CULTURAL COMPETENCY: CLINICAL STRATEGIES FOR ADDRESSING HIV AND OTHER STIs AMONG HBCU STUDENTS

ORLANDO O. HARRIS, PhD, RN, FNP, MPH
FELLOW
CENTER FOR AIDS PREVENTION STUDIES
DEPARTMENT OF MEDICINE
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

APRIL 5, 2018



CME Disclosures:
Planning Committee And Speaker

Speaker: The following speaker has nothing to disclose in relation to this activity: Orlando O. Harris, PhD, RN, FNP, MPH

Howard University
CME Accreditation

Sponsor Accreditation: Howard University College of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Credits for Physicians: Howard University College of Medicine, Office of Continuing Medical Education, designates this live activity for a maximum of 1.0 *AMA PRA Category I Credit(s)*TM . Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Goulda A. Downer, PHD, RD, LN, CNS – Principal Investigator/Project Director

CME Disclosures:
Planning Committee And Speaker

AETC-Capitol Region Telehealth Project
Planning Committee: The following committee members have nothing to disclose in relation to this activity:

Goulda A. Downer, PhD, RD, LN, CNS
John I. McNeil, MD
John Richards, MA-AITP
Denise Bailey, MED

Speaker: The following speaker has nothing to disclose in relation to this activity: Orlando O. Harris, PhD, RN, FNP, MPH

Howard University CME Accreditation Requirements For Internet Viewers

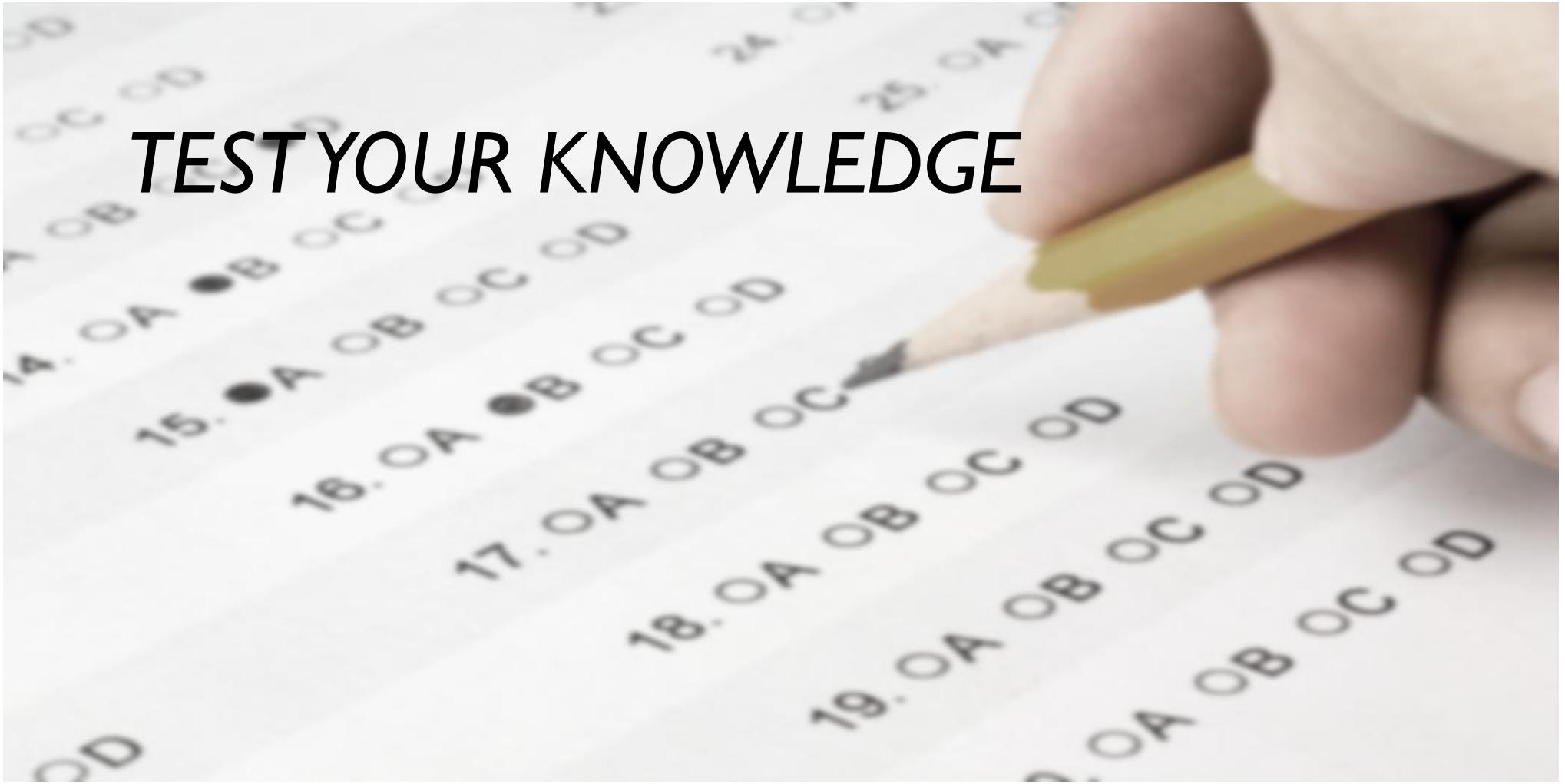
Intended Audience: Health service providers: Physicians, Physician Assistants, Nurse Practitioners, Pharmacists, Dentists, Nurses, Social Workers, Case Managers and other Clinical Personnel.

Webinar Requirements: A computer, phone, etc., with internet accessibility and a telephone line.

- Your presence on the call must be acknowledged at the start of each session. Please log in for the session **announce your name loud and clear at the beginning of the session.**
- You will *not be able* to receive CME credits if you leave the session early.
- At the end of the Webinar our Training Coordinator will email a **CME Evaluation Survey.**
- **All participants are required to complete and return the CME Evaluation Survey** at the end of each session. It may be scanned and emailed back to den_bailey@howard.edu, or faxed to: AETC-Capitol Region Telehealth Project (***FAX#: 202.667.1382***) **ATTN: Project Coordinator. Please indicate in your email or FAX if you would like to receive CMEs.**

AETC
CAPITOL REGION TELEHEALTH PROJECT

TEST YOUR KNOWLEDGE



Test Your Knowledge
Question #1

Which geographical region has the highest rate of HIV infection?

