

# HEALTH, HOPE AND HOME?

The possibilities and constraints of voluntary return  
for African rejected asylum seekers and irregular  
migrants living with HIV in the Netherlands



IOM International Organization for Migration





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IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental body, IOM acts with its partners in the international community to assist in meeting the operational challenges of migration; advance understanding of migration issues; and uphold the human dignity and well-being of migrants.

This research report is published within the framework of the project 'Return Migration & Health III'. The research was conducted in the Netherlands, Angola, Cameroon, Ghana, Nigeria and Sierra Leone. The project was financed by the European Refugee Fund and the Dutch Ministry of Justice, and implemented by IOM in partnership with STI Aids Netherlands, the Working Group of HIV Consultants (WVAC) and the PharmAccess Foundation.

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January 2009

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# EXECUTIVE SUMMARY

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This report deals with the issue of voluntary return of HIV-positive Africans in the Netherlands, who have been rejected for asylum or are staying in the country as irregular migrants. Dutch immigration policy stipulates that any migrant without a legal status is under the obligation to leave the Netherlands, with voluntary return being the preferred way of meeting this obligation. In this report, we will examine under which conditions these HIV-positive migrants may be able to return voluntarily in a manner that allows for a sustainable situation in the country of origin. We will explore the possibilities of providing assistance to help create conditions for voluntary return, but also critically discuss constraints that are likely to be encountered in this return. The results of this exploration, which is primarily based on interviews with twelve migrants living with HIV in the Netherlands, and consultations with stakeholders in five African countries, can be summarised as follows:

- For most migrants living with HIV, *sustainable* return and reintegration requires that, at a minimum, the following conditions are met:
  - 1) necessary medical treatment (antiretroviral drugs, testing, treatment of opportunistic infections) is *available* and the returnee has *durable access* to such treatment;
  - 2) the returnee can acquire a sufficient income to cover regular expenses (food, accommodation, education, etc.) for him/herself and the family *and* to cover all costs related to medical treatment (also including transport to hospital, health insurance fees, etc.);
  - 3) the returnee finds a place within a supportive social network (family, peers, etc.) and has the ability to cope with possible stigma from society as a whole.

These conditions are seen as very closely interlinked: if one of these does not materialise, it is likely that other conditions cannot be met either.

- Attitudes towards return are generally very negative, as most migrants living with HIV do not believe that these conditions can be adequately met, particularly with regard to access to medical treatment. The certainty that they can access treatment in the Netherlands is an important motivator not to return. Not all migrants living with HIV have up-to-date information about the possibilities and constraints in their countries of origin, nor do they want to have this. Peers in the Netherlands often play an important role in the mental and physical survival of migrants living with HIV, but they can, in some cases, also reinforce a taboo on thinking about return.
- Whether the right conditions for voluntary return are in place (or can be created) can only be assessed by taking into consideration an individual's specific situation and the specific context in which he/she would return.
- From the level of the individual returnee, there are only limited means to influence these conditions. Many conditions are beyond the direct influence of the potential returnee or others assisting him/her. Acknowledging structural conditions, particularly in the country of return (including unavailability of certain types of treatment, poverty

and unemployment, widespread stigma and discrimination), is crucial in coming to a well-informed decision about return.

- When conditions *can* be influenced at the individual level, the most important ‘instrument’ for doing so is the returnee him/herself. A positive outlook on a future in the country of origin, motivation and a proactive attitude are essential for achieving sustainable return and reintegration.
- Assistance by third parties (IOM, civil society actors) in the return process is most likely to be useful with regard to:
  - 1) information gathering on medical, economic and social conditions in the countries of origin and provision of referrals;
  - 2) providing resources to assist the development of income generating activities for the returnee and/or his/her family. A stable economic situation is a precondition for durable access to medical treatment and can have a very positive impact on the social support network available to the returnee.
- Providing return assistance may also lead to ethical questions, including:
  - Are HIV-positive returnees an added burden on their (often already vulnerable) communities in their countries of origin?
  - Should return assistance be focused specifically on migrants living with HIV or does this discriminate against other groups (e.g. migrants with other illnesses)
  - Which limits do assistance providers put on their responsibility towards returnees?
  - Does voluntary return by an HIV-positive migrant have a negative impact on the chances of others who wish to remain in the Netherlands?
  - Can returning migrants living with HIV form a public health risk to their countries of origin?
- Dutch immigration policies are not always conducive to making voluntary return a viable option for migrants living with HIV:
  - 1) There is an enormous gap between the legal focus on *availability* of medical treatment in countries of origin, and the basis for decisions of migrants to return, which is related to de facto *accessibility* of this treatment.
  - 2) Returning without any option to come back to the Netherlands deprives returnees of a medical (and sometimes socio-economic) ‘safety net’. This is a major deterrent for migrants living with HIV to think about return.
  - 3) The consequences of not having a legal status (e.g. no access to social benefits, housing, etc.) can force migrants living with HIV in a very basic ‘survival mode’, which does not allow for reflection on future options, including voluntary return.

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## LIST OF ABBREVIATIONS

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AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
ART	Antiretroviral Therapy
AVR	Assisted Voluntary Return
BMA	Bureau for Medical Advice (Netherlands Ministry of Justice)
DT&V	Netherlands Return and Departure Service ( <i>Dienst Terugkeer &amp; Vertrek</i> )
ECRE	European Council for Refugees and Exiles
EMN	European Migration Network
ERF	European Refugee Fund
HIV	Human Immunodeficiency Virus
HMF	HIV Monitoring Foundation
HRT	Return and Reintegration Regulation ( <i>Herintegratieregeling Terugkeer</i> )
IOM	International Organisation for Migration
IND	Immigration and Naturalisation Service
MVV	Authorisation for Temporary Stay ( <i>Machtiging Voorlopig Verblijf</i> )
NGO	Non-Governmental Organisation
PEPFAR	President's Emergency Plan for AIDS Relief
REAN	Return and Emigration from the Netherlands programme
RMH III	Return Migration and Health III project
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
Vc	Dutch Aliens Act 2000 Implementation Guidelines ( <i>Vreemdelingencirculaire</i> )
WVAC	Working Group of HIV and AIDS Consultants and Nurses ( <i>Werkgroep HIV-Consultants en Verpleegkundigen</i> )
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees

# Part I: Background



# CHAPTER 1 – INTRODUCTION

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## 1.1 HIV-POSITIVE AND NO LEGAL STATUS: WHAT NEXT?

### *1.1.1 The obligation to leave the Netherlands*

This report deals with the issue of ‘voluntary return’<sup>1</sup> of African migrants living with HIV in the Netherlands. A considerable proportion of non-Dutch persons living with HIV in the Netherlands are migrants<sup>2</sup> from Sub-Saharan Africa. Among them are rejected asylum seekers and irregular migrants, who do not have a legal status that permits them to reside in their host country. Dutch immigration law states that any migrant without such a status is obliged to leave the Netherlands, with voluntary return being the preferred way of meeting this obligation<sup>3</sup>. While a decision to return is a difficult one for any migrant without a legal status, the obligation to leave is particularly problematic for those who are living with HIV. In the eyes of many of them, the difficulties in accessing medical treatment in their countries of origin makes return equivalent to ‘a death sentence’. This, however, is by no means the only reason for their negative perception of return, as shall be discussed at length in this report.

Not a lot is known about the way that rejected asylum seekers and irregular migrants living with HIV deal with return, and which factors influence the decisions they make when confronted with this issue. With this report, a first – if tentative – attempt is made to explore this more thoroughly. It does so by drawing on interviews with several migrants living with HIV in the Netherlands, as well as the results of visits to five African countries that often receive returnees from the Netherlands<sup>4</sup>. These efforts were part of the Return Migration and Health III project (see 1.3), which had the aim of creating a better understanding of:

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<sup>1</sup> The term ‘voluntary return’ is by no means an uncontroversial one. We will adhere to the use of this wording for the simple reason that is the terminology used in policy documents to refer to those instances in which migrants, either with or without external assistance, leave their host country out of their own initiative, rather than being forcibly removed by the authorities of that country. However, different authors have suggested alternatives, which they feel might better cover the realities as faced by migrants who are obliged to leave their host country. These include ‘mandatory return’ and ‘independent return’ (e.g. ECRE 2003). The issue of what constitutes voluntary return and the role of voluntariness and choice will be discussed in more detail in section 4.2.

<sup>2</sup> For the purposes of this report, the term ‘migrant’ means any non-national who has migrated to another country in order to establish him/herself for a prolonged period or permanently. Although often the term migrant is used to distinguish those migrating for ‘economic’ reasons from asylum seekers or refugees who have migrated in order to find protection from persecution or violence, we use the term here to encompass both groups. Where it is necessary to make a distinction between these groups (for example, when speaking about their legal status in the Netherlands) we will specify this (e.g. by using the term ‘asylum seeker’ or ‘irregular migrant’).

<sup>3</sup> It should be noted that a failure to comply with the obligation to leave the Netherlands can lead to forced removal from the Netherlands. The issue of forced removal of migrants by the authorities of the host country is outside the scope of this research, as this does not provide the migrant with a ‘choice’ between different options. This does not mean, as we shall see, that the threat of forced removal does not have a significant impact on a migrant’s attitude towards the issue of voluntary return.

<sup>4</sup> These countries are: Angola, Cameroon, Ghana, Nigeria and Sierra Leone. The rationale for the choice of these five countries will be discussed in more detail in section 2.5.2 of this report.

- the current legal and policy frameworks that govern the situation of migrants living with HIV in the Netherlands;
- the situation faced by HIV-positive migrants in the Netherlands when they are rejected for asylum or otherwise do not have the right to remain;
- the practical possibilities and impossibilities of voluntary return for these migrants;
- the conditions under which voluntary return, with respect for the migrant's well-being and dignity, could be a suitable alternative to irregular stay in the Netherlands; and
- the feasibility of providing assistance in support of the return and reintegration of migrants living with HIV.

These issues are discussed, first of all, in light of current policies and practices. This provides us with a starting point to further inform the development of future policies and practices related to the voluntary return of migrants living with HIV, and to identify issues that require further exploration in order to improve these policies and practices.

### ***1.1.2 Ethical considerations related to the return of migrants living with HIV***

A policy and practice-oriented discussion cannot take place in a moral vacuum. From very early on in the research process it became clear that the issue of return of migrants living with HIV provoked strong emotions among both the migrants themselves and the professionals who worked with them. Our encounters with them inevitably led to discussions of the ethical dimensions of this issue. Originally, the research was not intended to focus on these ethical questions. However, as the research progressed, these questions, rather than merely being the 'by-products' of the process, began to emerge as fundamental to the problem of return for persons living with HIV. As such, reflecting on these questions has become an integral part of this attempt to better understand the issue of return and HIV. It is important to note that this report will not provide any definitive answers to these questions. This will require further debate among the various stakeholders concerned. The identification of relevant issues in this report, however, can provide an impetus for such debate.

## **1.2 AFRICAN MIGRANTS AND HIV**

It is difficult to get a clear picture of the number of Africans living with HIV in the Netherlands, and even more so to gain an insight into their legal status. In general, it can be said that Africans form a significant group among persons living with HIV in the Netherlands. In June 2007 there were more than 13,000 persons known to be living with HIV in the Netherlands (UNGASS 2007)<sup>5</sup>. Approximately 17 percent of these were of Sub-Saharan African origin (this represents almost one third of all persons of non-Dutch origin living with HIV in the Netherlands). An overview of the number of Africans living with HIV in the Netherlands is provided in box 1. It should be noted that these statistics are based on country of birth, rather than the legal status of these persons, and does not distinguish between persons with Dutch citizenship who were born in other countries, foreigners holding Dutch residency permits, asylum seekers still in procedure, or irregular migrants. As such, they tell us little about the proportion of people with precarious legal statuses.

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<sup>5</sup> This only includes cases that are registered in Dutch hospitals. In May 2008, an Aidsfonds campaign was launched to address the issue that a significant number of people living with HIV were unaware of their HIV-positive status. The total number of persons infected is was estimated to be around 18,500 in 2007 (UNGASS 2007).

**Box 1: Persons of African birth living in the Netherlands known to be HIV-positive (June 2007)<sup>6</sup>**

Country	#	Country	#	Country	#
Angola	113	Ghana	243	Nigeria	133
Burkina Faso	13	Gambia	5	Rwanda	127
Burundi	154	Guinea	57	Seychelles	1
Benin	7	Eq. Guinea	2	Sudan	65
Botswana	6	Guinea-Bissau	8	Sierra Leone	126
DR Congo	112	Kenya	71	Senegal	13
CAR	3	Liberia	68	Somalia	101
Chad	2	Madagascar	2	Tanzania	31
Rep. of Congo	93	Mali	4	Togo	40
Côte d'Ivoire	47	Mauritania	11	Uganda	58
Cameroon	162	Malawi	8	South Africa	58
Cape Verde	56	Mozambique	13	Zambia	60
Eritrea	51	Namibia	3	Zimbabwe	35
Ethiopia	185	Niger	5		

A small-scale survey, undertaken as part of this research, helps to shed a bit more light on this issue. Box 2 (next page) provides an overview of the (presumed) legal status of 85 African migrants living with HIV, as known by health care staff in thirteen hospitals<sup>7</sup>. More than forty percent of the included migrants were believed to be in an uncertain situation regarding their possibility to stay in the Netherlands. Another twenty percent were believed to have had their claims rejected or never tried to obtain a legal status in the Netherlands, thus facing a legal obligation to leave the country. While this survey is by no means representative of the entire population of African migrants living with HIV, it does show that there may be a potentially large group that is forced to make a 'choice' between irregular stay or fulfilling the legal obligation to leave the Netherlands at some point during their stay.

<sup>6</sup> These figures represent the state of the HIV Monitoring Foundation's database as of June 2007.

<sup>7</sup> The survey was undertaken by WVAC (see box 3) between March and August 2007, as part of the research project presented in this report. The research team would like to thank the members of WVAC for their kind cooperation. The figures provided are based what health care providers knew of the legal status of their patients. As this status is sometimes difficult to accurately pin down, both by migrants themselves and by health care providers, these figures are merely indicative and not verified through other sources.

**Box 2: Migrants living with HIV and their legal status (n = 85)**

<b>Legal status</b>	<b>#</b>	<b>% of total</b>
Temporary or permanent right to remain		
• asylum status	4	4.7%
• regular grounds	24	28.2%
• grounds unknown	1	1.2%
<b>Sub-total</b>	<b>29</b>	<b>34.1%</b>
Still in procedure		
• asylum procedure	19	22.4%
• regular procedure	16	18.8%
• type of procedure unknown	2	2.4%
<b>Sub-total</b>	<b>37</b>	<b>43.5%</b>
No right to remain		
• asylum application rejected	7	8.2%
• application for regular status rejected	2	2.4%
• both asylum and regular applications rejected	3	3.5%
• no attempt to gain (asylum or regular) status	5	5.9%
<b>Sub-total</b>	<b>17</b>	<b>20.0%</b>
Unknown status	2	2.4%
<b>TOTAL</b>	<b>85</b>	<b>100%</b>

Furthermore, the development of HIV treatment initiatives in almost all African countries, in conjunction with the current focus of Dutch immigration law regarding migrants with medical conditions, may lead to an increase of migrants living with HIV who face such a situation. In short, (temporary) residency on medical grounds – which is an important avenue for gaining a legal status for migrants living with HIV – is primarily dependent on the availability of appropriate medical treatment in the country of origin of the migrant. As HIV treatment options in various African countries expand, this may lead to more migrants living with HIV being legally obliged to leave the Netherlands<sup>8</sup>. At the same time, many migrants and professionals working with them have been strongly critical of migrants living with HIV being told to return. They question whether current developments in the expansion of treatment programmes in African countries are actually contributing to better access to treatment. They argue that, in many cases, treatment being available in a particular country does not mean that the HIV-positive returnee will actually be able to enjoy that treatment.<sup>9</sup>

These circumstances all played a part in the development of the Return Migration and Health III research project. A brief explanation of this project will be provided in section 1.3, as it forms the organisational background against which the results and conclusions set out in this report need to be understood.

<sup>8</sup> In chapter 3, the Dutch policy regarding residency on medical grounds is discussed extensively.

<sup>9</sup> The debate on availability of treatment versus the de facto accessibility of treatment is a major bone of contention in legal procedures for residency on medical grounds. This debate will be discussed in more detail in chapter 3.

### 1.3 RETURN MIGRATION AND HEALTH III PROJECT

The research presented in this report is one of the main results of the two-year Return Migration and Health III project (RMH III)<sup>10</sup>, funded by the European Refugee Fund and co-funded by the Dutch Ministry of Justice. The immediate impetus for the project was formed by a small number of encounters of the staff of the International Organisation for Migration (IOM) with migrants living with HIV in the Netherlands, who requested assistance in returning to their countries of origin<sup>11</sup>. While IOM had been providing return assistance for rejected asylum seekers and irregular migrants since the early 1990s, the organisation had little experience dealing with the specific needs of HIV-positive returnees. Given its desire to be able to provide return assistance to all those who request it, IOM sought the advice of organisations in the field of HIV prevention and treatment, in particular Soa Aids Nederland, to discuss what could be done. IOM and Soa Aids Nederland jointly initiated discussions with other stakeholders in the field, including the project's other partners WVAC and PharmAccess Foundation (a brief description of all four organisations involved in the project is provided in box 3 below).

#### Box 3: Partners in the RMH III project

- The *International Organisation for Migration* (IOM), as the main organisation facilitating voluntary return from the Netherlands, was the lead agency in this project and carried the responsibility for its implementation<sup>12</sup>. In carrying out the project, IOM worked together with the three non-governmental organisations listed below. These organisations comprised the project's Advisory Board, providing advice on methodology, critical feedback on results and other support throughout the project's implementation.
- *Soa Aids Nederland*<sup>13</sup> is the national institute for sexually transmitted infection (STI) and AIDS control in the Netherlands. It works to prevent STIs and improve the quality of STI control in the Netherlands. Among other things, Soa Aids Nederland houses the national focal point for ethnic minorities and STIs, who was closely involved in the project. Soa Aids Nederland participated in the country studies on Ghana and Nigeria.
- The *Working Group of HIV and AIDS Consultants and Nurses* (WVAC)<sup>14</sup> The WVAC is an association of nurses and consultants dealing with HIV-positive patients in the twenty-five HIV-treatment locations for adults and five locations for children in the Netherlands. Besides from being a representative organ of HIV nurses and consultants, the WVAC works on information dissemination and knowledge development on HIV treatment and care issues.

<sup>10</sup> RMH III is a follow-up of earlier projects by the International Organisation for Migration in the Netherlands, which were concerned, respectively, with voluntary return of migrants with health problems in general (RMH), and the voluntary return of migrants with psychiatric disorders, including a particular focus on schizophrenia (RMH II). Publications that resulted from these earlier project include Conze and Muller (2004) and Engelhard (2004).

<sup>11</sup> As shall be discussed in more detail (see section 3.6), IOM in the Netherlands provides assistance to migrants who wish to return to their countries of origin, , particularly those who are faced with an obligation to leave the Netherlands, or expect to be faced with the obligation in the near future.. This assistance includes the provision of an air ticket to the country of origin and, for particular groups, a reintegration grant. IOM's assistance is limited to those migrants who return 'voluntarily' (also see footnote 1). The organisation is prohibited by its international mandate from assisting in the forced return of migrants (article 1(1)(d) of the IOM Constitution).

<sup>12</sup> The role of IOM in voluntary return programmes will be discussed in more detail in chapter 3. For more information on the activities of IOM in the Netherlands, see [www.iom-nederland.nl](http://www.iom-nederland.nl). For information on IOM's worldwide programmes, see [www.iom.int](http://www.iom.int).

<sup>13</sup> For more information, see [www.soaaids.nl](http://www.soaaids.nl).

<sup>14</sup> For more information, see [www.wvac.nl](http://www.wvac.nl) (in Dutch only).

<sup>15</sup> For more information, see [www.pharmaccess.org](http://www.pharmaccess.org).

- *PharmAccess Foundation*<sup>15</sup> is a Dutch not-for-profit organisation supporting access to HIV treatment, primarily in Sub-Saharan Africa. To this end, PharmAccess Foundation provides quality assessments of treatment sites, training and monitoring, and implements various projects, including workplace programmes.

In these discussions, it was confirmed that there might be a broader need among certain categories of migrants living with HIV, for assistance in their return, and especially in their sustainable reintegration in their countries of origin. However, it was also acknowledged that how such assistance could be implemented, should be explored in more detail before developing specific activities. The desirability of such an exploration was primarily prompted by the lack of in-depth information about the experiences of migrants living with HIV who have to choose between returning and staying in the Netherlands. Additionally, it was noted that those organisations that worked closely with HIV-positive migrants in the Netherlands, had little experience and knowledge of the issue of return. This led to the development of the RMH III project, which was both intended to bridge the knowledge gap between the ‘migration’ and the ‘HIV’ parties at the table, and, ultimately, to move towards a better understanding of voluntary return as a practical solution to the problem of irregular stay in the Netherlands by migrants living with HIV. Additionally, the RMH III project incorporated a pilot, in which return and reintegration assistance – based on the insights gained through the research – would be made available to a small number of HIV-positive migrants who considered returning.

#### **Box 4: A hidden agenda?**

Throughout the project, there was an inherent tension between the knowledge-building aspect and the development of interventions for migrants living with HIV. Several interlocutors suggested that the fact that the provision of return assistance was an integral part of the project, this would bias the research’s towards the issue how migrants living with HIV could be ‘made’ to return, rather than answering the fundamental question whether it would actually be feasible and desirable to actively engage in return assistance for this group. IOM’s position as a major player in the Dutch government’s return strategy (see sections 3.5 and 3.6) also contributed to concerns about the objectiveness of the research. After all, would IOM in the Netherlands, as an agency with a primary focus on facilitating voluntary return, not have a vested interest in suggesting that return for migrants living with HIV would be desirable? And would it not be in the interest of the Dutch government (one of the funders of the project) to hear that there were ample opportunities for migrants living with HIV to return?

In reaction to this, discussions followed in which it was explained that there was no intention to use the project to significantly increase the number of returnees living with HIV. Rather, its aim was to look at the possibilities of better assisting those migrants living with HIV who already had an intention of returning (such as those who had approached IOM in the past) and to inform those who were weighing up their options. Nevertheless, it should be noted that by the time of the publication of this report the provision of assistance to migrants living with HIV will have started. The decision to go ahead with the development of assistance activities, however, is no longer merely the product of the project’s initial design, but also of a well-considered deliberation that – in specific circumstances – return assistance to migrants living with HIV may both be desirable and possible. The rationale behind this deliberation, as well as the limitations it entails, will be discussed at length throughout this report. Additionally, one of the outcomes of the discussions with various stakeholders was that more focus was put on raising awareness and facilitating policy-level dialogue about the situation of migrants living with HIV without a legal status, and which alternatives – both in the Netherlands and in their countries of origin – should be made available for them.

## 1.4 CHAPTER OVERVIEW

In the next chapter, we will first describe the methodological approaches through which we have gained our results. Chapter 3 describes the legal and policy framework that governs the situation of migrants living with HIV in the Netherlands. Chapter 4 discusses some of the basic concepts related to the issue of voluntary return and it provides a frame of reference for understanding migrants' decisions to return or to stay.

These general chapters are followed by six chapters in which we present our main findings. Chapter 5 presents the results of interviews with twelve migrants living with HIV in the Netherlands. Chapters 6 to 10 outline the results of the visits to five African countries (Sierra Leone, Ghana, Nigeria, Angola and Cameroon respectively), in which the possibilities and constraints of reintegration in those countries were explored. Chapter 11 links the findings from the interviews with those of the country studies. Chapter 12 provides the major conclusions about the desirability, possibilities and limitations of return, and the specific role that return assistance can play in this respect. It also includes recommendations for how such assistance could take shape. Chapter 13, finally, provides a closer look at current Dutch immigration and residence policies towards migrants living with HIV, and how these impact on the possibilities of these migrants to find sustainable perspectives for their futures.



# CHAPTER 2 – METHODOLOGY

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## 2.1 OVERVIEW OF METHODOLOGY

In gathering information about the possibilities and constraints of the return of migrants living with HIV, the following instruments have been used:

- a literature review;
- ongoing consultations with experts in the Netherlands;
- interviews with individual migrants living with HIV in the Netherlands; and
- interviews with stakeholders in five African countries.

In this chapter, we will briefly discuss each of these instruments in turn, beginning with the two that were primarily aimed at gathering information on the broader context of our research topic: the literature review and expert consultations. Subsequently, we deal with the target group interviews and the country studies respectively, which form the core of our research, as they provide more specific insight into the issue of return for African migrants living with HIV.

## 2.2 LITERATURE REVIEW

A fairly broad academic and practice-oriented body of literature exists on both the issue of (voluntary) return of rejected asylum seekers and irregular migrants, and on the issue HIV among migrant communities in the West. However, there is a significant gap in knowledge where these two issues meet; no specific research has on the return of migrants living with HIV from Europe or other Western countries is available. This does not mean that existing sources cannot help us gain some insight into this topic. The body of work on the issue of return, for example, provides valuable information on the challenges for migrants who are not HIV-positive in deciding whether to return and in their actual return and reintegration. Quite a few of these challenges are no different for migrants living with HIV, although the latter group is likely to face additional constraints. Additionally, there is an increasing research focus on the linkages between mobility and HIV, which also provides some insights into the specific issue of return migration. Finally, there is extensive information available on the lives and survival of people living with HIV in Africa. This is particularly relevant to our purposes, since this literature deals with the situation that migrants living with HIV would find themselves in should they return. These different sources have provided much of the ‘ground work’ for this research, in terms of:

- being the theoretical background for the development of the target group interviews and country studies;
- providing a description of the legal and policy frameworks that govern the situation of migrants living with HIV in the Netherlands;
- being an instrument for verification of, and critical reflection on, the research results.

The literature review is primarily incorporated in the next two chapters, which provide a description of the policy and legal context governing the situation of migrants living with HIV in the Netherlands, and a discussion of the theoretical concepts and frameworks used in this report respectively.

## 2.3 CONSULTATIONS WITH EXPERTS IN THE NETHERLANDS

Various health care professionals, assistance providers, representatives of migrant organisations and others, collectively referred to here as ‘experts’, were consulted during the research process. These experts included representatives of charities providing assistance and support to migrants living with HIV, representatives of community-based organisations, staff of municipal health services, a physician and several IOM staff members who had encountered migrants living with HIV who wanted to return. The consultations were usually of an informal nature, but they yielded lot of information about perceptions of the issue of return for migrants living with HIV, about the different organisations that are involved with this group, and about the practical dilemmas encountered by aid and health care workers. Perhaps most importantly, these discussions inevitably led to critical questions about the desirability of return, and the roles that different actors, most notably the Dutch government and IOM, play herein.

In addition to these ad hoc consultations, the research process provided for structural discussion through the project’s Advisory Board. The Advisory Board provided a platform for discussion and reflection not only on the results of the research, but also on the research process itself. The sessions with the Advisory Board were complemented by a number of one-on-one meetings between IOM’s researchers and representatives of the three individual NGOs involved.

Finally, the preliminary results of the research were presented during several conferences, i.e. the 2<sup>nd</sup> and 3<sup>rd</sup> Annual Conferences on Ethnic Minorities and STI/HIV Prevention (5 October 2007 and 3 October 2008), and the 11<sup>th</sup> National Conference on STIs, HIV and AIDS (30 November 2007)<sup>16</sup>. The subsequent discussions with civil society actors and migrants also provided a lot of valuable input for this report.

Like the literature review, the discussions with experts have mainly provided a basis for the verification and for critical discussion of the results of the target group interviews and the country assessments.

