

Chapter 8: Asylum seekers and other non-UK nationals with HIV

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Migrating change

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Britain's commonwealth links, its reputation abroad as a liberal, stable democracy together with civil unrest and conflict abroad have all combined to boost migration here. The explosion in global travel means the UK receives vast numbers of visitors with London being one of the world's busiest international airport hubs. It is rare that people from abroad have an HIV diagnosis before arriving¹. People enter the UK for a host of reasons such as doing the tourist thing, to visit friends and relatives, as students, refugees, and as migrant workers amongst others.

Asylum seekers and other migrants

The really exceptional impact of migration began around 2000 in the North West, and it was black Africans becoming diagnosed in considerable numbers. In the public's mind, African migrants with HIV can only mean asylum seekers. This is far from the whole truth, but certainly changes were seen around the millennium when Northern cities welcomed asylum seekers who the Government had decided needed to be dispersed from London and the South East.

By the end of 2005, 17% of all those seen for HIV treatment and care in the North West were non-UK nationals. Slightly over half of non-UK nationals in the North West with HIV are asylum seekers (less than 10% of all those diagnosed)². Very few asylum seekers (whether they have HIV or not) are ever given refugee status - just 1 in 10 in the North West have been accepted as refugees. A further 14% of North West migrants with HIV are overseas students, whilst just 3% are migrant workers and 5% are visitors or tourists. The remainder fall into one of the many other immigration categories, or are asylum seekers granted a period of leave to remain, or have stayed irregularly, sometimes because of the lack of and costs of HIV treatment in people's home countries. Most, but by no means all, of non-UK nationals diagnosed with HIV in the North West are black Africans and around 92% became infected heterosexually. As an ethnic group, black Africans are a tiny fraction of the North West population (under 1% in the 2001 census) but bear a hugely disproportionate burden of HIV infections here.

NHS treatment for HIV positive migrants

Obscure NHS regulations mean that unlike all other sexually transmitted infections, HIV is not automatically treated by the NHS. These rules fall hardest on some migrants including HIV positive women who become pregnant (with the attendant high risk of infecting their baby). Although asylum seekers are among the groups that the rules do allow HIV treatment, other migrants can and do fall foul of the rules. Civil servants tell us that Department of Health ministers believe there is widespread "treatment tourism", and there are significant numbers of people with HIV who know this and deliberately come here for treatment. The ministers were unable to produce any evidence of this and just blustered when asked for proof at a House of Commons Health Select Committee hearing. The Department of Health chooses to ignore all the evidence that HIV diagnosis and treatment reduces sexual risk-taking and infectivity.

Trusts do not always apply the treatment rules properly and the official guidelines are seriously inadequate, leading to further mistakes. Nor do the rules take any account of the Human Rights Act - especially that no-one should be subject to inhuman and degrading treatment. A recent Court of Appeal ruling against the Home Office puts NHS Trusts at high risk of expensively losing cases of charging for HIV treatment at Judicial Review. The reality is that almost no migrants with HIV have the means to pay for necessary HIV treatment. The rules provide that only when things reach a crisis point and treatment becomes "urgent" or "immediately necessary" does it have to be provided by the NHS irrespective of whether the person will ever be able to pay. There is then a wasteful bureaucratic game while Trusts try to collect non-existent money before having to complete complex forms and obtain Board and Health Authority approval to write off each debt. As financial pressures on Trusts mount it is the most vulnerable who will suffer, but others will become unnecessarily infected as a consequence of these short-sighted rules. The Government committed itself at the G8 summit in 2005 to ensuring that everyone in the world needing HIV treatment gets it by 2010. It is hard to see the point behind not doing this for everyone here just a few years earlier.

Targeted prevention

A small but rising number of HIV transmissions involving migrants are now occurring in the UK. To date targeted HIV prevention work in the UK has been relatively straightforward. Most effort must be directed at gay men and other men who have sex with men; in the North West, gay men account for most transmissions. Pregnant women are also routinely offered a HIV test. Injecting drug users (IDUs) are another discrete group who are provided with harm reduction tools like free needles and syringes to reduce infections through sharing behaviour. Mainly heterosexual migrants, widely scattered, socially isolated, excluded and often living in extreme poverty, are much more of a challenge to reach.

The extreme stigma associated with HIV in sub-Saharan Africa for example means that there is a high level of denial and reluctance to test. Testing is further discouraged when the incentive of being able to assure people that they will be treated by the NHS and that treatment works so that the cultural mindset "HIV = death" does not apply (as it might in people's home countries), simply cannot be offered to all migrants.

The pattern of diagnoses among black Africans in this country is that around two thirds of those diagnosed are women. There are strong cultural reasons that discourage African men from testing. This, however, must not be used as an excuse to neglect the needs of African men for testing and treatment, not least because of the high risk of otherwise avoidable transmissions. Untested African women may need empowerment support and skills development around negotiating safer sex, and access to free prevention, particularly the femidom, that are not dependant on men. For this reason, the development of microbicides that women can use independent of men is also critical here, as they are in the developing world.

