SHORT REPORT

Treatment and care of HIV positive asylum seekers

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Background: Enhanced regional surveillance in north west England suggests that the proportion of HIV positive people who are asylum seekers (AS) is increasing. Nationally, there is no empirical evidence that HIV positive AS use HIV services to a greater or lesser extent than HIV positive non-AS. This report compares stage of disease and use of services between HIV positive non-AS and AS.

Methods: Data on those accessing HIV treatment and care (from hospitals and non-governmental organisations (NGOs)) in the north west of England for the first time January 2001–June 2004 (total 2204; AS 409) were extracted from the regional enhanced surveillance system.

Results: Compared with non-AS, AS did not differ in stage of HIV disease on first contact ($p > 0.05$), were no more likely to stay overnight in hospital ($p > 0.05$), but had an average of one extra outpatient appointment per year (median seven compared with six, $p = 0.014$). AS were much more likely to have accessed NGOs for support (43% compared with 27%; $p < 0.001$).

Conclusions: Use of specialist hospital services by HIV positive AS differs little from HIV positive persons who are not AS. However, HIV positive AS rely more on NGOs at a time when such voluntary services are under increasing financial pressures.

Internationally, health needs of asylum seekers (AS) are a growing concern. AS can be portrayed as a burden upon health services in general and especially when considering diseases such as HIV.¹ In the UK, while treatment and care services are available free of charge to AS, such persons face barriers to accessing screening and GP services,² feel stigmatised by healthcare screening processes,³ and can be reluctant to seek help.⁴ Moreover, there is a lack of information about the number and health needs of AS, hampering attempts to plan for their needs.⁵ Currently, no national data are collected on HIV in AS in the UK. However, enhanced regional surveillance in the north west of England shows the proportion of people (in HIV treatment) who are AS increased from 3% (59 of 1964) in 2001 to 11% (408 of 3574) in 2004. Here, the same enhanced system allows us to compare the health status of AS and non-AS when they first enter HIV services (as measured by their stage of HIV disease), the amount of clinical services received (in terms of clinic appointments and hospital admissions), as well as support received from non-governmental organisations (NGOs).

METHODS

The enhanced regional surveillance system has collected longitudinal data on all people accessing hospitals and specialist HIV NGOs annually since 1996. A subset of the variables from the hospital dataset is submitted to the national HIV surveillance system (survey of prevalent HIV

diagnosed (SOPHID)). For this study, data were extracted from records of all HIV positive persons accessing treatment for the first time in the north west between January 2001 and June 2004 (2204 persons, of whom 409 were AS). The ethical approval governing the maintenance and development of the surveillance system incorporate data extraction for monitoring and research purposes. Basic demographics (sex, ethnicity, age, infection route), stage of HIV disease when first seen (to measure health on first presentation), access and use of treatment and care services (whether the patient had ever required a stay of at least one night in hospital, number of outpatient clinic appointments per year), and latest antiretroviral therapy (ART; to measure differences in prescriptions) were compared. Independently, data were also collected from NGOs to establish which people had used these during the same period. After univariate comparisons, the continuous variable clinic visit rate (square root transformed to improve normality) was entered as the dependent variable in a general linear model. Potential predictors and all two way interactions were included and then non-significant predictors and interaction terms were removed in a stepwise manner until only significant terms remained. Logistic regression was carried out on the binary dependent variables (ART, hospital overnight visits). Data were analysed on SPSS (version 12).

RESULTS

Most AS were female (68%) infected via heterosexual sex (95%), compared with 23% ($\chi^2 = 312$, $p < 0.001$) and 35% ($\chi^2 = 479$, $p < 0.001$) correspondingly for non-AS. Most AS were black African (95%) with a further 1% in other black categories, while 22% of non-AS were in black ethnicity categories. AS were significantly younger (median 33 years) than non-AS (37 years, $Z = 7.6$, $p < 0.001$).

Univariate analysis showed that AS were no more likely to enter services at a later stage in their HIV disease (68% of AS were asymptomatic compared with 62% of non-AS, $\chi^2 = 6.8$, $df = 4$, $p = 0.148$), and no more likely to stay overnight in hospital ($p > 0.05$, table 1). After multivariate adjustment, ethnicity, but not AS status, was a significant predictor of hospital admission, with people from black ethnic groups being less likely than white persons to have been admitted (table 1). AS were more likely to be prescribed ART, although this relation did not remain significant after logistic regression (table 1). AS had an average of one extra outpatient appointment a year (median seven compared with six, $Z = 2.45$, $p = 0.014$). After accounting for other factors, the significant terms predicting number of clinic attendances were route of infection ($F_{2,2198} = 42.4$, $p < 0.001$) and an interaction between AS status and sex, with male AS having a higher rate of clinic appointments ($F_{3,2198} = 3.89$, $p = 0.009$). AS were much more likely to have accessed the NGOs for care (43% compared with non-AS (27%; $\chi^2 = 27.9$; $p < 0.001$).

