



HIV and the UK Asylum Pathway

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HIV in the UK



- ⦿ In 2006, 73,000 adults living with HIV
(41% gay and bisexual men)
(50% heterosexual – 34% African-born)
- ⦿ 41% of Black Africans diagnosed late (CD4 < 200)
and the average length of time between arrival
and UK diagnosis was 4.4 years
- ⦿ HPA does not collect data on residency status but
does on ethnicity, country of birth, year of arrival
and probable country of infection

Asylum Seekers in the UK

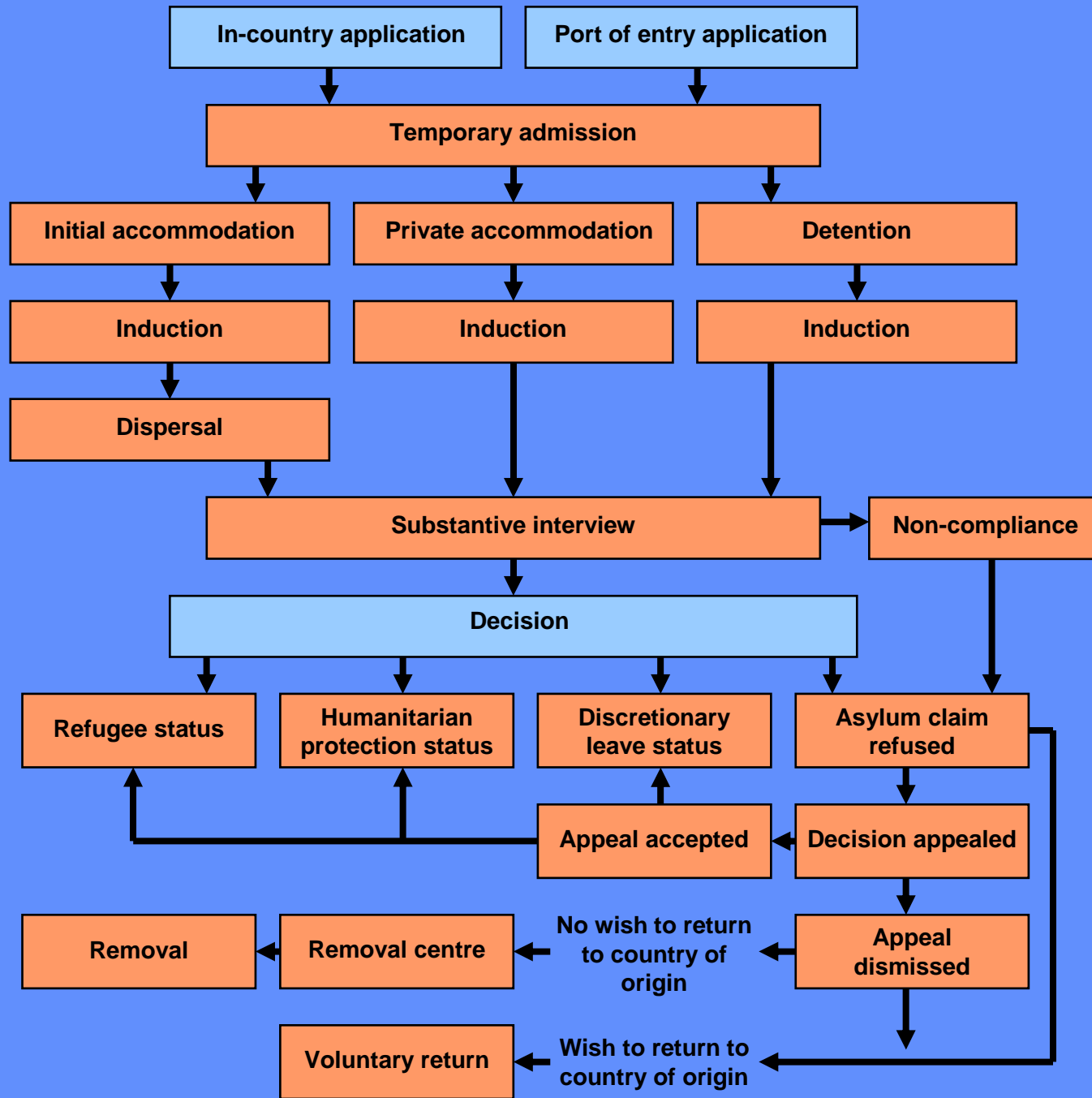


- ⦿ In 2007, 23,430 applications for asylum
- ⦿ Five most common nationalities - Afghani (2,495), Iranian (2,210), Chinese (2,120), Iraqi (1,835) Eritrean (1,820)
- ⦿ 8,440 applications from Africa - main countries of origin: Eritrea (1,820), Zimbabwe (1,755), Somalia (1,620)
- ⦿ 17,455 applications for asylum support

