HIV among Sub-Saharan African communities living in Flanders

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Outline

1) Description of Sub-Saharan African Migrants (SAM) living in Belgium
2) HIV among SAM in Belgium
3) HIV testing and access to care
4) Provider-Initiated HIV Testing and Counseling (PITC) for SAM
5) Culturally adapted counselling for SAM living with HIV
6) Conclusion
HIV-SAM Project - Mission

- Created in 1996 by the Institute of Tropical Medicine
- Funded by the Flemish Government
  - Current Covenant: 2017-2019
  - HIV-SAM “Field organisation”
- Mission:
  Promotion of HIV prevention and sexual health among sub-Saharan African migrants living in Flanders
- Team: Ceulemans Monique, Ddungu Charles, Manirankunda Lazare, Noestlinger Christiana
Demographic characteristics of SAM in Belgium

- SAM are a small minority
  - 175,000 individuals in Belgium
  - 56,000 individuals in Flanders (32% of total; 0.94% of the Flemish population)

- Distribution per province
  - Antwerpen: 35% (Antwerp city: 21.6%)
  - Oost-Vlaanderen: 21% (7.7% in Gent)
  - Vlaams Brabant: 29%

- Men (50.5%), Women (49.5%)

- Young: 15 – 49 years (70%), <18 years (22%)
Social- anthropological characteristics

- **Heterogeneous population**
  - 48 nationalities (ethnicity/cultures/languages/religion)
  - Hard to reach
  - DR Congo (24.2%), Ghana (10%), Nigeria (8.2%), Kameroen (6.7%), Rwanda (6.6%), Angola (6.6%)

- **Homogeneous (organized by ethnic group/religion)**

- **Socio-economically vulnerable (J. Loos, 2014)**
  - Migration trauma (war, human trafficking...)
  - Education level: low (19%), high level (35%)
  - Financial security: 37% didn’t have any financial problem last year
  - Housing: 9.2% no stable housing
HIV among SAM living in Belgium


a. MSM transmission
b. heterosexual transmission

Year of HIV diagnosis

Nationality
- Belgian
- Europ.
- Subsah. Afr.
- other/unk.
HIV in SAM in Belgium

- Data from WIV-ISP, 2016
- SAM are 2nd group affected by HIV (31%) after MSM
- More women affected (63%) than men (36.6%)
- Reproductive age (15-45 years): 86.5%
- Patients on medical follow-up: 30% are SAM (68% are women)
- Late diagnosis: 47%
- Drop in new diagnoses (2012-2015): Women (38%); Men (60%)
HIV in SAM in Belgium (Cont...)

- Together study in Antwerp (J. Loos, 2014)
  - Prevalence: 4.8% (5.9% women, 4.2% men)
  - 65% were not aware of being HIV infected

- Similarity with HIV in Africa:
  - Prevalence: 4.8%;
  - 50% are women;
  - drop in new infections: 41% (2000 - 2014)
HIV in SAM (Cont..)

- HIV acquisition in the host country after migration
  - 15% reported by WIV-INS (unknown data: 37%)
  - 27% of SAM living with HIV acquired HIV in Belgium (Alvarez-del Arco et al. 2015)

- Factors associated with HIV infection among SAM
  - Undetermined sexual factors for HIV infections
    → Hardships increase HIV risks (Parcours study in France, 2014)
    → Migration

- SAM perceptions of HIV
  - Killer disease
  - Fear of contamination → stigma and discrimination/ per association
Conclusion

- Minority, young people, heterogeneous communities, disproportionately affected by HIV
- HIV: killer disease, fear, discrimination
- Many SAM who are HIV infected are not aware
- High rate of late diagnosis
- Transmission in the host country

>>> Public health concern

→ Promotion of HIV testing
HIV testing among SAM-linkage to care

Patient's HIV test request
- SAM: 29% vs 46% in MSM

Consequences of late diagnosis (Burns et al. 2007, Krentz et al. 2004)
- Delay in medical & psychological care
- Reservoir for onward transmission
- High morbidity & high cost of care
- Mortality
Barriers to HIV testing

