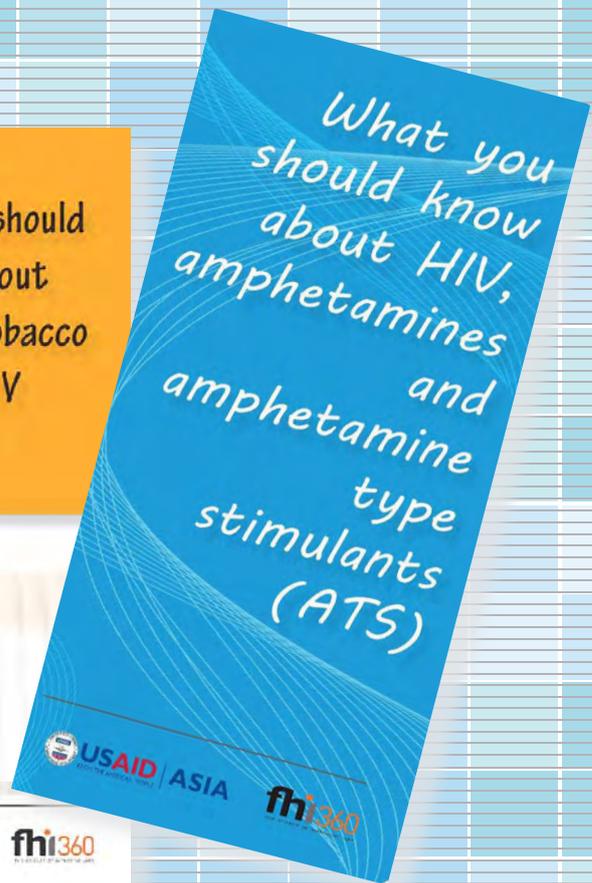
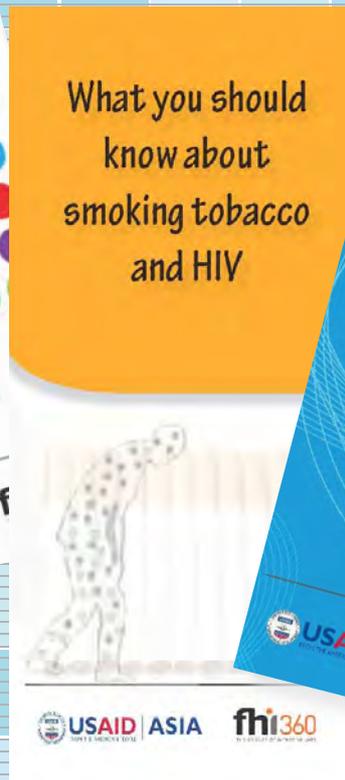
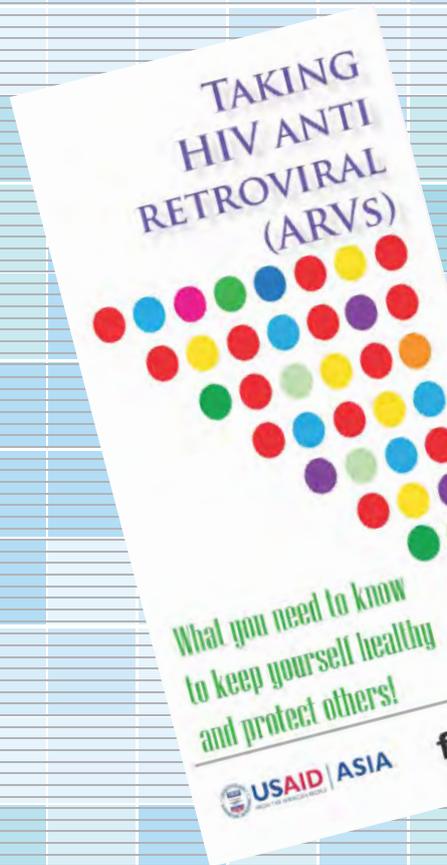


# Positive Health: Prevention in Care Training Resources Package



Positive Health: **Prevention in Care**  
Training Resources Package

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# Positive Health: **Prevention in Care** Training Resources Package

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# Preface

## Positive Health: Prevention in Care Resource Package

The Positive Health: Prevention in Care Resource Package is a comprehensive training package for HIV clinical service providers working with most at risk populations (MARPS) in Thailand. While there are many Prevention with Positive resources, few specifically target working with sex workers, substance users, men who have sex with men and transgender.

This resource goes beyond the usual approach of many prevention resources that limit the sphere of prevention with PLHIV to offering risk reduction strategies to protect others. The package is predicated on the concept that individuals from vulnerable and highly stigmatised populations may not always have the motivation, power, or means to protect others. Rather the focus of this resource is to engage individuals to protect their own health and in doing so they also protect the health of others. It is a core premise of this work that HIV prevention is a shared responsibility and that HIV transmission risk reduction should not be the sole responsibility of the PLHIV.

Additionally, most “Positive Prevention” resources target individuals who have been formally diagnosed as HIV positive. However, many individuals from most-at-risk populations frequently present for HIV testing with recent transmission behaviour and therefore their antibody status may not be confirmed by the standard antibody testing in HIV testing and counseling services. It is critical therefore those positive prevention activities also address the neglected issue of HIV transmission related to Acute HIV infection (AHI) as this is the period that a person is most infectious with the highest viral load.

This package was originally conceived as a regional resource and was later tailored to the socio-cultural and epidemic contexts of Thailand. Developed in consultation with experts and people living with HIV throughout the region, this tool concentrates on meeting the specific needs of people living with HIV (PLHIV) from socially marginalized populations, who are often challenged to protect their own health, or the health of others. It outlines the key activities and information involved in training HIV counsellors, nurses, doctors, patient coordinators and PLHIV peer counsellors working in HIV treatment and care facilities.

The resource package is intended to be adapted to suit specific work settings. It comprises three complementary elements: The Trainer’s Manual, which contains essential information intended for those conducting or facilitating the training; Technical Briefs, which provide trainers and service providers with a quick reference to the essential elements and procedures of Prevention in Care, and; the Toolkit for service providers and patients, a collection of counselling tools for use in presenting examples, to supplement the Technical Briefs and the Trainer’s Manual, and for use by health service providers in care, support and treatment settings.

This training package is intended to be a three-day programme. However, realizing that time and human resource constraints may limit the length of a course, the training package has been designed as a modular programme that can focus on the most relevant topics. Training package components can be included or omitted to best supplement the core modules and highlight specific social, geographic, or epidemiological issues.

# Acronyms

ADC	AIDS dementia complex
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy / treatment
ARV	Antiretroviral Drugs
BBV	Blood-borne virus
CBC	Complete blood count
CBO	Community-based organization
ESSE	Exit, survive, sufficient, enter
FP	Family planning
FHI	Family Health International
FSW	Female sex worker
HAART	Highly active antiretroviral therapy
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HCT	HIV counseling and testing
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
ICD-10	International Classification of Diseases 10th revision
IDU	Injecting drug user
IMB	Information Motivation Behavior skills model
MARPs	Most at risk populations
MDMA	Methylenedioxymethamphetamine, "ecstasy"
MDR	Multi-drug resistance
MMT	Methadone maintenance treatment
MSM	Men who have sex with men
MSW	Male sex worker
NNRTI	Non-nucleoside reverse transcriptase inhibitors
NRTIs	Nucleoside reverse transcriptase inhibitors
NGO	Non-governmental organization
OI	Opportunistic infection
PLHIV	People living with HIV and AIDS
PI	Protease inhibitor
PITC	Provider initiated testing and counseling
PMTCT	Prevention of mother-to-child transmission
PTCT	Parent to child transmission
SCM	Stages of change model
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary counseling and testing
WHO	World Health Organization

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Positive Health: **Prevention in Care**

# INTRODUCTION



## Positive Health: Prevention in Care Resource Package

### A Comprehensive Training Package for HIV clinical service providers working with MARPS in Thailand

The Positive Health: Prevention in Care Resource Package is a modular, three-part training resource and reference tailored to the socio-cultural and epidemic contexts of Thailand although readily adapted to the broader Asian region. While there are many Prevention with Positive resources, few focus on regional aspects of the epidemic and specifically target working with sex workers, substance users, men who have sex with men and transgender.

This resource goes beyond the usual approach of many prevention resources that limit sphere of prevention with PLHIV to offering risk reduction strategies to protect others. The package is predicated on the concept that individuals from vulnerable and highly stigmatised populations may not always have the motivation, power, or means to protect others. Rather the focus of this resource is to engage individuals to protect their own health and in doing so they also protect the health of others. It is a core premise of this work that HIV prevention is a shared responsibility and that HIV transmission risk reduction should not be the sole responsibility of the PLHIV.

Additionally, most “Positive Prevention” resources target individuals who have been formally diagnosed as HIV positive. However, many individuals from most-at-risk populations frequently present for HIV testing with recent transmission behaviour and therefore their antibody status may not be confirmed by the standard antibody testing in HIV testing and counseling services. It is critical therefore those positive prevention activities also address the neglected issue of HIV transmission related to Acute HIV infection (AHI) as this is the period that a person is most infectious with the highest viral load.

This package originally was conceived as a regional resource and was later adapted to the needs of Thailand. Developed in consultation with experts and people living with HIV throughout the region, this tool concentrates on meeting the specific needs of people living with HIV (PLHIV) from socially marginalized populations, who are often challenged to protect their own health, or the health of others. It outlines the key activities and information involved in training HIV counsellors, nurses, doctors, patient coordinators and PLHIV peer counsellors working in HIV treatment and care facilities.

The overall objectives of this training package are:

- ◆ To improve the technical capacity of care, support and treatment providers working in HIV treatment and care services to provide positive health and transmission risk reduction interventions across the disease continuum;
- ◆ To health service providers to use evidence-based counselling strategies that may help reduce HIV transmission;
- ◆ To provide health service providers with skills to maintain health and treatment efficacy in the delivery of HIV treatment care and support; and
- ◆ To reduce the psychological morbidity associated with HIV disease and improve the quality of life of people living with HIV.

## Elements of the resource package

The resource package is intended to be adapted to suit specific work settings. It comprises three complementary elements:

- ◆ *Trainers resources – Trainer’s Manual?*
- ◆ *Technical Briefs*
- ◆ *Toolkit for service providers and patients*

The **Trainer’s Manual** contains essential information intended for those conducting or facilitating the training. It is composed of 7 modules with clearly stated objectives, session plans, and activities. These focus on topics represented in the Technical Briefs. Each module section consists of a session plan, trainee activity sheets, and tools. These are detailed in the Training Resources Outline section of the manual. The appendix also includes additional health provider educational resources.

The **Technical Briefs** are intended to provide trainers and service providers with a quick reference to the essential elements and procedures of Prevention in Care. It provides an orientation integration of prevention activities into treatment and care services. Additionally, it offers more focused guidance on marginalized populations, to reduce HIV transmission and improve the quality of life of PLHIV who use drugs and alcohol, men who have sex with men, sex workers, and other groups. Topics covered include: Acute HIV Infection, case support planning, positive sexual health, interventions to support HIV and sexuality disclosure, reproductive health and family planning, interventions to support the maintenance of health and treatment efficacy and strategies for integration of prevention into care support and treatment.

The **Toolkit for service providers and patients** provides a collection of counselling tools for use in presenting examples, to supplement the Technical Briefs and the Trainer’s manual, and for use by health service providers in care, support and treatment settings. It contains different types of tools: forms, patient education brochures, patient information cards, and job aids.

*Note: The Technical Briefs are designed as an essential complement to the trainer’s manual and toolkit. For training purposes, these elements must be used in conjunction with the Technical Briefs.*

## Course flexibility for specific training needs

**Adapt to the local setting.** For training purposes, the contents of this training package may be supplemented with other resource materials tailored to local cultural contexts.

**Optimize the course length.** This training package is intended to be a three-day programme (a detailed schedule can be found in the Training Program Timetable in the trainer’s manual). Realizing that time and human resource constraints may limit the length of a course, the training package has been designed as a modular programme that can focus on the most relevant topics. Given limited time and special groups, activities and case studies can be included or omitted to best supplement the core modules and highlight specific social, geographic, or epidemiological issues. The time devoted to training and practical, hands on exercises can also be adjusted to meet scheduling demands.

# How to use the manual

## Introduction and use of this manual

### Overall objectives of the training

- ◆ To improve the technical capacity of clinical service providers working in HIV clinical settings to deliver transmission risk reduction strategies to individuals living with HIV.
- ◆ To improve the sexual and reproductive health of individuals living with HIV.
- ◆ To improve the quality of life of people living with HIV.

### Introduction to the resource package

While no training manual can be exhaustive, this package attempts to outline the key activities and information involved in HIV transmission risk reduction, and the maintenance of health and treatment efficacy among individuals living with HIV.

The resource package comprises three complementary elements:

- ◆ *Positive Health: Prevention in Care - Technical Briefs for Course Participants*
- ◆ *Positive Health: Prevention in Care - Trainer's Manual*
- ◆ *Positive Health: Prevention in Care Toolkit with tools for providers and patients*

This trainer's manual contains essential information for the use of those facilitating or conducting the training of health workers working in HIV clinical services in Thailand.

The Trainers manual contains 7 modules with clearly stated objectives and session plans. All the training resources required for delivery of training are listed in the Training Resources Outline. This outline gives the module numbers, the titles of the sessions, and the corresponding numbers of these associated materials:

- ◆ Session plans, and
- ◆ Trainee activity instructions.

Before starting any training programme, you may wish to refer to the "Preparation for the Training" section, which follows this introductory section.

**Remember:** The session plans and activity sheets included in this trainer's manual should be used in conjunction with the Participant Technical Briefs and the Toolkit in this training package.

### Time required for training

This is a three-day training programme that may be adapted as appropriate to longer or shorter periods of training.

The modular format allows sessions or "modules" to be added or omitted according to their relevance to the training needs of the service providers.

# Materials List

Below is a list of the documents and tools that make up this package. File names are provided for each in order to facilitate finding them on the CD-Rom (included).

## Technical Briefs

Technical brief name	File name
1. Orientation to positive health prevention in care	M00-TB00 Intro to PWP
2. Acute HIV infection and prevention in care	M01-TB01 AHI
3. Entry into care: Case support planning	M02-TB02 Entry into Care
4. Positive sexual health	M03-TB03 Pos Sex
5. HIV disclosure & sexuality disclosure	M04-TB04 Disclosure
6. Reproductive health & family planning	M05-TB05 Repro H & FP
7. Maintaining health and treatment efficacy	M06-TB06 Maintain Health
8. Integrating Positive Prevention into Clinical Services	M07-TB07 Integration

## Trainer's Manual

### Session Plans

Session plan name	File name
1. Introduction	M00-SP00
2. Acute HIV infection and prevention in care	M01-SP01
3. Entry into care: Case support planning	M02-SP02
4. Positive sexual health	M03-SP03
5. HIV disclosure & sexuality disclosure	M04-SP04
6. Reproductive health & family planning	M05-SP05
7. Maintaining health and treatment efficacy	M06-SP06
8. Integrating Positive Prevention into Clinical Services	M07-SP07
9. Post-exam and course evaluation	A1 & A2

## PowerPoint Presentations

PowerPoint name	File name
1. Orientation to Positive Health: Prevention in Care	No presentation
2. Acute HIV infection	M01-PPT01
3. Entry into care: Case support planning	M02-PPT02
4. Positive Sexuality and Positive Prevention	M03-PPT03
5. Disclosure: Telling partners and family	No presentation
6. Reproductive Health Issues: MSM with female partners, female sex workers and substance users	No presentation
7. Maintaining health and treatment efficacy	No presentation
8. Integrating Positive Prevention into Clinical Services	M07-PPT07

## Activity Sheets

Activity sheets	File number
1. Explaining acute HIV infection	M01-AS1.1
2. Mapping a patient's care needs	M02-AS2.1
3. Sexual health: Readiness to change	M03-AS3.1
4. Provider challenge response	M04-AS4.1
5. Support HIV disclosure case studies	M04-AS4.2
6. Reproductive Health & Family Planning: Ask-Screen-Intervene	M05-AS5.1
7. Adherence screening	M06-AS6.1
8. Positive prevention: Everybody's responsibility	M07-AS7.1
9. Positive health strategies across treatment services	M07-AS7.2

## Toolkit

Tool name	File number
1. Could it be HIV?	M01-T1.1
2. Case support planning form	M02-T2.1
3. Patient record	M02-T2.2
4. Consent for release of information	M02-T2.3
5. Referral form	M02-T2.4
6. Sexually transmitted infections (STIs), HIV and your health	M03-T3.1
7. Practitioner's guide to HIV & STI transmission	M03-T3.2
8. Telling partners and others	M04-T4.1
9. When you have been told a family member or friend has HIV	M04-T4.2
10. Contraception & HIV – Provider guide	M05-T5.1
11. Contraception, pregnancy and HIV	M05-T5.2
12. Adherence screening tool	M06-T6.1
13. Treatment adherence: Checklist and summary record form	M06-T6.2
14. Practical problem solving for managing common barriers to adherence	M06-T6.3
15. Patient education brochures	M06-T6.4
Alcohol, Hepatitis and HIV- what you should know!	M06-T6.4.1
Some things just don't mix! Mixing prescribed and non-prescribed drugs	M06-T6.4.2
Sedatives, tranquillizers and HIV	M06-T6.4.3
What you should know about HIV, amphetamines and amphetamine type substances (ATS)	M06-T6.4.4
What you should know about smoking tobacco and HIV	M06-T6.4.5
16. Taking HIV antiretrovirals (ARVs)	M06-T6.5
17. Mental health presenting problem (MHPP) flowcharts	M06-T6.6
18. Explaining treatment resistance	M06-T6.7
19. Oral and Dental problems – Patient education	M06-T6.8

# Preparation for Training

## Selecting a suitable training venue

### Location

Ideally the training should be located away from the trainee's normal work-place to avoid interruption. It will be also be important to consider the transport needs of the trainees when you select a venue.

### Venue characteristics and facilities

This is participatory styled training requiring trainees to participate in large and small group case-based learning activities. It is therefore essential that you book a room that does not have fixed lecture style seating. The room should be large enough to allow for the anticipated number of trainees to be seated in small table groups (usually not more than 5 per table) and for there to be sufficient space to engage in other learning activities that require individuals to move around the room.

It is further recommended that the training venue has an adequate number of toilet facilities, has adequate heating or air-conditioning and lighting to ensure the comfort of trainees. A back-up power supply is highly recommended. Also avoid venues near construction zones.

It is highly desirable that the room can be used exclusively for the purposes of training for the entire period of the training. This will avoid the necessity of having to pack-up equipment and materials and then re-organise the room again each day. The room should also have adequate security so that equipment can be left and be available for use each day, thus requiring minimal daily preparation.

Consider the advantages of offering training on a residential basis. This will reduce the disruption to training that occurs as a consequence of trainees arriving late to class each day.

When training is not to be offered on a residential basis, consider the advantages of providing meals to the trainees at the training venue. The training course follows a very strict timetable. It is therefore essential that the sessions commence and conclude at the nominated times. The provision of morning tea, lunch and afternoon tea at the site of the training has the advantage of ensuring all trainees promptly return from breaks. It also creates flexibility within the program should there be a need to shorten breaks or complete work within a break. Further, it tends to contribute to the general satisfaction of trainees and allows them to focus on the material being learned to a greater degree.

### Group size

Group size for classroom counselling training should not exceed 28 participants. An ideal number is 21-27. The smaller the group, the more quality time and opportunity is afforded for trainees to practice their skills. As a number of group activities require splitting the trainees into groups of threes, it is suggested that course trainee numbers are divisible by three.

### The training team

Roles and responsibilities

**There may be many people involved in conducting a training course, these can include:**

- ◆ A training coordinator or director
- ◆ Administration assistants
- ◆ **Trainers**
- ◆ Training assistants
- ◆ Trainees

**In training courses a trainer may be undertaking one or more of these roles. Each role has different responsibilities:**

### Training coordinator or director

Starting several months before the training is to be conducted the director should:

- ◆ Obtain approval for conducting the training from relevant bodies.
- ◆ Develop a training programme and timetable.
- ◆ Develop a budget for training.
- ◆ Obtain funding for conducting the training course, e.g. through training grants, government bodies, non-government organisations or sponsors.
- ◆ Develop criteria for trainers, send invitations and training details (dates, venue, contact details) to potential trainers, identify trainer availability.
- ◆ Arrange for course materials, including session plans, handouts and PowerPoint or overhead presentations to be forwarded to trainers so they can become familiar with the contents of their sessions and practice presenting.
- ◆ Decide on an appropriate number of participants. It is recommended that you do not invite more than 28 trainees to a course to ensure that they all benefit from the discussions and practical work.
- ◆ Develop criteria for trainees and send invitations to potential trainees or send course announcements to relevant health facilities, asking them to identify suitable trainees.
- ◆ Choose the training facility, keeping in mind the number of trainees attending and ensuring that all necessary equipment and resources will be available and within the budget.
- ◆ Arrange accommodation for trainers and trainees if necessary and according to budget.
- ◆ If applicable arrange transportation for trainers and trainees to and from their accommodation to the training venue.
- ◆ Arrange payment for trainers (if appropriate), or reimbursement for their related training expenses.
- ◆ Plan the timetable and details for trainer preparation.
- ◆ Arrange catering for the course including morning and afternoon teas and lunch.
- ◆ If training is to take place in another language besides English then course materials will need to be translated, the need for training sessions to be translated should also be assessed and an appropriate interpreter arranged.
- ◆ Arrange printing of trainers and trainee manuals (and other supporting materials like CD's, disks etc), as resources and budget allow.
- ◆ Arrange for other training resources such as name badges, paper, pens etc.
- ◆ Develop overall evaluation forms.
- ◆ Develop training checklist to help in planning.
- ◆ Delegate some of the responsibilities to administrative assistants and/or trainers.
- ◆ Facilitate opening and closing ceremonies at training course, invite guest speakers, if appropriate, and brief them.
- ◆ At the completion of training, collate training evaluations and write report or delegate someone else to do this.

### Administrative assistants

Where staff are available to support and assist the training coordinator then these staff should undertake any of the above tasks as delegated by the training coordinator. The administrative assistant or support staff should be available for the duration of the training course should any problems arise with any of the arrangements for trainers or trainees. These staff can also be responsible for trainee registration, distribution of trainee materials, keeping appropriate documentation for auditing or report writing and maintenance of equipment.



## Trainers

Ideally trainers should:

- ◆ Be working in the field they will be asked to present about. This allows trainees to establish important linkages to external individuals and agencies who may assist them in their future clinical work.
- ◆ Have had previous training experience.
- ◆ Be fluent in the language the session is to be delivered in.
- ◆ Be motivated and enthusiastic.
- ◆ Be willing to attend the entire course.
- ◆ Be willing to prepare adequately for the course and assist or work with other trainers where required.
- ◆ Be willing to attend a planning and preparation day before the course where trainers are briefed, details are reiterated and presentation of sessions practiced. They also should modify training styles, techniques, or length where suggested from peer review.
- ◆ Be guided by the training co-ordinator.
- ◆ Be willing to attend daily debriefing sessions if required.
- ◆ Evaluate their training sessions and analyse results for contribution to final training report.

## Inviting external trainers/guest speakers

Use of a range of external trainers or guest speakers presents both advantages and disadvantages. Some of the advantages include:

- ◆ Trainees have access to “experts” in their respective fields.
- ◆ Trainees establish important linkages to external individuals and agencies that will assist them in their clinical work.
- ◆ External presenters add variety to the programme of regular trainers.

Some of the disadvantages of using external trainers or guest speakers include:

- ◆ When inadequately briefed, speakers may launch in to their standard lecture response.
- ◆ Speakers may present non evidence based or erroneous information.
- ◆ Speakers may pitch their presentation inappropriately in terms of language used and target audience.
- ◆ Some speakers may be uncomfortable with the use of more interactive learning methodologies.
- ◆ Speakers may not adhere to the time frame provided.

To maximise the use of external trainers or guest speakers:

- ◆ Ensure they are adequately briefed, verbally as well as in writing, in terms of what is expected of them. Provide a guideline that specifies the content to be covered, the style of methodology to be used, the level and type of language, and the timeframe by which to adhere. In addition, clearly describe the type of trainees they are working with and the overall aims of the training programme.
- ◆ Choose speakers who are known to be effective for your goals. Alternatively, “groom” them to attain the desired outcome.
- ◆ Ensure that the regular trainer remains present where possible whilst the external speaker presents. This ensures continuity if there are any issues arising. In addition, regular trainers are also able to thus observe and provide useful feedback to the external trainer/guest speaker.
- ◆ Always ensure that external trainers/guest speakers are given feedback from both the organisation and trainee evaluations in order to continue to improve their sessions.

Training team members should attend a pre-training meeting to discuss logistics, roles and responsibilities.

## Preparation of materials for participants

It is absolutely essential that each participant and member of the training team is provided a copy of the **Technical Briefs and Toolkit**. It is recommended that each of these is spiral bound.



Additionally, a CD-Rom can be prepared with electronic files of the Technical Briefs and Toolkit and these can be distributed at the end of training.

In addition, all members of the training team should be provided with a copy of the Trainers Manual and a set of the Training Tools.

### **Preparation of materials for trainers**

All trainers should have a Training Manual with Session Plans (SP) Technical Briefs (TB) Activity sheets (AS) and Tools (TN).

### **Important note: Preparation of Activity Sheets.**

As many of the activities require that the trainees do not have advance knowledge of the content of an activity, prior to training you should photocopy enough activity sheets for each participant.

Then make sure you bundle each activity according to the activity number and distribute them only when advised by the session plan e.g. there are 25 trainees expected to attend the training so you would photocopy and bundle all Activity sheet AS 1.1 together and all AS 2.1 activities together and so forth.

*The activity sheets required for each day should be placed in a bundle on the "materials table" and be only accessible to the training team for distribution immediately prior to the commencement of an activity.*

Checklist of what is needed for the training (supplies and space)

- Timetable
- Room
- Adequate seating ("Café style" seating for table group work)
- Personnel (trainers, resource persons, and administrative support)
- Participant notebooks and pens
- Coloured crayons or markers (at least one box per class table)
- Sufficient copies of the Handbook for HIV Counselling (1 per trainee)
- Flipchart paper and stand
- Markers (blue and black - colour markers are not viable from a distance)
- "Sticky stuff"/cellophane tape
- Scissors
- Sufficient copies of activity sheets (bundled in multiple copies, e.g. 28 copies of AS 3.1)
- Blank overhead transparency sheets
- Overhead projector and markers
- Box for collecting written questions trainees have felt unable to ask in public
- Box for collecting evaluation forms
- Condoms (allow two per trainee)
- Penis and vagina models for condom demonstrations
- Injecting equipment (needle, syringe, two small bowls, red food colouring and water)
- Samples or photographs of antiretroviral pills for the Counselling for Treatment Adherence module.
- SPECIAL PREPARATION REMINDER: Module 7 photocopy pages 3 and 4 of the Session Plan (one per participant) for distribution after case work activity de-brief.



