



LÄKARE I VÄRLDEN  
MÉDECINS DU MONDE  
DOCTORS OF THE WORLD

**HIV-SWEDEN**  
SWEDISH ASSOCIATION FOR HIV-POSITIVE PEOPLE

23 October 2007

The Committee on Economic, Social and Cultural Rights  
Re: Supplementary information on Sweden  
Scheduled for pre-session review by the Committee on Economic, Social and Cultural Rights during its 41<sup>st</sup> Session.

Dear Committee Members:

Medicines Du Monde (MDM) and HIV-Sweden submit this letter to supplement the 5<sup>th</sup> periodic report of Sweden to the Committee on Economic, Social, and Cultural Rights, which is scheduled to be reviewed by the Committee in 2008. We submit this letter for the Committee's pre-session meeting during its 41<sup>st</sup> session in November 2007. We hope that the Committee's review will cover several areas of concern related to the status of the health and rights of undocumented migrants and persons with HIV in Sweden. This letter is intended to provide a summary of the issues of greatest concern in this regard, as well as a list of questions that we hope the Committee will raise with the official delegation from Sweden.

Medicines Du Monde-Sweden is an organization established in 1995. The mission of Medicines Du Monde, Sweden is to help, care and give witness for undocumented migrants concerning health care. One of the activities of Medicines to Monde, Sweden is to provide basic medical services to undocumented migrants; it has one of only two such clinics in Sweden's capital, Stockholm. It serves approximately 800 undocumented migrants every year and has seen over 10,000 patients since the clinic opened. Medicines Du Monde is completely dependent on private donations to run this clinic; it receives no financial or in-kind support from the Swedish government.

HIV-Sweden is an umbrella organisation (NGO) that works on HIV issues at the national level to protect the interests of HIV-positive persons. It is an ideologically, party politically and religiously independent organisation. HIV-Sweden's objectives are to combat discrimination and attitudes and work for the rights of HIV-positive persons,

The report was written with support from Christina Zampas, Senior Legal Adviser for Europe at the Center for Reproductive Rights.

### **Legal background on the right to health**

Because health is fundamental to the exercise of many other rights including equality and non-discrimination, States parties' (including Sweden's) commitment to ensuring them should receive serious attention. Furthermore, health and rights receive broad protection under the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12(1) recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." And according to the Committee this requires states to take affirmative steps to promote health and to refrain from conduct that limits people's abilities to safeguard their health.

In interpreting the right to health, this Committee, in General Comment 14, has explicitly stated that "[H]ealth is a fundamental human right indispensable for the exercise of other human rights" and that "[E]very human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity" (emphasis added).<sup>1</sup> The Committee has defined this rights to include "a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health".<sup>2</sup> The right to health contains several interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party. One of them is economic accessibility (affordability): " ...health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households."<sup>3</sup>

### **Non-Discrimination and Equal Treatment**

Articles 2(2) and 3 guarantee all persons the rights set forth in the ICESCR without discrimination, specifically as to "sex, social origin or other status." The Committee has characterized the duty to prevent discrimination in access to health care as a "core obligation" of the state and proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status..." The Committee has also stressed that discrimination in access to health care must be eliminated through repealing discriminatory legislation or through dissemination of information.<sup>4</sup>

Under the ICESCR, States have a "special obligation . . . to prevent discrimination in the provision of health care and health services, especially with respect to core obligations of the right to health." The Committee has emphasized that "States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services...". A core obligation of the state is to "ensure the right of

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<sup>1</sup> Committee on Economic, Social and Cultural Rights, General Comment 14 (2000) on the Right to the Highest Attainable Standard of Health, para 1.

<sup>2</sup> Id., para 8.

<sup>3</sup> Id., para 12 (b).

<sup>4</sup> Id., para 18.

access to health facilities, goods and services on a nondiscriminatory basis, especially for vulnerable or marginalized groups;...<sup>5</sup>

### **Sweden's non-compliance with the ICESCR**

The UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, undertook a mission to Sweden in 2006, his report on this mission, the experiences of the NGOs submitting this shadow report and most importantly, the reality of people's lives living in marginalized situations in Sweden indicate the government's failure to comply with the Convention. Sweden, despite its high ranking as one of the most developed and richest nations in the world continues to essentially deny its most vulnerable populations the most basic and fundamental service that is necessary for the sustainability of their lives: health care. As a result, thousands of persons most basic health needs are not being met which leads not only to serious physical health issues but, but also hinders their ability to exercise other fundamental rights.

