

“IT IS NOT EASY”: CHALLENGES FOR PROVIDER-INITIATED HIV TESTING AND COUNSELING IN FLANDERS, BELGIUM

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This study identified physicians' HIV testing practices and their barriers toward implementing provider-initiated HIV testing and counseling (PITC) for Sub-Saharan African migrants (SAM) in Flanders, Belgium. In-depth interviews were conducted on a purposive sample of 20 physicians (ten GPs and ten internists). GPs performed mainly patient-initiated tests, while internists carried out tests based on disease indicators and risk behavior. For the most part, World Health Organization (WHO) guidelines were not followed. Study participants were not in favor of implementing PITC. Reasons included lack of information on the HIV epidemic among SAM, fear of stigmatizing patients, perceiving testing as unethical for undocumented patients, questionable relevance of pre-test counseling, lack of expertise in discussing sexuality, language barriers, lack of time, and the absence of a national or regional HIV testing policy.

Implementing PITC will require appropriate training of service providers. Also, supporting policies should be developed with the participation of stakeholders encouraging “normalization” of HIV testing.

HIV testing is an entry point for treatment, care, and prevention services. Despite the high availability of HIV testing facilities and antiretroviral treatment, an estimated 30% of HIV infections remain undiagnosed in Europe (Hamers, Devaux, Alix, & Nardone, 2006), concerning people who potentially present late to care. Undiagnosed individuals and late diagnosis increase onward HIV transmission and contribute to high morbidity and short-term mortality among people living with HIV (PLHIV) (Chadborn, Delpech, Sabin, Sinka, & Evans, 2006; Marks, Crepaz, Senterfitt, & Janssen, 2005).

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Many PLHIV who were diagnosed late previously reported one or more visits to healthcare services with HIV/AIDS-associated symptoms or with identified risk factors for HIV acquisition (Burns et al., 2008; Duffus et al., 2009). Determinants for late diagnosis reported in the literature include being heterosexual, a (Sub-Saharan African) migrant, and having older age (Borghi et al., 2008; Ndiaye et al., 2011; Yang et al., 2010).

Sub-Saharan African migrants (SAM) living in Flanders, the Northern Dutch-speaking part of Belgium where this study was carried out, are disproportionately affected by HIV. While they constitute a relatively small community both among overall migrant populations and the general population, they account for 28.6% of the cumulative total of HIV-diagnoses. In Flanders, 62.5% of the 932 SAM diagnosed with HIV between 2000 and 2009 were diagnosed late with a CD4 count below 350 cells/mL blood or an AIDS defining illness (A. Sasse, personal communication, April 18, 2010).

A previous qualitative study (Manirankunda, Loos, Alou, Colebunders, & Nöstlinger, 2009) identified socially and culturally grounded barriers for seeking an HIV test among SAM, such as low risk perception, fears of social exclusion if found positive, no preventive culture, and lack of information on HIV testing. To address these barriers, study participants recommended that physicians should proactively propose HIV testing. Physicians were seen as respected authorities, implying that many SAM would accept a proposed test when accompanied by appropriate counseling and ensured confidentiality. This recommendation is congruent with international guidelines on provider-initiated testing and counseling (PITC), suggested to reduce the rate of late diagnosed HIV infections. WHO/UNAIDS (2007) promote PITC since 2007 in health facilities alongside patient-initiated HIV voluntary counseling and testing (VCT). PITC refers to HIV testing and counseling recommended by healthcare providers to patients irrespective of their reasons for the visit as a standard component of medical care. This strategy is tailored to local HIV epidemics. In generalized epidemics, HIV testing is recommended for all patients in all health facilities, regardless of the existence of HIV-related symptoms or the cause of the visit. However, PITC is more selective in concentrated or low-level epidemics, where recommendations refer to PITC implementation in services for sexually transmitted infection (STI), health services for most-at-risk populations (injecting drug users, MSM, sex workers, prisoners), antenatal, childbirth, and postpartum services, and tuberculosis (TB) services.

PITC has the dual objective of diagnosis and prevention as stipulated by the three "Cs," that is, providing (pre-test and post-test) counseling, obtaining consent, and assuring confidentiality (WHO/UNAIDS, 2007).

The U.S.-based Centers for Disease Control and Prevention recommend an opt-out approach for all patients aged between 13 and 64 years. HIV testing is performed unless the patient declines. For prevention counseling, patients are referred to community organizations, if needed (Branson et al., 2006).

