

Euro HIV EDAT Project

WP8. ACCESS TO HIV TESTING AND LINKAGE TO CARE FOR MIGRANT POPULATIONS IN EUROPE

RESULTS OF THE QUALITATIVE STUDY

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BELGIUM



DENMARK



FRANCE



GERMANY



PORTUGAL



SPAIN



SLOVENIA



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ESSENTIALS ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBVCT	Community-Based Voluntary Counselling And Testing
FGD	Focus Group Discussion
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IDU	Injection Drug Users
LAC	Latin America and the Caribbean
MSM	Men Who Have Sex With Men
NGO	Non-Governmental Organization
PEP	Post-Exposure Prohylaxis
PREP	Pre-Exposure Prohylaxis
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection

EXECUTIVE SUMMARY

This report provides the results of a qualitative research which constitutes the second phase of the Work-Package 8 study on “Access to HIV testing and linkage to care for migrant populations in Europe” of the EURO HIV-EDAT project co-funded by the Consumers, Health and Food Executive Agency (CHAPEA) under the European Union (EU) Public Health Programme for the period April 2014-September 2017 (No. 2013 1101).

This second phase of the study aims to gather in-depth insights on the barriers and the facilitators for HIV testing in both the health care services and Community-Based Voluntary Counselling and Testing services (CBVCTs) but also generate new data on the linkage to care of targeted migrant population (Sub-Saharan Africa and Latin America) among the participating countries. This research was conducted for a period of eight months in five participating countries (Belgium, Denmark, France, Portugal and Spain). The study consisted of carrying out a qualitative study based on 5 focus groups conducted with key informants (medical, advocacy, NGO, community representative) in the participating countries and 49 semi-structured interviews conducted among first generation HIV-/HIV+ migrants from Sub-Saharan Africa and Latin America.

Section 1 of this document provides a brief presentation of the study background. Section 2 presents the study methodology. Finally, section 3 offers findings of the qualitative research.

Key findings

For most of the participants, HIV testing offer is available in their country of residence but not always accessible for migrants and thus leading to late diagnosis. A large number of social, financial, cultural, psychosocial and linguistic barriers are identified.

- Interviews show that mistaken belief on HIV/AIDS along with the lack of access to relevant health information about transmission modes, means of prevention constitute major obstacles for migrants to identify their health needs. Lack of information about where to get tested (especially in CBVCT centres) prevent also migrant to access to HIV testing.
- Cultural and traditional representations of the disease lead to fear of HIV infection and its consequence (stigmatization, social exclusion etc.) and thus discourage migrants to seek for HIV testing. Additionally, participants highlight that respecting confidentiality and privacy among migrants, especially from Sub-Saharan African communities is essential. The fear of crossing someone from their community during an HIV test or to be reported by health providers to immigration service may hinder many migrants to go get tested.
- Participants stress that migrants seeking access to HIV testing can face many obstacles. In some countries, undocumented migrants can have limited legal entitlements. In countries which provide a greater extent of access to health care, interviewees underline repeatedly the stringency and

complexity of the administrative procedure for access to care. Moreover, the lack of information and knowledge about their entitlement can also prevent migrant from using these services.

- Finally, after an HIV diagnosis, fear of stigmatization and exclusion along with insecure conditions of life can prevent linkage to care and continuity of care. Fear of treatment and its side effects can also constitute great obstacles.

Interviews with key informants and migrants allow to identify facilitators to access to HIV services. Participants stress the importance on the one hand to diversify the HIV testing offer and strategy and on the other hand to provide more appropriate and accessible HIV testing and care services for migrants.

- Participants highlight the importance of a targeted information and communication to improve knowledge on HIV prevention and fights against misguided ideas. Outreach activities and collaboration with intermediaries are crucial elements to really reach the targeted migrant populations to provide information or offer HIV test and care.
- Participants underline the importance to diversify the HIV testing offer (statutory and community-based HIV testing offer). They also stress that CBVCTs meet migrants' expectations notably regarding privacy and confidentiality but also by providing social and administrative support. Several participants mention the idea of integrating HIV testing into a comprehensive health check which could reduce the psychological barriers (especially fears of stigma, images associated to HIV) of migrants to get tested.
- Regarding linkage to care, we find that collaboration between statutory health care services and CBVCTs might be crucial as it is a lever for patient participation in health care decision making and thus a lever for decrease risk of patients lost to follow-up.

The results of the qualitative study give some insights to improve early HIV diagnosis and linkage to care for migrants populations.

1. Background

1. Study context

The **European HIV Early Diagnosis and Access to Treatment Project (Euro HIV EDAT) project** (co-funded by the Consumers, Health and Food Executive Agency (CHAFFEA) under the European Union (EU) Public Health Programme for the period April 2014-September 2017 (No. 2013 1101) aims to generate operational knowledge to better understand the role and impact of Community Based Voluntary Counselling and Testing services (CBVCTs). It also aims to explore the use of innovative strategies based on new technologies and to increase early Human Immunodeficiency Virus/ Sexually Transmitted Infection (HIV/STI) diagnosis and treatment in Europe among the most affected groups. The Euro HIV EDAT ensures **continuity in the conduct of previous European projects on community-based HIV testing (e. g. the COBATEST Project)** and strengthens existing knowledge about vulnerable populations in Europe, such as men having sex with men (MSM) and migrant populations stemming from high endemic regions.

The project is divided into several work packages including the **work-package 8 (WP8)** which aims to describe **HIV testing patterns as well as identify the access and barriers for HIV testing and linkage to care among the main concerned migrant populations in community-based and statutory health services**. Previous mobilization, awareness campaigns and different initiatives among MSM have already enabled to gather data regarding this population and set up services and programs in several countries of the European Union. Nevertheless, regarding other populations, like migrants, there is an evident lack of data and mobilization is still strongly needed. If some programs already exist, they are not well-known; and besides, access to statutory health services is particularly difficult to reach for this population.

8 organizations among 7 countries are participating in this WP8 (in this document we will refer to them as associated partners):

- AIDS-Fondet (Denmark)
- AIDS-Hilfe NRW e.V. (Germany)
- Association AIDES (France)
- BCN Checkpoint-Hispanosida (Spain)
- ICO-CEEISCAT (Spain)
- Institute Tropical Medicine (Belgium)
- GAT-Grupo Português de Activistas sobre Tratamentos de VIH/SIDA (Portugal)
- Legebitra (Slovenia)

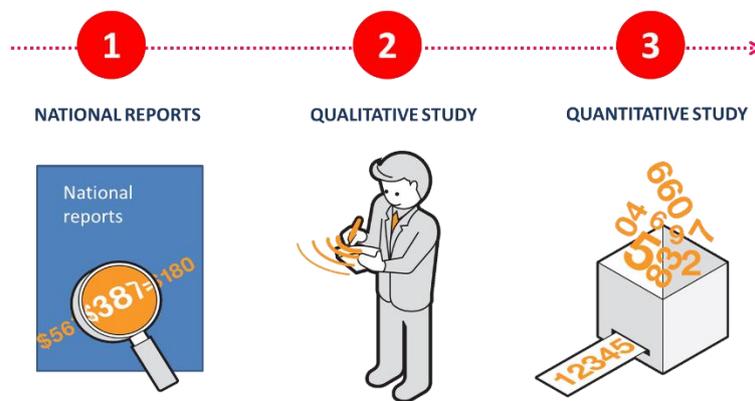
This study is divided into three successive phases:

- (1) Providing a national report on the situation of migration and HIV in Europe. This phase allowed to define most HIV affected migrant groups in each participating country to this study,

gave an overview on their legislative framework to access to health care for documented and undocumented migrants and offered preliminary findings on obstacles and levers to access to HIV testing, linkage to care and continuity of care for migrants (*see the synthesis of the national reports*).

(2) Conducting a qualitative study to identify barriers and facilitators to improve HIV testing and linkage to care among migrant populations in Europe

(3) Conducting a quantitative study to further explore and quantify the results obtained by the qualitative study. To this end a questionnaire is distributed among migrants in the participating countries in order to shed some light on the data obtained during the qualitative study.



2. Objectives

This study aims to gather in-depth insights on the barriers and the facilitators for HIV testing in both the health care services and CBVCTs but also generate new data on the linkage to care of individuals with a migrant background.

This study aims to **explore in-depth the use of HIV testing services and linkage to care** by sub-Saharan African and Latin America and Caribbean migrants in different types of settings, i.e. in CBVCT, low-threshold HIV testing (referred to as 'CBVCT'-like settings) and the regular health system.

More specifically, this study intends:

- (1) To determine the **perceived facilitators and barriers for HIV testing** in services of the CBVCT/CBVCT-like and the regular health care system;
- (2) To **identify the needs** of the migrants regarding HIV testing and the linkage to care
- (3) To **determine the factors associated to getting tested** at an early stage of HIV infection against those screened in a late stage;
- (4) To **describe the involvement of the migrants in the community mobilization** regarding HIV migration, prevention and testing and migration.

2. Methodology

1. Study design

The qualitative study was conducted for a period of eight months in 5 countries (Belgium, Denmark, France, Portugal and Spain). The French community-based HIV/AIDS organization AIDES coordinates the WP8 supported by a working group and an advisory group (which is formed by experts and community representatives from the participating countries).

The qualitative study collected data in two distinct groups: migrants from high prevalence areas and key informants comprising advocacy, health system and community-based organization representatives. Data collection was done by trained data collectors through semi-structured interviews and focus group discussions (FGDs). Topic guides (*see annex A and B*) have been developed to guide the data collection in an iterative way.

Inclusion and exclusion criteria:

Inclusion criteria for participation in the semi-structured interviews:

Participants of both genders, aged 18 years old or more, born in a country from high endemic areas (and chosen on the basis of the national report), speaking French, English or Spanish, residing in the host country for 6 months or more with at least one contact with a health care institution, can be included in the study irrespective of their HIV status.

Exclusion criteria for participation in the semi-structured interviews:

Participants younger than 18 years, with a psychiatric pathology that could disturb the conduct of the study or the data analysis, persons deprived of their liberty, adults subject to a legal protection order or not in position to express their informed consent has be excluded from the study.

Inclusion criteria for FGD participation:

Participants of both genders, aged 18 years or above, with experience in HIV and migration context, stakeholders of the health care system, the advocacy field or the community.

Exclusion criteria for FGD participation:

Participants younger than 18 years, with a psychiatric pathology that could disturb the conduct of the study or the data analysis, persons deprived of their liberty, adults subject to a legal protection order or not in position to express their informed consent has be excluded from the study.

2. Recruitment procedures

Purposive sampling has been used to select participants. About **10 participants per country** have been recruited for the semi-structured interviews and **between 4 and 10 key-informants per country** has been recruited for the FGD.

Each associated partner had to define which migrant populations from high prevalence area and key informants they worked with. On the basis of the national reports and according to the prevalence of the HIV epidemic, each participating country identified one or more targeted migrant populations. Migrants from Sub-Saharan Africa were identified as the targeted group for this study by all the associated partners (except Slovenia). Portugal and Spain also identified migrants from LAC as the targeted group and thus have two targeted group for this study.

Other criteria that were taken into consideration for the purposive sampling included sex, age, sexual orientation, time since arrival, HIV status, early diagnosis/late diagnosis, etc. This was essential to ensure comprehensive and rich data. The stakeholders have been chosen according to their expertise and the additional insight they could provide on these issues.

For the recruitment of the participants, associated partners have been highly encouraged to collaborate with intermediaries (other structures, NGOs etc....) in order to reach the “hard-to-reach” communities and to ensure diversity of profiles among the sample.

3. Data collection procedures

This study is an **inductive qualitative study**. Data collection techniques use face-to-face semi-structured interviews for migrants, and one focus group discussion (FDG) on the regional level for data collection among key informants.

It was fundamental for this study to discuss with hard-to-reach groups and to assess as much details and explanations as possible. Semi-structured interviews were the data collection technique of choice (Patton 2005), because it allowed having more in-depth exchanges, and it was an appropriate way to identify gaps in the life route of the participants, thus leading to a better understanding of the barriers and obstacles to HIV testing and linkage to care. The interviewees were asked about their whole life in order to describe a life trajectory both residential and professional, through marriage and family, medical background, etc. This ensured that participants, who were willing to tell their story but who felt uncomfortable about talking in a group or were unable to attend a group or wishing to maintain the confidentiality, had the opportunity to be listened to. Through this story telling process and the narratives themselves, participants enabled the researcher to gain a deeper understanding or of their situation and all the complexities they had experienced in their lives.

In order to being able to triangulate the data collected from different data sources and thus increase the trustworthiness of the qualitative data, we gathered different perceptions of different stakeholder's perspectives and not just "personal opinions". Subsequently it was important to also interview the services coordinators' of the participating CBVCTs and other key informants identified through the national reports when possible.

The working group team has been actively involved in developing the research study including literature review, design, data collection, dissemination and follow-up. The advisory group makes sure that all key concepts and topics have been addressed, and ensures at the same time that linkage with ongoing and past projects is respected, gathering insights and expert views into different stakeholders perspectives.

In order to maintain a cross cultural understanding of our topic, the same researcher (i.e. the WP8 leader) conducted the interviews and moderated the FGD whether in English, Spanish or French in all participating countries, with the exception of Portugal where migrants spoke only Portuguese or Creole.

4. Data analysis

After agreement of the participants the interviews were fully recorded and completely transcribed. The qualitative approach entailed a vertical and horizontal analysis of the collected data and enabled us to first compare individual experiences of the participants with their biographical experiences, and then to compare documented experiences between different participants. We performed a vertical and then a horizontal thematic analysis to systematically identify the different themes appearing in each interview, that is, the different units of meaning that made sense to the interviewee (Bardin, 2005). We used methodologies which are close from those employed in the context of interpretative phenomenological studies (Smith, cited by Apostolidis, 2003). In the first phase of "immersion [into] and familiarization [with]" (Apostolidis, 2003, p. 22) the data, exploratory coding of all the interviews was performed to distinguish between the themes arising during the interviews. The second phase entailed the creation of an "inventory and [a] systematic identification of themes emerging from the corpus" (Apostolidis, 2003, p. 22). An analysis chart was then constructed and applied to each interview. This enabled us to highlight the thematic categories in conjunction with the various connections revealed and in association with the data from the FGDs.

We decided to use the conceptual framework offered by Levesque JF.¹ and al. to analyze and present the data. Within this framework, access is defined as the possibility to identify health care needs, to seek health care services, to reach the health care resources, to obtain or use health care services, and to actually be offered services appropriate to the needs for care. Access to health care is viewed as resulting from the interface between on one hand the characteristics of people, social and physical

¹ Levesque JF et al., Patient-centred access to health care: conceptualising access at the interface of health systems and populations, *International Journal for Equity in Health*, 12:18, 2013

environments and on the other hand the characteristics of health systems, organizations and providers. Thus, the framework is comprised of five dimensions of accessibility of care services: approachability (i), acceptability (ii), availability and accommodation (iii), affordability (iv), appropriateness (v) and five corresponding abilities of patients and populations to access of care ability to perceive (i), ability to seek (ii), ability to reach (iii), ability to pay (iv), ability to engage (v). Table 5 below presents the characteristics of these five “paired dimensions” of accessibility.

5. Ethical issues

While we are aware that this study will cover sensitive topics, in particular in the case of personal interviews with HIV positive study participants, we estimate that this study does not comprise major ethical problems. Sensitivity issues will be mitigated through proper conduction of interviews and safeguarding confidentiality.

An informed consent must be given to all participants of the study to ensure the good understanding of the project by the participants and also make sure their rights regarding personal data protection have been well addressed. They will be given specific information on the EURO HIV EDAT Project (project leaflet and oral explanations) and about protection on personal data before signing the informed consent.

The privacy of the respondents and their confidentiality will be protected. The information recorded during the interviews and focus groups are confidential. The entire interview and focus groups will be tape-recorded, but no-one will be identified by name on the tape. The information recorded is confidential, and no one else except the coordinator of the WP8 will have access to the tapes. Even if personal data are provided the study team will not have access to personal data (name, phone number to be called etc.), but only to anonymous data. After data analysis, the audio-recordings will be destroyed.

6. Limitations

Several limitations should be highlighted:

At the beginning of the project (precise in Annex I), we decided to use a qualitative approach, called “Rapid Assessment Process” (RAP). This method is defined as intensive, team-based qualitative inquiry using triangulation, iterative data analysis, and additional data collection to quickly develop a preliminary understanding of a situation from the insider's perspective. But because of logistical and financial constraints, this method appeared too complex to implement.

