WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Engaging Immigrant and Refugee Populations in HIV Services

24 September 2015

CHELSEA WHITE: Good afternoon, everyone. Welcome to today's webinar, titled Engaging Immigrant and Refugee Populations in HIV Services. Today's presenter will be Deliana Garcia. My name is Chelsea White. I am one of the two training and technical assistance specialists for the Partnerships for Care project. The Partnerships for Care projects is a three year, multi-agency project funded by the Secretary of Minority AIDS Initiative fund and the Affordable Care Act.

The goals of the project are to expand provision of HIV testing, prevention, care and treatment in health centers serving communities highly impacted by HIV. It is also to build sustainable partnerships between health centers and their state health departments, as well as improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training, Technical Assistance and Collaboration Center.

Today's presenter will be Deliana Garcia. Deliana Garcia is Director of International Projects, Research, and Development for the Migrant Clinicians Network. Deliana writes and presents on the health needs of migrants and the disparities in the provision of health care services they suffer. She has developed clinician training on infectious and chronic diseases and programs to assist migrants to remain in clinical care as they move for purposes of employment.

Ms. Garcia has been involved with migrant populations for 20 years. She has worked in the areas of reproductive health, access to primary care, and infectious disease at the local, state, national, and international level through program and policy development and publication for more than 25 years. Her past experience includes direct patient education, legislative advocacy, and as a consultant to federally qualified health centers in the United States.

DELIANA GARCIA: My disclosure, only to let you know that I don't have any interest related to this presentation or relationships to therapeutic pharmaceutical companies, biomedical devices, and it's always important in my estimation to say that, because I really would like everybody to know that my concern for the care of migrants and immigrants and refugees is strictly based on the work that we're doing here out of the migrant clinicians network and the desire for them to receive the services that they deserve.

Part of what will help me-- although I've read about the Partners for Care Project-- is to understand a little bit more about all the folks who are on the phone with us. And so they're going to be opening a poll that will ask you to tell us what your role is in the P4C project. And so

what you'll see in front of you then is a screen that asks you to describe your role for us as best as you can. Are you part of the non-clinical staff or the clinical staff?

And I know that this is a partnership between health centers and health departments. And so if you are partnering from one of the health departments in the states that are participating in the project, we'd love to hear that as well. Or if you're a federal staff person who's participate as a listener to this to see how we're doing, we would really love to know who all is on the line. If you just hover your mouse over the appropriate circle, then it'll allow us to highlight which of the categories you believe you fall into.

And then here very quickly they're going to be able to outline for us what's the sort of number of folks in these different categories that are on the line with us today. And it'll hopefully also direct where I need to have greater emphasis, so I want to reiterate the point that was made to you earlier-- if you have a question on a particular issue that gets raised, please use the chat option so that people can see what your questions might be and we can be more specific in our response.

So it indicates that we have no clinical staff and that better than half are clinical staff in the partner sites. But we have good representation, equal representation, from health department and federal staff. So it's wonderful to know that you're on the line with us. What would also help me is if you would please answer the next poll question that's going to come up. Because what we'd really like to know is tell us about your immigrant or refugee population that's being served.

Is there a preponderance from one of these regions of the world-- Caribbean, Africa, South American, Asian. Other really could mean that it's really a combination, not one of the stands out. Whatever other really means to you, it really can just be that none of the previous four speaks directly to the people that you have coming in seeking services in your site. I know that many parts of the US have had a growing representation from a particular region, but that their populations are also changing.

So we can also, if you'd like, in the chat portion say that your answer currently represents one region of the world and that this is really changing from what you might have seen as little as three, four, five years ago, because that's also good to know. I know that many places like Minnesota are starting to see many more African refugees coming in and that arrival of larger Somali populations has really created a change in how they've been structuring their health care services.

So from our response, we can see that an equivalent number have folks coming from the Caribbean and South America, but that greater than half of you would have to pick other as the category. So I'm interpreting that-- and please show us in your chat box if my interpretation is incorrect-- that you are really starting to see a mix of patient populations coming to you for HIV services. And I think that really speaks to the migrant experience of the US overall, which is that we have individuals arriving to us at varying frequency from all over the world.

And I think that what's important to me-- and as we were preparing for this presentation, the staff had to back me off from this a little bit, because my interest is always in talking to people about migration and what we know to be going on. And the recent story of human migration, even in the last, gosh, 25 years, but certainly even in shorter periods of time, is that improvements in transportation and communication-- meaning that you can get all the way around the world in just a little over 24 hours, or that your message can come to you in an international text message from any where, coupled with the fact that there's really a growing world economy-- whereas in previous decades, the economy was really highlighted in Western regions, we now see economic growth in parts of Africa that's really unprecedented.

But with that growing economy, what we're also seeing is a greater social inequality. And the fact that is so visible to people, whereas before it might have been much more difficult to understand and to see the evidence of it, is now so clear-- that coupling that with the fact that people can now move around more easily. While the news has been rife with restrictions for people's movements, things like the European Union have created ways for folks to move around in a way that is very much different.

And really then ultimately the rapid dissemination of the information about all of these things. For people to hear so quickly that transportation has approved, that messages get communicated, that they can see the social and economic inequalities and they can really see themselves taking advantage of the movement, then really sets the stage for human migration now. What I think is historically the case is that human migration, particularly in the United States-- I would say that this is somewhat different in other parts of the world, but certainly within the US-- human migration is principally perceived as being slow and unidirectional, resulting in permanent resettlement of the global south into the global north.

I think when we ask people or we think about the news and we look at what's been covered, mostly what's said is it's people coming from poorer countries in the south to richer countries in the north, and while that is certainly true for a significant number, it's also important for us to understand that better than half of the population, human population, migration that we see in the world is going from the global north to the global south, and then certainly east to west and west to east-- much more than what we see in moving from global south to global north.