In many European countries, primary care settings constitute the first entry-point to healthcare. Studies found that a third of HIV-infected individuals attended primary care in the year before diagnosis (Fakoya, Reynolds, Caswell, & Shiripinda, 2008), yet only 71% of countries have HIV testing available in primary care settings, and only six countries (Denmark, Germany, the Netherlands, Norway, Spain, and Switzerland) have a testing strategy that primarily operates through general practitioners (GPs), while testing is also offered in other settings (Mounier-Jack, Nielsen, & Coker, 2008). Recently, awareness for promoting routine HIV testing in Europe

has been increasing and translated into national policies in some countries. In her study, Deblonde and colleagues (2011) showed that 9 out of 24 European countries surveyed oriented their client-initiated HIV testing and counseling policy toward the general population while another group of eight countries (e.g., France, Iceland) had a single national policy covering HIV testing in a variety of health facilities targeting the general population.

Aside from policy-related barriers, specific healthcare-related barriers have been said to undermine HIV testing in the healthcare setting. These include a lack of appropriate knowledge and skills of GPs to offer testing and communicate the benefits of testing, failure by doctors to recognize symptoms, absence of clear guidelines regarding testing, and shortage of trained counseling staff (WHO/EURO, 2010).

In Belgium, a wide range of facilities are offering HIV testing, including GP offices, HIV/STI clinics, hospitals, and student services centers. Routine HIV testing is offered to clients of sexual health services, TB patients, high-risk groups for HIV infection (injection drug users or sex workers), and pregnant women. Free antiretroviral treatment is offered to all HIV patients. Patients can freely choose or change their GPs, and specialists can be consulted without referral from a GP. For patients, who are covered by health insurance (including asylum seekers), the costs of medical consultation, lab tests, and treatment are partially covered by the health insurance. While health insurance is mandatory, those who are not covered (e.g., undocumented migrants) have to pay the full costs.

This study on current PITC practices among SAM was carried out in Flanders. Here, as in the rest of Belgium, SAM are a minority and heterogeneous group consisting of many different nationalities and ethnicities. Their accurate number is not known. The officially registered 64,386 SAM living in Belgium represent 6.42% of all migrants and 0.06% of the general population. Ten of 45 different nationalities account for 80.8% of SAM: Democratic Republic of Congo (34.2%), Rwanda (8.7%), Cameroon (8.3%), Guinea (5.9%), Angola (4.7%), Ghana (4.4%), Togo (3.8%), Nigeria (3.4%), Ivory Coast (3.4%) and Burundi (3.3%). Most SAM (40.90%) live in Brussels, the Belgian capital, 30.52% and 28.58% live in Flanders and Wallonia regions, respectively. The proportion of men and women is equal (50.8% for men, 49.2% for women), and 70% are between 15 and 49 years old (Service of the Immigration Authorities; Ministry of Internal Affairs, personal communication, April 2007).

This qualitative study is complementary to the above-mentioned study on SAM's barriers to HIV testing. It aims to explore GPs' and internists' practices in relation to HIV testing among SAM and their perceived barriers on the implementation of PITC. The evidence accumulated from both studies will inform strategies and policies for increasing the uptake of HIV testing and improving the quality of HIV testing services in this target group.

METHODS

We used an inductive methodological approach and in-depth interviews as a data collection technique. Between October 2007 and December 2008, 66 physicians (45 GPs and 21 specialists in internal medicine) working in two Flemish cities where most SAM reside were approached for recruitment. Twenty physicians (ten GPs and ten specialists in internal medicine) consented to an in-depth interview. The main

reasons for the refusals were lack of time, few or no SAM among their patients, and little or no experience with HIV testing. The primary care level performs about 55% of all HIV tests in Belgium (RIZIV, personal communication, May 12, 2011), supporting the choice of GPs as study participants. Specialists in internal medicine (internists) were chosen because they are frequently used by SAM as first line care providers working in hospitals. For both professionals, working conditions are favorable for carrying out PITC because their consultations allow for sufficient time, building trusting patient-physician relationships, and proper follow-up.

Potential participants were identified through existing inventories of registered GPs and internists, key informants, and peers. They were purposively sampled according to specialization, gender, HIV testing experience, and experience with SAM patients. Face-to-face interviews were done at their work place. Study participants completed a short sociodemographic questionnaire and provided informed consent for participation. No incentive was given to study participants.

