



Adviescommissie voor Vreemdelingenzaken

Advisory report on the medical aspects of asylum and regular residence procedures

1. Introduction

August 2007, the Dutch State Secretary for Justice primarily requested the Advisory Committee on Immigration (Adviescommissie voor vreemdelingenzaken, ACVZ), to advise her on how to separate the asylum and regular residence procedures as completely as possible in the specific case of a residence permit granted on medical grounds. Furthermore, the ACVZ was asked to elaborate on its earlier proposal to make the investigation of asylum seekers' medical status an integral part of the asylum procedure, as described in its 2007 advisory report entitled 'Towards a single, thorough asylum procedure with strict limits and variable speeds'.

Currently, persons whose asylum application has been denied often apply for a regular residence permit on medical grounds, and if this too is denied, resort to a second asylum application. This accumulation of procedures is creating an undesirable situation in which asylum seekers spend years of uncertainty in the Netherlands.

This document discusses two questions.

1. *How can the assessment of applications for admission and residence based either wholly or partly on medical grounds give proper consideration to medical issues without undermining the separation of asylum and regular residence procedures?*
2. *In what way can medical status be included in the asylum procedure without this leading to the medicalisation of the procedure?*

The report commences with an analysis of the system of *Residence permits granted on medical grounds* – A review of current practice shows that in a substantial number of cases, following denial of an asylum application and conclusion of review/appeal proceedings, the person concerned applies for a regular residence permit on medical grounds. It also emerges that under current legislation and policy based on it, the medical status of an alien may lead to both an asylum and a regular residence permit being granted. This state of affairs is confusing and could be improved.

The focus of the final part of the report is on the *Examination of medical issues during the asylum procedure* – The new health check, as outlined by the ACVZ in its 'Towards a single, thorough asylum procedure' advisory report, is worked out in detail in this report. Although the health check will apply to all asylum seekers, the ACVZ emphasises that it would not lead to the medicalisation of the asylum procedure. The detailing of the health check proposal demonstrates that it is designed to establish quickly and simply whether the asylum seeker has health problems that require further attention.

2. Residence decisions in relation to medical issues

2.1 Asylum and medical issues

Under current policy, as laid down in the Aliens Act Implementation Guidelines 2000 (VC 2000), medical issues play in principle no role in the assessment of an asylum application, '*since in medical terms there are on the whole no definite conclusions to be drawn as regards the causes of medical complaints and/or scars.*' However, medical issues may well provide grounds for granting a residence permit in three situations.

*** Section 29, subsection 1 (a) of the Aliens Act 2000: refugee status**

In a limited number of cases a report drawn up by Amnesty International's Medical Group (MOG) is used to support the applicant's account of the reasons for seeking asylum. This report shows whether there are medical complaints or symptoms which are consistent with or typical of torture, abuse or other traumatic events that the asylum seeker claims have occurred. Each year only a few dozen reports are issued.

*** Section 29, subsection 1 (b) of the Aliens Act 2000: article 3 ECHR**

An asylum residence permit may be granted under application of section 29, subsection 1 (b) of the Aliens Act if a person runs a real risk of being subjected to torture, or inhuman or degrading treatment or punishment if expelled from the Netherlands. Section 29, subsection 1 (b) thus implicitly refers to article 3 of the ECHR. According to established case law of the European Court of Human Rights, expulsion is in breach of this article if 'substantial grounds have been shown for believing that the person in question, if expelled, would face a real risk of being subjected to treatment contrary to article 3' (ECHR 11 July 2000, Jabari vs. Turkey). In such 'classic' cases the assessment relates to actual ill-treatment *after* expulsion to the country of origin.

A distinction should be drawn between the above situation and that in which the expulsion of an alien may constitute a violation of article 3 of the ECHR in connection with his *state of health*, the 'humanitarian' cases. Such cases would involve the expulsion of seriously ill persons who are likely to end up in appalling circumstances in their countries of origin.¹ These circumstances, combined with the deterioration in their state of health resulting from the termination of treatment and care in the community in the expelling state, as a consequence of expulsion, can together be seen as exposure to ill-treatment. To date, the European Court of Human Rights has granted only one application invoking these grounds (St Kitts, 1997).

Humanitarian cases – case law under article 8 ECHR

A complicating factor plays a role in an extremely limited number of cases. This is the possibility, according to ECtHR case law, of invoking article 8 of the ECHR in certain cases against a decision to expel which would lead to a dramatic deterioration in the health of the alien. The conditions subject to which and the cases in which such an invocation of article 8 would be successful are not yet clearly settled in the case law of the Court. This provision protects the right to respect for family life and private life. Expulsion leading to exposure to an acute medical emergency, as was the case in St Kitts, for example, will often constitute an interference in the private life of the person in question. That is irrelevant if the action is also covered by article 3, since the latter offers more protection because it does not permit any weighing of interests. However, if expulsion results in a situation which is not serious enough to exceed the lower limit of article 3, the right to respect for private life as referred to in article 8, paragraph 1 may also be at issue.

