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HIV – health promotion and prevention

Hangzhou, 25.10.08

Thank-you for giving me this opportunity to share what we have learned about health promotion about HIV and AIDS, in the UK. You all know your own context best, here in China, but I hope some of the things we have learned in the UK, and after considering the global evidence, will be relevant to you here.

Slide 2 In my presentation, I am going to address these issues:

Firstly I'm going to talk about my own experience in Edinburgh, in 1980's, when I worked as an HIV counsellor. I'll then go on to consider

- HIV/AIDS in Edinburgh in 1980's
- Health promotion about HIV
- Prevention of spread of HIV, including stigma and HIV testing
- Preventive Care
- Role of community nursing and primary care

Briefly addressing preventive care, and then the role of ourselves as community nurses.

Slide 3 Athens of the North

Where I work in Edinburgh, is the capital of Scotland, I think a beautiful city, and full of educational institutions and ideas. Indeed, in the past, it has been compared to Athens, the capital of ancient Greece and birthplace of Western civilisation.

Slide 4 or AIDS Capital of Europe?

But, in the late 1980's it acquired another title – the AIDS capital of Europe – how did that happen?

Slide 5

In 1983, HIV was introduced into the intravenous drug using population in Edinburgh.

At the same time, the police had a crack-down, and were successful in cutting the number of available syringes and equipment

Result: drug users shared needles, and HIV spread among this population.

At one point, looking at the age groups 15-49 in Edinburgh, 1:100 men were HIV positive, and 1:250 women.

Slide 6 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

Slide 7 What worked – a whole city public health approach

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

Slide 8 Outcome

Epidemic slowed dramatically, in all modes of transmission. That includes drug users, through heterosexual sex, from mother to child, through hospital equipment, even male to male sexual 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.

Slide 9 Worldwide

So, the global perspective

- 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)

But – these figures are an estimate, still difficult to gain totally accurate figures e.g. first figure could be as low as 30.6 million, or as high as 36.1 million.

Slide 10 Distribution across China of HIV estimated cases

Darker colours have higher incidence

Slide 11 Annual reported HIV positive cases and AIDS in China

Large increase 2003-2007, but apparently under control

Slide 12 Prevention

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

Slide 13 Health promotion in UK

So, in primary prevention, let's consider methods of health promotion

- 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 the time, only affected high risk populations such as injecting drug users, gay men, and commercial sex workers.

So, we started with individual approaches. However, targeted approaches, depicting for example HIV affecting African people, was offensive and stigmatising, which stopped people working well together. We needed to consider acceptable alternatives

It was only later, as we developed greater understanding of how this epidemic was being spread world-wide, that we considered wider aspects.

Slide 14 All HIV 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

So, the first perspective looks on it as a medical problem, and aims to develop ways of tackling it through medical treatments.

The second perspective looks on it as a behavioural problem, which can be solved by individuals acting on information, resulting in AIDS education campaigns.

So, separately each approach does not work – need to use both approaches.

As you are all nurses, I am not going to expand on the bio-medical approaches – that is something you know about already, but I will focus on the wider picture.

Slide 15 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)

For example, South Africa: land expropriation, and a migrant labour system, eroded the fabric of rural communities, and has shaken the stability of families and community life, and has heightened gender inequalities. In some societies, economics has driven many women, either formally or informally, to exchange sex for resources. Women through anatomy are more vulnerable to contracting the virus, and in addition rape has been used as a weapon of war.

HIV flourishes where the conditions of under-development – poverty, disempowerment, gender inequality, and poor public services – make societies susceptible to HIV (Holden 2003). This brings us to the concept of a risk environment.

Slide 16 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

Slide 17 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)

Barnett and Whiteside 2002 *AIDS in the 21st Century : Disease and Globalisation* (Palgrave)

These are “Enabling” environments. So, move away from individual-focussed interventions, towards concepts of community participation, community mobilisation and empowerment.