A. Northeast

B. Midwest

C. South

D. Southwest

Test Your Knowledge
Question #2

The CDC recommends that all patients aged 13-64 be screened for HIV:

A. True

B. False

AETC
CAPITOL REGION TELEHEALTH PROJECT

Test Your Knowledge
Question #3

ARV adherence concerns in adolescents includes all of the following except:

A. Understanding and acceptance of their HIV infection

B. Misinformation

C. Distrust of the medical establishment

D. Low self-esteem

CULTURAL COMPETENCY: CLINICAL STRATEGIES FOR ADDRESSING HIV AND OTHER STIs AMONG HBCU STUDENTS



LEARNING OBJECTIVES

1. List the current epidemiological profile of HIV among young adults
2. Identify the symptomatology of acute HIV infection
3. Describe the screening processes for STI and HIV infection in young adult populations
4. Identify the roles of health providers in delivering culturally competent care

AETC
CAPITOL REGION TELEHEALTH PROJECT

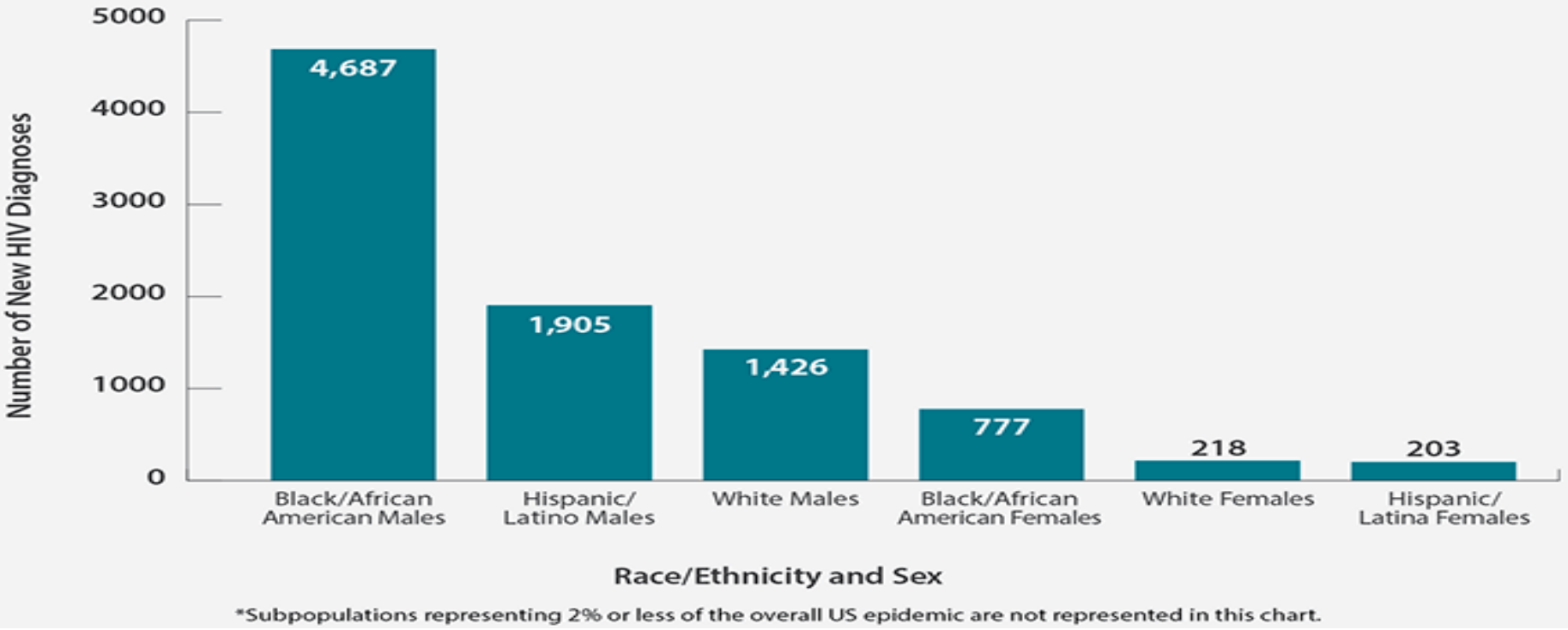
HIV AMONG YOUTH (13-24)

- Youth aged 13-24 accounted for more than 1 in 5 new HIV diagnoses in 2015
- Young people in that same age group accounted for 22% of all new HIV diagnoses in the United States
- Most of those new diagnoses among youth (81%) occurred among gay and bisexual males
- Black and Latino gay and bisexual males are disproportionately affected.
- Within this bleak landscape, we are seeing some progress
  - Estimated annual HIV infections fell 18% among young gay and bisexual males from 2008-2014

