SPEAKING OUT
CHANGING LIVES

NAT
NATIONAL AIDS TRUST

Report: April 2008

HIV and the UK Asylum Pathway

An overview by the National AIDS Trust of the pathway an asylum seeker takes in the UK from application to either integration or removal

HIV and the UK Asylum Pathway

An overview by the National AIDS Trust of the pathway an asylum seeker takes in the UK from application to either integration or removal

Introduction

The National AIDS Trust (NAT) is the UK's leading independent policy and campaigning charity on HIV and AIDS. The National AIDS Trust develops policies and campaigns to halt the spread of HIV, and improve the quality of life of people affected by HIV and AIDS, both in the UK and internationally.

This overview builds a picture of the pathway of an asylum seeker in the UK from the point of application to when a decision is made on their claim and they are either given leave to remain or they leave the country (whether voluntarily or forcibly removed).[1] The report also aims to highlight the needs of an HIV-positive asylum seeker during the process and point to where there are opportunities and challenges to addressing these needs.

This overview is aimed as an informational resource for organisations working with asylum seekers living with HIV. It is not intended as a substitute for legal advice, but as an outline to give organisations a better general understanding of the asylum process. The National AIDS Trust will use this overview to inform its work with healthcare and voluntary sector professionals and to identify and support consistent best practice in meeting the HIV-related needs of migrant communities throughout the asylum process.

1. Link between migration and HIV

Globally, migration is increasing. Between 1960 and 2005 the total number of migrants more than doubled, from 75 million to 191 million.[2] In 2005 Europe received 33 per cent of this global total, making it home to the largest number of migrants. Between 1990 and 2005, 1.6 million migrants came to the UK.[3]

In the UK, most migrants live in London and the South East. However, the Home Office Border and Immigration Agency's policy of dispersal (see section 2.7), means that since 1999 many asylum seekers have been moved to other areas outside the South East until a decision can be made on their asylum claim.

Migrants living in the UK are a very diverse group coming from a wide range of countries for a wide range of reasons. Main reasons include employment, education and asylum.[4] Migrants live in a variety of social circumstances, but in London, for example, the wards with the highest proportions of non-UK born residents also tend to be the areas with the highest levels of deprivation.[5]

Migrants have a range of health needs similar to those of individuals of equivalent age and sex in the native UK population. However, for certain

---

1: An asylum seeker is an individual who has made a formal application for asylum. If their application is accepted, they are recognised as a refugee in accordance with the 1951 UN Refugee Convention. An asylum seeker may also mean a person who has applied for protection under Article 3 of the European Convention on Human Rights. If their application is accepted, they will be granted humanitarian protection or discretionary leave to remain.

2: Migrant refers to those who change their country of usual residence. Home Office and Foreign and Commonwealth Office (2007) *Managing Global Migration*, www.bia.homeoffice.gov.uk/sitecontent/documents/managingourborders/internationalstrategy/internationalstrategy.pdf?view=Binary.

3: Home Office and Foreign and Commonwealth Office (2007) *Managing Global Migration*, www.bia.homeoffice.gov.uk/sitecontent/documents/managingourborders/internationalstrategy/internationalstrategy.pdf?view=Binary.

4: Home Office and Foreign and Commonwealth Office (2007) *Managing Global Migration*, www.bia.homeoffice.gov.uk/sitecontent/documents/managingourborders/internationalstrategy/internationalstrategy.pdf?view=Binary.

5: Health Protection Agency (2007) *Testing Times*, www.hpa.org.uk/infections/topics_az/hiv_and_sti/publications/AnnualReport/2007/HIVSTIs_AR2007.pdf.

infections, the major burden of disease may fall upon particular groups of people who were not born in the UK. For example, three-fifths of all HIV cases reported in England, Wales and Northern Ireland in 2006 were cases where the individual had been born outside the UK.[6] More than 90 per cent of heterosexual Black Africans diagnosed with HIV in the UK probably acquired their infection abroad.[7] However, this does not necessarily mean that these groups overall have a very high prevalence of HIV when compared to the prevalence rates in their countries of origin.[8] There are factors that may put some migrants, particularly asylum seekers, at risk of HIV infection after their arrival in the UK. Some of these factors include the high risk of poverty and poor access to safer sex education and healthcare.[9]

With more people than ever before living with HIV in the UK[10] and a large number of asylum applicants coming from high HIV prevalence countries, including Eritrea, Somalia and Zimbabwe,[11] there is a real and urgent need for the HIV risk in migrants to be considered earlier in the asylum process.

The Government must look at its immigration processes to ensure they promote rather than undermine the health and well-being of migrants in the UK. It is important to examine the opportunities and challenges presented to us and to consider how to support asylum seekers who may be living with HIV, or are vulnerable to infection. These opportunities and challenges are discussed in further detail below.

FACT

There are factors that may put some migrants, particularly asylum seekers, at risk of HIV infection after their arrival in the UK. Some of these factors include the high risk of poverty and poor access to safer sex education and healthcare.

6: Health Protection Agency (2006) *Migrant Health*, www.hpa.org.uk/publications/2006/migrant_health/migrant_health.pdf.

7: Health Protection Agency (2007) *Testing Times*, www.hpa.org.uk/infections/topics_az/hiv_and_sti/publications/AnnualReport/2007/HIVSTIs_AR2007.pdf.

8: Health Protection Agency (2006) *Migrant Health*, www.hpa.org.uk/publications/2006/migrant_health/migrant_health.pdf.

9: National AIDS Trust and Crusaid (2006) *HIV and Poverty*, www.nat.org.uk/document/207.

10: Health Protection Agency (2007) *Testing Times*, www.hpa.org.uk/infections/topics_az/hiv_and_sti/publications/AnnualReport/2007/HIVSTIs_AR2007.pdf.

11: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

2. The UK asylum pathway

2.1 Application

A person is not officially described as a refugee in the UK until they have been granted refugee status as a result of the determination of their case.

However, technically speaking, the state does not make someone a refugee. Rather, it recognises them to be one by declaring that their circumstances meet the criteria of Article 1(A)(2) of the Refugee Convention.[12]

Article 1(A)(2) defines a refugee as someone who has a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinion.

A person may also invoke articles of the European Convention on Human Rights (ECHR) to seek permission to stay in the UK. The ECHR provides protection from torture, or inhuman and degrading treatment. It also provides for a right to liberty and a right to respect for a private and family life, subject to permissible restrictions in the wider public interest. Only a small number of applications are made through the ECHR.

Until a determination has been made on a person's refugee claim, they are known as an asylum seeker. In 2007, approximately 6,000 individuals applied for asylum in the UK in each quarter.[13] The number of asylum applicants from some countries with high HIV prevalence has been increasing. For example, in the fourth quarter of 2007, the number of applicants from Eritrea increased by nine per cent and from Zimbabwe by 159 per cent since the previous quarter.

Asylum applications can be made either at a 'port of entry' (e.g. at an airport, seaport or trainport) or 'in-country' at an Asylum Screening Unit.

2.1.1 Port of entry

If a person makes a port of entry application, then they will usually be given an asylum screening interview by an immigration officer shortly after arrival or are asked to return for one at a later date. The purpose of this interview is to establish the identity and nationality of the asylum seeker, their travel route to the UK, the documentation used to travel to the UK and to take the fingerprints and photographs of the applicant and his or her dependents. All of this information is subsequently sent to the Home Office.