## Provision of pre-course information to potential trainees, and their employers

The effectiveness of training is diluted when firm trainee selection criteria is not applied. This training assumes the ability to read and write, though illiterate individuals have attended the course with additional trainer support. It is however, disruptive to the learning environment of trainees when individuals who have no interest or likelihood of post training opportunity to engage in HIV counselling participate in the course.

Trainers and course organizers are strongly encouraged to issue selection criteria and to follow-up this issue with prospective trainees and their employers. It is also strongly recommended that you notify prospective participants in advance of the expectations of the trainees with regard to attendance, punctuality and level of participation in learning activities. Often when these expectations are spelt out in advance you will only have participants who truly wish to be involved attend the training.

The following suggestions are made to ensure a satisfactory learning environment:

- ◆ All trainees must be present for the ENTIRE training. It is suggested that certificates are not provided to trainees who do not attend the entire course. In the event of an emergency arising where the trainee cannot complete the course, the trainer should negotiate with the trainee to complete the missed segments at a future course and then obtain the certificate. Note this is critical to ensuring quality of counselling. If a trainee misses any segments, the trainer should brief the trainee when they return about what they have missed. This will ensure that they do not disadvantage their role-playing partner when they do role plays or other activities.
- ◆ Ensure training sessions commence on time. All trainees should arrive on time. There is much material to be covered each day, and it can be very disruptive to have trainees arrive at the training sessions once the sessions have already begun.
- ◆ Ensure mobile phones and other communications media are only used during meal breaks and not during class time. Prospective trainees and their employees should be advised of this in advance of their participation. A copy of the training schedule with the break times should be sent to all prospective participants.



# Training Workshop Timetable

- ◆ Registration on the first day is at **07:45 – 08:30** followed by an **Opening Ceremony** (if desired).
- ◆ The training workshop follows a three-day schedule, which begins each day at **08:30** and ends at **17:30**. However, it is possible to adjust the timetable to a three-and-a-half day schedule if the training participants must leave the workshop at 16:30 each day. Lunch and tea breaks are based on appropriate starting and stopping points between and within modules.
- ◆ The schedule assumes strict adherence to the specified break times: 15 minutes for morning tea and afternoon tea; one hour for lunch.
- ◆ Participants are advised that they are expected to attend all sessions

## Day 1

07:45–08:30	Registration & Opening ceremony
08:30–09:30	Workshop introduction
09:30–10:15	Module 1: Acute HIV infection and positive prevention
10:00–10:15	Morning tea
10:15–12:30	Module 1: Acute HIV infection and positive prevention
12:30–13:30	Lunch
13:30–15:30	Module 2: Entry into care - Case support planning
15:30–15:45	Afternoon tea
15:45–17:30	Module 3: Positive sexual health (through introduction of tools)

## Day 2

08:30–08:45	Recap of previous day
08:45–10:15	Module 3: Positive sexual health (through triad role play activity)
10:15–10:30	Morning tea
10:30–11:00	Module 3: Positive sexual health
11:00–12:15	Module 4: Disclosure – Telling partners and family (through reading of technical brief)
12:15–13:15	Lunch
13:15–16:00	Module 4: Disclosure – Telling partners and family
16:00–16:15	Afternoon tea
16:15–17:30	Module 5: Reproductive health and family planning (through PPT presentation)

## Day 3

08:30–08:45	Recap of previous day
08:45–10:15	Module 5: Reproductive health and family planning
10:15–10:30	Morning tea
10:15–12:15	Module 6: Maintaining health and treatment efficacy (through introduction of tools)
12:15–13:15	Lunch
13:15–14:45	Module 6: Maintaining health and treatment efficacy
14:45–15:00	Afternoon tea
15:00–17:30	Module 7: Integration of prevention in treatment and care

# Training resources outline

Training modules	Title	Session plan	PowerPoint	Activity sheets	Tools
M00	Introduction	M00-SP00	None	None	None
M01	Acute HIV infection and prevention in care	M01-SP01	M01-PPT01	AS1.1 Explaining acute HIV infection	T1.1 Could it be HIV?
M02	Entry into care: Case support planning	M02-SP02	M02-PPT02	AS2.1 Mapping a patient's care needs	T2.1 Case support planning form T2.2 Patient record T2.3 Consent for release of information T2.4 Referral form
M03	Positive sexual health	M03-SP03	M03-PPT03	AS3.1 Sexual health: Readiness to change	T3.1 Protecting yourself and others: What you should know about HIV and other sexually transmitted infections (STIs) T3.2 Practitioner's guide to HIV & STI transmission
M04	HIV disclosure & sexuality disclosure	M04-SP04	None	AS4.1 Provider challenge response AS4.2 Support HIV disclosure case studies	T4.1 Telling partners and others T4.2 When you have been told a family member or friend has HIV
M05	Reproductive health & family planning	M05-SP05	None	AS5.1 Reproductive Health & Family Planning: <b>A</b> sk- <b>S</b> creen- <b>I</b> ntervene	T5.1 Contraception & HIV – Provider guide T5.2 Contraception, pregnancy and HIV

Training modules	Title	Session plan	Power-Point	Activity sheets	Tools
M06	Maintaining health and treatment efficacy	M06-SP06	None	AS6.1 Adherence screening	T6.1 Adherence screening tool T6.2 Treatment adherence: Checklist and summary record form T6.3 Practical problem solving common barriers to adherence T6.4 Patient education brochures (5) T6.5 Taking HIV antiretrovirals (ARVs) T6.6 Mental health presenting problem (MHPP) T6.7 Explaining treatment resistance T6.8 Oral-dental problems
M07	Integrating Positive Prevention into Clinical Services	M07-SP07	M07-PPT07	AS7.1 Positive prevention: Everybody's responsibility AS7.2 Positive health strategies across treatment services Prepare answer key as per instructions on SP07	None

HIV = human immunodeficiency virus, ARV = antiretroviral medicine, STI = sexually transmitted infection



Positive Health: **Prevention in Care**

# MODULE 00



## Introductory session

### Session objectives:

- ◆ To establish expectations and group norms for the training workshop.
- ◆ To introduce the participants to each other.
- ◆ To provide an overview of the curriculum and resources.
- ◆ To introduce the topic and relevance to the participants HIV clinical work and public health responsibilities.

### Time to complete module:



60 minutes

### Training materials:



Participant folders containing technical brief and tools.

### Content:



- ◆ General course administration and “housekeeping”
- ◆ Training workshop expectations
- ◆ Definitions and overview of Positive health: Prevention in care curriculum

### Session instructions



Time

**5 minutes**

#### 1. Workshop housekeeping

- ◆ Make sure all participants have registered for the training workshop.
- ◆ Explain to the participants the locations of toilets and location of lunch and morning and afternoon tea.
- ◆ Review the training timetable.
- ◆ Show participants the question box and inform them that they may place any question in this box anonymously that they do not want ask in front of others. Further explain that if time constraints do not permit the trainer/s to address all questions within a given module they may also submit these anonymously into the box and trainers will endeavour to find time elsewhere in the training program to address these. Indicate that this will most likely occur in the daily recap sessions.
- ◆ Discuss and gain consensus on class participation and training rules.

**2. Introductions****15 minutes**

- ◆ Tell the training participants to write the following things on a sheet of paper:
  - Their name and title
  - What work they do and where (name of organization / office)
  - Three “personal facts” about themselves that the other training participants will not know. Two of the items should be “true” and one “false.”
- ◆ Instruct the participants to move about the room and introduce themselves to other participants, one at a time.
- ◆ Find a partner and then you and your partners should show each other your list of “personal facts” to try to guess each other’s personal fact that is “false.”
- ◆ Once you have each made you guess, you may reveal which personal fact is truly false.
- ◆ Find a new partner and repeat the process.

**3. Reorganize participants into table groups****5 minutes**

Ensure that you have a mix of participants from different agencies, gender and experience levels at each table group. This may be achieved by simply counting 1, 2, 3, 4, 5 and asking all people who are number 1 to move to a table labeled #1, all 2’s to table labeled #2 etc.

To maintain focused discussion and interest in technical reading exercises, inform the group that throughout the training period a competition will be held whereby participants can answer questions and earn a point for their table group. A certificate and small prize will be awarded to the winners at the conclusion of training. Draw up a tally sheet on flip chart paper so that as participants from each table group respond correctly to a question you can easily add a point to their group.

**4. Participant reading (TB00)****30 minutes**

Participants are asked to review the hand-out. Allow 15 minutes for reading.

Ask the following questions and award points.

- ◆ Has the rate of new infections decreased in Thailand?
- ◆ What population or demographic group in the community is seeing increasing rates of HIV? (Answer: adolescents)
- ◆ In what other groups do we see stable or increasing rates of new infections? (Answer: MSM, TG, MSW/TGSW and IDU).
- ◆ In one study reported in the technical brief what was the percentage of patients that reported that they did not understand information provided to them by a nurse or doctor during a consultation about their health? (Answer: 85%)
- ◆ What are the reasons we need to extend a greater effort providing prevention reduction messages and counseling in HIV clinical care, support and treatment programs?
- ◆ When we talk about building a client/patient’s self-efficacy what specifically do we mean? (Answer: Building the client/patient’s ability to believe they can regulate their own behaviour, and overcome barriers they encounter in changing their behaviour).
- ◆ What attitudes and beliefs do we need to explore with the client/patient? (Answer: negative attitudes, knowledge of transmission risk behaviour, barriers to change)
- ◆ What are some specific skills we need to support client/patients acquiring? (Answer: Condom use, condom negotiation skills, safe injecting, how to change negative beliefs about one’s ability to make changes)

**5. Ask the participants** to again, review the WHO Conceptual framework in the final page of the technical brief.**6. Close the session**

Inform the participant you will cover all of the areas briefly mentioned in this introduction in detail, progressively throughout the course. Remind participants about the use of the question box.



## Positive Health: Prevention in Care

### MODULE: 00

## Orientation to Positive Health Prevention in Care

### What is Positive Health: Prevention in Care?

- ◆ Targets persons who are living with HIV.
- ◆ Places the responsibility to reduce transmission on both the uninfected and infected.
- ◆ Looks into the social, cultural, economic contexts of the PLHIV and how these impact risk and health behaviors.

### HIV Thailand

- ◆ New HIV infections (incidence) in Thailand have not decreased;
  - A trend of increasing spread of HIV is noted in the population of adolescents.
  - Rate remains high in the traditionally higher-risk populations (FSW, MSW, MSM and IDU) with no indication of declining any time soon.

### A need to refocus prevention efforts

- ◆ With increased access to treatment more Thais are living longer with HIV.
- ◆ Every transmission comes from an HIV-positive person.
- ◆ Newly diagnosed patients tend to modify behavior to prevent transmission—but often relapse.
- ◆ Positive Health framework – focus on the health of individuals
  - Healthier PLHIV less likely to transmit?
- ◆ Reduce STIs, maintain treatment efficacy, reduce psychological morbidity
- ◆ Unique opportunity to influence prevention practices of PLHIV—throughout the course of treatment visits

### Positive Health: Prevention in Care

- ◆ Should not be restricted to “protecting others”
- ◆ Reframe messages to emphasize transmission reduction to “improving and maintaining health”
- ◆ Socially marginalized populations may not see protection of others as a major priority.
  - Most individuals may be highly motivated to protect their own health.

### Prevention continues through treatment and care

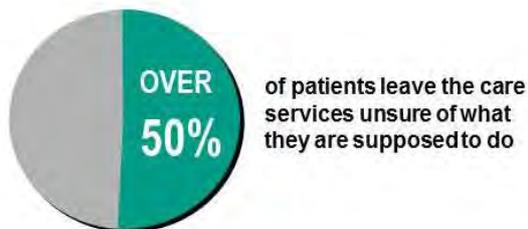
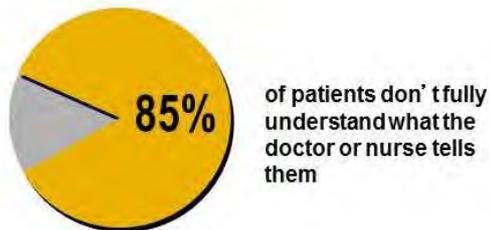
- ◆ Many interventions require some form of “booster” - relapse of transmission risk reduction strategies and treatment adherence is common after interventions have ceased.
- ◆ Transmission risk reduction, treatment adherence and health seeking behavior needs to be addressed over the course of treatment with each individual.

### Communication is the key to effective prevention in care.

- ◆ Ensure the facility staff and culture are not discriminatory
  - ◆ Display visuals and literature sensitive to sexual diversity
  - ◆ Provide non-intimidating medical literature
  - ◆ Use inclusive language in intake forms
  - ◆ Be aware of verbal and body language
  - ◆ Be open and non-judgmental
  - ◆ Show willingness to listen
  - ◆ Be sensitive to confidentiality concerns
- Remember: It only takes a few more minutes to motivate your patients**



## Communication is key



### MSM, TG, SW and substance users:

- ◆ Face a high level of stigma and discrimination: few are able to disclose status
- ◆ Experience economic challenges: employment opportunities, daily needs
- ◆ Some have "access to treatment" and adherence issues
- ◆ Influenced by societal norms relating to gender roles and sexual behaviors
- ◆ We need to build self confidence

### Prevention with the individual patient

We need to build:

- ◆ Belief in one's ability
- ◆ Self regulation of behavior
  - Adherence, transmission, health seeking behavior, substance use {dependency, binge and casual use of substances.

It is important to build the client's self-efficacy, self-efficacy:

- ◆ One's judgment of personal capability to perform a behavior.
- ◆ Confidence in overcoming barriers to adopting a behavior.

## Challenges to implementation positive health and prevention in care

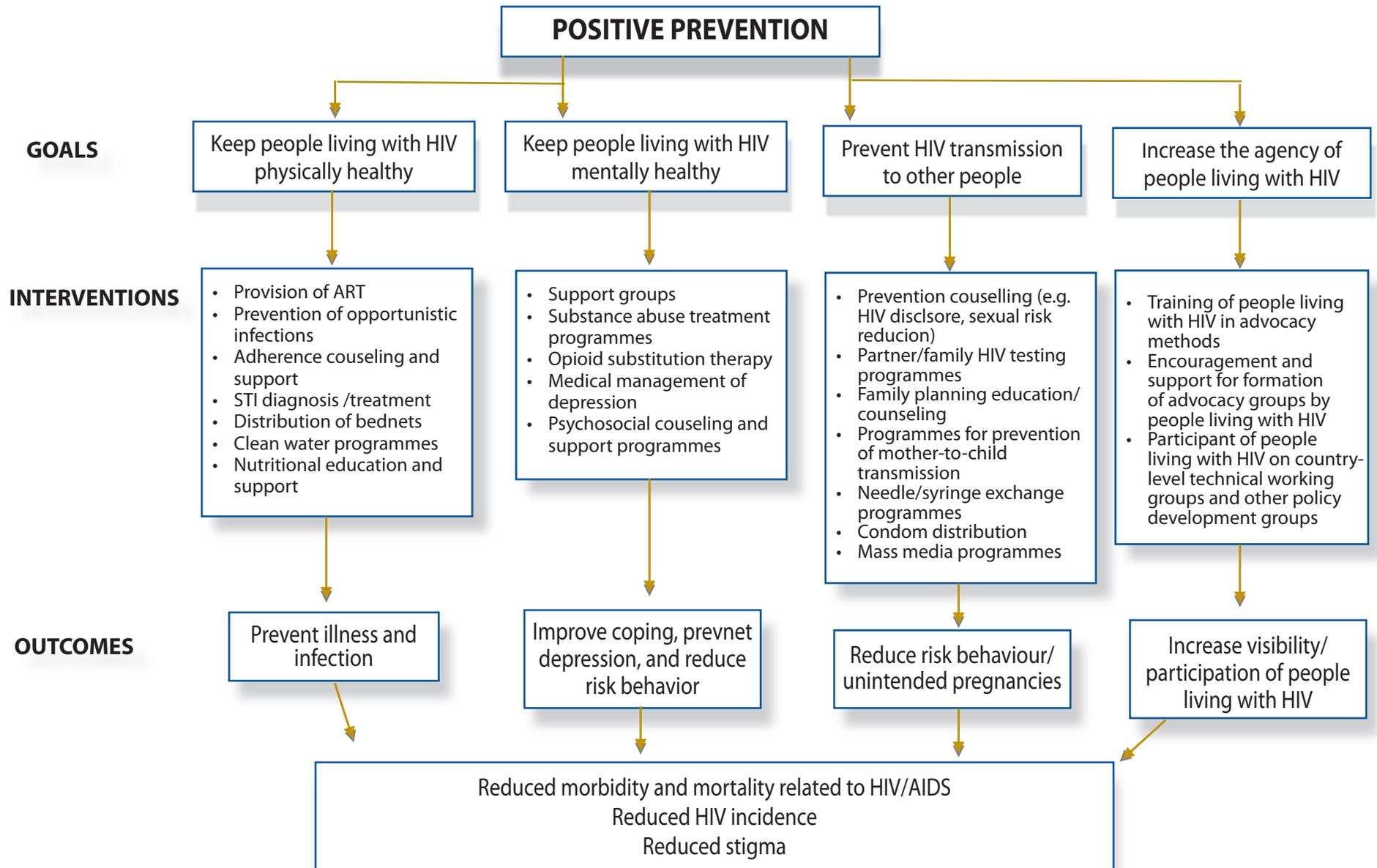
- ◆ For interventions to be scaled up and integrated into all interventions that bring the PLHIV into contact with service providers
- ◆ There is a need to include:
  - Risk reduction
  - Negotiation for safer sex – condom use, contextual abstinence
  - Build self-efficacy
  - Create supportive environment

### The key starting point for prevention in care activities:

Exploring client/patient attitudes and skills:

- ◆ What are the existing negative attitudes?
- ◆ What are the health and transmission risk behaviors?
  - Have the behaviors been acknowledged?
  - What are the barriers to change?
- ◆ Learning a set of skills e.g.:
  - Condom use skills,
  - Condom negotiation skills,
  - Safe injecting skills,
  - Safe injecting negotiation skills,
  - Treatment adherence strategies
  - How to challenge negative beliefs e.g. challenging beliefs about one's own behavior

Putting it all together: WHO conceptual framework





Positive Health: **Prevention in Care**

# MODULE 01





## Acute HIV infection and positive prevention

### Session objectives:

At the end of the training session, trainees will be able to:

- ◆ Communicate prevention information related to acute HIV infection to patients.
- ◆ Identify strategies for integrating prevention in care, HIV testing and counseling.

### Time to complete module:



3 hours

### Training materials:



1. Technical Brief (TB01)
2. PowerPoint presentation PPT01
3. Activity Sheets, AS1.1
4. Overhead transparency sheets or flipchart paper
5. Question box

### Content:



- ◆ The process of early HIV infection
- ◆ HIV diagnosis in the acute infection phase
- ◆ Clinical signs and symptoms
- ◆ Counseling and service provider interventions
- ◆ Transmission risk reduction message for Acute HIV infection.

### Session instructions



Time

#### 1. Introduction and PowerPoint Presentation (PPT01)

15 minutes

- ◆ Start the session with the presentation of PowerPoint PPT01. Put up the slide 1 and ask the class at what stage is the viral load (amount of virus) in the blood highest?
- ◆ Ask the participants what special problems this presents for VCT counselors and HIV prevention in the community. (Answer: the HIV test may not detect the presence of HIV early in the infection, people may get a negative result and think they are not infected and have unsafe sex, breastfeed infants, or share injecting equipment and pass on HIV more easily, etc.)
- ◆ Show the slides showing “Acute HIV and the window period” and “Probability of HIV transmission” to emphasize the point of increased probability of HIV infection. STOP PPT01 here.



**1. Read Technical Brief (TB01)****30minutes**

Instruct the participants to read Technical Brief (TB01) from the beginning and stopping at the heading “Kay AHI positive prevention activities.” Allow 20 minutes for reading time and ten minutes for answering questions.

- ◆ What are the limitations of HIV antibody tests?
- ◆ What alternatives are available to identify individuals with early HIV infection?
- ◆ What are some of the common signs and symptoms of Acute HIV infection?
- ◆ Why is addressing Acute HIV critical to Prevention in Care?
- ◆ What are critical counseling interventions in HIV pre and post-test counseling that are linked to acute HIV infection?

Don't forget to award the groups points for correctly answered questions!

**2. Recommence PPT01****5 minutes**

Briefly present the slides as a summary of the reading “Implications for testing and counseling”.

**3. Continue with the PPT01****15 minutes**

Then move to the case study. Briefly present all of the case example slides (through slide “Day 8 of Consultation.”

**4. General community and health system strategies, PPT01****5 minutes**

Inform the group, “We have some general community and health system strategies that were touched upon in the technical brief.” Just quickly put the last slides up to remind the group. Do not go through each point in detail in the slide.

**5. Activity: Acute HIV Infection****90 minutes****Instructions**

- ◆ Tell the participants to organize themselves into groups of three (triads). Explain that each triad is to be comprised of a “provider”, “patient” and “observer”. And that everyone will have a chance to be in each of these roles in one of three rounds of role-plays.



- ◆ Instruct all members of the triad to read each case study at the beginning of each round of role-play.
- ◆ Then explain that the roles of the “provider”, “patient” and the “observer” are as follows:

**Provider:**

Your task is to address acute infection with your patient and motivate them. It may be helpful to identify the following:

- ◆ When was the patient's most recent exposure? Is it in the window period?
- ◆ What behavior places patient at risk?
- ◆ What sign or symptoms does the patient have?
- ◆ What immediate actions should the patient consider?

**Patient:**

Your role is to play the patient in a realistic way and to ask questions that require the provider to explain information to you.

**Observer:**

You are to observe the role play without interruption and specifically to look at the following

points:

- ◆ How well the counselor explained the signs and symptoms of acute infection.
  - ◆ How well the counselor explained the window period.
  - ◆ How well the counselor explained the positive health benefits of the client taking immediate action related to acute infection.
  - ◆ How well the counselor responded to client's questions.
  - ◆ How well the counselor used the tools to facilitate the client's understanding.
- ◆ Inform the participant that they will have a maximum of thirty minutes for each round: 20 minutes for the role-play and 10 minutes for the triad members to debrief each other.

## 7. Activity case study answer key

**15 minutes**

Copy the "Activity case study answer key" located on last two pages of this session plan and hand out to the participants. Quickly review the key points from each case study.

## 8. Session recap

**5 minutes**

- ◆ Ask the group to summarize and discuss the key learning points from the activities
- ◆ Remind to read the detailed information in the Technical Brief
- ◆ Ask the group if they have any questions and remind them about the "question box".

## Activity case study answer key

### Case study 1

You are a female sex worker and you have just received a negative result. You have had significant risk exposure within the last three weeks. You are not currently using any family planning method; you use condoms inconsistently as the clients in your service don't like them. Your boyfriend is an injecting drug user. You have visited the VCT service many times and received a negative result each time. Each time you present for the test you are in the window period. For more than a week you have had a fever, a severe throat, and now have lumps in your neck and groin.

### Key points for case study 1

Last exposure	Window period Y/N	Behavior / context	Signs / symptoms	Action
3 weeks (3/52)	Y	Inconsistent condom use Boyfriend is an injecting drug user	Fever Sore throat Swollen lymph nodes	Referral to doctor Repeat HIV test STI testing & follow-up Follow-up counseling – practice negotiation skills for condom use with male partners and boyfriend

### Case study 2

You are a MSM and you are attending the VCT service for a test for the second time this year. Last time you were in the window period. However, you failed to come back for your follow-up test. You have a wife at home and she is not aware that you are having sex with men. You are getting your results today after having a HIV test and your results are negative. You still occasionally have unprotected receptive anal sex when you drink. You last risk exposure was two weeks ago. You report that you are experiencing aching muscles, night sweats, and an unexplained lumpy (raised, red) rash on your chest and abdomen.

#### Key points for case study 1

Last exposure	Window period Y/N	Behavior / context	Signs / symptoms	Action
2 weeks (2/52)	Y	Unprotected anal sex Degree of patient's self-acceptance of sexuality. Alcohol use	Aching muscles, night sweats, and an unexplained lumpy rash	Refer to doctor Repeat HIV test STI testing & follow-up Follow-up counseling – practice negotiation skills for condom use with male partners and introducing condom use with wife for PTCT

### Case study 3

You are a male fisherman in Pattaya and you frequently have sex with female sex workers when you are away from your wife and family. You have had frequent STIs. You have had a HIV test before and it was negative and you did not come back for a follow-up test when the counselor told you to come back. You received a negative result today but your last risk was only 8 days ago. You mention that you have had diarrhea, vomiting and have been feeling very tired over the past few days.

#### Key points for case study 3

Last exposure	Window period Y/N	Behavior / context	Signs / symptoms	Action
8 days (8/365)	Y	Inconsistent condom use (?) Frequent STI	Diarrhea, vomiting and have been feeling very tired over the past few days.	Refer to doctor Repeat HIV test STI testing & follow-up Follow-up counseling – practice communication skills for condom use with wife for PTCT

## Positive Health: Prevention in Care MODULE: 1 Acute HIV infection and prevention

### Prevention in care starts before HIV diagnosis

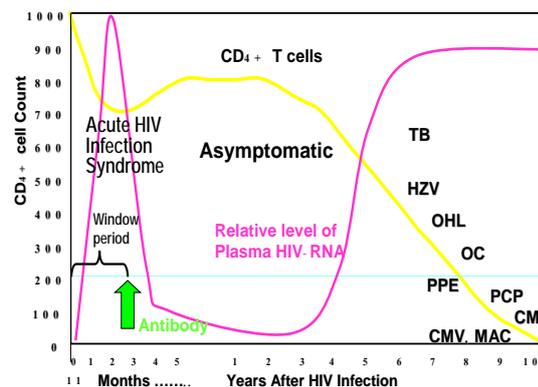
Often people at risk of HIV will present for other health services in non HIV treatment facilities including tuberculosis clinics (TB), services for treatment of sexually transmitted infections (STI), antenatal care services or drug and alcohol treatment (D&A) facilities. Often these individuals may present with signs and symptoms of either early HIV infection or late stage disease. This therefore presents an opportunity to identify individuals, who are at risk of HIV, and an opportunity to offer testing and HIV prevention information to individuals who are at risk but who have not considered finding out their HIV status.

Provider initiated testing and counseling (PITC) refers to HIV testing and counselling recommended by health care providers to persons attending health care facilities for non-HIV related health concerns or treatment needs. Individuals attending health services who have symptoms consistent with early HIV infection, should be asked about recent HIV transmission risk behavior, and offered a HIV test. Whilst a HIV antibody test may not identify recent infection, the testing and counseling process affords an opportunity for the individual to be informed about transmission risks associated with early HIV infection and the need to adopt transmission risk behavior.

