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# **MIGRANTS AND HIV STIGMA: FINDINGS FROM THE STIGMA INDEX STUDY (UK)**

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## ABBREVIATIONS

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AIDS	Acquired Immune Deficiency Syndrome
HPA	Health Protection Agency
HIV	Human Immune Deficiency Virus
IPPF	International Planned Parenthood Federation
NHS	National Health Service
UN	United Nations
STI	Sexually Transmitted Infections
UK	United Kingdom

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## FOREWORD

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## EXECUTIVE SUMMARY

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The Human Immune Deficiency Virus (HIV) has affected families and individuals for over three decades. Despite developments in the clinical and social care of people living with HIV, 'stigma' remains one of the areas where it is complex to measure progress. The Stigma Index is an international action research intervention assessing experiences of stigma by people living with HIV. This report is based on results of the migrant sub-sample of the UK Stigma Index Survey questionnaire respondents. Key findings include:

- 276 survey participants described themselves as 'migrants': 195 women and 81 men. All women and 74 men reported heterosexual identities. They were 7 gay or bisexual men. Most participants were above 40 years of age, reflecting the ageing profile of people living with HIV in the UK.
- Most participants lived in major cities including London, Manchester and Leeds, with a few in rural areas.
- Deprivation was a key theme, reflecting research findings from other studies amongst HIV-affected immigrants in the UK. Most participants reported that they were unemployed. A fifth reported that they had experienced episodes of food insufficiency in the past year.
- Survey respondents reported other stigmatised chronic conditions and physical disabilities that compounded their experiences of living with HIV-related stigma.
- Control of information about a positive diagnosis is critically managed by persons living with HIV. More than half the survey participants reported that they had personally disclosed to family members. Ten percent reported a breach in confidence where members of their families had been informed about their HIV status without participants' consent.
- 40 men and 90 women reported that they had personally told their sexual partners that they were living with HIV. In 12 cases participants reported that they gave consent for someone else to inform their partners. As above, in some cases, disclosure to sexual partners, presumably by a third party occurred without the participants' consent.
- Felt stigma was common. Over half of the survey participants reported feeling ashamed because they were living with HIV. There were concerns about breaches of confidentiality, as some participants perceived that others were 'gossiping' about their positive HIV diagnosis.

- Felt stigma increased anxieties about personal safety, particularly amongst men. Male survey participants were three times more fearful than women of being insulted, physically harassed and/or assaulted. Depression was also reported. Nearly half the number of men and a third of the women reported that they felt suicidal.
- Personal strategies for safeguarding against the negative impact of stigma included avoiding social gatherings, friends, intimacy, clinical and social care settings.
- Participants believed that stigma arose through ignorance about HIV and how HIV was transmitted.
- Most participants were unaware of policies and declarations that protected them as persons living with HIV. Although some participants believed that their human rights had been violated, they were unlikely to seek legal redress.

## KEY RECOMMENDATIONS

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The involvement of people living with and affected by HIV is important in designing anti-stigma interventions as this gives HIV a 'human face' and increases the cultural relevancy of such interventions. Anti-HIV stigma campaigns embedded in human-rights approaches may help fight the discrimination experienced by people living with HIV. Based on experiences reported by the UK Index Study migrant sub-sample it is recommended that:

- Efforts to fight stigma must recognize the social determinants of health, that is, the individual cultures interacting with wider social and political factors to impact on health and wellbeing of migrants living with HIV. Such efforts should take account of discourses emanating from, for example, race, racism, migration. Efforts to fight stigma amongst migrants should utilize orchestrated efforts and collaborative partnerships between policy makers, HIV activists, academics, health planners and individuals living with HIV.
- Efforts to fight stigma must seek to build capacity in human rights approaches amongst migrant community groups, policy makers and individuals. This can be achieved through training, skills building and increasing networking opportunities amongst various stakeholders. Initiating such cultural shifts in the workforce, will enable workers and people living with HIV to incorporate human rights approaches in anti-stigma campaigns.
- Efforts to fight stigma must seek to increase mentoring opportunities amongst migrant communities living with HIV so as to fight stigma' from within'.
- Efforts to fight stigma must extend HIV awareness campaigns beyond the 'suspect high risk groups' that have historically included gay men and African communities.

## **INTRODUCTION: MIGRANTS AND STIGMA IN THE UNITED KINGDOM**

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Debates about marginalising and discriminating people on the basis of poorer sexual health outcomes, disabilities and mental health have a long history. The word 'stigma', originally meaning a mark of disgrace, is also used as a metaphor by Goffman (1963) to capture the experiences of socially excluding people who cannot conform to what is perceived as 'normal' by the larger society. Individuals suffer from 'felt stigma' when they internalize negative perceptions regarding themselves (Yebei, 2008). The experiences of HIV-related stigma are varied and change dynamically throughout the course of living with HIV.

