



THE CHARACTER OF EXCEPTION

A REPORT ON HUMANITARIAN RESIDENCE PERMIT

MICHALA CLANTE BENDIXEN

REFUGEES WELCOME

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” *My body is tired now. It cannot go on anymore. See how much medicine I have to take now! I have waited for nine years in Denmark – for what? They cannot send me back. Why do I have to die here, in my small room in the asylum camp? I'm tired of all the new people arriving all the time and disappearing again.”*

Elsa Hapte Tokloog, Eritrea
Case, page 52

THE CHARACTER OF EXCEPTION— a report on humanitarian residence permit

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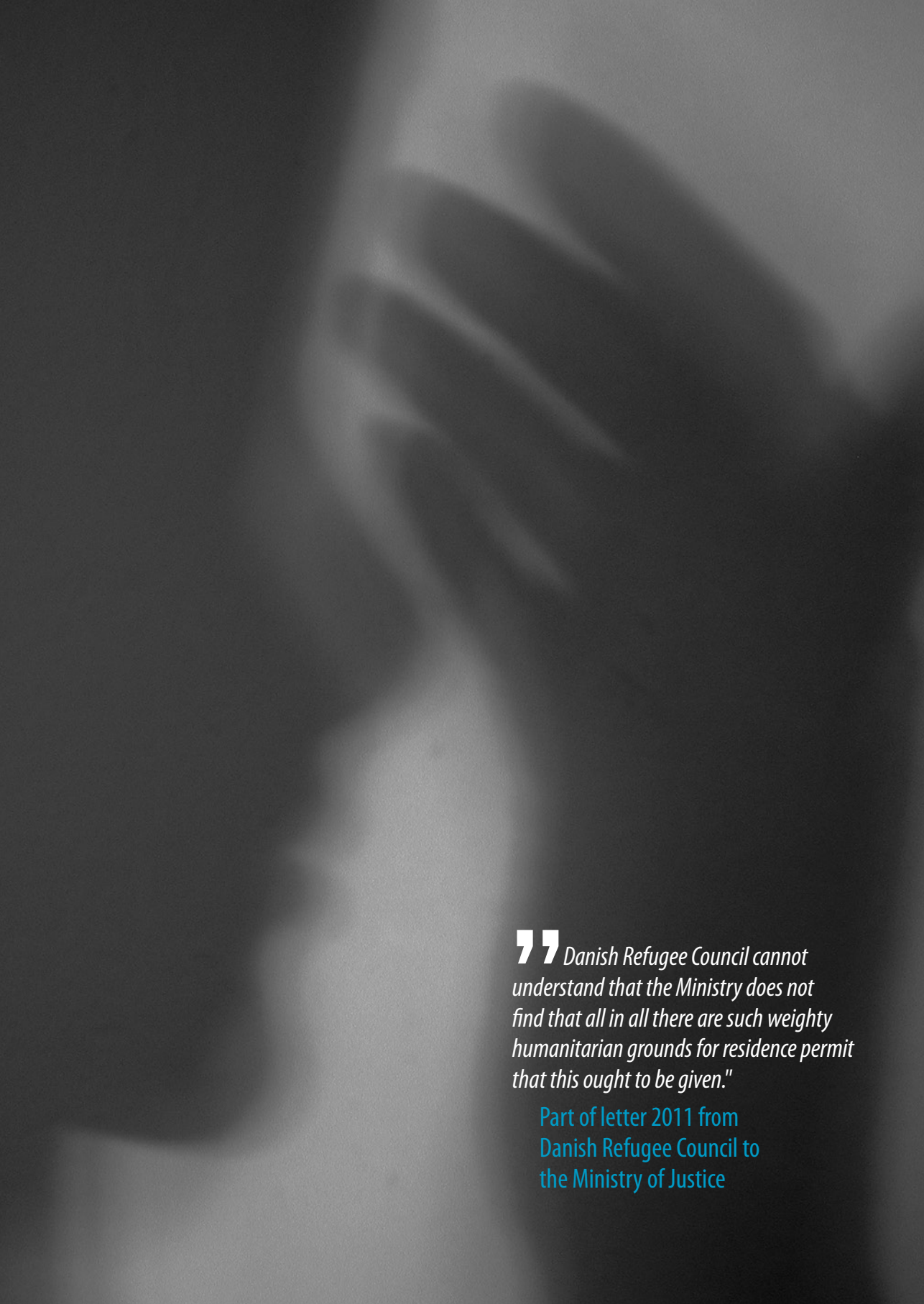
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” *Danish Refugee Council cannot understand that the Ministry does not find that all in all there are such weighty humanitarian grounds for residence permit that this ought to be given."*

Part of letter 2011 from
Danish Refugee Council to
the Ministry of Justice

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1. WHAT IS THE REPORT ABOUT?

“Humanitarian residence permit” (HR) is often mentioned in the Danish media, but what does the expression actually mean? It is a temporary residence permit, which the asylum seeker may obtain as an alternative to getting asylum. It is issued by the Ministry of Justice based on criteria decided by the Parliament and as such has nothing to do with the treatment of asylum cases or the Refugee Convention.

Frequently, politicians, private citizens and asylum seekers request humanitarian residence permit for a person in exceptionally unfortunate circumstances, referring to charity, decency and humane treatment.

But the word humanitarian is no longer used in this sense by the authorities. Since the law was passed in 1985, the Parliament has time and again adjusted the access to humanitarian residence, both by changing the wording of the law itself and through practice guidelines from the Ministry of Justice. The current practice guidelines, adopted in 2010 during Birthe Rønn Hornbech's ministry, are the strictest we have ever had. Getting a permit depends on having a verified serious illness – often life threatening – which requires treatment, yet cannot possibly be treated in the country of origin. However, the guidelines mentions a number of other situations which can lead to residence permit – but they are not used in practice.

The application procedure demands voluntary and free help from lawyers, refugee organisations and doctors. Together with the strict practice this means that only very few obtain this kind of residence in Denmark – and generally only after having stayed in refugee centres for many years. Only 121 people (family members inclusive) received humanitarian residence permit in 2011, and for the first three quarters of 2012 published so far, the amount is down to 31. The residence permit is initially valid for just six months, one year or two years.

As part of the fundamental principles of Helle Thorning-Schmidt's government, the issue is to be reconsidered and this report offers, for the first time, a thorough review. The information herein may contribute more factual premises for the discussion. The report points to flagrant problems regarding both the criteria and the process, and offers concrete recommendations for their solution. The 12 case stories will hopefully contribute to illustrate the problems and obliterate some of the myths.

Even though politicians maintain that humanitarian residence permit should be given as an exception only, there is reason to consider the expression “humanitarian grounds” more seriously.

(Humanitarian residence permit is abbreviated to HR throughout the report)



MØDE NR. 102
8. september 2008 kl. 10:00

DAGSORDRENS PKT. 1
1. behandling af B. 145

Om dansk smaltstet bidrag til den afledede FNs-aflyt i Libanon

Førelser
OCCFØRES
Morten Højsgaard Petersen (PV)

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2. WHAT DOES THE LAW SAY?

2.1 THE LEGAL BASIS

“According to the Aliens Act § 9 b (1), residence permit may be issued to an alien who, in cases not falling within section 7(1) and (2) is in such a position that essential considerations of humanitarian nature conclusively make it appropriate to grant the application. The decision, according to the Aliens Act § 9 b. (1), is made by the Minister of Justice, according to the Aliens Act § 46 a.

The Article on humanitarian residence permit was inserted in the Aliens Act as § 9.2, by Act no. 232 of June 6 1985.”

(...)

“The proposed article in the Aliens Act § 9.2.2 is also formulated in a manner which requires that essential considerations of humanitarian nature conclusively recommend residence permit. With this choice of words it has been intended to give the article a field of application which is at the same time both wide and restricted.

Special restrictions must not be inserted when it comes to the very special circumstances which may justify residence permit. On the other hand the considerations in question must conclusively recommend granting the permit and thus conveys that the law is meant for exceptional cases and that the Minister of Justice gives residence permit to persons, whose status as true refugees has not been accepted by the Refugee Authorities.”

The expression “conclusive considerations of humanitarian nature” especially refers to the considerations listed in § 26 of the Act of 1985, of the humanitarian considerations which must particularly be considered in connection with decisions on expulsion or remittance of residence permit.

The special considerations which may justify that the Minister of Justice, after a concrete assessment, grants residence permit, first and foremost comprise the foreigner's age, health and other personal circumstances, compare to § 26. 1 (now § 26, (1). In this connection, it is to be emphasized that the subjective fear that a foreigner may have at the thought of repatriation, may cause such a substantial nervous pressure on the person in question that residence permit can be recommended.

The assessment of whether the conditions for granting residence permit according to the proposed article meets the criteria must, in the nature of things, be very concrete. As mentioned above, the regulation is meant for a limited field of application, and the weight of the single consideration and not the least if they coincide, will therefore be important in relation to the assessment.”

(This translation has been made for this particular report, as no official translation in English exists.)

In brief: The law on humanitarian residence permit (HR) was originally passed in 1985. Rejected asylum seekers can get residence permit on this basis, under very specific circumstances. The issue is “humanitarian considerations”, which is not precisely defined. The assessment includes age, health and personal fear of returning – but it is a question of an individual assessment, and the idea is that the law should be applied strictly, that is as an exception.

2.2. CURRENT PRACTICE GUIDELINES, 1 AUGUST 2010

“(…) The special circumstances,” which are part of the discretionary assessment, are especially the considerations contained in the Aliens Act § 26.1, among other things, the age, health and other personal matters. In practice, the foreigner's health is the main issue when it comes to applying the law, as the majority of the cases refer to the refugee's health in support of the application.

It is furthermore assumed that granting a humanitarian residence permit is the exception and that the regulations apply in restricted circumstances; the humanitarian considerations should be the decisive factor in the decision.”

(Extract. See more extracts in chapter 4.3. The full text can be found in Danish only at www.nyidanmark.dk under “Humanitært ophold”)

3. WHO CAN APPLY AND HOW IS IT DONE?

All asylum seekers are automatically asked if they will apply for HR, as soon as their case is opened in Denmark. If they apply within the first 14 days, expulsion will be suspended – something only relevant for those whose cases are urgent. It is very rare that these early and automatic applications result in HR (apart from single Afghani women, who have special access according to practice guidelines). This is because the majority only develop illnesses after several years of staying in Denmark and because the application requires documented medical assessment, something new arrivals are not at all able to present.

In principle, asylum seekers can apply themselves, but in practice, lawyers, private interlocutors, and organisations like Danish Refugee Council, Refugees Welcome, and Asylret (Right to Asylum), send in the applications without charge. It is the asylum seeker's own responsibility to submit documentation and it is not enough to send in a copy of the medical file from the asylum centre. The Ministry has a list with a number of concrete questions, which must be answered by a physician (see chapter 3.3).

The replies from the Ministry are always sent in Danish only, and usually contain approximately seven pages of arguments and references to the law, which are hard to understand for anyone without legal expertise.

3.1 NO RIGHT OF APPEAL

The verdict cannot be appealed in the legal system, nor does it belong in the Ombudsmand's ambit. It is possible to apply again at a later date, but this does not always produce a permission to stay in Denmark while the case is being processed. At the moment it typically takes 12 months before a verdict is reached.

Cases are only reopened due to “new information of such conclusive significance that it is likely that the case would result in another ruling, if the information had existed when the case was decided in the first place” (here the Ministry refers to Gammeltoft-Hansen a.o., ‘Administrative Law’, 2. ed. (2002)

In its consultation reply of 2012 concerning the establishment of the new Immigration Board (Udlændingenævnet), The Red Cross recommends the creation of a possibility for appeal in humanitarian residence permit cases. “In these cases, which are processed by the Ministry of Justice, the due process of law suffers from lack of the possibility of appeal. The right to appeal to an agency like The Refugee Appeals Board and the proposed Immigration Board would be a welcome initiative.” Refugees Welcome endorses this recommendation.



3.2 THE IMPORTANCE OF PHYSICIANS

Applications are processed by the officials of the Ministry of Justice, and medical consultants are not affiliated. The Ministry requires that a physician answers 17 specific questions concerning diagnoses, treatment and the consequences of discontinuing the treatment. Usually, it is necessary to have a medical statement from the applicant's specialist, for example a psychiatrist (see chapter 3.3).

