

HIV PREVENTION IN CARE AND SUPPORT SETTINGS: THE PUBLIC HEALTH BENEFIT

BACKGROUND

Three new developments in the response to HIV/AIDS are coming together to create new opportunities for HIV prevention: 1) several countries' willingness to adopt widespread voluntary confidential counselling and testing (VCT) for HIV; 2) the increasing availability of affordable and supervised antiretroviral therapy; and 3) the emphasis on HIV prevention counselling and support targeted for the HIV-infected person, as summarised in recently released guidelinesⁱ. This section will discuss VCT and methods to include preventive approaches in HIV care and support programmes.

Knowing one's HIV status in order to institute appropriate self-care, access medical treatment, and protect others is always important. Now, however, more attention is being paid to improving care and treatment of PLWHA. Because HAART is becoming more available and affordable, it is vital to persuade members of the public, particularly adolescents and adults, to ascertain their HIV serostatus. In this regard, the expansion of HIV VCT training and services in the Caribbean and elsewhere is timely.

With respect to prevention in care and support settings, it is recommended to strengthen the following approaches and their regular use by healthcare workers in the Caribbean:

- ✓ Screening HIV-infected patients for risk behaviours
- ✓ Identifying and treating other sexually transmitted infections (STIs)
- ✓ Positively reinforcing changes to safer behaviours
- ✓ Referring patients for associated services as necessary (e.g. substance abuse treatment)
- ✓ Communicating prevention messages to the client
- ✓ Facilitating partner notification, counselling, and testing

It is clear that the successful adoption of these approaches will require changes in current policy and practice at points of service delivery. For example, health managers will have to reassess how services are organised. Creating confidential spaces in clinics or offices may be necessary to bring new categories of workers into the team and to improve the flow of confidential information between front-line staff and the broader public health team. Practitioners may need to upgrade their skills in regard to prevention, and some will need to learn entirely new skills. As policies and programmes gain momentum, healthcare practitioners will be privy to a larger amount of private information, which needs to be handled with maximum discretion.

In a busy fee-for-service-type practice or in an overflowing public clinic, primary caregivers may find it challenging to incorporate many (if any) of these approaches into their work. Ideally, however, it is key that every team member portray genuine interest in the incorporation of prevention into care. A reasonable practical approach is to *recognise the need in this area, determine how much the caregiver can contribute, have a list of referral resources close at hand, and put the client into contact with other team members who can address the preventive issues*. Training programmes must be instituted to aid healthcare workers in improving relevant skills and in boosting their own confidence levels.

Actual recommendations challenge the dichotomy that often exists between public health and 'real-life' medical practice. After all, who is more influential in the eyes of the client than his/her professional caregiver, and who is therefore best-suited to deliver messages about safety? In addition, there is evidence that brief, provider-delivered counselling messages, which can be delivered within the context of a clinical encounter, can have a measurable effect on patient behaviour.ⁱⁱ

To date, there are no published data from the Caribbean on practices such as screening and assessment of behavioural risk or prevention counselling for HIV-infected persons. Few professional counsellors or social workers are employed in health services in this part of the world. Anecdotal reports suggest that few doctors, nurses, or pharmacists spend any time in preventive counselling or behavioural risk assessment related to any disease, including HIV. In an unpublished study among Jamaican doctors, more than 60% admitted their need to be trained in personal and family counselling.ⁱⁱⁱ In another recent study, sixty-four of eighty-nine pharmacists and pharmacy technicians admitted that no general counselling about HIV/AIDS took place at their pharmacies.^{iv}

Data from the United States indicate that approximately one-third of HIV-infected patients report that their providers have never counselled them about HIV prevention; in some settings, as many as three-quarters of HIV medical care providers do not ask about sexual behaviour and as many as half do not ask about recreational drug use.^v Apart from lack of time, as mentioned above, many practitioners confess discomfort in raising personal matters, such as sex, with their patients. Recognising and acknowledging such obstacles, however, are the first steps toward positive change. The practical notes below are written against this background.