### What is acute HIV?

Acute HIV infection (AHI) is also referred to in HIV literature as "primary" HIV infection or "early HIV infection". The acute Infection phase of the illness is the time immediately following exposure to the HIV virus.

Fig. Natural course of HIV infection and common diseases



Source: UNICEF WHO FHI (2010) HIV Counselling Handbook for the Asia-Pacific. UNICEF EAPRO Bangkok p7

### Understanding primary infection is key to identifying appropriate intervention strategies.

An antigen is a substance (such as HIV) that, when introduced into the body, stimulates the production of an antibody (antibodies fight antigens). Antibodies form in a person's blood when HIV or other antigens enter the body.

During acute infection the timing of events varies from person to person but the order in which they occur is fairly uniform. First, there are high levels of viral replication in the blood, leading to a detectable viral load (HIV RNA) within the first week or two following infection. At almost the same time, the p24 antigen (a protein made by the virus) is also detectable in the blood.

Subsequently, a person's immune system begins making antibodies to HIV, and tests for these antibodies will show positive results. This process of detection of antibodies to HIV is often referred to as "sero-conversion."

## HIV testing and acute HIV infection

Detection of acute HIV infection not only enables us to counsel the patient on taking active steps to reduce transmission, it also enables us to better identify potentially infected partners as the time span we need to focus on is still relatively short.

Currently the vast majority of HIV tests are conducted using antibody tests. The limitation of antibody tests is the window period. Antibody tests may not be able to pick up HIV infections for up to 3 months after an individual is infected. This is far from ideal because this is exactly the period that a person is most infectious with the highest viral load.

Under special circumstances (e.g., in a recently infected individual, during the window period, or in the case of a child born to an HIV-positive mother), more direct diagnostic methods may be used. Unlike antibody tests, virological tests determine HIV infection by directly detecting the virus itself. There are three types of virological tests:

- viral antigen detection tests (also known as p24 antigen tests);
- nucleic acid–based tests (specialized tests that look for genetic information on HIV through polymerase chain reaction or PCR); and
- virus culture, which isolates the virus.

Nucleic Acid Amplification Tests (NAAT) for HIV requires only 10 days post exposure to be accurate.

Benefits of NAAT include:

1. Earlier identification of infected persons leading to reduced transmission risks
2. Facilitate partner identification, counseling and testing
3. Early diagnosis leads to early initiation of follow up and treatment leading to better prognosis

### Does the patient have signs or symptoms?

Probably 50-70% of people infected with HIV have an "acute retroviral syndrome." A few days or weeks after being exposed to HIV, many individuals develop a characteristic, flu-like illness that lasts approximately two weeks.

Recognizing symptoms early, being tested for HIV, and starting treatment as soon as possible could help to decrease the risk of transmitting HIV to another person. In most individuals, symptoms of HIV begin about two to four weeks after exposure. The symptoms typically have an abrupt onset, beginning with a fever between 100.4°F (38°C) to 104°F (40°C). Most patients tend to develop the "full-blown" syndrome within one to two days.

During the second week of the illness, most patients also have painless swelling of certain lymph nodes, including those under the arms and in the neck. Although the lymph nodes decrease in size after the first few weeks, some moderate swelling remains. Some patients develop mild enlargement of the spleen (known as splenomegaly). The spleen is an abdominal organ, located to the left of the stomach.

Some patients experience lingering fatigue, listlessness, or depression that lasts for weeks to months.

**Skin, mouth, genital symptoms** — A characteristic feature of acute HIV infection is open sores or ulcers involving the mucous membranes and skin in certain areas of the body. They may be located in the mouth; the esophagus (throat, which extends from the mouth to the stomach); the anus; or the penis. Ulceration involving the esophagus often causes pain during swallowing. The ulcers tend to be shallow, with sharply defined edges, and are typically swollen and painful. Many patients also develop a rash or reddish inflammation of the skin about two to three days after the onset of fever. The rash usually affects the face, neck, and upper chest or may be more widespread, involving skin of the scalp, the arms and legs, and the palms and soles. The inflammation is usually pink to deep red spots and/or small, solid, slightly raised areas of the skin. Itching is rare and tends to be mild.

**Digestive symptoms** — Many patients with primary HIV infection develop nausea and vomiting, diarrhea, lack of appetite (known as anorexia), and associated weight loss. Rarely, more severe abnormalities of the digestive system develop, such as inflammation of the liver or the pancreas.

**Respiratory symptoms** — A dry cough is usually the only respiratory symptom associated with acute HIV infection. A few rare cases have been reported in which patients developed inflammation of the lungs, resulting in difficulty breathing, coughing, and insufficient supply of oxygen to tissues.

**Neurologic symptoms** — Headaches are common in persons with primary HIV infection. Patients often describe pain behind the eyes that worsens with eye movement. Rarely, more severe neurologic features have been reported, including:

- Inflammation of the protective membranes that cover the brain and spinal cord (meningitis), with associated fever, severe headache, skin rash, abnormal sensitivity to light, or other signs
- Inflammation of the brain (encephalitis), sometimes with meningitis. Symptoms can vary and may include fever, headache, confusion, personality disturbances, and episodes of uncontrolled electrical activity in the brain (seizures).
- Impairment of certain peripheral nerves or motor and sensory nerves outside the brain and spinal cord. For example, following acute HIV infection, some patients develop facial nerve paralysis; paralysis and muscle wasting (shrinking of muscle) of the arm; or Guillain-Barré syndrome. Guillain-Barré syndrome causes weakness, tingling, and numbness that begins in the legs and progresses upward to the chest, arms, and facial area. Weakness is rapidly progressive and can sometimes lead to paralysis.

### Why is acute infection important for Prevention in care?

HIV counselors and physicians have long called it the “window period” -- the brief time, lasting a few weeks or months, between when someone is infected and when he or she begins to test positive on HIV-antibody tests. For most of the last 20 years, this window period has been viewed as a complicating factor in HIV prevention counseling, since the results of any one HIV test cannot be viewed as definitive proof that an individual is not actually infected.

During this brief but crucial period, blood and genital secretions are highly infectious to others – at the very time that people are unaware of their infection and have, by definition, recently engaged in unprotected sexual or drug using behavior. As an example, a man could potentially infect 7 to 24 percent of susceptible female partners during the first two months of HIV infection.

Many of the individuals from most-at-risk populations (MARPs) that we see at our HIV Testing and Counseling services, drug dependency treatment services, STI clinics and prisons may present for a test during the window period.

For some time, now research has shown that high viral load found during the acute phase of HIV infection. Whilst the research data is not definitive, a considerable number of studies suggest that as many as 50 percent of new infections may attributed to people having been infected by somebody who was in the Acute infection phase.

### Key AHI positive prevention activities

Early detection of new HIV infections may provide opportunities for immediate prevention and treatment counseling for the newly infected individual, as well as quick contact tracing, partner notification, and risk-reduction counseling for at-risk partners. Such prompt intervention, particularly those that tap into high-risk sexual and drug-using networks, could help to break the chain of new infections.

### “Could it be HIV?” Awareness campaigns

There is a need to promote a greater awareness of the increased transmission risks associated with AHI. Not all individuals who are tested receive appropriate information about the relationship between exposure in the window period and implications for HIV transmission and re-testing.

### Awareness messages and strategies

1. Raise awareness among MARPs  
{Refer to diagram at end of this technical brief}

Raise awareness of the common signs and symptoms of AHI among MARPs. This should be accompanied by a message about HIV testing including the benefits of early diagnosis such as “When you know that you’re infected, you may make lifestyle changes that will maintain or improve your health; and you will also be able to gain access to treatment and care, prevent Parent to Child transmission (PTCT) and reduce transmission risk to your partners”.

2. Raise awareness among medical, nursing and counseling personnel in generalist and specialist health facilities.

{Refer to diagram at end of this technical brief}

### STI Clinics & AHI

Individuals presenting at STI clinics for treatment should be informed that the same behaviors that put individuals at risk of STI also expose them to risk of acquiring HIV. Clinicians should also enquire about the presence of early signs and symptoms of HIV. When STI contact tracing is conducted for STI infections there should be an offer of a HIV test.

### Drug and alcohol treatment facilities

These facilities often offer HIV testing to clients at the point of entry into treatment and care. Too often follow-up HIV testing is either not considered or not offered in a systematic way that could detect individuals who may have AHI. In these facilities individuals may be simply screened for HIV infection and not be provided adequate information about the risks of passing on HIV.

### Custodial clinical services

It is common that many individuals are tested on either voluntary or involuntary basis on admission to custodial services. Detainees should be informed of the need for follow-up testing where necessary during detention; they should also receive information about the HIV transmission risks that occur within the window period and be offered pre-release referral to STI and HIV testing and counseling services in the community.

### HIV testing and counseling services

Nurses/counselors should explicitly inform clients who receive a negative test that if they have had any exposure risk within the window period or subsequent to the blood collection, they may still be infected and highly infectious. Explicit information should be given in relation to risk reduction strategies.

It should be standard practice for counselors to undertake a detailed exposure risk assessment of the client and to offer a follow-up appointment for all individuals who test within the window period. Counselors should educate on and assess all clients presenting for the presence of any signs and symptoms of AHI.

### HIV Treatment and Care

The focus of attention in HIV clinical services is on the individual being treated. Clinical services could offer basic health check services to the HIV negative regular partners of HIV positive patients from targeted populations. These basic services would include provision of information about screening for the common signs and symptoms of acute infection, and the offer of HIV testing. There should be routine assessment of all ongoing patients to review difficulties they may have in engaging in risk reduction and partner disclosure. Counselors and nurses could conduct such enquiries within the context of the routine patient assessment and casework support planning. This will be discussed in more detail in module 2 of this curriculum.

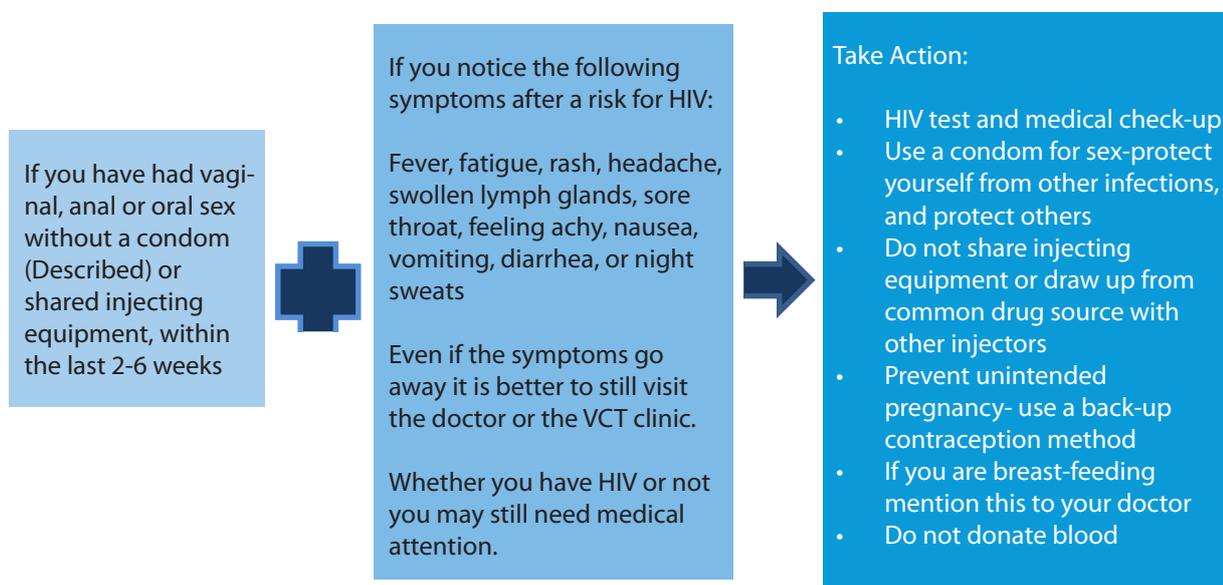
## Strategy 1 – Provide brief intervention messages to positive individuals

The message is “we know sometimes it is hard to practice safer sex or use your own injecting equipment”. We recommend that you have a HIV test and STI check-up every 3-6 months. Better still, if you “slip up” and do not protect yourself, get yourself to a health service for a check up as soon as possible.

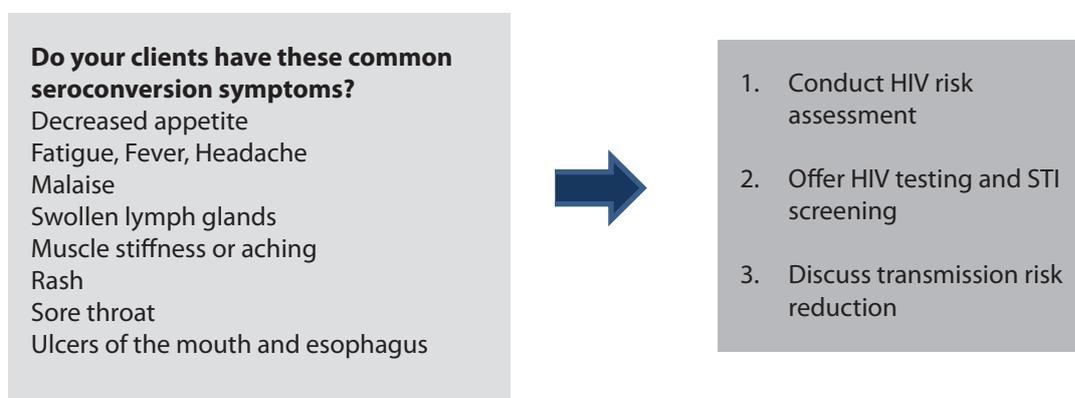
HIV could be in your body whether you choose to have a test or not. The difference is if you know you can do some things that will keep you healthy. If you do not test HIV could be silently destroying your health. “Knowledge = the power to act to protect your health”

Strategy 2 – Promote self assessment

## Strategy 2 – Promote self assessment



## Strategy 3 – Raise awareness amongst general and targeted health service providers “Could it be HIV?”



## Acute HIV infection and positive prevention

### Activity Instructions

1. Organize yourselves into groups of three (triads). Each triad is to comprise of a “provider”, “patient” and “observer”. Everyone will have a chance to be the “provider”, “patient” and the “observer” in one of three rounds of role-plays.



2. All members of the triad will read each case study at the beginning of each round of role-play.
3. The roles of the “provider”, “patient” and the “observer” are as follows:

#### Provider:

Your task is to address acute infection with your patient and motivate them. It may be helpful to identify the following:

- ◆ Is the patient currently in the window period due to recent exposure?
- ◆ What behavior places the patient at risk?
- ◆ What sign or symptoms does the patient have?
- ◆ What immediate actions should the patient consider?

#### Patient:

Your role is to play the patient in a realistic way and to ask questions that require the provider to explain information to you.

#### Observer:

You are to observe the role play without interruption and specifically to look at the following points:

- ◆ How well the counselor explained the signs and symptoms of acute infection.
- ◆ How well the counselor explained the window period.
- ◆ How well the counselor explained the positive health benefits of the client taking immediate action related to acute infection.
- ◆ How well the counselor responded to client’s questions.
- ◆ How well the counselor used the tools to facilitate the client’s understanding.

4. A maximum of twenty minutes will be allowed for each role-play.
5. At the conclusion of each round of the role play the triad is to debrief each other (10 minutes).

### Case study 1

You are a female sex worker and you have just received a negative result. You have had significant risk exposure within the last three weeks. You are not currently using any family planning method; you use condoms inconsistently as the clients in your service don't like them. Your boyfriend is an injecting drug user. You have visited the VCT service many times and received a negative result each time. Each time you present for the test you are in the window period. For more than a week you have had a fever, a severe throat, and now have lumps in your neck and groin.

### Case study 2

You are a MSM and you are attending the VCT service for a test for the second time this year. Last time you were in the window period. However, you failed to come back for your follow-up test. You have a wife at home and she is not aware that you are having sex with men. You are getting your results today after having a HIV test and your results are negative. You still occasionally have unprotected receptive anal sex when you drink. You last risk exposure was two weeks ago. You report that you are experiencing aching muscles, night sweats, and an unexplained lumpy rash on your chest and abdomen.

### Case study 3

You are a male fisherman in Pattaya and you frequently have sex with female sex workers when you are away from your wife and family. You have had frequent STIs. You have had a HIV test before and it was negative and you did not come back for a follow-up test when the counselor told you to come back. You received a negative result today but your last risk was only 8 days ago. You mention that you have had diarrhea, vomiting and have been feeling very tired over the past few days.

## Could it be HIV?

**Exposed:  
Last risk**

January						
				1	2	
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

February						
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

March						
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

April						
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

**End of window  
period**

## Could it be HIV?

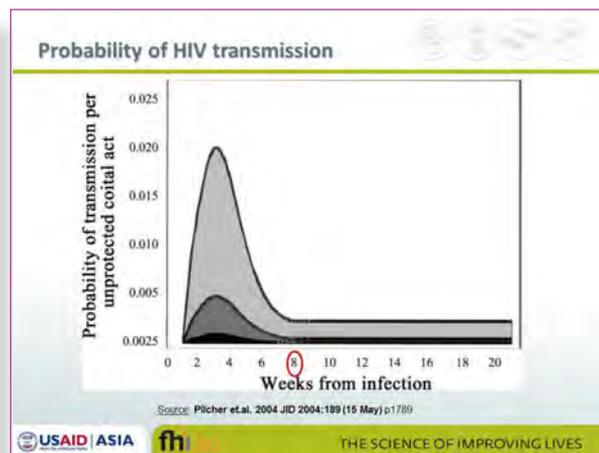
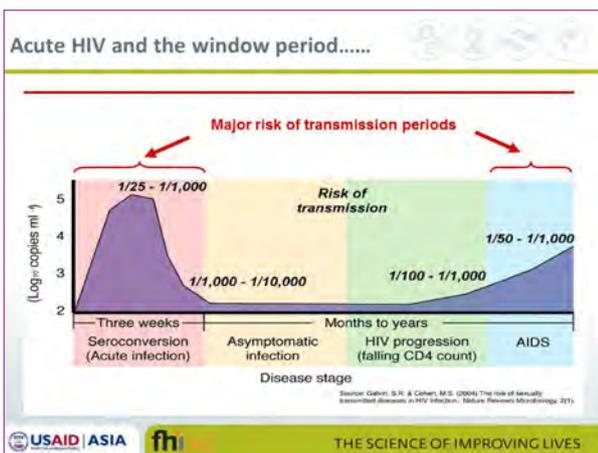
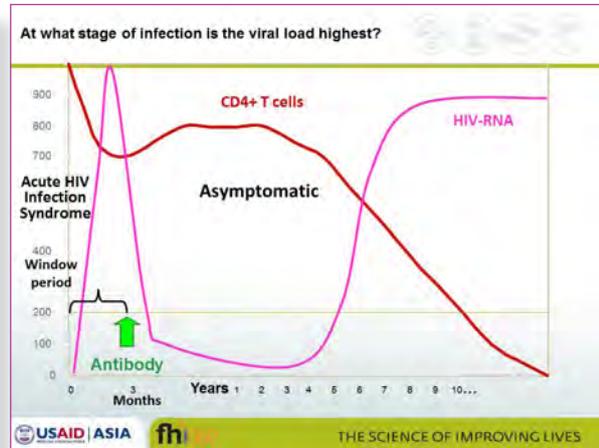
- ◆ What i
- ◆ Does the patient have a flu-like illness?
- ◆ Does the patient show any signs and symptoms, such as fever, muscle and joint pain, and swollen lymph nodes?
- ◆ Does the client exhibit open sores or ulcers in the mouth; the esophagus; the anus; or the penis?
- ◆ Does the patient complain of pain during swallowing?
- ◆ Does the patient display a rash or reddish inflammation on the face, neck, and upper chest?
- ◆ Does the patient complain of nausea and vomiting, diarrhea, or lack of appetite and weight loss?
- ◆ Does the patient have a dry cough?
- ◆ Does the patient complain of headache and/or pain behind the eyes that worsens with eye movement?

## Acute HIV infection and positive prevention

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Positive Health: Prevention in Care

Acute HIV Infection



MODULE 01

Implications for testing & counseling

- Negative result provision
  - Detailed advice on need for re-testing and explicit advice on re-test dates and HIV prevention
  - Clients with suspected seroconversion symptoms and significant risk history
    - Referred to physician for differential clinical diagnosis.

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Detailed risk assessment and patient education

Information → How to protect → Last date this risk occurred?

*"Anal sex: HIV can be transmitted during anal sex. HIV can be found in the fluids of the anus of the receptive person; or in the 'pre-cum', or ejaculate or the penetrating penis.*

*"You can protect yourself or your partner by using a condom from the time penetration"*

Ask "Can you tell me when this type of risk last occurred?"

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### Case Presentation

- A 34 year old man who has sex with men presents with a 4-day history of fever, sore throat and rash
- Identifies as gay (homosexual)
- Graphic designer
- Non-smoker, occasional alcohol use
- No reported history IDU

Source: Martin Markowitz, M.D., The Rockefeller University, Center For Clinical and Translational Science

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### Sexual History

- 10 male sexual partners in the past 3 months
- Multiple episodes oral sex without condoms and anal intercourse with condoms
- Receptive anal intercourse without condoms with partner of unknown HIV status two weeks prior to onset of symptoms

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### Review of Symptoms

- Fever
- Sore throat
- Fatigue
- Myalgia/Arthralgia
- Headache
- Eye pain
- Diarrhea

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### Physical Exam

- Remarkable for:
  - Temp 38.6 C (oral measure)
  - Bilateral cervical swollen lymph nodes
  - Oral ulcers
  - Maculopapular rash (see next slide)

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### Maculopapular rash



Source: Markowitz, 2007

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### Lymphadenopathy



Source: Markowitz, 2007

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### Oral ulcers



Source: Markowitz, 2007

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### Initial lab tests (when available...)

- Exclude other illnesses e.g. monospot and throat culture > negative
- Syphilis test negative (RPR non-reactive)
- HIV antibody test negative

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### Day 8 of consultation

- Symptoms persist but are improving
- HIV Test remains negative
- CD4 266 cells/mm<sup>3</sup> (19%)
- HIV-1 RNA 2,528,000 c/ml (HIV-1 RNA =1,358,665 c/ml on Day 1)

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### "Targeted community messages"

- "We know sometimes it is hard to practice safer sex or use your own injecting equipment"
- "We recommend that you have a HIV test and STI check-up every 3-6 months"
- "If you 'slip up' and do not protect yourself, get yourself to a health service for a check up as soon as possible"
- HIV could be in your body whether you choose to have a test or not. The difference is if you know, you can do some things that will keep you healthy. If you do not test, HIV could be silently destroying your health. "Knowledge=the power to act to protect your health"

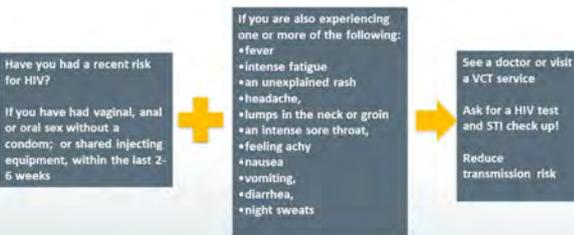
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### HIV is like a ticking bomb

- HIV could be in your body whether you choose to have a test or not.
- The difference is if you know, you can do some things that will keep you healthy.
- If you do not test, HIV could be silently destroying your health.
- "Knowledge about your HIV status gives you the power to act to protect your health"

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### Could it be HIV? – Targeted population message



```

    graph LR
      A[Have you had a recent risk for HIV?  
If you have had vaginal, anal or oral sex without a condom; or shared injecting equipment, within the last 2-6 weeks] -- "+" --> B["If you are also experiencing one or more of the following:  
• fever  
• intense fatigue  
• an unexplained rash  
• headache,  
• lumps in the neck or groin  
• an intense sore throat,  
• feeling achy  
• nausea  
• vomiting,  
• diarrhea,  
• night sweats"]
      B -- "➔" --> C[See a doctor or visit a VCT service  
Ask for a HIV test and STI check up!  
Reduce transmission risk]
    
```

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### Could it be HIV ?– medical personnel

Do your clients have these common sero-conversion symptoms?

- Decreased appetite
- Fatigue Fever Headache
- Malaise
- Swollen lymph glands
- Muscle stiffness or aching
- Rash
- Sore throat
- Ulcers of the mouth and esophagus

→

Conduct HIV risk assessment

- Offer HIV testing and STI screening
- Discuss transmission risk reduction



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### Time for the activity!

Form three groups



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Positive Health: **Prevention in Care**

# MODULE 02





## Entry into care: Case support planning

### Session objectives:

At the end of the training session, trainees will be able to:

- ◆ Identify barriers to care, support and treatment services for PLHIV
- ◆ Conduct case support planning through the use of appropriate tools.

### Time to complete module:



2 hours

### Training materials:



1. Technical brief, TB02
2. PowerPoint presentation PPT02
3. Activity Sheet, AS2.1
4. Flipchart paper / overhead transparencies
5. Tool, T2.1, T2.2, T2.3, T2.4
6. Question box

### Content:



- ◆ Post diagnosis challenges
- ◆ Patient barriers for care, support, and treatment services
- ◆ Casework planning
- ◆ Referral and follow-up
- ◆ Mapping out patient needs

### Session instructions



Time

#### 1. Introduction

5 minutes

- ◆ Ask training participants:
  - What are key post HIV diagnosis challenges in providing treatment and care services?
  - What barriers may prevent patients from accessing care, support and treatment services?

#### 2. Technical Brief (TB02) and Tools (T2.1, 2.2, 2.3, 2.4)

25 minutes

- ◆ Instruct the participants to read the technical brief: (TB02) and Tools (T2.1, 2.2, 2.3, 2.4)



### 3. Debriefing from the reading and tool review

20 minutes

Points can be awarded to groups for correct answers.