At the moment of the study, we had no information on epidemiological data for migrant populations in Slovenia and Germany. We could not identify migrant population from endemic regions and both structures do not conduct interventions targeting migrants. Thus, we decided to not conduct the

qualitative study in Slovenia and Germany since the process of recruiting participants for the qualitative study would have been complex.

Although particular attention has been given to the diversification of the profiles of recruited migrants, most of them have been recruited only through the associated partners. The sample is thus composed of rather similar profiles: people who are fairly well integrated into the host country, often close to prevention and care structures and well informed about HIV/AIDS.

The interview-based qualitative approach we used here did not aim to be representative of the population through the use of a large number of interviewees, but rather aimed at assessing rich information through the collection of high-quality data, collected to understand and comprehensively analyse the daily-life experience of interviewees and the meaning which they give to their special status.

Also, due to the study design pre-scribed by the European project (10 interviews per country), the principle of data saturation could not be respected in this study for certain population, which may form a study limitation. Indeed, the sample of Latin American migrants is probably too small to reach the data saturation.

In addition, there were some recruitment errors, with migrants who did not meet the target of the study (European migrants, not from endemic areas). However, they belong to most-at-risk group for HIV.

The same researcher (i.e. the WP8 leader) conducted the interviews and moderated the FGD whether in English, Spanish or French in all participating countries, with the exception of Portugal where migrants spoke only Portuguese or Creole. Interviews with migrants and FGDs with key-informants in Portugal have been carried out in Portuguese or Creole by the Portuguese associated partner and then translated into English. This process of translation could lead to a loss in quality of information. Moreover Interviews and FGDs topics with migrants and key informants in Portugal differ from those conducted in other European countries since several topics have not been discussed or deepened.

3. Findings of the qualitative research

1. Description of the sample/interviewees

- ***Key informants***

The five focus groups allowed us to hear the experience and expertise of **31 key informants**. The table below presents the diversity of profile of the key informants.

Table: Number of key informant according to their organisation profile

Organization profile	Nb
Non-governmental organization	15
Public hospital or health care centre	8
Member of the migrant community	5
Research institutes - researcher	2
Public authority	1
Total	31

Among the 31 keys informants, **almost half are non-governmental organization representatives and 13 of the 15 NGOs are community-based.** Most of the key informants are project managers or supervising staff working for an AIDS organization (as ethnic or migrant programme manager, advocacy officer...). Three are medical workers and one is a health and cultural mediator (belonging to the so-called migrant community). **8 keys informants** are working for a public hospital or a health centre as general practitioner, nurse, infectious disease doctor and one as a health and cultural mediator. **5 key informants** are community mobilisers or representatives of the migrant community. Finally, two of the key informants are researchers specialized in migration and health issues and one is responsible for health issues in a public service for migrants.

- **Migrants**

A total of **49 migrants** have been interviewed. The table below presents the characteristics of the study sample (age, sex, sexual orientation, region of origin...). A table in annex C presents the detailed information.

Table : Characteristics of the study sample (N=49)

Median age (IQR)	39.8 (22 – 73)
Sex	
Women	18
Men	28
Transgender	3
Sexual orientation	
Homosexual	8
Heterosexual	38
Bisexual	1
Unknown/other	2
Region of origin	
Sub-Saharan Africa	39
Latin America	6
North Africa & Asia	2
Europe	2

Arrival in the host country	
Less than 2 years	7
Between 2 years and 5 years	8
Between 5 years and 10 years	16
More than 10 years	17
Legal status	
Citizenship	11
Residence permit	27
Application pending and/or undocumented	10
Other/ Unknown	2
Serological status	
HIV+	29
HIV-	13
Co-infection	4
Hepatis B or C	2
Unknown	1
Injecting Drug Users (current or former)	
Yes	5
No	33
Work	
Worker	20
Retired	3
Unemployed	22
Student	3

Migrants' sample differs from country to country. In **Denmark**, migrants interviewed are all legal residents or citizens. Few of them declare to be in financial difficulty in comparison to other countries. **The Spanish sample** presents also some specific configurations. Among the 8 homosexual migrants of the sample, 6 have been recruited in Spain (through BCN Checkpoint and other collaborative structures). Half of the sample declare to have a good financial situation (regular and sufficient income). Most of them completed university degree. Migrants from **the French and Belgian sample** are generally in a more vulnerable situation (undocumented, with low income, no stable housing situation, single...).

The sample in **Spain and Portugal** differ from the other participating countries since both identified two targeted migrants populations. Thus, they recruited both Sub-Saharan African and Latin American migrants.

Two of the migrants interviewed in Spain are born in Europe (Italia) and thus not belonging to the target group of the study. These migrants are however MSM or IDU and thus belonging to a more-at-risk group for HIV. It is also interesting to note that, according to key informants attending the Focus group in Spain, Italian along with Argentinean are the two biggest migrant communities in Barcelona.

Some information presented in the table deserves consideration and comments. Among the 20 migrants working most of them are part time job and/or with low wages and/or undeclared. Among

the whole sample, a great majority declare to be in a difficult financial situation with low income (with regards to exception presented below).

Finally, the country of birth is quite homogenous within a country sample. **In Belgium**, among the 10 interviewed, 4 are from Congo Kinshasa and 2 from Burundi. In Portugal, among the 10 interviewed, 5 are from Guinea-Bissau. In France, among the 10 interviewed, 3 are from Côte d'Ivoire and 3 from Cameroon. This shows how the colonial past had a great influence on migration flows.

Also, on the 49 migrants from the sample, **21 are volunteers** in an organization (AIDS organization or migrants NGO) or participate to research program as community mobiliser.

2. Life path and migratory route

Interviews conducted focused on life-course and migration background: situation in the country of origin, reasons for migrating, conditions and moment of arrival in the country, etc. These elements show the difficulties and needs met by migrants and allow us to have a more comprehensive approach of the patterns, barriers and facilitators to access to HIV testing.

Reasons for migrating

Table 2: Reasons mentioned for migrating per country among the 49 interviews conducted

	Belgium	Denmark	France	Spain	Portugal	Total
For political reasons	9	3	0	0	0	12
To join or follow someone/reunification with family or partner	0	3	4	0	5	12
For personal health reasons	1	0	3	3	2	8
For economic reasons	0	2	1	1	1	4
For ethnic, religious or sexual orientation reasons	0	0	0	4	1	4
To study	0	2	0	1	1	4
Because of family conflict	0	0	2	0	0	2
Total	10	10	10	9	10	49

There is a great variety of reasons for migrating. Among the sample interviewed, the most cited are: political crisis and reunification with family or partner.

Indeed, one fourth of the interviewees explain that their departure to Europe was motivated by political reasons such as escaping from political persecution and imprisonment, civil war, armed conflict, refusal to partake in warfare... In Belgium, we note that almost all people interviewed (9/10) mention political conflict in their country of origin as reason for migrating.

The third reason mentioned by interviewees is for their own health i.e. for HIV care. Many of them did not come to the country seeking care but firstly to visit family or friends. During their stay, they have been tested HIV positive and so decided to overstay to benefit from HIV care. For HIV-positive people arrived in the 2000s, coming from countries in conflict, the asylum application was accepted within a reasonable time (about a year). However, we can observe that for arrivals that took place in the 1980s, obtaining papers was much more complicated and longer than for those who arrived after the 2000s.

"I came with a tourist visa. It then took me 12 years to obtain refugee documents. For 5 years I benefited from a renewal of my receipt before it was confiscated and this with an order to leave the territory. I spent 7 years without papers." (Interview 3 Belgium, man from Congo Kinshasa, 60 years old, arrived in 1991)

"At that time, I did not know what to do, because I was waiting for the Department of Foreign Affairs to give us the papers. The papers did not come. We were undocumented diplomats. We stayed like this undocumented for a long time. Then we asked for asylum. We waited almost 2 or 3 years. (Interview 4, Belgium, woman from Congo Kinshasa, 48 years old, arrived in 1989)

One fourth of the interviewees explain to have migrated to join or follow someone (reunification with partner or family). In France and in Portugal, half of the people interviewed declare that they wanted to join their family or partner and thus asked for family reunification. This is can be due to the fact that migrants from Africa and Latin America share a common colonial history with France and Portugal.

In Spain, almost all people interviewed declare that they wanted to come to Spain to have a better quality of life since they had experienced homophobic abuse, harassment or violence in their country of origin (4/9) and benefit from a better and regular access to HIV treatments (3/9).

Some key informants interviewed during the focus groups in France and Spain highlight the fact that migrants who come to a country with a "health project" are usually from higher socio-professional categories and more informed about legal procedures to access to rights. This is corroborated by the profiles of the migrants interviewed in France and Spain. Among those that came for health reasons, all have completed university degree.

Difficulties met at the time of arrival

Table 2: Difficulties met at the time of arrival among the 49 interviews conducted

	Belgium	Denmark	France	Spain	Portugal	Total
Linguistic and cultural difficulties	7	10	1	4	Not available	23
Financial problems (unemployment, housing etc.)	5	2	9	5	Not available	21
Administrative problems (Misunderstanding of the system...)	5	0	9	6	Not available	20

Social integration difficulties	1	6	3	0	Not available	10
Health problems (health care coverage etc.)	1	0	2	5	Not available	8
Discriminations	4	4	0	0	Not available	8
Total	26	20	32	22	Not available	100

The difficulties most often mentioned by the interviewees are linguistic and cultural difficulties, financial (unemployment, housing, etc.) and administrative problems (legal status, paperwork problem, no understanding of the system...).

Most of the people interviewed declare that their financial and administrative difficulties are consequences of the linguistic and cultural difficulties migrants could encounter at the moment of the arrival since administrative procedures to obtain papers or finding employment are all difficult tasks when people do not master the language of the hosting country. **In Denmark and in Belgium**, the linguistic barrier seems to be a major obstacle for the integration process of the migrants interviewed. In Belgium, since the migrants interviewed did not speak French or Flemish at the moment of their arrival, half of the sample faced difficulties to manage administrative procedures and find a job. Migrants interrogated **in Denmark** did not mention administrative procedures as main difficulties. Nevertheless they experienced social integration obstacles and discriminatory situations related to their ethnic origin and/or the incapacity to master the language as well as the migrants in Belgium.

"You don't speak the language you don't know anything, a different culture, the immersion is really hard." (Interview 6, Denmark, MSM from Ghana, 29 years old)

"You don't know the language, you don't know where to go in the first days, you don't know what to do, because you don't know how to use the tram, how to use the metro, you don't know how to use the bus, where to buy tickets, because everything is different from Africa." (Interview 10, Belgium, men from Uganda, 30 years old)

In France and in Spain, we can observe that linguistic and cultural difficulties are not too much mentioned since the migrants interviewed spoke already the language of the hosting country at the moment of their arrival. Although Sub-Saharan African migrants among the French sample spoke French they have still experienced administrative difficulties, mainly due to misunderstanding of the system.

"Yes, I overcame a lot of obstacles. First, there was the language barrier because I did not speak French when I left Africa [...] Then, everything was difficult, to get my resident permit, to find a job, etc." (Interview 3, France, man from Nigeria, 35 years old)

3. Barriers and obstacles to HIV testing, linkage to care and continuity of care for migrant populations

Access to HIV testing and care results from a complex process. Interviews with key informants and migrants highlight that even when testing and care offer is available it is not always **effective and accessible for migrants**. Indeed, a large number of social, financial, cultural, psychosocial and linguistic barriers discourage migrants from accessing care services. These barriers are related to the care providers or system or/and to migrants characteristics. They imply a gap between the theoretical and the effective access to HIV/AIDS prevention service for migrants.

These various barriers can prevent migrants to **identify their need for HIV testing and/or care** and to identify the **relevant care service (see section 1)**. Interviews show that the lack of information on where to get tested (especially in CBVCT centres) along with the lack of knowledge or false representation about HIV/AIDS constitute major obstacles. In order to truly address their health needs, migrants also need to have the **opportunity to seek care (see section 2)**. The configuration of health care services along with HIV-positive stigmatization and discrimination can prevent them from seeking care. Afterwards, migrants need to have the **possibility to reach and use health care HIV/AIDS services (see section 3)**. However, they often face the complexity of administrative procedures and a lack of a relevant support. Also, it appears that some barriers prevent migrants from having the opportunity to **actually be offered services adapted to their needs for care (see section 4)**, which limit the effectiveness of the linkage to care and continuity of care. Furthermore, the representations surrounding HIV/AIDS, the stigmatization of HIV barriers as well as the vulnerable situation people might find themselves in, are also defining factors.

*“In France, we should talk about **differences between law and practice** [...] practices are deteriorated under the pressures of migratory policies.” (Focus group, France, Researcher in social sciences)*

“They have equal access but specific problems” (Focus group, Denmark, Researcher in social sciences - NGO)

Finally, these **barriers vary significantly depending on the countries and within a country and the administrative regions**. Indeed, Spanish, Belgian and Portuguese key informants highlight the existence of geographical disparities in terms of access to health care for migrants including access to HIV testing and linkage to care. This is due to a high decentralization of the health system.

“We do not treat everyone the same way, nor are offering the same things in different places in the country, and that’s something that should be focused, and people in Bragança should be treated the same way as people in Lisbon.” (Focus group, Portugal, Medical staff - Hospital)

“We know in Antwerp the situation is already more difficult than in Brussels.” (Focus group, Belgium, Medical staff - Hospital)

“The difficulties have been different, things have changed, here in Cataluña they are a bit better I think in respect to other communities, but well, here we are trying to do what we can with a lot of difficulties.” (Focus group, Spain, Project manager – NGO)

1. Barriers to identifying health care needs and to identifying relevant HIV testing services

Cultural belief systems and practices along with the **lack of access to relevant health information** can constitute great obstacles for migrants to **identify and express their health care needs**. It is particularly interesting to note how these two elements influence each other. Moreover, in order to access to testing or care, migrants also needs to **identify the relevant health care services**. Once again, a lack of access to information on where to get tested can prevent them from accessing health care when needed or within a reasonable time.

Cultural representations of the disease and lack of access to health information

Among the Sub-Saharan African migrants interviewed in all countries, disease and especially HIV/AIDS appears to be subject to **cultural representations and interpretation**. **Deficiencies of knowledge and lack of access to information about HIV/AIDS in Sub-Saharan African communities** are elements that are also mentioned repeatedly by interviewees in the different participating countries. Indeed, interviewees report having had at some point in their lives, very little knowledge or incorrect knowledge about the means of prevention and the disease.

“But in our African culture and mentality, they are always diseases we do not know about” (Interview 4, Belgium, woman from Congo Kinshasa, 48 years old)

“It will be like this with you. He told me: you are HIV positive. I told him: I don't know what that is. He replied: You don't know what it is? I answered: No, I do not know. So he said: So you have never heard about HIV either. I said no.” (Interview 4, France, woman from Mali, 41 years old)

“Many don't even know what HIV and AIDS are, if you don't have the knowledge this affects then your ability to go and seek a chance to get treated or to get a test.” (Focus group, Denmark, Medical staff - NGO)

Mistaken beliefs and lack of knowledge apply on one hand on transmission modes, method of preventing the transmission of HIV and on the other hand on characteristics and stage of the HIV.

- **Beliefs and lack of knowledge on modes of transmissions and means of prevention**

Many beliefs and myths surrounding HIV/AIDS, means of prevention and healing methods exist among the African and Latin American communities. HIV infection can be perceived as the **result of personal irresponsibility or moral fault** (such as infidelity or prostitution) that deserves to be **punished**.

Therefore, HIV/AIDS can be seen as a punishment from God, therefore God only can cure the people. Some interviewees also explain that HIV/AIDS is the result of an occidental conspiracy to kill Africans.

"Because there's always this label. It is as if we have been looking for it, because anyways, it is sexual. The first idea that comes, is ... I would say, prostitution." (Interview 10, France, woman from Cameroon, 46 years old)

"You're seen as the plague, a womanizer." (Interview 2, Belgium, man from Burundi, 51 years old)

"They still believe AIDS does not exist. AIDS is from GOD so you have been bewitched." (Interview 7, Belgium, woman from Kenya, 38 years old)

"In our African mentality they are diseases which are associated with witchcraft, which we consider as being a curse or a sign of bad luck, like demonic spells." (Interview 4, Belgium, woman from Congo Kinshasa, 48 years old)

"In my country I was very clever and when I meet with women I used condoms but one time I heard that white people they insert the virus into the condoms to finish Africans you know I heard that and immediately I stop use condoms." (Interview 2, Denmark, man from Ethiopia, 38 years old)

These mistaken beliefs and lack of information about how HIV is transmitted create **irrational behaviour and misperceptions of personal risk**.

