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Original Article

Experiences of accessing HIV testing for migrants living in Denmark

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ABSTRACT

INTRODUCTION. About 40% of all new HIV cases in Denmark are migrants. Studies show that migrants are typically diagnosed several years after arriving in Denmark, indicating a worrying missed opportunity for testing. The aim of this study was therefore to explore the experience of accessing HIV testing among migrants living in Denmark.

METHODS. The study participants were recruited from April to July 2021 at the outpatient HIV clinics in the departments of infectious diseases at two large hospitals in Denmark. We included informants who were: 1) > 17 years, 2) born in Eastern Europe, Asia, Latin America or Africa, and 3) had tested positive with HIV after 1 January 2013 in Denmark. In total, 19 particpants were included. We conducted interviews based on a semi-structured interview guide and analysed them through thematic network analysis.

RESULTS. The study found that risk perception and stigma were important factors in seeking HIV testing among migrants. From the study, three pathways to diagnosis emerged: 1) feeling ill and seeking healthcare, 2) fertility or pregnancy-related screening and 3) routine HIV testing. Pathways differed considerably between men who have sex with men and heterosexual informants.

CONCLUSIONS. The study showed an increased need for provider-initiated testing to promote early diagnosis of HIV among migrants in Denmark. Structural policies and practices should be introduced to ensure this.

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TRIAL REGISTRATION. Not relevant.

In Denmark, approximately 6,700 people live with HIV. About 40% of all new HIV cases in Denmark are migrants [1]. Furthermore, late presentation is more prevalent among migrants than among locally born Europeans [2-4]. In Denmark, a study showed that late presentation was about twice as common among refugees and family reunified migrants as among Danish-born individuals [2]. Another Danish study found that migrants carried a higher risk of being late presenters than Danish-born people [3]. A large register-based nationwide study examining delays in HIV diagnosis and care among migrants living with HIV in Denmark found that they lived a median of 3.7 years in Denmark before being diagnosed, indicating a worrying missed window of opportunity for testing [5].

Testing requires knowledge about HIV risk, prevention and treatment, and access to testing points. A Swedish survey study of barriers to HIV testing among newly diagnosed individuals showed that migrants reported more barriers to HIV testing the longer they had resided in the country. The authors also found that individuals who were offered a test by their provider were less likely to report any barriers, structural or individual, to testing [6].

Among migrants, late presentation is often associated with fear of stigma, concerns about legal status and potential repercussions, experiences of racism, limited knowledge about HIV and difficulties accessing or navigating healthcare services [7, 8]. On the system side, late presentation may be related to a lack of targeted outreach activities and systematic testing opportunities after immigration. In Denmark, HIV screening is provided under an opt-in policy. The Danish Health Authority and international guidelines recommend that general practitioners (GPs) routinely offer HIV screening to people at high risk of infection [9, 10]. HIV screening is not offered systematically as part of the health reception of asylum seekers in Danish Red Cross asylum centres, and testing is only offered upon resettlement in the two largest municipalities as part of their local resettlement programmes [11]. Furthermore, AIDS Foundation Denmark provides anonymous HIV testing and counselling in several cities.

It is well documented that migrants are an especially vulnerable group at risk of being diagnosed with HIV at a late disease stage. Even so, there is a lack of studies qualitatively exploring migrants' experiences, studying what shapes their attitudes, and describing their test-seeking behaviour. This study aims to explore the experience of accessing HIV testing among migrants living in Denmark.

Methods

Participants

The study participants were outpatients recruited from April to July 2021 through the departments of infectious diseases at two large hospitals in different regions of Denmark. We included informants who: 1) were 18 years of age or older, 2) were born in Eastern Europe, Asia, Latin America or Africa [12], and 3) had tested positive with HIV after 1 January 2013 in Denmark. The latter criterion was employed to avoid recall bias.

Data collection

The interviews were conducted by phone (n = 8), video call (n = 7) or in person (n = 5). Two patients were recruited from Aarhus University Hospital; the rest, from Hvidovre Hospital. The interviews were conducted during the COVID-19 lockdown. We used a professional interpreter when needed. MCB conducted all 20 interviews. All interviews were audio recorded, except for one, where thorough notes were taken instead. Subsequently, the audio-recorded interviews were transcribed. One interview was excluded due to poor audio quality. Two informants had tested positive for HIV before our cut-off point on 1 January 2013. Since this only became apparent during their interviews, they were still included.

Interview guide

We conducted the interviews based on a semi-structured interview guide (Supplementary 1). The guide was structured as follows: sociodemographic background and migration history, experience of being tested for HIV, experience of starting treatment and previous test experiences. The AIDS foundation provided important feedback on the contents of the interview guide, which was then revised based on their input.

