

IMMIGRATION REMOVAL CENTRE RESPONSES TO HIV AND AIDS: RESULTS OF A SURVEY OF HEALTHCARE MANAGERS – NAT DISCUSSION PAPER

1. About the National AIDS Trust

The National AIDS Trust (NAT) is the UK's leading independent policy and campaigning voice on HIV and AIDS. NAT develops policies and campaigns to achieve four strategic goals: effective HIV prevention to halt the spread of HIV; early diagnosis of HIV through ethical, accessible and appropriate testing; equity of access to treatment, care and support for people living with HIV; and eradication of HIV-related stigma and discrimination.

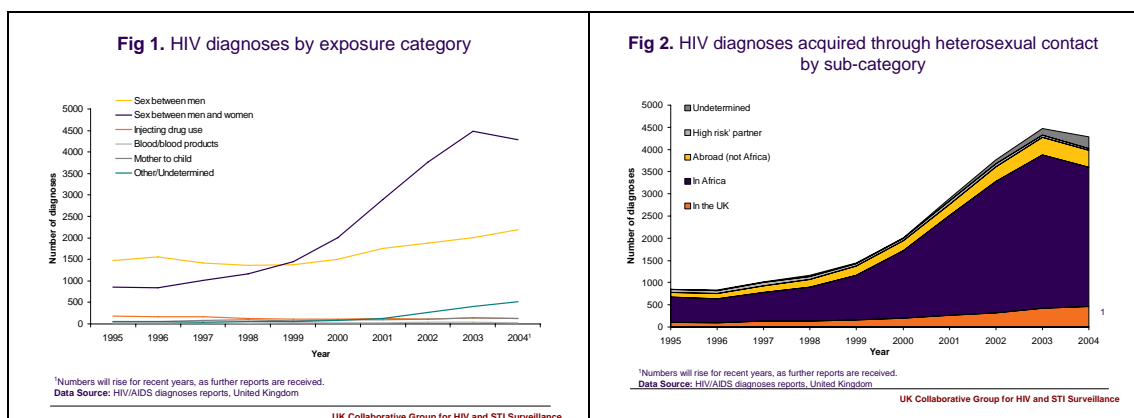
2. Introduction

This paper presents results of a survey of healthcare managers in the ten Immigration Removal Centres (IRCs) in the UK regarding the management of HIV and AIDS.¹ These preliminary results are presented for internal discussion to progress a humane, consistent and effective response to HIV in IRCs. We begin by presenting some background information regarding the issues, and present our findings and conclusions with a view to stimulating further discussion about how best to progress. We thank the IRCs who participated and officials at the Department of Health who facilitated the study. The interpretations and conclusions remain our own.

3. Background

3.1. UK HIV Epidemiology

In 2004, there were an estimated 58,300 people living with HIV in the UK with around a third (19,700) believed to be unaware of their infection. In all sexual exposure categories, numbers of transmissions have increased since 2000, with the greatest rate of increase among heterosexuals (see figure 1). In 2004, three-quarters of heterosexual infections were probably acquired in Africa (see figure 2).²



¹ Immigration Removal Centres (IRCs) are holding centres for foreign nationals waiting decisions on their asylum claims or waiting deportation following a failed application.

² Health Protection Agency (2005) Mapping the Issues. HIV and Other Sexually Transmitted Infections in the United Kingdom. London: HPA. http://www.hpa.org.uk/publications/2005/hiv_sti_2005/pdf/Mtl_FC_report.pdf

3.2. Migrants and HIV Epidemiology

Due to a lack of official data, Gazzard, *et al* sought to estimate the number of asylum seekers living with HIV and AIDS in order to calculate treatment costs. Despite the acknowledged limitations, using immigration and HIV prevalence data for 2003/4 they estimated that there would be 899 asylum seekers living with HIV (ASLWH) from the top ten applicant countries.^{3,4} This currently stands as the most useful estimate of the number of ASLWH in the UK.

However, there is simply no accurate way of knowing how many migrants are living with HIV. Extrapolation from HIV prevalence data in applicant countries is problematic because it assumes that the HIV prevalence among migrants is the same. This may not in fact be the case – migrants could be more or less vulnerable to HIV infection for a variety of reasons. However, it is a reasonable assumption that HIV prevalence will be higher than the UK.⁵

3.3. Immigration Policy

In the UK, the Immigration Act (1971), the Nationality, Immigration and Asylum Act (2002) and the Home Secretary's 'Immigration Rules' govern migration in the UK. Under present legislation, migrants without legal right to remain and refused asylum seekers can be lawfully detained and removed from the country.⁶ Including dependants, 15,055 refused asylum seekers were removed from the UK in 2005. In the first quarter of 2006, 4,930 refused asylum seekers (including dependants) were removed. The five countries to which the largest numbers of refused asylum seekers were returned in the first quarter of 2006 were Iraq, Turkey, Serbia & Montenegro, Afghanistan, and Pakistan.⁷

At present, official annual data on the total numbers of people detained under immigration powers is unavailable. However, quarterly data reports numbers being held on a given census day. Over the last four quarters, numbers of people being detained under immigration powers ranged from 1450 to 1745, with the majority held in IRCs. Turkish, Pakistani and Nigerian featured strongly in reported nationalities of those detained.