We would like to take the opportunity to bring the Committee's attention to following issues of concern, which directly affect the health and lives of Sweden's most vulnerable populations:

This parallel report will provide information on the following issues:

- 1) State failure to ensure access to health care for undocumented migrants;
- 2) State failure to ensure access to health care for undocumented HIV positive persons and resulting discrimination
- 3) State failure to provide access to clean needles for injecting drug users;

### **International Human Rights, including the right to health's, applicability to undocumented migrants.**

The principle of non-discrimination holds that all migrants, whether documented are not, are accorded certain rights and standards of treatment.<sup>16</sup>

The Special Rapporteur on his report on Sweden has noted that "under international human rights law, some rights, notably the right to participate in elections, to vote and to stand for election, may be confined to citizens. However, human rights are, in principle, to be enjoyed by all persons." He notes specifically that the protections of international human rights law are more

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<sup>5</sup> Id. para. 43 (a) These core obligations include ensuring nondiscriminatory access to health facilities, especially for vulnerable or marginalized groups; providing essential drugs; ensuring equitable distribution of all health facilities, goods and services; adopting and implementing a national public health strategy and plan of action with clear benchmarks and deadlines; ensuring reproductive, maternal and child care; taking measures to prevent, treat and control epidemic and endemic diseases; and providing education and access to information for important health problems. To justify the failure to meet at least minimum core obligations as based on a lack of available resources, a state party "must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations."

<sup>6</sup> Amnesty International, "Living in the Shadows: A Primer on the Human Rights of Migrants," September 2006, AI Index: POL: 33/006/2006.

extensive in their scope than the European Commission council directive 2003/9, which lays down minimum standards for the reception of asylum seekers.<sup>7</sup>

In 2000 this Committee explicitly applied the non-discrimination provisions of the ICESCR to undocumented migrants. It noted that “States are under an obligation to respect the right to health by refraining from denying or limiting equal access for all persons, including...asylum seekers and *illegal immigrants*, to preventative, curative and palliative health services (emphasis added).<sup>8</sup> The UN Committee which monitors the Convention on the Elimination of Race Discrimination (CERD) has also taken this position<sup>9</sup>. In its most recent recommendations on Sweden’s compliance with CERD the Committee has noted concern with “the persistence of discriminatory attitudes faced by persons of immigrant origin in certain areas, such as the labour market, housing and access to public services.” The Committee recommended that Sweden strengthen its efforts in these areas, specifically including the right to public health and medical care.<sup>10</sup>

Thus, the rights guaranteed under the ICESCR to Swedish citizens and residents, including the right to health, are also applicable to undocumented migrants.

### **The Reality of Undocumented Migrant Access to Health Care in Sweden**

There are an estimated 15,000 undocumented people living in Sweden. Undocumented persons, who seek medical care in public health care facilities, are theoretically to receive the treatment required. However, 3 obstacles stand in their way: money, discriminatory attitudes of health care personnel and fear of being reported

So while undocumented persons, including children, can legally have access to health care, adults and children **will have to pay the full cost of the treatment** and medication (children that have been in the asylum process but have fallen out of legal status and are currently undocumented can still get health care, for undocumented children that never been in the asylum process they have to pay the full cost). For most undocumented migrants, these fees are impossible to pay. As a result, either they do not seek the health care they need; many of which fact further health deterioration or they seek only the absolutely necessary services, such as maternal health care, but give a false address. It is worthy to note that hospital costs just for giving birth in Sweden, not full prenatal health care, are approximately 30.000 Swedish Crowns (3,000 Euros), a sum which many lower income Swedish citizens would not be able to pay if they had to, never mind undocumented migrants. Such insurmountable barriers, in effect make access to health care an unrealizable right for Sweden’s undocumented migrants.

The Committee has asserted that States parties are required to take “measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, emergency obstetric services and access to information, as well as to resources necessary to act

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<sup>7</sup> UN Special Rapporteur Report on his Mission to Sweden, A/HRC/4/28/Add.2, 28 Feb. 2007 page 19

<sup>8</sup> Committee on Economic, Social and Cultural Rights, General Comment 14 (2000) on the Right to the Highest Attainable Standard of Health, para 34.

