Listening to Those Who are Living With HIV and Tobacco Dependence and Exploring Their Health Care Context

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*The emergence of antiretroviral therapies extends the life span of people diagnosed with HIV and shifts health priorities toward chronic disease management. People living with HIV (PLWH) who smoke cigarettes are more likely than nonsmokers to develop health conditions such as pneumonia, cancer, emphysema, and heart disease. Our mixed methods study utilized semi-structured interviews (*n = *29) to explore PLWH perceptions of tobacco and its role in their lives. We also explored HIV health care services and tobacco dependence treatment. Local HIV clinic staff (*n = *4) participated in interview and focus group discussions that examined their practices and clinic services concerning tobacco dependence treatment. A brief survey of Canadian AIDS Society members shed light on trends in clinic-based tobacco dependence treatments (*n = *24). The following themes emerged: competing health priorities for PLWH; interest in quitting; and disconnect between tobacco use, health, and living.*

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Today, receiving a diagnosis of HIV in a developed country commonly means learning to live with a chronic health condition that may last for decades. This shift in reality for people living with HIV (PLWH) has occurred as a result of antiretroviral therapy (ART) that slows the progression of HIV. Unfortunately, the effects of living with HIV, taking ARTs, and engaging in unhealthy behaviors synergistically increase the odds of developing a diverse array of secondary health conditions. Subsequently, health care priorities for PLWH now focus on remaining as healthy as possible for as long as possible, including enhanced quality of life, management of medication regimes, and lifestyle behavior interventions (Siegel & Lekas, 2002).

Tobacco use is common in PLWH, with reported rates ranging from 47% to 84% (Amiya et al., 2011; Fuster et al., 2009; Lifson et al., 2010; Marshall et al., 2011; Tesoriero, Gieryic, Carrascal, & Lavigne, 2010); these rates are more than double those amongst the general population (Lifson et al., 2010). PLWH who use tobacco are at greater risk for a variety of health

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problems such as cardiovascular disease, cancer, and respiratory illnesses (Grinspoon & Carr, 2005; Lifson et al., 2010; Rahmanian et al., 2011); the risk of developing cardiovascular disease is even greater when taking ART (Vidrine, 2009). In a retrospective cohort study of more than 2,000 PLWH, risk of mortality among current smokers was almost twofold higher than among nonsmokers (Pines, Koutsky, & Buskin, 2011). Two possible mechanisms have been suggested: (a) that ART is less effective at reducing the incidence of AIDS and death among smokers when compared to nonsmokers (Feldman et al., 2006), and (b) that tobacco use negatively impacts the immune response (Rahmanian et al., 2011).

High rates of smoking among PLWH have been attributed to physical and mental distress, marginalized social conditions, use of other substances, and limited access to smoking cessation services (Reynolds, 2009). Studies have shown that many PLWH have a desire to or have recently attempted to quit (Shapiro, Tshabangu, Golub, & Martinson, 2011; Tesoriero et al., 2010), suggesting that these individuals require tobacco dependence treatment as part of their chronic disease management. Integration of tobacco dependence treatment within existing HIV clinic services is an emergent health care imperative (Shuter et al., 2012) to ensure optimal quality of life for PLWH.

Recent studies that examined the practices, beliefs, and attitudes of care providers working with PLWH have identified several possible improvements to tobacco dependence treatments. In one such study, a survey of HIV care providers across the United States suggested that these professionals were aware of the importance of addressing smoking with their clients (Shuter et al., 2012). Unfortunately, they also reported that care providers were not engaging their clients in adequate discussions/activities related to smoking cessation. In another study, less than half of HIV care providers were assessing tobacco use and readiness to quit with their clients (Tesoriero et al., 2010). Care providers have cited a variety of reasons for their inattention to treating tobacco dependence, including time and cost constraints, concerns related to clients' other health issues and lack of request for services, and provider lack of knowledge and training (Tesoriero et al., 2010). Nahvi and Cooperman (2009) suggested that research evidence is required to tailor tobacco dependence treatment programs for PLWH.

To date, studies of PLWH have involved surveys that focus on tobacco use in relation to co-addictions and/or comorbidities; investigate smoking cessation, including interest in quitting and number of quit attempts; and document motivations for continued smoking (Amiya et al., 2011; Reisen et al., 2011; Shapiro et al., 2011; Tesoriero et al., 2010). PLWH have often cited the following as reasons for continued tobacco use: weight management, stress management, emotional support, and personal pleasure (Peretti-Watel et al., 2009). Although these studies provide evidence to support tobacco dependence treatments, they have not examined the voiced experiences of PLWH with respect to tobacco use and dependence. In order to initiate practice changes, we must first understand how PLWH frame tobacco use and dependence treatment within a health care context.

Our primary research objective was to explore the experiences of PLWH with respect to tobacco use, dependence, and cessation. The secondary objective was to investigate tobacco use, dependence, and cessation within the context of current Canadian HIV health care services.

Methods

Our mixed methods design (Creswell, 2003) included semi-structured interviews and focus group discussions with PLWH and HIV clinic care providers as well as a survey of Canadian HIV agencies. Ethical and institutional access approvals were obtained through the Education/Nursing Research Ethics Board at the University of Manitoba and Health Sciences Centre HIV Clinic and Nine Circles Community Health Centre, which were the main sources of HIV-specific health care services in Manitoba.

Sampling

We used interpretive descriptive theoretical sampling to recruit PLWH and HIV care provider participants (Thorne, 2008). Thus, participants were required to have specific personal knowledge of the phenomena of interest, to help researchers explore the knowledge and/or lived experiences relevant to