

# Recent Migrants Using HIV Services in England



Policy, Campaigns & Research Division, Terrence Higgins Trust, October 2003

Data supplied by Terrence Higgins Trust (THT) and George House Trust (GHT)

This snapshot, undertaken in October 2003, used basic, anonymised information from recent users of THT and GHT services who are also adult migrants to the UK. It aimed to map

- when they arrived
- how they entered
- when they were diagnosed with HIV
- under what circumstances that diagnosis was made.

## Methods

The records of 60 recent users of services were examined by the following agencies: Lighthouse Kings (part of THT) in South London (14), George House Trust in Manchester (24), Terrence Higgins Trust in the West Midlands (22). The identifying factors for selecting records were that they should be of the most recently presenting migrants with HIV who had asked for support and who had provided enough information about their circumstances for staff to be able to complete the survey with confidence.

## Countries of origin

In all, seventeen different countries were represented, 15 of them African. Of the 60 people whose case notes were revisited, just over 50% (31) were of Zimbabwean origin. One in twelve (5) was from Uganda. Only 7% (4) were not from Africa, of whom three were Jamaican and one Afghani.

## Date of entry

Just over 18% (11) had arrived in the UK before 2000. Ten entered in 2000, nine entered in 2001 and 20 (33%) entered in 2002. Only five had arrived in the first nine months of the current year, 2003. Five people did not have dates of entry in their case notes. The numbers appear to rise in 2002 and then return to a steady level, and this may be explained in part by the preponderance of Zimbabweans. 2002 was a particularly turbulent year in Zimbabwe, with many people fleeing persecution and others taking advantage of work or study opportunities to stay away from the violence

and intimidation in their home country. Other data on migrants and people seeking asylum in 2002 confirms an across-the-board rise in the number of Zimbabweans entering the UK in that year.

### **Method of entry**

Despite many suppositions to the contrary, only 13 (22%) in all were recorded as having entered the UK to seek asylum. Almost half of these were Zimbabwean (6), with others being from Uganda, the Congo, Sierra Leone and Afghanistan – all areas of acknowledged political turbulence within the last few years. Another 12 (20%) had entered to study. A similar number, 13 (22%) had entered as visitors for unspecified reasons, with a further seven (12%) coming to join family already here. Others had come on work visas, to join the army or to get married. Method of entry to the UK was not known in 11 (18%) cases, but this was incomplete data records on the part of the responding agencies rather than failure to disclose. Most HIV support agencies only collect data necessary to respond to someone's support needs and reason for original entry to the UK may not have been relevant to these in all cases.

These findings indicate that there is no identifiable single way in which people subsequently diagnosed with HIV are entering the UK; rather, the picture is a complex and diverse one. It strongly suggests that making testing a condition of work visas (a common move amongst industrial countries to quiet popular fears about HIV and migration) would have very little impact upon the issue. It is also clear that the commonly made link between asylum and HIV is a tenuous one.

### **Date of diagnosis**

Five people were diagnosed with HIV before 2001, with a further four diagnosed in 2001. Ten people were diagnosed in 2002, with the vast majority, 41 (68%) diagnosed only recently, in 2003. To some extent, this may reflect the fact that recently diagnosed people may be those most likely to access community services, but it also reflects the pattern of diagnoses amongst African migrants to the UK and recent testing campaigns targeted at those communities. There is also a likely link to the rising efficiency of antenatal testing, through which an increasing number of heterosexual women with HIV are being identified.

### **Time between entry and diagnosis**

In order to examine the contention that people are entering the UK with the specific intention of obtaining treatment, two other pieces of data were examined; length of time between arrival in the UK and diagnosis, and circumstances of diagnosis. Only five people (8%) were diagnosed within three months of entry to the UK. The most common timespan between entry and diagnosis was ten to twelve months, with 14 people (23%) diagnosed at this time. In all, at least 45 (75%) waited more than 9 months to test after their entry. One third of people in the cases examined (20) had tested more than eighteen months after entry. In six cases (10%), it was not possible to determine the length of time between entry and testing due to missing data.

This data militates against the argument that people are coming to the UK in order to obtain treatment. Were this the case, one would expect to see a far swifter progression in the overall data from arrival to testing, rather than three quarters of people testing

after nine months or more. This view is strengthened by the final category of data collected below.

### **Impetus to test**

Possibly the most interesting data was on how people came to be tested. This data was available for all 60 people, as something highly likely to have been relevant to the reasons they initially sought help from the organisation. By far the most common reason given for testing was the onset of symptomatic HIV, with 35 people (58%) testing when they became actively unwell. Almost half of these people (27% in all) fell severely ill before diagnosis, as measured by CD4 counts, emergency admission to hospital, or conditions such as TB. Ten women were diagnosed antenatally (17%) through routine offers of testing to all pregnant women. Another nine (15%) tested only after the death or diagnosis of a partner. Only two people reported being diagnosed prior to entering the UK, and only one person (less than 2% of the sample) was diagnosed as the result of an unprompted visit to a GUM clinic. Other ways in which people came to test included testing following sexual assault, army medical and a medical for a visa.

This data shows that people discovered their HIV status by a wide range of methods common amongst those who are unaware that they have HIV. More than a quarter became severely ill before being diagnosed with HIV, some having presented at hospital with mystery symptoms a number of times or succumbing to life-threatening conditions before HIV was suspected; not the mark of people undertaking "treatment tourism". In only one case out of the 60 examined had someone attended at a GUM clinic for sexual health screening without an obvious external trigger, the action most likely by someone who might be already aware of their HIV status and wanting to access services for it.

Obviously, this is a relatively small sample and there is a need for further investigation of a wider cohort. However, it is clear that the picture is a far more complex one than most coverage of the issue has suggested.

- People with HIV arrive in the UK in a wide range of ways for many reasons
- Many are diagnosed in a manner that contraindicates any previous knowledge of their condition
- The majority do not obtain a diagnosis early upon arrival in the UK, but in the course of ordinary living over an extended period of time
- Many are spurred to test by the onset of ill health associated with relatively late stage HIV.

Terrence Higgins Trust would welcome further factual investigation of this issue, in order to conduct the debate about migration, treatment tourism and sexual health in a more constructive and rational manner.