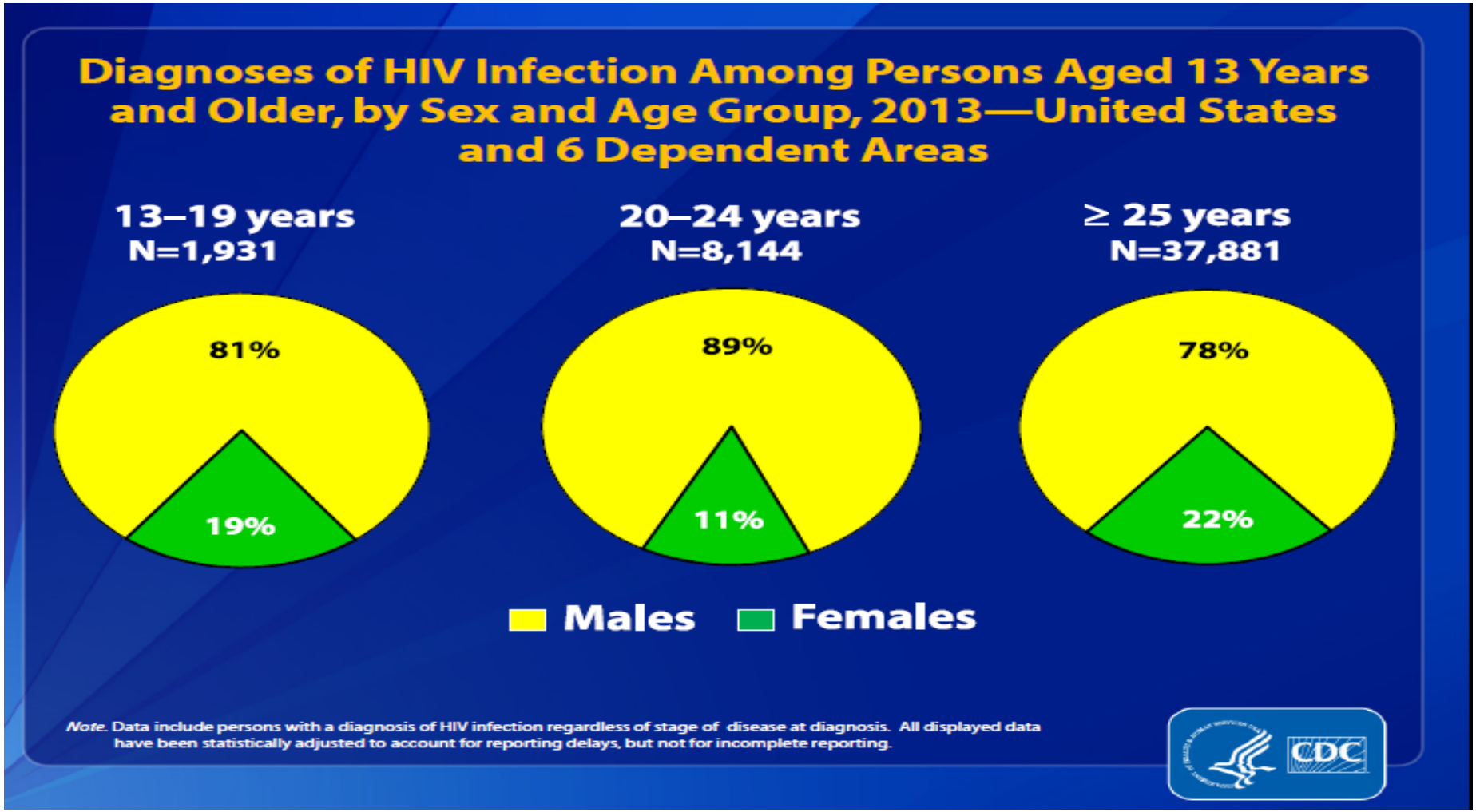
CDC, 2017

AETC
CAPITOL REGION
TELEHEALTH PROJECT

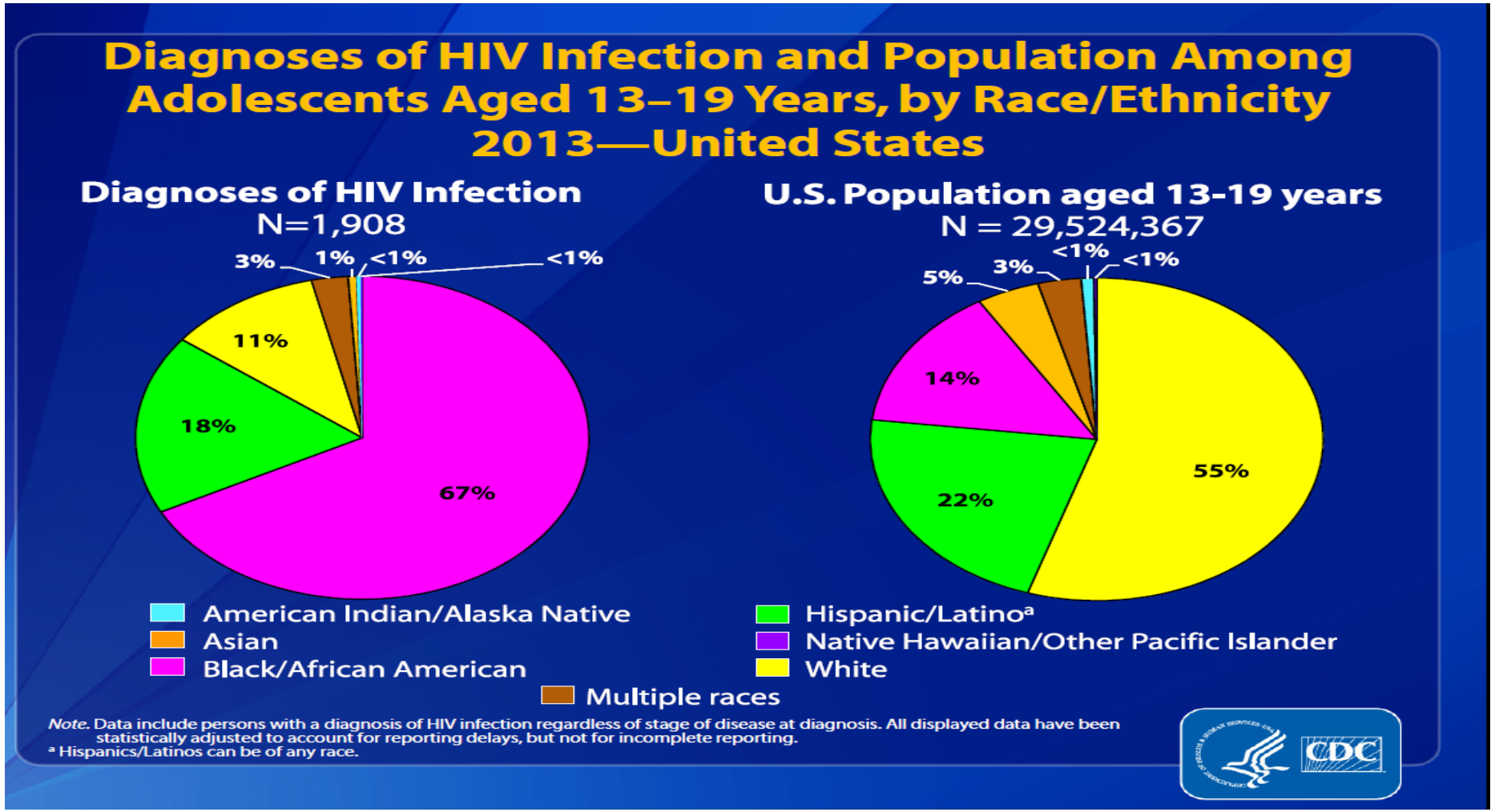
ESTIMATED NEW HIV DIAGNOSES AMONG YOUTH AGED 13-24 IN THE UNITED STATES, BY RACE/ETHNICITY AND SEX, 2014



Source: CDC. Diagnoses of HIV infection in the United States and dependent areas, 2014. *HIV Surveillance Report* 2015;26.


