

July 8, 2010

MN Dept. of Health Refugee Health Program and HIV/STD Program

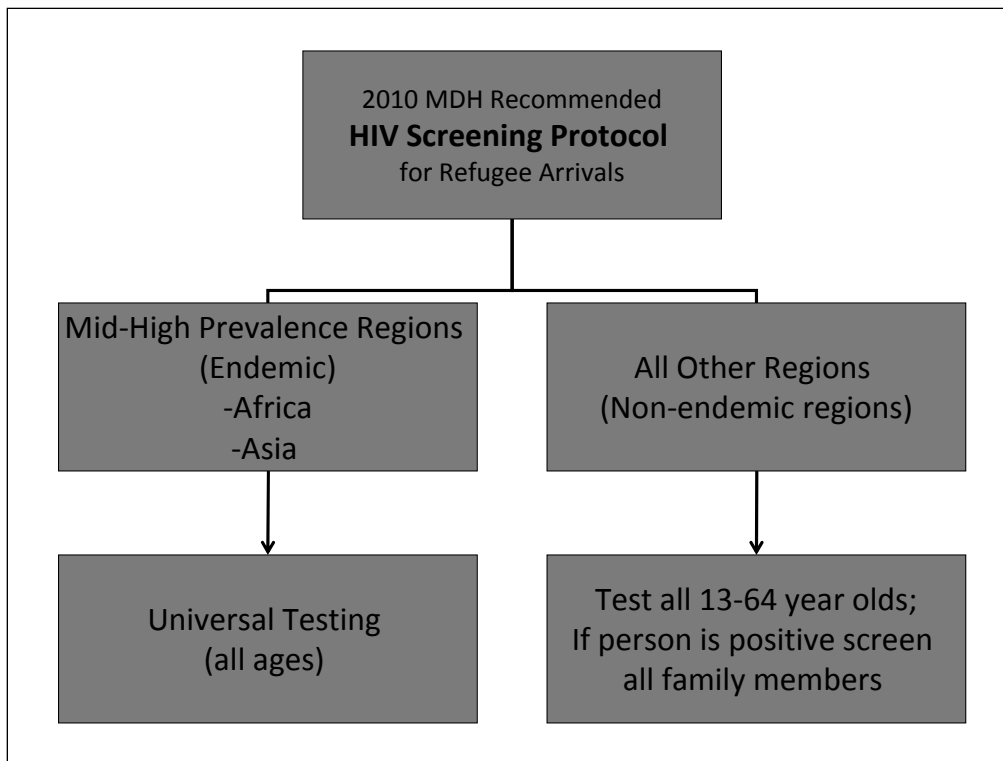
Midwest Aids Training and Education Center

# Objectives

- Know which refugee populations to test for HIV based on MDH recommendations
- Understand rationale for testing
- Know which HIV screening tests are recommended for Refugee Health Screening
- Specific recommendations for pre and post counseling
- Resources

## **Agenda July 8, 2010**

- Background, Susan Dicker, MS, MPH (5 mins.)
- Routine HIV Testing, Alan Lifson, MD, MPH (20 mins.)
- Q & A (5 mins.), Sarah Rybicki, MSW, MPH
- Post Test Counseling: De-Stigmatizing HIV  
Sarah Gordon, MPH (10 mins.)
- Dr. Joyce Onyekaba, (5 mins.)
- Q & A (10 mins), Rybicki
- Webinar ends (1:00 pm)



As you are aware as of Jan. 2010 of this year HIV is no longer considered an excludable condition for immigration to the U.S. and as part of that determination, HIV screening is no longer included in the overseas medical exam. What we do see in the overseas paperwork as part of the informed consent that refugees sign is a statement that reads:

I understand that , per currently valid Technical Instructions, I do not have to be tested for HIV;

....I may request the IOM Medical Team to test my blood for HIV for my own benefit, in which case the results of the test will be included on the medical paperwork...

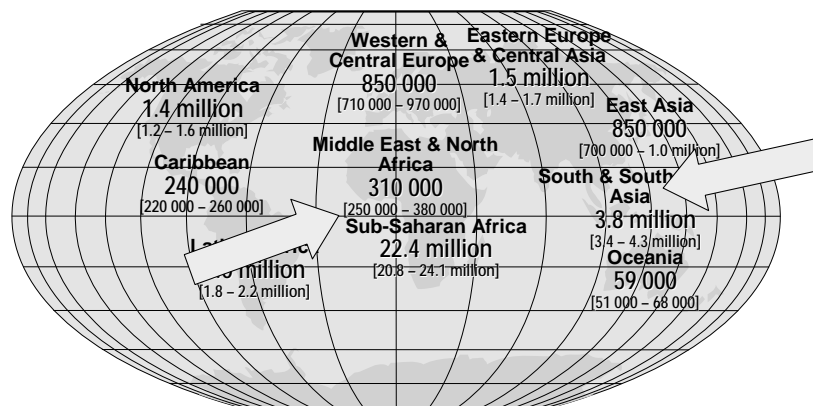
However, we've seen very few that have opted to have the test before departure.