In 2003 an All-Party Parliamentary Group on AIDS identified growing stigma surrounding people with HIV in the UK, in particular against migrants and asylum seekers. The stigma experienced by immigrants in the UK has been heightened by stories printed in the media. There is a perception that immigrants, and asylum seekers in particular, enter the UK so as to access HIV treatment. However, compared to non-migrants, immigrants, including asylum seekers, access HIV clinical interventions later in the course of living with HIV, thereby questioning such 'health tourism' claims (National AIDS Trust and Terrence Higgins Trust, 2006)

Migration has always been at the centre of the UK HIV epidemic. Some of the earlier HIV cases amongst migrants were identified in London hospitals (Low et. al 1996). In the UK, migrants living with HIV present with a whole range of complex social as well as clinical issues, including pending immigration asylum applications, poverty and limited knowledge about local health and social care services (Prost, 2008). According to the United Nations Convention Relating to the Status of Refugees (1951), asylum is the process of seeking protection from another country for reasons of fear of persecution in one's own country. In the UK, 'migrants' are a very diverse group that includes asylum seekers, students, work permit holders and tourists.

It is estimated that, in 2008, there were approximately 77,500 people infected with HIV in the UK. The most affected groups are men who have sex with men (N= 24,350), heterosexual women born in Africa (N=13,850), heterosexual men born in Africa (N=6,650) and other heterosexual groups including men and women born in the UK and outside the UK (HPA, 2009). Immigrants from high-endemic countries are largely affected by HIV.

## **INTERVENTIONS TO COMBAT STIGMA IN THE UK**

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In the past there have been a number of interventions that aimed to combat stigma, including posters, seminars, workshops, peer support and research. *Stopping Stigma with Awaradressers* was a qualitative study that explored reactions to the THT HIV Prejudice and Discrimination Poster Campaign following distribution of the campaign posters through the Awaradressers network of hairdressers, barbers, shopkeepers and restaurateurs in Barnet (Elam, 2004). Support for the Awaradressers project was high amongst African business volunteers, their customers and other residents. Other researchers have found that integrating asylum seekers into mainstream services may help reduce the stigma of accessing such services (Allan and Clarke, 2005). Others recommend that clinicians seeking to assist members of the migrant population to disclose need to assess the specific reasons for, and barriers against, disclosure for that individual (Calin et al 2007).

## **THE UK STIGMA INDEX STUDY**

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The Stigma Index action research Study (also referred to as the Stigma Index Study) was an international endeavour to empower people living with HIV to enforce change around anti-stigma and anti-discrimination practices. The Stigma Index study fostered voices of people living with HIV in bringing about the change, through training, research, advocacy and fostering opportunities for change.

In the UK, the Stigma Index Study used a hub and spoke model of community engagement in HIV interventions (see Fenton et al, 2002). This was a mixed method study, co-ordinated by the International Planned Parenthood Federation (IPPF), London Office. The IPPF was the 'hub' collaborating with HIV community groups and organisations the 'spokes'. Some people living with HIV were recruited from these 'spokes' and then trained in action research methods. These trained individuals then recruited the survey sample and facilitated focus group discussions, conversations about stigma and the research amongst their peers. In 2009 a sample of 867 people living with HIV in the UK took part in the Stigma Index study. This report is informed by data from the survey questionnaire, with a special focus on the migrant sub-sample, i.e. people who completed the questionnaire and described themselves as 'migrants'.

### **AIM OF REPORT**

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This report uses quantitative data generated from the Stigma Index Study to explore the different layers of stigma experienced by migrants living with HIV in the UK. The report :

- Describes the demographic characteristics of the migrant sample
- Explores the migrant sample's experiences of actual and perceived stigma and discrimination
- Describes migrant sample's awareness of anti-stigma policies and legislations
- Makes recommendations for policy and practice that are informed by evidence from the UK migrant sub-sample