*** Section 29, subsection 1 (c) of the Aliens Act 2000: trauma and individual compelling reasons of a humanitarian nature**

¹ In itself, this situation is not so serious that it can be deemed to constitute 'ill-treatment' within the meaning of article 3. There is thus no real risk of treatment following expulsion that is in breach of article 3 as in 'classic' cases.

If residence is not permitted under section 29, subsection 1 (a) or (b) of the Aliens Act 2000, it may be granted under section 29, subsection 1 (c) in cases involving compelling reasons of a humanitarian nature connected with the reasons for departure from the country of origin. The policy developed in this context is also known as 'trauma policy'. It concerns cases in which personal experience of specified, shocking events have been so traumatic for asylum seekers that they cannot reasonably be expected to return to their country of origin.

In addition, *exceptional, individual*, compelling reasons of a humanitarian nature connected with the reasons for departure from the country of origin and with the asylum seeker's account in support of his application may constitute grounds for granting a residence permit pursuant to section 29, subsection 1 (c) of the Aliens Act 2000.

2.2 Regular residence permit granted on medical grounds

Regular immigration policy states that a residence permit may be applied for on medical grounds. A distinction is drawn between a permit granted for the purpose of *medical treatment* and a permit granted on account of a *critical medical condition*.

A residence permit for the purpose of medical treatment is usually granted for the duration of the treatment, subject to a maximum period of one year. If the medical treatment can only be given in the Netherlands, a period of five years may be allowed.

A residence permit granted on account of a critical medical condition is a logical extension of the permit for medical treatment. A critical medical condition is defined as follows in the Aliens Act Implementation Guidelines: '*a situation in which the person concerned is suffering from a disorder in relation to which current medical opinion has established that the absence of treatment will lead in the short term to death, invalidity or another form of serious mental or physical harm*'.

Under policy as pursued since 2003, a distinction is drawn between critical medical conditions lasting less than one year and those lasting for longer than one year. At present, a residence permit is only granted for conditions expected to last for over a year. In other cases, applicants are permitted to postpone their departure pursuant to section 64 of the Aliens Act 2000.

The following criteria must be met if a residence permit on the grounds of a critical medical condition is to be granted:

1. termination of medical treatment would lead to a critical medical condition; and
2. the treatment in question cannot be given in the country of origin or another country to which the aliens could go; and
3. the medical treatment needed to prevent a critical medical condition from arising is expected to last for longer than a year.

The Immigration and Naturalisation Service (IND) consults its Medical Advice Bureau (BMA) to determine whether these criteria have been met (see also 2.4 Advice from the BMA).

A residence permit on account of a critical medical condition may be granted for one year. After three years the alien is eligible for a permit for continued residence.

Former asylum seekers and residence granted for the purposes of medical treatment/on account of a critical medical condition

Looking more closely at the application of the policy outlined above, it is worthy of note that a substantial group of former asylum seekers have been granted a residence permit for the purposes of medical treatment in recent years. It is unlikely that this group met the conditions governing the granting of a regular residence permit for the purpose of

medical treatment. A logical explanation of these facts might be that these former asylum seekers had first successfully invoked section 64 of the Aliens Act 2000 while at the same time meeting the condition imposed by the Asylum Seekers and other Categories of Aliens (Allowances) Order (RVA 2005), which provides for medical insurance. These persons could therefore demonstrate that there were arrangements in place for financing the medical treatment, one of the conditions for the grant of a residence permit for this purpose.

2.3 Postponement of departure on medical grounds

If an alien is unable to leave the Netherlands for medical reasons, the departure can be postponed. This is provided for in section 64 of the Aliens Act 2000 and applies to failed asylum seekers and to regular aliens who have exhausted all legal remedies, as well as to aliens who have resided illegally in the Netherlands from the outset. In practice, there appears to be a degree of uncertainty as to the exact scope of section 64. On closer examination the rules prove indeed to be very complex.

Under section 64 of the Aliens Act 2000, expulsion does not currently take place *'as long as the state of health of the alien or of a member of his family would make it inadvisable to travel.'* If this section of the Act is applied, the alien's residence in the Netherlands is legal for the period of postponement pursuant to section 8 (j) of the Aliens Act 2000.

