-citizen migrants in the country in 2008 (SOUTH AFRICA, 2008?, p. 1), compared with an overall population of 47 million (FEDERATION INTERNATIONALE DES DROITS DE L'HOMME [FIDH], 2008, p. 8). Most of these migrants come from other countries in the Southern African Development Community, especially from Zimbabwe, Mozambique, and Lesotho. As a result of the political and economic crisis in neighboring Zimbabwe, especially, migrants have come to South Africa in large numbers: at least one to 1.5 million Zimbabweans are estimated to have fled to South Africa since 2005 (HRW, 2008, p. 23), leaving a country with vastly inadequate access to ART and health care generally (HRW, 2006). Increasingly, migrants are coming to South Africa from across the continent and the world (FIDH, 2008, p. 11).

Under the South African Constitution, individuals with irregular legal status are accorded a wide range of human rights, including the rights to access to emergency and basic health care, and ART (SOUTH AFRICA, 2007). Asylum seekers and refugees are accorded free care if they are indigent and are assessed according to the same means test used to evaluate South African citizens if they are not. The Department of Health has issued memoranda clarifying that these rights apply equally whether the patient has documentation or not.

However, Human Rights Watch research (2008, p. 43), as well as NGO and media reports, has described a striking gap between South Africa's inclusive policies and the reality of access to health care for refugees, asylum seekers, and especially undocumented migrants. Some public clinics demand a South African identification document before offering health care, denying treatment for those without

identification papers (IRIN PLUS NEWS, 2008a). Asylum seekers have experienced continuing difficulties accessing ART (CONSORTIUM FOR REFUGEES AND MIGRANTS IN SOUTH AFRICA, 2008; AIDS LAW PROJECT et al, 2008). Human rights organizations and journalists have documented verbal abuse, sub-standard treatment, insensitivity by providers, unusually long wait times, and outright denial of services facing migrants seeking health care (FIDH, 2008, p. 31). Other migrants are illegally charged prohibitive fees for treatment or medication, or told they must carry a green South African citizenship card in order to receive basic services. Undocumented Zimbabweans in need of health care have overwhelmed South African charities and churches (HRW, 2008, p. 36), and been turned away from government clinics when unable to present citizenship papers. Basotho mineworkers, infected with HIV and multi-drug resistant tuberculosis (MDR-TB) have faced deportation and been left at the border of their home country without any treatment or referral to local health services for treatment (SMART, 2008).

Spokespeople for the Office of the UNHCR and Médecins Sans Frontières (MSF) confirmed in July 2008 that they had observed cases of foreign nationals discriminated against and refused HIV treatment by health workers unaware of the law (PALITZA, 2008). In recent research from the University of Witwatersrand, non-citizens in need of ART reported more challenges accessing the drug than did South African citizens. Individual hospital staff who discriminate against migrants, either through verbal or physical abuse or through denial of care, are rarely held accountable. The victims of such abuses frequently do not know their rights with regard to healthcare, since public hospitals do not employ translators or provide linguistically appropriate educational material, and rarely lodge formal complaints. This research further suggests that National Department of Health policies are not uniformly applied in public institutions, and that while citizens are referred to government ART sites, non-citizens are routinely referred by local clinics out of the public sector to NGOs to receive ART. This practice has led to the creation of a “dual-health care system, public and non-governmental, providing ART through separate routes” to citizens and non-citizens (VEAREY, 2008b).

NGOs in South Africa have spent many hours advocating for individual refugees and asylum seekers who are denied care in the public sector, writing letters and accompanying patients to make sure they are treated in accordance with the law. Even where these patients are eventually able to obtain diagnosis and treatment for HIV, they may suffer late diagnosis and treatment from earlier unsuccessful attempts and the time it takes to arrange advocacy. Migrants coming from countries with a lower incidence of HIV than South Africa, such as Somalia, may lack information about HIV and linguistically appropriate resources are rare. Furthermore, researchers have pointed out that South African doctors are not trained to treat migrants who have been on a different ART regime in their home country, and many erroneously believe that changing regimes will cause drug resistance or treatment failure.

