PERCEPTION OF GENERAL PRACTITIONER CARE AMONGST HIV POSITIVE HETEROSEXUAL BLACK AFRICANS AND HOMOSEXUAL MEN IN LONDON

Nigel O’Farrell¹, Hayley Gardner

ABSTRACT

a. Objective

To identify differences between heterosexual black Africans (HBA) and men who have sex with men (MSM) in their perception of general practitioner (GP) care for HIV.

b. Methods

HIV positive patients attending an HIV clinic completed a self-administered anonymous questionnaire about access to general practitioner and other services for HIV care.

c. Results

Compared to MSM, HBA were less likely to receive their HIV diagnosis in the UK (P= 0.09), more likely to prefer both an earlier HIV diagnosis (P<0.001) and polyclinic attendance to hospital (p=0.02), and in those with GPs, were less likely that their GP was aware of their HIV diagnosis (P=0.004), more likely to have confidentiality concerns about their GP (P=0.0003), less happy both for letters to be sent to their GPs (P=.0001) and for them to manage their HIV care (P=0.03). The most common reason for not having a current GP was concern about confidentiality.

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d. Conclusions

Although similar proportions of HBA and MSM currently had a GP, barriers exist for HBA to identify their HIV status to GPs. Further work is required to encourage HBA to divulge their HIV status to GPs and improve patients’ perception of confidentiality in the surgery setting.

Keywords: HIV care, primary care, Black Africans, men who have sex with men

INTRODUCTION

Although late diagnosis of HIV in heterosexual black Africans (HBA) in the UK was identified as a common occurrence in the mid 1990’s, this situation still continues [1, 2]. Public health recommendations and UK National targets have recently focused on this issue and seek to engage general practitioners (GPs) both to undertake HIV testing and have a greater awareness of medical conditions associated with HIV [3].

Compared with previous versions, recent HIV treatment guidelines now recommend earlier treatment for HIV [4]. Models of care will therefore have to adjust to accommodate the increased capacity required. The vast majority of patients started on antiretrovirals at reasonably high CD4 counts are unlikely to develop classical HIV associated illnesses if they maintain high CD4 levels and could be managed in primary care. Furthermore, getting patients’ opinions about where they would prefer to be treated is therefore crucial if they are to engage with services. Recently in London, polyclinics have been put forward as a new way for people to receive healthcare. These clinics will provide a wide range of services in a more accessible, local and convenient location [5]. We therefore sought to identify any differences between the two largest groups at risk of HIV in the UK- men who have sex with men (MSM) and HBA in their perception of GP care for HIV.

a. Methods

All patients attending the Ealing Hospital HIV clinic between Feb.-March 2008 were asked to self complete a questionnaire in English after a short explanation about the survey. The survey was anonymous and verbal consent was obtained. The questionnaire asked about HIV diagnosis and access to care through hospital-based specialist units, traditional GP surgeries and polyclinics.

The chi square test was used to determine any differences in variables between HBA and MSM.
Eighty HBA and 62 MSM completed the questionnaires. Six subjects either declined or were unable to complete the questionnaire because of language issues. No MSM were of black African ethnicity. The mean age of the HBA was 41 and for MSM was 47. Overall, 118/146 (80.8%) had GPs of whom 36/62 (56.5%) were HBA and 41/50 (82%) were MSM.

Compared to MSM, HBA were less likely to receive their HIV diagnosis in the UK (P= 0.09), more likely to prefer both an earlier HIV diagnosis (P<0.001) and polyclinic attendance to hospital (p=0.02) [Table]. Amongst those with GPs, HBA were less likely than MSM that their GP was aware of their HIV diagnosis (P=0.004), more likely to have confidentiality concerns about their GP (P=0.0003), less happy both for letters to be sent to their GPs (P=.0001) and for them to manage their HIV care (P=0.03). The most common reason for not having a current GP was concern about confidentiality.

Reasons given for not having a GP were for MSM and HBA respectively: confidentiality concerns- 4 and 6, not happy with previous GP- 3 and 4, difficult to get an appointment- 2 and 1, and immigrant issues- 0 and 3.

**DISCUSSION**

We identified a number of significant differences between HBA and MSM. Fewer HBA had GPs and used the HIV clinic both for specialist and primary care. HBA unsurprisingly were less likely to receive their diagnosis in the UK although a high proportion did so (84%).

More HBA would have liked an earlier HIV diagnosis. This may reflect a tendency for HBA to be diagnosed later when CD4 counts are low thereby making them less likely to achieve normal levels CD4 levels after highly active antiretroviral therapy (HAART) is started.

