CANDIDATE NUMBER 1088

SSM 1

CONVENOR Dr O‘NEILL

Word count 2905

IS IT ETHICAL TO DEPORT REFUSED ASYLUM SEEKERS SUFFERING FROM HIV BACK TO ZIMBABWE FROM THE UK?

Figure 1

"They said they would give me some medication but sometimes they don't give me all the combination. Sometimes I have to do without. It makes me very anxious. It is really scary. You don't know whether you are going to make It [2]*."*

Sitiwe (preferred not to give real name).

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Refugee and Asylum Seeker Health, Dr O'Neill

Word count 2905

Abstract

Background

Everyday asylum seekers face the fear of deportation; this fear is greatly increased if you are returning back to a country with poor health care and limited access to medication required to keep under control a chronic disease, in this case HIV. Without access to the required medication death is a certainty.

Aims

To explore current literature on the ethical implications of deporting a refused asylum seeker suffering from HIV back to Zimbabwe.

Method

Use a variety of data bases including AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE. Use News search engines including: The independent, The Guardian, The Times and The Telegraph. Use Primary sources (case studies).

Results

It is evident that this group of asylum seekers fear for their life with the prospect of deportation back to Zimbabwe. This is due to the poor health care system and unreliable source of antiretroviral drugs which are required to keep them alive.

Conclusion

It is unethical to send this group of people back to Zimbabwe with the current state of the health care system; however, it is not a practical solution to grant asylum to all immigrants from Zimbabwe who are HIV positive, as the United Kingdom doesn't have the facilities and resources required to treat all those infected by HIV in Zimbabwe.

Contents

Learning Objects

- Begin to understand why people flee their home country to seek sanctuary in another.
- To learn and gain awareness about the asylum process.
- To understand and compare differenced in health care available in the United Kingdom and Zimbabwe for the treatment of HIV
- Ethically look at the medical implications of deportation back to Zimbabwe for this group of people.

Core Learning Objectives

- Learn how to write a systematic review including how to reference, critically appraise articles and other data sources, collect data and present my findings.
- To visit various services for asylum seekers.
- To interview and record brief histories from asylum seekers.

AKNOWLEDGEMENT AND THANKS

I would like to thank all those who have helped me open my eyes to the reality of the struggle many are currently facing all over the world as they flee from persecution to countries where they seek the "right to life, liberty and security of person" (Article 3 of The Universal Declaration of Human Rights), but are denied this basic human right and are sent back to their home country. I would like to thank all the organisations I had the privilege to visit, the asylum seekers who gave me their time and told me their stories and special thanks to Siobhan and Dr O'Neill for their help and inspiration.

Definitions

Health

The World Health Organisation's definition of health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[3]". This has not changed since 1948

Human Rights

"Human rights are basic rights and freedoms that all people are entitled to regardless of nationality, sex, national or ethnic origin, race, religion, language, or other status" . Universal Declaration of Human Rights (1948) by the United Nations General Assembly consolidated the human rights that belong to each individual of the world. It is adopted and applied by countries of the European Council as the European Convention on Human Rights (ECHR)[4].

Asylum

Shelter or protection from danger [5]

Asylum Seeker

An individual that has applied for the right to remain within the UK for the purposes of safety in accordance with the 1951 United Nations Convention relating to the Status of Refugees. Individuals maintain the status of asylum seekers while their applications are being processed, and if their applications are rejected, they are entitled to appeal against their decision – during which they also remain asylum seekers in status [6]

Failed Asylum Seeker

"A failed asylum seeker is someone whose application for asylum has been refused by the UK authorities and has exhausted all rights of appeal… A failed asylum seeker has no legal entitlement to remain in the UK and should seek to leave the UK at the earliest opportunity" [6]

Refugee

A person who has been forced to leave their country in order to escape war, persecution, or natural disaster [5]

Deportation

The action of deporting a foreigner from a country [5]

Immigrant

A person who comes to live permanently in a foreign country [5]

Destitute

Extremely poor and lacking the means to provide for oneself [5]

HIV

Human immunodeficiency virus, a retrovirus which causes AIDS [5]

AIDS

A disease in which there is a severe loss of the body's cellular immunity, greatly lowering the resistance to infection and malignancy [5]

Introduction

The General Medical Council's guidelines "Good Medical Practice", is a list comprised of doctors "absolute duties". All doctors that are registered with the Council are expected to fulfil these duties (appendix 2). The duties are there so doctors are justified to have patients trust, with their life[7].

The Beauchamp and Childress four prima facie ethical principles (Appendix 3). These principles provide "a simple, accessible, and culturally neutral approach to thinking about ethical issues in health care" This gives all doctors the same principles and work ethic[8].

Together, these guidelines and principles help to ensure everyone is treated with the basic human rights as declared in "The universal declaration of human rights"[9].

Introduction to Asylum

Article 14, of The Universal Declaration of Human Rights

"Everyone has the right to seek and to enjoy in other countries asylum from persecution"

As declared on 10 December 1948 by the General Assembly of the United Nations, It states that everyone has the right to leave their home country and flee if being persecuted to another country where they can seek asylum[9].