"Then there are many myths and legends surrounding everything, around consumption, around diseases that could be HIV, depending of the country you come from. Then, mouth to mouth, from one to another, some stories that, uff..." (Focus Group, Spain, Medical staff - NGO)

"Low class people use condoms in Egypt, if you are a high class person you don't use because you're clean." (Interview 4, Spain, MSM from Egypt, 24 years old)

"There is a universe of preconceptions, wrong ideas, badly created information for safety strategies that are now obsolete but they are still in people's head and well it is very confusing for many people." (Interview 6, Portugal, MSM from Venezuela, 53 years old)

"Migrants did not know anything about protected sex, like if you know nothing about the protection, we just do it like that. So the risk is very very high." (Interview 5, Denmark, MSM from Ghana, 29 years old)

Most of the sub-Saharan African migrants living with HIV, who were interviewed, declare that they **did not feel at risk** before discovering their HIV infection as they only had few sexual partners or had a stable partner. The distinction between **stable partners and casual partners** seems to play an important role in the perception of the risk taken by those interviewed. When people have a stable or regular partner, the risk perception is relatively low. Furthermore, being in a stable relationship also

seems to be an obstacle for negotiating the use of a condom, for it can generate suspicions of infidelity, womanizing, etc.

"Condoms are good. It is advisable for people especially who have an intense sexual life with different partners. For myself, as I'm not in that life, I do not use it. (Interview 6, Belgium, woman from Congo Kinshasa, 40 years old)

"I did not feel concerned. Really, I did not feel concerned, because I was really leading ... even now, as in the past ... a healthy life. At the time, I was thinking, I thought people who have this pathology ... are light headed people." (Interview 10, France, woman from Cameroon, 46 years old)

"You know, Africans, when we are together, if you use condoms too much, they kind of think: you do not want to be with me." (Interview 1, France, woman from Côte d'Ivoire, 27 years old)

"I also think that especially women from Sub-Saharan Africa, they don't even recognize that they are at risk. A few of them have only a few partners, and are very surprised, when they turn up for a test, they have only one or two partners, how is it possible? They don't even acknowledge that they are at risk." (Focus group, Denmark, Medical staff - NGO)

This low perception of risks has led to risky behaviour among most people interrogated. Indeed, a majority of people declare to have had a relatively low use of condoms because they did not consider taking a risk.

"In the 90's, you only prevented yourself from getting pregnant. People mostly used contraceptives. We knew about condoms but we didn't really use them. When I had my African boyfriends, I didn't use them." (Interview 1, Denmark, woman from Zambia, 47 years old)

"Yes, in Africa. I did not think ... At the time, I did not think we had to protect ourselves. It was like that." (Interview 10, France, woman from Cameroon, 46 years old)

"With us ... it was perhaps a mistake, it is true, but we did not really use the condom." (Interview 1, Belgium, man from Burundi, 62 years old)

Information does not always circulate since the issue of sexuality and **HIV/AIDS is taboo in Sub-Saharan African communities**. For the great majority of interviewees, HIV is seen as a shameful disease. According to many interviews, the fact that HIV is transmitted mainly through sex, which is a taboo subject in African cultures, make more difficult to talk about the disease.

"And also, we must know that sexuality, in African culture, we do not talk about!" (Interview 9, Belgium, woman from Congo Kinshasa, 44 years old)

"It's difficult for Africans to talk about HIV." (Interview 9, Denmark, woman from Uganda, 30 years old)

*"They do not have the necessary information. So far, this is still the taboo subject in Africa."
(Interview 5, France, woman from Cameroon, 37 years old)*

If it appears that the sub-Saharan African heterosexual migrants have a low perception of the risk, it seems that MSM among our sample have a better perception of their risk and a better knowledge of the mode of transmission and means for HIV/AIDS. However, responsible or **preventive sexual behaviour does not only depend on knowledge**. MSM migrants among our sample explain they have HIV-risk practices, despite of their good knowledge on HIV/AIDS and means of prevention. The search for pleasure in sexuality through risky sexual practices (multi-partners, unprotected sex, use of chemical drugs during sexual intercourse) sometimes can be an obstacle for adopting preventive behaviours.

"In London it was sex parties with alcohol, drugs and multi partners." (Interview 5, Spain, MSM from Portugal, 33 years old)

*"I was having a lot of sex maybe 3 men every day. I did not use condoms, every time I had unsafe sex I was worried for 2 or 3 days and that was it. But I knew that I had to do the test."
(Interview 7, Spain, MSM from Egypt, 24 years old)*

Among the injecting drug users interviewed, almost all of them report having been engaged in behaviours that placed them at risk of HIV or HCV infection, through **unsafe injecting of unsafe sexual behaviour**.

"I didn't take care of myself at all, it seemed to be something too far from my reality [...]. It has happened to me when I have sexual intercourse to obtain money, to get drugs." (Interview 10, Spain, woman IDUI from Italy)

- **Belief and lack of knowledge on the characteristics and stage of HIV/AIDS**

For the majority of the Sub-Saharan African migrants interviewed, the **lack of physical symptoms play a central role in the failure to go get tested or to consult a health professional**. According to interviewees, African communities, especially men, consult a health care professional only when they feel really sick. This is also the case with the Latin American migrants who according to the key informants interviewed, tend to practice self-management of their health, and thus until the last moment.

"I was healthy, I'm not frivolous, why should I get tested?" (Interview 9, France, man from Gabon, 37 years old)

*"Insidious illness because even when you are told that you have HIV you do not feel sick."
(Interview 1, Spain, MSM from Madagascar, 22 years old)*

"Africans often go to the hospital only when they are sick, you know? When they feel physical effects, symptoms." (Interview 3, Belgium, man from Congo Kinshasa, 60 years old)

“They told me that I had it since more than a year, that I had it and I didn’t know, never had had a symptom, nothing. Nothing at all, at all, at all.” (Interview 3, Spain, MSM from Argentina, 25 years old)

These factors may explain **the large number of late diagnoses** (more than ten) among the total sample. In France, two thirds of interviewees waited until they had physical symptoms of HIV to consult a health professional. Moreover, for the majority of people living with HIV interviewed, they had little or no recourse to testing before the diagnosis. For the majority, their first HIV test and thus the diagnosis took place in Europe.

“I had a very bad fever and diarrhoea and 3 weeks of fever.” (Interview 7, Spain, MSM from Egypt, 24 years old)

“I was not feeling good, I was getting weak and weak, they (ed.: medical staff) wanted to know my status.” (Interview 10, Belgium, man from Uganda, 30 years old)

“And I got ill, I was thin, I did not eat anymore ... I said to myself: this time, if I go on, I'm going to die. There, I went to get tested. My CD4 dropped down to 20 points.” (Interview 5, France, woman from Cameroon, 37 years old)

“They go when they are already sick, they wait a too long time [...]. Migrant population count much amongst the late testers in Denmark.” (Focus group, Denmark, Community mobiliser – NGO)

“They come when they are very sick and they come to emergency services” (Focus group, Portugal, Medical staff - Hospital)

- **Cultural and social representation of health care provider**

If we observe that migrants encountered some difficulties to talk about sex and HIV, we notice also that it exists some taboos and **cultural barriers from medical staff toward migrants**.

Many key informants declare that General Practitioners (GPs) usually did not offer them HIV testing when they consulted. Also, according to the key informants interviewed in the different participating countries, even if national authorities in several countries provide recommendations to offer HIV testing to people coming from endemic regions (in particular Sub-Saharan Africa), GPs do not always offer testing to this group because they fear stigmatizing people.

“So it is not always from the ethnic minority group, it is also both sides [...] they don’t want to stigmatize people.” (Focus Group, Denmark, Community mobiliser - NGO)

“The doctor doesn't know and they feel uncomfortable about offering HIV testing.” (Focus group, Belgium, Medical staff - Hospital)

"General practitioners in the social housing of the 93rd (ed.: district of Paris region) use to meet newly arrived migrants because these big popular districts are places where they pass. They can follow people for one, two, three years without offering them HIV testing." (Focus group, France, Researcher in social sciences)

Lack of information on HIV prevention and care services

In order to access HIV testing or care, it is also necessary to know where you can get tested or where you can find support. A large proportion of interviewees said they did not have **information on existing testing services at the time of their arrival**.

"The main obstacle to testing would be that when you arrive, you don't know where to go to get tested." (Interview 9, Denmark, woman from Uganda, 30 years old)

"I didn't know what to do, where to go and walked with my head down." (Interview 2, Portugal, woman from Guinea-Bissau, 49 years old)

«The information. Information about everything. I didn't have information, I didn't know where to go, where to look for, who to talk to, who to arrive with, do you understand? How could that be possible? » (Interview 4, Spain, trans woman from Brazil, 26 years old)

"Already, there is a barrier, there is actually ignorance towards the testing services nevertheless." (Focus group, France, Health and cultural mediator - Hospital)

"It is hard for them to access any kind of organization." (Focus group, Spain, Project manager - NGO)

It appears that some testing services are more or less known by migrants. CBVCT centres appear to be little identified.

"Because I did not know that there was AIDES (ed: French NGO) ... If I had known, maybe I would have come before a year." (Interview 6, France, woman from Côte d'Ivoire, 38 years old)

"So they do not know where to look for these kinds of NGOs or centres. If you do not tell him, he does not go there. They do not go to that corner. They are among them. It's a bit complicated." (Interview 2, Spain, man from Mauritania, 45 years old)

"There are associations, but you have to know these associations or organizations. You, you have freshly come. First of all, you have to get in touch with ... get to have contact with your peers, get to be able to discuss some of the issues, including the health issue. All this is a long process." (Interview 9, Belgium, woman from Congo Kinshasa, 44 years old)

In the absence of information on community-based screening structures, it appears that the **hospital remains a well-identified place for migrant populations**, particularly for sub-Saharan African migrants, who tend to move towards this structure in the event of serious health problems.

"I go to the hospital because of a lack of alternative." (Interview 4, Portugal, trans woman from Brazil, 23 years old)

Again, in **Spain** the sample of migrants interviewed differs a little. Among them, some have been diagnosed in their country of birth and decided to emigrate in order to have access to antiretroviral therapy. Thus, they were before their departure **well-informed on the health system and administrative procedure** of their host country as they have chosen to emigrate in this one, in part, to access to treatment. The latter, generally coming from a higher socioeconomic status than most migrants from the other countries surveyed, state that they were able to carry out the procedures and contacts, in particular with community-based structures, in order to ensure the good continuity of their treatment. Several of the NGO staff in Spain state that they had noticed this new phenomenon in recent years. Indeed, Spain seems to be a preferred country for people seeking care or continuity of care, this could be explained by the tightening of migratory policies and the restrictions on access to health in several other European countries.

"They get in contact before you come. They get in contact to ask us about the access to health." (Focus group, Spain, Project manager – NGO)

"From Colombia I was looking for information and contacts, because my treatment is a concern obviously, it's something that I had in my head, that I was risking but if it had not been so, my opportunity to study in another country, then I couldn't have made it real." (Interview 6, Spain, MSM from Colombia, 40 years old)

"Illegal migrants in Spain can have access to lawyers to derive your health card. I think that should be reported a bit. [...] Not everybody knows that they have free access to a lawyer. I searched on the internet to find the information. Not everyone could do it." (Interview 3, Spain, MSM from Argentina, 25 years old)

In **France** as well, we can note that many of the well-informed migrants interviewed came to the host country with a health project, but this represents only a small part of the sample.

"In 2005, in Cameroon, we did not have enough treatments. Not everyone had access. [...] Indeed, I was obliged to go private. And even in the private sector, sometimes, there was none available. I said to myself: If I stay here, I think I can lose my life. I think that's what brought me to France. I came to France, when I already knew my condition." (Interview 5, woman from Cameroon, 37 year old)

2. Barriers to seeking HIV testing services

Interviews show that **social representations of the disease and mistaken beliefs** may lead to fear and even denial. Those elements can severely undermine the expression of the intention to obtain health care (testing or care). It is interesting to note that access to testing or care is not always viewed as a

good opportunity. **The configuration of the health offers** which does not guarantee to patients the expected level of confidentiality and privacy can also constitute a barriers. Moreover, sometimes **health is not a priority**.

Fears of the results and of social exclusion

Several interviewees highlight the **impact of denial of recourse to testing and HIV care**. According to the Sub-Saharan African migrants interviewed, it seems that the main causes of denial are on one hand the **fear of the result** and on the other hand the **fear of stigma**. It must be noted that these fears are strongly linked to the cultural belief and lack of health information.

Access to antiretroviral therapy has significantly reduced mortality and morbidity associated with HIV and AIDS and enables HIV-positive people to have an improved quality of life. However, for the majority of people interrogated, the moment of the diagnosis still remains a **death sentence**, which can constitute a barrier for migrants to get tested.

*"A lot of migrants, would rather die than going to the test [...], it is denial. We veiled our faces."
(Interview 9, Belgium, woman from Congo Kinshasa, 44 years old)*

"I think there are two things: Fear and not knowing. They say "What you don't know doesn't kill you". (Interview 1, Denmark, woman from Zambia, 47 years old)

"People think they know, but they don't know, and there is too much fear. They fear to know the end results." (Interview 10, Belgium, man from Uganda, 30 years old)

Some people declare that they did not know their status but **still preferred not to be tested** because of their fear of a positive result, especially at the moment of their arrival in the host country.

"I, for example, never voluntarily wanted to go and get tested. I have never done it. Because I am afraid, I will discover that I have the disease and that I am going to die. (Interview 7, France, man from Côte d'Ivoire, 60 years old)

"The newly arrived migrants who do not yet have papers are afraid to cross the barrier of the results." (Focus Group, France, Health and cultural mediator - NGO)

"People do not want to know that they are HIV positive, and I would not want to either. From there on their lives, which are already not good, will get even worse." (Focus group, Portugal, Researcher - Institute)

"They don't want to hear about it, they can't imagine how they are going to live if they are HIV positive." (Focus group, Denmark, Medical staff - Hospital)

Also, as seen previously, HIV/AIDS is considered by many as a shameful disease. The disclosure of seropositive status in close or distant surroundings can lead to the stigmatization and exclusion of HIV-positive people from their community. According to many interviews, there is a **misguided idea** that

HIV can be transmitted through casual contact (by hugging, shaking hands, sharing toilets, sharing dishes, or closed-mouth or “social” kissing with someone who is HIV-positive).

“More worried about having contact with positive people than about contracting HIV “always a fear of having contact with someone, of drinking from the same glass of water.” (Interview 4, Portugal, trans woman, 23 years old)

“It is a spell. People don’t share food with you, do not share drinks, clothes, anything you cannot tell anyone.” (Interview 8, Portugal, woman from Guinea-Bissau, 50 years old)

All Africa Sub-Saharan migrants interviewed mention the **fear of being rejected by their community** as a barrier to testing.

“The second thing is this stigmatization, this ostracism, because a person who has HIV, we look at him with another eye, which means he also excludes himself. He does not want to go towards information.” (Interview 2, Belgium, man from Burundi, 51 years old)

“You see yourself in the grave [...]. We are afraid to talk to others. It's the fear of being rejected.” (Interview 10, France, woman from Cameroon, 46 years old)

“Africans are afraid of being exposed, afraid of being known for having HIV, they are afraid of stigma.” (Interview 4, Denmark, woman from Burundi, 44 years old)

These elements are not specific to the Sub-Saharan African community, even though they are mostly mentioned by them. Indeed, **in Spain, Latin American migrants also repeatedly insist on the fear of being stigmatized**, the feeling of shame that follows the moment of the diagnosis, but also the fear of the treatment and its side effects that push them away from testing and care.

“I think that you don’t do it because of fear and shame [...] I think that people are very scared, they are ashamed, they don’t have so much information, and HIV is a very taboo subject in our community.” (Interview 3, Spain, MSM from Argentina, 25 years old)

“To be afraid of someone new, to be afraid of the stigma, to be afraid of the treatment, of the person that's going to deal with you. This is for Egypt. Here in Spain, sometimes I feel also that people are afraid of the stigma. They try to hide and get over it.” (Interview 7, Spain, MSM from Egypt, 24 years old)

Lack of confidentiality and privacy

The notion of confidentiality and privacy among migrants, especially from Sub-Saharan African communities, is essential. Migrants interviewed express **the need for confidentiality and privacy** to be fully guaranteed. The fear of crossing someone from their community, at the infectious diseases service in the hospital, in a testing centre, or even in a mobile unit during street actions may hinder many migrants to go get tested.