Social Services and legal obligations

Social Services are not off the hook either in meeting the needs of migrants with HIV. A landmark judgement in 2006 against Slough Council by the Court of Appeal means that social services now have to accommodate and support asylum seekers and other migrants who are on HIV treatment, under their National Assistance Act 1948 duties. Councils that fail to comply will lose at any Judicial Review hearing, face censure from the Ombudsman and could be liable for unlimited damages for disability discrimination (everyone diagnosed with HIV is now a 'disabled person' under the recently amended Disability Discrimination Act).

Human Rights review

Parliament's Joint Committee on Human Rights is investigating the 'Treatment of Asylum Seekers' in late 2005 - early 2006. The HIV community sector is submitting detailed evidence of the difficulties currently being experienced by asylum seekers and other migrants living with HIV. This includes the poor quality of much accommodation provided by the National Asylum Support Service (NASS); widespread destitution of people outside the NASS system and many within it; problems with dispersal; access to NHS treatment; deportation decisions; and the state of and treatment of people in deportation centres.

Migration and HIV have highlighted many significant gaps in the welfare state and have led to some remarkably illiberal Government policies and practice in one of the world's wealthiest countries. In response, there have been some remarkably creative attempts at local and national levels by the HIV sector to provide the welcome and support positive migrants need and deserve if the UK is continue to maintain its reputation as a humane and liberal democracy.

Introduction

The number of people migrating to the UK increased by 85% between 1994 and 2004. In 2004, over half a million people migrated to the UK, and just under 1% of the UK population were people who had immigrated that year³. Migrants tend to be younger (most are in the age range 15 to 44 years), and the most common reason for coming to the UK was to study or work³. In addition, more than one fifth had a specific job arranged for their arrival. Given the changes to the demography of the UK that migration on this scale causes, it is vital that health professionals understand the needs of immigrant populations, and target health promotion at those at high risk of disease⁴. Many studies have shown that people migrating to western countries suffer less from chronic diseases associated with 'westernisation'⁵ (e.g. hypertension⁶, heart disease⁷ and asthma⁸) and have a lower rate of pregnancy complications⁹. Conversely, migrants and other people arriving in the UK from other countries are at higher risk of infectious diseases prevalent in that country. For example, people visiting friends and relatives in sub-Saharan Africa are more at risk of returning with malaria¹⁰. Similarly, those originating from countries with a high prevalence of HIV are more likely to be HIV positive¹¹. A survey of genito-urinary medicine (GUM) services in the UK in 2002 suggested that people of uncertain immigration status or seeking asylum made up as much as 42% of GUM clinics' workload¹². However, only one third of GUM clinics in the survey had information systems capable of providing information on care for immigrants.

A significant health consequence of migration is the stress caused by coping with two cultures (e.g. discrimination/prejudice, uncertainty over immigration status, and acculturation, where members from one culture adopt the behaviour and beliefs of another), and this often leads to mental health problems¹³. This effect is also seen in the children of migrants, who have poorer mental health than their non-migrant counterparts, and ultimately are more likely to attain lower occupational status as an adult¹⁴. Studies on migrants with HIV show that the significant causes of stress are not necessarily the result of HIV infection¹⁵. For example, a health needs assessment of black Africans with HIV showed that those who had lived in the UK for the shortest time were more worried about money, immigration status and housing than they were about their health. They were more likely to lack access to skills, training and job opportunities and lack knowledge of anti-HIV treatments¹⁶. A survey by Terrence Higgins Trust and George House Trust showed that migrants with HIV accessing their services had come to the UK for a variety of reasons: to study (20%), to seek asylum (22%), to visit (22%) or to join family (12%)¹.

In the UK asylum seekers suffer from high levels of absolute material deprivation, marginalisation and stigmatisation. The prevalence of HIV among this group is likely to reflect that of their country of origin. Currently asylum seekers have the right to HIV treatment whilst seeking asylum. Previously, due to the policy of dispersal without reference to medical needs, many asylum seekers found themselves in areas where the medical services were unaware and unprepared for their health status and sometimes lacked sufficient expertise¹⁷. An inquiry by the All-Party Parliamentary Group on AIDS concluded that while resident in the UK, asylum seekers were at an increased risk of developing resistance to treatment if dispersed away from their source of treatment and support. This is due to the 95% adherence to antiretroviral therapy (ART) that is required to have the greatest effect in treating the virus¹⁸. As a result of this, there are new guidelines from the National Asylum Support Service (NASS) about the dispersal of HIV positive asylum seekers. These require the consent of the person's consultant to dispersal and advance arrangements being made for continuity of care where the person is to be relocated.

