

# Two worlds colliding:

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## Adjustment of HIV positive refugees and their health care professionals in a Montreal HIV hospital clinic

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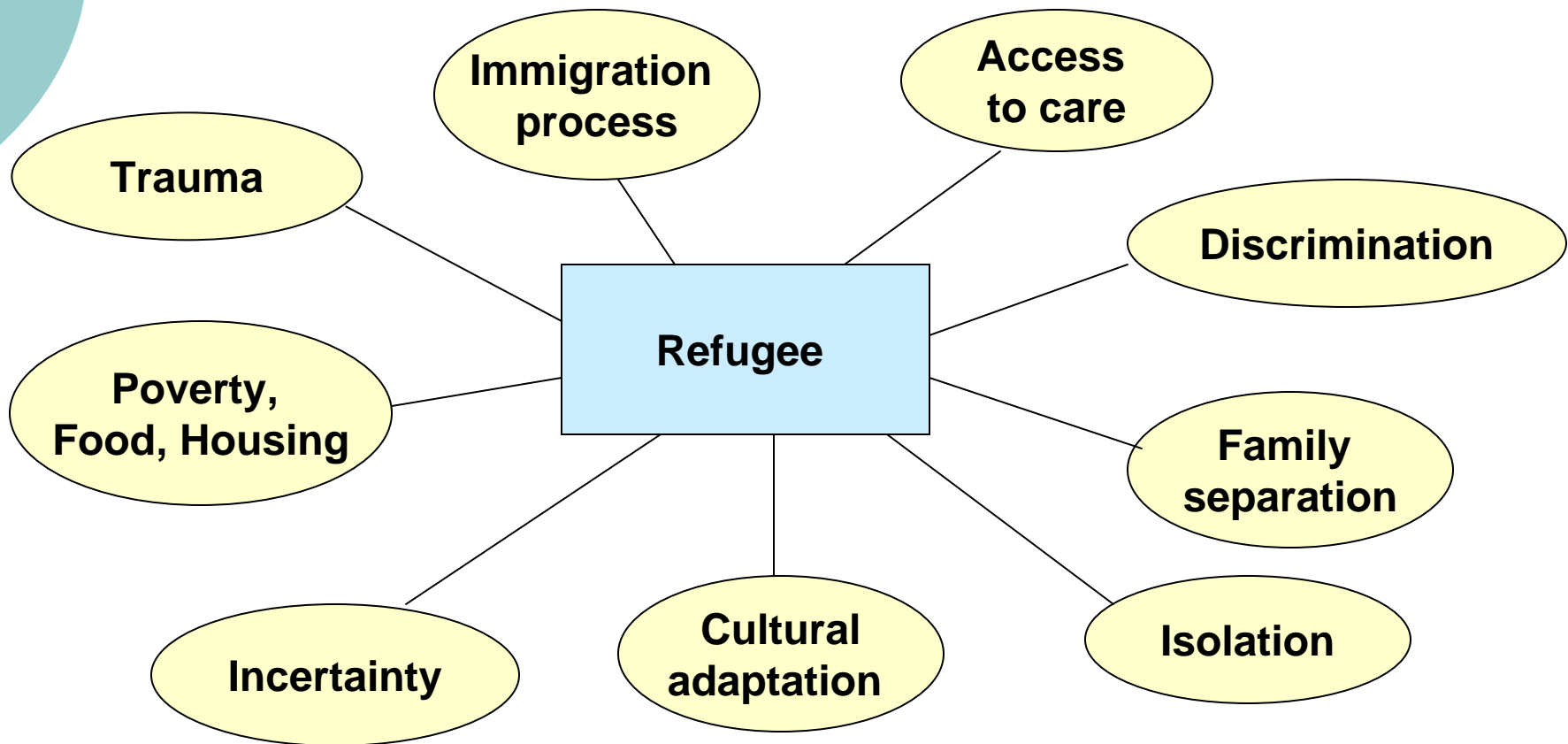
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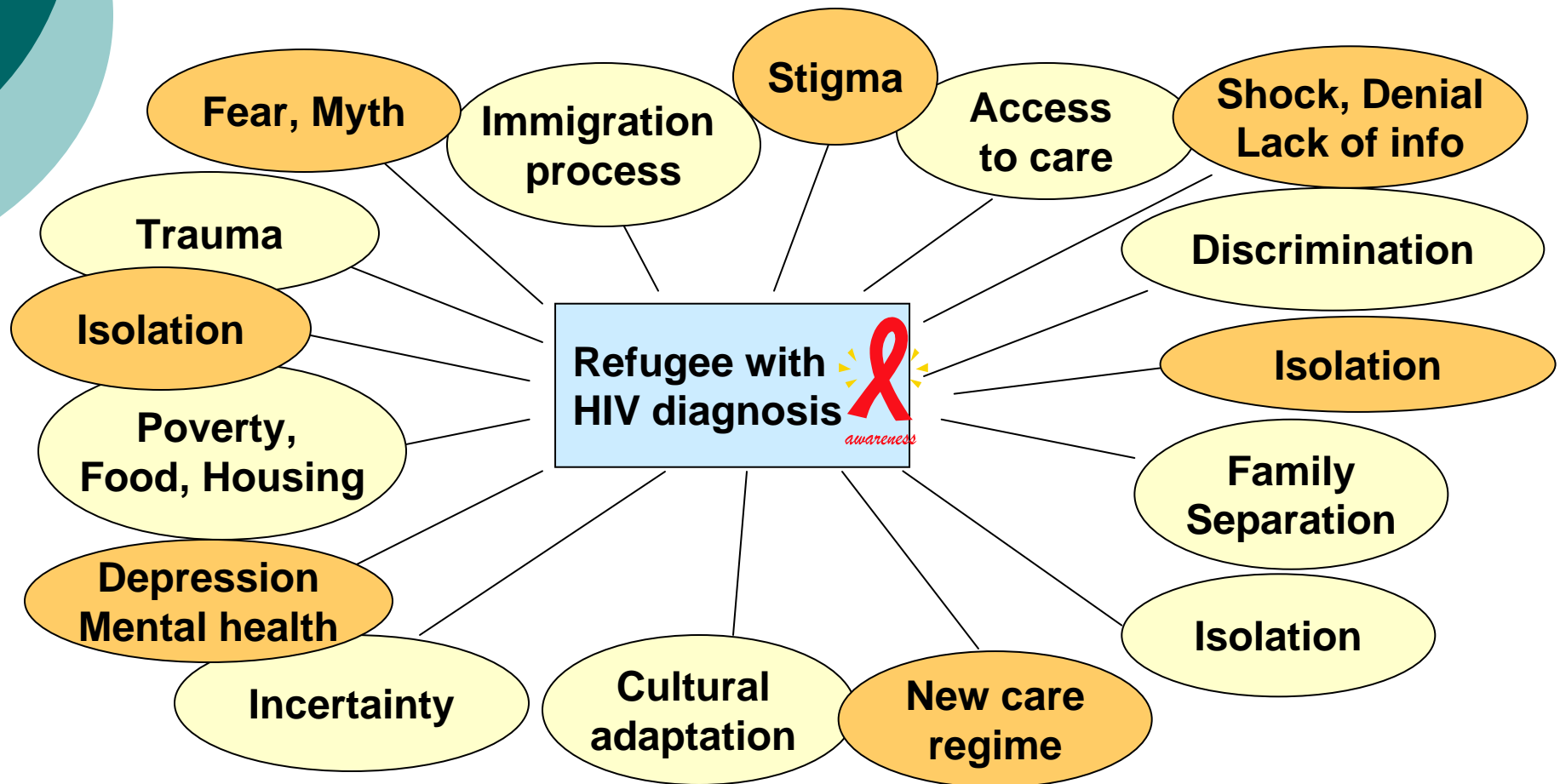
# Reality of adjustment for refugees