Poor living conditions and frequent forced internal displacement further challenge migrants in South Africa from accessing HIV testing and treatment. Thousands of undocumented Zimbabweans live in the open near the border, without access to shelter, food, clean water and sanitation facilities. Thousands more sleep in cramped shelters and

on church floors in city centers. Food insecurity and hunger make compliance with ART challenging. Frequent arrests, detention and deportation create a climate of fear in which many migrants, especially near the Zimbabwean border, refuse to seek health care for fear of being arrested there. For people seeking HIV diagnosis and prophylaxis after sexual assault, public hospitals pose a particular risk, as many have a policy of calling police before offering treatment. Together with high rates of xenophobic violence against foreigners, these factors seriously limit South Africa's realization of its progressive policy toward ART provision to migrants. The example of South Africa highlights the importance of general human rights compliance for migrants in order for HIV treatment regimes to function as de

3.2 Thailand

In 2004, Thailand was home to 1.25 million registered migrants and at least again as many unregistered ones (IOM, 2007?). A large percentage of these migrants are Burmese. Indeed, estimates of the number of Burmese migrants in Thailand have ranged from 2 to 6 million (YANG, 2007, p. 488-489). Migrants arriving in Thailand from Burma come for reasons associated with the economic devastation in their home country, economic opportunities in Thailand, and conflict and persecution by the ruling military junta. The Burmese health care system is also broadly insufficient to meet the needs of the population, and decades of repressive military rule, civil war, corruption, lack of investment, isolation, and widespread violations of human rights and international humanitarian law have rendered Burma's health care system incapable of responding effectively to endemic and emerging infectious diseases (STOVER et al, 2007, p. 1).

The Thai government has developed a program to register migrants and regularize their status. In 2004, the Thai Ministry of Labor registered 1,280,000 migrants, 814,000 of whom also applied for work permits (YANG, 2007, p. 506). Registration allows migrants access to basic health care services through the national health plan (YANG, 2007, p. 507). Indeed, the Ministry of Public Health has noted that where migrants are registered and hold work permits, they are entitled to access health services including treatment, disease control, health promotion, and rehabilitation, to obtain regular health check-ups, and to enroll in the national health scheme, which involves a fixed co-pay and the government paying the remainder of the cost of services (YANG, 2007, p. 520-521).

However, ART is not generally considered part of the package of public health care involved in registration, except for in the case of pregnant women (IRIN PLUSNEWS, 2007, PHYSICIANS FOR HUMAN RIGHTS [PHR], 2004, p. 45). Antiretrovirals are distributed to Thais through a separate scheme than registered migrants' health coverage, effectively barring non-Thais (PHR, 2004, p. 45-46).

Additionally, registration is problematic for migrants because of steep registration fees and the fact that migrants cannot change employers once registered, nor move outside the province in which they are registered (YANG, 2007, p. 507-511). Registration eligibility changes annually and restrictions stemming from a lack of coverage of typical migrant job categories, and linkage of registration to specific places of employment keep many from accessing the registration program (PHR, 2004, p. 2). Further, while

migrants themselves are entitled to have possession of their registration, work permit, and health insurance documents, employers often hold these documents and migrants find copies of the documents insufficient for actually obtaining care (SAETHER et al, 2007, p. 1004-1005). Most Thai health care facilities do not provide any services to unregistered migrants (YANG, 2007, p. 522).

A 2004 Physicians for Human Rights Report dealing with Burmese migrants in Thailand expressed concern about the government's "commitment to human rights protection and HIV/AIDS prevention, care, and treatment for migrant and hill tribe populations" (PHR, 2004, p. 1). The group called for HIV care and treatment for migrants on equal terms as Thai citizens, as, among other barriers

access to health care for Burmese and hill tribe populations is critically limited because of the threat of arrest and deportation, forced confinement, confiscated legal documents, discrimination, lack of financial resources, lack of information, and/or language barriers. (PHR, 2004, p. 3).