So it is between equally poor countries and between equally rich countries. And the motivations for people's movements are really varied. And so just understanding that it is a non-stop process with a great many causes. What I think is important for us to also understand is that countries, when they're grappling with HIV in migration-- this is certainly true for the United States-- is not only looking at the population that's in front of them, but then it's also looking at a whole host of competing forces that control their ability to respond perhaps as effectively as we might like.

They may be looking at economic development and working with a part of the world with a trade agreement that should bring with it then freer movement of individuals, but it might-- any time that there's a movement of individuals, we need to worry about organized crime.

Certainly, a lot of people are leaving because they are trying to respond to the economic needs of their home and so they're sending back remittances. But there's not good mechanisms for that. Poverty relief is huge.

And what we see in a number of countries is that the greatest source of poverty relief is remittances as opposed to any other kind of investment. So the US and other countries in the world are grappling with all of these competing forces while they're trying to respond to public health concern and respond effectively to HIV and AIDS. Human migration really over the last, oh, I'd say 30 years, is really quite impressive. I think if you look at what was going on in 1990, 155 million people were living outside of their country of birth.

But then you go to 2005 and it's now up to 195 million people who are international migrants. And that constitutes 3.1% of the world population. And then just as recently as 2013, we are now looking at 232 million international migrants worldwide. So that if you took that number of individuals and collected them into a single country, they would be the fifth largest nation of the world. So thinking about the quantity of individuals then, we want to think about migration.

And so in the same way that we often focus on movement from the global south to the global north, we often don't tease out the very multiple reasons of why people are moving. So when we think about migration, I'm asking us to think about it a little bit more globally. It's any movement by humans from one location to another. Now it can be over a very long distance, or it can be a shorter distance but a much larger group, or any combination therein.

And then to keep in mind that people move for mixed reasons. We talk about that previously it was mostly men that moved from Mexico and Central America to seek work. We now see the number of women who are migrating to be equal almost to that of men. And so while we may say that women have migrated to find employment, we also see that they're moving to become more modern, to be in a place where they have greater opportunities.

We also know that men who have sex with men may be leaving home for reasons of employment, that they have the same forces on them, but that they're also escaping local stigma and discrimination because of the choices that they'd like to make. And there's now a term that we're starting to hear more and more in migration literature about the sexual migrant-- those individuals, by virtue of their choices, find themselves to be marginalized or endangered.

And then we also need to think about migration-- and we know about this a great deal in HIV care-- that health care workers from countries that are in conflict may migrate to look for better working conditions in wealthier countries, but also to escape oppression. And so they have multiple reasons to be leaving. And so then the reasons that motivate people to come to us and what they may be facing as we're starting to work with them can be really varied.

So I want to go over a few of the items that become important in the whole discussion around migration, that have an effect on HIV risk and vulnerability and our ability to respond

effectively. And the first of the distinctions that I would make is the difference between voluntary migration and involuntary migration. I think even if you have the chance to go of your own volition, while that is certainly different than having come because of human trafficking, there's a lot that goes on. And it's very complex, and it's sometimes very contentious.

So when we talk about mobile groups or individuals who migrate, we're talking about international migrants, internal migrants, irregular migrants, trafficked people, international labour migrants, internally displaced people, refugees, asylum seekers, stateless persons, tourists, and international students. So you can already see that whole combination of describing people, what is motivating their movement, is that whole combination of voluntary and involuntary.

The next thing to consider too, then is whether they were able to come in sort of an anticipatory state-- meaning that they made a plan to leave and they had some resources. The community had pooled their funds so that this person would have some money to function with, they had some education, they have some social connection in the destination point, and so then they've been able to clearly choose what that destination point might be.

And so the other thing to consider though is that HIV risk and vulnerability while the person is moving can become acute. So especially if the journey takes longer or takes place under much more difficult circumstances than they had expected. So vulnerability in transit is affected by the extent to which that person is able to prepare for the journey, then control the conditions and have their resources remain available to them.

So I would offer as an example the women who've come up from Guatemala. And even though they may have anticipated the movement, as they transit through Mexico they're not able to control the conditions, and they certainly have no knowledge of the resources. So they did leave Guatemala in anticipation of coming to the United States and were still deeply affected by what went on while they were transiting. And then you all may have been receiving many individuals who've arrived who've departed from their country in a really acute state.

They're escaping. They often arrive in a state of shock and sort of have the post traumatic stress disorder. They're unable to really make clear decisions. And they really are relying very heavily on the receiving community. And the thing to consider, too, is that the movement is really in flux. And they can shuttle between countries of origin and destination, they can move through several countries in their quest to get refugee or asylee acceptance. And then you also have individuals who sort of had a plan, but their intent to migrate was interrupted by the fact that they were intercepted on the path.

You hear about it a great deal now of individuals who've left Syria and they've come across and they enter in and they're trying to get to one of the preferred EU countries, but then they've been stopped by Hungary. And the interception then there-- they come in, they're in an acute state. They're really in a state of shock. They're really driven to try and get on. They may have suffered just unbelievable trauma in transit. And now it is exacerbated by the fact that they're

being held from being able to move forward. And so then the next distinction that I would like to make and really sort of the last distinction, because I think it controls a lot of our conversation, is whether or not they're irregular or an unofficial-- meaning are they authorized or unauthorized to be in the country.

And so if they're regular, they came based on a passport or on a visa. There's an international convention for refugees and asylees, and then there's those individuals who arrive in an unofficial capacity, and they don't benefit from being recognized as having arrived with a valid passport or visa. And so many of our decisions about who can access care, what kind of care and assistance they can receive, is really based on this particular question.

And so before we move any further, what I'd like to do is ask you yet another question. But just so that I have a sense of the kinds of information you're requesting from the people seeking services with you. And it would be to know, are you aware of the immigration status of your immigrant patients, either because they declare to you or it is an element of your eligibility information that you need to obtain, or it's a part of your health history and you try and collect that information so that you have a sense in the aggregate about the composition of your patient population?