Analyses

Data were analysed using thematic network analysis [13]. Firstly, the text was coded into segments. Next, a thematic network of basic themes, organising themes and subsequently global themes, was constructed. Basic themes were constructed based on facilitators and barriers to achieving an (early) HIV test, and two global themes were derived.

Approvals and ethics

Ethical approval was obtained under the joint record of research projects of the University of Copenhagen (case no. 1993284/4242). All study participants received written and oral information about the study, and written informed consent was obtained before the interviews. In the few cases where obtaining written informed consent was impossible, the informants consented orally in the audio recordings, which were later transcribed.

Trial registration: not relevant.

Results

Table 1 shows characteristics of the informants. The different analytical themes are shown in **Figure 1**. Overall, the experiences of diagnosis differed considerably between heterosexual informants and informants who were men who have sex with men (MSM). The experiences of the two groups are unfolded below.

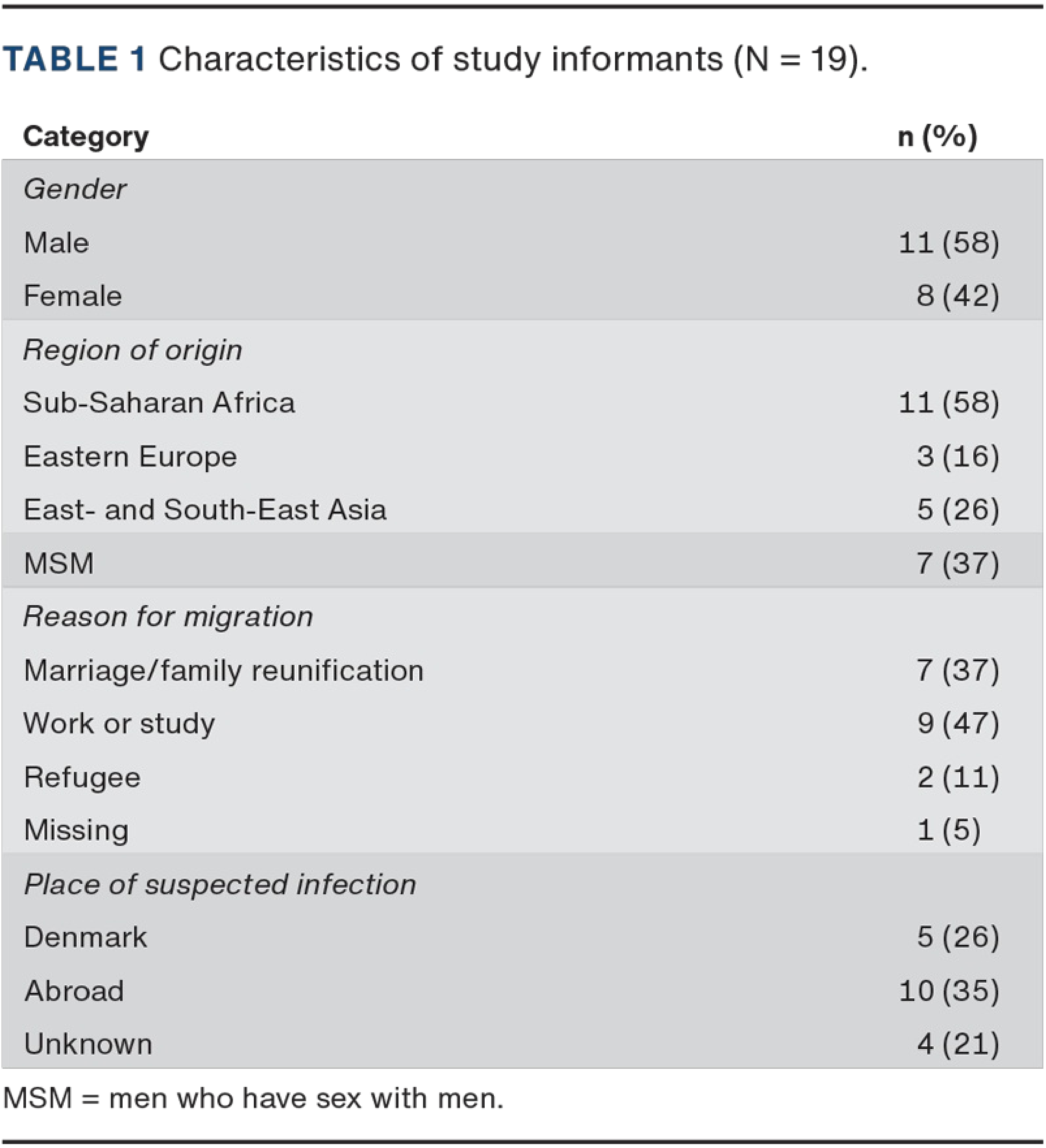
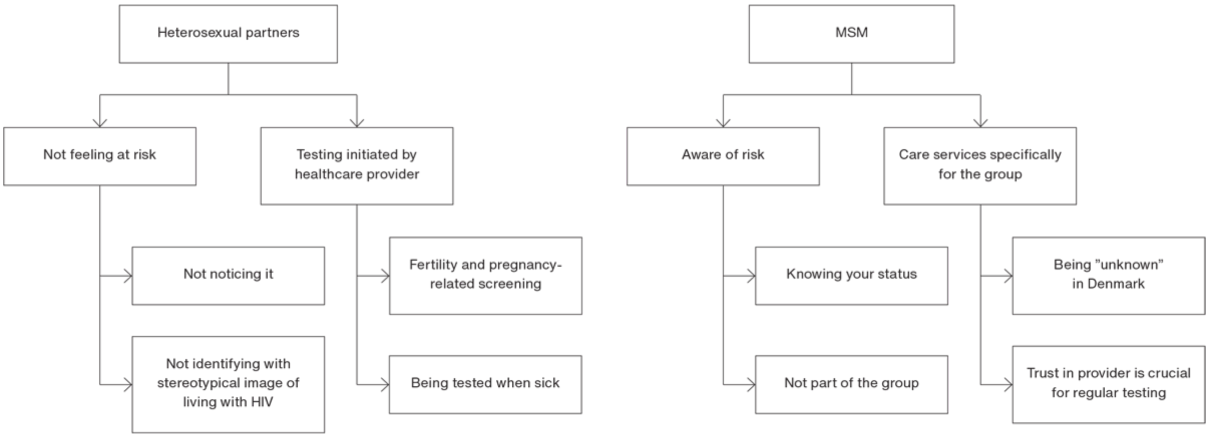