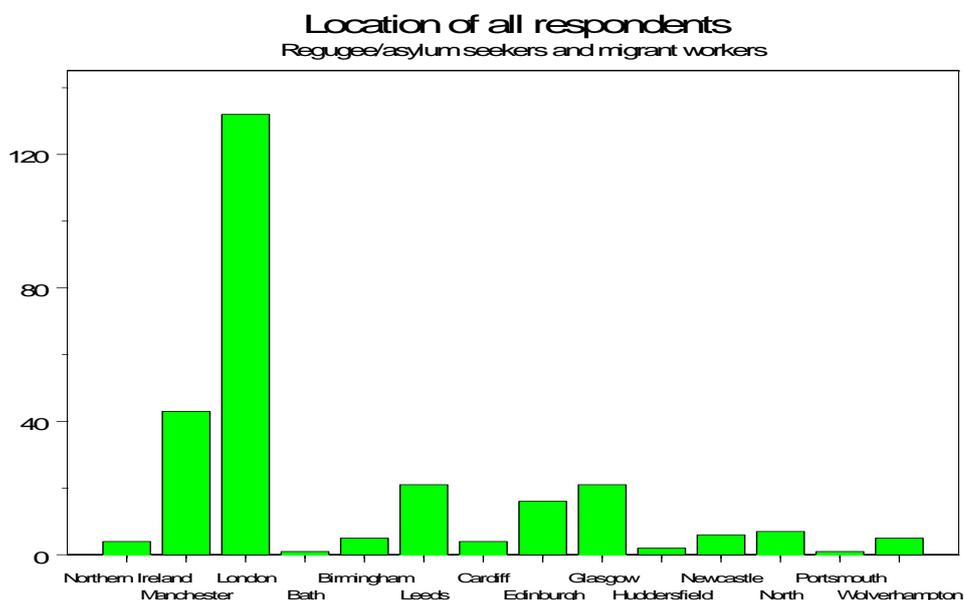
## MIGRANT DEMOGRAPHIC CHARACTERISTICS

In the UK 867 people living with HIV took part in the Stigma Index Study. 22% (N=276) described themselves as 'migrants'.

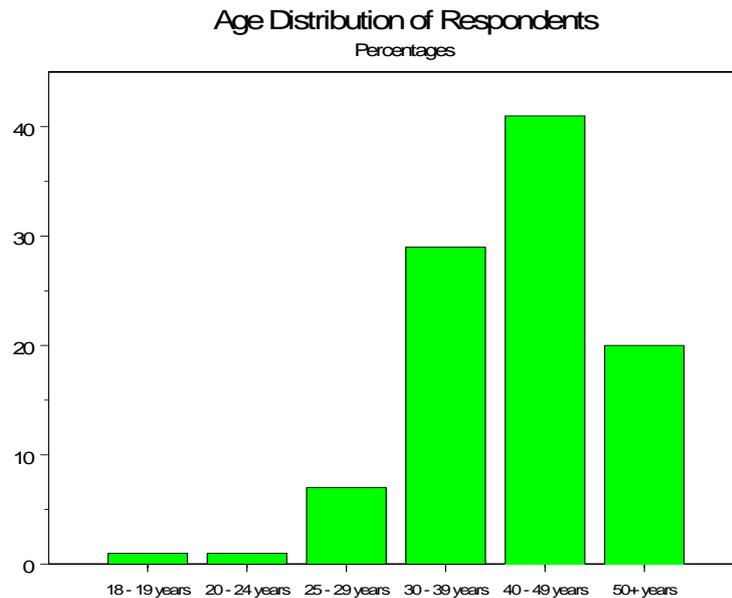
**Sex:** Most migrant participants (71%) were women (N= 195) .A majority of the 81 men (91%) and all the women reported heterosexual identities. Seven men (8.6%) reported gay and/or bisexual identities. No women reported lesbian and/or bisexual identities. The over-representation of women in this sample is not surprising as the HPA (2009) reported that women born outside the UK were the largest group affected by heterosexually contracted HIV in the UK.

**Residential location:** location reflects the historical settlement patterns of migrants in the UK: London, Manchester, Leeds, Cardiff and a few in Glasgow, Newcastle and rural England. Figure 2 illustrates this distribution.

**Fig 1: Location of the respondents**



**Fig 2: Age distribution**



**Age:** Over a third of the survey participants reported that they were within the age groups 40-49, followed by those aged 30-39, with those above 50 years the third largest group. There were fewer participants below 29 years of age. This age profile reflects findings from other UK studies that indicate that the population of people living with HIV is getting older.

**Living arrangements:** 125 participants (45%) reported that they lived alone and 80 (29%) reported having other people; including sexual partners and children in their households (Can we say where the other 26% are?). Living alone also indicates increased isolation. Asylum seekers are more likely to be isolated than UK residents and it has been suggested that the provision of befriending or mentoring schemes would be a useful (Allan and Clarke 2005; Anderson et al, 2008).

**Sexual behavior:** 81% of men and 51% of women reported that they were sexually active. This is not surprising, as research on sexual behaviours of migrant populations in UK settings has shown that more men than women report being sexually active (see also Fenton et al 2002).

**Table 1: Sexually active by gender**

			Sexually active		Total
			Yes	No	
Gender	Male	Count	66	15	81
		% within Gender	82%	18%	100%
	Female	Count	99	95	194
		% within Gender	51%	49%	100%
	Total	Count	165	110	275
		% within Gender	60%	40%	100%

**Marital status:** survey participants reported varied marital statuses with a third of the participants single; 23% in a non-cohabiting relationship 20% married and living with their partners, 7% widowed or divorced, and 5% married to an absent partner.

**Education:** Participants reported different levels of education with over half (58%) reporting post secondary school education, almost a third (32%) secondary education and a few (10%) no education or primary school education.

