Reflections on Providing non stigmatizing STBBI Services

Ameeta Singh, BMBS (UK), MSc, FRCPC
ameeta@ualberta.ca

Disclaimer

- All views expressed in this presentation are mine and do not represent the views of any affiliated organizations

Risk Assessment vs Stigma/Discrimination – Slide 1

- Case example:
  - 60 year old Caucasian male referred to the OPIV clinic at my inner city hospital for iv antibiotics. Diagnosed with endophthalmitis L eye by Ophthalmologist
  - O/E: left eye red, well dressed, good hygiene
  - Most common cause of endophthalmitis is bacteria such as *Strep. pneumoniae*, *Staph. aureus*, etc
  - Patient on Vancomycin and ceftriaxone

Risk Assessment vs Stigma/Discrimination – Slide 2

- I start to take a social history and learn that he is single, lives alone, no substance or alcohol use, employed (office) and then I learn he has sex with men only
  - And only then do I think – could he have syphilis????
  - Subsequent syphilis test positive and diagnosis is therefore ocular syphilis

Risk Assessment vs Stigma/Discrimination – Slide 3

- So, was this just risk assessment or was it is discrimination (I suspect I may not have ordered the test had I not had the sexual history and know that we have a significant resurgence of syphilis in MSM in Edmonton)

Cultural influences on “sex”

- I am:
  - Female
  - Of East Indian origin
  - In my family, we did not/do not take about sex except in the vaguest terms!

Reflections on why I am now "comfortable" taking a sexual history and substance use history

- Years of practice and self reflection and learning of skills – some by reading good references
- Took me 1-2 years of doing this regularly before I became "comfortable"
- When asking patients this history now, I sit close to them, concentrate only on them, eye contact and ask the questions in a matter of fact, "non judgmental" way

"I'd like to ask you some personal questions if that's OK with you".....start with work, where live, who do you live with, alcohol/drugs and then," do you have sex with men or women or both"

Asking questions in a "non-judgmental way"

- How?
  - One of the ways is that I respect that there are differences among people
  - Different cultural and behavioral norms
  - A "live and let live" philosophy
  - An understanding that for substance users esp. that many are in this situation because of life circumstances

"We need to be reminded that it is not our role to judge others"

Focus group participant[1]

[1]Ontario HIV/AIDS Strategy for African, Caribbean and Black Communities, 2013-2018

HIV testing

- I have never had anyone refuse to have an HIV test when I have asked – why?
- One possible explanation is – too "intimidated" or afraid to say "no"!!
- Or – could it be because I suggest the test in a matter of fact way in an attempt to "normalize" testing – "would you like us to do an HIV test? I think it would be a good idea.. What do you think?"

HIV testing: the case for "normalizing" testing

- PHAC estimates that in 2011: 25% people living with HIV in Canada were unaware of their infection
- Benefits to reducing the number of undiagnosed infections:
  - Relieve anxiety about an unknown HIV status and to establish baseline for overall health care
  - Those testing negative are provided with an opportunity to receive risk reduction counseling
  - Those testing positive can receive info, counseling, care, Rx and support

PHAC. HIV Screening and Testing Guide, 2012

HIV testing: Canadian guidelines

- **It is recommended that the consideration and discussion of HIV testing be made a component of periodic routine medical care**
  - Based on good evidence demonstrating the individual and public health benefits of "normalizing" HIV testing
  - Early diagnosis and Rx can led to reduced morbidity and mortality associated with HIV
  - Individuals who test positive are more likely to take measures to prevent onward transmission of HIV

PHAC. HIV Screening and Testing Guide, 2012

Barriers to reducing # of undiagnosed cases of HIV in Canada

BARRIER	Recommendations
Inability to accurately assess levels of risk for exposure to HIV by some clients and providers	Normalise HIV testing; simplify risk assessments; make the consideration of an HIV test part of periodic routine medical care.
Lack of comfort discussing HIV testing and knowledge about HIV among some clients and providers	Normalise HIV testing; simplify risk assessments; make the consideration of an HIV test a part of periodic routine medical care.
Provider time constraints for risk assessments and pre- and post-test counselling	Simplify risk assessments; streamline the provision of pre-test information using print, video, mobile and web-based resources; alternate approaches offered to provide negative results.
Cumbersome consent procedures	Verbal consent for HIV testing, as with other tests, is sufficient; testing remains voluntary.
Fear of stigma and discrimination associated with risk behaviours and/or	Normalise HIV testing and simplify risk assessment to reduce discomfort and stigma and increase uptake of testing; emphasize HIV as a chronic manageable condition and the benefits of

PHAC. HIV Screening and Testing Guide, 2012

HIV/STI testing: consent vs pre-test counseling

- Minimum needed to proceed with HIV/STI testing:
  - Verbal consent- need to understand that HIV/STI test being conducted, how long until test result available
  - If patient expresses reluctance, discuss why (e.g. just had testing done)
- This typically takes a maximum of 1-2 minutes and allows the opportunity for patient to ask questions
- If decline and no strong medical reason to do the test, I typically do not pursue this at that visit but may discuss again at a later visit

