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*Corresponding author: Agnes Ebotabe Arrey, Mental Health and Wellbeing Research Group, Faculty of Medicine and Pharmacy, Department of Public Health, Vrije Universiteit Brussel, Brussels, Belgium

E-mails: aarrey@vub.ac.be,
agnes_arrey@yahoo.com,
agnes.arrey@gmail.com

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PUBLIC HEALTH | RESEARCH ARTICLE

A qualitative study of the perspectives of Sub-Saharan African migrant women with HIV/AIDS and their caregivers on treatment and care in Belgium

Agnes Ebotabe Arrey^{1*}, Johan Bilsen¹, Patrick Lacor² and Reginald Deschepper¹

Abstract: HIV treatment may be less effective as a prevention option when HIV patients especially migrants encounter difficulties in accessing treatment and care even in resource-rich settings. This paper explores perspectives of HIV-infected Sub-Saharan African (SSA) migrant women and their caregivers on HIV treatment/care in Belgium. We conducted a qualitative study between April 2013 and December 2014. We included HIV-infected SSA migrant women and their caregivers providing treatment and care in a university teaching hospital in Belgium. Data was analyzed using thematic analysis. A total of 44 patients and eight HIV healthcare providers were included in the study. All participants acknowledged the availability and accessibility to free treatment that contributes to long-term survival if treatment is adhered to. Women with uncertain immigration status and unstable housing reported difficulties in obtaining treatment/care and the fear of discontinuity if deported to their country of origin. Free, available and accessible healthcare remains paramount and makes living with HIV/AIDS tolerable despite the chronic nature and seriousness of the disease. HIV/AIDS SSA women believe that adhering to antiretroviral therapy increases longevity; greatly improve quality of health and restores self-esteem. Barriers to obtain care for the undocumented may have dire consequences on public health.

ABOUT THE AUTHOR

Agnes Ebotabe Arrey received a PhD in Social Health Sciences from the Vrije Universiteit Brussel. She has a master's degree in Business Administration, International Politics and Culture and Development Studies. She also holds postgraduate diplomas in Entrepreneurship and New ventures and International Educating. Previously, she studied law in Cameroon. Her research focus is on social issues for women and migrants with HIV and AIDS. She has experience in qualitative ethnographic research focused on the experiences of Sub-Saharan African migrant women living with HIV/AIDS in Belgium. She hopes to build actively on the foundations of her doctoral degree by pursuing postdoctoral research that focuses on social and behavioural change that will lead to stigma reduction and improved mental health for women living with HIV/AIDS.

PUBLIC INTEREST STATEMENT

The paper highlights the perspectives of Sub-Saharan African (SSA) migrant women and their caregivers on treatment and care in Belgium. The study elicited general perspectives through two scenarios namely: availability and accessibility to free treatment to SSA migrant women with legal immigration status and the uncertainty of access to treatment and care for the undocumented SSA migrant women. The paper demonstrates that increased availability and free access to treatment and care has greatly contributed to decreasing AIDS-related deaths, improve quality of life and makes living with HIV/AIDS tolerable despite its seriousness as a disease if treatment is adhered to. In general the participants deplored the barriers to obtain care for the undocumented set by the Belgian government. Of interest, however, is the finding that adhering to treatment enabled the SSA migrant women to return to normality while living with the hope that a cure for HIV will be found.