Based on this change in the overseas medical exam, MDH's HIV screening guidelines strongly recommends the following:

For all refugee arrivals coming from mid- high prevalence regions -which is Africa and Asia – universal testing (all ages);

For those refugees coming from all other regions (non-endemic) test all 13-64 yr olds and if person if positive, screen all family members

## Adults and children estimated to be living with HIV, 2008



**Total: 33.4 million (31.1 – 35.8 million)**

SOURCE: [www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2009/default.asp](http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2009/default.asp)

While, our recommendation does differentiate between endemic and non-endemic regions of the world, functionally this ends up including all the refugee populations we are seeing, as this map demonstrates. [Sub-Saharan Africa, includes areas where we see refugees coming from: Cameroon, Congo, Democratic Republic of the Congo, Eritrea, Ethiopia, Kenya, Somalia, Togo, Uganda]

South/southeast Asia: Although overall adult HIV prevalence in South and South-East Asia is still relatively low at <1%, the HIV epidemic affects a large number of people - an estimated 4.7 million were living with HIV in this subregion in 2008]

We also want to emphasize that today we're specifically discussing refugees, which is our area of concern and the recommended protocol is particular to the context of the domestic MN Refugee Health screening, although the new HIV ruling does impact all immigrant categories.

The refugee screening is typically a 2-3 visit exam, in a local public health or private clinic setting. In most of the settings, for the first visit, education is provided about the health screening and labs are drawn, and then depending on the clinic, (and which test was administered for TB) a return visit is set up with the provider for 2-3 weeks later. This allows the provider to have results of the lab when he/she then does the complete history and physical.

The take-away point for clinics and providers is MDH strongly promotes HIV screening as best practice for routine preventive care; this is consistent with CDC recommendations for the US population and it is a priority to link any one who tests positive for HIV with appropriate and supportive care.

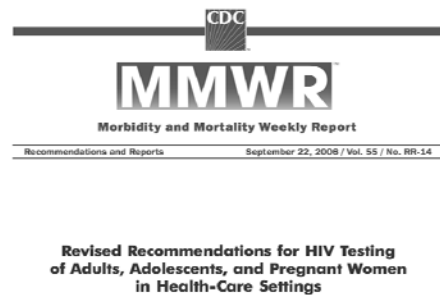
While in any given year less than 1% of the new arrival refugee population has been positive for HIV it's also important to note the vast majority of refugees we see are coming from endemic areas. In addition we know that HIV is one of the most powerful risk factors for development of active TB and that refugees we see have significant rates of LTBI. In 2008, in MN the overall TB infection rate among refugees was 30% - among sub-Saharan Africans, it was 45%, among and SE Asians 24%. So there are a number of compelling reasons to screen for HIV.

In terms of offering a snapshot of the work to be done regarding HIV testing in new refugee arrivals- we can look at some initial trends in MN screening - if we compare the first 6 months of 2009 with the first 6 months of 2010, we can see that in 2009 27% of the refugee arrivals were screened for HIV, whereas in 2010, 45% of arrivals were screened for HIV. This is very preliminary data though and should be considered tentative.

## **Routine HIV Testing: Refugee Populations**

- I. Diagnostic tests for HIV infection
- II. What is Screening?
- III. Opt-out screening, Routine testing
- IV. Specific MDH recommendations for refugee populations
- V. Communicating results (negative, indeterminate)

MMWR Sept 22, 2006, Vol 55, RR-14  
[www.cdc.gov/mmwr/PDF/rr/rr5514.pdf](http://www.cdc.gov/mmwr/PDF/rr/rr5514.pdf)



This brief presentation will cover five topics:

1. Diagnostic tests for HIV infection
2. A brief description of screening and its purposes
3. A brief discussion of what opt-out screening is, and the rationale for opt-out and routine testing. Much of this material is also covered in the CDC guidelines in the MMWR report referenced here.
4. The specific MDH HIV testing recommendations for refugee populations
5. Communicating results for those who have negative or indeterminate results.

Sarah Gordin will be discussing how to communicate results to a patient who has a positive HIV test

## **Diagnosis of HIV Infection**

### **I. Detection/quantitation of HIV**

- p24 antigen
- Viral culture
- PCR (qualitative, quantitative), measure of viral load  
--detect viral nucleic acid (e.g., RNA)

### **II. HIV Antibody Tests**

- Enzyme immunoassay (screening), followed by Western blot or other confirmatory tests

Before discussing testing strategies, we should say a few words about the HIV test itself.

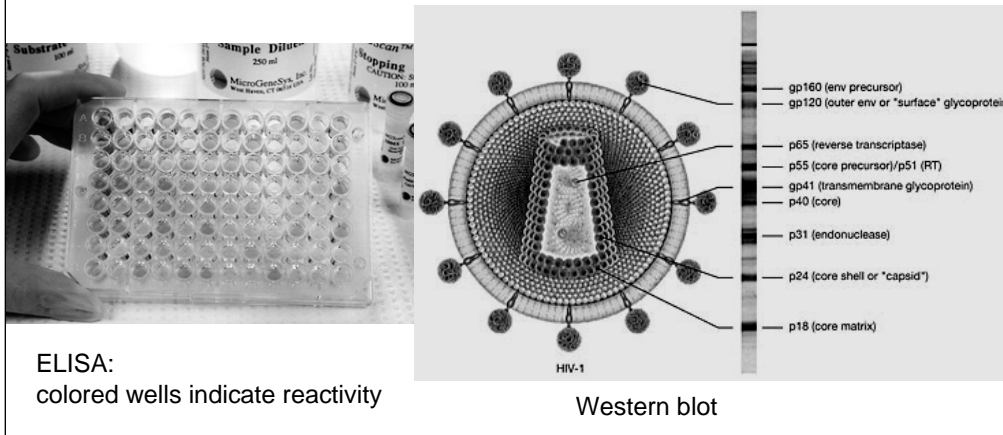
For completeness, there are a number of assays that detect the virus itself or components of the virus, the most important of which is the PCR test, which detects viral nucleic acid. This test can be either qualitative (positive/negative), or quantitative (detecting the amount of virus, or viral load)

The most commonly used test, and the one which generally used, is the antibody test.