- Precarious living conditions; adjustment can be overwhelming for asylum seekers (Silove et al, 1998; Mollica, 2001).



# Reality of adjustment to an HIV diagnosis

- Reaction and adjustment to an HIV diagnosis is overwhelming (Angelino et al, 2001; Cooke et al 2002; Tate et al, 2003, CAAT Think Tank 2006)



# Mandatory HIV testing in Canada

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As of January 2002: Mandatory HIV testing for all applicants of immigrant or refugee status

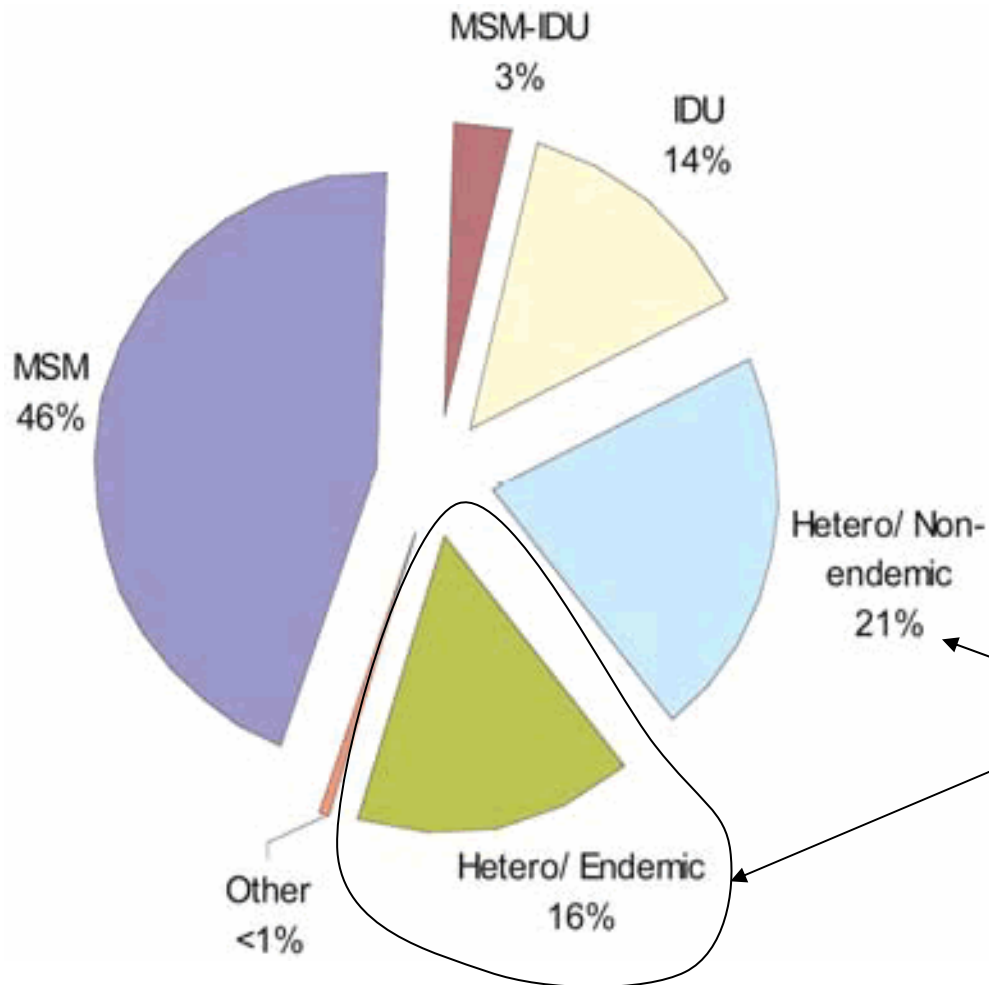
January 2002 - December 2004

*Applicants with positive tests:* **1,474**

- 556 tested positive outside of Canada
- 918 tested positive in Canada
  
- 981 (67%) born in Africa / Middle East
- 334 (23%) in the Americas
- 109 (7%) in Asia
- 50 (3%) in Europe.