Because I think there has been a long history of not wanting to ask, so that people don't feel challenged and are not made uncomfortable, if indeed they've arrived in an unauthorized status. And so I think for the purposes of our discussion, I would just be very interested to see whether or not you're functioning with a really clear sense of the status under which your immigrant patients have arrived. So isn't that interesting?

So the same percentage of you say, yes, you really do know, as those of you who are uncertain about whether or not that information is collected or anyone in your health center is aware of the immigration status. And then a full fifth of you do not know. And so this is one of those very difficult questions to deal with in a health center setting, because you don't want anyone to feel turned away. We're fearful of people being challenged. And so very often, we don't ask.

But I think having some sense of the migration experience that the person in front of you has had can also really help you put in place your care plan and think about the additional services that you might need to provide. And so I always like to talk about migration as presenting both vulnerabilities-- because person is transiting and often under certain circumstances-- but also presenting opportunities. And I talk about vulnerability because when we talk about risk, as we often do in HIV, we're talking about the probability that that person will acquire the infection.

And risk is really influenced by epidemiological conditions, as well as the person's behavior. The concept of vulnerability is a little broader. And vulnerability hinges on structural conditions that reduces the person's ability to avoid or control their risk. So some of them can be personal, like fear and loneliness and separation from their social group. Some can be societal, like poverty or exclusion from legal protections. Or they can be programmatic, lack of access to appropriate prevention and treatment.

And multiple causes of vulnerability can be experienced by the same person or the entire community. So migration itself doesn't drive the risk, but the conditions under which the mobility took place really do. And then I think another critical issue for us to consider is stigma. I think if you've worked in HIV for any period of time-- and really in a lot of other diseases where there's some sense of the person's behavior affecting what's going on-- then stigma has had a role in it.

And it's a key concept when we're discussing HIV in people who are moving around-- the prejudice, the discounting, the discrediting, the discrimination that's directed at people who perceived to have HIV and AIDS, and not only at the individual, but the groups that they're a part of or the community where they live, then can make it very difficult to gain entry into that world. I think the fear of AIDS interacts with social judgment and some of the behaviors are related around HIV transmission, like the use of injection drugs.

And so HIV related stigma, including self stigma, can be really widespread. And that HIV related stigma really compounds then the person's vulnerable and their marginalization, because they can have the stigma that's related to their HIV status as well as the stigma that's related to their mobility and migration, which include limited language or can include poverty. So the range of elements that create stigma, including self stigma for the poor person, are quite broad.

But I think that there's a great deal that we can do. And so I offer as an example this particular case study. We had an individual patient. And he came into our system, the Health Network-- and I'll describe that a little bit later-- as someone who had been coming from Central America and transiting through the US southern border, and he was detained because he was intercepted by the Border Patrol. And at the time that he went into the facility, he was screened.

But he wasn't given any of those results until after he'd been removed. He didn't have any symptoms. There was no weight loss, no night sweats, whatever. And so there was no medication given to him because it was really not an issue of concern. And then in March of 2013, Health Network received notification from the center where he'd been held and tested that, indeed, he was positive. And so we made every effort at that time after he'd been enrolled with Health Network prior to his return to be in communication with him.

So we sent medical records back to his home country and made contact via telephone with his family. But what happened was the wife told us when we first communicated that he'd already left to return. And then shortly after his wife called us to say that her husband was being held by a coyote, a person who assists individuals to transit international borders for a fee, and that he was being held somewhere on the West Coast. And so our staff then immediately called and was able to speak to the patient and say to him, you know, you've really got to get care.

And then a piece that I just passed. But we also initiated a human trafficking investigation via Immigration and Customs Enforcement. And somehow in that whole conversation then, he was able to get free and move on. And so in June of that year then he contacted us to say that he'd

been released, they'd turned him loose, which was really quite remarkable and we're not quite sure the whole conversation that went on, and that he immediately departed and went all the way across the United States to somewhere in the northeast.

But because he felt like there had been an interest and a relationship established by our staff, he called. And so then our staff people immediately found a clinic where he was, got his medical records sent there, gave them the testing results, and the patient was started on treatment. And so what we can say is that in September-- not to be dissuaded from moving, because he needed to be employed so he could support his family-- he called us to say that he was moving to another eastern state.

And so the same thing occurred. We found him a clinic, made appointments, transferred the record, the patient continued their treatment. And then we updated his wife in Central America, because we had his permission to share the personal health information with her. And so then I think what we can say is that we feel very successful because he continues to be able to move, to remain employed, to take care of his family, but his treatment continues. I think that when we talk about population, mobility, and HIV vulnerability, there's several phases-- and I think the previous case described them quite a bit-- that need to be considered. And that when you look at the patient that's standing in front of you, I think it also becomes important to think about where they are in their phase of transit. Because HIV risk is really complex-- a lot of characteristics, behaviors, access conditions, prevalence in the partner population or with anyone they might be moving.

And so I think when we look at mobility, migration, displacement, and how it affects risk indirectly because it creates these conditions, it's important to know where the person is, because it might be at that juncture where there needs to be greater emphasis in protective sexual behavior or there might need to be more behavioral health support so there's not turning to self medication and drug use because of loneliness. Or they may need some sense of how they can function more effectively in their community because they're feeling like they're unable to protect themselves.

So we talk about the various phases as during transition, in the destination community, and in the community of departure or return. But I think the thing to consider is that these phases of mobility really can occur for us in a cyclical nature. There can be the pre-departure conditions. They may be coming from a country where there's a high rate of HIV. And then we don't know fully their transiting conditions. They may have to go through a region where there are human traffickers, where there are gangs, where the complicity of the police is such that then they're at greater risk.

And then they go into a host community. And the host community can be not particularly receptive, or the situation can change for the person and they would like to return to their country of origin. And the time between when they leave this host community and have to consider their conditions of return to go back can be so long as to say that what's going on in

the country that they left no longer resembles what they might remember and the risk in that location now is much greater and very different.

And to think about when the person is transiting, that when they come to you, they have certainly come from somewhere, but to keep in mind they are likely going on to another place, that they may have come to your health center in your region first, but should they learn of a more receptive community, members of their family, members from their hometown, hearing about a job, hearing about educational opportunities, they can move on.