Indeed, this population is essentially forced to live with and soon die of AIDS as a result of discriminatory denial of treatment (PHR, 2004, p. 4). MSF (2007) has also asked the Thai government to improve migrant workers' access to health services, noting the gap between the government's broad health care policies and the practice in some provinces where few migrants have basic healthcare.

In addition to the legal barriers to free care discussed above, practical challenges inhibit the treatment of HIV positive migrants in Thailand. Awareness of and utilization of all health care rights is low even among registered migrants (YANG, 2007, p. 521). Furthermore, interviews with migrants have found that severe financial challenges (which, in addition to cost of treatment, included cost of transportation to health facilities and cost of missing work for medical appointments), fear of police, difficult work and communication challenges all factor into ART treatment access (SAETHER et al, 2007, p. 1004-1005). Studies have also concluded that "[t]he cost of medication and health care services pose a major obstacle in attempting to adhere to ART" long-term, as the medicine is lifelong and the cost would prohibit migrants from affording other necessities such as food (SAETHER et al, 2007, p. 1004-1005).² Furthermore, studies have shown that migrants in Thailand have experienced discrimination in seeking treatment, ranging from rudeness, to denial of access to treatment, to substandard care (SAETHER et al, 2007, p. 1004-1005).

Drug adherence guidelines may also be detrimental to access by migrants. The ART regimen most commonly used in Thailand must be taken every 12 hours, which is difficult for migrants working long hours who would find it impossible to stop work to take medicines and who might be fired if their HIV status were discovered (SAETHER et al, 2007, p. 1004-1005). A doctor at one Thai hospital said that even while migrants are not denied ART unilaterally, many do not fit the inclusion criteria, including anticipated adherence to ART (SAETHER et al, 2007, p. 1004-1005). Non-medical criteria for ART access such as "anticipated adherence" have been used to restrict access to migrants as well as other "non-desirable" patient populations, including drug users.³

4. International Law

International law provides for the basic right to the highest attainable standard of health. This right, along with the right to non-discrimination, implies a right to access a core minimum set of health care services, including ART, without citizenship-based discrimination.⁴

4.1 Right to *Highest Attainable Standard of Health*

All individuals have the right to enjoy the highest attainable standard of health, a right which has been enshrined in international and regional treaties.

According to the Universal Declaration of Human Rights (UDHR), “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services” (art. XXV(1)). The International Covenant on Economic, Social and Cultural Rights (ICESCR) also guarantees the right of everyone to the highest attainable standard of health, and requires States parties to take steps individually and through international cooperation to progressively realize this right via the prevention, treatment, and control of epidemic diseases and the creation of conditions to assure medical service and attention to all (art. 12). “Progressive realization” demands of States parties a “specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of [the right]” (UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS [UNCESCR], 2000, paras. 30-31). According to the WHO and the Office of the UNHCR,

[w]hen considering the level of implementation of this right in a particular State, the availability of resources at that time and the development context are taken into account. Nonetheless, no State can justify a failure to respect its obligations because of a lack of resources. States must guarantee the right to health to the maximum of their available resources, even if these are tight. (UNHCHR; WHO, 2008, p. 5).

The concept of available resources is intended to include available assistance from the international community (CHOLEWINSKI, 2000, p. 714-719).

The right to health is further guaranteed by a number of other international human rights treaties and commitments. The Convention on the Rights of the Child (CRC, 1980) binds states to

recognize the right 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 health care services. (Article 24:1).

In fact, States parties shall take appropriate measures, among other things, “[t]o ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care (CRC, 1989, art. 24:2(b)).” The right to

health is also protected under the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, and the Convention on the Rights of Persons with Disabilities. The right to health has been proclaimed by the Commission on Human Rights, the Vienna Declaration and Programme of Action of 1993 and other international instruments (UNCESCR, 2000, para. 2). Additionally, governments committed in the 2001 Declaration of Commitment on HIV/AIDS to “promote and protect all human rights and fundamental freedoms, including the right to the highest attainable standard of physical and mental health” (para. 37) and

in an urgent manner make every effort to: provide progressively and in a sustainable manner, the highest attainable standard of treatment for HIV/AIDS, including the prevention and treatment of opportunistic infections, and effective use of quality-controlled antiretroviral therapy in a careful and monitored manner to improve adherence and effectiveness and reduce the risk of developing resistance. (para. 55).