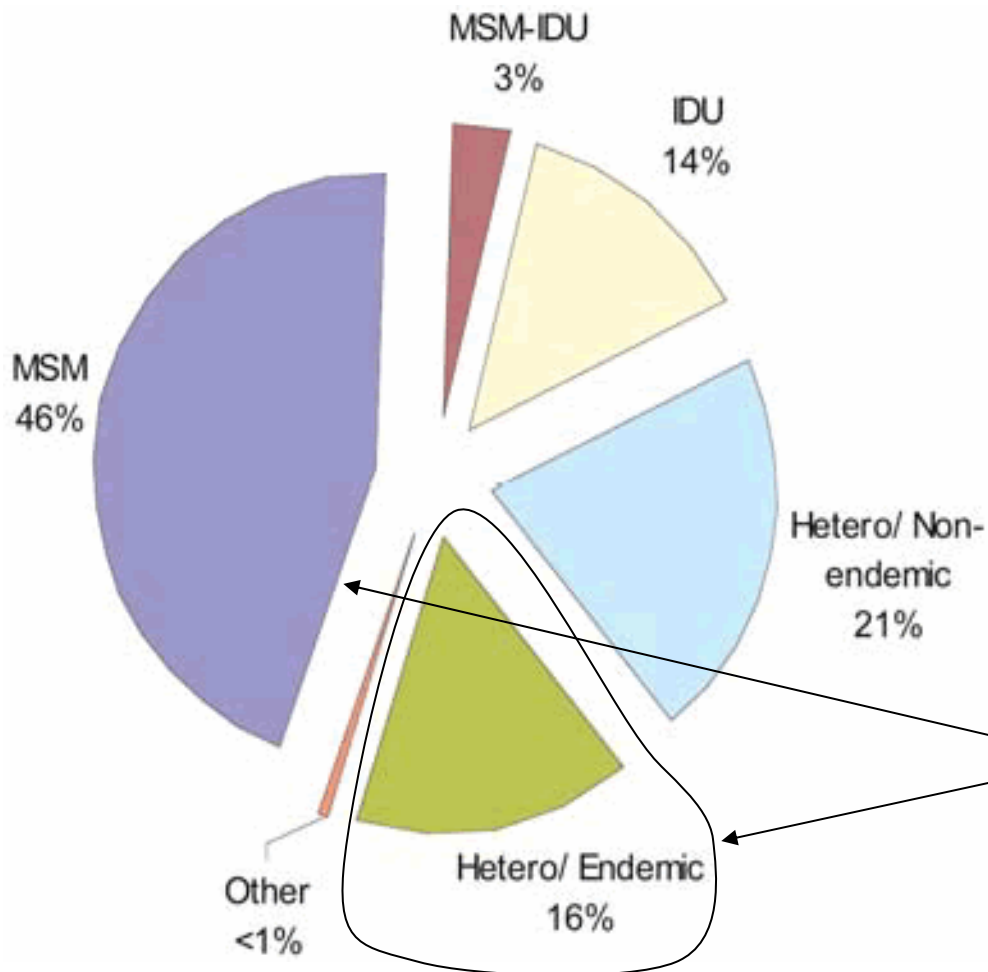
# Incidence HIV in Canada, 2005



**Estimated number of new HIV infections by exposure group in 2005 (CIDPIC)**

NB: Majority refugees fall in endemic group, but some are from non-endemic countries

# Incidence HIV in Canada, 2005



**Estimated number of new HIV infections by exposure group in 2005 (CIDPIC)**

NB: Groups do not distinguish b/w MSM from endemic countries



# HIV Clinic, Montreal Chest Institute

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- **HIV/AIDS ambulatory care clinic in teaching hospital**
  - Montreal Chest Institute, McGill University Health Centre
  - *UHRESS, Unité hospitalière de recherche, d'enseignement et des soins sur le sida*
  - Provincial mandate for AIDS Day Hospital
- **Interdisciplinary HIV team (all on one floor!)**
  - Nurses, outreach nurse in addictions
  - Family doctors, infectious disease, microbiologists, hematologist
  - Social worker, psychiatrist, psychologist
  - Clinical research team, 1-800 AIDS Consultation line
  - Pharmacists, nutritionist
  - Reception and clerical staff
  - Lawyer, hospital chaplain

# HIV Clinic, Montreal Chest Institute

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- 16% of new HIV infections in Quebec in 2005 were in group of people from endemic countries
- Quebec HIV surveillance data based on provincial health card
- Does not include asylum seekers or “*les sans papiers*”
- Also, an MSM/endemic is automatically placed in MSM group
- Underestimation of actual reality of HIV refugees