So understanding where your patients are in their phase of mobility I think can be quite helpful. And so I think what's also important to consider then is if you have individuals, particularly if they're arriving in an unauthorized status, that we're very frequently talking about the intersection of poverty, migration, and HIV. Let me go back just one more moment to say-- and I think what's very intriguing about the US is that globally a great deal of attention has been placed on the importance of caring for and thinking about population mobility worldwide as associated with HIV and AIDS.

And the United Nations and all those member states have really spent a great deal of time to look at the challenges and threats to migrant populations. They've made huge commitments to providing access to HIV prevention and treatment since 2001-- somewhat earlier, but certainly since all of that time. It's been twice reaffirmed. There are specific commitments by these countries to provide humanitarian aid and treatment assistance and in all of these foreign countries. And the US has participated in that.

And I think that commitment external to the US has been very different when in regard to migrants than it has been sometimes internal to the US. And the same circumstances that we've studied a great deal for other parts of the world can exist in this country. And so we need to focus on them and take some of the lessons that have been learned by our participation in the global discussion around migration and HIV and apply them here in the US.

And so what we think about in local communities that make it difficult for migrants to make healthy choices are some of the factors that may have pushed them to migrate in the first place. They came from economic deprivation, but they can come to a place where it's difficult for them to get a job. They come from disadvantaged communities, but they are forced by circumstances to be clustered in regions where there continue to be structural disadvantages.

They may have limited access to health care and support services because of where they wind up, and then certainly that can include access to HIV prevention services early on in the whole process as opposed to just speaking to it in terms of HIV treatment and care. So I think the ability to make healthy choices also affects how well our communities, our immigrant and refugee communities, are doing. I think one of the biggest challenges, too, is this myth about migrants bringing HIV and what that does in the national dialogue.

But I think what's important for us to consider is that people do travel between locations where there's a difference in HIV prevalence, and that mobility can have a significant impact on the community of origin as well as the one through which they transit. And I think it's important for us to remember that a lot of migrants, displaced people, refugees, acquire HIV while they're living abroad and they eventually returned to their home countries.

So I think for many years the predominant model was that the migrant worker would acquire HIV from unprotected sex with partners while they were broad and then transmit that virus back to their wife or other partners at home. And that's certainly been observed in a number of studies. And I think then challenges this myth about migrants bringing into the US HIV. For example, if you just look at the studies that have been conducted in Mexico, the number one risk factor after being a man who had sex with men is that you migrated or that your partner migrated to the US. So I think it's important for us to be attentive to the realities of both migration and then the presentation of HIV disease.

Because I think a great deal of attention is given to migration from low income countries to high income countries. But really, with a notable emphasis on the fact that it's going to overburden the health care system-- and not to say that the health care system doesn't have some fragility, that there are not some points where it can really struggle under the weight of demand, but I think that it is really important to not let the dialogue just be around the economic burden that can be experienced in the health care system, and that we look at having the health care system be as responsive as possible.

So when we talk about models of mobility and HIV risk, here's the interplay that I think is important for us to consider. You can have migrants or displaced people who will acquire it while they're living abroad. But then the other thing to consider is that there can be a couple where one partner migrates for work, but they may not be the first person to acquire HIV. The affected partner can stay home, the person who migrated fails to send remittances, so there's no money to maintain the family, and the person who remains at home then can engage in unprotected transactional sex to make ends meet.

And so where the risk now resides is really quite variable. And so I think it's important for us to be concerned about the health of the individual, not just while they're in front of us, but thinking about that entire circle of transiting, which means that they can return to their communities. And so we have access to them and a responsibility to them while they're right in front of us, certainly.

But we also have something that we can contribute to reducing the possibility of spread to other countries when they leave us and perhaps move back and return to their community of origin. And it really is starting to receive greater attention in the countries that are now seeing huge out migration, and then preparing to see the return of their co-nationals, and having a real sense that HIV, among other things, is one of the issues that they to which they need to be attentive.

I think one of the compelling issues when you're working with an immigrant population is understanding that it's the very same government and not to cast aspersions but to say the same government that is trying to implement their immigration requirements at the same time that the health care arm of it is trying to encourage undocumented immigrants and migrants to come in and utilize health care services. And that the individual who's then being recruited to participate in services and take advantage of them is also a living in a community where the conversation around the government's efforts to apprehend them and return them can make it difficult for them to see the value of one versus the other and not roll them all together and see them as one and the same.

So I think HIV and AIDS, particularly for the populations that you are concerned with, see that their risk increases by the fact that, even if they're not migratory workers, they're coming in as immigrants and refugees and may feel the need to move on to a place that is more hospitable, where their language and their culture are really not barriers because they've heard that there is a community to which they can be incorporated and where their immigration status may be sheltered, may be hidden, and that is a real motivation.

I think the risk, however, is also increased by the fact that, because they may have this documentation concern or limitation of language, that then they are often incorporated into jobs that are really quite dangerous. And so that also increases the risk that we need to consider, because their employment opportunities can be so uneven and their ability to remain employed and survive can be up and down and they may need to engage in other transactional pieces then for survival.

And then of course they will lack access to insurance and other financial resources. And when I talk about lack of regulatory protections, for example then when we talk about HIV risk and dangerous occupations and lack of regulatory protections, we hear the experience of female agricultural workers who are unauthorized immigrants. And because there are no real regulatory protections, the rate of sexual harassment and coercion is really quite high and their ability to protect themselves is really quite low.

So the fact that they migrate per-say is really not the issue. It's really the conditions under which they live and need to move around. And of course barriers to health care access are, as we see for a lot of groups-- they can be unfamiliar, they can come to the community from somewhere else and be unfamiliar with local resources. But when we talk about refugee and immigrant populations, then of course, it's language. They may not drive, may not understand the local transportation system or there may not be one, if it's in a more rural or urban setting.