Slide 18 Health Promotion – models in action

- Behaviour change approach – addresses risky behaviour of individuals, eg condom use
- Empowerment approaches – focus on individuals taking control, approaches to safer sex education that emphasise communication and negotiation
- Community-oriented approaches – move away from individual approaches to emphasising groups, group norms, and community structures e.g. outreach work with sex workers and injecting drug users
- Socially transformatory approaches – far-reaching changes needed . Divisive ideologies of race, class, age, gender, and sexuality must be challenged.

(Aggleton 2005)

Slide 19 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 e.g. that's why needle exchanges work.

Knowledge, attitude, practice and behaviour – KAPB studies

Slide 20 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

Paul Farmer's work is very interesting, as he is both a physician and anthropologist. He worked with infectious diseases and the poor, and found that it was not the poorest who developed the first infections, but everyone was affected, even the rich, but the poor followed in large numbers. Risk factors not how many sexual contacts, but who these were – more at risk if with truck drivers, military, house servants, migration (new social mixing patterns)

Barnett & Whiteside – focus on changing risk environment

Catherine Campbell – need to go beyond biomedical, behavioural, human rights, into social and developmental issue. Providing info does not necessarily change behaviour

Infectious diseases – Inhorn and Brown – disillusion with eradicating infectious disease

Development theory neo-liberal/modernisation theory – more money, benefits of capitalism, more treatments

Theory related to gender – role of women and men, . Gupta 5 responses (Eldis)

Psychosocial well-being – analysis of emergencies or difficult environments – human capacity, social ecology, culture and values

Slide 21 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)

So, one thing we do know – stigmatising the individual does not help!

Slide 22 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.

That is one lesson we learned, that we should have addressed earlier in our care of people with AIDS. Our media talked about “innocent” victims, such as babies, or those who contracted the virus through blood transfusions. There are no “guilty” victims of being HIV positive.

(Concept of AIDS related stigma as being nurtured by historical components - social fear, anxiety, denial, racism etc

Aggleton: research on AIDS related stigma must go beyond behavioural and psychological models- look at social processes

Authors link stigma and structural inequality - argue these links reinforce marginalisation of already stigmatised groups.)

Slide 23 HIV ribbon

So, we’ve talked about primary prevention, now let’s turn to secondary prevention
How do people know they have the virus?

In the UK, knowledge of HIV is significantly less now than in 2000 (National Aids Trust Mori poll 2007) – needs a “Comeback” campaign – address fear, worry, lack of knowledge, misplaced or erroneous beliefs.

As community nurses, we may be in contact with patients who may not be aware of their status. We have a role in raising awareness, and in educating those we work with.

Slide 24 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
- The importance of disclosing infection status to those giving medical care to allow adequate clinical management

Slide 25 –early symptoms (skin)

Many people completely asymptomatic

At seroconversion, can experience fatigue, a fever, rash, joint pains, swollen lymph glands, headache – very general symptoms.

As an example, we come across many with skin conditions as part of our work:

Rash often occurs soon after seroconversion

- Widespread
- Erythematous
- Hot
- Involves hands and feet

Can have no symptoms for 10 years. As syndrome progresses, then neurological symptoms from HIV encephalopathy, later on opportunistic infections, such as pneumocystis, cytomegalovirus, or cancer.

Three phases are primary HIV, latency, and overt AIDS, based on lab counts of CD4+ T cells.

Later skin problems can include staphylococcus infection, folliculitis, molluscum contagiosum, and dermatitis.

Other later symptoms can include: candidiasis, herpes zoster (shingles), hairy oral leucoplakia, pneumonia, Kaposi's sarcoma, in women pelvic inflammatory disease, cervical cancer etc

Slide 26 & 27 REASONS FOR HIV TESTING

- Sexual risk, injecting risk
- Had physical symptoms
- Partner tested HIV positive
- STI check-up
- Antenatal screening
- New relationship / stopping condom use
- Importance of disclosing infection to those giving medical care so that appropriate care given
- Worried well

- Sexual assault
- Blood donation / operation
- Medical examination
- Occupational exposure
- New drug therapies

Slide 28 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).

