REFUGEE HEALTH TECHNICAL ASSISTANCE CENTER

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Clinical Care for Refugees with HIV Infection

November 30, 2011

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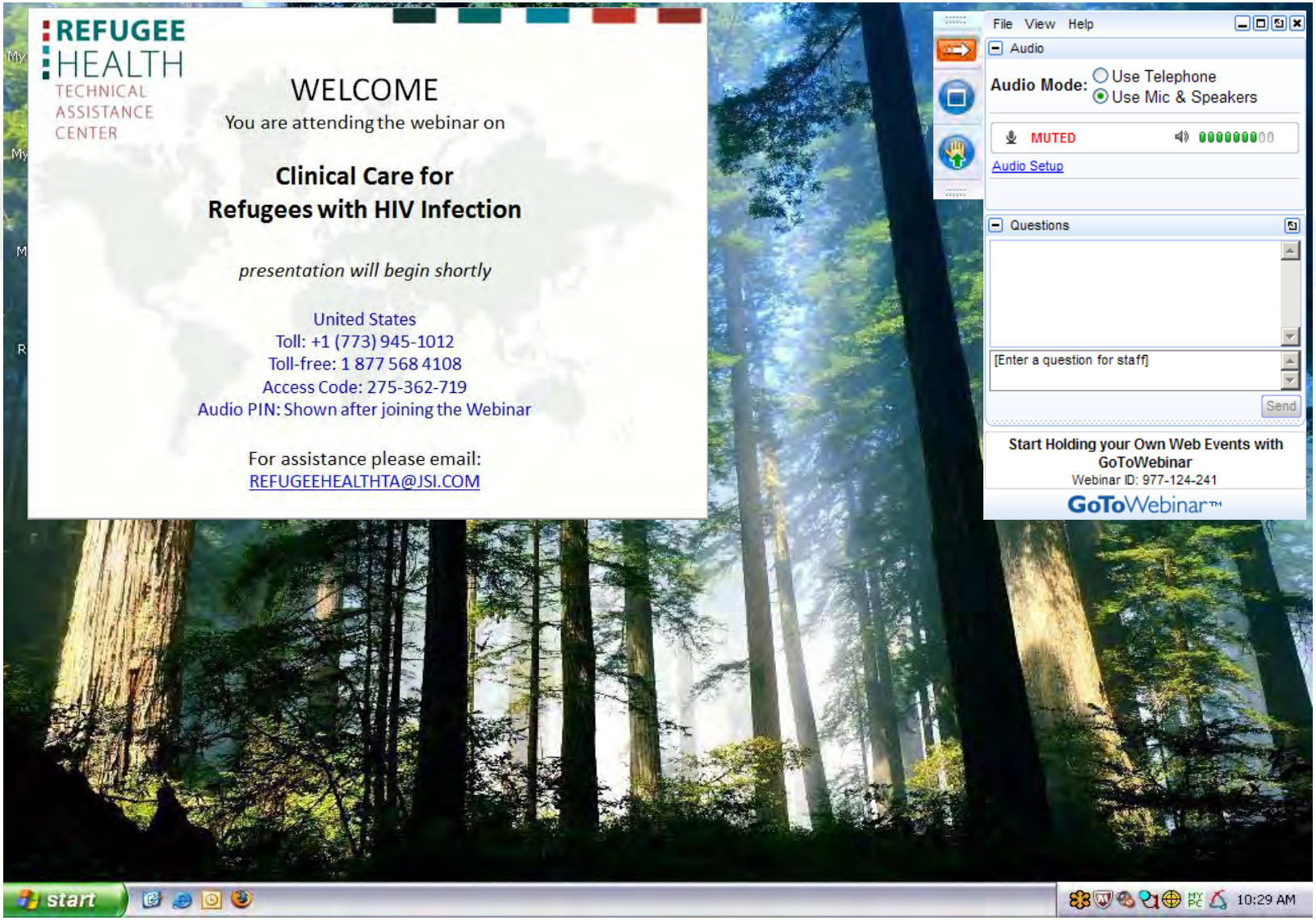
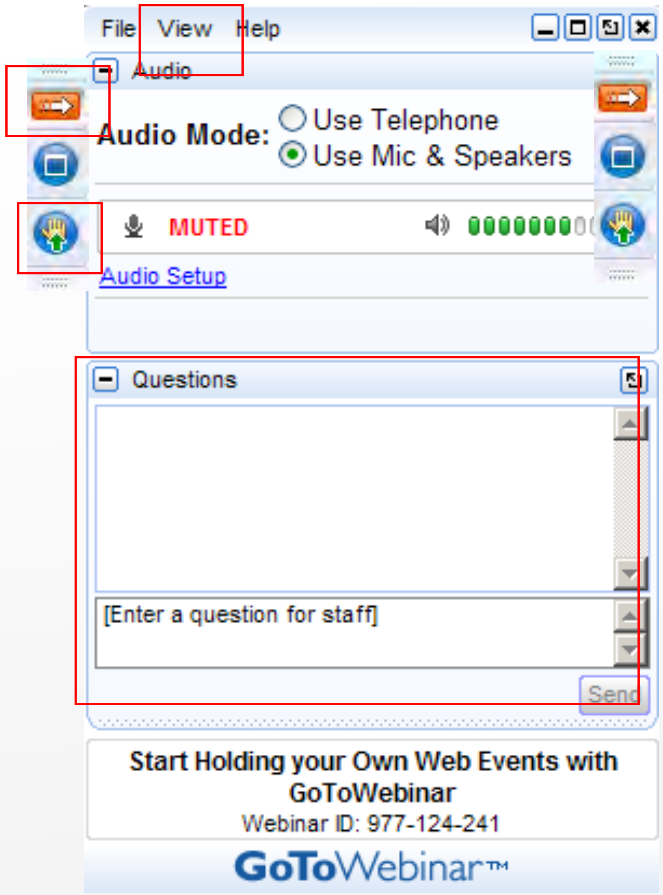
Housekeeping



How to Participate Today

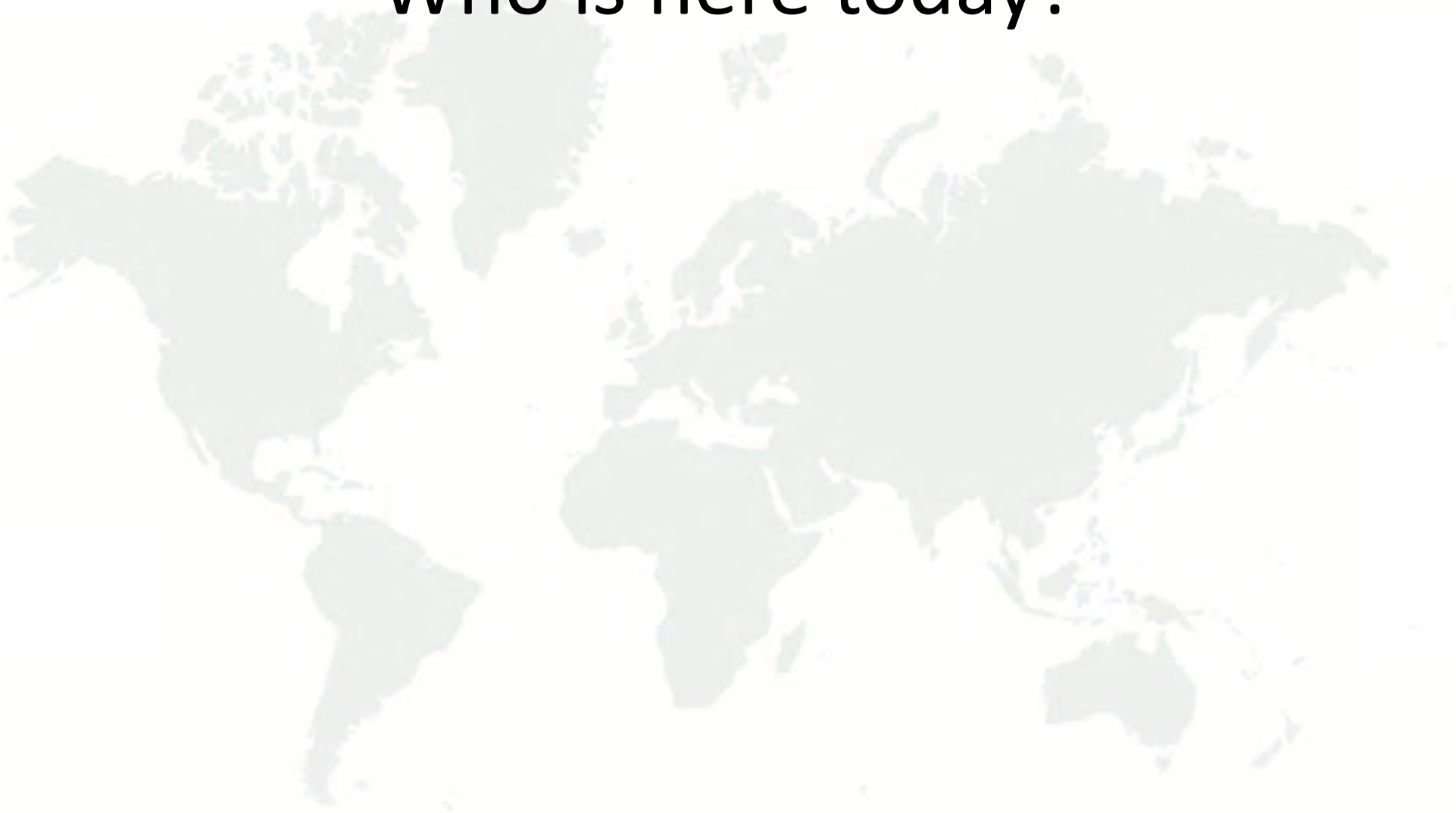


- Open and close your panel
- Submit text questions
- Raise your hand
- Q&A addressed at the end of today's session
- Mute your phone and computer
- Evaluation questions at end

Webinar Overview

- Presentations by Sondra Crosby, MD
- Q&A (25 minutes)
- Slides, webinar recording, Question and Answers, and additional resources will be posted to http://refugeehealthta.org after the webinar
- Email refugeehealthta@jsi.com if you have any questions after the webinar

Who is here today?