- ◆ What are the two types of “loss to follow-up” that could occur after provision of a positive result? {Answer: Treatment delay where client waits greater than 3 months to seek a post diagnosis check-up and support, and “failure to initiate treatment” where the client never attends a treatment and care service after diagnosis}
- ◆ What are some of the reasons identified in research for why we have “loss to follow –up”?  
Answers include: any of the following:
  - The initial HIV diagnosis was made without knowledge or consent;
  - Poor quality service provision during HIV testing experience;
  - Identity cards being required for access to HIV treatment and care;
  - Prior adverse experience in any health service contact;
  - Poor targeted population opinion of a specific clinical facility;
  - HIV treatment facility with street level HIV signage – clearly denoting the individual is entering a HIV clinic;
  - Inconvenient hours of service operation;
  - “Cost-benefit” analysis by cl of attending the hospital, ART provided with low CD4).
- ◆ What are some simple strategies mentioned in the technical brief that could reduce loss to follow-up  
Answers include:
  - Early post-diagnosis services located in VCT sites, e.g. initial CD4 blood draw and results, basic health check-up, treatment literacy education, ongoing counseling support
  - Formal Pre-ART enrollment at VCT clinic immediately post diagnosis.
  - Being offered an accompanied first visit to HIV treatment service e.g. Positive support club “treatment buddy”
  - HIV treatments integrated into multi service facilities – available with value-added services e.g. Family planning, STI, emotional support, relationship counseling (especially MSM and discordant couples)
  - HIV health care provided under national insurance coverage
  - Voluntary enrollment in either home-based care, or health visitor programs, immediately during post HIV test counseling

### 4. Activity (AS2.1)

60 minutes

- ◆ Divide the training participants into three small discussion groups
- ◆ Explain:
  - You have been assigned to three groups Group 1 will work on case 1, Group 2 will work on Case 2 and Group 3 will work on case 3. You will have 15 minutes for your group work. Identify a group facilitator, a group note taker and presenter for large group feedback.
  - Next, read the case study assigned to your group in activity sheet (AS2.1) and do the following:
    - » Determine the key issues – care needs and potential barriers to care – of the patient.
    - » Identify considerations / strategies that will aid the patient in getting the care needed, include what tools will be needed for different strategies.
  - Prepare feedback on the OHP transparency, or flip chart paper, using the format given in the activity sheet. To save time please record your answers directly onto your OHP transparency, or flip chart paper as they are discussed. Avoid wasting time writing out on paper first and then transferring into the format neatly.

### 5. Session recap

5 minutes

- ◆ Briefly show the summary slides in PPT02.
- ◆ Ask the group if they have any questions and remind them about the “question box”.

## Activity case studies

### Case study 1

A 23-year-old male found out he was HIV positive two months ago. While on holiday abroad with his girlfriend, he had gone with her for a test at a local clinic because they had decided to get married. He tested positive and his girlfriend tested negative. His girlfriend left him after that. He is an occasional drug user but he reports that his drugs use has increased since he found out his test results. He also reports he gets very drunk on the weekends and visits female sex workers since his girlfriend left him. He mentions that he has painful urination and a skin rash. He has also not been sleeping or eating well. He has not been to see a doctor since his diagnosis because he does not know anyone else who is HIV positive and is scared about what may happen to him. His family is asking him why he is not getting married and he is not sure how he should explain the situation to them. This is his first follow-up visit to your service.

Key issues	Considerations / Strategies
Delayed presentation after diagnosis related to emotional disturbance after diagnosis and relationship breakdown	Assessment of mood using tool 2.1.
Drug and alcohol related to ongoing potential transmission risk behavior	Assess what substances, when he uses them and how frequently and whether use is increasing, method of use (injection or oral), and whether patient experiences withdrawal if not using.
Sleeping and eating difficulties	Are these related to substance use? Examination of drug use Prior behavior or related to diagnosis? Relaxation techniques.
Reporting medical symptoms, possibly STI-related	Referral to STI doctor. Education about risk posed by STI to his health.
Unprotected sex	Assess attitudes and barriers toward condom use. Education about re-infection.
Scared to see the doctor	Information about HIV and the progression from HIV to AIDS and treatment opportunities. Discuss importance of ongoing monitoring
Family pressuring him	Does he need or want assistance with disclosure to family? Discuss disclosure to his family.
Partner in the window period	It is possible that his partner was in the window period when she was tested, and should be retested when and if possible.

## Case study 2

Eight months ago a 22-year-old male developed a rash on his body that would not go away. He was tested for HIV by a doctor and diagnosed HIV positive. He lives at home with his mother, father, and two sisters. They are aware of his HIV status but they do not know about his regular male partner who has not yet been told of his HIV test result. Recently, he has been losing weight and feeling very tired. Some traditional medicine recommended by the village healer made him feel a bit better after two weeks, but then he started to have diarrhea every day. He went to the pharmacy and was given tablets that help the diarrhea sometimes. When he last weighed himself at the pharmacy he had lost another five kilos. These physical symptoms have led him to stay home more than he used to.

Key issues	Considerations / Strategies
Condom use with male partner	Assess attitudes and barriers toward condom use with partner. Education about re-infection. Assist with the development of skills to discuss condom use with partner.
Disclosure to partner on HIV status	Does he need or want assistance with disclosure to partner? Discuss options for disclosure to partner
Self medication for diarrhea	Discuss the importance of non-self medication and referral for medical review. Is the reason for self-medication due to a concern for the cost of treatment?
Use of traditional medicine for other symptoms	Discuss lack of evidence and potential harms related to the use of traditional medicine. The traditional medicine may also be responsible and contributing to the diarrhea. Importance that his doctors be made aware of what traditional medicine is being used – related to possible drug interactions
Rash on his body	Medical review and STI check-up. [Rash could also be due to use of traditional medicine, presence of an STI, or HIV-related illness or pre-existing skin condition].
Weight loss	Referral for nutrition assessment and medical review. Drug and alcohol use assessment. Providing the patient with dietary fact sheets can be helpful
Withdrawal from social activities	Mood assessment using tool 2.1. Build awareness of available support networks.

### Case study 3

A 25-year-old female sex worker found out that she had HIV three years ago in her home province. After her diagnosis, she attended clinical services regularly. One year ago, she moved to Bangkok and has not attended services because her official housing registration is still registered in her home province. In this time, she has had many opportunistic infections. She has been very distressed by her recurrent periods of illness and feels that she is a burden to her family. She is undergoing treatment for TB as an outpatient but she is not sure whether she is getting better and has not been back to see the doctor because of the cost. She does not know how to access the social health scheme. She reports that she is having irregular menstrual periods. When asked, she indicates she is taking oral contraception but sometimes she forgets to take it. She mentions that she often forgets many things lately. She has informed you that many of her clients do not want to use condoms and offer her more money not to use them. She often drinks alcohol with clients in order to get a percentage of the bar fee. .

Key issues	Considerations / Strategies
Engaged in sex work without 100% condom use	Referral to senior peer who can help her work out strategies for negotiating for and using condoms with clients. Refer to free supplies of condoms.
Financial worries	Referral to social worker to assist in changing official registered housing address in order to access national health scheme support for HIV treatment. Discuss the advantages of STI prevention (condoms, loss of income if decline sex without condom), over the cost of treatment for STI.
Forgets oral contraception	Mood and cognitive assessment (HIV memory impairment). Referral to family planning service or gynecologist.
Irregular menstrual periods	Possibly related to inconsistent use of oral contraceptives. Referral to family planning service or gynecologist. Inquire and educate about sex work during menstruation and education about increased HIV transmission risk
Current and regular TB treatment (?)	Assess treatment adherence. Discuss strategies for transmission risk reduction. Discuss the importance of informing her TB physician about her HIV status.
Self-reported alcohol use	Discuss relationship between impaired ability to negotiate for and use condoms correctly. Screen for possible dementia.
No recent HIV follow-up	Reassert the importance for routine follow-up. Referral to an HIV physician for treatment. Assess the need for and educate about referral related to treatment. Opportunities for peer support and possibility for having a treatment "buddy" to assist them.
Concerns about family	Assess how she feels she is a burden on the family. Discuss possibility of disclosure to one or more family members. Possible referral for family counseling.
Coping with infection	Conduct suicide risk assessment

## Positive Health: Prevention in Care

### MODULE: 2

## Entry into Care: Case support planning

### Post diagnosis interventions - entry into care

International experience has shown that often individuals from marginalized populations including sex workers, substance users, men who have sex with men and transgender who are diagnosed HIV positive fail to attend post diagnosis care support and treatment services. This is commonly referred to as a “post HIV diagnosis loss to follow-up”. Loss to follow up is a significant challenge confounding HIV prevention efforts, and has implications for the health of the HIV infected individual. Loss to follow-up manifests in two ways:

- ◆ Treatment delay which refers to the situation where an individual waits more than 3 months after the HIV test to present for treatment
- ◆ Failure to initiate treatment which occurs when an individual never approaches a treatment and care service after a positive diagnosis

Some of the reasons identified in the literature include:

- ◆ The initial HIV diagnosis was made without knowledge or consent;
- ◆ Poor quality service provision during HIV testing experience;
- ◆ Identity cards being required for access to HIV treatment and care;
- ◆ Prior adverse experience in any health service contact;
- ◆ Poor targeted population opinion of a specific clinical facility;
- ◆ HIV treatment facility with street level HIV signage – clearly denoting the individual is entering a HIV clinic;
- ◆ Inconvenient hours of service operation;

- ◆ “Cost-benefit” analysis by client - a weighing of perceived negative outcomes versus limited benefits (costs, ART provided with low CD4) – primarily cited by asymptomatic individuals from marginalized populations.

Strategies that have been demonstrated to reduce this loss to follow-up after diagnosis include:

- ◆ Early post-diagnosis services located in VCT sites, e.g. initial CD4 blood draw and results, basic health check-up, treatment literacy education, ongoing counseling support
- ◆ Formal Pre-ART enrollment at VCT clinic immediately post diagnosis.
- ◆ Being offered an accompanied first visit to HIV treatment service e.g. Positive support club “treatment buddy”
- ◆ HIV treatments integrated into multi service facilities – available with value-added services e.g. Family planning, STI, emotional support, relationship counseling (especially MSM and discordant couples)
- ◆ HIV health care provided under national insurance coverage
- ◆ Voluntary enrollment in either home-based care, or health visitor programs, immediately during post HIV test counseling

### Casework planning

Individuals infected with HIV and their significant others such as partner or partners, family, and friends can experience profound emotional, social, behavioral, and medical consequences. It is important that casework planning is initiated as soon as practicable after diagnosis.

To address emotional, social, behavioral, and medical needs, it is important to develop an individual action plan and, where feasible, to identify a case-manager (the preferred term is patient support coordinator), social worker, or counselor who can provide continuous care and support and assist the client in negotiating complicated medical and social service systems.

Casework planning involves assessing needs, developing an individual action plan, providing follow-up services and monitoring medical records to ensure there are no identified gaps in service delivery.

Remember:

- ◆ A trusting relationship between the patient support coordinator and the person living with HIV is integral to providing adequate assistance and follow-up services.
- ◆ The patient support coordinator should be sensitive to the individual needs of each client when providing assistance and developing action plans.
- ◆ The patient support coordinator should have extensive knowledge of available clinical, community, and social service systems, along with a basic understanding of counselling skills.

### Developing follow-up and referral plans

In the context of patient diagnosis occurring in an external VCT and initial entry into hospital based- treatment programs, referral is the process of assessing and prioritizing immediate client needs for prevention, care, and support services, and assisting clients in gaining access to these services (e.g., by making appointments or providing transportation). Referral from the external VCT service should include the facilitation of the initial patient contact at the HIV treatment and care service.

Patients' care and support needs change as HIV infection progresses. Although the patient support coordinator cannot fulfill all client needs, they can mobilize additional resources to reinforce the care and support they offer. This requires the involvement of the family, community, religious groups, self-help groups, nongovernmental organizations (NGOs), development partners, health care facilities, and others. Counselors or patient support

coordinators should refer clients to services that address their highest-priority needs and are appropriate to their culture, language, gender, sexual orientation, age, and developmental level.

Patient support coordinators or counselors must be aware that there are limits to the services they can offer. These limitations should be explained to clients clearly so they do not feel rejected if the coordinator or counselor makes a referral. Patient coordinators or counselors can refer clients during the post-test counseling session/s; at the initial presentation in a treatment and care service; or at various significant points across the course of a person's treatment. It is important that the coordinator and counselor knows to make appropriate referrals with clear plans, and how to develop a post-discharge plan for discharging hospital inpatients.

### Potential referral needs to consider

Clients may have complex needs that affect their ability to adopt and sustain behaviors that will reduce their risk of transmitting or acquiring other infections. They may need referrals for medical evaluation, care, and treatment of opportunistic infections (OIs) and communicable diseases (e.g., TB, hepatitis, and STIs). Referrals may also be needed for clients who need:

- ◆ treatment of a drug or alcohol addiction;
- ◆ care and treatment because of mental illness, developmental disabilities, or difficulties coping with an HIV diagnosis or HIV-related illnesses;
- ◆ legal services to prevent discrimination in employment, housing, or public accommodation;
- ◆ individual counselling;
- ◆ relationship counselling;
- ◆ family counselling;
- ◆ spiritual counselling;
- ◆ access to social services;
- ◆ home-based care;
- ◆ condom supply;
- ◆ needle-syringe exchange;
- ◆ peer educator support for sex worker – client condom negotiation support; or
- ◆ family planning services.

HIV-positive pregnant women and HIV-affected families with orphans and vulnerable children may also need to be referred for assistance with childcare whilst they are in the birthing centre, or undergoing drug or alcohol detoxification or when admitted for inpatient HIV treatment.

### Assessing clients' referral needs

Patient coordinators or counselors should identify the key factors that are likely to influence a patient's ability to adopt or sustain behaviors that:

- ◆ reduce the risk of transmitting HIV or acquiring STIs;
- ◆ promote health; and
- ◆ prevent disease progression.

The assessment should include an examination of the patient's willingness and ability to accept and complete a referral (see box below regarding measures intended to preserve confidentiality in the referral). Service referrals that match the priority needs identified by the client himself or herself are most likely to be completed successfully. Patient coordinators or counselors may refer a client to clinical or community support groups, depending on the client's needs and responsiveness to counselling.

### Mapping out the client's needs

Review your client counselling notes and assessments, determine the key issues, and then, one by one, identify specific intervention strategies. Let us look at an example in the case study below.

**Case study.** The client is a woman who was brought to the clinic by a female co-worker from the bar where she engages in sex work. The woman has known she is HIV-positive since her first husband died two years ago. After her husband's death, she came to Bangkok. She met another man and they live together.

She has not told her boyfriend that she has HIV and does not know that this is an HIV service. She also says that there is pressure from her own family to marry and to start a family. She reports she is not using contraception at present and has unprotected vaginal and oral sex with her boyfriend.

Often unwell, she complains of recurrent diarrhea and weight loss, loss of appetite, and decreased sexual desire. In addition, she has a smelly vaginal discharge and itching. She also reports that she has a persistent cough and recently coughed up blood, and she finds it difficult to sleep at night. Her situation, she says, is hopeless. Her employer is upset because of the increasing time she is taking off work for illness. She no longer wants to talk to her friends at work. She has not had any HIV follow-up and has only limited knowledge of treatment options.

Refer to the sample client support plan in the table below.

Mapping (case study)

Issue	Strategies
Brought to the clinic by co-worker after crying at work; was not aware this facility was for HIV and now fears people suspect she has HIV.	<ul style="list-style-type: none"> <li>Suggest strategies for responding to questions from her co-worker regarding the clinic visit (e.g., "How did it go?")</li> <li>Discuss how she can negotiate with this co-worker to maintain confidentiality</li> </ul>
Reporting STI, HIV, and TB related symptoms	<ul style="list-style-type: none"> <li>Refer to local TB service and medical doctor trained in HIV care and treatment</li> <li>Refer for STI treatment if local HIV service does not offer service</li> <li>Link to treatment and care team or patient support coordinator</li> </ul>
Boyfriend and family unaware of her status	<ul style="list-style-type: none"> <li>Provide counselling in support of disclosure to partner and family</li> </ul>
No contraception and unprotected sex with her boyfriend.	<ul style="list-style-type: none"> <li>Discuss risk of PPTCT if she becomes pregnant</li> <li>Offer pregnancy test or refer for pregnancy test</li> <li>After partner disclosure offer to refer couple to family planning service</li> <li>Discuss safer sex strategies and the need to protect her and her partner/s from STIs, and other infections; offer condoms for contraception after disclosure to partner</li> </ul>
Pressure from partner and family to have a child	<ul style="list-style-type: none"> <li>Obtain client's consent to conduct PMTCT counselling of partner and family after disclosure</li> </ul>
Loss of appetite, decreased sexual desire, unwillingness to talk to friends at work, sleeping difficulties	<ul style="list-style-type: none"> <li>Assess/refer for depression and drug and alcohol use</li> <li>Assess reason for sleep difficulties e.g. drug or alcohol use; anxiety or HIV related sleep disorders.</li> <li>Teach relaxation exercises.</li> </ul>
Lack of appetite and weight loss	<ul style="list-style-type: none"> <li>Refer to nutrition counselling service</li> </ul>
Time off work due to illness	<ul style="list-style-type: none"> <li>Discuss strategies for explaining absences at work</li> <li>Refer to NGO for financial assistance if required</li> </ul>
Increasing social isolation	<ul style="list-style-type: none"> <li>Offer referral and introduction to peer support</li> </ul>

HIV = human immunodeficiency virus,  
 NGO = nongovernmental organization,  
 PPTCT = prevention of parent to-child transmission,  
 STI = sexually transmitted infection.

## Making a successful referral

- ◆ Prioritize with clients to decide what their immediate referral needs are.
- ◆ Outline the health and social service options available and help the patient choose those most suitable (in terms of distance, cost, and client's culture, language, gender, sexual orientation, age, and developmental level).
- ◆ In consultation with the patient, examine the factors that may make it difficult for the patient to attend the referred service (e.g., lack of transportation or child care, work schedule, cost) and address those factors.
- ◆ Make a note of the referral in the patient's file. Follow up and monitor the referral process (e.g. whether patient attended the referral point).
- ◆ Give the patient a list of recommended services with addresses, telephone numbers, and hours of operation. Also, be aware of community support groups near the counselling site, the services they offer, their hours of operation, and contact persons.
- ◆ Ask the patient for feedback on the quality of the services to which he or she has been referred.

### Ensuring consent for release of information

Some services ask patients to sign a release of information form to allow the exchange of information between services. This form is one way of demonstrating to clients that you are serious about respecting their wishes and protecting their confidentiality. It also emphasizes to the receiving agencies the need to respect confidentiality. Some agencies have a prepared form for referral information. Where appropriate, the referral information is documented on the referral form and signed copies of the form and the release of information form are either sent directly to the agency or placed in an envelope that the clients take with them to the service. Copies of the referral and release of information forms should be stored in the patients' file. Sample referral and release of information forms (T2.3 Consent for release of information form and T2.4 Referral form) are included in Positive Health: Prevention in Care toolkit.

### Monitoring case-work and referrals

A medical record audit can assist patient coordination. Often patients will attend a number of services within a hospital or treatment service and the audit or review can assist with identifying gaps in services and situations where a patient has failed to return or follow up on their treatment plan.

Tool (T2.2) the Patient Record Review Checklist may assist you in monitoring service delivery.

## Mapping a patient's care needs

### Activity Instructions

Timing::

15 minutes for case discussion in groups  
30 minutes (10 minutes for large group feedback for each group)  
15 minutes for facilitator debriefing (5 minutes after each group feedback presentation)

1. You will be assigned to three groups: Group 1 will work on case 1, Group 2 will work on Case 2 and Group 3 will work on case 3. You have 15 minutes for your group work. Identify a group facilitator, a group note taker and presenter for large group feedback.
2. Next, read the case study assigned to your group and do the following:
  - a. Determine the key issues – care needs and potential barriers to care – of the patient.
  - b. Identify considerations / strategies that will aid the patient in getting the care needed, include what tools will be needed for different strategies.
3. Prepare feedback on the OHP transparency, or flip chart paper provided in the following format. To save time please record your answers directly onto your OHP transparency, or flip chart paper as they are discussed. Avoid wasting time writing out on paper first and then transferring into the format neatly.

Key issues	Considerations / Strategies

## Activity case studies

### Case study 1

A 23-year-old male found out he was HIV positive two months ago. While on holiday abroad with his girlfriend, he had gone with her for a test at a local clinic because they had decided to get married. He tested positive and his girlfriend tested negative. His girlfriend left him after that. He is an occasional drug user but he reports that his drug use has increased since he found out his test results. He also reports he gets very drunk on the weekends and visits female sex workers since his girlfriend left him. He mentions that he has painful urination and a skin rash. He has also not been sleeping or eating well. He has not been to see a doctor since his diagnosis because he does not know anyone else who is HIV positive and is scared about what may happen to him. His family is asking him why he is not getting married and he is not sure how he should explain the situation to them. This is his first follow-up visit to your service.

### Case study 2

Eight months ago a 22-year-old male developed a rash on his body that would not go away. He was tested for HIV by a doctor and diagnosed HIV positive. He lives at home with his mother, father, and two sisters. They are aware of his HIV status but they do not know about his regular male partner who has not yet been told of his HIV test-results. Recently, he has been losing weight and feeling very tired. Some traditional medicine recommended by the village healer made him feel a bit better after two weeks, but then he started to have diarrhea every day. He went to the pharmacy and was given tablets that help the diarrhea sometimes. When he last weighed himself at the pharmacy he had lost another five kilos. These physical symptoms have led him to stay home more than he used to.

### Case study 3

A 25-year-old female sex worker found out that she had HIV three years ago in her home province. After her diagnosis, she attended clinical services regularly. One year ago, she moved to Bangkok and has not attended services because her official housing registration is still registered in her home province. In this time, she has had many opportunistic infections. She has been very distressed by her recurrent periods of illness and feels that she is a burden to her family. She is undergoing treatment for TB an outpatient but she is not sure whether she is getting better and has not been back to see the doctor because of the cost. She does not know how to access the social health scheme. She reports that she is having irregular menstrual periods. When asked, she indicates she is taking oral contraception but sometimes she forgets to take it. She mentions that she often forgets many things lately. She has informed you that many of her clients do not want to use condoms and offer her more money not to use them. She often drinks alcohol with clients in order to get a percentage of the bar fee.

## Case support planning: for positive health<sup>1</sup>

Client/Patient Number:

Today's Date: \_\_\_/\_\_\_/\_\_\_

Date of original HIV diagnosis:

### 1. Medical follow-up

*For newly diagnosed clients or clients new to your service.*

Has the client seen a HIV doctor since they were originally diagnosed HIV positive?

YES Date:  NO, Reason?

When was the last time that you saw a HIV doctor? Date:

What has the doctor (or nurse) told you about your health? (Brief note)

Did they give you any medicine to take? Details

Are you experiencing any difficulties with taking the medication (correct dose, correct way, and correct time)?

**2. Wellness** – Medical review and general observations required. Liaise with treatment doctor in relationship to required tests or health screen.

#### Routine Laboratory Tests

- ◆ CD4 Count
- ◆ Viral Load
- ◆ Resistance test
- ◆ Complete Blood Count (CBC)
- ◆ Chemistry Panel
- ◆ Toxoplasma IgG
- ◆ Blood Fats
- ◆ Blood Sugar
- ◆ Pap Smear
- ◆ Tuberculosis
- ◆ Urinalysis
- ◆ Tests for Sexually Transmitted Infections
  - Syphilis
  - Gonorrhea
  - Chlamydia
  - Human Papilloma Virus (HPV)
  - Other

<sup>1</sup> Adapted from Counselling Tool 4.6, Post-diagnosis follow-up counseling form, HIV Counselling Training Package, Family Health International, UNICEF EAPRO, WHO WPRO & SEARO, February 2010.

- ◆ Hepatitis tests
  - Hepatitis A
  - Hepatitis B
  - Hepatitis C
- ◆ Vaccinations
  - Human Papilloma Virus (HPV)
  - Hepatitis
  - Influenza
  - Measles, Mumps and Rubella

General medical review/notes for follow-up

### 3. Brief psychological assessment

Over the last month (existing patients) or since patient diagnosis (newly diagnosed patients)

Has the client experienced any of the following? <sup>2</sup>  
(tick the appropriate box):

- A persistent sad, anxious or “empty” mood
- Too little or too much sleep
- Reduced appetite and weight loss or increased appetite and weight gain
- Loss of interest or pleasure in activities once enjoyed
- Withdrawing from friends, relatives or others they are normally close too
- Agitation, restlessness or irritability
- Persistent physical symptoms that don’t respond to treatment (possible indicator of health anxiety disorder)
- Difficulty concentrating, remembering, or making decisions
- Hallucinations (hearing voices or seeing things others cannot hear or see)
- Fatigue or loss of energy
- Feelings of guilt, hopelessness or worthlessness
- Thoughts of death or suicide<sup>3</sup> (briefly note the thoughts)

### 4. Social and welfare

Does the client/patient experience difficulties with any of the following:

- |  |                              |                             |          |
|--|------------------------------|-----------------------------|----------|
| Accommodation                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Details: |
| Finances                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Details: |
| Obtaining food, medications              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Details: |
| Relationships (partner, family, friends) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Details: |

<sup>2</sup> If the client/patient experiences five or more of these symptoms for longer than two weeks or if the symptoms are severe enough to interfere with their daily routine. Conduct a more detailed assessment if you are a psychiatric nurse, psychiatric social worker or psychologist; if not refer to a doctor or a qualified mental health professional.

<sup>3</sup> If the client indicates “Yes” to suicide conduct a detailed suicide risk assessment which is available in the Toolkit.

## 5. Positive prevention

### 5.1 Partner disclosure

Already disclosed  Yes  No

Notes on outcome of any disclosures / reasons for non-disclosure:

#### Future disclosure plan

- ◆ Client/patient will self-disclose
- ◆ Client/patient would like to disclose in presence of counselor
- ◆ Counselor to disclose on behalf of client/patient without the presence of the client/patient (who must complete signed release of information)
- ◆ Client/patient wishes counselor to disclose in his or her presence
- ◆ Client/patient will disclose to a trusted third party and request that individual to make disclosure on the client/patient's behalf.

### 5.2 Transmission risk reduction:

Use of condoms

- ◆ Doesn't use condoms with any sexual partners
- ◆ Condoms used with regular partner only
- ◆ Condoms used with all partners EXCEPT regular partner
- ◆ Condoms used with ALL partners

Does the client/patient indicate that s/he has difficulties with sexual functioning?

Yes  No

If yes (Indicate which)

Arousal  Difficulty maintaining erection  Difficulties with ejaculation

Does the client/patient indicate that the above-mentioned problems make it difficult to use condoms?  Yes  No

Does the client/patient indicate that s/he is using any sexual performance enhancing substance (e.g. sildenafil / Viagra®)?

Yes  No .....If yes, what?

#### Details of any treatment or referrals the client/patient has received or requires:

Has the client/patient used any non-prescribed drugs (including hormones and steroids) and/or alcohol in the last month?

Yes<sup>4</sup>  No

Has the client/patient been prescribed any hormones or steroids in the last month?

Yes  No

<sup>4</sup> If yes, please conduct the detailed "Drug and Alcohol Assessment" available in the Toolkit.



Sharing needles and equipment  Yes  No Details:  
 Drug dependency assessment or management referral required  Yes  No  
*(Refer to the International Classification of Diseases (ICD) website: <http://www.who.int/classifications/icd/en/>)*

**Pregnancy**

Client/patient is pregnant  Yes  No NA Partner is pregnant  Yes  No

If Yes, stage of pregnancy

1-3 months  4-6 months  More than 6 months

On ARV prophylaxis?  Yes  No NA  
 Client/patient's partner uses contraception regularly  Yes  No NA  
 Family planning referral required:  Yes  No  
 Pregnancies test referral required:  Yes  No NA  
 Client/patient support plan (attached) has been completed  Yes  No  
 Release of Information signed for referrals  Yes  No NA

Additional counseling notes:

Counselor signature

Name of patient casework coordinator

Date:

**Client/patient support plan**

Key issues	Considerations / support strategies

## Patient record

### Patient Record-Review Checklist <sup>1</sup>

Site: \_\_\_\_\_ Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

This checklist is for staff to determine whether key information is being documented accurately and completely in patient records. Place a checkmark in the appropriate box if the item in the checklist was recorded on the patient’s record; put N/A if the item is not applicable to the patient. Comments and clarifying remarks should be made in the space provided in the table or at the end of this form.