Subjects: AIDS & HIV; Cultural Studies; Development Studies; Gender & Development; Health & Society; Health Conditions; Mental Health; Public Health Policy and Practice; Sexuality - Gender Studies; Women's Studies

Keywords: African migrant women; HIV/AIDS; HIV treatment/care; Belgium

1. Introduction

HIV/AIDS is a significant public health issue in the European Union (EU) (WHO/ECDC, 2015) and HIV prevalence in the 27 member states differs substantially, ranging from 0.2 to 0.7%. There has been an overall 80% increase in new diagnoses in 2013 as compared to 2004 (European Centre for Disease Prevention & Control, 2014). Though great steps have been made in combating HIV/AIDS globally (Venkatesh, Mayer, & Carpenter, 2012) and in Europe (Jansson, Wilson, Carr, Petoumenos, & Boyd, 2013) with antiretroviral therapy (ART) and other preventive methods (Crepaz et al., 2006), new HIV cases are still being reported, especially among certain populations like men having sex with men (MacCarthy, Brignol, Reddy, Nunn, & Dourado, 2014) and migrants from high-prevalence and low-resource countries (Shivaji, Diniz, & Cortes-Martins, 2014). In 2007, the right to HIV/AIDS prevention, treatment, care and support for migrants and ethnic minorities was reiterated at a conference on HIV and migration (European AIDS Treatment Group, 2007). Additionally, the WHO Europe and UNAIDS progress report on Dublin Declaration commitments (updated in 2013) identified migrants as particularly vulnerable to HIV, (European Center for Disease Control, 2004) especially with the rising wave in migration.

Europe is experiencing dynamic migration flows not only for humanitarian reasons but also for labour, studies and family reunification purposes (Frederiksen, Kamper-Jorgensen, Agyemang, Krasnik, & Norredam, 2013). Migrant populations also differ within the states, depending on historic, geographic and economic factors (European Centre for Disease Prevention & Control, 2009). Most migrants may be susceptible to pre-migration risk factors as many originate from similar geographical and economic settings (Warfa et al., 2012), with healthcare systems different from those of their host countries (Beasley, Starfield, van Weel, Rosser, & Haq, 2007). Documented and undocumented migrants' access to healthcare varies across countries in Europe (Allan & Clarke, 2005; Jensen et al., 2011; Norredam, 2011).

Anecdotal evidence suggests that Sub-Saharan African (SSA) migrant women with HIV/AIDS receiving treatment and care in Western European countries associate their longevity and relatively good quality of life with the availability, accessibility and quality of healthcare as compared to their counterparts in SSA (Bezabhe et al., 2014). Belgium is one of the EU states that provide free access to quality treatment and care to legal residents living with HIV/AIDS (Sasse, Van Beckhoven, & Verbrugge, 2014). In Belgium, the cost of HIV healthcare is mainly covered by national health insurance. This system makes expensive treatment of most chronic illnesses like diabetes, cancer and HIV available to patients. In 2013 there are about 13,941 HIV-infected people receiving medical care in Belgium, of whom about 35.4% ($n = 4,879$) were SSAs. About 23.7% ($n = 3,307$) of the 35.4% were African women. It is also very pertinent to note that of the 5,065 women in medical care in Belgium in 2013, 3,307 were SSA women, showing the extent of the disease among this population and why it is vital to research on this group (Sasse et al., 2014).

Relatively, little is known about the perceptions of SSA migrant women and HIV care providers on access to treatment and care in Belgium. To examine this issue, results were pooled from a larger study describing the experiences of living with HIV/AIDS among SSA migrant women. This paper explores perceptions of HIV-infected SSA migrant women and their caregivers on HIV treatment/care in Belgium.

2. Methods

2.1. Ethical statement

The study was approved by the Ethics Committee (EC) of the Universitair Ziekenhuis Brussel, Belgium (Approval number B.U.N. 143201215911) and the Institutional Review Board (IRB) of the Institute of Tropical Medicine, Antwerp, Belgium (Approval number IRB/AB/ac/141). Participation was voluntary. The approved informed consent form made provisions for participants to include names, contact addresses and signatures if they agreed to participation. Following the confidentiality section on the approved informed consent form, participants could opt not to give contact addresses or withdraw from the study without fear of repercussion on treatment and care. All identifiers were removed from the text. There were no financial incentives to the patient. Neither the participants nor the researcher were exposed to unnecessary risk. Due to the sensitive nature of the study, the audio-recordings and transcripts are stored and data cannot be made public for ethical restrictions protecting participant confidentiality.