**Employment:** compared with the national unemployment rates, the respondents reported much higher levels of unemployment (79% for women and 69% for men) or casual working patterns as shown in table 2:

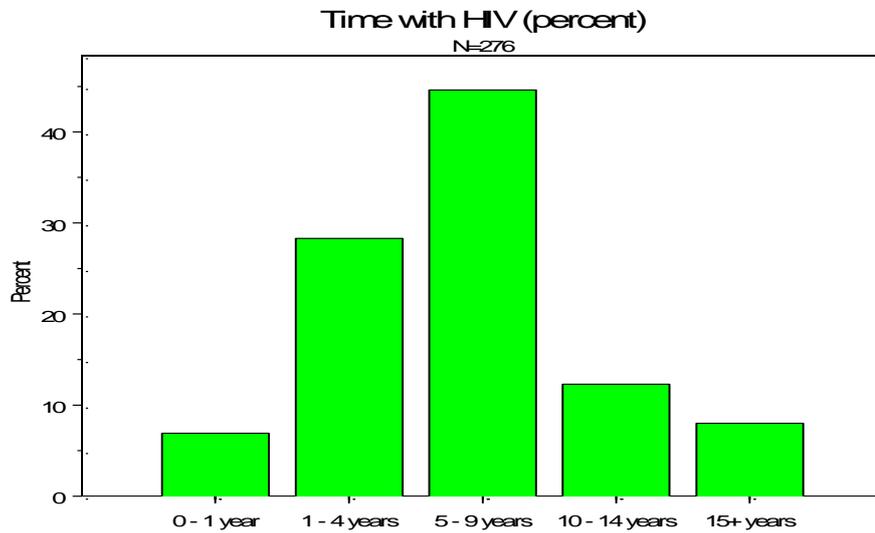
**Table 2: Employment Status by Gender**

Gender		Full time employee	Part time employee	Full time self employed	Casual/part time self employed	Unemployed/not working
Male	N (%)	12(15)	7 (9)	0	6 (7)	56 (69)
Female	N (%)	12 (6)	20 (10)	2 (1)	3 (2)	153 (79)

Employment patterns impact on access to financial resources. Poverty, including limited access to money, was found to impact on the everyday lives of people living with HIV, including migrants (Weatherburn et al, 2003). Subsequently, due to poverty, 22% of the survey participants reported that in the past year they had experienced times when they had had insufficient food to eat within their households.

**Knowledge of living with HIV:** Fewer participants had been diagnosed with HIV within the current year. Most reported that they had been living with HIV for more than a year, the majority between 5-9 years. (Figure 3):

**Fig 3: Known years, living with HIV**



## EXPERIENCES OF DISABILITIES

Under the provisions of the Disability Discrimination Act (DDA) 2005, all persons living with HIV are defined as disabled in terms of the Act. The DDA protects individuals from the point of diagnosis with HIV. This means that people living with HIV are protected from discriminatory practices in work places, service provision, education etc (NAT, 2006). Participants were asked if they had other disabilities in addition to HIV. Almost a quarter (23%) of the participants reported additional disabilities and other chronic health conditions as shown in table 3:

Table 3 shows that there were no marked gender differences in reporting non-HIV related disabilities. In a free text question, participants listed additional disabilities which included: arthritis, mental health, problems with mobility, circulatory conditions, cancer and deterioration of eye sight. The listed disabilities brought with them other dimensions of discriminations, compounding the experiences of HIV-related stigma. Others have noted that stigma associated with mental health has been a major obstacle to recovery (Toulmin, Pinfold and Bryne, 2005). Migrants living with HIV experience complex forms of discrimination related to other disabilities, other than HIV.

**Table 3: Reported additional disabilities**

Additional Disabilities			Physical disability not related to HIV		Total
			Yes	No	
Gender	Male	Count (%)	20 (25%)	60 (75%)	80 (100%)
	Female	Count (%)	44 (23%)	149 (77%)	193 (100%)
Total (%)			64 (23%)	209 (77%)	273 (100%)