Should an asylum application fail, the individual concerned ceases to receive benefits, and is not permitted to seek employment. However, it is not always possible to return failed asylum seekers to their countries within months or even years, leaving such individuals reliant on charity¹⁹. Except for emergencies, failed asylum seekers lose the right to free treatment in a hospital, including treatment for HIV^{19,20}. While there are ethical arguments for providing HIV treatment for all²¹, there is also a powerful argument on public health grounds that HIV treatment should not be withdrawn (as set out by the independent expert medical panel reporting to the All Party Parliamentary Group on AIDS²⁰). This is because HIV positive failed asylum seekers may not necessarily be deported within the target time period and could transmit HIV to others. Also, an individual with HIV who is denied treatment may ultimately require more expensive emergency care²². The expert medical panel also identified inconsistencies in policies between HIV and other infectious diseases such as TB (where treatment is available to all regardless of immigration status) and other STIs (where free treatment is available to all), and recommended that HIV be reclassified as an STI. UNAIDS and WHO (2005) argue that it is essential to the fight against HIV/AIDS that universal access to treatment and care is achieved. Treatment should be freely available to all those who are aware of their positive status as part of the global effort to combat the infection and to help to create a more effective environment for HIV prevention²³.

During 2006, the UK received 23,520 asylum applications, 9% fewer than in 2005 (25,710)²⁴. Of the applications received in 2006, 44% were from Africa, the global region with the highest prevalence of HIV. The most common origin of asylum seekers applying from African countries was Eritrea (25%), followed by Somalia (18%) and Zimbabwe (16%). According to Home Office statistics, there are currently 6,515 asylum applicants residing in the North West receiving supported accommodation from the National Asylum Support Service (NASS) and a further 585 receiving subsistence only support. Within the North West, the largest numbers of asylum seekers are located in Manchester (1,355), Salford (945) and Liverpool (810). On a national level, no data are collected on how many asylum seekers seek treatment for HIV. In the absence of such data, the expert medical panel calculated the number of asylum seekers from each country and assumed the HIV prevalence of the country of origin to estimate

that there were approximately 900 asylum seekers with HIV entering the country in 2003/04²⁰. **Table 8.1** shows similar estimations for the North West in 2005. The official statistics do not reveal the country of origin of asylum applicants for each region, but assuming that the North West asylum seeker population has the same profile as the national figures, we would expect around 150 African asylum seekers with HIV to be receiving support in the North West in 2006. Not all of these would necessarily have their HIV infection diagnosed, and this figure does not include dependents. Because of the uncertainty around estimates such as this, since 2002 the North West HIV/AIDS Monitoring Unit has requested information about HIV positive individual's residency status. In 2005 the number of individuals classified as asylum seekers was 398 (9.5% of the total HIV positive population that accessed treatment and care in the North West)², and a somewhat larger figure than that expected on the basis of the estimations in table 8.1.

Despite anecdotal evidence that asylum seekers enter the system already at a late stage of HIV²⁵, there are no empirical data to confirm this. In addition to asylum seekers, there are a number of other categories of migrants with HIV, including temporary workforce and students², and little is known about the health needs of these populations in the North West. The aim of this chapter is to compare the demographics, health and service use of migrants and non-migrants with HIV in the North West.

Table 8.1: Estimating the number of HIV positive asylum seekers from Africa in the North West

African country	Percentage of total asylum applicants from Africa ^a	Estimated Number in NW	Prevalence of HIV in country of origin (%) ^b	Estimated number with HIV
Tanzania	0.1	4.4	6.5	0.3
Rwanda	0.2	5.8	3.1	0.2
Burundi	0.3	8.7	3.3	0.3
Liberia	0.4	13.1	-	0
Congo	0.5	14.5	5.3	0.8
Angola	0.9	27.6	3.7	1.0
Kenya	0.9	27.6	6.1	1.7
Gambia	1.1	32.0	2.4	0.8
Ghana	1.2	36.4	2.3	0.8
Sierra Leone	1.2	36.4	1.6	0.6
Uganda	1.6	48.0	6.7	3.2
Ivory Coast	1.6	49.4	7.1	3.5
Ethiopia	2.0	59.6	-	0
Algeria	2.1	64.0	0.1	0.1
Cameroon	2.5	74.2	5.4	4.0
Dem. Rep. Congo	5.5	165.8	3.2	5.3
Sudan	6.5	196.3	1.6	3.1
Nigeria	7.5	223.9	3.9	8.7
Zimbabwe	15.8	474.1	20.1	95.3
Somalia	17.9	538.1	0.9	4.8
Eritrea	25.2	756.2	2.4	18.1
Africa Other	4.8	145.4	-	0
Africa Total	100.0	3001.5	-	152.6

