

## **“IT’S BETTER NOT TO KNOW”: PERCEIVED BARRIERS TO HIV VOLUNTARY COUNSELING AND TESTING AMONG SUB-SAHARAN AFRICAN MIGRANTS IN BELGIUM**

Lazare Manirankunda, Jasna Loos, Thérèse Assehide Alou,  
Robert Colebunders, and Christiana Nöstlinger

This study explored perceptions, needs, and barriers of sub-Saharan African migrants in relation to HIV voluntary counseling and testing (VCT). Using an inductive qualitative methodological approach, data were obtained from focus group discussions. Results showed that participants were in principle in favor of VCT. However, they indicated that barriers outweighed advantages. Such barriers included fear of positive test results and its related personal and social consequences, lack of information, lack of preventive health behavior, denial of HIV risk, and missed opportunities. Limited financial resources were only a concern for some subgroups like young people, asylum seekers, and recent migrants. This study identified multiple and intertwined barriers to VCT from a community perspective. In order to promote VCT, interventions such as raising awareness through culturally sensitive education should be adopted at community level. At level of service provision, provider initiated HIV testing including target group tailored counseling should be promoted.

Sub-Saharan African migrants residing in western Europe are highly affected by HIV/AIDS (EuroHIV, 2007a). Between 2004 and 2006, 45.7% of 2,245 new HIV cases diagnosed in Belgium were among people of sub-Saharan African origin (Sasse, Defraye, Buziarsist, Van Beckhoven, & Wanyama, 2007), yet sub-Saharan African migrants account for only 0.65% of the general Belgian population. The current HIV epidemic in Africa is reflected in a concentrated HIV epidemic in Belgium with comparable characteristics. As in other western European countries, sub-Saharan African migrants diagnosed with HIV in Belgium are more likely to have acquired

---

Lazare Manirankunda, Jasna Loos, Thérèse Assehide Alou, Robert Colebunders, and Christiana Nöstlinger are with the Institute of Tropical Medicine, Nationalestraat 155, 2000 Antwerp, Belgium. Robert Colebunders is also affiliated with the University of Antwerp, Belgium.

This study was funded by the Flemish Government, Ministry of Welfare, Public Health and Family. The authors thank the participants of the focus group discussions and the key persons who recruited them for study participation. They also thank Audrey Prost and Anali Conesa Botella for their comments on this article and Rebecca Woo for language editing.

Address correspondence to Dr. Lazare Manirankunda, MD, Msc, Sexual Health Promotion and HIV Prevention Among sub-Saharan African Migrants in Flanders, Institute of Tropical Medicine, Nationalestraat 155, 2000 Antwerp, Belgium; e-mail: lmaniran@itg.be

the infection via heterosexual contact before migration and to be young women (EuroHIV, 2007a; Sasse et al., 2007).

The Belgian HIV policy (EuroHIV, 2007b) offers HIV testing at various premises: general practitioners' offices, clinics, hospitals, and student services centers. Partner notification is not mandatory and there is no requirement or systematic testing of particular individuals/groups. However, routine HIV testing is offered to pregnant women, hospital patients with tuberculosis, clients of STI (sexual transmitted infection) clinics, injection drug users, and sex workers. For HIV tests during preoperative checkups an opt-out strategy is used.

All HIV-positive tests are confirmed at one of the eight AIDS Reference Centers, providing HIV specialized services including antiretroviral treatment (ART), before test results are communicated to the patient. Tests are free of charge at few sites, but generally there is a fee with 80% coverage of the costs by the social security system. All HIV patients including migrants receive free ART if indicated. Voluntary HIV counseling and testing (VCT) is not widely promoted, and studies have shown that VCT-related guidelines such as pretest and posttest counseling and informed consent procedures were not always respected (Devroey, Van Casteren, & Sasse, 2001; EuroHIV, 2007b; Van Casteren, Devroey, Sasse, & Wallyn, 2004). Although Belgium has a well working health and social welfare system with high-quality health care facilities and a high coverage of health insurance for any resident, few migrants do spontaneously test for HIV. Clinical observations have shown that they test late, after they have already fallen ill. In Belgium, the median CD4 count at the time of HIV diagnosis was 307 for African men and 323 for African women; for 38% of all HIV cases among Africans, the CD4 count was less than 200 or equaled an AIDS diagnosis (data refer to the 2001–2006 period; A. Sasse, personal communication, January 13, 2009).