Asylum on a global scale

Refugees, asylum seekers, internally displaced persons (IDPs), returnees (refugees and IDPs) stateless persons, and others of concern to The United Nations High Commissioner for Refugees (UNCHR) in 2009

Refugees	10,396500
Asylum seekers (pending cases)	983,900
Returned refugees	251,500
Absolute values IDPs protected/assisted	15,628,100
Returned IDPs	2,229,500
Stateless persons	6,559,600
Others of concern	411,700
Total	36,460,800

As is evident by the figures above, there are many people who fear for their lives in their country of origin and flee to find asylum in other countries. However not all the people who seek asylum in a country are granted asylum and are forcible deported back to their home country[10].

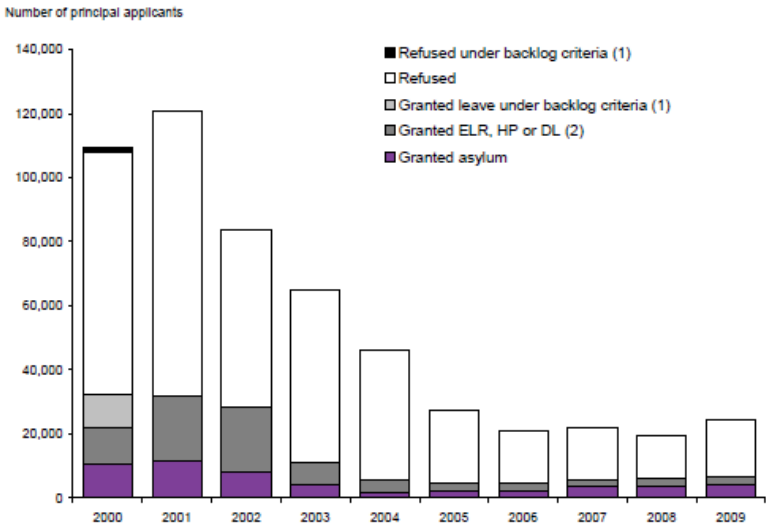
Asylum on a national scale, UK

Refugees, asylum seekers, stateless persons, and others of concern to (UNCHR) by country/territory of asylum, in the United Kingdom, end 2009[10]

Current number of refugees	Current number of asylum seeker pending cases	Current number of stateless	Overall population of concern
269363	12400	205	281968

As you can see from the above figures the United Kingdom is a destination for asylum seekers[10].

Figure 2.2: Initial decisions, 2000 to 2009 (principal applicants)



(1) Cases decided under measures aimed at reducing the pre-1996 asylum backlog.
(2) Humanitarian Protection and Discretionary Leave replaced Exceptional Leave to Remain from 1 April 2003.

As you can see by this graph however the number of people actually granted asylum in the United Kingdom is low, around 25%, the other 75% are refused and deported back to their country of origin [11].

Asylum seekers access to health care

Status of person	Access to primary health care	Access to secondary health care
Asylum seeker	YES	YES
Granted Discretionary Leave to Remain	YES	YES
Granted Humanitarian Protection	YES	YES
Refused asylum seekers	GP practices discretion	NO unless are considered to be "ordinary resident in the UK" If undergoing a course of hospital treatment at time their claim is rejected should continue to receive treatment free of charge until completion.
It remains the BMA's view that it is not the responsibility of individual doctors to make decisions about the immigration status of patients. Decisions regarding eligibility for treatment lie with trusts' Overseas Visitors Managers.[12]		

The Asylum Process in the UK

Application for Asylum

Screening interview

- Produce passport or travel document
- establish identity and nationality
- Take fingerprints, photograph, and any other physical identification information we think is required.[13]

Asylum interview

- Asked to explain reasons for seeking asylum in the United Kingdom.
- Must attend interview otherwise asylum will be refused.
- The full interview is only chance to say why they fear return to their country.
- Can bring legal representation. [15]

Case worker assigned

- Explain the asylum process to you;
- Invite you to the interview at which you will provide full details of your asylum application;
- Tell you how we expect you to stay in contact with us;
- Offer you help in finding legal representation; and
- Give you a form that confirms your address and any requirements you must follow, such as for reporting to us regularly[14]

Decision made

Refusal

Status granted

Appeal

Refusal

Asylum and refugees from Zimbabwe

Refugees, asylum seekers, stateless persons, and others of concern to UNCHR by country/territory of asylum, country of origin Zimbabwe, end 2009.

Current number of refugees	Number helped by UNCHR	Current number of asylum seeker pending cases	Returned refugees	Total population of concern
22449	921	1404	19	23872

As you can see there are still people fleeing Zimbabwe for fear of persecution and attempting to find asylum in other countries [10].

Introduction to HIV

HIV is the virus that can lead to acquired immune deficiency syndrome, or more commonly known as AIDS.

There are two types of HIV, HIV-1 and HIV-2. Both types of HIV damage a person's body by destroying specific blood cells, CD4+ T cells, which are essential to the body's immune system.

All people with HIV should be seen on a regular basis by a health care provider experienced with treating HIV infection. The medications can limit or slow down the destruction of the immune system, thereby improving the health of people living with HIV, and reducing (depending on the treatment used) their ability to transmit HIV.

Due to being infected by HIV, the body's immune system is weakened and therefore the body is weakened and the following diseases are associated with HIV: cardiovascular disease, kidney disease, liver disease, and cancer.

AIDS is the late stage of HIV infection, when a person's immune system is severely damaged and has difficulty fighting diseases and certain cancers. Before the development of certain medications, people with HIV could progress to AIDS in just a few years. Currently, people can live much longer, fuller and normal life.