Immigration officers should refer individuals who appear in poor physical or mental health to a port medical inspector for a health assessment which should include screening for tuberculosis (TB) if the applicant is arriving from an area where TB is common and intending to stay in the UK for more than six months.

However, technically speaking, the state does not make someone a refugee. Rather, it recognises them to be one by declaring that their circumstances meet the criteria of Article 1(A)(2) of the Refugee Convention.

2.1.2 In-country

If a person enters the country legally (e.g. by being granted leave to enter on another basis, such as a visitor or student) or illegally (e.g. by evading immigration control on arrival such as being concealed in the back of a lorry) and then makes an application for asylum, they are making their claim in-country. The vast majority, more than 83 per cent, of applications are made 'in-country'.[14]

Applications must be submitted in person to the Home Office at an Asylum Screening Unit. In-country applicants are usually given a screening interview by the Home Office to establish their identity and nationality, and may be referred for a health assessment. They are also photographed and fingerprinted.

2.1.3 Registration card

Both in-country and port applicants will usually be given an identity document, called an asylum registration card, after their screening interview. The card is the size of a credit card and contains important information about applicants such as their name, date of birth and nationality. There is also a picture of the applicant and their fingerprints stored on the card. Fingerprints are checked against existing Home Office records and EURODAC.[15]

12: UNHCR (2007) *Convention and Protocol Related to the Status of Refugees*, www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf.

13: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

14: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

15: EURODAC is a system that enables EU Member States to compare fingerprints of asylum seekers to determine which state is responsible for an asylum applicant.

16: Support granted may be withdrawn at any point should the Home Office believe an asylum seeker has not been or will not be compliant during the asylum application process.

2.2 Temporary admission

If the asylum application is made either at a port or in-country by a person without current leave to remain and the applicant is not being detained, then they will be given an IS96 paper which grants them 'temporary admission' into the UK. This allows them to remain in the country whilst their asylum application is being determined. It does not mean that a person has been given 'leave to enter' the UK.

2.3 Statement of evidence form

Applicants who are not processed under fast track procedures (see section 3) are likely to be given a 'statement of evidence form' to complete. On this form, the applicant is required to write down their reasons for claiming asylum. A more detailed account may also be provided on an accompanying statement. The form has to be returned within 10 working days (28 days for unaccompanied minors) and is usually used as the basis for a substantive interview which will be conducted by the Home Office. If the form is not returned within 10 days, then the claim is likely to be refused on non-compliance grounds.

2.4 Support

Under Section 95 of the Immigration and Asylum Act 1999, the Home Office Border and Immigration Agency can provide basic support for asylum seekers who fulfil certain criteria.[16] Applicants have to be able to show, according to Section 55 of the Nationality, Immigration and Asylum Act 2002, that they applied for asylum 'as soon as reasonably practicable' after arrival in the UK and that they have no access to alternative support, and/or that refusing them support would breach their human rights.[17] Provision of shelter, food and basic amenities are considered to be basic means of support.[18]

About half of asylum seekers receive some kind of support during the asylum application process, whether it be accommodation, subsistence benefits or both. For adult asylum seekers, cash support is 70 per cent of the amount paid to permanent residents of the UK on income support, and is at full income support level for dependent children under the age of 18. For an adult asylum seeker, this is £41.41 per week. Pregnant women and women with young children are entitled to an additional amount intended for the purchase of healthy foods.[19]

In 2007, nearly 70 per cent of support applications were for accommodation and subsistence support, and 21 per cent were for subsistence only.[20] Asylum seekers who are not in need of, or do not apply for, support may already be living in private housing, or with family or friends, and with enough means for subsistence.

Unless there are exceptional circumstances, asylum seekers who qualify for accommodation support (e.g. those who would otherwise be destitute) are offered accommodation outside London and the South East (see section 2.7) after being housed temporarily in initial accommodation.

2.5 Initial accommodation

There are nine initial accommodation centres in the UK; seven in England, one in Wales and one in Scotland.[21] All facilities support men, women and families. These centres are:

- South East Central Induction Centre (Kent)
- London Initial Accommodation Centre (Croydon)
- Clearsprings (Cardiff)
- Astonbrook (West Midlands)
- YMCA (Glasgow)
- Yorkshire & Humberside Induction Centre (Leeds)
- Angel (Wakefield)
- North West Consortium Induction Service (Greater Manchester)
- Accommodata (Liverpool).[22]

According to the most recent data available, 1,440 asylum seekers including dependents were supported in initial accommodation as at the end of December 2007.[23] The Home Office aim is to disperse applicants from this temporary initial accommodation within two weeks to more permanent accommodation outside of London and the South East. However, research shows that the average length of time an applicant is supported in initial accommodation is approximately 27 days (range 18 to 67 days).[24]

The five most common nationalities supported between October and December 2007 were Iraqi, Iranian, Eritrean, Somalian and Zimbabwean.[25]

17: On 17 December 2003, the Home Secretary announced that asylum seekers would be considered to have made their claim 'as soon as reasonably practicable' if they could give a 'credible explanation' of how they arrived in the UK within three days of applying for asylum.

18: Although an applicant does not have to take both accommodation and subsistence benefits.

19: Further information is available at www.bia.homeoffice.gov.uk/asylum/support/cashsupport.

20: The remaining 10 per cent of applications were deemed invalid or the application type had not been identified at the application stage. Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

21: Initial accommodation centres are not detention facilities.

22: Liverpool City Council will be providing initial accommodation in place of North West Consortium Induction Service.

23: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

24: National AIDS Trust (2007) *Initial Accommodation and HIV*, www.nat.org.uk/document/366.

25: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

The New Asylum Model (see section 3) may shift focus away from initial accommodation to rapid dispersal and removal or integration.

2.6 Induction

While supported in initial accommodation, asylum seekers will be provided with information about asylum procedures and their rights and responsibilities. They are also offered a voluntary health assessment by healthcare staff in the centre.[26] Asylum seekers receive a book detailing their personal health record ('blue book') which is intended to facilitate information sharing by health professionals during the asylum application process. This book includes past medical history on blood disorders (e.g. Hepatitis B, HIV, anaemia), TB (more migrants now come from parts of Africa where there are increasing rates of TB and HIV co-infection[27]) and sexual health (e.g. sexually transmitted infections, other sexual health problems, actions taken).

Asylum seekers who are not in need of or eligible for support will be given a day's induction at the Home Office or one of its regional induction centres, where their immediate health needs will also be addressed.

2.7 Dispersal

Following induction, asylum seekers supported in temporary initial accommodation are then dispersed to accommodation outside London or the South East, where the applicant stays until his or her asylum application is decided. Applicants are required to regularly report to local Home Office officials during this time.[28] Asylum seekers may also be transferred between dispersal locations.

Accommodation may be provided by a Local Authority, a registered social landlord or a private landlord. These are called 'accommodation providers'. One of the responsibilities of accommodation providers is ensuring asylum seekers with pre-existing health conditions, including HIV, are registered with a General Practitioner (GP) on arrival in a new area.[29]

As at the end of December 2007, 34,150 asylum seekers including dependents were supported in dispersal accommodation.[30] The five Local Authorities with the highest number of asylum seekers in dispersal accommodation at this time were: Glasgow, Birmingham, Leeds, Manchester and Newcastle.

FACT

Home Office guidance on the dispersal of asylum seekers with healthcare needs requires accommodation providers in dispersal locations to ensure asylum seekers with pre-existing health conditions, including HIV, are registered with a General Practioner on arrival in a new area.