As stated above, with the introduction of the policy on critical medical conditions a distinction was drawn between medical conditions lasting less than one year and those lasting for longer than a year. The rationale for this was that it was not considered expedient, in the context of a restrictive admissions policy, to issue a residence permit in temporary but critical medical situations, i.e. in those lasting less than a year. As a result of this distinction, such conditions were classified under the 'postponement of departure' regime.

Currently, section 64 of the Act is thus applied both to situations in which there is an *obstacle to travel* caused by an acute health problem and those in which the *termination of medical treatment* gives rise to a critical medical condition that is expected to last for less than a year. In 2006, the BMA issued a total of 647 opinions on whether a 'section 64 situation' was at issue. It is not known in how many cases expulsion ultimately never took place following application of section 64.

2.4 Problematic issues

The ACVZ has noted the following problems in relation to current legislation and to policy on medical issues.

Accumulation of procedures

The system under the current Aliens Act leads in some cases to an accumulation of procedures. In practice it emerges that if an alien follows multiple, successive procedures, an asylum residence permit is often ultimately granted, despite an initial refusal. In the ACVZ's view, there is a better, more efficient approach in such cases. A permit could be granted at an earlier stage in the procedure if the result of an early medical examination could be taken into account in the assessment of the asylum application. In a number of cases the current procedure puts a burden on the alien's mental or physical health due to the long period of uncertainty as to whether he can stay in the country or not. Practice has also shown that when health problems have been established, aliens are not or cannot be expelled, or are given leave to remain after a long period. The ACVZ would therefore advise as follows.

- * As it indicated in its report 'Towards a single, thorough asylum procedure', medical issues should be investigated at an earlier stage in the asylum procedure. In the ACVZ's view, insight into the extent, nature and seriousness of medical problems should be gained while the asylum

procedure is still in progress, so that these factors can be taken into account in the procedure and thus reduce the number of repeated and new applications.

- * If no asylum residence permit is granted, it should be decided, either automatically or on the basis of statements made by the alien, whether the state of health of the alien should lead to some form of temporary stay. The legislation should be amended to this effect.

Overlapping criteria in critical medical condition policy and section 64 Aliens Act 2000

Policy on critical medical conditions and the application of section 64 contains criteria which partially overlap. Policy is therefore not always clear and transparent.

- * The ACVZ favours a simpler and more uniform policy framework with clear criteria, allocation of powers and margin of discretion. A point worth considering is if the question of whether medical issues should lead to some form of temporary stay should automatically be examined directly following an application for a residence permit for the purpose of medical treatment. The seriousness as well as the expected duration of the medical situation should be part of this assessment.

Advice from the BMA

To date, the BMA has advised not only on the significance of medical information obtained about an applicant, but also on the question of whether medical treatment is available in the country of origin. It is primarily the latter form of advice that has come in for criticism. The medical disciplinary board has repeatedly warned that BMA physicians may not issue such recommendations on the basis of general assumptions in an individual case. Furthermore, both the Healthcare Inspectorate (ICZ) and the Royal Dutch Medical Association (KNMG) have recently argued that the availability of medical treatment in countries of origin is not a question that doctors should decide upon.

- * The ACVZ takes the view that the BMA should be very careful in advising on the significance of medical information relating to the medical status of an individual alien. It further believes that the Immigration and Naturalisation Service (IND) should itself collect information from a range of sources on the availability of medical treatment in countries of origin. For example, such information could be obtained from embassies and from the resources of international bodies such as the World Health Organisation (WHO).

2.5 Proposal for a new decision-making framework

The ACVZ has considered three options.

1. Leave the situation roughly as it is and accept that in terms of medical issues, the accumulation of procedures is inevitable

The ACVZ finds that current legislation regarding critical medical conditions and 'section 64 situations' lacks transparency and consistency. The way in which the different permits and their associated, similar criteria are subdivided is not logical. Policy on critical medical conditions should therefore be formulated as an exception to the rules for medical treatment and be given a basis in law, namely in article 3.46 of the Aliens Decree 2000, replacing the present construction via article 3:4, paragraph 3 of the Decree. The two provisions (medical treatment and critical medical condition) are after all closely related. The primary rule should be policy on medical treatment, with policy on critical medical conditions as an exception to the primary rule. If an alien fails to meet the conditions for medical

treatment, a check should automatically be made to ascertain if he qualifies as having a critical medical condition.

This solution is however far from optimal, because the procedure for residence on account of a critical medical condition thereby becomes or remains part of the procedure for residence for the purposes of medical treatment. An asylum seeker who claims that he has health problems and whose asylum application is denied will first have to apply for a residence permit for the purposes of medical treatment in order to be eligible for a residence permit on account of a critical medical condition.