## 2.4 TARGET GROUP INTERVIEWS

### 2.4.1 Main objective

The main objective of the target group interviews was to ensure that our discussion of voluntary return for migrants living with HIV would incorporate the experiences and perceptions of these migrants themselves. In other words, it was a means to ensure that we did not only engage in a discussion *about* voluntary return of migrants living with HIV, but also to discuss voluntary return *with* migrants living with HIV<sup>17</sup>. The interviews were aimed at uncovering their opinions, experiences, expectations, hopes and fears related to the issues of

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<sup>16</sup> These conferences were organised by Soa Aids Nederland. The research team thanks Soa Aids Nederland for its invitation and the opportunity to speak at these conferences.

<sup>17</sup> Although this discussion with migrants was mostly sought to obtain information, the encounters have – in some cases – also led to further reflection by migrants about their futures; in particular with the information that extra assistance to rebuild their lives in their countries of origin might become available. As shall be discussed in chapter eleven, this ‘thinking about ones future’ is an essential part of ensuring a migrant’s well-being, either in the Netherlands or in his/her country of origin.

living without a legal status and the possibility of return. In chapter five, these results will be discussed at length.

#### **2.4.2 Selection of respondents**

The target group of this research was initially limited to African (rejected) asylum seekers<sup>18</sup>, and particularly those from the five countries that would be included in the country studies (see section 2.5). This limitation in the target group, however, proved to be untenable, for various reasons.

First of all, a major issue in terms of selection was the practical problem of how to get people to participate in the interviews. IOM in the Netherlands had not previously been engaged in issues concerning HIV, and as such had no networks of its own among groups of migrants living with HIV. As such, it had to rely primarily on the contacts provided by the project's NGO partners, who brought the researchers in touch with several organisations dealing directly with migrants. These were asked to mediate between the researchers and potential respondents. For this to be possible, in some cases, hesitations about the objectives of the research, as well as IOM's role as an organisation implementing governmental return policies, had to be overcome. Personal meetings with representatives of these organisations helped to allay their fears to some extent, and a number of organisations eventually helped establish contacts between the researchers and the migrants.

While being a good method for gaining access to migrants living with HIV, the use of mediators significantly influenced the composition of the eventual group of respondents. The mediating organisations were provided with information about the research, and the desired profiles of respondents. It was left up to them to pass on this information to persons who might potentially agree to be interviewed. Only when a person agreed to be interviewed the research team was notified and arrangements were made for the interview. Persons who were approached by the mediators, but who declined to participate in the interviews, never had any dealings with the research team. This method provided target group members a high degree of anonymity, and the research team the assurance that participation in the interviews was strictly voluntary. This did mean, however, that the mediators formed a filter in the selection process<sup>19</sup>. Also, mediators sometimes only had access to specific groups (e.g. West-Africans, women, etc.), which of course limited their ability to meet the 'demand' for certain profiles of respondents. Adhering strictly to the profiles, due to the sensitive nature of the subject and the process of selection, would have made it impossible to achieve a reasonably sized pool of respondents. The choice was therefore made, while still aiming primarily for respondents from the five selected countries, not to exclude potential interviewees from other Sub-Saharan African countries<sup>20</sup>.

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<sup>18</sup> This initial brief was not due to a methodological or theoretical choice, but inspired by the limitations of one of the project's funders, the European Refugee Fund. Its funds can only be used to benefit refugees and asylum seekers, and not other types of migrants.

<sup>19</sup> Choosing, for example, persons whom they knew well – and thus could assess accurately their willingness to cooperate.

<sup>20</sup> For the purposes of this report, we consider Sub-Sahara Africa to comprise all countries on the African continent, including the island states, with the exception of countries in the Maghreb and North African region (Morocco, the Western Sahara, Algeria, Tunisia, Libya and Egypt).

A second important factor in the selection process was unclarity about the legal status of migrants<sup>21</sup>. This led to the ‘accidental’ arrangement of interviews with migrants who were not (rejected) asylum seekers, and thus, should have been excluded from the interviewing process according to the initial criteria. However, the discussions with these persons quickly showed that in terms of the problems they faced, there was little difference between rejected asylum seekers and other migrants who were not allowed to remain in the Netherlands, or might be confronted with this situation in the future. In addition, we came across migrants who did have a legal status (often on regular grounds and thus excluded from our initial target group) but who had reflected extensively on the issue of a potential return to their countries of origin. Their ability to reflect and their insights gained, provided an excellent source for further discussion of the issue of voluntary return, and thus became an integral part of this study<sup>22</sup>.

In the end, interviews with twelve migrants living with HIV were carried out, all taking place between May and September 2007. A profile of these respondents is provided at the start of chapter 5.

#### ***2.4.3 Representativeness and generalisability***

As discussed at the start of this report, the exact size and make-up of the group of HIV-positive migrants living without a legal status in the Netherlands is unknown. As such, there has been no way of ensuring that the selected respondents constituted a representative sample of the target group at large. Rather, the interviews provide anecdotal evidence of the perceptions of certain migrants living with HIV of the issue of voluntary return. The highly individualised circumstances of our respondents, the unrepresentative sample, and the sample size make it impossible to claim that our results are in any way representative of the entire population of migrants living with HIV in the Netherlands. Nevertheless, the interviews are very useful in identifying possible issues relevant to the problem of return, even if this cannot be done in an exhaustive way.

#### ***2.4.4 The interviews***

As noted at the start of this chapter, the main objective of the interviewing process was to get a clearer picture of the perceptions of migrants living with HIV on the issue of voluntary return. Uncovering these attitudes and perceptions necessitates getting ‘into the heads’ of our target group members. Our approach, therefore, was focused on individual experiences, and less on analysing trends across the target group. The main consideration in choosing the interview format was the possibility for target group members to get their stories across, and to leave enough space for further discussion. This resulted in the use of an open interview structure, in which only broad topics were suggested, but which left a lot of space for the respondents’ own narratives. Each respondent was asked to discuss his/her:

- attitude regarding the issue of return: was this considered an option or not?
- situation before departing his/her country of origin
- reasons to migrate to the Netherlands;
- current situation in the Netherlands;

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<sup>21</sup> There is a certain fluidity to the legal status of these migrants, often changing between ‘asylum seeker’, ‘regular migrant’ and ‘irregular migrant’. For example, a person who has been rejected for asylum might be considered an irregular migrant until he/she applies for a regular residence permit on medical grounds.

<sup>22</sup> In many cases, this ability to reflect was not a ‘luxury’ that the interviewed rejected asylum seekers and undocumented migrants had. As shall be discussed in chapter five, their focus was often so much on daily survival, that it was very difficult, if not impossible, to ponder the potential implications of return. From a perspective of discussing the possibilities and impossibilities of return, therefore, the interviews with migrants who had a temporary or permanent legal status in the Netherlands were often richer in information.

- knowledge about current conditions in his/her country of origin and the channels of information used;
- expectations in case of (a hypothetical) return.

Each time, the respondents were asked to reflect on at least three aspects: medical, economic social. The rationale for these three dimensions as a focus for our investigation will be explained in chapter three. The interviewers were briefed to encourage a free-flowing conversation, rather than the respondent merely being subjected to a string of questions. This was done in order to allow the respondents to also ‘lead’ the topics, by focusing on what was important to them, and by proposing further dimensions of interest. Building trust between the interviewer and the respondents was an essential part of the process. One of the ways in the building of trust was stimulated was by employing interviewers who themselves hailed from Sub-Saharan Africa. This was meant to facilitate communication and understanding. This had advantages and drawbacks. These, and other considerations during the interviewing process, are discussed in more detail in the box 5 below. Each interview, with the permission of the respondent, was tape-recorded and transcribed. All interviewees received a compensation for their participation to the amount of € 30.

**Box 5: Making return a topic for discussion: some reflections**

Return is not a very accessible topic for most migrants, particularly for those living with HIV. Since many of the respondents were still focused on gaining a legal status in the Netherlands, speaking about return required a mental leap that was not always easily made. Even though the interviews only dealt with the hypothetical situation of return (a ‘what if’-scenario), for some respondents this may have felt like a ‘weakening’ of their resolve to fight a status in the Netherlands. This phenomenon is also noted by Engelhard (2004) in his study on refugees and asylum seekers with medical conditions and the problem of return.

<sup>23</sup> The decision to use African interviewers was not taken lightly. An elaborate discussion within the research team, as well as with the project’s Advisory Board, took place before the interviewers were recruited. The interviewers, although themselves Africans, were not nationals of any of the five pilot countries of the study nor were they – as it turned out – of the same nationality as any of the interviewees from other African countries. Whether the use of interviewers of African origin did actually lead to increased trust between the interviewer and the interviewee is still a matter of debate. The interviewers themselves remarked on several occasions that respondents were apprehensive about talking about their HIV-positive status with them for fear that they would spread rumours within the African community. In some cases, it was suggested that having a non-African as the interviewer might have helped the respondent to open up more. On the other hand, several interviewees seemed to have regarded the fact that the interviewers understood ‘African culture’ as a positive factor.

<sup>24</sup> It was suggested by some that other organisations, such as the various aid providers and support groups with which the research team had been in touch, could have undertaken some of the interviewing, in order to avoid some of the difficulties mentioned here. However, such ‘out-sourcing’ of the interviewing to different groups was believed to potentially compromise the consistency of the way in which the interviews were undertaken. It would also have made it more difficult to safeguard objectivity and confidentiality, which were central to the success of the research process.

<sup>25</sup> The interviewers were instructed to briefly explain IOM’s role and the goals of the research project at the start of each interview. They were also provided with some information materials (leaflets etc.) about IOM in case the respondent required further information. In order to keep the interview as ‘pure’ as possible, the interviewers would not discuss the role IOM could play in the respondent’s individual case. For such questions the respondents were referred to the project coordinator. Nevertheless, in some cases it was necessary for the interviewers to adjust expectations of the respondents, who sometimes thought IOM would be able to play a positive role in their struggle for a legal status in the Netherlands. In at least one interview this may have been the main motivation of the respondent to agree to the interview. When the interviewer explained that IOM does not play a part in the decision-making process on admission and residency in the Netherlands, this resulted in the respondent being very defensive throughout the remainder of the interview.

Moreover many of the respondents took great care to keep the fact that they were HIV-positive secret from anyone but those assisting them and – in some cases – a very small circle of friends or family. As a result, most respondents were not very keen to talk about their situation with an unknown interviewer and some were afraid that participating in the interviews would lead to unwanted speculation by members of their communities. Securing the confidentiality and anonymity of respondents was therefore key to the research process.

Therefore, despite the above mentioned methodological difficulties regarding sampling and representation of the target group, using 'gatekeepers' was deemed necessary to ensure that participation was strictly voluntary and that the research team would not receive any information about persons who did not want to participate in the research. When interviews occurred, these were carried out by researchers who were themselves of African origin, who were able to meet with respondents in their own communities without attracting too much unwanted attention<sup>23</sup>. This limited the chance of unwanted disclosure of the HIV-positive status of the respondents. Also, the respondents were allowed to choose an interview location, which they thought most suited their needs and ensured confidentiality. In the end, the interviews took place in a variety of locations, such as the offices of the assistance providers who acted as gatekeepers, the homes of interviewees, and IOM's regional office in Amsterdam.

Finally, the fact the interviewers were employed by IOM, an organisation known by most respondents to be primarily concerned with return assistance, also had an impact on the interviewing process. The interviewers were sometimes put in a position where they would not only have to elicit information from the respondents, but were also expected by these respondents to provide information on the activities of IOM<sup>24</sup>. Efforts were made to separate the role of interviewer from the role of information provider, although this was not always strictly possible<sup>25</sup>.

## 2.5 COUNTRY STUDIES

### *2.5.1 Objectives and setup of assessments*

Together with the target group interviews, the country studies formed the research's main source of empirical data. The main objective of the country assessments was to exchange views with a variety of stakeholders in potential countries of return about the practical possibilities and difficulties that migrants living with HIV might encounter on return. Five such country visits took place, each taking approximately one week. In chronological order these were: Sierra Leone (9-16 July 2007), Ghana (13-18 August 2007), Nigeria (19-25 August 2007), Angola (20-27 September 2007) and Cameroon (29 October-3 November 2007). In each case, one member of the research team met with representatives of governmental agencies, international organisations, non-governmental organisations, and support groups of persons living with HIV. Each time, the researcher was accompanied by a member of staff of the IOM office in the visited country, and, in the case of Ghana and Nigeria, a representative of Soa Aids Nederland. In each meeting, the interlocutors were asked to reflect on, and provide their personal opinions of, the possibilities and constraints of return and reintegration, particularly concerning such issues as:

- the existing (medical, economic and social) opportunities for people living with HIV;
- the gaps in existing services and the reasons for these gaps;
- the potential barriers for returnees to access these services;
- more generally, the barriers to (sustainable) reintegration after return;
- the possibilities (within existing frameworks or through new initiatives) to help returnees overcome these barriers.

It should be noted that way in which these topics were addressed during each country assessment varied according to the opportunities, practical circumstances and the particular areas of expertise of our interlocutors. A report of each visit was made. These are each presented in a separate chapter in this report (see chapters 6-10).

### ***2.5.2 Selection of countries***

A selection of five African countries was made based on a range of criteria and data. Two main concerns were that (1) the selected countries would be common destinations for returnees from the Netherlands and (2) there were relatively sizeable groups of HIV-positive migrants originating in these countries staying in the Netherlands. The relevant statistical data related to these indicators is presented in various places in this report<sup>26</sup>. In addition to these criteria, issues relating to the practical implementation of an assessment, such as the presence of an IOM office and/or of partner organisations, as well as the general security situation and infrastructure, were taken into consideration.

### ***2.5.3 Scope of the reports of the country visits***

Like the interviews with migrants in the Netherlands, the reports of the country visits cover a wide range of professional and personal perspectives. Given the explorative nature of this research, these perspectives were used to identify the issues of concern related to the return of migrants living with HIV as broadly as possible. It was not feasible, nor the intention, to independently verify all the information provided by our interlocutors in the five countries. By no means, therefore, should the accounts of the visits – as presented in this report – be seen as providing a comprehensive or factual reference on the state of medical, economic and social issues confronting people living with HIV in the five selected countries. Rather, it provides a synopsis of the various opinions and impressions of persons interviewed.

In addition, the reports provide only a partial picture that is location and time-sensitive. For example, the visits usually only allowed for meetings with stakeholders working in the capitals of the five selected countries, thus gaining much more information about the lives of people living with HIV in these cities than those in rural areas. Also, where medical-technical information is discussed by those interviewed, it is possible that this information will already be outdated by the time of the publication of this report<sup>27</sup>. This is also the reason why, for example, different drugs are not mentioned specifically<sup>28</sup>.

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<sup>26</sup> See, for example, boxes 1, 2, 6 and 8.

<sup>27</sup> As such, there were some concerns during the writing up of this report that the different country chapters would be used by some as reference documents to make a case for or against the return of individual migrants, despite the inadvisability of such action based on the limitations outlined above. We feel it is crucial to re-emphasise the general nature of our discussions and the necessity of assessing the possibilities of voluntary return of individual migrants should be done on a much more specific basis than our report can ever provide (also see chapters eleven and twelve). It is for this reason that the choice was made not to provide lists of medications available in the countries, or other very specific medical-technical information. Even when such lists were provided by governmental officials or other interlocutors, it was impossible within the limited time available for the visits, to independently verify whether these lists reflected reality in either the country as a whole or specific locations (this would have necessitated long-term investigation of, for example, availability and distributions of these medications).

<sup>28</sup> It should be noted that this report has no pretence to be a clinical study. Medical issues are therefore only discussed in laymen's terms. Medical professionals who are in search of case-specific information on treatment possibilities in the five countries are advised to consult with hospitals and government agencies there. In case of voluntary return, IOM mediates between health care professionals in the Netherlands and those in the country of origin, to ensure that all relevant information related to treatment possibilities is exchanged, and that an appropriate handover of the patient can take place. For more information on IOM Netherlands' assistance to returnees with medical problems, please see [www.iom-nederland.nl](http://www.iom-nederland.nl).

Finally, it should be noted that the reports vary (sometimes significantly so) terms of structure, length and content. These depend on the number of consultations that feasible within the duration of each visit, which actors were willing and able to meet with the researcher at that time, and the professional backgrounds of those actors and the activities implemented by them. In some cases, those consulted spoke a lot about the general problems that returnees living with HIV might experience, while others chose to focus on their own activities, and how these might benefit returnees.

# CHAPTER 3 – HIV AND DUTCH IMMIGRATION AND RETURN POLICIES

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## 3.1 INTRODUCTION

Although there may be different circumstances in which a decision to return is made, this decision becomes particularly pressing matter when the migrant in question does not receive a legal status, or is in danger of losing that status. For this reason, in this chapter we will first provide an overview of legislation and policies related to the status of migrants living with HIV in the Netherlands. There is a lot that can be said about migration legislation and policy, and especially about how it is implemented (and contested) in practice. Because jurisprudence and policies are constantly evolving, it is impossible to go into all details and developments. We will therefore limit ourselves to a broad overview of the criteria for residency and how these relate to the position of migrants living with HIV. Following this, we shall discuss the circumstances that migrants living with HIV are faced with if they do not obtain a legal status. Finally, we will cover policies and practices in the Netherlands related to the return of migrants.

## 3.2 ASYLUM AND HIV

Migrants who do not already have a legal status in the Netherlands have two ‘gateways’ to a legal status. One is through a so-called regular immigration procedure, which covers all manner of reasons for (temporary or permanent) residency, including work, education, family reunification and medical circumstances. The other is by applying for asylum. An asylum application is a request to the Dutch government to grant protection against persecution or violence in the applicant’s country of origin<sup>29</sup>.

The fact that an asylum seeker is HIV-positive usually plays a minor role in the asylum procedure. Medical circumstances<sup>30</sup> can be relevant when these corroborate an asylum seeker’s claim that he/she has been facing persecution or other treatment that may lead to an asylum status<sup>31</sup>, which would usually entail an intentional act. This will generally not be the case with HIV<sup>32</sup>. HIV may play a role in determining whether the return of the asylum seeker could amount to “inhuman or degrading treatment or punishment”. This concept is derived from article 3 of the European Convention on Human Rights and Fundamental Freedoms, which protects against such treatment, and prohibits countries to deport persons who may be subjected to such treatment. In “very exceptional circumstances”, the forced return of a person living with HIV may amount to inhuman or degrading treatment. These circumstances are

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<sup>29</sup> Under Dutch law, an asylum status can be granted to a person if (1) he/she is a refugee as defined in the 1951 Refugee Convention; (2) upon return to his/her country of origin, he/she would be subjected to torture or other inhumane or degrading treatment or punishment; (3) humanitarian circumstances in the country of origin would make it unreasonable to expect him/her to return to his/her country of origin; and (4) return to his/her country of origin would be deemed particularly harsh in light of general circumstances there (article 29(1)(a)-(d), Aliens Act 2000). The law also makes provisions for spouses, children or other dependents of persons deemed to be in need of protection according to the grounds described here.

<sup>30</sup> Asylum policy does not have specific provisions for HIV.

<sup>31</sup> See Aliens Act 200 Implementation Guidelines (*Vreemdelingencirculaire*), section C1/3.2.4.1.

<sup>32</sup> Although there may be cases when the person involved became infected, for example, due to rape.

outlined in a key case at the European Court for Human Rights<sup>33</sup>. In this case, the court deemed the deportation of D., who was terminally ill and would not be able to get treatment and support needed to prevent unnecessary suffering, would lead to inhuman or degrading treatment in his native St. Kitts. The mere fact that the quality of health care was significantly lower in the country of return, or that return would have led to a shorter life expectancy of D., was not found sufficient by the Court to judge that a violation of article 3 would occur. With this interpretation, the Court has set a very high threshold for a violation of article 3. In those cases when the forced return of a migrant living with HIV would meet the threshold of a violation of article 3 of the Convention, the Dutch Aliens Act provides the person with an asylum status. It is unlikely, though, that many cases will be considered to meet the “very exceptional circumstances” of the case of D.

Apart from medical conditions being evidence for persecution, or as part of an argument that forced removal would lead to a violation of article 3 of the European Convention on Human Rights, there is relatively little leeway in the asylum procedure to consider these conditions. If the asylum application has been made because the applicant wishes to undergo medical treatment in the Netherlands, he/she will be referred to the regular immigration procedure, which also covers (temporary) residency on medical grounds<sup>34</sup>. The same is true for asylum applicants who claim they cannot be removed from the Netherlands due to medical circumstances that make them unable to travel. These instances are covered in more detail below.

### 3.3 REGULAR IMMIGRATION AND HIV

#### 3.3.1 Introduction

Regular immigration law covers all non-asylum related grounds for residence, including family formation and reunification, labour and education. All of these grounds may be applicable to migrants living with HIV if they meet the circumstances, but they do not have any specific provisions for HIV as a reason for residency. As such, they will not be discussed here. Where regular immigration legislation and policy do impact on the issue of HIV is in its residency status related to medical conditions.

The medical grounds track of Dutch regular immigration policy comprises two separate permits, one based on ‘medical treatment’ and one based on ‘medical emergency’. However, since the conditions for these permits are often closely linked, any application for residence on medical grounds will be assessed against the criteria for both these permits. This means that cases of applicants, who do not qualify for a permit on the grounds of medical treatment, are automatically also assessed against the applicability of the grounds of medical emergency.

Before discussing the specific permits for medical cases, it should be noted that a set of general conditions, which are unrelated to the medical status of the migrant, need to be met to be eligible for a regular residence permit. These conditions include the migrant having a valid passport, the migrant not being considered a threat to public order or national security, and the migrant being in possession of a so-called authorisation for temporary stay (*machtiging voorlopig verblijf* or MVV)<sup>35 36</sup>. These conditions are already not easily met. Not all migrants

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<sup>33</sup> European Court of Human Rights, case no. 30240/96.

<sup>34</sup> See Aliens Act 200 Implementation Guidelines (*Vreemdelingencirculaire*), section C1/3.2.4.1.

<sup>35</sup> See Aliens Act 2000, article 16(1). Another condition, having a sufficient income, is waived in case of an application for a regular permit on medical grounds.

applying for a medical residence permit will have a valid passport. Also, when migrants have entered the country as an asylum seeker, or as an irregular migrant (i.e. they did not hold a valid residence permit on other grounds before applying for a medical permit), they will not have the required MVV. Exemption from these obligations is only granted in exceptional circumstances<sup>37</sup>.

### **3.3.2 Residency on grounds of medical treatment**

Dutch immigration policy allows migrants to apply for a residency permit on the basis that they need to undergo medical treatment in the Netherlands. This permit is only awarded if three conditions are met. These are:

1. the Netherlands is considered the most appropriate country for the treatment;
2. the treatment is deemed medically necessary; and
3. there is a sound financial basis for covering the costs of the treatment.

The first condition, that the Netherlands is considered the most appropriate country, is only met in exceptional circumstances, and is dependent on a broad range of factors<sup>38</sup>. For assessment of the second issue, whether the desired treatment is medically necessary, the Immigration and Naturalisation Service seeks the opinion of its Bureau for Medical Advice (BMA). The role of the BMA is highlighted in box 6 on page 28. The third condition implies that the costs for the desired treatment can be covered by the migrant, and that the Dutch state should not be made responsible for these costs. This means, generally, that the migrant must be in possession of a health insurance that covers the costs of the treatment. Registration for health insurance, however, is usually dependent on having a legal status, resulting in a somewhat of a Catch 22 situation. This makes gaining a regular status on account of medical treatment extremely difficult for rejected asylum seekers and other migrants without a legal status.

### **3.3.3 Residency on grounds of medical emergency**

If an application for residency on grounds of medical treatment is rejected, the application will be assessed according to the criteria related to medical emergencies. The medical emergency permit can be obtained if all of the following conditions are met:

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<sup>36</sup> An MVV is a visa that allows a person to enter the Netherlands on the basis that he/she is deemed to fulfil the requirements for obtaining a residence permit. The would-be migrant applies for an MVV while still in his/her country of origin. The application is then assessed on the basis of all the relevant requirements for the procedure at hand (e.g. family reunification, labour, medical grounds). Only after the migrant is in possession of the MVV, can he/she travel to the Netherlands. After arrival, the actual residence permit application has to be made. Nationals of countries in the European Union or European Economic Area, as well as Australia, Canada, Japan, New Zealand, South Korea and the United States, as well as certain other categories of migrants, are exempt from the obligation to have an MVV prior to arrival (see [www.ind.nl](http://www.ind.nl) for more information).

<sup>37</sup> In case of not having a passport, the migrant will have to show it is impossible for him/her to obtain one from the authorities of his/her country of origin. In the case of an MVV, the migrant will have to show that he/she is not able to travel back to his/her country of origin for medical reasons (an MVV is only issued in countries of origin and cannot be obtained in the Netherlands) or that – due to medical circumstances – it would be unreasonable to expect the migrant to do so.

<sup>38</sup> The Aliens Act implementation guidelines state explicitly that the appropriateness of treatment in the Netherlands is not a function of the quality of Dutch health care compared to that in the migrant's country of origin. Issues that *do* affect appropriateness include whether the Netherlands' has specific medical expertise with regard to the desired treatment, the length of the migrant's legal residency in the Netherlands, the lack of availability of the treatment in the migrant's country of origin, the consequences of not receiving treatment, the presence of necessary social support in the Netherlands, as well as a number of provisions related to pregnancy.

1. discontinuation of medical treatment will result in a medical emergency;
2. treatment of the illness or condition cannot take place in the country of origin of the applicant or any other country that the applicant would be allowed to enter;
3. the treatment that prevents a medical emergency from occurring is expected to continue for a period of more than one year;

The first condition, that discontinuation of treatment will result in a medical emergency, implies, first of all, that the applicant is already receiving treatment. If this is not the case, such as with persons who are HIV-positive but who have not (yet) started antiretroviral therapy, the application for a permit will – in all likelihood – be rejected. In case treatment *is* taking place, the issue arises whether discontinuation of that treatment would result in a medical emergency. The Aliens Act implementation guidelines<sup>39</sup> define a medical emergency as an illness or condition that – within a period of three months – will result in the “death, invalidity or another form of serious mental or physical damage of the applicant”. The BMA advises the Immigration Service on the question of whether an illness, if untreated, would result in a medical emergency.

The fact that discontinuation of treatment will result in a medical emergency in and of itself, however, is not sufficient to be eligible for a ‘medical emergency’ residency status. This also depends on whether or not treatment can be continued in the migrant’s country of origin. In order to assess this, the BMA is asked to advise on whether treatment of the illness or condition is available in the country of origin. That this condition deals with the availability of treatment in a general sense, and not the practical possibilities of individual migrants to access this treatment, is a very important – and for migrants living with HIV often frustrating – aspect of the medical immigration procedure. Its implications, therefore, deserve more attention (see paragraph 3.3.4).

The final condition, that treatment is expected to continue for more than one year, is one that is easily satisfied by migrants living with HIV, since they will have a life-long dependence on treatment.

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<sup>39</sup> B8/3.2.

### Box 6: The Bureau for Medical Advice (BMA)

The Bureau for Medical Advice (BMA) is a specialised department within the Immigration and Naturalisation Service, providing support to the decision-making process in medical cases. The BMA gathers information about medical treatment options in the country of origin. Based on this information, the BMA reports to the Immigration Service. In brief, the BMA generally provides information about: (1) the nature of the medical condition of the applicant; (2) the nature and expected length of the treatment the applicant is receiving; (3) the availability of necessary treatment in the applicant's country of origin<sup>40</sup>; (4) the possibility of a medical emergency occurring if treatment is discontinued; and (5) the ability of the applicant to travel.