| Asylum Seekers Detained Under Immigration Act Powers* | | | | |
|--|------------------------------------|-------------------------------|-------------------------------|-------------------------------|
| Review Date | Q2 - 25/06/2005 | Q3 - 24/09/2005 | Q4 - 31/06/2005 | Q1 - 25/03/2006 |
| No Detained in IRCs | 1540 | 1560 | 1340** | 1585 |
| No Detained in Holding Facilities | 45 | 30 | 15** | 35 |
| No Detained in Prison | 95 | 105 | 100** | 125 |
| Total | 1680 | 1695 | 1450 | 1745 |
| 3 most common nationalities | Chinese Nigerian Afghanistan | Turkey Pakistan Nigeria | Turkey Nigeria Pakistan | Turkey Pakistan Nigeria |

³ Gazzard, B., Anderson, J., Ainsworth, J. and Wood., C. (2005) Treat With Respect – HIV, Public Health and Immigration. http://www.ukcoalition.org/migration/HIV-Treat_With_Respect1.pdf

⁴ In this paper we use the acronym ASLWH to denote asylum seekers and others with uncertain residency status. This may include people who are seeking leave to remain on grounds other than the need for asylum.

⁵ National AIDS Trust (2006) Dispersal of Asylum Seekers Living With HIV <http://www.nat.org.uk/document/113>

⁶ For an overview of the process, see National Audit Office (2005) Returning Failed Asylum Applicants. London: NAO http://www.nao.org.uk/publications/nao_reports/05-06/050676.pdf

⁷ Immigration and Nationality Directorate, Home Office (undated) Asylum Factsheet <http://www.ind.homeoffice.gov.uk/applying/asylumapplications/asylumfactsheet>

Source: Quarterly Asylum Statistics Home Office, Immigration Research and Statistics Service

* Excludes those detained in police cells and under criminal and immigration powers

** Figures on location of detention rounded up to nearest five

3.4. Asylum Seekers and Health

That asylum seekers suffer disproportionately poorer physical and mental health is well documented. This can be related to factors of the country of origin such as poverty, malnourishment, poor access to preventive healthcare and medical services, higher rates of communicable diseases and rape/sexual abuse and torture used as weapons of war and oppression. In addition, psychological, familial and the social upheaval of having fled conflict-torn countries, as well as the pressures of negotiating immigration process and resettlement in a new country can all contribute to poorer health.⁸

There have been concerns expressed in a number of quarters about responses to the health needs of asylum seekers within the UK.⁹ A recently published British Medical Association briefing reiterated the conclusion of its 2002 report *Asylum Seekers: Meeting Their Healthcare Needs*:

‘...the health of asylum seekers may actually get worse after entry to the UK and that we are failing vulnerable people who have often been subjected to persecution and possibly torture and rape.’¹⁰

This concern is particularly acute in the case of ASLWH. Eminent HIV clinicians have criticised government immigration policy as leading to the inappropriate dispersal of ASLWH and threatening wider public health by charging refused asylum seekers for vital NHS HIV treatment and care.¹¹ A recent NAT report has reinforced the need for concern, detailing the experiences of clinicians treating dispersed ASLWH.¹²

There have also been particular concerns about the impact of immigration detention. A report produced by Bail for Immigration Detainees employed an independent physician to carry out medical assessment of 16 detainees (13 adults, 3 children). Their report listed a number of serious concerns:

- Evident mental health problems among detainees.
- Deteriorating health in detention.
- Disrupted medical treatment.
- Failure to access external secondary health services.
- Unidentified health needs and lack of follow up.
- Detention of torture victims.
- Inadequate continuity of case and incomplete medical notes.
- Inadequate translation services.¹³

⁸ Refugee Council (2006) First Do No Harm: Denying Healthcare to People Whose Asylum Claims Have Failed. London: Refugee Council. http://www.refugeecouncil.org.uk/downloads/rc_reports/Health_access_report_jun06.pdf

⁹ Williams, P.D. (2004) Why Failed Asylum Seekers Must Not Be Denied Access to the NHS. *British Medical Journal* 31 July 329: 298.

¹⁰ See Asylum Seekers and Their Health, July 2005, (unpaginated) <http://www.bma.org.uk/ap.nsf/Content/asylumseekershealth>

¹¹ Gazzard, B., Anderson, J., Ainsworth, J. and Wood., C. (2005) Treat With Respect – HIV, Public Health and Immigration. http://www.ukcoalition.org/migration/HIV-Treat_With_Respect1.pdf

¹² National AIDS Trust (2006) Dispersal of Asylum Seekers Living With HIV <http://www.nat.org.uk/document/113>

¹³ Bail for Immigration Detainees (2005) Fit to Be Detained. London: BID. <http://www.biduk.org/pdf/Fit%20to%20be%20detained/FittobedetainedReport.pdf>

Again, concern is particularly acute in relation to ASLWH.¹⁴ The All-Party Parliamentary Group on AIDS enquiry (reporting in 2003) concluded:

*'All evidence received during the inquiry suggests that removal centres are unsuitable places for people living with HIV. Detention can undermine efforts to maintain good health (p. 37).'*¹⁵

Key amongst the concerns expressed by the APPGA were:

- The psychological (and physiological) impact of the threat of removal.
- Lack of continuity of care with community healthcare providers (poor communication between community and IRC healthcare service providers).
- Lack of expertise among IRC medical staff about HIV and AIDS.
- Disruption to anti-retroviral (ARV) therapy on arrival and as a result of the operation of the regime, leading to the potential for drug resistance to be developed.¹⁶
- Disrupted or missed appointments with external healthcare providers due to logistical reasons or the shackling of detainees during medical appointments.
- The potential threat posed to people with weakened immunity to infection (such as those living with HIV) of close confinement with those suffering serious communicable diseases (such as tuberculosis).
- Lack of access to mental health services.
- Inability to give genuinely informed consent to HIV testing and medical treatment in cases where English is not spoken and when incarcerated.