^a Home Office (2005) Asylum Statistics²⁴

^b UNAIDS/WHO (2006) Global epidemic update²⁶

Methods

Records from all those who were new to the region from 2005 to mid-2006 were extracted from the treatment and care database. New cases were used to exclude people with a longer history of HIV infection (since the comparison, non-migrant population is disproportionately represented by longer standing cases). This procedure also excluded people who have been classified as an asylum seeker for over eighteen months, whose classification may therefore be out of date (since people cannot be asylum seekers indefinitely). After excluding 26 people for whom stage of disease was not recorded, records for 1392 individuals were extracted: 193 (14%) of whom were asylum seekers; and 148 (11%) were other non-UK nationals (48 overseas students, 30 refugees, 26 temporary visitors, 13 migrant workers, 4 dependents and 28 individuals in other categories). For 219 individuals (16%), residency status was unknown. Using the same methodology as chapter 4, residence data were coded to lower super output area and linked to deprivation scores. Scores were then placed in three equally sized categories, with least deprived areas having index of multiple deprivation score less than 36, the average was a score of 36 to 58 and most deprived category comprised individuals living in an area with a score of 59 or more. In order to compare the number of asylum seekers in a one year period with the prediction in table 8.1, new asylum seekers classified as being of black African ethnicity in a one year period (mid 2005 to mid 2006) were extracted, along with the county of infection.

Admission to hospital was defined as having had at least one period of inpatient care. Logistic regression was used to predict admission to hospital from health and demographic variables. Service use was measured as the number of outpatient visits (to measure routine care). The number of outpatient visits was adjusted for the number of six-month periods attended and log transformed (to improve normality for statistical analysis). The means were back transformed and presented as annual number of visits. Multivariate analysis was performed using the general linear modelling (GLM) procedure in SPSS (version 14). Contact with voluntary agencies was measured by matching records with datasets submitted by voluntary agencies, using new cases in 2005 only as 2006 data were not available (n=925). Only those with an exact match on soundex (surname encryption) and date of birth were coded as having attended voluntary agencies, therefore this is likely to be an under representation of voluntary sector service use.

Results

Of the 193 asylum seekers contacting statutory treatment centres between the beginning of 2005 and mid 2006, 119 were new to treatment in a one-year period and were of black African ethnicity, for comparison with the predictions in table 8.1. Of those whose country of infection (and therefore presumably country of origin) was known (70%), 52% were from Zimbabwe, 11% from Malawi, 7% from Cameroon and 6% from Congo, with the remaining being low numbers from other African countries.

Table 8.2 shows that HIV positive asylum seekers comprised a greater proportion of women (65%) than those identified as UK nationals (20%). The overwhelming majority of asylum seekers were black Africans (95%) and were infected through heterosexual sex (96%). Non UK nationals who were not asylum seekers had a similar profile (60% female, 91% black African, 87% heterosexually infected), while UK nationals were predominantly male (80%), white (78%) and infected through sex between men (59%). UK nationals tended to be older (34% were aged 40 or more years) compared to asylum seekers (24% aged 40 or more years) and other non-UK nationals (18% aged 40 or more years). There was a significant association between residency and deprivation categories ($P < 0.001$). While only 8% of HIV positive asylum seekers lived in the least deprived areas, 30% of UK nationals did so. Asylum seekers and other non-UK nationals were more likely to live in the most deprived areas (34% and 32% respectively), although a high proportion of postcodes were unknown or out of region (34% asylum seekers, 24% other non-UK nationals and 30% of those whose residency status was unknown). Table 8.2 also demonstrates that there was no significant association between stage of HIV disease and residency status ($P = 0.225$), with most individuals being in the asymptomatic category (66%) and only 16% having had AIDS or having died.

The requirement of a stay in hospital of at least one night was used as an indicator of the state of health of HIV positive individuals. **Table 8.3** shows that those infected through routes other than sexual intercourse were more likely to require a hospital stay (other routes include injecting drug use, mother to child transmission and blood products, as well as those whose route was unknown). Those with symptomatic HIV (Adjusted odds ratio=3.0), had AIDS or who died (Adj OR=19.2), were more likely to have stayed in hospital than those who were asymptomatic. Only 11% of those who lived in the most deprived areas were admitted to hospital, compared to 17% of the relatively more affluent areas (Adj OR=0.46, $P = 0.004$). Those with no postcode information were the most likely to be admitted to hospital (21%). After controlling for all these factors, asylum seekers did not differ from UK nationals as to whether or not they had a hospital stay. Although not significant, there was a marginal tendency for people classified as non-UK nationals other than asylum seekers to be less likely to require a stay in hospital than UK nationals.

Table 8.4 shows the number of outpatient visits a year broken down by demographics. The average number of outpatient visits a year was 6.5. Compared to the other categories, MSM had the highest numbers of outpatient visits (7.1 visits per year) followed by those infected through heterosexual sex (6.3 visits) and those infected

through other routes (5.1 visits). Not surprisingly, those with AIDS or symptomatic HIV had more visits (7.4 and 7.3) than those with no HIV symptoms (6.1 visits). Those with no residence information visited less frequently (4.3 times per year) than those who had complete information. There was no difference in number of visits between those living in different deprivation categories after multivariate adjustment.