Data from the North West



- 🎗️ Of those accessing HIV care in 2006 - 916 of 4,761 (19%) were non-UK nationals
- 🎗️ Of 916 non-UK nationals, 605 were asylum seekers or refugees
- 🎗️ One in eight of all accessing HIV care are asylum seekers or refugees



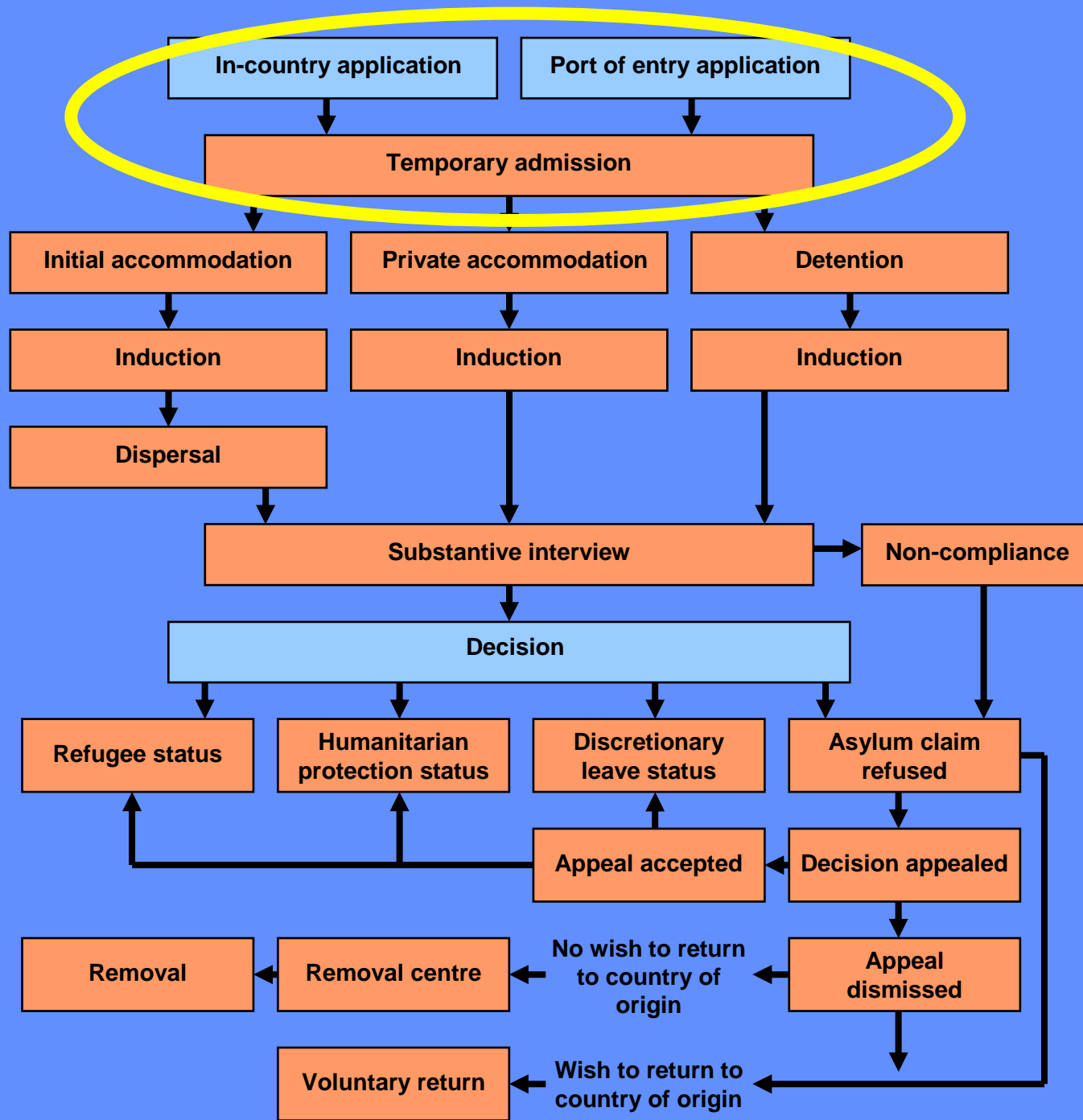








“ A majority of the women had already experienced at least one profoundly traumatic life event. These included rape, murder of partners and various other forms of persecution. 27 [of the 62] women spoke of direct experience of HIV-related death and ill health in close relatives or friends, and eight had experienced the death of at least one child from HIV.



Asylum Application



- ⦿ An asylum application can be made either at port of entry (17%) or 'in-country' (83%)
- ⦿ The application is based either on the Refugee Convention ('a well-founded fear of persecution ...') or the European Convention on Human Rights (ECHR)
- ⦿ Those not detained receive an IS96 paper and 'temporary admission'