Regional treaties also speak to the right to health. The African [Banjul] Charter on Human and Peoples’ Rights ensures the right to health and binds States parties to “take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick (art. 16).” Furthermore, the African Charter on the Rights of the Child provides for the right of every child to the best attainable health, and binds States parties to move toward implementing this right, including the provision of “necessary medical assistance and health care to all children with emphasis on the development of primary health care” (art. 14:2(b)). Article 10 of the European Social Charter of 1961 also recognizes the right to health, as does Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988.

4.2 Principles of Equality and Non-Discrimination

International law also establishes the basic principles of non-discrimination and equality. The Universal Declaration of Human Rights proclaims that “[e]veryone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” (art. 2). Additionally, under that Declaration, “[a]ll are equal before the law and are entitled without any discrimination to equal protection of the law” (art. 7). The International Covenant on Civil and Political Rights (ICCPR) echoes the UDHR’s proclamations against discrimination, binding States parties to recognize the rights it guarantees without distinction of any kind, including based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (art. 2(1)). The ICCPR also notes the equality of all persons before the law and requires that the law prohibit discrimination and guarantee equal protection against discrimination on any ground, including the

above-noted ones (art. 26). The Human Rights Committee (UNHRC) (1994b, para. 1), the ICCPR's monitoring body, has determined non-discrimination, equality before the law, and equal protection, to be basic principles in the protection of human rights.

Furthermore, following this principle, that Committee (1994b, para. 1) has noted that, in general, the rights guaranteed in the Covenant apply to all people, regardless of an individual's nationality or statelessness. Indeed,

the general rule is that each one of the rights of the Covenant must be guaranteed without discrimination between citizens and aliens. Aliens receive the benefit of the general requirement of non-discrimination in respect of the rights guaranteed in the Covenant, as provided for in article 2 thereof. This guarantee applies to aliens and citizens alike. (UNHRC, 1994a, para. 2).

With few exceptions, and including the non-discrimination clause, the rights in the ICCPR apply to both nationals and non-nationals (CHOLEWINSKI, 2000, p. 714-719). The Committee has noted that the ICCPR permits states to distinguish between citizens and non-citizens with respect to political rights explicitly granted to citizens (such as voting) and freedom of movement (that is, there is no general right of non-citizens to enter a country, though they must be granted the rights in the ICCPR once permitted to enter the country) (UNHCHR, 2006, p. 9). The general principle of non-discrimination has also been proclaimed by international documents including the CRC (art. 2:1) and the Convention on the Elimination of Racial Discrimination, though this Convention itself by its terms does not apply to non-citizens.

Regional treaties confirm the basic international principle of non-discrimination. The African Charter on Human and Peoples Rights guarantees the right to equality before the law and equal protection of the law (art. 3), and the African Charter on the Rights and Welfare of the Child prohibits discrimination (art. 3). The European Convention on Human Rights and Fundamental Freedoms provides that the rights and freedoms guaranteed in the Convention be secured without discrimination on any ground including sex, race, color, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status (art. 14).

Opinions differ as to whether the broad non-discrimination provision in ICESCR Article 2(2) may apply to non-nationals. Article 26 of the ICCPR creating substantive equality certainly provides non-nationals with some socioeconomic rights, and the Human Rights Committee has deemed unjustified discrimination against non-nationals in pension rights to be an infringement of this provision (UNHCHR, 2006, p. 9). But non-citizens nevertheless are guaranteed a minimum core of economic and social rights under the Convention on Economic, Social and Cultural Rights, discussed in detail below.