Figure 8.1 shows that there was a highly significant difference across residency categories in the proportion of people accessing voluntary agencies for both males (Chi square=26.1, df=3, P<0.001), and females (Chi square=62.2, df=3, P<0.001). For both sexes, non-UK nationals (other than asylum seekers) were more likely to contact voluntary agencies, while those whose residency status was unknown were the least likely to access such support. Female non-UK nationals (other than asylum seekers) were particularly likely to access voluntary agency support (49%), while female UK nationals were the least likely to do so (7%).

Table 8.2: Demographics, infection route and stage of disease by residency category

	UK	Asylum Seeker	Other non UK	Unknown	Total	Chi square
Sex						P<0.001
Male	662 (79.6%)	68 (35.2%)	60 (40.5%)	117 (53.4%)	907 (65.2%)	205.0
Female	170 (20.4%)	125 (64.8%)	88 (59.5%)	102 (46.6%)	485 (34.8%)	df=3
Age						P=0.006
Under 25	92 (11.1%)	26 (13.5%)	16 (10.8%)	26 (11.9%)	160 (11.5%)	27.6
25-29	139 (16.7%)	41 (21.2%)	36 (24.3%)	48 (21.9%)	264 (19.0%)	df=12
30-34	144 (17.3%)	41 (21.2%)	36 (24.3%)	47 (21.5%)	268 (19.3%)	
35-39	172 (20.7%)	39 (20.2%)	33 (22.3%)	41 (18.7%)	285 (20.5%)	
40+	285 (34.3%)	46 (23.8%)	27 (18.2%)	57 (26.0%)	415 (29.8%)	
Ethnicity						P<0.001
White	647 (77.8%)	2 (1.0%)	8 (5.4%)	69 (31.5%)	726 (52.2%)	681.8
Black African	125 (15.0%)	184 (95.3%)	134 (90.5%)	118 (53.9%)	561 (40.3%)	df=6
Other/Unknown	60 (7.2%)	7 (3.6%)	6 (4.1.0%)	32 (14.6%)	105 (7.5%)	
Route of infection						P<0.001
MSM	487 (58.5%)	3 (1.6%)	13 (8.8%)	54 (24.7%)	557 (40.0%)	377.6
Heterosexual	273 (32.8%)	185 (95.9%)	129 (87.2%)	138 (63.0%)	725 (52.1%)	df=6
Other	72 (8.7%)	5 (2.6%)	6 (4.1%)	27 (12.3%)	110 (7.9%)	
Deprivation[†]						P<0.001
Least deprived	251 (30.2%)	15 (7.8%)	20 (13.5%)	40 (18.3%)	326 (23.4%)	72.9
Average	189 (22.7%)	46 (23.8%)	44 (29.7%)	54 (24.7%)	333 (23.9%)	df=9
Most deprived	159 (19.1%)	66 (34.2%)	48 (32.4%)	59 (26.9%)	332 (23.9%)	
Unknown	233 (28.0%)	66 (34.2%)	36 (24.3%)	66 (30.1%)	401 (28.8%)	
Stage						P=0.225
Asymptomatic	566 (68.0%)	124 (64.2%)	97 (65.5%)	132 (60.3%)	919 (66.0%)	8.2
Symptomatic	140 (16.8%)	35 (18.1%)	27 (18.2%)	54 (24.7%)	256 (18.4%)	df=6
AIDS/death	126 (15.1%)	34 (17.6%)	24 (16.2%)	33 (15.1%)	217 (15.6%)	
Total (100%)	832	193	148	219	1392	

[†]Least deprived has index of multiple deprivation score less than 36, average is 36 to 58 and most deprived has a score of 59 or more

Table 8.3: Univariate and multivariate predictors of requiring a stay in hospital of at least one night