2.2. Study design and sample

A qualitative study consisting of semi-structured interviews, observations and basic information from hospital records as to socio-demographic characteristics of patients was conducted. The purpose of the study was to describe, from the point of view of HIV-infected SSA migrant women and their caregivers, access to HIV treatment/care in Belgium. The research took place between April 2013 and December 2014.

Patients were included in the study if they were aged 18 or above, SSA women, English or French-speaking and receiving treatment and care in any AIDS Reference Centre (ARC) in Belgium. Patients were recruited through purposive sampling from the consultation lists in a large Brussels AIDS Reference Centre (ARC) and snowball techniques. Eligible participants were purposively recruited and informed about the objectives of the study by healthcare professionals in a large Brussels ARC. In addition, women attending AIDS workshops in Brussels were approached by the first author during coffee breaks and invited to participate in the study. These women in turn introduced other women they believed would agree to participate. Interviews were then arranged at a place selected by each participant. The patients' anonymity was assured and they could withdraw from the study at any time. Refusal to participate had no influence whatsoever on the standard of care that the patients were receiving.

The recruitment of the HIV healthcare providers was done through verbal invitations by the first author. Interview date and time was arranged by each care provider. All participants gave oral permission for interviews to be recorded.

2.3. Data collection

In-depth semi-structured interviews were conducted with an interview guide of the main themes including elements related to access to treatment and adherence to treatment for longer term survival. Emerging themes relevant to the purpose of the study were followed up during interviews. The study objectives were explained to all participants and informed consent forms were signed by patients. Interviews were audio-taped. HIV experts at ARC were also interviewed to add insight into the women's perspectives on treatment and care in Belgium.

Observations were conducted during patients' consultations with HIV treating physicians. Notes were taken as to what was observed and heard during sessions. The first author also obtained permission from participants to be present during consultations.

Hospital records provided basic additional information like age, country of origin (left out for purposes of anonymity) and year of diagnosis to complement data.

2.4. Data analysis

Thematic analysis was conducted to identify themes rooted in the basic principles of grounded theory (Glaser & Strauss, 1967). Tape-recorded interviews were transcribed by the first author. The transcripts from the interviews and notes from the observations were read by the first author to identify patterns of words or statements related to the focus of the study. The transcriptions were then coded and categories were constructed grounded on data (Braun & Clarke, 2006; Hennink, Hutter, & Bailey, 2011). Information from data collection was constantly compared to emerging categories during the analysis phase (Creswell, 2013; Glaser & Strauss, 1967). Categories were then formed from the groups of words or statements. The categories were then analysed to identify themes reflecting the findings within data. Data analysis occurred concurrently with each new data collection in order to understand emerging themes. This iterative process of data collection and analysis eventually led to a point where no new themes emerged (saturation) (Creswell, 2013).

For this study, some basic principles of grounded theory were applied to inductively derive results following an iterative data collection-data analysis in using thematic approach recommended by some authors (Braun & Clarke, 2006; Frost et al., 2010; Pettigrew, 2000). The basic principles of grounded theory are used because they provide flexibility, analytical rigour in interpreting qualitative data. Some underlying principles of grounded theory include: the circular process of data analysis, use of verbatim transcripts, linkage between data collection and analysis, inductive construction of concepts grounded in data, constant comparison and the development of explanatory frameworks or theory (Miles & Huberman, 1994).

To increase the reliability of the study, the analysis was cross-checked and discussed with co-authors (Braun & Clarke, 2006). Moreover, the authors reviewed the text several times in an attempt to avoid misinterpretation of individual themes. NVivo 8 was used to aid data management.