3.5. Case Studies

Also informing the background to this research were anecdotal reports of inadequate treatment of ASLWH reported to NAT. Here we reproduce two accounts that reiterate many of the concerns highlighted by the APPGA.

From the Case Files of Africans Getting Involved...

Emmanuel was an elderly man from Uganda who had been living in UK for more than five years. He was diagnosed HIV positive four years ago and started his medication then. He had been signing on for about one year after the Home Office refused his immigration application. While signing on, he was arrested and detained in an IRC for two weeks without his medication. AGI contacted his solicitor who intervened and gave assurances that he would be bailed on medical grounds and released on the following Friday. Before Friday, AGI received a message from Emmanuel from Uganda – he had been repatriated.¹⁷

¹⁴ For a concise overview of the implications of immigration law for people living with HIV, see <http://www.nam.org.uk/en/docs/940D4E16-06E6-4396-A69C-67917CF75DC0.asp#190829bd-bf50-472a-93fe-5542370fc0c7>

¹⁵ All-Party Parliamentary Group on AIDS (2003) *Migration and HIV: Improving Lives in Britain*. London: APPGA.

¹⁶ HIV drug resistance occurs when viral replication continues despite HIV treatment. It is associated with (among other factors) poor adherence to treatment. See 'HIV Drug Resistance', *Positive Nation*, Issue 110, March 2005 for an accessible presentation of the issues.

<http://www.positivenation.co.uk/issue110/treatment/treatment2/treatment2.htm>

¹⁷ We are grateful to Africans Getting Involved for details of this case study. AGI seeks to bridge the gap between the grassroots and policy makers through greater meaningful involvement of Africans living with HIV and AIDS. For further details, see <http://www.ukcoalition.org/agi/index.htm>. Emmanuel is not his real name.

Amelia's Story

Amelia escaped from Rwanda after the murder of her husband.¹⁸ He was stabbed on the doorstep of their home for testifying against those involved in the genocide. Amelia was detained by the forces alleged to have murdered him. While in detention she was raped.

Eventually, she escaped and arrived in the UK in 2002, seeking asylum. In 2003 she was dispersed to a northern city. Shortly after arriving, she began to experience a series of genito-urinary problems. She was advised to have an HIV test, which proved to be positive.

In 2005, because of an administrative error on the part of her lawyer, a crucial document supporting her application was not provided. Immigration officials and police came to her home to detain her. She had been in the bath when the officials came but she insisted on being allowed to get her medication.

She spent the first twenty-four hours in the police station – her medication was taken from her on arrival. A social worker intervened so that she would be allowed to take her evening dose.¹⁹ She was then transferred to an immigration removal centre.

On arrival at the removal centre, her medication was given to the healthcare service. Her social worker again had to intervene to ensure that she was given medication at the right time. Amelia spent three weeks in detention and was then released. She was required to report weekly to immigration officials.

She was detained again three weeks later when her application for asylum was refused. She had not been expecting to be detained at the reporting centre and had no medication with her. She was detained at 7pm. Due to the need for the transport van to collect other detainees, she arrived at the removal centre at 4am – she had already missed an evening dose. Amelia had to explain to the nurse in the healthcare centre why it was so vital not to miss doses.

An appointment was made for Amelia to visit the local hospital to see an HIV consultant. The healthcare centre did not have ready access to the medication he prescribed. It took four days for a full complement of medication to arrive. However, it was of an inadequate dosage for Amelia's treatment combination. Amelia had to explain to the nurse why she could not simply 'double-up' on pills (which would have led to over dosage) – HIV medication taken in excessive doses can cause severe side effects and compromise treatment.

Amelia also explained that she had acquired treatment-resistant HIV and that it was vital to follow this regimen strictly to prevent further resistance developing. For Amelia, the current HIV treatment combination was literally a lifeline. Amelia felt such despair about the prospect of being deported that she struggled to find the will to argue for what she needed.

While detained, Amelia found that it was impossible to keep her HIV status private. She had to go to the healthcare service every day to take some of her medication

¹⁸ We are grateful to the African HIV Policy Network for enabling Amelia to tell us her story. Amelia is not her real name.

¹⁹ HIV treatment requires strict adherence to a medication schedule. Late or missed doses can seriously compromise the effectiveness of treatment and lead to treatment resistant HIV developing. The National AIDS Manual advises that adherence of less than 95% can lead to poor suppression of HIV, increases in viral load and poor gains or falls in CD4 count. For a person taking HIV treatment once a day, 95% adherence means missing no more than one dose per month (see National AIDS Manual (2006) Living With HIV. London: NAM).

because it had to be refrigerated. Sometimes, if there were no custodial staff available to escort her, she was late in taking her doses. Because she had to take some of her pills with food she had to ask for it outside of mealtimes. This caused the other detainees to wonder why she had disputes with some of the custodial staff who didn't understand why she was being so 'awkward'. During a 'spot-check' security sweep, detainee's rooms were searched. Other detainees were present while Amelia's medication was removed from a wardrobe and left in plain sight on the bed. They were curious why she had so many pills. Other detainees who knew what the medication was for began to openly discuss her HIV status in the centre. Amelia was eventually again released but her final application for asylum has failed.