Neither doctors within the asylum centres nor those outside are remunerated for doing this job, and this means that they either have to do it for free in their spare time or demand payment from the applicant. In addition, until recently there has been disagreement among Red Cross doctors as to whether they are allowed to do this at all. It is now the policy of the Red Cross that their doctors may only fill in forms or answer the questions of the Ministry at "the patient's own costs", as the Ministry has refused to cover the expense. Therefore, many statements are written by medical specialists outside the asylum system, either for free or against payment. A statement from a specialist typically costs DKK 3-7000. Generally, there are several statements, because a description of the diagnosis, medication etc. must be made before the case is opened at all and it is to be assessed if expulsion can be deferred. The time required for processing the case in the Ministry is usually seven months. Then up-to-date answers to the 17 questions is demanded and only then is the case decided.

” It is quite unreasonable that in this way the doctor has to write a statement twice – the first time when the application is sent and again after seven months when the Ministry get to the case, as the information that the doctor gave when the application was sent is now obsolete. In addition, it is unreasonable that a case lies unprocessed in the Ministry for seven months, whereupon the deadline for writing a new statement is only 14 days.”

Immigration lawyer Marianne Vølund

The asylum seeker cannot freely choose a doctor and is not allowed to earn money, hence is barred from applying if the physician does not want to write statements for free in his spare time. No doctor is obliged to write these statements. It is not even sure that a random doctor will do it for payment if he has no connection to the patient. It is thus possible that the applicant may end up in a situation where his or her illness cannot be documented. In addition, the asylum seeker will almost always be dependent on free help from a lawyer or an NGO to write the application.

“A statement from a physician, in which the physician displays a personal engagement in the case in a way which may create doubt as to whether the statement expresses a neutral assessment of the asylum seeker's health, cannot be taken into consideration in the assessment” (extract from current practice guidelines, August 2010).

This article is applied if the doctor has written that he or she recommends that the applicant gets asylum. Several doctors and lawyers have opposed this article as expressing disrespect for their professionalism. Indirectly, the Ministry claims that a doctor may feel so much sympathy for a patient that he or she gives in to his or her feelings, and that therefore the diagnosis and treatment described cannot be relied on. The Ministry can also reject a statement if the doctor has made public his or her attitude to the case in the press. This can be considered a restriction of the freedom of speech.

The problems could easily be avoided if the Ministry used medical consultants, as it is done with insurance and social cases, and if they financed statements from specialists in those cases where the existing medical file was insufficient.

” *The Ministry does not verify medical statements as a basis for the casework, which means that decisions are based purely on the physician's diagnosis. However, a diagnosis is not adequate for making decisions about which treatments should be given in any specific case. Therefore the Ministry should have their own medical consultants who can make decisions on the basis of medical histories, as do the other authorities.”*

Psychiatrist Ebbe Munk-Andersen,
Danish Red Cross asylum department

3.3 THE MINISTRY'S LIST OF QUESTIONS:

In all cases the following questions must be answered :

- 1) For how long has the asylum seeker been a patient with the physician?
- 2) How many telephone consultations and how many personal consultations have taken place?
- 3) Case history comprising
 - Is it an emergency?
 - Is it a chronic disease?
 - At what time did the applicant fall ill?
 - At what time did treatment become necessary?
 - Diagnosis (to be written in ICD-10 code)

For mental health illnesses the following information must be submitted:

- 5) A description of current symptoms – containing signs of psychosis and a possible risk of suicide - and from where the physician has his information about the patient (for example from his own examination, from relatives, from journals etc.)
- 6) Has an objective psychological examination been made? If yes, describe mood, ability to concentrate, memory, thoughts, the rate of thought, empathy and psycho-coordination.
- 7) Current treatment – as to medical treatment state what medicine and daily doses in mg.
- 8) Is there another possible medical treatment?
- 9) Information on possible consequences if treatment is discontinued.
- 10) Prognosis. The psychiatrist's assessment of the patient's possibility of regaining health. State the expected duration of the current or planned treatment

As to somatic (physical) illness, the information on the points below must be given:

- 11) Describe current symptoms, and from where the physician has information about the patient (for example from his own examination, from relatives, from hospital records a.s.o.)
- 12) Has an objective examination, focusing on relevant matters, been carried out?
- 13) Current treatment – as to medical treatment, stating medicine and daily doses in mg. and other treatment (control or consultation)
- 14) Information on possible need for or use of disability-compensating equipment.
- 15) Information on possible consequences if treatment is interrupted.
- 16) Prognosis. Assessment of whether the patient may return to health or a state of significantly better health. State expected duration of current treatment or planned treatment. Describe especially assessment of expected ability to function, including possible disability-compensating arrangements.
- 17) Is the illness in question terminal? And in this case, what is the life expectancy?

(Schedule used by the Ministry of Justice, translated for this report).



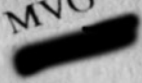
JUSTITSMINISTERIET

28 FEB. 2013

Dato:
Kontor:

Kontoret for Humanitært
Ophold og Udsendelser
MVO

Sagsbeh:
Sagsnr.:



” It is really important to consider the particular case and not just refuse the different illnesses, one by one, as done in this ruling.”

Eva Singer, head of asylum department of Danish Refugee Council, on the case Zoran

In total, these rules make it very difficult for asylum seekers to obtain the necessary documentation. Often, the applicants have neither the money nor the personal resources required. Hence there is a risk that persons who are in fact entitled to HR are barred from having their application accepted.

3.4 THE DURATION OF PROCESSING

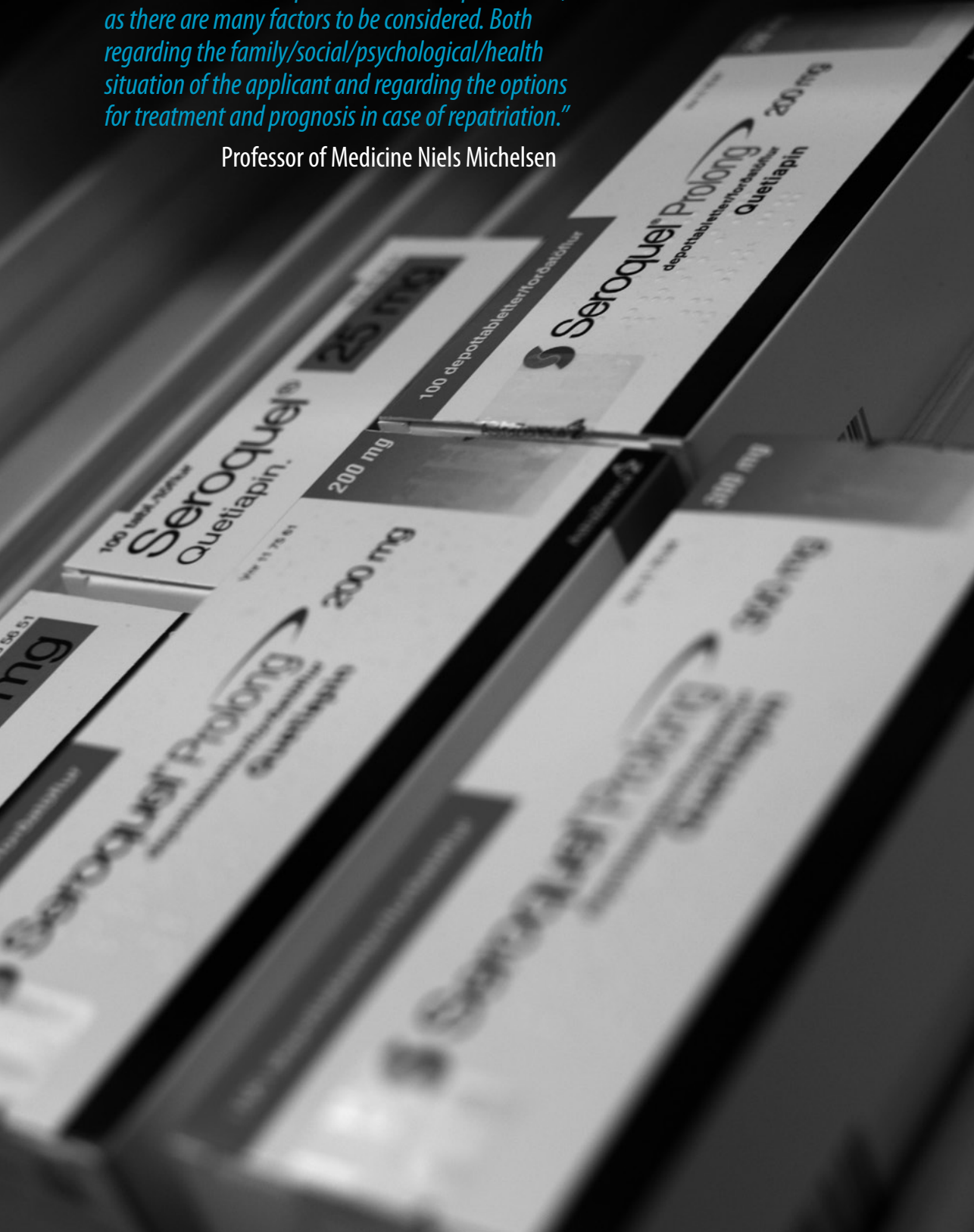
There is an unfortunate paradox between the 14-day deadline typically given to asylum seekers to acquire current, comprehensive information on health, compared to the three months required by the Danish Immigration Service in order to accept or refuse a guarantee for treatment by, for example, a psychiatrist.

The time spent on processing these cases varies. Many cases take a year before the final verdict is given, others even more – often with several requests for new and current information from the physician. A few are decided relatively quickly, usually with a rejection after three to four months. The many manifestly unfounded cases mean a longer processing time for the more serious applications.

It is also a problem that cases already fully clarified remain on the Ministry's desk for at least seven months and then the applicant suddenly has a deadline of just 14 days for submitting current information.

” It is difficult/impossible to write a positive list, as there are many factors to be considered. Both regarding the family/social/psychological/health situation of the applicant and regarding the options for treatment and prognosis in case of repatriation.”

Professor of Medicine Niels Michelsen



4. HOW IS THE VERDICT REACHED?

Processing of the applications is done by officials of the Office for Humanitarian Residence and Repatriation within the Ministry of Justice, and as mentioned above, no medical consultants are attached, as is the case with for example the National Board of Industrial Injuries. Cases are supposedly processed according to the text of the law and current guidelines from the Minister. It is natural to question, whether officials can decide a case correctly and consider all the aspects of a case, when it comes to medical questions.

Politics clearly play an important role. There are many examples of persons, who, in spite of having their application rejected, have received residence anyway after the case has been published in the media. In some cases this has led to the creation of support groups and petitions. Among the group of Iraqis who moved into Brorson's Church, an unusually high number later obtained HR. This may be due to the publicity and the popular sentiment, or perhaps the reason is that only by occupying the church did the applicants get access to the necessary medical and legal aid to get an application processed.

A number of criteria for HR, which are listed in the current guidelines, are consistently rejected in particular cases. This implies that the administration of the law is much stricter than its wording.

4.1 DIAGNOSES

Initially, the Ministry decides whether the illness or the applicant's general situation falls within the compass of the law. In case of physical or mental illness, the diagnosis must meet certain criteria. Only very few diagnoses are accepted: Schizophrenia, paranoid psychosis, serious kidney diseases, insulin demanding diabetes and certain diseases of the heart, intestines and blood, plus terminal cancer and AIDS. See also the list of permits given on page 28.

Psychiatrist Ebbe Munk-Andersen from Danish Red Cross asylum department says to this report: "Psychosis is a normative concept and is used only in connection with enforcement, for example in relation to sectioning, deciding if a person lacks the capacity to make decisions for themselves or when sentencing a person to psychiatric treatment. In daily practice there is often doubt as to whether or not a psychological condition is psychotic or not. A range of psychological illnesses can be perceived as psychotic, for instance anorexia nervosa, mental retardation and PTSD. All of these conditions can lead to significant reduction in the ability to function normally but do not provide access to HR. The criteria for whether someone is ill should therefore be based on functionality rather than on a psychosis diagnosis."

” *The Ministry is very concerned with certain words. What is, for instance, the difference between ‘on a psychotic level’ and ‘psychotic symptoms’? The first choice of words would result in a rejection and the second in a residence permit.”*

Immigration lawyer Marianne Vølund

A great number of diagnoses may, in serious cases, be just as life threatening and invalidating according to the patients' medical specialists, for example, depression, dementia and epilepsy. The most common diagnosis for traumatised refugees is Post Traumatic Stress Disorder (PTSD), which exists in different degrees. This diagnosis does not give HR, nor does it give access to dispensation on application for Danish citizenship. This change took place after Søren Krarup (The Danish National Party) accused physicians of using the diagnosis PTSD too freely.* Hence the policy on the diagnosis PTSD is political and not medical. Among accepted refugees severe PTSD is often the cause of early retirement and in this connection is still regarded as very serious and disabling. In the government policy statement from 2011 it is mentioned that PTSD should in the future be on equal footing with other permanent dysfunctions in relation to obtaining citizenship.