Current medication to delay the effect of HIV has to be taken daily and for the rest of a person's life, they will also require consistent monitoring and may experience side effects with the medication.[16]

The global picture of HIV

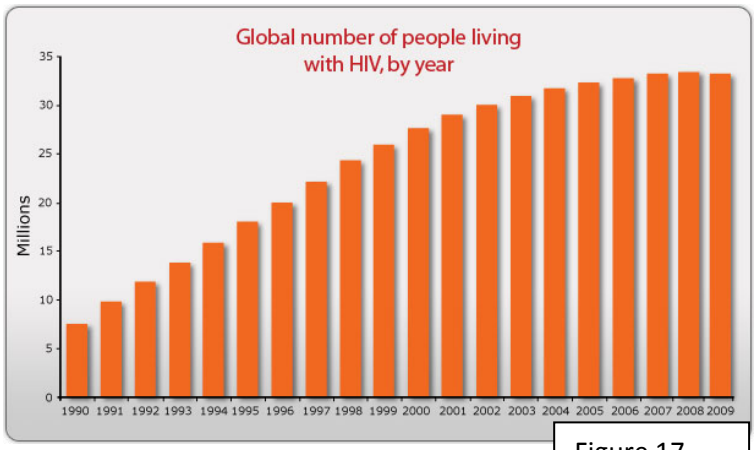


Figure 17

The graph shows a steady increase in the number of people living with HIV every year from 1990 to 2009. However the number of new reported cases each year is decreasing, this is likely to the development of antiretroviral therapy which is becoming increasingly available around the world[17]

Here on the global view of HIV infection you can see the epidemiology of the virus. Sub-Saharan Africa evidently has the highest prevalence of HIV.[18]

Zimbabwe Currently has the fifth highest prevalence of HIV in the world.[18]

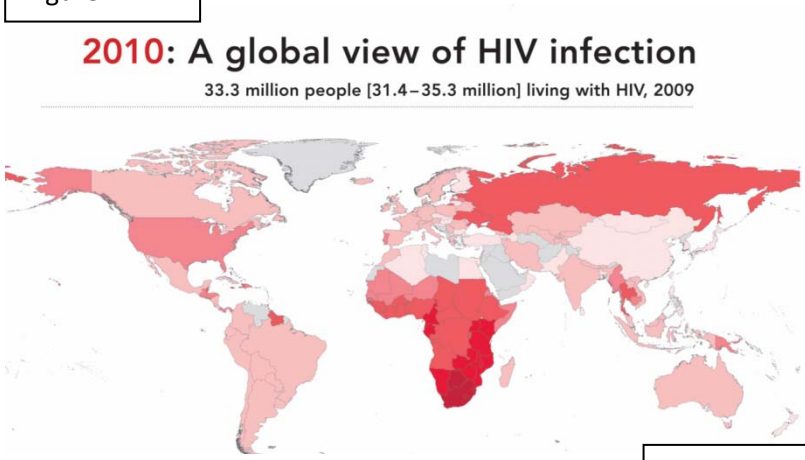


Figure 18

Access to HIV treatments Globally

At the start of the 21st century the access to HIV treatment in the developing world was limited primarily due to the high prices of antiretroviral drugs. In 2001 drug manufacturers in developing countries began to produce generic drugs at cheaper prices, bills where passed in sub-Saharan African countries making it legal for them to purchase these drugs from abroad. The vast reduction in price meant that these drugs were now available on a global scale. [19]

The graph below illustrates the effect of generic competition on proprietary drug prices between 2000 and 2001. It shows the lowest world price per patient per year of triple combination therapy.

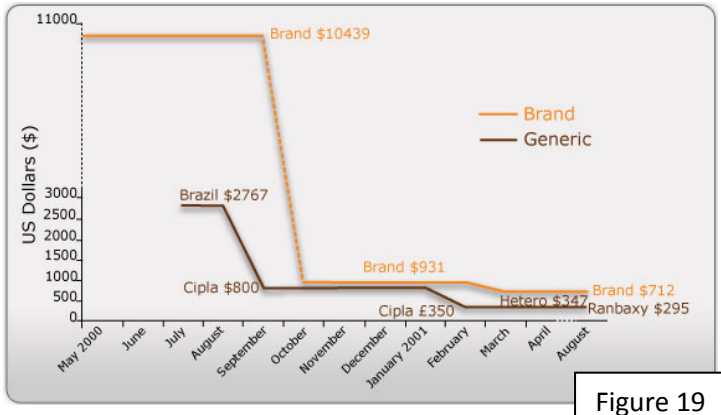
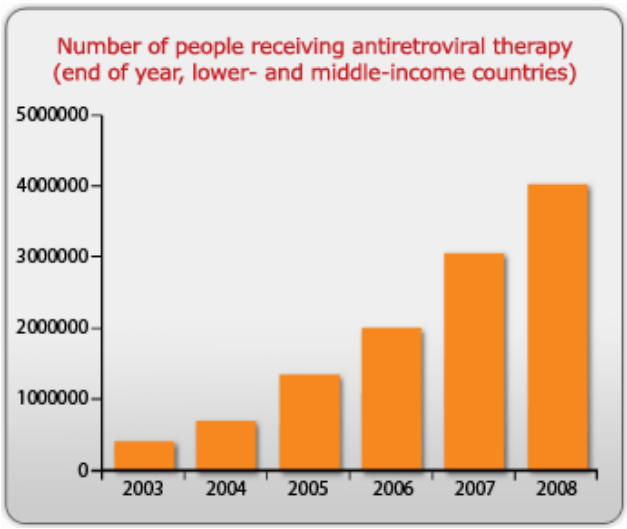