At the time of writing, she faces the prospect of being detained and deported to Rwanda at any moment.

3.6. Summary

- ➔ The UK is experiencing an increase in the numbers of people living with HIV. Epidemiological data indicates that the migration of people from high prevalence countries is a significant factor in this increase among heterosexuals.
- ➔ Government immigration policy, particularly charging refused asylum seekers and other migrants for HIV treatment and care, has been criticised as a regressive measure on public health and humanitarian grounds. There is already anecdotal evidence that it deters people coming forward for HIV testing and treatment.
- ➔ It is sensible to assume that if the numbers of people removed from the country increases (as has recently been the case) the numbers of people living with HIV who pass through IRCs will also increase.
- ➔ The APPGAs thorough enquiry concludes that IRCs are not suitable places within which to detain people living with HIV. Recent case studies indicate that concerns remain.

4. Aims and Objectives

Given, a growing body of concern about the impact of immigration detention on the health of ASLWH, the NAT carried out a study of healthcare managers in the ten IRCs in England and Scotland (there are none in Wales). The aims of the study were:

- To collate information about the measures currently undertaken in each removal centre to prevent and treat HIV;
- To gather examples of good practice in the prevention, testing and treatment of HIV and to identify gaps and barriers in these areas;
- To promote improvements in healthcare for people living with HIV.

5. Methods

All healthcare managers were sent an electronic questionnaire for completion (available on request from NAT) in December 2005. Responses were received from all ten establishments. The questionnaire asked about:

- Gender of detainees.
- Length of detention periods.

- Numbers of detainees known to be HIV positive.
- Management of HIV testing and advice.
- Provision, administration and funding of anti-retroviral therapy (ARV).
- Access to specialist community services.
- Communication between IRC and community healthcare services.
- Healthcare for pregnant women in the facility.
- Preventative education and advice interventions.
- Mental health support available.
- Training for staff.
- Provision of condoms and/or clean injecting equipment.
- Processes to enable detainees to prepare for removal.
- Examples of good practice in responding the needs of detainees living with HIV.

6. Findings

Nine facilities were located in England and one in Scotland. All of the facilities detained men, half also detained women and two detained children. Private contractors ran the majority of establishments and healthcare facilities (n=7).

| Establishment | Local Primary Care Trust/Board | Facility Management | Healthcare Provision |
|----------------------|---------------------------------------|----------------------------|-----------------------------|
| Campfield House | North East Oxfordshire PCT | Private | Private |
| Colbrook | Hillingdon PCT | Private | Private |
| Harmondsworth | Hillingdon PCT | Private | Private |
| Dover | East Kent Coastal PCT | Public | Public |
| Haslar | Fareham & Gosport PCT | Public | Public |
| Lindholme | Doncaster East PCT | Public | Public |
| Oakington | South Cambridgeshire PCT | Private | Private |
| Tinsley House | Crawley PCT | Private | Private |
| Yarlswood | Bedford PCT | Private | Private |
| Dungavel | Lanarkshire Health Board | Private | Private |

6.1. Length of Stay

Respondents reported that average length of stay in the facility was around 18 days (range 3 days to 30 days). The shortest and longest periods of detention reported was 30 minutes and 18 months respectively. Over the last twelve months, the three most commonly reported detainee nationalities were Chinese, African and Turkish.

6.2. Known HIV Cases

In the previous 12 months, 159 detainees were known to healthcare facilities as HIV positive, of which 140 were diagnosed before entering the facility. In total, 28 of the HIV positive detainees were pregnant women. Respondents reported that 91 detainees received ARVs while detained over the previous 12 months.

6.3. HIV Testing

All facilities provided access to pre and post HIV test discussion. In five facilities this was done by facility clinical staff alone, in the remainder (n=5) this was provided by both visiting and facility clinical staff. In the majority of cases, HIV testing was carried

out in the facility, either by clinic staff or by visiting clinical staff (n=6). Three facilities arranged for detainees to visit external medical services for HIV testing.

None of the facilities offered HIV testing routinely to all detainees. Almost all offered HIV testing if requested by the detainee (n=9) and four offered this where it was clinically indicated. However, there was some ambivalence expressed about promoting HIV testing due to the short detention periods reported.

'The majority of detainees are here for a short time and so the timescale prohibits testing for HIV. We feel sending results via the post is completely unacceptable and does not adhere to practice guidelines.' (IRC healthcare manager)

The majority of facilities reported that detainees would have to wait a week or less (n=6) for an HIV test. The longest period specified was two weeks (n=1). Two facilities stated that the wait would depend on patient circumstances and clinical judgement or the availability of local GUM appointments (n=2).

The majority of facilities stated that detainees would wait a week or less for the HIV test result (n=8). In two facilities, the wait extended to two weeks.

6.4. HIV Treatment

Respondents were asked to describe the circumstances within which detainees would be provided with ARVs. In every case, local Primary Care Trusts funded provision of ARVs. In almost all cases ARVs were provided where clinically indicated (n=9). In one case, however, ARVs were only provided where the detainee was already taking the medication prior to detention. Respondents frequently reported that the initial healthcare screening process was a fundamental tool for determining the need for continuing medication. The following response was typical.