In addition, it should be noted that distinction between groups is not in itself prohibited by non-discrimination provisions. Indeed, distinctions between groups have been interpreted as permissible under the ECHR if dictated by law and strictly proportionate to the pursuance of a legitimate aim, and under the ICCPR if based on reasonable and objective criteria (CHOLEWINSKI, 2000, p. 714-19). The UNHCHR (2006, p. 7) has further noted that when considering discrimination against non-citizens, one must take into account the interest of the state in certain rights, the different types of

non-citizens and their relationship to the State, and finally whether the State's reason for distinguishing between citizens and non-citizens (or between non-citizens themselves) is legitimate and proportionate. UNHCHR has also noted that “[a]ll persons should, by virtue of their essential humanity, enjoy all human rights. Exceptional distinctions, for example between citizens and non-citizens, can be made only if they serve a legitimate State objective and are proportional to the achievement of that objective” (2006, p. 5).

4.3 Non-Discrimination in Health

Numerous international and regional bodies, considering the abovementioned right to the highest attainable standard of health and principle of non-discrimination, have addressed specifically the prohibition of discrimination in offering health services.

According to the Economic, Social and Cultural Rights Committee (UNESCR) (2000), the Convention on Economic, Social and Cultural Rights' monitoring body, States must guarantee certain core obligations as part of the right to health, including ensuring non-discriminatory access to health facilities, particularly for vulnerable or marginalized groups; providing essential drugs; ensuring equitable distribution of all health facilities, goods and services; adopting and implementing a national public health strategy and plan of action with clear benchmarks and deadlines; and taking measures to prevent, treat and control epidemic and endemic diseases. While the Committee (2000, para. 30), in its General Comment 14, notes the progressive nature of the right to health, it also points to the fact that states must immediately take steps to realize the right to health, and must immediately guarantee the exercise of the right without discrimination of any kind. The right to health is thus centrally linked to the right to non-discrimination. Indeed, the Committee has stated that

the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status [...] With respect to the right to health, equality of access to health care and health services has to be emphasized. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and 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 [...]. (UNCESCR, 2000, paras. 18-19).

More specifically with respect to migrants, the Committee notes that “States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services” (2000, para. 34). Thus, a prohibition against discrimination against non-citizens in receiving health care, and an immediate call to eliminate discrimination, emerge from the Committee's findings.

Other bodies have spoken to the obligation not to discriminate against non-citizens

in providing core health care services. While the anti-discrimination provisions in the Convention on the Elimination of Racial Discrimination do not generally apply to non-citizens, the Committee on the Elimination of Racial Discrimination (UNCERD) (2004) - the oversight body under the treaty—in 2004 reminded states of their obligations to non-citizens. The Committee noted that no distinctions permitted on grounds of citizenship should “detract in any way from the rights and freedoms recognized and enunciated in particular in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights” (UNCERD, 2004, para. 2). They recalled that while some right

such as the right to participate in elections, to vote and to stand for election, may be confined to citizens, human rights are, in principle, to be enjoyed by all persons. States parties are under an obligation to guarantee equality between citizens and non-citizens in the enjoyment of these rights to the extent recognized under international law. (UNCERD, 2004, para. 3).

To this end, the Committee called on all States parties to adopt measures including: those that would remove obstacles that prevent the enjoyment of economic, social and cultural rights by non-citizens, notably in the areas of education, housing, employment and health (UNCERD, 2004, para. 29); and those that would ensure that States parties respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services (UNCERD, 2004, para. 36).

The Committee on the Rights of the Child (UNCRC) has spoken specifically to the relationship between HIV/AIDS and the rights outlined in the Convention, determining that the right to non-discrimination should be one of “the guiding themes in the consideration of HIV/AIDS at all levels of prevention, treatment, care and support” (UNCRC, 2003, para. 5). The Committee (2003, paras. 7/ 9) has noted with concern the role that discrimination plays both in fueling the HIV/AIDS epidemic and in targeting the victims of it. And, with respect to HIV-related services, the Committee mandates that

States parties must ensure that services are provided to the maximum extent possible to all children living within their borders, without discrimination, and that they sufficiently take into account differences in gender, age and the social, economic, cultural and political context in which children live (UNCRC, 2003, para. 21).