"Some people don't want to be seen and don't want to be tested in public space. When you meet someone from your community at the hospital they pretend they are not here for that!" (Interview 9, Denmark, woman from Uganda, 30 years old)

"The other gathered his courage to go and get tested in the truck. The others also wanted to do it, but they were ashamed." (Interview 8, France, man from Cameroon, 45 years old)

While the confidentiality problem in testing centres was less common among MSM, they insist more on **the feeling of intrusion** that was sometimes experienced due to the questions asked during counselling interviews in CBVCTs.

"Yes they ask too many questions. I know they use it for research or like information purposes, but I think sometimes it's a little bit too much. They ask you; guys how many partners do you have, and how many people? I think it's a little bit too much. How many sexual encounters, how many partners once again, I think it's a little bit too much." (Interview 5 Denmark, MSM from Ghana, 29 years old)

"The questionnaire is a bit strong. It gets on our nerves. They make everything clear, they explain a lot of things, so that's when those who go there to get tested get like that [scared]. The questionnaire is heavy on us. [...] I don't mind if they get to know me. But a discreet gay man, who doesn't want to go to the hospital, who is afraid of that type of exposure will feel bad with these types of questions." (Interview 4, Portugal, trans woman from Brazil, 23 years old)

A health professional working in an NGO also points out that it was sometimes **difficult for staff** to ask mandatory questions which appears **"intrusive"**.

"It is not easy to ask these kind of intimate questions, the questionnaire is too long, and then, the way the issues are introduced in the questionnaire is not appropriate in my opinion. Sometimes I feel uncomfortable and the client too..." (Focus group, Spain, Medical staff - NGO)

Among the interviewees, **the fear of being stigmatized for belonging to a group** is very present. Indeed, interviewees mention the feeling that they did not wish to be associated with men who had sex with men or with injecting drug users or HIV- positive people when entering or going to a place of HIV testing and care.

"If it were something similar SAPS (ed: is a centre for injecting drug users in Barcelona) but only for people with HIV, I do not think anyone would get tested." (Interview 9, Spain, women from Italia, 31 years old,)

"This is one of the challenges of the projects surrounding sexual health, that is to say if it is a place stamped with AIDS, or a truck stamped with gay, mmm ... I don't want to go there. Whereas if we have something like "you have a blooming sexuality, come and see me", there, all of a sudden, it's more enjoyable." (Focus group, France, Advocacy officer - NGO)

“We had headquarters where we were in a space defined by the LGBT community but we decided to move from there for a very specific reason. People who wanted to find access there, did not get access, for the reason of self-exclusion. So then we decided to go to a cultural centre, a civic centre, in which anyone can enter.” (Focus Group, Spain, Project manager - NGO)

Finally, according to some interviewees, the fact that NGOs **target certain "at-risk" populations**, can lead to people sometimes feeling stigmatized, or even insulted.

“I think that in the organization I was called to do the same thing and test the immigrant people but sometimes they feel like: you are talking to me like I'm HIV positive, if you stopped me in the middle of the street and asked me “oh can I test you for HIV” I would feel insulted honestly.” (Interview 6, Denmark, man from Ghana, 30 years old)

In addition, and thus according to the key informants and migrants interviewed, migrant communities are faced with another great concern: they fear **that immigration services** will be informed by health providers of their illegal residence. Indeed, some of the interviewees say they wanted to get tested at the time of their arrival in Europe, but since they had no papers, they were afraid to approach health care facilities. They think this might **lead them to deportation**. These fears can also prevent HIV-positive people from seeking treatment. These fears are unfounded except for migrants residing in Spain and Denmark where some public bodies have the duty to inform the authorities of the whereabouts of known undocumented migrants.

“You're afraid of the immigration services so you stay underground.” (Interview 10, Denmark, woman from Uganda, 63 years old)

“People are scared they will find them, that maybe they will go to the police, so maybe they are scared of the authorities, scared they will deport them back home.” (Interview 5, Denmark, MSM from Ghana, 29 years old)

“Fear... They think that you are walking them towards the police.” (Interview 10, Belgium, man from Uganda, 30 years old)

“Not accessing the public services because they think they are going to be reported by them, that they are going to experience problems with the police, they did not access the services.” (Focus group, Spain, Project manager - NGO)

“If they are positive they don't want to tell anyone. They are scared that this may lead them to be thrown out of the country.” (Focus group, Denmark, Researcher - NGO)

“It is a very big fear. You never know when you can be deported [...] Health services are seen as the government, but health services are independent here, not run by the government”. (Focus group, Belgium, Community mobiliser)

Health is not the priority

For the majority of migrants interviewed, **obtaining documents upon arrival in the country is often one of the priorities of migrants**, relegating to a position of second importance the question of health. **Obtaining residence permits** is often considered by the interviewees **as a point of entry towards access to other rights**, such as health care coverage.

"Getting tested is not on their mind at the moment of the arrival." (Interview 1, Denmark, woman from Zambia, 47 years old)

"Throughout the migratory path, the administrative situation is the priority issue, compared to health concerns. The question of entry into a health, prevention or other system is secondary ... The priority really is the regularization of the administrative situation, because it means access to a job, because it means access to housing, because it means access to resources." (Focus group, France, Advocacy officer - NGO)

"That does not have this as a priority because they are healthy, and no one has health as a priority when they are healthy, especially when they have other challenges." (Focus group, Portugal, Researcher – Institute)

Most interviewees were undocumented at the time of their arrival in the country and declare that being in an illegal situation was a major obstacle to accessing health.

"We can say that sometimes there are migrants who are undocumented. For them, it is difficult to go to the hospital, to go in for a consultation. For them, it's difficult." (Interview 4, Belgium, woman from Congo Kinshasa, 48 years old)

"Yes, there is that. Because if you do not have the AME (ed: French Medical State Aid), if you do not have papers, to go to the hospital, how do you do it? And the disease, it is not going to wait." (Interview 6, France, woman from Côte d'Ivoire, 38 years old)

"The issue of documents is the biggest problem because then it limits everything except NGO support because we don't ask for papers". (Focus group, Portugal, Project manager - NGO)

3. Barriers to reaching and using HIV services

Once migrants accept the mere idea of being HIV tested or treated, they need to have the possibility to really reach and use health care HIV/AIDS services. However, **the lack of knowledge** about their entitlement to access health care can prevent them from using these services along with the **complexities** they face with the **administrative procedures**. Migrants who do not benefit from an entitlement to access health care can also face financial difficulties to pay for these services.

Limited legal entitlements

In **Denmark**, asylum seekers and undocumented documents have very limited rights to access health care. Access to care is very restrictive, even access to HIV treatments.

“There are obstacles. Here you cannot go to the hospital without any identification. If you have no identification, where do you go? Who can accept you to? If you don't have any papers, if you don't have anything, how can you be?” (Interview 10, Denmark, woman from Uganda, 63 years old)

“In this system we are allowed to treat patients with emergency needs, but we are not allowed to treat those who do not have acute illness. In Denmark, if you have a patient with HIV and AIDS at a critical level, we will treat that, but if the patient is in a steady state he does not need to stay in hospital, we are not allowed to continue HIV treatment.” (Focus group, Denmark, Medical staff - Hospital)

“That clearly depends on what group you belong to. Because if you come to Denmark and seek asylum, when you are in the system, I think you have quite good access to help. But if you are not part of the asylum system, or if you stay illegally afterwards it's very difficult for you.” (Focus group, Denmark, Medical staff - Hospital)

However, few of the interviewees underline difficulties to access health care as many explain having obtained, over time, a residence permit. Moreover, according to the interviewees, their residence permit was obtained within a **fairly reasonable time** compared to the difficulties expressed by other migrants in other countries.

“For me it was fast [...]. It took one year and maybe two months but I didn't expect that so I was happy.” (Interview 4, Denmark, woman from Burundi, 44 years old)

“You only had to go to the administration to get registered as a married person, they gave you a number and a "yellow card". I only had to wait a month or so to get my resident permit. After 2 years, you get a permanent resident permit. It was not difficult.” (Interview 1, Denmark, woman from Zambia, 47 years old)

In **Spain**, a health care reform of 2012 has excluded undocumented migrants from the Health care system. Many of the 17 Spanish Autonomous Communities adopted legislative and administrative actions to void or limit its effects, while others decided to apply it. The key informants underline the fact that Spain suffers from a lack of homogeneity in terms of access to care which has become accentuated in the last few years because of its decentralized system and the previous reform of the health care system.

“In Barcelona, something that does not happen in all cities, you can register without an address which is a positive element for people who do not have a place to register.” (Focus group, Spain, Project manager - NGO)

“The difficulty that our organizations have here in Spain, is that we have 18 health systems, one for each Autonomous Community and in the case of Ceuta and Melilla it depends on the government of Spain. And that complicates everything a lot, because there are different modalities of care and access.” (Focus group, Spain, Project Manager - NGO)

The interviewees in Spain are all residents of the Barcelona area. Many of them benefit from a health card (called “tarjeta sanitaria” in Spain) which allows them access to the health care system.

Lack of information and misunderstanding of its entitlements

The majority of interviewees refer to the **lack of information and lack of knowledge of the host country's administrative and health system** as an important barrier to access to care. Indeed, for many migrants who arrive, the latter do not know where to go or what to do and do not have sufficient information to carry out the administrative procedures there and *“often get lost in the administrative maze.” (Focus group, Spain, Project manager - NGO).*

Many of those interviewed - mostly undocumented or undocumented at some point - also mention that they thought they could not **access the health care system, and thus not access it free of charge**. As a reminder, all migrants with residence permits benefit from the same entitlements as the nationals. Undocumented migrants have **access to a great extent of care services in Belgium, France and Portugal**. They have **limited or very limited entities in Denmark and Spain**. Moreover, in all the participating countries, NGO also offer a free health service panel such as access to HIV testing.

“People often in irregular situations think they do not have ease of access to health care, so they do not go. And they often pay more than they would normally do.” (Focus group, Portugal, Project manager - NGO)

“But really, I was told: to have access to drugs, to screening ... especially medicine, to get treatment, here you need an AME card. You had to have papers, and everything. I did not have this information ... ”(Interview 6, France, woman from Côte d’Ivoire, 38 years old)

“This return to a more restrictive health system is a super negative message that makes people think that they do not have access to health. So many people think that they cannot access the system, even when they could gain access.” (Focus group, Spain, Project manager - NGO)

“I mean HIV tests are always free in the CBVCT, they don't care if you have papers or no papers. However I think that not every person knows about it, that it is free, that it doesn't matter if you have papers.” (Interview 5, Denmark, MSM from Ghana, 29 years old)

On the other hand, once people access to care facilities, they sometimes get **poor information** about their rights and about the administrative procedures to be carried out. Key informants in Spain and Portugal mention the fact that **social workers and / or health professionals** are sometimes not aware of the conditions that undocumented migrants have to fulfil to access the health care system.

"You arrive, you have no papers, but how are you going to have access? Since the first thing when you arrive somewhere, is being asked for what? Your identity card. You see, it's already a barrier. So you do not have access, end point. You do not have access!" (Interview 9, Belgium, Congo Kinshasa, 44 years old)

"They are said they are illegal and don't have that right, that's a matter of procedures that are not clearly defined, communicated and shared. Then with one or another doctor or administrative staff is different, even in the same group of health Centres." (Focus group Portugal, Project manager - NGO)

Moreover, staff working in the statutory health care system do not always refer to these same NGOs, who can, nevertheless, properly **inform people about their rights** (since they have a good knowledge of the health care system) but also **assist them in administrative procedures**.

"Administrative staff is unaware of people's rights, and we have to address it." (Focus group, Portugal, Project manager - Public service)

"Primary care centres have no idea of the existence of these special programs. So what happens? A person with HIV, an immigrant, goes to a primary care centre and says I have HIV. "Look, the first thing you have to do is to register and you have to wait 3 months. And once these 3 months have passed, you can apply for the health card. It is absolutely absurd because they can give you information like: "if you go to this type an organization, there you will have easier access." (Focus group, Spain, Project manager - NGO)

It also emerge from the interviews with **French and Belgian migrants and key informants** that mechanisms for accessing and maintaining the care of people living with HIV are too often unrecognized by people. In these countries, residence permits can be granted for medical reasons. Several people interviewed notably in France declare that they have **no knowledge of this administrative procedures** which nevertheless allows them to obtain documents and legally reside on French territory while benefiting from free HIV treatment for several years.

"With the hospitalization, the visa had expired. [...] It was during this time that I was put in contact with a NGO. I met the coordinator and I explained my situation to him. He told me "you can get a medical permit", which I did not know." (Interview 7, France, man from Côte d'Ivoire, 60 years old)

A complex and stringent administrative process

Even when migrants (documented or undocumented) **have access to the system in theory, in practice this is often quite complicated**. Indeed, all the conditions and administrative procedures to access to documents or access to care that migrants have to complete, constitute major barriers and obstacles to their access to health.

In France, Belgium and Portugal, where migrants have access to guaranteed care irrespective of their administrative and legal situation, the difficulties and complexity of the administrative procedure for

access to care have been repeatedly underlined by the interviewees. The steps are described by people "as long and tedious". Administrative procedures **require a good knowledge of the codes and rules of the administration.**

In France and Belgium, access to the health system requires people to obtain what is known as State Medical Aid and Emergency Medical Aid and thus respectively. For this reason, they have **to provide many administrative documents** (which may vary a lot according to the place of residence) as evidence of residence proof, which, according to the interviewees, is often very difficult to provide.

"They told me I have to appeal. But I have no address. So, what can I do?" (Interview 5, Belgium, man from Congo Kinshasa, 51 years old)

"To get Emergency Medical Aid, you need an address. Also, when you have no address, you do not get any care." (Interview 6, Belgium, woman from Congo Kinshasa, 40 years old)

"It was said that I did not have a document such as a Navigo card (ed.: Paris public transport card) because I had no money either, but you had to have a Navigo card to say that you are in France, some time ago [...] So I prayed not to get sick." (Interview 6, France, woman from Côte d'Ivoire, 38 years old)

"A very lengthy deadline for accessing it, a lack of information, documents improperly requested." (Focus group, France, advocacy officer - NGO)

Respondents in **Portugal** describe the same difficulties in obtaining the requested documents so that they can obtain access to health care services.

"They didn't want to explain her how to get her household documents. And she is in Portugal since about 12 years. Everything is complicated in Setúbal, they complicate everything, they ask for documents she doesn't have." (Interview 4, trans woman from Brazil, 23 years old)

In Spain, in some autonomous community, undocumented migrants still have access to health care despite the 2012 health care reform. Also, some specific categories of people (such as sex-workers or drug users) particularly infected or exposed to HIV or other infectious disease can benefit from a health card (called "tarjeta sanitaria" in Spanish). **This requires the provision of documents that are not always available to migrants**, particularly undocumented migrants. According to the majority of the people interviewed, administrative barriers constitute a main obstacle.

"The biggest barrier to accessing care is bureaucracy. I fight against the wind. I fight against the tide. I fight against everything. Because I have to survive. And a person without papers, it's complicated, do you understand? It becomes very complicated." (Interview 2, Spain, man IDU from Mauritania, 45 years old)

"Me, whenever I want to do the papers here, I need the criminal record. And the criminal record, I have to do it at home. Translated into Spanish, translated by the Spanish Consulate, and I have bring it here, within 3 months. Those are the difficulties that I found here to solve my problem

... And yet, I had a house, I had an address and everything. I remember that I had given my address. But I did not have papers, I did not have a health card.” (Interview 2, Spain, man IDU from Mauritania, 45 years old)

“It was a great struggle to become registered and thus benefit from the health card. Between 2008 and 2010 they have imposed a number of conditions.” (Interview 8, Spain, man from Italy, 35 years old)

Even when migrants obtain papers to legally reside on the territory, ensuring access to care is not always guaranteed in the long term. **The timeframe for resident permit** are not always sufficient to ensure good continuity of treatment.