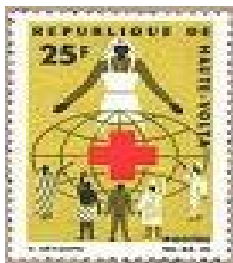
- Asylum seekers and immigrants are referred to clinic by immigration MD (often only 3-4 weeks after arrival to Canada)
- **1/3** of our total clinic population are immigrants/refugees
- Majority are refugees from HIV endemic and politically unstable countries in Francophone Africa and Haiti, but also Latin America, Anglo Africa and the Caribbean

# HIV Clinic, Montreal Chest Institute

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- Serious shortage of family doctors in Quebec
- HIV clinic becomes default primary care centre for many patients who cannot find family doctor or access traditional health care system due to IFH
- Refugee patients are being seen at our clinic for wide variety of medical and psychosocial issues
- (emergency walk-ins, regular health check-up, psychological therapy, psychosocial issues)





## Emerging research to address issues

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- Recent increase in community-based research concerning issues of HIV and migration
  - Proactive community health organizations and researchers (Montreal, Toronto, Vancouver, Ottawa, etc)
  - Canadian Council for Refugees
  - Toronto Think Tank
- But how is this issue addressed by the health care staff in medical HIV clinics? Especially in Quebec?

# Two worlds “colliding”



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## Research Questions:

- What is the process of adaption of refugees in relation to an HIV diagnostic following forced migration, and in the Canadian (Quebec) context of health care?
- What is the process of adaptation of a specialized HIV health care team in relation to the care of a refugee population and the refugee context of HIV?



# Diverging perceptions

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*« The way a health care team responds to sensitive issues within a multicultural setting can be symbolic of the « culture of learning » of the clinic (Fowler, 1993)*

Important to understand the perceptions of:

- 1) Refugees and asylum seekers
- 2) Members of the interdisciplinary team

# Note on ethical considerations

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- Important to give a voice to the numerous refugees in the world, in order that their experiences are included in local and global HIV studies **BUT** in such a way that they are neither exploited nor put in danger
- **Ethical considerations** are essential to consider when recruiting this **vulnerable population**

(Ruppenthal, Gagnon, Tuck, 2004;  
Jacobsen & Landau, 2003)





# Qualitative methodology

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- Reflexive practice - 8 months of observations during clinical nursing interventions in an HIV clinic 2003-04 (several new patients seen during this time)
- Recruitment of a diverse group of patients and also members of the health care team in order to elicit wide range of issues affecting migration and HIV
- Multiple semi-structured interviews & home visits (pts)
- Limiting factor of time in recruitment of participants



## Patient sample (n=7)

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All in Canada < 2 years; HIV diagnosis < 6 months after arrival

3 Women 4 Men	3 Asylum seekers 3 Refugees (arrived as AS) 1 Humanitarian appeal	5 Parents (all separated from spouse & children)
Ages 26-46 mean = 37	5 Africa 2 South / Central America	2 MSM (separated from partners)
2 English 2 Spanish 3 French	Civil war, Corruption, Political instability, Genocide	Variation in stage of illness (ARV, cancer, hepatitis...)



## Health care team sample (n=6)

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4 Women 2 Men	2 Nurses 1 Medical specialist 1 Psychiatrist 1 Social worker 1 Hospital chaplain	Experience HIV 3-15 years Mean = 8.5
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# Overview Results and Discussion

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1. Adjustment of refugees / asylum seekers to HIV
2. Diverging themes
3. Adjustment of HIV team to refugee population
4. Conclusions
5. Future directions