While states have an obligation under the Convention to ensure children’s equal access to treatment and care without discrimination, including antiretrovirals, states are also directed to pay special attention to factors within their societies limiting equal access for all children to treatment, care, and support (UNCRC, 2003, para. 28).

Governments have committed in the 2001 Declaration of Commitment to enact and enforce legislation eliminating discrimination against persons living with HIV/AIDS and members of vulnerable groups in their access to health care services, including treatment and support for HIV/AIDS (para. 58). The United Nations High Commissioner for Human Rights has further noted that

States must avoid different standards of treatment with regard to citizens and non-citizens that might lead to the unequal enjoyment of economic, social and cultural rights. Governments shall take progressive measures to the extent of their available resources to protect the rights of everyone—regardless of citizenship—to: social security; an adequate standard of living including adequate food, clothing, housing, and the continuous improvement of living conditions; the enjoyment of the highest attainable standard of physical and mental health; and education. (UNHCHR, 2006, p. 25-26).

Furthermore, the International Convention on the Rights of Migrant Workers, which recently entered into force, explicitly guarantees the rights of migrant workers and their families to emergency medical care, providing them with medical care “urgently required for the preservation of their life or the avoidance of irreparable harm to their health” on an equal basis as a state’s nationals, without regard to irregularity of status (art. 28). With respect to additional health services, the Convention guarantees migrant workers equality of treatment with nationals in access to social and health services if requirements for participation in those schemes have been met (art. 43(1)(6)).

5. Looking Forward

Providing ART to migrants requires a two-fold effort on the part of states in the Global South and among international donors and NGOs: citizenship-based discrimination in the provision of ART must be eliminated, and cross-border and migrant-friendly treatment mechanisms must be created.

5.1 Citizenship-Based Discrimination in the Provision of ART

As noted above, the Economic, Social and Cultural Rights Committee has mandated that states have an obligation to provide a certain “core” minimum of rights, including: ensuring non-discriminatory access to health facilities, particularly for vulnerable or marginalized groups; providing essential drugs; ensuring equitable distribution of health facilities, goods and services; adopting and implementing a national public health strategy and plan of action with clear benchmarks and deadlines; and taking measures to prevent, treat and control epidemic and endemic diseases (UNCESCR, 2000). Further, according to the Committee, states have an *immediate obligation* to eliminate discrimination in access to health care, and to take concrete steps toward the full realization of the right to health.

The core minimum obligation to provide health care, which the Committee has explicitly noted, includes access to ART treatment drugs included on the WHO List of Essential Medicines.⁵ Some sources have argued that essential medicines, as part of the core of the right to health, are even subject to immediate rather than progressive realization. The UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health has noted that access to essential medicines is a “fundamental” part of the right to health (HUNT, 2006, p. 10-11). States have a duty to make existing medicines available within their borders

and to make sure that they are accessible, meaning that the medicines are available in all parts of the country, economically affordable for all and available without discrimination on any prohibited grounds, and that reliable information on the medicines must be available to patients and health professionals. States must also ensure that they are culturally acceptable (HUNT, 2006, p. 13). Indeed, according to the Special Rapporteur,

States have an immediate obligation to avoid discrimination and also to make certain pharmaceuticals — known as “essential medicines” — available and accessible throughout their jurisdictions. These core obligations of immediate effect are not subject to progressive realization. (HUNT, 2006, p. 14).

Thus,

[i]n summary, the right to health encompasses access to non-essential and essential medicines. While a State is required to progressively realise access to nonessential medicines, it has a core obligation of immediate effect to make essential medicines available and accessible throughout its jurisdiction. (HUNT, 2006, p. 15).

National governments, such as those of South Africa and Thailand, need to make essential ART treatments available to non-citizens and citizens alike in order to honor their commitment to non-discrimination in core health care services, which include the provision of essential medicines. These treatments need to be provided on the same terms without discrimination as to citizenship or residency status. Included in States obligation to provide free or low-cost ART irrespective of citizenship is, crucially, the duty to offer ART for Prevention of Mother-to-Child Transmission (PMTCT) for migrant HIV-positive pregnant women.