Recent government initiatives have signalled the promotion of polyclinics in community settings and we found that 48% preferred the former to hospitals. We believe that polyclinics could be used to see those maintaining high CD4 counts that are unlikely to develop HIV-related problems at least in the short term after becoming stabilised on HAART.

Disclosure of HIV status to others has been identified as an issue in HBA compared to MSM with the latter more likely to tell partners, friends and employers about their HIV status [6, 7]. Whilst confidentiality with GPs was an issue for both groups, it appeared to be a significant problem for HBA. Patients did not confine their concerns about confidentiality to any one person, that is, doctor, nurse or receptionist but rather the service as a whole. A previous small study in black Africans in the UK identified problems with GPs’ lack of knowledge resulting in judgemental comments reinforcing
stigma [8] whilst in a mainly MSM group in Brighton, confidentiality and discussing lifestyle choices were the main issue identified as barriers to GP involvement [9].

Amongst those with GPs, MSM were happier than HBA for GPs to manage their care and for letters to be sent to their GP about their HIV diagnosis. Although our clinic policy is to encourage all HIV patients to inform their GP about their HIV status and to get a GP if they do not have one, a significant proportion do not access GPs services for HIV related problems. There were some limitations to this study. Although we classified MSM as a single group, the ethnicity of the individuals enrolled may be diverse particularly in London. Also, women may seek primary care for reproductive health issues unrelated to their HIV status.

As survival increases for those on HAART, so they are more likely to visit GPs with various ailments associated with aging. If these patients are to have a satisfactory outcome it is vital that they feel confident about HIV disclosure to their GP. The likelihood of serious drug reactions is increased significantly if prescribers are unaware of treatments that patients are taking.

REFERENCES

5. www.healthcareforLondon.nhs.uk/about-polyclinics/
ACKNOWLEDGMENTS

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There are no competing interests

Table: GP management and HIV risk group

<table>
<thead>
<tr>
<th>Variable</th>
<th>Heterosexual African (male and female) N = 84</th>
<th>Homosexual N = 62</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age</td>
<td>41</td>
<td>47</td>
<td></td>
</tr>
<tr>
<td>Received HIV diagnosis in UK</td>
<td>67/80=83.75%</td>
<td>55/59=93.2%</td>
<td>P=0.09</td>
</tr>
<tr>
<td>Earlier HIV diagnosis preferred</td>
<td>61/72=84.7%</td>
<td>29/56=51.8%</td>
<td>P&lt;0.001</td>
</tr>
<tr>
<td>Think GP’s should offer HIV testing in surgery</td>
<td>46/77=59.7%</td>
<td>32/53=60.4%</td>
<td>P=0.94</td>
</tr>
<tr>
<td>Would approve of HIV being managed in polyclinics</td>
<td>22/75=29.3%</td>
<td>20/58=34.5%</td>
<td>P=0.52</td>
</tr>
<tr>
<td>Would prefer polyclinics for HIV management to hospital</td>
<td>42/75=56.0%</td>
<td>21/58=36.2%</td>
<td>P=0.02</td>
</tr>
<tr>
<td>Confidentiality concerns at this clinic</td>
<td>17/77=22.1%</td>
<td>10/62=16.1%</td>
<td>P=0.37</td>
</tr>
<tr>
<td>Currently have a GP</td>
<td>67/77=87.0%</td>
<td>51/62=82.3%</td>
<td>P=0.44</td>
</tr>
</tbody>
</table>
HIV risk group and patients with GPs

<table>
<thead>
<tr>
<th></th>
<th>N = 67</th>
<th>N = 51</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP aware of HIV diagnosis</td>
<td>35/62=56.5%</td>
<td>41/50=82.0%</td>
<td>0.004</td>
</tr>
<tr>
<td>Happy to use GP for non-HIV related matters</td>
<td>57/64=89.1%</td>
<td>46/49=93.9%</td>
<td>0.37</td>
</tr>
<tr>
<td>Problems with GP</td>
<td>7/63=11.1%</td>
<td>3/47=6.4%</td>
<td>0.40</td>
</tr>
<tr>
<td>Confidentiality concerns at surgery</td>
<td>34/67=50.7%</td>
<td>8/46=17.4%</td>
<td>0.0003</td>
</tr>
<tr>
<td>Happy for letters to be sent to GP</td>
<td>29/65=44.6%</td>
<td>40/49=81.6%</td>
<td>0.0001</td>
</tr>
<tr>
<td>GP prescribes regular meds</td>
<td>22/66=33.3%</td>
<td>20/50=40.0%</td>
<td>0.46</td>
</tr>
<tr>
<td>Happy for GP to manage HIV care</td>
<td>7/63=11.1%</td>
<td>13/47=27.7%</td>
<td>0.03</td>
</tr>
</tbody>
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