Trained interviewers conducted semi-structured interviews in Dutch or English, including questions on perceived differences between SAM and Belgian patients, their perceived professional role in HIV/AIDS prevention, their current HIV testing practices, and their views on PITC for SAM. When assessing current HIV testing practices, interviewers probed for the steps of client-initiated VCT. WHO and UNAIDS guidelines on PITC were also explained before exploring the participants' perceptions, perceived benefits, and barriers. Interviews lasted between 40 and 90 minutes. After each interview, the research team held debriefing discussions to identify newly emerging themes, which then were integrated in the subsequent interviews.

All interviews were audiotaped and transcribed verbatim. No software program was used for organizing or analyzing the transcripts. The analysis adopted an inductive approach, guided by grounded theory principles (Charmaz, 2006). Narrative accounts were repeatedly scrutinized by a team of three researchers for common items for which meaningful codes were developed independently. With each new transcript, newly emerging codes were added until saturation was achieved. This resulted in a codebook containing the specific codes and their descriptions. Codes were combined to overarching themes, relevant to the study's objectives. Disagreements between coders were solved by discussion until consensus was achieved. Quantitative sociodemographic data were analyzed using SPSS 18 employing descriptive statistics.

This study received ethical approval from the Institute of Tropical Medicine's Institutional Review Board and the University of Antwerp.

RESULTS

PARTICIPANTS' SOCIODEMOGRAPHIC CHARACTERISTICS

Sixty percent of the physicians were male, slightly more than half worked in Antwerp, and the mean age was 42 and 44 years for GPs and internists, respectively. All internists worked in hospitals. Eight of the ten GPs worked in group practices while the remaining worked alone. Participants' overall professional experience was high and comparable between the two groups. GPs saw four times more SAM patients on a monthly basis than internists. They performed fewer HIV tests but diagnosed an equal number of SAM with HIV. See Table 1 for a summary of the participants' characteristics.

TABLE 1. Participants' Characteristics

Characteristics	General practitioners (n = 10)	Internists (n = 10)
Gender		
Male	5	7
Female	5	3
Age (mean in years)	41.6	44.4
Setting		
Antwerp	5	6
Gent	5	4
Professional experience (in years)		
Mean (standard deviation)	14.6 (12.5)	16.1 (8.3)
≤ 5 years	4	2
> 5 years	5	8
SAM patients		
Total of SAM received last month	216	56
Total of SAM received last 6 months	621	226
HIV testing (all patients including SAM)		
Total of HIV tests performed last month	253	54
Total of HIV tests performed last 6 months	827	127
HIV testing with SAM patients		
Total of HIV tests performed last month	35	8
Total of HIV tests performed last 6 months	148	38
HIV-positive diagnosis among SAM patients		
Last month	2	2
Last 6 months	6	6

PHYSICIANS' PERCEIVED ROLE IN HIV PREVENTION

All participants perceived their roles to be primarily diagnostic, by performing HIV tests, diagnosing new infections, and sensitizing patients about the importance of knowing their HIV-status. Internists thought that discussing specific HIV prevention topics, like information about HIV and safer sex counseling, were GPs' tasks. GPs, however, felt they had a limited preventive role and referred to the regional sexual health organization as the key actor in HIV prevention.

CURRENT PRACTICE OF HIV TESTING

Study participants' accounts of current HIV testing practices demonstrated that most were unaware of the WHO/UNAIDS guidelines for VCT and, apart from a minority, were against their implementation. Those who were in favor of guidelines (four internists and two GPs) thought that standardization would improve the quality of their services and the patients' trust in their test results.

Initiating an HIV Test upon Request. The majority of HIV tests performed by GPs were patient-initiated and/or partner-initiated. However, patients who spontaneously asked for an HIV test were mostly native Belgians. According to the GPs, SAM rarely asked for a test. Five physicians who had long-term experience in working with SAM (three GPs) or had worked in Africa (two internists) mentioned that some SAM requested general health check-ups while their intention was actually to get tested for HIV.

Internists and GPs performed provider-initiated testing on indication either when patients presented with HIV-related illnesses (tuberculosis, chronic diarrhea, pneumonia, other opportunistic infections) and/or had known sexual risk behaviors. They also recommended an HIV test for pregnant women and patients who came for pre-operative check-ups. Some GPs additionally suggested giving an HIV test to young people seeking contraceptive advice.