Figure 19



In 2003 the world health organization (WHO) created a target of 3million people in low and middle income countries to be provided with antiretroviral drugs (ARVs) by 2005. This is a small step towards the overall aim of universal access. The target of 3million people as you can see in the graph was obtained in 2007. The biggest difference in access to these drugs was seen in Sub-Saharan Africa where an eight fold increase was observed.[20]

Regional antiretroviral therapy coverage in low and middle developed countries

Region (lower- and middle-income countries)	Antiretroviral therapy coverage	Estimated number of people receiving antiretroviral therapy	Estimated number of people needing antiretroviral therapy
Sub-Saharan Africa	37%	3,911,000	10,600,000
Eastern and Southern Africa	41%	3,203,000	7,700,000
Western and Central Africa	25%	709,000	2,900,000
Latin America and the Caribbean	50%	478,000	950,000
Latin America	51%	425,000	840,000
The Caribbean	48%	52,400	110,000
East, South and South-East Asia	31%	739,000	2,400,000
Europe and Central Asia	19%	114,000	610,000
North Africa and the Middle East	11%	12,000	100,000
Total	36%	5,254,000	14,600,00

As you can see by the table, sub-Saharan Africa, accounts for 72 percent of antiretroviral therapy need globally. However it has one of the lowest actual coverage of only 37%. Consequently there is still another 63% of the infected community still requiring antiretroviral drugs.[20]

Comparing basic statistics of Zimbabwe and the UK

	UK	Zimbabwe
Population	**62,348,447**	11,651,858
Age structure 0-14 years	**16.7%**	**43.9%**
15-64 years	**67.1%**	**52.2%**
65+years	**16.2%**	**3.9%**
Median age	**40.9**	**17.8**
Population growth rate	**0.563%**	**2.954%**
Birth rate	12.34 births/1,000 population	31.57 births/1,000 population
Death rate	9.33 deaths/1,000 population	14.9 deaths/1,000 population
Infant mortality	4.69 deaths/1,000 live births	30.9 deaths/1,000 live births
Life expectancy at birth	79.92 years	47.55 years

Figure 21 and 22

It is evident from the above data that there are large differences in the demographics between the two populations.

- Zimbabwe has a much younger population compared to the UK
- Zimbabwe's life expectancy is a lot lower than the UK and has a considerably higher infant mortality rate.

Both of these statistics tend to indicate that the UK has a better health and hygiene system and is a more stable developed country compared to Zimbabwe

Comparing 2009 HIV statistics of the UK and Zimbabwe

Country	People living with HIV/AIDS	Adult (15-49) rate %	Women with HIV/AIDS	Children with HIV/AIDS	AIDS deaths	Orphans due to AIDS
United Kingdom	85,000	0.2	26,000		>1,000	
Zimbabwe	1,200,000	14.3	620,000	150,000	83,000	1,000,000

Figure 10

As you can see from this table there are substantially more people suffering from HIV in Zimbabwe during the year of 2009. The number of deaths in Zimbabwe is also extremely high comparatively to the UK as well as the number of people living with the virus. 6.9% of the Zimbabwe population suffering from HIV died due to the virus compared with 1.2% of the UK population suffering from the virus.[10]

Case Study Sarah

For confidentiality purposes I have used an alias name

Having been through the system, waited 5 years, and finally granted asylum, Sarah is one of the lucky, approximate 25% who have their asylum claim granted.

Today 25th January 2011, at LASAR in Leigh. Sarah aged 39 is sat before me wearing a black polo neck top, shift dress, tights and boots. Originally from Zimbabwe, employed as a journalist, married with two children aged eight and nine; she fled from the country for political reasons, leaving behind her husband though taking her two children of which both are currently studying in primary school at the time of this interview.

Sarah and her children arrived into London by aeroplane and claimed asylum about six years ago. She still remembers and occasionally feels the fear that gripped her during the journey and the first few weeks. She explains continuous fear of deportation which she believes would have ended in her being hurt with the possible resultant of death.

They were put into temporary accommodation for 8 months; here they experienced communication difficulties due to language barriers with the other occupants, before being put into permanent accommodation. The accommodation was fully furnished and she describes it is a *"nice house but home isn't here, home is Zimbabwe"*. Sarah and her children were given asylum seeker identification documents, and helped to be put in contact with the national asylum seeker service, who she describes as *"helpful and nice"*.

She described the state help available to her and her children; she received £35 for herself and £42 for each child a week which she collected from the post office. This total of £119 a week had to buy them everything apart from the accommodation costs which was provided for free and was basically furnished. School was also paid for and they had access to the NHS as well. However she said the help she received from LASAR was essential as it gave her the opportunity to socialize with people and not feel as lonely in this new county with an entirely new culture.

Having been used to working and being in a high social class, Sarah explains the difficulties of adaptation to suddenly being in a low class were some people treated them poorly and were bullied by the neighbours (accommodation provided was in a high crime area) and police were constantly being called around to sort out the problems. Not being able to work and provide for her family was also a major adaptation, *"suddenly finding myself with nothing to do but worry about our situation made it so much worse, stress was a big problem in that time"* Expanding on the stress she explains how she suffered from Post-Traumatic Stress Disorder and attended counselling sessions even now.