Slide 29 PRE-TEST DISCUSSION

Informed consent

- aware of what is being tested
- HIV antibody test
- difference between HIV/AIDS
- advantages vs disadvantages of testing
- confidentiality & insurance implications

Assess risks

- Why test today?
- Risk assessment
- 3 month window period

Prepare for positive diagnosis

- If positive how would you cope?
- If positive would you want to know the result?

Health promotion

- Safer sex/safer injecting drug use.
- Screening for other STIs & Contraception

Partner notification

- Does your partner/friend/family know you're testing?
- Who would you tell about the test result?

Closure

- Are you going ahead with the test today?
- How results obtained.
- Is referral appropriate?

Slide 30

Post-test if negative – health promotion

Post-test, if positive

Initial consultation

- Awareness of shock factor
- keep information to a minimum.
- Focus on coping today, tonight, next few days.
- Who knows that person is receiving result today?
- Arrangements for confirmatory HIV test
- Follow up appointment, ongoing support& counselling.
- Safer sex, partners.

Long term

- Medical assessment, treatment and care.
- Counselling support: partner notification.
- Telling others: who and how to tell.
- Support networks - family, friends, community.
- Counselling for partners/family.
- Lifestyle balance, keeping well.
- Sexual health.
- Ongoing referral e.g. psychology, welfare rights, social services

Slide 31 HIV Prevention

- Preventive vaccines – none currently – possibility of range of partially effective vaccines
- Post-exposure prophylaxis – needlestick injuries – low risk, 3 per 1000.
- Safer sex
- Drug use
- Microbicides and spermicides
- Perinatal anti-HIV treatment

I am not going to say any more about this slide, as this is something you can explore from the textbooks, but just to say we have made great advances in treatment, in HIV medicines, antiretroviral drugs...which gives a greater incentive for earlier testing and diagnosis .

Slide 32 Preventive Care

- Improving the quality of life
- Support system, for person with AIDS and families
- Team approach

Treatment is not enough by itself, we need holistic care and palliative care in place for treatment to be successful.

(People with HIV living longer and healthier, and of course carers now have to consider co-morbidities)

I include this as it is important to integrate prevention and care, as only when we include all aspects of prevention, including enhancing the quality of life, will efforts to fight this epidemic succeed.

Slide 33 : in China, a time of change. The 21st century = Chinese century

You live in a country of great diversity and this is a time of great change - move to a market-driven economy, industrialisation, and a rising affluence – changing patterns of behaviour, and increased awareness of HIV. I've been reading that in China, there has been a similar picture, of a localised epidemic among needle-sharing IV drug users in 1980's. Now you have a young sexually active population, changing sexual behaviours and norms, increasing numbers of commercial sex workers, and massive internal migration.

Where once transmission was among drug users, commercial sex workers, migrant workers, commercial blood donors:

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

(figures from Health minister Chen Zou, Lancet 2008)

You have a government supportive of public health measures, so this is a wonderful opportunity to make a difference, and as community nurses can you contribute to this..

Slide 34 Role of Community Nurse and primary care

- Help to remove stigma
- Focus on risk reduction, rather than behaviour
- Health education about HIV transmission
- Encourage testing
- Early diagnosis
- Support prevention

Remove stigma – both about HIV, but also e.g homosexuality

Education about transmission: We as healthcare professionals know the virus is only transmitted in 3 ways: through contact with infected blood, through contact with infected body fluids (semen and vaginal fluids), and from infected mother to her baby

Sex and condoms, preventing STI's, support prevention – infection control

Slide 35

So, in conclusion, in a relatively short space of time, we have learned a lot about the most effective ways of organising health promotion., prevention and care. Edinburgh is no longer AIDS capital of Europe (Barcelona is)

Slide 36

Multi-faceted approaches and all working together is most effective for prevention and health promotion of HIV and AIDS.