# Diagnosis of HIV Infection

## II. HIV Antibody Tests

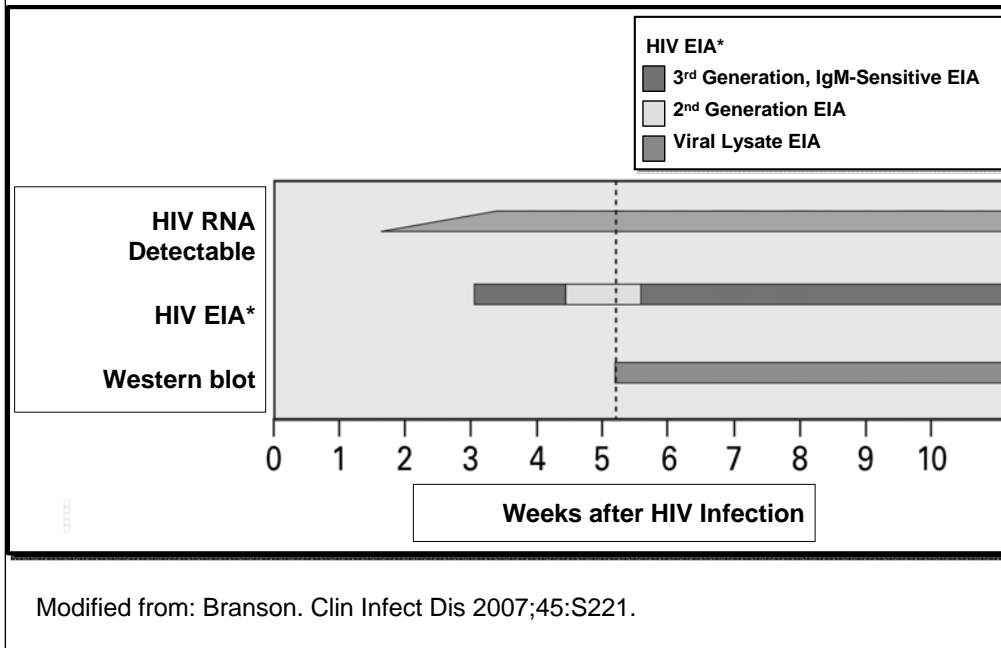
- Enzyme immunoassay (screening), followed by Western blot or other confirmatory tests



The first test that is performed, or the screening test, is called the enzyme immunoassay, or EIA, or ELISA. This is a very sensitive test for detecting HIV infection, is relatively inexpensive, is easy to perform in most laboratories, and is typically reported based as positive or negative. However, the test does have a certain number of false positive results associated with it. If someone is positive on the initial EIA, it is typically repeated to be certain, and if they are still positive, or repeatedly reactive, their results are confirmed by a more specific test.

The Western blot is the most commonly used confirmatory test. It tests for antibodies to specific parts of the virus, such as p24, which represents the inner core of the virus, and gp120, which represents the outer envelope. A positive test requires evidence of antibodies to more than one part of the virus, using certain standard definitions. This test is more expensive and technically complicated, but in combination with the EIA results, can help confirm the presence of HIV infection.

## Time to HIV detection for various diagnostic tests

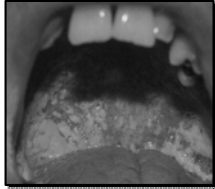


Like all antibody tests, it takes time for someone who has recently become infected to develop a detectable level of antibodies. Each generation of antibody tests has gotten better at decreasing this "window period" .

HIV infection remains undetectable until 1-2 weeks after infection, after which tests can detect HIV RNA. The various generations of screening EIAs begin to detect HIV antibody 2–6 weeks later, sometimes before results of a Western blot are positive.

## **Routine HIV Testing: Diagnostic Testing vs. Screening**

Diagnostic testing for clinical purposes. Performing an HIV test for persons with clinical signs or symptoms consistent with HIV infection.



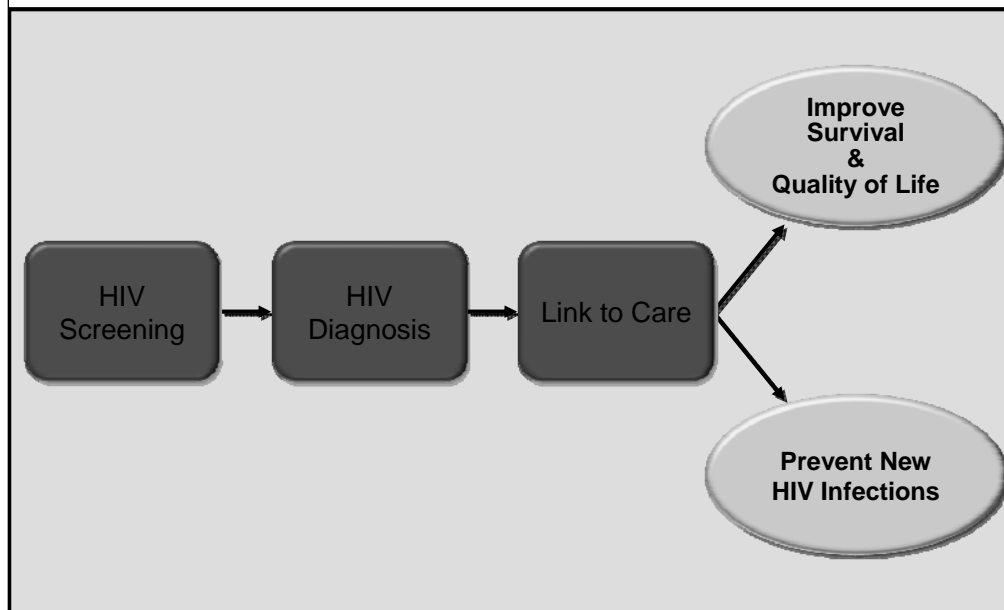
Screening. Performing an HIV test for all persons in a defined population.