Furthermore, international donors position as dispensers of the funding for ART programs places them in a position of some authority when it comes to influencing state policy on the dispensation of funded drugs. International donors should exert their influence on national policymakers to ensure that national eligibility criteria are not discriminatory and that donor contributions are not used in a discriminatory manner. International donors should condition funding for ART drugs for the general population on the equal availability of these drugs to both citizens and non-citizens, including non-citizens with irregular and undocumented status. Adequate funding of ART for non-citizens is also essential to the success of any official policy granting access.

5.2 Cross-Border and Migrant-Friendly Treatment Mechanisms

Migrants, especially short-term, mobile ones, require additional attention from national governments and the international community in creating mechanisms to adequately provide continuity of care. Individuals who move frequently requiring ART are faced by multiple treatment challenges, as noted above. Cross-border tuberculosis (TB) treatment systems developed between the United States and Mexico may serve as an example for enabling care for mobile individuals (HARLOW, 1999, p. 1581). In the context of

HIV, neighboring states could work together to standardize health passports or health information cards used by individuals on both sides of the border so that consistent information is provided and health providers in multiple locations will be able to recognize a patient's health information, treatment stage, and required next steps. Next, states could discuss recommended treatment regimens with neighboring states with common migration routes so as to standardize drug regimens and ensure that patients can seamlessly switch treatment at a clinic from one side of the border to another. Further, while challenging, states could consider working across borders to provide an international registry or statistical database for collecting patient data in an accessible, confidential format. Additionally, states could provide translators in clinics along common border routes who speak the languages commonly spoken by migrants to the area.

International organizations and donors could aid states in creating each element of the cross-border treatment scheme. UNAIDS has called for “regional protocol for the standardization of HIV treatment, as well as a regional system and means to secure such treatment by affected individual[s]” (2008a, p. 6). Together with state governments, international organizations and donors could play a role in making sure that health passports, treatment regimens, and ART guidelines already implemented by governments are adjusted so show uniformity across borders. These actors could also crucially take part in establishing an international registry or database for collecting confidential patient data in an accessible format.

Additionally, international sources could be instrumental in hiring translators for clinics to aid in counseling migrants, in providing transport from migrant settlements or refugee camps to clinics, and in providing nutritional assistance and other supplementation to ART regimens to improve the health of migrants. Offering information in a format that is most accessible to the migrants—whether through a hotline, pamphlets, or verbal counseling—on locations of other clinics along common migrant routes and at the migrant's next destination could serve to help mobile populations access services. UNAIDS (2008a, p. 6) has also recommended the development of reception centers in each country providing information for migrants to access information and services, including referrals for health care.

6. Conclusion

UNAIDS has called for measures ensuring that

sending, transit and receiving countries have joint/tripartite health access programmes in place to address all possible time and place points on the moving continuum for citizens/migrant workers, including pre-departure, the migration itself, the initial period of adaptation, successful adaptation, return migration, and reintegration into the original community. (UNAIDS; IOM, 2001, p. v and 39).

The right to health care and to equality and non-discrimination create a commitment by states to provide a core of health care on the same terms as citizens even for non-citizens of irregular status. This statement of best practice and this requirement of international law,

have not, in practice, been met. The result is that millions of individuals fail to access the HIV treatment they need and risk needless health complications and premature death.

The benefits of allowing migrants to seek care early and to obtain medication for treatable disease, and the consequences of failing to provide this care, are considerable. Studies have documented that immigrants tend to be in better health upon arrival than native born individuals (McDONALD; KENNEDY, 2004, p. 1613-1627). Yet, lack of legal status, fear of detection, and legal restrictions on care lead to a lack of utilization of health services and delays in seeking care. This article provides suggestions for a way forward with the aim of increasing access to ART for non-citizens in countries of the Global South, including long-term and short-term migrants, and refugees. Only with concerted global effort on the part of states, international organizations, and donors, will migrants' right to health care, and particularly to ART, be fully realized. Legislative and programmatic action to eliminate citizenship-based discrimination and improve migrants' access to ART is not only dictated by public health considerations, but immediately required by international law.

