This is an author-formatted version of a presentation published as:


Accessed from:

http://eresearch.qmu.ac.uk/1024/

**Repository Use Policy**

The full-text may be used and/or reproduced, and given to third parties for personal research or study, educational or not-for-profit purposes providing that:

- The full-text is not changed in any way
- A full bibliographic reference is made
- A hyperlink is given to the original metadata page in eResearch

eResearch policies on access and re-use can be viewed on our Policies page: http://eresearch.qmu.ac.uk/policies.html

Copyright © and Moral Rights for this article are retained by the individual authors and/or other copyright owners.

http://eresearch.qmu.ac.uk
HIV: Health Promotion and Prevention

• Dr Shona Cameron, Course Director, School of Health Sciences
Structure of this presentation

• Story of Edinburgh in 1980’s
• Health promotion about HIV
• Prevention of spread of HIV
• Preventive Care
• Role of community nursing and primary care
Edinburgh – Athens of the North?
Or AIDS capital of Europe?
In 1983, HIV was introduced into the intravenous drug using population in Edinburgh.

At the same time, the police were successful in cutting the number of available syringes and equipment

Result: drug users shared needles, and HIV spread.
A health promotion success story

- Community drugs problem service
- Oral methadone to minimise need for intravenous drugs
- Needle exchanges
- Primary care services worked together
- Advertising campaign
What worked – a whole city public health approach

- Multi-dimensional approach
- Inter-agency working
- Harm reduction
- Non-stigmatising
Outcome

Epidemic slowed dramatically, in all modes of transmission.

One calculation, by comparing money spent in one year on prevention against the money that is needed for intensive healthcare, suggests health services had 39,000% return on investment.
Worldwide, in 2007

Now a generalised epidemic, main mode of transmission is though heterosexual sex.

- People living with HIV - 33.2 million
- New HIV infections - 2.5 million
- Deaths due to AIDS - 2.1 million

(UNAIDS and WHO, 2007)
Distribution of 2007 estimated cases
Annual reported HIV + and AIDS cases in China, 1985-2007 (www.unaids.org.cn)
Prevention

• Primary prevention – preventing people becoming HIV positive
• Secondary prevention – preventing passing on virus
• Tertiary prevention – minimising the ill-effects of being HIV positive
Health Promotion in UK

In UK, started off in 1980’s with national advertising campaign - “Don’t die of ignorance”

This was for everyone living in the UK – although at time, only affected high risk populations such as injecting drug users, gay men, and commercial sex workers.
All HIV health promotion work needs to consider:

- **Biological perspective**
  - Efficiency of transmission
  - Different types of HIV
  - Susceptibility to infection
  - Resistance to infection

And

- **Socio-economic perspective**
  Focus has been on individual change, rather than on impact of socio-economic issues on biological outcomes
Impact of socio-economic issues

- migration,
- poverty,
- gender inequality,
- stigma reduction,
- conflict, and natural emergencies
- concentration in certain populations and geographical areas (Kim et al 2002)
What is a risk environment?

- In a risk environment, individual, group and general social predisposition to virus transmission is increased.
- Due to poverty there may be forced migration, single head of household
- May lead to women exchanging sex for security, transport, food or other goods
- Nutritional disadvantage leads to increase in HIV infections and to progression to AIDS
Context of risk environment

- Transmission influenced by environments within which risk is produced
- Prevention strategies aimed at individual can only partially reduce transmission
- Need to reduce the risk environment
- Must create local environments and social conditions supportive of risk reduction by individuals and communities

(Rhodes and Simic 2005)
Health Promotion – models in action

- Behaviour change approach
- Empowerment approaches
- Community-oriented approaches
- Socially transformatory approaches

(Aggleton 2005)
Individual behaviour change

- Theory of reasoned action
- Stages of behaviour change model
- AIDS risk reduction model
- Common sense model of illness and danger
- Health belief model
Theoretical approaches to structural factors affecting HIV

- Paul Farmer: rights-based approach
- Barnett and Whiteside: social cohesion theory
- Catherine Campbell: integrated approach to prevention – health promoting community
- Infectious diseases
- Development theory
- Theory related to gender
- Psychosocial well-being
Challenges

Our understanding of what needs to be done is substantially more evolved than our understanding of How to do it (Radar, 2002:16)

But we know:

- Take into account the person
- Promote meaningful participation
- Make commitment to rights
- Promote gender equity
- Tackle risk and vulnerability

(Aggleton 2005)
Stigma

Perception of “fault” due to mode of transmission

Effect for the person with HIV – denial, fear of being turned away from treatment, may feel shame, fear rejection, and thus delay treatment.
"Realization of human Rights and fundamental freedoms for all is essential to reduce vulnerability to HIV/AIDS. Respect for the rights of people living with HIV/AIDS drives an effective response."

Early diagnosis

• Early symptoms
• Encourage HIV testing
• HIV+ people need to know the nature of the disease, and its medical, social and occupational implications
• Ways of protecting others from infections
Rash often occurs soon after seroconversion

- Widespread
- Erythematous
- Hot
- Involves hands and feet
Reasons for HIV testing

- Sexual risk/injecting risk
- Had physical symptoms
- Partner tested HIV positive
- Check-up for sexually transmitted infections
- Antenatal screening
- New relationship/stopping condom use
Reasons for HIV testing (continued)

- The importance of disclosing infection status to those giving medical care to allow adequate clinical management
- Worried well
- Sexual assault
- Blood donation / operation
- Medical examination
- Occupational exposure
- New drug therapies
What is HIV/AIDS Counselling?

The Global Programme on AIDS defines HIV/AIDS counselling as:

“a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and take personal decisions related to HIV/AIDS. The counselling process includes an evaluation of personal risk and facilitation of preventative behaviour." (WHO, 1995).
Pre-test discussion

• Informed consent

• Assess risks

• Prepare for positive diagnosis

• Health promotion

• Partner notification

• Closure
Post-test

• If negative – health promotion, and future prevention

• If positive – initial support
  – Coping, follow up counselling, safer sex

• If positive – longer term support
  – Medical assessment, counselling, telling others, support networks, sexual health, lifestyle balance, keeping well, ongoing referral e.g. psychology, welfare rights
HIV Prevention

- Preventive vaccines
- Post-exposure prophylaxis
- Safer sex
- Drug use
- Microbicides and spermicides
- Perinatal anti-HIV treatment
Preventive Care

• Improving the quality of life
• Support system, for person with AIDS and families
• Team approach
In China, a time of change:
Move to a market-driven economy, and a rising affluence – changing patterns of behaviour.
Sex is now the main route of transmission:-
44.7% heterosexual transmission
42% intravenous drug use
12.2% from men having sex with men
1.1% mother-to-infant (Lancet 2008)
Role of community nurses and primary care

• Help to remove stigma
• Focus on risk reduction, rather than behaviour
• Encourage community action
• Health education about HIV transmission
• Encourage testing
• Early diagnosis
• Support prevention – infection control
We have learned a lot about the most effective ways of organising prevention and care.
Multi-faceted approaches and all working together is most effective for prevention and health promotion.