3. Results

3.1. Study participants

Table 1 presents the socio-demographic characteristics of 44 women aged 20–67 years receiving treatment and care in any ARC in Belgium. Eight HIV experts (five doctors, HIV therapist, a psychologist and a social assistant) at a Brussels—based ARC were also interviewed. In addition, we conducted eight participant observations where notes were taken of what was heard and observed during patient consultation with doctors. More than half of the participants had completed high school and only one had no formal education. They could all speak English or French and there was no need for an interpreter. The main themes that emerged from the data were free access to treatment and care; adherence to treatment for long-term survival; strong belief that God can cure HIV and influence treatment pattern and uncertain immigration status and unstable housing.

3.2. Access to free treatment and care

In this study, all participants reported not having to pay for treatment and care directly linked to HIV/AIDS infection. Participants reported only paying for non-HIV medications like vitamin supplements or blood-enhancing pills. A woman indicated:

Table 1. Characteristics of patient participants (N = 44)^a

Characteristics	Variable	Frequency	%
Origin	Known SSA countries	15	–
	Unknown SSA countries	7	–
	Born in Belgium	–	–
Age range (in years)	20–29 years	5	11.3
	30–39 years	11	25
	40–49 years	15	34.1
	50+ years	13	29.6
Education	University	12	27.2
	High school	9	20.4
	Secondary school	17	38.7
	Primary school	1	2.3
	None	1	2.3
	Unknown	4	9.1
Civil status	Married	24	54.6
	Single with partner	11	25
	Single/widowed without partner	9	20.4
Reported mode of transmission	Heterosexual	38	86.3
	Homosexual	0	0
	Service-related	1	2.3
	Perinatal	1	2.3
	Unknown	4	9.1
Probable place of infection	Belgium	5	11.4
	Country of origin	39	88.6
Knowledge of HIV status	Before leaving Africa	9	20.5
	In Belgium	35	79.5
Years living with HIV/AIDS	0–10 years	12	27.2
	10 years and above	32	72.8
Employment status	Employed	23	52.2
	Unemployed/jobseekers	13	29.6
	Retired	4	9.1
	Disability	4	9.1
Have children	Yes	35	79.5
	No	9	20.5
Reproductive intentions	Pregnant while on ART	14	34.1
	Fertility desires	6	13.7
	No desire for children	1	2.3

(Continued)

Table 1. (Continued)

Characteristics	Variable	Frequency	%
Support group adherence	Members	19	43.2
	Non-members	25	56.8
Reported religious affiliation	Christians	42	95.5
	Moslems	2	4.5
Safe sex (condom usage)	Always use condom	13	29.6
	Use condom to prevent pregnancy	3	6.8
	Never use condom	28	63.6
Sexual activity	Sexually active	31	70.4
	Complete abstention	7	15.9
	Interruption of sexual activities	6	13.7
Intimate partner HIV status	Positive	12	27.3
	Negative	21	47.7
	Unknown/No intimate partner	11	25

^aThis table presents characteristics of patients who were interviewed. All the women were on antiretroviral therapy at the time of the study (100%).

The [HIV] medications are very expensive but the state pays for the treatment and care for everyone who is HIV infected. Until now, I have taken my medications without paying a cent. (Participant 5, age 39)

Participants also indicated that good HIV treatment and care has improved their quality of life and made it possible for them to live with HIV as with any other chronic disease. The progress in research and hope for more effective treatment was echoed by a participant:

Honestly, I have hope in medicine. There are times that I forget that I am HIV infected. It's [HIV] just like the other chronic illnesses that I have. I have been on medications for the past 12 years. Life continues with medications. (Participant 21, age 65)

Living in a healthy and clean environment was reported by many women as necessary for good quality of life in addition to medical treatment, as one woman said:

Here, [in Belgium] I'm fine. I don't pay for HIV/AIDS therapy and I can afford to provide and eat healthy food because taking only HIV medications is not enough. You have to eat well and think positive. (Participant 2, age 43)

A similar reflection was made by another woman:

We live in a healthy environment as compared to most women with HIV/AIDS in Africa. Here in Belgium the social insurance fund covers the cost of the medications. In Africa, not all patients have free access to HIV treatment. My cousin in Africa had HIV and she could neither afford the treatment nor sustain her feeding. She had tuberculosis and died one year later. I had tuberculosis too but I was cured. (Participant 3, age 50)

Many participants also reported that they could get their medications from their pharmacists with whom they had built up a rapport, and later presented a valid prescription from their treating doctors. In addition, the first author observed and listened to a participant who asked for a prescription from her HIV physician during a consultation for medications she had already bought from her pharmacist.