Caring for Refugees, Asylees, and Immigrants with HIV Infection

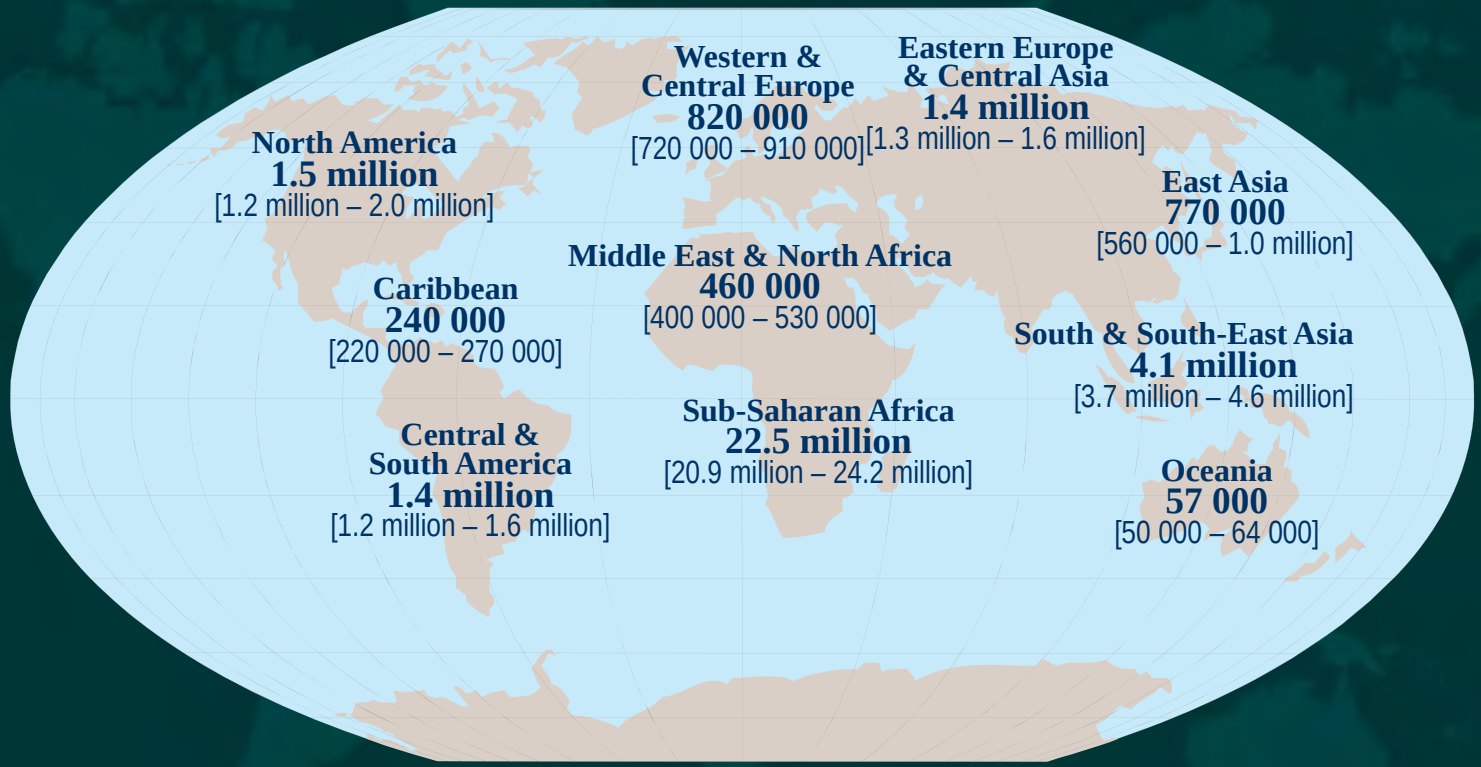
Sondra S. Crosby, MD
Associate Professor of Medicine
Boston University School of Medicine

BOSTON UNIVERSITY

Objectives

- To review the principles of screening for HIV infection in Refugees and Immigrants
- To increase awareness of potential issues that impact care of HIV positive refugees, asylum seekers, and immigrants
- To learn strategies for successsful engagement in medical care and treatment of HIV positive refugees, asylum seekers, and immigrants

Adults and children estimated to be living with HIV | 2009



Total: 33.3 million [31.4 million – 35.3 million]

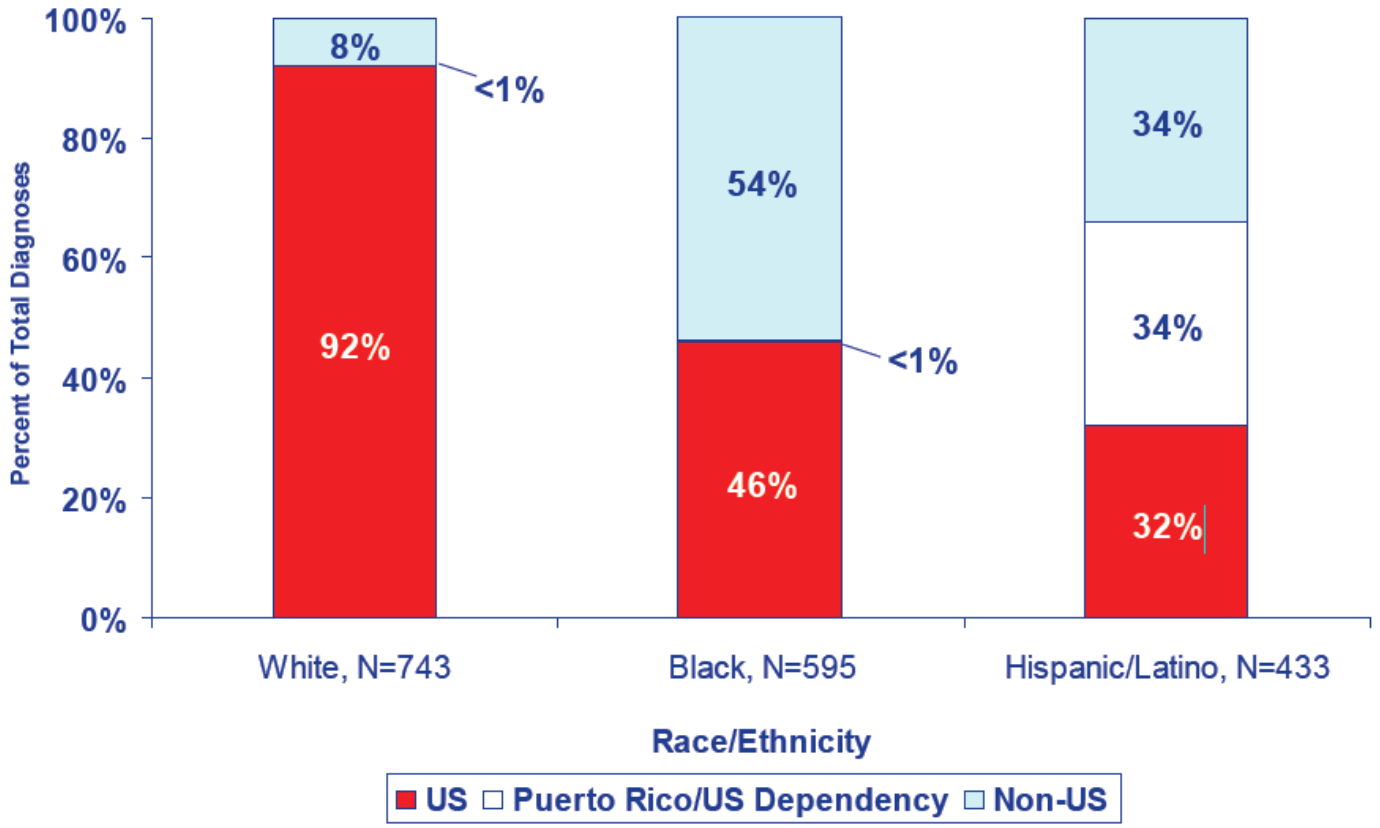
Epidemiology

- Immigrant communities disproportionately affected by HIV/AIDS epidemic:
  - In Mass, From 1999 to 2009, the proportion of people born outside the US among those diagnosed with HIV infection has increased from 18% and has remained between 28-32%.
  - From 1999 to 2009, the proportion of females diagnosed with HIV infection and born outside the US increased from 27% to 46%.

http://www.mass.gov/dph/aids

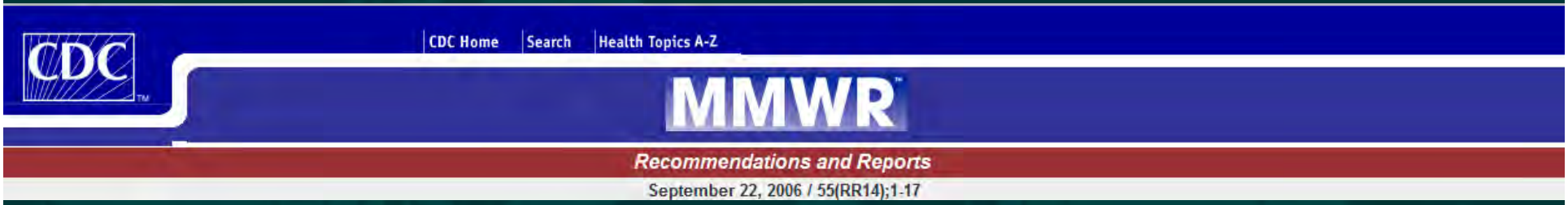
Massachusetts HIV/AIDS Data Fact Sheet
The Massachusetts HIV/AIDS Epidemic at a Glance