The actual prevalence of HIV in Belgian's sub-Saharan African migrant communities might even be higher than available figures suggest, as one third of people living with HIV in Europe are assumed to remain undiagnosed (Hamers, Devaux, Alix, & Nardone, 2006). A study performed in the United Kingdom, even found that two thirds of sub-Saharan African migrants living with HIV/AIDS were unaware of their infection (Sadler et al., 2007).

This lack of awareness combined with stigma, immigration issues, different perceptions of HIV, problems of accessing health care, and so on do explain why sub-Saharan African migrants are often diagnosed in an advanced stage of disease (Boyd et al., 2005; Burns, Fakoya, Copas, & French, 2001; Chee et al., 2005; McGarrigle et al., 2006). Late HIV diagnoses have major personal, epidemiologic, and health-economic consequences (Burns et al., 2001; Burns et al., 2005; Burns, Imrie, Nazroo, Johnson, & Fenton, 2007). They limit the opportunities for individuals and their partners to access treatment and psychosocial support, increase the risk for onward HIV transmission, and have a significant impact on health care costs (Krentz, Auld, & Gill, 2004). Thus, reducing the number of undiagnosed HIV infections clearly is a public health priority (Hamers et al., 2006).

The available evidence from different African countries shows that VCT is much more accepted in spite of difficult access to ART. The median overall acceptability was 65%, ranging from 33%–95%, and 71% (with a range of 46% to 92%) of those who received pretest counseling in antenatal services were tested. The return rate for collecting the results remains low. Positive impact on sexual behavioral change associated with increase in condom use, reduction of the number of sexual partners,

and low seroconversion rates in discordant couples have been observed as favorable outcomes of VCT services (Mola et al., 2006; Painter, 2001; UNAIDS, 2001).

The multiple beneficial outcomes of VCT on the continuum between primary and tertiary prevention could contribute to reducing the number of late HIV diagnoses and subsequently late access to ART. To develop a VCT promotion strategy tailored to the needs of sub-Saharan African migrants in Belgium, our study aimed to explore their perceptions, barriers, and needs toward VCT.

## METHODS

This focused qualitative study used an inductive methodological approach and focus group discussions (FGDs) as data collection techniques (Morgan & Krueger, 1998). Between September 2007 and April 2007, eight FGDs were held with 70 sub-Saharan African migrants of both gender. sub-Saharan migrants were defined as being any foreigner originating from any country of the sub-Saharan region, identifying themselves as such, independent of whether they already lived in Belgium legally or whether they were in the process of asylum seeking.

Inclusion criteria for participation were being male or female French- and English-speaking Africans aged 18-49 years and residing in the provinces of Antwerp, East Flanders, or Flemish Brabant.

Participants were selected from three main groups to reflect the typical pattern of sub-Saharan African migrants: *residents*, comprising both young people (18-24 years) and adults; *newcomers*, consisting of people recently accepted as refugees and having been allowed to settle (with the obligation to attend the course for social integration); and *asylum seekers*.

Participants were recruited through purposive sampling using community key-persons. Recruitment of residents involved members of local and regional HIV prevention networks, consisting of volunteer community organizations to identify and recruit young and adult FGD participants. Newcomers were recruited by lecturers at the centers for integration, and asylum seekers were recruited by health service providers at the reception center. All the potential participants were contacted by telephone. After the aim of the study and the informed consent procedure were explained, recruits were invited to participate in the study. They were also informed that the discussions would be audiotaped. This resulted in the final selection of participants who were both eligible and willing to participate. All groups were organized as to result in homogenous FGDs according to the different selection criteria (e.g., age, gender, language capacity, city of residence). Combining the above criteria, we formed eight focus groups (four with English- and four with French-speaking participants). Three groups consisted of adult males (including one group with asylum seekers), three groups of adult females (including one group with newcomers), one group of young females (aged 18-24 years), and one group was a mixed-gender group with young people of the same age.

The FGDs were conducted using a pretested topic guide assessing the following themes: perceived differences between African and Belgian health care systems (as an ice-breaker question), perceptions of VCT, personal experiences with HIV testing, perceived barriers to and facilitators of VCT, and the design of culturally sensitive VCT services.

Ethical approval was obtained by the Institute of Tropical Medicine's Institutional Review Board/University of Antwerp. All study participants provided writ-

ten informed consent prior to participation. Discussants could participate on an anonymous basis, if they wished. Participants received € 15 as reimbursement for travel costs. Socio-demographic data were collected through a short anonymous self-reported questionnaire. All participants but one provided these data. All FGDs were audiotaped and the data were transcribed verbatim.