2. Incorporate into the grounds for being granted an asylum residence permit the option of granting to leave to remain on the basis of compelling reasons of a humanitarian nature, without there necessarily being a relationship between the humanitarian grounds and the country of origin.

A second option is to add to section 29 of the Aliens Act 2000 a new subsection, or to amend section 29, subsection 1 (c) to the effect that an asylum application may be granted on the basis of compelling reasons of a humanitarian nature. Section 29, subsection 1 (c) at present only provides for a permit being granted in the case of aliens who cannot be expected to return due to 'compelling reasons of a humanitarian nature *connected with the reasons for departure from the country of origin*'. Removing the latter phrase would mean that the provision would also allow for other compelling reasons of a humanitarian nature. The advantage of this construction is that situations in which such reasons are at issue can be assessed within the asylum procedure, thus avoiding the accumulation of procedures. A disadvantage is that it becomes possible to obtain an asylum residence permit on general humanitarian grounds that need have no direct connection with reasons for seeking asylum.

Another problem is that it creates two policy frameworks for medical issues: one covering the regular procedure (for medical treatment and critical medical conditions) and one covering the asylum procedure. Care must be taken to avoid differences in the applicable criteria developing and making transfer between the asylum and the regular route an attractive option again.

3. A separate residence permit for compelling reasons of a humanitarian nature

In highly exceptional circumstances, refusing to grant residence rights leads to an unacceptable situation. If an asylum application is denied, and medical issues have been taken into account in the asylum procedure but have not resulted in the granting of asylum status, it is possible that leave to remain has to be granted on account of *compelling reasons of a humanitarian nature*. In such cases, an automatic assessment of the individual's situation should take place immediately after the assessment of the asylum application. A residence permit issued on these grounds falls outside both the regular and the asylum categories. A separate category based on compelling humanitarian grounds should be created alongside the regular and asylum categories, but it *should not involve a separate procedure for submitting applications*. The automatic assessment in the light of the criterion of compelling humanitarian grounds would follow on immediately from the assessment of an asylum application or a regular application for the purposes of medical treatment. This new policy category, which in the ACVZ's view would neither create more bureaucracy nor lead to medical tourism, would prevent the accumulation of procedures.

The ACVZ is of the opinion that this third option is by far the best solution to the very diverse medical problems that at the moment fall partly under regular policy

and partly under asylum policy. It also fulfils the Government's wish to make the separation of regular and asylum admission procedures as watertight as possible.

The ACVZ would therefore make the following recommendations with regard to the new decision-making framework.

- * Separate the granting of residence rights on humanitarian grounds from asylum and regular residence permits. Create in this way a third residence entitlement for 'compelling reasons of a humanitarian nature', embracing all existing medical grounds for admission but excluding the regular permit for purposes of medical treatment.
- * Provide in legislation that in the event of refusal to grant residence rights a decision will always be taken (either at the request of the alien or automatically) on whether compelling reasons of a humanitarian nature are present.
- * Grant a residence permit for compelling reasons of a humanitarian nature in all cases involving a critical medical condition, whether short or long-term. Only in cases where there is an obstacle to travel should the permit be granted pursuant to section 64.
- * Ensure that the decision on compelling humanitarian grounds forms part of the broader decision. The alien can then apply for review of the refusal to grant the residence permit either in part or in its entirety. In this way, no separate review procedure is created, merely an extra ground for review.
- * Create within the category 'compelling reasons of a humanitarian nature' a procedure whereby a medical opinion can rapidly be obtained from the BMA in cases involving a critical medical condition.
- * Abolish the BMA's current practice with regard to the gathering of information about the availability of medical care in countries of origin. Instead, the IND itself should gather such information from various sources.

3. The health assessment for asylum seekers

3.1 Introduction

The ACVZ takes the view that medical (i.e. mental and physical) complaints should be identified as early as possible in the asylum procedure. As the ACVZ advised in its earlier report ('Towards a single, thorough asylum procedure'), a health assessment should become part of that procedure.

To avoid medicalising asylum procedure, the ACVZ proposes a 'filter system', beginning with a relatively simple and effective screening using a standard list of early warning signs, followed in a limited number of cases by a more extensive examination. The health assessment can reveal medical problems that have implications for the way interviews are conducted or possibly provide grounds for their postponement. In addition, it can offer insight into problems that may be relevant to the assessment of the asylum seeker's account in support of his asylum application. The principles of the Istanbul Protocol should be adhered to in such cases. The health assessment also makes it possible to begin curative treatment immediately where necessary. Finally, early establishment of medical status can prevent later applications being submitted on the grounds of pre-existing health problems.