Some GPs and internists believed that if SAM did not request an HIV test, it was probably not a matter of ignorance. They believed SAM to be sufficiently informed because of the high HIV prevalence and impact of the HIV epidemic in their home countries. This was repeatedly reported, justifying why physicians did not propose HIV testing.

Pre-test Counseling and Informed Consent. Most providers did not offer pre-test counseling according to WHO/UNAIDS guidelines, thereby not supporting informed choice about testing among their patients. Only when patients requested an HIV test, did some physicians assess risk behavior: “...if patients ask me to do the test, I ask them if they have had a risk behavior—just to know if I should talk a little bit more [time], but many people say: no, I just want to be sure and I want to do the test” (male internist, 21 years of experience).

All but three providers always requested permission to carry out an HIV test because the existing law on privacy, patients’ rights, and on the physical integrity supported by the Medical Council required them to do so, and to “...avoid the problems one may face when the test turns out positive” (male internist, 3 years of experience). Although they obtained informed consent, some physicians questioned its usefulness: “I need their consent. Legally in Belgium we have to, which is a strange thing because you don’t have to do this for syphilis, and other venereal diseases, but you do have to ask it for HIV” (female internist, 3 years of experience).

Five physicians who adopted an opt-out approach (four internists and one GP) stated that no patient had ever refused their proposal to test for HIV. “I warn them, I’m going to do this test because it is important for medical reasons to know if you are HIV positive or not, so nobody refused the test until now” (male internist, 21 years of experience).

One internist admitted to testing without patients’ consent because he feared their decline, which he interpreted as doubting his medical expertise: “I have the right to do so. It [the informed consent] is not useful. If he says no, then you’re not going to do the test? Then I will say what? Look for another doctor, I will say ‘sorry, I’m not going to treat you...’ ” (male internist, 28 years of experience).

Returning Test Results and Post-test Counseling. In our sample, 17 of 20 participants did not provide any post-test counseling when returning negative results. Nine physicians (five internists and four GPs) announced results during a follow-up consultation, while 11 physicians (five internists and six GPs) did this by phone. The latter argued that patients will not come back to collect their results. Both GPs and internists emphasized that only negative results were given over the phone, positive results would always be communicated personally: “I tell them ‘call me after two days, I will have the test results’...then when the test is positive, I call and say, ‘I would like to see you because there is something important found [in your blood].’ Of course, they know that this is not good news, and it is sometimes dramatic” (male GP, 32 years of experience).

Only one internist routinely sent a letter to the patients’ GP to communicate the test results.

When returning an HIV-positive result, participants were mainly concerned about alleviating the first shock of diagnosis before the actual referral to the local AIDS Reference Centre (ARC), which is recommended by the existing HIV care guidelines. However, most informed their patients about the effective treatment options resulting in a favorable prognosis: “HIV is treatable today, the prognosis is not

as bad as it used to be 15 years ago, the reputation of HIV meant I'll be dead within 6 months, you know, some people still think so. We don't give concrete details about the therapy, no real counseling on prevention, we refer to the ARC" (female internist, 3 years of experience).

An internist mentioned three important messages he gave to newly diagnosed patients: giving hope, informing about the effectiveness of the medical treatment, and the possibilities of having healthy children. *"I say, come on, this is not the end of your life, we will help you and we will work hand in hand ...I have learned to say to an African woman during the result announcement that 'this [HIV] is not anymore a barrier for getting children.' This is also very important [for them]" (male internist, 21 years of experience).*

Six providers (two GPs and four internists) did not offer any post-test counseling for HIV-positive test results at all; they simply referred patients to the ARC.

BARRIERS TO PROVIDER-INITIATED HIV TESTING AND COUNSELING (PITC) AMONG SAM PATIENTS

In general, the physicians interviewed did not support the model of PITC, questioning the medical relevance of specifically targeting SAM, and the exceptionalism of the model. They also saw many practical barriers in implementing PITC.