Checklist Item	Yes	N/A	No/Missing	Remarks
Patient identification information (e.g., name, age, sex, residential/postal address, and telephone or other contact information, registration number)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Emergency contact person (name, relationship, residential/postal address, telephone or other contact information)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Date of visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Assessment of health and sexual history, including risk for sexually transmitted infections (STIs) / reproductive tract infections (RTIs) and for gender-based violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical exam results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discussion with the patient about disclosure of HIV status and partner notification issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drug allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Current medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Past antiretroviral (ARV) exposure (if patient is not currently on ARVs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Assessment of signs / symptoms of OIs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<sup>1</sup> Adapted from “Client Record-Review Checklist” in EngenderHealth (2008) COPE for HIV Care and Treatment Services: A Toolbook to Accompany the COPE Handbook, pages 55-56.

Checklist Item	Yes	N/A	No/Missing	Remarks
Assessment of adherence to ARVs and other medications (if patient is already undergoing treatment)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Results of clinical or laboratory procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Results of ongoing clinical and laboratory monitoring for toxicity and treatment failure (if patient is currently on ARVs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HIV clinical stage (if patient is not currently on ARVs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ARV eligibility criteria (if patient is not currently on ARVs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Type of ARV or other OI treatment prescribed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Provision of STI/HIV prevention counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fertility desires/family planning needs discussed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Referral for clinical services not available onsite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Signed consent for release of information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Referral for adherence counseling (if currently on ARVs or if ARVs were prescribed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other referrals (e.g., community or home-based care, nutritional counseling, psychosocial support, people living with HIV groups)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Next scheduled appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physician's name and signature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Before using this checklist, compare the items in the checklist with your facility's record form(s). Consider if any important items are missing from your facility's forms, whether there is a need to update your record form(s), or whether any items are missing from the checklist and need to be added.

Review the data collected in the above checklist. Any negative responses to a checklist item suggest there is room for improvement. Consider the answers to the following questions when reporting back to the group and making recommendations for the Action Plan:

- Was any key information missing from the Patient record?
- What could be the root cause?
- What are some possible solutions?



# Consent for release of information<sup>1</sup>

Client/patient code: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_  
 Client/patient name if agreed for release: \_\_\_\_\_  
 Contact details (if client/patient agrees): \_\_\_\_\_

Instruction for completion: If client/patient is unable to read this form please read each instruction to the client. No coercion is to be exerted. Inform the client/patient this can be revoked at any time.

\_\_\_\_\_, consent to \_\_\_\_\_,  
 (Name of client/patient) (Name of doctor/counsellor)

Tick ✓ which you agree to. Cross X what you do not want to be provided.

- Referral release of information
- Release of information to partner
- Release of information to family member

\*\*\*\*\*

**For Referral Release** Tick ✓ which you agree too. Cross X what you **do not** want to be provided.

I agree to the counsellor doctor providing the following information for the purposes of referral:

- HIV test results       My medical records       Counselling information
- Financial information       My contact details       Other (specify)

This information is to be provided to:.....  
 (Name of staff member of referral agency)

at the .....  
 (Name of centre)

I understand that where information is provided for referral purposes I am consenting to that organization providing information back to my counsellor about my referral.

\*\*\*\*\*

**For Partner disclosure release**

I consent to the following:

- The counsellor telling my partner/family in my presence
- The counsellor being present whilst I disclose to my partner/family, and the counsellor answering questions.
- The counsellor telling my partner/family I am HIV positive, when I am not present.
- The counsellor telling \_\_\_\_\_ (nominee's a name) so that they will tell my partner or family on my behalf.

Anything you do not want the counsellor to disclose to partner/family/other? (Record here)

(Signature of client/patient)

(Signature of doctor/counsellor/patient coordinator)

Date Signed: \_\_/\_\_/\_\_

<sup>1</sup>From Counselling Tool 4.7, Consent for Release of Information, HIV Counselling Training Package, Family Health International, UNICEF EAPRO, WHO WPRO & SEARO, February 2010.



## Referral form<sup>1</sup>

To the receiving referral agency:

This client/patient has signed a “release of information” for release of confidential information. Please provide information back to us about the outcome of this referral.

Detailed client/patient notes and/or assessments are attached Yes  No   
 If No, they are available on request Yes  No

Client/Patient code: \_\_\_\_\_ Date referral made: \_\_/\_\_/\_\_

Name and address of client/patient (if required and client/patient has agreed):

Referred to (specific contact person at referral agency):

Address of referral agency/ individual provider:

Telephone:

Referral feedback to be sent to (referring counselor address & phone contact):

Type of assistance sought for the client/patient:

- HIV medical assessment and treatment
- STI medical assessment and treatment
- TB assessment and treatment
- Family planning advice or contraception
- Ante natal or post partum care (circle which)
- Psychological or psychiatric assessment and treatment
- Drug/alcohol counseling/treatment
- Welfare assistance (includes housing, financial, schooling for children, etc)
- Legal
- Others (specify): \_\_\_\_\_

Summary back ground information:

Detailed client notes and or assessment are attached Yes  No   
 If No, they are available on request Yes  No

Patient coordinator name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup>From Counselling Tool 4.6, Referral form, HIV Counselling Training Package, Family Health International, UNICEF EAPRO, WHO WPRO & SEARO, February 2010.



## Entry into care: Case support planning

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Entry into Care: Case support planning  
Session Summary PPT02

### Two key post diagnosis challenges

- **Treatment delay-** an individual who waits more than 3 months after the HIV test to present for treatment
- **Failure to initiate treatment-** an individual who never approaches a treatment and care service after a positive diagnosis

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### Mapping out patient needs

1. Conduct an assessment (T2.1)
2. If existing patient – review medical record using Patient record – Review checklist(T2.2)
3. Identify key issues & gaps in services
4. Identify “considerations/strategies” for addressing issues and gaps ( casework map format)
5. Referral– Patient signs release of information (T2.3)
6. Referral form completed (T2.4)
7. Follow-up to check if patient attended

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Positive Health: **Prevention in Care**

# MODULE 03



## Positive sexual health

### Session objectives:

To raise awareness of Positive sexual health as an important positive prevention activity. At the end of the training session, trainees will be able to:

- ◆ Identify key strategies for transmission reduction for people living with HIV (PLHIV).
- ◆ Rehearse communication of information related to positive sexual health with clients

### Time to complete module:



3 hours

### Training materials:



1. Technical Brief (TB03)
2. PowerPoint presentation PPT03
3. Activity Sheets, AS3.1
4. Tools T3.1, T3.2
5. Overhead transparency sheets or flipchart paper
6. Question box

### Content:



- ◆ The concept of shared responsibility
- ◆ Positive prevention and maintaining the health of PLHIV
- ◆ Positive prevention and risk reduction
- ◆ The relationship between STIs and HIV
- ◆ Targeting interventions to address the needs of positive individuals from MARPS

### Session instructions



Time

#### 1. Introduction

5 minutes

- ◆ Introduce the session by asking the trainees to respond to the following question:  
What does positive sexual health mean?
- ◆ Write key words from the trainees' responses on flipchart paper.
- ◆ Explain that these issues will be examined further throughout the session.

#### 2. Technical Brief (TB03)

45 minutes

- ◆ Instruct participants to read Technical Brief 03, Positive sexual health, in their technical brief folder. (20 minutes)

- ◆ Randomly ask participants some questions to review important information in the reading. (25 minutes)
  - What is co-infection? When does it occur in HIV infection?
  - What is Reinfection?
  - How is HIV still transmitted when viral load is undetected?
  - What are two common sexual dysfunctions among men in HIV disease? How do they contribute to transmission risk?
  - What are the stages of change?
  - What are appropriate interventions for someone in the pre-contemplation stage?
  - What are appropriate interventions for someone in the contemplation stage?
- ◆ What are appropriate interventions for someone in the maintenance stage?

### 3. Tools (T3.1, 3.2)

**10 minutes**

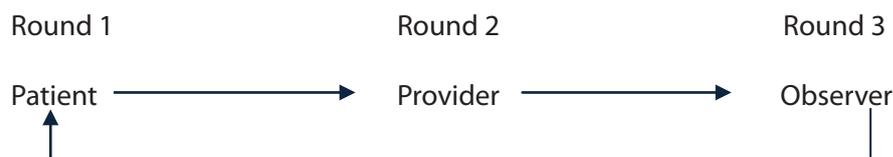
Introduce tools T3.1 and T3.2 and explain how the tools may be used to provide sexual health information to patients.

### 4. Activity: Positive sexual health

**90 minutes**

#### Instructions

- ◆ Tell the participants to organize themselves into groups of three (triads). Explain that each triad is to be comprised of a “provider”, “patient” and “observer”. And that everyone will have a chance to be in each of these roles in one of three rounds of role-plays.



- ◆ Instruct all members of the triad to read each case study at the beginning of each round of role-play.
- ◆ Then explain that the roles of the “provider”, “patient” and the “observer” are as follows:

#### Provider:

Your task is to identify the following in your patient:

- What are the patient’s sexual health Issues?
- What is the patient’s readiness (stage of change)?
- What are the appropriate interventions?
- What are the patient’s referral needs?

#### Patient:

Your role is to play the patient in a realistic way and to ask questions that require the provider to explain information to you.

#### Observer:

You are to observe the role play without interruption and specifically to look at the following points:

- How well the provider identifies the patient’s sexual health issues.
- How well the provider addresses these issues.
- How well the provider is able to identify the stage of change.
- How well the provider used the tools to facilitate the patient’s understanding.
- How well the provider came up with strategies to motivate behavior change.
- How well the provider identified the patient’s referral needs.

- ◆ Inform the participant that they will have a maximum of thirty minutes for each round: 20 minutes for the role-play and 10 minutes for the triad members to debrief each other.

### 5. Activity: Pop quiz

20 minutes

- ◆ Why does having an STI make it easier to transmit HIV?
- ◆ What are five key messages we need to tell patients about STIs?
- ◆ What are three STI that are transmitted readily through oral sex?
- ◆ What are the different ways hepatitis B is contracted?
- ◆ What are special concerns if a person with HIV has hepatitis A, B or C?
- ◆ How can infection with hepatitis be prevented?
- ◆ Why are condoms less effective in preventing STIs than preventing HIV?
- ◆ What is the reason why vaginal douching (washing) is not recommended?
- ◆ What should we tell our patients regarding the use of drugs to self-treat sexual dysfunction?

Answer key below

### 6. Session recap

10 minutes

- ◆ Briefly summarize the key points using the PowerPoint presentation (PPT03)
- ◆ Ask the group if they have any questions and remind them about the “question box”.

## Activity case studies

### Case study 1

You are a HIV positive female sex worker. You frequently have STIs but have not gone to the STI clinic. You do not think STIs are very important as they are curable and you usually get some pills from the market. You are not using condoms with your HIV positive boyfriend as you do not see it is necessary. Condoms are not used in oral sex with clients and are used in vaginal sex only if the client requests their use.

#### Possible responses for case study 1:

Issues	Stage of Change	Interventions	Referral
Unprotected sex with boyfriend	Pre-contemplation	<ul style="list-style-type: none"> <li>Explore the benefits of protecting herself</li> <li>Discuss possible reinfection with HIV for both patient and her boyfriend</li> <li>Provide information about STI and STI treatment and possible reinfection between girl-boyfriend</li> <li>Provide information materials on STI and impact of STI on treatment and care for consideration</li> </ul>	Provide information on services available and possible referral
Unprotected sex with clients	Pre-contemplation / perhaps contemplation	<ul style="list-style-type: none"> <li>Discuss possible reinfection with HIV and infection with STI</li> <li>Explore the benefits of condom use with clients from patient's perspective</li> <li>Discuss ability to initiate condom use with clients</li> <li>Identify supplies of condoms</li> </ul>	Same as above Possible referral to SW peer network to learn more about condom use and negotiation for condom use with clients
Self-treating STI	Pre-contemplation	<ul style="list-style-type: none"> <li>Provide information materials on STI and impact of STI on treatment and care for consideration</li> <li>Discuss possible reinfection with STI and HIV for both patient and her boyfriend</li> <li>Provide information on possible drug resistance from possibly taking the wrong dose or wrong medication.</li> </ul>	Provide information on services available and possible referral

### Case study 2

You are a HIV positive MSM and you have a negative male partner. You do not understand why you should use condoms with your regular partner since your viral load was “undetectable” on your last visit to the clinic. You also discuss that you do not like using condoms because you have problems in maintaining an erection and you find this embarrassing. You tell the provider that you found out you can get some Viagra on the internet and maybe this can help.

#### Possible responses for case study 2:

Issues	Stage of Change	Interventions	Referral
Unprotected sex with partner	Pre-contemplation	Discuss possible HIV transmission with “undetectable” viral load Provide information materials on STI for patient and partner to consider	Provide information of services available and possible referral
Sexual dysfunction	Pre-contemplation / perhaps contemplation	Explore how condoms are used and difficulties in using them. Discuss possible physiological and psychological causes of sexual dysfunction including the appropriate prescription and use of sexual function treatment drugs e.g. sildenafil (Viagra). Provide information materials on STI and impact of STI on treatment and care for consideration	Provide information of services available and possible referral

### Case study 3

You are a HIV positive male and you have a wife at home and have not told her you are HIV positive. You do not want to tell your wife you have HIV as you believe she will find out you have sex with men. You have an STI at the moment and have bought some medication from the pharmacy. You will take the medication so there is no need to tell your wife about the STI.

#### Possible responses for case study 3:

Issues	Stage of Change	Interventions	Referral
Unprotected sex with male partners	Pre-contemplation	Explore the benefits of condom use with clients from patient's perspective Discuss patient's comfort level with own sexuality	Encourage coming back for additional appointments Provide information on services available and possible referral
Unprotected sex with wife	Pre-contemplation	Discuss possible reinfection with STI and HIV for both patient and his wife Provide information on parent to child transmission of HIV and possible impact of STI on unborn child.	Provide information on services available and possible referral
Self-treating STI	Pre-contemplation	Provide information materials on STI and impact of STI on treatment and care for consideration Provide information on possible drug resistance from possibly taking the wrong dose or wrong medication.	Provide information on services available and possible referral
Disclosure to wife	Pre-contemplation	Discuss possible transmission of HIV and STI to wife and subsequent possibility of reinfection with STI and HIV for both patient and his wife Provide information on parent to child transmission of HIV and possible impact of STI on unborn child.	Provide information on services available and possible referral

## Pop Quiz

- 💧 **Why does having an STI make it easier to transmit HIV?**

  - Discharges associated with gonorrhoea, for example, have been shown to contain high levels of HIV.
  - Bleeding from genital sores associated with some STIs may make it easier for blood to be exchanged during sex.
  - Open sores and skin or mucosal irritation make it easier for HIV to enter and exit the body
- 💧 **What are five key messages we need to tell patients about STIs?**

  - If you are treated but partner is not, if you have sex with them, you will be reinfected.
  - Not all STIs have symptoms so you need a regular check-up.
  - Having an STI makes it more difficult for your body to fight opportunistic infections
  - Having an STI may make HIV treatments less effective or difficult to prescribe, e.g. hepatitis
  - Take all of your medication even if symptoms disappear (correct dose, correct way, correct time) and go for a post-treatment check-up
- 💧 **What are three STI that are transmitted readily through oral sex?**

  - Gonorrhoea
  - Hepatitis B
  - Herpes
- 💧 **What are the different ways hepatitis B is contracted?**

  - Unprotected anal or vaginal intercourse
  - Unprotected oral sex
  - Sharing injecting or tattooing equipment
- 💧 **What are special concerns if a person with HIV has hepatitis A, B or C?**

  - Hepatitis A, B and C can cause liver disease and make it difficult for PHA to take ART.
- 💧 **How can infection with hepatitis be prevented?**

  - Hepatitis A and B can be prevented through a course of vaccinations under clinical supervision to people with HIV
  - Using condoms during sexual intercourse
  - Not sharing injecting equipment
- 💧 **Why are condoms less effective in preventing STIs than preventing HIV?**

  - Condoms don't cover the entire male sexual organ or genital area. STI may be in areas not protected by the condom
  - Herpes on the mouth can be transmitted during contact with another person's genital organs.
  - Many STIs are more readily transmitted through a single incident of unprotected sexual activity than HIV
- 💧 **What is the reason why vaginal douching (washing) is not recommended?**

  - Vaginal douching may cause irritation of the mucosal lining making it more vulnerable to infection and may facilitate the transmission of HIV and transmission of HIV to others.
- 💧 **What should we tell our patients about self-treatment for sexual dysfunction?**

  - Some commonly marketed drugs for sexual dysfunction, not provided by a doctor may be counterfeit and harmful to your health.
  - May have interaction with hormones in transgender. <sup>1</sup>
  - Interactions with recreational drugs, e.g. ecstasy, poppers
  - May interact with OI treatment and ARVs
  - Some drugs that help maintain erection will make retarded ejaculation worse

<sup>1</sup> Discussed in Reproductive Health module

## Positive Health: Prevention in Care

### MODULE: 3

## Positive sexual health

### Positive sexuality

Positive sexuality addresses the right of HIV positive people to have sex and supports transmission risk reduction.

#### **“Shared Responsibility” and prevention**

HIV transmission risk reduction is a shared responsibility. “Shared responsibility” means sharing of responsibility for safe sex between all people (regardless of HIV status).

### Shifting the focus of prevention

It is important that prevention in care activities refocus on the needs and benefits to health of the infected individual, as well as addressing the responsibility to protect the community.

Individuals who are frequently subjected to social discrimination and who engage in stigmatized practices such as sex workers, substance users and individuals with diverse sexual orientation may respond better to transmission risk reduction messages that emphasize personal health benefits rather than messages that preach “social responsibility”.

A far more effective message may emphasize the health benefits to the individual.

“Now that you have HIV it is really important that you take care not to bring other infections into your body. Look after yourself and in doing so you also look after the health of others.”

### Ask Screen Intervene

It is recognized that it is difficult to sustain enduring risk reduction practices over time. It is therefore critical that we routinely and frequently assess risk behavior across clinical visits. Providers need to fully understand the challenges an individual patient confronts when trying to implement transmission risk behaviors.

Behavior change interventions related to risk reduction should not be reliant on simple information provision. Interventions need to address issues related to sexual identity, HIV-related sexual dysfunction, discrimination, fear of rejection and lack of knowledge that all contribute to PLHIV finding it difficult to engage in transmission risk reduction. It is therefore important that we routinely assess our patient’s risk situation.

Many questions confront individuals who are living with HIV. These include:

- ◆ “Can I ever have a satisfactory relationship with a partner who is HIV negative?”
- ◆ “How do I minimize the risk to my sexual partners but still enjoy sex?”
- ◆ “What effect can STIs have on my health?”
- ◆ “We are both HIV positive, so is it ok not to use condoms?”

Many HIV positive individuals can and do have healthy and satisfying sex lives.

### Infected and still at risk

It is essential that PLHIV understand that having unprotected sex or sharing injecting equipment may continue to expose them to risk of infections that are harmful to their health. Specifically, providers should discuss HIV coinfection and reinfection.

1. Coinfection, or infection with more than one HIV viral strain at or near the same time, is believed to occur around the time of initial infection.
2. Reinfection with a different strain, also known as superinfection or serial infection, presumably takes place later on during early infection (the first few years of HIV disease, after seroconversion) or chronic (long-term) infection.

### Box3.1 An early Asian case study

A report in the *Journal of Virology* in August 2005 drew attention to possible HIV reinfection in two injection drug users (IDUs) from Thailand (one female, one male). The woman was initially diagnosed with HIV subtype AE only, followed by detection of subtype B approximately two months later.

The man was apparently reinfected with subtype AE virus approximately six to ten months after his primary diagnosis with subtype B virus. Neither individual was being treated for HIV during the study period.

*Source:* Ramos, A. Intersubtype human immunodeficiency virus type 1 superinfection following seroconversion to primary infection in two injection drug users. *Journal of Virology* 76(15):7444-7452. August 2005

### Coinfection, Reinfection and Acute HIV infection: Are they related?

**Box 3.2** Theoretically, any apparent case of reinfection could be a case of coinfection in which one of the coinfecting strains remains undetectable until it emerges sometime after seroconversion (the point at which HIV antibodies can be detected and a person can be diagnosed as being HIV positive). This is sometimes called sequentially expressed coinfection.

The testing limitations that we discussed under "Acute Infections" in Module 1 prevent detection of very small viral populations in the body and make it difficult to distinguish between coinfection

and reinfection. Researchers believe that until a source partner for dual infection is found and the timing of exposure confirmed, it is not possible to determine that the second virus was acquired after seroconversion.

While finding source partners (also known as contact tracing) is a continual problem, determining the timing of exposure is aided in some cases by the emergence of acute retroviral syndrome (often flu-like symptoms, including fever and fatigue) in the person presumed to be reinfected. It is not known whether overgrowth of a previously dormant coinfecting strain might also trigger acute retroviral syndrome

Source: Adapted from (Cheonis 2006)

### Patient education

The take home message is that individuals living with HIV need to adhere to HIV transmission risk reduction for the following reasons:

*Emergence of drug resistant subtypes:* Incorrect ARV use may lead to the significant emergence of drug-resistant subtypes that may be transmitted in the population and responsible for super-infections.

*Transmission of drug resistance:* Acquiring a drug resistant viral strain could increase the likelihood of losing a response to antiretroviral therapy. For example, if person "A" has an HIV type that has been responsive to therapy and person "B" has an HIV type that hasn't, passing that type of HIV from "B" to "A" will make it harder to treat person "A", possibly making therapy ineffective in person "A" as well.

*Normal CD 4 and undetectable viral load:* It is important the individuals understand that having either "undetectable viral load" or "normal range-CD4 counts" does not mean that individuals cannot infect others and that using these test results is an unreliable way to make decisions about the kind of sex they engage in. Whilst there is a lower risk if the viral load is undetectable this is not "no risk".

People responding well to treatment can still have sudden viral surges caused by stress, influenza or general poor health.

### Understanding individual risk practices

Different sexual and injecting practices are associated with different levels of HIV and other sexually transmitted infections (STI) and transmission risk. It is important that providers communicate specific information to patients so that they have the opportunity to choose to engage in practices with low transmission risk.

When we have the opportunity to work directly with patients in a face-to-face context, we also need to explore and discuss the context in which the behaviors occurs (e.g. mutual masturbation may be generally considered to be a low risk sexual activity, however within certain contexts or sequence of events the transmission risk may be increased). Generally information should be specific to a broad range of sexual and injecting behaviors and where possible target the specific affected population (e.g. HIV positive transgender).

Often providers fail to consider prevention education with positive women engaged in same-sex relationships. Whilst female to female sexual activities including oral-genital sex are low risk for HIV transmission they still place the women at risk of contracting or transmitting STI. Further, women engaged in same sex relationships may also engage in sex work with male partners, have concurrent male partner (e.g. husband and have unprotected sex with those partners). Women who have same sex relationships may also transmit HIV to others if they share injecting equipment or rely on insemination of donor semen to become pregnant.

### Non-sexual transmission of blood borne infections

We also need to be careful and clear in our style of communicating advice to patients. Too often injecting drug users are advised to use their own needle and syringe however this message fails to fully acknowledge the risks associated with using your own syringe to “draw-up” from a common drug source or container.

Remember that a shared source of hormones and/or injecting equipment will increase the risk of infection among transgender patients.

### STIs and positive living

Many patients and health workers have become complacent about STIs.

There is a need for HIV positive patients to understand that having an STI increases the viral load in semen or vaginal fluids. The discharges associated with gonorrhoea, for example, have been shown to contain high levels of HIV. This can result in the semen, pre-ejaculate fluid (pre-cum) and rectal mucus of an HIV positive individual with gonorrhoea containing more HIV, therefore creating a higher transmission risk. Also, bleeding from genital sores associated with some STIs may make it easier for blood to be exchanged during sex. This means the individual is more likely to pass on HIV during this time as there will be a greater amount of the virus present in these fluids.

In situations where both individuals have HIV it is important providers discuss the benefits of condom use to protect against STI, and reinfection. This is particularly important when there is the possibility that either partner has other sex partners, or if one partner is already on ART.

Whilst STIs are generally treatable, STIs may be more difficult to treat when the individual has HIV. How long STIs take to clear, and the impact that they have on the immune system may be dependent on the health of the individual's immune system. Some opportunistic infections (OIs) such as cytomegalovirus (CMV) and Kaposi's sarcoma (KS) rare related to STI and can be difficult to treat in advanced HIV infection. In people with AIDS, Kaposi's sarcoma is caused by an interaction between HIV, a weakened immune system, and the human herpes virus-8 (HHV-8). Kaposi's sarcoma has been linked to the spread of HIV and HHV-8 through sexual activity. Infectious CMV may be shed in the bodily fluids of any previously infected person sexually or after close contact through saliva (kissing), blood, tears, semen, cervical secretions, urine or also breast milk. Complications for infants with congenital CMV, especially from mothers who become infected or have a recurrence during pregnancy, are associated with problems at birth and serious consequences later in life such as hearing loss, blindness, epilepsy, and varying degrees of mental retardation.

### Key Messages about STI

- ◆ STIs can make it hard for your body to fight HIV. When you have HIV it is even more important for you to have regular STI check ups. Let your HIV doctor know what STI medications you are taking.
- ◆ If you have multiple partners have a check-up every three months. You can have an STI without having symptoms!
- ◆ Having an STI can put you at greater risk giving it to others.
- ◆ DO NOT ENGAGE IN SELF-TREATMENT! Specific drugs are needed for specific STIs. Therefore, only a trained STI doctor will know what medication is right for you and your condition. There are a lot of counterfeit drugs available in shops and pharmacies. Buy from a hospital or clinic recommended by the doctor.
- ◆ Take your STI medication for the entire course even if your symptoms disappear. Otherwise, your STI may come back. Also, take the medication in the correct dose, in the correct way, at the correct time.
- ◆ Find a way to tell your partners! If you are treated, but your partner is not treated and you have sex with them, you are at risk of getting the STI again (reinfection). Partner treatment is essential.
- ◆ Many STIs can be transmitted from mothers to babies and can cause serious health problems in the infant.

Hepatitis B (HBV) is more readily transmitted through sexual contact than HIV, and through tattooing and Hepatitis C (HCV) can be transmitted through sharing of injecting equipment and tattooing and it is also through sexual transmission. Hepatitis potentially causes liver disease, and complicates HIV treatment. All HIV positive individuals should be screened

to determine if they have HBV or HCV, and to assess immunity. Where individuals do not have any immunity to Hepatitis A (HAV) and HBV they should be offered vaccination under the supervision of their HIV clinician.