- **Barriers of SAM** (L Manirankunda et al, 2009)
- **Barriers of healthcare providers** (L Manirankunda et al, 2012)
- **Recommendations of SAM and healthcare providers for HIV test uptake**
- **Evaluation of the PITC’s guidelines in GPs’ practice** (J. Loos, 2013)
Barriers of SAM for HIV testing

- Fears of the consequences of an HIV positive result
  - HIV is a killer disease
  - Fear of physical conditions deterioration
  - Fear of death sentence

- Stigma/stigma per association
  - HIV = prostitution, womnazers,
  - Uncurable disease
  - Uncertainty on transmission ways
  - Deportation
Barriers of SAM for HIV testing (cont...)

- Low perceived risk
- Lack of information
  - Health system (when, where, how, €)
  - Entitled to care, free medication,
- Lack of culture of health promotion (consult when very sick)
- Lack of opportunity
- Lack of money
Recommendations for increasing HIV testing uptake

To healthcare providers
- SAM rely on Dr’s decision (expert)
- If doctor suggests an HIV test, nobody will refuse, but we need appropriate information

In communities
- SAM mobilize for HIV testing
- Outreach HIV testing

Similar with international recommendations and Belgian HIV National Plan
National and international recommendations, 2015

- WHO guidelines on HIV testing services
- ECDC evidence brief on HIV testing in Europe
- National HIV Plan (Belgium)

• Priority: diagnosing the undiagnosed & linkage to care

• Diversification of HIV testing services
  o Clinical settings
  o Non-clinical settings – trained lay providers
  o Self-testing
Why should we promote HIV testing?

1. Many people who are infected are not aware of it.
2. Center for testing in the area.
3. There is hope (Medication free in Belgium)

Theorie

Praktijk
Primary prevention and HIV testing by the communities

- Raising awareness on HIV prevention and testing
- Distribution of condoms/brochures/posters
- Organising info session
- Organising info stand (social events and festivals)
- Organising outreach HIV testing

TAKE AN HIV TEST!
TAKE CARE OF YOUR HEALTH
In gemeenschapssettings, in samenwerking met gemeenschapsleiders

1. Groepscounseling & getuigenis

2. Gratis HIV speekseltest

3. Resultaat
   • Online, via beschermde web
   • Consult in Helpcenter-ITG
Conclusion 2

Few SAM request HIV test because of many barriers.

- They expect that Dr will do the test (*expert, (s)he knows what is good for the patient*)
  - “If the doctor suggest an HIV test, nobody will refuse, but we need appropriate information”
- SAM mobilize communities for HIV testing
Barriers of healthcare providers for initiating an HIV test

- Lack of information on medical/epidemiological relevance
  - Is HIV prevalence really high in SAM?
  - Why proactively HIV request only for SAM? Belgians request it themselves

- Not wanting to discriminate against SAM (double stigma)

- Practical problems with undocumented migrants
  - Who will pay
  - If HIV+, will they get care?
  - If they are deported, what happens?
Barriers of healthcare providers for initiating an HIV test

- Reluctance to use the WHO/UNAIDS guidelines of VCT (why the exceptionalism?)
  - HIV/AIDS ‘exceptionalism’ (informed consent, pre-test counselling)?
  - Lack of time
  - Lack of expertise in discussing sexual issues
  - Lack of expertise in transcultural communication
  - Language barrier

- Lack of national policy on provider-initiated HIV testing
Missed opportunities for an earlier HIV testing

- 58.3% in GPs’ practice in Brussels (Genotte AF, 2013)

- 76.4% of SAM had seen their GP prior the year to HIV diagnosis (Burns FM, et al, 2008)
  - HIV and/or HIV testing was raised for 17.6%
  - 37.1% had a previous negative HIV test,

- From 50% to 100% of diagnosed individuals had clear triggers for HIV testing (Kuo AM et al, 2005; Liddicoat RV et al, 2004)
  - a documented risk factor or
  - an HIV related illness documented in the medical records without the diagnosis being made