'All medications are flagged up to healthcare staff on admission to the centre. New detainees are seen within two hours of admission.' (IRC healthcare manager)

Respondents were also asked to describe how ARVs were administered in the facilities. ARV therapy requires strict adherence to a complex regime of treatment at set time intervals. Guidelines suggest at least 95% adherence is required for effective treatment.²⁰ This makes it especially important for detainees taking ARVs to receive the correct dosage at the right time. In four facilities medication was administered by medical staff, in five facilities, detainees were allowed to have medication in their own possession, in one facility both systems were in operation. Respondents described the circumstances by which 'in-possession' medication would be allowed.

'If someone has been diagnosed for some time and there is no risk then medication is issued in possession. If newly diagnosed, then medication will be issued until the detainee understands the regime. We would [then] normally begin by gradually introducing the drugs in possession.' (IRC healthcare manager)

²⁰ National AIDS Manual (2006) Living With HIV. London: NAM.

6.5. Communicable Disease Prevention

Concern has also been expressed about the location of detainees living with HIV (and thus potentially compromised immunity) in close proximity to those with highly infectious diseases such as tuberculosis. However, most respondents reported that universal infection control measures designed to protect the general population were used, such as isolation of the infectious patient, which would also protect detainees living with HIV.

'Anyone within the centre with TB or chicken pox for example, would be admitted to healthcare and isolated until considered no risk to the general population.' (IRC healthcare manager)

6.6. Access to Community Services

Respondents were asked about specialist healthcare services in the community that detainees could access. Respondents described access to NHS services (e.g. HIV and genitourinary medicine, drug treatment) as well as non-statutory services such as those provided by the local branch of Body Positive or the Terrence Higgins Trust. In one facility, there were no visiting services but where indicated, external referrals could be made.

Respondents were also asked about how often HIV positive detainees would be able to see an HIV specialist in the community for routine appointments. Respondents reported that detainees would be able to attend appointments whenever required and as arranged by the treating clinician. However, in one example of good practice this was facilitated by the arrangement of a GUM consultant visiting the establishment.

On the question of how long detainees would wait to access a specialist HIV service in the event of health complications related to their HIV status, half of respondents (n=5) reported that they would be seen in the same day, four respondents reported they would be seen within a week and one respondent reported that this would depend on the nature of the complication. Other respondents also stressed that they sought to give individual care, depending on the individual patients' circumstances.

HIV treatment can be a complex matter requiring specialist medical expertise. In the case of HIV, it is therefore particularly important that there is good communication between community and facility healthcare systems to enable continuity of care. Respondents were asked about how communication was maintained with community healthcare services. It emerged that communication was a problematic issue. It was commonly the case that facilities had no prior knowledge about the health status of the detainee prior to detention and were reliant on the detainee for all health information.

'We are not informed of their HIV status until the detainee arrives at [facility].' (IRC healthcare manager)

'Medical records often arrive after the detainee had left. We rely on the detainee telling us about his/her HIV status on arrival.' (IRC healthcare manager)

Anecdotal reports suggest that this can be problematic because the detainee may not speak English, or may perceive that informing healthcare staff of their HIV status may prejudice their immigration application. They may also fear discrimination if

confidentiality is breached. It cannot be assumed that detainees are familiar with the standards of confidentiality that UK healthcare professionals are obliged to observe.

6.7. Pregnant Women

We were particularly keen to explore the provision made for pregnant women living with HIV. With early diagnosis and good antenatal and obstetric care, only 4.1% of babies perinatally exposed to HIV in 2004 in England and Scotland went on to develop HIV.²¹ Only half of the facilities detained women and one reported that women were only detained there for a maximum of 72 hours. Facilities tended to report that specialist external staff (community midwives and HIV clinicians) would manage the healthcare needs of pregnant women. Respondents were of the view that this would include advice and treatment to prevent peri-natal HIV transmission, but reported that they were not privy to the detailed aspects of the clinical care given. One facility was particularly impressed by the local midwifery care provided.

'Every pregnant detainee is fully screened by a local midwife – full 'bloods' and scans available. [We have] excellent links with the local ante-natal clinic.'
(IRC healthcare manager)

6.8. HIV Education and Advice

IRCs can also play a crucial public health role in educating detainees about HIV and providing information about HIV prevention and testing. We were therefore keen to explore the educational activities within facilities. While mass media interventions were common and access to one-to-one interventions (initiated by detainees) was available. Providing opportunities to address HIV in group contexts was less common. While some facilities reported that they struggled to find materials in different languages, others reported that they had been able to do so. Specified languages included Arabic, Chinese, French, Italian and Russian.

| Educational Interventions Provided for Detainees Regarding HIV and AIDS | | | |
|--|-----|----|------------|
| | Yes | No | Don't Know |
| HIV and AIDS related posters/information in communal areas | 9 | 1 | |
| Reference to HIV and AIDS in induction sessions* | 1 | 7 | 1 |
| Specific discussions or talks focussing on HIV and AIDS* | 3 | 6 | |
| One-to-one counselling sessions available to discuss HIV and AIDS | 9 | 1 | |
| *Responses <10 due to missing data. | | | |

The questionnaire asked for further detail about access to individual advice and information. In most cases described, GPs or practice nurses were the point of access for individual support. Two facilities also described having mental health professionals (counsellors and/or mental health nurses) available who could be accessed on referral. We were keen to ascertain what mental health support was available following a recent HIV positive diagnosis. The period immediately following diagnosis can be a difficult time for many HIV positive people, requiring intensive mental health support and care, often of a specialist nature.²² Again, where facilities had them, respondents reported that referrals would be made to on-site mental