Figure 4. People Diagnosed with HIV Infection Within the Years 2007–2009 by Race/Ethnicity and Place of Birth: Massachusetts



Data Source: MDPH HIV/AIDS Surveillance Program, Data as of 1/1/11

Removal of HIV Entry Ban from Immigration Medical Screening



- Opt-Out testing
- Test performed as part of routine testing for all patients 13-64 unless patient declines
- Signed consent not required

HIV Screening in Refugee Populations

Mid-High Prevalence Regions

Universal testing

Non Endemic Regions

CDC Guidelines Ages 13-64

Routine Testing

- De-stigmatizes testing
- Part of standard health screening for everyone

The case for universal testing…

Photo by Sondra Crosby

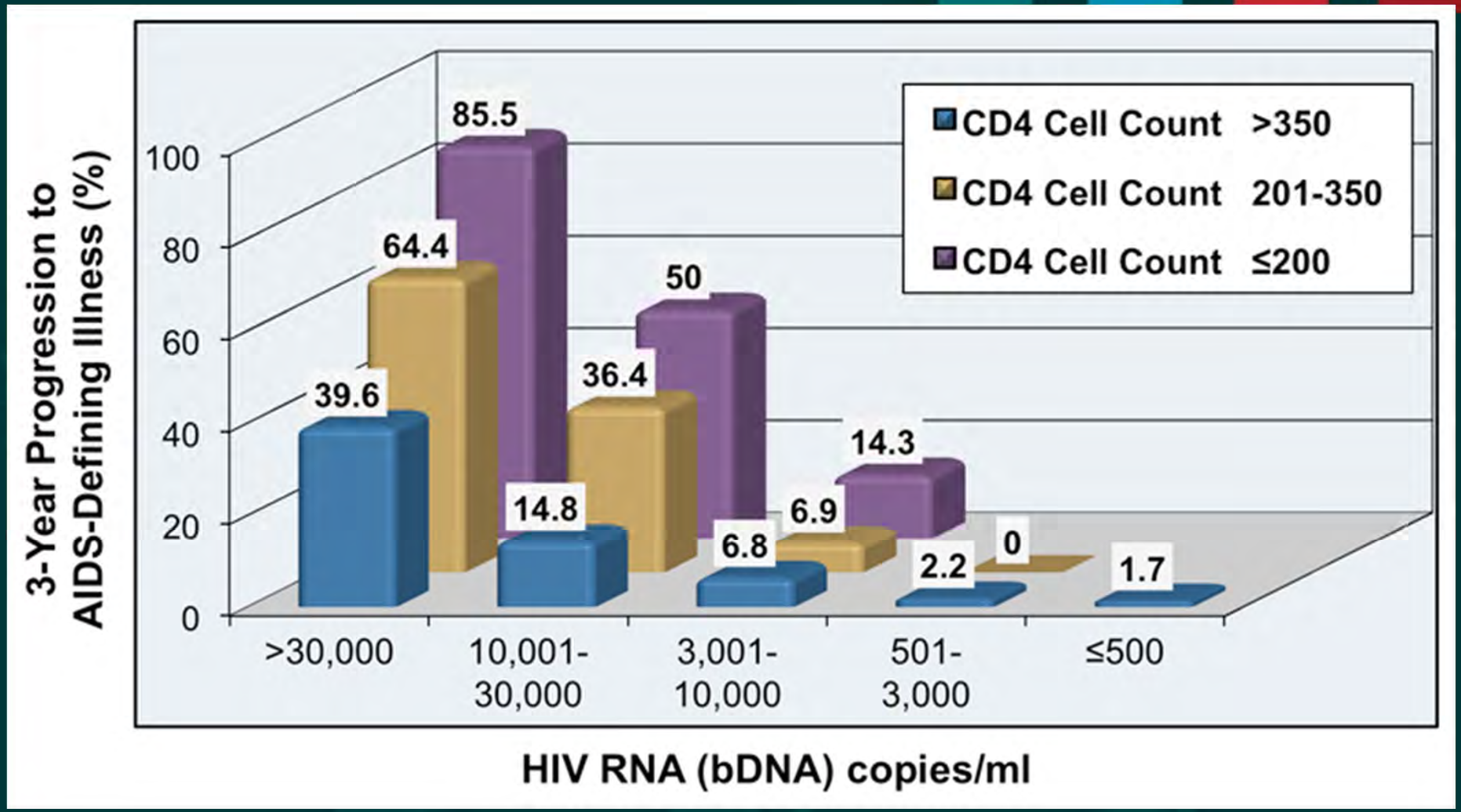


Figure 3. MACS Cohort Data: Risk for Progression to AIDS-Defining Illness by 3 Years After Becoming Infected with HIV This figure is based on data from the MACS cohort and involved men who have sex with men. AIDS-defining illness was based on the 1987 CDC definition of AIDS and did not include asymptomatic persons who had a CD4 count less than 200 cells/mm^3. The HIV RNA values were measured using version 2.0 bDNA. In general, RT-PCR values are consistently 2 to 2.5-fold greater than the 2.0 bDNA assay. The newer 3.0 bDNA assay provides values similar to the RT-PCR except at the lower end of the linear range (less than 1,500 copies/ml). This figure is adapted from DHHS Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. May 4, 2006.

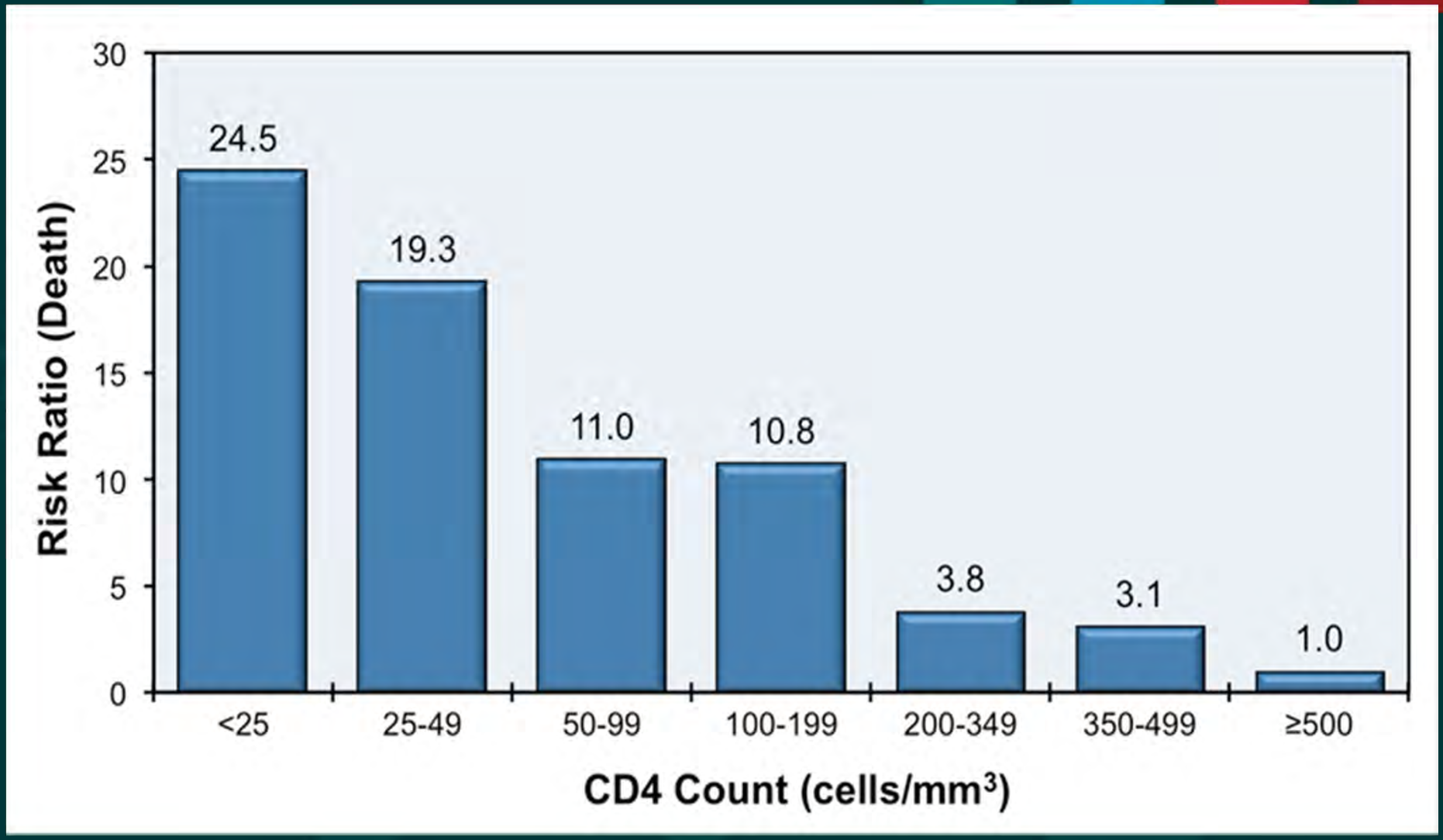


Figure 6. Relative Risk of Death After Starting Antiretroviral Therapy Based on CD4 Cell Count Prior to Initiating Therapy
The analysis is based on 1,219 antiretroviral-naïve adult patients started on any triple-combination antiretroviral therapy between August 1, 1996 and September 30, 1999. The analysis is a Cox Proportional hazard for the patient's risk ratio of death based on CD4 cell count prior to initiating antiretroviral therapy. Figure based on data from Hogg RS, Yip B, Chan KJ, Wood E, Craib KJ, O'Shaughnessy MV, Montaner JS. Rates of disease progression by baseline CD4 cell count and viral load after initiating triple-drug therapy. JAMA. 2001;286:2568-77.

