Women's ASYLUM NEWS

Refugee Women's Resource Project - **Asylum Aid - Issue 22 June 2002**

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African asylum seekers with HIV/AIDS: the challenges [1]

According to the United Nations Programme on HIV/AIDS (UNAIDS), HIV/AIDS is currently the fourth biggest killer worldwide and at the end of 2001, an estimated 40 million people globally were living with HIV. Young adults and women especially are the most vulnerable, and not more so than in Africa.

The scale of the epidemic amongst black communities: In most part of the world, HIV is increasing faster among women than men and African woman are particularly at risk: In sub-Saharan Africa for instance, for every 10 men with HIV, there are 12 HIV-positive women (NAM report p. 41). In fact, AIDS is the leading cause of death in sub-Saharan Africa and of those infected worldwide, 70% are found in Africa. Such figures are reflected in the UK: Black African communities constitute the second largest social group affected by HIV and AIDS in England and approximately 80% of all infected women in the UK are black African and more than four fifths of these get the virus from a male partner via heterosexual intercourse.

Factors for transmission/infection: African women are particularly at risk for a whole range of reasons: as far as sexual transmission is concerned, it is already established that physiologically, the risk of infection from an HIV-infected person is higher for a woman than for a man. Such a risk is however increased when women starts intercourse young (an experience of many African women), with coercive sex (30% of women surveyed in South African reported that their first sexual experience was forced upon them, 11% said they had been raped). The risk also increases with anal sex, the use of agents to tighten the vagina (common in Africa) and practices such as infibulation as inflammation, bleeding and abrasions could increase the risk of HIV transmission.

There are other reasons associated with the status of women in some African societies: women who try to access information about sex will be seen as sexually active and stigmatized as 'bad' women. In practice, they are denied a contraceptive of their choice as well as information about risk reduction and safer sex. At the same time, age differences and sexual intercourse between very young women and older men (known as 'sugar daddy') is common. In addition, in a number of African countries, men believe that having sexual intercourse with a virgin is believed to cure them from infection: '*sexual cleasing*' is widely practiced in Western Kenya and led several men in

[1] See PART II in our July issue (No. 23). Information drawn from Fieldhouse, R., '*aids reference manual*', NAM, October 2001; RWRP, '*No Upright Words, the Human Rights of Women in* Kenya', February 2001 and www.unaids.org/epidemic_update/report_dec01/index.html.

South Africa to rape a baby girl only few months old.

Other factors such as economic dependence influence African women's capacity to negotiate safe sex whilst poverty means reduce access to health facilities and may lead many to resort to prostitution for a living. Very often these factors mean that women who have been infected by a sexually transmitted disease are often not aware of it.

Increased rates of HIV infection is also prevalent amongst African refugees and displaced persons, especially women and girls who are at increased risk of sexual violence during civil war and flight: thousands of women from Rwanda, the Congo (DRC) and Congo-Brazzaville have been infected whilst being raped by militias and soldiers. Women and children may be coerced into having sex to provide for their needs in time of survival. Other groups at risk are women who are sexually assaulted as a means of persecution in their country, especially where the prevalence of HIV/AIDS is high.

In Kenya, an epidemiologist for the Ministry of Health revealed in 2000 that 50-70% of blood donated from prisons during the national blood donation day was found to be contaminated. Yet not only are women at serious risk of sexual assault from prison warders and police officers, but also from male inmates who have in cases been encouraged by the police to harass and/or rape women kept in the same cell.

Challenges for asylum seekers with HIV/AIDS in the UK Finding out if they are HIV positive or not is probably the lowest priority for many black African asylum seekers in the UK. So what can be more important to refugees than their health?

Many refugees may have endured long periods of imprisonment, psychological abuse or torture. Many have endured frequent displacement, chronic low-level violence and the continuous threat of/or actual sexual abuse.

Many are likely to have been separated from family and friends and may not know what has become of them. They often have no savings or familiar possessions, and will be unable to work. They are likely to be housed singly or in a group with others of the same age rather than in an extended family. Refugees may have been people of some status and consequence in their own country, but in the UK their education, connections and family background frequently count for nothing. They arrive in a country which is unfamiliar and which is largely inaccessible because of their economic and ethnic marginalisation. This will make their own national community all the more important.

Not only is being tested for HIV not a priority but also HIV is greatly stigmatised in black African communities and it is in the context of secrecy, financial insecurity and uncertainty about immigration status that many have to face up to their HIV diagnosis.