Descriptive content analysis focusing on the perceptions of the groups was carried out by two independent researchers, establishing an open coding guide. By constantly scrutinizing the data, concepts, categories, and their properties and dimensions were identified inductively. Subsequently, different findings were compared and dissonant items retained or rejected after consensus was reached by the two researchers.

## RESULTS

### PARTICIPANTS' CHARACTERISTICS

Eight diverse subgroups of sub-Saharan African migrants participated in the study, and their specific characteristics are displayed in Table 1. Overall, participants in the study tended to be young women, single, settled residents (mean duration of stay 8.5 years), highly educated and with low employment rates. Participants stemmed from 14 African countries. We certainly do not intend to ignore the cultural differences of participants from different ethnic backgrounds, but for the ease of reporting the results we feel it is justified to speak homogeneously about "sub-Saharan African migrants" and "sub-Saharan African cultures," as there are certainly some pan-African elements shared by sub-Saharan Africans living as migrants in Belgium.

### PERCEPTIONS OF VCT

Participants acknowledged the many benefits of VCT. They perceived an HIV negative diagnosis as confirming good health and excluding the possibility of HIV infection. They also felt that acknowledging a positive result would enable them to protect themselves and their sexual partners. Furthermore, VCT was ascribed an important role in curbing the HIV epidemic. In spite of these positive perceptions, major barriers prevented sub-Saharan African migrants from presenting themselves voluntarily for an HIV test.

### EMERGING BARRIERS TO VCT

*Fears and Concerns:* "It's better not to know." HIV/AIDS generally evoked feelings of fear, mainly owing to its severe personal and social consequences on both health and emotional well-being. Because of these fears, most participants preferred not to know their HIV status: "From the moment they begin to know that they have the [HIV] virus, they begin to think. That thinking can cause you to die early. So, if I don't know my status, I don't think about it. That's why I think fear is an important factor" (young male Anglophone resident).

For most participants HIV/AIDS was synonymous with death. Many of them had witnessed the often fatal effects of HIV in their home countries and were afraid of facing the same fate when taking an HIV test: "If you see somebody really slim, if you can count every body part of him, it scares you ... You start thinking: 'If I am

TABLE 1. Participants' Characteristics<sup>a</sup>

Variables	Female <i>n</i> (%)	Male <i>n</i> (%)	Total <i>n</i> (%)
Total	36 (52)	33 (48)	69 (100)
Age (mean in years)	24	22	22
Residence duration (mean in years)	9.7	7.6	8.6
Country of origin			
Democratic Republic of Congo	12 (33)	10 (30)	22 (32)
Ghana	12 (33)	7 (21)	19 (27)
Nigeria		7 (21)	7 (10)
Other West African countries	4 (11)	2 (6)	6 (9)
East Africa	2 (6)	7 (21)	9 (13)
Other Central African countries	6 (17)		6 (9)
Religion			
Protestant	27 (75)	15 (45)	42 (61)
Catholic	5 (14)	9 (27)	14 (20)
Islam	4 (11)	4 (12)	8 (12)
Other		5 (15)	5 (7)
Marital status			
Single	24 (67)	18 (55)	42 (61)
Married	9 (25)	12 (36)	21 (30)
Other	3 (8)	3 (9)	6 (9)
Source of income			
Employed		8 (24)	8 (12)
Student loan	5 (14)	5 (15)	10 (14)
State financial support	22 (61)	11 (33)	33 (48)
No income	8 (22)	9 (27)	17 (25)
Missing	1 (3)		1 (1)
Educational level			
Primary school	5 (14)	3 (9)	8 (12)
Vocational school	2 (6)	1 (3)	3 (4)
Technical school	1 (3)	5 (15)	6 (9)
Secondary school	18 (50)	10 (30)	28 (41)
High school/university	10 (28)	14 (42)	24 (35)
Health insurance			
Yes	55 (97)	22 (67)	57 (83)
No	1 (3)	11 (33)	12 (17)

<sup>a</sup>Missing information for one participant.

going [for an HIV test], they will tell me ... I might get like that.' Then let me just die, I don't need to know" (young male Anglophone resident).

The fact that ART is currently freely available in Belgium seemed to have exerted little influence on the fear of dying. Although ART was valued for its life-prolonging effects, it was not perceived as an incentive for HIV testing because "it did not offer a cure." Participants explained that taking ART would not take away the upsetting thought that one "carries death inside" and that "death has a cause and a term": "Still, the uh... retroviral-something is just prolonging your life, eventually you will die. (...) If you have this medicine '100% working,' it is good. Then maybe you'll find more people going for the test" (Adult female Francophone resident).