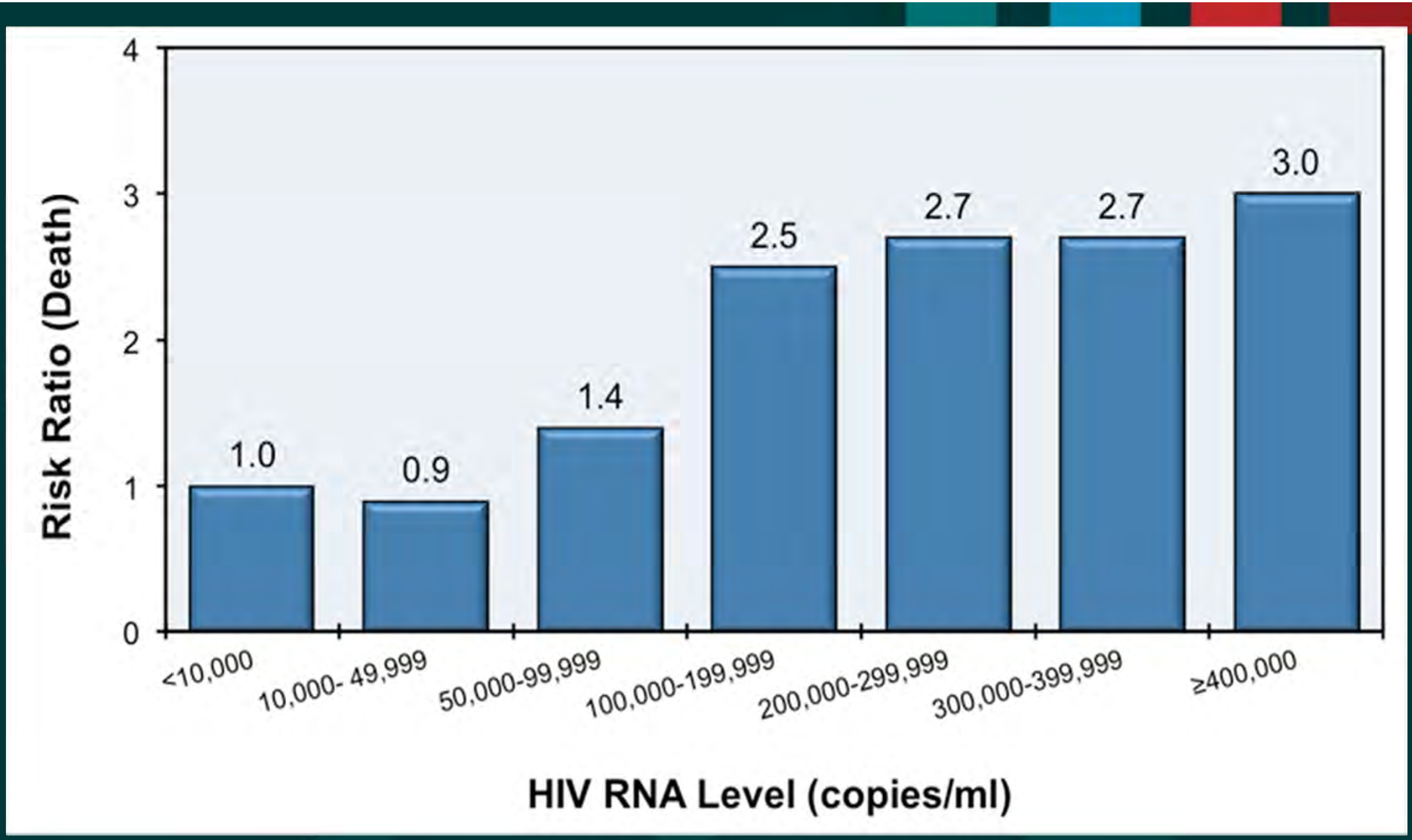


Figure 7. Relative Risk of Death After Starting Antiretroviral Therapy Based on HIV RNA Value Prior to Initiating Therapy
The analysis is based on 1,219 antiretroviral-naïve adult patients started on any triple-combination antiretroviral therapy between August 1, 1996 and September 30, 1999. The analysis is a Cox Proportional hazard for the patient's risk ratio of death based on HIV RNA level prior to initiating antiretroviral therapy. Figure based on data from Hogg RS, Yip B, Chan KJ, Wood E, Craib KJ, O'Shaughnessy MV, Montaner JS. Rates of disease progression by baseline CD4 cell count and viral load after initiating triple-drug therapy. JAMA. 2001;286:2568-77.

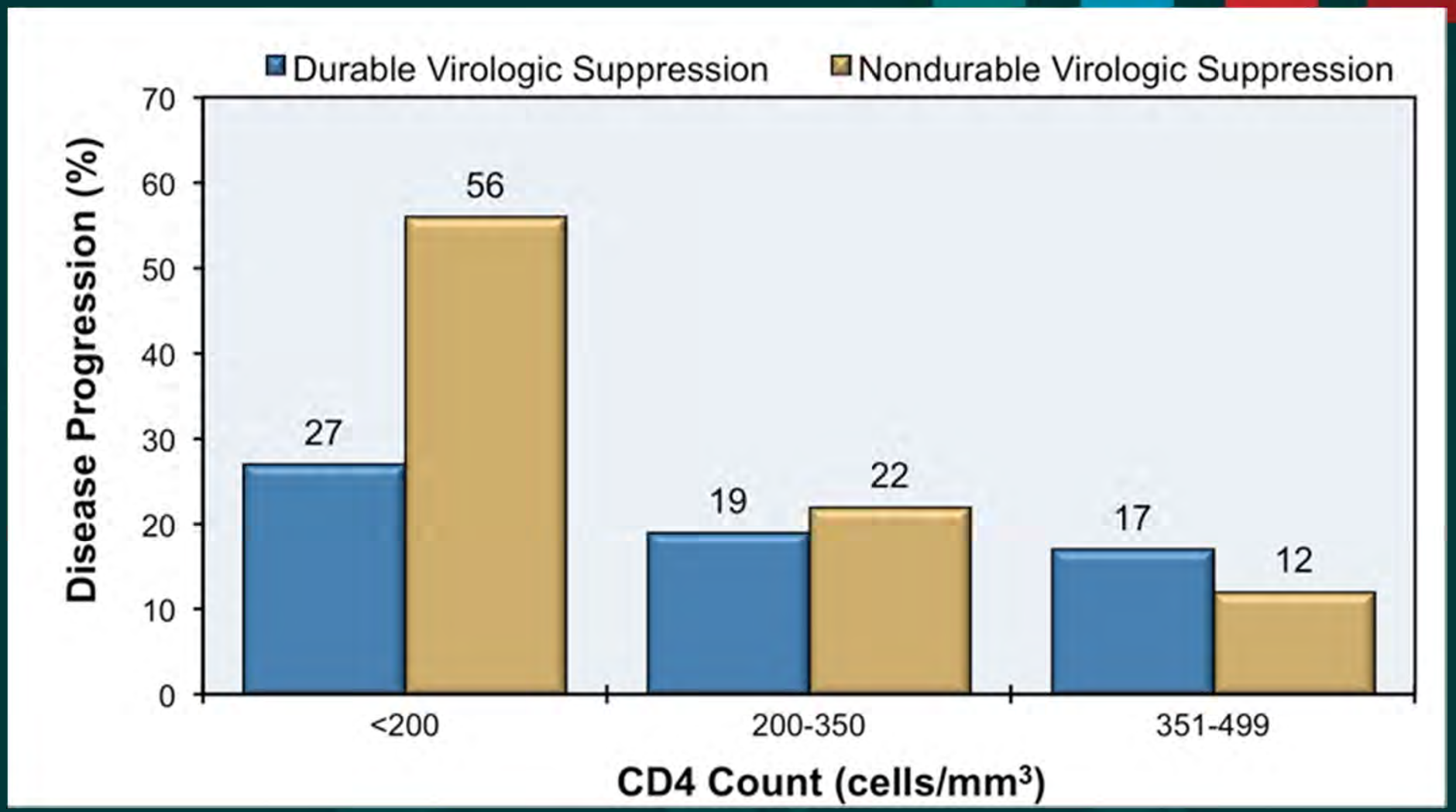


Figure 8. Disease Progression Related to Baseline CD4 Cell Count and Status of Virologic Suppression
In this study, 1173 patients were followed on highly active antiretroviral therapy and data was analyzed according to the baseline CD4 cell count, durable virologic suppression, and evidence of disease progression. A durable virologic response was defined as having a greater number of undetectable [less than 400 copies/ml] viral loads than detectable viral loads after initiating therapy; disease progression was defined as a new AIDS-defining illness or death. This figure is based on data from Sterling TR, Chaisson RE, Keruly J, Moore RD. Improved outcomes with earlier initiation of highly active antiretroviral therapy among human immunodeficiency virus-infected patients who achieve durable virologic suppression: longer follow-up of an observational cohort study. J Infect Dis. 2003;188:1659-65.

Pretest Counseling

- Development of trust/confidentiality
- Awareness of fear of stigmatization
- May trigger painful recollections of those who have died
- May trigger flashbacks

- 29 yo old woman from an African country in conflict, when told about positive HIV test, became hysterical, started having flashbacks.
- She stated that she wanted to die.
- Hours spent in posttest counseling and support with urgent psych consult.
- Helped her to make plans to stay in Boston with friends because she could not face her family.