Lack of Information on HIV/AIDS among SAM. Most participants were not sufficiently informed about the HIV epidemic in this target group and thus saw no epidemiological relevance for PITC: *"Is HIV really a problem among SAM? My perception is that HIV/AIDS is not really high in that group" (female GP, 15 years of experience).*

They felt supported in their opinion by the absence of national or regional guidelines: *"I think one really has to base this on hard scientific facts, there should be a guideline from the government. Not like, we're gonna try this out, I think you really need hard evidence..." (male internist, 15 years of experience).*

Migration-Related Barriers. Most participants were concerned about discriminating against SAM when implementing PITC, because it was seen as selective HIV testing. Since HIV is highly stigmatized, they believed SAM patients would accuse them of racism when proposing an HIV test. Some were also concerned about a bad reputation for their practice if it became known that they routinely proposed an HIV test to SAM. *"I don't think I would just go on [and propose an HIV test] if somebody comes for no matter what, definitely not only because they are sub-Saharan. There has to be something more than [the origin]....No, I would, myself, consider it as an offense if somebody would ask me to do an HIV test only because I was from x city....Again, I need something more than that. If somebody comes in with a sore throat or a sprained ankle...I really cannot, for me, find enough reason to start about HIV testing" (female GP, 15 years of experience).*

Participants also named other migration-related issues. They felt that carrying out an HIV test among undocumented migrants who might be deported at any time was unethical. They did not want to leave patients with an HIV diagnosis if they could not assure proper follow-up care. Because most SAM were perceived to only consult medical facilities in case of an emergency, uncertainty about returning test results was also perceived as a barrier.

Many participants mentioned SAM's financial difficulties and reliance on social benefits as additional barriers, jeopardizing their receiving payment for the test.

SPECIFIC BARRIERS RELATED TO THE USE OF PITC GUIDELINES

HIV/AIDS Exceptionalism. Some participants found it inappropriate that HIV/AIDS was treated differently compared to other chronic diseases and did not feel that it required specific guidelines. Such exceptionalism made it difficult for them to integrate HIV testing into routine care. *“If you see someone who has a liver failure and the liver tests are bad...you do a lot of tests, you never ask for the consent of the patients, not for hepatitis C for instance, which I think is also severe...ok, maybe it’s not a stigma like HIV, it still comes as a shock I think for people to hear it...I think we make such a big distinction between HIV and other tests that sometimes it would be easier maybe to just test”* (male internist, 19 years of experience).

Barriers to Initiating an HIV Test. Physicians felt that an HIV test could only be proposed on the basis of a trusting provider-patient relationship, which was often lacking, particularly with new patients or undocumented migrant patients. *“It is not easy to initiate an HIV test particularly when you have a new patient who doesn’t come for an HIV test, because first you have to build trust and confidence with the patient, otherwise the patient can feel uncomfortable and consults another physician”* female GP, 1.5 years of experience).

Some participants felt they would be making insinuations about fidelity in a patient’s sexual relationship by proposing a test. They usually struggled with this when testing pregnant women, for whom HIV testing is generally recommended. *“If, for instance, I see this woman who is in a stable relationship for many years, I would never assume that in this family...and then to give this whole explanation, that’s a bit too much, but it must happen if you think that her baby could be positive; for the baby, if it’s not known...that’s the only thing, but otherwise it’s a bit exaggerated”* (female GP, 2 years of experience).

Physicians were reluctant to integrate HIV testing into their routine consultations. They felt proposing an HIV test would distract the focus from the patients’ actual problem and consume consultation time. *“It is not really applicable, I think... during a consultation of half an hour and people come with a specific problem you don’t really discuss things like that...”* (male internist, 23 years of experience).

Thirteen providers (eight GPs and five internists) perceived PITC for SAM as a discriminatory practice and therefore were not in favor of its implementation: *“I don’t see why targeting only Africans; there are people from many parts of Eastern Europe and Asia at high risk too. So I don’t see why only targeting the Africans”* (male internist, 21 years of experience). *“I don’t see how one can offer an HIV test for all the blacks and not do so for whites. I think it will not work”* (female GP, 2 years of experience).

Perceived Problems with Pre-test Counseling. Almost all participants anticipated problems with offering pre- and post-test counseling within a framework of PITC. Extensive pre-test counseling was seen as unnecessary, since they believed SAM to be sufficiently informed about HIV/AIDS and testing. Only one physician expressed doubts: *“Probably we assume too much that people are already informed; we probably assume that too much about Belgians also”* (male internist, 23 years of experience).

Participants also felt that giving detailed information before a test would scare patients. Some thought it would be better to give information only when returning results, similar to other diseases.