A small minority of respondents, however, did not share this sense of fatalism regarding HIV/AIDS. As they commented, diseases like cancer, Ebola, and malaria would kill much faster and should therefore be considered more dangerous.

Many participants reported fear of stigma and social rejection following a positive diagnosis as an important barrier to VCT. These fears originated in experiences in their home countries; the majority of participants acknowledged having lost a member of their family due to HIV/AIDS. Drawing on this, participants felt that if a person was known to be HIV-positive, rumors would start, speculating about how the person got infected. Because it was a commonly held belief that only "bad

people” crossing sexual norms, like womanizers, prostitutes, polygamists, and unfaithful or promiscuous people engaging in unprotected sex were affected by HIV/AIDS, these rumors led to stigma and social rejection: “Once you have it: you are an outcast. It’s like you are a dead person ... It’s like you’re guilty. It’s your fault. Why should you have this?” (Adult male Anglophone resident). Such normative judgments were supported by stories of people living with HIV/AIDS (PLHA) deliberately infecting innocent children, confirming that they were indeed “bad people,” therefore justifying social exclusion. Fearing that stigma, sub-Saharan African migrants preferred not to know their own HIV status in order to avoid the anticipated negative social consequences.

The social rejection of PLHA was reinforced by a persistent lack of appropriate information about HIV transmission routes, which in some instances made people avoid physical contact with PLHA. “If the machine says you’re sick, your friends will run from you ... It’s a lack of information. They think that if you drink from the same glass, you get AIDS. They think that if you shake hands, you get AIDS” (Adult female Francophone resident).

Most sub-Saharan African migrants participating in the study emphasized that “HIV is not only transmitted through sex”: One can also be infected through blood contact; blood transfusions; haircuts at the barbershop; or cuts with knives, razors, or nails. By dissociating HIV/AIDS from sexuality, participants tried to counteract the HIV related stigma: Many felt that because there were nonsexual routes of HIV transmission, it would be unjustified to stigmatize PLHA .

Deportation owing to a positive HIV diagnosis was another frequently mentioned concern among participants with a pending asylum procedure. The way the Belgian authorities handle asylum seekers and the issue of migration fed this fear. The lack of transparency of procedures, the fact that people whose application for asylum had been denied were regularly picked from the reception centers, a general societal climate that is perceived as in favor of deportation of illegal migrants, and various recent policy changes regarding the asylum seeking procedures all contributed to considering unknown people or organizations as suspicious and therefore having a possible negative influence on asylum applications. In Belgium an HIV diagnosis has no negative impact on asylum applications. On the contrary, it may make it possible to obtain resident status through a policy that grants resident status on medical grounds.

In addition, a minority of study participants mentioned concerns related to living with a positive HIV diagnosis as additional barriers, including routine condom use, strict treatment regimes, and employment difficulties resulting from a potential HIV diagnosis.

*Lack of Information.* Although the study participants had a general awareness and basic knowledge of HIV/AIDS, we also found a lack of in-depth information. There was a dearth of proper information on HIV, its modes of transmission, and how to cope with HIV in daily life. Participants also lack information about where and how to obtain an HIV test. Discussants wanted to be informed about the consequences of a positive diagnosis and expressed the need to be assured of their entitlement to treatment and care as well as about their legal rights as an HIV patient. The lack of information about HIV also gave room for misconceptions and reenforced existing barriers to VCT. As indicated by some study participants, false beliefs like HIV transmission through touching or the bad character of PLHA, persisted in the community because of insufficient information.

*Missing Tradition of Preventive Health-Seeking Behavior.* “Where I come from, we are not people who like to go to the hospital unless the person is experiencing something in the body that’s really bad” (young male Anglophone resident).

According to the study participants, it was uncommon for Africans from diverse regions to visit a hospital or a medical doctor regularly. In most parts of sub-Saharan Africa where participants came from, hospitals were described as being remote, costly, and having a bad reputation. When ill, many people would practice self-diagnosis and treatment or consult a traditional healer. Others trusted in the care of God. As long as they regarded themselves as healthy, they perceived no need to consult a doctor. Culturally grounded beliefs and contextual factors (e.g., no preventive services) contributed to emergency health-seeking behavior rather than preventive and health-promoting behavior including VCT.