In talking about HIV testing, it is important to distinguish diagnostic testing for clinical purposes from screening

Diagnostic testing is performing an HIV test on persons with clinical signs or symptoms consistent with HIV infection, such as if you see someone with oral thrush, or Kaposi's sarcoma, or a pneumonia that might represent an opportunistic infection

Screening involves performing an HIV test for all persons in a defined population, irrespective of their clinical status.

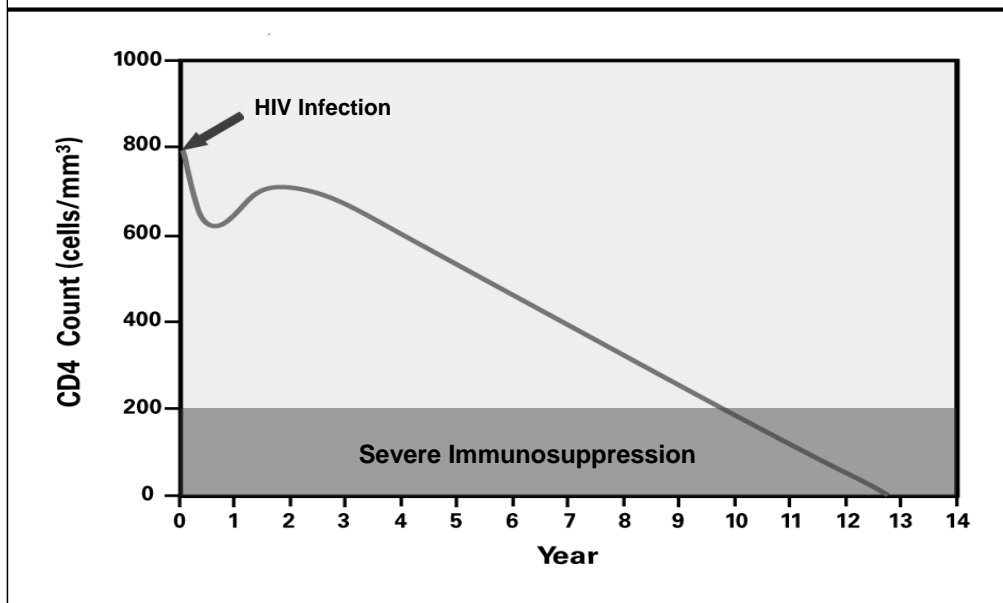
## Desired Outcome of Routine HIV Screening



The purposes of screening are to detect a potentially serious health condition before it develops. Ideally if you detect this earlier form, you can introduce a treatment or other beneficial intervention which decreases the likelihood of developing this serious outcome, improving survival and the quality of life.

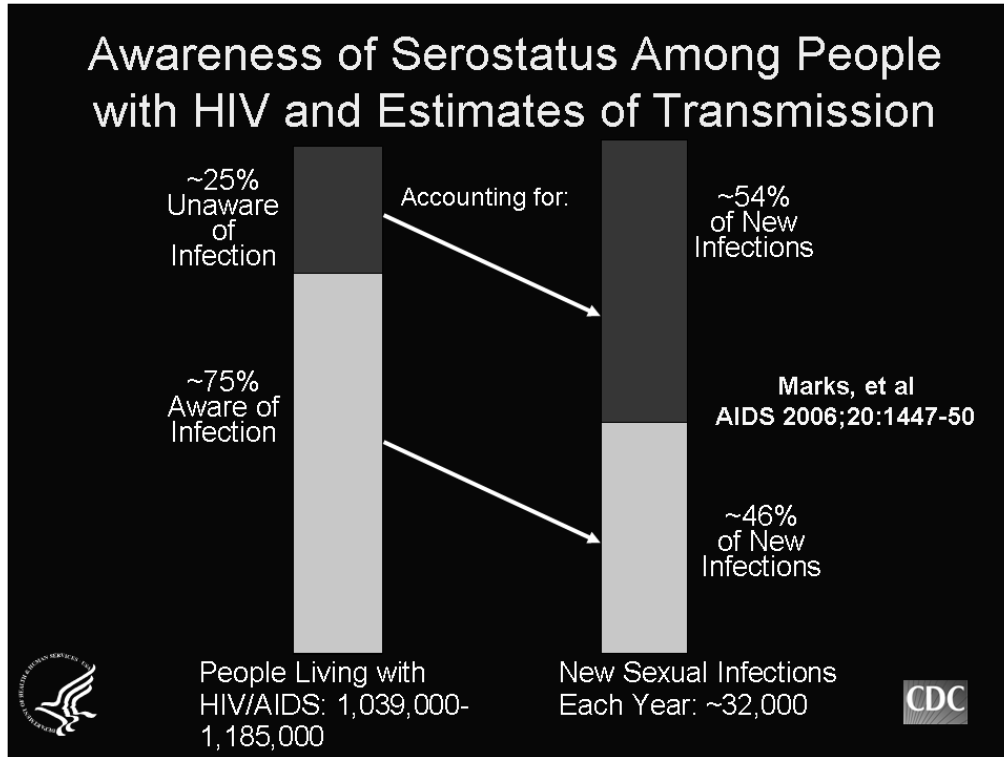
In the case of HIV screening, as we will discuss, there are also public health benefits of screening in terms of preventing new HIV infections.