There are examples of a medical specialist having written clearly in his statement, that the case in question must be regarded as life threatening without the correct treatment, but the Ministry refused anyway, arguing that the illness in question could not be regarded as “very serious” (se case Mehdi).

There is a special problem when it comes to HIV/AIDS: AIDS results in residence permit, but not medicated HIV infection. According to many specialists, this differentiation does not make sense, as all HIV-infected persons sooner or later develop life threatening AIDS, if they do not get the right treatment. As long as the patient remains in Denmark, they are well-medicated and do not show acute symptoms (see cases on HIV).

There are also cases where several less serious diagnoses in total create a situation equally serious. Although the law states that the assessment must be made on basis of a comprehensive view of the situation, the tendency is that the Ministry assesses the different diagnoses in isolation and rarely grants residence founded on several, but less serious diagnoses/disabilities (see cases Elsa and Zoran).

*) “We have 50 applications for dispensation (from the criteria for citizenship) every week, 35-40 of these are from people who could not manage to learn Danish, because they suffer from PTSD (posttraumatic stress syndrom) – we are tired of this. PTSD is something psychologists and physicians often write, and I am fed up with this nonsense and people swindling their way through.” (Politiken, 9.12.2005).

4.2 TREATMENT

If the diagnosis meets the criteria, the Ministry takes the next step to find out if the applicant receives the necessary treatment and, in that case, if the treatment is offered in the country of origin. For example, certain antipsychotic medicines are unavailable in some countries. The research of the Ministry is, however, limited to asking the appropriate country's nearest embassy, which may have an interest in giving Denmark a more positive impression of the conditions in its country. On their home pages, several African countries proudly write that free HIV-medicine is supplied to all citizens, but WHO research shows that a large part of those infected do not receive treatment. Corrupt practices and uncertain supplies may prevent the patient from getting the necessary medication. Many asylum seekers tell that access to physicians, hospitals and medication is only for those who live in the capital and only against payment of large amounts of money or through private health insurance.

The treatment is generally seen only as medication – although an important part of necessary treatment almost always includes access to specialists and examinations. In many countries this access is very limited, even in places where medicine can be bought.

According to Ebbe Munk-Andersen, psychiatrist from the Danish Red Cross asylum department, it is a paradox that HR is only given to people who are actually undergoing medical treatment while other ways of rehabilitating people are not taken into consideration. It means that people with very serious illnesses risk being sent home to countries where there is not only a lack of medical treatment but also no other care for people with such needs.

Until 2010 it was possible to get residence if treatment was not *realistically* available, i.e., because of long distances or very high expenses. This has been changed so that these factors are no longer taken into account: "In this connection, if a certain treatment, comprising medical treatment with one or several medicines, is only available against payment in the country in question, this will not influence the decision of the Ministry" (from the bill 2010). This tightening of the rules was strongly criticised when enforced, among others by the Institute for Human Rights and Danish Refugee Council. There are cases after 2010 in which extended residence has been granted on grounds of medical expenses – this is due to the processing of the application having begun before the restriction.

The extension of the law from 1999 regarding the aggravation of a disability has, in our experience, not been applied in practice. In the case Zoran it was very clear that his disability had been alleviated in Denmark and would be aggravated by repatriation, but still his application was rejected.



” Lastly, the Refugee Council must emphasise that the applicant, all things considered, should be granted a permit based on a combination of criteria. The practice guidelines state that the Ministry can grant humanitarian residence permit founded on the fact that the application combines a number of criteria which, one by one, cannot lead to humanitarian residence permit”

Extract of letter of 2011 from Danish Refugee Council to the Ministry of Justice

4.3 OTHER CRITERIA

Apart from physical and mental illness, the law allows for residence on other grounds. However, Refugees Welcome has found that these criteria are never used in practice. When asked, the asylum department of Danish Refugee Council and a number of lawyers specialising in immigration law say that their experience is the same. It seems strange that casework is considerably more restrictive than either legislation and practice guidelines. The following criteria are listed in the current practice guidelines:

- Risk of suicide
- Severe disability
- Families with children, whose parents have great difficulties taking care of their children because of illness
- The duration of an applicant's stay in Denmark
- Families with small children, coming from a country at war
- The criterion of survival
- Other things, including the above circumstances in combination
- Subjective fear
- Torture
- Widow/widower

One of the criteria is **the risk of suicide**. However, it must be a “current, impendent risk of suicide.” With a processing time of about a year it is difficult to imagine a person who is constantly in this situation. As a rule, medication and hospitalisation would take place in the meantime. “Humanitarian residence permit can normally not be founded on the circumstance that the applicant claims that he or she will commit suicide in case of expulsion” (from the practice guidelines). This situation has occurred several times when an asylum seeker, fetched by the police, has promptly stabbed himself in the stomach, drank Clorine or tried to hang himself. Suicide attempts are often related to subjective fear.

The case Zoran demonstrates how a **severe disability** is defined. This application was dismissed, although the boy has multiple disabilities, has a 100% need for nursing and professional treatment and suffers from nine illnesses. Furthermore, he uses a wheelchair, but this, according to the law, is not of itself a severe disability.

Families with children, where the parents because of disease have great difficulty in taking care of their children. This possibility is rarely used. Often this situation would lead to placement of the children away from the parents, something the parents will try to avoid by hiding their own illnesses. The case Asefa is an example of this.

Families with small children coming from a country at war seems to be a very clear criterion, but it has not been possible to find a positive decision where this is given as the reason. Somali families with small children might have been a clear case. Recently, residence for this reason has not been granted to families from Iraq, Afghanistan or Syria either.

The criterion of survival is not used in practice either. It has for example been rejected in the cases Mehdi and Elsa and also in specific cases of elderly, single women from Somalia and Ethiopia in periods with danger of famine. The special acceptance of single women from Afghanistan without network/male relatives is, however, applied quite often.

As to the **duration of stay in Denmark**, the practice guidelines say: "The period of residence must be about five to six years for this criterion to be applied as grounds for granting HR. The length of an applicant's residence in this country can only be regarded as valid if the stay, without interruption, has been legal in the form of processional residence." However, Refugees Welcome has never heard of a case where this criterion alone has given residence, or being mentioned together with other less important factors (see for example the case Elsa). In practice, legal residence will never be four to five years – as a rule, a case is decided within a maximum of two years and the lengthy stays (up to 17 years) are due to a rejected applicant's being unwilling or unable to go home, so the residence is no longer legal.

Other criteria, including the above mentioned circumstances in combination have, according to Refugees Welcome and Danish Refugee Council, never been accepted, in spite of the fact that many cases actually combine circumstances, which together results in a very serious situation – for example the cases Elsa, Zoran, Emma and Maureen.

Subjective fear and torture are not in themselves accepted as grounds for granting HR. Many applications have been rejected in spite of the subjection of convincing reports of torture. Survivors of torture often have a tendency to react to situations that remind them of the violation – in this case also with strong subjective fear of going back to the place where the violation took place. If the applicant refers to a report on torture or subjective fear, the Ministry responds that this aspect has been considered as part of the asylum process.

A young, single woman from Georgia, who was gang raped by soldiers in her home country, suffered from panic and fear at the thought of being sent home (even though the war was over). She was refused HR and tried, at the prospect of deportation, to commit suicide several times. She spent many months in a closed psychiatric unit. Only after several years, when she had become severely mentally ill, was she granted HR.

4.4 CHILDREN

There are particular issues with regard to children's access to HR. The psychiatric diagnoses required are typically not found in children. Child psychiatrists will also be very reticent about giving children, who are still growing, the diagnosis as chronically mentally ill, and also be reticent when it comes to medication. The case is often that the child shows signs of mental health problems, which, if not treated, may develop into chronic mental illnesses, which will have serious consequences for the child's adult life. The consequence of the restricted focus on mental illness means that a child cannot get HR, in spite of having a mental health problems. Even though from a child psychiatric point of view, this should point towards continued residence in Denmark in order to obtain treatment and regained health. Children in asylum seeking families have often been in very injuring situations and therefore have special needs, which require remedies. Many of these children suffer from anxiety and trauma. They have problems sleeping, nightmares, difficulty with concentration, and aggressive/irascible or introvert and/or depressed behavior. In many of the children's countries of origin there is no general access to specialised help (see cases Emma and Zoran).

The Convention on the Rights of the Child, article 6, demands that the child's survival and development is ensured. These factors are not at all part of the Danish law or the practice guidelines on HR.

Another problem when it comes to children's possibility of being granted HR, is that children are not processed as individuals, but are accepted or rejected as a direct consequence of the decision in their parents' case. This practice is not in complete accordance with the Convention on the Rights of the Child, which demands that children are treated as individuals with full rights. As appears in the paragraph on HR in Sweden and Norway, these countries have particularly lenient conditions for children. This is in stark contrast to Denmark, where there are very few examples of children getting HR based on the child's own conditions. It usually only happens as a consequence of a parent getting HR.

About children not having real access because of the choice of diagnoses:

“*This is a political question which we should consider as a people. To refuse helping seriously ill children because of a checklist blocking access is a derision against the applicant and really also against a society ruled by law.*”

Rasmus Heje Thomsen, physician

In 2009, at their own initiative, four child psychiatrists examined 21 children from rejected Iraqi families of asylum seekers. It was clear that the children had substantial psychological problems – and many of the children had not been examined or offered treatment in spite of many years' residence in Denmark. On this background Save the Children, The National Council for Children and Children's Welfare demanded that the conditions should be “thoroughly researched on the basis of the Convention on the Rights of the Child – both in relation to the welfare of the children while in Denmark and their possibility of being granted residence.” Neither the present, nor the former government have taken steps in this direction.

” *Parliament needs to understand that practice must be changed when it comes to humanitarian residence permit. It is clear that only the circumstances of the adults are considered – not the children's. We worried about this from the start – and it appears that we were right to do so.”*

Mimi Jakobsen, general secretary of Save the Children

” *We have a report which tells us that 20 out of 21 children have psychological disorders, which threaten their personal development and health. These children have consistently been ignored on their way through the system. Therefore I think we need to discuss how to improve the treatment of children in asylum seeking families.”*

Peter Albæk, chairman of Children's Welfare

4.5 CONFUSION WITH THE RIGHT OF ASYLUM

Single women, with or without small children, who lack male family members or a social network in Afghanistan have, according to the law, access to HR. This option is used relatively often, as a third of the registered permits of three quarters of 2011-12 were given with reference to this law. In some cases the women were even granted HR before their asylum application had been decided. All background reports unanimously point out that it is life-threatening for a single woman to live in Afghanistan. Women are completely subjected to their male family members, and only in the biggest cities is it possible for women to appear alone in public. Therefore

it is of course to be welcomed that the Ministry recognises the women's situation by granting them HR. However, there is a reprehensible confusion of definitions in this law and its application. If a woman is in danger in her home country and cannot seek protection from the authorities, she should have asylum according to § 7 and not HR.

” *It is obvious that single women in Afghanistan are subject to violations in such a way that they ought to be recognised as ‘prima facie’ refugees in accordance with the Refugee Convention 1.A, and be given asylum in Denmark according to the Aliens Act §7.1.*

When single Afghani women are not given asylum instantly, it is due to two factors. One of them is that Danish asylum practice is very reticent about defining women as a special social group in the sense of the Refugee Convention, even when they clearly are, as in Afghanistan. The other factor is probably the traditional fear of ‘opening the floodgates’ – the risk that a changed practice would mean that single Afghani women in large numbers would move towards Denmark in order to get asylum. This is, of course, a risk which is not real.”

Claus Juul, legal consultant at Amnesty International

The Aliens Act § 7. (1) Upon application, a residence permit will be issued to an alien if the alien falls within the provisions of the Convention relating to the Status of Refugees (28 July 1951).*

(2) Upon application, a residence permit will be issued to an alien if the alien risks the death penalty or being subjected to torture or inhuman or degrading treatment or punishment upon returning to his country of origin. An application, as referred to in the first sentence hereof, is also considered an application for a residence permit under subsection (1).