²¹ The Health Protection Agency reports a vertical transmission rate of 26.5% among undiagnosed women and 2.2% in diagnosed women. See Health Protection Agency (2005) Mapping the Issues. HIV and Other Sexually Transmitted Infections in the United Kingdom. London: HPA.
http://www.hpa.org.uk/publications/2005/hiv_sti_2005/pdf/Mtl_FC_report.pdf

²² National AIDS Manual (2006) Living With HIV. London: NAM.

health professionals. For those that did not, respondents reported that referrals would be made to community mental health services (such as counsellors and psychologists). In an example of good practice, one facility reported that the Terrence Higgins Trust would also be invited into the establishment to provide support.

6.9. Staff Training

In order to respond effectively to the needs of detainees living with HIV and to respond more broadly to the public health challenges presented, it is essential that IRC staff have a basic level of knowledge about HIV and AIDS. The questionnaire asked about training for staff groups. As might be expected, there was some variability, with nurses being the most likely to have received HIV training. However, only 6 of the 10 respondents positively stated that custodial staff were given HIV training.

6.10. Enabling Safer Sex and Harm Reduction

People are at risk of HIV infection through three main routes: through unprotected sex or sharing injecting drug equipment with an infected person and through perinatal transmission (see above regarding provision for pregnant women). In order to prevent HIV transmission, detainees need access to information and advice (see above regarding educational initiatives), condoms and, where injecting, clean equipment (or the means to sterilise injecting equipment). The questionnaire asked about the provision of prevention materials. While male condoms were commonly available, female condoms were much less so. This is perhaps a reflection of the fact that fewer facilities detained women. None of the facilities made injecting equipment or sterilising tablets available.

| Items Available to Detainees | | | | |
|---|---------------|------------|--------------------|------------|
| | Not Available | On Request | Freely Distributed | Don't Know |
| Male condoms* | | 8 | 4 | |
| Female condoms** | 3 | 1 | 1 | 1 |
| Sterilising tablets ** | 7 | | | |
| Clean injecting equipment** | 6 | | | |
| *Respondents gave more than one answer. | | | | |
| **Responses <10 due to missing data. | | | | |

6.11. Preparation for Repatriation

As well as the social, psychological and familial upheaval that repatriation might entail, it may also mean that access to lifesaving HIV treatment is either drastically reduced or completely unavailable. As noted above, it is vital that ARV treatment is not disrupted for optimum effectiveness and also to avoid HIV treatment resistance from developing. Two facilities reported that no arrangements were made to enable a detainee living with HIV to prepare for repatriation. However, most respondents reported that they tried to enable some continuity of treatment by providing additional supplies of medication; ranging from one to six months supply. In one example of good practice, information was provided so that the detainee could, where possible, remain in contact with their healthcare providers.

'All detainees on removal will be provided with three months supply of medication. A discharge letter will be issued with relevant contact names and telephone numbers, including the name and address of the [treating] consultant.' (IRC healthcare manager)

6.12. Identifying Good Practice

We were keen to identify examples of good practice in responding to the needs of HIV positive detainees. In the main, the examples given showed IRC healthcare staff going beyond the call of duty to provide compassionate care.

'If a detainee has a specific need that requires addressing, healthcare will attempt to source anything to assist the detainee, e.g. [local] Body Positive coming to visit the detainee, a visit from the Terrence Higgins Trust, an internet search on a specific condition.' (IRC healthcare manager)

'On one occasion, an individual had gone to court, unbeknown by the nursing staff without his medication and was released. The staff nurse contacted his solicitor and passed on his medication along with the name of his consultant and any other necessary information.' (IRC healthcare manager)

'Upon request recently, a transfer time was held back to enable a detainee to attend a clinic in order to obtain a larger supply of [anti]-retroviral meds.' (IRC healthcare manager)

7. Conclusions

While some detainees might stay for extended periods, the average stay according to respondents' estimates was around two-and-a-half weeks. This is useful in giving an indication of the scope for activity to assist ASLWH. IRCs were dealing with an estimated 159 ASLWH per year; the majority were diagnosed before entering the facility (n=140). An estimated 91 detainees were provided with ARVs over a 12-month period.

IRC's were highly reliant on information reported by detainees themselves about their health status during the initial healthcare screening process since communication with external healthcare providers was problematic. There are several questions raised by this. There are the generic problems that detainees may not speak or understand English well in order to communicate their needs. They may also be mistrustful of those they regard as 'state agents' or authority figures in light of traumatic past experiences or may simply not know salient facts about their health status or treatment. This is compounded in relation to ASLWH because they may fear that disclosing their HIV status will expose them to discrimination or prejudice their asylum application. Further research is needed to fully examine whether these anecdotal assertions are supported and what can be done to overcome such barriers.

HIV testing was made available in all establishments but the waiting time was variable (one to two weeks). With the additional time spent awaiting results, many detainees would barely be able to receive their results before being released or repatriated. However, early HIV diagnosis has significant benefits, not only in terms of the individuals' health but also in alerting the infected person to the need to prevent onward transmission. It is therefore important that where requested or clinically indicated, a speedy test should be carried out. Given that the average stay is around 18 days it is important that this process is considerably accelerated.