She then went on to describe her other health issues. Arriving in England she had a HIV test, this came back positive, since then she has been on medication and is currently responding well to treatment. Her children were also tested and the results came back negative for HIV. I asked her if she would be worried about her HIV status if she returned to Zimbabwe and she explained that although there are clinics she could attend easily, she would be worried about the lack of security of whether the medication would always be available to her as pharmaceutical stock isn't as well managed as in the UK. Consequently she is worried that with the lack of the medication she could quickly deteriorate with the possibility of death. I asked if she knew anybody who had experienced this problem back in Zimbabwe and she replied *"many people."*

Methodology

Before beginning the literature search using databases, journals and online sources; initial searches on internet sites were carried out to provide very basic background information on: the Asylum Process in the United Kingdom, current state of healthcare in Zimbabwe and HIV. This research was accompanied by a variety of visits to various local Liverpool Asylum Seekers help, aid and social venues; where meeting with a variety of Asylum seekers provided an insight into the likely outcomes of the project as well as valuable information which aided the project (see results).

Selecting criteria

Inclusion Criteria

- Articles must be in English
- Articles must relate to human beings
- Articles must be published within the last 5 years
- Full text must be available

Selecting Search terms

The PICO system[23] was used to select the search terms.

Terms may be used in isolation or combination

- Asylum seeker
- Immigrant
- Refugee
- Destitute
- Deportee
- Deportation
- HIV
- AIDS
- Zimbabwe
- Sub-Saharan Africa
- UK
- England

Search methods

For the literature search for this paper the following data bases will be used AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE using the NHS Evidence Health Information Resources (www.library.nhs.uk).

For the newspaper article search I will use the following broad sheet search engines, The Independent[24], The Guardian[25], The Times[26], and The Telegraph[27].

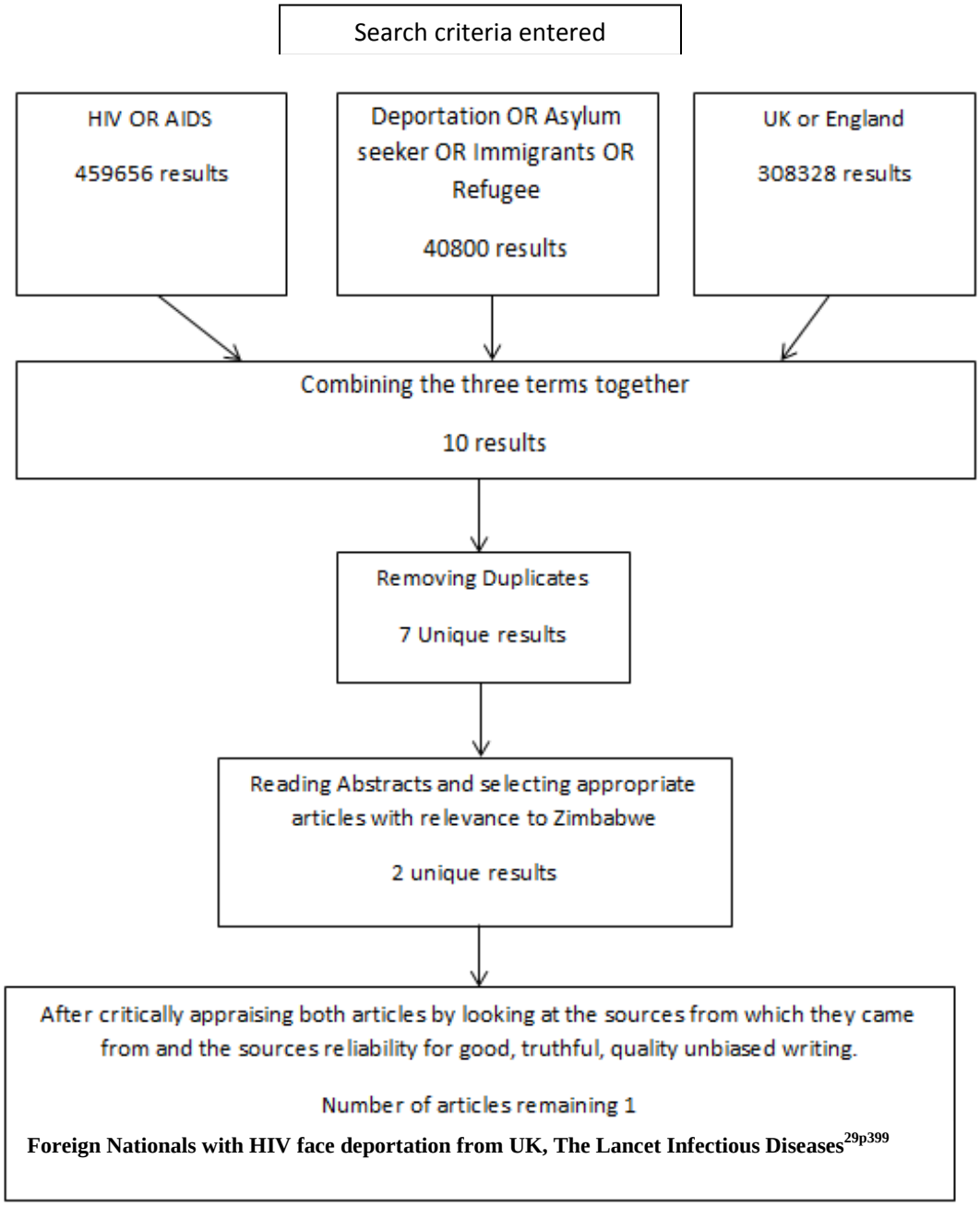
Choosing the studies

The abstracts will be read and then if are relevant to the project will be critically analysed to quality access them, this will be done were necessary by the CASP[28] technique.