*) The 1951 Refugee Convention endorses a single definition of the term “refugee” in Article 1: A refugee is someone who owing to wellfounded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

4.6 REVIEW OF GRANTED APPLICATIONS

– from the third quarter 2011 to the 3rd quarter 2012, in other words: the last 15 months of available data, and a total of 42 cases. All permissions are described briefly and anonymously on the Home page of the Parliament every quarter.

Diagnosis	Length of stay	Country
Psychosis	382 days after rejection	Kosovo
Psychosis	218 days after rejection	Kosovo
Psychosis	656 days after rejection	Serbia
Psychosis	231 days after rejection	Afghanistan
Organic psychosis	346 days after rejection	Kosovo
Paranoid psychosis	262 days after rejection	Armenia
Paranoid psychosis	446 days after rejection	Afghanistan
Paranoid psychosis	3.386 days after rejection	Kosovo
Paranoid psychosis	160 days after rejection	Serbia
Paranoid psychosis	793 days after rejection	Iran
Affective psychosis	1.615 days after rejection	Congo
Schizophrenia	770 days after rejection	Afghanistan
Schizophrenia	801 days after rejection	Bosnia
Schizophrenia	664 days after rejection	Serbia
Schizophrenia	Before asylum decision	Armenia
Schizophrenia + psychosis	714 days after rejection	Bosnia
Skizoffective psychosis	651 days after rejection	Serbia
Paranoid schizophrenia	1.136 days after rejection	Iraq
Paranoid schizophrenia	Length of stay not known	Afghanistan
PTSD with psychosis	Length of stay not known	Kosovo
PTSD with psychosis	2.639 days after rejection	Iraq
PTSD with psychosis	449 days after rejection	Bosnia
Depression with psychosis	701 days after rejection	Kosovo
Major depression with psychosis	2.805 days after rejection	Iraq
Chronic dementia (+ son Danish citizen)	332 days after rejection	Uganda
Complicated HIV-infection + resistance	366 days after rejection	Uganda
Diabetes, insulin demanding	Length of stay not known	Somalia
Terminal kidney failure + other things	106 days after rejection	Afghanistan
Heart disease	Min. 570 days after rejection	Peru
Leuchemia, terminal	Before asylum decision	Syria
12 single women from Afghanistan (one wheelchair bound, one suffers from depression and PTSD, one has a son in Denmark, one has in-laws in Denmark, 401 / 174 / 81 / 392 / 350 days after rejection – not stated for all, some granted before decision on asylum)		

The average residence after rejection is 726 days (for those whose time of residence is known).

This is two years and one month more than it takes to process asylum cases, which is typically about one year.

4.7 WHO IS INCLUDED IN A HR?

When a person is granted HR, it is typically extended to the closest family, meaning spouse and children under the age of 18. Children who arrive together with their families, but have turned 18 and have their own families, are not granted residence. Siblings, who may have spent several years together in the asylum system may be separated. Parents of adults, who are granted residence founded on illness, are usually not included. In some cases it is a particular problem, because the parents have looked after the ill person for years, and the ill person is dependent on the help of a mother or father. Refugees Welcome has recorded two cases where an adult son/daughter has been granted residence in order to tend and support a sick parent. But Fadila from Bosnia (see case) has had her application to be able to stay with her sick adult son rejected – and Farhad's mother and adult brothers were not granted residence until the case had been covered by the media (see case). It seems as if there are no clear guidelines behind these decisions.

4.8 FOR HOW LONG IS RESIDENCE GRANTED?

HR is always granted for a limited, temporary residence. It may be valid for six months, one year or two years from the date the permit is granted. After that it is necessary to apply for renewal within the time of expiration and this necessitates a new statement from a specialist as to diagnosis, treatment and medication. The first time HR is granted for a maximum of two years, the second time for a maximum of three years and after five years for a maximum of five years at the time. Still, all the original criteria must be fulfilled. When extension has been granted up to the time when it is possible to apply for permanent residence, the case is processed in the Danish Immigration Service with permanent residence in view and this can also be applied for according to the rules for other foreigners.

A family from Iraq with three children

A family was granted residence in 2008, due to the mother being psychotic, and was granted extended stay for one year at a time, all in all for three years. The fourth time they did not submit a statement from the psychiatrist, but only a letter from the family doctor, who wrote that the mother's condition was unchanged, but who had not written the magic word "psychotic". The whole family was promptly expelled with a fortnight's notice and was told that they had to move into an asylum centre at once and leave the house where they had lived for the past years – and the three children were to leave their school. The Minister would not grant extenuation on grounds of the complaint and a new medical statement which was submitted instantly. Neighbors and friends were so outraged that they collected money enough to pay for the family's room and board, which was refused by the municipality. A new statement from the psychiatrist was submitted, but rejected by the Ministry as "a non-impartial assessment". Friends paid for a statement from another psychiatrist and this time it served as a criterion – the mother being still psychotic, and this time the family was granted five years.

Mental illness is normally what provides HR. According to many psychiatrists, peace and security are necessary conditions if a mentally ill person is to get better. The stress produced by the permit being temporary and short, the time of waiting while the application is being processed of unknown duration, is in itself a mental health hazard – not only for the sick person, but also for family members.

The ultimate consequences of the law are that if a person recovers, he or she has to leave the country. This means that the patient has no inducement to get better and that the temporary character of the residence in itself is stressful. At the same time it is almost impossible for a person who has been granted HR to meet the normal requirements for permanent residence, as these mainly consist of availability on the labour market, education and the ability to speak Danish. But according to the lawyers' experience, permanent residence is normally granted after five years' residence, if the application refers to the Disability Convention. The recommendation to be made must be that HR ought to be a more permanent residence – as it is in Sweden.

” *We were granted humanitarian residence permit one and a half year ago because of my wife's illness. She has become very depressed and anxious after having stayed for more than nine years in the asylum centres. There was nothing wrong with her when we came. I have worked all the time since we were granted residence, but I cannot apply for permanent residence until we have had it for five years. In half a year we must apply for extension for humanitarian reasons, and already now my wife is worse due to stress about the extension. Our 12-year old daughter has started to ask 'What will happen if we are not granted extension? Do we have to go back to the asylum centre?'*

I think it is inhumane to give people temporary residence – the ill persons do not stand a chance of getting well. It is a dark and uncertain future, almost like living in an asylum centre. Our social workers in the municipality also think it is terrible, but they cannot do anything, as it is up to the Parliament to decide."

Anonymous because of the wife's fear of
not getting extended residence

5. WHICH AMENDMENTS HAVE BEEN MADE?

The Law was originally passed in **1985**, the premise of a broader definition of humanitarian aspects. “Fear of returning to the home country” was listed (after experiencing extreme infringement of rights, for instance) and “the significant psychological pressure on the person concerned.” Health aspects appear on a par with age and other personal details but not as independent criteria.

In **1992** the Minister informed the Parliamentarian Committee for Legal Affairs that “Humanitarian Residence Permits (HR) will be issued to persons suffering from life-threatening diseases.” An average of only 60 HR were issued yearly from 1992 to 2001.

In **1993** the practice was revised to include “survival criteria” particularly for single women and families with younger children from particular problem areas, for example, famine. Health criteria, more precisely, would include incurable mental illnesses and very serious mental illnesses not necessarily life-threatening, acute or incurable.

In **1995** a special entry permit for ethnic Albanians from Kosova was introduced because of the malfunctioning health sector there after the war. This modification is not reflected in HR figures which fell drastically from 115 to 17 between 1995 and 1997.

In **1999** there was yet another expansion: entry for persons at risk of or experiencing a serious disability. But this led more to a fall than to an increase in the numbers – only 31 HR in 2000.

In **2007**, parental ill-health making child care extremely difficult was included, also in cases of less serious illnesses or disabilities.

In **2010** two restrictions were added. It would no longer be counted whether or not treatment was actually within reach of the applicant in his/her home country. As long as the treatment was officially available, HR should be refused. And, physicians would be considered incompetent if they publicly criticised the minister’s handling of a case stating that a patient should be issued a residence permit.

The latter proposal met with enormous criticism from doctors who considered it an infringement of their rights of freedom of speech: doctors are not only entitled to but

also obliged to speak out when witnessing irresponsible decisions and measures in a health context. The Medical Association reacted to the hearing on the bill of 2010:

”” *The Medical Association note the sharp criticism levelled against physicians’ medical certificates even though we were not provided with any concrete examples of cases and in general find that physicians take great care when drawing up medical certificates.”*

– from the Medical Association's consultation reply to the bill 2010

5.1 – AND WHAT WERE THE REACTIONS?

Appeal from five NGOs: In June 2009 five important organisations submitted an appeal to Birthe Rønn Hornbech, Minister for Integration, to give HR to the 282 rejected Iraqi asylum seekers from an area where the UNHCR called for protection for everybody. The appeal began: “Amnesty International, the United Nations Association, the Danish Institute Against Torture, Save the Children, and the EURO-Mediterranean Human Rights Network call on the government to ensure that Denmark follow international conventions and respect calls from the UNHCR not to force rejected asylum seekers to return to the home country. In addition, we call for HR to be issued to Iraqi refugees on both humanitarian and security grounds.”

In September 2009 **Amnesty International** organised a concert in the city hall square and rapidly collected 35.000 signatures calling for HR for the rejected Iraqis. The Minister refused to accept the signatures and, in reply, Amnesty International published the appeal in full-page announcements in daily newspapers.

DSU (Danish Young Social Democrats) joined the call for HR for the Iraqis: “Denmark’s Young Social Democrats find it disturbing and a clear example of the government’s cynicism that Lars Løkke & Co. will send the rejected Iraqis home to a country at war – a war which they themselves were involved in starting; in our opinion it is completely inhuman to deport Iraqis who have spent several years in asylum centres in Denmark, and that at least the government should give them HR.” (DSU.net)

In 2010, **the Institute for Human Rights** (IMR) warned against the tightening of conditions for HR. The Institute reviewed cases from 2009 and concluded that at least half the people who had been given residence on grounds of serious illness would risk refusal under the new rules. The Institute feared a breach in the illegality of torture, inhuman or degrading treatment. In an example from 2009 the Institute

found that a man suffering from “paranoid psychosis and post traumatic stress disorder” would very likely be refused even though his monthly medicine expenses were estimated to be 17500 DKK (Information, 20 May, 2010)

The Danish Refugee Council also warned against the restrictions in 2010: “They are extremely stringent and will have grave consequences for HR. Not exactly as though they were generously distributed before. The applicant would have to have a life-threatening illness, terminal cancer or AIDS – or a clinical diagnosis,” explained General secretary Andreas Kamm who assessed that the proposed amendment would reduce chances of obtaining asylum so drastically that the only way to obtain a residence permit in Denmark would now be with asylum as a criteria.

The Danish Refugee Council questioned the basis for changing procedure and wondered if, in recent years, it was made to seem that the increased numbers only sought asylum in order to be treated for a physical or mental illness. “It is somewhat absurd to think that a physically or mentally ill person would come to Denmark in order to sit in an asylum centre – often for many years – in the hope that at one point or another HR would be given with the treatment,” said Andreas Kamm. (flygtning.dk)

Amnesty International likewise proposed rolling back the rules to pre-2010 so that HR is given if treatment is not actually available for the applicant in the home country. (Amnesty.dk – refugees – recommendations.)



6. HOW MANY RECEIVE RESIDENCE PERMIT?

In 2011, **121** persons, including family members, received HR. The number in 2012 looks lower in that there is a total of **31** in the first three quarters.

The number of HR in relation to the persons who received asylum in 2010 was **5.2%** (111 out of 2.124) and in 2011 **5.4%** (121 out of 2.249). So a very small number of asylum seekers receive residence by that route. Numbers include applicant's family members. Only 62 HR on average were issued per year from 1992 to 2001. During that period an average of 5.950 persons were granted asylum every year (twice as many as now). Eligibility for asylum was about 50%.

De facto asylum status was removed in 2002 and the more limited B-status (protection) introduced. In 2002 1.689 received *de facto* asylum status and 45 HR. Only 602 received B-status the following year while 203 got HR, and it became even clearer in 2004: 229 received B-status and 351 HR. The different kinds of residence permits do not follow automatically. In fact, almost the opposite.

From 2003 to the end of September 2006, 869 HR were issued – an average of 289 per year compared to 663 in the period 1992 to 2002 – an average of 66 annually. (As the Anders Fogh Rasmussen government's tightening of the Aliens' Law came into force on 1 July 2002, it was only during 2003 that the consequences were seriously felt.)

The figures are presented on the next page, and see next chapter for comparison with other countries. In 2012 Sweden issued HR to 1.060 persons, Norway 293 and Finland 143.