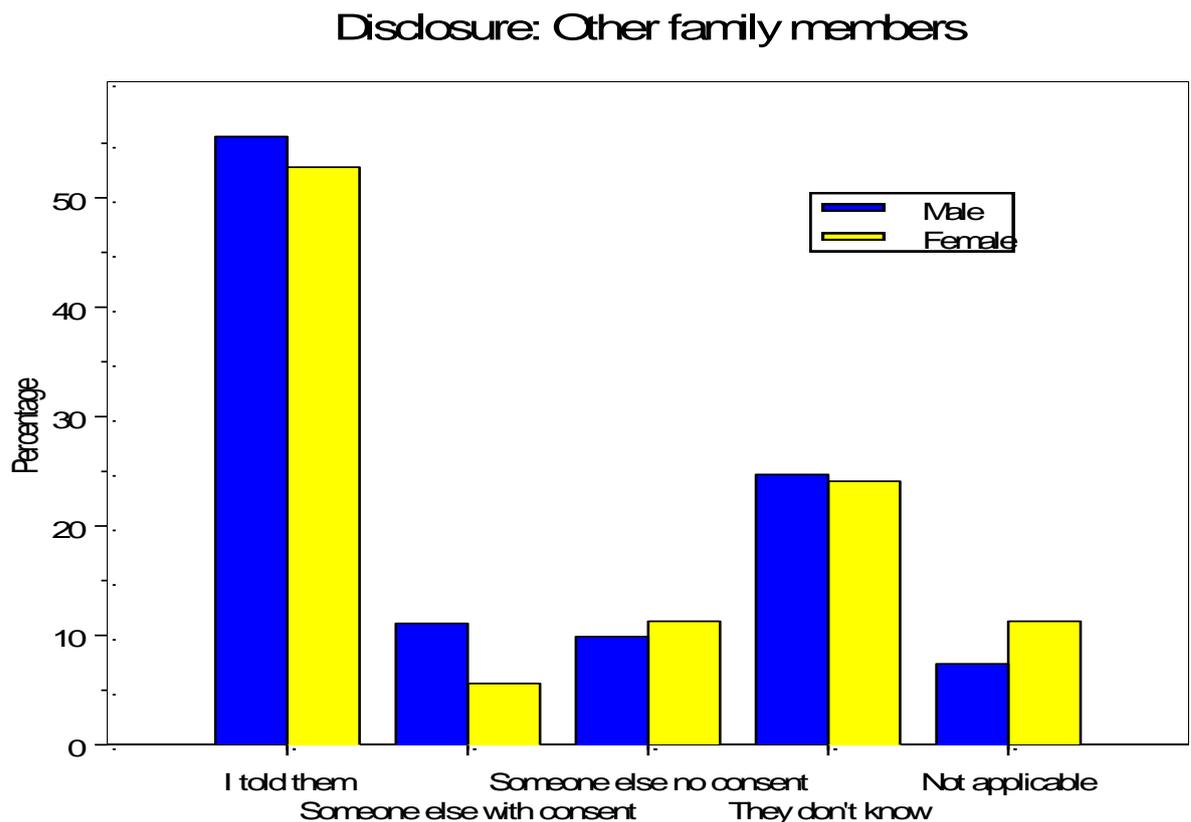
## DISCLOSURE OF HIV

Disclosure is the process of telling others that one is living with HIV. The research highlights fears of rejection, abandonment, isolation and hostility from partners, families and wider society following disclosure of HIV status. Not surprisingly, control of information about one's HIV status is a matter of concern.

### DISCLOSURE TO THE FAMILY

More than half the participants reported that they had personally told family members that they were living with HIV. When asked about decisions to inform their families, participants had the option to say whether they personally, had disclosed to family members, or whether someone else had disclosed the information, with, or without, their consent (see Fig 4).

**Fig 4: Disclosure to family**



There were instances (10%) where confidentiality had been breached as family members had been told by someone else without the consent of the participant. Confidentiality is stressed amongst professionals (e.g. clinicians) but is very complicated to enforce/monitor in community settings.

## DISCLOSURE TO SEXUAL PARTNERS

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Understanding HIV disclosure processes amongst migrants and their sexual partners is very important for HIV prevention. Participants were asked if they had told their current sexual partner that they were living with HIV. More than half (51%) of the men and women (54%) reported that they had disclosed to their current partner. There were no significant differences between men and women in sharing their diagnosis with their current partners. Residential proximity may have influenced decisions to tell current sexual partners: Slightly more married or cohabiting men (60%) compared to women (42%) reported they had told their partners about the positive HIV diagnosis.

## PRESSURE FROM OTHERS TO DISCLOSE

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Pressure from others to disclose a positive diagnosis can be construed as harassment, as people living with HIV have the right to confidentiality and the right to informed choice regarding when and who they should inform.

Participants were further asked: *'How often did you feel pressure from other individuals living with HIV or from groups/networks of people living with HIV to disclose your HIV status?'* Results indicate that over a third of the men (41%) and women (37%) had experienced at least one incident of peer pressure from other individuals or groups/networks to disclose their HIV status.

In addition, participants were asked: *How often did you feel pressure from other individuals not living with HIV (e.g. family members, social workers, non-governmental organization employees) to disclose your HIV status?'* Results indicate that 43% of men and 47% of women had, on at least one occasion experienced pressure, from other individuals not living with HIV to disclose their HIV status.

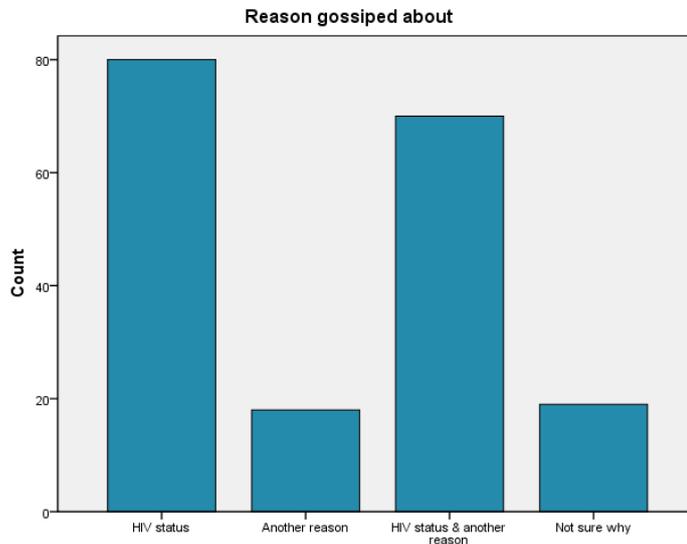
## FELT STIGMA

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Amongst the participants 'felt stigma' was reported as being experienced in various ways. (59% of men and 48% of women reported that they felt guilty living with HIV. Additionally, more than two-thirds of all participants (68% men and 66% women) reported low self-esteem. Other studies have also found HIV stigma impacting on anxiety self-confidence and self-esteem (Weatherburn et al, 2003).