AMEFUGA GA'BUGANDA
BUGANDA INDEPENDENCE (OCT 8TH 1962)
SAT,OCT 18 2008
LEXINGTON ELKS LODGE
959 WALTHAM ST. LEXINGTON MA 02421
5PM - TILL LATE.FREE ADMISSION
MUSIC BY D.J KASENGE,DINNER
@ 6:00PM,CASH BAR,DRESS ELEGANTLY
HIGH LIGHTS
MESSAGE FROM KABAKA
RONALD MUWENDA MUTEBI
MESSAGE FROM BETTY NAMBOOZE
CULTURAL PERFORMANCE BY
ANETTE NANDUJJA & THE PLANETS
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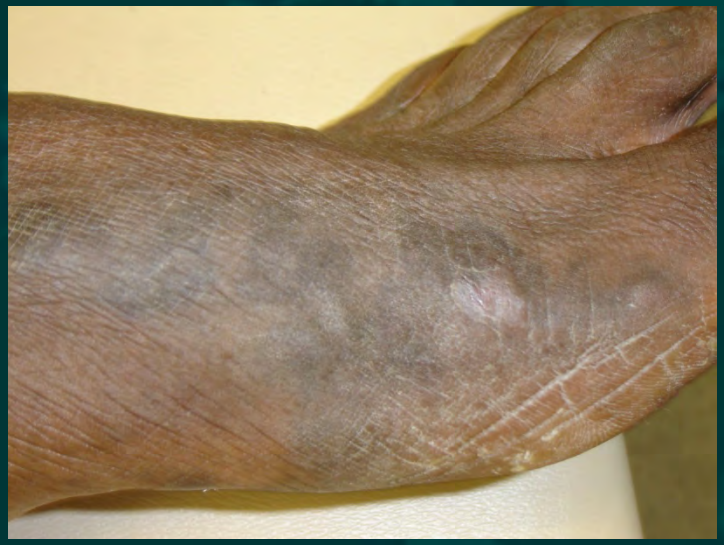
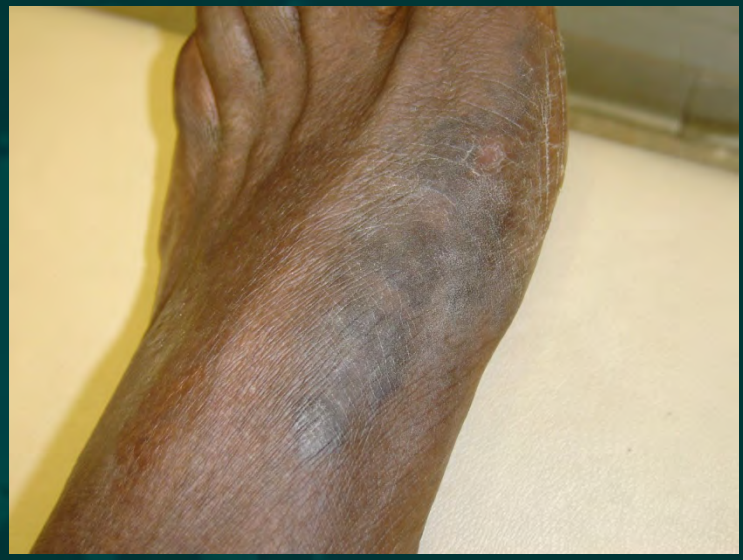
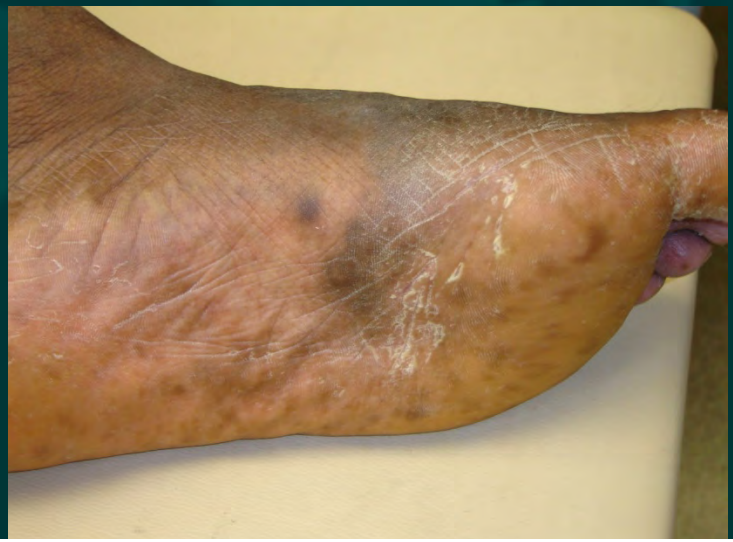
Situations where testing should be prioritized

- Pregnant women
- Breastfeeding women
- Seroconversion illness
- Signs of opportunistic infection/illness

Poll







Photos by Sondra Crosby

The diagnosis is

- Bacillary angiomatosis (Bartonella)
- Ectopic dermatitis
- Kaposi’s sarcoma
- Malignant melanoma
- Fungal infection

HIV in Refugee Women

- Women are majority of infected adults in sub-Saharan Africa, North Africa and middle East
  - Increased physiologic susceptibility
  - Violations of human rights (subordinate position in family, unequal access to medical care, education)
  - Domestic violence

Rape as a weapon of war

"We are not killing you. We are giving you something worse. You will die a slow death", taunted the mercenaries who raped and mutilated the Tutsie women, some as young as 12, after killing their menfolk.

- Rwanda genocide – 80% of women raped who opted for voluntary testing were found to be HIV positive.

Care of HIV-Infected Refugees

An AIDS victim in Malawi with her daughter: females contract HIV 5-10 years earlier than males on average.

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http://intl.elsevierhealth.com/journals/ijid

HIV infection in refugees: a case–control analysis of refugees in Rhode Island

Curt G. Beckwith [a,b,*], Allison K. DeLong [c], Simon F. Desjardins [a], Fizza Gillani [a], Lauri Bazerman [a], Jennifer A. Mitty [a,b], Heather Ross [a], Susan Cu-Uvin [a,b]

[a] *The Miriam Hospital, Providence, Rhode Island, USA*
[b] *The Alpert Medical School of Brown University, Providence, RI 02906, USA*
[c] *Center for Statistical Sciences, Brown University, Providence, Rhode Island, USA*

	Refugees n (%)	Non-Refugees n (%)	p-Value
Latent TB (N = 98) Negative Positive Unknown	 24 (49) 13 (27) 12 (24)	 27 (55) 0 (0) 22 (45)	<0.001
Active Hepatitis B Negative Positive Unknown	 42 (81) 10 (19) 0	 50 (96) 0 (0) 2 (4)	0.002
Initial CD4 count, cells/dl (N = 100) Median Range	 396 20-1252	 313.5 2-1176	0.51
Initial Plasma viral load (log_{10}) Median Range	 4.07 1.72-5.7	 4.32 2.06-5.88	0.10

Conclusions

- Although refugees and non-refugees had similar stages of disease, refugees were less likely to start ARVs (56% vs 79%)

Health Assessment of HIV-Infected Refugees

To the Editor:

Although more than 2.3 million refugees have resettled in the United States since 1975,[1] few of them have been HIV-positive. This is because the Immigration and Naturalization[4] Act requires testing for HIV infection and finds almost all individuals infected with HIV inadmissible.[2] Furthermore, no data

TABLE 2. Health Screening Results

	N*	n (%)
CAGE† score ≥2	31	1 (3)
Tobacco use	31	6 (19)
Injection drug abuse	32	1 (3)
Positive PPD test	34	15 (44)
Toxoplasma antibodies (IgG)	32	15 (47)
Intestinal parasites	25	7 (28)
Hepatitis A antibodies (IgG)	32	31 (97)
Hepatitis B core or surface antibody	33	22 (67)
Hepatitis C antibody	33	4 (12)
Rapid plasma reagent serology	33	1 (3)

*Number of subjects with information concerning this result.
†Screening test for alcohol abuse.

* Moreno, Crosby, *et.al*, JAIDS; 34 (2):251-253

Understanding the Psychological and Physical Health Status of HIV-Positive Refugees

- HIV positive refugees, Latinos, and U.S. borne assessed across domains of psychological, psychosocial and physical health functioning (n=84)
- Refugees and Latinos assessed for level of acculturation and immigrant related stigma.

"Charney, M.E. & Keane, T.M. (in press) The psychological, psychosocial and physical health status of HIV-positive refugees: A comparative analysis. Psychological Trauma: Theory, Research, Practice, & Policy."

	PTSD	Traumatic Evens	Depression	Mental Health Related Quality of Life	Physical Health Related Quality of Life	Stigma	Social Support, Family	Social Support, Community
Refugees	40.52	8.30*	16.07	34.76	49.55*	23.50*	30.32	18.19*
Latinos	43.08	5.75	21.08	34.89	44.33	13.00	27.76	27.08
US Born	40.90	5.09	14.84	36.66	44.57	15.00	30.62	30.53

"Charney, M.E. & Keane, T.M. (in press) The psychological, psychosocial and physical health status of HIV-positive refugees: A comparative analysis. Psychological Trauma: Theory, Research, Practice, & Policy."

Conclusions

- Compared to the other two groups, refugees :
  - more traumatic experiences
  - greater psychosocial stress on measures of traumatic events, stigma, and social support within the community.
  - Refugees reported greater physical-health related quality of life
- PTSD prevalence rates were approximately 36% among all groups.

- Refugees reported significant isolation from their community and perceive considerable HIV-related stigma.
- The combination of elevated psychosocial and psychological distress may be associated with greater barriers to healthcare and difficulty integrating into American society for refugees.

Conclusions

- Clinical programs to treat refugees living with HIV that integrate physical healthcare and assistance with psychological and psychosocial functioning may be warranted.