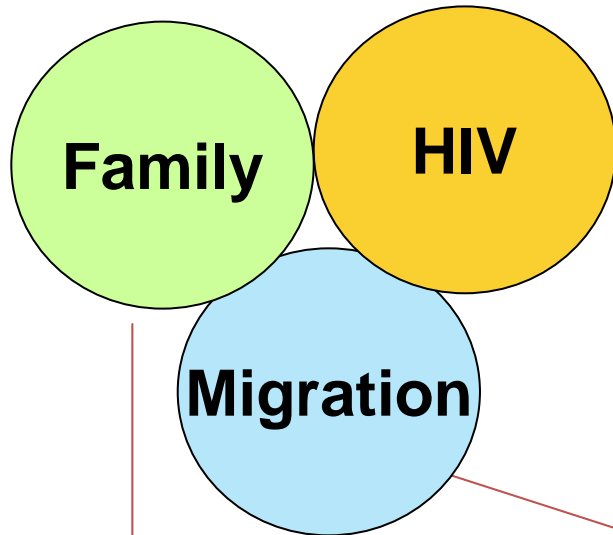


# 1. Spheres of Adjustment

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- High level of complexity of issues
- The refugee patients and the member of the health care team identified several layers of complexity, difficult to isolate any one individual issue
- Emergence of three spheres of adjustment in refugees and asylum seekers :  
Migration, HIV, Family

## Spheres of adjustment



### HIV

- Shock, beliefs, previous experiences
- Mode of transmission, attribution of HIV
- Stage of HIV/AIDS illness (primo, late)
- Treatment issues (OI, Rx, adherence)
- Other physical or mental health issues
- Stigma, Isolation, Discrimination

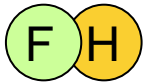
### Migration

- Torture, trauma, PTSD, depression
- Migration trajectory to Canada, flight
- Refugee claim, immigration, hearing
- Access to basic needs (\$, housing, food)
- Access to health care (Interim Federal)
- Discrimination, racism, isolation
- Adaptation (culture, language, society)
- Access to community resources

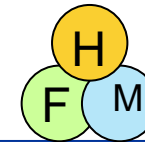
### Family

- Relations with spouse, children, friends
- Roles and responsibilities within family
- Other social support networks
- Access to community resources

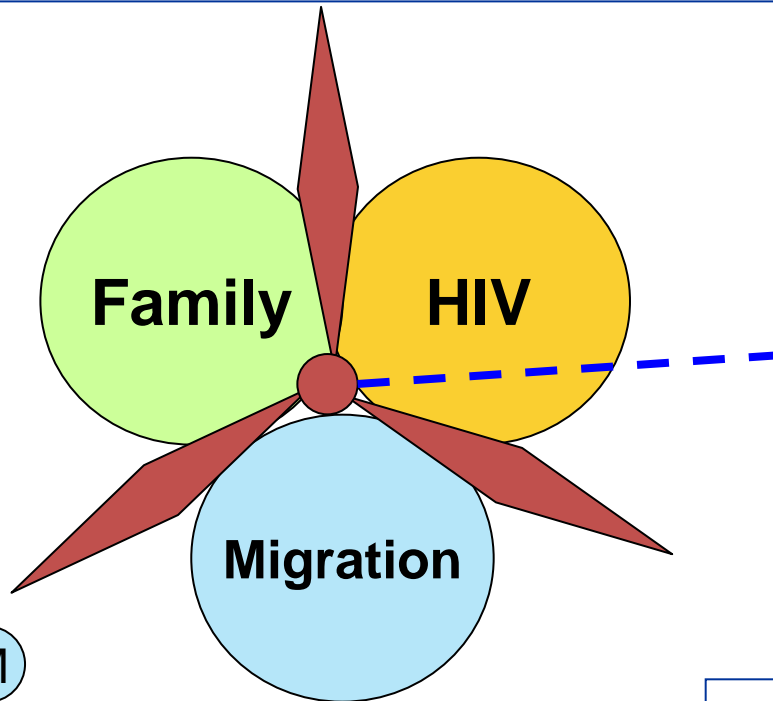
## Complex intersection of adjustment spheres



- Mode of HIV transmission (eg. partner)
- Disclosure of HIV serostatus to family
- Sero-discordance with spouse/partner
- Desire for children, meaningful relationship



- Disclosure, transmission (eg. via rape)
- Discrimination: Refugee + HIV
- Discrimination: Refugee + HIV + MSM
- Fear to test children still abroad for HIV
- Family reunification in context of HIV
- Access health care/Rx for family abroad
- Impact on physical and mental health
- Illness prevents work, family role, \$\$
- Ability to adhere to ARV and care plan
- Cultural and health aspects of food