TABLE 1 Characteristics of study informants (N = 19).

Category	n (%)
Gender	
Male	11 (58)
Female	8 (42)
Region of origin	
Sub-Saharan Africa	11 (58)
Eastern Europe	3 (16)
East- and South-East Asia	5 (26)
MSM	7 (37)
Reason for migration	
Marriage/family reunification	7 (37)
Work or study	9 (47)
Refugee	2 (11)
Missing	1 (5)
Place of suspected infection	
Denmark	5 (26)
Abroad	10 (35)
Unknown	4 (21)

MSM = men who have sex with men.

FIGURE 1 Thematic network of analytical findings.



MSM = men who have sex with men.

Heterosexual informants

Heterosexual partners emerged as one global theme (see Figure 1) when analysing barriers and facilitators to early diagnosis and awareness of risk status. Heterosexual informants were either diagnosed through 1) fertility or pregnancy screening programmes or 2) when falling ill and therefore contacting their GP or being admitted to hospital.

Not feeling at risk

Not noticing it: Eight of the informants mentioned having little or no knowledge of HIV before receiving their diagnosis, and not having believed that they were at risk of acquiring it. Not knowing anyone living with HIV was also a barrier to seeking a test, since HIV was not considered an actual risk: *'[...] but if you don't have it around you, then you will never care about it, you will never care about it.' [10]*

Not identifying with their perceived image of living with HIV: Before being diagnosed with HIV, five informants described how they had a particular understanding, or even prejudice, about people living with HIV.

Another two informants also could not identify themselves as living with HIV. Their point of reference for a person living with HIV was a relative who was constantly, and visibly, ill.

Living with HIV could also conflict with an image of being strong, healthy and fit. One informant explained why it was difficult to reconcile himself with the fact that he was diagnosed with HIV: *'First of all, I am a really strong man, I have never... my family does not have any kind of diseases.' [14]*

Thus, the perceived traits of a person living with HIV constituted a barrier for the informants to seek HIV testing. They expressed a wish that other people's stories about getting HIV should be heard as a means of promoting being tested, since it would have been helpful for them to know that everyone can be affected by HIV.

Testing initiated by a healthcare provider

Fertility or pregnancy-related screening: Five informants tested HIV positive during routine pregnancy screening. Three of the informants were unaware that HIV was part of the pregnancy-related screening: *'She told us that she makes a lot of tests, but at the time I gave my blood, she didn't tell me that they would be looking for HIV and other sickness.' [2]*

Tested when falling ill: Seven informants fell ill and contacted their GP or went to the hospital for diagnostic investigations. Some of them were unaware of the exact diseases, including HIV, that they would be tested for. Many in this group suggested that being invited to a general health check-up, including an HIV test, may benefit those who do not consider themselves at risk and who therefore may not seek HIV testing themselves.

Men who have sex with men

MSM emerged as the second global theme (see Figure 1). This group was diagnosed through either 1) routine testing at their GP or an NGO-run clinic, or 2) when falling ill and contacting their GP or the hospital.

