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Dealing with denialism undocumented migrants and suspicion of service providers - Greece

What was the issue?

J, a Nigerian man, presented at a Checkpoint to get an HIV test with clear symptoms of AIDS. After questioning, it emerged that he had been diagnosed a decade earlier but told by a pastor not to take medication because Jesus would save him.

Why was change needed?

The blood tests and an MRI scan showed that J had toxoplasmosis, meningo-encephalitis and quite possibly leukaemia. He also had black, mole-like marks on his body. All these were signs of AIDS. Without urgent treatment, J was likely to die.

What were the barriers to change?

J was extremely reluctant to disclose his medical history, though records showed that he had been diagnosed at the same clinic ten years previously and had also been hospitalised and re-diagnosed nine months before with pneumonia. He was reluctant to abandon the beliefs his faith had led him to. He also had no insurance, no legal papers or passport and had not applied for asylum. He was deeply suspicious of the authorities.

How long did change take and who was involved?

Following his reactive rapid test at the Checkpoint, the counsellor physically accompanied J to the hospital rather than lose him to follow up. The doctor admitted him on the spot and kept him for 40 days as an emergency patient, while PV members and staff provided financial support for additional medicines until his case was sorted out and even clothes. The PV Empowerment Officer worked on his asylum application and documents and involved the Greek Council for Refugees who gave legal advice and assistance. At the end of the 40 days he agreed to keep taking treatment and stop following the advice of his pastor, and he continues to have monthly checkups with PV to support him in managing his medication.

How was change made?

The shock that came along with his hospitalization pushed J to accept that his religious practices, that he had believed for so long would save him, had brought him to the edge as his health had seriously deteriorated. The doctor and Checkpoint counsellor collaborated and made it clear to him that his health was at a critical stage, where he either followed his doctor’s advice or died. He was really scared so he agreed to start treatment again and adhere.

In the 40 days as an inpatient his condition got a lot better as he received very good care. Members and employees of Positive Voice paid regular visits, keeping him company,

giving him clothes and helping him take showers as well as covering the cost of additional medicine which was not covered by the hospital.

When J left the hospital he agreed to visit the Checkpoint every month to see the counsellor and show them his medication.

What lessons have been learnt?

The complexity of this particular case lay mostly in the reluctance of the beneficiary to share personal information and disclose medical history. The role of the religious group he belonged to was his justification for this, and it was clear that it had previously been a stronger influence on his health related decisions than clinical advice.

This experience illustrated the need to have sharp reflexes and to be able to address multiple issues at the same time. The medical attention M needed would not have been addressed if it was not for the initiative taken by the counsellor, and subsequently the empowerment officer in Thessaloniki. PV had not previously experienced refusal of HIV treatment on religious grounds.

What is important to underline here is the relationship of trust that was built slowly and steadily with a beneficiary of such a background, which enabled him to eventually believe what they were telling him and accept treatment as necessary. Often counsellors have to work extra hours and be available around the clock in order to provide better services. This is something that could not be put in their job description, but this case illustrates what empowerment and support mean in practice.