- Lack of knowledge or information (reasons for testing, symptoms, policy)
Recommendations of GPs for an early HIV diagnosis

- Promotion of early HIV testing in GPs’ practice
  - *Training and continued education*
  - *Knowledge of clinical symptoms of HIV infection*
  - *Applying provider-initiated HIV testing and counseling*

- Promotion of HIV testing in SAM communities
Promotion of the Provider-initiated HIV-testing and counseling

- Distribution of the brochure
  - Epidemiological facts
  - Guidelines of PITC
  - Communication with SAM patients
  - Overcoming the barriers
  - Examples (initiating an HIV request)

- Training offer
  - LOK (GPs)
  - Huisartsen in opleiding
Evaluation of the PITC guidelines

- **Easier opportunities**
  - Blood tests
  - New patient
  - Consultation on sexual and reproductive reasons
  - Patient with the HIV-indicator conditions

- **Frequency of HIV test**
  - 1 test/year
  - More often if risk behaviours
Guidelines for Provider-initiated HIV testing and counseling

- With or without HIV-related symptoms

- Principles
  - Counseling/information
  - Verbal consent (voluntary)
  - Confidentiality
  - Linkage to care
Culture considerations

- SAM trust in GPs (*authority, experts*)
- Communication:
  - *Eye contact*: fixing the eyes of an authority means “you are not polite”
  - *Questions*: asking many questions to the authority is not culturally acceptable, you better listen
  - *Indirect talk*
Steps of HIV testing

- Introducing the request (*reasons & advantages*)
- Pre-test information (*test, services, confidentiality, voluntary decision, questions*)
- Consent: if no (*reasons, *)
- Post-test counseling
  - Negative HIV test result
  - Positive HIV test result
- Linkage to care
Pre-test information

- Informing the patient why an HIV test
  - HIV is real, clinical and prevention advantages
  - Confidentiality
  - Voluntary testing
  - Window period
- Give time for questions
- Verbal consent
- Concrete appointment for delivering test result
- Optional
  - Assessment of sexual risks
  - IST

HUMOR helps
Delivering negative HIV results

- Face to face
- Be sure that patient understands the result (negative=positive)
- Discuss window period
- Opportunity of prevention (remain negative, give condom)
- Questions
Delivering HIV positive result

- Face to face (avoid weekend time)
- Plan more time
  - Be sure that patient understands the result (positive=negative)
  - Take care of emotions, concerns and fears*
    - Ask if the patient has someone to share about the situation
    - Share about existing services and their offer (patient support groups, social services, Aids Reference Centers)
    - Evaluate the psychological situation (Depression, suicide thoughts)
- Linkage to care (make together the first appointment to ARC)
Delivering HIV positive result (Cont...)

- Take care of emotions, concerns and fears*
  - Fear of death (effective free medication, chronic disease)
  - Fear of discrimination, rejection (Care providers don’t stigmatise)
  - Fear of getting medication (free medication in Belgium)
  - Fear of deportation (No deportation if you have documents, no influence on the asylum request, medical secrecy)
  - Fear of getting children (with medication, uninfected child)
  - Fear of getting married (When undetectable viral load, very low risk to transmit HIV)
Delivering HIV positive result (cont...)

- Discuss possibility of coming back to consultation when very chocked
  - Give a folder and details of ARC
  - Possibility of associating the partner

- Optional
  - Partner violence
Guidelines on indicator conditions (HIV in Europe)

1. Conditions which are AIDS defining among PLHIV* (based on CDC and WHO classification system)

2a. Conditions associated with HIV undiagnosed prevalence of >0.1% ** (based on a systematic Review, evidence based)

2b. Experts are convinced that the conditions are likely to have an undiagnosed prevalence of >0.1%

Sillivan AK et al. PLOS ONE (2013), vol 8, issue 1, e52845
http://newsite.hiveurope.eu/
HIV test strongly recommended:
1. *AIDS defining conditions among PLHIV* *