*Low Self-Perceived Risk.* In the FGDs implicit “risk categories” emerged, which participants used to illustrate how risk assessment was done by telling stories about “others” and their “risk behaviors.” Although some of these categories were congruent with high-risk behavior, the narratives in which they were embedded reinforced HIV related stigma. Most behaviors categorized as risks (e.g., having multiple partners, being unfaithful or promiscuous, engaging in prostitution and having unprotected sex), were perceived as immoral as they related to transgressing sexual norms. Behavior categorized as risk-free (e.g., abstinence, monogamy, and protected sex), confirmed this sexual norm. Participants did not perceive themselves as personally engaging in such behaviors; subsequently they did not feel the need to take an HIV test: “I see myself not too much in those activities to get HIV, [so] I don’t see the reason why I would go out one day and test. Even your mother would tell you: ‘What is wrong with you?’ Even in Africa, if you would do it, it brings a lot of thoughts” (young male Anglophone resident).

However, risks were not always described as obvious. Participants mentioned for instance that one could never be sure of the sexual partner because it was socially unacceptable to tell the truth about one’s sexual behavior and history: “Every man is going to tell you: I am married,” or “I am with a woman,” or “I stay with that woman.” Even women also say that [kind of thing], but you don’t know... At this point it’s not transparent” (adult male Anglophone resident).

Some participants said that owing to this growing nontransparency, it should be recommended that everybody goes for an HIV test.

Even people assessing their risk accurately were reluctant to seek VCT because they feared the severe personal and social consequences of HIV: “The people who doubt don’t present themselves ... If the lady with whom I had sex, has AIDS, and you would ask me [to go for an HIV test]—and I would ask myself—I would not come with you” (adult male Francophone resident).

*Missed Opportunities.* Sixty-five percent of the study participants (72% of the women and 58% of the men) had undergone an HIV test, with 76% of them performed in Belgium (88% of the women and 58% of the men). HIV tests were performed mainly when requested by health professionals during antenatal screening and pre-operative or general health checkups. In many instances, tests were performed without proper pretest and posttest counseling and, in some cases, even without prior informed consent procedure. Only a small minority had ever actively sought an HIV test, mainly owing to fearing health care providers’ judgment. However, if service providers proposed an HIV test, participants accepted. Also, because participants

perceived doctors as a health authority knowing what is best for the patient, they were also inclined to not question this advice and adhere to the doctors' suggestion to do a test.

*Limited Financial Resources.* Young people and asylum seekers mentioned financial cost as an important barrier to VCT. They usually had tight budgets and were not sufficiently informed about free testing sites and the health care reimbursement system: "They really have to inform us and emphasize that the test is free because the people, they are always afraid ... They know that the laboratories, if you test, cost a lot and that is the problem" (adult female Francophone resident).

## DISCUSSION

This is the first qualitative community-based study on the barriers to VCT uptake among sub-Saharan African migrants in Belgium. Detailed barriers and facilitators to VCT are presented.

The results of this study need to be interpreted with caution because we recruited participants on a voluntary basis and some may have had a special interest in discussing VCT or may already have acquired some experience related to the issue at stake. We may have missed hard-to-reach populations. However, given the representation of different subgroups (as displayed in table 1), we achieved a sufficiently broad range of participants to draw some general conclusions.

Most study participants were in favor of VCT in principle. They suggested that health care providers should actively initiate HIV testing in order to overcome the patients' fear of asking for a test; however, they recommended that appropriate counseling should be provided.

Our results show the persistence of previously acquired experiences before respondents had migrated and its impact on their perceptions regarding VCT in the new host country (Körner, 2007). This was true even for migrants who had been in the country longer. The images of their relatives or friends who may have suffered and even died of HIV/AIDS and all surrounding experiences still were present and may have shaped their current attitude toward VCT. This perception was continuously fed by information they received from their home countries, when families sought financial help for caring for a relative who became newly infected or when migrants themselves had met someone living with HIV/AIDS during their visit to their country of origin. The influence of such experiences on the uptake of HIV testing remained strong because the majority of our respondents did not know any person living with HIV/AIDS in Belgium. Seeing PLHA in good health conditions, coupled to the testimonies of PLHA about how to live with HIV, could be an effective way to change such perceptions and normalize HIV. At the same time more efforts should be made to inform sub-Saharan African migrants on the national policies regarding the health system, HIV testing and HIV/AIDS care.

The major barriers toward VCT uptake identified in this study were fear of dying, fear of stigma and discrimination, low perceived risk of HIV infection, lack of preventive culture, and lack of relevant information. Some specific subgroups expressed additional concerns (e.g., recent migrants and asylum seekers feared deportation) and had concerns about financial costs.