2.8 Substantive interview

The purpose of the asylum interview is to establish whether or not an applicant is at risk of persecution for one of the five reasons outlined in the Refugee Convention, or at risk of torture or ill-treatment under Article 3 of the ECHR, and to assess their credibility.[31] The interviewing officer will ask a range of questions relating to the applicant's history and reasons for flight. Some applicants are entitled to have a representative at their interview and others can request to have the interview taped. Interpreters are provided for individuals by the Home Office if required. This interview forms part of the evidence for the application and any subsequent appeals.

2.9 Living as an asylum seeker

Applying for asylum can be a stressful and overwhelming experience, particularly for individuals with healthcare needs.

Asylum seekers may face a range of day-to-day obstacles whilst their application is being considered, including language barriers and regular reporting requirements to Home Office officials. In addition, refused asylum seekers may not be entitled to free National Health Service (NHS) care, including HIV treatment.

26: Initial accommodation healthcare staff are NHS staff provided by the local PCT.

27: Health Protection Agency (2006) *Migrant Health*, www.hpa.org.uk/publications/2006/migrant_health/migrant_ health.pdf.

28: This is sometimes referred to as 'signing on'.

29: The National AIDS Trust has developed advice to healthcare professionals and voluntary sector organisations about supporting dispersed asylum seekers living with HIV, which is available at www.nat.org.uk/document/208.

30: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

31: UNHCR (2007) *Convention and Protocol Related to the Status of Refugees*, www.unhcr.org/protect/PROTECTION/3b66c2aa10.pdf.

32: In February 2005, the UK implemented the European Council Directive 2003/9/EC of 27 January 2003, which allows asylum seekers to apply for permission to work if they have not received an initial decision on their asylum claim from the Home Office after 12 months.

Individuals do not have the right to work while their application for asylum is being considered unless the application process takes more than 12 months.[32] This inability to work may translate for some into an inability to support themselves and their dependents whilst in the UK.

Although some asylum seekers may be entitled to asylum support during the application process, including accommodation and subsistence benefits (see section 2.4), these limited benefits still mean that many experience poverty and destitution while in the UK.[33]

Although there are no comprehensive national statistics related to destitution[34] among asylum seekers, some local research projects monitor the programmes of local agencies working with destitute asylum seekers and refugees. For example, in June 2005, Refugee Action tracked 168 individuals using one of the six agencies in Leicester that support destitute asylum seekers and refugees and found that 78 per cent had been destitute for over a month, and 40 per cent for over six months.[35] In another example, in Scotland between January 2000 and May 2004, of over 1,000 applications for asylum support to the Home Office, almost a third of applicants had experienced homelessness at some point during their time in the UK and 75 per cent of all applications were for food and basic necessities.[36]

In 2007, 43 per cent of applications received an initial decision within two months.[37]

2.10 Decisions

There are four possible outcomes of an initial claim for asylum. These are:

2.10.1 Refugee status

The applicant is recognised as a refugee and given leave to enter/leave to remain. This is for a limited period of time (i.e. up to five years and renewable).

At the end of this period, the case will be reviewed. If the circumstances that led to the granting of refugee status are found to endure, then either an extension will be granted to bring the period of refugee status up to five years or, if the applicant has already had five years of refugee status, they can apply for indefinite leave to remain.

2.10.2 Humanitarian protection

The applicant is given humanitarian protection which is for a limited period of time (i.e. up to five years and renewable).

Humanitarian protection will be granted to people who have been refused refugee status, but cannot be returned to their country of origin as they face a serious risk to life or person including the death penalty, unlawful killing, torture, or inhuman or degrading treatment or punishment.[38] Humanitarian protection may also be granted under a separate application in response to an Article 2 or 3 claim under the ECHR (see section 2.11).

At the end of the period of humanitarian protection granted, the case will be reviewed and renewed as outlined above.

2.10.3 Discretionary leave

The applicant will be given discretionary leave to remain which is for a limited period (i.e. up to three years and renewable).

Discretionary leave is granted outside the immigration rules in very limited circumstances to people who have been refused refugee status, but who do not fulfil the criteria for humanitarian protection. Discretionary leave may be granted when the applicant:

- Is an unaccompanied asylum-seeking child for whom adequate reception arrangements in their country are not available
- Is able to demonstrate particularly compelling reasons why removal would not be appropriate (e.g. extreme medical grounds or the right to family life under Article 8 of the ECHR).

Discretionary leave is granted for up to three years (unaccompanied asylum-seeking children are normally granted discretionary leave for three years or until their 18th birthday, whichever is earlier) and will be reviewed at the end of that period. At that point it can be extended for a further three years. After six years of discretionary leave, an application can be made for indefinite leave to remain.

33: The National AIDS Trust aims to look at issues relating to destitution and asylum seekers in 2008.

34: According to the Nationality, Immigration and Asylum Act 2002, destitution means that the asylum seeker does not have adequate, or cannot obtain adequate, accommodation, food and essential items for themselves and their dependents.

35: Refugee Action and Refugee Council (2006) *Inhumane and ineffective*, www.refugeecouncil.org.uk/NR/rdonlyres/141F513D-7A98-4026-BC94-C114B9D5FF3C/0/Section9_report_Feb06.pdf.

36: Refugee Survival Trust and Oxfam (2005) *What's going on? A study into destitution and poverty faced by asylum seekers and refugees in Scotland*, oxfamgb.org/ukpp/resources/downloads/Whats_going_on.pdf.

37: Two months is defined as 61 days. Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

38: Returning people to face such treatment is contrary to the UK's international obligations under Article 3 of the European Convention on Human Rights.

2.10.4 Refusal

The applicant is refused. When asylum is refused a formal notice of refusal and a 'reasons for refusal letter' is issued and applicants have the opportunity to appeal against the decision.

For the period October to December 2007, 16 per cent of initial asylum decisions were to grant asylum. 11 per cent of initial decisions were granted humanitarian protection (one per cent) or discretionary leave (10 per cent).[39] 73 per cent of initial decisions were refusals.

2.11 Appeals

Applicants whose asylum claims are initially refused can appeal against the decision. However, they have a limited time to lodge their appeal. In most cases, applicants are allowed 10 working days after hearing that their application has been refused; five days if they are being detained; and two days if they are being detained in either Harmondsworth or Yarl's Wood IRC under the fast track process (see section 3.1). Refused applicants are informed of their rights and told how to make an appeal.

It is possible to appeal on the grounds that the reasons for an asylum claim have not been fully considered, and also on the grounds that the Human Rights Act (1998) might be breached if the asylum seeker were returned.

The Government has developed a 'one-stop' system for appeals. This means that the person making the appeal must bring forward all their reasons at once. Effectively, it prevents applicants from making more than one appeal at different times.

Immigration appeals are heard by the Asylum and Immigration Tribunal. Appeals are decided by one or more immigration judges who are sometimes supported by non-legal members of the Tribunal. Both immigration judges and non-legal members of the Tribunal are appointed by the Lord Chancellor and are independent of the Government. A Tribunal can be requested to reconsider its ruling where there has been a material error of law. In some cases, there is a final right of appeal to the Court of Appeal.

During the appeals process, an applicant may invoke the ECHR. In 1998, the Human Rights Act was passed in the UK, incorporating the ECHR into UK law. Although the ECHR does not specifically address the rights of asylum seekers or refugees, the basic human rights enshrined in the law as a result of the 1998 Act do have an important impact upon asylum seekers. Immigration rules require immigration officers and all staff at the Border and Immigration Agency to ensure their decisions comply with the Human Rights Act.

