Engagement with Refugees with HIV

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Conflict of Interest Disclosure Statement

Speaker has nothing to disclose.

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). Under grant number U1OHA33225 (South Central AIDS Education and Training Center). It was awarded to the University of New Mexico. No percentage of this project was financed with non-governmental sources. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

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Learning Objectives

1. Understand context and process for refugee and immigrant resettlement
2. Understand HIV-related barriers to entry into third country for resettlement
3. Discuss trends between established care groups (refugee vs. non-refugee) living with HIV
4. Grasp cultural considerations in treating and ways to support refugee populations with HIV
5. Review sample scenario and brainstorm engagement solutions

“Why did you flee?”

Legal definition (United Nations [UN]-specific) of a refugee is:

“someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion."

82.4 million individuals were forcibly displaced in 2020

- Asylum seekers, internally displaced individuals, immigrants, and migrants are not technically refugees, though meet the same definition.
- Must be identified as UN-crisis to be labeled as a refugee and receive aid.

Numerous UN Refugee Camps across the globe.

- Resettlement process begins here

Resettlement Process

- Typically, a refugee leaves their home country and finds a UN refugee camp in a neighboring country
- Less than 1% of refugees are resettled to a third country yearly
- Individuals may stay in refugee camps for years or decades before being resettled
  - Conditions in camps are often inhospitable with high rates of crime and violence, including sexual violence
  - Conditions contribute to trauma, substance abuse, and rates of contracting HIV

HIV Related Barriers to Entry

- 1993-2009: HIV listed as "excludible condition for entry to the US"
- HIV testing was required for overseas medical examinations before US arrival
  - US immigration policy stated that HIV-infected refugees had to "prove" that they would not be a financial burden to US government
  - What message does this send?
  - Requirement of HIV testing before arrival removed in 2010
  - Now post-arrival medical screening & testing is "highly encouraged" by CDC

Stigmatization

- Systemic, societal, cultural
  - Sex and drugs may be taboo to discuss given cultural factors, specifically sexual behaviors that are “unacceptable”
  - Lack of supports due to multilevel stigmatization of being a refugee and individual living with HIV

Trends between established care groups

Refugees with HIV

- Primary risk factor: heterosexual risk
- MSM or IDU risk factors: "almost no reported"
- Latent TB: 27%
- + Hep A antibody: 81%
- + Hep B: 19%
- Initial CD4 count: 396
- Adherence to appts: 75%
- Antiretroviral (ART) use: 56%

Non refugees with HIV

- Primary risk factor: MSM risk
- MSM or IDU risk factors: higher
- Latent TB: 0%
- + Hep A antibody: 38%
- + Hep B: 0%
- Initial CD4 count: 313.5
- Adherence to appts: 86%
- ART use: 79%

Cultural Considerations

Orientation to US healthcare

- May be a shift into viewing healthcare as preventative
- Scheduling appointments vs. walk-ins
- Understanding insurance policies, what is covered vs not
- Understanding who is who & their roles in the clinic

Primary language

- Interpreters
  - Not relying on family members
  - Maintain awareness of vocabulary despite using interpretation
  - Advocate for what needs to be said
  - Use silence often to give individual chance to process, think of questions, speak up

Cultural Considerations

- Empower
  - "What questions do you have" vs. "Do you have any questions"
- Handouts in preferred language if literate
  - Consideration of alternative methods for communicating reminders and/or important information

Education: repeat new information

- Teach back process: "Now that was a lot of information. Tell me what your understanding of what I said is" and modify as needed.
  - e.g., "the devil is in me" in referencing HIV. Spend time to understand what this means to the individual – not an immediate referral to BH

Cultural Considerations

- Normalize impact of stress on functioning and help-seeking behaviors
- Provide information about clinic-specific processes
- Highlight privacy and confidentiality
- Take time to understand what help/support means to them
- Connect with resources (refugee resettlement agency, faith-based communities)

Ways to support engagement

Person-centered factors

- Research supports nonspecific factors accounting for engagement in patient interactions
  - Letting the person's story be told
  - Demonstrating awareness that multiple barriers existed before showing up in clinic
  - Being patient, curious, and warm
  - Offering culturally affirming care

Balance between facilitating and empowering

- Facilitating: When adjusting to US healthcare system, going above and beyond typical care may be beneficial
- Empowering:
  - Recognizing patient's needs & circumstances will persist in/out of clinic
  - Encourage autonomy, skills acquisition, & agency in healthcare decisions and dynamics

Resources

- Refugee resettlement agencies
- Refugee and immigrant local organizations
- Faith-based communities
  - Local mosques
- How BH can help
- What medical providers can do
- What MAs, front desk staff, and others can do

Resources

- Clinical Consultation Center
  http://nccc.ucsf.edu/
  - HIV Management
  - Perinatal HIV
  - HIV PrEP
  - HIV PEP line
  - HCV Management
  - Substance Use Management
- AETC National HIV Curriculum
  https://aidsetc.org/nhc
- AETC National Coordinating Resource Center
  https://targethiv.org/library/aetc-national-coordinating-resource-center-0
- Additional trainings
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