Search results

Database search results

Data bases used AMED, BNI, EMBASE, HMIC, MEDLINE, PsycINFO, CINAHL, HEALTH BUSINESS ELITE



Newspaper engine search results

The Following results were obtained using the search terms below for the news article search.

- HIV
- UK
- Zimbabwe
- Deportation

	Number of articles originally	After reading abstracts	After critically apprising articles
The Independent	No results		
The Guardian	13 results	1 result	1 result
The Times	No results		
The Telegraph	2 results	No results	

Result of newspaper search

One suitable article was found titled, British Criticised for deporting HIV patients[30]

Other results of information obtained or discovered during initial research

Case study, Sarah

While doing initial research into the project interviews were conducted with several people to find out and gain a greater understanding of the Asylum Process. One of the people meet during this initial research time was an asylum seeker from Zimbabwe suffering from HIV. Her case study is a true account of her feelings, beliefs and experiences.

At the end of the interview verbal assurance was given that everything she said was to the best of her knowledge true.

A positive Partnership, The HIV immigration project 2003 -2009[31]

While doing initial research the project, A Positive Partnership, The HIV immigration project 2003 – 2009 was read[31]. The Project summary document had much relevant information. After critically appraising the project using the CASP technique, the project data was valid fit for use.

Internet website called Avert HIV and AIDS[32]

While doing initial research this website had a lot of good quality articles with a lot of useful, relevant data on HIV and AIDS in Zimbabwe.[33]

End Results

Name of articles	**Source**
Sarah	Case Study
A positive partnership The HIV immigration Project 2003-2009[31]	Project findings and Summary
British Criticised for deporting HIV patients[30]	Guardian article
Foreign Nationals With HIV face deportation from UK[29p399]	The Lancet Infectious Diseases
HIV and AIDS in Zimbabwe[33]	Website

Research Data

Due to the type of publications uncovered in the searches, all the data is qualitative. Having read through the articles there were several reoccurring themes these were

1. The idea that by being sent back to Zimbabwe it would equate to being sent back to die.
2. There is no reliable access to treatment

	Data from articles relating to lack of treatment in country of origin	**Data about the effect of deportation regarding medication for HIV in country of origin**	**Case studies within articles**	**Other Data of interest from the articles**
Case study Sarah	Easy to accesses to clinics however clinic may not have the required stock for the medication required	Unreliability of medication supply Sarah is worried her condition could quickly deteriorate with the possibility of death if she were to return to Zimbabwe	Not Applicable	Knows many people in Zimbabwe who have had problems regularly accessing the correct antiretroviral drugs.
A positive partnership The HIV immigration Project 2003-2009	Removal of a person living with HIV could constitute a breach of their human rights because appropriate treatment would not be accessible in their country of origin	Concerns that many women living with HIV could soon face enforced removal to countries where their health would deteriorate because of lack of access to appropriate treatment meaning they could die	Case Study k was diagnosed with HIV in the UK and stabilised on combination therapy. Her asylum was then refused. Using support services she was put in contact with another HIV positive woman who will meet with her on arrival and discuss potential treatments which may be available	Unlikely that women living with HIV would be protected from removal on the basis of their need to stay in the UK to access life-prolonging treatment. European Court of Human Rights decided that the Universal Declaration of Human Rights doesn't encompass the right to social welfare and consequently HIV treatment.
British Criticised for deporting HIV patients Guardian article	UK government, permits the deportation of people diagnosed in the UK with HIV to countries where they may not get the drugs they need to stay alive UK is sending back people to places where they have little hope of continuing their effective medication started in the UK	Virtually a death sentence Sending somebody back knowing if they are not able to get treatment they will die is a horrible contradiction It is really scary. You don't know if you are going to make it.	Sitiwe was on regular medication for HIV in the UK but was deported back to Zimbabwe. Now goes to the only clinic that can supply her with the three drug combination she needs. She sometimes leaves empty handed or with a different combination.	The UK has strongly supported the G8 pledge to get treatment to all people who need it in poor countries Solid progress in getting drugs available in Sub Saharan Africa therefore is a short term problem
Foreign Nationals With HIV face deportation from UK The Lancet Infectious Diseases	Deeply immoral to deport people suffering from HIV when they cannot get antiretroviral drugs in their home countries	Decision amounts to sending them to their death		Unfair to people with other serious diseases House of lords noted that a decision in her favour would risk drawing large numbers of individuals with HIV/AIDS into the UK
HIV and AIDS in Zimbabwe	Threat to health due to interruptions of regular supplies of ARVs. Physicians switching patients on established regimens due to lack of drug availability could all lead to drug resistant HIV strains developing. Women and children who live		A Statement by a HIV positive women in Zimbabwe "I said [to the doctor]: "Why have you tested me - you have just put me on a death sentence because I'm scared now because I know I am HIV positive. If you test me, it was to give me tablets." Here in Zimbabwe we don't have something like that. We don't have tablets"	Consultation fees charged in state public health institutions are deterring people from accessing any health services, including HIV testing and treatment, until their immune systems have become very weak. This is problematic not only for the patient, but for efforts to prevent further HIV transmission.

	in rural areas reportedly find it very difficult to obtain ARVs.			