- ⦿ Applicants have 10 days to complete a 'statement of evidence form', the basis for the Home Office substantive interview

New Asylum Model



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Asylum seekers face tough controls under new fast-track system

- Detention and tagging for those facing removal
- Immigration service to improve claims handling

Alan Travis, home affairs editor
The Guardian, Tuesday January 3 2006
[Article history](#)

A large-scale overhaul of the asylum system has begun which will lead to at least a third of all asylum seekers being placed in detention centres for the

- Introduces a faster, more tightly managed asylum process with an emphasis on fast tracking applications, and rapid integration or removal
- Each applicant has a single 'case owner' for the entire process
- Has the potential to increase the number of asylum seekers in detention

Home Office
Press office

Search > **The New Asylum Model: Swifter Decisions - Faster Removals**

Press Releases

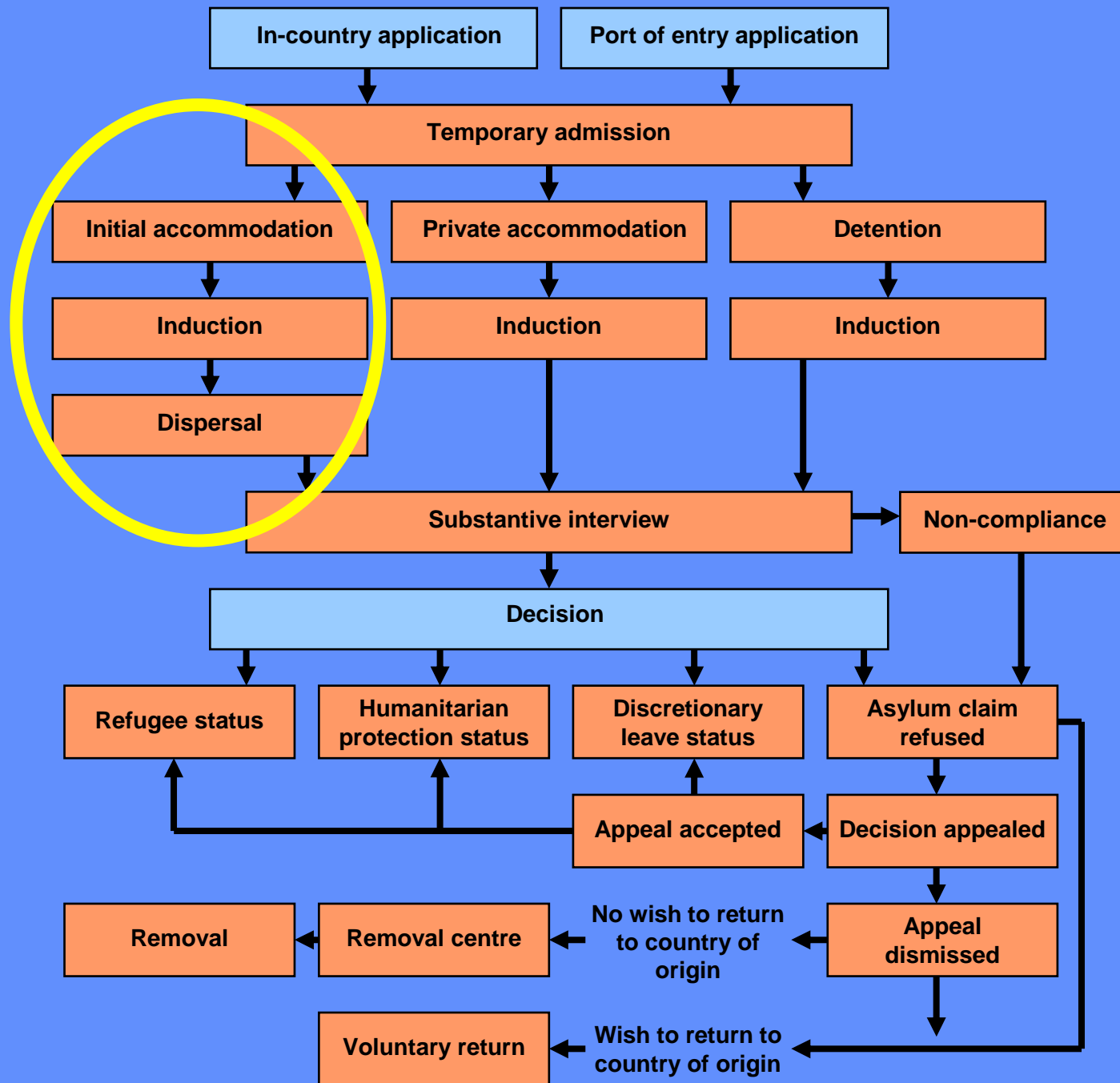
[Search for press releases](#)