Injecting drug users who continue to share injecting equipment also risk contracting other such as syphilis and other blood borne viruses and bacteria that can be difficult to treat, complicate HIV treatment and generally adversely affect the individual's health.

### The positive sex worker and transmission

In many countries laws have been passed which are intended to prevent people with HIV from selling sex and these laws are frequently used against sex workers. However, such laws almost always drive HIV-positive sex workers away from the HIV Prevention, Testing, Counseling, HIV/STI Treatment and Support services which could help them to live well and safely. Where this is the case, such laws and policies are clearly counterproductive.

Positive sex workers need access to affordable reliable and supportive STI and HIV treatment and care. They may also need voluntary access to comprehensive prevention services for HIV infected injecting users. Often sex workers have limited financial resources and may need support in obtaining commodities such as condoms to assist them in preventing HIV transmission. Sex workers benefit from peer education on, initiating negotiating condom use with clients and strategies for engaging clients in sexual practices that are less likely to transmit HIV/STI. Sex worker peer educators are often able to offer context appropriate strategies that would be acceptable to both the sex worker and the client.

### Sexual dysfunction in HIV

*"I felt really aroused and started having sex, but I just lost it and the condom came off inside her" (PLHIV)*

*"I just couldn't cum (ejaculate) and so I withdrew and took off the condom...I don't think I will use a condom next time" (PLHIV)*

*"I just couldn't feel aroused and it hurts whenever my husband tries to have sex with me and use a condom" (PLHIV)*

This is a topic rarely addressed in peer groups, in health promotion or in clinical services and indeed there is little available research to guide us in developing appropriate intervention strategies. HIV positive men may have a greater risk of developing sexual dysfunction than HIV negative individuals. HIV positive individuals may experience higher prevalence of problems with arousal, maintenance of erection and difficulties with climaxing and ejaculation (retarded ejaculation). Whilst some of these sexual dysfunctions are related to the psychological issues related to living with HIV, others are related to biological factors such as androgen deficiency. Transgenders undergoing hormone therapy may be a significant risk of sexual dysfunction.

Some sexual dysfunctions may be iatrogenic for example individuals taking protease inhibitors (PIs) in their ART may experience higher than normal community prevalence of sexual dysfunction. Additionally, some PLHIV may take antidepressant medications especially serotonin reuptake inhibitors (SSRIs) have been noted to reduce sexual arousal. Using non-prescribed drugs or alcohol may also contribute to sexual dysfunction.

The psychological factors associated with sexual dysfunction in HIV include: preoccupation with the risk of transmitting to others, feelings of guilt and shame about HIV or sexuality and for some sex represents a constant reminder that they are living with a life threatening disease.

### Sexual dysfunction and transmission risk

The presence of a sexual dysfunction irrespective of whether it is psychological or physiological can make it difficult to engage in safer sex and specifically serves as a barrier to condom use.

Specific enquiries should be asked about sexual functioning. All HIV positive patients should be routinely asked if they are experiencing difficulties practicing safer sex.

### Assessment and treatment of sexual dysfunction

It is important health workers learn to assess and treat or refer to treatment these problems

as they have a significant impact on an individual's willingness or ability to use condoms, and engage in transmission risk reduction. It is also important that patients are specifically warned about the dangers associated with self treatment of sexual dysfunction. It is common for men who access illegal supplies of sildenafil (Viagra®) to do so as they often do not want to disclose that they have a sexual dysfunction to a health provider. Specifically, there are many counterfeit drugs available for purchase through non regulated supply outlets. These drugs may not only be ineffective, they maybe harmful to the individuals health. Also men need to also understand that sildenafil (Viagra®) is not a suitable treatment for some types of sexual dysfunction such as retarded ejaculation and in fact, taking it may exacerbate the disorder.

Patients should also be warned that drugs such as sildenafil (Viagra®) can interact dangerously with non-prescribed drugs such as nitrates, found in "poppers" and also with amphetamine-type substances (e.g., "ecstasy"). Sildenafil also interacts with ARVs (e.g., protease inhibitors and delaviradine) and thereby can increase its side effects, such as flushing and headaches.

### Sexual identity and Transmission risk behavior

*"My wife doesn't know about the men, I go out to parks and bars. I don't plan to have sex...no I don't take condoms. I don't really want to have sex with men...when I go out I don't I will have sex... but I just can't seem to help it..." Jo (PLHIV)*

Transmission risk is often related to comfort with sexuality. It may take along time for an individual to accept their sexual orientation and in the process they may not focus their attention on transmission risk reduction. Individuals who are in denial may not prepare themselves for sexual encounters. Others who are in the process of becoming more open

about their sexuality may feel so relieved that they no longer feel the need to hide their sexuality that they assert their “freedom” by having frequent unprotected sex with different partners. Similarly, somebody who is insecure with their sexual identity may be easily coerced into having unprotected sex, often because they are uncertain about their sexual attractiveness and sexual skill in same sex relationships. This is all compounded by feeling insecure about disclosing their HIV status.

These issues highlight the complexity of transmission risk reduction with positive individuals from MARPS. Clearly information provision is not sufficient.

### HIV-psychiatric related conditions and prevention

HIV related neuropsychiatric disorders are the result of direct or indirect effects upon the brain of HIV or from complications resulting from the individual’s immunosuppression, such as opportunistic infections or tumors. Such conditions include:

- ◆ Depression
- ◆ Personality change
- ◆ Psychosis
- ◆ HIV Mania
- ◆ Minor Cognitive /Motor impairment
- ◆ AIDS Dementia complex

Undiagnosed and untreated depression can result in the patient being unmotivated to meet challenges such as condom negotiation and may result in increased drug and alcohol use, which in turn may also result in reduced capacity to engage in safe behavior. It is important that health workers are able to recognize HIV mania and provide treatment. Individuals with HIV mania may become sexually uninhibited and engage in frequent transmission risk behavior. Individuals with AIDS Dementia complex may have difficulties planning for sexual contacts (preparing condoms in advance; negotiating condom use or even remembering that they have an infectious disease). Similarly, some patients with psychosis may not be aware they have an infectious disease or may simply not care about transmission. Fine motor skill loss may make it difficult to apply condoms.

### Routine assessment of transmission risk

In order to improve the health of HIV positive individual the provider needs to routinely assess the individual’s ongoing risk behavior. This routine assessment should be framed in terms of assessing the individual’s ongoing health and psychosocial welfare. It is important to assert that the questions relating to transmission risk related to trying to assist the individual maintain their health by reviewing their potential of acquiring infections, and protecting the health of their partners. These assessments should be conducted across the continuum of the individual’s clinical management (refer to T2.1 Case support planning form). This assessment tool will assist you to explore the patient’s adherence to transmission risk reduction and also to explore the challenges that confront the individual’s ongoing transmission risk.

After assessment, the provider’s job is to motivate and support patients in sustaining safe and healthy behavioral patterns. Supporting patients to recognize which behaviors leave them vulnerable to contracting infections and place others at risk is a critical element of HIV clinical care.

#### Applying “Ask Screen Intervene” to behavior change

**Ask** patients what are they doing to protect their sexual health?

**Screen** for barriers to adopting protective behaviors and assess patient readiness to change behavior.

**Intervene** Match intervention strategy to the patient’s readiness to change.

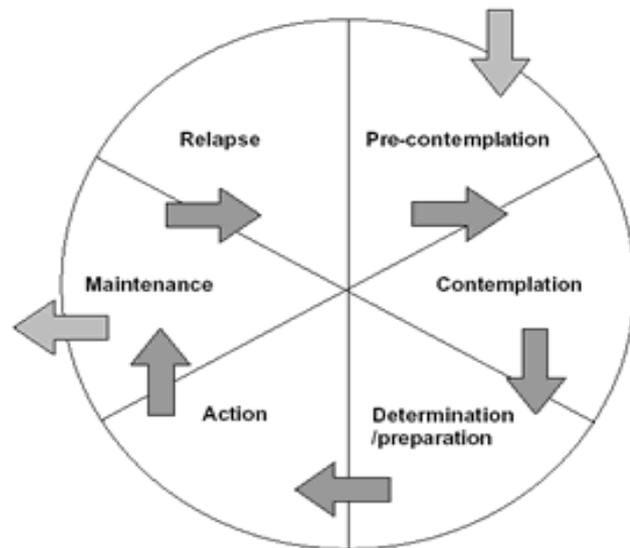
### Patient readiness for change

The patient’s readiness for change should guide your choice of intervention. Prochaska & DiClemente’s Trans theoretical model<sup>1</sup>, often called the stages-of-change model was designed to describe the stages people go through when changing behaviors. The stages described by the model are:

<sup>1</sup>Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*, 390-395.

- ◆ **Precontemplation** - when the person has no intention to adopt (and may not even be thinking about adopting) the recommended protective behavior;
- ◆ **Contemplation** - when the person has formed either an immediate or long-term intention to adopt the behavior but has not, as yet, begun to practice that behavior;
- ◆ **Preparation** - when there is a firm intention to change in the immediate future, accompanied by some attempt to change the behavior;
- ◆ **Action** - when the behavior is being consistently performed but for less than 6 months; and
- ◆ **Maintenance** - the period beginning 6 months after behavior change has occurred and during which the person continues to work to prevent relapse.

The stage of change model is represented below in figure 3.1



The stages-of-change perspective is important because it recognizes that people are at different stages of readiness when it comes to using condoms or making other changes. Individuals at different stages may be receptive to different types of intervention messages. Clearly, a different strategy is necessary when one is dealing with someone who has no intention of changing his or her behavior than when one is dealing with someone who intends to change but has not been able to act upon that intention. Similarly, someone who is trying to change but has not been able to consistently perform the protective behavior requires a different message or strategy than someone who is consistently performing the behavior. The stages-of-change model suggests that rather than viewing behavior as an “all or nothing” phenomenon, it is important to view behavior change in terms of a sequence of steps and that interventions should be tailored to the stage that an individual is in. An example of the various interventions that can be used in relationship to the “Stages of change” model can be located at the end of this technical brief.

## Matching the Intervention to the patient's stage of change

### Safer sexual behavior

STAGES OF CHANGE	STAGE SPECIFIC BEHAVIOR-CHANGE STRATEGIES		
<p><b>PRECONTMPLATIVE STAGE</b></p> <p><b>Patient sees no need to practice safer sex</b></p> <p>"There's no way I need to worry about safe sex"</p>	<p><b>Story-telling:</b></p> <p>Tell patient a "success story" that highlights similar obstacles to change and potential solutions</p> <ul style="list-style-type: none"> <li>✓ Another one of my patients...</li> </ul>	<p><b>Information giving:</b></p> <p>Specific to patient's situation</p> <ul style="list-style-type: none"> <li>✓ What do you know about...?</li> <li>✓ Would you be interested in knowing more about...?</li> </ul>	<p><b>Discuss impact of behavior on others:</b></p> <p>How behavior is negatively impacting on their health</p> <ul style="list-style-type: none"> <li>✓ How do you think infection with other types of HIV or STI may affect your health?</li> </ul>
<p><b>CONTEMPLATIVE STAGE</b></p> <p><b>Patient sees the benefits of practicing safer sex but is still hesitant to change</b></p> <p>"Yes, I worry about unsafe sex but..."</p>	<p><b>Explore ambivalence / Offer substitutes:</b></p> <p>Help patient's see why s/he is "on the fence"</p> <ul style="list-style-type: none"> <li>✓ It seems that you enjoy taking drugs but you are anxious that you have unsafe sex when intoxicated. What difference would it make not having to worry about this</li> <li>✓ Having this STI seems to have shocked you, have you thought about how to reduce the chances of this happening again?</li> </ul>	<p><b>Discuss pros &amp; cons:</b></p> <p>Explore the patient's costs and benefits of change:</p> <ul style="list-style-type: none"> <li>✓ What for you are the good and bad things about using condoms</li> </ul> <p><b>Offer substitutes:</b></p> <p>Harm reduction options</p> <ul style="list-style-type: none"> <li>✓ E.g. not mix alcohol / drugs and sex</li> </ul>	<p><b>Discuss behavior in relation to self-image:</b></p> <ul style="list-style-type: none"> <li>✓ Working to help your family / get an education is great but how can you do these things if you get sick?</li> </ul> <p><b>Increase self-efficacy:</b></p> <ul style="list-style-type: none"> <li>✓ You gave up smoking so it seems you can make difficult changes...</li> <li>✓ What is the difference between the times you use condoms and when you don't?</li> </ul>
<p><b>DETERMINATION / PREPARATION STAGE</b></p> <p><b>Patient is ready to practice safer sex and may already be trying safer sex.</b></p> <p>"I want to prevent reinfection with HIV and infection with STI."</p>	<p><b>Getting started / Planning:</b></p> <p>Help the patient to plan to accomplish the behavior change</p> <ul style="list-style-type: none"> <li>✓ E.g. Patient aims to buy or obtain free condoms and carry them</li> <li>✓ Patient has a supply of condoms and water-based lubricant</li> </ul>	<p><b>Build self-efficacy, confidence, practice skills and establish a first step:</b></p> <ul style="list-style-type: none"> <li>✓ Patient demonstrates putting a condom on a model correctly</li> <li>✓ Role play practicing asking partners to wear condoms</li> </ul>	<p><b>Support and referral:</b></p> <p>Increase access to prevention tools and services by referral</p> <ul style="list-style-type: none"> <li>✓ Provide information on where free condoms and water-based lubricant are available</li> <li>✓ Refer patient to relevant support group</li> </ul>
<p><b>Action</b></p> <p><b>Patient is implementing safer sex</b></p> <p>"I carry and use condoms"</p>	<p><b>Continued support:</b></p> <p>Counselor, friends</p> <ul style="list-style-type: none"> <li>✓ Role play asking for condoms in different situations</li> <li>✓ Supply of condoms and water-based lubricant</li> </ul>	<p><b>Find substitutes:</b></p> <p>When partners refuse condoms</p> <ul style="list-style-type: none"> <li>✓ Negotiate for and practice sexual behaviors that reduce risk of infection</li> </ul>	<p><b>Follow-up:</b></p> <p>Follow-up on patient's experiences</p> <ul style="list-style-type: none"> <li>✓ Acknowledge successes.</li> <li>✓ Problem solve where difficulties still exist</li> </ul>
<p><b>MAINTENANCE STAGE</b></p> <p><b>Patient anticipates triggers for relapse and coping strategies</b></p> <p>"I can anticipate what may happen and prepare myself accordingly."</p>	<p><b>Recognizing relapse as part of change process:</b></p> <p>Assist patient in identifying possible "triggers," which lead to a lapse in safer behavior and how s/he may cope with these.</p> <p><b>Identifying rewards:</b></p> <p>For maintaining change</p>	<p><b>Find substitutes:</b></p> <p>When condoms are not readily available or partners refuse their use</p> <ul style="list-style-type: none"> <li>✓ Negotiate for and practice sexual behaviors that reduce risk of infection</li> </ul>	<p><b>Identify supports:</b></p> <p>Help patient identify peer support</p> <ul style="list-style-type: none"> <li>✓ Who has experience and can help you practice negotiating with difficult clients?</li> </ul> <p><b>Become a role model:</b></p> <p>Help patient become a role model of change for peers</p>
<p><b>RELAPSE</b></p> <p><b>Patient may have had a time when they didn't use a condom</b></p> <p>"I forgot to use a condom this time but..."</p>	<p><b>Recognizing what lead to relapse:</b></p> <p>Help patient identify and understand circumstances that led to lapse</p>	<p><b>Highlight triggers/barriers to lapse:</b></p> <p>Review plan and encourage confidence that they are able to commence safer sex again</p>	<p><b>Review &amp; modify plan:</b></p> <p>Identify what has worked and what has not</p> <ul style="list-style-type: none"> <li>✓ A lapse doesn't mean failure it means that we just need to review</li> </ul>
<p><b>TERMINATION</b></p>	<p><b>Patient is 100% confident in all trigger situations.</b></p> <p><b>Congratulate the patient and again remind him or her that you are available for continued follow-up</b></p>		

Adapted from *Readiness for Change Tool: What to do with patients at risk of HIV and STIs*. (2006) South Eastern Sydney ILLAWARRA, NSW Health

## All teams members can contribute to ensuring clients/patients look after their health and the health of others.

### Nurses/counselors

- ◆ Regular assess patients capacity for the individual to engage in transmission risk reduction;
- ◆ Explore and address barriers to risk reduction including the presence of HIV related sexual dysfunctions;
- ◆ Review the patient for psychological issues such as poor self esteem, drug and alcohol use, or HIV related psychiatric disorders that may impair capacity to engage in safe behaviors.
- ◆ Offer or refer to counseling for psychiatric follow-up where required.

### HIV physicians

- ◆ Assess HBV vaccination status and where appropriate offer vaccination and post vaccination check-up.
- ◆ Routinely screen for/ and treat STIs;
- ◆ Screen for treatment resistance and review history of unprotected sex with partners;
- ◆ Screen and treat sexual dysfunctions;
- ◆ Screen drug and alcohol use and gain patient concurrence for referral to manage drug or alcohol dependency.
- ◆ Offer basic oral-dental health care services as many infections can be transmitted through oral sex. The importance of oral health in both the transmission of infections, and the maintenance of health in HIV is further discussed in Module 6.

### Positive peer support groups

- ◆ Provide support to peers in attending routine HIV and STI checkups. Offer "treatment buddies"
- ◆ Encourage discussion about sexual dysfunction and discuss the relationship to transmission; and also the dangers posed by self treatment with drugs purchased in streets, or over the internet.
- ◆ Recognize and refer peers who exhibit signs and symptoms of psychological disturbance for assessment.

- ◆ Peer sex workers share success stories on client condom negotiation and how to negotiate for alternate lower risk types of sexual activities.

## Positive sexual health

### Activity Instructions

1. Organize yourselves into groups of three (triads). Each triad is to comprise of a “provider”, “patient” and “observer”. Everyone will have a chance to be the “provider”, “patient” and the “observer” in one of three rounds of role-plays.



2. All members of the triad will read each case study at the beginning of each round of role-play.
3. The roles of the “provider”, “patient” and the “observer” are as follows:

#### Provider:

Your task is to identify the following in your patient:

- ◆ What are the patient’s sexual health issues?
- ◆ What is the patient’s readiness (stage of change)?
- ◆ What are the appropriate interventions?
- ◆ What are the patient’s referral needs?

#### Patient:

Your role is to play the patient in a realistic way and to ask questions that require the provider to explain information to you.

#### Observer:

You are to observe the role play without interruption and specifically to look at the following points:

- ◆ How well the provider identifies the patient’s sexual health issues.
- ◆ How well the provider addresses these issues.
- ◆ How well the provider is able to identify the stage of change.
- ◆ How well the provider used the tools to facilitate the patient’s understanding.
- ◆ How well the provider came up with strategies to motivate behavior change.
- ◆ How well the provider identified the patient’s referral needs.

4. A maximum of twenty minutes will be allowed for each role-play.
5. At the conclusion of each round of the role play the triad is to debrief each other (**10 minutes**).

### Case study 1

You are a HIV positive female sex worker. You frequently have STIs but have not gone to the STI clinic. You do not think STIs are very important as they are curable and you usually get some pills from the market. You are not using condoms with your HIV positive boyfriend as you do not see it is necessary. Condoms are not used in oral sex with clients and are used in vaginal sex only if the client requests their use.

### Case study 2

You are a HIV positive MSM and you have a negative male partner. You do not understand why you should use condoms with your regular partner since your viral load was “undetectable” on your last visit to the clinic. You also discuss that you do not like using condoms because you have problems in maintaining an erection and you find this embarrassing. You tell the provider that you found out you can get some Viagra on the internet and maybe this can help.

### Case study 3

You are a HIV positive male and you have a wife at home and have not told her you are HIV positive. You do not want to tell your wife you have HIV as you believe she will find out you have sex with men. You have an STI at the moment and have bought some medication from the pharmacy. You will take the medication so there is no need to tell your wife about the STI.

Take your STI medication for the entire course even if your symptoms disappear. "Correct dose – at the correct time in the correct way". Otherwise, there may not be enough of the drug in your body to fight the STI and then STI may come back.

- Your partner(s) needs to be treated as well as you. If telling your partner(s) is difficult so talk to your counselor about how to tell them.
- Let your HIV doctor know what medications you are taking and let your STI doctor know about the HIV medications you are taking.

### STIs and Pregnancy and HIV

- The consequences of an STI can be significantly more serious, even life threatening, for a woman and her baby if the woman becomes infected with an STI while pregnant.
- STIs can be passed from a pregnant woman to the baby before, during, or after the baby's birth. Some STIs (like Syphilis) cross the placenta and infect the baby while it is in the uterus (womb). Other STIs (like Gonorrhea, Chlamydia, Hepatitis B, and Genital Herpes) can be transmitted from the mother to the baby during delivery as the baby passes through the birth canal.
- A pregnant woman with an STI may also have early onset of labor, premature rupture of the membranes surrounding the baby in the uterus, and uterine infection after delivery.

- The harmful effects of STIs in babies may include stillbirth (a baby that is born dead), low birth weight, conjunctivitis (eye infection), pneumonia, neonatal sepsis (infection in the baby's blood stream), neurologic damage, blindness, deafness, acute hepatitis, meningitis, chronic liver disease, and cirrhosis.

In Thailand women who are diagnosed with an STI during pregnancy may be offered a caesarian birth (C-section) to reduce the chance of the baby being infected during delivery.

If you would like an STI check-up ask your HIV doctor to refer you to a service that has expertise working with STIs in people who also have HIV.



## Sexually transmitted infections (STIs), HIV and your health



M03 - T3.1

### How do STIs affect my health when I have HIV?

If you are already HIV-positive, an STI increases your ability to transmit HIV. STIs can increase the amount of HIV (viral load) in the semen and vaginal fluids of a person living with HIV, even while HIV remains undetectable in your blood. (Viral load testing is usually measured in blood). STIs can also potentially increase your chances of "superinfection" with HIV (being infected with a different strain of the same virus you already have) which would make management of your HIV more difficult.

Having both HIV and an STI can make it more difficult to treat your STI, as it can drive up your viral load (a measure of the amount of HIV virus in your blood). It can make it difficult for your body's immune system to fight the STI, and it can increase the chances of getting serious complications such as cancer or lesions. Many STIs are curable, but they can have serious temporary or permanent health consequences for people living with HIV if they remain undiagnosed and untreated.

### How do I know if I have an STI?

You can have a sexually transmitted infection (STI) without knowing it. Although many people do not show signs of STI, some common symptoms are the following:

- Itching, burning, or discharge** from the penis, anus or vagina are the most common symptoms of STIs.
- Rashes or bumps** anywhere on the body, that may or may not itch or be painful, can also be symptoms of an STI. If you have an STI in your throat, you may not have any symptoms.

Some STIs, such as syphilis or gonorrhea, can get in your throat when you perform oral sex on someone without using a latex barrier (such as a condom). Infections can be passed from his or her mouth or throat to your body. The infection can enter the urethra (the tube in your penis) or in through the vagina and infect you causing sores/ ulcers. It is important remember that you may not have any noticeable symptoms of these infections gonorrhea in the throat can be detected by a doctor or nurse taking a swab of your throat and checking it for the infection, and syphilis is diagnosed by a special blood test.

Because STIs can have few symptoms, sexually active people should get an STI check-up every three to six months, as this is the only sure way to know if you have an STI. By getting regularly tested for STIs, you will know if you have an infection, and you can then get the STI treated as soon as possible.

### How can I protect myself?

Some people think that they can save more money by not using condoms but you never can be sure who is infected with STI. You may end up spending more money on STI treatment than you save by not using condoms.

Remember: Using condoms will help sexually active people reduce, but not eliminate, the risk of infection.

Condoms do not cover everything!



### What would an STI check-up involve?

A blood test alone will not detect all STIs; discuss your sexual practices with the nurse or doctor to ensure that you receive a thorough check-up. STI check-ups could involve:

- Talking about your sexual history

The doctor or nurse will ask you some questions about your sexual practices to find out which parts of your body may have been put at risk for an STI (e.g. penis/vagina, anus or throat etc). This helps them decide what tests and/or physical examinations are needed. Some diagnostic tests and other examinations could include:

- A blood sample to check for HIV, syphilis and immunity to hepatitis A and B.
- A urine sample or swab of the fluid from your penis or vagina to check to check for Chlamydia.
- If you have anal sex then a swab of your anus to check for Chlamydia and Gonorrhea (a swab is like a cotton bud you would use to clean inside your ears).
- A swab of your throat to check for gonorrhea.
- A physical examination to check for crabs, scabies, warts, syphilis and herpes.

If you have symptoms you may be offered different tests.

### Some important things to consider about STI treatments.

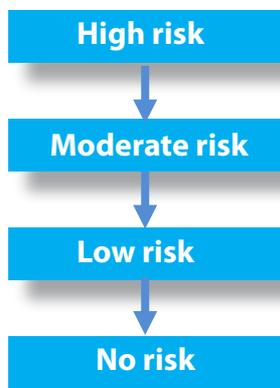
- DO NOT ENGAGE IN SELF-TREATMENT!** - Specific drugs are needed for specific STIs. Therefore, only a trained STI doctor will know what medication is right for you and your condition.



## Practitioner’s guide to HIV & STI transmission

The four principles of HIV transmission can help providers and patients assess the level of risk of different sexual practices for HIV infection. In order for HIV transmission to occur, all four principles of HIV transmission are needed.

- E EXIT** – the virus must **exit** the body of an **infected** person
- S SURVIVE** – the virus must be in conditions in which it can **survive**
- S SUFFICIENT** – there must be **sufficient** quantities of the virus present to cause infection
- E ENTER** – the virus must **enter the bloodstream** of another person



Sexual practices can generally be assessed as “high risk,” “medium risk,” “low risk,” and “no risk.” The level of risk, however, can vary with the context and manner in which behaviors occur.

While the risk for HIV transmission may be low for some practices, there may still be a risk of infection with other sexually transmitted infections

MODULE 03

### Sexual Practices

- ❖ **Deep kissing** -No risk for HIV.
  - Exit:* Minute amounts of HIV are found in the saliva of a person infected with HIV.
  - Sufficient:* Saliva contains insufficient amounts of HIV for transmission.
  - Survive:* Saliva is alkaline, so if HIV comes in contact with the saliva of a non-infected person, it will be destroyed.
  - Entry:* Only possible risk is through bleeding sores in the mouth, however kissing would be unlikely under this circumstance.

STI risks include

- Human papilloma virus (HPV)
- Oral herpes
- Gonorrhea
- Hepatitis A and B
- Molluscum contagiosum
- Syphilis

Viruses and bacteria can be transmitted through kissing. Red, fleshy, waxy-looking and pus-filled lesions present around the mouth may indicate an STI.