Many refugees dread another member of their own community finding out about their diagnosis. This fear is secondary only to their fear of being returned to their country of origin. This can affect their choice of interpreter; make them shun community groups who could support them in the UK; that they will never take an HIV antibody

test at all; and that they don't disclose vital information to their legal representatives.

The benefits of early diagnosis Yet, medically speaking, the earlier the diagnosis the better the prognosis as late diagnosis can seriously affect the effectiveness of the treatment. There are facilities for 24 hours anonymous testing in the UK and all asylum seekers are entitled to medical treatment.

If the consultant at the hospital will not prescribe the drug therapies an asylum seeker believes s/he needs, the asylum seeker needs to get a second opinion and . seek advice to help her/him to secure appropriate medical care. Pre-test and post-test counselling is available at all reputable GU clinics.

This is vital as refugees should be able to make an informed choice about having the test and the consequences of a positive and a negative diagnosis. Most large London clinics will also be able to advise refugees if the treatment is available in their country of origin and of the consequences of starting and stopping the drug therapies. This way refugees can make informed decisions about their treatment.

The legal implications of a positive diagnosis **Many asylum seekers believe that if they are diagnosed HIV+ this information will be passed to the Home Office and will affect their right to stay in the UK.** This, of course, is incorrect: all medical personnel are tied by confidentiality which means they cannot even inform a family member or partner who may be at risk that a patient is HIV+ and will certainly not inform the Home Office or an other person or organisation without the express permission of the patient. It must always be the individual's decision whether to disclose or not to disclose the diagnosis. This decision should be taken with the benefit of expert legal advice.

Asylum seekers who are considering disclosing their status can ask their solicitors to apply for anonymity, as the determination of an asylum appeal is a public document. This may mean an initial or single letter would be used through the determination to identify the appellant. A solicitor can also ask for their case to be heard 'in camera' which means public access to the court would be restricted. The earlier a solicitor asks for anonymity the more likely the asylum seeker's identity is to be protected throughout the process.

Although disclosing HIV status will not prejudice a right to stay in the UK it will not necessarily assist an asylum/human rights claim either. Refugees who are asymptomatic and/ or well are unlikely to benefit from the Home Office policies or from asylum or human rights claims on the basis of their diagnosis.
Additionally, late disclosure of HIV status, for example after the asylum process has begun, makes an application for anonymity less likely to be granted and, if granted, less effective. It is important to remember immigration courts are public courts and the determinations from these courts are public documents.

New Home Office policy harsher on asylum seekers with HIV/AIDS The Home Office revised its HIV/AIDS policy from December 2000. It is now much more difficult for asylum seekers to qualify for leave to remain under the new policy and many are now being sent home to their

country of origin where the drug therapies which suppress the virus are either not available or unobtainable because they are very expensive.

The new policy states that the following three requirements must be satisfied in order to meet the UK's obligations under Article 3 of the ECHR:-

- The UK can be regarded as having assumed responsibility for a person's care; and
- There is credible medical evidence that return, due to a complete absence of medical treatment in the country concerned, would significantly reduce the applicant's life expectancy; and
- Subject them to acute physical and mental suffering.

Most refugees who have a positive diagnosis and have started a regime of drug therapies can fit into the first and the last category. To fit the first category a refugee requires a GP or hospital which is monitoring and/or prescribing.

To fit the last category your legal representative needs to contact the GP or preferably the hospital consultant for a detailed account of the health consequences of stopping the drug therapies if returned to a country where they are unavailable or too expensive. A patient with symptomatic HIV infection (or advanced HIV infection/AIDS) who is taken off these drug therapies will be "subject to acute physical and mental suffering". The HIV virus in the blood will multiply quickly once the anti-viral drugs are withdrawn and the immune system will crash. A damaged immune system will result in infections, illnesses and conditions related to HIV swiftly take hold and the person will probably die. Additionally, the withdrawal of the drugs can result in the strain of HIV infection becoming drug resistant. If such a strain is contracted the current drug therapies will not be effective.

The second category is carefully worded and would be difficult to satisfy on the grounds of HIV/AIDS alone or the cessation of drug therapies. Recent case law (both at domestic and Strasbourg level) has confirmed that the circumstances when Article 3 can be used to resist removal on medical grounds will be 'exceptional'.

The HO policy goes on to say it will be applied to all applications for leave that involve serious medical issues: '***this approach, which reflects recent case law at both domestic and Strasbourg level, will enable us to take a sympathetic approach when considering removing an applicant to their home country where a total lack of treatment and support would cause severe distress and suffering***. *But it should also help to avoid turning the UK into a magnet for all those wishing to benefit from treatment here which is more advanced than their own country and is free at the point of delivery*'.