“Regarding obtaining residency due to illness, the problem is that it doesn’t mean you obtain the work permit and there are difficulties to get renewal in these times in Spain.” (Focus group, Spain, Project manager - NGO)

“It is not a door opener either to have a residence permit for medical reasons, it must be renewed in time and this can be a very tough process.” (Focus group, France, Advocacy officer - NGO)

In Denmark, since most of the interviewees declare to have experienced little difficulties in obtaining papers, administrative barriers is little mentioned. Legal migrants in Denmark automatically benefit from a free health card for all care, from HIV testing to treatment.

“Administrative, I think I’m not mistreated as such, because, when you have paper here and you abide the law there’s no problem to access to care.” (Interview 10, Denmark, woman from Uganda, 63 years old)

“In Denmark, health care is free when you have documents. Everybody has a doctor, you can get an appointment if you're sick you can get tested. It's accessible, very good.” (Interview 2, Denmark, man from Cameroon, 30 years old)

“In the hospitals here they don't discriminate you. You only have to give your card. The rest is there. You just have a card, a card of your visiting. You have your doctor’s card.” (Interview 10, Denmark, woman from Uganda, 63 years old)

4. Barriers to being offered HIV services appropriate to the needs for care

Despite the diagnoses and the existence of ART which clearly improves patient outcomes, including quality of life and life expectancy, linkage to care sometimes still fails. Linkage and continuity to care relies on many factors related to the care provider and patients characteristics. Some of the barriers already presented below also constitute **barriers to linkage to care and continuity to care**. It is especially the case for **stigmatization and exclusion of people with HIV** or the **fear of disclosure** along

with the conditions of life of migrants which can be very insecure. **Fear of treatment**, side effects and refusal of care can also prevent linkage and continuity to care.

Vulnerable and insecure situations

The **great vulnerability** of the situation of some migrants especially of undocumented migrants constitute a major barrier to linkage to care. The lack of residence permit, stable housing and telephone numbers can prevent linkage to care. **In France and Belgium**, according to the key informants, most of the loss of follow ups are of undocumented migrants.

“Mostly they receive the confirmation, but often people disappear, especially if they have no address, no telephone, no legal status, and then people disappear and it’s difficult to get them in care. The linkage to care, to me, is more problematic than the testing itself”. (Focus group, Belgium, Medical staff - Hospital)

“There, they see that they are HIV-positive, but they are in denial, they do not accept. They do not have a fixed address. So you do not know where you’re going to find them. Sometimes they come to the association, try to tell them, but if he comes and finds someone from his community, they say, “Do not worry, here everyone is talking the same language “. But he’s afraid. There is always stigma, that’s it. He disappears.”(Focus group, France, Health and cultural mediator - NGO)

“Some people say they don’t have time to come get their results. To get tested is easy but to get the results, it’s difficult for some people. If you don’t feel sick why come? Some people don’t get tested and some others get tested but don’t come get the result.” (Interview 3, Denmark, man from Cameroon, 30 years old)

The question of financial problems as a barrier to HIV testing is rarely mentioned by our sample of migrants. However regarding **linkage to care**, some interviewees also highlight **the difficulties to follow a HIV treatment in precarious living conditions**. **In France and Portugal**, many of the migrants interviewed report having difficulty following a HIV treatment due to the lack of adequate housing, the inability to follow a balance and healthy diet taken on a regular basis at regular hour and the high cost of transportation to get to the hospital.

“So people come to get treated, but then they have no food, and to go to the Hospital, they have to walk, or they don’t go, and they start missing appointments, then they have negative consequences because they don’t go, and it’s a snowball...” (Focus group, Portugal, Researcher - Institute)

“People that come with health agreements have free medical consultations, free medication, etc., but who pays for transportation to go to the Hospital? Who pays for food?” (Focus group, Portugal, Project manager - NGO)

“You should take the medication two hours after the meal, or two hours before the meal. [...] I sometimes have to take the tablet just like that without eating ... maybe a piece of bread that

I have consumed. If I were in a stable place, I could arrange my meals. This is what I tried to explain to my doctor. (Interview 7, France, man from Côte d'Ivoire, 60 years old)

"For three weeks I slept just like that in the street, in the emergency room at the hospital. I slept sometimes, until the day when the 115 (ed: emergency number for emergency housing) had to come and get me ... Sometimes my mood is high, when I think about my children, sometimes I do not eat, sometimes I do not take the medication." (Interview 9, France, man from Gabon, 37 years old)

Moreover, among the IDU's interviewed, a number of people have experienced several **therapeutic failures** linked to difficult living conditions.

"The first treatment I took, I took it for three-four months. Afterwards, I gave up. I stayed almost four years, five years without taking treatment. But I was fine. I felt good. And afterwards I took the medication again for a year, and I gave up again. And now since four years I take it. (Interview 2, man IDU from Mauritania, 45 years old)

"Then I arrived at the centre, I followed the treatment because I had a small desire to live, I left again when I arrived here, in January I left the treatment again." (Interview 9, Spain, woman IDU from Italy, 31 years old)

Acceptance of the disease and disclosure

According to several key informants interviewed in the participating countries, sometimes certain people **know about their HIV status but refuse to consult a health professional** to avoid arousing suspicion. They fear the news or gossip to be spread and therefore of being rejected by the community. Also, the diseases and potential death associated with HIV/AIDS can also lead to patient's denial.

"Even sometimes really it's like you have to diagnose for the first time, and for them it's the first time they hear, and it's a complete denial of the status, and then if you ask "you really didn't know about your positivity?" and then after a long time they say "yes I knew, but I just don't want to accept." (Focus Group, Belgium, Medical staff - Hospital)

"We also receive people that were already diagnosed and were not linked at the time and that requires from us to be relinked to health care. People also have their own times." (Focus group, Portugal, Project manager - NGO)

In Spain, several people feel that **taking a treatment represents a heavy burden** in their life. For many of them, taking a treatment means accepting the illness and therefore feeling sick.

"I confess that I had a hard time deciding whether or not to start taking the medication. That 'yes', is a decision that cost me quite a lot. Because I felt that if I take a pill, I was going to die, quite the opposite. I felt it the other way round. I felt that starting the treatment would make it worse." (Interview 3, Spain, MSM from Argentina, 25 years old)

"I was afraid to start the treatment, I didn't want a treatment because I just didn't want to take it and could not face reality. Many people do not want to confront HIV, it was my fault, it's my fault, and I'm the one to blame." (Interview 5, Portugal, MSM from South Africa, 33 years old)

False beliefs about HIV (on mode of transmission etc.) often prevent people, notably Sub-Saharan migrant, **from disclose their HIV status**. The majority of HIV-positive interviewees declare that they do not talk about their HIV status to people around them by fear of being discriminated, rejected or excluded from the community. Some people manage to overcome their fear of stigma by talking to very close family members or by joining support groups of people living with HIV. This, however, constitutes a minority of people interviewed. The barrier to disclosing the status is less mentioned and therefore present among migrants from Latin America who were interviewed.

The fact that one cannot disclose his serological status to his surroundings and thus has to **hide his treatment and medical appointment** is a major obstacle to ensure the continuity of care. Most of the interviewees do not reveal their HIV/AIDS status to their close relatives. They fears worrying their relatives, being stigmatized, excluded or subject to gossip.

"My mother, my brothers, my sisters, in any case, there is no one [who knows] ... And then at home, if there is anyone who knows that I am sick, If I come home to visit him, he cannot give me a cup like that ... [...] and when I leave, it's over, they can no longer use it. (Interview 5, Belgium, man from Congo Kinshasa, 51 years old, HIV-positive)

"Today, HIV, does not kill any more, they say. So, no, I'm no longer afraid of it, but I'm afraid of the community. For example, treatment, I do not take it in front of everyone. I still hide to take it." (Interview 2, France, MSM from Benin, 32 years old, HIV-positive)

"I live hidden because I cannot show people around me that I'm sick. That's what tired me a lot. And then when I go for the health check-up, I am given the check-up sheets, I cannot take them home. (Interview 4, France, woman from Mali, 41 years old, HIV-positive)

This fear of disclosure prevents them also from benefiting from the support of their close relatives which is essential to face their HIV-positive status. According to the interviewees in **Spain**, the **moral support** given by the sexual partner or close entourage contributed to the **acceptance of the disease and to the good compliance to the treatment**.

"It also depends a bit on the people who are by your side. If you have a good, good person, as I have and who supports me, a friend, then it is easier to accept the disease and to follow the treatment." (Interview 5, Spain, MSM from South Africa, 33 years old)

"My boyfriend insisted when I did not take the medication. It was largely part of my decision to start the medication." (Interview 3, Spain, MSM from Argentina, 25 years old)

Treatment: side effects and practical considerations

Several interviewees in Belgium mention that the **fear of the medications side effects** constitutes an obstacle to access to treatment. Sub-Saharan African migrants arriving in Europe often carry out representations surrounding treatment. Many people think they will have a bad quality of life once they start to be in care. Many people said that in Africa, treatments are often poorly adapted to the specificities of the patients and sometimes the side effects can be very strong.

"Me, before, I was afraid of the side effects. I was afraid of being swollen, my hair ... I do not know how ... but really, in Africa, people change when they start the medication." (Interview 8, Belgium, woman from Burundi, 31 years old)

"In Africa, everyone takes the same medication, and it is not always adapted to the person and gives heavy side effects. Here in Belgium, everyone has medication according to the different examinations we are given here." (Interview 6, Belgium, woman from Congo Kinshasa, 40 years old)

In Spain and Portugal, interviewees also point out the fact that treatments are sometimes too **restrictive** and thus can dissuade people to seek treatment.

"For me personally, it had to be me who dealt with this, you wake up in the morning, you have to take 4 medications. Before, it was a little more complicated. You had to run the treatment, medication." (Interview 5, Spain, MSM from South Africa, 33 years old)

Moreover, HIV-positive patients need to go frequently to the hospital for medical appointments and to get their medicine. It can be sometimes complicated to reconcile medical imperatives with professional and personal lives of migrants.

"It is complicated to go get the treatment because I have to catch a train or the underground to go to the hospital to collect my medication." (Interview 8, MSM from Italy, 35 years old)

"Getting medication only in the hospital you are being followed in is quite a limitation for example." (Interview 6, Portugal, MSM from Venezuela, 53 years old)

The doctor-patient relationship plays a particularly important role in the good adherence to treatment by migrants. They also mention several times that being able to discuss the side effects with their doctor, allows to adapt and find the most appropriate treatment.

"I think that private doctors should also get informed about HIV and AIDS. They need to be extra-cautious about the side effects of the HIV medication. If someone comes and complains about a side effect, they should be careful if both medications can be taken together." (Interview 1, Denmark, woman from Zambia, 47 years old)

Discriminations and denial of care

Some people in **Belgium** report situations in which they **were refused care and experienced discrimination** linked to their pathology or their origin and thus by medical staff. For example, one interviewee explain that he had been reoriented to a hospital for a conventional dental care because of his HIV status.

“He told me I must send you to the hospital because of your HIV status and he said “next time, you must say that you are HIV positive so that we give you the last appointment of the day. We will have to use a lot of water, so that there is not a lot of blood.” (Interview 8, Belgium, woman from Burundi, 31 years old)

“If you're HIV positive, you don't get to see the normal doctors, you have to be sent to a special hospital [inaudible] hospital actually, but they don't touch you without gloves... Just a little bit too much, it's too exaggerated.” (Interview 7, Belgium, woman from Kenya, 38 years old)

The key informants also confirm that some **discriminations still exist in the statutory health care system** prompting people to give up care to avoid situations of discrimination and humiliation.

“We still let discrimination pass in the health care system.” (Focus group, Portugal, Project manager - NGO)

Moreover, some people have been **discriminated by the immigration services** linked to their pathology. The effect is that it sometimes discourage people from carrying out the administrative procedures necessary for their medical care.

“I assure you, especially the staff, those at the counter, when they look at you, you feel discrimination. They talk about your private life aloud, they do not respect professional secrecy. This is an obstacle for migrants.” (Interview 10, France, woman from Cameroon, 46 years old)

“There should be a certain confidentiality because when you arrive at one of these centres it is the ladies who attend and the Spaniards always speak very strongly.” (Interview 6, Spain, MSM from Colombia, 40 years old)

“Once a person told me loudly at the hospital “You know you are staying in the territory because you have an infection. You'll get the doctor's paper, if not you must leave!” (Interview 4, France, woman from Mali, 41 years old)

Linguistic barrier

One barriers plays a significant role in both access to HIV testing and care: **language**. The linguistic barriers to access to HIV services have been **mentioned mainly by migrants living in Denmark, Belgium and Spain** because they did not master the language of the host country at the moment of their arrival. Among our sample, migrants from the French and Portuguese sample were mainly migrants from former French or Portuguese colonies who therefore speak the language of their host country.

"Because in order to follow the procedure to get the papers and access care, for example, it can be complicated when you do not speak the language of the country" (Interview 4, Belgium, woman from Congo Kinshasa, 48 years old)

"My big issue was language because the doctors start explaining the results of your analysis and I understood the third of what I was told." (Interview 8, Spain, MSM from Italy, 35 years old)

"It's difficult, especially for undocumented migrants, because you have to follow all the procedures to get all the documents, you have to speak Dutch, to fill in the document in Dutch and you can't get the correct, right information to access to documents and care if you don't speak the language. (Interview 7, Belgium, woman from Kenya, 38 years old)

4. Facilitators for improvement in HIV testing, linkage to care and continuity of care for migrant populations

Interviews with key informants and migrants allow to identify facilitators to access to HIV prevention. As for barriers, these facilitators are both on patient and care provider level. Migrants and key informants highlight the importance of a targeted information and communication to improve knowledge on HIV prevention and fights against misguided ideas. Outreach activities and intermediaries help to better reach the targeted population. Those elements might give the opportunity to migrants to identify their health care needs and relevant health care services (**see section 1**). In order, to seek, reach and use health care HIV/AIDS services, these services should be adapted and tailored to migrants needs (a comprehensive health offer, respect of privacy and confidentiality...). Interviewees with key informants and migrants highlight that some CBVCTs' key characteristics help meet these needs on an evolving basis (**see section 2**). Collaboration between statutory health care services and CBVCTs is important, it permits from one hand patient to a better understanding of their health needs and participation in decision-making and from another hand medical staff to better take care of patient's needs (**see section 3**).

1. Facilitators to identifying health care needs and relevant HIV services

Targeted information and communication

All interviewees without exception recall the importance of **targeted public information destined to migrants** to overcome stereotypes, representations and to combat lack of knowledge about HIV.

"What I really want and care about is to raise the awareness about HIV." (Interview 7, Spain, MSM from Egypt, 24 years old)

"Information is the best tool against HIV". (Interview 3, Denmark, man from Cameroon, 30 years old)

To make this idea suitable and effective it is important that it be **co-built** with the people concerned; young people, doctors, community organizations, public bodies, etc.

"It is up to the politicians to work collaboratively with doctors, young people, NGOs, etc., to produce leaflets that will be distributed in schools, and to give courses on this." (Interview 9, Belgium, woman from Congo Kinshasa, 44 years old)

According to interviewees, Information surrounding the modes **of HIV transmission, testing and treatment, must be provided**. This information will help limit HIV-risk practices and reinforce the recourse to testing. It will also permit to fight against stigmatization and discrimination of HIV-positive people. Interviewees stress the importance of communicating with the migrant population on **existing HIV treatments** in order to limit barriers to HIV testing and linkage to care with the fear felt towards the disease. Interviewees therefore explain that many people in the community today are unaware that HIV treatments help improve health, the quality of life as well as life expectancy and also helps prevents further transmission of HIV.

"It takes a lot of information to de-dramatize this disease. It is only a chronic disease." (Interview 4, France, woman from Mali, 41 years old)

"Back then in Africa, if you were told to be HIV positive, you were sentenced to death. But now, it's "get tested". If you know your status, you know you're gonna get to live longer because you get the treatment." (Interview 1, Denmark, woman from Zambia, 47 years old)

"Explain that it is a chronic disease such as cancer or diabetes that is being treated with treatments." (Interview 5, Belgium, man from Congo Kinshasa, 51 years old)

"I would say the services for testing, and if you get tested and then start your medication that's the most important. The campaign should be large and come out and talk about HIV [saying that] if you live here, you have the opportunity to get your medication also to prevent and adapt, there's a real opportunity if you're here. You get your medication and its good medication." (Interview 6, Denmark, man bisexual from Ghana, 30 years old)

In addition, several migrants also **stress the need for more communication on all existing HIV prevention tools**, such as Pre-Exposure Prophylaxis (PrEP) or Post-exposure Prophylaxis (PEP) so that people the most at substantial risk of HIV infection can choose **HIV-combination prevention strategies** that suits them best.