3.3. Adherence to treatment for long term-survival

To a majority of the participants, staying on treatment is very important. Self-reported treatment adherence dominated the narratives of most participants.

I take my medications as instructed by the treating physician and pray. HIV is like cancer, diabetes, hepatitis and I am living with HIV like anyone living with these chronic diseases. (Participant 15, age 45)

There was also a strongly-held belief among all interviewees that the treatment and care they receive has greatly contributed to their wellbeing and longevity since they were diagnosed HIV positive. A woman commented:

I was diagnosed HIV positive in 1987. At that time I thought I was going to die within a short period of time. Here am I, 27 years later, still living and active despite some emotional and health issues. (Participant 27, age 49)

There was also a wide range of views relating to decisions as to when to start treatment. Some said they wanted treatment immediately after diagnosis like this participant:

I was really afraid when I was diagnosed HIV positive, especially as back in Africa I saw so many people die of AIDS. I was advised to go to the HIV clinic where I could get medications. I wanted medications immediately on my first my consultation at the HIV clinic. On that day, I asked the doctor if I could start taking the medications immediately. The doctor told me that some blood samples have to be taken and analysed to see if it was necessary or not to start treatment. I was in great fear while waiting to start treatment. If I was still in Africa, I might have been dead. Here, I'm fine because I know that the medications I take prevent the occurrences of other illnesses that can kill me. I know that the doctors are there and I go for medical check-ups every three or four months and that gives me peace of mind. My partner reminds me when to take my drugs. (Participant 16, age 45)

Some women reported delaying treatment decisions because they were in denial of their HIV+ status, as this woman comments:

I rejected the diagnosis and refused to go to the clinic for treatment. I said "if I go to the hospital, I might meet people and my HIV status will be disclosed". I had to run away from people. I was hiding and did not want to accept and start treatment. I was still not on treatment after the birth of my first and second babies. The birth of my third child made me to realize that I had to accept my HIV+ status and start treatment because my CD4 was very low. (Participant 32, age 35)

The decision to start treatment was mostly made by the doctors, as this woman reported:

My HIV diagnosis was confirmed in Belgium but the doctor did not put me on medications till a year later. We receive special medications and have good follow-up here [in Belgium]. (Participant 19, age 52)

Most participants reported that ART enable them to return to normality while living with the hope that a cure for HIV will be found. A participant said:

Now I live normally though the virus is ever present in my head. Research has succeeded in controlling HIV but it still needs to find a cure. I would like to see a cure before I die. (Participant 3, age 50).

3.4. Strong belief that God can cure HIV

Many participants reported strong belief that God can cure HIV and influence treatment pattern. Staying on treatment was motivated by their beliefs that a miracle will happen and they will be cured of HIV as indicated by a woman:

When I was diagnosed HIV-positive 10 years ago, I asked the doctor if there was treatment. The doctor told me that there was treatment but no cure. I told the doctor that I will be cured in the name of Jesus Christ ... If I'm with my God, I will be cured ... Less than 6 months after starting treatment, I was told that I was already below 50 ... the doctor asked if I was on alternative treatment ... It was my prayers ... The doctor advised me to continue taking my medications. As Christians, we are not ill. I eat well and take my medications. (Participant 18, age 57)

A few cases of not adhering to treatment because of patients' belief for a miracle were indicated by some HIV experts. One said:

A patient who had been invited twice to participate in the study does not adhere to treatment. This patient refuses treatment, believing that a miracle will happen and she will be cured of her illness. Her CD4 is very low since she went off medications. The patient has not yet accepted the diagnosis and believes that she is better off medications, which makes her sicker. Her not adhering to her treatment results in very low immunity, putting her life at risk. (HIV physician)

Similarly, a participant reported being discouraged by her former husband from taking her medications on the basis that God will cure her of her disease. She explained:

He always wanted me to pray and fast without my medications. This was a source of tension between us because I told him that I could not survive without my medications. This tension contributed to our divorce. (Participant 23, age 31)

3.5. Uncertain immigration status and unstable housing

Strikingly, some participants with precarious legal status evoked the uncertainty and difficulty in getting their HIV/AIDS therapy, making adherence difficult with a risk of disease progression as indicated by a participant:

It is always a problem when you don't have legal papers to stay in the country. I was given papers to stay and they were later withdrawn and I was asked to go back to my country with the claim that HIV therapy is available to patients there. I was told that I will not be given medications because I was asked to leave Belgium. (Participant 21, age 65)

This concern of the undocumented HIV/AIDS patients was highlighted by a social nurse:

My biggest concern is for them to have the authorization to have their medications from the social service of the local government ... Sometimes I don't have the time to know how they are feeling because of the urgent need to do the paperwork for them to have their medications. It takes a lot of time to call the social services and if they refuse, you have to call organizations that can help or call a lawyer. It takes a lot of time but you want to be sure that when they start their medications they don't need to interrupt their therapy because that is very bad. (Interview with social nurse)

Participants with illegal status also linked their treatment adherence to their unstable housing as reported by a participant:

I don't have a fixed place to stay. I go to homeless shelters during the night to sleep and have to leave in the morning. Sometimes I miss my doses because I have to move or don't have food to eat. Taking medications as the doctor asked is not possible for fear of other shelter occupants discovering that I am HIV positive' (Participant 24, age 60)

This concern was reiterated by a social nurse:

There was a time when they had a lot of medications to be put in the refrigerator and that was difficult for many patients, especially those with housing problems. When they were staying with friends, they would not put their medications in the refrigerator because somebody would see it. Now they can really hide their medications ... It is good when they have a stable place to stay and you know that the social service has agreed to cover the cost of housing and treatment ... It's not always that easy. It [ART] is a very expensive therapy and many city councils refuse to cover the cost of the treatment. Once you get a social service that accepts a patient, and wants to pay for the medications, you have to keep that patient in that locality ... (HIV social nurse at an important HIV centre in Belgium)

4. Discussion

This paper explores perspectives of HIV-infected SSA migrant women and their caregivers on HIV treatment/care in Belgium. Our study revealed that SSA migrant women and their caregivers associate the availability of and free access to treatment and care as well as treatment adherence with their long-term survival and wellbeing after a positive HIV diagnosis. This is consistent with other studies (Wasti, Simkhada, Randall, Freeman, & van Teijlingen, 2012). Interestingly, this study highlights the positive combination of belief in God and HIV treatment. Conversely, we also found out that some patients abandoned their treatment because they believed in divine intervention for the cure of HIV. Additionally, uncertain immigration status and access to HIV treatment and care were major concerns raised. Overall, SSA women with HIV/AIDS believe that the tailored treatment and care they receive contributes to prolonging their lives and restoring their self-esteem, as they are better able to take care of their health and other basic needs.

Although this study provides important insights into the perceptions of SSA women on HIV treatment and care, some limitations need to be considered. Firstly, the origin of the first author, herself an African migrant, might have contributed to the reluctance of many patients to participate in the study of a sensitive topic like HIV/AIDS and among people from similar origin. Secondly, the fear of breach of confidentiality might have prompted many participants to refuse to give interviews or be observed. Disclosure concern might have been exacerbated by their prior awareness of stigma and discrimination related to HIV/AIDS. Distrust of the diaspora in Belgium was also reported as a reason for refusing to participate in the study. Thirdly, the researcher was limited to the narratives of the participants who might have chosen how to frame their answers in view of concealing certain information related to treatment adherence. Finally, we acknowledge that those who agreed to participate may have had different perceptions from those who did not, creating a selection bias (Pannucci & Wilkins, 2010), which may also limit generalization of our findings (Muhib et al., 2001).