Medical problems

A range of studies have shown that, on average, asylum seekers have more health problems than the Dutch population.² This is partly the result of what are known as 'imported diseases' such as TB and parasite infections, where preventing the spread of the disease is important. In addition, some are suffering from 'standard' complaints such as diabetes and coronary disease.

But asylum seekers' health problems may be connected with the reason for their departure from the countries of origin or hardships suffered during the journey. Studies have shown that asylum seekers who have undergone torture and/or other forms of violence are at greater risk of physical, psychosocial or psychiatric health problems than other asylum seekers.³ This does not, however, mean that asylum seekers who exhibit no serious health problems have not experienced shocking events. Tension arising from uncertainty regarding their residence status and other stress factors following their arrival in the Netherlands, may influence their state of health.⁴ No epidemiological data relating to the health problems of asylum seekers immediately after arrival in the host country are as yet available.

3.2 Medical problems and the consistency of the asylum account

To be able to assess an asylum application on its merits, the asylum seeker has to be interviewed. The ACVZ believes it is important that the interview to substantiate the asylum account focuses primarily on credibility and establishing the truth. It also believes it is important, in the light of the Istanbul Protocol, to ensure that the interview is conducted with all due care from a medical point of view. To this end, interviewers should have insight into the asylum seeker's state of health. The medical status of the asylum seeker may in some cases be a reason for adapting the interview (for example, ensuring that the interviewing officer is a woman or providing extra breaks) or in exceptional cases, postponing it.⁵

The Istanbul Protocol

Drawn up by a large number of experts in 1999 and adopted by the United Nations in 2000, the Istanbul Protocol offers doctors and lawyers guidelines for investigating, establishing and reporting on cases of torture and other ill-treatment in the best possible manner.⁶

The Protocol contains specific guidelines on the circumstances under which interviews should be conducted, and medical examinations and reporting carried out. In addition, it describes the aims of such reporting, i.e. to provide expert advice on the degree of consistency between the medical findings and claims of alleged torture or other inhumane treatment.⁷

In the ACVZ's opinion, Dutch policy on the asylum determination process should explicitly include that the principles and guidelines of the Istanbul Protocol will be applied where appropriate.

² Gerritsen et.al. (2006), 'Psychische en lichamelijke gezondheidsproblemen van, en gebruik van zorg door Afgaanse, Iranese en Somalische asielzoekers en vluchtelingen' (Psychological and physical health problems experienced by Afghan, Iranian and Somali asylum seekers and refugees, and their use of care services), *Nederlands Tijdschrift voor Geneeskunde* (Dutch Medical Journal)150: 1983-9

³ Quiroga & Jaranson (2005). *TORTURE*, Vol. 16, No. 2-3. See too Hondius et.al. (2000) 'Post-traumatic stress among refugees in the Netherlands', *Journal of Traumatic Stress* 13 (4): 619 – 634.

⁴ Gerritsen et.al. (2006) 'Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands', *Social Psychiatry and Psychiatric Epidemiology*, 41: 18-26.

⁵ Council Directive 2005/85/EC of 1 December 2005 on minimum standards on procedures in Member States for granting and withdrawing refugee status, Section 12, subsection 3, *OJ* 2005, L326/13-34.

⁶ The Manual on Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, 1999 <www.unhcr.ch/html/menu6/2/training.htm> en <http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>.

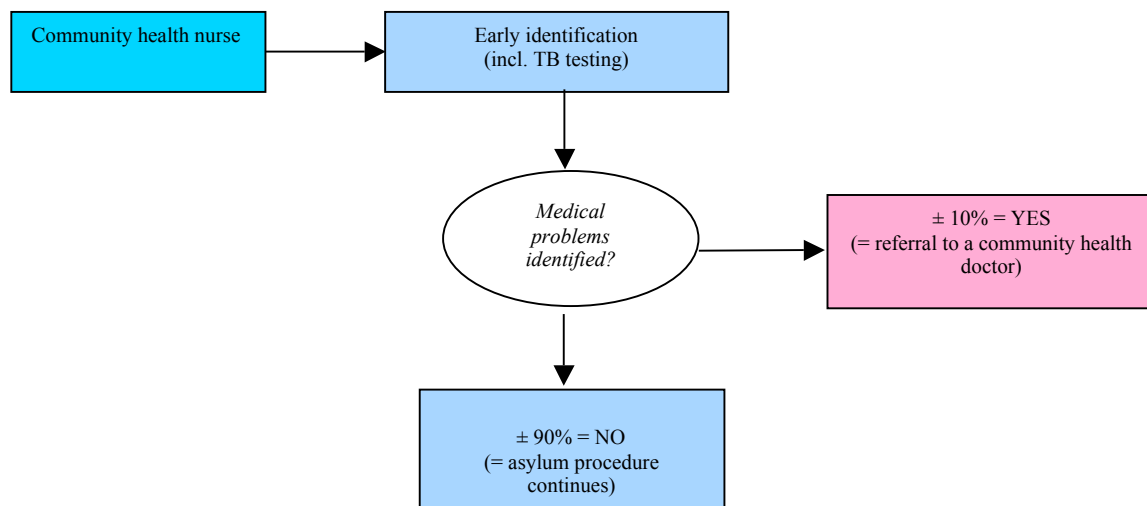
⁷ Also: ECtHR 7 March 2000, T.I. vs. United Kingdom; ECtHR 6 March 2001, Hilal vs. United Kingdom; ECtHR 6 February 2001, Bensaid vs. United Kingdom.