Variable	n	Univariate			Multivariate		
		Number (%)	Chi square	df	P	Adj OR (95% CI)	P
Sex			0.3	1	0.575		0.661
Male	907	141 (15.5%)				Reference category	
Female	485	81 (16.7%)				1.104 (0.709, 1.721)	
Age			7.6	4	0.108		0.527
Under 25	160	23 (14.4%)				1.652 (0.863, 3.162)	0.130
25-29	264	35 (13.3%)				1.140 (0.639, 2.034)	0.656
30-34	268	38 (14.2%)				Reference category	
35-39	285	43 (15.1%)				0.966 (0.555, 1.683)	0.904
40+	415	83 (20.0%)				1.157 (0.697, 1.92)	0.572
Ethnicity			4.9	2	0.087		0.427
White	726	102 (14.0%)				Reference category	
Black African	561	98 (17.5%)				1.42 (0.774, 2.602)	0.257
Other/Unknown	105	22 (21.0%)				1.434 (0.743, 2.769)	0.283
Route			30.1	2	<0.001		<0.001
MSM	557	61 (11.0%)				Reference category	
Heterosexual	725	127 (17.5%)				1.489 (0.866, 2.563)	0.150
Other/Unknown	110	34 (30.9%)				3.495 (1.925, 6.349)	<0.001
Deprivation[†]			13.1	3	0.004		0.007
Least deprived	326	55 (16.9%)				Reference category	
Average	333	46 (13.8%)				0.710 (0.433, 1.162)	0.173
Most deprived	332	38 (11.4%)				0.455 (0.267, 0.772)	0.004
Unknown	401	83 (20.7%)				1.002 (0.631, 1.590)	0.995
Residency			6.4	3	0.094		0.069
UK	832	131 (15.7%)				Reference category	
Asylum Seeker	193	41 (21.2%)				1.035 (0.577, 1.856)	0.908
Other non UK	148	17 (11.5%)				0.476 (0.237, 0.959)	0.038
Unknown	219	33 (15.1%)				0.673 (0.401, 1.128)	0.133
Stage of disease			298.6	2	<0.001		<0.001
Asymptomatic	919	61 (6.6%)				Reference category	
Symptomatic	256	43 (16.8%)				3.016 (1.936, 4.698)	<0.001
AIDS/death	217	118 (54.4%)				19.291 (12.822, 29.023)	<0.001
Total	1392	222 (15.9%)					

[†]Least deprived has index of multiple deprivation score less than 36, average is 36 to 58 and most deprived has a score of 59 or more

Table 8.4: Number of outpatient visits per year by demographics, infection route and stage of disease: univariate and multivariate analysis[†]

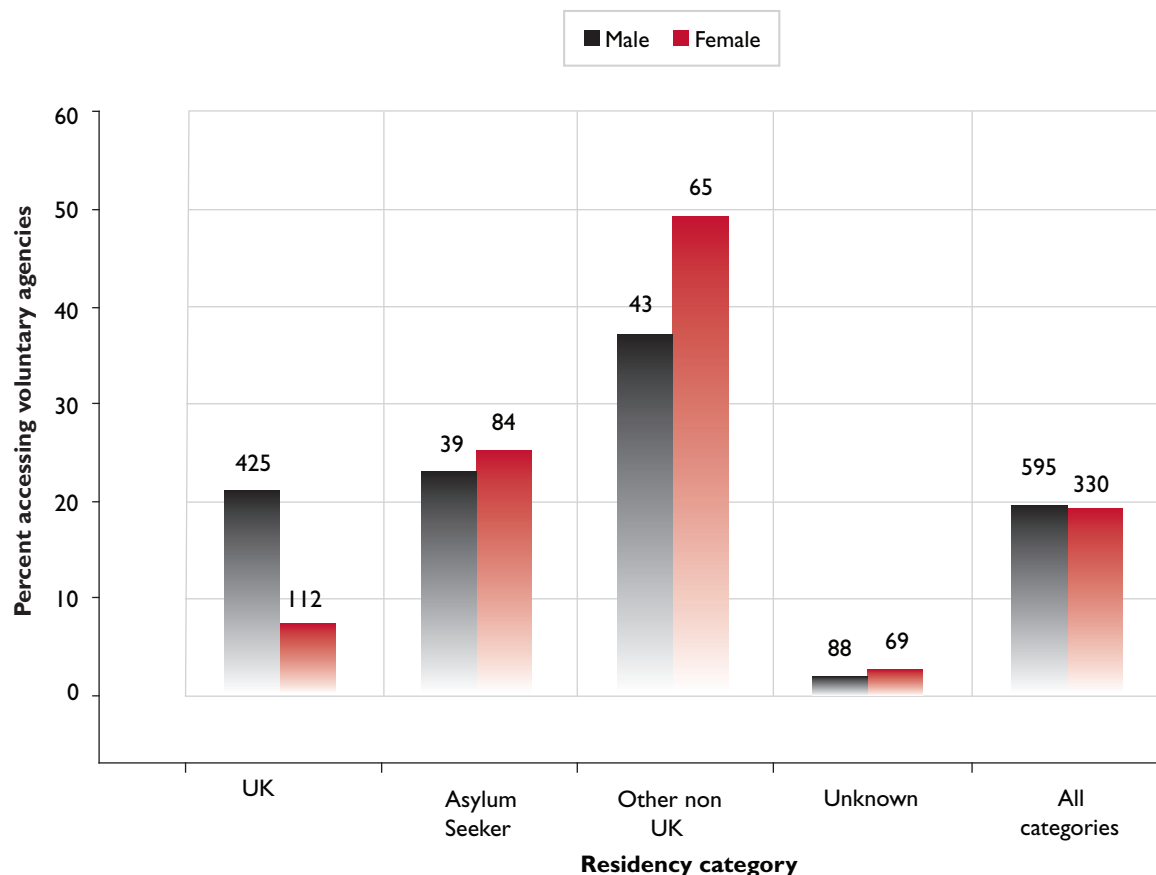
Variable	Univariate				Multivariate			
	Mean (95%CI)	df	F	P	Adj mean* (95%CI)	df	F	P
Sex		1	0.7	0.406				
Male	6.6 (6.3-6.9)							
Female	6.4 (5.9-6.8)							
Age		4	2.1	0.079				
Under 25	6.8 (6.0-7.7)							
25-29	6.0 (5.4-6.6)							
30-34	6.2 (5.7-6.7)							
35-39	6.5 (5.9-7.1)							
40+	7.0 (6.5-7.5)							
Ethnicity		2	1.8	0.165				
White	6.7 (6.4-7.1)							
Black African	6.3 (5.9-6.7)							
Other/Unknown	5.9 (5.0-7.1)							
Infection Route		2	8.5	<0.001		2	6.7	0.001
MSM	7.1 (6.6-7.5)				7.5 (7.0-8.0)			
Heterosexual	6.3 (6.0-6.7)				6.9 (6.5-7.3)			
Other	5.1 (4.3-6.1)				5.7 (4.9-6.6)			
Deprivation[#]		3	56.6	<0.001		3	53.8	<0.001
Least deprived	7.7 (7.2-8.3)				7.6 (6.9-8.3) ^a			
Average	7.9 (7.4-8.5)				8.0 (7.3-8.8) ^a			
Most deprived	7.3 (6.8-7.9)				7.3 (6.7-8.0) ^a			
Unknown	4.3 (4.0-4.7)				4.4 (4.0-4.8)			
Residency		3	1.1	0.37				
UK	6.7 (6.4-7.1)							
Asylum Seeker	6.4 (5.7-7.2)							
Other non UK	6.3 (5.5-7.1)							
Unknown	6.1 (5.5-6.8)							
Stage of disease		2	8.7	<0.001		2	8.9	<0.001
Asymptomatic	6.1 (5.8-6.4)				6.0 (5.6-6.3)			
Symptomatic	7.3 (6.7-8.0)				6.6 (6.0-7.3) ^a			
AIDS/death	7.4 (6.5- 8.4)				7.4 (6.7-8.3) ^a			
Total	6.5 (6.2-6.8)							