One of the participants' greatest concerns was the fear of being the subject of gossip. Almost three-quarters of the sample (75% men, 72% women ) feared that they could be a subject of gossip. Participants appeared to judge themselves unfavourably when positioning themselves against what they thought others were saying about them. Most participants believed the subject of gossip was their living with HIV (see fig 5).

**Fig 5: Perceived reasons for being a subject of gossip**



Often, when disclosure of living with HIV has occurred, implicitly or explicitly, participants do not have personal control of that information. This lack of control can, in some cases, increase anxieties confidentiality is being breached through gossip. This may or may not be the case.

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## FEAR OF VERBAL ABUSE AND HARASSMENT

The feeling that one is being stigmatised or discriminated against can impact on subjective notions of safety within the community. Most participants reported that they feared verbal abuse, harassments or threats due to their HIV diagnosis.

**Table 4: Fear of being abused**

Gender		Frequency
Male	Yes	47 (63%)
	No	28 (37%)
	Total	75 (100%)
Female	Yes	80 (46%)
	No	94 (54%)
	Total	174 (100%)

Table 4 shows that men (63%) compared to women (46%) were more fearful of being abused (i.e. verbally insulted, harassed or threatened because of their HIV status). In addition, it also emerged that men were more afraid than women of being physically abused because of their HIV status.

**Table 5: Fear of physical abuse by gender**

Gender		Frequency
Male	Yes	42 (57%)
	No	32 (43%)
	Total	74 (100%)
Female	Yes	52 (31%)
	No	117 (69%)
	Total	169 (100%)

Heterosexual men were three times more fearful than women of being insulted and four times more fearful of being physically harassed or assaulted.

## **REASONS FOR BEING STIGMATISED**

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Survey participants were asked to give reasons why they were stigmatised and some of the free text responses are reproduced:

**Table 6: Perceived reasons for being stigmatised (free text responses)**

<b>Men</b>
<i>'...for being gay but not because of my HIV status'</i>
<i>'... sometimes they think I'm going to head butt them [because of how I look]'</i>
<b>Women:</b>
<i>'...because I live in a refuge'</i>
<i>'...because I once had a breakdown'</i>
<i>'...because I over stayed in the UK'</i>

Some responses (Table 6) suggest that 'other reasons' for feeling stigmatised were not directly connected to living with HIV, rather other stigmatised identities such as migrant and/or gay identities. Other researchers have found that homophobia, racism and xenophobia underpinned individuals' experiences of HIV-related stigma: "Citizenship, nationality and cultural integration conferred particular rights to British men which meant that access to basics such as food, shelter, and healthcare were rarely under threat—even while they faced stigma and discrimination because of their HIV. As such, the sheer magnitude of the impact of HIV related stigma took on a different order between these different groups" (Dodds, 2006, p.478).

In addition to the free text responses, participants were asked the question 'If you have experienced some form of stigma and or discrimination within the last 12 months, why do you think this is so?'

**Table 7: Reasons for being stigmatised**

<b>Response*</b>	<b>Male (%)</b>	<b>Female (%)</b>
People are afraid of getting infected with HIV from me	49 %	28%
People don't understand how HIV is transmitted and are afraid	43%	33%
People think that having HIV is shameful and they should not be associated with me	36%	35%
Religious beliefs or "moral" judgements	25%	16%
People disapprove of my lifestyle or behaviour	26%	5%

I look sick with symptoms associated with HIV	12%	5%
I don't know/I am not sure of the reason(s)	14%	19%