The New Asylum Model: Swifter Decisions - Faster Removals

18 January 2006

Greater numbers of successful asylum seekers will benefit from swifter decision-making. Unsuccessful claims will be removed more quickly under the expansion of the Government's decision making processes, the Home Office announced today.

The New Asylum Model, a key part of the Government's five year strategy for asylum and immigration, will streamline the asylum process and build on the significant progress the Government has already made in reducing



Accommodation and Dispersal



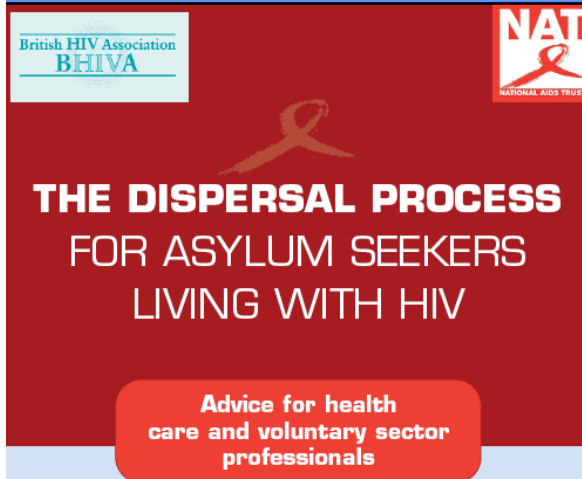
- ⦿ 35% of asylum seekers receive state-provided accommodation, which is on condition of dispersal from London and the South East
- ⦿ In Q4 of 2007, 34,150 asylum seekers were in dispersal accommodation - Yorkshire & the Humber (21%), North West (20%), West Midlands (16%), Scotland (11%) and North East (10%)
- ⦿ Five local authorities with highest numbers in dispersal accommodation - Glasgow, Birmingham, Leeds, Manchester and Newcastle

Accommodation Standards



“ A number of women pointed out that their living conditions sometimes made adherence to drug regimes difficult. Those living in shared accommodation described the difficulties of concealing medicines and the need to avoid taking them in public. For women with limited access to food or cooking facilities drugs requiring dietary manipulation were especially difficult to manage.

Dispersal Process



THE POLICY CONTEXT

The Immigration and Nationality Directorate (IND) of the Home Office revised its policy on dispersing asylum seekers with health care needs in 2005.

This leaflet provides information and guidance on how the policy should work in relation to the dispersal of asylum seekers living with HIV for both health care and voluntary sector professionals. It provides sources of further information should your experience differ from the process outlined in the new policy.