Diagnoses of HIV Infection Among Persons Aged 13 Years and Older, by Sex and Age Group, 2013—United States and 6 Dependent Areas
13–19 years
N=1,931
81%
19%
20–24 years
N=8,144
89%
11%
≥ 25 years
N=37,881
78%
22%
Males
Females
Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting.
CDC

Diagnoses of HIV Infection and Population Among Adolescents Aged 13–19 Years, by Race/Ethnicity 2013—United States



HIV AMONG YOUTH (13-24)

- According to the CDC 8,807 youth were diagnosed with HIV in the United States in 2015
  - Eighty percent (7,084) of those diagnoses occurred in persons aged 20 to 24
- Among youth diagnosed with HIV in 2015, 81% (7,109) were gay or bisexual males
  - Of the newly diagnosed males, 55% (3,888) were black, 24% (1,672) were Hispanics/Latino, and 16% (1,159) were white
- A total of 1,489 youth were diagnosed with AIDS, representing 8% of the total AIDS diagnoses in 2015.

AETC
CAPITOL REGION
TELEHEALTH PROJECT

RISK FACTORS FOR STI's IN YOUNG ADULTS

- Age at first sexual intercourse
  - Women with 1st sexual intercourse **< age 15** are:
    - Nearly four times as likely to report a bacterial STI
    - More than twice as likely to report PID
    - than women who first had sex after age 18

- Sexual activity with a new partner
  - Several studies have shown that:
    - Being in a new sex partnership is a predictor of an STI
    - Due to greater uncertainty about partners' sexual history & STI status

AETC
CAPITOL REGION TELEHEALTH PROJECT

RISK FACTORS FOR STIs IN YOUNG ADULTS

- Multiple sexual partners
  - More than one at a time sexual partner increases exposure and therefore increases risk of STI.
  - CDC reports that about 16% of 14-19 year olds reported four or more sexual partners in their lifetime.

- Substance Use/Abuse
  - Lowers inhibitions and increase risky behaviors
  - Consider the use of alcohol and marijuana use
  - Risk of GHB (date rape drug)

AETC
CAPITOL REGION TELEHEALTH PROJECT

HIV/AIDS AMONG COLLEGE YOUTH

- 1 in 500 college students are infected with HIV

- Risk Factors that put college students at a risk for HIV infection
  - Peer pressure
  - Lack of maturity
  - Alcohol and drug use multiple sex partners
  - Inconsistent condom use (vaginal, anal, oral - *Dental Dams; Cervical caps; Diaphragms*)
  - Tendency to combine alcohol and/or other drugs with their sexual experiences
  - Limited communication among partners about safer sex
  - Intimate partner violence

Reference: State University Blog http://www.stateuniversity.com/blog/permalink/College-Students-and-HIV-AIDS.html

STI AND HIV TRANSMISSION

SEXUALLY-TRANSMITTED INFECTIONS & HIV TRANSMISSION

- STI's result in inflammation and migration of immune cells into the genital tract.
  - Inflammatory cytokines increase HIV replication and make immune cells more susceptible to HIV infection

- Genital Ulcer Disease (GUD) caused by STI's (HSV-1,2, syphilis) compromise the integrity of the mucosal barrier and facilitate HIV transmission

SEXUALLY-TRANSMITTED INFECTIONS & HIV TRANSMISSION

- STI's (e.g. gonorrhea) can increase the amount of HIV in semen and vaginal fluids up to 10x increasing exposure to the partner
- Reproductive Tract Infections (RTI; bacterial vaginosis, *Trichomonas*) increase HIV in vaginal fluids and risk of transmission
- STI's and RTI's increase the risk of HIV transmission from seropositive individuals and also HIV acquisition by a seronegative individual

ACQUISITION ROUTES FOR STIs

Sexually transmitted diseases (STDs), or sexually transmitted infections (STIs), are generally acquired by:

- **SEXUAL CONTACT**
  - Blood
  - Semen
  - Vaginal
  - Anal
  - Other bodily fluids
- **NON-SEXUALLY**
  - Neonatal transmission
  - Blood transfusions
  - Shared needles
  - Shared sex toys

RISK OF HIV TRANSMISSION BY TYPE OF SEX

	Sexual
Type of Exposure	Risk per 10,000 Exposures
Receptive anal intercourse	50
Receptive penile-vaginal intercourse	10
Insertive anal intercourse	6.5
Insertive penile-vaginal intercourse	5
Receptive oral intercourse	Low[a]
Insertive oral intercourse	Low[a]

Risk of Transmission:

- Viral load of the source
- STI's in the source or subject
- Type of sex
- Type of bodily fluids

AETC
CAPITOL REGION TELEHEALTH PROJECT

COMMON STIs

- Chlamydia
- Gonorrhea
- Genital Herpes (HSV-2)*
- Genital Warts (HPV)*
- Hepatitis B
- HIV and AIDS
- Pubic Lice*
- Syphilis
- Trichomoniasis

Reported STDs in the United States: 2012 National Data for Chlamydia, Gonorrhea, and Syphilis. 2014.

AETC
CAPITOL REGION TELEHEALTH PROJECT

PREVENTION CHALLENGES

- Inadequate sex education
  - The status of sexual health education varies throughout the United States
  - Many curricula do not include prevention information for young gay and bisexual youth
  - Sexual education is not starting early enough
- Risk behaviors
  - Low rates of testing
  - Substance use
  - Low rates of condom use and increase number of partners
- High rates of sexually transmitted infections (STIs)
  - Some of the highest rates of STIs are seen among youth of color aged 20 to 24
  - The presence of another STI greatly increases the likelihood that a person exposed to HIV will become infected

AETC
CAPITOL REGION
TELEHEALTH PROJECT

PREVENTION CHALLENGES

- Stigma around HIV
  - A 2012 Kaiser Foundation survey indicated that 84% of youth aged 15-24 said there is stigma around HIV in the United States
  - This could mean that they are not comfortable discussing their status with others and talking with their partners about ways to protect themselves from HIV
  - For gay and bisexual youth who are just beginning to explore their sexuality, homophobia can pose obstacles to utilizing HIV prevention services, testing, and treatment

- Feelings of isolation
  - Gay and bisexual high school students may engage in risky sexual behaviors and substance abuse because they feel isolated and lack support
  - They are more likely than heterosexual youth to experience bullying and other forms of violence

AETC
CAPITOL REGION
TELEHEALTH PROJECT

SCREENING FACTORS TO CONSIDER

SCREENING FACTORS TO CONSIDER

- All patients aged 13--64 years
- Initiate screening unless prevalence of undiagnosed HIV infection in patients has been documented to be <0.1
- All patients initiating treatment for TB should be screened routinely for HIV infection
- All patients seeking treatment for STIs, including all patients attending STI clinics

AETC
CAPITOL REGION TELEHEALTH PROJECT

HIV TESTS FOR SCREENING AND DIAGNOSIS

Antibody tests

- Detect the presence of antibodies, proteins that a person's body makes against HIV, not HIV itself.
- Most HIV tests, including most rapid tests and home tests, are antibody tests.
- It can take three to twelve weeks for a person's body to make enough antibodies for an antibody test to detect HIV infection.
- In general, antibody tests that use blood can detect HIV slightly sooner after infection than tests done with oral fluid.

Combination or fourth-generation tests

- Looks for both HIV antibodies and antigens.
- Antigens are a part of the virus itself and are present during acute HIV infection.
- It can take two to six weeks for a person's body to make enough antigens and antibodies for a combination test to detect HIV.
- Combination tests are now recommended for testing done in labs and are becoming more common in the United States.
- There is also a rapid combination test available

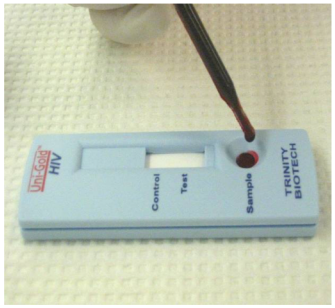
https://www.cdc.gov/hiv/testing/

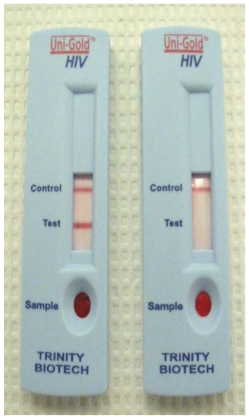
AETC
CAPITOL REGION TELEHEALTH PROJECT

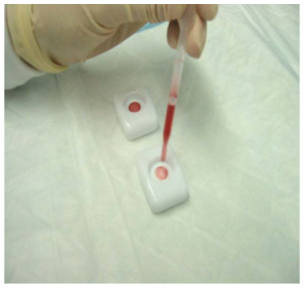
HIV TESTS FOR SCREENING AND DIAGNOSIS

- **PCR**
  - Detect HIV the fastest by looking for HIV in the blood.
  - It can take 7 to 28 days for NATs to detect HIV.
  - This test is very expensive and is not routinely used for HIV screening unless the person recently had a high-risk exposure or a possible exposure with early symptoms of HIV infection
- **An initial HIV test**
  - Will either be an antibody test or combination test.
  - It may involve obtaining blood or oral fluid for a rapid test or sending blood or oral fluid to a laboratory.
  - If the initial HIV test is a rapid test and it is positive, the individual will be directed to get follow-up testing.
  - If the initial HIV test is a laboratory test and is positive, the laboratory will usually conduct follow-up testing on the same blood specimen as the initial test.
  - Although HIV tests are generally very accurate, **follow-up testing** allows the health care provider to be sure the diagnosis is right

AETC
CAPITOL REGION TELEHEALTH PROJECT

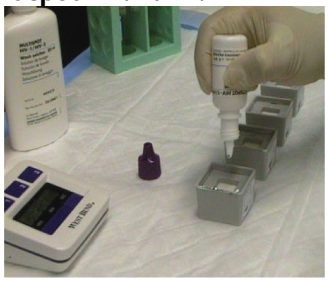




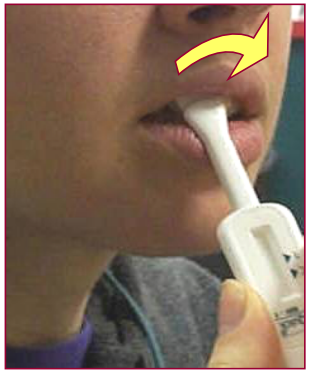




Multispot HIV-1/HIV-2







OraQuick Advance

STI SCREENING RECOMMENDATIONS

- **Take a Comprehensive Sexual History using the Five P's**
  - **Partners**
    - "Do you have sex with men, women, or both?"
    - "In the past 2 months, how many partners have you had sex with?"
  - **Practices**
    - "To understand your risks for STDs, I need to understand the kind of sex you have had recently."
    - "Have you had vaginal sex, meaning 'penis in vagina sex'?" If yes, "Do you use condoms: never, sometimes, or always?"
  - **Prevention of pregnancy**
    - "What are you doing for family planning?"
  - **Protection from STIs**
    - "What do you do to protect yourself from STIs and HIV?"
  - **Past history of STIs**
    - "Have you ever had an STI?"
    - "Have any of your partners had an STI?"

https://www.cdc.gov/hiv/testing/

AETC
CAPITOL REGION TELEHEALTH PROJECT

STI SCREENING RECOMMENDATIONS

- **Screening of Asymptomatic and Symptomatic STIs**
  - Men who have sex with men should be screened at least annually at sites of contact (pharynx, urethra, rectum) regardless of condom use. (If unable to obtained samples, an examination of these sites may assist in identifying and treating potential health related conditions.)
  - Every 3 to 6 months if at increased risk
  - For persons living with HIV and is sexually active, screen at first HIV evaluation, and at least annually thereafter.
  - More frequent screening might be appropriate depending on individual risk behaviors and local epidemiology.
  - Provide treatment for asymptomatic and symptomatic STI as appropriate.

https://www.cdc.gov/hiv/testing/

AETC
CAPITOL REGION TELEHEALTH PROJECT

SEXUAL HEALTH AND HISTORY

- Sexual health is a state of well-being in relation to sexuality across the lifespan that involves physical, emotional, mental, social and spiritual dimensions.

- Sexual health is an intrinsic element of human health and is based on a positive, equitable, and respectful approach to sexuality, relationships, and reproduction, that is free of coercion, fear, discrimination, stigma, shame, and violence.

- A sexual history includes information on **normal** sexual functioning as well as "that portion of the medical, surgical, and /or psychiatric conditions or circumstances that might compromise the sexual and reproductive functioning of an individual.

WHY TAKE A SEXUAL HISTORY?

- Sends a message that the clinician is concerned about the patient's quality of life.
  - To not ask, the patient may assume that sexuality is not an okay topic to discuss, or that the patient has no sexual life.
- Provides the patient with an opportunity to discuss concerns, that without asking, the patient may be unwilling to bring up
- Explores a variety of factors that may have an impact on sexual functioning, and may help to identify potential problems.

ASSESS THE PATIENT'S PERCEPTION OF RISK

- Ask the patient about his/her perception of own current risk of acquiring STD/HIV, e.g.,
  - Are you worried about getting HIV &/or STDs?
  - Do you every worry about getting these infections?

- Ask about the rationale for the patient's own risk perception, e.g.,
  - Can you tell me more about…being worried ~ or about ~ not being worried)?
  - Why or why not?

THE PATIENT'S NEXT STEP

- Ask the patient whether he/she thinks that, after today's discussion, if he/she might do anything different, e.g.,
  - We talked about a lot here today – can you tell me if you think you might make any changes based on our discussion?
  - Is there anything you think you would like to change now?
- If so, then ask the patient to tell you what seems reasonable, e.g.,
  - Do you think you might try to talk with your partner about getting tested?
  - Do you think you might be able to practice using condoms before the next time you have sex?
  - Would you try to think about what we've discussed today?

EARLY HIV EXPOSURE

CASE #1

- Alex is a 20-year-old junior in college. He is returning to your clinic for his first follow-up visit after receiving an HIV diagnosis the previous week. Upon interviewing Alex, the provider asks him if he has shared his diagnosis with his girlfriend and if she has been tested.
- Alex responds that he has not shared the information about his HIV status yet because he is afraid that she will reject him. Further discussion about how Alex contracted HIV reveals that he has been engaging in unprotected anal intercourse with other men he met off Grindr, a gay sex app. He does not want his girlfriend to know about his diagnosis.
- His girlfriend has never been tested for HIV. He self-identifies as heterosexual and says that he only has sex with men because it is something new and different, not because he is attracted to men. He says that he loves his girlfriend very much, and that he does not want to hurt her.

AETC
CAPITOL REGION TELEHEALTH PROJECT

EARLY HIV INFECTION

- Acute HIV infection
  - Initial phase of infection; HIV RNA and p24 Ag are present but anti-HIV antibodies are undetectable

- Recent infection
  - The phase up to six months after infection; anti-HIV antibodies are detectable

AETC
CAPITOL REGION TELEHEALTH PROJECT

EARLY HIV INFECTION: ACUTE RETROVIRAL SYNDROME

- 40-90% have symptoms of acute retroviral syndrome but acute HIV often not recognized
- Maintain high level of suspicion in patients with compatible clinical syndrome plus risks
  - Fever
  - Lymphadenopathy
  - Pharyngitis
  - Rash
  - Myalgia or arthralgia
  - Diarrhea
  - Headache
  - Nausea and vomiting
  - Hepatosplenomegaly
  - Weight loss
  - Thrush
  - Neurological symptoms

AETC
CAPITOL REGION TELEHEALTH PROJECT

EARLY HIV INFECTION

- Acute HIV infection
  - Initial phase of infection; HIV RNA and p24 Ag are present but anti-HIV antibodies are undetectable

- Recent infection
  - The phase up to six months after infection; anti-HIV antibodies are detectable

AETC
CAPITOL REGION TELEHEALTH PROJECT

ACUTE HIV INFECTION: DIAGNOSIS

- Usually, detectable HIV RNA or p24 antigen with negative or indeterminate HIV antibody test result

- Combination HIV Ag/Ab tests
  - Detect HIV-1 and HIV-2 and HIV-1 p24 Ag
  - Recommended by CDC as preferred assay for HIV screening, including for possible acute HIV-1
  - Reactive specimens should be tested with assay that differentiates HIV-1 and HIV-2
  - If reactive on Ag/Ab test but negative or indeterminate on Ab differentiation test: retest with quantitative or qualitative HIV-1 RNA test
    - If negative on RNA test: Ag/Ab was falsely positive
    - If positive: likely acute HIV-1; consider ART
      - ✓ Confirm HIV-1 infection with subsequent testing to document HIV Ab seroconversion

ACUTE HIV INFECTION: DIAGNOSIS

- If initial testing done with assay that tests only HIV Ab:
  - If Ab is negative or indeterminate but acute HIV is suspected:
    - Check HIV RNA: if positive, presumptive diagnosis is acute HIV-1
    - Low-positive HIV RNA (<10,000 copies/mL) may be false positive – repeat test on different specimen
  - If diagnosis is made by HIV RNA testing, confirm diagnosis with subsequent Ab testing

AETC
CAPITOL REGION TELEHEALTH PROJECT

SPECIAL CONSIDERATIONS:
CARE OF YOUNG ADUALTS LIVING WITH HIV

THE ADOLESCENT WHO IS HIV-INFECTED

- **Transitioning care:**
  - Recognize differences between many adolescent and adult HIV care models
  - Consider issues of independence, autonomy, decisional capacity, confidentiality, consent, medical insurance
  - Recognize different biomedical and psychosocial needs of perinatally infected vs behaviorally infected youth

THE ADOLESCENT WHO IS HIV-INFECTED

- **Facilitators to successful transitioning:**
  - Optimize communication between adolescent and adult providers, including multidisciplinary case conferences
  - Address patient/family resistance (e.g., owing to knowledge deficits, stigma, disclosure, differences in practice styles)
  - Prepare youth for life-skills development (e.g., appropriate use of care providers, medication management)
  - Identify optimal clinic model
  - Evaluate success of care model
  - Include interventions that improve outcomes (e.g., support groups and mental health consultation)
  - Incorporate a family planning component

AETC
CAPITOL REGION
TELEHEALTH PROJECT

THE ADOLESCENT WHO IS HIV-INFECTED

- **Challenges to adherence:**
  - Denial and fear of HIV infection
  - Misinformation
  - Distrust of the medical establishment
  - Fear and lack of belief in the effectiveness of medications
  - Low self-esteem
  - Unstructured and chaotic lifestyles
  - Lack of familial and social support
  - Unavailable or inconsistent access to care

THE ADOLESCENT WHO IS HIV-INFECTED (5)

- **Special considerations:**
  - Preventing (and screening for) STDs (including HPV)
  - Family planning counseling
  - For females, gynecologic care, contraception (including interactions with ARVs)
  - For transgender youth, sensitive psychosocial and health supports
  - Prevention of HIV transmission

AETC
CAPITOL REGION TELEHEALTH PROJECT

CULTURAL COMPETENCY

CULTURAL COMPETENCY

- Cultural competency is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables effective work in cross-cultural situations."

- Applying a critical cultural lens to our approach to patient care will ensure that our patients walk away feeling supported and respected.

- Remember that cultural competency might not always include race and race relations
  - Gender differences
  - Sex and sexuality
  - Nationality
  - Immigration status
  - Social class

CASE # 2

- Jenice is a 25-year-old African American transgender woman (male to female) who presented to the hospital following an altercation with her new partner, Tony. She reported being thrown from the third floor balcony by Tony who thought she was born female.
- During sexual intimacy Tony realized that Jenice was transgendered and as a result he reacted violently. Jenice suffered several broken bones and other injuries. On the front of the chart, the receptionist listed the patient as male, although she identified as female and preferred to be addressed as Jenice. She requested a female medical provider.
- However, a male NP was assigned to her case; he told his female NP student to accompany him. It was very apparent that the patient and NP were uncomfortable during the encounter. Jenice never made eye contact with the NP and would only speak to the female student.
- On leaving Jenice's room, the NP referred to her as a "she-male" to the NP student. Jenice overheard him. She left the office before receiving treatment.

AETC
CAPITOL REGION TELEHEALTH PROJECT

CONDUCT ROUTINE SELF-REFLECTION

- "Where we stand depends on where we sit—or situated."
- To understand the impact of culture in our own lives and others', we can look directly at how we are situated and the ways in which it might influence our perspectives and behaviors
- To help us explore our own identity, we can ask ourselves the following self-reflection questions:
  - Where am I from (nationality, region, and heritage)?
  - What are my beliefs, values, and religious and political affiliation?
  - What is my biological sex and gender identity?
  - What is my social class?
  - What life events have greatly affected me?
  - What stereotypes do I hold?

COMMUNITY ENGAGEMENT

- Cultural competence is essential to fostering meaningful stakeholder engagement

- As clinicians, we need to familiarize ourselves with the cultural context and settings of our patient population
  - What is the community history?
  - What traditions and norms exist in the community?
  - What are the community demographics and trends?
  - What are the community's specific interests, needs, and assets?

CLINICAL PRACTICE AND CULTURAL COMPETENCE



CULTURAL FACTORS TO CONSIDER

- **Cultural sensitivity when discussing HIV, mental health, and substance abuse**
  - Assess concerns related to initiating ARTs
  - Discuss the potential impact of HIV on their respective communities (racial, ethnic, geographic, gender, etc.)
  - Address issues related to stigma directed towards marginalized groups (i.e., women, MSM, transgender people, IDUs, or bisexual persons)
  - Discuss issues related to substance use
  - If negative experiences with health care were verbalized, validate them; yet still discuss the advantages of ART in all communities for HIV positive persons.

NYS Taskforce to End AIDS, 2015; UCSF, 2015

AETC
CAPITOL REGION TELEHEALTH PROJECT

CULTURAL FACTORS TO CONSIDER

- **Cultural sensitivity when discussing ARTs**
  - Be sensitive to all cultural characteristics of your at-risk patients
  - Breaking down barriers to treatment may also facilitate access to and use of treatment for HIV-infected partners
  - Remember that starting treatment is a choice; however, discuss the benefits of early initiation
  - Not every patient will ultimately decide on taking advantage of starting right away

NYS Taskforce to End AIDS, 2015; UCSF, 2015

AETC
CAPITOL REGION TELEHEALTH PROJECT

TYING IT ALL TOGETHER:
CULTURAL COMPETENCY AND HIV PREVENTION AMONG HBCU

PRIORITIES FOR MOVING FORWARD

- Address Barriers to HIV/STD Access to Care and Treatment
- Provide Comprehensive Health and Wellness for Students
- Develop structural interventions and policy changes to improve the long term health disparity and disease burden among students
- Implement culturally competent strategies are needed to encourage students to seek testing and, once aware of their status, to obtain and remain in care.

AETC
CAPITOL REGION TELEHEALTH PROJECT

PRIORITIES FOR MOVING FORWARD

- Adopt a strong resolution and a plan of action to address STI prevention strategies at the University/College level
- Each University/College commit to playing the advocate for policy change and action at local, regional and national level
- Use available or new state (regional) data to determine the immediate need for planning
- Build national stakeholder consensus of College/University needs to implement a clearly defined package of services including HIV/AIDS within the existing health system

AETC
CAPITOL REGION TELEHEALTH PROJECT

PRIORITIES FOR MOVING FORWARD

Increase the number of HBCU College students who know their HIV status

- Persons aware of their HIV infection reduce their risk behaviors, which could reduce HIV transmission
- People with unrecognized infection primarily responsible for ongoing epidemic
- Efforts to ensure annual physical examination with HIV testing should be strengthened
- Increase efforts to educate HBCU students and health-care providers about HIV testing guidelines and to reduce barriers to HIV testing

AETC
CAPITOL REGION
TELEHEALTH PROJECT

PRIORITIES FOR MOVING FORWARD

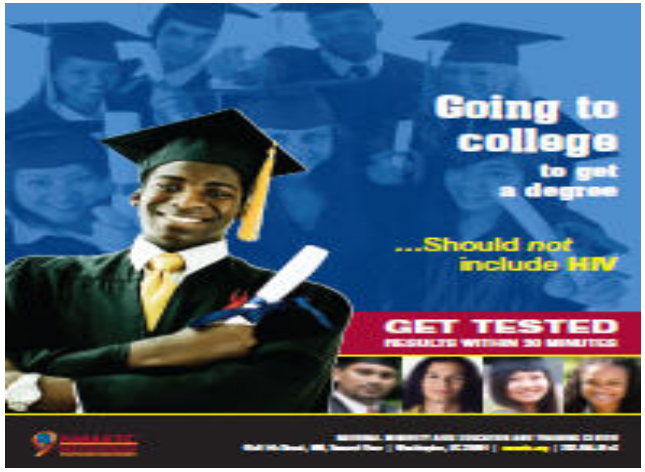
- Cultural and psychosocial factors need to be incorporated to more effectively reach and impact HBCU College students
- Work to educate students and eliminate stigma, discrimination and homophobia.
- Use structural-level interventions to effect change and to leverage potential assets for interventions such as the Student Health Center, Peer support groups, Fraternities & Sororities, etc.
- Identify strategies that are responsive to the unique challenges that HBCU College students face, are needed to encourage HBCU students to seek testing and, once aware of their status, to obtain and remain in care

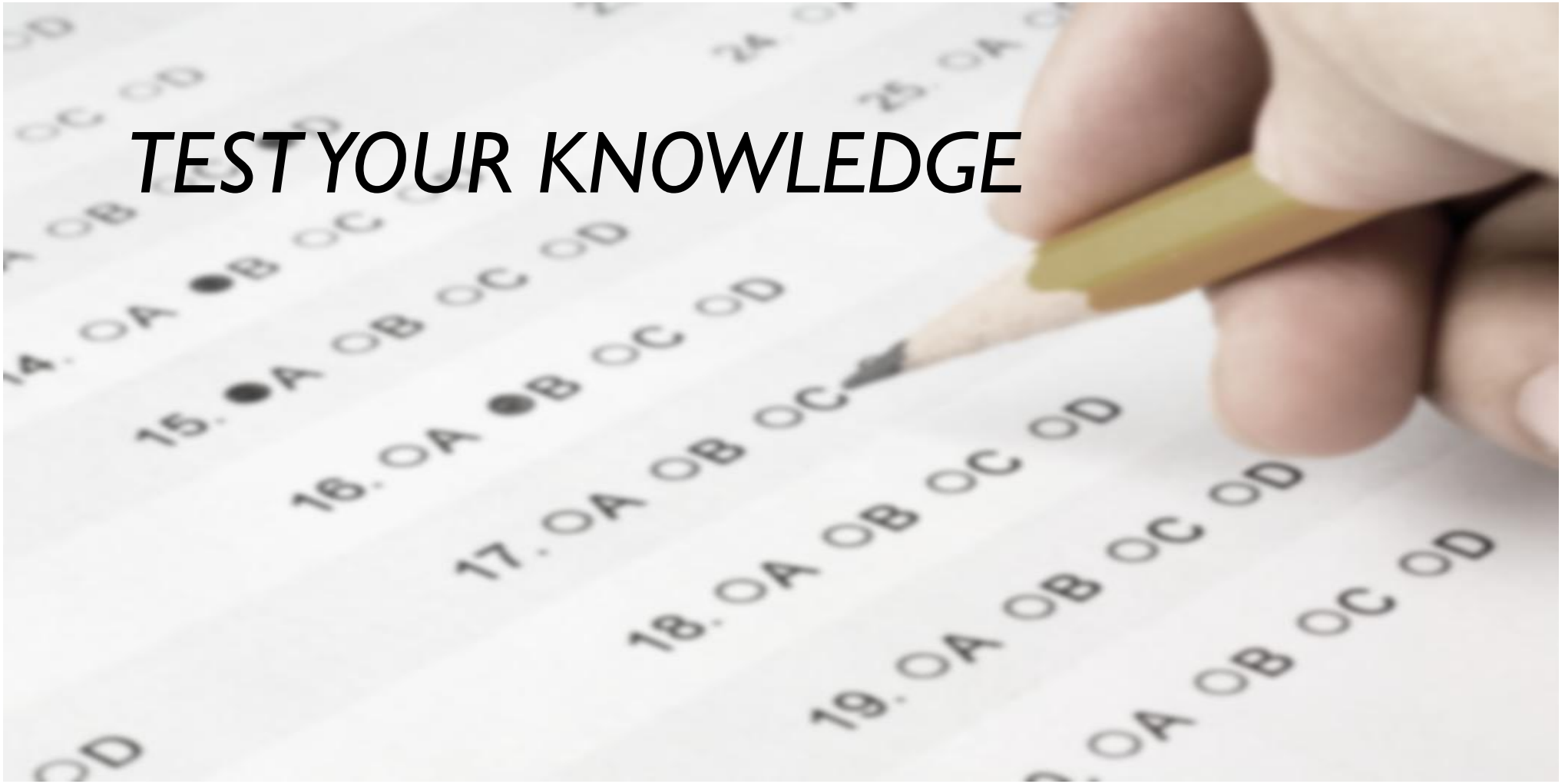
CASE # 3

- A NP with clinical training in women's health saw a patient from Somalia. The woman had undergone a form of female circumcision. She had a clitorectomy and her vagina had been sutured, leaving only a small opening to allow for menstrual flow.
- For much of her life, the scar tissue had interfered with the flow of urine. She had recently arrived in the United States, and in spite of how deeply personal gynecological problems are regarded in her country, she decided to seek medical assistance in her adopted country.
- The NP had never met anyone from Somalia and never heard of female circumcision. Upon examining her, she exclaimed, "Oh my God! What happened to you?" The woman cringed with shame and tried to explain that this was a traditional rite of passage in her country.
- The NP completed her examination and scheduled a follow-up visit, but the woman was never seen at the clinic again. The patient from Somalia was too ashamed to return to the clinic and to see the same provider.

Thank You!

Going to college to get a degree
…….should not include HIV/HCV




TEST YOUR KNOWLEDGE

Test Your Knowledge
Question #4

Which geographical region has the highest rate of HIV infection?

A. Northeast

B. Midwest

C. South

D. Southwest

AETC
CAPITOL REGION TELEHEALTH PROJECT

Test Your Knowledge
Question #5

The CDC recommends that all patients aged 13-64 be screened for HIV:

A. True

B. False

AETC
CAPITOL REGION TELEHEALTH PROJECT

Test Your Knowledge
Question #6

ARV adherence concerns in adolescents includes all of the following except:

A. Understanding and acceptance of their HIV infection

B. Misinformation

C. Distrust of the medical establishment

D. Low self-esteem

AETC
CAPITOL REGION
TELEHEALTH PROJECT

Howard University HURB 1
1840 7th Street NW, 2nd Floor
Washington, DC 20001
202-865-8146 (Office)
202-667-1382 (Fax)

As a Reminder: At the end of the Webinar, All participants are required to complete and return the CME Evaluation Survey. It may be scanned and emailed back to den_bailey@howard.edu, or faxed to: AETC-Capitol Region Telehealth Center (*FAX#: 202.667.1382*) ATTN: Training Coordinator.

Please indicate in your email or FAX if you would like to receive CMEs.

www.capitolregiontelehealth.org

www.aetcnmc.org