They may have a really confused knowledge about their rights and their legal status may change, or what was provided by the initial legal status is then removed. Certainly you know that refugees who arrive have access to Medicaid, but that really only extends for six months. And then at the end of six months, they roll off. So that then when we start looking at income verification status-- and it's right at that decision point that can be really quite confusing.

And in general, unless there are specific supports that come to people, then they may lack the funds for the kind of health care that they require. I'd like to talk for just a moment about barriers for women and risks for women. And not to say that there should be greater concern more or less, but I think that what is really true is that women continue to function under some of the same social norms that made HIV risks so big for them in their countries of origin.

And certainly if they've come and they now find themselves isolated in a rural area, then the things that we've talked about before in terms of transportation and whatever can be missing. But also what we're starting to see is the lack of access to a telephone. The whole group may have one cell phone that is held by the male in the family and they take it with them to work and there is no other access, so that the ability to call and try to make an appointment or find out about services is really limited.

And then there are often not the social supports. And it creates an extreme isolation, not only because of where they are geographically, but because then they don't have the resources to try and create more human connections. The cultural piece, we talked about slightly. But I think the male dominance in the family and in those relationships is what I want to emphasize here, because it creates, for many women, an economic dependence that also then increases their risk.

And one of the things that we've recognized for a long time is that, for many women, the well being and their children is much more important than their own health. And so then the stress related to if they're in an isolated rural region or far way or unable to communicate with assistance services or support means that then they'll forego any effort to understand more about their own health or seek health care, because they're concerned about their children's success in school and general well being.

The other thing that I would want to speak to is some of what we touched on before, which is that women can then really be subject to the sexual harassment and abuse-- certainly trafficking-- and while men are trafficked as well, the greater number for sexual slavery are woman, and that where there is an inequality in power and in position, then there's also the possibility for violence. Men coming as immigrants, certainly as unauthorized immigrants, can feel also the tenuous nature of their work circumstances, the absence of sound living conditions, their sense of loss of authority, to be challenged themselves, to feel the deprivation that comes from being in a place where you are not respected, where there's a lot of stigma, then I think what we see is that their ability to look at those relationships and not to turn to violence becomes much more difficult.

There is often among young women from regions of the world a real desire to be pregnant. They've had difficulty being pregnant or with pregnancy or the desire to be pregnant then. There is limited risk protection taken on their part. And then certainly what we've spoken of before, which is access to screening and preventive care. Not to belabor the point too much, but I really do want to say that human trafficking is huge. It's enormous and much greater than I think many of us really understand.

And so I add this here not to say it can be our sole focus, but as we're talking about HIV risk and vulnerabilities, that we understand that human trafficking is a huge, huge impediment to sound care and sound HIV prevention, because so many of the victims are coerced and wind up-- if not in labor exploitation where it's servitude-- there is also the additional element of they will be exposed, they'll be turned in, they'll be turned over to ICE unless they submit.

And so then it can be both work that's like sweatshop work, but also then prostitution to maintain what is a limited liberty, but liberty from being returned to their country of origin. So I go back to this graphic that we saw just a little bit earlier, because as I said, I think it's really important for you to consider where your patients are in the phase of mobility. And are they just coming to you from their country of origin so that your questions to them can really be about the pre-departure conditions? If they came as refugees, then what were the transit conditions? Were they held for a long time in a refugee camp before they were able to come?

You are the one who can best determine what the host community is going to be like for them. But I think it's always important that as you look at an immigrant or refugee patient, you consider the fact they are always going to be in a place to want to return, to perhaps need to return, or to need to go on. So the phase of their mobility can have an important effect. And then those of you who've been engaged in HIV work for a long time really I think the note that I would want to make it is that there's no reason to presume that an immigrant or a refugee patient is going to engage in more or less risky forms of sexual behavior than an individual in your domestic population.

So I think if you've been engaged in HIV work that you need to understand that the lessons that you've learned to try and work with individual risk groups or segments of your population will have application here as well, because any of those subgroups of concern in the general population are going to be present in your immigrant and refugee population. So the lessons that you've learned about HIV prevention when you're working with men who have sex with men, or intravenous drug users, or sex workers, or clandestine migrants who may be having sexual contact for survival, would be then need to be carried forward into the new population with whom you are working.

It may mean that they need to be modified for language, that there are some cultural issues to continue, but that some of the driving forces behind the risk that these different groups lived with and lived under are going to be present for others. So if you've been working with teenagers who've been thrown out of their home because there is a desire to have a sexual representation and presentation different than what their family will accept, may have turned to drugs on the street or transactional sex for survival. Those lessons then have application to other groups, and you come to this work with a lot that you can rely on.

And you need to take that to heart. I think the differences become, when we start looking at immigrant and refugee populations, is that the person in front of you may find themselves in what they believe to be a social and cultural context that's very different from their own. So that even if it is an individual who is using intravenous drugs and there is a lot about addiction

and use of drugs for self medication that you can bring forward, they are standing in an environment that feels really different for them.

And that feeling of being alien can then be constantly present and very difficult to overcome. So then the linguistic differences, particularly individuals who are older when they come, stay, and become really a distinction between themselves and the domestic population. And while we see people really learning English and amazingly being able to apply themselves and navigate when they are intent to do so, they will often for the remainder of their lives not be as articulate or able to express what's going on for them as well as they would in their native language.

And so you have lessons that you've learned. You're receiving segments of the population very similar often to other segments. But the additional overlay of feeling of difference that the person in front of you may have may make it difficult to bridge the gap between what you know and what they need, only because they are struggling also with how to represent themselves in a new place and in a new environment. And I think the language issue is really huge.

So we have another poll that we wanted to ask right at this point. And it's really, if you can tell us, do you know how many languages are spoken by your patients? I think we hear a great deal, particularly from rural settings where they have been longstanding Anglo and African American communities-- for example, in the South-- who are now receiving an extraordinary influx of Latino immigrants and so they are trying to catch up with that language experience.