- After discussion and expert clinical advice from the current treating clinician.
- If the asylum seeker is medically stable, with no other health complications.
- Once the asylum seeker and current treating clinician have had time to prepare for dispersal and have confirmed the arrangements for transfer of clinical care with an IND caseworker.

PUTTING IT INTO PRACTICE

Role and responsibilities of health care professionals

[References to the patient' denote an asylum seeker living with HIV.]
To obtain the best health outcomes for individual patients it is important that HIV clinical teams communicate appropriately with IND caseworkers.

Clinicians – whether GPs, specialist nurses, HIV consultants or other health care professionals – should ensure that patients understand what information is being shared and why, and give appropriate consent.

If IND is aware that an asylum seeker is HIV positive, the IND caseworker should contact the treating clinician prior to dispersal

are known to be living with HIV and who are not yet receiving clinical care in the UK will be dispersed at the earliest opportunity to enable them to engage with clinical services at the dispersal destination.

In other cases dispersal of HIV positive asylum seekers should only take place in the following circumstances:

- Anyone wanting state-supported accommodation must be dispersed on a no-choice basis via an initial accommodation centre
- Joint NAT/BHIVA publication (agreed by the Home Office)
- Dispersal can lead to interruption of ongoing clinical care and compromise drug adherence
- Clinicians are meant to be satisfied that a person is fit to be dispersed and that arrangements are in place for the handover of care
- Asylum seekers with HIV should always be registered with a GP in their dispersal area

Continuing Problems



“ A woman living with HIV in Berkshire was moved to Plymouth in early 2007. Her clinician advised the Border and Immigration Agency that the woman should not be moved for medical reasons, and raised concerns that the woman would not be able to access a similar support structure in the new area. The Border and Immigration Agency was aware of this woman's HIV-positive status, but she received a letter giving one day's notice of her dispersal to Plymouth. This did not allow an appropriate amount of time to prepare adequately for the journey and, being on treatment for HIV, she did not have the opportunity to organise sufficient medication for the move.

Subsistence and Poverty



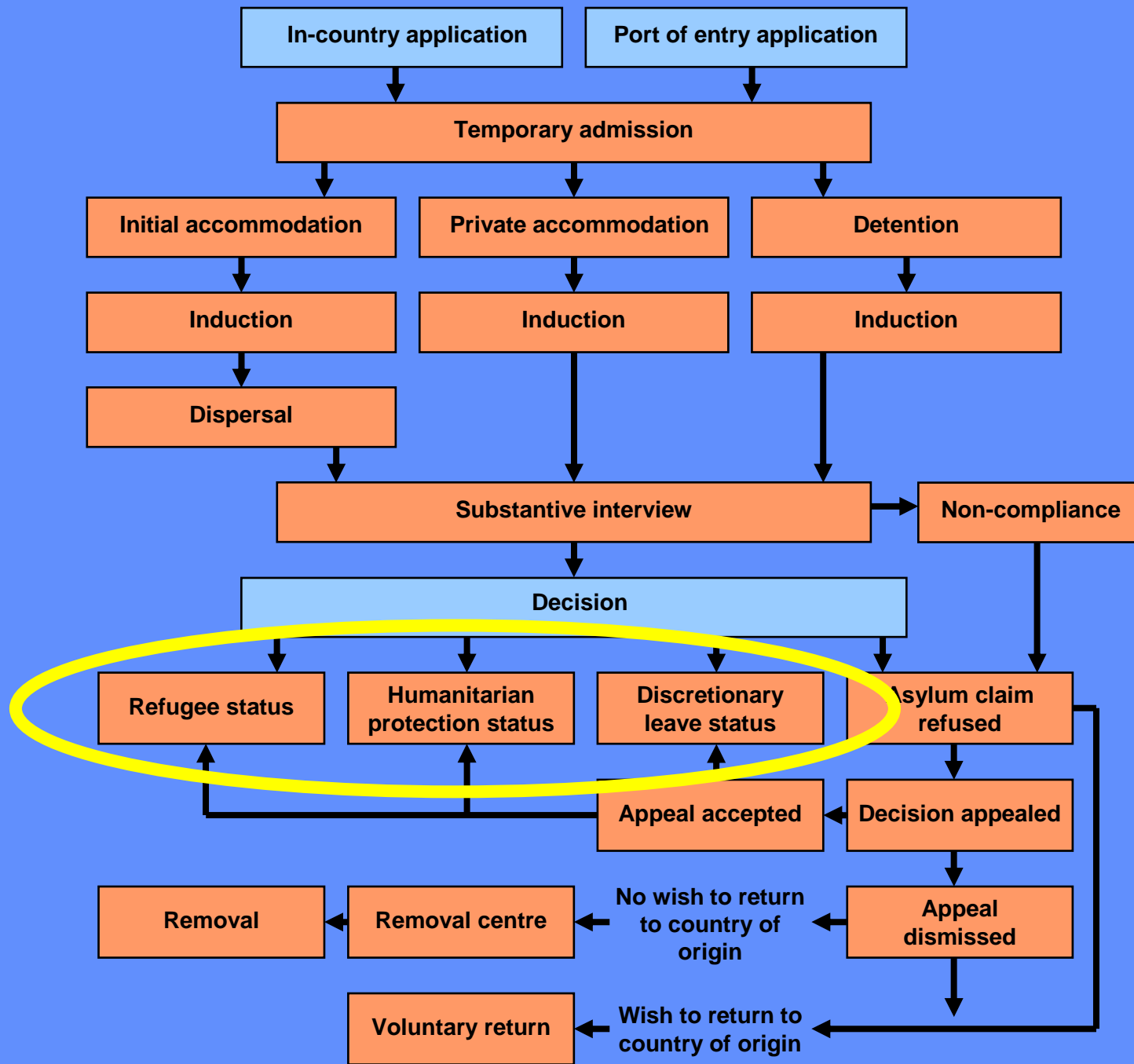
- 🚫 Asylum seekers are not allowed to work (but can apply for permission to work after 12 months in the UK)
- 🚫 About half of adult asylum seekers receive cash support of £41.41 per week, which is 70% of income support