<sup>9</sup> CERD General Recommendation No. 30, Discrimination Against Non-Citizens (2004), paras 20 and 36 require states parties to “Remove obstacles that prevent the enjoyment of economic, social and cultural rights by non-citizens, notably in the areas of education, housing, employment and health;... Ensure that States parties respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services;”

<sup>10</sup> CERD Concluding Observations, Sweden, para 16, U.N. Doc. CERD/C/64/CO/8 (2004).

on that information.” General Comment 14 also specifically states that “[t]he realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health.” In its past Concluding Observations, CESCR has expressed concern over women’s inability to access reproductive health services and has criticized states parties’ inadequate policies and programs. The Committee has noted that a state’s failure to ensure access to reproductive health care for women constitutes discrimination in that it deprives them of their ability to fully enjoy their economic, social and cultural rights on an equal basis with men.<sup>11</sup> In his most recent report, the Special Rapporteur on the Human Rights of Migrants recognized the multiple forms of discrimination that migrants may face, the report stated:

“Discrimination is a key factor in many human rights violations affecting migrants. It has thus been, from the start, at the core of the mandate of the Special Rapporteur. . . . The interplay of different grounds of discrimination suffered by migrants results in experiences and patterns of exclusion, disadvantage and abuse that tend to accumulate and intensify and that cut across all spheres: the workplace; access to social services, justice, education, housing and health care; and participation in public life and decision-making bodies . . . . For example, the disadvantages or deprivations that migrant women experience because of gender cannot be separated from the disadvantages stemming from other personal attributes and identities related to their religion, race or national extraction.”<sup>12</sup>

Sweden should in order to comply with the right to health provisions of the ICESCR, remove these discriminatory barriers to all health care, including barriers to reproductive health care.

### **Access to Emergency Health Care**

Undocumented migrants must have to pay full fees for health care, including for emergency procedure. Asylum seekers in Sweden are covered by national health insurance for emergency health care. Undocumented children who has been in the asylum process should receive health care on the same basis as resident children but this is not applied in all hospitals, as is illustrated below. The costs of such services are unaffordable for most asylum seekers and undocumented foreign nationals, resulting in effect of the failure of the state to provide emergency care and thus, a clear violation of the ICESCR provisions on health and the right to non-discrimination. The UN Special Rapporteur encouraged the Swedish government to “reconsider its position with a view to offering all asylum-seekers and undocumented persons the same health care, on the same basis, as Swedish residents. By doing so, Sweden will bring itself into conformity with its international human rights obligations.”<sup>13</sup>

A real story given by health care providers at Medicines Du Monde concerns a newborn child was born in a hospital in Stockholm in 2004. The baby has a serious case of jaundice which needed acute medical attention, the parents however, fell into undocumented status after a failed asylum process and they were concerned about having to pay the bill for their baby’s medical needs. The baby was admitted to the Astrid Lindgrens Hospital in Stockholm. The situation was

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<sup>11</sup> Center for Reproductive Rights and University of Toronto Programme of Reproductive and Sexual Health Law, *Bringing Rights to Bear: An Analysis of the Work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights*, page 117 (2002)

<sup>12</sup> *Specific Groups and Individuals: Migrant Workers*, Report of the Special Rapporteur on the human rights of migrants, Jorge Bustamante, E/CN.4/2006/73, 30 December 2005

<sup>13</sup> UN Special Rapporteur Report on his Mission to Sweden, A/HRC/4/28/Add.2, 28 Feb. 2007, para 75

so serious that doctors were considering a blood transfusion, the baby girl stayed in the hospital for 10 days. All the time in addition to the anguish and distress faced by the parents in having a very sick newborn, they were also constantly worried about being able to pay the bills for their baby's care. The parents soon after receive a bill of 32.000 Swedish crowns and were unable to pay even a fraction of it. Staff at Medicines Du Monde intervened asking that the payment be cancelled since the child should have had access to free medical care, the hospital then agreed to cancel payment.

Another incident to illustrate this problem, as reported by Medicines Du Monde- Sweden, concerns a mother (undocumented migrant) that seeks medical care for her 8 month old child. The child has a severe rash all over its body. But even before the baby sees a doctor, the mother is told she must pay 2.000 SEK. The mother tells the staff that she does not have money to pay, the staff in turn, refuses to provide the care to the child. The mother seeks the assistance of Medicines Du Monde who intervenes and facilitates the baby's access to health care. There are literally hundreds, if not thousands of people in this same situation in Sweden every year, almost all of them do not have the assistance of organizations such as MDM, and as such never get the necessary care that they need or are put in untenable situations.