Or we have sites who've worked very hard to make sure that they have Spanish language capability only come to find out that they are now receiving immigrants from indigenous populations. And so then those languages become an impediment because they don't have anyone who is able to translate for them and a person coming to them is really not able to rely on Spanish-- and certainly not English-- to articulate their needs for health care services to the person who is trying really quite desperately to help them.

And then we're certainly finding some urban settings where the population is so varied that the number of languages that have to be negotiated is really quite large-- places like Houston, who've had a significant influx of Asians and east Asians, are finding the need. So about equal numbers of you need at least three languages and then the same number needing five or more. And that really is, even for the 25% of you who are able to navigate with two languages, it is one of those pieces that needs to be kept in the forefront as you're trying to put your services together.

Five or more. That's really quite impressive. And it would be interesting if in the notes some of you could give us a sense of what those languages are, or any of the ideas of how you've been able to handle them. We're going to discuss language a little bit later in the presentation, but I would love to hear from you in the notes section some of what you're using. As far as the partners for care project is looking at then, we're talking about those services that are required

through the 330, the health care system-- which means that all of the programs that are involved in this project have to be providing primary care, preventive services, emergency services, pharmacy, and outreach and enabling services, either directly or through some kind of contract negotiation, some kind of referral service.

And then now looking at HIV services, certainly what everyone is asked to bring to the table is the ability to provide early intervention. But in all cases, the outreach and the ambulatory medicine piece, as HIV becomes in many people's thinking more of a chronic disease, even though this is a population where we're needing to make inroads. And then there's the entire issue of AIDS drugs. So much of that is state based. And so how you integrate that then into your system is another element that needs to be braided in with oral health.

And behavioral health services, very often because of the folks coming to us then, there also needs to be the referral and the connection to recovery, to substance abuse outpatient, and then certainly-- and for so many things, and principally for people who are on the move-- case management. Because treatment adherence is so important for the maintenance of the person's health. And we need to look also at the person's eligibility to health insurance or cost saving assistance, cost sharing assistance for low income patients-- I know that around HIV and AIDS, nutrition therapy and certainly hospice services and home and community based health services and home health are also elements of the required system that we'd like to see in place for individuals living with HIV and AIDS. And so the reality is that you're standing in the middle of a set of systems that can really be quite different in how the care is structured and then can be quite different in how payments is structured.

And it's a little bit like standing on two little ice floes, one going one direction and the other foot on one that's going another direction, and they're difficult to hold the piece together. But I think that what's important to recall is that both of these are safety net systems and unauthorized immigrants are eligible for them, so that we don't want to see those individuals lost to care. And the ability to explain to them what are the services are provided in the whole and how it is but that they may be eligible for one or the other and they can be sort of complicated braiding together of eligibility and supports, that is the effort that needs to be in front of us for immigrant and refugee populations.

I think as we look at the age of individuals who are coming in to us as immigrants and refugees, that they are starting to be younger and younger over all. And because many of them are coming for purposes of employment and looking for better opportunities, then their effort can really be that they just want to work. And they don't present at clinics unless they're really quite ill or they've been hurt. And so what we would recommend to you as one of your strategies when you look at HIV care is that you offer the opportunity to have a conversation with all of your young patients and provide them a chance to be tested, even if they've come in for something completely unrelated.

Because that may be your single moment of opportunity that you will have with them for quite some time. We all, I think, feels like there are cultural differences that make it very difficult to

raise questions with individuals or that we have people coming to us who are sort of knowledge naive. And I think it is important to consider that immigrants and refugees very often are coming from parts of the world where effort has been made to do a lot of HIV education.

Global Fund and others have really made it an effort to go out into these communities. And so we're starting to see more and more that these individuals come with an increased knowledge at least of the basics, including transmission. And that because they've engaged in perhaps some outreach efforts or there's been a film or something that's gone on in their home community or in a refugee camp where they were being held, there is an increased willingness often to discuss HIV sort of in the abstract.

It exists out there in the world, but that we continue to see when anyone is surveyed or when the question posed that there is still a great deal of stigma against HIV and those who are affected by it. And that when you start talking to individuals about treatments, that they're confused about what it all means. The whole discussion that it's a lifelong process now or that it's not a death sentence, but it just requires attention and adherence. There's just a lot of misunderstanding and confusion.

And that what we also see, however, is that there continues to be distrust of institutions and providers as representatives of those institutions, some of what I was saying before-- you don't quite understand the distinction of a federally supported health center and then a federally supportive system that's trying to remove you from the country as being two arms of the same government and them having your best intentions at heart.

So just some of the realities around HIV knowledge and discussion and what we see in research and literature when trying to establish good treatment practices with immigrants and refugee populations. And the other piece that I think MCN has looked at a great deal is how clinicians function. And what we really come to understand through education with health care providers and research where we've gone in and then specialized patient instructors, which means that we've been actors and pretended to be clients of these clinicians, it is that is most often the health care professional who is uncomfortable with the emotionally charged topics.

I've been in health centers where two to one, the clinicians did a great job with me on an entire discussion of breast self examination. But when it came to a discussion of my sexual contacts as an older middle aged woman, boy, everybody just really choked up and was unable to go on. And the reality that we've also seen is that if you can be professional and open-- in other words, this is the action that you take with any and all of your patients, then we can see that the individuals with whom we work can be much more forthcoming.

And I think that this was truly brought to light for me years and years ago. I began working in HIV in 1986 with Planned Parenthood. And I went out into the community because I was able to speak Spanish and do patient education and community education-- and realized that I'd gotten to a place in my life where I could say just about anything in Spanish, when I talked about

reproductive and sexual health, until I got into a room full of women who looked exactly like my grandmother.

And then I just sort of seized up. And I wasn't able to go on until one of them reached over and patted me on the hand and in Spanish said to me, we're all here because we really want to know. And you're the person who can tell us. So I think that this was an important lesson for me to learn, that if I could maintain my professionalism and be really open and willing to engage in emotionally charged topics, that I had a critical responsibility that I needed to meet and I could do that.