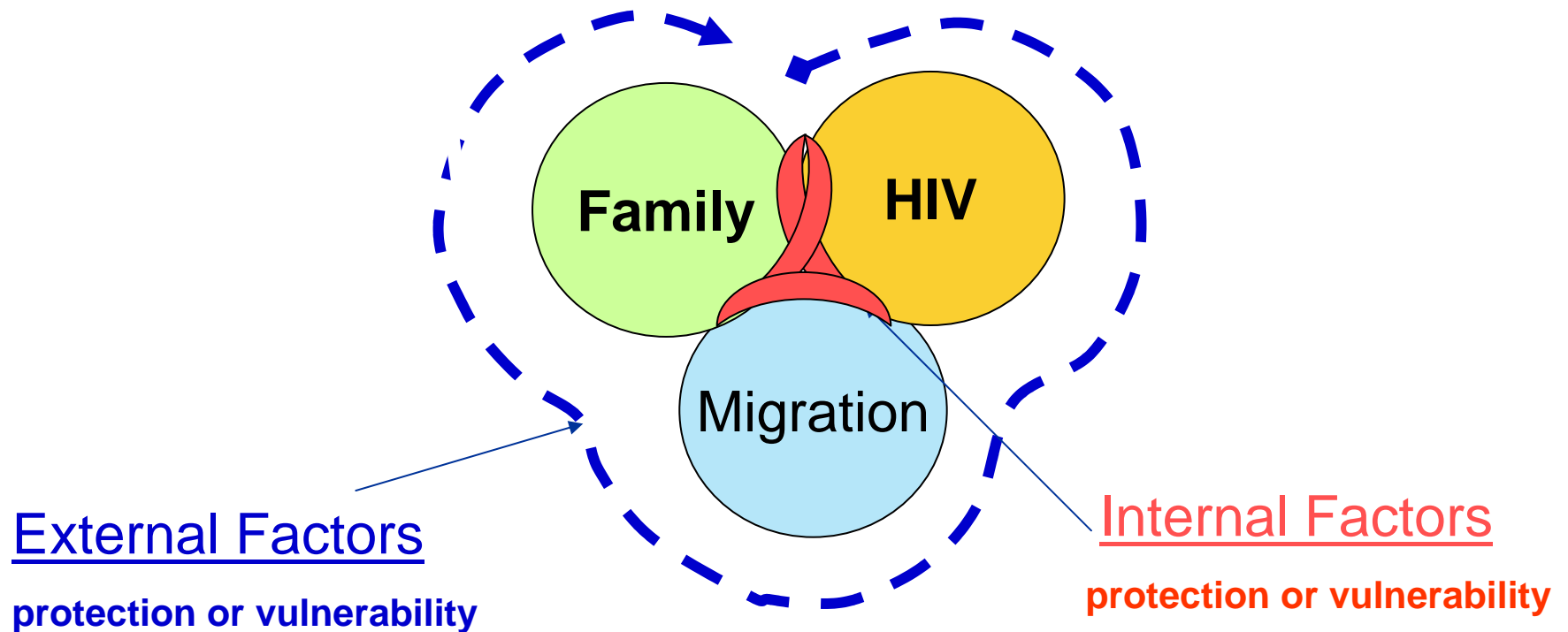


- Separation of family, isolation
- Presence of family in Canada
- Responsibility to \$\$ for family
- Access to resources for refugees



- Obligatory HIV test, shock of results
- Fear impact of HIV on refugee claim
- Access health care (interim federal health)
- HIV Transmission through violence (rape)
- Access HIV resources for HIV immigrants

# External and Internal Factors affecting the adjustment



- ++ Interdisciplinary team, safe space**
- ++ Moral / communautaire support**
- Separation from family**
- Refugee process and immigration delays**

- + + Religious belief / faith**
- + Hope in a new life**
- + / - Hx of adverse events**
- “The little devil’s voice”**

# Increasing degrees of complexity

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Ashley Luckwill



## 2a. Example of diverging themes

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### *Physical space of HIV clinic (“8<sup>th</sup> floor”)*

#### **Potential source of anxiety?**

- Fear of being seen by others, presence at clinic will disclose HIV status to community
- Mistrust of Institution linked with fear of immigration process