*\*Multiple responses were allowed therefore totals do not sum to sample size.*

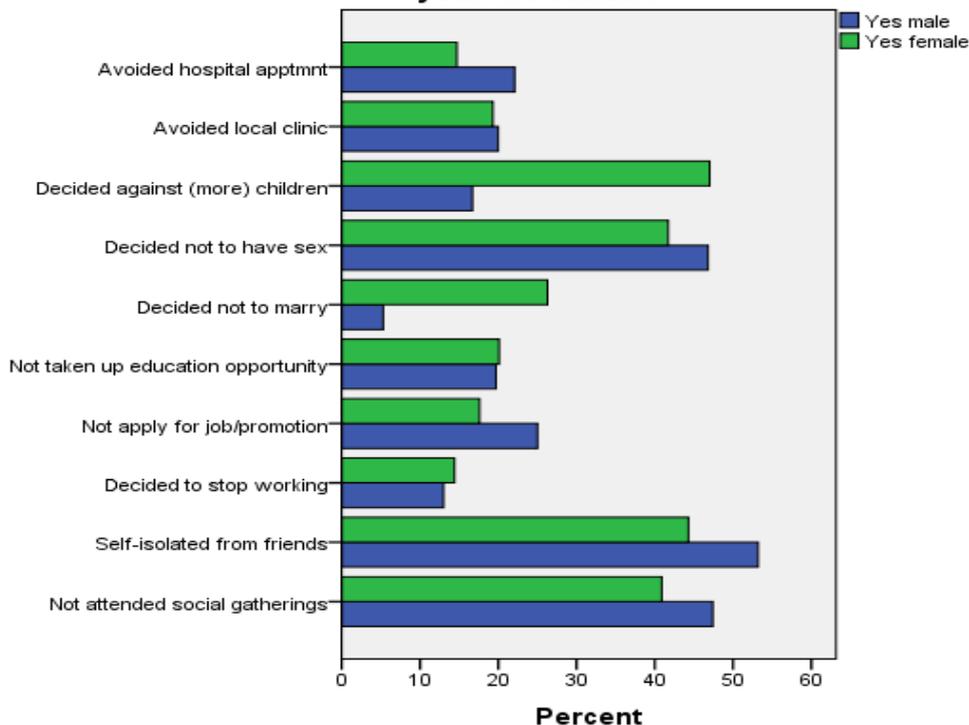
The responses presented in table 7 suggest that participants believed that other people's lack of knowledge, understanding and religious beliefs about HIV underpinned the reasons why some participants were stigmatised and discriminated within the last 12 months.

## AVOIDANCE STRATEGIES

The complexity and interplay of stigma-avoidance-strategies to cope with everyday life with HIV has been revealed by small-scale qualitative studies in the UK. Research has shown that perceived stigma also impacts on how women access health services and voluntary sector agencies (Anderson and Doyal, 2004). In a study in South and West Yorkshire HIV/AIDS emerged as an issue of primary concern and stigmatisation was a recurrent theme in focus group discussions, with one group noting that stigma is two-fold: people who have HIV/AIDS are stigmatised by their communities, and the communities are stigmatised by professionals (Wilson et al, 2007, p.29). HIV stigma can hinder access to support organisations, peer-support and emotional support, that may be helpful in overcoming stigma (Flowers et al, 2006). Survey participants were asked if they had avoided certain situations because of their HIV status.

**Figure 7: Avoidance strategies**

**In the last 12 months, have you done any of the following things because of your HIV status?**



The presentation of the data in figure 7 shows that slightly more males than females avoided social gatherings, isolated themselves from friends and avoided sex, hospitals and clinics because of their HIV status. More women compared to men decided against marriage and having children. Avoiding these situations potentially increases isolation, for example, avoiding friends, and may negatively impact on health, for example, by avoiding attending clinics.



## AWARENESS OF FRAMEWORKS TO GUARD AGAINST DISCRIMINATION

In the UK there are legislative frameworks that protect people living with HIV from discrimination and these include:

- a) *United Nations General Assembly Special Session Dedicated to HIV/AIDS (UNGASS) Declaration* is an international human rights framework that outlines time bound commitment and a regular process to review country progress in meeting these commitments. The UK was one of the 189 countries to endorse the UNGASS Declaration in 2001.
- b) *The Disability and Discrimination Act (1995-2005)* offers protection from discrimination for all persons living with HIV including other disabilities. From October, 2010, the Equality Act replaced the *Disability and Discrimination Act*, protecting all people living with a disability from discrimination in the areas of employment, education and access to services.
- c) The Offences Against the Persons Act (1861) defines a situation in which a person may be held criminally liable for harming other people in England, Wales and Northern Ireland. There are sections within the Act that relate to inflicting 'grievous harm'. Section 18 and 20 can apply to the situation where it is established that one person has infected another with HIV (<http://www.tht.org.uk/binarylibrary/grevoiusharmsigmareport.pdf>)

All participants were protected under the provisions of the *Disability and Discrimination Act* (1995-2010) and Equality Act as they were living with HIV and had other disabilities, beside HIV. Survey participants were asked if they were aware of the UNGASS declaration which protected their rights as individuals affected by HIV.. Like the participants in the main UK Index Study, knowledge about the legal frameworks was limited, as illustrated in table 8:

**Table 8: Awareness of UNGASS**

	Gender	Frequency
Male	Yes	28 (35%)
	No	52 (65%)
	Total	80 (100%)
Female	Yes	58 (30%)
	No	134 (70%)
	Total	192 (100%)

Approximately one-third of the sample, with slightly more men (35%) than women (30%), had heard of *UNGASS*.