WAYS TO INCORPORATE PREVENTIVE STRATEGIES INTO HIV/AIDS CARE AND SUPPORT PROGRAMMES

1. Screening Patients for Risk Behaviours

Ideally, a brief history should be taken at each regularly-scheduled clinic visit to ascertain the patient's sexual and drug-using behaviour; understanding of HIV transmission; and symptoms of an STI, such as urethral or vaginal burning or discharge, dysuria, genital or anal ulcers, lower abdominal pain, or intermenstrual bleeding in women. It is often necessary for the healthcare worker to build rapport with the patient before he/she will disclose details about risky behaviour. In addition, in a team setting, one or more persons can interface with the patient in order to obtain a complete history. Questionnaires may be useful in capturing such personal information, and can be given to the patient while he/she is waiting to be seen (literacy level permitting). Research suggests that patients may provide more honest and detailed responses to questionnaires not administered face-to-face. In this area of history-taking, it has been shown, not surprisingly, that healthcare workers who have been trained to discuss sensitive sexual and drug-using issues are likely to perform better than those who have not had such training. In reference to HIV risk assessment, depending on the comfort levels of both the provider and the patient, either open- or close-ended questions can be used. Examples of each are provided in *Table 9*.

Table 9: *Sexual History-Taking: Examples of Open- and Closed-Ended Questions**

Open-Ended Questions
What do you know about HIV transmission?
What, if anything, are you doing that could result in transmitting HIV to another person?
Tell me about any sexual activity since your last clinic visit.
What do you know about the HIV status of each sex partner?
Tell me about condom use during any sexual activity.
Tell me about any drug use or needle sharing since your last clinic visit.
Closed-Ended Questions
Do you know the facts about how HIV is and is not transmitted?
Have you had sex (vaginal, anal, or oral) with any partner since your last clinic visit?
For each of your partners, do you know if he or she has HIV infection, doesn't have HIV

infection, or are you not sure?

Did you use a condom every time, from start to finish of each sexual encounter?

Have you shared drug injection equipment (including needles, syringes, cotton, cookers, water) with anyone?

**Note: Symptoms of STIs (e.g. urethral or vaginal burning or discharge, dysuria, genital or anal ulcers, intermenstrual bleeding, or lower abdominal pain among women) are asked in a closed-ended format, regardless of behavioural question format.*

Medical and Laboratory Screening

Symptoms or signs of STIs or known or suspected exposure to STIs should prompt immediate physical and laboratory examinations. However, because STIs are often present without symptoms, every patient should be screened for laboratory evidence of syphilis, trichomonads (women only), gonorrhoea, and chlamydia at the initial visit and then at least annually.

Co-infection with HIV and certain strains of human papillomavirus (HPV) can increase the occurrence and accelerate the clinical course of cervical cancer. Therefore, all HIV-positive women should be screened at frequent intervals with Papanicolaou smears. Current guidelines suggest that Pap smears be performed every six months for HIV-infected women, though clinically asymptomatic women who have CD4+ T cell counts >200 cells/mm³ and who have had two normal Pap smears may be screened annually.

Some experts also recommend type-specific testing for herpes simplex virus (HSV) type 2 because of its association with a higher risk of HIV transmission and possible need for enhanced counselling. However, this test is not commonly available in the Caribbean.

More frequent screening for STIs is appropriate with evidence or suspicion of high-risk sexual behaviour (e.g. sex with a new partner, sexual activity without consistent and correct condom use, or change in intimate partners); however, there are no data to guide the precise frequency. More frequent screening might also be appropriate in asymptomatic men who have sex with men (MSM) and younger women because of a higher STI prevalence among these demographic groups. Where it is known, the local prevalence of these infections should help to guide the frequency of screening.

Note: In some parts of the Caribbean, not all of these laboratory tests are available routinely. However, taking cost and cost-benefit into account, it may be prudent to build such laboratory capacity over time. In places where access to the laboratory is limited or whenever there is a risk of further spread of STIs, it is practical and recommended by the Caribbean Epidemiology Centre (CAREC) and the Pan-American Health Organisation (PAHO) to use a syndromic approach to the treatment of STIs.