3.3 The health assessment procedure

Initial stage: screening using a standard list of early warning signs by a community health nurse.

In its report entitled 'Towards a single, thorough asylum procedure', the ACVZ proposed that a health assessment should be carried out in the 'rest period' before the asylum procedure begins in order to identify at an early stage any health problems asylum seekers may have. The first step in the assessment is carried out by a community health nurse and is aimed at early identification of medical problems. Using a standard list of early warning signs the nurse takes the asylum seeker's medical history and then refers him on to the TB test (already a compulsory part of the procedure). In most cases no further examination will be required. If medical issues have been identified that could influence the asylum procedure, the asylum seeker is referred to a community health doctor.

Diagram showing early identification process



On the basis of the experience of those directly involved and the organisations consulted, the ACVZ estimates that no further medical examination will be necessary for around 90% of asylum seekers. If medical problems are suspected, however, referral to a *community health doctor* follows (see below).

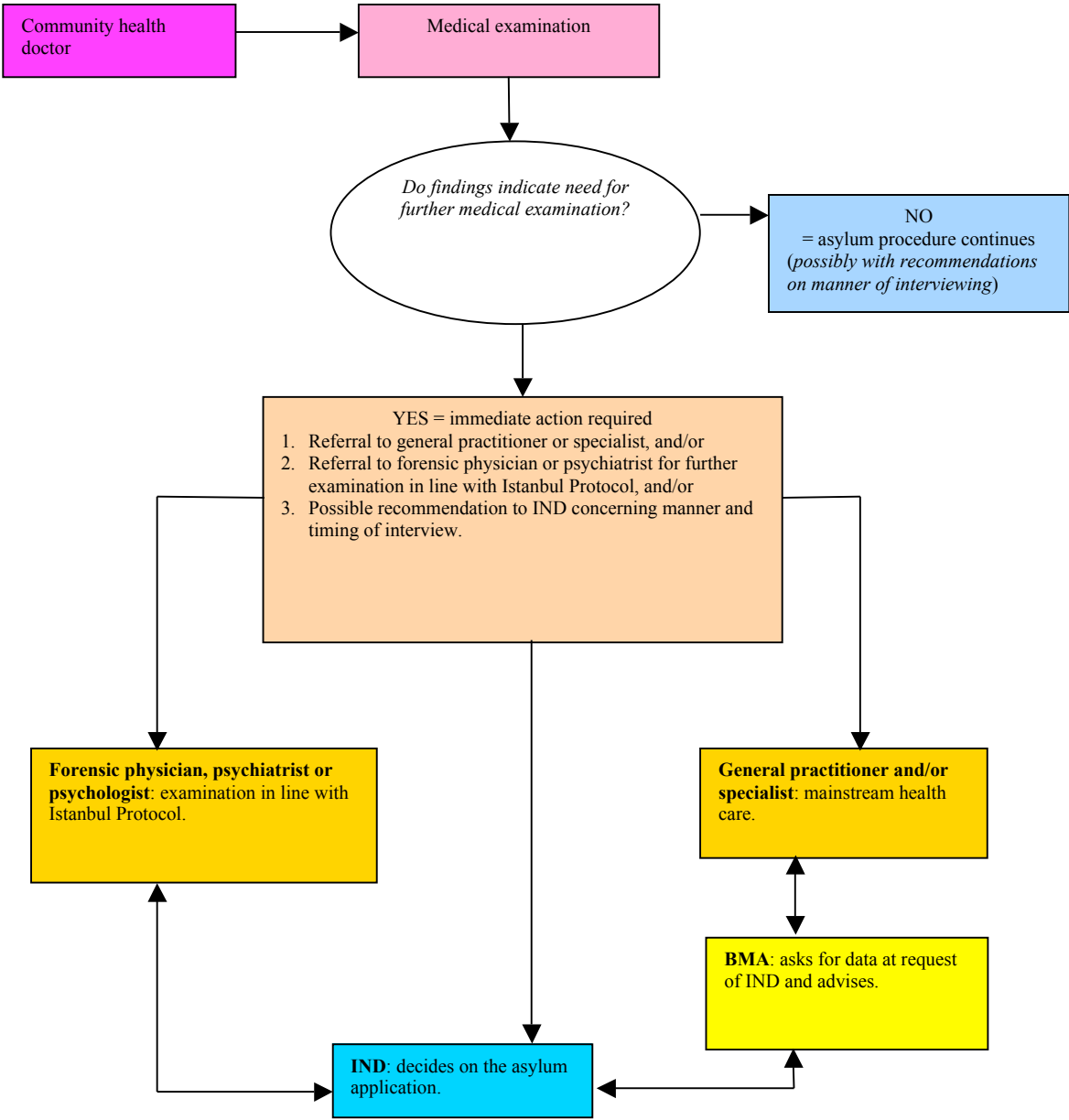
Follow-up stage in the event of health risks being identified: further examination by a community health doctor