"I think there should be more communication about PrEP among migrants from Sub-Saharan Africa, because it would be a good tool for them. [...] The experience I have made, even here in France, when I am somewhat mixing with the black gay community, we can say that there are many who have dropped the use of condoms." (Interview 2, France, MSM from Benin, 32 years old)

"PEP is something that you should be able to get access to as easily as condoms." (Interview 6, Portugal, MSM from Venezuela, 53 years old)

"The fact that you do not speak means you do not get the information. And then the last decision is yours. Maybe being aware about using the condom, knowing post-exposure prophylaxis, I do not want to do anything, you'll know, but let me have the tools, then I'll decide, what I can or cannot, what I want to do or not." (Interview 8, Spain, MSM from Italia, 35 years old)

Interviewees strongly support **the need to better adapt messages and communication to its targeted population and to better target places and areas frequented by migrants** (such as churches, deprived neighbourhoods, etc.) in order to more effectively disseminate health messages.

"In a couple of places Checkpoint is advertised, but doesn't have much promotion. I'd maybe exploit it more. Information they give you, more advertising, and maybe I would move it closer to the centre of Barcelona where people pass by, look at the poster where it says "test in 30 minutes". "Do I do it, don't I do it? Yes, I do it." And you do it. Because if not the information has to come from somewhere and you have to call and make an appointment. I would put it in a more popular place perhaps." (Interview 3, Spain, MSM from Argentina, 25 years old)

"Information, to give more information to the people I think, because there are many people who don't have the notion of everything they could access or how easy it is to come to make tests here at the Checkpoint..." (Interview 4, Spain, trans woman, 26 years old)

"It comes with awareness raising. We have to understand which group we are addressing to adapt the communication." (Focus group, Portugal, Project manager - NGO)

Among the sample of migrants from Sub-Saharan Africa who were interviewed, many state that **communication media such as brochures, campaigns, posters, are not always useful and effective** to broadcast prevention messages. They recommend we promote more **human contact** within the African community.

"Verbal information, especially with ethnic minorities because if you give them papers they throw them away but if you talk to him and you put some sense in his brain it is better." (Interview 8, Denmark, man from Zanzibar, 73 years old)

"They take it but after they go two meters away from you they throw it on the floor. I found all the brochures I gave, counted them. We need to change the way we communicate [...]. They should talk to the media companies with the billboards and also on TV, just a spot on TV every 5 hours would be nice..." (Interview 7, Denmark, man from Burundi, 42 years old)

"Maybe just use the African method. Information is spread by word-of-mouth. To talk about it, and perhaps train people to enter the communities, to discuss ... that's what works as communication!" (Interview 7, France, man from Côte d'Ivoire, 60 years old)

Many interviewees in Belgium also highlight the importance to increase **awareness through families**, especially parents so that they educate their children on the issue of HIV and sexuality. We must also communicate to the youth who will become a vector of diffusion within the community.

"So I tried to go into the houses to try to change prevention a little to the parents. It is necessary to have this influence with the parents so that they can act on the children ..." (Interview 3, Belgium, man from Congo Kinshasa, 60 years old)

"But we must start, work with youth. I think that this youth, we must explain to them, make them understand that thanks to knowledge, the disease can be spared..." (Interview 9, Belgium, woman from Congo Kinshasa, 44 years old)

"There is real work to be done on the side of the younger generation who can also discuss it later with the family. It can be a vector of information and transmission." (Interview 4, Belgium, woman from Congo Kinshasa, 48 years old)

Intermediaries

All the interviewees emphasize the importance of working with **intermediaries to reach the most reluctant populations to HIV testing**. Indeed, according to the migrants interviewed, working closely with **social and cultural mediators** who understand both the codes of the migrant communities and of the host country could facilitate access to HIV testing and linkage to care for these populations. These intermediaries make it possible to connect health professionals, NGOs and other stakeholders and communities to reach people, not only to get them tested, but also to bring them back to care.

"It's not only the language barrier but also the structural barrier, in the past this figure existed in some hospitals, somewhere, the figure of cultural mediators, and that allowed us to explain to the person that it isn't the awareness of the culture that isn't conscious about the chronic disease." (Focus group, Spain, project manager, NGO)

"In migrant communities specifically, mediation work is a leverage to reach these communities." (Focus group, Portugal, project manager, NGO)

"Also I think there should be a lot of work with religious leaders. They are very important. [...] Families that were accompanied by mediators had a very different idea of HIV and changed their behaviours and then themselves spread that." (Focus group, Portugal, Medical staff, Hospitals)

"I think that what you should work on. Mediation for both the arriving immigrant and the person who is also attending. The health system official as well." (Interview 6, Spain, man from Colombia, MSM, 40 years old)

Social and cultural mediators are also able to identify and raise awareness among the influential people within the community such as religious leaders, community leaders. The importance given to the discourse and opinion of **religious leaders** is repeatedly mentioned by Sub-Saharan African

migrants who were interviewed. They mention that in the Sub-Saharan African community, people sometimes give more credit to the messages of religious leaders than to those of the health care stakeholders engaged in prevention. Leaders constitute actors that should be involved in the prevention of HIV.

“The spiritual leaders and the community leaders, yeah yeah yeah, they're very influential. If the pastor says no, they don't test. If the pastor says yes, they test.” (Interview 7, Belgium, woman from Kenya, 38 years old)

“To get the message across to communities, the leaders need to be able to explain things well to people, so that people, once reassured, go get tested. The most important thing is to take the step towards testing.” (Interview 7, France, man from Côte d'Ivoire, 60 years old)

“So that's another thing we do, another approach we have, so we are linked to some minority groups, high risk groups. And we try to add into that for example churches. Churches are almost always community based.” (Focus group, Denmark, Medical Staff - NGO)

Outreach actions

Whether the offer of HIV testing is statutory or community based, all the interviewees affirm that it is essential to promote **outreach actions** in order to reach the most vulnerable and those who have the poorest utilization of health care services.

“We need something outside the hospital ... let's stop putting things in the hospital!” (Focus group, France, Medical staff - Hospital)

“We need to take out our health to get out of our clinic because we know it is a barrier. Transport to come to the clinic, to the polyclinic...” (Focus group, Belgium, Medical staff - Hospital)

“We need a sensitive approach, we need to go to them because they had little information, a lot of bad information and a big need to talk.” (Focus group, Portugal, Project manager - NGO)

“We need to develop other strategies to meet this population. We need proactive actions, we must go to meet them.” (Focus group, France, Health and cultural mediator - Hospital)

Given that it is sometimes difficult to target populations in certain countries. **In Denmark** for instance, Sub-Saharan African migrants are very few and dispersed around the country, so it might be difficult to identify and map most relevant places to conduct outreach actions. This is why, according to key informants interviewed, to develop **outreach actions that “[are] very dynamic because people are always moving jobs, and their life is upside down. Outreach actions need to adapt to their fluid lifestyle”**. (Focus group, Denmark, Project manager - NGO)

Interviewees also mention **the need to innovate, to get closer to the people, to where they live**. Indeed, the use of mobile units during outreach actions is mentioned several times as a lever. They are

perceived as being facilitators for access to HIV testing for populations with the poorest utilization of health care services.

"It is a good thing to have HIV testing in public places where there is a lot of people so they can see this is a reality and that organizations do their jobs; to show that people's health is an issue that is being addressed. When you do this in secret, people do not believe the issue exists. But when you do this openly, people see and realize this is real." (Interview 3, France, man from Nigeria, 35 years old)

"Using a mobile unit for HIV testing is a good way to reach people. If it's a targeted approach, people get tested and if it's working then why not continue. For example, you could have a mobile unit at a football match, outside the field, people could get tested before the match and get the result on their way home. I think it's a good thing. You need to go to people where they are, like in a community or in groups." (Interview 3, Denmark, man from Cameroon, 30 years old)

Finally, innovative outreach strategies such as **door-to-door** were suggested by the interviewees as facilitators to inform and to offer testing.

"Moreover, the systematic side, ringing on all the doors, causes you to no longer be stigmatized, and it is the NGO which has come to you, and not you who went to her..." (Focus group, France, Project manager - NGO)

"There should be awareness-raising campaigns in different neighbourhoods, in different buildings, in people's quarters ... [...] Going to the people, where they live, maybe ringing, maybe displaying" today, obligatorily, we will bring awareness to this building". Yes, to go to people ... To knock on the door, enter ... because that is direct and effective ... it is a minute, it is a second..." (Interview 9, France, man from Gabon, 37 years old)

"Diffusing information through door-to-door, meetings, bringing people together ... we need to mobilize people, go and find them in schools, in communities, in meetings." (Interview 5, Belgium, man from Congo Kinshasa, 51 years old)

"It would be good for people to get tested at home. You know, the rapid test has been extended to social workers, so it would be perfect if people could call and say "I'm ready to get tested" and the social worker came to their home and do the test." (Interview 1, Denmark, woman from Zambia, 47 years old)

Most of the interviewees stressed the importance of **the use of new testing tools to reach vulnerable populations**. Indeed, rapid testing (on the finger) is described as a particularly effective tool to get closer to migrant populations, especially during outreach activities, and helps prevent lost to follow-up.

"The fact of not waiting for a week to get results, to have it in twenty minutes, I think it's good. The person, in twenty minutes, knows the result. She will not cogitate a week to find out if

everything is ok? Is everything not ok? ... depressing ... in a week, the person may even change his mind and not go back and get the results because he does not want to know.” (Interview 2, France, MSM from Benin, 32 years old)

“A rapid HIV test is good because migrants do not have to bother to make appointments, to schedule to come and get their results because it is not always feasible for them. We could go directly to them and offer it to them, it would be more effective.” (Interview 1, Belgium, man from Burundi, 62 years old)

“These tools address the fears and the stress people have about receiving their results.” (Interview 2, Belgium, man from Burundi, 52 years old)

Some interviewees in **Belgium** describe **the saliva testing as an interesting tool to improve HIV testing** among migrants. However, some people explain that the delays to obtain the results are longer (about 5 days) than rapid tests, which can lead to lost-to-follow up for some of the migrants who will not return to get their results.

“The salivary test is something easier. It's more appropriate. It's less medical and it can be done by peers.” (Interview 3, Belgium, man from Congo Kinshasa, 60 years old)

“It is too long to get the results with the saliva test, it is around 5 days.” (Interview 8, Belgium, woman from Burundi, 31 years old)

The home testing kit also is mentioned several times as a facilitator. However, the issue of linkage to care regarding home testing is also highlighted by interviewees.

“The big problem about selling the home testing kit, is how you get people to give and share their results.” (Focus group in Belgium)

“If there is a good linkage to care it could become a trend that will catch on as time goes on”. (Focus group in Denmark)

2. Facilitators to seeking health care, reaching and using HIV services

Comprehensive health offer

Several interviewees mention the idea of introducing a comprehensive health offer to migrants. **Integrating HIV testing into a comprehensive health check** (hypertension, diabetes, liver, etc.) would probably reduce the psychological barriers (especially fears of stigma, meaning given to the HIV test) of migrants to getting tested. They mention that it would be appropriate to have a structure set up where they can undergo a comprehensive health check without it necessarily being linked to HIV.

“But there is not just HIV, there are other health-related illnesses, people have to get used to doing a check-up at least once a year. By starting there, I think it could pass. But if we come

and talk to them only about HIV, and all this, people can get blocked.” (Interview 4, Belgium, woman from Congo Kinshasa, 48 years old)

“This is what we mentioned earlier, the global approach ... I tend to move onto sexual health ... I mean, in terms of the ideal offer, I think that it is disengaged from an exclusively HIV offer that is stigmatizing in many respects, which does not answer to the fact that people do not feel concerned and that they are asymptomatic.” (Focus group, France, Advocacy officer - NGO)

“If they are offered a (testing) project, a health check-up, (in the context of global health), it works quite well ... So when they come, nobody knows they come to get tested ... well actually, everyone knows, but it is neutralized by a global health offer. » (Focus group, France, Medical staff - Hospital)

A comprehensive health check will also allow some persons with the poorest utilization of health care services to benefit from a health care check.

“It's not just about HIV, but really about being health conscious ... doing a global health check-up, seeing where I stand in relation to my health. This is extremely important.” (Interview 1, France, woman from Côte d'Ivoire, 27 years old)

“I don't know maybe there is a big discussion whether HIV should take as much place and importance as it did before, because before people were afraid to die or heard bad things about HIV but now they also talk about having diabetes or hepatitis. So it is still a question, but now we are talking about HIV. I think that maybe we could add what they have in mind for preventing hepatitis, more awareness raising in ADA, more interest, and more costly diseases like hepatitis C.” (Interview 4, Denmark, man from Burundi, 44 years old)

Among the sample, several participants, mainly MSM declared to be in favour of a specific place structured around **a comprehensive sexual health services and not focusing only on HIV and HIV positive people**. They suggest **a sexual health centre, not in a hospital**, where people can get tested for other STIs, can get their HIV treatment, PrEP, PEP, etc.

“Ideally for me ... a sexual health centre, why not? But something like that, big, outside the hospital.” (Focus group, France, Medical staff - Hospital)

“I don't know, something that I thought would help me integrate more, is the attention given at the Hospital Clinic as a sexual disease unit, a transmission unit. Then you go there and if you suspect something, they check you, they make tests, they make analysis's and maybe that could be more integrated because I think that there is a narrower relation between VIH and other sexually transmitted diseases, and in sexual behaviour, especially with gays.” (Interview 6, Spain, MSM from Colombia, 40 years old)

“Treating them, not just HIV, we have to create the conditions so that we can offer things in an integrated health context.” (Focus group, Portugal, Medical staff - Hospital)

*"It would take a place where you can check for other diseases to not feel stigmatized."
(Interview 8, Belgium, woman from Burundi, 31 years old)*

"You would have to have a doctor here, every day, to be able to follow the treatment. Being able to make a more specific test, it could be a bit more complete." (Interview 5, Spain, MSM from South Africa, 33 years old)

"Also, for PLHIV, there are several things. I get calls from people saying things like I am wherever in the country, and have 1 pill. What do I do? The only answer is get a train and come to the Hospital to get more. Getting medication only in the Hospital you are followed in is quite a limitation for example. Well for HIV treatment, STI consultations, a PEP and PrEP response, all in the community are missing in the current services." (Interview 6, Portugal, MSM from Venezuela, 53 years old)

Diversity of the care providers

A large majority of interviewees **highlight the importance of the diversity of health care providers regarding HIV testing** (statutory health system with medical staff, CBVCT with community workers, non-medical staff...).

"I think that it has to be a diverse offer but also with an offer that could be adjusted to the diversity of immigrants." (Focus group, Spain, Project manager -NGO)

*"It would take a place where you can check on other diseases so you do not feel stigmatized."
(Interview 8, Belgium, man from Burundi, 31 years old)*

"I think that the Checkpoint model is very good. I mean I still think there has to be adaptations for everyone, there is not "one" model. Models exist but they have to be adapted to the reality of each place. I think there should be different alternatives and each person should pick what they think is best." (Interview 6, Portugal, MSM from Venezuela, 53 years old)

"All places are safe, it is just a question of preference." (Interview 8, Denmark, man from Tanzania, 73 years old)

"In any case, it is good enough to diversify the offer, whether it is a hospital, an institute, or the Help Centre, or other centres in Brussels, such as Elisa, etc., or then rapid tests, saliva tests ... finally, diversify the offer to try to reach the populations." (Interview 6, Belgium, woman from Congo Kinshasa, 40 years old)

CBVCT assets

The majority of the migrant sample state that CBVCTs characteristics **facilitate the recourse to testing and linkage to care**. These characteristics can also be found in statutory health care services. However, it appears these characteristics are more generalized in CBVCT and they were commonly used in order

to describe the CBVCT characteristics and assets (confidentiality, community volunteer or worker, reception, social and administrative support...).

- **Reception and patient relation**

Many interviewees express the importance of a **warm and non-judgmental welcome**, with doctors or staff who know how to address themselves to the migrant population. Thus, they mention the importance of a **service tailored to the lifestyles and cultures of the public concerned**.