Nearly all of the facilities provided ARVs where clinically indicated. However, there was some variability in that one supplied them only where the detainee was already being prescribed them. Variation in practice can be inequitable and steps should be

taken towards consistency – it should not be the case that access to ARVs depends on where one is detained rather than clinical need.

For those who were taking ARVs, flexibility had been introduced in some establishments to allow 'in-possession' medication. However, this was not universally the case. Given the demanding nature of HIV treatment, it is important that there is sufficient flexibility to accommodate individual needs and that barriers to adherence are removed. This means enabling people to access their medications exactly when they need them, providing access to food as and when required and facilitating access to specialist advice about maintaining adherence where necessary.

With regards to access to community services, there were examples of good practice where specialist clinicians were available in the facility. However, it was more common that detainees would require an external appointment for specialist treatment. Respondents reported fairly rapid access to external specialists where there were HIV-related complications but there was variability so that waiting times could range from the same day to one week. There were also examples of good practice where external support organisations (most notably the Terrence Higgins Trust) would be invited to enter establishments but this was not the norm and was generally in response to a particular request rather than a routine event. As well as responding to the needs of individuals, external support organisations can carry out important HIV-related health education and there appears to be considerable scope to explore the opportunities here further. Similarly, the efficiency and cost-savings that might arise from the involvement of visiting specialist clinicians should be further explored.

We were particularly concerned to enquire about the treatment of detained pregnant women living with HIV (of which there were an estimated 28 in the 12 months preceding the survey). Optimum antenatal care and advice can very substantially reduce the risk that the baby will acquire HIV infection. Healthcare managers were confident that local midwifery services were addressing their needs adequately. The National Institute of Health and Clinical Excellence advises that pregnant women diagnosed with HIV should be managed and treated by specialist teams.²³ The Royal College of Obstetricians and Gynaecologists advises that these should be multi-disciplinary and include an HIV physician, an obstetrician, a midwife and a paediatrician and may also include a psychiatric team and support groups.²⁴ Detailed investigation of adherence to this guidance and any examples of good practice would be valuable.

We were similarly concerned about the extent to which mental health support was available. As well as its physical manifestations, HIV can significantly affect mental well-being; whether in the early emotional response to HIV diagnosis or the gradual emotional adjustment required in living with a highly stigmatised long-term health condition.²⁵ It appeared to be the case that mental health provision was variable between facilities, with some facilities retaining counsellors and mental health nurses whereas in others, mental health support was the job of primary care nurses. It was beyond the scope of this study to examine the extent to which these professionals were equipped to respond to the specific mental health needs of people living with HIV. It is worth noting that there are a number of organisations from the non-for-profit sector able to provide mental health support to HIV positive people and there appeared to be considerable scope to further involve them.

²³ National Collaborating Centre for Women's and Children's Health (2003) Antenatal Care: Routine Care for the Healthy Pregnant Woman. London: National Institute for Health and Clinical Excellence.

²⁴ Royal College of Obstetricians and Gynaecologists (2004) Guideline 39: Management of HIV In Pregnancy http://www.rcog.org.uk/resources/Public/pdf/RCOG_Guideline_39_low.pdf

²⁵ National AIDS Manual (2006) Living With HIV. London: NAM.

Education is one of the most powerful tools available to enable people to protect themselves from HIV infection and to eradicate stigma and discrimination against people living with HIV. Respondents reported that low-threshold interventions (posters and leaflets) were common, although some facilities reported that they struggled to obtain material in a range of languages. In addition, opportunities to provide educational interventions that would enable people to ask questions or clarify information were missed (e.g. induction or through the provision of education sessions). More involved group interventions can be helpful not only in imparting knowledge but in enabling people to examine attitudes and values. Evidence suggests that these are much more effective than so-called 'passive' interventions.²⁶

The need for education and training also extends to professionals working with detainees. As expected, nurses were thought to have received training on HIV and AIDS (although it was unclear whether this was as part of generic training or of a specialist nature). Of greater concern was the relative lack of training provided for custodial staff. Given their pivotal role in the day-to-day care of detainees (including those living with HIV), this perhaps indicates something of an omission. It cannot be assumed that only medical staff need training. All staff need a basic level of awareness about how HIV is (and is not) transmitted (dispelling any myths) and the need for confidentiality and anti-discriminatory practice. This is essential to enable them to fulfil their duty of care. It should not be the case that a detainee is regarded as 'awkward' for requesting food that must be taken with their HIV medication. Similarly, it cannot be assumed that medical practitioners have been able to supplement their initial training with updated information. This is especially important in relation to HIV, where the clinical context changes rapidly. Given that IRC staff deal with people from some of the highest prevalence countries in the world, perhaps more significant was the fact that knowledge about which occupational groups had received training about HIV training was patchy.

Education to prevent HIV transmission without the means to put it into practice is of limited value. It is general principle in HIV prevention that barriers to condom acquisition must be reduced as far as possible. Most IRCs reported that male condoms were available (most commonly on request). However, we were unable to devote attention to the specific processes by which a request could be made and responded to. It has also been difficult to arrive at an estimate of the number of injecting drug users being detained, however, there is evidence of drug misuse among some immigrant communities from community-based studies.²⁷ This may suggest that harm reduction measures such as provision of sterilising tablets or clean syringes should be examined. None of the facilities offered this at the time of the study.