Lack of Culture-Sensitive Sexual Counseling Skills. Most participants reported that general communication with SAM patients was more difficult than with Belgians. SAM with low education, newly arrived SAM, and those coming from rural regions were seen as being especially difficult to communicate with. Particular discomfort related to communication about sexuality (for instance, when assessing HIV-related risks) and disrespecting patients' privacy because of a lack of understanding cultural norms: "Some of the questions are not so easy to ask, for instance about sexual behavior...because it is private. I think in general, I don't want to offend the patient. Maybe the young doctors could ask. It is not easy, like [to ask] about homosexual behavior, how do we discuss with them, even for Belgians [it's difficult]" (male internist, 28 years of experience).

One physician mentioned the culturally grounded taboo to discuss sexuality with SAM. "It [sexual risk assessment] is necessary, but there are problems with SAM: language problems, emotional problems, SAM have greater difficulties to talk about their sexuality than our people" (male internist, 21 years of experience).

Some participants found that SAM patients minimized their symptoms, which they interpreted as denial or lying: "Truth with African man and woman is different than with European; truth and lies are something different for them than for us, you have that impression sometimes. It's very difficult to make them understand that it's very important to have clear facts" (male internist, 23 years of experience).

Language Barriers. Some physicians felt that it was difficult to discuss medical issues in English and French, which were not the first languages of their SAM patients either. This applied particularly to sensitive issues such as sexuality and HIV.

Lack of Time. Participants found that following PITC guidelines was too time consuming, burdening both the physicians' and the patients' limited time. "Well, it depends on how elaborate the entire process is, I mean, how much time does a negative HIV counseling take, how much time does a pre-test counseling take? We must remain realistic...if the pre-test counseling takes two hours, to give you an extreme example, that's just not feasible" (female internist, 3 years of experience).

DISCUSSION

This is the first study in Flanders exploring physicians' current HIV testing practices and perceptions regarding PITC among SAM. The findings contribute to a better understanding of the barriers to implementing this approach. With a small community carrying a disproportionate HIV burden, providing alternative testing models is a public health priority. While PITC recommended by WHO/UNAIDS for concentrated epidemics aims at combined outcomes on diagnosis and prevention, its implementation has to be feasible for service providers. Our study confirms that overall physicians contribute little to HIV prevention, and they hardly adopt existing VCT guidelines. In this respect, not much progress has been made during the last decade (Devroey, Van Casteren, & Sasse, 2002; Van Casteren, Devroey, Sasse, & Wallyn, 2004). GPs mainly conduct patient- or partner-initiated HIV tests, while internists generally perform opt-out testing based on disease-related indicators, including systematic HIV testing during pregnancy or preoperative check-ups. This approach has been described as contributing to high numbers of late HIV diagnoses (Burns et al., 2008; Duffus et al., 2009; Kuo et al., 2005).

Our study found that reasons for providers' reluctance to engage in PITC were manifold, ranging from contesting the HIV/AIDS exceptionalism (i.e., the notion that because of the stigma attached to HIV and the lack of its curability, HIV/AIDS had to be approached differently; Bayer, & Fairchild, 2006), to lack of knowledge on the HIV epidemic in the target group on HIV testing guidelines, and to lack of skills to adopt PITC, among others.

While some of the participants referred to HIV/AIDS exceptionalism as an explanation of why they were not able to adopt PITC, others argued that routine HIV testing contributes to normalization of HIV as part of medical care (Branson et al., 2006).

VCT guidelines were generally not well known due to lack of training, which could also explain the discomfort for discussing sexuality with patients and the fear of offending them (Khan, Plummer, Hussein, & Minichiello, 2008; Partridge, Colini, & McKendrick, 2009). Training could contribute to a change of attitudes and behavior in relation to HIV testing (Korthuis et al., 2011).

Although our respondents were aware of the requirement for informed consent, it was often not obtained. Doctors believed that patients were sufficiently informed, which, however, has been contested by previous study (Manirankunda et al., 2009). In Belgium, informed consent procedures are regulated by the law on privacy, patients' rights, and physical integrity, and they are supported by the Medical Council. By testing without informed consent, physicians can be prosecuted under disciplinary jurisdiction, civil rights, and criminal law (Van Casteren et al., 2004).

Respondents questioned the relevance of pre-test counseling and often chose opt-out procedures. A potential explanation for the preference of an opt-out approach may also be seen in the discomfort of discussing potential risks and consequences of HIV. While patients need personalized information prior to testing, participants in our study were badly equipped to provide it adequately. This referred to both pre-test counseling (Manirankunda et al., 2009; Torrone et al., 2010) and post-counseling, which helps patients to cope with their HIV infection (Worthington & Myers, 2002). Even in the opt-out model, ethics would recommend that physicians make sure their patients understand the implications of the test results, allow time for questions, and indicate that patients can decline without any negative implication on the care provided (Celada, Merchant, Maxman, & Sherwin, 2011).