"We have a language that shows that we care and we link them directly." (Focus group, Denmark, medical staff -NGO)

"Atmosphere is nerve-wrecking, they make you nervous. NGO is smoother, friendlier. Hospital more accurate but NGOs friendlier." (Interview 7, Spain, MSM from Egypt, 24 years old)

"A warm welcome is very important. Amongst Africans, we say hello. We're raised like that. We like to say hello, even if we do not receive. But here you arrive at the hospital at the reception, and no one answers you. The person, she just tells you: "What is it? Wait!"... From there you feel even worse, you fall." (Interview 4, France, woman from Mali, 41 years old)

Interviewees also highlight the **advantage of being received by someone from their community** to create an environment of trust. Concerning the role of community-based staff in performing the test, the majority of interviewees believe that having a person from the community is more appropriate to practice the test. According to them, it is easier to get tested by someone who knows the community codes and speaks the same language.

"People that probably are in the same condition than you and that give you that test, I think that is important sometimes to feel the same with another person that you are not going to feel either pointed at or damned or criticized." (Interview 6, Spain, MSM from Colombia, 40 years old)

"I think young people (ed.: HIV positive) are comfortable to talk to a person who has been living with HIV for 30 years. In Denmark, they have the possibility to talk to someone from their community when the results are positive in the hospital. They will ask you if you want to talk to someone who has experience, the same skin, or language etc." (Interview 6, Denmark, man from Ghana, 30 years old)

- **Confidentiality and privacy**

The notion of respect of privacy and confidentiality, particularly the fact of **not providing personal data** for testing was mentioned by the majority of interviewees as a facilitating factor.

"The other part is people come anonymously here. But in the other health setting they need to produce their security number, everything. But here it is their right to be anonymous. » (Focus group, Denmark, Project manager - NGO)

*"I feel more comfortable in NGOs because in the hospital they record dates and times."
(Interview 7, Spain, MSM from Egypt, 24 years old)*

"First, to not question the issue of identities, that topic can vary depending on where you come from, and the other issue is that one, the idea of keeping to the maximum the issue of privacy, that is one of the issues that you have to keep in mind." (Focus group, Spain, Project manager - NGO)

"There are a lot of minorities that come in here [ed.: AIDS Foundation], but none of them I know about their status. So I think that confidentiality is ok here and is very very important, because if people feel more confident or more secured about their status then they will likely be more comfortable to go for regular check-ups and testing." (Interview 5, Denmark, MSM from Ghana, 29 years old)

According to the migrants interviewed, the fact that CBVCTs are **NGO and a confidential, anonymous and free place** is a facilitator, especially for illegal migrants and/or MSM migrants.

"There is an aspect that is important, if we manage the card, the cards are sent here, and we give them to the user. That is very important because it gives you more confidence." (Focus group, Spain, Supervising staff - NGO)

"At the AIDS Foundation, it's anonymous. You get a number, you get yourself tested and then they give you the results. You choose if you come pick up the results or if you want them mailed to you. This is good for confidentiality." (Interview 3, Denmark, man from Cameroon, 29 years old)

- **Location and service hours**

Among the sample surveyed, a large proportion of migrants report that the **geographic location** of community-based testing centres facilitated their access to testing. CBVCTs are often located in an accessible location, close to the population, but still quite isolated, allowing people to be tested in a "discreet" way. Interviewees also have the impression that in this type of place, they are less likely to meet someone in their community than in a hospital.

"The location plays a big part." (Focus group, Denmark, Project manager - NGO)

"I think we need a somewhat isolated place, especially for Africans. They are afraid to meet someone they know. And when people know you, once they get out of the hospital, they'll start talking. Even when I have to go to testify, I prefer to do it in a group of people who are not from my country. I can testify to the Angolans, the Ghanaians, all that, but not to a group of Congolese." (Interview 6, Belgium, woman from Congo Kinshasa, 40 years old)

"You need a place like the "HelpCenter". There, it is good, because everybody does the testing. It does not show you're sick. For if someone in your community sees you in the hospital, he will necessarily think you're sick." (Interview 8, Belgium, woman from Burundi, 31 years old)

"They should be in a secret place, it should be, you call you make appointment and then you come and nobody knows where you're going. When I go to my hospital I always see emigrant people that are hiding." (Interview 6, Denmark, man bisexual from Ghana, 30 years old)

"These services should be near me, near my house." (Interview 2, Portugal, woman from Guinea-Bissau, 49 years old)

"A place close to people's homes and easy in terms of access." (Interview 10, France, woman from Cameroon, 46 years old)

Also, interviewees point out that offering **flexible opening hours**, every day, could help encourage more migrants to get tested.

"They can do it after working hours they can come with family they can come alone, they can come with their partner and get tested together." (Focus group, Denmark, Medical staff - NGO)

"About schedules, I think it should be 24 hours, somehow it should be possible, even for those people that go out of a bar and say "now is the time". (Interview 6, Portugal, MSM from Venezuela, 53 years old)

"I think it is safe to come and get tested here because you can decide if you don't want to come in opening hours, they are quite flexible." (Interview 4, Denmark, man from Burundi, 44 years old)

"You can do [a test] just by calling and can easily get tested and it's not the same in Africa, or in Ghana." (Interview 5, Denmark, man from Ghana, 29 years old)

Interviewees also highlighted the importance of having a service that allows for immediate results.

"Positive things, it seems there are many. It's a place that I like, it seems very professional. It seems that is very well organized, they take good care of you, and it works fast. I think it is the system, you can make an appointment, you come, they puncture a little finger, they extract a bit of blood and after 30 minutes they tell you the results. That is, it's like wow..." (Interview 3, Spain, MSM from Argentina, 25 years old)

"Checkpoint LX is better because there is less exposure, you just go in, then wait for less than 5 minutes" (Interview 4, Portugal, trans woman from Brazil, 23 years old)

- **Social and administrative support**

Among the sample of interviewees, many state that the **administrative and social support** provided by community-based structures was highly facilitating to access testing and care. According to key informants interviewed in the different participating countries, access to rights is often an important entry point towards health, testing and care.

"When they come to live here, it is more for the social aspect than for health. When they come to the organization, they want ... I want a house, I want to work ... "(Focus group, France, Health and cultural mediator - NGO)

"The support of the NGO is more important than the treatment, the drugs we are given, because without them, we do not come to the drug. We do not come at all." (Interview 4, France, woman from Mali, 41 years old)

CBVCT structures, very **familiar with legal systems** are often able to direct and support **undocumented migrants** to take the necessary steps to access treatment and care. For some interviewees who did not have residence papers or health coverage when their HIV status was detected in the host country, the CBVCTs played a crucial role in their access to HIV treatment and continuity of care.

"The Checkpoint recommended to me that I should start to medicate because I was really down, and he told me that I could process the health card through them. I explained to them that I didn't have papers, they told me that there was no problem, that they could make a provisional one." (Interview 3, Spain, MSM from Argentina, 25 years old)

"I think getting tested at an organization like the Checkpoint is not bad for immigrants, because sometimes we don't know what to do. When you are still in "asyl", you don't know what to do. At the hospital, they give you appointments like "Today you have to go to the hospital." If you're not sick they don't give you appointments. Here, you just ask "Can I be tested?" and if you are positive they find out what to do." (Interview 8, Denmark, man from Tanzania, 73 years old)

"How did I get to know this organization? Because my sister took me to Médecins du Monde (ed.: Doctors without borders) in Saint-Denis (Suburbs of Paris) to get the AME card (ed.: French Medical State Aid). "(Interview 8, France, man from Cameroon, 45 years old)

"Then we helped them, we provided them the antiretroviral treatment until they could have direct access to the health system with many difficulties." (Focus group, Spain, Project manager - NGO)

CBVCTs make a special focus on the **moral support** offer before, during and after HIV-testing. Interviewees highlight that they appreciate the time spent by CBVCT staff to listen, to prepare for the results (pre-counselling, for example) or to make referral for care.

"In the associations like AIDES, I think we are safer ... I feel safer, because when you get tested, you are taken care of, in fact you are accompanied." (Interview 8, France, man from Cameroon, 45 years old)

Many CBVCTs also offer to **accompany people physically** to their first medical appointment after the discovery of their HIV status and offer a **long term social support**. CBVCTs staff act as a mediator by accompanying HIV-positive persons to medical appointment and helping the person understand the medical discourse. This physical and/or psychological support is described as necessary and useful by

the respondents to better accept and understand the disease. Indeed, several people say that CBVCTs support after their diagnosis had helped them to better understand what it meant to be HIV-positive, to better understand the treatment and thus to ensure good compliance.

"It was an initial shock, a very big one, but the support that you have here, they tell you, they explain to you, that you don't die of this, that a treatment exists, that a possibility exists, it leaves you more relaxed." (Interview 5, Spain, MSM from Argentina, 25 years old)

"CBVCT can help people getting into the hospital." (Interview 9, Portugal, man from Cape Verde, 55 years old)

"I did not speak Portuguese, but Edna translated and helped me understand what was going on. She came to the hospital to see me and explain what the doctor said." (Interview 5, Portugal, man from Guinea-Bissau, 42 years old)

"They helped me. They translated, prepared me to go to the doctor. They explained everything. You are family. My family from Portugal. They are also going with me to the Positivo association and they will help me with food and transportation, because transportation is important for me to go the hospital and get the medication and go to the doctor and to come here." (Interview 8, Portugal, woman from Guinea-Bissau, 50 year old)

"The person who has tested you can accompany you, guide you, so that care is adopted as quickly as possible." (Interview 7, France, man from Côte d'Ivoire, 60 years old)

"Those who help me here, they help a lot. And they speak my language and I understand what I have to do. They come with me to the hospital and help. I am happier now." (Interview 2, Portugal, woman from Guinea-Bissau, 49 years old)

Importance of statutory health care services

Hospitals remains a well-identified place for migrant populations, especially for migrants from sub-Saharan Africa who tend to go towards this structure in the event of serious health problems. Moreover, for some interviewees hospital is a confidential place where no one can know why you needed to go there.

"A hospital is good because it is an area where everyone who comes has some disease and no one will know for which disease you are coming. That is why I think it is better to be tested just at the hospital, for confidentiality." (Interview 7, Denmark, man from Burundi, 42 years old)

"The current system they have at the hospital. You go in the morning to the hospital, you do the screening and you go to your house. It is something fast and confidential. I think it's a good system. No one here knows your illness, only you and the doctor." (Interview 2, Spain, man from Mauritania, 45 years old)

Moreover, among key informants interviewed in the focus groups, several stress the importance of **maintaining and strengthening the statutory offer of testing and care**, since the hospital remains a

benchmark for many newly arrived migrants. Furthermore the hospital staff, as well as the staff of the CBVCT is able to provide support.

"I think we can offer the same here, because we are carers, so if people come to us we take care of them straight away." (Focus group, Denmark, Medical staff - Hospital)

"Newly arrived migrants go mainly to the hospital. Particularly the beneficiaries of state medical aid, they mainly go to the hospital. Perhaps there is also a point of attachment to the hospital on the offer of testing compared to the migrant populations." (Focus group France, Advocacy officer - NGO)

According to migrants, **general practitioners**, with whom migrant can have a relationship of trust, have also an important role to play in recommending migrants to get tested.

"I would say it would be nice because everyone has their own doctors, their own practitioners so that's how it should start, from there. Today I have such a headache, so they would take some blood and tell you why they're doing so they could test you for HIV and other infections as well but you should do it at your own doctor." (Interview 6, Denmark, man bisexual from Ghana, 30 years old)

"The family doctor, the general practitioner, he should always suggest a check-up. Many people, have confidence in their family doctors. When someone presents themselves, I think it would be better to offer the test each time." (Interview 1, Belgium, man from Burundi, 62 years old)

It is thus important to better **train general practitioners on issues related to sexual health and HIV** so that they are able to offer more HIV testing to their patients.

"There is a need for GP trainings to talk about sex with the patient's" (Focus group, Belgium, Medical staff - Hospital)

"There is a need for trainings in the health centres. That's the first barrier, talking about sex. Then, offering a test to someone they know, someone who is their client or patient for years, that's another step." (Focus group, Portugal, medical staff, hospitals)

3. Facilitators to being offered HIV services appropriate to the needs for care

Co-operation between the various statutory and community-based structures

Experts interviewed in the different participating countries all stress the importance of strong **cooperation between hospitals, GPs, community-based testing structures and migrant communities** to improve testing and ensure better follow-ups and support for people diagnosed HIV positive. We note that this cooperation varies greatly from one country to another depending on the national context. In **Denmark and Belgium**, the experts interviewed describe the cooperation between the

various organizations as being efficient. The close link between health professionals and community-based workers makes it possible to refer patients and quickly start the anti-retroviral therapy.

“The NGOs are often working as complementors of each other and not as competitors and medical doctor’s volunteers staff doctors, nurses etc. There has always been a great synergy between organizations and very little conflict”. (Focus group, Denmark, Medical staff – NGO)

“It is a cooperation between the hospitals and our offers, because no matter what, we have to work with you guys and we have a very good immediate contact and then they follow onto the hospital and then they get medicine from you too. We cannot function without the hospital.” (Focus group, Denmark, community-based worker - NGO)

“The linkage to care is of course not 100% but I think it’s quite good.” (Focus group, Belgium, Medical staff – Health centre)

“So the Checkpoint tests you and finds out, and then they direct you to the hospital. Then they prove the truth from the hospital. The cooperation between hospitals and checkpoint is good.” (Interview 9, Denmark, woman from Uganda, 63 years old)

This cooperation still needs to be improved in other countries according to the interviewees. In France, Spain and Portugal, experts describe this cooperation as fragile and sometimes insufficient.

“It does not work at all, nobody works together, little coordination.” (Focus group, France, Medical staff - Hospital)

“It is a question of will, the will of people not of the services, of the people.” (Focus group, Spain, Medical staff - NGO)

“There is no contracting for partnerships and cooperation with the community.” (Focus group, Portugal, Project manager - Public services)

All interviewees stress the importance of **maintaining or increasing and strengthening this cooperation**. Several areas for improvement are mentioned. First of all, the interviewees speak of setting up more frequent moments to share good practices.

“We need to have close contact and to know each other better. Sessions where we can meet together and discuss and share our knowledge on all these cases, because we off course want to know who and what they tested, so with nurses and doctors who were linking to care . So that they are not lost in the system.” (Focus group, Denmark, Medical staff - NGO)

All the experts from different countries also support the establishment of **clear and transparent practices and procedures**. This would allow all the stakeholders to have the same level of knowledge on the existing measures and the rights of access to care for migrants in legal and illegal situations. For example, in Portugal experts agree that the linkage to care really depends on the hospital.

“There are Hospitals that don’t care about Law and norms, and that just don’t accept people. They say they don’t have the conditions to accept anyone else.” (Focus group, Portugal, Medical staff - NGO)

“Last year I went to give trainings in the north and south, and what I realized was that the legislation was completely unknown for professionals. For many people, foreigners are not entitled to be treated in Portugal.” (Focus group, Portugal, Project manager – Public services)

Thus, the setting up of **training courses for health professionals and the communities** themselves seems particularly appropriate, according to the interviewees.

“And also, we need more training of team... Helping the others, other people, migrant and professionals to know more and more. To supply session for training and training in order to help the other people from there, foreign countries.” (Focus group, Belgium, Community mobiliser)

“People really need training and it cannot be voluntary. Professionals have to speak the same language about legislation.” (Focus group, Portugal, Project manager – Public services)

All the people interviewed also mention the importance of better involve **migrant in this collaborative process** in order to put in place testing and linkage to care strategies which are more adapted to the needs of the patient.

“Working for the communities to get to know their needs and from there on to establish strategies. » (Focus group, Spain, Supervising staff - NGO)

“Just to mean that migrant’s minorities there are so many stories, sometimes it is a good idea that there is cooperation between AID Foundation and hospital staff whatever it is, a kind of cooperation with minorities.” (Interview 7, Denmark, man from Burundi, 42 years old)

“At AIDS Foundet, we are very open to anyone in that aspect who wants come and be part of, to give them the tools necessary, and this training session that goes on is for the volunteers.” (Focus group, Denmark, Project manager - NGO)

“Migrants need to be involved in the whole process ... Because all the organizations that are there are closed to each other. They do not let us participate.” (Interview 2, Spain, man IDU from Mauritania, 45 years old)

According to experts interviewed in France, Spain, Portugal and Denmark, CBVCT structures provide mediation between medical staff and patients, particularly for people who do not master the language or cultural codes of the host country. This way, they facilitate understanding, compliance and adherence to HIV treatment by people. This social and psychological support which is provided by the community-based structures are sure facilitators for the continuity of care of migrant populations.