6.1 STATISTICS THROUGH THE YEARS

Asylum application in total + recognition rate + HR

Year	Applications in total	Recognition rate, asylum	HR*
2002	6.068	28%	45
2003	4.593	22%	203
2004	3.235	10%	351
2005	2.281	17%	186
2006	1.960	18%	216
2007	2.246	30% **	223
2008	2.409	45%	157
2009	3.855	44%	55
2010	5.115	38%	111
2011	3.806	33%	121
2012	6.141	46%	31***

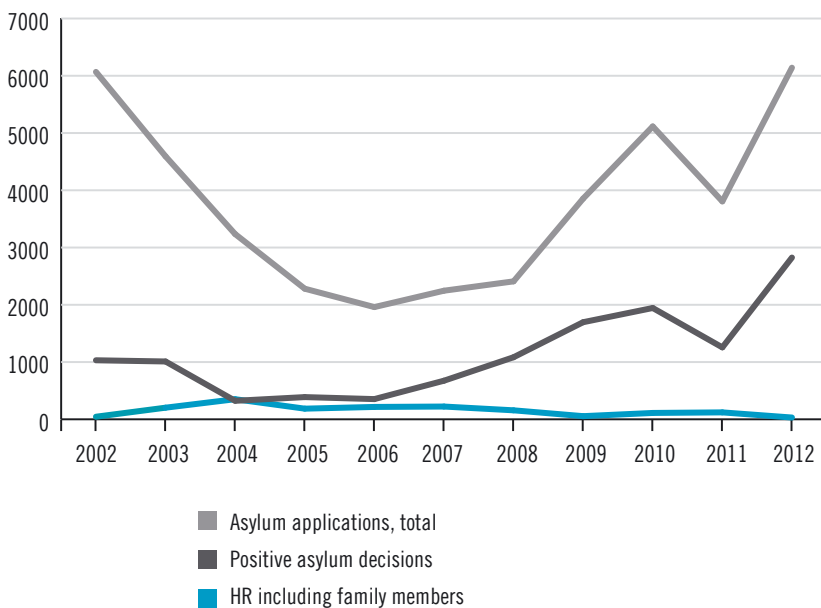
*) Including family members

Source: www.nyidanmark.dk

***) Excluding Iraqi interpreters

***) Numbers only available for the first three quarters

Average number of HR granted 2002-2011: 167 a year.



7. WHAT DO OTHER COUNTRIES DO?

Criteria for asylum are based on the UN Refugee Convention. The international and European Conventions on Human Rights contain other stipulations which can be taken into account for rejected asylum seekers, for example, the family as a unit, the right to health care, and protection of vulnerable groups. European countries have different laws and it is difficult to make comparisons.

Secondary protection (persons at risk but not directly defined by the Refugee Convention) is granted under different headlines, and in some countries ill persons belong in this category. In Sweden, by percentage, more permits are given on humanitarian grounds (broadly defined) but on the other hand they have nothing that compares exactly to Danish protection status.

The European Court of Human Rights has established a very low entry threshold for member states' responsibilities vis-à-vis ill persons from other countries and their needs for treatment.

EUROPEAN COUNCIL ON REFUGEES AND EXILES (ECRE) 2009 Report

The report contains a review of 22 countries' admissions rules for complementary protection but does not examine how they are interpreted and function in practice.

“Among the most common European grounds for complementary protection, the survey identified four grounds based on the State's obligations before international and European human rights law. Besides three specific tendencies – family unity, health and the protection of minors – some provisions include general references to obligations and treaties.” (...)

“The European Court of Human Rights has declared that persons suffering from serious illness may in certain circumstances fall within the scope of Article 3 of the ECHR. Most of the surveyed countries maintain mechanisms of complementary protection based on health issues. While in most States legislation makes unspecified reference to health or medical necessity, in the United Kingdom, the Home Office Asylum Policy Instruction indicates the requirement of a ‘serious medical condition’ for granting Discretionary Leave.

Besides those common grounds, the surveyed countries have adopted systems considering the situation in the country of origin, which appears either in general terms or in concrete cases, such as armed conflict, generalized violence or poor conditions of living. Further examples include victims or witnesses of human trafficking, stateless persons and persons fleeing from environmental disasters. Finally, two States have provisions for the protection of people denied status due to the application of exclusion clauses.”

SWEDEN

In Sweden, residence permits comparable to HR in Denmark are granted in “particularly distressing circumstances.” The law reads:

“If a permit cannot be given on other grounds, an alien can be granted residence permit if an overall rating of the alien's situation seems particularly distressing, so that the person concerned should be granted residence permit in Sweden. When considering permits the applicant's health, adaptability to Sweden and the situation in the home country should be taken into account. Children can be granted residence in accordance with this paragraph even if the mentioned circumstances are not quite so disturbing.”

Social exclusion, injuries following torture and human trafficking should also be taken into consideration according to the law.

Illness and severe disability may give access, but illness alone must be life-threatening and, as in Denmark, there must be evidence of lack of access to treatment in the home country.

This kind of HR is decided by special immigration courts at three levels together with the asylum case, whereas in Denmark it is separated from the asylum procedure and accessed by Ministry of Justice officials on application.

In 2012 in Sweden a total of 12.576 persons were given residence in the asylum area (including quota refugees and those prevented from repatriation). Of these, 1.060 were granted HR, that is 8.4%. The year before, 1.345 (10.5%) received the same permits compared to 12.726 who were given asylum. The percentage granted HR in Sweden was twice as great as in Denmark (2011). On the other hand chances for asylum were lesser (2012).

This form of residence permit is nearly always permanent – again as opposed to Denmark where it is given in the first instance for six months to two years at a time. Nevertheless, there has been strong criticism from physicians and the Swedish Red Cross because (as in Denmark) applicants can be turned down if the relevant treatment is available in the home country – whether accessible to the patient or not.

Demand for modification

In 2012 three parties of the opposition expressed the importance of changing “extraordinarily distressing circumstances” to “particularly distressing circumstances,” a modification which, among others, should be extended to sick persons unable to afford prescribed treatments and children diagnosed with “apathy” of which there were many in Sweden. It turned out that in March 2013, 19 of 23 children who last year manifested symptoms of “apathy” and “resignation syndrome” were granted residence on humanitarian grounds even though the law’s working text was not amended. But Miljöpartiet is so disappointed with the government’s refusal to amend the definition that it is threatening to withdraw from all collaboration on immigration policy.

There is a big difference between Denmark and Sweden in the area of entry for children. Whereas in Sweden the law specifically states that entry for children should be easier, Danish provisions in practice impede the entry of children (see Chapter 4.4). In addition, HR is possible when a strong connection with Sweden exists, especially concerning children who have gone to school in Sweden and lived a great deal of their lives there. This is not taken into consideration in Denmark where, for example, many Iraqi children have been repatriated even though they lived in Denmark all their lives and barely speak Arabic.

In Sweden, corresponding stipulations were called “de facto refugees” from 1989 to 1997 and “humanitarian grounds” from 1997 to 2006. Previously, the largest group of refugees were granted residence on humanitarian grounds but the picture is now reversed and resembles more the Danish one where the majority get residence permits due to a recognised need for protection.

Example of a judgment from Sweden, 2011

(MIG 2009:31)

A residence permit was granted to a single woman with a young child from Sudan. The woman had no social network in her home country and the question of social ostracism on repatriation was raised. She hadn’t been in her home country for 14 years. The court stated that the situation in a country can make it unacceptable to repatriate someone, even if the person is not assessed as a refugee or in other need of protection, and without the country being at war or civil war.

(source: www.migrationsverket.se, www.regjeringen.se)

NORWAY

In Norway there are stipulations corresponding to those in Denmark, and the Norwegian Directorate of Immigration's (UDI) home page states:

“Residence on humanitarian grounds

If asylum in Norway is not granted, the UDI must evaluate whether there is a basis for a residence permit on strong humanitarian grounds or a particular connection with Norway. In such cases there is always a complete evaluation.

The UDI examines the applicant's health and social and humanitarian conditions on return. Human trafficking is also taken into account. If a single person under 18 is involved, the possibility of responsible care in the home country is evaluated. The first rule is that in order to qualify the applicant should be able to document his/her identity, usually with a passport.

The UDI also checks whether immigration regulation concerns would contradict a permit on grounds of strong humanitarian considerations. This evaluation would emphasise the societal consequences of granting residence in such cases.

Childrens' best interests

The government has decided to make an explicit reference to the child's best interests a basic condition and has prescribed a lower threshold for children's permits.”

Here, too, is a big difference from Denmark, where in reality children are in a more difficult situation than adults and not even mentioned in legal texts (see Chapter 4.4).

In Norway in 2012, 4.776 asylum seekers were granted a form of residence. Of these 293 were on 'humanitarian grounds' corresponding to 6%.”

(source: www.udi.no, www.noas.no)

FINLAND

From the Finnish immigration services home page:

“Residence permits on humanitarian grounds

If you do not meet the requirements for asylum or secondary protection you may be granted a residence permit on humanitarian grounds. A residence permit can be granted if you have no possibility of returning to your home country due to a natural catastrophe or for reasons of security. A bad security situation could be due to armed conflict or a problem with regard to human rights. Residence permits are issued for four years with a possibility of extension to permanent.”

Finland gave residence to 1.271 persons in the asylum area in 2011, out of these 143 on humanitarian grounds which equals 11.2%.

(source: www.migri.fi).

8. WHAT CAN BE DONE BETTER?

8.1 REFUGEES FOR MEDICAL REASONS

Explaining restrictions in 2012, the Minister wrote: "... in recent years there has been an increase in asylum seekers whose only reason for coming to Denmark appears to be to apply for humanitarian residence in order to be treated for physical or mental illness."

This allegation is completely undocumented. On the contrary, the review of HR on page 28 shows that applicants have waited on average two years and two months after being rejected (and they will often have waited one year before the rejection). New arrivals are always offered to apply for HR but very few receive positive replies. This can be due to two things: the person in question did not fulfil the criteria on arrival – and/or they were unable to provide evidence for their illness at that time. In other words, the majority are healthy when they come to Denmark (apart from effects of torture or other trauma) but a proportion become ill during the long and debilitating wait in the Danish asylum system. Research by Peter Hallas et al: "BMC Study: Length of stay in asylum centres and mental health in asylum seekers: a retrospective study from Denmark (2007)" establishes that asylum seekers' health problems increase dramatically in relation to the length of stay in the centres.

On the basis of the figures, it can be argued that the stay in Denmark makes people ill, whilst there is little evidence for the argument that people come to Denmark because they are ill. On average, applicants were granted HR 26 months after their final rejection, which is, in most cases, more than three years after arriving.

Recently there has been a large increase in the numbers of Serbian asylum seekers, who are Roma. In these cases we are talking about people who are fleeing, amongst other reasons, from poverty and illness. These cases are quickly dismissed from the asylum system as "manifestly unfounded". But these people can expect that the pace of the casework will be slow because it is not possible to reject their applications for HR so easily. Roma from Serbia are subject to severe discrimination and do not have access to health services and housing on an equal footing with other citizens. This is well documented including in the Amnesty International report, "After Belvil", 2012. The majority of Serbian Roma know very well that they can't get HR, but in the meantime they can benefit from the accommodation and health care – it is a tragic situation and a misuse of the asylum system, one which the EU and Denmark should take up with Serbia.

If the recommendations in this report were followed, then most of the Serbian Roma could be rejected quickly on the basis of general humanitarian criteria – because

the situation in Serbia is not life-threatening. The small number who suffer from serious illness could continue in the process. In this way, it would be possible to save the high costs related to the lengthy stay in Denmark and also the time taken for the case work could be reduced.

The case of Zoran is an example of a family who came because of health problems, but this is an exception when reviewing the total number of asylum seekers and where they come from. By far the greatest number over the years are trying to escape from dictatorship, war and persecution in countries like Afghanistan, Iran and Somalia. In many cases they had a good life before the conflict and very often paid large sums to come to safety.

8.2 FALSE ILLNESS

The suspicion of "false illness" has also been advanced, more or less directly. The disputed lawyer, Hans Boserup, was investigated by police for pressuring doctors to over-medicate but was found not guilty. In his turn, Søren Krarup (The Danish National Party) declared that psychiatrists were too liberal with diagnosing PTSD and wanted it removed from both citizenship and HR (see note page 20). It was an indirect allegation that doctors allowed their feelings to take over instead of objective professionalism. The same could be said about the tightening from 2010, according to which doctors' statements could be ignored on grounds that they were personally involved. It is difficult to imagine that an experienced psychiatrist would put his reputation and career at risk by writing a consciously incorrect diagnosis. Refugees Welcome has never seen anything that could be remotely interpreted in this way. Our experience is more that doctors are extra careful when their statements are used officially and are of such great significance.