When asked if they had read or discussed its contents, it emerged that, of those who had heard about the *Declaration*, more men (32%) compared to women (25%) had read or discussed the contents:

**Table 9: Reading and discussing UNGASS**

Gender		Frequency
Male	Yes	15 (32%)
	No	32 (68%)
	Total	47 (100%)
Female	Yes	29 (25%)
	No	88 (75%)
	Total	117 (100%)

Participants were asked if they had heard of *The Disability and Discrimination Act* that protects the rights of people living with HIV in the UK. Responses indicate that more men (66%) than women (44%) had heard of relevant national law/policies:

**Table 10: Awareness of national legal policies and laws**

Gender		Frequency
Male	Yes	50 (66%)
	No	26 (34%)
	Total	76 (100%)
Female	Yes	74 (44%)
	No	95 (56%)
	Total	169 (100%)

Participants who reported that they had heard of the UK DDA were further asked if they had read or discussed its contents. More men (35%) than women (23%) had read and discussed the contents of the *Disability and Discrimination Act*

Questions were further asked if their rights as persons living with HIV had been abused: 21% of men and 23% of women agreed 'Yes, their rights as persons living with HIV had been abused'. Some men (26%) and some women (31%) were not sure whether their rights as persons living with HIV had been abused. Examples of abuse of rights are:

- Over a fifth of men (22%) and women (21%), reported that they had, at least once, in the last 12 months been denied health care, including dental care, because of their HIV status
- 12% reported that they had been denied life insurance because of their positive HIV diagnosis. Women were more likely to report this experience than men.

- Eight respondents (3%), all of them women, reported being arrested or taken to court on a charge related to their HIV status.
- Seventeen participants (6%), all female, reported that they had been detained, quarantined, isolated or segregated.

Survey participants reporting that their rights had been abused, were then asked if they had sought legal redress. The majority (65%) of this subset did not seek legal redress. For those that had sought legal redress, the cases were still being processed and had not yet been settled.

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## DISCUSSION

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Despite legal frameworks that protect the human rights of people living with HIV from discrimination, stigma poses a threat to the ways in which 'rights' are exercised by migrants with HIV and disabilities in the UK.

The UNAIDS, together with the Office of the United Nations High Commission for Human Rights, have called for the respect of human rights of all persons living with or affected by HIV and effective responses that promote access to HIV prevention, treatment and care services. *The Disability and Discrimination Act (1995-2005)* in the UK protected people living with HIV from all forms of discrimination within the work place, education and health care settings. Findings from the Sigma Index Study have shown how experiences of stigma and discrimination impede on the ways in which migrants exercise their rights to HIV-related care and support.

Felt stigma, including the shame of living with HIV, has a negative impact as some migrants report avoiding social and health care services including clinics and hospital appointments. Some participants reported avoiding intimate relationships because of felt stigma. Decisions to avoid sexual contact and not to have any children may need further exploration: did these migrant participants receive comprehensive sexual education and information about medical advancements that reduce mother to child transmission of HIV? Some survey participants reported experiencing discrimination and being denied health care whilst others reported that they were denied access to insurance services because they were living with HIV. Migrants living with HIV also experienced stigma 'within' where they stigmatised themselves and were also discriminated by some health care professionals as well as by their communities.

The composition of the UK Index Study migrant sample highlights a range of social, economic and political vulnerabilities that place some migrant groups at higher risk of poorer health. The UK migrant sample was dominated by migrant women living with HIV, some of them asylum seekers. This sample demonstrates the biological, social and economic vulnerability of women to HIV. Women born outside the UK form the largest proportion affected by heterosexually-contracted HIV, together with a significant number of heterosexual and bisexual migrant men. Poverty is a major impact on migrant participants' lives. V.

Migrants living with HIV in the UK are confronted by a range of historically embedded sources of discrimination, including racism and xenophobia that impact on their health and mental wellbeing. In this report, the migrant participants were also affected by other disabilities that could have been exacerbated by their positive HIV status. Survey participants were also getting older as they lived with HIV, thereby becoming a feature of wider political and practical debates concerning the UK's ageing population.

For the UK Index Study migrant sample, chronic conditions associated with and/or exacerbated by HIV and ageing brought with them additional stigma. Some migrants reported additional

disabilities such as physical disabilities and mental health, adding another dimension of stigma to already stigmatised lives. For migrants, these additional disabilities can compound the experiences of stigma and discrimination brought by living with HIV.

In the UK, interventions aimed at addressing stigma have targeted negative perceptions about HIV amongst members of the public. There has been limited research (Yebei, 2008) and limited interventions that focus on 'felt stigma'. A study of the experiences of felt and enacted stigma amongst women with HIV/AIDS (Lekas et al, 2006) identified felt stigma as the primary adaptational challenge and the findings of this study confirm that situation. An important finding from this report is the negative impact of inner thoughts about oneself or 'felt stigma' amongst the migrant participants.

Felt stigma increased concerns about the mental wellbeing of some migrants living with HIV. Felt stigma led to lower self esteem, fears, suicidal thoughts and 'real' anxieties about accessing social care and support services. Some participants reported feeling 'ashamed' because of their positive HIV diagnosis whilst others avoided hospital appointments.

Participants also reported that they were afraid of being the subject of verbal and physical abuse, with men more likely to report these concerns. This gendered dimension of 'fear', particularly amongst men, indicates the complexity of being a migrant man living with HIV in the UK.

The experience and impact of felt stigma needs further exploration, in particular the notion of 'fear' that has been expressed by the migrant men in this sample.

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