So when you are working with your patients then, we have some recommendations that we think make for effective assessment. And that is that it's easier for clinicians, for anyone, to ask the questions if they're on the health history or risk assessment form. If they need to remember them, if they need to come up with them, it becomes much more difficult. But if the questions that are asked are printed on the form and the patient can see that the person is looking at the form and asking the questions and can understand that they will be asked of every one, then it really does lessen the tension and the anxiety of the clinician and the ease with which the patient can accept the question.

And I think we need to-- when we talk about how many people with whom the person has had sex in a lifetime or in the past six months-- that we be willing to ask the additional question of, and this can include anyone with whom you've had sex against your will. And then we need to know if the person with whom they've had sex has sex with others, if they use IV drugs, if the person has been able to ask to use a condom.

And when we ask about how often, what are the restrictions to their ability to do so? And is there a threat of violence or force if they don't? And then really asking if the person has sex with men and women or both. Again, I had the experience of being in a health department and a young man was being interviewed and the clinician said, do you use a condom every time you have sex? And he said, with women? And she said yes. And he goes, yes I do. And then she did not follow it up with the next question-- and do you have sex with men, and if you have sex with men, do use a condom with them?

So I think if the questions are present on your form and they just become a matter of course, then it becomes questions that we ask everyone. There are some recommendations for screening. I think you can find these at the CDC sites and others. I think it's really important to think about the fact that we need to screen immigrants and refugees in those ages, but also younger and older. And then repeating it, because we need to be clear that their exposure could have been during an interval of high risk as they were transiting.

And so what has changed for them then is the risk may have been reduced, but the time period-- the clock is ticking, and we need to know what has gone on previously. And then additionally, if you have individuals coming to you from certain parts of Africa, there will be the need to test for HIV II. Pediatric considerations. Children under 18 then still having antibodies

from the mom and so wanting to test further. What we really need to understand now is the number of children who were exposed because of sexual violence and abuse is really quite high.

And so we can never presume that a child's only risk would be through maternal exposure, that there are so many things affecting children now. And certainly immigrant women who are pregnant should receive HIV screening during the entire period of their prenatal care, because we don't know the circumstances for the pregnancy and we don't know what she's been experiencing during the period that she has been pregnant-- perhaps not at the hands of a partner, but of someone else.

So internal to your health center. And then you want to make sure that you help everyone understand that migrants are eligible for both health center and [INAUDIBLE] and a majority of other supports to medical care, clinical care, for HIV, that they can get testing and treatment and certainly treatment if the disease is found, that you can keep them in care as they're moving. Because I think it's always important that migration or mobility should not be an impediment to care. So let's talk a couple of solutions.

I'm hoping that you all will give us in the chat section some of the things that have been useful for you. But I think always when we talk about language as a barrier then I cannot speak highly enough for the role of community health workers-- trusted individuals from the community that are brought in and really trained to act as cultural translators, not just language translators, but cultural translators between the community and the health system.

Because the health system has a culture all its on that often needs to be described for someone. For example, just the difference between coming from a region of the world where you get up in the morning and you go to the health center and you queue and you wait for your opportunity, versus a health center in this country that is really quite distressed. If you make an appointment and then don't show up, or arrive without having made an appointment.

I think outside language supports are getting much better. Our system here at MCN relies on a telephone service and we see more and more that they're adding a broader array of both written and non-written languages, that they have native speakers who are working with them, and that they really understand the importance of having sound medical, as well as legal, translation capability. And there are other resources out there-- universities. There are cultural groups. Indigenous individuals in California have come together to make sure that they can act as a resource to be a mentor or representative to someone in your community if they come by themselves and they would like to feel like they could have a companion come to medical appointments with them.

So reducing the language barrier is one. Reducing isolation is another one that I think is huge. When we talk about the risk of participating in unhealthy behaviors or not taking the time or not having the ability to reach out for essential services, this is really exacerbated by isolation. And what we've seen in some communities that has been so exciting to experience is that

they're engaging women in cooking classes. But that they are also engaging in gardening for men.

There's been a lot of communities that have put in place competitive soccer leagues so that men from specific communities are able to meet with co-nationals or others from their part of the world, regions of the world, and get together and use sports as an opportunity to reduce their isolation, but also then to present important information about HIV prevention and the seeking of assistance and treatment.

And so when we think about what else might be out there, this is the place where I was hoping if you've had a successful intervention that you would tell us about it. I think that we are talking that nutrition plays such a strong part in it, and so the cooking classes allow you to do the double duty of bringing women and men together, but principally women-- in the core cooking classes that I've seen, it allows us to talk about the importance of nutrition for individuals living with HIV and AIDS, and also gives an introduction to a discussion of the different foods that might be available or different cooking methods for the same kinds of food so that there's not a complete loss of what's familiar to them.

And support groups continue to be important in the same way that we've seen function well for individuals who are trying to grapple with substance abuse. Support groups work well particularly for individuals from communities where there is a real communal sense, where they-- in their own lives-- have lived where decision making was much more done in a group, where there is the consideration of individuals sitting together and contemplating and discussing what was going on and feeling like it was the strength of the group that made it possible for people to go forward.

So support groups are an important item to continue. But I think the biggest thing is what we've talked about previously, which is just normalizing the discussion of HIV, having it be present in the restroom in terms of little things that are posted, having it be present in the waiting room with videos that are ongoing, having it be present on the radio stations with little announcements, little vignettes, little novellas that are going on that talk about people's lives and how they've been affected, but have been able to surmount what was going on for them and they've been able to turn to the local health system.

So I think normalizing the discussion around HIV so that it doesn't become so emotionally charged or remain so emotionally charged is important. So we want to reduce isolation. We want to reduce the problems with language barriers that are created. We want to normalize the HIV discussion. And then we really want to reduce the reluctance to testing. So we want to encourage everyone to acknowledge it as a possibility, because I think it also allows us to say what may have gone on for them--

They've engaged at will or against their will, and that we understand everybody has a story and that that's not the piece that we want to focus on, that we want to focus on them knowing and then on them preventing, if they can, or them addressing, if they need to. And I think part of

what it also helps in the discussion to reduce the reluctance to enter treatment is to really offer stories of hope. And I think that there are a number like this that you can really turn to. This is an example that came to us from Partners in Health out of Haiti.