Another barrier is the **discriminatory attitudes of health care personnel**. The UN Special Rapporteur has raised concern that "... health professionals in Sweden did not always know about, and sometimes acted contrary to, their patients' human rights."<sup>14</sup> He noted that important link between the practice of health professionals and the ability of persons to exercise their right to health, including medical confidentiality, privacy and equitable access to treatment.<sup>15</sup> Thus, in order to ensure access to health care for undocumented migrants, it is essential that Sweden take responsibility in training health care personnel on their obligations to provide health care in a non-discriminatory and respectful manner for *all* their patients, irrespective of their legal status. This would help create an environment where patients are respected regardless of their status. A study shows that pregnant foreign-born women in Sweden have higher rates of non-normal childbirth which may be due to not getting the same level of maternal health care as pregnant Swedish women.<sup>16</sup>

It is also essential that **reports of discrimination in access to health care be encouraged** and taken seriously by law enforcement officials and other bodies monitoring human rights, as required by the ICESCR. General Recommendation 14, specifically lays out Sweden's responsibilities in this respect:

59. Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition.

National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.

60. The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases. Incorporation enables courts to

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<sup>14</sup> UN Special Rapporteur Report on his Mission to Sweden, A/HRC/4/28/Add.2, 28 Feb. 2007 page 18

<sup>15</sup> Id.

<sup>16</sup> Center for Family Medicine Stockholm, Karolinska Institute, Sweden. Do Foreign-born women in Sweden have an increased risk of non-normal childbirth? Eva Robertson, Marianne Malmström, Sven-Erik Johannson (2005).

adjudicate violations of the right to health, or at least its core obligations, by direct reference to the Covenant.

61. Judges and members of the legal profession should be encouraged by States parties to pay greater attention to violations of the right to health in the exercise of their functions.

62. States parties should respect, protect, facilitate and promote the work of human rights advocates and other members of civil society with a view to assisting vulnerable or marginalized groups in the realization of their right to health.

In addition, Sweden has an obligation under the ICESCR to fulfill the right to health by **training health personnel to deal with the needs of vulnerable groups**, such as undocumented migrants. As noted in its General Recommendation 14, such obligations include: “...ensuring that health services are culturally appropriate and that health care staff are trained to recognize and respond to the specific needs of vulnerable or marginalized groups...”<sup>17</sup>.

Another major barrier that undocumented migrants face, which is closely related to the above-mentioned problems concerning discriminatory attitudes of health care personnel is the fear **that undocumented migrants have of being reported** to authorities by medical staff, resulting in them often refraining from seeking medical assistance even in the most serious cases. Under Sweden’s Secrecy Act, general care staff are, as a general rule, prohibited from divulging information of individuals, however, it is unclear to what degree this applies to undocumented migrants. There are no known official guidelines for health care personnel on their obligation not to divulge the legal status of patients despite this being a well-known fear. In order for the state to seriously respect inhabitants confidentiality and privacy in the health care setting, it must clarify this and disseminate this information to health personnel and ensure that there are repercussions for anyone divulging this information. While it may be understood that this fear cannot be eliminated altogether, given the vulnerable situation of undocumented migrants, Sweden should take steps towards addressing these fears and in doing so would come closer to fulfilling its obligations under the Convention, such steps include ensuring that the system of health care is non-discriminatory and protects confidential information, as is required for the realization of the highest attainable standard of health set forth by the ICESCR.

Many of the undocumented migrants coming to Medicines du Monde’s clinic for undocumented migrants in Stockholm express fear of being reported if they go to a hospital for care. Medicine’s du Monde reports on a child that had an allergic reaction – the father did not go to the hospital for fear of being reported to the police or migration authorities-- the family had been in a failed asylum process and was undocumented and in hiding. A MDM staff took the father and child to the hospital as support and proper care was given. Medicines du Monde also reports on a pregnant woman who during the asylum process had gone to a Maternity Health Center for her prenatal health care needs. In her fifth month of pregnancy she was denied asylum by the Swedish Migration Board and was subsequently turned away for continuing maternal health care at the Maternity Health Center. She then sought care at Medicine’s du Monde’s clinic but was very afraid and worried about her situation for fear of being reported when she came to MDM’s clinic.