## HIV Progression CD4 Cell Count Decline Over Time



What are the medical benefits? We know that those who get HIV infected and who do not get treatment develop gradual decreases in their CD4+ count, a T-helper white blood cell that helps to orchestrate and enhance the immune response. As people with HIV become progressively more immune suppressed due to loss of CD4+ cells, they become more susceptible to a variety of opportunistic infections, cancers and other complications that collectively are called the acquired immunodeficiency syndrome, or AIDS.

In Minnesota, among foreign born persons with HIV, 41% either have AIDS or develop AIDS within a year after their HIV is first diagnosed. This says that we are first detecting HIV infection too late for many people, after the virus has already done severe damage to their immune systems. HIV treatment started at these advanced stages is still certainly beneficial, but it is not as good as if treatment is started earlier.



What about the public health benefits on HIV transmission? One of the things we know is that the probability of HIV transmission from infected to uninfected persons is increased in those with greater HIV viral loads. Although people with undetectable viral loads can still potentially transmit HIV, the likelihood is less if an HIV infected person receives antiretroviral therapy and their viral replication is decreased.

In addition, there is evidence that many people, when they learn they are HIV positive, take steps to reduce HIV transmission to their partners, such as using condoms, reducing the number of partners or other safe sex measures.

The public health issue is that those who are unaware of their HIV status may be contributing to a substantial portion of HIV transmission. CDC estimated in 2006 that about a quarter of all people living with HIV were unaware of their status, but that they contributed to over half of the new sexual infections occurring each year.

Finally, it should be noted that pregnant women who are HIV positive should receive a treatment regimen which is highly effective in reducing perinatal HIV transmission to their babies.

## **CDC Recommendations for HIV Testing of Adults and Adolescents in Healthcare Settings**

- Routine voluntary HIV screening for all persons 13-64 in health care settings, not based on risk
- Repeat HIV screening of persons with known risk at least annually
- Opt-out screening includes opportunity to ask questions and opportunity to decline
- Include HIV consent with general consent for care; separate signed informed consent for HIV testing not recommended

Source: CDC. MMWR 2006;55(no. RR-14):1-17.

In 2006, CDC published updated guidelines for HIV testing of adults and adolescents. Some of the key aspects of these recommendations were:

Routine voluntary HIV screening not based on risk for all persons 13-64 in health care settings, with repeat HIV screening of persons with known risk at least annually.

Opt-out screening for HIV testing, which include HIV consent with general consent for care. Patients had the opportunity to ask questions and to decline HIV testing, but a separate signed informed consent for HIV testing was not recommended.

The following slides will discuss these issues

## **Routine HIV Testing to De-stigmatize HIV Testing Process**

- Assessment of risk behaviors: Many people do not perceive themselves to be at risk or do not disclose risks
- More patients accept HIV testing when it is offered to everyone
- Everyone screened routinely for HIV, regardless of risk behavior

Source: CDC. MMWR 2006;55(no. RR-14):1-17.

Prior to these recommendations, some guidelines recommended HIV counseling and testing for persons at increased risk for HIV. However, busy providers often lacked the time necessary to conduct risk detailed assessments and some perceived counseling requirements as a barrier to testing. Many people do not perceive themselves to be at risk or do not disclose risks to their provider. In addition, testing that requires assessment of risk behaviors was seen as potentially stigmatizing.

In contrast, routine represents a policy to provide testing to all clients after informing them that testing will be conducted. This policy was initially recommended for screening of pregnant women to prevent perinatal transmission, and has been extended to all adults. The basic concept is to make HIV testing a routine part of medical care on the same voluntary basis as other diagnostic and screening tests. It was felt that more patients would accept recommended HIV testing when it was offered routinely to everyone.

It is recommended that health-care providers test all persons likely to be at high risk for HIV more often, at least annually, but even in the absence of identified risk factors, CDC recommended that everyone should get an HIV test.

## Opt-Out HIV Testing

- Performing an HIV test after notifying the patient that testing will be done
- Testing is voluntary: Patient should have full knowledge and understanding that test will be performed
- Consent may be incorporated into general informed consent (no separate test form)
- Consent inferred unless patient declines
- Informational materials should be made readily available (culture and language appropriate)

Source: CDC. MMWR 2006;55(no. RR-14):1-17.

In the past, HIV testing in many settings required pre-test counseling, asking people they wanted to get the test, and obtaining explicit written consent.

In contrast, opt-out screening involves performing HIV screening after notifying the patient that the test will be performed unless the patient specifically declines. Consent is inferred unless the patient declines.

Consent for HIV screening should be incorporated into the patient's general informed consent for medical care; a separate signed consent for HIV testing is not recommended.

Having said this, screening should be voluntary and undertaken only with the patient's knowledge and understanding that HIV testing is planned. As it would be for any screening or diagnostic tests, information for patients should be culture and language appropriate.

## Key Elements of Opt-Out Notification

- Bundle information about HIV with information about other diagnostic tests (e.g., TB skin test, parasitic infection, lead for children, etc)
- What is HIV and why is it important to test?
- Meaning of a negative and positive test.
- Testing will be performed unless you decline.
- Questions

Human immunodeficiency virus weakens the immune system and may cause AIDS, which makes you more likely to get some serious infections and cancers. HIV might not make you feel sick at first, and the test is the only way to know if you have HIV. If you have HIV and wait too long for treatment, you could become quite sick. Early treatment can help you live a longer, healthier life.

Most people test negative for HIV. This will mean that you don't have HIV. If your test results are positive, you are infected with HIV. If your HIV test result is positive, doctors can help you remain healthy.

The test is simple, and doesn't take much time. You have the right to say "no" to any of the tests you will get today, including HIV.  
Do you have questions about any of the tests you will get today?

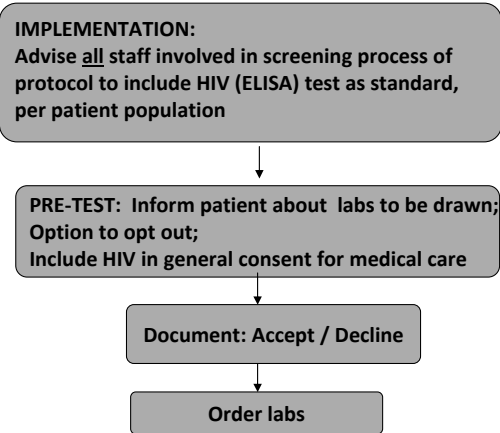
Each clinic and provider will need to determine the best way to provide this information, but it is suggested that you bundle this information with information about other diagnostic tests the patients may receive, such as a TB skin test, stool for intestinal parasites or screening children for lead. HIV is one of a number of screening tests you will be giving people some brief descriptions about before you perform them.

In terms of information about HIV, CDC recommends that patients should be informed orally or in writing that HIV testing will be performed unless they decline. Oral or written information should include an explanation of HIV infection and the meanings of positive and negative test results, and the patient should be offered an opportunity to ask questions and to decline testing.

On this slide, we have suggested some scripting that addresses each of these key points. You may want to use your own words and adapt these to fit your specific circumstances and personal style.

Whatever you choose, CDC guidelines say that easily understood informational materials should be made available in the languages of the commonly encountered populations within the service area. The competence of interpreters and bilingual staff to provide language assistance to patients with limited English proficiency must be ensured.

## 2010 MDH Recommended HIV Screening Protocol: Refugee Arrivals



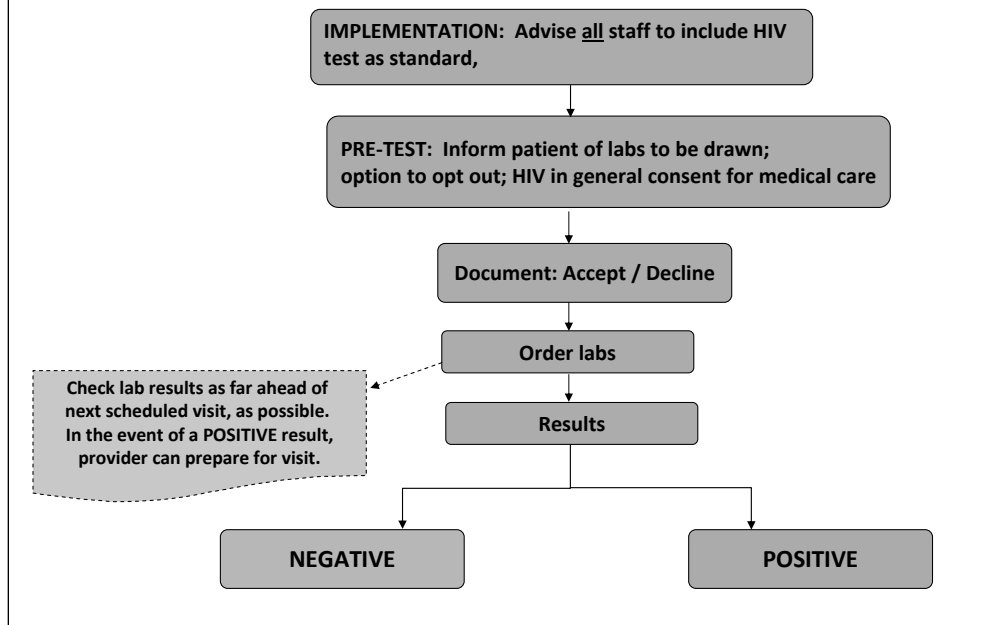
These are the recommendations developed by MDH which address each of these points.

Advise all staff involved in the screening process of the protocol to include HIV (ELISA) test as standard, per patient population

Ore-test notification should include informing patients about the labs to be drawn and other diagnostic studies;  
the option to opt out;  
and include HIV testing in the general consent for medical care

The patient's decision should be documented in the medical record.

## 2010 MDH Recommended HIV Screening Protocol: Refugee Arrivals



Once the test is ordered, patients will need to receive results during their return visit.

MDH recommends you check lab results as far ahead of next scheduled visit, as possible. In the event of a positive result, providers can then prepare for the patient's visit, and coordinate follow-up with MDH.

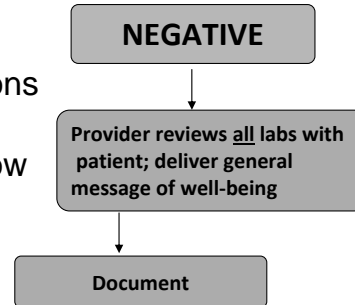
## 2010 MDH Recommended HIV Screening Protocol: Refugee Arrivals

HIV test result is negative  
HIV infection has not been detected

Counsel high-risk persons

- Periodic retesting for high risk persons
- If an individual has previous or ongoing high-risk, may be in window period (false negative)

HIV prevention measures



A negative HIV test result means that HIV infection has not been detected.

Re-testing may be suggested in several situations. As noted, periodic retesting is recommended for high risk persons. In addition, if an individual has previous or ongoing high-risk, they may be in window period, before the antibody test turns positive; this would give a false negative result. In this case, re-testing would be recommended.

Finally, it is important to give the patient general information about ways to remain healthy, including HIV prevention measures. This may include some brief messages that patients in the U.S. are still at risk for HIV, as well as hepatitis and other infections.

Because certain patients might be more likely to think about HIV at the time of HIV testing, testing might present an ideal opportunity to provide or arrange for prevention counseling to assist with behavior changes that can reduce HIV risks—to provide some information about partner reduction, condoms and other preventive measures.

## Communicating Indeterminate HIV Test Result

- Explain test results are unclear
  - no clear HIV status (either HIV positive or HIV negative) can be assigned
- Ask about recent exposure to HIV, and discuss importance of follow-up testing



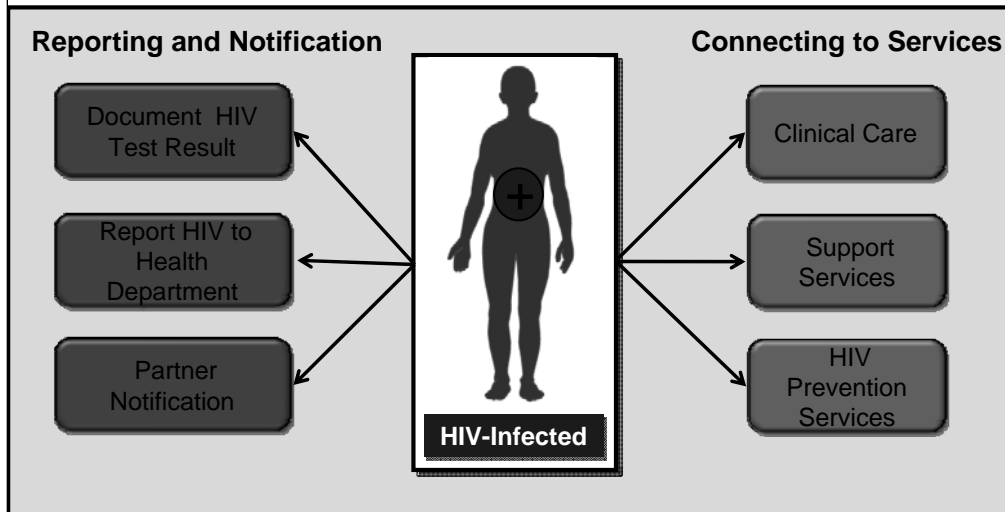
Although most HIV tests will come back positive or negative, they may occasionally come back with an indeterminate result. This is usually a case where the EIA is reactive, and the Western blot is not clearly positive or negative, such as if only one of the required bands is present as shown here.

There are a number of reasons for this result, possibly including certain disease or other infections.

One of these could be if a person is in the process of seroconversion. Since virtually all people with true HIV infection develop a positive Western blot within about 6 months, a repeat test is usually recommended. MDH can help advise you on the timing on follow-up testing and other recommendations.

If follow-up tests are negative or remain persistently indeterminate, then they are considered to not have HIV infection.

# Counseling a Client with Newly Diagnosed HIV



Source: CDC. MMWR. 2006;55(RR-14):1-17.

## Reactions to Positive

- Feelings of shame and/or guilt are common
- These feelings can be easily exacerbated unintentionally by a provider with...
  - ... a lackadaisical response
  - ... who rushes through results
  - ... appearing disinterested
- A patient who feels shamed by the testing process is less likely to enter care