Barriers to HIV testing and treatment of African Immigrants and HIV/AIDS

- Fear of legal system
- Linguistic barriers
- Fear of the American health system
- Misunderstanding of modes of HIV transmission
- Themes –lack of disclosure to partners and social risks associated with disclosure

Foley et al. AIDS Care.2005;17(18):1030-43

- Privacy and confidentiality more important than overall health status
- African women in this study had limited power to negotiate condom use or testing of partners

- 37 yo woman who has been tortured and is seeking political asylum. She is extremely paranoid, which worsened after 9-11.
- Does not want to fill out any personal info on registration forms or free care forms.
- She does not pick up her HIV meds in the pharmacy because she has heard in her community that the INS is monitoring pharmacy records, and develops resistance

Challenges to providing care
Basic needs

- Safety
- Food
- Clothing

- Housing
- Separation from children
- Legal Needs
- Employment
- English classes

- A woman from Africa presents for care. She is a single mother with 6 young children, illiterate, and in trouble with police and DSS. She has done commercial sex work to help make ends meet.

- 30 yo is failing her antiretroviral therapy.
- It is finally discovered that she is sending a portion of her medications to Uganda for a family member who is unable to get therapy for HIV.

Challenges to providing care
language barrier

- Interpreters
  - in person
  - telephone
- Gender of interpreter
- Do not use family members

- 39 yo female with neuro-vegetative symptoms and disabling PTSD symptoms, refuses a mental health referral or pharmacologic therapy because she is “not crazy.”
- In addition, she does not want to use the hospital Arabic interpreter, because he is in her community and goes to her mosque.

Challenges to providing care

- Mistrust of medical system
  - Previous bad experience, poor communication
  - Fear of bills
  - Not familiar with confidentiality laws
  - Physicians may have participated in previous trauma

Race, Ethnicity, and medical care, a survey of public perception and experiences. Kaiser Family Foundation; 2005

Challenges to providing care

- complicated health care system
- unfamiliar with preventative health, medical procedures
- lack of acceptance of mental health
- transportation
- child care

Challenges:
adjusting to a new health system

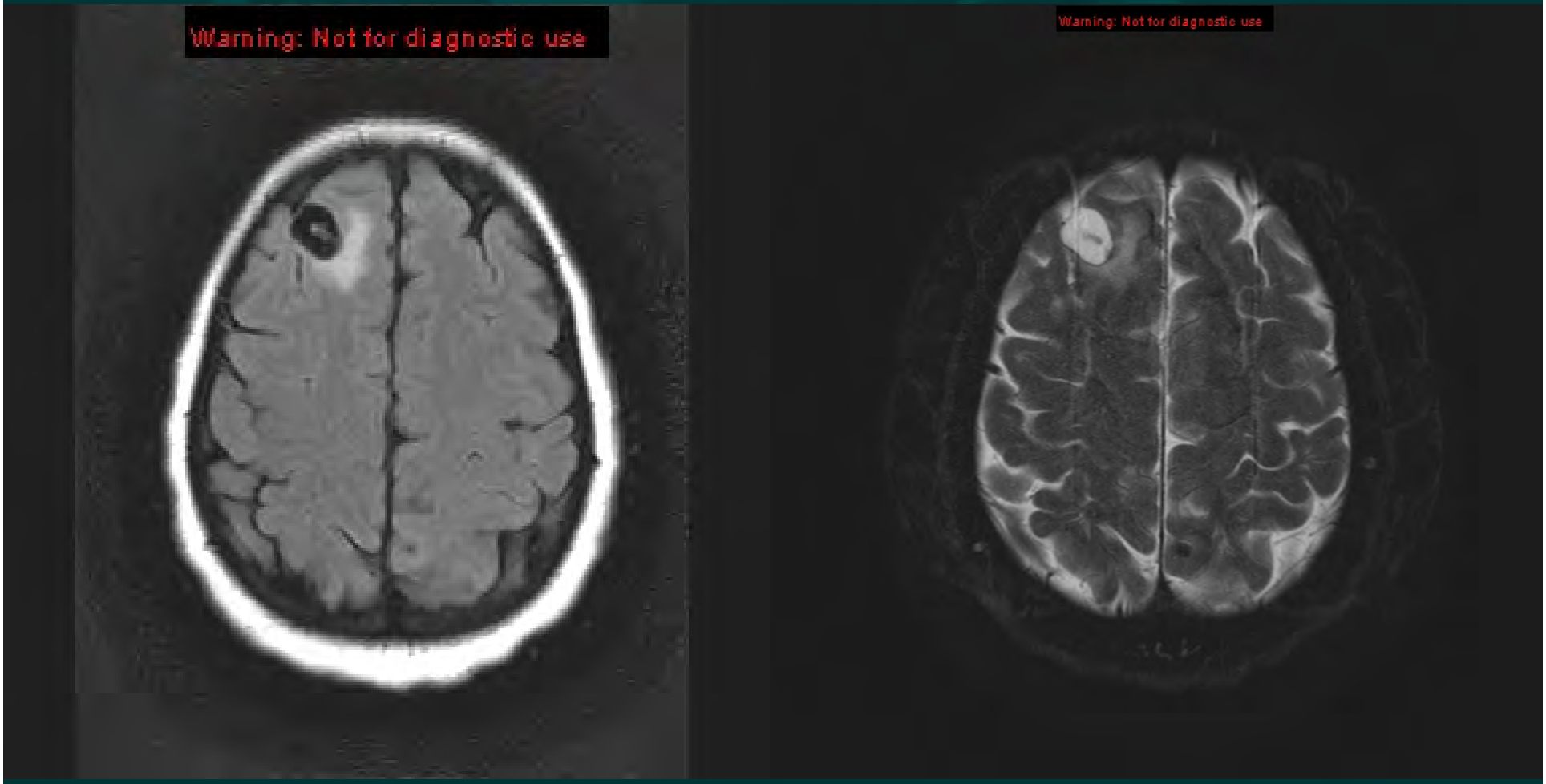
- Idea of appointments may be new, *i.e.* coming from an area where you just wait your turn
- Roles of providers and staff
- Understanding bio-medical model

- 22 yo male from Africa, feels that having blood drawn (as is required for HIV monitoring) makes him feel very weak.
- He believes giving up blood is fundamentally wrong, and frequently refuses blood draws.
- He is labeled “noncompliant” by the staff

Case

- Female in mid thirties with HIV from Subsaharan Africa, in US for 10 years
- On HAART, CD4 > 400, HVL undetectable
- Brought to Emergency Department with generalized tonic clonic seizures

Poll


Warning: Not for diagnostic use
Warning: Not for diagnostic use

The diagnosis is

- AIDs related CNS lymphoma
- Toxoplasmosis infection
- CNS tuberculosis
- Cryptococomma
- Neurocystocercosis

Challenges:
Knowledge and Beliefs about HIV

- Denial of HIV status
- Lack of knowledge or erroneous knowledge about HIV
- Community perception – without symptoms, no illness, no risk of transmission
- Shame and fear of stigmatization
- Fatalistic beliefs
- Modes of transmission

Examples of beliefs:

- “HIV is a death sentence”
- “HIV does not exist and may represent an effort by the West to control other parts of the world”
- “HIV is punishment from God”
- “Homosexuality will result in imprisonment or death”
- “HIV infected persons cannot marry or have children”

HIV Education Needs Among Sudanese Immigrants & Refugees in the Midwestern US

- 55% thought HIV transmitted by mosquitoes
- 40% thought transmitted by cough/sneeze
- 55% thought protected if had sex with persons who looked healthy
- 40% thought person could get HIV from public bathroom
- 36% thought HIV punishment
- Large proportion engaged in high risk behavior

Tompkins et al. AIDS and Behavior. May 2006

HIV Prevention/ Safe Sexual Practices

- Resistance to condom use
  - Oppose pregnancy prevention
  - Impregnation of women is sign of virility
  - Condom use would indicate HIV positivity
- Lack of empowerment of women

AIDS Care
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713403300

Pregnancy among HIV-infected refugees in Rhode Island

Erica Blood[a]; Curt Beckwith[b]; Lauri Bazerman[b]; Susan Cu-Uvin[b]; Jennifer Mitty[b]
[a] Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, US [b] The Miriam Hospital, Alpert Medical School of Brown University, Providence, US

Boston Medical Center

- 22 pregnancies/ 47 HIV-infected women: 2002-2007
- 5 women disclosed HIV status to partner

- 21 yo male refugee whose family arranged a marriage for him in Sudan (raised the payment of 100 cattle).
- He is to return to Sudan for the wedding, and is concerned about condom use. Condoms are not used in his village. His wife and family will not approve, and think "something is wrong".

Treatment approach:
how to engage and keep people in care

- Establishing rapport and trust is essential for development of a therapeutic alliance.
- Earning trust of immigrant requires attentive listening, communication, genuine empathy, and respect.