CONCLUSIONS

AS were much more likely than non-AS to have accessed an NGO, reflecting their more complex social care needs.

Table 1 Univariate (χ^2) and multivariate (logistic regression) predictors of receiving antiretroviral therapy (ART) and being admitted to hospital for at least one night

	N	ART				Hospital admission			
		Univariate		Multivariate		Univariate		Multivariate	
		No (%)	p	Adj OR (95% CI)	p	No (%)	P	Adj OR (95% CI)	p
Sex									
Male	1520	767 (50.5)		Ref		357 (23.5)		Ref	
Female	684	424 (62)		0.75 (0.57, 0.98)	0.038	204 (29.8)	0.002	0.83 (0.61, 1.12)	0.225
Age									
Under 25	212	87 (41)	0.000	Ref	0.001	50 (23.6)	0.001	Ref	0.718
25 to 39	1277	666 (52.2)		1.54 (1.11, 2.13)	0.010	293 (22.9)		0.86 (0.58, 1.26)	0.433
40+	715	438 (61.3)		1.94 (1.36, 2.77)	0.000	218 (30.5)		0.9 (0.59, 1.36)	0.606
Infection route									
Sex between men	958	446 (46.6)	0.000	Ref	0.047	189 (19.7)	0.000	Ref	0.001
Heterosexual	1025	630 (61.5)		1.42 (1.05, 1.93)	0.024	295 (28.8)		1.59 (1.13, 2.24)	0.008
Other/not known	221	115 (52)		0.96 (0.68, 1.37)	0.832	77 (34.8)		1.96 (1.34, 2.86)	0.000
Stage of disease									
Asymptomatic	1392	584 (42)	0.000	Ref	0.000	191 (13.7)	0.000	Ref	0.000
Symptomatic	415	324 (78.1)		4.93 (3.8, 6.41)	0.000	136 (32.8)		3.05 (2.35, 3.96)	0.000
AIDS	312	270 (86.5)		8.26 (5.83, 11.72)	0.000	197 (63.1)		10.24 (7.69, 13.63)	0.000
AIDS related death	30	6 (20)		0.3 (0.12, 0.75)	0.010	28 (93.3)		95.1 (22.2, 407.4)	0.000
Unknown*	55	7 (12.7)		0.21 (0.09, 0.47)	0.000	9 (16.4)		1.37 (0.65, 2.9)	0.405
Ethnicity			0.000		0.314		0.024		0.013
White	1248	628 (50.3)		Ref		311 (24.9)		Ref	
Black	784	470 (59.9)		0.93 (0.68, 1.28)	0.669	210 (26.8)		0.67 (0.48, 0.95)	0.026
Asian subcontinent	50	31 (62)		1.51 (0.78, 2.92)	0.219	19 (38)		1.14 (0.56, 2.33)	0.710
Other/mixed/NK	122	62 (50.8)		1.31 (0.85, 2.02)	0.224	21 (17.2)		0.48 (0.28, 0.85)	0.011
Asylum seeker status			0.001		0.096		0.716		0.412
Non AS	1795	939 (52.3)		Ref		454 (25.3)		Ref	
AS	409	252 (61.6)		1.29 (0.96, 1.75)		107 (26.2)		1.15 (0.82, 1.63)	

*Univariate p values remained significant when repeated without unknown category.

Paradoxically, while this population contributes to a growing HIV positive population, funding is being diverted from NGOs to statutory services.⁶ In contrast with anecdotal evidence, two thirds of AS showed no symptoms of HIV when first seen, suggesting they may be unaware of their HIV status and challenging assertions that free treatment is their primary reason for entering the UK. After controlling for AS status, stage of disease, and other demographic and infection details, people categorised as being from black ethnic groups were significantly less likely to be admitted to hospital. This may reflect service design issues or cultural differences around accessing care.

This is the first attempt in the UK to evaluate the health status of HIV positive AS compared with non-AS for an entire HIV positive population. The classification of AS status relied on clinician reports, and may have been open to error. There are other non-UK residents (for example, students and people with temporary working visas) who access HIV services, for whom no data are currently collected. However, we have shown that AS are accessing services in time to benefit from lifesaving treatments, use treatment and care at comparable rates to non-AS, and are accessing support from NGOs to a greater extent. To fully understand

the implications more should be done at a national level to monitor the health of this vulnerable population.

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What is already known on this topic

- Media allegation and sometimes popular opinion suggest that HIV positive asylum seekers are health tourists who place a disproportionate burden on health service
- Information on asylum seeker status is not collected as part of national HIV surveillance, and their stage of disease status on contacting services, use of services, and access to other support mechanisms is unknown

What this paper adds

- Empirical data on asylum seekers accessing HIV treatment for an entire English Region identifies that stage of HIV disease when asylum seekers first contact specialist services and their use of such services is in general no different to HIV positive people who are not asylum seekers
- HIV positive asylum seekers rely more on non-governmental organisations than other HIV positive people at a time when such voluntary services are under increasing financial pressures

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