“They recommend most of our patients so that they can contact doctors and get counselling and socialize.” (Focus group, Denmark, Medical staff - Hospital)

“CBVCTs should also be in contact, they should have come kind of cooperation with the hospital, so that whenever they have someone that is in doubt, they can just address him or her to the hospital so that they can check him or her in the confidentiality of course.” (Interview 7, Denmark, man from Burundi, 42 years old)

ANNEX

ANNEX A: INTERVIEW TOPICS GUIDE

1. LIFE NARRATIVE

This part aims to understand the life course and the migratory path of the migrants and get information about their family, social, economic situations.

Dimensions to be questioned:

- A. **Get information on the life-course and migratory experiences:** situation in the country of origin, conditions of arrival in the country, etc.
- B. **Get information on the current situation:** economical, familial, social, integration in the host country (adoption of cultural codes and language), etc.
- C. **Get information on the difficulties experienced** during the last years.
- D. **Get information on socio demographic aspects**, progressively during the interview (according to the example of questions, make sure you get the main information).

Example of questions

- Can you tell me a bit about you?
 - Country of birth
 - Age
 - Matrimonial status
 - Family situation
 - Schooling
- Can you describe your arrival in your host country?
 - Different steps of the migratory path
 - Difficulties at the moment of the arrival
- Can you tell me a bit about your current situation?
 - Economical: employment, financial income
 - Legal and administrative issues
 - Familial
 - Language
 - Relation with your country of origin
- How do you feel in your life today?
 - Most important issues about living in your host country
 - Most positive things about living in your host country
 - Prospect for the future

2. SEXUAL LIFE AND KNOWLEDGE ON HIV

This part aims to assess the knowledge about HIV and STI and also get information on sexual practices and representations of the disease of the migrants interviewed.

Dimensions to be questioned:

- A. **Get information on sexual and practices:** sexual orientation, number of partners, risk-assessment practices (frequency), etc.
- B. **Get information on HIV knowledge:** HIV transmission, risks associated with practices, knowledge about prevention tools, treatments, screening information.
- C. **Get information on HIV representations:** Fear of disease, perceptions of HIV and people living with HIV, being aware of positive people in the participant's entourage, image of HIV within the community, stigma and discriminations.

Example of questions

- What do you think about HIV?
 - Knowledge on HIV transmission
 - Knowledge on HIV prevention
 - Knowledge on HIV treatment
 - Knowledge about the TPE, PrEP
- How do you estimate your risk of being infected?
 - Sexual orientation
 - Risk practices
 - Perception of at risk practices
- Can you tell me a bit more about your sexual partners?
 - Women/Men/Both
 - Steady partner/non-steady/casual
 - Number of partners recently
- What is your relation with prevention tools?
 - Perception of effectiveness
 - Frequency of use
 - Context of use: casual/steady/non steady sex partner
 - Supply
 - Obstacles & barriers
- What does it mean for you to live with HIV today?
 - Perception of HIV/ Fear of HIV
 - Image of HIV in your community
 - Knowledge of people living with HIV in your entourage
 - Discrimination, stigma

3. ACCESS TO TESTING AND OTHERS SERVICES

This part aims to get information on testing experiences of the migrants interviewed and better understand their difficulties and barriers to have access to health services and get tested.

Here, the interviewer explains the definition of community-based health services. Make sure everyone have the same understanding of the concepts used.

What do you think of when I say community-based sexual health services? What do you think of when I talk about community-based services? What do they include? How would you describe them to someone else?

Dimensions to be questioned:

- A. **Get information on access to health:** current administrative situation, legal issues, possession of health care, difficulties etc.
- B. **Get information on testing experiences:** frequency, screening habits, place where they get tested, etc.
- C. **Get information on barriers and levers on access to testing:** psychosocial and practical difficulties, opinions regarding the testing offers, ways of improving the services, etc.

Example of questions

- Administrative situation regarding health care
 - Legal and administrative issues: documented/undocumented
- When you get health problems, how do you do?
 - Places to go.
 - Persons to consult (GP, “voodoo”, emergency services, nurses...).
 - Main difficulties to access to health services.
- Have you ever gone for an HIV or other STI test?
 - If you get tested in statutory services/CBVCTs:
 - Description of the experience.
 - Reasons of being tested.
 - Reasons of being tested in these services in particular.
 - Positive and negative aspects of being tested in these services.
 - If you were tested in CBVCTs, was the staff from medical or community based field?
 - If you never get tested:
 - Do you know where to go if you wanted to be tested?
 - Reasons of not being tested so far: psychosocial barriers (stigma, fear of looking weak), practical barriers (work schedule, location, fear of disclosure, fear of statutory services and institutions, fear of being deported), etc.
 - Can you think of anything that would make you want to go? (Personal reason or change in the services offered).

4. HIV TEST RESULTS, SUPPORT & LINKAGE TO CARE

This part aims to get information on test result experiences of the migrants interviewed and better understand their difficulties and barriers to get tested and linked to care.

Dimension to be questioned:

- A. **Get information on test result experiences:** feeling, needs at the moment of the announcement, pre-test or post-test counselling, support, impact on sexual practices and testing and prevention habits.
- B. **Get information on linkage to care:** specific needs and support needed after the result, ways of improving the services.
- C. **Get information on stigma and discrimination:** feeling about being HIV positive, perception of HIV in the family, friends, and community.

Example of questions

- If you were tested HIV negative
 - Description of the experience.
 - Services offered: pre and post-test counselling, access to support group/other services? (Advice, contraception, STIs, etc.).
 - Impact of the results on your testing practices: frequency, others IST, etc.
 - If you were tested HIV positive
 - Description of the experience.
 - Services offered: pre and post-test counselling?
 - Information on contamination: early or late diagnosis, physical symptom before to get tested, mode of transmission, etc.
 - Reasons of the late testing and diagnosis: lost opportunities, improvement of services and needs for being tested earlier.
 - Image of HIV and stigma: feelings about being HIV positive, image of HIV in your community, disclosure the HIV status, etc.
- **Support**
- Specific needs: practical information, emotional support (peer support), medical, immigration advice, advocacy, etc.
- **Linkage to care**
- Description of the experience.
 - Expectations according to linkage to care.
 - Improvement and needs regarding linkage to care.

6. MOBILIZATION, EMPOWERMENT & DESIGNING A SERVICE

This part aims to know what does it mean for the migrants interviewed the approaches of “mobilization” and “empowerment” and gather their experiences and involvement in association or others organizations. Also, get information on how they imagine an ideal service that could enhance their access to testing and linkage to care.

Dimensions to be questioned:

- A. **Get information regarding mobilization and empowerment:** relation with both approaches, past and present experiences, involvement in association and organization, feeling of being concerned or not.
- B. **Get information on the design of an ideal service:** features, tools, role of the associations, importance of the culture and identity.

Example of questions

- What does it mean for you the following terms of “mobilization” and “empowerment”?
 - Previous involvement in an association or any other organization: description of previous experiences to influence the way the services in your area run (CBVCT and statutory ones).
 - Willingness to be involved in the improvement of these services (CBVCT and statutory ones).
- What would an ideal service look like to you?
 - Type of places: hospital, association, outreach, etc.
 - Type of counselling: one-on-one private, group session, etc.
 - Type of prevention/information offered in these services.
 - Confidentiality issues.
 - Delay and rapidity issues.
 - Practical issues: close to your home, more isolated place, schedule etc.
 - Relation to the community: led by peers, led by medical professional, both, others, etc.
- What would you change about the current services?
 - What sort of services did you find useful as time went on after your diagnosis?
 - What sort of services is most useful to you now?

ANNEX B: Focus group topics guide

Issue
PRESENTATION
Overview of the migrants situation regarding HIV and access to health
How would you describe the current situation of migrants regarding access to health in your country?
What are the most important needs (job, accommodation, documents, health, etc.) that migrants should fulfil at the moment of their arrival in the host country?
What are, in your opinion, the main reasons for failure for migrants to be tested/linked to care?
What are, in your opinion, the most important economic, social, cultural and administrative barriers for migrants to be tested?
Description of the HIV testing offer
Could you please describe the HIV testing offer (statutory and community-based) available in your country?
This HIV testing offer is it easily accessible and effective for migrants?
Could you describe a "typical" situation where migrants experienced a lack of access to HIV testing services?
What does Community-Based Voluntary Counselling and Testing (CBVCT) means to you? Do you know the activities/services proposed by the CBVCT?
Which would be the major differences between CBVCT and other HIV screening settings?
Could you describe the most positive and negative things of the CBVCT and the formal health setting? Why are they positive and negative?
HIV testing and linkage to care: what procedures?
How would you characterize the cooperation (or lack of cooperation) between formal health settings, migrants associations and the CBVCT? How could this cooperation be improved?
How would you describe the procedure of confirmatory tests of positive results? Are there specificities for migrants? How would you improve it?
What are the referral procedures for accompanying HIV + diagnosed patients in the clinical setting? Are there specificities for migrants? How would you improve them?
Is the procedure the same when HIV-positive patients are being referred to you from e.g. a GP or another hospital ward?
Are there specific problems in linkage to care from the CBVCT – compared to linkage from other test sites (GPs, other hospital wards, etc.)? If yes, how could it be improved?
Design a better service of HIV testing for migrants

Could you describe mobilization (if any) regarding the access to health of the migrants in your country?
Do you think migrant's populations in your country are well targeted regarding HIV testing? How could it be better?
What would an ideal service of HIV testing for migrants look like to you?
Would you say that the migrant community is involved in the process? How could it be better?
What do you think of cultural mediation? Could it be a good lever to improve access to HIV testing and linkage to care among migrants? Could you think of any other lever?
ENDING OF THE FGD

Annex C: Table with detailed characteristics of the study sample (N=49)

	Sex	Place of birth	Age	Job	Administrative status	Sexual orientation	Serological status	Partner/family	Arrival in the host country	Year of diagnostic	Place of HIV diagnosed
France											
ITW 1	W	Côte d'Ivoire	27	Worker	Application pending	Heterosexual	HIV+	In a relationship	[2-5[	2013	France
ITW 2	M	Benin	32	Worker	Residence permit	Homosexual	HIV+	Married	[2-5[	2012	France
ITW 3	M	Nigeria	35	Worker	Residence permit	Heterosexual	HIV-	Married w/ children	[5-10[
ITW 4	W	Mali	41	Unemployed	Citizenship	Heterosexual	HIV+	In a relationship	>10	1996	France
ITW 5	W	Cameroon	37	Worker	Residence permit	Heterosexual	HIV+	Married w/ children	[2-5[	2003/2004	Africa
ITW 6	W	Côte d'Ivoire	38	Unemployed	Undocumented	Heterosexual	HIV+	Children	> 2 years	2013	Africa
ITW 7	M	Côte d'Ivoire	60	Unemployed	Residence permit	Heterosexual	HIV+	Married w/ children	> 2 years	2015	France
ITW 8	M	Cameroon	45	Worker	Residence permit	Heterosexual	HIV+	Single	[2-5[	2006	Africa
ITW 9	M	Gabon	37	Unemployed	Application pending	Heterosexual	HIV+ IDU	Married w/ children	[2-5[	2015	France
ITW 10	W	Cameroon	46	Worker	Residence permit	Heterosexual	HIV+	Married	>10	2004	France
Spain											
ITW 1	M	Madagascar	22	Student	Residence permit	Homosexual	HIV+	In a relationship	> 2 years	2014	Madagascar
ITW 2	M	Mauritania	45	Unemployed	Application pending	Heterosexual	HIV+/HCV	Single	>10	1998	Spain
ITW 3	M	Argentina	25	Worker	Residence permit	Homosexual	HIV+	In a relationship	> 2 years	<1 year	Spain
ITW 4	TW	Brazil	26	Unemployed	Application pending	Other/unknown	HIV-	In a relationship	[5-10[
ITW 5	M	South Africa	33	Worker	Citizenship	Homosexual	HIV+	In a relationship	> 2 years	2015	Spain
ITW 6	M	Colombia	40	Worker	Residence permit	Homosexual	HIV+	Single	[2-5[	2005	Colombia
ITW 7	M	Egypt	24	Worker	Residence permit	Homosexual	HIV+	In a relationship	> 2 years	2014	Egypt
ITW 8	M	Italy	35	Worker	Residence permit	Homosexual	HIV+	In a relationship	[5-10[	2008	Spain
ITW 9	W	Italy	31	Unemployed	Residence permit	Heterosexual	HIV+/HCV	In a relationship	>10	2014	Spain

Denmark											
ITW 1	W	Zambia	47	Worker	Residence permit	Heterosexual	Unknown	In a relationship w/ children	>10	?	?
ITW 2	M	Ethiopia	38	Unemployed	Residence permit	Heterosexual	HIV+	Single	[5-10[	2006	Africa
ITW 3	M	Cameroon	30	Worker	Residence permit	Heterosexual	HIV-	Married w/ children	[5-10[
ITW 4	W	Burundi	44	Unemployed	Citizenship	Heterosexual	HIV-	Single w/ children	>10		
ITW 5	M	Ghana	29	student	Residence permit	Homosexual	HIV-	Married	>10		
ITW 6	M	Ghana	30	student	Residence permit	Bisexual	HIV+	Married w/ children	[5-10[	2004	Africa
ITW 7	M	Burundi	42	Worker	Citizenship	Heterosexual	HIV-	Single	>10		
ITW 8	M	Tanzania	73	Retired	Citizenship	Heterosexual	HIV-	Married w/ children	>10		
ITW 9	W	Uganda	32	Unemployed	Undocumented	Heterosexual	HIV+	Single w/ children	>10	2001	Denmark
ITW 10	W	Uganda/Rwanda	63	Retired	Residence permit	Heterosexual	HIV+	Single w/ children	>10	2000	Denmark
Belgium											
ITW 1	M	Burundi	62	Worker	Residence permit	Heterosexual	HIV+/HCV	Married w/ children	[5-10[	1998	Africa
ITW 2	M	Burundi	51	Unemployed	Citizenship	Heterosexual	HIV+/HCV	Single	>10	2004/2006	Belgium
ITW 3	M	Congo Kinshasa	60	Retired	Residence permit	Heterosexual	HIV-	Single	>10		
ITW 4	W	Congo Kinshasa	48	Worker	Citizenship	Heterosexual	HIV-	Single	>10		
ITW 5	M	Congo Kinshasa	51	Unemployed	Residence permit	Heterosexual	HIV+	Single w/ children	>10	2006	Belgium
ITW 6	W	Congo Kinshasa	40	Unemployed	Citizenship	Heterosexual	HIV+	Single	[5-10[	2002	Africa
ITW 7	W	Kenya	38	Worker	Residence permit	Heterosexual	HIV+	Married w/ children	[5-10[	2007	Italy
ITW 8	W	Burundi	31	Unemployed	Residence permit	Heterosexual	HIV+	Married w/ children	[5-10[	2011	Belgium
ITW 9	W	Congo Kinshasa	44	Worker	Citizenship	Heterosexual	HIV-	Married w/ children	>10		
ITW 10	M	Uganda	30	Unemployed	Residence permit	Heterosexual	HIV+	Single	[5-10[	2006	Africa

Portugal											
ITW 1	M	Nepal	27	Unemployed	Undocumented	Heterosexual	HIV – IDU	Unknown	[2-5[
ITW 2	W	Guinea-Bissau	49	Unemployed	Residence permit	Heterosexual	HIV+	Single w/ children	[5-10[
ITW 3	W	Guinea-Bissau	57	Worker	Residence permit	Heterosexual	HIV+ IDU	Single w/ children	[5-10[	2010	Africa
ITW 4	TW	Brazil	23	Unemployed	Undocumented	Other/unknown	HIV-	Unknown	[5-10[
ITW 5	M	Guinea-Bissau	42	Unemployed	Undocumented	Heterosexual	HIV+	Unknown	[2-5[		Portugal
ITW 6	M	Venezuela	53	Worker	Citizenship	Homosexual	HIV-	Single	>10		
ITW 7	M	Guinea-Bissau	23	Unemployed	Undocumented	Heterosexual	Hepatitis B	Unknown	[5-10[
ITW 8	W	Guinea-Bissau	50	Unemployed	Other	Heterosexual	HIV+	Unknown	> 2 years		
ITW 9	M	Cape Verde	55	Unemployed	Residence permit	Heterosexual	Hepatitis C IDU	Unknown	[5-10[
ITW 10	TW	Brazil	38	Worker	Citizenship	Heterosexual	HIV +	Married			