2. Communicating Prevention Messages to the Client

Face-to-face talks, audio and videotapes, literature, and drama are among the methods that can be used to communicate prevention messages in clinical settings. The principles of reinforcement of safe behaviour include giving consistent and unambiguous messages; using “teachable moments”; using familiar and/or attractive media; speaking in the “heart language” of the recipient; and pitching the message at a level appropriate to the recipient. Guided discussions with groups of patients can be an effective way of reinforcing behavioural messages and addressing genuine queries. Pictures or charts are useful both for the literate and for the less literate; in situations where recipients are unable to read, leaflets with text messages are relatively useless. Moreover, multimedia approaches, including wall posters, can help to reinforce practical messages in the setting of an HIV/STI clinic. Please take caution, however, in regard to overkill or message fatigue.

It is vital to evaluate the impact of each method and to put it into the context of the patient’s everyday life when he/she is away from the clinic environment. Competing messages and other needs and drives can hinder the success of transient education messages. From another

perspective, it would be ideal if messages given directly and indirectly in the popular mass media are consonant with the messages given by healthcare workers.

A practical way to encourage or reinforce prevention messages is to highlight choices and potential consequences of these choices, including abstinence, mutual fidelity, and the use of barrier methods such as condoms. Many authorities recommend that condoms should be freely available at all HIV/STI points of service.

3. Contact Tracing and Partner Notification

In some countries, the practices of confidential contact tracing and partner notification are used along with other methods of tracking and attempting to curb the spread of HIV and some other STIs. Consistent application of these methods is believed to augment other preventive approaches. However, carefully designed studies are still needed to confirm the added value of contact tracing in the prevention of the spread of HIV.

The practice of partner notification of HIV infection is humane and is to be encouraged. In several parts of the United States, notification of partners is required by law; in Jamaica, health practitioners are asked to provide a confidential list of the names and addresses of patients' sexual partners. The responsibility for notifying partners can be given to the patient, but many patients hesitate for fear of rejection or reprisal, and notification is delayed in some instances when patients struggle with denial of the diagnosis. It is not clear from the literature whether a single notification is sufficient to convince the partner of an HIV-infected person.

4. PLWHA as Health Promoters

Now that groups or networks of PLWHA are becoming stronger in the Caribbean, it has been suggested that some of these persons may be highly effective preventive counsellors at points of service delivery, without necessarily divulging their serostatus. A few Caribbean countries are starting to pilot test this idea. Early results are very encouraging and should be immediately promoted by the Caribbean Regional Network of People Living with HIV/AIDS (CRN+).

Note: There are definite limitations to the delivery of optimal care to every patient and family living with HIV/AIDS, more so in resource-limited settings. For this reason, continued advocacy for improvements in equipment, supplies, services (including self-help initiatives), education, and the alleviation of poverty will continue to be crucial to improving the management of PLWHA.

ⁱCenters for Disease Control and Prevention. Incorporating HIV prevention into the medical care of persons living with HIV: recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. *MMWR* [serial on the Internet] 2003 Jul 18 [cited 2005] 52(RR12):1-24. Available at: <http://www.cdc.gov/mmwr>.

ⁱⁱ[Kamb ML, Rhodes F, Hoxworth T, Rogers J, Lentz A, Kent C, et al.](#) What about money? Effect of small monetary incentives on enrollment, retention, and motivation to change behaviour in an HIV/STD prevention counselling intervention. The Project RESPECT Study Group. *Sex Trans Infect* 1998;74(4):253-5.

ⁱⁱⁱBain B and Reid M. An assessment of the readiness of Jamaican doctors to receive further training in HIV/AIDS care. Paper presented at: Institute for Healthcare Improvement (IHI) International Conference on Excellence In HIV/AIDS Education and Training, Sept 2002, Arlington, MD.

^{iv}Bain B, McGaw A, et al. Jamaican Pharmacists and HIV/AIDS. Paper presented at the Eighth Conference of the Commonwealth Pharmaceutical Society, 14-17 Aug 2003, Ochos Rios, Jamaica.

^v[Natter J, Fiano T, Gamble B, Wood RW.](#) Integrating HIV prevention and care services: the Seattle "Collaboration Project". *J Pub Health Manag Pract* 2002;8(6):15-23.