Another claim is that asylum seekers suddenly get better when they get HR, and this is a sign that they were pretending to be ill. It is quite logical and natural that there is improvement when one's plight is taken into account and there is an end to the insecurity of staying in an asylum centre. There are many examples of traumatised refugees who receive asylum and improve with the right treatment – and they have had no reason to "play ill."

8.3 CAN WE AFFORD TO GIVE MORE HR?

How Denmark should contribute to humanitarian assistance in the world is a political priority. But no matter what comparisons are made HR is a negligible expense, even if the number were to be increased. The Danish involvement in Afghanistan up to now has cost 13 billion DKK., and the total foreign aid contribution amounts to 16 billion DKK this year of which 1.2 billion DKK finances the whole Danish asylum system. See further details in the box on the following page.

Expenditure

Board and lodging at an asylum centre costs on average from 211,000 to 508,000 DKK annually*

Social welfare, single over 25: 10,335 DKK monthly = 124,020 DKK annually

Average health care costs in an asylum centre 21,500 DKK annually*

Average health care costs for a Danish citizen 20,000 DKK annually**

*) Figure from the official report on the possibility for asylum seekers to achieve access to the labour market and live outside an asylum centre 2012. The higher figure is for unaccompanied minors.

**) Figure from the Danish health services, a short analysis prepared for the Parliamentary Committee on Health in 2007.

Figures show that here and now it is cheaper to grant HR than keep people in asylum centres. It also shows that board and lodging in the individual centre costs far more than a citizen on the dole.

A great number of asylum seekers who come to Denmark are traumatised. According to a study by Amnesty International's medical group from 2009 about 45% had suffered some form of torture. It is clear that this group is both physically and mentally ill and requires more treatment than the average citizen. When thinking economically in the short term, a rejected asylum seeker costs much more than those who receive residence. Over the longer term it would possibly cost more to grant them residence if they continue to be ill, but not if they are helped to get better and later become self-sufficient. In many cases, a patient's family could become good citizens and contribute to the economy (see case Sahra).

We could choose to consider HR for the ill and particularly vulnerable as a form of humanitarian help: money for the asylum system at the moment comes out of the foreign aid budget. Many millions in the world, recognised as refugees by the UN, are unable to return home and live in temporary barracks and tent camps. The asylum seekers who find their own way to Denmark are very few compared to the number who end up in other European countries. Between 2007-11 Denmark ranked 22nd in Europe having 16 asylum seekers per 1,000 residents.

Of the 500 quota refugees which Denmark accept every year through the UN, a certain number are chosen because they have particularly demanding health treatments or disabilities. So the idea is not particularly foreign to us. But the law might be too strict when only 5% of all residence permits in the asylum area are given on humanitarian grounds. And it must be seen as somewhat a paradox that a part of them are given residence because they become ill due to many years' stay in asylum centres. In the interests of the applicants and society as a whole, it would make more sense to give immediate HR based on more humane criteria.

8.4 RECOMMENDATIONS

There should be two kinds of humanitarian residence permits:

Humanitarian reasons:

When the person concerned will be in genuine need or distress on return (for example because of conditions like war, drought, famine) and/or belongs to a particularly vulnerable group (single women with children, minors, the elderly). The actual length of stay in Denmark should also be taken into consideration. In the first instance the permit could be limited to, for example, two years if changes in the home country are likely, and thereafter with a view to permanent residence. Where children are concerned, consideration should be given to their needs and other articles of the Convention on the Rights of the Child.

Illness/disability:

Illness or disability should be individually reviewed by a medical committee, and residence granted when diagnosed as very serious and in need of treatment. There should no longer be a list of recognised diagnoses. Treatment should be actually accessible for the applicant in the home country. Requirements for children should be easier than for adults. HR should, like asylum, be with a view to permanent residence, because uncertainty is a negative factor for the sick and there is no point in keeping the applicant sick in order to get an extension.

Access to automatic evaluation should be incorporated into the handling of all asylum cases in the first instance under the Danish Immigration Service. That is, an evaluation whether the applicant meets the criteria for Humanitarian reasons (see above). The Immigration Service should hold the necessary competences for this.

At present, all new arrivals are offered a medical examination. If this indicates that an applicant may meet the criteria for residence due to Illness/disability, then he/she should be entitled to a more thorough examination and a statement by a specialist – likewise if the illness develops later. The statement should then be sent to a medical committee for evaluation. This would mean a quick screening system and would reduce expenses and waiting time. Everyone would have the same opportunity to explain his/her case, and decisions would be professionally based.

Appeals on decisions should be under the auspices of the new Immigration Board (Udlændingenævnet).

” In my opinion it is imperative for correct decisions in cases of HR for health reasons that these appraisals are made by medical specialists. The Zoran case clearly shows that the involved officials did not understand or had the authority to make an evaluation of the condition of a very ill child.”

Rasmus Heje Thomsen, physician



Elsa shows the ten pills she has to take every morning. On top of these, five for lunch and eight in the evening. Read her story page 52.

9. CASE STORIES

Individual names have been changed by request. The case studies have been chosen to give a broad picture of the many aspects – including people's background, how the case was handled, medical statements, diagnoses and the criteria for rejection. An individual case may well illustrate several problems at once, but the main issue is indicated in the title.

UNDECIDED:

Asefa, Afghanistan (diagnosis and treatment)

Zoran, Serbia (disability, child)

REJECTED:

Elsa, Eritrea (combination)

Mehdi, Afghanistan (epilepsy)

Maureen, Cameroun (HIV + drain in brain)

Abigail, Lydia, Mariama ... (HIV)

Emma, Kosova (child)

Fadila, Bosnia (relative)

RESIDENCE PERMITS:

Sahra, Somalia (kidney disease)

Arman, Armenia (schizophrenia)

Farhad, Afghanistan (retarded)

Hassan, Iraq (dementia)

ASEFA, AFGHANISTAN (DIAGNOSIS AND TREATMENT)

In the spring of 2011 Refugees Welcome was contacted for help by a boy of 12. He came two years earlier with his parents and four siblings. The family had been turned down for asylum and HR and were now in position to be deported.

They came from Afghanistan, lived in Iran for 15 years as paperless refugees and were discriminated against in various ways. They managed to come to Denmark to seek asylum in 2010. In the course of this two-year period the childrens' mental state was severely challenged by life in asylum centres with repeated moves and an everyday with a severely mentally ill mother. The two eldest children ran away and went underground.

Asefa was only 16 when she had her first two children, twins. She had been mentally ill for several years before arrival in Denmark. Her condition was never properly assessed in the various asylum centres – they thought she was suffering from acute stress disorder because of the rejection of asylum, and she was just given anti-depressive medicine. The family had tried to hide how ill she really was, for fear the children would be taken away. The father's own condition was equally affected by the burden of having to take care of the mother and children: he couldn't leave the children alone with their mother.

Refugees Welcome quickly arranged for Asefa to be examined by an independant psychiatrist. The medical statement identified psychotic tendencies and serious mental illness and recommended further investigation to develop a proper plan of treatment. On the basis of this, the Justice Ministry reopened the application for HR. The Ministry, however, only gave 14 days to supply further information in the form of final diganosis and medication program. If this was not supplied within the two weeks, the family would de deported in spite of the serious circumstances. But in the asylum system, a psychiatrist surety must first be sought, which can take several months. And, a psychiatrist can rarely make a diagnosis after just a single consultation. Refugees Welcome requested an extension, but received a telephone rejection on the grounds that 'one can't wait forever for documentation.'

The family was returned to an asylum centre in Jutland, and nothing further was done about Asefa's illness. After waiting for ten months, Refugees Welcome lost patience and arranged an examination with a psychiatrist who had Asefa as a patient for a short period in an asylum centre in Zealand, and who judged her condition as much more serious than the psychiatrist used by the centre in Jutland. This psychiatrist gave a final diagnosis and a prescription for an anti-psychotic drug.

So now, after several years in Denmark, Asefa is clearly getting better, with much less anxiety. The correct diagnosis and treatment would never have been obtained

if Refugees Welcome and two psychiatrists had not given many hours of voluntary work to help Asefa and her family.

In January 2013 the Ministry queried if another medicine could be used instead of that prescribed, and again Refugees Welcome had to ask an independent psychiatrist for a review in his free time. The case is not yet decided.

Quote from a psychiatrist in the Jutland asylum centre in September 2012: *“We insist that the daily walk is the best treatment the patient can get.” “I use the patient’s own experiences and stick to the fact that she should not keep doing all the things which do not work (banging her head against the wall, for example).”* Prescribes a larger dosage of Lyrica (anti-depressive).

Quote from the Zealand psychiatrist’s statement, October 2012: *“The patient has ongoing hallucinations both visual and aural, is delusional, shows signs of negative symptoms in the form of severely deteriorated social capacities, withdrawing from her surroundings and lack of initiative. She manifests pronounced labile affect and occasional aggressive behaviour. Behaviour on the whole appears pretty eccentric and often cannot be explained. Patient has not previously been treated with anti-psychotic medicine. It is proposed to start with T. Solian 200 mg with a view to increasing according to effectiveness and side effects to maximum 1200 mg over 24 hours.”*

Quote for the independent psychiatrists report no. 2, February 2013:
*“As can be seen in the case file, I saw the patient in November 2011 and immediately wrote a medical certificate to the Ministry. A copy was sent to the Red Cross Asylum Department’s health department so they would be aware that this tormented and chronically ill woman should have been further examined and started treatment a long time ago.
(...) She doesn’t know the time of day, where she is or anything about herself. When I asked how many children she had, she replied ten. She was not able to remember the name of even one of them and didn’t think that strange. She expressed several delusions, including that she hammers nails into her body and is in pain, and that there are several nails in the wall behind me.”*

ZORAN, SERBIA (DISABILITY, CHILD)

Zoran is 12 years old, his family Roma from Serbia. They came in 2010, applied for asylum but were turned down. The family's problem was a kind of indirect persecution. Zoran is ill, has had multiple disabilities from birth and is totally dependent on professional care which he cannot get in Serbia because he is a Roma.

The family was turned down for HR on the grounds that: "... according to the report, Zoran does not suffer from a very serious physical or mental illness (...) and the point that the applicant's disability would be reduced if he stayed in this country, cannot be grounds for HR."

Zoran suffered a cerebral hæmmorage during birth, lacks part of his brain, inhibiting the rest from developing normally. The bleeding caused water on the brain, and at five months increased pressure in the brain's ventricle necessitated insertion of a drain to the abdominal cavity (ventriculoperitoneal shunt).

Zoran has a serious psychomotor disability and functions physically like a few months old child; has spastic paralysis with high loss of function in all four limbs, chronic epilepsy needing treatment, strongly reduced vision in the form of blindness from damaged sight canals in the brain, permanent need of medication and control by a pediatrician specialised in the nervous system and brain diseases.

The child was undernourished on arrival according to his medical journal, and had an undiagnosed asthma and recurring severe cramp attacks of the 'grand mal' type. There had been no attempt at training. In Denmark due to nutrition, vitamins and especially epilepsy medicine there was a noticeable improvement in his general function and use of motor devices, relieving the spastic cramps. In addition, his psychomotor level went from a few months old baby to a child of one to two years with use of a few words and improved contact. Patience and daily training in a special school made him smile, laugh, respond and be active. He needs 100% care, medicine and physiotherapy.

All relevant journals and examination reports were submitted to the Ministry.

The Ministry rejected the application while requesting answers to the 17 questions asked in such cases. Physician Rasmus Heje Thomsen answered based on the medical journals and statements, and arrived at nine separate serious diagnoses. But this new questionnaire was never evaluated because the family had already gone home. If they hadn't, they would have been denied re-entry for years.

As the Ministry did not view Zoran as seriously ill or disabled, there was no investigation of treatment possibilities in the home country. Another boy, from Pakistan, with almost exactly the same diagnoses was however, previously rejected

on the basis that the necessary treatment (in the form of tube-feeding alone) was available in Pakistan

The family was not always able to get the necessary epilepsy medicine for him in Serbia, and he had no kind of physiotherapy. They quite simply feared that he would die if they did not seek help elsewhere. Roma are systematically discriminated in Serbia and have limited access to health care – as documented by Amnesty International and Human Rights Watch.