**The mental health status of illegal migrants** and those seeking asylum is undoubtedly a problem. As reported by the UN Special Rapporteur on the Right to Health in his report on Sweden, “[U]p to a quarter of refugees and asylum seekers are affected by post-traumatic stress

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<sup>17</sup> Committee on Economic, Social and Cultural Rights, General Comment 14 (2000) on the Right to the Highest Attainable Standard of Health, para. 37

disorder and have difficulty accessing mental health care.<sup>18</sup> He has urged the government of Sweden to "...ensure that mental health care, including psychiatric care and other therapies, is made more accessible for marginalized groups."<sup>19</sup> Medical providers at the Medicines du Monde clinic for undocumented migrants often see patients whose have psycho-somatic health problems. This issue is further exacerbated when there are pre-existing mental health problems.

In accordance with article 12.1 and 12.2 of the Covenant, States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and *mental* health" (emphasis added). Sweden has an obligation under the Convention to create "conditions which would assure to all medical service and medical attention in the event of sickness", both physical and *mental*, includes the provision of "...*appropriate mental health* treatment and care."<sup>20</sup>

HIV-Sweden reports on a situation concerning a Ukrainian woman who was seeking asylum in Sweden in 2004. During her wait on her asylum application, she was institutionalized for a serious self destructive mental illness for almost a year. Her husband was also depressed and during this time their 2 year old child was placed in a foster home, as the mother nor the father could take proper care of him. Over the Christmas holidays, the woman was given leave from the institution for a few days to spend the holidays with her husband. Their child was still with the foster parents. During her leave, the police, without notice, came to their home and physically removed them for deportation back to the Ukraine, as their applications for asylum were denied. In addition, the police, without notice to the foster parents, also forcibly removed the child from the foster parents home and deported the child together with his biological parents back to Ukraine. After the deportation the mother was cut off from mental health care and her mental health quickly deteriorated. The child, who did not have much contact with his parents for almost a year while he was with his foster parents, became seriously depressed and stopped eating when he returned with them to the Ukraine. The health status of the family is currently unknown.

### **Access to HIV/AIDS Treatment and Prevention Programmes**

There are several problems regarding access to HIV treatment and prevention programs in Sweden. This letter raises several issues: 1) discriminatory treatment of persons living with HIV in the health care system 2) undocumented migrants lack of access to treatment 3) deportation of persons living with HIV back to countries where HIV treatment is not accessible and 4) state failure to ensure availability of needle exchange programs.

**Undocumented migrants with HIV** face even double discrimination; discrimination based on their legal status and discrimination based on HIV status. A third form of discrimination they may face is because of their ethnicity or race. HIV-Sweden reports on an African woman who was recently denied care at an antenatal clinic after she informed them that she was HIV-positive. It is not uncommon for people living with HIV in Sweden to be afraid of going to primary healthcare because of stigma and discrimination.

The Covenant proscribes any discrimination in access to health care, including HIV/AIDS status.<sup>21</sup> The UN Office of the High Commissioner for Human Rights and UNAIDS has issued human rights guidelines on HIV/AIDS which are meant, in part, to provide guidelines for

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<sup>18</sup> UN Special Rapporteur Report on his Mission to Sweden, A/HRC/4/28/Add.2, 28 Feb. 2007, pages 13-14.

<sup>19</sup> UN Special Rapporteur Report on his Mission to Sweden, A/HRC/4/28/Add.2, 28 Feb. 2007, page 15

<sup>20</sup> Committee on Economic, Social and Cultural Rights, General Comment 14 (2000) on the Right to the Highest Attainable Standard of Health, para. 17.

<sup>21</sup> Committee on Economic, Social and Cultural Rights, General Comment 14 (2000) on the Right to the Highest Attainable Standard of Health, para 18.

government efforts to ensure persons with HIV are not discriminated against in access to public services, including health care.

The UN Special Rapporteur on the Rights to Health has noted that “There are some worrying health trends in Sweden.. Since the 1990s, reported cases of chlamydia have significantly increased, and there have been increasing rates of infection of other sexually transmitted infections – particularly among youth - including gonorrhoea and syphilis. Cases of HIV are also increasing. Examined through the prism of the right to health, some health policies are a cause for genuine concern.”

Another troubling concern in this area is the failure of the Swedish Migration Board to look effectively at access to anti-retroviral treatment when determining whether to **deport an HIV-positive asylum seeker**. The government relies heavily on their embassies’ general reports on *availability* of HIV treatment, but does not consider *accessibility*, including the financial accessibility, of treatment. It fails to look into the particular circumstances of each case and makes very broad and harmful decisions based on very general and for the most part non-informative reports.