Discussion

Currently there are 22,449 Zimbabwean refugees around the world; some of these reside in the United Kingdom.[10] Currently the Black African community makes up less than one percent of the United Kingdom's population. However Black Africans accounted for one third of all new HIV cases diagnosed in the year 2009[34]. While residing in the UK under Asylum or Refugee status, access is granted to full National Health Services for free[12]; consequently access to the antiretroviral medication, used as an effective treatment for HIV is available. The treatment stops the deterioration of the body's immune system and allows the body to recover from damage which may already have been caused by the virus.

On October 14th 2010, the minister for Immigration, Mr Damian Green announced the intention to end the current suspension of enforced returns of failed asylum seekers to Zimbabwe. This means that Zimbabweans may now face deportation either if their asylum is refused or when their refugee status expires[35].

It is evident looking at the results that for some HIV positive Zimbabweans, being deported back to Zimbabwe may prove to be a death sentence. The United Kingdom saw only 1.2% aids related deaths out of the HIV positive population unlike the 6.9% seen in Zimbabwe in the year 2009[10].

A major worry is the lack of security to a reliable source of antiretroviral drugs. It is essential during HIV treatment that there are no interruptions in the taking of the medication for the medication to have the greatest effect. With Zimbabwe being a known country for pharmacy's and clinics to run out of antiretroviral drug stocks, many people suffering from HIV face difficulty maintaining the treatment course. With unreliable antiretroviral drug stock many HIV suffering Zimbabweans face changes to their treatment or walking away empty handed which is known to occur as in the situation of the case study Sitiwe[31]. In 2007 it was estimated 90 000 people on antiretroviral which dwarfed the 300 000 thought to have need them in Zimbabwe[33].

Another severe problem for Zimbabwe's health system is the lack of qualified medical staff. Due to poor pay there has been a dramatic reduce in the number of Zimbabwe's doctors, nurses, and other professionals. Zimbabwe now has just one doctor for 12 000 people. With an approximation of only 800 doctors registered in the country; therefore, there can be long waiting times in the clinics and long administrative delays[33].

Access to the antiretroviral drugs is also difficult in Zimbabwe due to financial reasons. With only approximately 5% of the population currently employed[36], few people can afford the cost of the antiretroviral drugs easily. Clinics can also be a long

distance away and require another financial burden to get there[33]. Once in the Clinics due to the low level of doctors and health care professionals there can be long waits in the clinics. Clinical staff have also been known to expect bribes from people in exchange for their medication, this puts further financial burdens on people already struggling, this further reduced their access to the medication they require and can potentially cause deterioration in health[33].

All the articles show little faith in the health care system of Zimbabwe and mention fact that access to the necessary medication is unreliable. Further research into the Zimbabwe health service confirms the articles fears of lack of health care and medication provision when it comes to HIV[37].

The question remains then as to whether it is ethical to deport refused asylum seekers who are HIV positive back to Zimbabwe.

Article three of the Declaration of Human Rights states "everyone has the right to life, liberty and security of person" meaning all human beings should feel safe and have a right to live[4]. If the United Kingdom cannot guarantee the health and wellbeing of a HIV positive deportee on return to their home country then this person wouldn't have this basic human right to life, which could have been provided by the United Kingdom. The European Court of Human Rights; however, decided that the Universal Declaration of Human Rights didn't encompass the right to social welfare. Consequently, and Lawfully HIV positive asylum seekers can be deported back to Zimbabwe as the declaration of human rights doesn't include the right to government assistance or institutions and consequently for the right to access of the United Kingdoms' National Health Service[30].

All the articles portray a sense of fear felt by the HIV positive asylum seeker of their quality of life, if they were to return back to Zimbabwe. There were many quotes relating to a sense of death if they were to return due to the poor quality of health care. *"It is really scary. You don't know if you are going to make it"* and *"Returning would be a death sentence for them"*. As Article 3 of the declaration of human rights declares that everyone has the right to security, It is evident that these people suffering from HIV feel extremely insecure about their return to Zimbabwe and consequently is a violation against human rights which could be prevented if they were permitted to stay in the United Kingdom.

Looking at the situation of deporting a HIV positive person back to Zimbabwe, a country with known limited health care and regularly access to antiretroviral medication from the Beauchamp and Childress perspective, produces the following out comes:

Autonomy, by respecting the decision-making capacities of the person they should be able to make an informed choice on where they would like to carry on their treatment.

Beneficence, what is best for the person in terms of treatment should be taken into account, consequently with the services that the National Health Service provides in the United Kingdom, this being free antiretroviral drugs to all citizens, refugees and registered asylum seekers who require them and with no current problems with access to these drugs; then the United Kingdom would provide the best overall health care for this person.