Eva Singer, Head of Asylum at the Danish Refugee Council does not understand the Ministry's reasons, and holds that it is important to review a case in its entirety, and not just reject the different diseases one by one as it was done in this decision.

The Danish Epilepsy Association is following the case, and points out that epilepsy is often underestimated because it is not evident how it interacts with other disabilities and illnesses, and therefore can aggravate the situation. The Chairman of the Association, Lone Nørager Kristensen, states that correct medication is decisive in order to limit potential life-threatening epilepsy attacks, and hopes for a solution guaranteeing the boy the needed treatment.

Four months after rejection and departure, the family returned to Denmark. Zoran's condition had worsened in Serbia and they could neither afford medicine nor had a place to live. The case is reopened on the basis of the medical documentation originally submitted, which was never evaluated before they were ordered to leave the country.

Physician Rasmus Heje Thomsen considers it vital in correct assessment of cases of HR on health grounds that these situations can be assessed by qualified physicians. He says the Zoran case clearly shows that the officials involved neither understood nor had the authority to judge the condition of a very sick child.

Four months later came a letter from the Ministry stating that the certificate could not be considered because it wasn't by the physician who normally saw Zoran. Red Cross physicians don't write medical certificates so, that at the time of writing, the only chance is that the consultant at the paediatric unit will sign a new certificate or add her name to the one Heje Thomsen has done.

ELSA, ERITREA (COMBINATION)

Elsa came to Denmark in 2003, sought political asylum because she was a women's rights activist, but was turned down. She is 64, divorced, and her two grown children escaped abroad. It is unlikely that she can be sent home by force. Almost all new asylum seekers from Eritrea get asylum today.

She was healthy when she came, with none of the illnesses she suffers now. She was a very active person and frequently served Eritrean coffee in her tiny cups, always ready with a smile or a hug, but now she is too exhausted to leave her little room in Kongelunden asylum centre. She has several diagnoses and takes many different medicines: high blood pressure with a risk of heart problems, cataracts, diabetes 2, osteoporosis, arthritis of the knee needing surgery, recurring lung and urinary infections, varicose veins, and abdominal cysts.

She has become very depressed and resigned, and says that she soon won't care if she lives or dies. There is no doubt that most of her illnesses are due to anxiety and worries, brought about because of living in the asylum centre.

According to a certificate from physician Rasmus Heje Thomsen, her overall health condition is life-threatening in the long run, and without treatment she will suffer progressive chronic diseases making her a quasi-invalid. She will probably need insulin soon and heart surgery.

Eritrea is one of the world's poorest countries with famine a constant threat. According to a report from the Swedish foreign ministry only 22% of the population have access to clean drinking water, more than half is dependent on UN emergency help and there is only one doctor per 100,000 inhabitants. According to the British foreign ministry "basic non-prescription medicine is available in the capital but the choice is small. Visitors are advised to take all their necessary and prescription medicine with them."

The Ministry does not think that Elsa meets the legal description "*physical disease of a very serious nature,*" "*single women from countries with extremely difficult living conditions,*" "*at risk of getting or experiencing a worsening of a serious disability,*" or "*a series of conditions which separately could not justify HR, existing in combination in the same person.*"

Many similar cases are refused. Among them **Germer from Eritrea** who is 74 years old and suffers from Horton's headache and increasing dementia. She has six daughters, three are dead, two disappeared and one was granted asylum in Denmark 1994. And **Amal from Iraq**, aged 65, who came ten years ago with two teenage daughters. Both have married Danish residents and have children, but the Ministry thinks that Amal should return to Bagdad where she has no family and no longer a network.

MEHDI, AFGHANISTAN (EPILEPSY)

Mehdi came to Denmark alone in 2010, and asylum was rejected in 2011. He suffered from a particularly serious form of epilepsy, difficult to treat, and was hospitalised three times in Hillerød Hospital. He had regular epileptic attacks and no long periods without them. He applied for HR but was refused in July 2011. After this, he was hospitalised after a violent attack when he collapsed on a train. He reapplied on the grounds of a statement by Christian Pilebæk Hansen, a specialist in epilepsy at Hillerød Hospital.

The reapplication was also turned down in November 2011, on grounds that according to information he did not have either a very serious physical or a mental illness. Nor did conform to any of the groups that according to § 9b were particularly vulnerable.

Refugees Welcome applied again in February 2012 and submitted Pilebæk Hansen's exhaustive answers to the Ministry's questions, which indicated that there was a life-threatening situation requiring life-long treatment. The Ministry again turned down the request on the grounds that he was not suffering from a very serious illness – as epilepsy is not on the list of diagnoses recognised by the Ministry. Mehdi was deported in July, and ostensibly accompanied on the flight by a physician or nurse which we were unable to clarify though recommended in his medical file.

It must be accepted as highly unlikely that Mehdi would ever be able to obtain the necessary newer anti-epileptics in his home country, or that there would be access to continuing check-up and specialised treatment. In Afghanistan he was treated with older anti-epileptics only.

Another relevant factor is that Mehdi's parents are dead. He has a half-brother and a sister in his home town with whom he does not get along, and has been out of touch with them for a long time. Therefore, Mehdi does not have a family network to look after him on return to Afghanistan and will have trouble finding work and taking care of himself due to his violent attacks.

Refugees Welcome has lost contact to Mehdi after his deportation to Afghanistan.

MAUREEN, CAMEROUN (HIV + DRAIN IN BRAIN)

Maureen arrived in 2007 with a scholarship to study sociology and anthropology at the University of Aalborg. She didn't know she had HIV, when a sudden infection with toxoplasmosis affected her brain and she was in a coma for four months. A drain was inserted (a shunt) to remove liquid from the brain. After many months of rehabilitation she was obliged to seek asylum and humanitarian residence, as she could no longer meet her study requirements. Both applications were rejected.

Lawyer Poul Roepstorff reapplied in January 2010 with statements by physician Rune Aabenhus and Professor of Medicine, PhD, Niels Michelsen.

Aabenhus wrote that HIV/AIDS *“is chronic, incurable and requires life-long treatment to control. If the patient does not get her HIV medicine the parasite disease (toxoplasmosis) in the brain will again become active with severe illness followed by death. Because HIV/AIDS weakens immunity it requires life-long monitoring, and on occasions preventive antibiotic treatment is needed to minimise the risk of infection.”* He adds that there is a chance that the virus would become resistant to the actual medication, and then she would be extra vulnerable to life-threatening infections because her immune system is already destroyed.

Michelsen wrote: *“the pressure-relieving drain is fragile and the least malfunctioning could have disastrous results and very likely lead to death within 24 hours, unless immediately specialised neurological treatment is applied.”* He adds that her cognitive function is so reduced that she would be incapable of recognising such symptoms fast enough. In addition, she is badly handicapped after the stroke and has difficulty keeping her balance. Exceptionally, Michelsen himself reviewed the possibilities for treatment in the home country. According to department head Michael Kosteljanetz at Rigshospitalet's neurosurgical department the necessary neurological treatment is not available in Cameroun. He worked for many years in different countries in Africa where he learned about conditions in Cameroun.

Then there was a strange turn in the progress of the case, when the application for HR was opened and closed three times, with the latest rejection coming on 23 December 2011 and sent only to the lawyer's office. The lawyer was on Christmas vacation, and without knowing the decision Maureen received a letter from the police on 30 December 2011 with an exit date of 3 January 2012. Strangely urgent during the Christmas time, when by now she had been in the country for four years.

Maureen was rejected, because according to the Consul General free HIV medicine is available in Cameroun, and health examination expenses are not unreasonably costly. Meanwhile, a scientific review from 2009 showed that 20% of HIV patients

in Cameroun were not adequately treated due to the high cost of medicine and medical examinations.*

The Ministry assessed the question of a pressure-relieving drain as "not requiring attention at the moment," and therefore treatment possibilities in the home country were not taken into account.

In October 2011, Danish newspaper Information wrote an article about Maureen's case in which Andreas Kamm, the chairman of the Danish Refugee Council, legal consultant Claus Juul from Amnesty International and Professor Niels Michelsen who had examined Maureen, expressed their dismay at the plans to send such a sick person out of Denmark, with no access to treatment in her home country.

On the morning of 3 January at four a.m. the police arrived to drive Maureen to the airport. Exceptionally she was accompanied by two Red Cross employees to help her as she had problems walking and orienting herself. Later she wrote to friends in Denmark that she had difficulty obtaining her HIV medicine. And, of course, she didn't know what she should do if the drain in her brain clogged up.

Niels Michelsen has written about the Ministry's handling of Maureen's case:

"The Ministry did not take into account (did not understand?) despite detailed explanations on many occasions that Maureen not only needed continuing treatment and monitoring of her HIV infection, but also because of brain damage had a permanent and clear reduction in functioning in the form of cognitive, motoric and orientation difficulties. In my opinion, her reduction in functioning would have entitled her to an early pension according to Danish practice. Her pressure-relieving brain drain wasn't taken into account either. If it becomes clogged, emergency neurosurgical intervention is necessary, and according to the information I received is not possible in Cameroun. So there is a serious life-threatening risk if Maureen stays in Cameroun. The Ministry did not take any of these many risk factors into account, and their handling of the case is incomplete and unprofessional. I have been a professor at the University of Copenhagen for many years, and if one of my students handed in an evaluation of Maureen's case like the Ministry's, he/she would clearly be failed with advice to read the case documentation properly and take all available concrete conditions into account."

*) <http://www.docstoc.com/docs/94954809/Financial-barriers-to-HIV-treatment-in-Yaound-Cameroon-first>

ABIGAIL, LYDIA, MARIAMA ... (HIV)

According to the Ministry, AIDS is a life-threatening disease, HIV is not. Therefore refusals are generally given without examining the possibilities for treatment in the home country. According to medical experts, HIV and AIDS cannot be separated in this way.

Abigail was rejected because: *“The fact that she suffers from HIV which is not a very serious physical illness means that according to the Ministry’s practice there are no grounds for a humanitarian residence permit.”* The evaluation was made based on a virus blood count which shows she is being treated but has low immunity, and therefore is given ongoing preventive antibiotics. The year before, she was hospitalised with an acute psychosis possibly brought on by the HIV infection. At that point her physician wrote in her file *“... which has now developed into AIDS which particularly requires treatment.”*

Attending physician Thomas Benfield from the Infectious Diseases Unit at Hvidovre Hospital wrote a letter to the Ministry about his patient, Lydia. *“At this point Lydia does not have full-blown AIDS but she will develop it without the relevant treatment which, according to my best belief, is not available in her home country. The reason for this treatment is precisely to inhibit the development of AIDS.”*

In Mariama’s case, physician Kim David of the Infectious Diseases unit at Hvidovre Hospital wrote that: *“The patient is suffering from HIV, which is stable because of antiretroviral treatment. A breach in treatment would lead to an accelerated fall in the CD4 cell count. A CD4 cell count under 200 would be connected to high risk, and life expectancy reduced to from six to 12 months.”*

The above-mentioned women are from Gambia, Zambia and Chechnya, and the Ministry did not check in any of the cases whether there was access to HIV medicine in the home countries, because the diagnosis was brushed aside as “not very serious.”

But a relevant note in the 2010 Ministry practice guidelines states: “Similarly a person suffering from a psychosis but not immediately manifesting psychotic behaviour due to being currently under antipsychotic treatment could be eligible for HR.” AIDS, like psychotic behaviour, can be managed with the appropriate medication.

According to the practice guidelines, HIV is not serious enough in itself to warrant HR, but it could be considered if the HIV is particularly advanced with a clear risk of developing AIDS if not treated. Then a complete health evaluation will be made, incorporating results of CD4 cell count, level of virus in the blood, the patient’s age and possible sequelae. But this evaluation must be made by civil servants, as the Ministry has no medical consultants.

EMMA (KOSOVA, CHILD)

This case dates back to 2008, but is still a good example of children having no access to HR, because the law does not provide for them. Emma and her family are Romas from Kosova, came in 2000, were rejected but couldn't be repatriated. They went underground for a year from February 2007 for fear of being sent back, which had become possible meanwhile. During that period, they stayed in the same place for only a few weeks at a time, the children were practically never out of doors and they spend some nights on park benches. By now Emma was nine and had lived in Denmark for seven years. These experiences and the constant anxiety of being sent back greatly damaged her psychologically, and she didn't speak at all for long periods after returning to asylum centre Sandholm.

In the spring she got a little better, and sometimes could be persuaded to go to school again, but later her condition worsened and she began to wake several times during the night with nightmares, often only sleeping for about an hour at a time.