Despite these limitations, the qualitative approach consisting of interviews, participant observations and information from hospital records allowed for a deeper understanding of the study (Reeves, Kuper, & Hodges, 2008). Additionally, this study is the first to highlight the perceptions of SSA migrant women and their caregivers with regards to their long-term survival with HIV/AIDS due to the free treatment and care received. The study also provided an insight into the uncertainty and precarious conditions of immigrants with HIV related to treatment and care in Belgium. In future research it would be valuable to investigate the barriers to and facilitators of HIV treatment among this group of women.

Participants believe that increased availability and free access to treatment and care has greatly contributed to decreasing AIDS-related deaths and improved the quality of life of participants, in line with other studies (Montaner et al., 2014). The participants received personalised care depending on their specific health conditions and HIV treating physicians were better able to monitor treatment evolution and side-effects. Access to modern treatment and care motivated them to continue exercising their real life activities like working, caring for their families and generally experiencing a positive and productive life. The environment where they are now living fosters HIV/AIDS prevention through available and accessible modern healthcare services. Additionally, there was the hope that a cure will be found as summarised in the words of one participant:

Our results further demonstrated the contribution of treatment adherence to long-term survival among several study participants. Several participants (78.2%) have been living with HIV/AIDS for more than 10 years and as long as 27 years. The most striking of all are participants who were diagnosed HIV positive in the 1980's and were still in apparent good health at the time of the study. Furthermore, this study reveals two main benefits of treatment adherence. Firstly, at the individual level, adhering to treatment has the benefit of lowering the risk of virus transmission to non-infected partners or infants at birth. Secondly, there are public health benefits of reduced HIV transmission and decreased HIV cost. Consistent with previous research, this study also revealed that strong religious/spiritual beliefs could enhance better treatment adherence for some patients (Kremer, Ironson, & Porr, 2009) and on the other hand foster non-adherence that could be deleterious to survival, quality of life and general wellbeing for others (Gwadz et al., 2014).

Despite being positive about treatment and care received, there is the dilemma of universal access to HIV treatment and care. At the global, European level and national level, there are considerable bottlenecks for the implementation of HIV treatment universality. In our study, participants with uncertain immigration status remain pessimistic and raise the challenge of the continuity of treatment and care in the current legal system applicable in Belgium. This "selective access to treatment" is contrarily to the Dublin Declaration that recognises migrants as vulnerable to HIV and should not be excluded from treatment and care in their host countries, irrespective of their legal status (European Center for Disease Control, 2013). All persons are entitled to treatment and care as stipulated in the United Nations Declaration of Human Rights and reiterated by the European Centre for Disease Prevention and Control (2009), the European AIDS Treatment Group (2007) and recently, the Belgian HIV Plan (Belgian Federal Ministry of Health, 2015). The controversy of excluding undocumented HIV patients from free access to treatment and care available in Belgium had been discussed by HIV treating physicians, activists, media and researchers (Demeester & Legrand, 2014). The findings further highlight the link between legal status and access to antiretroviral therapy for migrants living with HIV/AIDS in Europe (Fakoya, Reynolds, Caswell, & Shiripinda, 2008; Jensen et al., 2011; Marsicano et al., 2014; Norredam, 2011; Warfa et al., 2012). Refusing HIV/AIDS treatment is dangerous not only to the patient, but also to the family and public health in Belgium as well as in other EU states that refuse HIV/AIDS treatment and care to the undocumented migrants, considering the existing free movement agreement of persons within the European Union states (Jensen et al., 2011; Keygnaert, Vettenburg, Roelens, & Temmerman, 2014).