Non maleficence, sending this person back to Zimbabwe could potential harm them as without regular routine check-ups and with the potential for medication to be unavailable for long periods, it could lead to a deterioration in health and the possibility of death. If the person remained in the United Kingdom with the access to the National Health Service there is smaller chance of harm to the patient and would therefore be preferable.

Justice, with the idea that everyone should be treated fairly and resources fairly distributed, than HIV positive failed asylum seekers should have the same access to treatment as others suffering from HIV. If deported back to Zimbabwe than access to treatment may become difficult unlike in the United Kingdom.

Therefore looking at this situation it would ethically be wrong to send back a HIV positive person to Zimbabwe. However, practically there aren't the resources to look after all the potential HIV positive immigrants from Zimbabwe if we declared that everyone from Zimbabwe who was HIV positive could receive free antiretroviral drugs in the UK.

Conclusion

- Zimbabwe's health care system cannot cope with the demand for the antiretroviral drugs resulting with people in Zimbabwe not getting the required treatment for HIV.
- Zimbabwe's Health care staff cannot cope with the demand and pressure of the number of people requiring HIV treatments.
- The United Kingdom's health care system has enough staff and antiretroviral drugs to look after its population including its refugee population.
- HIV positive asylum seekers and refugees currently fear the lack of and reliability of treatment available Zimbabwe
- All four ethical principles highlighted that remaining in the United Kingdom and receiving treatment from the National Health Service, providing it was the wishes of the person in question to remain in the United Kingdom, would be most beneficial and cause the least harm to the HIV positive person in question.

Consequently ethically it is wrong with Zimbabwe's current health system to send back to Zimbabwe refused asylum seekers, unless either they choose to go back or there is guaranteed reliable treatment available to them.

Recommendations

- With 1,200,000 HIV positive people currently in Zimbabwe it is not practical to be able to offer all the Zimbabweans suffering from HIV who come over to the United Kingdom and attempt to gain asylum seeker status a guarantee of treatment due to the lack of treatment available in their home country which would, ethically, be the right thing to do. Consequently these are the recommendations I would make:
- To provide treatment for all people suffering from HIV crossing the United Kingdom boarder in the final stages of AIDS until they recovered to a state of health were they could have a good quality of life
- Put HIV positive people being deported back to Zimbabwe in contact with other HIV sufferers of similar social and financial class who know and have good access to HIV treatments in similar areas of residence
- For the United Kingdom to continue its support to the G8 pledge to get treatment to all people who need it in poor countries
- Promote and educated people on safe sex and adherence to treatment in Zimbabwe to try and reduce the prevalence of HIV.

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Appendix 1

Reflection

Having started the special select module on 24th January 2011 extremely naive on the entire asylum process and the people who go through this often extremely stressful process, my entire view has altered in just a few short days. It has been a most eye opening and emotional experience. Hearing the way these people have fled from persecution from their home country to here, the North West of England, where they face continuous questioning and interrogations from the UK Home Boarder Agency are unfairly labelled by most of the UK population due to media influence, suffer from post-traumatic stress disorder, live in accommodation with other people who don't necessarily speak the same language, live on £35 a week and yet are still grateful to be here. The people I have met over the last few weeks have made a real difference to the way I see my life. They are some of the most incredible people I have ever met with incredible stories and I feel very privileged to have met them and wish them all the very best with their asylum claims and hope they can build the future they deserve in the UK until their country is ready to accept them back.

Appendix 2

Good Medical Practice: Duties of a doctor[7]

The duties of a doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
- Keep your professional knowledge and skills up to date
- Recognize and work within the limits of your competence
- Work with colleagues in the ways that best serve patients' interests
- Treat patients as individuals and respect their dignity
- Treat patients politely and considerately
- Respect patients' right to confidentiality
- Work in partnership with patients
- Listen to patients and respond to their concerns and preferences
- Give patients the information they want or need in a way they can understand
- Respect patients' right to reach decisions with you about their treatment and care
- Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
- Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
- Never discriminate unfairly against patients or colleagues
- Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.

Appendix 3

Beauchamp and Childress Principles of Medical Ethics[8]

Respect for autonomy: respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices.
Beneficence: this considers the balancing of benefits of treatment against the risks and costs; the healthcare professional should act in a way that benefits the patient
Non maleficence: avoiding the causation of harm; the healthcare professional should not harm the patient. All treatment involves some harm, even if minimal, but the harm should not be disproportionate to the benefits of treatment.
Justice: distributing benefits, risks and costs fairly; the notion that patients in similar positions should be treated in a similar manner.

Appendix 4

Timetable

January 24th Introduction to asylum and refugee Health	**January 25th** Visit to LASAR and LCIP	**January 26th** Visit to Asylum Link Merseyside	**January 27th** Visit to the Welsh refugee and asylum council, Methodist church and WRASSG	**January 28th** Fade Library	**January 29th** Read through notes made and begin to think of a Title	**January 30th** learn how to use referencing software
January 31st Select a title	**February 1st** Start searching for literature	**February 2nd** Continue search for literature	**February 3rd** select suitable critically appraised article and prepare a presentation	**February 4th** how to write a systematic review and presentation (change of title due to poor literature quality)	**February 5th** New article search	**February 6th** Articles selected
February 7th Lecture Day	**February 8th** methodology and results write up	**February 9th** Discussion, conclusion and recommendations write up	**February 10th** Abstract, appendix write up start Referencing	**February 11th** Read through, finish any referencing and upload onto the internet		