“ I don't want to be fed by the state, I want to feed myself and the money the state gives me is not enough.

I want to survive, I want to win, I want tomorrow (2005) Doyal et. al. www.ahpn.org

“ For those living on state benefit, economic problems were paramount.

My Heart is Loaded (2003) Jane Anderson et. al. www.tht.org.uk



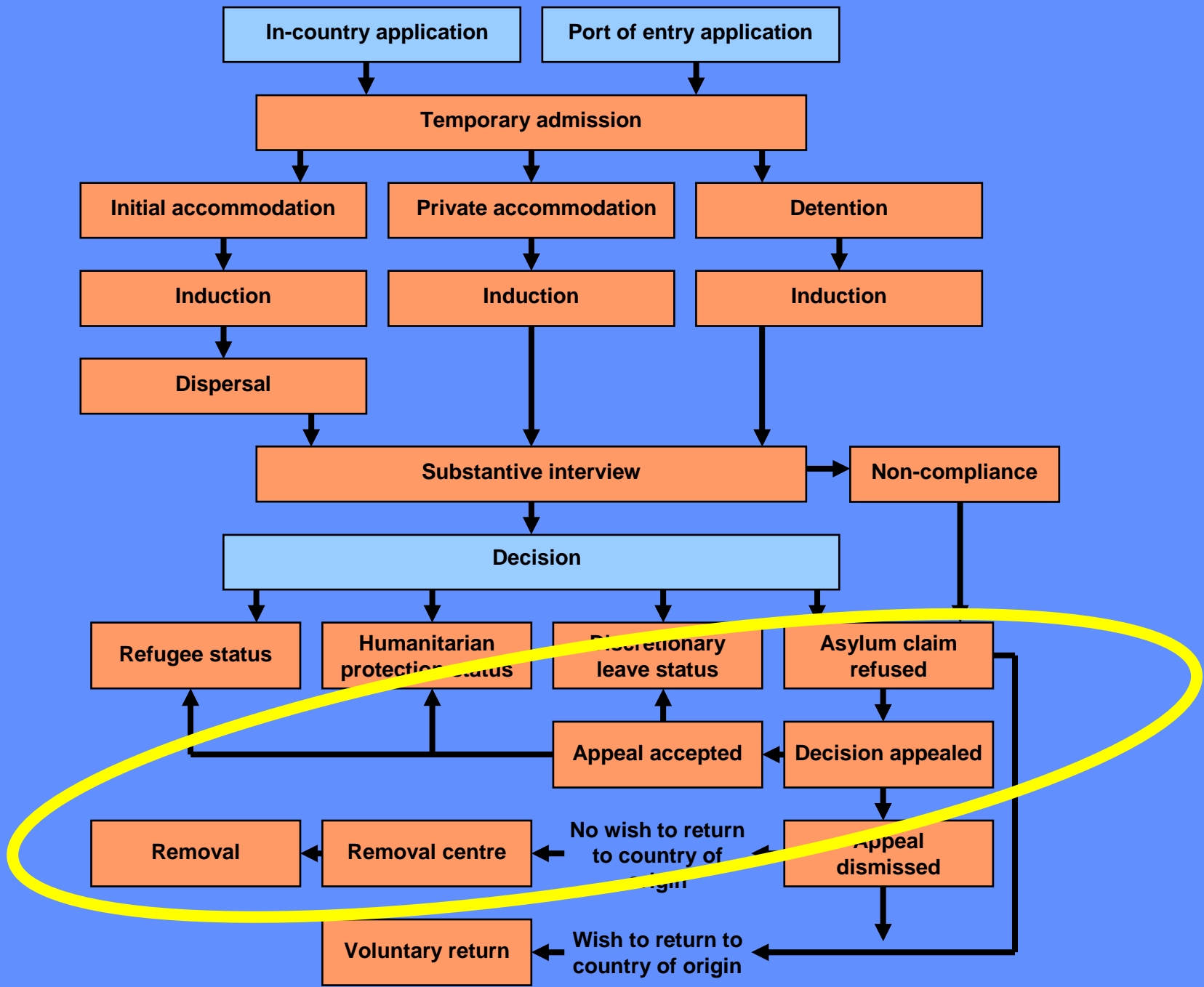
Successful Claim and Integration



- ⦿ Three forms of successful claim
 - (1) Refugee status - up to five years and renewable
 - (2) Humanitarian protection - up to five years and renewable
 - (3) Discretionary leave - up to three years and renewable for a further three years

- ⦿ Successful applicant receives Home Office support for a further 28 days during which time they must find means to support and accommodate themselves

- ⦿ Home Office also offer an interest-free loan of between £100 and £1,000 and support from the refugee integration service 'Sunrise'



Refusal and Appeal



- ⦿ In Q4 2007, 73% of initial decisions were refusals
- ⦿ Appeal must be made within 10 days (less if already detained or fast tracked)
- ⦿ In 2007, 72% of appeals dismissed and 23% allowed
- ⦿ Refused asylum seekers expected to leave at the end of appeal process - a 21 day period of further support after which they are refused asylum seekers pending removal

Access to Treatment for Refused Asylum Seekers



- ⦿ 2004 NHS regulations meant that a refused asylum seeker could not access free NHS secondary care, including HIV treatment