And Joseph came to them looking as he does there on the left. And yet as soon as they implemented treatment, six months later they were able to take the photograph on the right. And I think more and more of these examples provided to people so that they see themselves in this role and able to survive then will mean that we'll reduce reluctance to enter treatment. The other piece that I think is important is not letting mobility be a reason to be lost to care.

And so I offer you Health Network as one of the solutions as well. This is a Bridge Case Management project that's run by the migrant clinicians network. It's free of charge to the patient and to the health care provider. We just ask that the help care provider who's fearful that their person might be lost to care because of a need to move call us, enroll the patient with us. We ask for signed consent so that we're able to manage their medical records and send it on or receive it. And then we contact the person directly.

We remain in contact with them as they move. We help them get into a new health site, wherever it is that they go. But we also make it a point to communicate back to the enrolling site to say this is what is going on for your patient now. You were able to put them into care. This is what you've created for them. We helped them move forward. We passed forward the medical records of the care that you've given them, and now we want to let you know where they are and what's happening.

And so this is just an entire circle of support, communication, and education that we think is really an important solution when we're looking at providing HIV care to refugees and immigrants. So of in the slot, in the conversation slot, you can give us any of the strategies that you found effective for your immigrant and migrant population, then hopefully we can share them with one another. That would certainly be an important element, I think, only to remind us that not all cases look the same, that our immigrant and refugee patients that come to us really do come with a variety of circumstances.

So the first case study that I shared with you was an individual who was migrating in search of economic opportunity. He was detained. He was returned to his country. He was held. The case that I have in front of you right now is of a young woman who came to us from an African country to visit with family in a mid-Atlantic state. And while she was there, she fell ill and she was identified by the health department as having active tuberculosis.

And so when they brought her into care and they were getting her started, they employed what we consider the gold standard for TB treatment, which is that you also test for HIV. And she was found to be HIV positive. She was really quite upset by what was going on and decided that she needed to return home to be close to closer family members. And so we were able, through Health Network, to help her get home with all of her medical records and under treatment without any interruption from both the TB and the HIV.

She finished her TB treatment in her home country and then decided that she wanted to return to the US. And so she came back to a Northeastern state. And we were able to maintain her HIV treatment and transfer the records from her African home country to the US. And then just a few short months after arriving, she was accepted to school in the South and we were able to help her move again. She stayed for a period of treatment and then she returned to the eastern state to be nearer to the family that she had here in the US, rather than returning to Africa, which was not her choice. But there was a real need for her to be in close proximity to family members and we were able to negotiate that transfer as well.

So she had not had the kind of transit story that our previous case did. She had greater possibilities in terms of education, family connections, ease of mobility because she'd arrived with a visa and a passport. But her need to be held in care even as she moved around was the same as the gentleman that we spoke of before. And so each immigrant and refugee patient in front of us presents us with a number of different concerns and opportunities.

And so I would just ask in summary that you think about the state in which your immigrant or refugee patients arrive-- whether it's acute or anticipatory. Where are they are in their phase of migration? Every risk that they present to you-- whether they are someone who is using injection drugs, if it's a man who's having sex with men, if it's a transgender person-- all of those risks then have the overlay of mobility. And so we need to make sure that whatever we put in place for these individuals they can carry with them, regardless of where they wind up.

Because a huge percentage of the world population is on the move. And there's multiple and complex reasons for them to do that. They work. They move to other parts of the world. The distrust that they may have about two arms of the same government trying to provide them care and trying to exercise some kind of control over their movement can create distrust. But I think it's really possible for you to develop systems that are really effective in taking care of these populations.

And so we just need to remember that our immigrant and refugee patients and individuals affected by HIV and AIDS really do have the ability to function safely within the systems. We just need to make sure that those systems are responsive for them. I have a few resources here. One of the things that I mentioned in passing is that very often individuals may not be literate. And so you'll see that the third option down are free HIV videos in many, many languages.

While we do have the written material in the fact sheets above from the US committee on refugees and immigrants, I think the HIV videos that don't require that the person read are very useful and can be used in all sorts of settings-- just informal social settings, by a community health worker, in the waiting room while the individual is waiting to be seen. We can ask our local stations to show them during periods of late night when they might have some public service time available.

And then I would say that there are other educational materials that you can turn to. I feel like the very first resource the Refugee Health Technical Assistance Center certainly has been looking at the needs of refugees in terms of health services for a long time. And so they cover the waterfront on health issues. But this one segment on infectious disease and HIV is a good resource. And then I would ask you to keep Health Network in mind if you feel like any of your patients are in danger of leaving you during their care and you want to make sure that they're able to maintain adherent to whatever regimen you've put in place for them, that you look to Health Network for the Bridge Case Management that we can provide.

And that's the end of my presentation. And I know that we are almost at time. If there is nothing-- I was not able to see anything that might have been typed into the chat. And so what I have in front of you now is my contact information. And if something I said sparked an additional question that I didn't get to, if you need additional resources and you feel like we might be able to help you with that, if you are interested in Health Network for your mobile patients, please contact me at dgarcia@migrantclinician.org.

Or if you go to our website, migrantclinician.org, you can then look up Health Network. It'll show you what our enrollment process is. And if you'll go to contact us, this very same picture will appear. And you can communicate with me via email from that site as well. From my California office-- is that she was the person that put this presentation together for me and I'm very grateful.

CHELSEA WHITE: I'd like to thank you for this presentation. But again, I'd like to thank you and I'd like to thank everyone for participating in today's webinar. Thank you again, Deliana, for working with us. We appreciate all of the information that you were able to provide us with. And this presentation is accredited for nurses and physicians. So we are offering CME approved credits at the close of this presentation.

DELIANA GARCIA: Thank you so very much.