[†]Total outpatient visits: $F_{7,1369}=29.0$, $P<0.001$, adjusted $R^2=0.125$

*Adjusted means in the same group with the same letter do not significantly differ after post hoc analysis

[#] Least deprived has index of multiple deprivation score less than 36, average is 36 to 58 and most deprived has a score of 59 or more.

Figure 8.1: Percent of individuals in statutory care also accessing voluntary agencies, by sex and residency category (total numbers are above each bar)



Discussion

Records indicate that there were 193 asylum seekers receiving treatment for HIV in the North West from the beginning of 2005 to the middle of 2006. Of these, 119 were in contact with services for the first time in a one year period from mid-2005 to mid-2006 and were black African, for comparison with the 153 asylum seekers from Africa with HIV that would be predicted to have entered the North West in table 8.1. The estimate in table 8.1 was based on the number of asylum seekers supported in the North West, and made two assumptions: firstly that asylum seekers arriving in the UK from different African countries are dispersed equally across English regions; and secondly that the HIV prevalence in the country of origin would be reflected in the prevalence of HIV in asylum seekers coming from that country. The data used for the prediction also used a different time period (the whole of 2006). With these caveats in mind, these figures would suggest that over three quarters (119/153) of people with HIV from African countries seeking asylum were seen for treatment with the remaining unaware of their infection. However, the countries predicted in table 8.1 differed somewhat to the observed pattern in the HIV positive asylum seekers seeking treatment in the North West. These figures were less dominated by Zimbabweans (52% compared to 62% predicted) and Malawi, the second most common country (11%), is not listed as a common source of asylum applicants to the UK²⁴.

As expected, asylum seekers with HIV were predominantly black African (95%), heterosexually infected (96%), and were women (65%). Not surprisingly, asylum seekers were much more likely to live in the most deprived areas than were UK nationals (table 8.2). Since many live in supported accommodation with payments from the National Asylum Support Service (NASS) as the only source of income (around £40 per week for a single person²⁷), it follows that asylum seekers represent the poorest in society. For this analysis (and elsewhere in this report), deprivation was allocated on the basis of index of multiple deprivation score by lower super output area (LSOA), a geographical area with a standard population size of around 1,500 residents²⁸. Ideally, deprivation would be measured on an individual level, however, these area-based analyses confirm that asylum seekers represent the most materially deprived group (see also chapter 4, where the strong relationship between HIV and deprivation is explored further). For one third of asylum seekers, residential information was unknown. It is not clear why asylum seekers were less likely to provide clinics with accurate area of residence data (i.e. postcode), but lack of familiarity with postcodes by recent arrivals and language barriers are possible reasons.