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NOTES

- Note, however, that there is no internationally agreed-upon definition of "migrant" (Joint United Nations Programme on HIV/AIDS [UNAIDS]; International Organization for Migration [IOM], 2001, p. 1).
- Indeed, free access to HIV/AIDS treatment at point of service delivery has been determined by the WHO to be a component of universal access (SOUTEYRAND et al, 2008).
- For a discussion of the barriers in Thailand facing drug users in accessing HIV testing, support, and treatment, see Human Rights Watch (2007).
- Under international law, states have the right to control their borders and decide whom to admit or deport, following appropriate procedures and limited

by considerations of non-discrimination, prohibition of inhuman treatment, respect for family life, and other human rights and refugee law protections (UNhrc Human Rights Committee [unhrc], 1994a, para. 5). Non-citizens' rights to non-discrimination in core rights—such as health care—discussed in this document do not interfere with a nation's basic right to control its borders where otherwise condoned by international law.

- The WHO List of Essential Medicines includes antiretrovirals in three classes—nucleoside/nucleotide reverse transcriptase inhibitors, non-nucleoside reverse transcriptase inhibitors, and protease inhibitors—as essential drugs for the treatment and prevention of HIV (WHO, 2007).

RESUMO

Embora o direito internacional dos direitos humanos estabeleça o direito à saúde e à não discriminação, poucos países cumpriram com sua obrigação de oferecer tratamento de HIV para não cidadãos – incluindo refugiados, migrantes permanentes em situação irregular e migrantes transitórios. Dois países, África do Sul e Tailândia, ilustram como políticas e práticas governamentais discriminam não cidadãos negando-lhes o tratamento. Na África do Sul, ainda que indivíduos em situação irregular tenham direito a tratamento de saúde gratuito, incluindo a terapia antiretroviral, as instituições públicas de saúde frequentemente negam o tratamento antiretroviral àqueles que não são cidadãos sul-africanos. Na Tailândia, até mesmo entre migrantes regularizados, somente as mulheres grávidas têm direito à terapia antiretroviral. A fim de atender o direito internacional dos direitos humanos - que garante o fornecimento de um conjunto mínimo de serviços de saúde sem discriminação – os Estados do Sul Global e de todo o mundo devem disponibilizar drogas antiretrovirais e torná-las acessíveis aos migrantes nas mesmas condições que a seus cidadãos.

PALAVRAS-CHAVE

Migrante – HIV/AIDS – Terapia antiretroviral – Direitos humanos – Direito à saúde.

RESUMEN

Mientras que el derecho internacional de los derechos humanos establece el derecho a la salud y a la no discriminación, pocos países dan cumplimiento con sus obligaciones de proporcionar tratamiento contra el VIH a los no ciudadanos, incluyendo a los refugiados, los migrantes permanentes en situación irregular y migrantes temporarios. Dos países, Sudáfrica y Tailandia, dan ejemplos útiles de cómo las políticas públicas y sus prácticas discriminan a los no ciudadanos y se les niega atención médica. Aunque en Sudáfrica los individuos con estatus migratorio irregular gozan del derecho a la asistencia sanitaria gratuita, incluyendo el tratamiento antirretroviral (TAR), a los no ciudadanos sudafricanos se les niega frecuentemente el TAR en las instituciones de salud pública. En Tailandia, incluso entre los migrantes regulares, sólo las mujeres embarazadas tienen derecho al TAR. A fin de cumplir con las obligaciones internacionales de derechos humanos -que requieren de la provisión de un mínimo básico de servicios de salud sin discriminación- los estados en el sur global y en todo el mundo deben garantizar la disponibilidad y accesibilidad de los medicamentos esenciales para el TAR para los migrantes en las mismas condiciones que para los ciudadanos.

PALABRAS CLAVE

Migrantes – VIH/SIDA – Terapia antirretroviral – Derechos humanos. – Derecho a la salud.

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