#### **or Potential source of support?**

- Place to ask questions, vent, be listened to, not feel judged
- Sense of place, trust of those linked to 8<sup>th</sup> floor



## 2b. Example of diverging themes

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### ***Religious belief and faith***

#### **Potential source of conflict?**

- HIV as direct punishment from God for sins
- Faith alone will heal HIV alone (no need for ARV)

#### **or Potential source of support ?**

- Faith in God will help them face / overcome challenges of HIV

#### **Internal struggle:**

- profound faith versus fear of HIV disclosure to religious leader

#### **Lessons learned by team:**

- Integration of hospital chaplain into HIV team, monthly mass services
- Does NOT replace need for advocacy with religious community
- DOES promote coherence by allowing patients to address challenges of migration and HIV in the context of their faith



## 3a. Adjustment of Team - Insights

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### *Insights*

#### **Grasping complexity of issues**

- Importance of insight into the reality of this unique HIV group cannot be overlooked
- Teams acknowledges **conflicting priorities** for newly diagnosed refugees (eg. immigration, family, basic needs)
- Even if HIV status is precarious, team has to accept that HIV is often not pt's priority at that time
- Finding creative ways to offer appropriate care in this context



## 3b. Adjustment of Team - Learning

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### ***Learning curve***

**Discovery in motion, case by case**

- **Mental health** (eg. Post traumatic stress disorder, depression)
- **Physical health** (eg. Physical violence, rape, torture, HIV variance)
- **Women's reproductive health** (eg. Menopause, desire for children)
- **Global politics** affecting migration (eg. Civil war, genocide, justice)
- **Immigration process** (eg. refugee claim, IFH, family reunification)
- **Cultural issues** (eg. Concepts of health, social & religious norms)



## 3b. Adjustment of Team - Learning

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Intense learning can be **overwhelming**:

- “You read about it in the news but those atrocities always seem so far away, you know, the consequences of war and torture. Then one day, you are facing it, in your clinic right here in Canada. The stories are so shocking. You even wonder, can they all be true? But of course, you know it is ... I was never trained in school to deal with this kind of thing”.

But also **inspiring**:

- “I have worked for many years in HIV. Working with this group is so motivating, it has given a new breath of life to my work. ”



## 3c. Adjustment of Team – Team Space

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### ***Interdisciplinary team and shared space***

**Shared space is physical** (entire team on one floor, easy access) **as well as symbolic** (weekly psychosocial rounds)

- To better address multisectorial needs of patient
- But also, to offer moral support to each other when team members find themselves overwhelmed by the immensity of what are often tragic situations

## 4a. Conclusions

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### HIV+ Refugees and asylum seekers

- Unique and vulnerable HIV group
- Layers of complexity: Migration, HIV & Family
- Conflicting priorities, HIV is often not biggest concern
- Vulnerable population, but able to "rise against the odds"
- Specialized interdisciplinary HIV team supports existing resilience
- Lack of specialized care can risk them falling through the cracks

- Similar results were confirmed through a large scale study of refugees from sub-set of patients in same clinic:

*Optimizing health outcomes in a population of HIV+ refugees from Sub-Saharan Africa. (Report submitted to Health Canada, March 2007). Ankoud, A; Cyr, J; Duchesneau, C; Gilmore, N; et Thompson, D.*

## 4b. Conclusions

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### Interdisciplinary HIV team

- Adaptation of specialized HIV team to emerging populations is virtually unstudied phenomenon
- Learning process is intense ... and should be continuous!!
- HIV team is in a unique position to accompany patients
- As HIV specialized nurses, we have the privilege, as well as the moral responsibility to continue advocating for this population, both within Canada and on a global level



## 5. Future directions

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- Examine diversity of global regions and cultural HIV realities
- Family reunification in context of HIV
- Long term adjustment of refugees to HIV and migration
- End of life issues (Canada and abroad)
- Ongoing collaboration with community organizations
- Collaboration with HIV clinics in other cities across Canada
- Develop best practice guidelines
- Advocate for policy changes

# Acknowledgements

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# Limitations of the study

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- Small sample
- Convenience sampling
- Subjective analysis of data
- Interactive methodology can create bias
- Only a short term measure of adjustment
- Results cannot be generalized