In a relatively limited number of cases the initial screening will bring medical problems to light. If further investigation of the nature and seriousness of a physical or mental problem proves necessary, the asylum seeker is referred to a community health doctor. The latter decides whether referral to a forensic physician, psychiatrist and/or psychologist is indicated for the purpose of examination and possibly reporting on the consequences of torture or other inhuman treatment, as described in the Istanbul Protocol. S/He also determines whether the patient should be referred to mainstream medical services for further diagnosis and treatment, whether he can be interviewed and if so, whether the standard interviewing procedure should be adapted.

If the community health doctor makes a referral, he notifies the IND to this effect and advises on any necessary modifications to the interviewing procedure. If the IND departs

from these advices, it should clearly state its reasons in its notification of intent to refuse the asylum application or in its final decision on the application.

Diagram showing follow-up stage



Status of medical advice and reporting

The ACVZ is of the opinion that appropriate importance should be attached to a report by medical experts drawn up in accordance with the Istanbul Protocol. Both the examination carried out by the community health doctor and the forensic examination, as described in the Protocol, demand experience and expertise. As explained in the Protocol guidelines, that experience and expertise should be clearly stated in the report. In its 'Towards a single, thorough asylum procedure' report, the ACVZ has already advised designating the doctors involved as experts within the meaning of the General Administrative Law Act. A list could be drawn up of expert doctors who enjoy the confidence of relevant NGOs and

the IND. Reports and advices from these experts need *not* first be assessed by the BMA. They can be submitted directly to the IND.

Deadline for medical reports and advices

It is vital for medical reports to be quickly available. The procedural requirements should be based on a reporting deadline of maximum six weeks.

If the community health doctor has advised that interviewing cannot as yet take place, the IND decides on the basis of the information supplied when and how the interview should be conducted. In the rare case that, according to the medical reports and advices, an asylum seeker cannot be interviewed after a year has elapsed, a decision should be taken on the application using the information that is available. The fact that an interview cannot be conducted may not in itself negatively influence that decision.⁸

Interviewing asylum seekers

Expert knowledge and experience is necessary for interviewing vulnerable people (those who have undergone torture or other serious forms of physical, mental or sexual violence) in order to be able to interpret correctly any inconsistencies or incompleteness in the asylum seeker's account. For this reason the ACVZ would advise, where there is a medical indication, using experienced interviewers for vulnerable groups, in line with the designated interviewers employed to interview unaccompanied minors in a 'child-friendly' manner.

If the medical status of the asylum seeker is an obstacle to return

As the practice of the last ten years has shown, in highly exceptional cases a medical problem will be of a nature that prevents return to the country of origin. However, the current asylum procedure is structured in such a way that the question of whether this is the case is only addressed in the procedure which follows a negative decision on the asylum application. Because an application for a residence permit on account of a critical medical condition is only submitted after the decision to deny the asylum application has become final following appeal proceedings, the decision on such an application on medical grounds is only taken at a very late stage. By putting a procedure in place in which information relating to diagnosis and treatment is gathered at an early stage, the accumulation of procedures can be avoided. In cases where an asylum application is denied, a decision can be taken immediately and automatically on the medical aspects of return. The BMA is in that case the appropriate body to provide an advice at the IND's request.