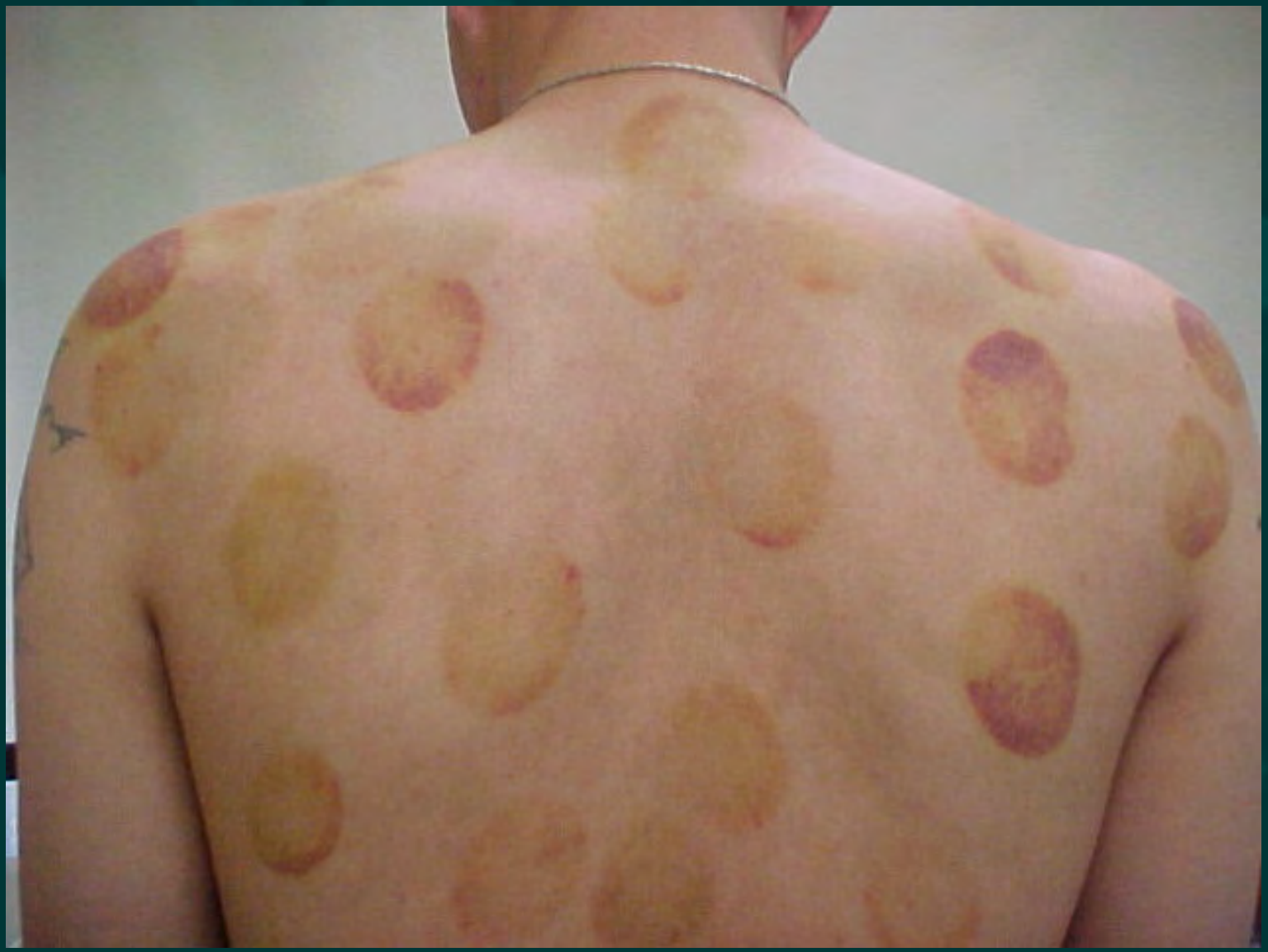
Strategies

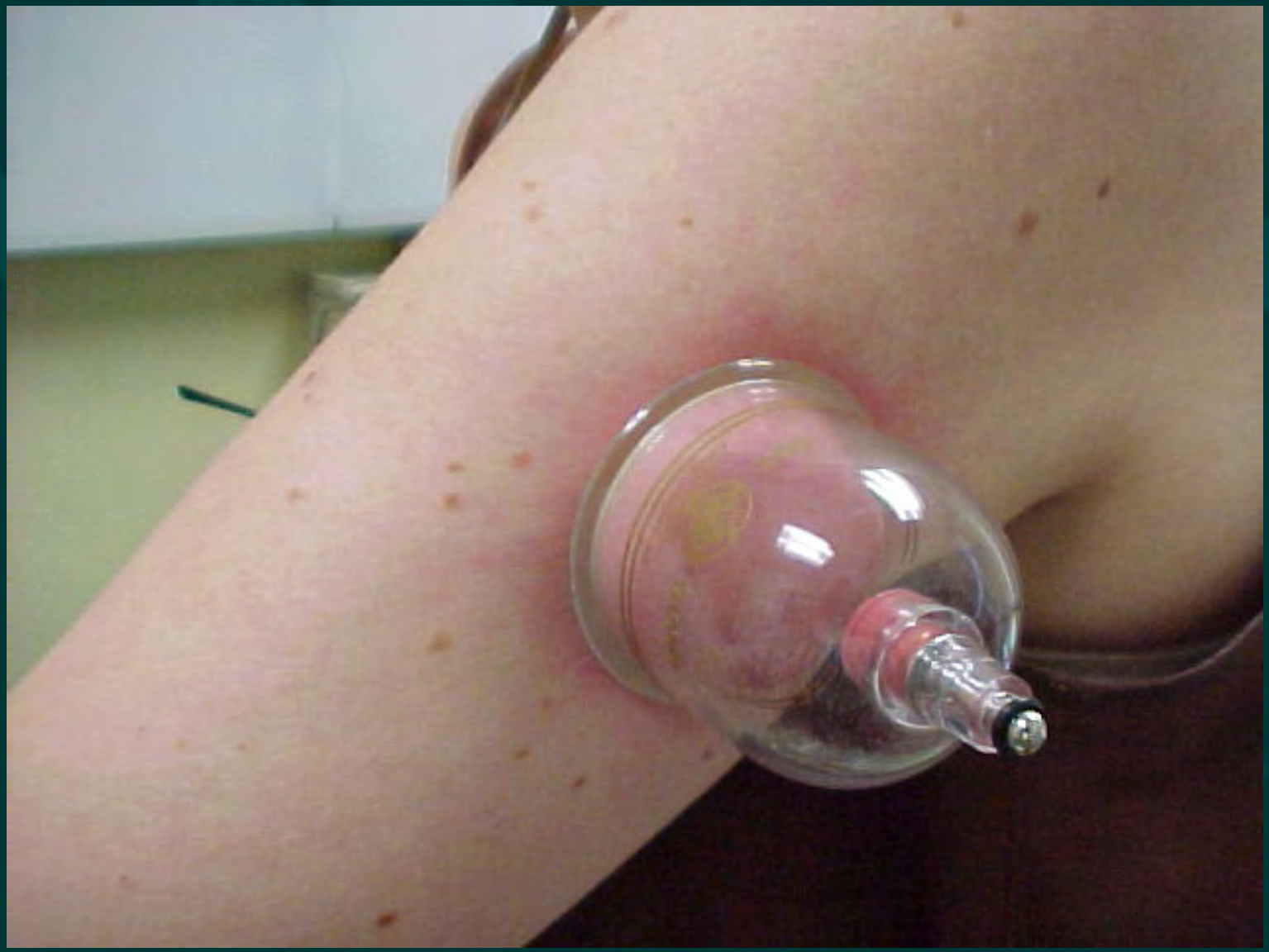
- Explore each patient's beliefs and knowledge about HIV and treatment, and work from their baseline
- Be aware of severe shame and stigmatization around HIV patient may be facing in communities
- Be prepared that talking about HIV may trigger remembering violence in patients who may have been exposed to HIV in the context of torture

- 20 yo male refugee who becomes angry during a clinic visit after he is told he doesn't need HIV medications because of his high t cell count and low viral load.
- He yells and accuses me of withholding medications because he is African.
- I learn from the interpreter this patient thinks the medications "cure" HIV.

Strategies:
cultural beliefs and customs

- Respect of health beliefs and flexibility
- Fasting
- Traditional treatments
  - incorporate if possible





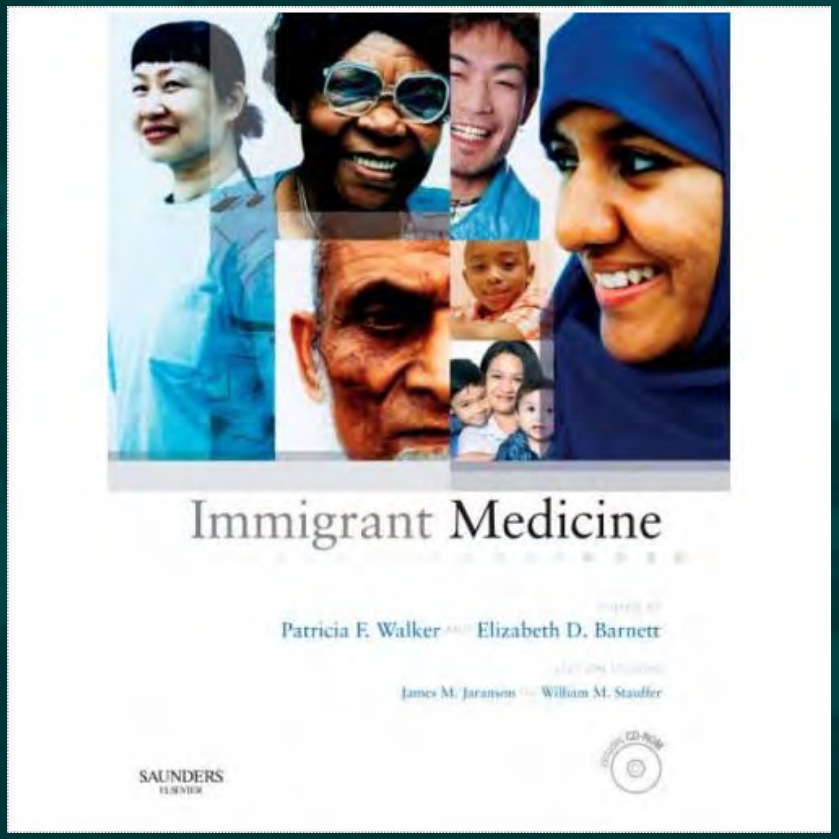
Treatment approach

- CONFIDENTIALITY
- Using treatment sites other than those specializing in HIV to maintain anonymity

Other testing considerations

- Non-B clades
- HIV-2

Medical screening for HIV-infected Refugees



Medical Screenings and Immunizations for New Immigrants. In Immigrant Medicine, eds Walker and Barnett, 2007

Initial lab screening

Test	Comments
CD4 count	
Viral load	
Resistance testing	
CBC with differential	
Chemistry panel	
Lipid panel	
Syphilis testing	Higher rate false positive, need confirmation
Hepatitis B serology	
Toxoplasmosis serology	
Tuberculosis testing	Positive 5mm, repeat annually if negative
G6PD	
PAP testing	High risk for cervical dysplasia/cancer