#### *Medical advice in HIV cases<sup>41</sup>*

In 2006, BMA provided advice in 198 instances where the applicant had been diagnosed as HIV-positive. This constituted the biggest group (12 percent) of all cases in which a physical medical condition was the subject of the advice<sup>42</sup>. Of the 198 cases, 168 (or 85 percent) dealt with persons from Sub-Saharan Africa<sup>43</sup>. The table below provides an overview of the countries of origin that were the subject of these 168 cases. Note that the six countries on which the BMA had to advise most frequently are the five pilot countries covered in this report plus the Democratic Republic of Congo.

Country	#	Country	#	Country	#
Ghana	23	Uganda	6	Niger	3
Cameroon	21	Burundi	5	Ivory Coast	2
Nigeria	18	Rep. of Congo	5	Tanzania	2
DR Congo	11	Sudan	5	Zimbabwe	2
Angola	10	Somalia	5	Cape Verde	1
Sierra Leone	10	Rwanda	4	Eq. Guinea	1
Ethiopia	9	Togo	4	Guinea-Bissau	1
Guinea	6	Zambia	4	Kenya	1
Liberia	6	Eritrea	3		

#### *Treatment availability*

BMA statistics covering 2006 show that in 38 cases (or 23%) of Africans living with HIV, appropriate treatment was deemed to be available in the country of origin. In 125 cases (74%) treatment was deemed not to be available or no information was available on treatment options<sup>44</sup>. There are, however, significant differences between individual countries. In cases of Ghanaians, for example, the BMA deemed treatment to be available in 13 out of 23 cases (57%). For Cameroon this was 2 out of 21 (10%). In none of the cases of Nigerians, Angolans and Sierra Leoneans, the BMA found treatment to be available<sup>45</sup>.

<sup>40</sup> The Aliens Act implementation guidelines make provisions for instances in which there is no adequate or reliable information about treatment in a certain country: "If, on account of a uncertain situation in the country of origin, BMA is not able to advise on the availability of treatment possibilities in said country, it will be assumed treatment possibilities are not available." (B8/6).

<sup>41</sup> The information presented here draws on statistics provided to the research team by the BMA. The research thanks the BMA for its kind cooperation.

<sup>42</sup> Overall, however, physical afflictions account for only a minority of the BMA's assessments. Of the 3,664 reports it produced, 2,050 deal with psychiatric afflictions (57 per cent) and only 1,614 with physical afflictions. Overall, cases in which HIV/AIDS was the main issue of concern constitute 5.4 percent of the advice reports.

<sup>43</sup> It is unclear how many individuals are concerned here, as in any individual case more than one BMA assessment might be necessary.

<sup>44</sup> In the remaining four cases, the availability of treatment was deemed not to be relevant (presumably because the applicant was not receiving treatment in the Netherlands).

<sup>45</sup> The BMA found treatment availability not relevant in one case from Sierra Leone and in one case from Angola.

### **3.3.4 Availability versus accessibility of treatment**

A major bone of contention in many cases in which being HIV-positive is the basis for a claim to residency, is whether appropriate treatment is available in the country of origin. The Aliens Act implementation guidelines make a clear distinction between the objective availability and the de facto accessibility of treatment. Objective availability should be understood here as the existence of certain forms of treatment in the country of origin. This is what the assessment of treatment options in countries of origin is based on. The implementation guidelines explicitly state that circumstances regarding the de facto accessibility of this treatment by an individual migrant will not be taken into consideration. These circumstances include:

- the inferior quality of medical care in the country of origin, compared to that in the Netherlands;
- the applicant's financial difficulties in accessing the appropriate treatment (i.e. the affordability of treatment based on the applicant's individual circumstances);
- the fact that the applicant may have to travel considerable distances to access the appropriate treatment;
- issues that may affect the applicant's ability to receive treatment that are considered 'asylum-related', such as discrimination or persecution. The implementation guidelines put these 'asylum-related' issues beyond the scope of the regular procedure;
- long waiting lists for the appropriate treatment;
- the fact that a medical escort is necessary during the travel home. The implementation guidelines state that arranging this escort is the responsibility of the applicant. It specifically points towards the facilitating role that IOM can play in the travel back to the country of origin (see 3.6.1). Should the applicant be forcibly removed from the Netherlands, the Dutch authorities will assume responsibility for the necessary medical arrangements en route.

Special consideration is reserved in the guidelines for preventing gaps in treatment from occurring, should the applicant return to his/her country of origin. The implementation guidelines consider this to be a matter of availability rather than accessibility of treatment, and therefore of procedural relevance. However, the responsibility for preventing such gaps in treatment is put on the applicant. For example, the applicant should make arrangements for carrying a sufficient stock of medication<sup>46</sup>.

### **3.3.5 Status**

If a status on medical grounds (either based on 'treatment' or 'medical emergency') is awarded, the migrant will receive a temporary residence permit, which – in principle – needs to be renewed (and thus is reassessed) after a maximum of one year. As such, the migrant may face uncertainty over the right to stay in the Netherlands each time his/her permit needs to be renewed. This is the case for several of our migrants we interviewed (see chapter five). The holder of such a permit on medical grounds is entitled to welfare benefits and housing<sup>47</sup>. However, he/she does not have the right to work.

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<sup>46</sup> See B8/4 of the implementation guidelines. Should interruptions in treatment be unavoidable if the applicant would return, the implementation guidelines state that an individual decision (incorporating the applicant's responsibility and the duration and regularity of these interruptions) needs to be made. If interruptions are found to occur for the duration of one month or longer, this will lead to the conclusion that treatment is not (sufficiently) available.

<sup>47</sup> In some cases, this may also be an asylum seekers' centre.

### 3.4 CONSEQUENCES OF NOT HAVING A LEGAL STATUS

#### 3.4.1. *Obligation to leave the Netherlands*

In the previous section we have discussed some of the grounds on which migrants living with HIV could be granted a legal status in the Netherlands. It shows that it is not self-evident that a migrant living with HIV will be able to obtain a legal status. This is particularly true for those who are not yet receiving treatment. In any case, the right to remain in the Netherlands will be very dependent on an individual's (medical) circumstances and the treatment options in his/her country of origin.

If a legal status is not granted, or the migrant has never applied to regularise his/her status, he/she will be under the obligation to leave the Netherlands of his/her own accord. Generally, the migrant will have four weeks to leave the country<sup>48</sup>. Once the deadline for independent departure has passed, the authorities are empowered to forcibly remove the migrant. If necessary, the migrant can be detained, provided that there is a reasonable prospect of the removal actually being effected. The Dutch policy related to return will be discussed in more detail in section 3.5.

#### 3.4.2. *Exclusion from public services and amenities*

In 1998, the *Koppelingswet* (Linkage Act) was enacted, which linked the legal status of migrants to their entitlements to public services and amenities. The Aliens Act 2000, enacted in 2001, reiterates this connection by stating: “[t]he alien who does not have legal residence cannot claim amenities, services or benefits administered by a governmental body” (article 10(1)). This means that migrants without a legal status are not entitled to such amenities as welfare benefits, rental subsidies or public housing, study grants or public health insurance. Also, the right to work is connected to a legal status, and migrants without a legal status are thus not allowed to work. The exclusion from entitlements, however, is not absolute:

“An exception [...] can be made when this [exclusion] relates to education, to the provision of medically necessary care, to the prevention of dangers to public health, or to legal assistance to the alien.” (article 10(2) of the Aliens Act 2000; emphasis added).

This means that even when a migrant does not have health insurance, which is generally impossible to register for without a legal status, he/she should receive ‘medically necessary care’. In a policy note on irregular migrants the Minister of Alien Affairs and Integration notes that:

“...out of humanitarian considerations, irregular migrants retain the right to humane treatment. This means that basic rights to education and health care will not be curtailed out of the Government's wish to combat irregular migration.” (*Illegaleennota* (Illegal Aliens Policy Note) of 23 April 2004).

What is ‘medically necessary’ is generally up to the health care provider to assess. However, the policy note states that “[i]f a situation occurs that is life-threatening or which entails the risk of permanent physical damage, medical assistance will always be provided” (ibid.). In general, treatment of HIV is always considered to be medically necessary.

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<sup>48</sup> However, in specific cases the obligation to depart is immediate. This is the case, for example, when a migrant does not have, and has not tried to obtain, a legal status; when he/she is not in possession of a valid MVV; or when he/she has been declared a so-called ‘undesirable alien’.

It is important to note that this does not mean that treatment of HIV, or any other medically necessary care, is free. In principle, uninsured migrants are expected to pay for treatment themselves. However, since costs may be very high (also see box 7), this is usually not possible. In order to compensate health care providers and institutions for the cost they incur when providing treatment to uninsured migrants, the Ministry of Health instituted two measures. Firstly, there is a special fund (often referred to as the *Koppelingsfonds*) which compensates first line care providers (e.g. general practitioners, obstetricians and pharmacists) for ‘excess costs’ for medically necessary care that has remained unpaid. Secondly, hospitals and other care institutions can make a provision within their budgets for patients who cannot pay their fees. The amount that can be set aside for this has to be agreed with health insurance companies on an annual basis<sup>49</sup>.

#### **Box 7: The cost of treatment of uninsured migrants living with HIV**

For hospitals, the treatment of undocumented migrants living with HIV can lead to considerable costs. Below are a few illustrative examples, which were provided by a nurse in one of the hospitals designated as an HIV treatment site.

- A woman was uninsured for ten months. She was never admitted to hospital, but only had consultations with physicians and underwent tests. Total costs: **€ 3,112.70**
- In March 2007 a woman was tested HIV-positive. She was pregnant and was admitted to hospital for her delivery. She stayed in the hospital for three or four days. Total costs: **€ 6,697.99**
- A man came for several check-ups and was admitted for six weeks in 2007. Total costs: **€ 9,257.22**
- An uninsured patient had to stay in the hospital for six months in 2006. He was supposed to be transferred to a nursing home after his initial admission, but this was not possible due to his lack of insurance. Total costs: **€ 20,851.20**

It should be noted that these figures only include hospital costs, and not the actual cost of the antiretroviral medication. The nurse who provided this information, also remarked:

“These are just a few from our group of uninsured patients. There are people who only come for check-ups and tests, but often these people come to us too late or – due to circumstances – are unable to follow their therapy well. Because of this, medical problems occur and they have to be admitted. In some cases they will have to stay for a long time, because they cannot go to another institution on account of their insurance problems.” (e-mail communication between nurse and researcher, 26 May 2008).

While the system in place grants all persons living with HIV, regardless of their legal status, access to treatment, this does not mean that all who are in need of treatment receive it. As several consulted experts noted, migrants without a legal status may be afraid to go to the hospital for fear of being identified by the authorities. Also, a significant proportion of persons living with HIV may not be aware of the fact that they are infected. Finally, it is important to note that the access to treatment is only one factor determining migrants’ mental and physical well-being, as we shall see in chapter five.

### **3.5 DUTCH RETURN POLICY AND PRACTICE**

The exclusion of migrants without a legal status from certain public services and amenities is part of a broader policy to discourage irregular immigration. Stricter immigration legislation

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<sup>49</sup> For more information, see the website of *Stichting Koppeling*, [www.stichingkoppeling.nl](http://www.stichingkoppeling.nl).

(both for regular migration and asylum cases), as well as measures to make the Netherlands less attractive as a country for immigration and irregular stay have been a major part of the development of the Dutch migration policy in the last decades. In recent years, this has been complemented by a strong focus on the return of migrants without a legal status. A central premise of the Dutch policy towards return is that it is the primary responsibility of the migrant him/herself to comply with the obligation to leave the Netherlands (see, for example, the *Terugkeernota* (Return Policy Note) 2003). When the migrant does not have the means to comply with this obligation, he/she can request assistance under the Return and Emigration of Aliens from the Netherlands (REAN) programme, which is implemented by IOM<sup>50</sup>. More details on the REAN programme are provided in section 3.6.

While the voluntary departure of rejected asylum seekers or other migrants without a legal status is regarded as the preferred solution, failure to comply with the obligation to leave the Netherlands may eventually lead to forced removal. In 2007, a special service within the Ministry of Justice, the Departure and Repatriation Service (DT&V) was set up to take responsibility for effecting return, whether voluntary or forced<sup>51</sup>. While only the possibilities and constraints of return on a voluntary basis are of concern in this report, it is important to bear in mind that (the threat of) forced removal has an important impact on the decision of migrants to return of their own volition.

### 3.6 ASSISTED VOLUNTARY RETURN

#### 3.6.1. Return assistance provided by IOM

As mentioned above, there is a strong policy preference for migrants without a legal status leaving the Netherlands voluntarily. To facilitate this, assisted voluntary return (AVR) activities have been set up, of which the most important one is the REAN programme, carried out by IOM<sup>52</sup>. This programme provides for basic assistance to migrants who seek to return to their countries of origin, and – in some cases – who resettle in third countries<sup>53</sup>. In the Netherlands, IOM operates a nationwide network of Project Officers, who provide the main points of call for migrants who want information about return. The assistance generally provided covers information about the return programme, obtaining travel documents, and circumstances in the migrant's country of origin. For those who meet the criteria of the REAN programme<sup>54</sup>, an air ticket and financial assistance for travel from the airport of arrival to the place of residence of the returnee. Where possible and necessary, IOM officers in the

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<sup>50</sup> The group that makes use of the REAN programme is very diverse. It primarily covers rejected asylum seekers and other migrants who are no longer allowed to stay in the Netherlands. This does not mean that 'pure' voluntary return cannot and does not take place under the REAN programme. There are many known instances of migrants returning home while still having the right to remain in the Netherlands, and giving up this right in doing so.

<sup>51</sup> Previously, the responsibility for overseeing the removal of migrants without a legal status was carried by a department within the Immigration and Naturalisation Service.

<sup>52</sup> IOM is an intergovernmental organisation that was set up in 1951 to assist governments in managing international migration. Currently, it has 125 member states. The organisation operated under a variety of names from its inception in 1951. In 1989, it was renamed the International Organisation for Migration, and its current mandate was adopted. While the organisation was initially concerned primarily with resettling and repatriating refugees in the aftermath of the Second World War, its activities have expanded significantly to cover almost all aspects of international migration. In European countries, IOM is best known in its role as implementer of return assistance programmes. This is also true for the Netherlands, where IOM implements the REAN programme.

<sup>53</sup> The group of migrants who resettle to a third country only constitutes a small minority of those assisted under the REAN programme. In most cases, migrants without a legal status do not have the possibility to legally travel to any other country than their country of origin.

<sup>54</sup> see [www.iom-nederland.nl](http://www.iom-nederland.nl).

countries of origin can provide arrival assistance, which usually covers reception at the airport and referrals to relevant services. The REAN programme also generally provides for a small cash incentive. The REAN programme is open to all migrants, regardless of their legal status and whether they are economic migrants or asylum seekers, although the extent of assistance that can be provided may differ according their legal status.

Annually, IOM assists the return of between approximately 1,500 and 3,500 persons from the Netherlands to their countries of origin, as can be seen in the table in box 8.

**Box 8: Overview of IOM-assisted returns to Sub-Sahara African countries from the Netherlands (2005-2007)**<sup>55</sup>

	2005	2006	2007
Angola	407	431	145
Burkina Faso	1	1	1
Burundi	2	2	14
Benin	13	17	7
DR Congo	0	0	7
Chad	1	1	0
Rep. of Congo	12	6	2
Côte d'Ivoire	0	0	1
Cameroon	17	16	5
Cape Verde	3	2	1
Eritrea	6	1	3
Ethiopia	21	11	7
Ghana	117	79	54
Gambia	1	2	0
Guinea	31	9	4
Guinea-Buissau	2	1	0
Kenya	3	6	2
Liberia	5	7	2
Mali	1	1	1
Mauritania	2	0	0
Niger	27	21	9
Nigeria	119	93	52
Rwanda	2	0	1
Soa Tome & Principe	0	2	0
Sudan	88	50	8
Sierra Leone	30	19	11
Senegal	1	1	2
Somalia	10	12	8
Tanzania	11	12	5
Togo	10	15	2
Uganda	4	7	2
South Africa	3	0	2
Zambia	0	0	2
Zimbabwe	0	0	2
<b>Sub-Sahara Africa total</b>	<b>950</b>	<b>825</b>	<b>362</b>
<b>Other regions total</b>	<b>2,513</b>	<b>2,024</b>	<b>1,197</b>
<b>GRAND TOTAL</b>	<b>3,463</b>	<b>2,849</b>	<b>1,559</b>

<sup>55</sup> Sources: IOM Netherlands annual report 2007, available at [www.iom-nederland.nl](http://www.iom-nederland.nl).

In addition to the REAN programme, there is a special Return and Reintegration Regulation<sup>56</sup> (*Herintegratieregeling Terugkeer* or HRT) for (rejected) asylum seekers. The HRT regulation gives extra financial assistance for reintegration in the country of origin of certain categories of (failed) asylum seekers. The REAN programme and HRT regulation form the core of the assisted voluntary return activities of IOM in the Netherlands. This is complemented by special projects aimed at providing additional assistance to specific, often particularly vulnerable, groups. An example of this that is particularly relevant for this report is the extra assistance provided to returnees with medical conditions. This extra assistance covers special facilities to make travel back to the country possible (if necessary) and referrals to treatment sites in the country of origin.

IOM is prohibited by its mandate from assisting in the forced removal of migrants<sup>57</sup>, which is the exclusive responsibility of the Dutch government. Nevertheless, IOM has frequently been criticised by civil society organisations and migrants for its close association with the Dutch government, which is the major funder of IOM's activities in the Netherlands. This, they argue, blurs the line between what is voluntary and what is forced return. In addition to this debate about the link between assisted voluntary return activities and forced return, the issue of voluntariness itself is a contentious issue, which will receive more attention in section 4.2.

### ***3.6.2. Other actors providing return assistance***

Return has become an increasingly mainstream issue in the migration debate in the Netherlands. This is particularly clear from the large number of organisations that have become involved in assisting voluntary return. A 2005 overview of return-related projects by IOM, governmental agencies and non-governmental organisations, illustrates the proliferation of the issue. It identified no fewer than sixteen projects related to the voluntary return of migrants (primarily rejected asylum seekers), while acknowledging that the study possibly did not encompass all activities in this area (Odé 2005). Although a similar study has not been undertaken recently, arguably the field of organisations providing return-related assistance has become even broader. Certainly, the topic has become more central to the agenda's of many organisations traditionally involved providing assistance to migrants in their legal procedures to stay in the Netherlands, or in their integration in their host country.

The activities these various organisations engage in range from counselling and preparation for return in the Netherlands, to training and material support in the reintegration process after the migrant's arrival in the country of origin. The actual travel back to the country of origin is usually arranged under the REAN programme. At the time of the research, there were no activities specifically aimed at the return of migrants living with HIV.

### ***3.6.3. Do migrants living with HIV return voluntarily?***

The sections above have attempted to provide a sketch of the context in which HIV-positive migrants without a legal status find themselves. This context is characterised by the primacy of the migrant's own responsibility to comply with the obligation to leave the Netherlands, the discouragement of further irregular stay by excluding migrants from certain public services and amenities, the proliferation of return assistance activities, and, ultimately, the threat of expulsion by the Dutch government.

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<sup>56</sup> see [www.iom-nederland.nl](http://www.iom-nederland.nl).

<sup>57</sup> Constitution of IOM, article 1(1)(d).

But does this context mean that migrants living with HIV are inclined to return to their countries of origin voluntarily? The available evidence suggests that this is not the case. As already mentioned in the first chapter, IOM has encountered very few instances in which people that were living with HIV turned to the agency to facilitate their return<sup>58</sup>. The reluctance to leave the Netherlands also shows from the interviews with migrant living with HIV, as presented in chapter five. Indeed, many of them have said they would prefer to stay in the Netherlands without a legal status and without access to many public services, rather than face the uncertainties of life in their countries of origin. The idea that most migrants living with HIV are unlikely, under current conditions, to return to their countries of origin voluntarily is confirmed by many of Dutch assistance providers, who regularly deal with persons without a legal status<sup>59</sup>.

But does this mean that return will always be an undesirable option for migrants living with HIV, even if certain interventions would be possible to make this return more feasible? Before going into the results of our investigation of this issue among migrants and in the five selected countries, we will first discuss some of the basic concepts related to voluntary return (in particular the issue of ‘voluntariness’) and set out a brief theoretical framework for understanding the decision-making process of migrants when confronted with the choice between irregular stay in their host country or return to their countries of origin.

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<sup>58</sup> Although it should be noted there is nothing prohibiting migrants from returning voluntarily without making use of IOM’s assistance.

<sup>59</sup> In addition, some have suggested that the Dutch government may be reluctant to forcibly remove migrants living with HIV, who have not departed voluntarily. In an e-mail to the research team, a solicitor with several years of experience representing migrants living with HIV wrote: “As of yet, I have not encountered any client infected with the HIV virus who has chosen to return to his country of birth voluntarily. Also, so far, I have not encountered anyone who has been deported to his country of birth against his will, after having exhausted his legal remedies.” (e-mail communication, 29 August 2007).

## CHAPTER 4 – VOLUNTARY RETURN AND HIV: SOME THEORETICAL ISSUES

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### 4.1 INTRODUCTION

As suggested in the first chapter of this report, exploring the possibilities of return specifically for migrants living with HIV takes us into relatively uncharted territory. This does not mean, however, that we are painting on a blank canvas. Increasingly, academic and practice-based literature is dealing with the issue of the return of rejected asylum seekers and irregular migrants from Europe (see, for example, Koser 2001, Black et al 2004, Van Wijk 2008). A specific area of interest within this literature is the issue of (sustainable) post-return reintegration (e.g. Black and Gent 2004, Ghanem 2003), which is of particular importance to the target group of this report.

While HIV has not been much of a topic in the debate on return migration, a small body of literature has developed on migrants with health problems generally and the consequences for their possible (voluntary) return (see, for example, Van Krieken 2001, Engelhard 2004). Part of this literature has been developed from activities that have preceded the Return Migration and Health III project<sup>60</sup>.

Other studies that are important for our purposes are those related to the lives of HIV-positive persons in their countries of origin, and in this particularly, in Africa. This literature covers a broad spectrum of topics, including the availability and accessibility of HIV treatment (see, for example, Hardon et al 2006). This literature does not tend to focus on persons living with HIV who return to their countries after having stayed abroad for prolonged periods of time, but on those who have always remained there. Nevertheless, such studies help provide a background to our study, given our focus on the possibilities and constraints migrants living with HIV re-establishing themselves in their countries or origin (and thus finding themselves in a similar situation to those who ‘stayed behind’).

The literature discussed above will be used to outline some issues, which will frame our subsequent discussion of return for migrants living with HIV. First of all, we will consider in a bit more detail the issue of what constitutes ‘voluntary return’. Secondly, we will provide a basic framework for understanding how and when a migrant might decide to return voluntarily. Thirdly, we will try to identify some factors that might specifically impact on this decision when the migrant in question is living with HIV.

### 4.2 WHAT IS VOLUNTARY RETURN?

#### *4.2.1 Voluntariness*

‘Voluntary return’ is a much used term in migration policy. Voluntary return implies that it can be distinguished from non-voluntary or forced return. It is this distinction that usually often cause for debate. We will attempt to provide a brief overview of this debate, and what this means for the use of the term ‘voluntary return’ in this report.

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<sup>60</sup> See footnote 9.

Returning to one's own country is a fundamental human right<sup>61</sup>. However, it is not usually the right to return that makes voluntary return a tricky issue, but the fact that return to one's country of origin can be also be a legal obligation. When this obligation is enforced by the government of the host country, by physically removing the migrant from its territory, this is a clear case of non-voluntary return. However, this still leaves a broad spectrum of return that is not forced, in which different levels of voluntariness can be identified.

The most clear form of voluntary return is "when migrants decide at any time during their sojourn to return home at their own volition and cost" with the migrant having "a clear and open choice...either to return to his or her country of origin or to stay permanently and integrate into the host society" (Morrison 2000, quoted in Black et al 2004: 4-5). In practice, a much more common situation which is "when persons are at the end of their temporary protected status, rejected for asylum, or unable to stay, and choose to return at their own volition" (IOM 2008a). This, as Morrison argues, confronts the migrant with "a choice between returning to the country of origin now in a voluntary fashion (perhaps with financial or other incentives) or staying risking forcible return later" (quoted in Black et al 2004: 4-5)<sup>62</sup>.

Apart from the legal situation, definitions of voluntariness can also be related to other circumstances in which the choice to return is made. IOM, for example, has argued that the migrant's choice between the different (if limited) options should be "based on adequate, available, accurate, and objective information" (IOM 2008a). Practically, the extent to which such information is available will depend on the resources of both the migrant and the organisation facilitating the return, the situation in the country of origin, how long before departure the information is sought, and a host of other circumstances.

When a migrant requests assistance to return, it is often very difficult to accurately assess the relevant individual circumstances leading to this request, and whether on what kind of information this has been based. In some cases, the motivation to return might lie in circumstances in the country of origin (an improved situation, family issues). In other cases, the pressure to leave the host country (for example, because forced removal is impending) may lead to the desire to leave voluntarily<sup>63</sup>. However, even though not a legal option, many migrants make the choice to stay in the Netherlands without a legal status, at the risk that they will be forcibly removed if found out.

Given the broad possibilities for interpreting voluntary return, it is important to clarify how we use the term here. For the simple reason that it connects best to the way it is used in policy and practice, when we refer to it as **a decision to return based on a conscious choice between staying or returning, regardless of the legal consequences that this choice entails for the migrant involved**. A 'conscious choice' suggests that the migrant has information about the different options and their consequences, and that he/she is able

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<sup>61</sup> This is laid down, for example, in the Universal Declaration of Human Rights, which states that "the right to leave any country, including one's own, and *to return to one's country*" (article 13(2), emphasis added).

<sup>62</sup> To some, this does no longer constitute voluntary return, since there is no legal option to stay. The European Council for Refugees and Exiles, for example, has suggested that when a person chooses return because he/she has no legal option to stay in the host country, the term 'mandatory return' would be more appropriate (ECRE 2003). Nevertheless, also for these situations, voluntary return has remained the dominant operational term.

<sup>63</sup> In a report on the return of Afghan rejected asylum seekers from Denmark/Norway, the fact that the returnees considered deportation to be 'undignified' was an important motivator to return voluntarily.

to fully understand this information and has a realistic view of the consequences of choosing either of the options<sup>64</sup>.

#### **4.2.2 Going 'home'**

Another conceptual issue related to voluntary return is what it means to return. Discussions of return often revolve around the themes like 'going home' or 'going back'. However, it is questionable whether anything as clear as 'home' or a place to go 'back' to exists for migrants. Our respondents, for example, arrived in the Netherlands between one and six years before the interviews took place. In some cases, they have stayed in other countries than their home country before coming to the Netherlands. This time-lapse has several possible consequences. First of all, the situation in the country of origin, in all its aspects, might have changed significantly since the migrant left. This is particularly relevant for those who have been out of their countries for long periods of time. In other cases, conflicts might have started, intensified or stopped, resulting in a very different political and economic situation. On a more personal level, the very fact that the migrant has been away from his or her family, friends and community members, who may have stayed behind, can have an impact on the extent to which the country of origin can still be considered 'home' by the migrant. This is particularly true when taking into consideration the changes in the migrants him/herself, due to new experiences in the Netherlands, and of course due to having found out he/she is HIV-positive. For this reason, it is questionable whether migrants can actually come 'home'. This discrepancy between a remembered or even imagined situation in the country of origin and the reality once a migrant returns is often referred to as the 'myth of return' (see, for example, Al-Rasheed 1994, Zetter 1999).

Apart from this discrepancy, there is a practical difference between returning 'home' (often seen as the migrant's prior place of residence) and returning to the country of origin. While there may be a legal obligation to return to the country of origin, there is no obligation for the migrant to settle in his hometown or village. In fact, some returnees may prefer, for a whole range of reasons, to settle elsewhere in the country of origin. This may be related to family circumstances, for example, or economic opportunities. When we talk about returning in this report, therefore, we relate this to returning to the country of which the migrant has the nationality, which may or may not entail returning to his/her former place of residence or social network within that country.

#### **4.2.3 Sustainability of return**

A distinction should also be made between merely returning, or returning indefinitely (or at least for a prolonged period). While in this report we focus on long-term, sustainable return, this does not mean that this is always the objective of the returnee. Migrants may return to their countries of origin purely to comply with the obligation to leave the host country, without any intention to settle there. Indeed, they may migrate again very quickly after their arrival (either back to the original host country or another country) or may use their time 'at home' to make preparations for future migration.

Apart from implying a long-term stay in the country of origin, what constitutes a 'sustainable return' for migrants can differ according to their own specific circumstances (Black and Gent 2004, Van Houte and De Koning 2008). In chapter five, the twelve interviewed migrants

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<sup>64</sup> This is not always self-evident. For example, IOM in the Netherlands has repeatedly dealt with migrants who requested return assistance, but who were coping with psychological or psychiatric disorders. In these cases, a minimum requirement for providing assistance is that the migrant's doctor or counsellor declares the person involved to be capable of making sound judgements.

provide a number of conditions under which they would be able to not only survive in the countries of origin, but also to have a long-term future. Our discussion of sustainability, therefore, focuses on the long-term needs of migrants, should they return. While these needs may differ, we will focus primarily on those issues that are common to all the interviewees. As we shall see, the focus on long-term solutions adds an important level of complexity to the already intricate issue of return.

### 4.3 DECISION-MAKING ABOUT VOLUNTARY RETURN

If voluntary return is conceived of as a conscious decision of the migrant, it is also necessary to provide a basic framework for understanding of how such a decision would be made. It is important to note that the decision to return or stay in the host country is an extremely complex one, as well as very personal. The description below is therefore by now means meant as an all-encompassing conceptualisation of this decision-making process. Rather, it provides a broad theoretical framework that covers certain elements generally considered to be part of this process. The main aim of this framework is to explain how our discussions with migrants and other stakeholders have been structured.

Several studies have been undertaken to map the motivations of migrants to return home or to stay in the host country. Most of these studies employ a push and pull factor approach. In the host country, 'push' factors constitute negative reasons to leave. These factors vary in nature, and can be, *inter alia*, of a legal, political, social, economic or personal nature (see, for example, Black et al 2004: 12). The legal obligation to leave is an example of a potential push factor (although it may not be experienced as such by everyone), but they can also be lack of possibilities to work or the inability to integrate in the host country socially. 'Pull' factors, conversely, are circumstances which form positive reasons to return to country of origin, such as the presence of family members at home or the end of a conflict. Van Wijk (IOM 2008) also uses the terms 'stay' and 'deter' factors to describe those elements that make the host country attractive to the migrant and the country of origin unattractive.

Very generally speaking, the pull and push and stay and deter factors in the host country and the country of origin are weighed against each other by the potential returnee. It is important to recognise that the eventual decision to stay or go is not a matter of rational 'bookkeeping'; a tallying of the plusses and minuses of each alternative. Rather, the decision to stay or to return is one that is intensely personal, and emotionally and socially charged. Also, it is not necessarily the *de facto* situation in either the host country or the country of origin that forms the basis for the decision to stay or go. It can also be the way that these situations are subjectively perceived or experienced by the person in question form the basis of his/her attitude towards return. In our study, we mainly consider this subjective perspective. We will attempt to deconstruct this subjective perspective in chapter 5 by focusing on (1) the migrants' experiences in their countries of origin before migrating and the reasons for leaving their countries of origin; (2) their experiences in the host country and; (3) the migrants' expectations of the current situation in their countries of origin. Finally, we look the subsequent attitudes towards the issue of return of the migrants and their actual decisions to return or to stay in the Netherlands.

## 4.4 HIV-SPECIFIC CONSIDERATIONS

While the discussion above provides us with a broad framework for understanding decision-making about return, it tells us very little about the specific factors relevant to migrants living with HIV who are confronted with the question of return.

The first, and perhaps the most obvious, factor to consider is the medical aspect of living with HIV. When it comes to treatment of HIV, three related issues can be identified: availability, accessibility and adherence (Hardon et al 2006). The former two have already been discussed in the context of the Dutch criteria for residency on medical grounds. Availability, in brief, refers to whether treatment exists in a certain place. Accessibility, on the other hand, is more individually determined, and includes the affordability for an individual, as well as other geographical, social and economic factors that determine whether or not the individual can actually make use of the available treatment. Adherence, finally, refers to the ability of individuals, once they have accessed treatment, to take this treatment consistently and continuously. Since HIV is treatable but not curable, a migrant living with HIV, who returns to his/her country of origin, will have a life-long dependency on treatment. Therefore, the durability of availability, access and adherence is an important overarching concern.

These medical issues are closely related to the other two factors that emerge from the literature: economic circumstances and social circumstances. As we shall see, being HIV-positive can have a significant impact on an individual's ability to earn a livelihood and meet his/her needs and those of his/her dependents. Alternatively, economic circumstances determine an individual's ability to access treatment and adhere to treatment. The same goes for social circumstances. On the one hand, HIV can have an enormous impact on the social life of an infected person, of which plenty of examples will be covered by our respondents. On the other hand, social relations are important to the mental and physical well being of a person living with HIV, and may also determine his/her ability to earn a livelihood.

Before going into these issues from the perspectives of migrants living with HIV themselves in more detail, box 9 provides a short overview of some aspects of HIV, which are relevant to understanding the concerns and issues raised by our respondents in the Netherlands and the five pilot countries.

### **Box 9: Some consequences of being HIV infected and the importance of treatment adherence<sup>65</sup>**

It would go much too far to go into the intricacies of HIV and the effects it has on infected persons. However, it is important that some aspects of HIV are covered, albeit very briefly. We limit ourselves to a very basic summary of some issues that will come back during the discussion of the interviews with migrants living with HIV and the country assessments. This summary is primarily aimed at migration practitioners and policy-makers who may be unfamiliar with HIV.

**HIV** – The Human Immunodeficiency Virus (HIV) is a virus which attacks the immune system. The ability of the immune system to resist infections gradually reduces, though the period in which the system breaks down can vary significantly in individual cases (median time in adults is around 8 -10 years. If the immune system is in an advanced state of breakdown, the HIV infection may advance to AIDS (Acquired Immuno Deficiency Syndrome).

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<sup>65</sup> The research team would like to thank Dr Sybil Geelen of PharmAccess Foundation for her input on the report generally, and this overview particularly.

**Opportunistic infections** – because of their weakened immune system, people with an advanced stage of HIV infection are vulnerable to infections that would not normally affect a healthy person. These infections are called 'opportunistic infections'. For people living with HIV, many opportunistic infections cause serious health problems and often threaten the life of the infected person.

**Treatment and monitoring** – there is currently no cure for HIV, but it is treatable. Treatment is done through antiretroviral therapy (ART), consisting of a combination of medicines which aim to stop the replication of the virus. As a result of this, the immune system has the chance to recover. For the decision to start treatment the clinical condition of the HIV infected person is important but also his/her 'CD4 cell' number. CD4-cells are an important sub-group of immune cells. When they are too low, a person will need to start therapy to prevent further illness. To determine the effectiveness of therapy, clinical recovery and recovery of CD4 cells are relevant, but also the 'viral load'. With a viral load test it can be determined if the HIV is optimally suppressed. Viral load tests are complicated and expensive, and availability in resource-limited areas is often limited to a few specialised centres.

**HIV resistance and adherence** – During any kind of antiretroviral treatment it is possible that the HIV virus becomes resistant. This means that the treatment is less or no longer effective in fighting HIV. The most important way to limit the danger of developing resistant HIV strains is to take medication consistently and continuously. Gaps in treatment significantly increase the chances of HIV becoming resistant to the combination of medicines that is taken. Adherence to treatment is therefore essential, particularly in situations where alternative drugs, and more complicated combinations, are less available, as is the case in many resource-limited settings

**Nutrition** – Different combinations may require different ways of taking medication. Some need to be taken with food, in order to assure the optimal effectiveness, others should be used on an empty stomach. Also, HIV infected persons generally benefit from a healthy diet.

**Psychological issues** – Being HIV-positive usually has a strong psychological impact. Stress, anxiety, fear of stigmatisation, fatalism and depression may all be experienced by the infected person. Several experts note that the relationship between HIV and psychological issues is cyclical: HIV can have an effect on the psychological wellbeing of a person, while at the same time the psychological wellbeing of the person is an important factor in successfully treating HIV. Stress, for example, might speed up the spread of HIV, while a positive attitude might make it easier to stick to a treatment regime.

*Further information about HIV and its consequences can be found, for example, on the website of the Dutch HIV Association ([www.hivnet.org](http://www.hivnet.org)), and The Body, a resource website on HIV and AIDS ([www.thebody.com](http://www.thebody.com)).*

# Part II: Results



# CHAPTER 5 – MIGRANTS' PERSPECTIVES

## 5.1 INTRODUCTION

In this chapter, we will present the results of the interviews with migrants living with HIV in the Netherlands. Between May and September 2007, twelve interviews were held. The respondents represented a wide variety of nationalities and legal categories. An overview of the characteristics of the respondents is provided in box 10. For the sake of anonymity, the names of the respondents have been changed.

**Box 10: characteristics of respondents**

Name*	Gender (M/F)	Country of origin	Age	Years in Neth.	Receiving medication?	Legal status
<i>Helen</i>	F	Sierra Leone	Mid-30s	5	Yes	Awaiting decisions on asylum and regular permit (medical)
<i>Virginia</i>	F	Uganda	Early 20s	3	Yes	Regular status (medical)
<i>Carolyn</i>	F	Zambia	Early 20s	2	No	Rejected for regular permit (medical grounds), intends to re-apply
<i>Sylvia</i>	F	Southern Africa**	Early 30s	2½	Yes	Awaiting decision on asylum application
<i>Diane</i>	F	Zimbabwe	Late 30s	4½	No	Regular status (labour)
<i>Elizabeth</i>	F	Zimbabwe	Mid-20s	6	No	Initially as a student. Currently awaiting decision on asylum application
<i>Margaret</i>	F	Nigeria	Mid-30s	3	Yes	None, intends to apply for regular permit (medical grounds)
<i>Michael</i>	M	Nigeria	Late 30s	1	No	Awaiting decision on regular permit (medical grounds)
<i>Frederick</i>	M	Nigeria	Late 40s	4	Yes	Regular status (medical grounds)
<i>Kenneth</i>	M	Ghana	Mid-40s	5	Yes	Renewal of regular status (medical) rejected. Awaiting decision on appeal
<i>Simon</i>	M	Cameroon	Early 30s	3	No	Asylum status
<i>Philip</i>	M	Cameroon	Late 30s	6	Yes	Rejected for asylum, now has regular permit (medical grounds)

\* All names have been changed to protect the anonymity of the respondents

\*\* To safeguard anonymity, if fewer than 10 persons living with HIV from the country of birth of the respondent are in the Netherlands (cf. HIV Monitoring Foundation, June 2007), the nationality of the respondent is withheld.

As suggested in the previous chapter, the factors that lead to a migrant's decision to return or to stay are highly dependent on the interplay between various factors, which in turn are highly specific to the individual's situation. It is impossible to exhaustively discuss all these factors and circumstances for each of our twelve respondents. Instead, a summary of the narratives of the respondents is provided, which covers five specific dimensions:

1. the experiences of the migrants while still in their countries of origin and their reasons for migrating to the Netherlands (5.2)
2. their experiences in the Netherlands (5.3)
3. their current perceptions of conditions in their countries of origin (5.4)
4. their deliberations about staying or returning (5.5)

In line with our framework set out in chapter 4, the discussion of these issues will broadly focus on medical, economic and social circumstances, while also leaving space for other issues of concern.

## 5.2 PRE-DEPARTURE LIVES AND REASONS FOR MIGRATING

### 5.2.1 Access to medical services

With the exception of Sylvia, who lived in South Africa and in her own country of origin for a few years after discovering she had HIV, all of the respondents say that they did not know they were living with HIV while still in their countries of origin. Some explain that they were already experiencing some medical problems, which could possibly have been related to HIV. Most of them had not had an HIV-test, however<sup>66</sup>. For this reason, most respondents do not have first-hand experience trying to access or receiving HIV treatment in their countries of origin. Some did have experiences with family members and/or friends who were (thought to have been) HIV-positive. These experiences are without exception negative. Kenneth from Ghana believes that two of his brothers were HIV-positive and that both of them died due to lack of treatment. Virginia from Uganda explains that when she was young, her father brought her to a hospital where he worked. There she encountered people living with HIV:

“And I say: ‘why are they looking like that? Why are they skinny?’. [My father] tells me: ‘they are positive.’ I said: ‘do they get medicine?’. He said: ‘some.’ So he tried to explain to me. I was young then, but it [stuck] in my mind.... Still my heart [hurts for] those hundreds of people I saw in the queue, and some were lying on the ground. That picture never gets out of my mind.”

Michael went to get tested while still in Nigeria, but found the experience disconcerting:

“The hospital was not organised... They told me to come and take the results. When I came back, they found that there were some results missing, [my file] is not complete. When you ask, they say they don't know about it – you should go to another office. If you go there, they say: we don't know about it; you go to the other office. It is the same problem for many people there. You will be annoyed. I went there for my second blood test, but I didn't get it. I met the doctor; he told me: ‘you have to do some questionnaire, I will tell them to look for it.’ But I didn't see it.”

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<sup>66</sup> Apart from Sylvia, Michael is the only respondent who said to have had an HIV test in his country of origin.

Sylvia is the only respondent with moderately positive experiences. She was included in antiretroviral trials when she was living in South Africa. However, after she went back to her country of origin, the logistics of accessing medication caused significant problems, and Sylvia stopped her treatment.

Unsurprisingly, given the fact that most respondents were not, or did not know that they were, HIV-positive, medical issues did not play any significant role in the decision to migrate to the Netherlands. The pull exerted by the quality and accessibility of the Dutch health care system (which, as explained, also provides medically necessary care to all migrants, regardless of their legal status) is sometimes cited as one of the reasons to restrict the number of persons eligible for a regular status on medical grounds. Some argue, that this would curtail so-called ‘medical tourism’, migration flows particularly driven by the search for higher quality health care (see, for example, NRC 2000). In the case of our respondents, there is no evidence for that ‘medical tourism’ was an issue. Even in the case of Sylvia, who knew she was HIV-positive before coming to the Netherlands, the accessibility of treatment only seems to have played a very limited part in her decision. She had previously been able to access treatment in South Africa and in the UK, where she also lived. In each case, she decided to leave the host country anyway, choosing to abandon this treatment when she did.

#### **Box 11: Health care as a pull factor for migration?**

Restrictions on residency on medical grounds are sometimes related to a fear of Western policy-makers and the general public that more lenient measures would encourage ‘medical tourism’<sup>67</sup>. Insofar as this is a motivation behind health-related immigration policies, it would be important to explore in more detail whether this fear is realistic. While there is an increasing body of literature on the links between migration and health, this tends to focus on the health care implications of migration, such as the health of migrants or the access of migrants to health care facilities once they are in the host country. However, some of the literature concerned with access to health care for irregular migrants and failed asylum seekers in Western countries has also addressed the question whether migrants are actually motivated to go to those countries because they provide them with high quality health care. This literature suggests that this is not the case. Faliek (1997: 980) asserts that in the United States, “health care is not a *pull* factor, nor will the halt of health care *push* immigrants away.” In the context of European countries, this view is supported by Romero-Ortuño’s later study of the policies of six EU member states. He suggests that “‘generous’ measures” for providing health care for undocumented migrants will “*not* have any ‘disastrous’ consequences”, such as providing a pull factor for potential immigrants (Romero-Ortuño 2004: 268).

The studies mentioned above are concerned with access to health care in general, and not with HIV treatment specifically. However, they indicate that fears of ‘medical tourism’ are not generally supported by evidence. Further research would be required to ascertain whether this is similarly true for HIV treatment.

#### **5.2.2 Economic opportunities**

In terms of their economic situation, the conditions of our respondents before their departure to the Netherlands vary considerably. Some interviewees (Michael, Frederick) were running their own businesses, while others had steady employment (Simon) or were studying (Sylvia).

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<sup>67</sup> When the revision of the Dutch aliens’ legislation was discussed in parliament in 2000, it was indeed suggested that one concern was that ‘medical tourism’ should be curtailed (Document of the Parliament (*Tweede Kamer*) 1999-2000, 26732, no. 14). A similar development has occurred in the United Kingdom, where “the declared purpose of the 2004 Charging Regulations was to crack down on ‘health tourism’” (Yates et al 2007: 299).

There are, however, few – if any – of our respondents that could be considered affluent citizens in their home countries. In many cases, the respondents had low-income (subsistence level) jobs, or none at all. Virginia from Uganda, for example, was living in a camp for internally displaced persons, after fleeing violence in the north of the country. Margaret depended on her family for housing and food. Quite a few respondents had enjoyed little formal education.

On the whole, it proved complicated to get a clear picture of the economic circumstances of the respondents while they were still in their countries of origin. The interviewers noted a certain reluctance of some respondents to explain why they chose to leave their countries. The negative connotations of the term ‘economic migrant’ in the Netherlands may have had something to do with this. Nevertheless, economic reasons for going to the Netherlands seem to have played quite an important role in the decision of most of our respondents.

That the search for ‘a better life’ was quoted as an important motivation to migrate is unsurprising given the economic situation of most respondents in their countries of origin. Whether or not this was intended to be long-term migration or only temporary is not always clear. Some seem to have had particular ‘projects’ in mind: goals they wanted to achieve before going back, such as completing a study or saving up a certain amount of money. In the case of Frederick, for example, there seems to have been no intention of staying in the Netherlands for a prolonged period, as he regularly travelled between Nigeria and the Netherlands for business. He more or less became ‘stuck’ in the Netherlands after being diagnosed with HIV. This is also true for other respondents, for whom finding out they were HIV-positive has completely disrupted any previous plans for their futures they had.

### **5.2.3 Social issues**

In terms of social relations, the situations are very different again. Some respondents did not have family members to rely on when they were still in their countries of origin. Virginia, for example, lost both her parents. Others did (and still do) have parents, siblings and even children in their countries of origin. Since the respondents usually did not know for certain that they were infected before they left their countries of origin, they have had no face-to-face reactions to them being HIV-positive from their families or friends. Sylvia, the only person to have been with her family while knowing (and telling them) that she was living with HIV, found them to be supportive. Similarly, most respondents do not have first-hand experience of how it is to live in their home societies as a person with HIV.

Social relations are generally considered to have a strong impact on a decision to migrate. The decision to migrate is seldom a decision that an individual migrant makes without significant influence from his/her direct social network. Furthermore, the lack of a social network (e.g. the disintegration of family ties in a civil war situation) may be a reason to migrate. More specifically, the destination itself may be influenced by existing social networks in a specific country. If family members, acquaintances or a large community of compatriots live in a certain country, this may provide a potential migrant with more opportunities than if he/she would migrate to a country with which he/she does not have any social connections (see, for example, Koser and Pinkerton 2002).

Within our group of respondents, however, there is only limited evidence that social relations have been a major reason for migrating, although there are some exceptions. Some respondents suggest that they had very little social support in their countries of origin. It is most likely that the impact of this on their livelihoods played a central role in the decision to

migrate. Likewise, the decision to come to the Netherlands only seems to be connected to pre-existing social relations in relatively few cases. Carolyn, for example, came to the Netherlands because members of her family were there. As mentioned, Frederick came to the Netherlands for business. In some other cases, a completely different kind of relation contributed to the ‘selection’ of the Netherlands as their destination. In the cases of Helen and Virginia, a ‘travel agent’ (i.e. a trafficker) chose the destination, with the respondents themselves not having a say in this.

It should be noted, that deconstructing the role of social relations in this matter is a very complex matter. Given the primary focus on issues related to HIV in the interviews, as well as the limited time available, the impact of social relations on the interviewees’ migration decisions can only be addressed here very superficially.

#### **5.2.4 Security**

Another major issue in the pre-migration lives of a few of our respondents is that of insecurity. Simon and Philip, both from Cameroon, experienced “political problems”, which made their lives untenable in their country of origin. Virginia spent a number of years in an internally displaced camp, was raped, and experienced problems with the authorities of Uganda. Helen’s tells that the conflict in Sierra Leone prompted her to leave. It is important to emphasise that our focus on issues related to HIV does not detract from the importance of experiences. In the cases of some of our respondents, factors like political security, that are completely unrelated to the issue of HIV, are just as relevant, if not more, in migrants’ attitudes towards return.

### **5.3 SITUATION IN THE NETHERLANDS**

#### **5.3.1 The impact of legal status**

When dealing with the respondents’ situations in the Netherlands, the issue of legal status cannot be ignored. As already discussed in chapter three, the legal status of migrants (or lack of it) has an enormous impact on the way these migrants can live their lives in the Netherlands. Our respondents, as listed in box 10, represent almost the full spectrum of legal possibilities. Michael is an irregular migrant. Several of our respondents are in possession of the coveted (temporary) medical emergency permit, while others are still awaiting a decision on their application. Our list of respondents also includes those who have a legal status that is not based on their HIV-positive status. Simon, for example, has been granted an asylum status based on his political problems in his country of origin, while Diane has a residence permit for work purposes<sup>68</sup>. Neither of them received antiretroviral treatment at the time of their interviews, but – contrary to those applying for a permit on medical grounds – this did not have an impact on their eligibility for a legal status.

It is worth noting that Michael is the only person who is not at least in a procedure to obtain a legal status. At the time of the interview, he said that he would start his antiretroviral treatment in one month, and would then immediately re-apply for a permit on medical grounds. The need for a legal status is emphasised by all our respondents. For those who do not have such a status, obtaining it, and thus avoiding the legal obligation to return, is their most important immediate goal. Holding on to their status is a major concern for those who have it<sup>69</sup>. Even for those who may have some intention of returning to their countries of origin,

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<sup>68</sup> Because this latter permit has no connection to the applicant’s HIV-positive status, it has not been discussed in chapter 3.

<sup>69</sup> Recall that the regular permit on grounds of a medical emergency is reassessed on an annual basis.

a legal status is a prized possession, as it provides a ‘safety net’ of some sorts. Furthermore, for as long as they are living in the Netherlands (and many intend to stay there indefinitely), life without a legal status is regarded as unacceptable. As we shall discuss below, the possibilities for HIV-positive migrants to sustain themselves without documents are generally smaller (often considerably so) than for their counterparts who are not HIV-infected. It is therefore unsurprising that obtaining a legal status is such a central concern to them.

### ***5.3.2 Access to treatment and coping with HIV***

Those respondents who were receiving treatment reported very few problems in accessing health care services. They all said they went to hospital regularly and obtained their medication. All those who were not yet receiving treatment went for regular check-ups and were in touch with HIV counsellors in hospitals.

Few respondents talked specifically about their health situation, although some explained that they experienced physical limitations due to either HIV or the side effects of the medication. These limitations, as we shall discuss below, mainly impact on their ability to earn a livelihood. Perhaps more poignantly, however, a number of respondents chose to emphasise their psychological, rather than their physical well-being. First of all, many respondents said they experienced a lot of stress on account of the uncertainty over their legal status. Secondly, they spoke of the mental impact of having to come to grips with the fact that they were HIV-positive. This is particularly true for those who had only recently become aware of their status. Margaret, for example, had found out she was living with HIV only a few months before the interview took place. At the time of the interview, she was still focused almost wholly on dealing with her new situation:

“I don’t want to accept that I have HIV. I don’t want to talk about it – I don’t even know why I am doing this interview. Because I can’t adjust, don’t want to believe I have...to live on drugs. Already life as it is... then you have to live on drugs – going to the hospital every time to get drugs, to live on drugs. I am not normal anymore...”

Others experienced similar feelings, but suggested that the counselling they received in the Netherlands helped them to develop a positive outlook again. Frederick from Nigeria, for example, wanted to go home to die as soon as he heard he was HIV-positive: “my conclusion by HIV [was] that if you have it, you are going to die.” “But”, he continues, “the doctor said that...if you have HIV that doesn’t mean you are dying. You can still have a normal life.” At first, Frederick did not believe this: “I insisted that I wanted to go back... They had to put someone at my door to be sure that I don’t go and run away.” Eventually Frederick was convinced to continue his treatment and to apply for a residence permit on medical grounds. When the interview took place, Frederick had been on treatment for several years, and was in possession of a residence permit. Furthermore, he became an active member of a support group for Africans living with HIV, helping others to accept their situation and look towards the future again.

Helen from Sierra Leone, who was awaiting a decision on her asylum application, told a similar story:

“I didn’t believe [I would survive] until I asked almost three or five nurses if I was going to die. They all said I was not going to die. They gave me courage. The social workers came to educate me, to tell me about the problem, how people can still have life.”

This positive outlook, as Diane from Zimbabwe explained, is crucial for both the mental and the physical well-being of persons living with HIV. She experienced herself how the stress about being HIV-positive had a severe impact on her health:

“If you accept things the way they are... Initially, you know, I was really drained...I lost weight and everything because I was so worried and because I wasn't eating at all – I couldn't. But with time, talking to other people, my family's support and everything, it changed. I started to work and everything.”

This importance of social support in gaining a positive attitude towards life generally, and living with HIV particularly, is emphasised by others as well, and we will come back to this later on.

### **5.3.3 Economic opportunities**

Only a few of the respondents had a status that allowed them to work legally. Diane's permit based on her work contract is a notable exception. Simon, who had an asylum status, also had the possibility to work legally, but he had not found a job yet. Those with a residence permit based on a 'medical emergency' did not have the right to work, sometimes to the frustration of the respondents. Philip, for example, felt well and wanted to work. Like the other respondents with a residence permit on medical grounds, he was on social welfare benefits to sustain himself. Helen and Simon were staying in an asylum seekers' centre, and received a small stipend.

For those who did not have either a job or received state support, the situation was precarious. Many relied on the support of local charities that helped them financially<sup>70</sup>. This assistance just about helps them keep their heads above water. Michael, for example, explained: “I am struggling... Every month I go to [this charity] to collect 375 euro... So that is how I am managing.” Margaret was relying on some friends, as well as the same charity to get by. She said this was not enough to meet her basic needs, but that it “is better than nothing”. Before finding out that she was HIV-positive, Margaret had fewer problems getting by without a legal status. She sustained herself by doing informal jobs here and there. By the time of the interview, this was no longer possible for her, since her health often did not allow her to work:

“You know, I don't have strength. Maybe some times...when I walk for too much... when I walk for one hour, two hours, it's like I want to faint... I don't know if it's just because of the medication, at least it was like that in the beginning. It depends on my body, sometimes I get weak, I get dizzy... The drugs are really affecting me.”

This situation was reiterated by others. Although some were still able to find some (unofficial) jobs to do now and then, they found it increasingly difficult to muster the energy needed for living outside the legal framework of Dutch society. It is thus clear that living with HIV has made it even hard to survive and even harder to realise whichever goals they wanted to achieve by coming to the Netherlands. Most respondents spent the little income they had, from whichever source it came, on surviving. On account of the costs of treatment, many of

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<sup>70</sup> These are the same charities that helped identify potential respondents. As such, the fact that a large proportion of the respondents receive assistance from such charities may not be representative. In fact, there are indications that our respondents are part of the 'lucky few'. Philip, for example, suggested that there are many migrants living with HIV who do not have any kind of assistance and are afraid to seek it. This, according to him, leads many of them – men and women – to resort to prostitution.

the respondents were accruing debts<sup>71</sup>. Philip, for example, had to use part of his social welfare benefits to pay back his debts to his pharmacy.

Of all the interviewees, only Elizabeth reported sending money back home. However, since this was not a specific topic for discussion in the interviews, it is unclear whether this makes her an exception. Nevertheless, given the financial situations of our respondents, if remittances were being sent, these were likely to be very limited<sup>72</sup>.

#### **5.3.4 Social issues**

The importance of social networks was emphasised by almost all respondents. These networks provided access to opportunities to sometimes earn some money, but more importantly, they provided the social support that helped many of the respondents cope with their situation. Diane and Elizabeth, for example, were both members of a support group for women living with HIV. Diane said that “talking with other people... actually helps me a lot”. Elizabeth supported this view: “I think, the main thing is that you realise you are not the only one. It can happen to anyone and so that’s why now I am more accepting than I was before.” She added: “For me, I get so much support from these people – they are like my good friends.”

The support groups provides an opportunity to talk about living with HIV, that none of the respondents thought possible with other Africans who are not HIV-positive, as Kenneth explained:

“The problem is that you cannot tell people about your problem... So it is [inside] you... the only place where we can express our problems is in this [support group], where you know that all who are coming there have the same problem as you... to go to your own community I don’t think is easy for anyone. You know our people, especially African people. [If] they hear that [you are HIV positive], even the cup you are drinking from, nobody will touch it. So it is something you should really keep to yourself.”

This stigma led some other respondents to close themselves off completely from other Africans, mainly out of fear that their HIV-positive status would become known. Michael explained:

“Nobody has ever known that I have something like that. I don't let it out for them to know, because I am scared for it. If you let them know, you would be another caste. They would be commenting to you, you understand?”

For this reason, they tended to keep the fact that they were living with HIV hidden from others, in particular other Africans. When they did disclose their status, this was usually to others who are living with HIV. The fear of being sidelined by the community has led some respondents to almost withdraw from social life altogether. Philip, for example, said he tried to avoid contact with others as much as possible. He suggested that if someone knew about his HIV-positive status, soon the whole community would know. Therefore, he preferred not to interact with other Africans.

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<sup>71</sup> Recall that treatment is not free, although it will be provided even if the person in question cannot pay for it (see chapter 3).

<sup>72</sup> Remittances have become a very important topic in migration studies. Not only is it regarded as a powerful instrument for the development of the families of migrants and more generally their home countries, it is also increasingly seen as a means to create ‘social capital’ that would enable migrants to return and reintegrate more easily.

## 5.4 EXPECTATIONS OF SITUATION IN COUNTRY OF ORIGIN

### 5.4.1 *Shaping expectations*

Discussing the respondents' expectations of which situations they would encounter if they went back, proved to be a difficult exercise. As already suggested, many of the respondents were focused almost exclusively on the immediate task of surviving, and on sorting out their legal status. Talking about return, even if only hypothetically, did not fit in well with these concerns. Also, since many of the respondents did not see return as a viable option (see 5.5), they saw no need to discuss what their lives would look like if they returned.

Nevertheless, all of the interviews yielded some information on what the respondents expected the situation in their countries of origin to be. From the interviews several factors emerged that helped shape these expectations. These included the pre-departure experiences of the respondents, their level of knowledge about recent developments in their countries of origin since their departure, and the influence of their social networks. The experiences of the migrants while still in their countries of origin have already been discussed (see 5.2). These experience often had quite a negative influence on how they saw their prospects should they return. As Helen from Sierra Leone said, as soon as she found out she was living with HIV "I just took my brain back home. I saw the situation, how people die of HIV."

Memories of pre-departure experiences did not form the only basis for the respondents' expectations. After all, they had left their countries of origin between one and six years prior to the interviews. The information they had received about developments since their departure also played a role. The extent to which the respondents had sought or received information about the circumstances in their countries of origin, however, varies. Simon, who drew mostly on his experiences before coming to the Netherlands three years earlier, acknowledged that "maybe things have changed." He had not tried to find out whether this was actually the case though, since he feared persecution in Cameroon and would not return to his country of origin regardless of the medical, economic and social circumstances. This does not mean that all respondents who rejected the idea of return did not have an interest in the state of, for example, antiretroviral treatment in their countries of origin. For them, however, obtaining such information was important for securing or prolonging their residence permit on medical grounds, and not as part of any plan to return.

There were some, however, who followed developments closely with an eye on a possible return, such as Sylvia and Virginia. In her interviewed, Virginia cited a number of reports, newspaper articles and statements by officials. She had little confidence in these sources though. According to her they provided a biased picture of the success of HIV prevention and treatment in her native Uganda, just to satisfy donors.

Negative perceptions of return also seemed to be reinforced by the social networks of which the respondents were part. While this was not explicitly stated by the respondents themselves, several of the consulted experts suggested that there was considerable pressure on migrants to maintain the image that return would be impossible no matter what. The tendency to frame return as negatively as possible has also been noted by Engelhard in his study on return for migrants with health problems. He quotes a health care worker who suggests:

“The problem is that asylum seekers picture the possibilities of return vis-à-vis themselves and their environments negatively, in order to reinforce the necessity of a residence permit (in terms of ‘return equals death’)” (Engelhard 2004: 84-85).

This does not mean that these negative perceptions of the situation in countries of origin are necessarily inaccurate. It does, however, suggest that they can be part of some kind of collective coping strategy. The reinforcement of certain images of countries of origin is also illustrated by the interviews with Frederick and Kenneth, who were part of the same support group. In his narrative Frederick quoted the prices of medication in the Netherlands and projected this directly to the situation in Nigeria. During the interview, Frederick produced several boxes of medicines and showed the prices: € 404.00, € 222.22, € 561.88. He explained:

“And this I have to consume every month. So what kind of work would I do [in Nigeria], so I can earn such an amount of money to be able to buy this medication every month? If you stop for one reason that you can’t continue for a few days, it becomes a problem... In my country I don’t know many people who can earn 1,000 euros permanently in a month. And if I don’t earn this money, how can I buy this medication [and get] the intensive treatment you get from the [Dutch] hospital also?”

Strikingly, given the distinct differences between the situations in their two countries, Kenneth from Ghana did exactly the same in his interview.

By contrast, while not mentioned by any of the respondents, there may also be pressure on migrants from within their communities to return. An illustrative case was provided when the research team came across a Ghanaian man in the Netherlands who wanted to know more about the possibilities of IOM to provide return assistance to a Ghanaian woman in his care, who was living with HIV. According to this man, the woman (who was not present) was seriously ill, and she was adamant that she wanted to go back home because this would be much better for her. When pushed on this issue by a representative of a support organisation for Africans living with HIV, who hosted the researcher and the Ghanaian man, the latter repeatedly complained of the burden he faced taking care of this woman, whose situation did not allow him to work<sup>73</sup>. This raised serious concerns about whether it was indeed the woman’s desire to return, or rather her caregiver’s<sup>74</sup>.

While anecdotal, both the case of Frederick and Kenneth, and the situation described above, suggest that if the issue of how migrants see the possibilities for return in their countries of origin is to be better understood, a focus on the mutual influence of migrants may be very insightful. Unfortunately, given the nature of our data, we have to limit ourselves to noting it as an issue that would require further research.

#### **5.4.2 Medical situation**

None of the respondents believed that accessing treatment in their countries of origin would be unproblematic. In fact, they listed a large number of concerns in relation to getting antiretroviral treatment and other medical care. The first issue was that of availability. Some believed that for them, no appropriate treatment existed where they would return. Margaret,

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<sup>73</sup> Coincidentally, the woman was allegedly doing fine when she was still receiving treatment from the local hospital, but she had discontinued this treatment on the advice of a member of her community, who had suggested she should bring her medication back to the hospital and limit herself to praying for her recovery.

<sup>74</sup> This is one of the reasons why IOM Netherlands never assists in the return of the migrant if he/she has not personally requested this.

for example, suggested that in her hometown “there is no government hospital there, maybe just a [primary health] clinic.” More often, however, respondents focused on the accessibility of treatment, rather than its existence. Affordability of medical care and drugs was a primary concern for almost all respondents. Simon stated that “you have to buy [medication]. There is no free medication. If you have money, you pay medication. That is how Cameroon is, as I know.” Kenneth was just one of many who confirmed the idea that medication was only accessible to those who were relatively well off: “Even to go for a check up, control in Ghana costs a lot of money. When you hear you have this problem there, then you are waiting [to] die... Only those with a little money they can use it...” Helen from Sierra Leone had a similar view: “If you are not rich, you are only waiting to die.”

Even with a decent income, some respondents said, they would still not be able to solve the problem of accessing treatment, because the provision of treatment could be unreliable. Michael explained:

“[The medication they have] is not the medication they use to cure. It is incomplete. Because the time I went to hospital, there were many people. This is the hospital they say that the government is sponsoring and drugs and everything. But the problem is that all these drugs, if they get it, they will sell it at the back. You understand? So, for the masses to come and collect it, they cannot. Sometimes some of them who would come, they will give them [something]. Like somebody who used to take three types of medication, when he will come they give him one and say that the other two are not there, that they don’t have it. And you know that when you start the medication you are supposed to take it regularly, every day the same time. The problem is complete medication. It is not easy”

Diane from Zimbabwe agreed: “Some of the medication is not there. You might have the money, but you won’t find the medication... it has to be sourced out from...neighbouring countries or here [the Netherlands].” According to the respondents, unreliability was also connected to the quality of health care. Frederick explained:

“If you stop for one reason that you can’t continue for a few days, it becomes a problem... And if you get resistance of these things, then it becomes more difficult for the doctor to handle... When I started medication I didn’t start with this one. They have to take blood to see which one works well, which one does not. Even with advanced technology they cannot get it [right] in one time... Let’s assume I [can] buy medication in my country. What about other factors like a good professional doctor?”

These are just some of the examples of the issues raised by respondents with regards to their medical situation, should they return. These concerns about availability, accessibility (in particular affordability), reliability and the quality of health care are common to all interviews.

#### **5.4.2 Economic situation**

All respondents agreed that an income was not only necessary to meet basic needs, but – as already suggested – could also be a piece of solving the puzzle regarding access to treatment. However, expectations of being able to earn enough money to sustain oneself *and* to cover all costs related to treatment, were generally low. Elizabeth suggested:

“Well, if I have to go back it would be terrible because at the moment, even for someone who has a normal job, even to take care of themselves it’s difficult. And for me, maybe by that time I will be taking my medication, so I don’t think I will be able to even pay for my medication and expenses, because I won’t have a job by then. So it will be very difficult when I go back..”

Elizabeth's concern is particularly noteworthy because she was – in contrast to some of the other respondents – highly educated. According to Carolyn from Zambia, was no guarantee for a positive economic outlook. She explained that in her country: “even those who are educated – they have gone to university – it is difficult for them to find a job. [...] you see people who are educated, they have papers, and [they're] not working.” Sylvia suggested that even if one is able to get a job, this may not be enough. One of Sylvia's wishes was to become a teacher, but she thought this would not be a viable option in her country of origin:

“It's a romantic idea to do a teaching career. You know, you don't earn much money as a teacher and...if I get medical aid, because I am HIV-positive, I have to pay much more into my medical aid than anybody else – and that's a big chunk of my salary. Perhaps...housing is not so much of an issue if I live in a rural area – I won't have to pay a big bond.”

However, Sylvia also explained that accessing treatment would be a lot more difficult in rural areas, thus negating any economic benefits of living there.

#### **5.4.3 Social situation**

Having a support network provides both an emotional safety net as a practical one, as Diane explained: “I have two kids to look after... In case I get sick, who's going to look after them? Because they need to go to school and things like that.” Whether or not the respondents expected to have a social support network in their countries of origin was dependent on very personal circumstances. Virginia from Uganda lost both her parents and lived alone in a camp for displaced persons, while Helen lived alone in Sierra Leone until she was brought to the Netherlands. Others had relatives, but did not expect to be able to rely on them, such as Carolyn from Zambia:

“All my family [on my mother's side] are dead... My brother is very very sick and my father... I have my father in Africa but he cannot take care of me. He is married, so he is just with his wife and they have their children there. So if I go back today to Africa, I will be stressed with many things...”

Another major issue for the respondents was the whether their family members and friends would accept them. Only a handful of respondents had actually told relatives and friends that they were HIV-positive. Sylvia found that her family and friends accepted her situation when she was living with HIV in her country of origin before coming to the Netherlands. Diane, although she had not been back, had found her family to be “very supportive”. Most others, however, felt that it would be impossible for their families and friends to deal with the fact that they were living with HIV. In Michael's case, only his older brother knew about his HIV-positive status, and he was afraid to tell other members of his family. Margaret also did not want to inform her mother that she was living with HIV: “she would even die before me”. Frederick suggested that his family would outright reject him if they knew he had HIV:

“Here in Europe now, HIV people, you hardly know them – did you know I am HIV positive? But where I come from in Nigeria, you can know, because there is no medication... all people know [when someone is HIV positive]. Maybe your family, they'll even disown you. If your family disowns you, they'll even make you want to kill yourself...it's like you don't even have family there, what kind of life are you living? So is it not better just to stay here? [Your family] cannot live with the shame, the disgrace, nobody wants to live with you. Your family, they disown you, they chase you out of the

house, you don't have friends anymore...though it's not good here, there, it's just, it's not a place to live. When you have this kind of sickness, it's not a place to live at all."

The stigmatisation and discrimination, Frederick suggested, would also affect his ability to earn an income. He had a trading business in Nigeria, but would have great difficulties to work with his old partners, who "when they find out about my AIDS, might be keeping their distance." As such, the reactions and support of family and friends, as well as the way in which society deals with people living with HIV in their countries of origin, were important deliberations for our respondents.

## 5.5 DECISIONS ABOUT RETURNING

### 5.5.1 *To return or to stay?*

When dealing with the issue of deciding about return, two separate groups can be identified among our respondents: those who had no intention to return, and those who might consider it, given the right conditions.

Among those who dismissed the possibility of returning out of hand were Frederick, Kenneth and Helen. For Frederick, this had, to some extent, to do with the stage of his life he is in. He did not want to make any plans for his long-term future:

"I am already in my future. I'll be fifty. A man of fifty should not be interested in his future. So I am living my future. I have kids. I am not looking for children anymore, I am not looking for a wife. What I am thinking is just to stay alive for a while. I don't know how many more years I have to live with this illness. I am living my future now."

Just "staying alive" was his main consideration, and this was possible because of the medication that he received in the Netherlands. Although he did not consider his situation ideal, he had a legal status which gave him peace of mind: "Otherwise I am not so comfortable; all my family [is] back there and I am staying here. But as it is now, because I have a permit, I can always go visit them and come back within one month."

Helen found it difficult to lead her life as she wanted in the Netherlands. Nevertheless, because of the availability of treatment, she wanted to stay in her host country at all costs:

"I want to be active. I want to be busy. I want to do something which will distract my brain from thinking... Of course in my country, I'll be more active than here. But the problem is that most people say if you go home you'll have medication. All these things are not true... If I should go back to my country it would be destroying my life. [Being in the Netherlands] is an opportunity God gave me. I see it as a chance to live. The last thing I'll do is go back to my country like now, because I need medications and I can get them here. I have no reasons to go back now."

Helen did not know whether she would be allowed to stay in the Netherlands, but was clear that she would prefer living as an irregular migrant over returning: "before...I was living out of procedure. I was on the street, but [the charities] took care of me." Like Frederick, Helen did not have a long-term focus. Her immediate concern was gaining a legal status, and she found it almost impossible to look beyond that: "I don't really want to think about the future. My life is short. I can't make plans. I wait for what the future brings. I don't have plans whatsoever, no. I just sit down and wait."

Margaret from Nigeria, who had recently started her antiretroviral therapy was also focused on the here and now:

“For now, I just want to concentrate. I started with the medication and am getting better. The medication is really breaking me down right now. I just don’t know, for now I just want to see if they will help me ... Maybe [also] just look for something so I can be supporting myself, helping myself, pay my bills, pay my rent.”

For her, return was out of the question: “if I [have to] go back, maybe I’ll just kill myself”. Kenneth also believed return could never be an option for him. Like the previous respondents, Kenneth saw major problems in accessing medication if he would be back. However, for him this was not the main consideration for not wanting to go back. Rather, it is the way society in his homeland Ghana deals with people living with HIV that is his major concern:

“Brother, I’ll never dream about going back. Because I know my country and even [if you can] get medicine, you are not comfortable in your own society, even in your own family. People don’t think you are a human being – they think you are something else.”

As suggested, there are also those who said they could not return for reasons unconnected to their HIV-positive status. Both Simon and Philip had fled Cameroon for political reasons, and had no intention of returning even in the hypothetical situation that all issues related to treatment, and economic and social reintegration could be resolved.

The second group of respondents would prefer to stay in the Netherlands, but could envisage circumstances in which they would consider returning. For some this was related to whether or not they would be able to get a legal status. Carolyn, from Zambia, for example, was not very satisfied with her life in the Netherlands: “Here, I don’t have a status, I don’t have anything, I don’t feel good.” At the same time, her outlook on the situation in her country of origin was bleak:

“You know, if I go back to Africa, the situation is very very bad. [...] I prefer to stay because of the medication. With the other things, I can go back. But me, I don’t want to die – really, when I go to Africa I can die.”

Nevertheless, Carolyn could see herself returning if she would be unable to secure a residence permit: “If I don’t get the status, then I’ll go back.” Elizabeth similarly framed her future around getting a legal status: “If everything goes well [I will] start thinking about getting a job and just continue being active and helping out people who are in need.” Her ability to earn some money to help her family was a motivator for staying in the Netherlands: “I think it’s their wish that I stay here, because I also help them out by sending some money.” To do this, Elizabeth needs a legal status. Without this, return would be a serious consideration for her: “if it doesn’t work out then, yes, I will probably be in Zimbabwe.”

Even some of the respondents who did have a legal status were tentatively thinking about return. However, they see themselves confronted with lots of doubts. Diane said:

“I would love to go home, but the thing is, I am scared. If I go home, suppose I start to need medication – how am I going to go about it? [Treatment] is the most worrying issue, if things are really sorted out with medication... My kids, they are also worried how I am going to get things to get well. The neighbouring countries, am I going to be able to go

there to seek medical [assistance]? Am I going to be on [public] medical aid, or do I need access to some private medical plan? All these things...”

In some respects, Diane was in an advantageous position. First of all, she was not yet receiving medication and thus not yet dependent on a ‘Dutch’ treatment regimen for which continuation might have been difficult in Zimbabwe. Also, because she still had a residence permit, she would have the possibility to travel back temporarily<sup>75</sup> to ‘test the water’, as she suggested: “I’d rather if I start with medication [in Zimbabwe], see how I go about, how I react to the medication and things like that. If I respond very well to the medication they give me, then I have no problem.” Despite these advantages, Diane did not think that permanent return was a particularly viable option at this time. She worried about the continuity of access to medication and the possibilities of importing additional medication from neighbouring countries or the Netherlands. She particularly related this to the political situation in her country of origin. For her, the right time to return had not yet come. In fact, for the short-term future, Diane did not see any positive change: “I think that is going to take so many years, it is not something which is going to happen drastically just like that. [It] is going to take a good number of years.”

The uncertainties identified by the respondents make return, to a certain extent, a leap of faith. Particularly for those who did not have the possibility to return temporarily to see first hand what the situation in their countries of origin was like, this was a scary prospect. As Frederick noted, once returned, there were no back-up options: “If anything goes wrong you have to learn how to survive, it is your own responsibility, not the responsibility of anybody else.”

### **5.5.2 The role of assistance**

While a broad spectrum of problems related to a possible return were identified, several respondents discussed the role that assistance programmes could help to solve some of them. For Michael, for example, having some money to re-start his business would be helpful. However, this would have to be accompanied by a guarantee that he could access medication: “if [medication] will be arranged for life, it will be OK.”

Sylvia suggested that she could benefit from temporary guarantees for medication that would “sustain me [...] until I adapt to the government programme.” This to her would involve:

“First of all finding out, if I was to go back, [if] a regimen that we know for sure I am not going to be resistant to [is] available there. And then giving it to me for a few years until I can actually get into a [government] programme.”

Also, she said that it would be essential “to go back with a skill that you know would be sellable back home”, which in her case could involve a scholarship to study. Virginia also suggested that if there was assistance to return, this would have to give her “medical security”. To her, this security could only be found by developing her own independence:

“Because we cannot ask to finance us all the way until our death now. Let them take, for example, me – I would like to go to school. [If] someone supports me to go to school, I’ll do social work, maybe counselling and humanitarian. Then I get employed in an organisation, where I can have the guarantee that I earn a living every year. Giving me an education is giving me a support that at some point I’ll be ready to stand on my own. It’s not that we migrants or asylum seekers need to be given money until the end of time. But

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<sup>75</sup> It should be noted that those who want to travel back temporarily cannot make use of the REAN programme. One of the conditions for return under the REAN programme is that the returnee relinquishes all claims to a legal status in the Netherlands. However, this does not stop migrants from making their own travel arrangements.

we don't have a... foundation. [Assistance has to have] a long-term effect on me. Because most help they give you in the Western world, what they give you back in Africa is short term – it is for the moment. But we don't want to look in the moment - we have to survive... Don't give me a push for three months and leave me there.”

Another area of concern is that of information. As already discussed, the extent to which respondents were informed about the situation in their countries of origin varied. The level of information was primarily connected to the desire of the respondents to return to their countries of origin. Those respondents who talked about different official sources of information usually had little confidence in the veracity of these sources. Some of them suggest they would want to go back temporarily and see for themselves how the situation is. They had little confidence in reports and other sources, which, as one of the respondents suggested, only give you “hearsay” and not eye witness accounts. According to Virginia, there could be a role for assistance providers to help gather reliable information: “Let them investigate [if] there is medicine in Africa. Let them send people who have got a heart to give [the] right information.”

### **5.5.3 The ‘activists’**

In addition to suggesting areas in which assistance could be useful for themselves, a number of respondents suggested that, if they went back to their countries of origin, they could have an active role in improving the lives of other people living with HIV there. Both Sylvia and Virginia wanted to draw on their experiences, and their positive attitudes to help raise awareness among others in their countries. Philip, although he could not go back due to his fears of the current regime in Cameroon, suggested making some of his land available for women and children living with HIV: “If I go back I will focus on these women and children, because the way they live is so bad; it is extremely bad.” He would let them use his land to sustain themselves, but would also offer skills training and opportunities for children to go to school. This, he said, “will show people that [...] these people are normal people. They can work, they can live, you can do everything with them normally.”

It is worth noting that this ‘activism’ was also part of the lives of quite a few respondents who were exclusively focused on continuing their lives in the Netherlands. In their cases, they were active members of support groups for migrants living with HIV in the Netherlands. Unfortunately, given the wide range of topics covered in the interviews, the possibilities of an ‘activist’ approach to return could only be discussed fleetingly. Further research would need to be done to explore the practical possibilities for this.

### **5.5.4 Perspectives from countries of origin**

In this chapter, we have provided a description of the way in which our respondents regard return, and which issues are relevant to them in making decisions about staying in the Netherlands or returning to their countries of origin. In the next five chapters, we will explore these issues further, but this time from the perspective of those who work and live in some common countries of return. We will start this exploration with the case of Sierra Leone, followed by Ghana, Nigeria, Angola<sup>76</sup> and Cameroon respectively.

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<sup>76</sup> As already explained in chapter two, it was not always possible to ‘fit’ the nationalities of the respondents with the five countries selected for a visit. In the case of Angola, no respondents from that country were included due to a lack of contacts with persons living with HIV and/or their willingness to participate in the research.

# CHAPTER 6 – COUNTRY REPORT: SIERRA LEONE

(9-16 July 2007)

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## 6.1 SIERRA LEONEANS IN THE NETHERLANDS: HIV, IMMIGRATION AND RETURN

The HIV Monitoring Foundation reports that in June 2007, there were 126 persons of Sierra Leonean birth registered as being HIV-positive, making it the seventh-largest group among Africans. In the survey of 85 migrants living with HIV (see box 2 on page 4), Sierra Leoneans formed the largest group behind Cameroonians (11 persons).

With 113 asylum applications between August 2006 and July 2007, Sierra Leone constituted the fourth-biggest African country of origin for asylum seekers in the Netherlands (behind Somalia, Nigeria and Burundi). Comparatively, numbers of persons returning to Sierra Leone are low. Between 2004 and 2006, IOM annually assisted approximately twenty persons to return to their country of origin.

## 6.2 SOURCES OF INFORMATION

During this country visit, representatives of the following organisations were consulted:

- IOM mission in Freetown
- the National HIV/AIDS Secretariat
- the United Nations Population Fund (UNFPA)
- the World Food Programme (WFP)
- the United Nations High Commissioner for Refugees (WFP)
- government-run urban hospital
- an association of people living with HIV
- a faith-based NGO working for women and girls living with HIV
- a faith-based organisation providing home-based care for people living with HIV
- a local micro credit NGO
- an NGO that provides home-based care, and social and palliative care to people living with HIV
- an NGO providing micro credit and training for small scale entrepreneurs
- an association of women living with HIV
- an NGO clinic
- a government-run hospital in a district capital
- a hospital run by a faith-based organisation in a district capital

Below is a summary of the various discussions held with these interlocutors, and their opinions and perspectives on the issue of return to Sierra Leone of people living with HIV. Opinions expressed by these interviewees do not necessarily reflect the policies and views of their respective organisations<sup>77</sup>.

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<sup>77</sup> At this point, it is worth recalling the limitations of the scope of the country reports, as outlined in 2.5.3.

### 6.3 MEDICAL ISSUES

At the time of the visit, ART services were said to be provided in all of the twelve district government hospitals. In all, 43 community health care centres where some form of treatment was available were open around the country. A representative of one NGO, however, suggested that while treatment was relatively well organised in the capital Freetown and in hospitals in the district capitals, access to treatment and care, as well as laboratory facilities, remained problematic in rural areas. He suggested that because of the cost of transport and distances that would need to be covered, returnees living with HIV might be forced to settle near a treatment site (i.e. in urban areas) to ensure they would have access to ARVs.

At the time of our visit, according to a government official, 1,416 persons living with HIV were receiving treatment, constituting about 25 to 30 percent of all persons believed to be in need of treatment<sup>78</sup>.

All medication (both first and second line) was reported to be provided free of charge. In addition, HIV testing, pre- and post-testing counselling and CD4 counts were also free. One physician expressed his concerns about the sustainability of this free treatment programme, however. He explained that the entire system was primarily based on international funding from the World Bank and the Global Fund, which, should it be withdrawn, would cause a collapse of the HIV treatment system, since no back up with national funds was in place.

It is also important to note that while most interlocutors agreed that there is a free treatment programme, they also noted that this programme does not cover everything. Blood, liver, stool and other tests, X-rays and treatment of opportunistic infections were likely to be charged to the patient.

In addition to the costs associated with the treatment of opportunistic infections, other factors which negatively affect adherence were identified. One main issue was that of food availability, as a representative of a women's NGO explained. She explained that food can be a serious problem for those who did not have a steady income. Food consumption is an important part of effective therapy, and those who do continue treatment 'on an empty stomach' are likely to encounter more serious side effects, she explained. However, not all persons living with HIV can afford to buy more food and may decide to stop treatment because of this. For this reason, returnees need to be self-sufficient in their nutritional needs. It was argued by some that for those working in agriculture, this might be easier than those who are undertaking other activities at a subsistence level. However, working in agriculture by default would also mean settling farther away from treatment sites.