- ⦿ In April 2008, the High Court ruled that charging refused asylum seekers for secondary care is unlawful. **No charges should be made for the treatment of refused asylum seekers and people should be encouraged to find out their HIV status and access the care they need**

Detention and Removal



- Ⓡ In Q3 2007, 2,890 asylum seekers were removed - 1,335 (47%) from immigration removal centres
- Ⓡ Lack of HIV treatment in the country of destination is not usually a legal basis to prevent removal - see the case of *N* before the House of Lords
- Ⓡ But there are circumstances in which removal can be prevented (e.g. extreme ill-health with no provision of care in country of destination, or trauma of witnessing probable death of parent, or likely experience of stigma upon return)
- Ⓡ NAT and BHIVA are working with IRC healthcare managers to develop advice on how to support people living with HIV during removal

Conclusions



- Ⓡ The asylum process can result in serious stresses for asylum seekers living with HIV
- Ⓡ The NHS is a vital source of support for asylum seekers living with HIV, often beyond immediate treatment needs
- Ⓡ In meeting the health needs of asylum seekers living with HIV effectively, clinicians need to be aware of the external stresses which can effect management of the condition
- Ⓡ Clinicians will be called upon to proactively provide advice both to asylum seekers living with HIV, but also to officials who administer the asylum process on such matters as accommodation needs, fitness to travel and be removed, and preparation for repatriation

Thank You



Asylum Pathway: www.nat.org.uk/document/421

Dispersal Guidance: www.nat.org.uk/document/208

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