Awareness of risk

Knowing your status: Many informants in this group routinely tested for HIV due to their own perception of being at risk. Some of them explained that the main reason for requesting an HIV test was to know their status: *'The sex is all protected, right? But still, I went there regularly to check. I don't really know why, but basically you just want to go there and check your status... Just like you refresh on a computer.'* [9]

Not part of the group: One barrier to getting regularly tested was not identifying as part of a high-risk group. For example, one informant considered that getting HIV was more common in a part of the gay community that he did not relate to.

Care services specifically for the group

Being unknown in Denmark: For some informants, being new to, and therefore relatively anonymous in Denmark, facilitated HIV testing. One informant had never been tested in his home country because he did not perceive it as a common practice there. Another informant spent time reassuring himself that he would suffer no social consequences of being HIV-tested in Denmark, unlike his ex-partner, who had suffered major consequences in their country of origin: *'It's because...our government, our society, has no reason to let HIV people in. So, if someone was affected by HIV, then you cannot work at the university, you cannot work at a government place, and my ex-boyfriend cannot get a job because he tested HIV positive.' [5]*

Trust in the provider is crucial for regular testing: Even for those who tested regularly, the test experience was often characterized by feelings of fear and anxiety. The health providers here played an important role in making the informants feel comfortable. One informant shared her experience of having an assigned NGO counsellor: *'he showed some sympathy, and then she gave me the number to contact the doctor in the hospital and asked me to go for confirmation and ... yeah. And she also gave me a sort of... how do you call this... box, and that you can hold all your medicine in'* [9].

Discussion

Our study identified three pathways to diagnosis among migrants living with HIV in Denmark: 1) feeling ill and seeking healthcare, 2) fertility or pregnancy-related screening and 3) routine HIV testing. Pathways notably differed between MSM and heterosexual informants. Further, we found important barriers to and facilitators of access to HIV testing.

Regarding barriers to testing, many informants did not feel at risk of contracting HIV and therefore did not consider being tested. Low-risk perception constitutes one of the most important barriers to migrant MSM, or migrants having heterosexual sex, seeking HIV testing [15]. Second, informants in this study experienced fear of stigmatisation, and many of our informants articulated a wish for people around them to know more about HIV, thereby expressing a need for education to reduce stigma. Third, informants described how health professionals may create a safe testing environment and how their communication can feel confusing or even stigmatising. These experiences underline that health providers play a crucial role in facilitating testing and diagnosis. Indeed, studies have demonstrated that provider-initiated testing is beneficial in increasing diagnoses. A US study found that only 58% of participants were offered an HIV test by their provider, and that 96% of those were tested [16]. A study among migrants in Amsterdam showed that among those who had experience with being HIV tested, only 28% requested it themselves [17].

Concerning pathways to diagnosis, studies have shown that most individuals who test positive for HIV have had multiple contacts with the healthcare system in the years leading up to their diagnosis [18, 19]. In a Danish study, migrants had a median of ten (men) or 13 (women) primary care visits in the three years before their HIV diagnosis [19]. Belgian GPs identified numerous barriers to offering HIV testing, including personal discomfort, limited knowledge of the benefits of early HIV diagnosis, misconceptions about HIV risk and lack of guidelines and time [20]. A systematic review of the effectiveness of HIV screening among migrants in the EU/EEA suggests that voluntary rapid testing, including provider-initiated testing, may potentially increase uptake [14]. Further, national and international guidelines recommend testing for HIV among persons originating from high-risk countries [9, 10]. However, our findings show that migrants are often diagnosed several years after their arrival, suggesting a lack of implementation of guidelines. For asylum seekers in Denmark, the reception facilities should routinely screen for HIV on a voluntary basis; and for other groups of migrants, such as quota refugees, family reunified or migrant workers, GPs should also routinely offer screening. Both health professionals at reception centres and GPs may, however, need educational efforts initiated by national authorities to raise awareness of their responsibility for implementing guidelines in practice.

Our study has several limitations. First, most participants were recruited from a single department of infectious diseases. We could potentially have provided further insights by including patients from other hospital departments or non-hospital sites. Second, the study was conducted during the pandemic. This may have resulted in fewer newly diagnosed participants due to healthcare-seeking delay. Third, our participants only included a minority of patients with a migrant background who were diagnosed with HIV during the inclusion period. Accordingly, we exercise caution in drawing general conclusions. Nonetheless, efforts were made to ensure gender representation, and the diversity observed in diagnostic trajectories reflects variations in gender, sexual orientation and migration experience. Lastly, we did not register those who chose not to participate and therefore do not know if or how they differ from our participants. However, our observations indicated that the majority agreed when asked.

Conclusions

The study identified various pathways to HIV diagnosis, highlighting that risk perception and stigma were important factors for testing. The study identified a need for increased provider-initiated testing to promote early HIV testing among migrants. Structural policies and practices should be introduced to ensure this.

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