Even if nutrition is not a problem and treatment is continued successfully, this can lead to problems if the patient is not informed well. An HIV counsellor in a government hospital discussed cases of people who, as a result of ART, were feeling better, and therefore decided they did not need treatment anymore. The representative of the women's NGO therefore urged that returnees should be properly educated regarding their health status and be given good and reliable info on the situation in Sierra Leone prior to coming back. The call for

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<sup>78</sup> PlusNews reported that in September 2006, the number of people receiving treatment was 1,253 out of a total of approximately 4,500 believed to be in need of treatment (see [www.plusnews.org](http://www.plusnews.org)). While this is a far cry from universal access, it is noteworthy that the number of persons reported to receive treatment, as a percentage of the total number believed to be in need of ART, was far higher than in any of the other countries included in this report.

active pre-departure and post-arrival counselling on drug adherence was reiterated by a doctor at a hospital run by a faith-based charity.

Finally, as far as medical issues are concerned, the representative of an NGO clinic called for attention to the mental health issues of people living with HIV, who, according to him, were prone to depression and other mental health problems.

## 6.4 ECONOMIC ISSUES

Those respondents that discussed the economic situation in Sierra Leone invariably described it as bad. Unemployment, both in rural and urban areas was said to be high. According to a representative of an NGO involved in providing economic support through micro credit and education, the Sierra Leonean economy is characterised by high inflation, resulting in a rising cost of living. Many people, he explained, are dependent on small retail activities to create some income. Gaining a decent income in this way is difficult as many people are selling the same things for the same price.

The respondents agreed that education and skills are essential for a returnee to survive economically. Carpentry, mechanics, tailoring, computer literacy and agricultural skills were said to be continuously in demand. In rural areas, an NGO representative said, the combination of agricultural activities and selling produce in markets seems to be working well for people. In most cases, some respondents suggested, it would be necessary to supply returnees with a start-up capital to enable them to set up their own business. Without a proper preparation of such a business and some money (e.g. taken from the host country) to make it work, it would be very difficult to make a living. A well thought out business plan, therefore, was seen as a precondition for economic reintegration.

There are organisations that provide micro credit to those interested. Returnees are free to apply, but must meet the requirements just like anyone else. Credit is usually provided to groups rather than individuals and the amounts are small.

There was consensus among our interlocutors that people living with HIV are in a more difficult position economically than the general population. If a person's HIV-positive status becomes known, finding and keeping a job will be difficult. An NGO director explained that a law to protect persons living with HIV had been passed, but she also said that it would take some time before it could be fully implemented.

Antiretroviral treatment is making it possible for Sierra Leoneans living with HIV to keep on working for longer periods than before, said a representative of a non-governmental clinic. However, he explained, if they do get ill, it takes them longer to recover than an HIV-negative person, thus running the risk that their employer will replace them with a healthy person.

Stigma and discrimination might not only lead to unfair dismissal from work. It was also identified as being the cause of people living with HIV being evicted from their houses, and of problems in getting houses allocated.

Food insecurity was seen as a problem for those who do not manage to get a sufficient income. While the World Food Programme, through partner organisations, was providing nutritional

support to some groups, this was only limited. Furthermore, due to lack of funds, a WFP spokesperson said, the agency was scaling down its food support programme in Sierra Leone.

Economic circumstances also impact on the type of medical assistance persons living with HIV can obtain. As a representative of a government hospital explained, those returnees who are relatively well off may prefer to pay for treatment in a private clinic. Others will be dependent on the services offered by public hospitals and health centres.

## **6.5 SOCIAL ISSUES**

Stigma and discrimination were seen by almost all respondents as major impediments to successful return and reintegration of persons living with HIV. While it was reported that the Sierra Leonean government and others actors were developing information campaigns to tackle this issue, the overall impression was that these, so far, had had little result. Among the direct effects of discrimination on persons living with HIV mentioned by the various interlocutors were loss of employment and eviction of persons living with HIV from their homes (see above). According to a physician in one of the government hospitals, depression, caused by the stigma and discrimination encountered, was a common occurrence among people living with HIV in Sierra Leone. The way persons living with HIV cope with this stigma and discrimination, a representative of a faith-based organisation suggested, is very dependent on their own attitude towards their situation. For a returnee living with HIV, it would be extremely important to be aware of the stigma he/she would be subjected too, and should be prepared for this by developing a good coping strategy. The involvement of support groups of people living with HIV, as well as that of family, a representative of an association of persons living with HIV explained, should be an integral aspect of such a coping strategy. These people have been living in Sierra Leone and have acquired survival strategies. They can share these with the returnees.

The importance of having a social network for returnees living with HIV was emphasised by almost all interlocutors. In particular, they stressed the traditional role of the extended family in Sierra Leone. Having the support of this extended family after return, especially if the returnee would fall ill, was found to be absolutely crucial. However, different respondents suggested that the support by the extended family would have its limitations. First of all, they argued, by taking care of a person living with HIV, the extended family itself would also become the target of stigma and discrimination, which would make them more reluctant to take up a role as caregiver. Also, as one NGO representative suggested, extended families may be hesitant to take a person living with HIV into their care, as they might not be well informed about the modes of transmission of HIV, and fear becoming infected themselves. This informant, therefore, called for particular attention to educating and counselling the potential caregivers of the returnee. The limitations of care and support by the extended family, according to both an NGO director and staff members of a government hospital, become most apparent when the returnee becomes more ill.

Apart from the misconceptions and misgivings about HIV, other factors that impact on the care and support by the extended family were identified. A UN official stated that the traditional extended family system had become weakened due to the large-scale displacement caused by Sierra Leone's civil war. An NGO representative agreed that an important reason why persons living with HIV might not want to return to Sierra Leone, is that their family members have left the country. Various interlocutors told that there was a distinct difference

between rural and urban areas, as far as the survival of the extended family system was concerned. The system, which had dissolved to a considerable extent in the larger towns and cities, according to one UN official. In the rural areas, most respondents agree, the extended family system is still relatively strong, while also from an economic point of view there might be advantages to living in rural areas. However, several interviewees noted that stigma and discrimination were also (much) stronger there, compared to urban areas, where persons living with HIV could be relatively anonymous. As one person explained, in rural areas HIV is still considered either a 'white man's disease' – which reflects negatively on a returnee from Europe – or as a punishment for behaving promiscuously while 'in the big city'.

Finally, the existence of support was related to the duration of the absence of the returnee, and the success or failure of the returnee to maintain good relations with the extended family while abroad. Sending money, and thus helping relatives, was considered an important means to maintain positive relationships. In these cases, the extended family would probably be more amenable to taking care of the returnee in his/her time of need. Coming back empty-handed, on the other hand, would put the returnee in danger of being isolated by his/her relatives.

In the absence of (or in addition to) family support, there are some organisations that provide home-based care to people living with HIV, but by their own admittance, the level of service provision is not adequate throughout the country.

Another thing that was repeatedly stressed by informants in Sierra Leone was the fact that returnees should be very aware of the situation that they would find themselves in. As a country in the process of reconstruction, Sierra Leone still faces many difficulties, they argued. This might be a big shock for Sierra Leoneans who have been away for a long time, particularly if they have become used to the 'European way of life'. It was emphasised that those thinking about return should have realistic (i.e. not too ambitious) expectations of the situation they would find. As one interlocutor suggested, all returnees were welcome and were free to use programmes and facilities, as long as they met the criteria for eligibility. However, the demand for assistance in all areas is very high, and returnees should not expect to be treated any differently from the rest of the population. Most importantly, therefore, potential returnees should have a realistic and clear view, as well as a plan, of what they would do when returning to Sierra Leone, so that it would be easier to re-adapt to the situation there.



# CHAPTER 7 – COUNTRY REPORT: GHANA

## (13-18 August 2007)

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### 7.1 GHANAIS IN THE NETHERLANDS: HIV, IMMIGRATION AND RETURN

In June 2007, the HIV Monitoring Foundation reported that there were 243 persons of Ghanaian birth known to be living with HIV in the Netherlands. This makes Ghanaians the biggest group of HIV-positive Sub-Saharan Africans in the Netherlands.

Ghanaians form a considerable part of Dutch immigrant society. A report by the Ministry of Interior (Choenni 2001) put the number of persons of Ghanaian origin legally residing in the Netherlands at more than 15,000 in 2000. As a country of origin of asylum seekers, Ghana is relatively insignificant in the Netherlands. Between August 2006 and July 2007 only 16 asylum applications of Ghanaians were received. A major gateway to the Netherlands for Ghanaians seems to be irregular migration. The estimates of the number of Ghanaians living in the Netherlands irregularly vary from several thousands to as many as 25,000<sup>79</sup>.

The large Ghanaian society in the Netherlands is also reflected in the voluntary returns from the Netherlands to Ghana. Between 2004 and 2006 an average of approximately 100 Ghanaians per year arranged their voluntary return through IOM<sup>80</sup>. This group constitutes primarily of persons irregularly residing in the Netherlands. In 2006, over eighty percent of Ghanaian returnees had never applied for asylum.

### 7.2 SOURCES OF INFORMATION

During this country visit, representatives of the following organisations were consulted:

- IOM mission in Accra (Migration & Health and Technical Cooperation departments)
- UNAIDS
- an NGO which supports associations of people living with HIV
- USAID
- the National AIDS Control Programme
- the World Health Organisation
- an international NGO concerned with HIV prevention and treatment
- a network of associations of people living with HIV
- the Dutch embassy in Ghana
- a local NGO providing HIV prevention, counselling and referral through support groups of people living with HIV
- a rural hospital
- an association providing home-based care and support for people living with HIV
- a national NGO network dealing with HIV
- an international health care NGO

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<sup>79</sup> Article in *Volkskrant*, 5 January 2000.

<sup>80</sup> See IOM annual reports 2007 and 2006, [www.iom-nederland.nl](http://www.iom-nederland.nl).

Below is a summary of the various discussions with these interlocutors, and their opinions and perspectives on the issue of return to Ghana of people living with HIV. Opinions expressed by these interviewees do not necessarily reflect the policies and views of their respective organisations.

### 7.3 MEDICAL ISSUES

Respondents consistently provided a figure of around 70,000 persons in Ghana in need of antiretroviral treatment ARVs. Of these, only about 6,000 (approximately 9 percent) were believed to be accessing treatment.

At the time of the visit, a government official reported that 42 treatment and ARV distribution sites were operational around the country. At the same time, a push was being made to expand this number. First line and second line treatment regimens were reported to exist. In addition, several private clinics – including some run by NGOs – were operational. The range of treatment provided was said to differ significantly; particularly in rural areas this was considered problematic. Given the fact that treatment was centralised in some locations, it was suggested that treatment sites may not always be able to cope with demand, particularly if they cater to a large geographical area.

Several of our interlocutors expressed doubts over whether the treatment available in Ghana would be suitable for returnees who had already been receiving medication in the Netherlands. They noted that HIV treatment in Ghana had only started a few years earlier, and qualitatively, therefore there would be a significant gap with the treatment regime in the Netherlands. The longer and more complicated the treatment in the Netherlands, the less likely it would be for returnees to be able to find adequate alternatives in Ghana.

Representatives of an association of people living with HIV, as well as an informant from an NGO mentioned that in the past there had been problems with the supply of ARVs, when some hospitals had run out of stock. However, since a public protest in 2005, this had no longer been the case.

The availability of qualified health care staff was recognised to be a problem. Ghanaians, it was argued, have a high mobility rate and many health care professionals have gone to seek employment in the West.

On the issue of cost of treatment, again respondents were very consistent. According to them, ARVs were available for a nominal fee of GH¢ 5 per month (equivalent to about USD 5). Although this seems like a relatively small sum, respondents indicated that even paying this amount could be a problem for the poorest segments of Ghanaian society. Some aid workers noted that those who were not able to pay for their medication were not necessarily turned away. They could sometimes receive medication ‘on credit’ but would inevitably run up high debts. The nominal fee did not include treatment of opportunistic infections, CD4 and viral load countries.

There is a National Health Insurance Scheme, which covers the treatment of opportunistic infections. One respondent noted that around one third of all Ghanaians were now registered with the Scheme.

A frequently mentioned barrier to treatment adherence was that of transport costs. Despite the scaling up of treatment sites, various interlocutors suggested, persons from more remote areas would still have to travel considerable distances to reach a treatment site. Also, persons who started treatment before the scaling-up operations might prefer to continue to travel to the treatment site where they have received treatment for some time, because of the relationship they had with health care workers, the presence of more qualified staff, or better quality of treatment at the more established sites. Finally, several respondents suggested that people often did not seek treatment in the nearest location, as the chances of running into an acquaintance – and thereby being identified as a person living with HIV – were bigger. The fear of stigmatisation from their immediate surroundings leads them to travel larger distances than objectively necessary. Because of this, they might also incur extra costs for overnight stays.

One clinician interviewed expressed concerns about the public health consequences of return of persons living with HIV/AIDS from the Netherlands. Returnees, he argued, might have been receiving treatment in the Netherlands for some time. The standard of this treatment, generally, will be more advanced than that in Ghana. If patients on treatment in the Netherlands have developed resistancies or mutated strains of the virus, it would be impossible for Ghanaian clinics to treat these appropriately. Also, if the returnees who have developed resistancies would infect others, these resistancies or mutated strains would be introduced in the Ghanaian situation, which is not prepared for dealing with this. The clinician, therefore, urged for more research done on the implications of return of HIV-positive persons who had received treatment in countries with advanced treatment regimes to countries where treatment regimes are basic.

## **7.4 ECONOMIC ISSUES**

Poverty and lack of employment opportunities were reported to be higher in rural areas than in urban areas. However, in rural areas there may be more financial support schemes (through NGOs) available than in urban areas.

Several activities for helping people to set up small businesses or to provide skills training exist in Ghana. Representatives of NGOs running these activities noted that these are open to returnees, but that they will have to meet eligibility criteria just as others who did not leave Ghana. Opinions varied about whether having stayed abroad would provide an advantage in reintegration. Some had the impression that skills acquired in the west and experience with western cultures would give returnees some ‘market value’. However, having an established network was also considered important. Returning migrants might miss this network and would need to invest heavily in their social relations to regain it.

Setting up a business would be very difficult if others would know the person is living with HIV. For example, as one person suggested, if a returnee would set up a shop it would become known that he/she is HIV-positive, the shop keeper was likely to lose all his/her customers.

One interlocutor noted that while difficulties for people living with HIV to find employment remain, both in the private and the governmental sector this situation seems to be changing slowly. Some large corporations have developed work place policies for people living with

HIV. Representatives of a network of people living with HIV noted that the government is working with other stakeholders to encourage businesses to employ people living with HIV. When applying for a job, there is no obligation for a person living with HIV to disclose his/her illness to the prospective employer, and few people do so.

Several respondents noted that a legal framework against the discrimination of workers living with HIV was in place in Ghana. They noted that it is illegal for employers to dismiss workers because of their HIV-positive status. It was unclear whether there were effective remedies against unfair dismissal. Most suggested that workers prefer not to disclose their status because of the fear of stigmatisation. For returnees seeking employment, it would be extremely difficult to get a job if employer would know or suspect that the candidate was HIV-positive.

Several respondents reported cases of people living with HIV being evicted from their houses when their landlords found out they were HIV-positive. At least one NGO in Accra suggested they were able to provide temporary accommodation for those who returned.

## **7.5 SOCIAL ISSUES**

Returning to a family network may be complicated by the stigma of people living with HIV. Associations and support groups for people living with HIV were considered well placed to help returnees to reconnect with their families. Their members had to deal with the issue of disclosure themselves, and were very willing to provide advice and counsel others in dealing with this.

There is an extensive network of local associations for people living with HIV, which are also connected at the national level. The activities of these associations vary and may include meetings or support groups, counselling and sometimes the provision of nutritional support. A network of these associations also engages in a political lobby to improve circumstances for people living with HIV.

A common issue identified by respondents was that of the perception of returnees from Europe and North America. In popular opinion, Ghanaians living abroad are rich, without exceptions. This idea is reinforced by the big houses that Ghanaian expatriates build for their families or for themselves when they return. A returnee without money, therefore, would be seen someone who was hiding his/her wealth from others, or as a failure. Particularly the latter might make their environments suspect that there was something wrong with the returnee.

Stigmatisation and discrimination of people living with HIV was said to be high. Several respondents noted the negative effects of this on social relations, economic opportunities and access to medical treatment. While there were intensive public campaigns to reduce stigma and raise awareness, the effects were thought to be only slowly showing.

While at lower levels, some people were publicly disclosing their status, this was not the case at higher levels. As a consequence, there were few public figures who are leading by example in the fight against stigma and discrimination. A representative of an association of people living with HIV noted that persons who were affluent had no need to come out and talk openly about his/her status, because he/she was able to survive anyway. People who are less

well off, it was argued, need certain public facilities and are therefore forced to stand up for their rights.

Self-stigmatisation was seen as an important problem for people living with HIV. This causes them to retreat from social activities and become socially and economically isolated. It is also associated with mental health problems.



# CHAPTER 8 – COUNTRY REPORT: NIGERIA

## (19-25 August 2007)

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### 8.1 NIGERIANS IN THE NETHERLANDS: HIV, IMMIGRATION AND RETURN

Nigerian-born persons account for the fifth-largest group among Africans known to be living with HIV in the Netherlands. In June 2007, 133 cases of Nigerians being infected with HIV were registered in Dutch hospitals<sup>81</sup>.

In 2005, the Ministry of Justice reported there were 7.615 Nigerians residing in the Netherlands (Van Heelsum and Hessels 2006). In recent years, Nigeria has become one of the biggest African countries of origin of asylum seekers in the Netherlands, with 205 asylum applications between August 2006 and July 2007. Somalia is the only Sub-Saharan African country to have produced more asylum seekers in the same period. No accurate estimate of the number of Nigerians residing irregularly in the Netherlands is available.

Between 2004 and 2006, IOM Netherlands facilitated approximately 95 voluntary returns to Nigeria each year, making Nigeria the third-largest African destination of voluntary returnees, behind Angola and Ghana<sup>82</sup>.

### 8.2 SOURCES OF INFORMATION

During this country visit, representatives of the following organisations were consulted:

- IOM mission in Nigeria (Abuja and Lagos offices)
- UNAIDS
- the National Agency for the Control of Aids
- a women's rights NGO
- an NGO focused on women and HIV
- an advocacy organisation for people living with HIV
- an association of people living with HIV
- an association of women living with HIV
- a government hospital
- three international health care NGOs
- an NGO dealing with human rights and health
- a religious-based NGO for people living with HIV

Below is a summary of the various discussions with these interlocutors, and their opinions and perspectives on the issue of return to Nigeria of people living with HIV<sup>83</sup>. Opinions expressed by these interviewees do not necessarily reflect the policies and views of their respective organisations.

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<sup>81</sup> According to the HIV Monitoring Foundation database.

<sup>82</sup> See IOM annual reports 2006 and 2007, [www.iom-nederland.nl](http://www.iom-nederland.nl).

<sup>83</sup> As this visit was shorter, and involved travel to both Lagos and Abuja, less time was available for consultations than for most of the other countries. This is also reflected in the length of this report.

### 8.3 MEDICAL ISSUES

A government respondent stated that a full range of HIV treatment services was available in Nigeria, which had been expanded to every state, including free treatment, testing and monitoring. However, several interviewees noted that a difference should be made between the treatment facilities offered under a PEPFAR<sup>84</sup>-funded scheme. When discussing treatment possibilities, it was not always clear if these related to this scheme or to other programmes. A government respondent stated that a full range of HIV treatment services was available in Nigeria, which had been expanded to every state, including free treatment, testing and monitoring. A respondent from UNAIDS added that there was no lack of medication, and that both first and second line drugs were available. He did, however, suggest that in some places it was difficult to find the right combination of ARVs and laboratory facilities needed by people living with HIV. All in all, about 160,000 people out of a total of 500,000 were said to be receiving treatment. A state government physician also explained that outside the PEPFAR programme, the Nigerian government set up 51 federal government hospitals providing first line medication. Laboratory facilities, however, were said not always to be available, and sometimes people would need to pay for these facilities. A government official added that although conditions in rural areas were more complex than in urban areas, it should still be possible for returnees to settle there.

Others paint a far bleaker picture of treatment possibilities. A women's rights NGO spokesperson suggested that, in her experience, only the hospitals that were running under the PEPFAR programme had sufficient drugs and laboratory facilities. Other hospitals, she argued, did not always have ARVs available, and their services were not always free. Another NGO representative also explained that the PEPFAR programme was only being run in selected states.

Most respondents felt that in rural areas problems would be much bigger, with insufficient staff, medication and transport to the treatment sites being available. One respondent expressed doubts about whether it would be practically possible for a returnee living with HIV to settle in a rural area, since this would offer considerable logistical problems.

Furthermore, the sustainability of the HIV response in Nigeria was called into question, as it was said to be built primarily on international funds.

Treatment in general was said to be free. However, several respondents noted that in some treatment locations, patients were obligated to pay for their medication. The free treatment does not include the treatment of opportunistic infections, for which patients need to pay. Even when treatment is officially provided for free, in some places people are still asked to pay.

In general, paying for health care costs can be a big problem for many people, a representative of a PLHIV association explained, as people living with HIV are not eligible for the National Health Insurance Scheme. According to him, people living with HIV are excluded from this Scheme since they are considered to suffer from a 'terminal' illness.

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<sup>84</sup> PEPFAR, the President's Emergency Plan for AIDS Relief, provides funding from the US government for the prevention and treatment of HIV. See [www.pepfar.gov](http://www.pepfar.gov) for details.

Lack of nutrition was identified as a major impediment to adherence of HIV treatment. As also mentioned in 8.2.2, some patients go as far as to sell their medication for food.

#### **8.4 ECONOMIC ISSUES**

In general, respondents explained that poverty is a major problem. For persons living with HIV this sometimes leads to desperate measures. Some register at treatment sites so that they can sell the medication they receive, and use the money to buy food for themselves and their families.

Having an education, as well as bringing some start-up capital from the host countries are important for returnees to survive, several respondents noted. Having a good idea of what to expect on return, and being prepared were considered as essential. One NGO representative particularly noted the role that corruption plays in Nigerian economics. According to him, a well-established network (connections) is therefore necessary to find work.

For returnees living with HIV, there was one of the major issue of concern arising from the interviews. Several respondents noted that in order to get employment in, for example, banks and other big companies, that candidates may be subjected to HIV testing. A representative of a human rights NGO also noted with concern that there had been a proposal to subject students to a mandatory HIV test. It was also suggested that people living with HIV were sometimes facing eviction from their homes, due to discrimination by their landlords.

#### **8.5 SOCIAL ISSUES**

Most respondents listed family support as an important factor in successfully returning for persons living with HIV. Stigma was considered a major impediment to getting this support from the (extended) family. The fear of the unknown is still great. Although the extended family system was said to be still functioning well in rural areas, these are also the areas considered to have the highest level of discrimination due to lack of education. Coming back empty-handed would also negatively impact on the relationship with family members and the support that could be expected from them.

Several respondents noted that while there were social support groups active in Nigeria, their activities were mostly concentrated near larger cities. In the rural areas, it would be very difficult to find social support groups.

A human rights NGO spokeswoman suggested that compulsory HIV testing was not just restricted to the economic area. She knew cases in which couples who wanted to get married in an (Anglican) church were also required to do an HIV test.

Some respondents said that re-adapting to the way of life in Nigeria should not be taken lightly, and that returnees would have to have strong personalities to do this. One official particularly stressed that the expectations of returnees should be realistic. In the end, he said, they will return to much the same situation that they tried to leave behind. They should not expect extra assistance because of being a person living with HIV or as a returnee (“the country owes them nothing”). He suggested that it would not be fair of returnees from the West to expect this extra assistance, as many people who never left Nigeria were also waiting

for this support. A hospital staff member reiterated this and stated that returnees might not receive much sympathy, because “they should not have gone to Europe in the first place.” The representative of an association of people living with HIV also reiterated that adapting to Nigeria might be one of the biggest hurdles returnees would have to face. In his opinion, returnees should not only be aware that fewer health services would be available, but that generally everything would require much more effort than they would be used to in Europe.

# CHAPTER 9 – COUNTRY REPORT: ANGOLA

## (20 – 27 September 2007)

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### 9.1 ANGOLANS IN THE NETHERLANDS: HIV, IMMIGRATION AND RETURN

Of the five countries included in this report, Angolans account for the lowest number of known persons living with HIV in the Netherlands, with 113 cases in June 2007<sup>85</sup>. This makes them the eighth-largest group of Sub-Saharan Africans.

In January 2004, some 12.000 Angolans resided in the Netherlands (Van Heelsum and Hessels 2006). In terms of asylum applications in the Netherlands, Angola has traditionally been an important country of origin. Between 2003 and 2005, approximately 250 asylum applications were lodged by Angolans every year. Recently, however, this influx has sharply declined. Between July 2006 and June 2007, only 27 new requests for asylum were made by Angolans (IND 2007).

In 2002, a 27-year long civil war came to an end, which led to a high number of Angolan (rejected) asylum seekers returning voluntarily. Between 2004 and 2006, more than 400 Angolans used the REAN programme each year, making them by far the biggest caseload of IOM in the Netherlands. In 2007, this number started to drop significantly (120 returns), but given the overall decline in return in that year, Angolans have remained a relatively prominent group in terms of voluntary return<sup>86</sup>.

### 9.2 SOURCES OF INFORMATION

During this country visit, the representatives of the following organisations were consulted:

- IOM mission in Luanda
- UNAIDS
- UNICEF
- UNHCR
- UN High Commissioner for Human Rights
- Ministry of Health
- Instituto Nacional de Luta Contra a SIDA
- an advocacy organisation for the rights of people living with HIV
- a network of associations of people living with HIV
- a women's advocacy group

Below is a summary of the various discussions with these interlocutors, and their opinions and perspectives on the issue of return to Angola of people living with HIV. Opinions expressed by these interviewees do not necessarily reflect the policies and views of their respective organisations.

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<sup>85</sup> According to HIV Monitoring Foundation database.

<sup>86</sup> See IOM annual reports 2006 and 2007, [www.iom-nederland.nl](http://www.iom-nederland.nl).

### 9.3 MEDICAL ISSUES

Before discussing the specific treatment of HIV in Angola, some attention to the general health care situation is in order. Many of the respondents expressed their concern about the availability and quality of general health care. During the 27-year conflict in Angola, much of the health care system was destroyed, they reported. One government official estimated that approximately seventy percent of the health care infrastructure had not survived the conflict. Although efforts were underway to rebuild this infrastructure, this official suggested, only about thirty percent of the population countrywide had access to health care facilities. Whatever the accuracy of these estimates, it must be noted that all respondents were in agreement that most of these health care services were concentrated in the capital Luanda, with far fewer facilities outside the city. Most of what was available elsewhere would most likely be concentrated in provincial capitals.

It was noted that ART was a very new venture in Angola. At the time of the interview, treatment was primarily located in the capital Luanda, mainly in the Hospital Esperanca, which was opened in 2005. A government official explained that it was the government's priority to start scaling up the availability of treatment to the various provincial capitals; the target was to increase this number to 15.000 in 2008. At the time of the visit there were 34 treatment sites with about 7.000 individuals receiving treatment. All interlocutors emphasised that there was a large gap between treatment possibilities in Luanda and in other parts of the country, particularly those areas not near a provincial capital.

The focus of the expansion of the governmental treatment programme, it was suggested, was on first line treatment, with the government doing a study to see how it could move into providing second line treatment. This second line treatment was not available at the time of the field research, although one respondent reported that there were small-scale private sector attempts to introduce this.

A UN official noted that despite the rapid expansion of treatment, many people were still trying to go to other countries, such as Namibia, South Africa and Brazil, to get medication there. A medical Junta Nacional existed that could approve people getting the necessary medication in from abroad. However, representatives from HIV advocacy groups argued that since the governmental HIV treatment programme had started, the Junta Nacional had effectively stopped providing such authorisation.