- ❖ **Licking** - No to low risk for HIV.
  - Exit:* The saliva of a person infected with HIV contains a minute amount of HIV. [HIV may exit an open wound on the skin].
  - Sufficient:* The amount of HIV in saliva is insufficient for transmission. [Blood from the wound can contain a sufficient quantity of HIV for transmission.]



*Survive: The minute amount of HIV in saliva cannot survive when exposed to air. [HIV cannot survive for a long period when exposed to the air. The saliva from the person licking may also help to destroy any HIV.]*

*Entry: Licking unbroken skin provides no entry for HIV. [There is no entry unless the person licking has sores on tongue, lips, or gums.]*

STI risks include

Gonorrhea  
Chlamydia  
Syphilis  
Herpes  
HPV and warts  
Parasites

Viruses and bacteria can be transmitted if the tongue contacts the mouth, urethra, or anus, through kissing. If these areas are not licked, there is no risk. A dental dam (a flat latex sheet) or ordinary plastic wrap can reduce the risk of exposure during oral to anal or oral to genital licking.

❖ **Frottage (genital to genital rubbing) - No risk for HIV.**

*Exit: There may be exit of HIV if genital to genital rubbing leads to orgasm.*

*Sufficient: In this case there would be sufficient quantity for infection to occur.*

*Survive: HIV can survive for limited time outside of the body.*

*Entry: There will be not entry unless there are cuts or sores or ulcerative STI in the genital area.*

STI risks include

Pubic lice ("Crabs")  
Syphilis  
Genital herpes (HSV)  
Scabies  
HPV and anogenital warts  
Parasites

If frottage is done while wearing clothes, there is no risk for spreading or contracting the viruses, but there is a risk for "crabs" and scabies. Syphilis, HSV and HPV may be transmitted through direct contact.

❖ **Mutual masturbation. Risk to either partner? - No to low risk depending on context and behavior**

*Exit: HIV may exit with ejaculation from masturbation*

*Sufficient: With ejaculation there is sufficient quantity for transmission.*

*Survive: Depending on the context, HIV may be able to survive.*

*Entry: If ejaculation takes place near the anal or genital openings, risk increases*

STI risks include

Syphilis  
HPV and HBV

STIs can be transmitted while masturbating a partner if semen enters a wound on the hand. It is advisable to keep semen away from open skin. The skin and the hands and fingers should be examined before masturbating a partner.

❖ **Anal stimulation with fingers – No to low risk for HIV.**

*Exit: There is no exit as long as the skin of the fingers and anus is intact (no wound).*

*Sufficient: If there is a wound there is sufficient quantity of HIV in blood for infection.*

*Survive: HIV can survive in the mucosal tissue of the anus.*

*Entry: There is no entry as long as the skin of the fingers and anus is intact (no wound).*

STI risks include

STI risks are primarily related to contact with feces but other can also be transmitted and include.

Hepatitis A, B, and C

Parasites (intestinal protozoa; e.g. Giardia lamblia, Entamoeba histolytica, Cryptosporidium parvum; spread by fecal-oral transmission)

Syphilis

Herpes

HPV and genital warts

Gonorrhea

Chlamydia

Others

As long as the skin of the fingers and anus is intact (wound free), there is little risk associated with finger-to-anus stimulation. If the fingers are cut or the anus torn, this method of stimulation is not advised. The above mentioned STIs can be spread through blood, semen, and body fluid.

The hand used for anal stimulation should be kept away from the mouth and genitals and should be washed afterwards to minimize the chance of spreading infections.

- ❖ **Using drugs (non injecting) prior to sex** – Moderate to high risk for HIV and STI  
*Using drugs prior to sex make a person less likely to remember to practice safer sex. Substance use will also affect motor skills, making it more difficult to use condoms correctly.*
- ❖ **Using alcohol prior to sex** – Moderate to high risk for HIV and STI  
*Using alcohol prior to sex makes a person less likely to remember to practice safer sex. Alcohol use will also affect motor skills, making it more difficult to use condoms correctly.*
- ❖ **Sharing syringe/needle** - High, , also risk for STIs, especially HCV and HBV  
*Exit: HIV can exit a person infected into the needle and syringe*  
*Sufficient: There may be sufficient quantity of HIV in blood remaining in the needle or syringe.*  
*Survive: HIV can survive in the needle and syringe*  
*Entry: Use of contaminated needles and syringes can facilitate the transmission of HIV directly into the blood stream (drugs commonly injected directly into the blood)*

STI risks include

Hepatitis B and C

HBV and HCV can survive for long periods outside the body. Needles and syringes should be sterilized using full strength bleach (5.25% hypochlorite). This should destroy HIV after 30 seconds. However, in order for bleach to kill hepatitis B that might be in the syringe and/or cooker, the bleach must be left in the syringe and cooker for at least two (2) full minutes. It is uncertain whether bleach kills Hepatitis C, even after two (2) minutes.

❖ **Tattooing**

*Requires further information on method and context of tattooing. If traditional tattooing is done, using a pipette, as used in Buddhist temples, then there may be high risk due to the drawing of blood and the practice of tattooing more than one person in the same sitting. All four principles of transmission would apply. Other forms of tattooing will depend on whether the needles are changed or cleaned.*

STI risks include

HBV and HCV

There is also the risk of HBV and HCV depending on whether the needles are reused and cleaned. HBV and HCV may also be transmitted through the ink if it has come in contact with a contaminated needle.

- ❖ **Oral-Anal Sex** - *No risk for HIV. Risk of Hepatitis A virus if contact with fecal matter. Possible risk of Hepatitis B Virus. Risk of papilloma virus if warts are present.*

*Exit: No exit of HIV unless penetrative sex took place before oral-anal sex*

*Sufficient: There may be sufficient quantity if there was bleeding from penetrative sex.*

*Survive: HIV can survive in the anus.*

*Entry: There will be not entry unless there are sores in the mouth*

STI risks include

- Parasitic infections
- Hepatitis A, B, and C
- Syphilis
- HPV and anogenital warts
- Genital herpes
- Gonorrhea
- Chlamydia
- Molluscum

If possible, the anus should be examined for signs of STIs and for injury. These signs include lesions, sores, bumps, tears, redness, blood, and irritation. It is advisable to avoid licking an anus that bears any of these signs. Open skin increases the chance for transmitting STIs. All but HIV and hepatitis B and C can be contracted from skin that is intact. The skin of a healthy anus is pink, intact, and lesion free.

STIs common associated with oral-anal sex are hepatitis A and parasitic infections. Because hepatitis A is usually transmitted through oral exposure to feces, it can still be transmitted when skin is intact. Persons who practice oral-anal sex are advised to get hepatitis A and B vaccinations. There is currently no vaccine for hepatitis C. It is recommended that the anal region be washed thoroughly before oral-anal sex.

- ❖ **Oral-Penile Sex (mouth to penis).** *Without condom. Risk to either partner? - Low to moderate risk for partner using mouth; no risk to man putting his penis in the partner's mouth for HIV.*

*Exit: There is exit of HIV in the pre-ejaculate and semen of a penetrating partner.*

*Sufficient: The quantity of HIV is sufficient for transmission*

*Survive: HIV can survive for some time in sufficient quantities. Small quantities may be destroyed by the receptive partner's saliva.*

*Entry: There may not be direct entry into the blood. Entry may occur through sores in the mouth (gums and mucosal tissue).*

STI risks include

- Gonorrhea
- Chlamydia
- Genital herpes
- HPV and anogenital warts
- Hepatitis A, B and C
- Molluscum
- Syphilis

STIs are transmittable in the fluid that exits the penis just before ejaculation. If STIs are suspected, or if the health status of the partner is unknown and a condom is not available it is advisable to withdraw the penis before ejaculation. This can significantly reduce the spread of disease.

Care should be taken to keep the skin and gums of the mouth intact and free from bleeding. Partners are advised to postpone oral sex for several minutes following brushing or flossing, as both can irritate the gums.

If a lesion, open wound, or pus is found on the penis, it is better to keep it out of the mouth as they may be signs of STI. Avoiding genital herpes, genital warts, and molluscum is harder because there are often no lesions and the lesions can be difficult to see. For example, molluscum often affects the pubic area and may be hidden beneath hair. Oral contact with these lesions, whether they are visible or not, can lead to infection.

- ❖ **Oral-Penile Sex (mouth to penis). With condom. Risk to either partner?** - *Low to no risk for partner using mouth; no risk to man putting his penis in the partner's mouth for HIV.*

*Exit: There is exit of HIV in the pre-ejaculate and semen of a penetrating partner.*

*Sufficient: The quantity of HIV is sufficient for transmission*

*Survive: HIV can survive for some time in sufficient quantities.*

*Entry: There is not entry with the proper use of a condom.*

STI risks include

Syphilis

Genital herpes

HPV and anogenital warts

Molluscum

Proper use of a condom that does not break eliminates the risk of STI transmission as long as the base of the penis and pubic area are avoided. It is important to avoid dental work while using a condom, as teeth, rough edges on fillings and braces can tear the latex.

- ❖ **Oral-Vaginal Sex (mouth to vagina) With / without barrier. Risk to either partner?** - *Low to moderate for partner using mouth; no risk to woman for HIV.*

*Exit: There is exit of HIV in the vaginal fluid of the woman.*

*Sufficient: The quantity of HIV is sufficient for transmission*

*Survive: HIV can survive in the vagina.*

*Entry: There may not be direct entry into the blood. Entry may occur through sores in the mouth (gums and mucosal tissue).*

STI risks include

Hepatitis B

Syphilis

Genital herpes

Syphilis and genital herpes be transmitted if a chancre and lesions are present on the receptive partner.

- ❖ **Anal Sex (penis-to-anus penetration) with condom** - *Low risk*

*Exit: HIV can exit through anal bleeding of the receptive partner.*

*Sufficient: There is sufficient quantity of HIV for transmission.*

*Survive: HIV can survive in the anus*

*Entry: Small tears may occur in the penis during anal intercourse, facilitating the transmission of HIV. The penetrating partner will be at higher risk if they have an untreated STI. Improperly treated STI may also facilitate transmission of HIV through weakened mucosal tissue in the urethra.*

STI risks include

HPV and anogenital warts

Genital herpes

Syphilis

Wearing a condom significantly reduces the risk of exposure to HIV, gonorrhea, Chlamydia, and hepatitis B and C if used properly. If a condom rips during anal intercourse, the penis should be withdrawn and the condom replaced. Condoms should be worn prior to penis-to-anus contact.

Wearing two condoms to maximize protection actually increases the likelihood that one or both condoms will rip. Oil based lubricants are not suitable lubricants because they destroy latex. The lubricant should be water-based.

Receptive partners should keep one hand on their partner's penis during the initial penetration to ensure that the condom is on. One partner should grasp it during withdrawal to make sure that it does not slip off in the anal canal or rectum.

❖ **Anal Sex without condom, no ejaculation - High risk**

*Exit: HIV can exit through anal bleeding of the receptive partner.*

*Sufficient: There is sufficient quantity of HIV for transmission.*

*Survive: HIV can survive in the anus*

*Entry: Small tears may occur in the penis during anal intercourse, facilitating the transmission of HIV. The penetrating partner will be at higher risk if they have an untreated STI. Improperly treated STI may also facilitate transmission of HIV through weakened mucosal tissue in the urethra.*

STI risks include

- HPV and anogenital warts
- Chlamydia
- Genital herpes
- Gonorrhea
- Hepatitis A, B, C
- Syphilis

Some STIs produce lesions (sores) or a discharge that is noticeable on the penis or anus and some do not. Before anal intercourse, partners should examine one another's penis and anus for lesions, growths, or torn skin.

Some people believe that it is safe to have anal sex without a condom if they are taking antibiotics for an STI. This is not true. The risk for transmission of a bacterial STI persists until the course of treatment is completed. Antibiotics do not cure viral STIs such as HPV and HSV.

People with HIV should talk about their status with their partners and their partners should ask. HIV-positive people can contract new strains of HIV, which can worsen an existing condition and complicate treatment, especially if they acquire a drug-resistant strain of HIV. If both partners are truly HIV-uninfected (remembering that there is a window period for HIV tests), there is no risk of infection.

Before anal sex, the anus should be relaxed by massaging it with a liberal amount of water-based lubricant. This reduces the chance for tearing and bleeding. Anal sex, especially without lubricant can cause rips and lesions.

❖ **Anal sex without condom, ejaculation. Risk to receptive partner? - High risk**

*Exit: HIV can exit through semen of the penetrating partner.*

*Sufficient: There is sufficient quantity of HIV for transmission.*

*Survive: HIV can survive in the anus*

*Entry: Trauma (tearing) of the mucosal tissues is common in anal intercourse, facilitating the transmission of HIV.*

STI risks include

See **Anal sex without condom, no ejaculation**

❖ **Vaginal sex, without condom. Risk to either partner? – High risk for HIV for female partner, also risk of pregnancy. Medium to high risk for male partner.**

*Exit: Virus may exit through pre-ejaculate and semen*

*Sufficient: The quantity of HIV is sufficient for transmission*

*Survive: HIV can survive in the vagina*

*Entry: Entry is possible through tears in the mucosal tissue. Greater risk if STI is present*

STI risks include

Scabies  
Lice  
Genital Herpes  
Genital Warts  
Gonorrhea  
Hepatitis B and C  
Syphilis  
Trichomoniasis  
Chlamydia

Scabies and lice may be transmitted from one person to the other through skin and pubic hair contact. Herpes and genital warts may also be transmitted if sores and lesions are present on either partner. Most bacterial STIs as well as viral hepatitis B and C may be transmitted.

- ❖ **Vaginal Sex, with condom. Risk to either partner?** – *Low risk. Condoms must be used correctly and consistently and with appropriate lubricants.*

*Exit: HIV will be present in either the vaginal fluid or semen of an infected person.*

*Sufficient: There is sufficient quantity of HIV for transmission. .*

*Survive: HIV will be able to survive in either the vaginal fluid or the semen.*

*Entry: HIV will not enter either partner if condoms are used correctly and consistently.*

STI risks include

Scabies  
Lice  
Genital Herpes  
Genital Warts

Even with the use of a condom, scabies and lice through skin and pubic hair contact. Herpes and genital warts may also be transmitted if sores and lesions are present on either partner.

- ❖ **Withdrawal prior to ejaculation. Option for safer sex?** - *Low to moderate risk.*

*Exit: HIV may exit a person infected through pre-ejaculate*

*Sufficient: There is sufficient quantity of HIV in pre-ejaculate for transmission*

*Survive: HIV can survive in the vagina.*

*Entry: HIV may enter through tears in the mucosal tissue. Withdrawal is a poor option for safer sex as couple may forget to withdraw*

STI risks include

See **Anal sex without condom, no ejaculation**

- ❖ **Vaginal Sex, no condom but use of other birth control methods** - *High risk. Birth control methods other than condoms do not provide protection against HIV or STI.*

*Exit: There is exit of HIV in semen, pre-ejaculate, or vaginal fluid.*

*Sufficient: There are sufficient quantities of HIV in semen, in pre-ejaculate or vaginal fluid for transmission.*

*Survive: HIV can survive in the vaginal cavity*

*Entry: There can be entry of HIV into the blood through micro tears in mucosal tissue during sex.*

STI risks include

See Vaginal Sex without condom above.

- ❖ **Sex during menstruation, with / without condom.** – *Low risk with a condom, High risk without a condom*

*Exit: HIV can exit an infected person through semen or menstrual blood.*

*Sufficient: There is sufficient of quantities of HIV in menstrual blood and semen for transmission.*

*Survive: HIV can survive*

*Entry: No entry if a condom is use correctly; entry if no condom is used.*

STI risks include

See **Vaginal Sex without condom** above.

❖ **Sharing Injecting Equipment (e.g. swabs, water, mixing bowls) – Low risk for HIV**

*Exit: There is exit of HIV through blood in used needles and syringes.*

*Sufficient: Depending on the injecting practices, the quantity of HIV may be sufficient.*

*Survive: HIV will not be able to survive in minute quantities outside the body and in contact with different substances for long.*

*Entry: HIV is more likely to enter through blood remaining in the needle or syringe than from the equipment.*

STI risks include

Hepatitis B and C

HBV and HCV can survive for long periods outside the body. Injecting equipment should be sterilized using full strength bleach (5.25% hypochlorite). This should destroy and HIV after 30 seconds. However, in order for bleach to kill hepatitis B that might be in the syringe and/ or cooker, the bleach must be left in the syringe and cooker for at least two (2) full minutes. It is uncertain whether bleach kills Hepatitis C, even after two (2) minutes.

❖ **Sharing sex toys – Low to moderate risk.**

*More information is required on the type of sex toy and how they are used, e.g. whether the sex toy is washed or sterilized before sharing, etc.*

STI risks include

Hepatitis B and C

Others

HBV and HCV can survive for long period outside the body. If sex toys are shared one person after the other, then transmission of hepatitis can occur. Ideally, sex toys should not be shared. If shared, they should be sterilized using full strength bleach (5.25% hypochlorite) for at least two (2) full minutes.

❖ **Watersports – No to low risk for HIV infection.**

*Watersports is the practice of urinating on one's partner. More information is required on the type of watersports that are practiced.*

*Exit: Small amounts of HIV may be present in the urine.*

*Sufficient: The amount is insufficient for transmission of HIV*

*Survive: Survival will depend on whether the urine enters the eyes, mouth or anus*

*Entry: Entry may occur if urine is sprayed on the face (eyes), in the mouth, or in the anus (especially after penetrative anal sex).*

STI risks include

Gonorrhoea

Syphilis

Chlamydia

Trichomoniasis

❖ **Double Penetration. No condoms. Risk to receptive partner? – High risk for HIV infection.**

*Double penetration is the practice of inserting two penises into the anus at the same time.*

*Exit: HIV can exit through semen of one of the penetrating partners.*

*Sufficient: There is sufficient quantity of HIV for transmission.*

*Survive: HIV can survive in the anus.*

*Entry: Trauma (tearing) of the mucosal tissues is common in anal intercourse, facilitating the transmission of HIV. The presence of two penises at once will increase the risk of tearing.*

STI risks

HPV and anogenital warts  
 Chlamydia  
 Genital herpes  
 Gonorrhea  
 Hepatitis A, B, C  
 Syphilis

❖ **Double Penetration. No condoms. Risk to penetrating partners?** – High risk for HIV.

*Exit:* HIV can exit through semen of one of the penetrating partners or from tearing in the rectal tissues of the receptive partner.

*Sufficient:* There is sufficient quantity of HIV for transmission.

*Survive:* HIV can survive in the anus.

*Entry:* The presence of two penises in the anus at once will increase the risk of tearing of the outer tissues of the penis, facilitating the transmission of HIV.

STI risks include

HPV and anogenital warts  
 Chlamydia  
 Genital herpes  
 Gonorrhea  
 Hepatitis A, B, C  
 Syphilis

❖ **Double Penetration. With condoms. Risk to all partner?** – Moderate to high risk.

*Exit:* HIV can exit through semen of one of the penetrating partners or from tearing in the rectal tissues of the receptive partner.

*Sufficient:* There is sufficient quantity of HIV for transmission.

*Survive:* HIV can survive in the anus.

*Entry:* Even though condoms are used, the presence of two penises in the anus at once will increase the amount of friction between skin tissues during sex, thereby increasing the risk condom breakage and tearing of the rectal tissues and the outer tissues of the penis, facilitating the transmission of HIV.

STI risks

HPV and anogenital warts  
 Genital herpes

❖ **Fisting. No glove. Risk to either partner?** – Low risk for HIV through fisting itself. High risk if practiced in combination with other sexual activities. Further information needed.

*Exit:* HIV can exit through tears in the rectal lining cause by the stretching of mucosal tissue. HIV would only exit the penetrating partner if he has fresh cuts or sores on his hand.

*Sufficient:* The amount of HIV is sufficient for transmission

*Survive:* HIV can survive in the anus

*Entry:* If no cuts or sores on the penetrating partner's hand, then entry will not occur. Entry could occur through tears in the rectal lining.

STI risks include

Possible transmission of STI from anus-to hand- to genitals of the penetrating partner. Transmission will depend on hygiene practices (whether the hand is washed before touching his own genitals).

Chlamydia  
 Genital herpes  
 Gonorrhea  
 Hepatitis A, B  
 Syphilis

❖ **Orgy. No condoms. Risk to all partners?** – High risk.

*An orgy is the practice of having sexual intercourse with three or more partners. More information needs to be collected about what sexual (and/or drug use) behaviors are practiced in the orgy: oral-penile, oral-anal, fisting, penetrative anal sex, etc.*

*Exit: HIV can exit through semen of one of the partners or from tears in the anus.*

*Sufficient: There is sufficient quantity of HIV for transmission.*

*Survive: HIV can survive in the anus.*

*Entry: Trauma (tearing) of the mucosal tissues is common in anal intercourse, facilitating the transmission of HIV.*

STI risks

Scabies  
Lice  
Genital Herpes  
Genital Warts  
Gonorrhea  
Hepatitis A, B and C  
Syphilis  
Trichomoniasis  
Chlamydia

❖ **Orgy. With condoms. Risk to all partners?** – Moderate to high risk for HIV.

*More information is needed about what is actually practiced.*

*Exit: HIV can exit through semen of one of the penetrating partners or from tearing in the rectal tissues of the receptive partners.*

*Sufficient: There is sufficient quantity of HIV for transmission.*

*Survive: HIV can survive in the anus.*

*Entry: Even though condoms are used, as the number of sex acts increases, condom use is likely to decrease. Condoms that are used for more than one sex act are at higher risk of breaking*

STI risks

Scabies  
Lice  
Genital Herpes  
Genital Warts  
Gonorrhea  
Hepatitis A, B and C  
Syphilis  
Trichomoniasis  
Chlamydia

Even though condoms are used, many infections can be spread through skin contact where the condom does not cover. Using condoms for more than one sex act can help spread Hepatitis A, B, and C as well as other infections among the orgy participants.

❖ **Felching. Risk to either partner?** –High risk for HIV infection.

*Felching is the practice of the penetrating partner ejaculating sperm into the anus of the receptive partner. The penetrating partner (or someone else) will then suck out the sperm.*

*Exit: HIV can exit in the penetrating partner's sperm or in blood from minute tears in the rectal lining.*

*Sufficient: The quantity of HIV is sufficient for transmission*

*Survive: HIV can survive in the anus and rectum*

*Entry: HIV can enter into the body either through minute tears in the rectal lining or in the penis.*

STI risks

Gonorrhea  
 Chlamydia  
 Genital herpes  
 HPV and anogenital warts  
 Hepatitis A, B and C  
 Syphilis

- ❖ **Trick Sex. Risk to either partner?** – *Low to moderate risk for HIV. Trick sex may include inter-femoral sex (penis between thighs) or armpit sex.*

*Exit: HIV can exit*

*Sufficient: The quantity in semen is sufficient for transmission.*

*Survive: HIV will not be able to survive for long outside the body.*

*Entry: Entry will depend on how trick sex is practiced. If frequent taping is practiced, there may be sores or abrasions in the groin area. This may provide direct entry of HIV for the receptive partner. Recent shaving under the armpits may also increase the risk for the receptive partner. The penetrating partner is at lower risk.*

STI risks

Scabies  
 Lice  
 Genital Herpes  
 Genital Warts

Infection with other STI will depend on whether there are sores or abrasions present.

- ❖ **Facial. Risk to receptive partner?** – *Low to moderate risk. A facial is the practice of the active partner ejaculating on the receptive partner's face.*

*Exit: HIV can exit in the penetrating partner's sperm*

*Sufficient: The quantity of HIV is sufficient for transmission*

*Survive: HIV can survive if it gets into the eyes or mouth.*

*Entry: HIV could enter into the body through the eyes or sores in the mouth.*

STI risks

Gonorrhea  
 Syphilis  
 Chlamydia  
 Trichomoniasis

- ❖ **Rimming (Oral-anal sex). Risk to either partner?** – *No risk of HIV infection.*

*Exit: No exit of HIV unless penetrative sex took place before oral-anal sex.*

*Sufficient: There may be sufficient quantity if there was bleeding from penetrative sex.*

*Survive: HIV can survive in the anus.*

*Entry: There will be no entry unless there are sores in the mouth.*

STI risks

Risk of hepatitis A virus if there is contact with fecal matter  
 Possible risk of hepatitis B virus, especially if activity follows penetrative sex  
 Risk of HPV if warts are present.

## Positive Sexuality and Positive Prevention – Session summary

## Paradigm shift to prevention

Protect your health and in doing so protect others

### Key provider messages for HIV

- Don't bring harmful infections into your body now
- Keep HIV treatments effective for you and others
  - Discussed in more detail in Maintaining Health and Treatment Efficacy module
  - Uninfected individuals could become infected with an HIV treatment resistant strain of the virus by:
    - Having unprotected sex with an HIV positive person who is on HIV treatment (ART);
    - Having unprotected sex with somebody who is infected with a resistant strain of the virus and not receiving treatment.
- Where both people have HIV they may sexually transmit HIV resistant to ART

### Ask- Screen-Intervene

- Ask** - HIV positive clients should be routinely asked if they are experiencing difficulties practicing safer sex;
- Screen** – physical & psychological check-up;
- Intervene** – It is important health workers learn to assess and treat these problems
  - pharmacological and psychological

### Stages of change

### Match the Intervention to the stage of change

Refer to Box 3.3 in the technical brief TB03

### A final word

- HIV transmission risk reduction is a shared responsibility.
- “Shared responsibility” means sharing of responsibility for safe sex between all people regardless of HIV status.

However.....

- HIV positive individuals do have some important reasons to protect themselves.



Positive Health: **Prevention in Care**

# MODULE 04



## Disclosure: Telling partners and family

### Session objectives:

At the end of the training session, trainees will be able to:

- ◆ Discuss the barriers patients face in HIV disclosure and disclosure of sexuality.
- ◆ Demonstrate practical partner disclosure counselling skills

### Time to complete module:



4 hours

### Training materials:



1. Technical Brief Disclosure: Telling partners and family
2. PowerPoint presentation PPT04 ( summary recap only)
3. Activity Sheets, AS 4.1 and AS4.2
4. Overhead transparency sheets or flipchart paper
5. Sample patient referral form T2.3
6. Question box

### Content:



- ◆ Why partner disclosure counselling is important
- ◆ Exploring the patient's barriers to partner disclosure
- ◆ Strategies for partner disclosure
- ◆ Problem solving partner disclosure
- ◆ Partner contact strategies

### Session instructions



Time

#### 1. Introduction

10 minutes

- ◆ Introduce the session by asking the trainees to brainstorm a number of questions.
  - What is disclosure?
  - Why do we need to encourage disclosure?
  - What is the role of the Provider in supporting partner disclosure?
  - When should the Provider begin discussing disclosure?
- ◆ Explain that these questions will be examined further through out the session.

## 2. Activity 1: Brainstorm, Advantages and Disadvantages of HIV/STI Disclosure

30 minutes

### Objective:

- ◆ To identify the advantages (benefits) and disadvantages (barriers) of HIV/STI partner disclosure.