Of particular relevance are Articles 2, 3 and 8 of the ECHR. Article 2 protects the right to life and Article 3 prohibits an individual from being returned to a country where they will be subjected to torture, or inhuman or degrading treatment or punishment. Article 8 prevents unjustifiable interference in an individual's right to respect for private and family life. It is therefore possible for asylum seekers who have established a family in the UK or have developed significant social networks to argue that removing them from the UK would be a breach of their rights under Article 8. However, courts have to take into account the right of the Government to maintain immigration controls when making decisions on Article 8 cases, although this is not relevant to cases raising rights under Articles 2 or 3 or under the Refugee Convention.

In theory, asylum seekers may also seek protection in the UK on the grounds that their rights under other articles of the ECHR would be breached by their removal. This includes the right to liberty (Article 5), the right to a fair trial (Article 6) and the right to marry and found a family (Article 12). Finally, Article 14 provides a right not to be discriminated against in the enjoyment of other ECHR rights. Appeals on these grounds, however, rarely succeed.

During 2007, 14,045 appeals were received by the Asylum and Immigration Tribunal.[40] 72 per cent of appeals were dismissed, while 23 per cent of appeals were allowed.

2.12 Removal

Applicants who are refused asylum, and are not awarded humanitarian protection or discretionary leave, are expected to return to their country of origin after they are notified of the decision. If they make an appeal which is refused, they are expected to leave at the end of the appeal process.

For those who opt to return voluntarily, accommodation and vouchers to cover the cost of food and other basic essential items are available under Section 4 of the Immigration and Asylum Act 1999. This is also known as 'hard case' support, for those who are assessed as destitute and are taking reasonable steps to leave the UK, but are unable to leave immediately. These reasons may include being unfit to travel, having

39: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

40: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

41: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

42: Further details can be found at www.iom.int/jahia/Jahia/pid/747.

no safe route available or appropriate documentation for return, or having applied to the High Court for judicial review of the refusal and been granted permission for the review to proceed. A significant category of asylum seekers who may be entitled to Section 4 support are those who have sought to make a fresh claim after their previous application was turned down, because of a change of circumstances or because new evidence has been obtained.

9,140 refused asylum seekers excluding dependants were in receipt of Section 4 support as at the end of December 2007.[41] In addition, a scheme to provide financial assistance for people who opt for voluntary return is run by the London branch of the International Organisation for Migration.[42]

Anyone who does not leave voluntarily can be forcibly removed. Refused asylum seekers can be detained until it is possible to remove them.

2.13 Detention

Applicants can be detained at any point in the asylum process at the discretion of the Home Office. There are several possible reasons for detention including 'good grounds' for believing the applicant will not comply with requirements to keep in contact with them and detained fast track application processing (see sections 3.1 and 3.2).

Between October and December 2007, 1,455 asylum seekers were detained at some point during the asylum process.[43] The five most common nationalities of those detained during this period were Chinese, Nigerian, Pakistani, Jamaican and Iraqi. Most were detained in immigration removal centres.

2.14 Immigration removal centres

There are ten immigration removal centres (IRCs) in the UK where asylum seekers are detained; nine in England and one in Scotland. In 2008 the Home Office plans to open another IRC (Brook House) at Gatwick Airport. All of the facilities detain men (M), about half also detain women (W) and three detain families (F). These centres are:

- Campsfield House (Oxfordshire) (M)
- Colnbrook (near Heathrow Airport) (M, W)
- Dover (Kent) (M)
- Dungavel (Scotland) (M, W, F)
- Harmondsworth (near Heathrow Airport) (M)
- Haslar (Gosport) (M)
- Lindholme (near Doncaster) (M)
- Oakington (Cambridgeshire) (M)
- Tinsley House (near Gatwick Airport) (M, W, F)
- Yarl's Wood (Bedfordshire) (M, W, F).

Seven IRCs are privately managed, on behalf of the Home Office Border and Immigration Agency, and three are publicly managed. Healthcare is commissioned through the private contractor or the local Primary Care Trusts (PCTs) to deliver the contract agreed with the Home Office and regulated by the Healthcare Commission.

Research shows that the average length of time a detainee spent in a removal centre was approximately 18 days.[44] Asylum seekers may also be transferred between IRCs. According to the most recent data available, 2,965 asylum applicants including dependents were removed from the UK from October to December 2007.[45] The five most common nationalities of those removed were Afghan, Turkish, Nigerian, Pakistani and Serbian. Those being removed from the UK upon leaving detention between July and September 2007 was 1,355.[46]

2.15 Integration

If an asylum claim has been determined successful, the refugee will have the same rights as permanent residents and will integrate further into society. Documents, including a residence permit and a National Insurance Number, will be provided. Refugees will also be allowed to work without any restrictions and apply for official benefits if additional support is needed. If an asylum seeker receiving Home Office support and accommodation is granted leave to remain in the UK, they will continue to receive this support for a further 28 days. The applicant is expected to find the means to support and accommodate themselves during this time.

Upon a successful asylum claim, the Home Office offers an interest-free integration loan of between £100 and £1,000 depending on need to help refugees with a deposit for accommodation, training for a job or buying essential items for their home. In addition, a refugee integration service called Sunrise has been specially established to help new refugees further build their lives in the UK.[47]

43: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.

44: National AIDS Trust (2007) *Immigration Removal Centre Responses to HIV and AIDS*, www.nat.org.uk/document/257.

45: Includes enforced removals, those departing voluntarily after enforcement action had been initiated against them, those leaving under assisted voluntary return programmes and those who it is established have left the UK without informing immigration authorities. Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

46: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.

47: More information can be found at www.bia.homeoffice.gov.uk/asylum/outcomes/successfulapplications/ integration/sunrise.

3. New Asylum Model

3. New Asylum Model

In February 2005, the UK Government published a five year strategy for immigration and asylum.[48] The strategy announced the development of the New Asylum Model (NAM). The aim of NAM is to introduce a faster, more tightly managed asylum process with an emphasis on rapid integration or removal. The Home Office began implementing NAM in May 2005 and is now processing all new asylum seekers within the new model as of 5 March 2007.[49]

3.1 Segmentation

Asylum applicants are assigned to one of five 'segments' that determine the future pathway of their claim. The segment is chosen on the basis of the characteristics of their asylum claim. The main factors affected by the segment a claimant is assigned to are:

- The speed at which a person's asylum claim can be processed
- How and when they are required to remain in contact with the Case Owner, that is, how often they are required to report in person.

The five different segments are:

- **Third country** – People who the Home Office believes have, or could have, applied for asylum in a third country and are thus deemed ineligible for asylum in the UK.[50] These individuals are likely to be detained and, where possible, removed to the appropriate country.
- **Children** – This segment applies to unaccompanied minors and children in families who apply in their own right. Children may require a social services assessment to confirm their age. If they are accepted as a minor they are accommodated by social services. Until a social services age assessment determines that an age disputed young person should be dealt with as an adult their case will be processed through this segment, and they may be provided with support during this time. Case Owners dealing with cases in this segment have been specially trained to deal with children.
- **Potential non-suspensive appeals**[51] Nationals from countries designated as generally 'safe' countries.[52] Cases are considered on their merits but may be certified as clearly unfounded in which case the right of appeal may need to be exercised from outside the UK. Applicants from this segment may be detained.
- **Detained fast track** – Any asylum applicant, whatever their nationality or country of origin, may be detained at either Harmondsworth or Yarl's Wood IRC and fast tracked. Initial decisions are usually made within three to four working days.[53]
- **General casework** – Cases that do not come into any of the above categories.

3.2 Fast track processing

Asylum applicants are fast tracked through the asylum determination process within two weeks if they are from a third country, a designated 'safe country', or if their application is considered to fall under the segment for 'detained fast track' claims (all discussed above). From 2007, a case owner may decide to detain an asylum seeker in an IRC if it is felt a determination can be quickly reached on their application. As at the end of December 2007, 400 applicants had been detained and recommended for fast tracking.[54]

3.3 Case ownership

A single case owner will have responsibility for a claimant throughout the asylum process from their application to the granting of status or removal. This means more contact with the applicant and will include an individual 'case management plan' for each claimant. The case owner also:

- Interviews the person seeking asylum
- Makes the asylum decision
- Presents on behalf of the Home Office against any appeals if the case is refused
- Has ongoing contact with the applicant
- Provides and manages support including housing and financial
- Helps to organise any voluntary returns or removal
- Helps with access to integration programmes if a person is granted status.

This new process for reviewing and deciding asylum claims, including appeals, aims to conclude 40 per cent within six months of receiving the application by 2007, and aims to conclude 90 per cent within six months by 2011. There are not yet any statistics showing if these targets have been, or are on track to be, met.

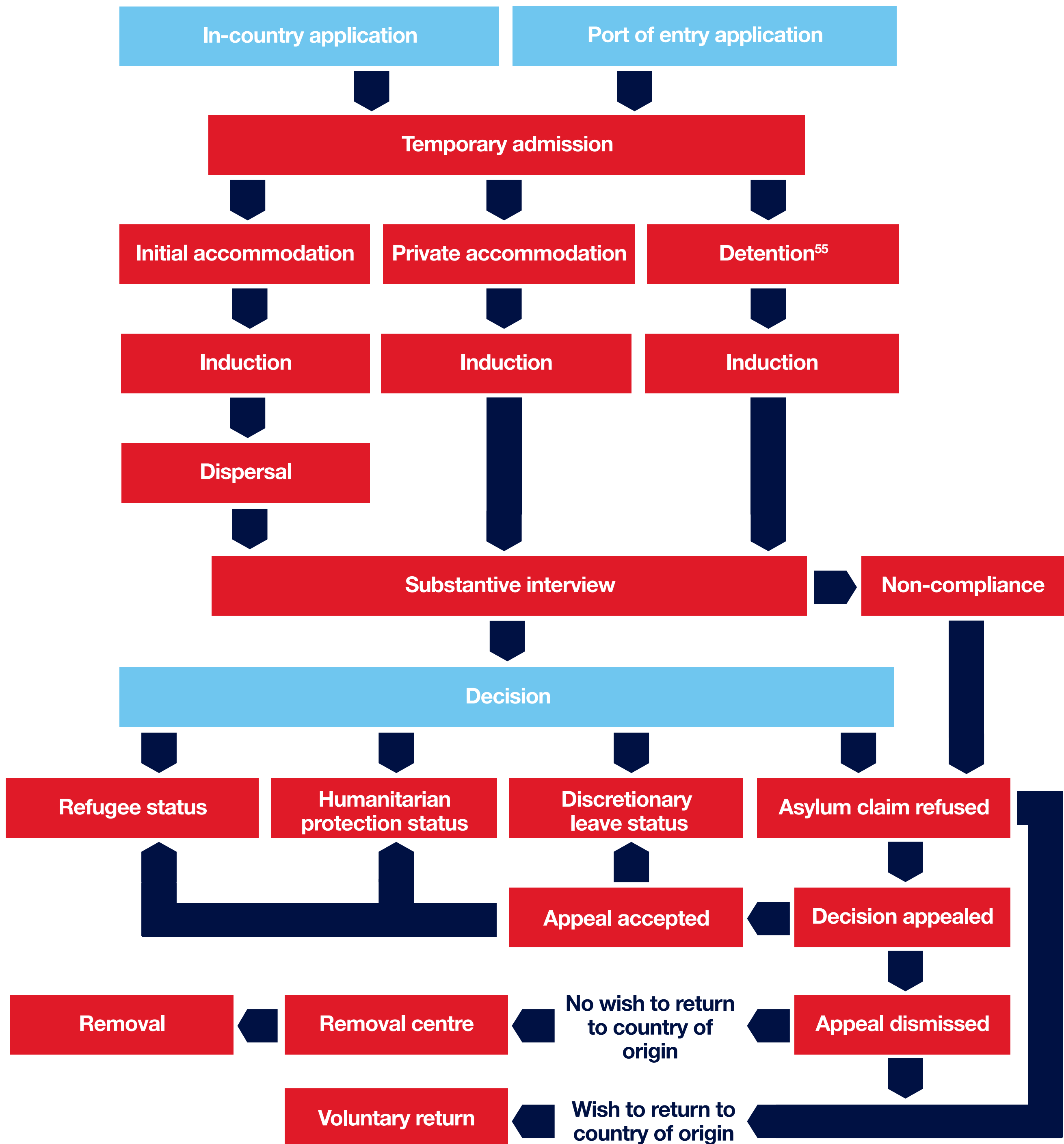
48: Home Office (2005) *Controlling our borders: Making migration work for Britain – five-year strategy for asylum and immigration*, www.archive2.official-documents.co.uk/document/cm64/6472/6472.pdf.

49: All claims made prior to implementation of the new model and awaiting a decision will move into the Case Resolution Programme for processing; all such cases will be assigned a case owner by December 2007 with the aim of concluding all incomplete cases by the summer of 2011.

50: Under the Refugee Convention countries have a duty not to return people to places where they might face persecution. However, Governments have given themselves powers to return people to countries they have passed through, where the Government believes they do not face persecution and should have applied for asylum. The most common mechanism used by the UK for returning asylum seekers to other 'safe' countries is the 2003 EU Dublin II Regulation affecting EU Member States plus Norway and Iceland.

51: Applicants whose cases are certified as non-

3.4 The pathway



suspensive appeal may only appeal against a negative decision on their asylum claim from outside the UK.

52: Designated countries that are seen not to generally violate international human rights law and therefore do not produce refugees. These include: Albania, Bolivia, Brazil, Ecuador, India, Jamaica, Macedonia, Moldova, Mongolia, Serbia, South Africa and Ukraine. In addition, for men: Ghana and Nigeria. A draft order to add 10 more countries to the list is currently before Parliament for approval. These include: Bosnia-Herzegovina, Mauritius, Montenegro and Peru; and for men: Gambia, Kenya, Liberia, Malawi, Mali and Sierra Leone.

53: Although there is a list of exceptions including pregnant women, torture victims and age-disputed minors.

54: Home Office (2007) *Asylum Statistics: 4th Quarter 2007*, www.homeoffice.gov.uk/rds/pdfs08/asylumq407.pdf.

55: Applicants can also be detained at other points in the asylum process at the discretion of the Home Office.

4. The UK asylum pathway and HIV-related needs

4. The UK asylum pathway and HIV-related needs

The asylum process itself presents both opportunities and challenges in meeting the needs of asylum seekers living with HIV.

4.1 Key opportunities and challenges

The following stages provide **opportunities** to address HIV-related issues during the asylum application process:

- At initial accommodation centres
- At the Home Office day induction for those in private accommodation
- During and after the dispersal process (for more information please see the National AIDS Trust's/British HIV Association's guidance on dispersal)[56]
- When granted refugee status
- When granted humanitarian protection
- When granted discretionary leave to remain
- When refused asylum seekers (as well as other detainees) are in IRCs
- When refused asylum seekers have agreed to voluntary return.

NAM's new feature of a single case owner who has responsibility for a claimant throughout the process of their application could help ensure these opportunities are maximised. Single ownership should provide more stability during the process. This will bring particular benefits for asylum seekers living with HIV as continuity may assist with treatment adherence and accessing healthcare.

Despite these opportunities, the asylum process raises **challenges** for providing HIV education, treatment and care to asylum seekers in the UK. Challenges include:

- NAM focuses on reducing the time it takes to reach a decision on an applicant's claim, with the aim of rapid removal or integration. The short time between entering and leaving the pathway may not allow sufficient time to meet asylum seekers' HIV-related healthcare needs.
- Asylum seekers not in need of or eligible for accommodation support may be difficult to reach and the Home Office's day induction may present the only real opportunity to educate them about HIV and how to secure testing, treatment and support in the UK.
- Similarly, asylum seekers who agree to voluntary return and are not housed within dispersal accommodation or IRCs may be difficult to reach with key HIV messages.
- Asylum seekers who are granted permission to remain in the UK will encounter a new set of challenges in relation to securing housing, employment and ongoing healthcare support.

4.2 Key considerations and recommendations

Section 4.1 highlights the opportunities and challenges to address HIV-related needs during the asylum process. When looking at these opportunities and challenges it is important to consider the following:

4.2.1 Prevention and testing

There are opportunities throughout the asylum pathway to promote voluntary HIV testing for those most at risk, either upon request or clinical indication. Early HIV diagnosis has significant benefits, not only in terms of an individual's health, but also in alerting an infected person to the need to prevent onwards transmission. It is important that asylum seekers understand that asking for a test or receiving a positive test result will not impact on the outcome of their asylum application. They need to be reassured that patient information and medical data are kept confidential and are only available to healthcare providers.

Recommendation: HIV tests should be offered to asylum seekers along the pathway, either upon request or when clinically indicated, at the earliest opportunity. Waiting times to receive results should be reduced in recognition of the speed at which asylum seekers move through the system.

There is also an opportunity to look at what health information is available at each stage in the process and provide asylum seekers with specific HIV and sexual health resources in

56: National AIDS Trust and the British HIV Association (2006) *The dispersal process for asylum seekers living with HIV*, www.nat.org.uk/document/208.

57: It may be possible for an applicant to use Article 3 of the ECHR to successfully appeal against removal to their destination country on the grounds of inhuman or degrading treatment or punishment due to their HIV diagnosis. However, since the case of N there is a high threshold set out by current law on HIV and AIDS that needs to be satisfied. N was from Uganda and was HIV positive on arrival in the UK. N was ill with AIDS-related illnesses including a form of cancer. Her condition had however stabilised as a result of antiretroviral treatment. Her life expectancy in the UK was around 10 years, but only two years if returned to Uganda. The Court found that these circumstances did not make removal a breach of Article 3. N appealed to the House of Lords [2005] UKHL 31. It was determined that removal of N back to Uganda where there would be difficulty in practically obtaining suitable medical treatment which would result in a drastically reduced life expectancy was not exceptional enough to reach the very high threshold required to establish a breach of Article 3 of the convention.

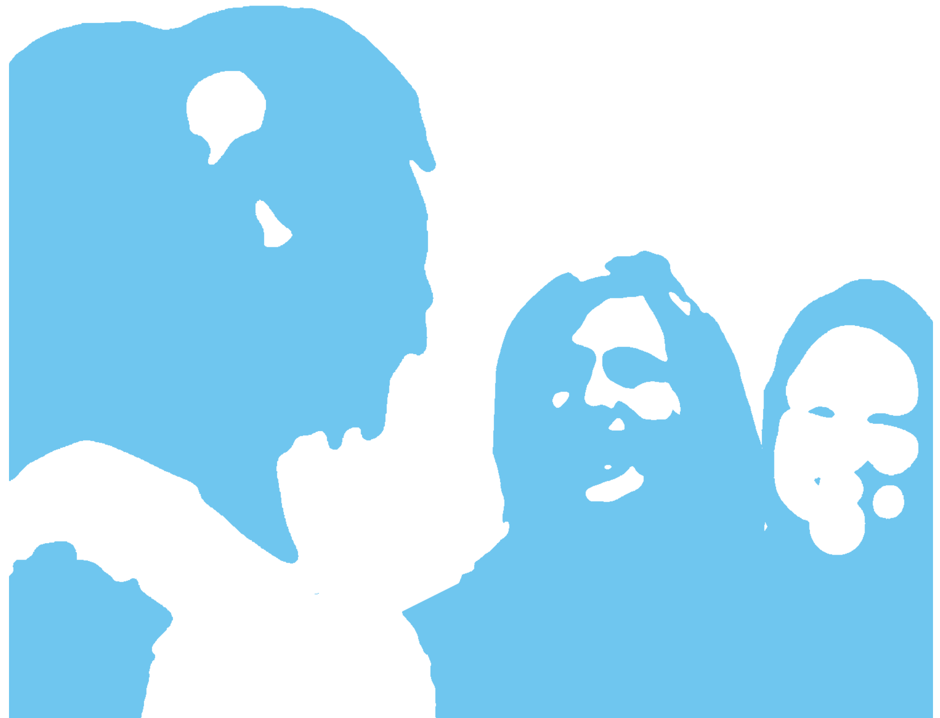
key languages. This is particularly relevant during the induction process and health assessment, as well as at dispersal locations.

Recommendation: Opportunities to provide sexual health information to asylum seekers should be maximised. Particular care should be taken to reach those either not in need of or ineligible for support who may be more difficult to reach (e.g. those in private accommodation).

4.2.2 Treatment and continuity of care

The development of antiretroviral (ARV) treatment has fundamentally changed the health prospects of those living with HIV in the UK. As long as diagnosis does not take place too late, ARV treatment usually means that an individual can live a long and healthy life. Once commenced, ARV treatment should not be interrupted. Strict adherence to this often demanding drug regimen is also essential if drug resistance is not to develop. This has particular implications for asylum seekers going through the increasingly rapid asylum process.

Continuity of care at all points during the asylum process, in particular during dispersal and removal, is essential. The National AIDS Trust contributed to the development of the Home Office's Policy Bulletin on the dispersal of asylum seekers with healthcare needs. As a result, the policy states that the treating clinician needs to be assured that appropriate arrangements are in place to ensure continuity of care before dispersal can occur. Accommodation providers in dispersal locations must ensure that asylum seekers with serious health conditions, such as HIV, are registered with a GP upon arrival. If implemented effectively, this new dispersal policy will have a significant and positive impact on HIV-positive asylum seekers.



Recommendation: The Home Office's Policy Bulletin on the dispersal of asylum seekers with healthcare needs should be fully implemented with reference to the National AIDS Trust's/ British HIV Association's guidance on dispersal.

Access to lifesaving HIV treatment may either be significantly reduced or unavailable in the country to which an unsuccessful asylum seeker is returned. Healthcare staff in IRCs should give consideration to the destination country of unsuccessful asylum seekers living with HIV.[57] An asulum seeker should be provided with additional supplies of medication and information about where to access treatment and support services in the country where they will be returned.

> **"The development of antiretroviral (ARV) treatment has fundamentally changed the health prospects of those living with HIV in the UK. As long as diagnosis does not take place too late, ARV treatment usually means that an individual can live a long and healthy life.**

Healthcare staff should take into account the way the removal process can undermine, perhaps fatally, the health of someone living with HIV.