In addition to the limited possibilities for antiretroviral treatment, testing was considered by many to be a problem. Only CD4 counts were reported to be available. Other types of testing were usually not feasible as the appropriate equipment was often broken, there were only few people qualified to operate this equipment or there the reagents necessary for the testing was not available. This problem was seen by some as indicative of the quality of health services and health care professionals in Angola generally.

Despite ARVs being available free of charge, accessibility was also reported to be hampered by the fact that demand for ART far outstripped the capacity, particularly in the capital Luanda. One interlocutor noted that around 11.000 people were registered at the Hospital Esperanca. The cost of treatment of opportunistic infections was said to depend on hospital, although some locations provided services free of cost. For exams and tests a nominal fee was usually charged in public hospitals. Treatment in private hospitals was widely seen as

unaffordable for people without a high income. (some people have health insurances that cover it)

With regard to particular groups, a spokesperson of a women's network told that a programme for the prevention of mother to child transmission (PMTCT) was being rolled out, but that access was still limited. UNICEF reported that treatment for children was difficult as there were few paediatric clinicians. In Luanda, two interviewees suggested, there were approximately 1.000 HIV-positive children and only two qualified doctors to deal with them, leading to long waiting lists.

## **9.4 ECONOMIC ISSUES**

Despite a booming economy, unemployment rates were reportedly high. One respondent suggested that this could be particularly problematic for people coming from abroad. They could be marginalised because they spoke other languages, and because there is already a fierce competition for jobs. Having a good personal network is important. Without such a network, finding employment could be very difficult.

For people with HIV, this may be even more difficult. Several respondents suggested that employers may ask for HIV-tests. When people are found to be HIV-positive, they may be fired. A advocacy group had recorded several instances of this happening. Getting legal aid in these cases could be problematic. Lawyers are overwhelmingly located in Luanda and there are only a few non-governmental groups providing legal counselling.

In the light of the difficulties of finding employment for people living with HIV, a representative of a women's network suggested the possibility of setting up cooperatives. These might provide more security for people living with HIV, including those returning from abroad.

While Luanda was widely acknowledged to hold more opportunities, both economically and in terms of treatment, for returnees, it was also found to be a very expensive place to live. A governmental official noted that some form of credit scheme might be beneficial to returnees, as borrowing money from banks is very difficult due to very high interest rates. This makes it difficult for returnees to build their own house. The women's network representative noted that there were no places where people with HIV could turn to when they were rejected by their families.

It should be noted that while discussions with our respondents concerned returnees from Europe, this is an issue of relatively minor concern in the grand scheme of Angolan return migration. Following the end of the war, more than 400.000 refugees have repatriated from neighbouring countries such as DRC, Namibia and Zambia. This puts an enormous strain on the countries capacity to assist in the reintegration of these persons, and possibilities for this are limited.

Nevertheless, the spokesperson of the returnees' association mentioned that there were several Dutch and NGOs and international organisations providing support for (European) returnees. However, he suggested that their lack of coordination may have limited their effectiveness. The association itself tried to mediate for employment of returnees, but these efforts were hampered by the lack of stable financial support from donors. The preparation of return in the

Netherlands also seems to be fragmented. Finally, the political will of the government to allow returnees enough time to properly prepare was debated. The possibility of economic reintegration, according to him, was intimately tied to this preparation. Organisations supporting returnees do not always focus on why a person left Angola in the first place. Motivation is an important aspect of the process. This is problematic for those for whom return is not really a free choice. As such, experiences have been very mixed. Some have been very happy to be back with their families and friends, while others have been disappointed.

Reintegration can also be provided by IOM, which has a special reintegration department. Whether assistance can be given, however, depends on the entitlements to support under schemes of the Dutch or other European governments. In many cases reintegration assistance involves setting up small businesses.

One respondent noted that skills that are offered in preparation for return should be useful in the Angolan context. In some cases, having stayed abroad might be considered an advantage. Returnees from the Netherlands may have extra skills, since they have experienced a different system. This experience can be used, for example in administrative functions.

## 9.5 SOCIAL ISSUES

Opinions about the level of stigma and discrimination were divided. Some saw the prominence of government sensitisation programmes as evidence that being HIV-positive was more and more acceptable. Others suggested that discrimination was not much of an issue for completely opposite reasons: in the current climate almost no one dared to disclose their status, so people did not know that others were HIV-positive. Still others rejected the idea that discrimination was not widespread outright. These interviewees talked about cases in which families had rejected members who were living with HIV, banks who refused to give loans to HIV-positive clients, and (as mentioned) people who had lost their job for this reason. Additionally, mention was made of discrimination of people with HIV by health care staff, who, as one person suggested, may have the attitude that “treatment of a ‘dying’ person is not worth the effort anyway.”

One interviewee suggested that the stigma of being a failure, merely due to the fact that one has returned, should also be taken into consideration. It would be important for returnees to be self-sufficient to expel this myth of failure. They would need the appropriate skills and equipment for this. The problem would be even worse when one comes back empty-handed and with HIV. This person could then very easily be considered a burden on his/her community. Several respondents noted that coming back would be particularly difficult for women living with HIV. One person wondered who would take care of them and their children when they fell ill, given that these women were traditionally the care providers in their families.

A UN official told that in some cases there were tensions between returnees and those who stayed in Angola. For example, those who stayed behind might think that people who had left the country were linked to the rebel group UNITA. In cases when returnees received assistance, this could lead to jealousy by those who had not moved. For this reason most reintegration programs focused on assistance to both – the receiving community and the returnees. It should be noted, however, that these examples were given in the context of repatriated refugees from neighbouring countries to rural areas in Angola, while most

returnees from the Netherlands and other European countries seem to congregate in Luanda, where they lead a more anonymous existence.



# CHAPTER 10 – COUNTRY REPORT: CAMEROON

*(29 October – 3 November 2007)*

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## 10.1 CAMEROONIANS IN THE NETHERLANDS: HIV, IMMIGRATION AND RETURN

Of the five countries included in this report, only Ghanaians account for more known cases of HIV than Cameroonians. In 2007, 162 Cameroonians were registered in hospitals as being HIV-positive<sup>87</sup>. This disproportionately high number was the main reason for the selection of Cameroon as the final pilot country.

This relatively high number of persons living with HIV contrasts sharply with statistics on asylum. Between August and July 2007, only 34 new asylum requests from Cameroonians were received in the Netherlands. No fewer than ten other African countries produced more asylum seekers in the same period.

This low number of asylum applications is also reflected in the number of voluntary returnees. Between 2004 and 2006, approximately fifteen Cameroonians returned home voluntarily using the REAN programme each year. In 2007, this number had reduced to only 5 cases<sup>88</sup>.

## 10.2 SOURCES OF INFORMATION

During this country visit, the representatives of the following organisations were consulted:

- IOM mission in Cameroon
- the National Aids Control Committee
- UNAIDS
- two hospitals
- a human rights NGO for people living with HIV
- a women's health NGO
- an NGO providing general health care services
- a network of support groups of people living with HIV
- three associations of people living with HIV (one with general membership, one for women, and one for youth)
- an NGO focused on reproductive health
- a church-based medical centre
- an NGO providing assistance to HIV-positive children and AIDS orphans

Below is a summary of the various discussions with these interlocutors, and their opinions and perspectives on the issue of return to Angola of people living with HIV. Opinions expressed by these interviewees do not necessarily reflect the policies and views of their respective organisations.

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<sup>87</sup> According to HIV Monitoring Foundation database.

<sup>88</sup> See IOM annual reports 2006 and 2007, [www.iom-nederland.nl](http://www.iom-nederland.nl).

### 10.3 MEDICAL ISSUES

At the time of the research, two major developments had taken place very recently. First of all, on the 1<sup>st</sup> of May 2007, a programme for free distribution of first line antiretroviral drugs was put in place. This programme was financed by the Global Fund. Distribution was taking place through certain approved treatment centres (CTAs) and smaller medical facilities called UPECs (*unite de prise en charge*). Accessing first line medication was considered to be easier in and around urban centres than in rural areas, where people would have to cover long distances to get to CTAs or UPECs. These would mostly be located in at district capitals in rural areas. One respondent noted that the areas furthest away from distribution sites were also often those where the standard of living was lowest, leading to problems in covering transportation costs to get treatment. Additionally, second line antiretroviral drugs had become available in September 2007, less than two months before the visit, but only to a very limited extent. Where they were available, these cost FCFA 7,000 (equivalent to about USD 14) per month, and were not subsidised. Also, resistance tests which should precede changing to second line medication were said to be very costly.

The costs of laboratory tests were covered by the government to the amount of FCFA 3.000 (about USD 6). However, other tests such as CD4 counts cost FCFA 10.000 apiece and these costs would have to be borne by the patient. Test related to opportunistic infections were provided free of charge, one official explained. He also noted, however, that the actual treatment of these infections could be very costly.

A representative of the National AIDS Control Committee (NACC) noted that the sustainability of Cameroon's HIV treatment programme should not be taken for granted, as it depended heavily on external sources of funding (in addition to the Global Fund, the World Bank and the Clinton Foundation were mentioned as contributors). Also, he suggested that funding brought in by NGOs also played an important part.

Members of associations of people living with HIV mentioned that community-based care for persons living with HIV were not yet well developed. This was due to lack of experience by those who were responsible for developing this. Where available, communities were not always aware of the possibilities.

### 10.4 ECONOMIC ISSUES

Associations of people living with HIV were considered to be important actors in helping with income generation. All of the associations encountered implemented some small-scale economic activities for their members. Some associations of people living with HIV were able to connect awareness raising activities to income generation. Those who would go out to give talks on HIV issues would receive some remuneration for this. The NACC was said to provide financial support to these associations for their income generating activities. At the time of the visit, the NACC representative said that 117 associations were receiving this support.

Several NGOs were also found to be providing micro credits or other financial support for small-scale economic activities. Also, some women's groups were reported to have set up 'solidarity funds', which could be used to help out those in need with paying school registration fees or medical bills.

One respondent noted that specific assistance from the host country to returnees in relation to income generation would be necessary to help them meet their basic nutrition and accommodation needs. He mentioned that rural areas might provide more opportunities to be self-sufficient at least in terms of nutrition, as returnees could engage in agriculture there, at least if they would be physically fit enough for this.

In terms of employment, the rights-based NGO reported that in the past, some companies had subjected their employees to unwanted medical tests. Those who were found to be HIV-positive were confronted with dismissal or were refused promotion. The spokesperson of this NGO noted, however, that such things were becoming less common.

### **10.5 SOCIAL ISSUES**

Despite activities to sensitise people on the issue of HIV, stigma and discrimination was considered to be widespread. This, staff members of a hospital suggested, can lead to persons living with HIV refusing community workers to visit them, for fear of their status becoming known by their neighbours. This also forces some to avoid nearby health centres, and to travel large distances to other places. Particularly for women, it was said, disclosing their HIV-positive status was a difficult issue, as this might lead to being abandoned by their spouses or families.

In addition to HIV-related problems, an NGO representative noted, social difficulties could arise from the economic expectations of returnees' families. They would expect much financial support from the person coming back from abroad, rather than the family having to support the returnee. He worried about families' reactions if returnees, particularly those who are in ill health, became to dependent on them.

The importance of connecting to associations of persons living with HIV was emphasised by almost all respondents. This would greatly benefit returnees, they argued, not only because of the support in income generation they can provide, but also for psychological support. As already mentioned, there are large numbers of such associations active in Cameroon.



# Part III: Conclusions



# CHAPTER 11 – CONSTRAINTS AND POSSIBILITIES OF RETURN AND REINTEGRATION

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## 11.1 WHEN MIGHT MIGRANTS LIVING WITH HIV CHOOSE TO RETURN?

In the previous six chapters we have presented the discussions we have had with migrants living with HIV in the Netherlands and with a range of interlocutors in five African countries. These have helped identify a broad range of issues concerning the desirability of voluntary return as an alternative to irregular stay in the Netherlands, and the potential problems to actually realise such an alternative.

From our target group interviews it is clear that some of our respondents consider return simply unthinkable. It is important to acknowledge that under current conditions, it is very likely that the majority of HIV-positive migrants without a legal status would opt to stay in the Netherlands, even if this means living in an irregular situation. As discussed in chapter five, they find the situations in their countries of origin much too uncertain, particularly in terms of access to treatment, while in the Netherlands this is guaranteed. Also, some might not see return as an option for completely different reasons. Regardless of the circumstances in the country of origin, they may value opportunities in the Netherlands too much to consider return. Examples of this could be the fact that they are able to send money back to their relatives, the possibility to enjoy high quality education, or the simple fact that they have become accustomed to life in the Netherlands.

In contrast, some respondents have indicated that they would like to return home, if only the conditions were right. They are motivated by a desire to be with their families, to continue their lives in ways that they are not able in the Netherlands, or to help improve the lives of others living with HIV in their countries of origin. The conditions that would have to be met for them to seriously consider returning generally encompass, at a minimum:

- sustainable access to suitable medical treatment;
- an adequate income to meet both ‘regular’ costs of living and costs of medical treatment; and
- successful reintegrating in social networks.

While these minimum conditions for voluntary return will probably be shared by many migrants living with HIV, this does not mean they will be shared by all. Some, for example might see the fact that they would have guaranteed access medication for only a limited time, with a reasonable prospect that treatment programmes in their countries would develop in the mean time, as sufficient. Others, on the other hand, would only find a life-long guarantee of medication acceptable. Also, as we have seen, there may be additional conditions that would need to be met, of which a political security, as perceived by the migrant, can be a particularly relevant one. Finally, it is imaginable that in exceptional cases, the ‘minimum conditions’ for return might actually be lower than the ones we have described here<sup>89</sup>.

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<sup>89</sup> IOM’s experience with persons with medical problems who return to their countries of origin, reveals a broad range of – sometimes unexpected – considerations. In 2008, a migrant living with HIV requested assistance from IOM to explore the possibilities for return. He knew that returning to his country of origin, with a considerably less advanced medical system, would in all likelihood shorten his life expectancy. However, he asserted, he was

The appeal of voluntary return as an alternative solution to staying in the Netherlands is not only determined by the conditions in the country of origin. Negative push factors in the Netherlands may also play a role. Some respondents noted that they life in the Netherlands was difficult for them. Particularly in the case of those who did not have a secure legal status the struggle for daily survival had detrimental effects on their well-being (also see, for example, Shiripinda and Van Eerdewijk 2008). This also led some experts to argue that migrants who find themselves ‘in the gutter’ in the Netherlands might benefit from returning to their countries of origin, provided that their basic medical, economic and social needs could be met. The voluntary return of migrants living with HIV being prompted by negative circumstances in the Netherlands, rather than by positive circumstances in the countries of origin, however, raises some difficult questions. First of all, it is debatable whether these migrants, who would return because it is ‘the lesser of two evils’ would have the right mindset to make their return a success (this is discussed in more detail in 11.3). Also, it raises questions about the relationships between assistance providers and migrants, and the extent to which this relationship influences the decision of a migrant, particularly when he/she is vulnerable. This discussion is briefly described in box 12.

**Box 12: Who decides what is best?**

Discussions about return put health care workers and other assistance providers in a difficult position. While all consulted experts agreed that the decision to return should be one that should be made by the migrant themselves, they struggled with the extent to which they should try to motivate the migrant to think about return as an option. They realised that their advice and opinions as a confidant and assistance provider could be a powerful influence on the decision-making process, leading to the question: at what point is the assistance provider deciding for the migrant what is best for him/her? These discussions also touched upon the professional framework of these assistance providers and the extent to which it was their responsibility to play a role in this process of thinking about return. Some health care professionals, for example, saw their role as being limited to providing medical care, while others found it necessary to help their patients find a solution that was best for their overall health, which could also mean making interventions on social, economic or legal issues.

## 11.2 BARRIERS TO RETURN

In the previous six chapters, it has become clear that meeting the conditions that would lead to migrants living HIV to opt for return encounters significant barriers. Below, we briefly summarise the main medical, economic and social barriers, as well as some of the suggestions made by migrants and experts how to deal with these barriers.

### 11.2.1 Medical issues

#### *Availability of treatment*

The most obvious concern of both our respondents and our discussants in the five African countries is the availability of suitable treatment. Based on our research, it is impossible to make sweeping statements about the extent to which HIV treatment will be available to returnees living with HIV. In all five countries some forms of treatment were in available and

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willing to exchange quantity of life for what he saw as a better quality of life – being with family, in a familiar environment, without the worry about legal procedures, etc.

Another illustrative case is that of a woman who suffered from cancer, and was expected to die shortly. She returned to her country of origin in order to be with her family and die in dignity.

the distribution of antiretroviral drugs was being expanded, often quite rapidly. It goes without saying, however, that the level of care and treatment significantly differed from that which migrants living with HIV are able to get in western countries like the Netherlands. Only specific medication were available, with people living with HIV usually relying on limited combinations of first and second line drug combinations. Whether this treatment would be sufficient for the individual returnee, therefore, is very much dependent on his/her personal situation. In general, our contact persons in the countries of origin considered that the more complicated the treatment received in the Netherlands was, the less likely it would be that appropriate treatment and follow-up would be available. Not all treatment sites could provide the same quality of care, with hospitals in urban areas usually considered to be better equipped and staffed than rural treatment sites.

While the availability of treatment is a concern for those who are not yet on antiretroviral drugs in the Netherlands, the issue is likely to become more complicated for those who are already on treatment before returning. Ensuring that no gaps in treatment occur in the post-return period is considered crucial. In some cases it was reported that supplies of even the most common types of medication were interrupted. It was also noted that the way that the HIV response in the different countries was financed might lead to continuity problems in the long run. With the exception of Angola, where the government provided the bulk of the resources for its HIV response, treatment programmes in other countries tended to rely heavily on international funds. While these funds seem to have some staying power, the sustainability of HIV treatment will remain somewhat precarious until governments are able to take full financial responsibility for their own programmes.

#### *Accessibility and affordability of treatment*

Even when adequate HIV treatment is available, there are several factors which affect the individual accessibility of this treatment. One important factor, which was a major concern for the interviewees in the Netherlands, is affordability. When comparing the views of our respondents in the Netherlands with the situation that was presented in the countries of origin, the question arises whether all target group members had a realistic idea of the cost of treatment. Better information about this issue might help these migrants consider their options better. However, even if prices were lower than some respondents suggested, the affordability of HIV treatment and monitoring may still provide significant problems in individual cases. This is determined by more than just the price of medication, so even in those cases that there is a free ARV distribution programme in place, other costs should be expected to occur. One of these costs is related to the treatment of opportunistic infections. This treatment was often not included in programmes that offered ARVs for free or at a reduced price. The cost of treatment of opportunistic infections was said to be quite considerable, especially in settings where there was no health insurance scheme. In those countries where health insurance schemes did exist *and* covered treatment of opportunistic infections *and* were open to persons living with HIV, fees had to be paid to make use of these schemes. In addition to these costs directly related to health care, people with HIV may be forced to travel considerable distances, leading to significant travel expenses. It is unsurprising, therefore, that many of the migrants and the experts that we consulted with considered economic reintegration as a major success factor in making return possible.

#### **11.2.2 Economic issues**

##### *Conditions for economic reintegration*

Economic reintegration was not only considered a necessary precondition for gaining sustainable access to treatment, but an important issue in its own right. Food, accommodation

and education are basic needs that are not limited to the concerns of returnees living with HIV; they are the concerns of all returnees, and of the vast majority of the citizens of the countries of origin we have visited. It is important to note here that all of these five countries have high levels of poverty and unemployment.

According to our informants in the countries of origin, successful economic reintegration depends on a number of factors. The first one is preparation. As many of our respondents suggested, economic reintegration is not easy because of the general economic situation. At the very least, therefore, a returnee should have a good plan for attaining economic self-sufficiency. He/she should be aware of the steps to take, which assistance programmes might be available and what kind of start-up capital would be necessary. Secondly, the importance of having sellable skills and/or training was emphasised. Especially in the post-conflict countries, having practical skills was seen as a necessity. Small-scale retail (e.g. selling products in the market), on the other hand, was seen as a difficult route to follow. Competition in that area was considered high and the possibilities for generating income viewed as low. It should be noted that most people in the five, regardless of whether they had migrated, only earned an income at a basic subsistence level (or below). It was emphasised that living with HIV places quite a considerable financial burden on the returnee. Therefore, if economic reintegration would amount to merely gaining a subsistence level income, this was unlikely to be sufficient for the returnee living with HIV to meet both his/her basic food, accommodation or education needs *and* pay for medical costs.

It was suggested that in most countries the possibilities of getting employed or keeping a job would likely to be seriously diminished if it were known the returnee was HIV-positive. Stigma and discrimination of people living with HIV was also said to lead to the failure of businesses run by persons known to be HIV-positive.

*Access to reintegration services and programmes: just a face in the crowd*

Several services and programmes that could potentially facilitate the reintegration of returnees living with HIV were available in the five countries. With the exception of some IOM activities in those countries, however, these services and programmes were generally not specific to returnees, but were offered to a broad population. It was seen as important, therefore, to reiterate that returnees need to have realistic expectations of the services available to them. In all countries, and particularly in Angola and Sierra Leone, which are recovering from devastating conflicts, the number of persons in need of assistance, whether economic, medical or otherwise, is huge. Rather than receiving special attention because of his/her situation, the returnee will probably become 'one of the crowd'. This seems like an obvious statement, but is extremely important in creating the right expectations of the post-return situation. The attention that is lavished on the issue of return (and by proxy on returnees) in the Netherlands and other European states might easily lead one to believe that a large apparatus just to help returnees reintegrate in their countries of origin is in place. In reality, however, returnee-specific programmes are usually small in scope, scattered and temporary. Where larger-scale activities for returnees were in place (e.g. in Sierra Leone and Angola) these were aimed at the large numbers of refugees returning from exile in neighbouring countries, and the displaced that were scattered around these. In these countries, the issue of returnees coming from western countries, was therefore a comparatively very minor one.

### **11.2.3 Social issues**

#### *Social support networks*

The importance of social support networks for successful return was emphasised by virtually all persons interviewed and consulted. The availability of a social support network is dependent on a lot of factors. In some cases, this network might not exist at all, since family members and others are not in the country of origin, or the migrant has lost track of them. This is particularly relevant for countries like Sierra Leone and Angola, where conflicts have led to a lot of people being displaced. Even if there is a support network in the country of origin, the extent to which a returnee can rely on it varies. Several respondents in the countries of origin noted that returnees should expect a *quid pro quo* attitude; if they had (financially) supported their network while being abroad, they could expect to be ‘rewarded’ for this by their family and friends, who would support them in their time of need. However, if the returnee would come back empty-handed, the willingness of families and friends to provide support could be diminished. In such cases, it was possible that the returnee would be seen as an added burden, especially because of carrying an illness that would reflect negatively on the family or circle of friends.

In all countries, associations of people living with HIV and mutual support networks were present. These support groups provided an important coping strategy for people living with HIV, and potential returnees were urged to connect with a local association. Some of these associations were also possible to provide a small measure of material support (e.g. food distribution) or provide the opportunity for skills training.

#### *Stigma and discrimination*

The issue of stigma and discrimination was an enduring theme in all interviews and consultations. Stigma and discrimination were found to work at three main levels: (1) self-stigma of the returnee, (2) stigma and discrimination by the returnee’s immediate social network (family and friends); and (3) stigma and discrimination in wider society. The issue of stigma and discrimination may be one of the biggest barriers to successful return and reintegration, and the importance of acknowledging this cannot be emphasised enough. As already discussed, discrimination was found to have a very negative impact on the ability of the returnee to earn a livelihood. This also goes for finding accommodation. In addition, people living with HIV were also sometimes found to be the targets of discrimination by health workers, affecting their enjoyment of medical treatment. While in several countries some formal legal protection system against such discrimination was in place, it is questionable whether those experiencing discrimination actually have recourse to legal remedies. However, this, it was suggested, would only be a relevant issue only when the HIV-positive status of the returnee was known. In most of the countries visited, persons living with HIV preferred not to disclose their status to anyone but their closest relatives. Our interlocutors stressed that returnees needed to think hard about whether they would want to disclose their status when back in their country of origin, and should realise the consequences of doing so.

## **11.3 OVERCOMING BARRIERS: VOLUNTARINESS, COMMITMENT AND PREPAREDNESS**

Above we have discussed several specific issues that need to be taken into consideration when migrants living with HIV consider returning. In the remainder of this chapter, we will discuss some more general preconditions for overcoming barriers to sustainable return and

reintegration. The first of these is psychological in nature. It was noted by several interviewees that overcoming barriers to return would require a very firm commitment to rebuilding a life in the country of origin. A positive, forward-looking attitude was considered crucial to have a chance of making return work. It should be noted that in our conception of what might constitute voluntary return (see 4.2.1), the existence of such a commitment is by no means self-evident. While we consider a migrant choosing to return due to a lack of viable alternatives in the Netherlands as one who is returning voluntarily, such a situation is unlikely to produce the sort of commitment to return that our respondents allude to. Rather, in order to have a chance of sustainable return, the interviewees suggested, the migrant needs to have a large measure of mental readiness, as well as being proactive in practically preparing for return.

As we have shown in chapter five, amongst our respondents, this state of mind was not a common thing. Quite a few of them firmly believed that return would never be possible for them, and as such did not have any interest in preparing for it, mentally or practically. Additionally, there was a group that, even if they would have wanted to, were unable to prepare for return. This was the group of respondents that was only living in the ‘here and now’ – they were exclusively focused on accepting the fact that they were HIV-positive, on obtaining a legal status, and/or on meeting their immediate needs. In other words, they were surviving rather than working towards a future. Until this group has found some measure of stability, it is highly unlikely they would be able to develop the forward-looking attitude needed to seriously consider return.

#### **11.4 THE RIGHT COMBINATION OF CIRCUMSTANCES**

While the agency of the potential returnee was seen as an important ‘ingredient’ for a possible sustainable return, this is by no means the only general condition. Sustainable return, as defined by the majority of our respondents, is dependent on a broad range of circumstances, which have been listed above. Often, these circumstances are closely interconnected. For example, appropriate medication, testing facilities and qualified staff should not only be available in or near the place where the returnee wants to settle, but this treatment also has to be reliable and affordable. This affordability is based on the costs of medication, treatment of opportunistic infections, testing, health insurance fees and a range of other issues, while the ability of the returnee to carry these costs depends on a sustainable income. Whether such income generation is feasible is dependent on, *inter alia*, the general economic conditions, the skills of the returnee, the health situation of the returnee, and whether or not he/she is known to be living with HIV. Also, the returnee has to be able to rely on family or other social network in case he/she gets ill and for psychological support. Whether this is the case depends on, for example, whether any support network still exists in the country of origin and on the returnee being accepted by this network. Particularly when the returnee comes back empty-handed, this may make it less likely that he/she will be able find the necessary support. Associations of people living with HIV, if present in the area of return, can provide some ‘surrogate’ support. Finally, the migrant him/herself has to be mentality prepared for what could be a considerable struggle to reintegrate.

While the circumstances mentioned above relate to the post-return situation, many of these circumstances are also connected to the situation of the migrant while still in the Netherlands. Counselling and participating in support groups in the Netherlands can lay the groundwork for the necessary positive attitude. Whether the migrant has sellable skills depends, to some

extent, on whether he/she has had the opportunity to learn and develop these skills while in the Netherlands. The possibilities of the migrant to send remittances to family members and/or to build up a 'nest egg' to take home also play an important role.

This enumeration is by no means exhaustive. Our point here is not to provide a list of all possible factors of importance; these depend, after all, on the specific situation of the individual involved. Rather, we have attempted to illustrate the interconnection of a diverse range of factors, and that it is by no means self-evident that the right combination of circumstances can be found in individual cases. In most cases, the combination of conditions is so closely related that if one does not materialise, most others will probably also not be attained.