These multiple barriers to VCT were grounded in the complex interaction between sub-Saharan African migrants' diverse social and cultural background and

their current migration status. The cultural values that African migrants attached to HIV were reinterpreted within their migration context. For migrants, who are often particularly vulnerable owing to legal, economic, and social uncertainties, the possibility of being HIV positive may constitute a greater concern than their health. Therefore, prevention and health promotion are at the lower end of their priorities of more urgent life problems, such housing, employment, and income (Anderson & Doyal, 2004; Burns et al., 2007). This suggests that structural interventions yielding a gain in durable social networks creating a personal and social safety net, as well as economic and legal security, would have a positive overall impact and could possibly reduce the existing barriers to VCT. However, the immense responsibility many recent migrant have toward their family and community members back home is much harder to address. Often the whole extended family, sometimes even the entire village, contributed to the trip to Europe, and they are all expecting to see their "investment" pay off; this expectancy is very hard to fulfill when the person concerned is ill.

The different barriers to VCT emerging in this study, largely dependent on personal level of information, attitudes and beliefs, social group norms, and other contextual factors, influenced to various degrees the decision process on whether or not to seek VCT. The group process occurring in the FGDs made it more likely to capture community views. On the basis of our findings, we argue that community norms exert a greater influence than individual opinions. Subsequently, the potential HIV related stigmatization within the community is of greater concern than possible advantages of VCT. Interventions that aim at changing groups' attitudes and norms are therefore likely to have more impact than individually targeted measures (McCree, Eke, & Williams, 2007). If well informed, social networks are less compromised by gossip and rumors. Due to the high social control within the tight African community networks, gossip usually spreads fast. In this way, gossip may quickly and severely damage the network ties, which are essential for the success of an individual's migration (Dodds, 2006). This may explain our finding that sub-Saharan African migrants who are in favor of VCT still do not present themselves for testing. They are simply avoiding the rumors which most likely occur if they were to be seen at a testing facility. In our study, participants said that Africans seen entering a specific AIDS reference clinic are considered to be HIV-positive, independent of their reason for visiting. Even when the clinic is also a well-respected expertise centre for other specialized services by the community and therefore often consulted, it becomes the symbol of HIV. This also has been observed in the United States (Foley, 2005) and South Africa (Frank, 2008).

Our data showed that the HIV related stigma was persistently present in these communities. From our experience with counseling and support of PLHA, we also learned that patients often avoid being linked to the HIV service, by, for instance, not staying in the waiting room. In this sense, we may interpret the emphasis that our participants put on the nonsexual HIV transmission modes as an implicit way of reducing the HIV stigma corroborated by the community and its influence on the personal risk perception.

Although 65% of participants have been tested for HIV during their lifetime, with the majority being tested in Belgium, very few tests took place voluntarily. Most tests were performed on the initiative of the health care providers whose clients were pregnancy or had any illness with symptoms suggesting HIV infection or for administrative reasons (e.g., loan or insurance). Although participants didn't complain about these procedures, they did ask to be well informed and counseled.

This calls for adhering to the existing guidelines of WHO/UNAIDS regarding any HIV testing, sometimes not respected by Belgian practitioners (Devroey et al., 2002; Van Casteren et al., 2004). It is not an exaggeration to conclude that sub-Saharan African migrants participating in this study were not educated on their rights to information on medical procedures. They believed a medical doctor to be a competent authority who made appropriate decisions, which ought not to be ignored, and if a physician didn't test for HIV when collecting blood, respondents understood this to mean a test was not necessary, and that they could conclude that they were HIV-negative. This was compatible with the hesitation to pursue an HIV test, owing to fear of normative judgment when personally asking for a test or having been seen when going for an HIV test.

Given the many existing concerns relating to HIV in general and HIV testing in particular, as described in this article, the promotion of opt-out HIV testing should coincide with culturally sensitive pretest and posttest counseling for sub-Saharan African migrants as it is recommended by WHO/UNAIDS. Although suggested strategies for targeted opt-out testing in western Europe included focused counseling for those found positive or at high risk (Hamill et al., 2007), this study shows the general need for counseling. By addressing target-group specific needs, fears, and barriers, counseling will contribute to risk reduction behavior (Voluntary HIV 1 Counseling and Testing Efficacy Study Group, 2000), reduction of stigma (Kalichman & Simbayi, 2003) and higher uptake of voluntary testing in the future. In line with the strong historical oral tradition of Africans, tailored pretest and posttest counseling can also be the start of a cycle of word-of-mouth promotion of HIV testing, safer sex behavior, and the reduction of stigma. When practical information is provided, culturally sensitive counseling will increase the knowledge of sub-Saharan African migrants on HIV testing services and the health care system. Because many health care providers may feel uncomfortable when targeting this group with specific VCT messages, or may be concerned about being perceived as discriminating against African migrants (Burns et al., 2005), guidelines on culturally sensitive HIV counseling should be developed in order to address these restraints.

