In Belgium, 1 in 3 HIV-patients are Sub-Saharan African Migrants (SAM) [1]

SAM are more likely to be diagnosed late [2]

<table>
<thead>
<tr>
<th>Year</th>
<th>Origin</th>
<th>N (% total HIV-patients ITM)</th>
<th>&lt;200CD4cell/μl</th>
<th>&lt;350CD4cell/μl</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>SAM</td>
<td>987 (52.1%)</td>
<td>47.3%</td>
<td>80.2%</td>
</tr>
<tr>
<td></td>
<td>Belgian</td>
<td>581 (56.2%)</td>
<td>33.2%</td>
<td>69.1%</td>
</tr>
<tr>
<td>2009</td>
<td>SAM</td>
<td>921 (52.3%)</td>
<td>48.4%</td>
<td>81.5%</td>
</tr>
<tr>
<td></td>
<td>Belgian</td>
<td>557 (55.2%)</td>
<td>32.3%</td>
<td>69.9%</td>
</tr>
</tbody>
</table>

HIV-positive SAM are more likely to be unaware of their status [3]

SAM suggest provider initiated HIV-testing and counseling

Prefer ignorance: “It’s better not to know”
- HIV = death and ‘slim’
- HIV = stigma and social exclusion
- HIV = fear of deportation

Lack of information
- Leads to misinformation and boosts existing stigma
- Increases doubts about entitlement to care and rights
- Maintains practical barriers

Culture of sheer emergency seeking behaviour, enforced by precarious migrant situation, limits preventive medicine

Low perceived susceptibility to HIV: “I didn’t run any risks”

Financial incapability

Lack of opportunity: “My doctor knows best and he didn’t propose the test to me”

Pre-test counseling: Little information provided
- Diagnostic testing
- “Everybody knows what HIV is”
- “Don’t want to scare the patient”
- No HIV exceptionalism: “When you test for cancer, you don’t give extensive counseling either”

Post-test counseling
- HIV+: Result communication and referral to ARC
- HIV-: Strict result communication (over the phone)

Need for increased efforts to promote HIV-testing and counseling

because mutually re-enforcing barriers of SAM and physicians are facilitating late HIV-diagnosis

Epidemiology

Findings

References


Provider initiated HIV-testing and counseling (PITC) face many barriers

A qualitative study assessing 20 physicians’ practices and barriers towards PITC for SAM [4]

Current HIV testing practices

- Patient initiated or on indication
- WHO: UNAIDS VCT guidelines are not respected
  - Pre-test counseling: Little information provided
    - Diagnostic testing
    - “Everybody knows what HIV is”
    - “Don’t want to scare the patient”
    - No HIV exceptionalism: “When you test for cancer, you don’t give extensive counseling either”
  - Post-test counseling
    - HIV+: Result communication and referral to ARC
    - HIV-: Strict result communication (over the phone)

Barriers to PITC

- Lack of information on medical relevance
- No policy prescribing PITC for SAM
- Caution not to create the impression of xenophobia by targeting SAM
- Questionable provision of care for non-resident migrants:
  - Who will pay?
  - Is follow-up assured?

“I don’t want to test, if they will be deported tomorrow”

“If an emergency visit, migrants often disappear again”

“After an emergency visit, migrants often disappear again”

Reluctance to provide intensive counseling:
- Time consuming
- Lack of cultural competence to discuss sensitive sexual issues
- Prevention is not the role of the physician
- Language barriers

Recommendations

Community level: Promotion of HIV-testing

- Outreach HIV-testing
- Sensitization by community leaders

Health care level: Promotion of PITC

- Epidemiological factsheet: medical relevance
- Counseling guidelines:
  - Clarify counseling steps
    - Background on cultural aspects
    - Practical tips
  - Currently implemented and systematically evaluated in GP practices in Flanders
- Sensitization by community leaders

Outreach HIV-testing

Sensitization by community leaders