Given current testing practices, participants' reluctance toward implementing the PITC model is not surprising. Congruent with other studies (Burke et al, 2007; ECDC, 2010; Mounier-Jack et al., 2008) on applying PITC in health facilities, our participants named policy barriers (burdensome, demanding counseling process, and inadequate reimbursement), educational barriers (lack of patient acceptance, lack of knowledge and training), and logistic barriers (lack of time, competing priorities, language). In addition, our study shows that barriers were grounded in a lack of intercultural communication skills, particularly relating to the perceived taboo of talking about a sexually transmitted disease like HIV and sexuality in general. Being unfamiliar with the culture of this ethnic minority may also have added to the pronounced fear of being accused of racism when suggesting an HIV test. The fear of being perceived as discriminating against migrants was also found in a study in the UK: midwives were reluctant to offer HIV testing to African women because they were concerned about being labelled discriminatory (Gibb et al., 1998). Indeed, the African HIV Policy Network (2008) raised this concern as a reaction to the 2008 UK HIV testing guidelines, which included opportunistic screening of populations indicated on the basis of prevalence data. While doctors in our study were

truly concerned about discrimination and sensitive to the many factors that render SAM vulnerable with respect to HIV, one may also argue that not offering relevant health services, such as HIV testing, may indeed reiterate HIV-related stigma and may therefore be counterproductive.

Our respondents were concerned about introducing an HIV test during the first visit. They felt HIV testing could only be done based in a trusting provider-patient relationship. Trust is essential because it assures adequate follow-up and supports patients in adherence. In Belgium, physicians practice in an “open market,” in which patients freely choose their care providers (Deveugele, Derese, van den Brink-Muinen, Bensing, & De Maeseneer, 2002). Compared to other European countries, GPs invest more time in an average consultation to encourage patients to return for services. Because physicians feel that proactively offering an HIV test could threaten their reputations, performing PITC for asymptomatic patients does not seem a logical choice. A clear policy enabling physicians to perform an HIV test within good clinical practice and encourage “normalization” of HIV testing is thus needed. This is also in line with another relevant study finding—that physicians are requesting a national or regional policy as guidance for implementing the PITC model.

In addition to policy guidelines, training service providers could contribute to overcoming many of the existing barriers. All physicians should be trained on disease-related indicators impacting on the high rate of late diagnosed individuals. However, increasing early diagnosis for asymptomatic patients will require (1) knowledge and skills training covering HIV testing guidelines (pre-test information, obtaining informed consent, post-test counseling and referral), epidemiological and medical relevance, and time management, and (2) incentives for securing the professionals. Studies found that pre-test counseling was a matter of changing providers’ attitudes and communication style rather than of additional time (Jones, Sadler, Low, Blott, & Welch, 1998; Rietmeijer, 2007).

Because we recruited participants on a voluntary basis and some doctors may have been specifically motivated to discuss the study topic, we should interpret the results of this study with caution. The purpose of this qualitative research was not to assess actual HIV testing behavior and perceptions of PITC in a representative sample of Flemish physicians, but to provide a better understanding of mechanisms relevant for the implementation of PITC for SAM. This in-depth exploration therefore enables us to draw the following conclusions.

CONCLUSIONS

Current practices of HIV testing need to improve. Given the increasing importance of test and treat approaches, a balance between the existing practice and patients’ needs compatible with PITC has to be found, with the aim of normalizing HIV testing for SAM. This could be achieved by a policy that increases opportunities for HIV testing at various levels, offering a choice of different testing methods (e.g., conventional and rapid tests, community- and health-care based) and promoting serostatus awareness in the target group.

Adapted policies for PITC among African migrants should be based on the evidence presented here and otherwise available and should strive for a consensus among all stakeholders: HIV clinics, physicians’ associations, community-based organizations, representatives of people living with HIV, the scientific community, and policymakers. Upon establishing such guidance, training should be organized to

equip all providers with adequate knowledge and the skills for offering good clinical practice that is adapted to the needs of the patients. Monitoring and evaluation should accompany up-scaled implementation of PITC approaches. Additional structural interventions on the community level are needed to promote sexual health and reduce HIV-related stigma.

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