The success of provider-initiated HIV testing and counseling in reducing the number of late diagnoses among sub-Saharan African migrants will depend on the accessibility of the health care infrastructure. Migrants, especially undocumented migrants, often encounter problems in accessing services (Hargreaves et al., 2006; Prost, Elford, Imrie, Petticrew, & Hart, 2008). Therefore, measures to promote HIV testing should not only be taken on the health care level but also on the community level. Community leaders should be educated in changing their attitudes regarding VCT and they should be involved in the development and implementation of interventions (Prost et al., 2008). This allows for promoting HIV testing in a culturally sensitive way, taking into consideration the diversity of the communities while contributing to reduction of HIV related stigma and increasing health related community knowledge (Burns et al., 2007).

## CONCLUSIONS

Overcoming the barriers to VCT and increasing VCT uptake requires the routine dissemination of culturally sensitive information tailored to the needs of the target group, using appropriate language that covers the organization of the national/regional health system and the personal benefits of VCT. PLHA should be involved,

for instance, by offering their testimonies. Their message can contribute to a change in migrants' perceptions on VCT and as a consequence to adopting a positive attitude toward HIV uptake. Adopting such an approach, African community members and service providers would have complementary roles. At community level, sub-Saharan Africans should focus on reducing HIV related stigma while service providers should implement migrant-friendly services, actively offering provider-initiated HIV testing with culturally sensitive information and counseling.

## REFERENCES

- Anderson, J., & Doyal, L. (2004). Women from Africa living with HIV in London: A descriptive study. *AIDS Care*, *16*, 95-105.
- Boyd, A. E., Murad, S., O'Shea, S., de Ruiter, A., Watson, C., & Easterbrook, P. J. (2005). Ethnic differences in stage of presentation of adults newly diagnosed with HIV 1 infection in south London. *HIV Medicine*, *6*(2), 59-65.
- Burns, F. M., Fakoya, A. O., Copas, A. J., & French, P. D. (2001). Africans in London continue to present with advanced HIV disease in the era of highly active antiretroviral therapy. *AIDS*, *15*(18), 2453-2455.
- Burns, F.M., Fenton, K. A., Morison, L., Mercer, C., Erens, B., Field, J., et al. (2005). Factors associated with HIV testing among black Africans in Britain. *Sexually Transmitted Infections*, *81*(6), 494-500.
- Burns, F. M., Imrie, J., Nazroo, J. Y., Johnson, A. M., & Fenton, K. A. (2007). Why the(y) wait? Key informant understandings of factors contributing to late presentation and poor utilization of HIV health and social care services by African migrants in Britain. *AIDS Care* *19*(1), 102-108.
- Chee, C. C., Mortier, E., Dupont, C., Bloch, M., Simonpoli, A. M., & Rouveix, E. (2005). Medical and social differences between French and migrant patients consulting for the first time for HIV infection. *AIDS Care*, *17*(4), 516-520.
- Devroey, D., Van Casteren, V., & Sasse, A. (2002). How are patients informed about their HIV test results? *Family Practice* *19*(2), 125-127.
- Dodds, C. (2006). HIV related stigma in England: Experiences of gay men and heterosexual African migrants living with HIV. *Journal of Community and Applied Social Psychology*, *16*(6), 472-480.
- EuroHIV. (2007a). *HIV/AIDS surveillance in Europe. End-year report 2006*. No. 75. Saint-Maurice, France: Institute de veille sanitaire. Retrieved 1/23/2008, from [http://www.eurohiv.org/reports/report\\_75/pdf/report\\_eurohiv\\_75.pdf](http://www.eurohiv.org/reports/report_75/pdf/report_eurohiv_75.pdf)
- EuroHIV. (2007b). *Report on the EuroHIV 2006 survey on HIV and AIDS surveillance in the WHO European Region*. Saint-Maurice: Institut de veille sanitaire. Retrieved 1/23/2008, from [http://www.eurohiv.org/reports/eurohiv\\_2006\\_survey\\_report/eurohiv\\_2006\\_survey\\_report.pdf](http://www.eurohiv.org/reports/eurohiv_2006_survey_report/eurohiv_2006_survey_report.pdf)
- Foley, E. E. (2005). HIV/AIDS and African immigrant women in Philadelphia: Structural and cultural barriers to care. *AIDS Care*, *17*(8), 1030-1043.
- Frank, E. (2008). Becoming positive, becoming modern: Testing for AIDS in Southern Zambia. *AIDS and Anthropology Bulletin* *18*(2), 7-11.
- Hamers, F. F., Devaux, I., Alix, I., & Nardone A. (2006). HIV/AIDS in Europe: trends and EU-wide priorities. *Eurosurveillance* *11*(47), pii-3038. Retrieved 3/10/2008, from <http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=3083>
- Hamill, M., Burgoine, K., Farrell, F., Hemelaar, J., Patel, G., Welchew, D. E., et al. (2007). Time to move toward opt-out testing for HIV in the UK. *British Medical Journal*, *334*, 1352-1354.
- Hargreaves, S., Friedland, J., Gothard, P., Saxena, S., Millington, H., Eliahoo, J. et al. (2006). Impact on and use of health services by international migrants: Questionnaire survey of inner city London A&E attenders. *BMC Health Services Research*, *5*, 153. doi:10.1186/1472-6963-6-153
- Kalichman, S. C., & Simbayi, L. C. (2003). HIV testing attitudes, AIDS stigma, and voluntary HIV counselling and testing in a black township in Cape Town, South Africa. *Sexually Transmitted Infections*, *79*(6), 442-447.
- Körner, H. (2007). Late HIV diagnosis of people from culturally and linguistically diverse backgrounds in Sydney: The role of culture and community. *AIDS Care*, *19*(2), 168-178.
- Krentz, H. B., Auld, M. C., & Gill, M. J. (2004). The high cost of medical care for patients who present late (CD4 < 200 cells/mu L) with HIV infection. *HIV Medicine*, *5*(2), 93-98.
- McCree, D.H., Eke, A., & Williams, S.P. (2007). Dyadic, small group, and community-level

