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Integrating Pregnancy Prevention Into an HIV Counseling and Testing Program in Pediatric Primary Care

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A B S T R A C T

Purpose: Certified health educator (CHE)-based HIV counseling and testing typically focus on HIV and sexually transmitted infection (STI) prevention only. A quality improvement initiative examined integrating assessment of reproductive life plans, counseling about pregnancy prevention, and contraception referral into a CHE-based HIV testing program.
Methods: Between February 2014 and January 2017, in one urban pediatric primary care clinic serving patients aged 0–25, CHEs assessed sexual history, HIV risk, short-term (i.e., the next 6–12 months) pregnancy desire, and current contraception method and satisfaction among patients aged 13–25 who had ever had vaginal sex, using a standardized questionnaire. Data were analyzed using a de-identified administrative dataset that also tracked referrals to initiate contraception and actual method initiation.
Results: Of 1,211 patients, most (96%) reported no short-term pregnancy or partner pregnancy desire. Use of less effective or no contraception, as well as method dissatisfaction, was common. A high proportion of female patients referred to new methods opted for more effective methods (62%) and initiated these methods (76%); a high proportion of male patients opted for receipt of condoms (67%). Patients reporting short-term pregnancy desire reported higher rates of previous pregnancy and STIs.
Conclusions: Program findings highlight the potential benefit of integrating assessment for and counseling about pregnancy prevention in a CHE-based HIV testing program. This can more effectively address the needs of patients with concomitant risks of STI/HIV and unintended pregnancy, and link patients who do not desire pregnancy to more effective methods.

IMPLICATIONS AND CONTRIBUTION

This report summarizes findings of a clinical program to integrate pregnancy prevention counseling and reproductive life plan assessment as part of rapid HIV testing and risk reduction services to improve patients' satisfaction with contraceptive use aligned with their reproductive life plan, and STI/HIV prevention.

Adolescents and young adults (AYAs) have high rates of unintended pregnancy, sexually transmitted infections (STIs), and HIV compared with adults [1–3]. Clinical practice guidelines by the Centers for Disease Control and Prevention and the U.S. Preventive Services Task Force support universal and routine HIV testing beginning in adolescence [4,5] and assessment of reproductive life plans to assist with pregnancy planning and prevention [6]. Although the risks of unintended pregnancy and STI/HIV often overlap for AYAs [7], established HIV counseling and testing

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program models do not typically integrate assessment of reproductive life plans and contraception provision to help reduce risk of both STI/HIV and unintended pregnancy. Such an approach in primary care is necessary given data showing that a large proportion of AYAs have a primary care visit at least annually, which has increased since the implementation of the Affordable Care Act [8–10].

Few studies have examined the process of pregnancy prevention needs assessment, counseling, and referral for AYAs in the context of their concomitant risk of STIs/HIV. Instead, studies have typically focused on either reproductive life plan assessment or contraceptive counseling, but not both. For example, one recent study that evaluated reproductive life plan assessment among female and male clients, including patients at publicly funded health centers providing family planning services, demonstrated that 58% of centers had protocols to assess reproductive life plans and that having a protocol increased the likelihood of routine assessment [11]. Another study, which examined the reproductive intentions of women and men (aged 13–44) in family planning settings, reported 86% of persons aged 13–29 were not currently seeking pregnancy [12]. However, this study did not stratify reproductive intentions by gender or examine concomitant STI/HIV risk factors. Neither of these studies asked about or provided counseling on contraceptive methods based on identified needs.

Regarding the abundant research on contraceptive counseling among AYAs [7,13–16], the Contraceptive CHOICE project, a frequently cited program, showed that by using a standard counseling approach and removing costs and access barriers, large proportions of female participants, including AYAs, chose more effective contraception [15,16]. Adolescent participants reported high rates of satisfaction with these methods over time and experienced reduced rates of unintended pregnancy [13,15–17]. This program trained nonclinician counselors on a standardized contraceptive counseling approach for female patients that took about 1 hour to complete, providing information on the most effective, reversible methods first and then proceeding through methods in decreasing order of effectiveness [13]. This program focused only on contraceptive choices and did not explicitly address STI/HIV risk reduction (study participants received STI testing and treatment only as needed) nor did it involve male patients.