There is a common perception that asylum seekers are more likely to present with more serious HIV disease²⁵. However, these perceptions may be generated by a relatively small number of individuals who present with very advanced disease. Indeed, in chapter 9, analysis of the small number of individuals whose diagnosis is followed shortly by death, compared to other people who died, demonstrates that asylum seekers and other migrants are over-represented in the late diagnosis group. A survey of migrants accessing the voluntary sector found that HIV

symptoms (in the case of 58%) and severe illness (27%) prompted their diagnosis of HIV¹. However, in this chapter it was shown that, in general, asylum seekers and other migrants in the North West were no more likely to present with more serious HIV disease (table 8.2), and no more likely to be admitted to hospital (table 8.3) after controlling for other demographic factors and stage of disease. They are also reported to have similar numbers of routine outpatient appointments as others with HIV, and thus do not appear to place a disproportionate burden on the health care system. These findings appear robust, since the same pattern was observed from earlier datasets (the beginning of 2001 to mid 2004)²⁹. In future years, for those granted refugee status or given leave to remain, it would be useful to assess whether having had a period as an asylum seeker has longer term consequences on health. In contrast to previous years²⁹, asylum seekers were not more likely to access voluntary agencies than other groups, with around one fifth of those receiving care from the statutory agencies also contacting the voluntary agencies.

Individuals classified as non-UK nationals, but who were not asylum seekers, had a similar profile to asylum seekers. The majority were black Africans (91%), heterosexually infected (87%) and were biased towards females (60%). This group included overseas students, people on work visas and temporary visitors. The numbers in these categories were too small to analyse separately, but as a whole there was no evidence that they presented to services at a later stage of HIV disease (60% were asymptomatic, compared to the total of 66%: table 8.2). Nor did they differ in attendance rates at outpatient clinics (table 8.4). They were marginally less likely to be admitted to hospital (table 8.3). However, this was the group that was most likely to present to voluntary agencies, especially among females (49% of whom accessed voluntary agency support: figure 8.1). This suggests that the needs of migrants were less related to HIV disease itself, and more to the other challenges of acclimatising to a new culture¹³. The group may also contain some failed asylum seekers and other groups whose immigration status is uncertain, who may have significant health and social care needs. These findings should be interpreted in conjunction with those in chapter 10, which focuses on use of the non-statutory sector and demonstrates that these agencies reach out to the poorest in society. The true rate of access to voluntary services is likely to be higher, particularly for migrants. This is because voluntary sector access was measured by matching identifying details from voluntary agency datasets with those from the statutory treatment services. Since full identifiers are not stored by the North West HIV/AIDS Monitoring Unit, this matching relies on accurate coding of the surname to soundex code (which may be more prone to error since the spelling of names of non-UK nationals may be less familiar), and accurate records of the dates of birth by both voluntary agencies and statutory treatment centres.

Although residency status was not linked to hospital admission, there was a significant effect of deprivation on hospital admission. These analyses were restricted to new cases of HIV, and the rate of admission was higher in new cases than all cases (14% overall compared to 11% for 2005: data not shown). The most deprived group were the least likely to be admitted to hospital, the reverse of the pattern shown for all cases (see chapter 4). This suggests that the factors that trigger a hospital stay are different for longer standing cases, perhaps with poverty having a cumulative effect on health over the years. Other factors linked to being admitted to hospital were route of infection, where those infected through non-sexual routes (via injecting drug use, from mother to child or contaminated blood) were the most likely to be admitted, as were those with more serious HIV disease, with AIDS or who died.

Those with no residential information had a much lower rate of attendance at outpatient clinics for routine monitoring and care, although they were more likely to be admitted to hospital. While this group does include some individuals with no permanent address, suggesting a more chaotic lifestyle, the lack of information gathered in many cases is likely to reflect clinicians limited knowledge of these patients (because of the lower rate of contact with services), and therefore not obtaining full residential information.

This chapter shows that non-UK nationals with HIV in general do not suffer greater levels of HIV-related ill-health than the resident population, do not use statutory services at a greater rate and are not more likely to be admitted to hospital. Two thirds have no symptoms of HIV when first seen for treatment, and may have been diagnosed during routine screening. This is contrary to popular opinion and media allegation that 'health tourism' is a significant factor attracting individuals with HIV to the UK. Rather, the difficulties and uncertainty associated with immigration leads to some categories of migrants being more likely to seek support from the voluntary sector. Asylum seekers and other non-UK nationals are more likely to live in poorer areas, and elsewhere in this report we show that poverty is a strong predictor of HIV-related ill-health. This overarching effect of deprivation needs to be addressed at all levels in society and in the health services if we are to see an overall improvement in the health of those with HIV.

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