Although treatment is available, our study highlighted that fact that valid residency in Belgium is a prerequisite for treatment eligibility (Demeester & Legrand, 2014). The fear of being sent back to their countries of origin where access and availability might not be guaranteed was present among undocumented migrant women in the study. Although access to antiretroviral therapy (ART) has gradually improved over the past decade in most SSA countries, only about seven million of the more than 23 million people with HIV/AIDS had access to ART in 2012 and people with no access accounting for almost 70% of all new HIV infections (World Health Organization, 2014). In addition, the fear of stigma and discrimination in their respective families and communities if their HIV+ status is known upon return was revealed by study participants, consistent with previous studies (Hatzenbuehler, Phelan, & Link, 2013).

Interestingly, the study revealed that undocumented participants with precarious housing found it more difficult to adhere to HIV treatment, engendering negative health outcomes for women with HIV/AIDS and public health, consistent with previous studies (Ehmsen, Biswas, Jensen, Krasnik, & Norredam, 2014; Frederiksen et al., 2013; Mladovsky, Ingleby, McKee, & Rechel, 2012). We documented perceived stress and anxiety over housing insecurity from the narratives of the participants concerns, similar to findings in previous studies where correlations between sustainable housing, treatment adherence and the health of people living with HIV/AIDS have been shown to impact treatment adherence (Milloy, Marshall, Montaner, & Wood, 2012).

Nonetheless, some misunderstandings exist about free HIV-related treatment and care in Belgium as perceived by many. Most SSA migrant women in the study living with HIV/AIDS do believe that they get their HIV medications for free but in reality their medications are paid for through the

Belgian health system of compulsory contributions to the insurance fund (Gerken & Merkur, 2010). This system is characterised by solidarity between the rich and the poor, including those who are not HIV infected, to contribute to the wellbeing of the infected. This system also allows the vulnerable and the poor access to HIV/AIDS treatment and also freedom of choice of physicians and hospitals. For optimal treatment and care, HIV/AIDS patients can change from one hospital to another without fear of repercussions (Gerken & Merkur, 2010).

5. Conclusions

Free treatment as practiced in Belgium is considered an effective way to reduce the spread of HIV and to enhance wellbeing, a policy that might be adopted by other countries too. SSA migrant women believe that available and accessible treatment and care makes living with HIV/AIDS in Belgium tolerable despite the chronic and serious nature of the disease. The HIV treatment and care dispensed improve the quality of health and restore self-esteem in HIV/AIDS infected SSA women. However, from the findings of our study we do recommend that every HIV/AIDS-infected SSA migrant woman **regardless of her legal status in Belgium** should be provided free treatment and care in order to prevent the spread of new HIV infections and a human right to treatment and care (Belgian HIV Plan). Specific culture-centred behaviour change messages to SSA migrant women/men, other vulnerable groups with HIV/AIDS and the general public is imperative to achieve better health outcomes. Treatment as prevention will not only be beneficial not to the individual, but to the general community as well.

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Competing Interests

The authors declare no competing interest.

Author details

Agnes Ebotabe Arrey¹
E-mails: aarrey@vub.ac.be, agnes_arrey@yahoo.com, agnes.arrey@gmail.com

ORCID ID: <http://orcid.org/0000-0002-1118-7400>

Johan Bilsen¹
E-mail: johan.bilsen@vub.ac.be

Patrick Lacor²
E-mail: patrick.lacor@uzbrussel.be

Reginald Deschepper¹
E-mail: rdeschep@vub.ac.be

¹ Mental Health and Wellbeing Research Group, Faculty of Medicine and Pharmacy, Department of Public Health, Vrije Universiteit Brussel, Brussels, Belgium.

² Department of Internal Medicine and Infectious Diseases, Universitair Ziekenhuis Brussel, Brussels, Belgium.

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