This approach successfully excludes most HIV+ refugees from any benefit under the policy and differs widely from the previous policy which is still in force for applications for leave for medical reasons made before 19 December 2000.

Legal caseworkers, lawyers and refugees themselves need to make marathon efforts to obtain accurate and detailed information on the health facilities and treatment available in the country of origin to make an application under the post 2000

concession and illustrate the complete lack of medical care. An expert report may be necessary which will, of course, be covered by legal aid. Additionally, a detailed medical report of the refugee's state of health including current treatment and prognosis under the current treatment regime and if this regime is curtailed, are the essential minimal evidence in cases of refugees affected by HIV.

The previous HO HIV policy depended on the following conditions:

- The nature of the asylum seeker's specific medical condition
- The treatment s/he has been receiving, its duration and the consequences of ceasing the treatment
- Her/his life expectancy
- Her/his fitness to travel if required to leave the country.

The previous policy was clearly more beneficial to refugees. Lawyers and legal caseworkers who were unsuccessful under the old policy also commenced arguments under the 1951 Convention using '*member of a particular social group*'. This argument remains unresolved and may still remain an option if Human Rights arguments are unattractive.

See Part II 'Legal arguments against the new Home Office policy' in our July edition (Issue No. 23) Also next month, information on weblinks on HIV/AIDS and health issues.

Follow-up to last month article on Lesbian/Gay and bisexual/ transgender asylum seekers

On the point of credibility (p. 2 of WAN Issue No.22), we wrote that if a client has not revealed his/her homosexuality, the Home Office (HO), adjudicator and or judges may question his/her credibility and we provided an example with Krasniqi v. SSHD CC-22108-00 (01TH02140), 30th August 2001.

However one of our readers pointed out to the case of Agron Sopjani v. SSHD (HX058554-00(01TH00863), 27 June 2001) where late disclosure of homosexuality at the end of his hearing before the first Adjudicator did not affect the credibility of the case. At the end of his hearing before the first Adjudicator, Sopjani revealed his homosexuality (and his related fear to return to a Muslim country). However, although the Adjudicator accepted that Sopjani was a homosexual, he declined to take his supplementary claim into consideration because of the lack of evidence on the issue (neither the Adjudicator, nor the respondent had then any objective material about the position of homosexuals in Kosovo).

Sopjani appealed the decision and the Tribunal found in his favour that it was '*somewhat surprising that the Adjudicator, having accepted that* [the] *Appelant was a homosexual, had not heard any evidence at all on the issue*' (by way of oral evidence at the hearing). The Tribunal were of the view that the matter should be properly addressed and considered whether the appeal should go back to the same Adjudicator. The counsel for the Secretary of State objected to this and submitted that the fairest and best course was for the case to be remitted back to another Adjudicator and to be heard totally afresh.

Sopjani's appeal was therefore successful as the Tribunal agreed that this was the best course of action to take in the interest of justice.[2]

[2] Many thanks to Julian Fountain for this contribution.

FGM asylum case in UK and Austria

UK Immigration Appeal Tribunal overturns Adjudicator's decision in favour of Kenyan FGM case[3] The Adjudicator had allowed an appeal against refusal of the Secretary of State to grant a Kenyan woman asylum. The basis of her claim was fear of having to undergo FGM by force. She did not want to undergo FGM primarily on health grounds but also as a practising Christian and as a result was effectively ostracised by the family. She was treated as an outcast and not permitted to eat with them and was excluded from any social conversation.

The Adjudicator had found that the respondent was a member of a particular social group, namely young girls living in tribal communities in Kenya where there is an ingrained practice of FGM. Satisfied that she had a well-founded fear of being subjected to FGM or of being persecuted because of her refusal to undergo FGM, the adjudicator concluded that she was a refugee within the meaning of the Refugee Convention. He also found that it would be '*unduly harsh to return the respondent to any part of Kenya because the objective evidence showed that if the respondent were to attempt to settle in any city, she is likely to become involved in crime or prostitution*'. Lastly he found that there was '*a real risk that the respondent's rights under Article 3 and 8 of the European Convention would be violated*'.

The Secretary of State appealed against the decision on three grounds:

1) That the Adjudicator's reasons for finding that the respondent is part of a social group do not amount to immutable characteristics which go to form a social group and therefore no Convention reason is engaged.
2) The reasoning of the Adjudicator on internal flight was based on pure speculation and was against the weight of the objective evidence.
3) The Adjudicator has not considered the issue of sufficiency of protection in relation to the Article 3 claim.