The National AIDS Trust is developing, in collaboration with the British HIV Association and IRC healthcare staff, guidance on supporting the needs of HIV-positive asylum seekers in detention and during the removal process.

Recommendation: The needs of refused asylum seekers living with HIV in IRCs must be considered carefully during the detention and removal process to ensure:

- **High-quality treatment, care and support are maintained during detention in IRCs**
- **The repatriation process does not dangerously undermine the health of the person living with HIV (e.g. they are too unwell to travel)**
- **Asylum seekers have sufficient additional medication for their journey and an initial period of readjustment**
- **Asylum seekers are provided with information about where to access HIV treatment and support once repatriated.**

It is also important to consider access to NHS treatment more generally. New Government regulations from 2004 mean that some vulnerable individuals, including refused asylum seekers and other undocumented migrants, may be charged for some forms of care. Evidence has shown that this has a negative impact on the health and well-being of those individuals, who are often destitute and, as such, unable to afford the care they need. The situation has also created some confusion amongst migrants who are entitled to healthcare.

Asylum seekers living with HIV with a current application ongoing (including appeals) are entitled to free NHS care for HIV or any other condition. If an asylum seeker is already receiving free NHS care and their right to residence in the UK comes to an end or their application is refused, they still have a right while in the UK to continue to get treatment for that condition free of charge. However, if an asylum seeker accesses NHS care only after their application is refused then, under current regulations, they should be charged for treatment. Anyone who has overstayed their visa or who is otherwise resident in the UK without legal status may be charged.[58]

Recommendation: HIV treatment should be free to all as the current charges have significant health implications both for refused asylum seekers living with HIV and for wider public health in the UK.

Recommendation: The Government should provide improved guidance on charging for healthcare to all NHS healthcare professionals and asylum seekers to end the current confusion around entitlement to care (e.g. the National AIDS Trust's/Terrence Higgins Trust's *Will I have to pay?* resource[59]).

4.2.3 Support and housing

It is widely acknowledged that poor accommodation and housing support have the potential to exacerbate the HIV-related needs of asylum seekers. Damp accommodation and inadequate heating creates an unhealthy and potentially dangerous environment for people with respiratory infections and TB. Daily ARV treatment regimes, periods of ill-health and frequent clinical appointments can be difficult to explain when living in shared accommodation.

For these reasons, asylum seekers living with HIV require self-contained accommodation and access, where appropriate, to a private fridge for storing medication. Asylum seekers are especially vulnerable to inadequate housing as they are least able legally and financially to take action to improve the poor quality of their housing.

Recommendation: All asylum seekers should have access to suitable accommodation and housing support. Case owners should consider the particular needs of asylum seekers living with HIV when arranging accommodation.

Recommendation: Asylum seekers living with HIV who are granted discretionary leave, humanitarian protection or refugee status need information and signposting to ensure they can access appropriate accommodation and housing support.

Access to employment is a major factor in maintaining income and living conditions. Employment also helps improve self esteem and mental health. However, asylum seekers in the UK do not legally have the right to work whilst their case is being heard, unless the process takes more than 12 months. Unemployment means that many asylum seekers are unable to adequately support themselves or their families.

Recommendation: All asylum seekers should be granted the right to work after six months.

FACT

It is widely acknowledged that poor accommodation and housing support have the potential to exacerbate the HIV-related needs of asylum seekers.

Recommendation: Asylum seekers who are granted discretionary leave, humanitarian protection or refugee status should be provided with information and support to help them back into employment.

It is equally important to consider the mental health needs of asylum seekers living with HIV. The asylum process in itself can be both frightening and stressful, particularly for a person unfamiliar with the UK and its regulations. It is extremely important that those working with asylum seekers establish strong links with local HIV organisations and support services so that asylum seekers living with HIV can access these while in initial accommodation, upon dispersal and during removal or integration.

Recommendation: The voluntary sector, healthcare workers and other staff working in the asylum pathway should work together to ensure that asylum seekers living with HIV can access appropriate mental health support.

To respond effectively to the needs of asylum seekers living with HIV, healthcare staff working at each point along the asylum pathway should have a basic level of knowledge about HIV and AIDS. It is vital that they have easy access to key resources on HIV. Specific training on HIV should be provided to case owners and those working with asylum seekers in initial accommodation, at dispersal locations and during removal or integration.

Recommendation: All staff working in the asylum pathway should have a basic knowledge of HIV and have access to relevant resources, with more specific training for those working in initial accommodation, at dispersal locations or during removal or integration.

HIV-related stigma and discrimination are persistent problems for those who have been diagnosed with HIV and contribute to reduced health and well-being.[60, 61] Stigma and discrimination also threaten the effectiveness of prevention and care programmes by discouraging individuals from coming forward for testing and from seeking information on how to protect themselves and others. This in turn may increase late diagnosis which lessens the effectiveness of treatment. Training for all staff should address the issue of stigma and discrimination and highlight the importance of developing a stigma and discrimination-free environment in initial accommodation centres, upon dispersal and in IRCs. It is also important that staff reassure asylum seekers about the accessibility and confidentiality of NHS services for HIV and sexual health.

Recommendation: HIV training should address the issue of HIV-related stigma and discrimination. All staff working throughout the asylum pathway should ensure they generate a stigma-free environment and reassure asylum seekers about the confidentiality of healthcare services.

Asylum seekers leaving the pathway, but remaining in the UK have particular support needs around integration and healthcare. As highlighted above, it is vital that those remaining in the UK have access to employment, housing and healthcare services during this difficult period of transition.

58: National AIDS Trust/Terrence Higgins Trust (2007) *Will I have to pay?* www.nat.org.uk/document/253.

59: It must be stressed that there are variances across the UK related to charging. There are areas where charges are ignored, for example in Scotland and Northern Ireland. Charges can be written off in England and Wales if a migrant is destitute or unable to pay.

60: UNAIDS (2005) HIV-related Stigma, Discrimination and Human Rights Violations: Case studies of successful programmes, http://data.unaids.org/publications/irc-pub06/JC999-HumRightsViol_en.pdf.

61: Sigma Research (2004) *Outsider Status: Stigma and Discrimination Experienced by Gay Men and African People with HIV*, www.sigmaresearch.org.uk/downloads/report04f.pdf.

Acronyms

AIDS	**Acquired Immune Deficiency Syndrome**
ARV	**Antiretroviral**
ECHR	**European Convention on Human Rights**
EURODAC	**European database of asylum seeker fingerprints**
GP	**General Practitioner**
HIV	**Human Immuno-deficiency Virus**
IRC	**Immigration Removal Centre**
NAM	**New Asylum Model**
NAT	**National AIDS Trust**
NHS	**National Health Service**
NSA	**Non-suspensive Appeal**
PCT	**Primary Care Trust**
TB	**Tuberculosis**
UK	**United Kingdom**
UN	**United Nations**

Recommendation: The particular needs of asylum seekers leaving the pathway and remaining in the UK need careful consideration and must be a priority for Government social integration policies and programmes.

There are many undocumented migrants who have been resident in the UK for years without legal status who may be destitute and unable to access the healthcare and support they urgently need.

Recommendation: The Government must consider a regularisation programme for those living long term in the UK without legal residency status.

4.3 Agenda for action

This section summarises the National AIDS Trust's recommendations on HIV and the UK asylum pathway.

