Addressing smoking in routine health care of people living with HIV (PLHIV): The practices and attitudes of Australian health care providers THE UNIVERSITY

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Background

- PLHIV have higher smoking rates than the general population. ^{1,2}
- Smoking is now the greatest risk factor for premature mortality for PLHIV.³
- International studies suggest a need to increase health provider engagement in addressing smoking among PLHIV, although no Australian data is currently available.^{4, 5}

AUSTRALIA

Aim

To assess attitudes, knowledge and practices of Australian health providers towards addressing smoking with their patients living with HIV and tobacco harm reduction approaches.

Method

An anonymous online survey of health practitioners who provide healthcare to

179 respondents The majority of participants (94%) believed that addressing smoking among people living with HIV was relevant important (Figure 1) and reported assessing their patients' smoking status (92%) and advising those who smoke to quit (82%) (Table 1).

89% reported providing at least one form of assistance. Health education was the most common form of assistance

Results

PLHIV in Australia.

- Distributed via clinical networks and professional organisations.
- provided (85%). Assistance in the form of pharmacotherapy (61%) or providing counselling (64%) was less common.
- Most participants supported tobacco harm reduction, 87% agreeing it could benefit PLHIV who do not want to quit and endorsed cutting down the number of cigarettes smoked per day (72%) and switching completely from smoking cigarettes to using NRT as a long-term substitute (79%) (Figure 2).
- Participants were most likely to report a neutral response (neither agree nor disagree, or reporting 'don't know') about vaporised nicotine products (e-cigarettes) (Figure 2).

| | N (%) | | | My patients will be offended |
|---|------------------------------|------------------------|-----------------------|--|
| 5A Domain | Activity | Activity | At least one activity | I prefer to wait for a patient to raise the issue |
| | | performed* | performed* | I don't feel confident in discussing the issue |
| Ask | Ask status | 164 (91.6%) | 169 (94.4%) | It is the the role of other health care professionals |
| | Record status | 164 (91.6%) | | I don't know where to refer my patients |
| Assess | Readiness to quit | 132 (73.7%) | 139 (77.7%) | Insufficient financial compensation |
| | Nicotine dependence | 89 (49.7%) | | Smoking is a useful coping strategy for PLHIV |
| Advise | Advise patient to quit | 147 (82.1%) | 147 (82.1%) | I lack the skills or knowledge |
| Assist | Health education | 152 (84.9%) | 160 (89.4%) | |
| | Self-help resources | 31 (17.3%) | | Competing priorities |
| | Referral | 111 (62.0%) | | Lack confidence in patients' ability to quit |
| | Counselling | 114 (63.7%) | | I don't have enough resources to give to my patients |
| | Pharmacotherapy | 109 (60.9%) | | I don't know enough about best practice of NRT prescribing |
| Arrange | Follow up progress | 119 (66.5%) | | It is relevant and important to discuss |
| | Discuss relapse prevention | 92 (51.4%) | 131 (73.2%) | 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 10 |
| All 5As | | | 110 (61.5%) | ■ Agree ■ Neutral ■ Disagree |
| | | | | |
| | Figure 2. Practi | itioner <u>Attit</u> u | udes to Tobacco Harn | m Reduction Conclusions |
| THR could benef | fit PLHIV who do not want to | o quit | | |
| Ał | ostinence should be the only | y goal | | High levels of adherence to each individual "A" were reported but overall adherence to the framework |
| Switching to term NRT reduces risk | | | | was less common. |
| Reducing CPD reduces risk | | | | Encouraging healthcare providers to proactively |
| Switching to long term VNP reduces risk | | | | assist their patients to address their smoking and prioritise this health issue could be an effective way |
| | VNP can help people to | o quit | | to increase cessation rates among this priority |

| Table 1. Frequ | ency and Percentage of Re | spondents V | Who Performed 5A | Figure 1. Practitioner Attitudes to Addressing Smoking With Patients Living With HIV Who |
|--|------------------------------|--------------------|-----------------------|--|
| Activities (*always or most of the time) | | | | Smoke |
| | N (%) | | N (%) | My patients will be offended |
| 5A Domain | Activity | Activity | At least one activity | I prefer to wait for a patient to raise the issue |
| | | performed* | performed* | I don't feel confident in discussing the issue |
| Ask | Ask status | 164 (91.6%) | 169 (94.4%) | It is the the role of other health care professionals |
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| Arrange | Follow up progress | 119 (66.5%) | 131 (73.2%) | It is relevant and important to discuss |
| | Discuss relapse prevention | 92 (51.4%) | | 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% |
| All 5As | | | 110 (61.5%) | 🗖 Agree 🗖 Neutral 🔲 Disagree |
| | | | | |
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| Abstinence should be the only goal | | | | reported but overall adherence to the framework |
| Switching to term NRT reduces risk | | | | was less common. |
| Reducing CPD reduces risk | | | | Encouraging healthcare providers to proactively |
| Switching to long term VNP reduces risk | | | | assist their patients to address their smoking and |
| VNP can help people to quit | | | | prioritise this health issue could be an effective way |
| | vivr can help people to | | | to increase cessation rates among this priority |

VNP is too harmful to recommend

population group.

90% 100% 0% 10% 20% 30% 40% 50% 60% 70% 80%

■ Agree ■ Neutral ■ Disagree

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CPD: cigarettes per day NRT: nicotine replacement therapy THR: tobacco harm reduction VPN: vaporised nicotine products

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