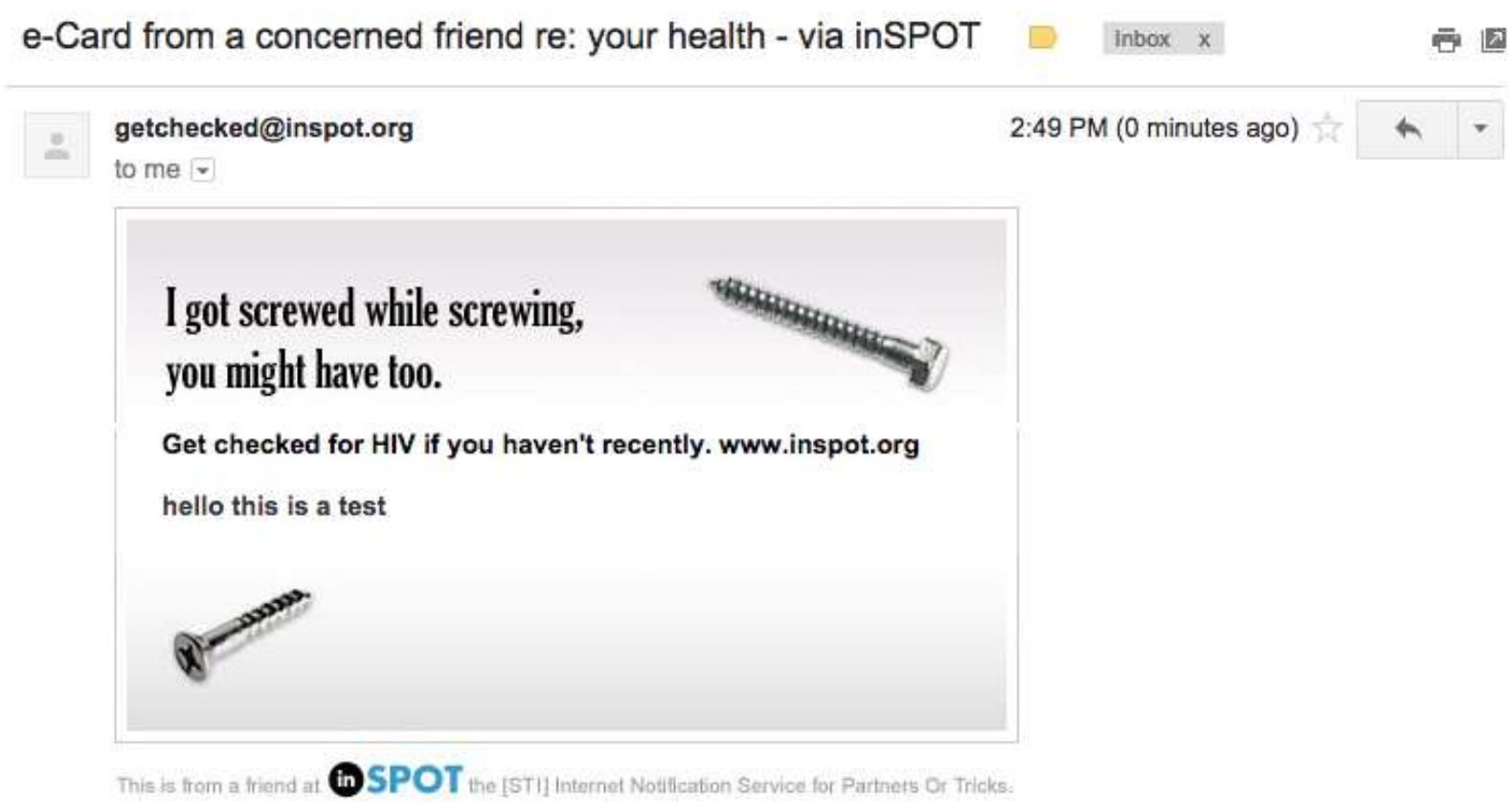
Note that this slide reflects my opinion

HIV/STI testing: post-test counseling

- Negative HIV test result:
  - In person/by phone
  - In person: an opportunity to discuss risk reduction counseling
- Positive HV test result:
  - Should be done in person, private/confidential setting
  - Offer support, e.g. psychology, social work, etc
  - Seek assistance from public health if needed, e.g. patient seen in ER and no scheduled follow up
  - Ensure referral to care/Rx, discuss how to prevent further spread of virus, partner notification

Note that this slide reflects my opinion

Help with partner notification – www.inspot.org



Summary

- It is possible to provide non-stigmatizing STBBI services
  - Requires thought and reflection
  - Learning some skills
  - Practice/experience

And now back to Rachel..