- **Neoplasms**
  - Cervical cancer, Non-Hodgkin lymphoma, Kaposi’s sarcoma

- **Bacterial infections**
  - Mycobacterium Tuberculosis, pulmonary or extrapulmonary
  - Mycobacterium avium complex (MAC) or Mycobacterium kansasii, disseminated or extrapulmonary
  - Mycobacterium, other species or unidentified species, disseminated or extrapulmonary
  - Pneumonia, recurrent (2 or more episodes in 12 months)
  - Salmonella septicaemia, recurrent

- **Viral infections**
HIV test strongly recommended:
1. AIDS defining conditions among PLHIV

- **Viral infections**
  - Cytomegalovirus retinitis
  - Cytomegalovirus, other (except liver, spleen, glands)
  - Herpes simplex, ulcer(s) > 1 month/bronchitis/pneumonitis
  - Progressive multifocal leucoencephalopathy

- **Parasitic infections**
  - Cerebral toxoplasmosis
  - Cryptosporidiosis diarrhea, >1month
  - Isosporiasis, >1month
  - Atypical disseminated leishmaniasis
  - Reactivation of American trypanosomiasis
HIV test strongly recommended:
1. AIDS defining conditions among PLHIV

- **Fungal infections**
  - Pneumocystis carinii pneumonia
  - Candidiasis, oesophageal
  - Candidiasis, bronchial/tracheal/lungs
  - Cryptococcosis, extrapulmonary
  - Histoplasmosis, disseminated: extrapulmonary
  - Coccidiodomycosis, disseminated/extrapulmonary
  - Penicilliosis, disseminated
HIV strongly recommended
2a. Conditions associated with HIV undiagnosed prevalence of >0.1% **

- Sexually transmitted infections
- Malignant lymphoma
- Anal cancer/dysplasia
- Cervical dysplasia
- Herpes zoster
- Hepatitis B or C (acute or chronic)
- Mononucleosis-like illness
- Unexplained leukocytopenia/thrombocytopenia lasting >4 weeks
- Seborrheic dermatitis/exanthema
- Invasive pneumococcal disease
- Unexplained fever
- Candidaemia
- Visceral leishmaniasis
- Pregnancy (implications for the unborn child)
2b. Other conditions considered likely to have an undiagnosed HIV prevalence of >0.1%

- Primary lung cancer
- Lymphocytic meningitis
- Oral hairy leukopenia
- Severe or atypical psoriasis
- Mononeuritis
- Subcortical dementia
- Multiple sclerosis-like disease
- Unexplained weight loss
- Unexplained lymphadenopathy
- Unexplained oral candidiasis
- Unexplained chronic diarrhea
- Unexplained chronic renal impairment
- Hepatitis A
- Community-acquired pneumonia
- Candidiasis
3. Conditions where not identifying the presence of HIV infection may have significant adverse implications for the individual’s clinical management despite that the estimated prevalence of HIV is most likely lower than 0.1%

- Conditions requiring aggressive immuno-suppressive therapy (cancer, transplantation, auto-immune disease treated with immunosuppressive therapy)
- Primary space occupying lesion of the brain
- Idiopathic/thrombotic thrombocytopenic purpura
Culturally adapted support for SAM living with HIV

- Peer support group of SAM living with HIV (Muungano)
  - Monthly meeting
  - Information and recreational sessions
  - Weekend with Sensoa
- Individual support
  - Legal issues (papers)
  - Desire of partner
  - Desire of children
- Workshop “coping with HIV diagnosis”: June 2017
- Advices to (ARC) care professionals
Conclusion

- SAM are highly affected and contaminated also in Belgium
- Unknown determinants for HIV acquisition but hardships increase HIV risks
- Many SAM don’t dare to ask an HIV test themselves, they want healthcare providers initiating the request (better not to know)
- Late diagnosis $\rightarrow$ undiagnosed reservoir $\rightarrow$ onward transmission
- Promote an early HIV diagnosis, early HIV care
  - Overcome barriers of patients and providers
  - Applying the provider initiated HIV counseling and testing,
  - Applying the guidelines on clinical indicator conditions for HIV testing
  - Sensitizing & mobilization for HIV testing in SAM communities
Thank you

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