The Counsel for the Kenyan woman submitted, as a preliminary point, that the appellant's grounds of appeal raise issues which were not part of the Secretary of State's refusal letter nor were they argued before the Adjudicator because the appellant was not represented at that hearing. Therefore it would be fundamentally wrong to allow such grounds as they are being raised for the first time. The tribunal disagreed and stated that the appellant could raise grounds of appeal against an Adjudicator's findings and was not limited to matters raised only in the Secretary of State's refusal letter. Nor was the appellant precluded from raising matters which have arisen as a result of the findings made by an Adjudicator.

On the points raised in the appellant's appeal, the IAT agreed with the Secretary of State that '*group of young girls living in tribal communities in Kenya where there is an ingrained practice of FGM*' does not have an immutable characteristic, '*because however ingrained the practice, not all the girls in such rural tribal communities will be forced to undergo FGM as many of the girls undergo FGM voluntarily without any means of force or coercion. Therefore on this matter alone, the respondent cannot be described as being a member of a*

[3] SSHD v. Julia Wanguru Muchomba, Appeal No.: CC-25710-2001([2002])UKIAT01348), 2nd May 2002.

particular social group and the Adjudicator was wrong to describe her as such. It therefore means that there is no Convention reason to her claim' (par. 19).

As the Secretary of State, the Tribunal also found that whilst it accepts that '*FGM will cause serious harm to the respondent, the objective evidence does not show that there is a failure on the part of the state to offer protection*'. The Tribunal based its opinion on the information produced in the [HO] CIPU report according to which numbers undergoing FGM are falling in Kenya and the government has designed a national plan of action for the elimination of FGM (par. 5.20).

The report also points to several cases where young girls took action in the court against their parents who forced them to undergo FGM. Thus the Tribunal concluded that such instances '*show that the state is willing and able to offer protection to those girls who have been forced to undergo FGM*' and that the respondent would be able to seek redress should she be forced to undergo FGM upon return and the fact that she does not know where her family are should also diminish her fear of her family forcing her to undergo FGM.

The Tribunal also disagreed with the Adjudicator's finding that it would be unduly harsh for the respondent to return to any part of Kenya because she is likely to become involved in crime or prostitution. The Adjudicator does not say how he arrived at this conclusion therefore the Tribunal rejected the finding whilst the Secretary of State's Counsel submitted objective evidence according to which there is a '*variety of women's human rights groups (…) committed to protecting women and other vulnerable groups*'.

Lastly, the IAT found that '*the description of FGM given by the UNHCR is more related to an abuse of the respondent's human rights under Article 3 of the ECHR. We do find that the authorities in Kenya can offer the respondent protection by way of redress through the courts. In relation to Article 8, the appellant will be at liberty to pursue her family through the courts and there by preserve her liberty and right to a private life without FGM*'. The Secretary of State's appeal was thus allowed.[4]

First case of asylum granted based on fear of Female Genital Mutilation in Austria[5] On 21 March 2002 a young woman from Cameroon was granted asylum by the Austrian second instance asylum authority, the Independent Federal Asylum Senate (IFAS/UBAS), on account of her fear of being subjected to female genital mutilation (FGM). The decision was based on well-founded fear of persecution for her membership of a particular social group, namely Cameroonian women who are to be circumcised (IFAS 220.268/0-XI/33/00). This was the first case ever in which fear of FGM was regarded as a reason for granting asylum by the Austrian asylum authorities.

Key facts After her father's death the applicant's mother married her uncle who arranged for her marriage with an old Muslim. The applicant was told that she had to undergo FGM before the wedding

[4] It is not known yet whether the respondent will challenge this decision but the evidence gathered by RWRP in our report '*No Upright Words: The Human Rights of Women in Kenya*' will contradict many of the findings held against the respondent.

[5] Source: UNHCR Information kindly provided by Eva Kalny, Austria.

so that her groom would not realise that she was not a virgin anymore. Since the applicant's sister had died after having been subjected to FGM, her mother advised her to flee the country.

Country of origin information When examining the claim the IFAS concluded *inter alia* that whilst Cameroon has signed the International Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), FGM is still practised on girls and women of different age in the North and in the Southwest of the country. Although the State disapproves FGM, there are no special provisions prohibiting FGM in Cameroonese law. Punishment is only foreseen in the framework of general offences against one's physical integrity and according to the German Ministry for Foreign Affairs, no criminal proceedings is known to have ever been initiated in such cases.

Women refusing FGM are socially excluded and suffer tremendous pressure from the part of their families. Due to the particularly close family and ethnic ties in Cameroon a woman of the applicant's profile would not be able to establish a new existence in another part of the country.

