

HIV health experiences among migrant Africans in Europe: how are we doing?

Julia del Amo^a, Georg Bröring^b and Kevin Fenton^c

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Research into health and migration is an area of growing interest, with many continuing to focus on the description of so-called ‘imported diseases’ or comparing disease burden in migrants from different countries in order to improve understanding of disease aetiology. In Western industrialized settings, these research studies have often considered migrants as ‘outsiders’, giving rise to concerns about ethnocentrism and racism [1–3]. Over the last few years, new approaches to researching the health of migrant populations and ethnic minorities have been proposed, and more attention is now being paid to the wider determinants of ill-health in these groups, such as social exclusion, racism and social disadvantage [4,5].

Despite these advances, relatively few studies have focused on the health experiences of migrant populations living with HIV in Europe, or on their patterns of access to, and utilization of, HIV treatment and care. In this issue of *AIDS*, Staehelin *et al.* [6] describe the characteristics, access to antiretroviral therapy, disease progression and survival of migrants from Sub-Saharan Africa in the Swiss HIV Cohort Study. They show a steady increase in the proportion of Sub-Saharan Africans entering the study between 1984 and 2001.

This trend is consistent with patterns observed in other Western European countries in the last few years, reflecting patterns of international migration and population movement and the impact of global HIV/AIDS epidemic; it also confirms the evolving nature of the HIV epidemic among migrants in Europe [7–9]. Data from EuroHIV indicate that, where information on geographic origin was available, 12.4% of those with AIDS diagnosed between 1997 and 1999 in Western Europe were foreigners. Of these, the commonest area of origin was Sub-Saharan Africa (5.5%), followed by other western Europeans (2.5%), North Africans (1.6%) and Latin Americans (1.3%) [9].

HIV-positive men from sub-Saharan Africa in the Swiss cohort presented with more advanced HIV infection, though this was not observed in sub-Saharan women. The nature of disease in women may reflect the implementation of antenatal HIV screening, but other factors, including differential migratory patterns and patterns of health-care access and utilization, may also operate. Late presentation of migrants and ethnic minorities have been reported in hospital-based studies in the UK [10,11] and population-based AIDS Registers in Europe [7] before and after the widespread

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From the ^aDepartment of Public Health, Miguel Hernández University, Alicante, Spain, the ^bAIDS&Mobility Project, Netherlands Institute for Health Promotion and Disease Prevention, Woerden, the Netherlands, the ^cMigration, Ethnicity and Sexual Health Programme, Centre for Infectious Disease Epidemiology, Royal Free and University College Medical School, London, and the HIV/STI Division, Health Protection Agency, Communicable Disease Surveillance Centre, London.

Requests for reprints to: Dr J. del Amo, Departamento de Salud Pública, Universidad Miguel Hernández, Campus de San Juan, Ctra, Alicante-Valencia Km.87, 03550 San Juan-Alicante Spain. Email: jamo@umh.es

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availability of highly active antiretroviral therapy (HAART). Even in the Western European context of universal health care, migrants and ethnic minorities often face strong barriers to accessing HIV/AIDS prevention and care services, many of which lie outside the health-care setting and require community-based interventions [12]. Studying the inequalities in access to health-care services, therefore, requires information provided by the community to complement that obtained from hospital-based cohorts. In a recent report from the *Seventh European Migrants Meeting: Access to HIV Care and Support for Migrants and Ethnic Minorities in Europe*, the European network AIDS&Mobility concluded that treatment of HIV/AIDS should acknowledge the precarious social and administrative circumstances of these communities and also that many friends and relatives at home have no access to antiretroviral medications [13].

Nevertheless, despite these barriers, it is reassuring to note that, once migrants eventually reach effective HIV treatment and care services in Europe, there are no differences in the uptake of HAART, in progression to AIDS or in survival. This main conclusion of the Swiss HIV Cohort Study has also been reported by other hospital-based studies in Europe [10,14]. HIV-positive Africans in London presented later than non-Africans and had similar progression rates to AIDS and death [10] and the EuroSIDA Study Group found that AIDS was diagnosed at the same level of immunodeficiency for subjects of European and non-European origin, with no differences in the level of CD4 cell count at which treatment was initiated, or in survival [14]. Similar results were obtained repeating analyses using the variable ethnic group instead of area of origin [14].

Stahelin *et al.* [6] raise concerns about the lack of ethnicity data in the Swiss Cohort, which may have lead to misclassification. This underscores the importance of understanding and clarifying the terminology used [15]. At present, substantial heterogeneity exists across Europe in the definition of 'migrants' and time at which migrants become, or may be considered to be, ethnic minorities. Nevertheless, no matter how unscientific these classifications may be, they provide a rough tool to capture and measure the reality of racism and discrimination within our societies [16,17]. In the United States, where racial/ethnicity data have historically been collected, there is clear evidence of racial/ethnic disparities in the use of antiretroviral drugs and prophylaxis for opportunistic infections [18–20]. Monitoring racial/ethnic discrimination requires variables that help to classify populations, and how best to do so is an area of intense debate [1,7,15–17,21,22]. This is particularly an issue in Europe, where data on race/ethnicity have not been collected historically. Parallel efforts should also be made to measure contextual variables, conduct multilevel analyses and to explore

how belonging to an ethnic minority affects health outcomes in the presence of different macroeconomic and social determinants. Since the integration of migrants in health services is a reflection of their integration in society, the variables 'migrant' or 'ethnic group' may have different prognostic value in different settings.

So what are the implications for HIV prevention and control among migrants in Europe? HAART is making inequality in HIV care more visible even in countries with free and universal access to antiretroviral drugs [20,23,24]. Health-care interventions alone cannot be expected to eradicate the racial/ethnic differences in access to health and health outcomes. Continued efforts are required to improve understanding of the health experiences of migrants and ways in which prevention policies may be best tailored to suit diverse and often conflicting needs. The data confirm that more concerted approaches need to be adopted for ensuring the health and well-being of migrant populations. Strengthening liaisons between HIV clinical care settings, surveillance networks, researchers and communities is the best way to achieve common goals.

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