In the context of the Special Rapporteur’s evaluation of **needle exchange for intravenous drug users**, he noted a need for an integrated, comprehensive harm reduction policy in Sweden. It is well-known that programs such as syringe exchange among the most well-researched HIV prevention strategies in the world and studies how that access to sterile syringes significantly reduce HIV transmission without increasing rates of drug use or drug-related crime. The World Health Organization and UN AIDS support such programs. WHO states that “[needle exchange programs] ability to break the chain of transmission of HIV is well established.”<sup>22</sup> In Sweden, the scarcity of needle exchange programs is a state-imposed barrier that interferes with the human right to health. The UN Special Rapporteur on the Right to health was encouraged by reforms in Sweden in 2006 which allows health and social services to introduce needle exchange programs but raised serious concerns by “allowing such an important human rights issue to be left to the discretion of local government.”<sup>23</sup> In Sweden there are only two needle exchange programs, in Malmö and Lund. The Special Rapporteur emphasizes that the Swedish Government has a responsibility to ensure the implementation, throughout Sweden and as a matter of priority, of a comprehensive harm-reduction policy, including counselling, advice on sexual and reproductive health, and clean needles and syringes.<sup>24</sup>

Unfortunately, the reality is that there will always be people who cannot or will not stop using drugs. Preventing this population from obtaining or using sterile syringes amounts to prescribing death as a punishment for illicit drug use.<sup>25</sup>

At Karolinska Sjukhuset, one of the large hospitals in Stockholm, a director of the hospital decided to give HIV-treatment free of costs to undocumented migrants. The decision came after a young man had died of Aids at the infection clinic in April 2001 because he was denied adequate antiretroviral treatment. He was an undocumented migrant from Chile and was thus, not covered by the national health insurance scheme. He could not pay the full price of antiretroviral medications and therefore did not receive any. After his death which was considered an ethical

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<sup>22</sup> World Health Organization, “Harm Reduction Approaches to Injecting Drug Use”  
<http://www.who.int/hiv/idu/en/index.html>

<sup>23</sup> UN Special Rapporteur Report on his Mission to Sweden, A/HRC/4/28/Add.2, 28 Feb. 2007, para 62

<sup>24</sup> Id.

<sup>25</sup> See Human Rights Watch, *Rhetoric and Risk. Human Rights Abuses Impending Ukraine’s Fight Against HIV/AIDS* (2006)

dilemma by the health care providers, the director of the hospital decided to give HIV-positive migrants treatment free of charge from the hospital's own budget. The Swedish state, however, has not explicitly supported this nor have there been government attempts to fund such urgent medical care through national health insurance.

**Conclusions:**

We would like to request that the Committee consider addressing the following questions to the Swedish government, pursuant to its obligations under ICESCR Article 12, 10 and 15(b) and explained in General Comment 14:

- What steps is the government taking to ensure access to health care for all persons regardless of their legal status?
- What steps is the government taking to ensure that health care providers are aware of their obligations to ensure non-discriminatory treatment of persons with non-Swedish backgrounds and to take special care with vulnerable groups? What steps is the government taking to ensure adequate legal redress when discrimination has occurred?
- What is the government doing to make explicit to health care providers that they should not report person's legal status to any law enforcement authorities when such persons seek medical treatment?
- How will the government improve treatment of people living with HIV in the primary healthcare and ensure them access to health care, especially in the case of undocumented migrants?
- How will the government make sure that asylum-seekers who have started life-sustaining treatment (like for example HIV-treatment) will not be deported to a country where they will not have access to treatment? How will they make sure that an individual-specific investigation concerning access to treatment is done as country reports from embassies only provide very general information about availability of treatment but do not discuss accessibility, including affordability, of treatment?
- How will the government try, according to existing laws, to improve access to needle exchange programs in Sweden?

There remains a significant gap between the provisions contained in the ICESCR and the reality of the right to attain the highest attainable standard of health for Sweden's most vulnerable population. We appreciate the active interest the Committee has taken on these issues and the strong Concluding Observations and Recommendations the Committee has issued to governments in the past, stressing the need for governments to take steps to ensure the realization of these rights.

We hope that this information is useful during the Committee's review of the Swedish government's report on its compliance with the ICESCR. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Very truly yours,

Åsa Cronberg  
HIV-Sweden

Anita Dorazio  
MDM Sweden

Marie-Louise Taylor  
MDM Sweden

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