Adherence to antiretrovirals in refugees and asylum seekers

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Adherence to antiretroviral regimes is essential to effective management of HIV. The cultural, social, religious and immigration status of refugees and asylum seekers can have an impact on their understanding of their care needs and maintenance of their treatment regimens.

Adherence to antiretroviral drugs is paramount to the successful management of HIV/AIDS (Jani, 2002). Ordinarily, individuals find completing a course of medication difficult and maintaining 95 per cent adherence might be considered acceptable (Ries, 2001). But in individuals with HIV, maintaining adherence above 95 per cent is considered a critical determinant of the effectiveness of Highly Active Antiretroviral Therapy (HAART).

Low levels of adherence to HAART lead to drugs not working effectively and are associated with an increase in viral load, a fall in CD4 count, increased risk of disease progression, greater predisposition to opportunistic infections and an increased risk of early death (Jani, 2002). Adherence levels of 95 per cent or greater are necessary to avoid viral replication and cross-resistance (Paterson et al, 2000).

Significant numbers of refugees and asylum seekers come from regions experiencing HIV/AIDS epidemics (Weston, 2004). Although mostly diagnosed in the UK, many are considered to have acquired the infection in their indigenous countries.

Barriers to adherence

Dispersal issues

The Immigration and Asylum Act 1999 means that asylum seekers are dispersed throughout the country, sometimes to areas with no experience of working with refugees (Burnett and Peel, 2001).

Asylum seekers have been identified as a ‘group at special risk’ requiring focused sexual health advice and information (DoH, 2001). However, dispersal often takes them away from support networks and leads to care disruption, problems with follow-up and continuity (Weston, 2004).

Insufficient resources have been allocated to the NHS in the dispersal areas to meet the special health care needs of asylum seekers (Woodhead, 2000). Many, particularly the young and the single, find it impossible to register with a GP or are given only temporary registration disqualifying them from health checks and treatments (Weston, 2004).

For those receiving antiretroviral medication, stopping treatment abruptly can promote drug resistance and treatment failure as well as pose an increased risk to public health (Robinson, 2003).

Immigration status

The rising cost of care provision and the confusion over immigration and entitlement to treatment has created tension. This stems from confusion of who is entitled to NHS treatment. Asylum seekers, people given refugee status, students and those granted indefinite leave to remain in the UK are all entitled to receive free medical treatment under the NHS in the same way as UK citizens (Weston, 2004).

Robinson (2003) noted reports that some trusts failed to provide treatment to prevent transmission of HIV from mother to child because the mother’s immigration status was unclear.
REFERENCES


This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net

KEYWORDS • HIV/AIDS • Antiretroviral drugs • Concordance

Communication issues

Many asylum seekers and refugees do not speak English and those who do speak it as a second language. This presents problems as many clinics have a shortage of suitable interpreters and have to rely on families or even friends, which is not appropriate. Concern about confidentiality and mistrust of the interpreters may discourage some from accessing HIV treatment.

Even among English-speaking asylum seekers, it takes time for them to understand the complexities of the HIV disease process and how the treatments work (Robinson, 2003). An understanding of the issues is essential to ensure adherence to the treatment regimen.

Cultural and religious factors

Differences in disclosure of HIV status to partners and carers and concerns about being seen by other community members accessing HIV services may inhibit regular clinic attendance and the uptake of interventions (Robinson, 2003).

Disclosure of HIV status can be connected to feelings of shame, which is unsurprising given the ostracism often imposed by extended family, friends and the general public (Reidy et al, 1995). This contributes to social isolation and reduces social support (Woodhead, 2000). Many asylum seekers are particularly fearful of losing friends and community support, given that most of them have left close families in their countries of origin.

For Muslim people Ramadan is important and some omit their medications between dawn and dusk as part of their fast. Modifying the times of therapy can risk development of drug resistance.

Side-effects

The most quoted reasons for missing medication are side-effects. These vary, and depend on the combination of therapy and range from nausea and diarrhoea to severe hypersensitivity reactions, bone marrow suppression, pancreatitis and glucose intolerance. Lack of privacy in shared accommodation can make it hard to follow complex drug schedules and manage these symptoms (Robinson, 2003).

Implications for practice

Experience and literature point persistently at the need for an ongoing adherence measures in managing HIV as a chronic disease.

Nursing staff in acute areas need education and awareness of adherence issues to play a part in assessing, advocating and encouraging patients.

Information and education on the need for treatment and the importance of adherence to prevent treatment failure and drug resistance at the onset of treatment is likely to have a great impact on adherence levels (Carter, 2004).

Some patients and staff agree antiemetic cover is essential at the start of therapy to guard against short-term side-effects of nausea and vomiting.

Forgettingness plays a part in individuals missing anti-HIV drugs and a few tips have been suggested. A written daily schedule that can be ticked off after a dose has been started in Southampton GUM/HIV clinic is being evaluated. Some patients are encouraged to use timers, alarmed watches or mobile phones to jog their memories and to keep a medication diary. Reducing the ‘pill burden’ if there is an option of simple combination can also help, as is changing to a once-daily dosing if it is available (Carter, 2004).

Clinics use a number of methods to monitor adherence levels and drug management effectiveness. These include: pill counts; directly observed therapy (DOT); medication event monitoring system (MEMS); pharmacy tracking of medication pick-ups; clinic visits; and viral load measurement. Some of these are combined.

Reports seem to suggest that self-report surveys that ask about missed doses within a very short time frame (one to four days), are more valid and reliable than surveys that ask respondents to remember a week or more ago (Jani, 2002).

Directly observed therapy has been recommended for use with intravenous drug users, although Chesney (2003) noted that there is no one-off adherence measurement that is absolutely accurate.

Attitudes needs to be influenced. Migrants often face difficulties in adhering to regimens. This may be due to side-effects that make an HIV diagnosis very visible and a resultant stigma can discourage them from continuing with treatment (Weston, 2004).

Some HIV clinics now have clinical nurse specialists and pharmacists who coordinate adherence support services. Southampton PCT, for example, has recently appointed an HIV specialist nurse to work with the homeless health care team and refugees.

Cultural differences, language barriers, psychosocial issues, lack of education and physical and emotional trauma are among the many obstacles that refugees and asylum seekers must overcome in the transition into a new life that includes learning to live with HIV/AIDS.

BOX 1. RECOMMENDATIONS

- Adherence support
- Use of adherence strategies
- Use of adherence measurement tools
- Improved networking between voluntary and health service bodies
- Improving attitude towards HIV/Aids in migrant groups