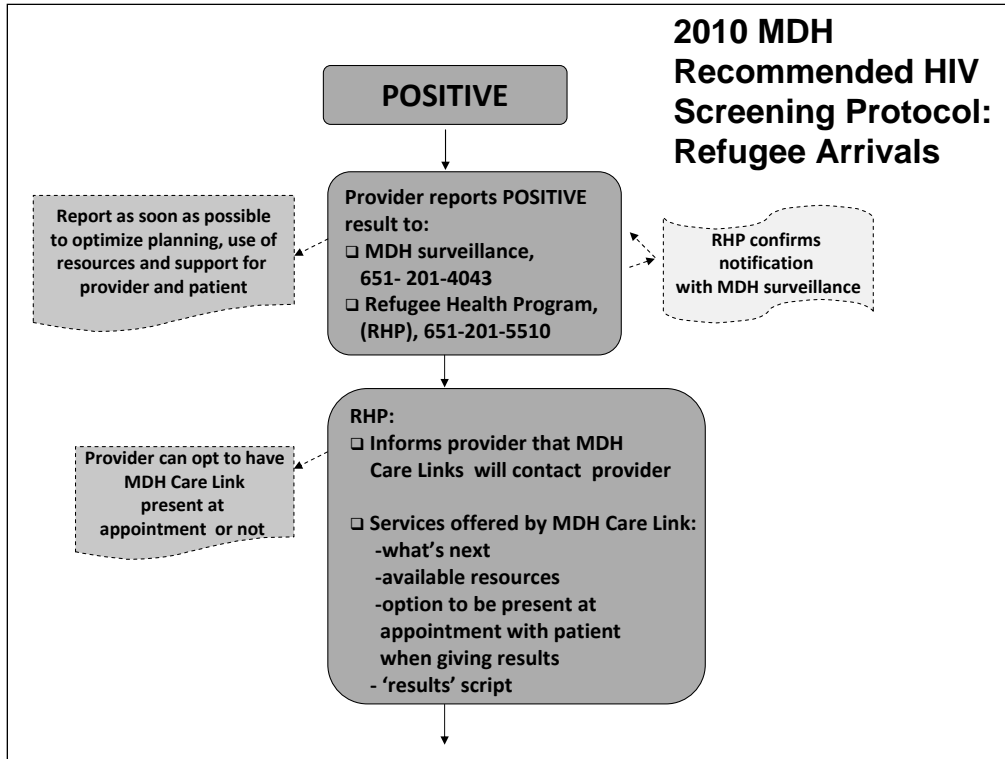
## **Other responses...**

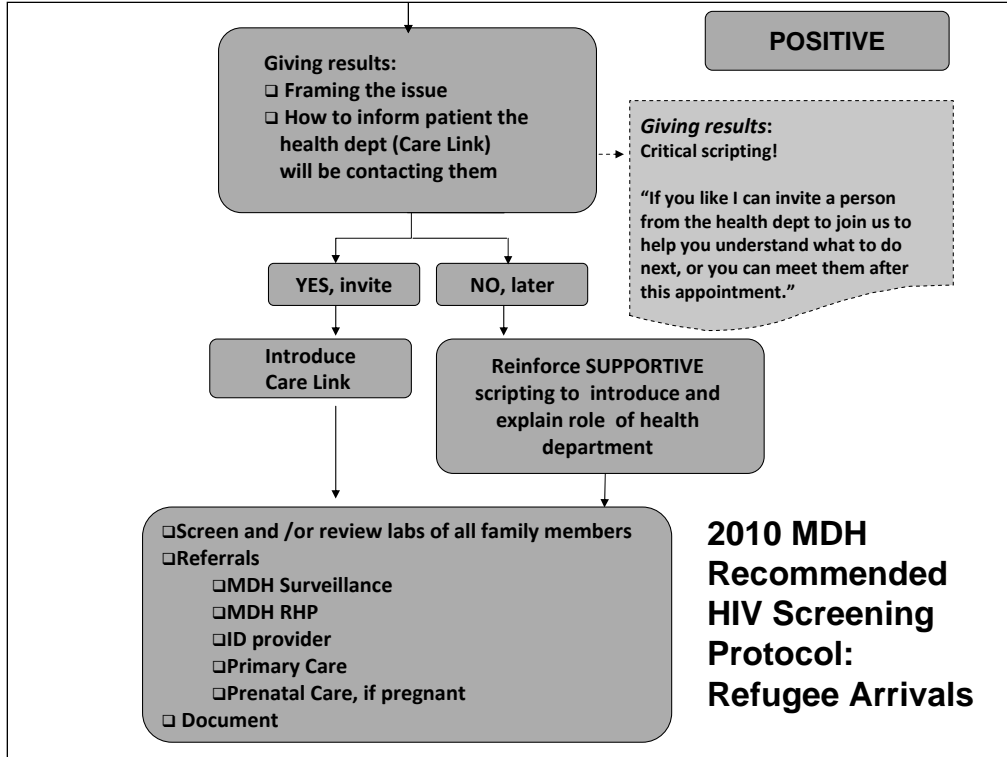
- Withdrawn
- Flat affect
- Desire to flee
- Desire to process
- Lightheaded
- Nausea
- Denial
- Request for another test

## **Counseling a Client with Newly Diagnosed HIV**

- Provide result by direct personal contact
- Disclose result confidentially
- Ensure client understands test result
- Provide basic information about HIV & AIDS
- Explain effective treatments available for HIV
- Discuss reducing risk of HIV transmission to others

## 2010 MDH Recommended HIV Screening Protocol: Refugee Arrivals





# **De-Stigmatizing HIV Testing**

Dr. Joyce Onyekaba  
Crown Medical Clinic

Rob Carlson, PA  
Center for International Health

Dr. Deborah Mielke  
Dr. Kelly Jewett  
Dr. Samuel Boadu  
Open Cities Clinic

## **Culturally Appropriate Care**

- Different cultures have different concerns
- Extent to which a person's homeland has or has not addressed AIDS epidemic can impact their perspective
  - Examples:
    - Anecdotally, newer Ethiopian refugees and immigrants have less stigmatized attitude toward testing than community here ( push in Africa to get tested/ more normalized than here)
- Language barrier
- Provider/clinic attitude

## **2010 MDH Recommended HIV Screening Protocol: Refugee Arrivals**

### **Checklist:**

- Inform staff / lab of HIV screening protocol**
- Review all lab results**
- Screen and /or review labs of all family members**
- Referrals**
  - MDH Surveillance**
  - MDH RHP / Care Links**
  - ID provider**
  - Primary Care**
  - Prenatal Care, if pregnant**
- Document**

# Reporting and Surveillance

## Step 1:

Use reporting form on the MDH website:

[www.health.state.mn.us/divs/idepc/dtopics/reportable/forms/hivform.pdf](http://www.health.state.mn.us/divs/idepc/dtopics/reportable/forms/hivform.pdf)

*or call:*

Luisa Pessoa-Brandao, 651-201-4032, or

Don Stiepan, 651-201-4043

## Step 2:

Contact Refugee Health Program:

Susan Dicker, 651-201-5510

# Resources

- **MATEC**

Sarah Rybicki, 612-626-3609  
<http://mnmatec.umn.edu/>  
rybic001@umn.edu

- **CDC**

[www.cdc.gov/immigrantrefugeehealth/index.html](http://www.cdc.gov/immigrantrefugeehealth/index.html)

- **HIV Perinatal Care Coordination**

Peggy Thornton, RN, ACRN  
651-220-6444  
612-964-8525 (c) preferred number  
peggy.thornton@childrenshc.org

- **MDH**

[www.health.state.mn.us/refugee](http://www.health.state.mn.us/refugee)

[www.health.state.mn.us/hiv](http://www.health.state.mn.us/hiv)

- **Rural Aids Action Network (RAAN)**

320-631-0404  
staff@raan.org  
[www.raan.org/index.html](http://www.raan.org/index.html)

## **More About Midwest AIDS Training and Education Center (MATEC)**

- Affiliated with University of MN
- Supports MN Health Professionals with HIV/AIDS clinical care and testing topics:
  - educational programming
  - technical assistance
  - on-site group and individual training
  - intensive individualized programs
- No-cost resource to health care providers, administrators, policy makers and others in MN
- Dedicated to increasing the number of Minnesotans living with HIV who receive high quality HIV medical care