We were particularly concerned to enquire about steps taken to prepare detainees for repatriation. This can be a time of terror for detainees as they may in some cases face political persecution, rape, and/or death. Three quarters of detainees in a Home Office study intended to try to return to the UK, either because they feared for their safety or because they felt that had no real 'home' to return to.²⁸ The situation is especially exacerbated for detainees who need ARVs but are returning to countries where there is limited or no access to them. NAT opposes in principle the forced

²⁶ Albarracín, D., Gillette, J. C., Earl, A. N., Glasman, L.R., Duranti, M. R., Moon, H.H. (2005) 'A Test of Major Assumptions About Behavior Change: A Comprehensive Look at the Effects of Passive and Active HIV-Prevention Interventions Since the Beginning of the Epidemic', in *Psychological Bulletin*, American Psychological Association, 131(6): 856–897.

²⁷ Bashford, J., Buffin, J. and Patel, K. (2003) *The Department of Health's Black and Minority Ethnic Drug Misuse Needs Assessment Project*. Preston: Centre for Ethnicity and Health, University of Central Lancashire.

²⁸ Richard Black, R., Collyer, M., Skeldon, R. and Waddington, C. (2005) *A Survey of the Illegally Resident Population in Detention in the UK*. Home Office <http://www.homeoffice.gov.uk/rds/pdfs05/rdsolr2005.pdf>

return of HIV positive detainees to countries where they will not be able to obtain the life-saving treatment they need.²⁹ However, in the absence of an end to the practice, we advocate a pragmatic position that as much as possible should be done to at least enable the detainee to prepare for repatriation. Healthcare staff are to be commended for their compassionate actions in facilitating access to extra supplies of ARVs but this ad hoc approach could be improved upon by coordinated planning for repatriation. This might include providing information about HIV and AIDS organisations in the country of origin and potential sources of ARVs (where these exist). Good practice was already being demonstrated in some cases by the provision of personal medical details and there is scope to examine whether this could be enhanced and formalised.

8. Next Steps

The results of this study present a challenge: on the one hand we report plausible accounts that ASLWH receive sub-optimal care in detention and credible bodies such as the APPGA oppose their detention. However, healthcare managers report for example, that access to ARVs is near universal and that in the majority of cases a detainee would see a specialist the same day if there were HIV-related complications. How can we reconcile these contradictions? Firstly, by acknowledging the limitations of the study: we were not able to include ASLWH in the study and were not able to do in-depth research in any of the centres. We are therefore reliant on the reports of the healthcare managers. However, we are confident that the information was provided in good faith with the full co-operation of those who participated. It is no doubt the case that IRC healthcare centres are striving to do the best for their HIV positive patients with the resources available and within the limitations of a custodial regime with significant inmate turnover. NAT therefore proposes that this paper form the basis for more detailed discussions among healthcare managers, facilitated by NAT about its findings and where improvements can be made. To this end, we propose the following questions could form the basis for useful further discussion.

- ➔ What significant inaccuracies, misinterpretations, gaps or omissions are there in the paper?
- ➔ What credible recommendations follow from this report and how can they be implemented? What barriers are there and how can these be overcome?
- ➔ What would a quality, equitable and consistent approach to the healthcare management of ASLWH include? Given an average stay of 18 days, what can reasonably be done to treat and support ASLWH?
- ➔ Is there a role for shared protocols around access to HIV testing, ARV provision, 'in-possession' medication, maternity care, mental health support and confidentiality arrangements?
- ➔ How can IRCs and community healthcare providers be enabled to share information and to work more closely together to provide better healthcare? What can be done to encourage HIV and AIDS organisations to work proactively with IRCs?
- ➔ How could better planning be carried out to prepare ASLWH for repatriation, particularly those on ARVs?

²⁹ National AIDS Trust (2005) Delivering the Goods: HIV/AIDS and the Provision of Anti-Retrovirals. <http://www.nat.org.uk/document/70>

- What are the needs of staff (healthcare and others) in responding to ASLWH and how can these be met? How can IRCs ensure that all staff have a basic understanding about HIV and AIDS and treat ASLWH respectfully, observing their right to confidentiality?
- What information gaps are there and what further research and investigation would be useful?

Finally, although the search for answers to these questions may present challenges, it is worth highlighting what might be gained. Firstly, there is the need to comply with the duty of care and legal human rights obligations owed to detainees.³⁰ Striving to improve quality care for ASLWH and removing organisational barriers also reinforces the professionalism and compassion of healthcare providers seeking to do their best for patients. Finally, IRCs can play their part in protecting public health in the UK. It remains the case that many of those detained will return to families and communities in the UK and IRCs are well-placed to assist in the drive to eradicate HIV and the stigma and discrimination that it still carries. We thank the IRCs for their cooperation with this project and hope they will continue to engage with NAT towards progress.

9. Recommendations

Outlined below are recommendations arising from this survey that NAT hopes to take forward in partnership with IRC staff, clinicians and other key stakeholders:

- Facilitate more detailed discussions on measures undertaken in IRCs to prevent and treat HIV, continue gathering examples of good practice, and identify appropriate networks and clinical pathways to ensure continuity of care in the removal process.
- Conduct additional research into HIV-related issues in IRCs, paying particular attention to the experiences of ASLWH and detainees.
- Develop best practice guidelines that ensure consistency and transparency in the removal process and support high quality care for ASLWH.

³⁰ Hall, P. (2006) Failed Asylum Seekers and Health Care. British Medical Journal, 15 July 333: 109-110.