

A Systematic Review of Health Care Provider-Perceived Barriers and Facilitators to Routine HIV Testing in Primary Care Settings in the Southeastern United States

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Despite efforts to improve HIV screening and testing, many primary care settings do not follow established guidelines. The purpose of our systematic review was to describe health care providers' perceived barriers and facilitators to testing for HIV at poorly used/novel testing sites in the southeastern United States. PubMed, CINAHL, and Embase databases were searched for peer-reviewed studies of providers' perceived barriers and facilitators to routine HIV testing from January 2016 to April 2017 according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement. Of 708 papers retrieved, 12 met inclusion criteria and were analyzed. Barriers to HIV testing in primary care existed at the societal, organizational, and individual levels. Providers need continuing sexual health education, including HIV and federal guideline updates, and students should have clinical experiences to supplement knowledge about sexual health. Clinic protocols should be updated to meet current policy guidelines.

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HIV infections continue to be a national and regional issue in the United States; an estimated 14% to 19% of

people in the United States infected with HIV are unaware of their positive status (Bradley et al., 2014; Skarbinski et al., 2015). Regionally, HIV disproportionately affects the southeastern United States (the Deep South). In 2015, 56.9% of new cases of HIV in the United States occurred in the Deep South (Krueger, Dietz, Van Handel, Belcher, & Johnson, 2016). The Deep South typically includes 12 states: Alabama, Arkansas, Florida, Georgia, Louisiana, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. Eight of the nine states leading the United States in new HIV diagnoses, prevalence, death rates, and racial disparities between 2008 and 2013 were in the Southeast (Reif et al., 2015).

In several studies, researchers indicated that the spread of HIV in the Southeast was and continues to be perpetuated by a variety of profound social constraints on health: racism (Arnold, Rebchook, & Kegeles, 2014; Baunach & Burgess, 2013; Thomas, 2006), poor health care access (Dorell et al., 2011), poor education (Adimora, Schoenbach, & Doherty, 2006; Painter, Winqood, DiClemente, Depadilla, & Simpson-Robinson, 2012), poverty (Reif et al.,

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2014; Schroeder, 2016; Thomas & Thomas, 1999), stigma (Baunach & Burgess, 2013; Kerr et al., 2014; Stringer et al., 2016), and public policy (Adimora, Ramirez, Schoenbach, & Cohen, 2014). Racism, poor health care access, and poor education contribute to an individual's perception of low HIV risk as a function of limited knowledge about HIV, and lack of resources to be tested and linked to care (Cook, Lutz, Young, Hall, & Stacciarini, 2015). People living in the U.S. South perceive HIV as stigmatizing (National Alliance of State and Territorial AIDS Directors, 2012), which leads to further delays in seeking HIV testing (Fortenberry et al., 2002) and is associated with decreased willingness to test among health care providers (Wong et al., 2013). These findings suggest that agencies and policy-makers should consider the historical and sociogeographic characteristics unique to the Deep South when developing strategies to address HIV in this region.

Despite federal guidelines from the Centers for Disease Control and Prevention (CDC) and White House Office of National AIDS Policy *National HIV/AIDS Strategy*, implementation of universal testing has varied in primary care testing locations. The 2006 CDC guidelines recommended universal testing for all individuals ages 13 to 64 years, regardless of risk behavior profiles (Branson et al., 2006). The latest CDC guidelines indicated the need for ongoing support for universal testing for individuals ages 13 to 64 years, as well as annual testing for gay, bisexual, and other men who have sex with men (DiNenno et al., 2017). By following these guidelines, providers can identify individuals with undiagnosed HIV sooner, reduce transmission rates, and initiate antiretroviral therapy earlier (Cohen et al., 2016). Certain settings are poorly used in terms of HIV testing: hospital emergency departments/urgent care clinics, substance use treatment clinics, public health clinics, community health clinics, and other primary care settings. Providers in primary care settings typically offer testing to individuals with perceived high risk, although some providers do not offer testing at all (McNaghten et al., 2013).

The purpose of our systematic review and our proximal goal was to identify and then address barriers and facilitators related to implementation of CDC guidelines for HIV testing, specifically focusing on Deep South states, where implementation has

been slow and HIV has spread disproportionately. Our distal goal was to increase HIV testing in primary care settings in the U.S. South.

Framework

A framework provides structure and explicates perspectives taken in an analytic endeavor such as a systematic review. For our review, we found the Ecological Model for Health Promotion (EMHP; McLeroy, Bibeau, Steckler, & Glanz, 1988) to be a robust framework by which to examine barriers and facilitators related to implementation of HIV guidelines. Central to the EMHP is the assumption that health promotion activities (e.g., HIV testing) occur in complex contexts of social and environmental structures. For example, public health officials have used the EMHP to organize implementation efforts such as health promotion activities to prevent obesity, a health problem deeply embedded in social (e.g., family) and environmental (e.g., poor access to healthy food) structures (Richard, Gauvin, & Raine, 2011). Furthermore, health promotion activities associated with behavior changes (providers' implementation of HIV testing guidelines in this case) are influenced by five multilevel factors explained by the EMHP: (a) public policy, (b) community factors, (c) institutional factors, (d) interpersonal processes and primary groups, and (e) intrapersonal factors (McLeroy et al., 1988). Providers recognize the difficult challenges facing patients when changing health behaviors; however, providers' own professional behaviors may be similarly intransigent. The use of up-to-date, evidence-based guidelines such as those of the CDC would ensure best practices with regard to HIV testing. The EMHP provides a means to understand the complexities of behavior change, which appear to be difficult even for primary care practitioners with vested interests in protecting and promoting health.

Methods

Our review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, a well-

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