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Psychological consequences of HIV-related stigma among African migrant women in Lower Saxony, Germany: What can we learn from their stories?

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HIV-related stigma denotes the link between sero status and negative behavior toward people who are seropositive. HIV-related stigma includes guilt, shame, denial, prejudice, discrediting, discrimination, stereotypes, denial and self-blame associated with one's serostatus. African migrant women are particularly vulnerable to HIV-related stigma because of their status in society back home and in another country. Women are perceived to be diseased and responsible for transmitting the HIV virus to uninfected partners. HIV-stigma constrains relationships within the family and in the community. Generally employees may not want to employee HIV+ person, community fear those infected leading to neglect, accuses the sick as diseased and ready to infect others without knowing the transmission dynamic. From a cultural perspective HIV affected individuals are also labeled in society as sick by the community. This in the long term results into secrecy affects HIV infection status disclosure and seeking of the much needed preventive services. Stigma affects seeking of health services since labeled people fear to seek health services and this affects their health in future. Stigma is linked to other mental health problems such as anxiety about disclosure, depression, social isolation and depression among others. The complexity of HIV-stigma and migrant African women is complex. It is therefore, prudent to design interventions that highlight importance of cultural variables, issues of gender and migration if we are to achieve effective prevention strategies among seropositive HIV migrant women. The psychological impact of the disease continues to affect seropositive women in negative ways in living fulfilled lives, impacting their wellbeing from fear of partner rejection (very often perceived stigma), unfulfilled sexual satisfactions due to continuous use of condoms as expressed by most respondents. The study showed that some participants were not comfortable getting in to relationships and also fear of partners engaging with other women because they did not consider themselves fit enough for lasting commitments. Thus, such insecurities become overwhelming at times pushing them to neglect their self-esteem as women.

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To study the alcohol related and non-alcohol related traumatic brain injury admissions to a neuro-intensive care unit

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We performed a retrospective analysis of 50 patients admitted to a neuro intensive care unit over a three months period. Data recorded included demographic details, mortality, injury, mechanism and length of stay. We then correlated the data with concurrent alcohol intoxication. 26% of our patients presented with intoxication. This cohort was younger than those who presented with TBI without intoxication (mean 50.4 vs. 52.3 years). Alcohol related TBIs were also more common in males than females (mean 20% vs. 6%). We did not find a statistically significant difference between the two groups for length of stay with the alcohol group having an average LOS of 3.2 days within the NICU. Overall mortality with TBI for our population was 8% with no deaths among the alcohol related admissions. We also found that alcohol did not play any significant role mechanism of injury with assaults, RTAs and falls being more common in the non-alcohol group. There has only been one previous study which examined the role of alcohol in traumatic brain injuries in the UK. Although alcohol use did not affect outcome in our population, some international studies have shown a protective effect of low dose alcohol intoxication in TBIs with higher levels of intoxication leading to worse mortality rates.

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