If this agenda for action is implemented it should ensure that consistent and high-quality support is provided for asylum seekers living with HIV during the application process. This will have benefits, not only for the asylum seekers themselves, but for wider public health in the UK.

4.3.1 Good practice actions

Review the opportunities in the asylum pathway to address HIV related needs: The opportunities set out in section 4.1 to address HIV issues during the asylum process should be reviewed in detail and priorities for action should be identified.

Joined up services: Improved communication between Home Office case owners, treating clinicians and support services working with asylum seekers living with HIV must be achieved as a matter of urgency.

Implementing policy: It is vital that there is consistent implementation of the Home Office's Policy Bulletin on the dispersal of asylum seekers with healthcare needs and the National AIDS Trust's/British HIV Association's advice for healthcare professionals working within the dispersal process.[62]

Guidance on charging: The Government should provide improved guidance on charging for healthcare to all NHS healthcare professionals and asylum seekers to end the current confusion around entitlement to care (e.g. the National AIDS Trust's/ Terrence Higgins Trust's *Will I have to pay?* resource).

62: In 2007, the National AIDS Trust evaluated the new Home Office dispersal process and found that it was not being consistently implemented and that best practice guidance was not always being followed.

Housing support: Asylum seekers living with HIV who are granted discretionary leave, humanitarian protection or refugee status need information and signposting to ensure they can access appropriate accommodation and housing support.

Employment support: Asylum seekers who are granted discretionary leave, humanitarian protection or refugee status should be provided with information and support to help them back into employment.

Mental health support: The voluntary sector, healthcare workers and other staff working in the asylum pathway should work together to ensure that asylum seekers living with HIV can access appropriate mental health support.

Stigma and discrimination: HIV training should address the issue of HIV-related stigma and discrimination. All staff working throughout the asylum pathway should ensure they generate a stigma-free environment and reassure asylum seekers about the confidentiality of NHS services.

Right to education: Asylum seekers should be able to access the same entitlements to further and higher education as refugees or UK citizens on welfare benefits.

Right to housing: Asylum seekers should have access to adequate housing support. All Home Office case owners and accommodation providers should treat as a priority the specific housing needs of asylum seekers living with HIV.

Right to adequate subsistence: Subsistence for asylum seekers should be increased to a level that is equivalent to income support.

Right to treatment: HIV treatment should be free to all. The current charges have significant health implications both for refused asylum seekers living with HIV and for wider public health in the UK.

Residency status: The Government must consider a regularisation programme for those living long term in the UK without legal residency status.

> **“Testing should be offered to asylum seekers along the pathway, either upon request or when clinically indicated, at the earliest opportunity.**

Social integration: The particular needs of asylum seekers leaving the pathway and remaining in the UK need careful consideration and must be a priority for Government social integration policies and programmes.

4.3.2 Policy actions

Right to work: Asylum seekers should be automatically granted permission to work after six months.

4.3.3 Healthcare actions

HIV testing: Testing should be offered to asylum seekers along the pathway, either upon request or when clinically indicated, at the earliest opportunity. Waiting times to receive results should be reduced in recognition of the speed at which asylum seekers move through the system.

Resources

Official Guidance

- Department of Health: www.dh.gov.uk
- Home Office Border and Immigration Agency: www.bia.homeoffice.gov.uk

Migrants

- Asylum Aid: www.asylumaid.org.uk
- Refugee Council: www.refugeecouncil.org.uk

Migrant health

- Health for Asylum Seekers and Refugees Portal: www.harpweb.org.uk

HIV

- National AIDS Trust: www.nat.org.uk
- African HIV Policy Network: www.ahpn.org
- HIV i-base: www.i-base.info
- NAM (National AIDS Manual): www.aidsmap.com
- Terrence Higgins Trust: www.tht.org.uk

5. Conclusion

Sexual health information: Opportunities to provide sexual health information to asylum seekers should be maximised. Particular care should be taken to reach those either not in need of or ineligible for support who may be more difficult to reach (e.g. those in private accommodation).

Removal centres: The needs of refused asylum seekers living with HIV in IRCs must be considered carefully during the detention and removal process to ensure:

- High-quality treatment, care and support are maintained during detention in IRCs
- The repatriation process does not dangerously undermine the health of the person living with HIV (e.g. they are too unwell to travel)
- Asylum seekers have sufficient additional medication for their journey and an initial period of readjustment
- Asylum seekers have information about where to access care and support once repatriated.

HIV training: All staff working in the asylum pathway should have a basic knowledge of HIV and have access to relevant resources, with more specific training for those working in initial accommodation, at dispersal locations or during removal or integration.

4.3.4 Research

Further research should be carried out looking at the experiences of asylum seekers living with HIV: There is inadequate data and research looking at the experiences of asylum seekers living with HIV, particularly looking at their experiences of housing and not being able to work and how these impact on an individual's physical and mental health.

5. Conclusion

Healthcare professionals working with asylum seekers are ideally placed to consider HIV risk in their assessment of a patient's health needs and should be supported in this role. With growing numbers of non-UK born individuals diagnosed with HIV in the UK, many of whom are diagnosed late, and the increase in the number of deaths related to HIV of non-UK born people, there is a demonstrated need for people to consider the HIV needs of asylum seekers early on in the asylum process.

Although there are inherent challenges related to HIV prevention, testing, treatment and care during the asylum pathway, it is worth highlighting what might be gained by taking advantage of the many opportunities that exist. In the end, there is not only a need to comply with the duty of care and human rights obligations owed to asylum seekers, but healthcare staff working with asylum seekers can also play their part in protecting public health in the UK.

Glossary

- Asylum seeker: An individual who has made a formal application for asylum. If their application is accepted, they are recognised as a refugee in accordance with the 1951 UN Refugee Convention. An asylum seeker may also mean a person who has applied for protection under Article 3 of the European Convention on Human Rights. If their application is accepted, they will be granted humanitarian protection or discretionary leave to remain.

- Migrant: An individual who has changed their country of usual residence, including economic migrants, students, asylum seekers, refugees and other undocumented migrants.

- Refugee: An individual who has been granted refugee status following a successful asylum claim, in accordance with the 1951 UN Refugee Convention.

About the National AIDS Trust

The National AIDS Trust is the UK's leading independent policy and campaigning charity on HIV and AIDS. The National AIDS Trust develops policies and campaigns to halt the spread of HIV and improve the quality of life for people affected by HIV, both in the UK and internationally.

All the National AIDS Trust's work is focused on achieving four strategic goals:

- Effective HIV prevention
- Early diagnosis of HIV through ethical, accessible and appropriate testing
- Equitable access to treatment, care and support for people living with HIV
- Eradication of HIV-related stigma and discrimination.

The National AIDS Trust would like to acknowledge the generous support of the following organisations who have contributed to our work around asylum and HIV: the Lloyds TSB Foundation for England and Wales, the AB Charitable Trust, the Rowan Charitable Trust and Goldsmiths' Company Charity.

National AIDS Trust
April 2008

SPEAKING OUT
CHANGING LIVES

www.nat.org.uk

National AIDS Trust
New City Cloisters
196 Old Street
London EC1V 9FR

T : +44 (0)20 7814 6767
F : +44 (0)20 7216 0111
E : info@nat.org.uk
W: www.nat.org.uk

National AIDS Trust is a registered Charity No. 297977 and a Company Limited by Guarantee (registered in England and Wales) No. 2175938.
Registered office: Winters, 29 Ludgate Hill, London EC4M 7JE