Vaccinations in HIV-infected Refugees

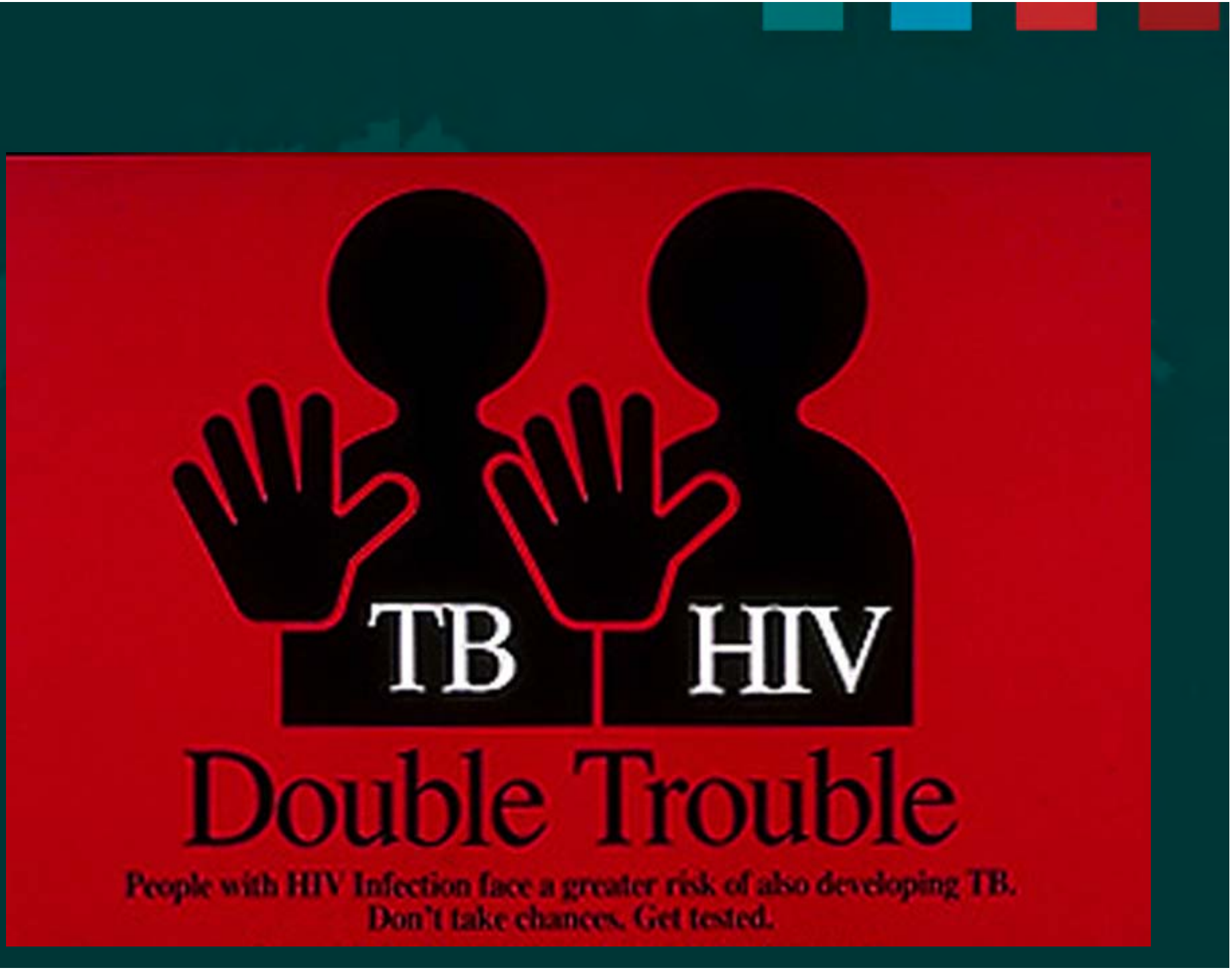
- Inactivated vaccines acceptable, live vaccines avoided
  - Td series
  - Polio- inactivated
  - Pneumococcal
    - At diagnosis if Tcell ct >200, or revaccinate once Tcell ct is >200
    - Single revaccination after 5 year
  - Influenza- inactivated
  - Hepatitis B
  - MMR, VZ if CD4 > 200

ARV Therapy

- Simplified regimens
  - Once daily therapy
  - Med boxes
- Pharmacy issues
- Efavirenz- dreams, PTSD symptoms

Co-infection

- Latent tuberculosis
- Hepatitis B


TB
HIV
Double Trouble
People with HIV Infection face a greater risk of also developing TB.
Don't take chances. Get tested.

Tuberculosis

- HIV infection increases risk of tuberculosis
- Tuberculosis is major cause of morbidity and mortality in HIV infected patients, including more rapid progression of HIV disease

LTBI

- Latent TB infection in HIV infected persons carries risk of reactivation of 5-10%/year
- Treatment of latent TB is effective in preventing active TB in HIV-infected persons
- Screen with TST (Mantoux) or Interferon-gamma release assay

Hepatitis B

- Coinfection increases risk for progression to cirrhosis, end stage liver disease, and hepatocellular carcinoma
- Chronic Hep B does not alter progression of HIV

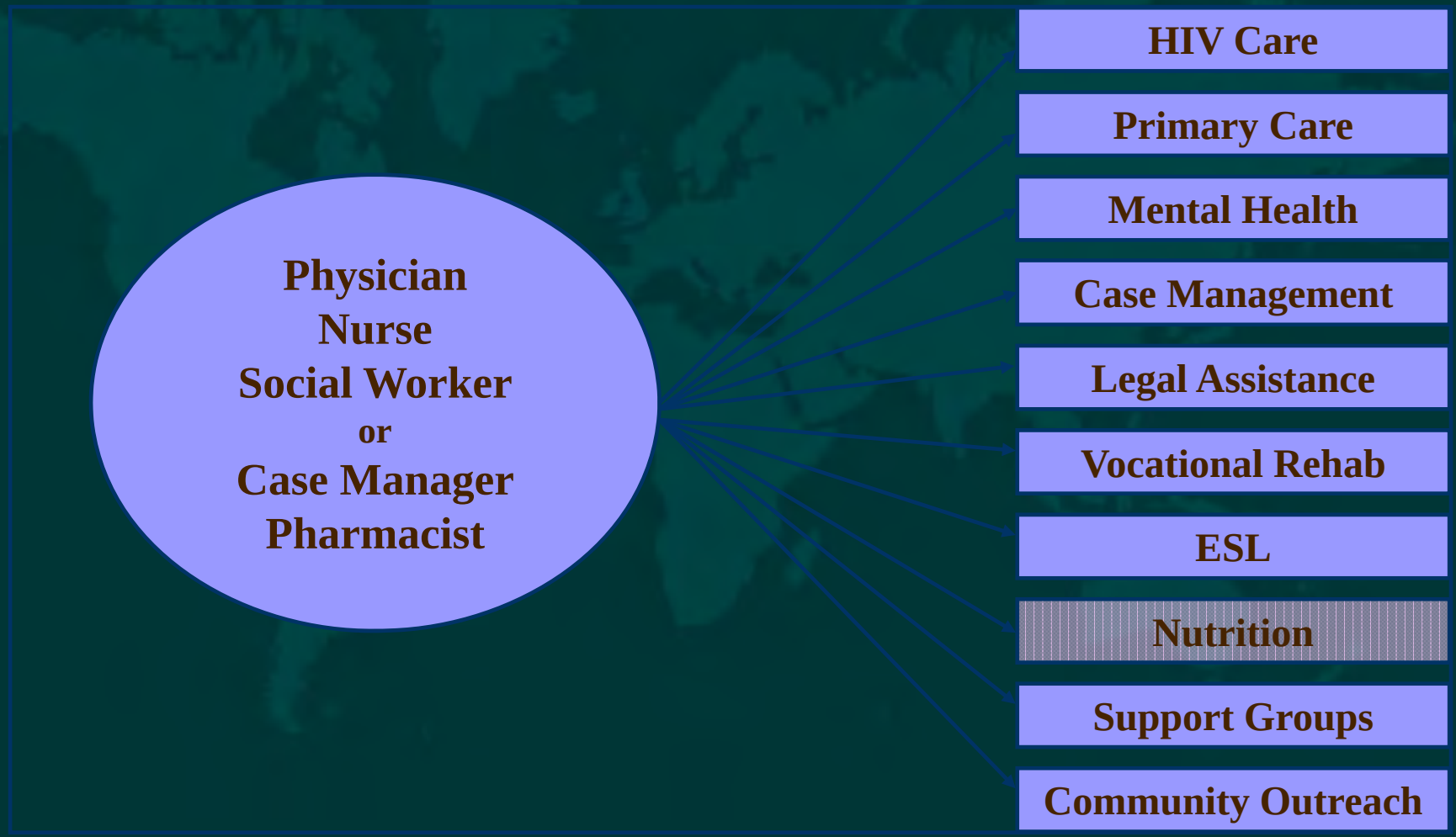
ARV Therapy

- Assessment of readiness to commit to therapy should include reassurance that other priorities are being met
  - Food, housing, children
  - Legal
  - Discussion of family members back home who are infected and may not have access to treatment

Outcomes

- Higher HIV death rate in minorities
- Longer delay to treatment
- No stratified data that compares outcomes of HIV treatment in immigrants compared to non immigrants in the U.S.

Team Approach



Summary

- Clinicians need to be educated in the evaluation and care of refugees with HIV
- Further study and development of improved methods of care for HIV infected refugees are needed.
- Need for comprehensive and coordinated care among all caregivers/agencies
- Need for community based education


Photo by Sondra Crosby

Resources

http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf