




Developing HIV/AIDS Health Care in the U.S. - Mexico Border

By:

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Objectives

- Ω **Review VAC statistics for HIV/AIDS in the South Texas border area for year 2001**
- Ω **Understand the Barriers to Quality Health Services in our area**
- Ω **Provide plan of action available to understand and address barriers issues**

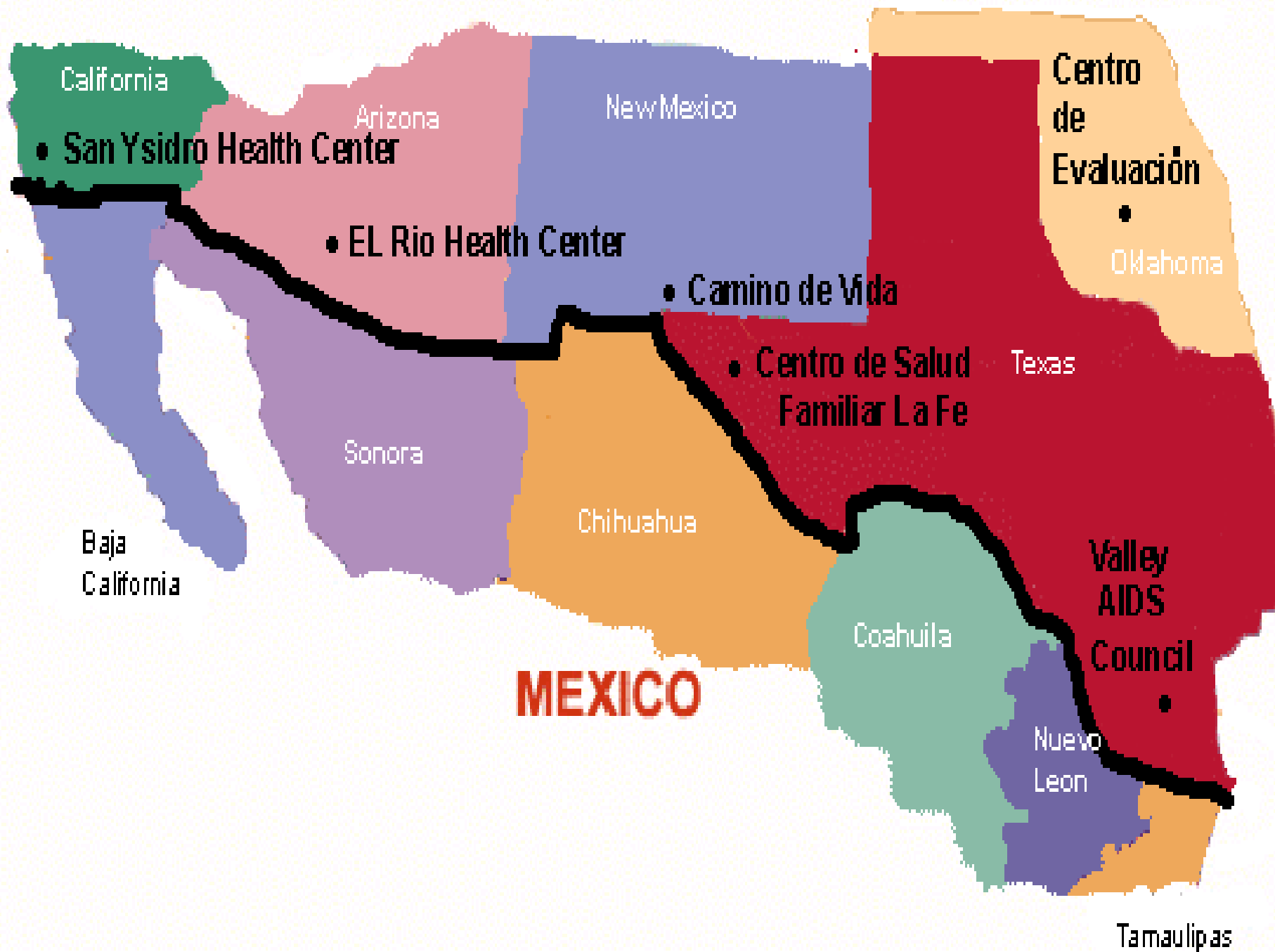


Ω If the 2000 mile long border between the United States and Mexico were the 51st state, it would rank:

**Second in death rates due to hepatitis
Third in death rates due to Diabetes
Last in health care access”**

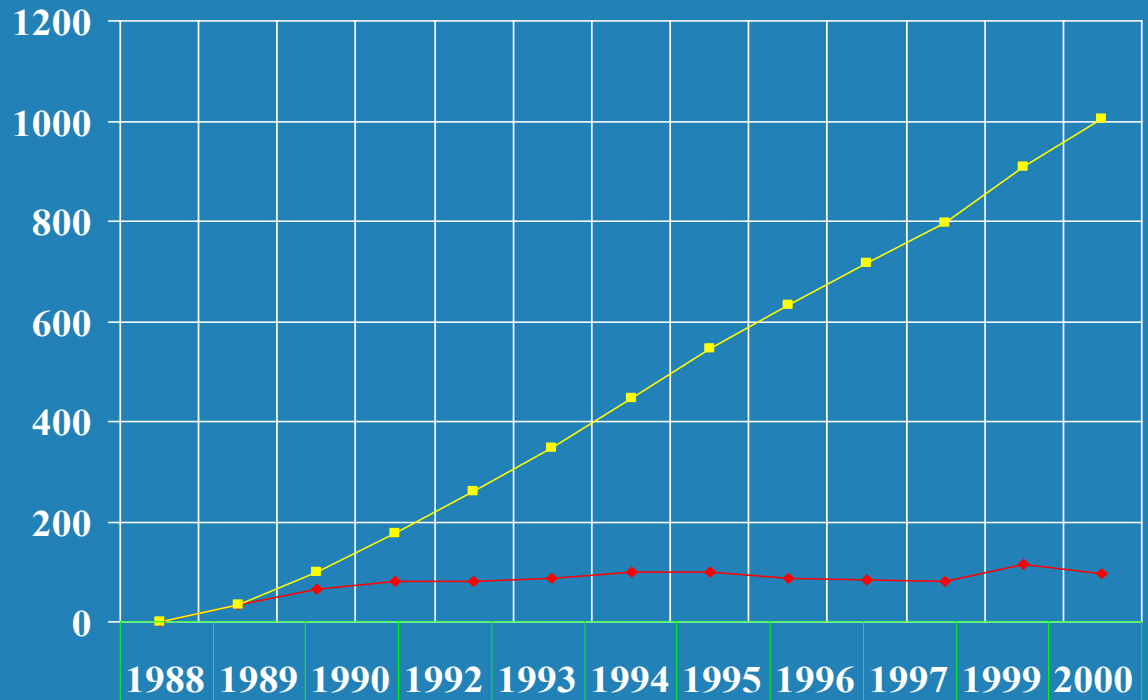
Dr. Charles E. Fox, HRSA Administrator, June 5, 1999

USA



MEXICO

Caseload Growth: 1988 - 2000




◆ Cases /Year	1	33	64	81	88	100	99	86	83	114	96
■ Cumulative Cases Opened	1	34	98	259	347	447	546	632	715	910	1006

VALLEY AIDS COUNCIL CLINIC PATIENT UTILIZATION

Valley AIDS Council Clinic Clinic Contacts for Health Care

by Six Month Period:

	Patients	Contacts
1999	181	444
2000	242	720
2001	318	1032



Valley AIDS Council Clinic

Cases Opened: Jan. -- June 2001

(N=58)

Sources of Referrals (%)

Hospitals	42
In-State Clinic	13
Correctional Dept.	12
VAC	10
MD Offices	9
GYN Clinic	3
Out of State	4
Mexico	5
Other	2

Valley AIDS Council Clinic Cases Opened -- Jan. - June 2001 (N= 58)

Ω **Gender: Male: 74% Female: 26%**

Ω **Heterosexual: 58%**

Ω **Race: Hispanic: Mexican: 88 %**

Caucasian: 10 %

Afro-American 2 %

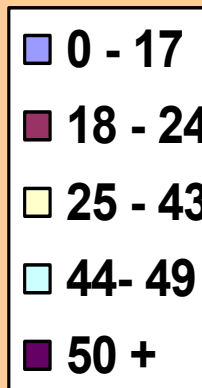
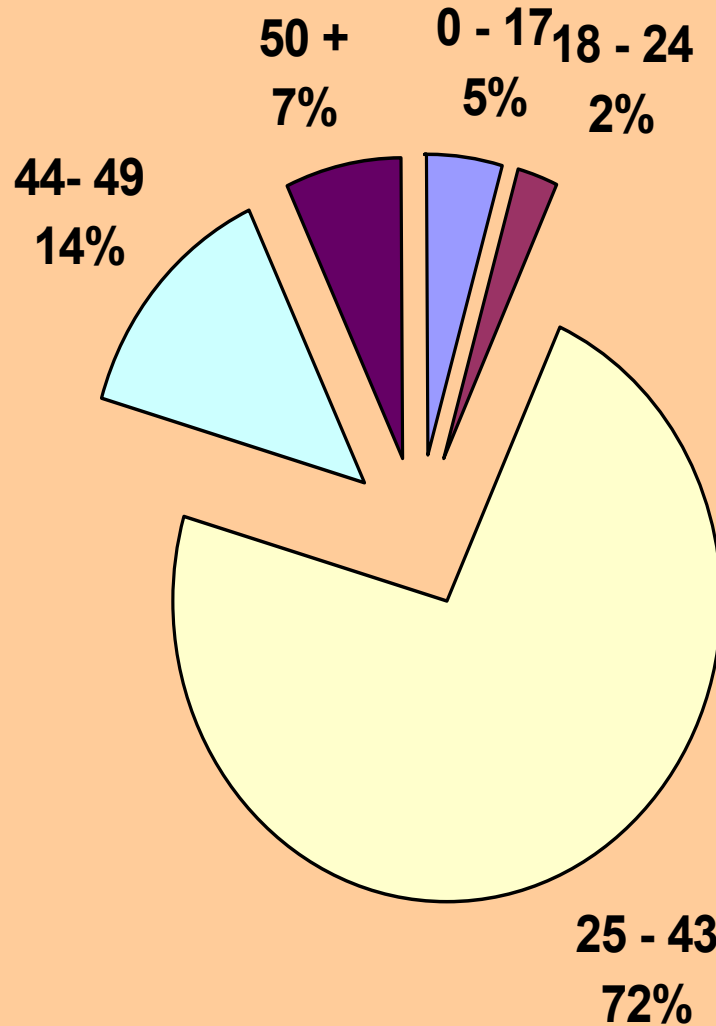
Disease Status (At Intake)

CD4 <200: 43%

Viral Load >100K: 57%

Naïve to Treatment: 57%

Valley AIDS Council Clinic
Cases Opened: Jan - June 2001 by Age Group
N = 58





Valley AIDS Council

Cases Opened: Jan. -- June 2001

Risk Factors Represented (%)

Inconsistent Use of Condoms	79
Multiple Sex Partners	78
Drug Abuse	60
STD's	31
Blood Trans. Prior to 1990	13
Blood Trans. From Mexico	3
Spousal Transmission	10

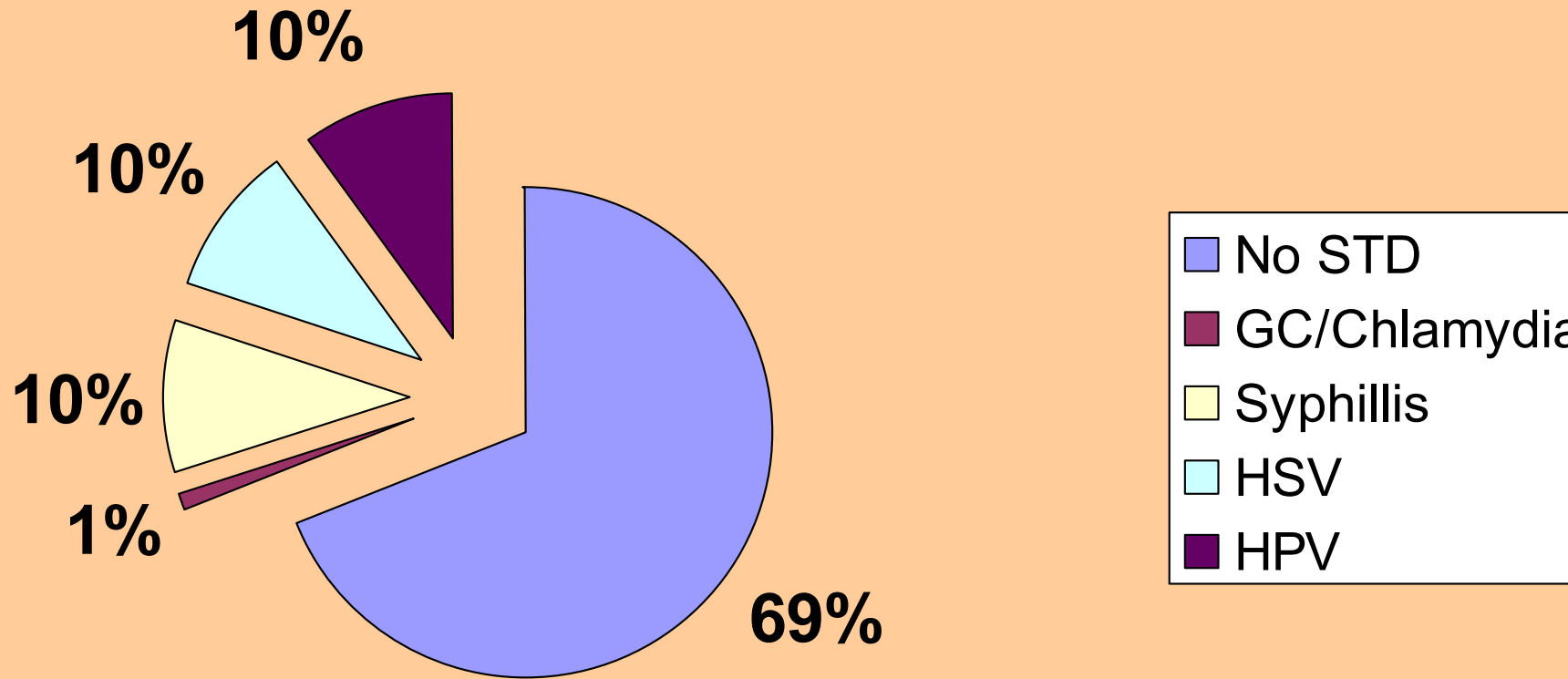


Valley AIDS Council Clinic Cases Opened: Jan. -- June 2001

Drug History

None:	40%
Cocaine	44 %
ETOH	31 %
Marijuana	29 %
Heroin	5 %

Percent of STD's in Cases Generated January - June 2001



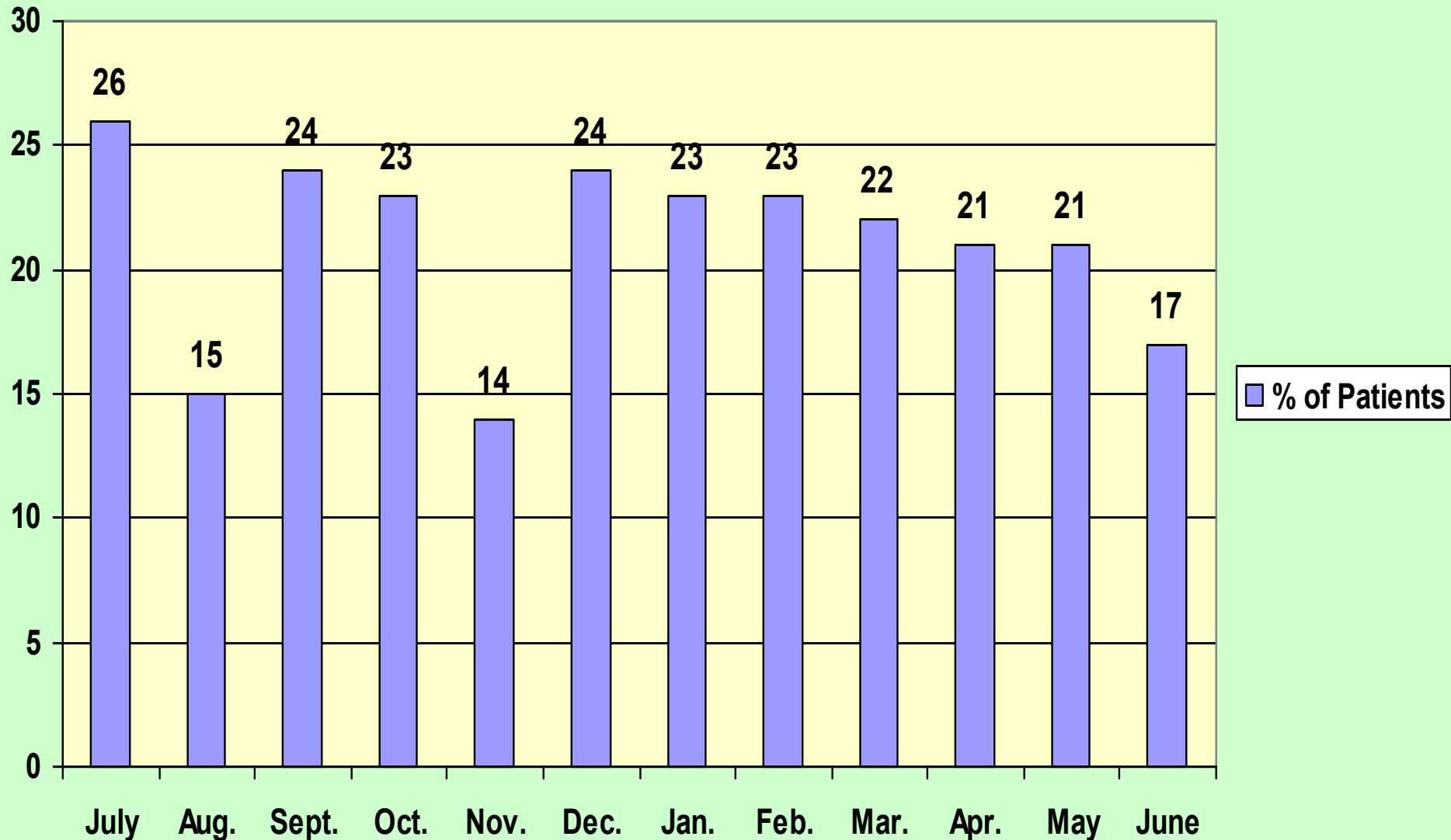
Valley AIDS Council Clinic

Case Characteristics: Jan. -- June 2001

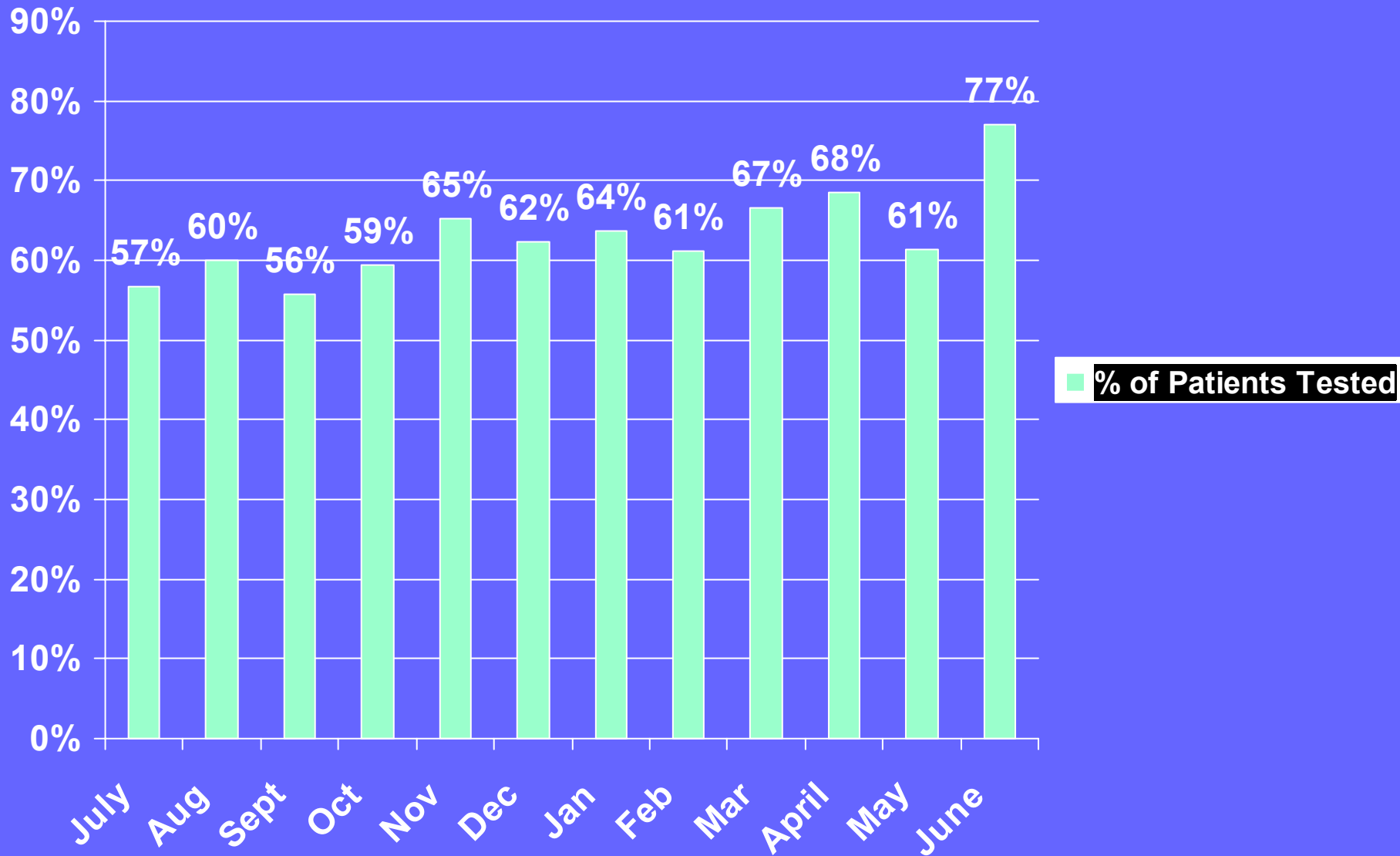
Opportunistic Infections (%)

None:	65
PCP	20
CMV Retinitis	5
Cryptococemia	5
Tuberculosis	3
Disseminated Candida	3
Others	5

Percent of Clinic Patients with CD4 Counts Less than 200 (Includes new cases beginning treatment)



Percent of Patients with Viral Loads 0 - 400 by Month Tested July 2000 - June 2001 (Includes New Patients and those in treatment.)



From Talk to Action in Fighting HIV/AIDS

- Ω Treatment of HIV is a challenge of long term, non-curative and complex therapy**
- Ω The need of medical care for HIV/AIDS patients is evidenced**
- Ω HIV/AIDS treatment is our priority**

Barriers to HIV Health Care

∞ **Barriers to medical care in HIV positive patients can be classified in :**

- **Patient barriers**
- **Cultural barriers**
- **Barriers in the Delivery of Health Care**

Patient Barriers

- Ω **Limited health education**
- Ω **Poverty and lack of personal resources**
- Ω **Mistrust of confidentiality**
- Ω **Fear of social and economic consequences**
- Ω **No community or family support**
- Ω **High risk behavior**
- Ω **Severe denial and fear of the disease**

Patient Barriers (Cont.)

- Ω Active drug abuse**
- Ω Active psychiatric disorders**
- Ω Inability to access health care resources
(Transportation and communication)**
- Ω Inadequate Housing**
- Ω Lack of Health Insurance**
- Ω Cost of medications**
- Ω Adherence to treatment regimen**



Cultural Barriers

- Ω **Family structure (Women - last to get care)**
- Ω **Machismo Hispano**
- Ω **Lack of health education**
- Ω **High risk behavior**
 - **No condom use**
 - **lay injections**
 - **limited education**

Cultural Barriers (Cont.)

- ∞ To obtain medical and dental care in Mexico is a family tradition**
- ∞ Easy access to prescription drugs**
- ∞ Religious beliefs - Fatalistic Determinism**
- ∞ Curanderas & alternative medicine**

Delivery of Health Care Barriers

Ω Primary Care physicians:

- **limited education of nurses, social workers and other medical staff**
- **Physicians with limited knowledge about HIV**
 - Diagnosis**
 - Vectors of Transmission**
 - Treatment and management**
 - Prognosis and complications**
 - Universal precautions**

Delivery of Health Care Barriers (Cont.)

- **Physicians risk of losing other patients**
- **Increased expenses**
- **Limited knowledge of cultural issues**
- **Not testing for HIV**
- **No patient education about HIV**
- **Severely ill patients**

Delivery of Health Care Barriers (Cont.)

Ω Hospital Barriers

- Limited health care provider education**
- Limited patient education**
- Limited education between admitting physicians**
 - low index of suspicion**

HIV Specialist Barriers (Cont.)

- Ω **Opportunistic Infections**
- Ω **Difficulty in obtaining primary care physicians for our patients**
- Ω **Difficulty in obtaining consults from specialists**
- Ω **Co-morbid diseases**



Objectives of Action

- Ω **To provide education to Health Care Professionals, at all levels, to improve the quality of medical care to HIV patients**
- Ω **To expand HIV care to primary care physicians in Community Health Centers**
- Ω **To diagnose HIV disease in early stages for early access to medical care**

Mode of Action

- Ω **Adherence team and support groups**
- Ω **Create a model of education for clinic staff members**
- Ω **Provide conferences for primary care physicians**
- Ω **Cooperate with Hospital based education**

Mode of Action (Cont.)

- ∞ Create specific clinics days to involve patient participation**
- ∞ Create research projects to address specific issues in our patient population**
- ∞ Create programs to expand access to our patients (SPNS)**
- ∞ Create new programs to improve adherence**

What have we learned?

- Ω **HIV/AIDS is a disease that does not select persons by gender, age, sexual preferences, education, or socio-economic status**
- Ω **HIV/AIDS - family support & involvement**
- Ω **Extensive education is needed for patients, families, health care professionals and the community**

What have we learned?

(Cont.)

- ∞ Maximum adherence is obtained if doctors, nurses, case managers and pharmacies work together**
- ∞ Patients need to be involved in their care in collaboration with the clinic**
- ∞ Address issues of poverty, transportation, housing and others as necessary**
- ∞ Team efforts are needed to improve quality of HIV care to our patients**

What have we learned?

(Cont.)

- Ω Communications between primary doctors, HIV specialists and other specialists are invaluable**
- Ω More research studies are needed in the area to address new concerns, barriers and outcomes**



MUCHAS GRACIAS

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