- behavioral interventions for STD/HIV prevention. In S.O. Aral, & J.M. Douglas (Ed.), *Behavioral interventions for prevention and control of sexually transmitted diseases* (pp. 105-124). New York: Springer Science & Business Media.
- McGarrigle, C. A., Cliffe, S., Copas, A. J., Mercer, C. H., DeAngelis, D., Fenton, K. A. et al. (2006). Estimating adult HIV prevalence in the UK in 2003: the direct method of estimation. *Sexually Transmitted Infections*, 82(Suppl. 3), iii78-iii86.
- Mola, O.D., Mercer, M. A., Asghar, R.J., Gimbel-Sherr, K.H., Gimbel-Sherr, S., Micek, M.A. et al. (2006). Condom use after voluntary counseling and testing in Central Mozambique. *Tropical and International Health*, 11(2), 176-181.
- Morgan, D. L., & Krueger, R. A. (1998). *The focus group kit*. Thousand Oaks, CA: Sage.
- Painter, T.M. (2001). Voluntary counseling and testing for couples: high leverage intervention for HIV/AIDS in sub-Saharan Africa. *Social Science and Medicine*, 53(11), 1397-1411.
- Prost, A., Elford, J., Imrie, J., Petticrew, M., & Hart, G. J. (2008). Social, behavioural, and intervention research among people of sub-Saharan African origin living with HIV in the UK and Europe: Literature review and recommendations for intervention. *AIDS and Behavior*, 12(2), 170-194.
- Sadler, K. E., McGarrigle, C. A., Elam, G., Ssanyu-Sseruma, W., Davidson, O., Nichols, T., et al. (2007). Sexual behaviour and HIV infection in black-Africans in England: Results from the Mayisha II survey of sexual attitudes and lifestyles. *Sexually Transmitted Infections*, 83, 523-529.
- Sasse, A., Defraye, A., Buziarsist, J., Van Beckhoven, D., & Wanyama, S. (2007). Epidémiologie du Sida et de l'infection du VIH en Belgique. Situation au 31 décembre 2007. Burssels: Institut de Santé Publique, Retrieved 8/13/2008, from <http://www.iph.fgov.be/epidemi/epifr/aidsfr/aidsanfr/aids07fr.pdf>
- Voluntary HIV 1 Counseling and Testing Efficacy Study Group. (2000). Efficacy of voluntary HIV 1 counselling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomised trial. *The Lancet*, 356(9224), 103-112.
- UNAIDS. (2001). *The impact of voluntary counseling and testing: A global review of the benefits and challenges*. Retrieved from [http://data.unaids.org/Publications/IRC-pub02/JC580-VCT\\_en.pdf](http://data.unaids.org/Publications/IRC-pub02/JC580-VCT_en.pdf)
- Van Casteren, V., Devroey, D., Sasse, A., & Wallyn, S. (2004). An 8 year nationwide prospective registration of nonconsented HIV testing in Belgium. *Journal of Public Health*, 26(1), 72-76.