Contraceptive counseling approaches typically do not include male AYAs, a population that also has pregnancy prevention needs [1]. However, male AYA patients report they want to discuss pregnancy prevention with their health-care providers [18]. A recent meta-analysis also demonstrated that brief condom skills interventions in clinical settings with male patients hold promise for improving males' condom behaviors and possibly reducing STI outcomes [19]; also the majority of these studies were conducted in STI clinics. Few male AYA patients in primary care report receipt of pregnancy prevention services (e.g., being asked about their plans to have children or partner birth control use, provided condoms, or counseled about pregnancy prevention) [20]. Although men may have more limited contraception options than women, counseling approaches can educate male AYAs about improvements in condom design, feel, and lubrication that have been shown to reduce differences in sexual pleasure between condom use and nonuse [21].

Given the concomitant risks of STIs/HIV and unintended pregnancy that many AYAs face, certified health educators (CHEs) trained on HIV counseling, testing, and referral, reproductive life plan assessment, and contraceptive counseling may be a natural fit when providing HIV testing while also assessing reproductive life plans and counseling on pregnancy prevention. HIV testing services led by CHEs may represent an opportunity to improve the identification of patients in need of pregnancy prevention services and referral for care. The use of CHE staff may also assist with managing the time constraints that providers may have when providing this level of service [22–24]. Given the increased time CHEs may be able to spend with patients, they may be more effective at individually tailoring counseling approaches to a patient's STI/HIV risk and pregnancy plan. Among patients with no immediate plans to have children, this would allow for a review of patients' satisfaction with their current contraceptive method(s) [16,17] and referral of patients who are not satisfied with their current method to a different method while reinforcing dual method use for both pregnancy and STI/HIV prevention. It remains unclear whether the use of such an integrated program will result in identifying adolescents with pregnancy prevention needs, as well as supporting AYA's contraception referral and method initiation.

The main goal of this report was to describe the short-term pregnancy plans (i.e., in the next 6–12 months) and current contraceptive use and satisfaction of a sample of AYA patients (aged 13–25) who had ever had vaginal sex. Patients were seen in a pediatric primary care clinic that serves patients aged 0–25 as part of a quality improvement project to integrate rapid HIV testing and pregnancy prevention counseling into the clinical setting using CHEs. A secondary goal included describing, among patients with no immediate short-term pregnancy plans who were not satisfied with their current contraceptive method, the proportion of patients who agreed to be referred to and initiated a new method (among women) and to receive condoms (among men) from a diverse selection of condoms.

Methods

The CHE-based rapid HIV testing quality improvement program began in February 2014 in one mid-Atlantic urban pediatric primary care clinic serving patients aged 0–25. CHEs completed a formal HIV testing and counseling course sponsored by the Maryland Department of Health and were certified by the state of Maryland to perform rapid HIV tests. Additional training provided by the clinic included training on motivational interviewing [25], risk reduction counseling [26,27], and pregnancy prevention assessment and counseling using evidence-based approaches [6,13,28]. The institution's human subject review board approved this study as part of an exempt quality improvement protocol.

The counseling and testing program used the Advise, Counsel, Test, Support (ACTS) program approach, which consists of pretest counseling and informed consent, HIV prevention and risk reduction counseling, and post-test counseling conducted by CHE staff, as a framework for the testing and counseling services [29]. The ACTS program approach was chosen because it is a well-known testing approach that has been found to increase HIV testing among adolescents [29]. Additionally, the use of rapid HIV testing, as opposed to venipuncture, is more acceptable to adolescents and increases testing rates and results receipt [30]. As part of the program protocol, CHEs approached patients in their examination room who met the program criteria: individuals aged 13–25 who had been identified as being in need of HIV testing based on the Centers for Disease Control and Prevention testing