3.4 Health problems arising or becoming known at a later stage

Health problems may also arise during the asylum procedure or after it has ended. Some of these may consist of medical problems related to trauma that for social and cultural reasons were not mentioned earlier. If attention is paid to medical issues early in the asylum procedure, we may assume that the asylum seeker will see the importance of disclosing any medical problems at the outset. If problems are nevertheless only disclosed at a later stage, this will not lead to a reconsideration of the application unless there are well-founded reasons for doing so. However, experience also shows that the physical and mental health of asylum seekers can deteriorate during the asylum procedure. The ACVZ therefore believes that it should also be possible during the procedure to refer the asylum seeker to the community health nurse on the basis of signs picked up by legal advisers, voluntary workers or professional staff.

3.5 Organisations involved in health assessment

⁸ Also: Council Directive 2005/85/EC of 1 December 2005 on minimum standards on procedures in Member States for granting and withdrawing refugee status, Section 12, subsections 3-5, OJ 2005, L326/13-34.

In drawing up its report entitled 'Towards a single, thorough asylum procedure', the ACVZ considered Community Health Services for Asylum Seekers (MOA) the most appropriate organisation to perform the early warning and health assessment, assuming that it has the necessary knowledge, expertise and various disciplines at its disposal. This would also ensure continuity of care. However, the Central Agency for the Reception of Asylum Seekers (COA) has since ended its contract with MOA with effect from 1 January 2009. At the time of publication of this letter, it was not yet clear which healthcare agency would be contracted to provide community health advice and preventive and curative care for asylum seekers. In the ACVZ's view, it is in any event essential that continuity of care is guaranteed; this means at the very least that as few organisations as possible are involved in preventive and primary care for this group.

The healthcare personnel that will be involved in the health assessment should possess broad experience and expertise. In particular, they should have knowledge of the health problems common among asylum seekers and experience in working in accordance with the principles of the Istanbul Protocol. In addition, medical advice and reporting should be separate from the provision of care, in accordance with the guidelines published by the KNMG.

The ACVZ would advocate that medical specialists be given a more explicit, advisory role in asylum procedure. The forensic physicians, psychiatrists and psychologists belonging to Amnesty International's Medical Group and those involved in the MAPP project (for asylum seekers with psychological problems) already have substantial experience in performing examinations and reporting following Istanbul Protocol guidelines. It would therefore be logical to make use of their expertise, at least initially. To this end, the MAPP project can be modified, expanded and put on a professional footing, possibly using the medical and other expertise of the Medical Group, so that medical examinations can become an integral part of the procedure in the manner described above.

3.6 Conclusions and points of interest

In the ACVZ's opinion the following principles should be adhered to in working out the practical details of the health assessment procedure.

- * The procedure should be designed in accordance with the principles of the Istanbul Protocol.
- * The voluntary nature of the health assessment procedure, in its entirety, must be guaranteed and it must meet the conditions set out in the Medical Treatment Contracts Act (WGBO). In the 'rest period', volunteers will inform asylum seekers of the importance of the health assessment and the possible consequences of deciding not to cooperate in the assessment.
- * All personnel carrying out the health assessment should have extra training in the health problems of asylum seekers and the Istanbul Protocol guidelines.
- * The professional autonomy of the nurses and doctors involved must be guaranteed by a protocol drawn up in cooperation with the relevant professional organisations.
- * Advices and reports issued to the IND should be sent at the same time to the asylum seeker or his representative. They should also be incorporated in the asylum seeker's file at the IND.
- * The IND should establish a policy rule that if medical advices or reporting as described above are set aside, the case should be handled by an experienced member of staff, who must state in the decision on the asylum application the grounds for acting contrary to the medical advices and/or report.
- * Medical and other protocols on early warning signs, the medical examination and medical/forensic reporting on the basis of the Istanbul Protocol should, as is customary in health care, be drawn up by experts in

the field (Pharos (national knowledge centre for refugee and newcomers' health), MAPP, MOA, MOG) and submitted for evaluation to the KNMG and other relevant professional groups. Consultations should be conducted with the IND on the way in which advice and reporting should take place.

Implementation

As the ACVZ stated in its 'Towards a single, thorough asylum procedure' report, it recommends starting with a pilot project in which experience can be acquired and a learning process initiated without too many risks. As described above, it would seem obvious in conducting such a pilot to draw on the expertise built up in the MAPP project and to call on the services of the MOG for forensic examinations on the basis of the Istanbul Protocol guidelines. In the ACVZ's opinion, the pilot project should be under the guidance of a 'solid' committee in which experts and the relevant professional groups, the KNMG, IND and BMA are represented. The ACVZ considers it important for data on the number of medical recommendations issued and how often the IND departs from medical advice to be recorded during the pilot project. Attention should be focused on the IND's reasons for doing so. Only then will it be possible, in the ACVZ's view, to obtain a clear picture of the way in which medical issues are taken into account in the asylum procedure.