The IFAS found: According to the explanatory remarks of the 1991 Asylum Act, the demand to add 'gender' to the five reasons for asylum under the 1951 Geneva Convention was rejected based on the argument that such persons would already be protected for 'membership of a particular social group'. The Higher Administrative Court ruled that these explanatory remarks should also be considered when interpreting the 1997 Asylum Act[6]. A social group is constituted by characteristics independent of the individual's disposition, such as gender. Women, for example, are considered a 'particular social group' within the 1951 Geneva Convention (with reference to Köfner/Nicolaus and prior IFAS jurisprudence). The applicant's fear of persecution is thus well-founded due to her membership in the particular social group of 'women in Cameroon, who are to be circumcised'.

The fact that the act of persecution is carried out by private actors is irrelevant as Cameroon, despite having signed the International Convention on the Elimination of all Forms of Discrimination against Women, has so far not been willing to consider legal sanctions against FGM. Moreover, no indictments or convictions for offence of one's physical integrity by committing FGM are known.

UK Events/Projects/News

Week of Action in Support of Migrants, Refugees and Asylum Seekers

Sat 15th to Sat 22nd June 2002 The event is called by Barbed Wire Britain, the Committee to Defend Asylum Seekers, the National Civil Rights Movement and the National Coalition of Anti-Deportation Campaigns organisations in response to the government's new proposals on the treatment of asylum seekers which will introduce harsher asylum measures.

The week will start with national demonstrations at Harmondsworth and Dungavel Removal Centres on 15th June and culminate in demonstrations in London

[6] (see VwGH 999/20/0497 dated 31 January 2002).

and Glasgow, on the 22nd June; there will be local activity, protests against deportations, pickets of companies who run the detention estate and public meetings.

To support the event, including by sponsorship, donation, and giving publicity to the week's events (bulk copies of leaflets and posters available on request), please contact: ncadc@ncadc.org.uk; info@barbedwirebritain.org.uk; info@defend-asylum.org; info@ncrm.org.uk

To find out about other events during Refugee Week 2002, including in your own area, see: www.refugeeweek.org.uk

GLDVP Seminar on Best Practice in Domestic Violence Service Provision is taking place on 8th July 2002 at LVSC Resource Centre, 356 Holloway Road, London N1, from 9h00 to 16h10. The seminar will include presentations on quality of service provisions, information sharing policy and practice, partnership and training along with workshops on the same issues. Participants are invited to bring good publicity material to be displayed and share examples of best practice in the field.

For more, contact Greater London Domestic Violence Project on tel: 020 7983 4238/5772, fax: 020 7983 4063 or email rachel.carter@london.gov.uk

Revolutionary Association of the Women of Afghanistan (RAWA) fundraising event takes place at the Comedy Café, 66-68 Rivington Street EC2 (and not the Arts Café, E1, as previously advertised).

Publications

New UNHCR guidelines on Gender-related persecution and 'membership of a particular social group' As a direct outcome of a series of expert roundtables, on various interpretative issues and other aspects of refugee law, during the Second Track of the UNHCR Global Consultations on International Protection, the Department of International Protection is in the process of revising position papers on a number of topics. The first two new interpretative guidelines produced (see below) have drawn on the conclusions arising out of the expert roundtable in San Remo, Italy. The documents are available on UNHCR's public website, www.unhcr.ch, under Protecting Refugees, Legal Protection, UNHCR's Handbook and Guidelines (else, contact your local unhcr for a copy) but will be eventually brought together in a UNHCR publication, to be read in conjunction with UNHCR's Handbook.

Guidelines on Gender-Related Persecution and Guidelines on 'Membership of a Particular Social Group', within the context of Article 1A(2) of the 1951 Convention and/or its 1967 Protocol relating to the Status of Refugees (HCR/GIP/02/01 and HCR/GIP/02/02 respectively, 7 May 2002)

'Meeting the health needs of refugees and asylum seekers in the UK' is a new comprehensive and clearly presented Information and Resource Pack by Angela Burnett & Yohannes Fassil. Building on the skills and experience of health workers, the pack contains practical information, details of useful contacts and resources and includes examples of good practice from around the United Kingdom. See:

http://www.london.nhs.uk/newsmedia/publications/Asylum_Refugee.pdf

An equivalent publication called '*Refugee Health Care, a Handbook for Health Professionals*' is available on the New Zealand government web site, www.moh.govt.nz or on www.asylumsupport.info/publications/mohnewzealand/handbook/healthcare.htm

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