The Danish Red Cross had not arranged a proper psychiatric statement of her condition, but the family's contact person did, and child psychiatrist Bente Rich drew one up in August 2008. It concluded that Emma's condition was depressive devitalising, depression, constant stress, and the diagnoses "single severe depressive episodes without psychotic symptoms and post traumatic stress reaction." The psychiatrist recommended child psychiatric treatment and rehabilitation, which means a highly specialised series of treatment over several years, as the situation is indefensible from health and developmental aspects.

The application was turned down, referring to the fact that no one in the family suffered from a very serious illness needing treatment.

One of the reasons why the family from Kosova could not be repatriated even though the war was over, was because there was not enough treatment available for the great number of traumatised inhabitants. Therefore UNMIK (the UN's special representative provisionally responsible for Kosova) opposed repatriation of thousands of asylum seekers for many years. Even though finally there was an agreement with Denmark in 2007, the number of physicians and psychiatrists was far from enough to meet the demand. Consequently it can be assumed that a Roma child like Emma would never be given any kind of treatment. The family would be lucky to get a roof over their heads.

Emma's father was arrested in May 2008 and first put in Vestre Fængsel (prison) and then in Helsingør Arrest (detention). Emma would not visit her father in prison because she was afraid of the police. In the end he was sent back alone to Kosova, when the mother and children had again disappeared. Several years later, Danish friends in touch with the family could tell that they live in Serbia, Emma is still very ill and only recently started school.

FADILA, BOSNIA (RELATIVE)

Fadila Husagic came many years ago with her grown son, Mohammed, because he was sick and they couldn't get him any help in Bosnia. Her other son and daughter-in-law were already legally resident in Denmark. She has no other family.

Mohammed received HR in 2010 with diagnoses of paranoid schizophrenia plus PTSD. All this time, Fadila has been his only carer, but she didn't receive HR. The local council was obliged to arrange for her to live in her son's apartment instead of in the asylum centre, because he is completely dependent on her, mentally and physically. But she has not received official permission from the Danish Immigration Service, even though she applied.

The local council, Mohammed's general practitioner and his psychiatrist have all stated that he will allow only his mother to help him and that it is impossible to get through to him unless she is present. All sides state that without her, it would be necessary to move him to an institution, and the relative improvement in his condition could not be maintained without her presence.

In other words, if his mother is sent home, Mohammed's condition will deteriorate and he will have to live in an institution, which is unacceptable from humanitarian and economic points of view.

Refugees Welcome applied to reopen her case in view of her son's case, but was turned down after 11 months, and Fadila is now due for repatriation. The case is somewhat similar to Farhad's (see page 61) and the Ministry was reminded of this – but the media did not take Fadila's case up, and one could suspect that this might be the reason for the different decisions in the two cases.

SAHRA, SOMALIA (KIDNEY DISEASE)

Sahra came in 2002, alone with six children (one of whom was over 18 at the time). She belongs to a minority clan from the Mogadishu area. The family was refused asylum, but could not be sent back to Somalia because there was no responsible authority in the country.

On arrival, Sahra complained of stomach pains and swollen legs. But she wasn't examined properly until her contact person from 'Amnesti Nu' arranged it in 2007, and chronic kidney disease was diagnosed. According to the specialist, she would soon need to go into dialysis with a view to possibly needing a transplant later. The kidney specialist wrote in a statement that the disease was life-threatening, chronic, and progressive. And there was no doubt treatment possibilities in the home country were out of the question.

Refugees Welcome and the contact person wrote an application for HR in January 2008, attaching a certificate from a specialist in the Nephrological Unit of Roskilde Hospital showing the diagnosis, treatment possibilities and prognosis if treatment was not provided. Even though chronic kidney disease is specifically listed in the Ministry's practice guidelines, they still asked for an expanded statement from the specialist who replied that "progressive renal failure over time would lead to life-threatening complications." The Ministry still did not understand, and requested a more precise assessment. In the third description of her condition, the specialist's irritation is evident: "... means: an irreversible process with slow decreasing kidney function. In time, without treatment, kidney function would be so minimal that continuation of life is not possible: one dies."

Sahra received HR, after seven months. All six children also received HR, even though two had reached 18 meanwhile and the oldest was 18 on arrival. He received HR with a view to the father role he had filled for his younger siblings. By then the family had lived six years in the asylum system, and had been moved seven times between four different centres.

Sahra did go into dialysis treatment laterly three times a week, and was wait-listed for a kidney transplant. After waiting two years and eight months in the Danish health system, Sahra took the situation into her own hands, borrowed from her brothers in UK and had a transplantation at a private hospital in Malaysia.

Sahra's children, now between 15 and 29, are all well functioning despite everything. All have undergone or are undergoing education: nursing assistant, building constructor, business school, high school and gymnasium. The oldest son always felt responsible for supporting the family, so he took a driving licence and has since worked as a bus driver.

ARMAN, ARMENIA (SCHIZOPHRENIA)

Arman came to Denmark with his pregnant wife in 2005 and sought asylum. He had been imprisoned and tortured in Armenia and Russia. His wife had a daughter in 2006. There were negotiations for several years to send the family onto Italy or Sweden and in the end, in the spring of 2010, Arman was deported from Sweden to Armenia. Meanwhile his wife and daughter went underground.

During the time in Danish asylum centres, Arman had complained of strong pains in his head, and Amnesty International had carried out a torture investigation which substantiated his assertion of torture in two different prisons.

In August 2010, he turned up again in Sandholm after eight months in his home country. During all this time, his wife and daughter who were hiding in Denmark and Sweden, had not heard a word from him. He had a complete lapse of memory, and couldn't understand what he was doing in Denmark and didn't recognise his wife and daughter. His case was reopened in November 2010 in Denmark. Amnesty's medical group examined him again and found a significant worsening of his condition.

He was hospitalised twice in closed psychiatric wards for acute psychotic and suicidal behaviour. At Refugees Welcome's request, psychiatrist Inger Ros set out a seven-page medical certificate with diagnoses of PTSD, memory loss and psychotic symptoms with a list of two kinds of medicine against depression and two against psychosis. Quotes from the statement: *"... is hallucinating and has paranoid episodes (...) significantly weakened regular and emotional contact (...) cannot tolerate other people, becomes anxious and irritable in the company of others (...) plagued by the violent headaches and complains of pain in hands and feet and the body in general."*

We submitted the application in June 2011. The Ministry referred to the Danish Embassy in Kiev (there is no representation in Armenia) only in December and asked if Arman's medicine was available in Armenia. In March 2012 the Ministry asked for "current information" even though we regularly submitted copies of comments by psychiatrists who were treating him under the aegis of the Red Cross and who added the diagnosis schizophrenia along the way.

Thirteen months later, in July 2010, there was a reply that at least one of the relevant medicines could not be obtained in Armenia, and the family got HR for two years.

Six months later, the couple's asylum case was finalised and they received asylum – eight years after they came to Denmark.

FARHAD, AFGHANISTAN (RETARDED)

A 25-year-old Afghani, who came to Denmark with his mother and two younger brothers in 2008, after their father had been killed. A psychology certificate describes Farhad as “a severely traumatised young man with a poor intelligence, who was exposed to war trauma growing up.” And on the grounds of a neuropsychological examination psychologist Kjeld Jensen estimated that Farhad’s “general abilities are about the level of a 3 to 5½-year-olds” and his IQ is about 35 to 49 where the normal range is 90 to 110.”

The department head in psychiatry, Henrik Rindom, wrote that “*from a personality point of view he is severely mentally retarded,*” and describes his assessment as “lacking” in that the patient was not able to give an account of his own situation. Rindom remarked that Farhad Rezae “*can be aggressive and get into such a violent state that it could be compared to passing psychosis.*” Farhad Rezae is being treated with the anti-psychotic remedy Truxal which “provides him with a certain relief from the most violent unforeseen attacks.” Rindom concludes that Farhad could not manage without the professional help in a social pedagogics institution as well as continued medical treatment. It is clear “*that it must be accepted that if sent home to Afghanistan he will go downhill as it is doubtful if he could receive sufficient treatment,*” writes Henrik Rindom.

Farhad is in an institution with 24-hour staffing because his mother is unable to take care of him.

The organisation Asylret applied for HR on his behalf in August 2011, but at first he wasn’t even allowed to stay while his case was being processed. The daily newspaper, Information, wrote about his case several times, and in August 2012 he was given HR. But his mother, who has taken care of him all his life, and his two younger brothers were to be sent home because Farhad had not been declared incompetent, and it was understood that he was given appropriate care in the institution. Several other newspapers wrote about the case, and in December the Ministry of Justice arrived at the conclusion that his mother and younger brothers should also be given HR after all.

The Centre for Rehabilitation of Torture Victims (RTC) (now called Dignity, Danish Institute Against Torture) in Information had called on the new government to re-examine Farhad Rezae’s case before he was forced home. According to the Centre’s legal adviser, Dorrit Ree Akselbo, the European Court of Human Rights had confirmed that when all concrete circumstances are taken into account, it would be a breach of the European Human Rights Convention to expose someone to inhumane handling by sending sick people back to a country where the right treatment is not available. “And if you look at Farhad Rezae’s case, it was found necessary to

institutionalise him in Denmark, where he gets treatment which, by all accounts, is not available in Afghanistan,” said Dorrit Ree Akselbo, and refers to the fact that the UN has warned against sending handicapped people to Afghanistan due to the poor quality of treatment in that war-torn country.

HASSAN, IRAQ (DEMENTIA)

When Brorson Church was cleared in August 2009, 72-year-old Hassan Gardi and his wife were among the Iraqis who were hunted out by the police. The couple went into hiding from fear of the police, with the help of young activists. A few days earlier, the former Ministry of Integration rejected reopening his case for HR. His wife of 47 had taken care of him like a child for years – he is incontinent and can only speak a few words.

The Ministry wrote in its rejection: “In addition, the fact that you, Hassan Mohammed Hussein Gardi, are unable to take care of yourself and are totally dependent on the care of others can lead to no other decision.”

“This severe dementia is like a very serious mental sickness,” wrote neurologist Bjarne Degnbol who had earlier examined Hassan, and whose medical certificate had been presented as grounds for the couple’s application for HR. Up to then Hassan had never had a CT-scan so the specialist arranged for one on his own initiative. Enhedslisten (the socialist party) asked the Minister of Health whether this form of dementia should not be considered a “very serious illness” and received a positive reply. So the Ministry of Health had a different assessment than that of the Ministry of Integration.

Hassan and Gulizar returned to Kongelunden asylum centre, but in October 2009 they were arrested and imprisoned with a view to deportation. Amnesty International condemned the action, calling it an abuse of human rights. “To send Hassan Gardi to Iraq is close to cruel and inhuman treatment,” said Amnesty International’s general secretary, Lars Normann Jørgensen. “Arresting a man in his condition is totally unacceptable and yet another example of the cynicism of Danish officials who have handled all the Iraqi cases. Denmark is in the course of carrying out an infringement of human rights.”

In April 2010 Hassan and his wife were given HR all the same, after the case had been reported in several newspapers.

Humanitarian residence permits. A safety net that Parliament has introduced to ensure that Denmark doesn't send people home to certain death or totally inhumane situations, even though they may not fulfil the criteria for gaining asylum.

The reality is somewhat more doubtful. An application procedure that requires professional assistance, criteria that in practice are not used even though they are in the law, civil servants who make decisions based on medical certificates, physicians who have to write certificates without being paid for doing so. All this has meant that only 121 people, including family members, were granted humanitarian residency in 2011 and in the preliminary published figures for the first quarter of 2012 the number is down to 31.

The government's policy statement for 2011 states that there should be "Clear and reasonable regulations", and "the circumstances in which humanitarian residence permits are granted will be tight and they will be continue to be the exception. A humanitarian residence permit is given for a maximum of either one or two years at a time. Nonetheless, the rules should be reviewed especially as very ill people can have great difficulty getting humanitarian residency".

This report presents for the first time a comprehensive review of the subject and will hopefully contribute to the government's deliberations. The report includes concrete suggestions as to how to solve the problems that are identified and twelve case stories which throw light on the complexity of the subject.

About the author:

Michala Clante Bendixen is a graphic designer and has worked voluntarily with refugees for many years. She is active in the on-going debate about asylum policy. As chair of the organisation, Refugees Welcome / The Committee for Underground Refugees she has gone through a large number of cases and thus has gained considerable experience of the legal, practical and personal aspects. In 2011, Michala published 'Asylum Camp Limbo. A report about obstacles to deportation'.

REFUGEES WELCOME