Many of these circumstances are related to the situation of the individual, such as his/her health or the presence of family in the country of origin, and are unchangeable. Others are inherent to the situation in the country of origin, such as the general levels of unemployment or the levels stigma and discrimination prevalent in the home society, and also not susceptible to intervention at the individual level. These circumstances are just facts that have to be accepted and dealt with; whether they provide an appropriate starting point for sustainable return is a function of – for lack of a better word – luck. Given the broad range of determinants, there can be many circumstances that make sustainable return, as defined by the individual migrant, *prima facie* impossible. This would be the case, for example, when there is no suitable follow-up treatment in the country of origin, or if the costs for such treatment are so high that even with a steady income, these are unaffordable for the migrant.

However, there may also be circumstances that *can* be changed to increase the probability of sustainable return. In the following chapter, we will look the possibilities for making interventions to help maximise the chance of sustainable return, how these could be shaped, and which limits there are on such interventions.



## CHAPTER 12 – ASSISTING THE VOLUNTARY RETURN OF MIGRANTS LIVING WITH HIV

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### 12.1 A ‘ROAD MAP’ FOR RETURN

#### *12.1.1 Role of assistance*

As discussed in the previous chapter, a precondition for return is that an individual migrant’s case shows a combination of circumstances that do not *a priori* preclude return. Additionally, interventions might be possible that increase the chances of sustainable return and reintegration. In this chapter we will discuss the scope and potential of return assistance activities for migrants living with HIV. For each possible intervention, however, it should be considered whether this is something that a migrant could do him/herself or whether active intervention by a third party would be necessary. In general, we would suggest that return assistance is merely complementary to migrants’ own efforts to try and realise their own return.

Before listing some potential practical interventions, we will first discuss more general framework preparing interventions. We suggest that this framework provides a possible ‘road map’ for dealing with migrants who consider returning, and to assess the practical possibilities for realising this. This road map is discussed below, and is illustrated in box 13.

#### *12.1.2 A road map<sup>90</sup>*

##### *Initial inventory of migrant’s situation*

Given our focus on voluntary return, the starting point is a desire of the migrant to, at the very least, explore the possibilities of return. This desire may lead to a request to assist exploring these possibilities, and to ultimately realise return. The request will have to be regarded in the context of the willingness of the migrant (is he/she really committed to return?); the personal characteristics of the migrant (including gender and age); his/her wishes (i.e. under which conditions will he/she consider return as a viable option); the migrant’s current conditions in the host country (for example, which medical treatment is provided and legal status); and the situation in the country of origin. Particularly the latter will require some extensive information gathering activities. Some information (such as the existence of a social network) can be provided by the migrant, but he/she might not always be aware of the current state of treatment options and/or economic opportunities in the area where he/she wants to return.

##### *Inventory of barriers and possible interventions*

An initial inventory of options enables the identification of certain constraints to return and reintegration. As discussed in the previous chapter, it is not possible to influence all of the circumstances which provide these constraints. An essential part of the assessment process, therefore, is to provide a realistic picture of which circumstances cannot be changed and for which interventions might be possible. If unchangeable circumstances provide barriers that preclude return, this will lead to the end of the return process (unless the migrant readjusts his/her criteria for return). For those circumstances that can be influenced, interventions in both the host country (pre-departure) as the country of origin (post-arrival) need to be examined.

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<sup>90</sup> Although developed in the context of returnees living with HIV, this road map may be equally applicable to other categories of returnees where a particular focus on sustainable reintegration is desirable/necessary.

### *Assessment of intervention options*

If a clear picture of desirable interventions has been produced, the feasibility of implementing these interventions need to be assessed. Again, this process will likely involve a lot of information gathering in the country of origin, but may also include a further exploration of pre-departure assistance possibilities in the host country. It is obvious but important to mention in this respect that the resources at the disposal of the organisation providing assistance as well as its mandate will play an important role in the feasibility of implementing certain assistance activities. The assessment of intervention possibilities will likely lead to the conclusion that some interventions, although desirable, might be practically unfeasible (for instance, due to resource limitations). Here again, the question needs to be asked whether return is still possible even in the absence of these interventions. The limitations and practical possibilities for intervention need to be communicated clearly with the migrant. It will then be up to the migrant to make a decision on whether to proceed with the return process<sup>91</sup>.

### *Implementation phase*

When a decision is made to try and realise return, interventions need to be prepared. As mentioned, the migrant him/herself has an important role to play in this preparation. However, assistance providers might complement the migrant's activities by, for example, mobilising or providing resources. This stage would also include agreeing on clear terms about the extent to which assistance will be provided. Clear mutual expectations between the migrant and the assistance provider are crucial to avoid ethical complications (see 12.4). Also, there needs to be a realistic time frame that is shared by both the migrant and the assistance provider. There might be a substantial time gap, for example, between the start of the implementation of pre-departure interventions and the actual return. If, for instance, these interventions include skills training, this may take a considerable amount of time<sup>92</sup>.

When the actual return takes place, it should also be clear which post-arrival interventions still need to be implemented, and whether it is the responsibility of the assistance provider (or a partner in the country of origin) or the returnee to instigate these interventions. In some cases, the assistance providers may not be able to do more than provide referrals to local organisations in the country of origin, without actually being able to influence the way in which these organisations deal with the returnee. This, also, needs to be communicated clearly with the migrant before the actual departure.

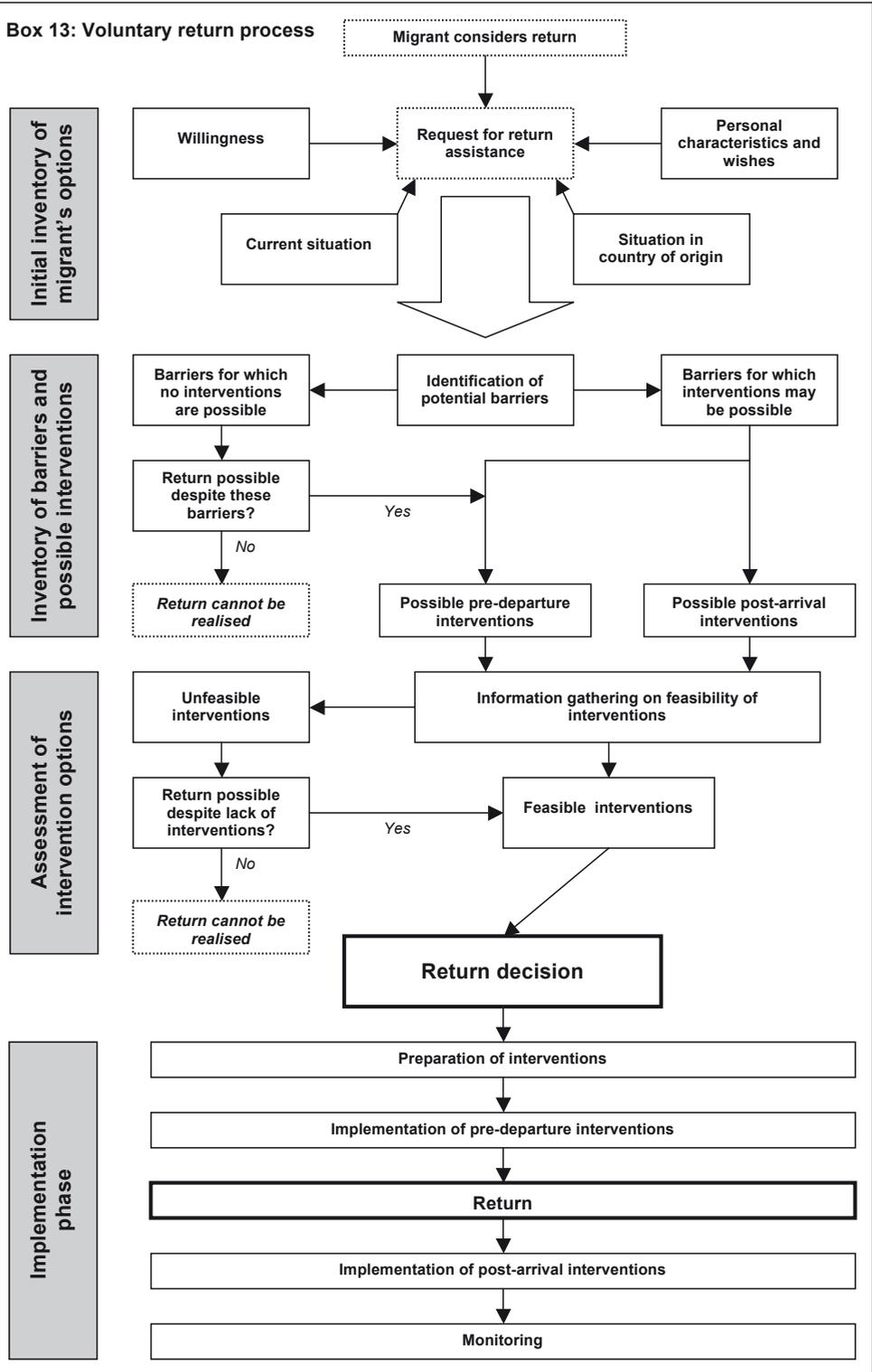
Finally, the assistance provider and the migrant may make arrangements to monitor the way the migrant is getting on after his/her return. However, the effectiveness of such monitoring arrangements may be limited (see 12.4).

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<sup>91</sup> Although the 'return decision' is described here as a specific point in time, in reality this is more likely to be a process, which already begins long before a request for assistance is made. Also, the voluntary nature of return would mean that this return decision is not a 'point of no return'. Even after the decision is made to go ahead with preparations for return, the migrant should have the possibility to change his/her mind.

<sup>92</sup> The extent to which a migrant might actually have this time depends, among other things, on his/her legal status (see chapter thirteen).

**Box 13: Voluntary return process**



Box 13 provides a schematic representation of a possible return trajectory. However, in reality such a trajectory might not always be as linear as suggested here. In practice, it might be possible to go back to a previous phase, sometimes even various times. Also, the starting point might be different. For example, there might already be information about intervention options from experience with previous cases or because the migrant has already gathered this information. It is therefore a model that can act as a reference, but which should always be employed with a large degree of flexibility.

## 12.2 INTERVENTIONS

In this section, we describe a number of practical interventions, which have been extracted from the interviews with migrants in the Netherlands and from our country studies. Box 14 provides a list of possible constraints to return and the interventions and considerations relevant to these constraints. This list is not exhaustive. Return assistance to migrants living with HIV is an unexplored area of practice, and as such it is very likely that new barriers and possible interventions would be identified if return would actually take place. Also, the feasibility of each of these proposed interventions can only be assessed on a case-by-case basis.

**Box 14 : Intervention possibilities**

<i><b>Barrier to return</b></i>	<i><b>Considerations for intervention</b></i>
<b>Medical issues</b>	
Antiretroviral medication not available or appropriate medication not available	<p>Is migrant planning to return only for a short period<sup>93</sup> or permanently?</p> <p><i>Short term return:</i></p> <ul style="list-style-type: none"> <li>• can migrant take a stock of medication?</li> <li>• is it possible to import medication from Netherlands or another country?</li> </ul> <p><i>Long term return:</i></p> <ul style="list-style-type: none"> <li>• no intervention feasible, unless broader treatment services and broader medication options become available</li> </ul>
Other crucial medical facilities not available (qualified health care staff, testing, treatment of opportunistic infections, etc.)	<ul style="list-style-type: none"> <li>• no intervention feasible</li> </ul>
Appropriate treatment available elsewhere in the country of origin, but not near preferred location of return	<ul style="list-style-type: none"> <li>• is migrant willing/able to settle closer to a treatment site? Does he/she have economic opportunities and a social support network there? (see below)</li> <li>• Will migrant have the financial means to travel to treatment site? (see economic issues)</li> </ul>
Appropriate treatment and monitoring is available but (parts of) treatment are not free	<ul style="list-style-type: none"> <li>• what are the migrant's short and long-term economic prospects? (see economic issues)</li> <li>• is it reasonable to assume that the migrant will be able to afford treatment if he/she has a sustainable income?</li> </ul>

<sup>93</sup> For example, a migrant might return in order to prepare another migratory movement to another country.

Appropriate treatment is available but treatment centres have waiting lists for entering of programmes	<ul style="list-style-type: none"> <li>• information gathering on state of waiting lists. When will migrant be able to enter the treatment programme?</li> <li>• Are there other treatment sites reasonably accessible to migrant without waiting lists?</li> </ul>
Concerns about the continuity of the availability of treatment at the treatment site	<ul style="list-style-type: none"> <li>• Information gathering about the history of the treatment site (start of provision of treatment, interruptions in supplies, etc.)</li> </ul>
<b>Economic issues</b>	
High levels of poverty and/or unemployment in the country of origin	<ul style="list-style-type: none"> <li>• No intervention feasible</li> </ul>
Migrant needs income generation strategy	<ul style="list-style-type: none"> <li>• Can migrant rely on family to sustain him/her?</li> <li>• Does the migrant want to find employment?</li> <li>• Does the migrant want to become self-employed?</li> </ul>
Migrant wants to find employment	<ul style="list-style-type: none"> <li>• Information gathering: are there job opportunities that match the skills/experiences/physical possibilities of the migrant?</li> <li>• Are there opportunities for training (before departure or in the country of origin) to improve the employability of the migrant?</li> <li>• Is some kind of mediation with potential employers possible (e.g. job placement)?</li> <li>• Information gathering: what protection is there against work place discrimination of persons living with HIV? Is legal assistance available and do effective remedies exist?</li> </ul>
Migrant wants to become self-employed	<ul style="list-style-type: none"> <li>• Can the migrant be advised on developing a viable business plan?</li> <li>• Information gathering: are there particular activities that are more likely to generate a sustainable income?</li> <li>• Does the migrant have the skills/experience to engage in these activities?</li> <li>• Is skills training (in the Netherlands or the country of origin) available?</li> <li>• Are there possibilities for micro credit or other financial assistance for business start-up?</li> </ul>
<b>Social issues</b>	
Migrant has no social network in country of origin	<ul style="list-style-type: none"> <li>• Can lost family be traced and contact re-established?</li> <li>• Are there alternatives for social support (e.g. local associations of people living with HIV)? Do these provide sufficient levels of support?</li> </ul>
Social network does not know migrant is HIV-positive	<ul style="list-style-type: none"> <li>• Are there possibilities for counselling and advice on disclosure process from host country?</li> <li>• Is family counselling available in the country of origin?</li> </ul>

Stigma and discrimination in wider society	<i>Individually:</i> <ul style="list-style-type: none"> <li>• Can support groups in host country and country of origin help migrant develop coping strategies?</li> </ul> <i>Structurally:</i> <ul style="list-style-type: none"> <li>• No interventions feasible</li> </ul>
<b>Other issues</b>	
Fears of violence or persecution in country of origin	<ul style="list-style-type: none"> <li>• No interventions feasible</li> </ul>

## 12.3 THE SCOPE AND POTENTIAL OF RETURN ASSISTANCE

As already suggested, return assistance does not have an unlimited scope and potential. In this section, we will discuss some issues related to the effectiveness of such institutionalised interventions. The limitations to return assistance should be clear to both the assistance provider and the migrant receiving this assistance.

### *The impact of return assistance should not be overestimated*

The limits on the impact of return assistance are primarily related to structural circumstances in the country of origin, as well as the migrant's own possibilities and proactiveness. To provide both migrants and policy makers with a realistic view of the scope and potential of return assistance, it is important that its impact should not be overestimated. It is a tool that is complementary in nature; in isolation, no form of return assistance can create the appropriate conditions for sustainable return and reintegration.

### *The availability of assistance does not lead to a desire to return*

Seeing return assistance as complementary is also important to understand the place it might occupy in policies towards migrants living with HIV, who do not have a legal status. In general, there is a tendency to see return assistance to rejected asylum seekers and irregular migrants as a tool to manage migration flows. In other words, return assistance is sometimes perceived as an instrument to maximise the number of returns of migrants who have a legal obligation to leave the host country. The underlying assumption seems to be that the availability of assistance will play a major role in the migrant's decision to return. Our interviews suggest that this assumption may not hold true for migrants living with HIV. Since return assistance can only marginally impact on the possibilities for return and reintegration, it only plays a very limited role in shaping the decisions of the interviewed migrants. In other words, the availability of assistance does not evoke a desire to return. Only if such a desire to return already exists does return assistance have a potential added value.

### *Interventions may reduce some uncertainties, but return remains a 'gamble'*

Finally, it is important to emphasise that, despite the fact that both migrants and assistance providers might look for the highest degree of certainty of sustainable return and reintegration, the sustainability of return can never be guaranteed. Given the broad range of factors of importance and their close interconnection, no level of preparation can provide complete certainty. Plans may not work out and unforeseen circumstances are likely to occur. This inevitably makes return a bit of a 'gamble'. For migrants living with HIV the stakes in this gamble are very high. A failure to find a sustainable situation after return can have disastrous consequences. There is very little margin for error, particularly considering the fact that they

will not be able to return to the Netherlands if things do not work out (see 13.2). Solid preparation and well-considered interventions may help reduce some uncertainties, but a degree of risk remains inevitable when returning. In the run-up to return, these potential risks should be clearly communicated to the migrant, so that he/she can make a decision based on realistic considerations.

## 12.4 RETURN ASSISTANCE: ETHICAL CONSIDERATIONS

As suggested at the start of this report, a discussion of return for migrants living with HIV cannot take place in a moral vacuum. Not only are there practical limitations to providing return assistance, but engaging in such assistance can have ethical implications. In this section we will explore some of these issues, without a pretence to definitive answers.

*Can returnees living with HIV be a positive influence, or are they an added burden on already vulnerable communities in their countries of origin?*

The current debate about return migration policies is heavily influenced by the concept of migration and development. This concept emphasises the possibilities of migrants to contribute to the development of their countries of origin. This issue also played a role in various discussions with experts in the Netherlands and in the countries of origin. These usually centred around the assumption that some Africans living with HIV in the Netherlands, who had received extensive counselling and had been able to create an attitude of ‘positive living’, would be able to share their experiences as peer educators in their countries or origin. This experience, it was suggested, would be a valuable asset upon return. The desire to contribute something to the well-being of people living with HIV in their countries of origin was also voiced by some of our respondents (see 5.5.3).

However, despite these possible benefits, there is also good reason to question whether it would actually be possible for returning migrants living with HIV to be ‘agents of change’. Given the considerable barriers that returning migrants would need to overcome, not least because of stigma and discrimination, it would already be an immense achievement to re-establish themselves, without the additional pressure of having to be an ‘added value’ in terms of development objectives. Much more than the difficulty of positively contributing, however, becoming an ‘added burden’ on family members or the wider community is an important consideration for many respondents. Their return, as a person coming empty-handed and being ill, could put pressure on the already fragile situation of their families and networks. Also, if family members accept the returnee back in their midst, stigma and discrimination might also be deflected towards those family members, who then might have even more difficulty maintaining themselves.

*Does providing return assistance to migrants living with HIV discriminate against other migrants?*

Our focus here has been exclusively on migrants living with HIV. However, many of the issues we have identified, especially the problems of availability, accessibility and affordability of treatment (including the necessity of a sustainable income at a certain level) will be no less crucial for other returnees with chronic mental and physical illnesses which may be life-threatening or have a severe impact on the health of the migrant if untreated. Additionally, economic and social reintegration is also an important consideration for migrants without health concerns. This leads to the question whether providing return

assistance for migrants with HIV, which is likely to be a very costly exercise given the scope of their needs, while excluding others from similar high levels of assistance, is justifiable.

*Where does the responsibility of assistance providers end?*

Providing return assistance to returnees living with HIV might put assistance providers in a difficult position. As already suggested by several of our respondents, assistance should be focused on long-term results, and not be a short-term stopgap. However, at the same time it is unrealistic to expect assistance providers to keep supporting returnees for the rest of their lives. Does this mean that assistance providers should only provide certain types of (pre-agreed) assistance and then cut all ties with the returnee? As noted above, returnees may encounter unexpected circumstances and problems, some of which they may not be able to overcome on their own. Should those institutions providing the initial return assistance – even if it has already fulfilled its obligations as agreed – then step in again with new interventions? This is an issue that needs to be considered carefully by assistance providers before engaging in interventions for migrants living with HIV.

The extent of responsibilities also becomes a topic for debate when looking at the issue of post-return monitoring. In general, the consulted experts agreed that it would be necessary to monitor how returned migrants were getting on. However, this raises the question of the purpose of such monitoring. Is monitoring exclusively a tool for improving future interventions for other returnees, or does it also entail an obligation to intervene when problems occur for the monitored returnee? As such, while monitoring might be a desirable and necessary part of any return assistance programme for migrants living with HIV, it may also drag assistance providers in an untenable, possibly life-long, relationship with returnees, who, as a consequence, may become increasingly dependent on the assistance provider.

*Will the voluntary return of migrants living with HIV lead to negative consequences for those who do not wish to return or cannot return?*

A recurring theme in our discussions with experts in the Netherlands was that of the legal consequences of facilitating the voluntary return of migrants living with HIV. There were worries that the provision of return assistance would send out a signal that it was generally possible for migrants living with HIV. This, it was argued, could lead to stricter measures to enforce the return of migrants living with HIV who do not have a legal status, and to difficulties in obtaining a legal status. Theoretically, at least, this seems unlikely. After all, the *objective availability* of treatment is the main consideration in legal procedures (see 3.3.4). Voluntary return assistance activities do not influence this availability; at most they can have a positive influence on accessibility of treatment. Considerations related to accessibility are explicitly excluded from legal procedures. Nevertheless, until significant numbers of migrants living with HIV would have returned, the legal and policy implications of return assistance for this group remains unclear.

*Can the return of migrants living with HIV lead to public health problems in their countries of origin?*

The final issue of concern that we mention here is the possibility of returnees living with HIV having an impact on the public health situation in their countries of origin. Given the fact that this report did not have a medical focus, this issue has not been explored further. However, during the visit to Ghana this issue was raised (see 7.3). If large-scale return of migrants living with HIV to a certain country would take place – a situation that seems unlikely under current circumstances – this issue would warrant more attention.

## CHAPTER 13 – THE IMPACT OF IMMIGRATION LEGISLATION AND POLICIES ON THE POSSIBILITY OF RETURN

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### 13.1 LEGAL STATUS AND THE POSSIBILITY TO RETURN

This report has taken the current Dutch legal and policy framework as its starting point for our subsequent discussion of voluntary return for migrants living with HIV. One of the main aspects of this framework is that it puts an obligation to leave the Netherlands on all migrants who do not have a legal status. However, in addition to determining *when* a migrant living with HIV would be expected to return, Dutch legislation and policies do not only set the conditions for when a migrant living with HIV would need to leave the Netherlands, but also have a distinct impact on *whether* migrants are inclined to meet this obligation. In this final chapter, some dimensions of this impact are discussed.

### 13.2 NO WAY BACK: RETURN AS PERMANENT RETURN

Once a migrant without a legal status leaves the Netherlands, there are very few possibilities to re-enter the Netherlands legally. This may seem like stating the obvious, but it actually has a strong negative impact on migrants' willingness to return. Dutch immigration law, as we have discussed, provides for a broad range of reasons for entering and staying in the Netherlands. As long as a migrant – even if he/she has previously left the country due to a lack of a legal status – meets the eligibility criteria, he/she will be allowed to re-enter the Netherlands. However, few migrants who are currently in the Netherlands without a legal status expect that they will be able to meet these eligibility criteria. For some, this may actually have been a reason to enter the country in an irregular manner. As such, for these migrants, leaving the Netherlands would mean a permanent farewell to their host country. This is problematic because this leaves them with no 'back up option' should things in their countries of origin not work out as planned. As discussed in chapter five, even those respondents that tentatively consider returning at some point in the future are worried about the sustainability of their access to medical treatment. For many of them, returning now, with no possibility of re-entering the Netherlands if they encounter problems in accessing their medication, or the alternative treatment regime turns out not catch on, would constitute too much of a risk. As such, many said they would prefer to remain in the Netherlands without a legal status, but with guaranteed access to medical treatment, at least until that time that medical conditions in their countries of origin have improved considerably. This, they usually do not expect to happen in the short term.

This also explains why some of our respondents with a residence permit are more open to thinking about return. Some of them even suggested that they might travel back temporarily to see for themselves what conditions would be like, and how they would cope with being back in their countries of origin. For them – even though they would only be able to visit their countries of origin for a short time – this would give them some peace of mind. And if they would still think the risk of returning was too great, they would at least have the certainty that

they resided legally in the Netherlands<sup>94</sup>. It should be noted too, that if migrants with a legal status choose to return using the facilities offered under the REAN programme, this would require them to relinquish all claims to a legal status in the Netherlands. Therefore, a ‘go and see’ visit to the country of origin would have to be arranged by the migrant from his/her own means.

### **13.3 WILLINGNESS, PROACTIVENESS AND LEGAL STATUS**

In the previous chapter we have already discussed the situation of HIV-positive migrants who were exclusively focused on ‘surviving’. While this ‘survival-mode’ was sometimes seen as a consequence of the psychological difficulties of the respondents in accepting their HIV-positive status, it is also clear that legal status played an important role. The results of not having a legal status, i.e. the exclusion from public services, resulted in a daily struggle for survival. As such, these measures that seek to ‘motivate’ migrants without a legal status to return voluntarily seem to significantly contribute to the inability of migrants living with HIV to focus on their futures. As discussed, for sustainable voluntary return to be considered a viable option by these migrants, such a positive focus on their futures is indispensable.

This leads to a paradoxical situation. On the one hand, we have approached voluntary return primarily as an alternative to irregular stay in the Netherlands. Particularly because of the difficult situation that rejected asylum seekers and irregular migrants living with HIV may find themselves in, the existence of such an alternative may be desirable. However, at the same time, the lack of a legal status may actually become a major deterrent to think about voluntary return.

### **13.4 NO LEGAL STATUS AND NO PROSPECT OF VOLUNTARY RETURN: WHAT NEXT?**

We have already noted that there is a significant gap between migrants’ criteria for sustainable return and the legal criteria for staying in the Netherlands. The availability-accessibility debate is the most obvious example of this. From our interviews it is also clear that most of our respondents are unwilling to return voluntarily under current conditions. Additionally, we have just suggested that measures to induce migrants to leave of their own volition may not work and may actually have an adverse effect on return. So where does this leave us?

This is where we must admit that we have reached the limits of our study. It is clear from our study that there is a significant gap between the objectives of the Dutch legislation and policies towards voluntary return and the interests of migrants with HIV. This gap can be assumed to be undesirable both from the perspective of the host state and of the migrants themselves. The state, for example, is confronted with considerable costs due to the presence of uninsured migrants living with HIV (see box 7), and the potential public health implications of the presence of groups of HIV-positive migrants who are ‘off the radar screen’<sup>95</sup>. Alternatively,

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<sup>94</sup> As discussed in chapter three, there are also limits to this certainty. Residence permit on medical grounds are generally awarded for a maximum period of one year, and have to be renewed. This means that – at least until a migrant receives a permanent residence permit – uncertainty will remain about whether or not a migrant can stay in the Netherlands for a prolonged period of time.

<sup>95</sup> As suggested earlier, there may be a significant group of migrants living with HIV without a legal status, who have not sought treatment and therefore are not registered in the hospitals.

migrants living with HIV may face serious consequences for their mental and physical well-being when they continue to live in the Netherlands without a legal status. Providing assistance to the voluntary return of migrants living with HIV may provide a solution for this clash of interests in some cases, but – under current conditions – is unlikely to be the answer in many others. It will therefore be essential that further research and debate take place on what governments, migrants living with HIV and other stakeholders can do to find durable solutions.



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