### Preparation:

- ◆ Prepare overhead transparency sheets or flipchart paper for group work.

### Instructions

- ◆ Divide the participants into two groups.
- ◆ Explain to the trainees that Group one will be responsible for identifying the advantages (benefits) of HIV/STI partner disclosure while Group two will identify the disadvantages (barriers) to partner disclosure through a group brainstorm (10 minutes). Each group should write its responses on flipchart paper or on an overhead transparency sheet.
- ◆ Each group will be given 5 minutes to present its findings to the large group (10 minutes). Allow members of the group not presenting to add or challenge ideas.
- ◆ The trainer should provide any additional points as needed (see trainer talking points below) and discuss the advantages and disadvantages to couples counselling in the context of disclosure.

## 3. Technical Brief (TB04)

30 minutes

- ◆ Ask participants to read Technical Brief 04, Disclosure- Telling partners and family, in their technical brief folder. (20 minutes)
- ◆ Randomly ask a few participants to quickly summarise each of the disclosure options suggested in the reading. (10 minutes)

## 4. Activity 2: Provider challenge response

30 minutes

### Objective:

- ◆ To challenge patient concerns about partner disclosure.

### Preparation:

- ◆ Prepare a copy of AS4.1 Provider challenge response for each participant.
- ◆ Instructions
- ◆ Revisit the question asked at the beginning of the session, "How do Providers support disclosure?" Randomly ask a few trainees for responses and then explain that Providers support disclosure:
  - By raising the issue with patients and exploring the barriers to disclosure
  - By helping the patient decide
  - By helping them decide who, why, what and when to disclose
  - By rehearsing with the patient
    - » How to make the disclosure
    - » Anticipating the partner's response
    - » Planning to manage the partner's response
- ◆ Discuss strategies on how the Provider may explore the patient's potential barriers and constraints with partner disclosure. (10 minutes)
 

Step 1- We open by use of open-ended questions

  - "Many patients that I give results to feel it will be difficult or not possible to tell their partner they have HIV. What difficulties do you think you would have?"

**Step 2- Listen and list**

- Make a list of the concerns the patient has.
- The provider should use reflection of emotion and paraphrase to demonstrate to the patient we have understood how they feel and what their concerns are.

**Note to trainer:** Please explain these terms

Paraphrasing involves restating, in your own words, the essence of what the patient has said. Reflecting emotions is similar to paraphrasing except that the focus is on the emotions expressed by the patient.

**Step 3: Challenge the patient's thinking**

- Review the reasons one by one gently and ask a provider challenge question. "Challenge questions" are designed to assess the validity of the patient's fears, gain more information and challenging the patient to think realistically and evaluate perceived threats and negative consequences.
- E.g. Fear of partner violence
  - » *What has happened in the past to make you believe your partner will be violent?*
- ◆ Handout a copy of AS4.1 to each person. Explain the statements on the activity sheet are concerns from different patients about partner disclosure.
- ◆ Instruct the trainees to write down questions that will challenge each of the statements. (10 minutes)
- ◆ Display a copy of the activity sheet on overhead transparency or on flipchart paper. Ask for two or three volunteers to provide examples of challenge questions to each statement. The trainer should request that each trainee should provide at least one response. One of the trainers should record the trainees' responses on the overhead transparency or flipchart paper. (10 minutes)

**5. Activity 3: Supporting HIV/STI Disclosure, Role Play****2 hours 5 minutes****Objective:**

- ◆ To practice partner disclosure counselling skills.

**Preparation:**

- ◆ Prepare the case studies from AS4.2 Supporting HIV disclosure.

**Instructions**

- ◆ Divide the trainees into small groups of three.
- ◆ Inform the trainees that they will now conduct another triad role-play to practice partner disclosure counselling skills. If necessary, remind the trainees of the steps to the role play (below). (5 minutes)
- ◆ Explain that the tasks set for the Provider are:
  - Explore the patient's barriers to partner disclosure.
  - Problem solve a key barrier to partner disclosure
  - Develop a disclosure plan with the patient.
- ◆ Handout case study 1 to the "patient." Remind the patient that they should not reveal information about their case to either the Provider or the observer.

**Steps to the Role Play****Step 1 - Role Play (20 minutes each round)**

Each triad should nominate a "Provider", a "Patient" and an "Observer". The triad members will be rotated between these three roles so that you all have an opportunity to experience each role. Accordingly there should be three rounds of cases with one case being conducted per round. For example round 1 case 1, round 2 case 2, round 3 case 3

Providers are to practice applying the knowledge and skills learned through the reading, discussion and other activities by completing their nominated tasks.

If during the role-play they become confused or uncertain they should be instructed to refer to their notes, review their material and recommence when ready. They should not ask for assistance from their patient or observer. If necessary, they should be instructed to put up their hand for assistance from a trainer. At the conclusion of the role-play the Provider should discuss what they were happy with in their practice and what things they would have liked to have done differently.

Patients are to play the role of the case outlined in the case study. They should attempt to allow the Provider to practice obtaining the information rather than simply reading out what is written in the case study. Trainers should instruct the patients to inform the Provider if they are role-playing a person of different gender e.g. if a trainee is female and playing a male patient she should inform the Provider that she is a male patient. Patients should provide feedback to the Provider at the conclusion of the role-play.

Observers are to observe the process of the role-play and provide feedback to the Provider at the conclusion of the role-play. Observers should be asked to first give positive feedback and then constructive criticism. This helps to increase confidence and avoids discontent between trainees. Facilitators should remind observers that they are not to interrupt the role-play.

#### Step 2 - Triad Feedback (5 minutes each round)

Five minutes should be allowed at the conclusion of each round for discussion and feedback within the triad. Observers should take the lead by stating what they observed.

#### Step 3 – Debriefing (15 minutes each round)

Form three small groups. One small group should comprise all the trainees who played Providers for that round, another group should comprise all the trainees who played patients and another group should comprise all the trainees who played observers.

The group trainers should ask the trainees to share their role-play experiences and guide the discussion to the following four questions:

- ◆ What made the patient feel comfortable in discussing disclosure?
- ◆ What skills were particularly important for the Provider to employ?
- ◆ How did the trainees manage to balance the provision of information with being responsive to the patient's concerns?
- ◆ What disclosure plan was the Provider able to develop with the patient?

## 6. Session recap

**10 minutes**

- ◆ Use the summary PPT04 to recap the key points of this session. There is only time to put each slide up for 1 minute. This is only to remind people of the key points. DO NOT READ EVERY POINT OUT. For example for slide #4 say "this slide shows the key disclosure strategies" show it for a few seconds and then do the same for each successive slide. Let the class briefly read.
- ◆ Ask the group if they have any questions and remind them about the "question box".

### Trainer Talking Points

Why do we need to encourage disclosure?

- ◆ So people can have access to treatment and care
- ◆ Major transmission risk reduction strategy for HIV & STI
  - Primary transmission
  - Re-infection
- ◆ We need to explain to patients that we encourage partner notification for the following reasons:
  - People can have HIV for a long time and not know and therefore pass to others (partners, children, blood donation)
  - The person who is in the window period (has a recent high risk) may actually be highly infectious but testing negative.

STI & HIV

- ◆ If your partner does not know they are at risk they will not suspect they are at risk and they will not think to get tested.
  - They will not be able to access treatment and care

HIV Re-infection

- ◆ Individuals can be dually-infected( for example two different viruses at the same time);
- ◆ ARV use may lead to the significant emergence of drug- resistant sub-types;
- ◆ Clinical visits should be used to facilitate discussion around maintenance of transmission risk reduction.
  - Exploring constraints to transmission risk reduction
  - Problem solving these constraints

STI Re-infection

- ◆ One partner gets treated only and then has unprotected sex with the untreated partner and gets the infection again.
- ◆ Over time the treatment resistance grows e.g. gonorrhoea

How do Providers support disclosure?

- By raising the issue with patients and exploring the barriers to disclosure
- By helping the patient decide
- By helping them decide who, why, what and when to disclose
- By rehearsing with the patient
  - » How to make the disclosure
  - » Anticipating the partner's response
  - » Planning to manage the partner's response

## Positive Health: Prevention in Care

### MODULE: 4 Telling partners and family HIV disclosure Sexuality disclosure

#### Counselling for HIV disclosure

Providers should indicate to patients that they understand that telling partners is difficult. It is important to recognize that a regular partner may describe a husband and wife relationship; a boyfriend and girlfriend relationship; a same-sex couple relationship; or regular sex buddy or even regular sex-work client relationship.

Providers should also acknowledge that HIV disclosure is often followed by major, life-changing consequences. The provider can further mention the general benefits and disadvantages to disclosure. Providers are also advised to ask the patient to think of the advantages and disadvantages relevant to their individual situation. Frequently patients will only be thinking of the disadvantages.

Many individuals will automatically think that disclosing their HIV status means that they will have to disclose their sexuality. Sex workers also may feel they need to disclose their sex work. It is important that the provider addresses these issues by informing the patient that this is not necessarily the case. The provider should advise the person that s/he does not need to share how transmission occurred.

#### Counseling for informed disclosure decisions

Counseling is not the process of telling people what to do. Rather, it is encouraging individuals to think through the advantages and disadvantages of options and helping them come to an informed decision. It also is about helping them overcome the barriers that they may encounter. Research demonstrates that when solutions are imposed on patients, they are less likely to stick to them. We can let our

patients know that we need to work together to overcome any anticipated difficulties in order to:

- ◆ allow partners to have early access to treatment and care;
- ◆ reduce HIV transmission to uninfected individuals;
- ◆ prevent reinfection with HIV and STIs; and
- ◆ reduce the risk of resistance to treatment.

A provider can assist patients to consider the individual benefits of disclosure, and to consider the benefits with their relationships with others, as well as the negative consequences. Because disclosure is a very private and individual decision, all relevant personal circumstances should be considered. The patient should be invited to discuss what they perceive to be the advantages and disadvantages of disclosure. If the patient can read and write, it is helpful to draw up a matrix and have the patient brainstorm advantages and disadvantages from their own perspective. Alternatively, the provider could make notes as the patient answers aloud, and then provide an oral summary back to the patient.

#### The menu of disclosure options

Another powerful way to support decision making around disclosure is to offer the patient a menu of disclosure options. Often patients feel that they cannot make the disclosure themselves; while others feel it would only upset their partner to hear the news from someone other than themselves. As a provider you should support the patient's decision making by presenting him or her with disclosure options and encouraging the patient to discuss the advantages and disadvantages appropriate referral to a VCT service.

### The menu of disclosure options

Another powerful way to support decision making around disclosure is to offer the patient a menu of disclosure options. Often patients feel that they cannot make the disclosure themselves; while others feel it would only upset their partner to hear the news from someone other than themselves. As a provider you should support the patient's decision making by presenting him or her with disclosure options and encouraging the patient to discuss the advantages and disadvantages of each option. If a hotline patient requires a provider to help with the disclosure, make an appropriate referral to a VCT service.

#### The menu of disclosure options

1. Patients discloses to partner/family alone
2. Patient brings partner/family member to clinic or service and discloses himself in presence of a provider.
3. Patient brings partner/family member to clinic or service and the provider discloses in the presence of the client.
4. Patient authorizes a provider to disclose on their behalf without the presence of the patient/client.
5. Patient discloses to a trusted friend, family member or community person and authorizes that person to disclose to their partner or other family members on their behalf.

Once the patient has decided on his or her preferred disclosure option, you can offer support in a number of different ways.

### Coaching for self disclosure

One key way to assist the patient is to help him think through the why, when, where, how, and what of disclosure. While this is important for all of the disclosure menu options, it is particularly critical for patient self-disclosure.

- ◆ **Why:** You need to make sure that patients think through why they are making the disclosure and what response they anticipate.
- ◆ **When:** Encouraging patients to consider the appropriate time for the disclosure is important. You need to have the patient

make the disclosure when no one else is present in the house to see the distress of the partner (e.g., the children are asleep). Patients should avoid making a disclosure during an argument.

- ◆ **Where:** Helping patients consider the place that they feel will give them the time for a confidential discussion and offer some security to both parties is an important consideration.
- ◆ **How:** You need to encourage the patient to think about the disadvantages of different methods of self-disclosure (face-to-face or by telephone, email, or letter).
- ◆ **What:** Plan with the patient how to initiate the conversation and anticipate the partner's likely response. You can then plan with the patient a constructive response to the partner's reactions. Role play can be an extremely useful technique to employ and can be done in person or over the phone in a hotline call situation or in face-to-face counselling. When getting the patient to anticipate how the partner will respond you can take on the role of the partner in the dialogue.

Have the patients consider carefully what they will disclose:

- full disclosure—nothing is barred, patient gives full consent; or
  - partial disclosure—some things will be discussed (HIV status) but others not (e.g., sexuality; the way the person became infected; risky practices such as injecting, sex work).
- ◆ **Planning for next steps:** Plan with the patient how to get partner support after disclosure, HIV testing and counselling, and how to manage the relationship issues arising from the disclosure.

### Disclosure to anonymous and casual sexual partners

Many positive individuals have been rejected upon disclosing to potential partners and some threatened with physical violence. That is why some patients choose to use a non-verbal form of disclosure by insisting on safe sex. Often, simply reaching for the condom at the appropriate time is enough. This method does

have its risks because an HIV-positive individual may assume his/her partner is also positive because s/he doesn't insist on condoms. A negative individual may assume his/her partner is negative for the very same reason. Some people will make assumptions about their partner's status based on how they look. Lipodystrophy, (e.g. hollow cheeks) a side effect of ART, for example, can often be recognized, but not all hollow cheeks are related to HIV.

Basing sexual decisions on how a person looks can lead to people becoming infected.

There is no easy way to disclose HIV status to sexual partners, nor is there any guarantee they will respond positively. When it comes to relationships, however, most positive individuals who choose to disclose early in the relationship find that their partner is supportive. Especially if during the disclosure they emphasize that it was hard to disclose but they did so because they cared about their partner's well being. There is a possibility the other person also has HIV or that it makes no difference to the relationship and in some cases it even brings the couple closer together. The dilemma is: when does a casual partner become a potential relationship? In an ideal world we would all disclose and all our partners would be supportive however this may be unrealistic.

Some good reasons to tell casual partners:

- ◆ It is a quick way to find out if you want to get to know the person better.
- ◆ If you think that you are eventually going to tell someone you have met, the longer you delay it, the harder it can become and the more resentment you might have to deal with.
- ◆ You might be seeking other positive partners.
- ◆ It makes it more likely that you will stick to practicing sex that is safe for you and your partner.
- ◆ If a condom breaks, you've at least told the partner first of the potential risks.

### When should the client tell a casual partner?

In telling sexual partners, timing can be important. It can be difficult to talk about HIV when you have only just met someone, but putting it off may cause problems later. If your partner does find out later on but cannot accept it, it may be more upsetting for both of you.

If you have just met someone, you might not feel that you know enough about them to anticipate their reaction, or to judge whether they will respect your privacy. You might be in a bar, a party or another place where it feels out of place to talk about HIV. Some people go to a more neutral environment, arrange to meet up later or decide to talk about HIV once they've got to know the person better.

Other people drop HIV into the conversation very early on, in a very casual and matter-of-fact way, so that

if the other person cannot accept it, no time is lost.

Some people drop hints about HIV or try to guess the status of their partner. But these judgments are not always accurate.

*Source:* [http://www.afao.org.au/library\\_docs/resources/Jan10factsheet\\_disclosure.pdf](http://www.afao.org.au/library_docs/resources/Jan10factsheet_disclosure.pdf)

### Counselling for sexuality disclosure

Often providers are called upon to help patients decide on whether to disclose their sexuality to a partner, family member or friend. Sometimes patients will seek assistance from a provider or health worker or peer before making the disclosure.

### Coming to a decision to disclose

Before patients think about how to come out to their family and friends, what is most important is that they feel a strong sense of acceptance themselves, about their sexuality and their reasons for disclosing their sexuality. As they begin to acknowledge their sexuality to themselves, it is very common that they will

experience guilt, shame, doubt and confusion. Negative social messages, discrimination and violence are not eradicated overnight. Even in a country like Thailand where men and women who have same-sex orientation have begun to demand rights, recognition and protection under the law, social attitudes and belief systems continue to discriminate.

Many men and women struggling with telling their family fear the news will “destroy” their parents or create problems for the whole family. Patients should be warned immediately after the disclosure there is the possibility that parents or other family members may initially reject them. However, many, particularly those who had a good relationship will come to accept the news over time. Some men who have disclosed also find that their relationship with their parents or family members eventually improves because of the increased openness and honesty that comes with sharing this knowledge. Many also experience a great sense of relief in knowing that they no longer need to keep their true identity a secret.

Examples of common concerns of parents:

*“People will think I am a bad parent because my son/daughter is psychologically disturbed and is attracted to men/women.”*

*“I worry my child will find it hard to get a good job.”*

*“Being attracted to somebody of the same sex is seen as sick and perverted by many people. How will other family, friends and work mates treat my child if they know he has sex with men?”*

*“I worry my son/daughter will never have children. Every parent looks forward to their grandchild.”*

Parents and other family members will need reassurance that often if people can feel comfortable and accepting of their child/relative’s sexuality they are less likely to be psychologically disturbed, more able to adapt to a positive living outlook and are less likely to engage in behavior that transmits HIV. Parents also need reassurance that they are not bad parents who did something wrong in their child-rearing.

## Strategies for disclosure

There are many ways a patient can tell their partners, families or friends. Some men and women confide in a brother or sister, cousin, uncle or aunt; who they feel will accept, and support the patient in telling other family members.

- When the patient is ready to tell their parents, they could be advised to start with the parent to whom they feel the closest.
- Advise your patients not to “blurt out” the news inappropriately. Guide them to choose an unstressed time for disclosure.
- Instead of telling the parents, another option is for the patient to write the parents a letter then send it to them telling them that they find it hard to say what they have to say, so they explain that they are writing down what they want to say.
- When the patient meets with their parents, either after they have sent a letter, or even when they tell them for the first time fact to face, they might want to consider bringing along a supportive friend, family member or even their healthcare provider.
- If the atmosphere between the patient and their family is already a tense one; and especially if the patient has been away from home, suggest that perhaps they may need to meet the parents at another location other than the family home. Advise the patient to explain how hard it has been for them (and to say they are sorry about past problems if necessary) and advise them to assure the family that they love and respect them.

## Suggestions you can provide to patients on how to manage family reactions.

- Advise patients to manage their emotions. Getting into a verbal fight no matter how much provoked, may result in saying things which they will later regret, or angrily leaving the house.
- Healthcare providers can offer to meet with the patient and their family or provide a phone number parents can

call to have general questions answered. Remember however, to get the patient's signed "Release of information" if you are to discuss their specific personal situation with the parents.

### **Making the patients aware of the adjustment process that families will go through**

It is important that the patient understands that even though they are the "child" they may need to "take the lead" until their parents get over the first shock and initial feelings of distress. The parents/family member will need time, may be lots of time, and support. The patient will need to patiently explain sexual orientation is not a 'choice' or a 'lifestyle' and their parents didn't 'cause' them to be this way.

Providers should remind patients to "Remember when you first realized you were attracted to the same sex. Remember how long it took to sort out your feelings? Parents and other family members will need time to adjust."

Family members may experience conflict with religious or cultural traditions. Patients need to understand that the person they disclose to may react in many ways (or a combination) including: fear for the patient's health or safety, grief; anger; shock; guilt and more. Patients need to be informed that these emotions are genuine because the person loves them and not because they do not.

Mothers in particular may cry and try to cope by making their son feel 'guilty' for hurting them. Fathers are more likely to either not react or be angry. Other parents may react with a form of psychological denial where they hope if they ignore the news it will just go away; some will want to 'fix it' in various ways like send their son to a doctor, religious person or psychologist because that is what parents do when their kids are seen to be 'hurt'. It may take time for parents to understand that this is neither helpful, nor likely to change their son or daughter's sexuality.

### **Disclosing sexuality to a regular partner**

#### **Some reasons for disclosing to regular partners:**

- ◆ They think that their partner may already suspect their sexuality.
- ◆ They consider that they cannot keep their secret any longer
- ◆ They have had sexual experiences with other men/women and run the risk of being discovered, or
- ◆ They are subjecting their partner to a health risk such as HIV or another STI.

Some patients may consider it is time to tell their wife or regular partner. Again, the patient should already be at ease with their own sexuality because revealing it to the partner is going to be a major shock, unless they already suspect.

Patients should be cautioned that this needs careful planning. Timing will also be important.

Some partners, when they are told, can accept the situation. Some cannot. Some are affected catastrophically. Probably, all will start to ask questions and patients should be advised to have considered and prepared answers to the following likely questions:

#### **Why have you not told me before?**

- ◆ Have you always been gay or bisexual?
- ◆ When you married me, did you love me?
- ◆ Do you still love me?
- ◆ Has having sex with me all these years been a pretence?
- ◆ Have you been with other men?
- ◆ Do you have a lover?
- ◆ What is our future together?

Providers can help patients think through their responses and help role play the situation.

Questions about “our future together” is one of the more difficult ones to answer, but remember that it is the decision of both parties as to whether there is a future together, and they have to be for the right reasons. Remember the history that a couple may have had together, sometimes 10 or more years, sometimes 30 years of reasonable happiness. Consider what brought them together in the first place.

#### Should the relationship continue?

- ◆ Is there any reason why the fundamental friendship that has built up over the years should be broken?
- ◆ Do they no longer have a need for each other?

## MODULE 04

The moment the patient tells the partner, the couple will experience “emotional ups and downs”. There will be acceptances and there will be refusals. The patient should be counseled to understand that if they wish to see their relationship, in some form, survive, that they must give it their time and understanding, and only give up if things are seemingly irreconcilable. It is strongly recommended that both patient and partner seek counseling with a supportive health professional.

## Provider challenge response

The following are a list of concerns from different patients about partner disclosure. Respond to them one by one by asking a counselor the challenge question.

1. My parents would disown me and kick me out of our family home.
2. My boyfriend will beat me. He always gets very angry.
3. My girlfriend will not marry me if she knows so I cannot tell her.
4. I (HIV symptomatic peer outreach worker) will lose my job if I tell my boss that I have HIV and that I need time off for treatment.
5. I cannot tell my doctor or he will not operate on my leg.
6. My family will be suspicious of how I got infected. They will press me to tell everything. I cannot tell them because they will find out I am gay.
7. I cannot tell my wife. I am a respected member of the community and she will be angry and tell everybody.
8. I cannot tell any family member. They will reject and blame me. Nobody will be sympathetic.
9. My father gets very angry. He will make me leave home and probably beat me up.

## Support HIV disclosure case studies

### Case study 1

You are a twenty four year old HIV positive male. You are coming into the clinic for your first post HIV diagnosis visit, and you have recurrent genital herpes. After your diagnosis, you were too distressed to discuss disclosure in any detail and you have not yet told your wife. You have sex with men but nobody knows. Your wife is 8 weeks pregnant and looking forward to your first child. Your family members are all very anxious for you to have your first child. You feel pressure to marry. You cannot explain to your wife that she is at risk as you do not want anyone to know you are a MSM. You say your wife will leave you and both her and your family will reject you. You are worried as you work in the family business. If you anger the family you will have no job and you feel your life will be over.

### Case study 2

You are a 19 year old male IDU, who also does some sex work. You have been diagnosed HIV positive for several months. You previously told a nurse that you told your girlfriend of your infection but now admit that you still have not told her. Recently, you have also been told you have syphilis, and frequent genital herpes. Your girlfriend works as a brothel based SW. You love her very much and are afraid she will leave you if she knows you are infected with HIV. You are also afraid she will tell everybody and you cannot work any more. You need to work as you have very serious drug addiction. You have no other job skills and only limited education. Your family members have already rejected you as you use drugs.

### Case study 3

You are a 22 year old transgender (male to female). You have been diagnosed HIV positive for 3 years and you have a new foreign boyfriend. You also have gonorrhoea, and recurrent genital herpes. Five years ago you worked in hotel and had sex with some men for money. Your boyfriend does not know about your previous sex work, which paid for your gender reassignment surgery. Your boyfriend and family would be very angry if they knew what you had done in the past. Your boyfriend sometimes gets very angry after he has been using amphetamines. He threatens you many times. However he has never hit you yet. You are worried that he will hit you and your family will reject you.

My dear...  
I have HIV...

## Telling partners and others

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M04 - T4.1

Telling your partner (husband, wife, boyfriend, or girlfriend) that you have HIV is never easy. It takes courage and you may risk rejection, even anger. However, many people manage to maintain relationships after telling their partner, even if their partner finds that they are not infected.

### Advantages of telling your partner

- 1 They can get tested and be offered treatment and support.
- 2 If you or your sexual partners are pregnant there are steps that can be taken to prevent your unborn child being infected.
- 3 They will be more motivated to practice safer sex and use condoms to prevent themselves being infected
- 4 It really shows they are important to you. You risk their anger and rejection but because you care for them you told them anyway.
- 5 You don't have to try to keep a secret, which can be difficult especially when you are upset or unwell.
- 6 You do not have to hide medications and lie about visits to the clinic

A counselor can help you plan and even rehearse how you will do this.

### You can tell your partner in different ways

- 1 You can tell him/her by yourself – a counselor could help you plan how to do this;
- 2 Bring your partner to the hospital or clinic and have a counselor be present whilst you tell your partner – the counselor is then available to answer any questions about HIV, tests or treatments.
- 3 Bring your partner to the hospital or clinic and have the counselor tell your partner - you are there to support your partner.
- 4 You can authorize a counselor to make the disclosure alone – you may be required to sign a written consent giving the counselor permission to do this.
- 5 You can disclose first to a trusted family member, community leader or religious leader who can disclose on your behalf – this may be useful if you fear your partner will be aggressive toward you.

Here are some things to consider when you are planning to tell your partner if you decide that you will do this alone.

### Timing

- 1 Not while the children or parents may walk into the room and interrupt or overhear.
- 2 Not after your partner has been drinking or when she or he is intoxicated as this may lead the person to respond aggressively or to harm himself or herself

### Where

- 1 Privacy and freedom from interruption are important considerations. However if you fear your partner will be aggressive you could do it in a public place, however choose a place that is far enough way from other people to allow you conversation not to be overheard

If you have told a close relative first, maybe you could plan to visit that relative with your partner and ask that relative or friend to disclose to the partner during the visit.

### How

Knowing what to say is hard. Choose your words carefully. An example is below

- 1 Start by saying that you need to discuss something important in private. That it will take some time to explain.

Ask them to sit down with you

Say that what you have to say is difficult and explain that do not want them to interrupt you until you have finished

You might choose words like the following  
*"this is difficult for me...you are important to me and that is why I need to tell you that I am HIV positive, that means I have HIV an infection and this may have either been passed from you to me or me to you without knowing, I am telling you this even though I may even risk losing you because I care about you, your health and the family"*

- It is a good idea to wear latex gloves when mopping up blood spills.
- If there is an accident in the home and the infected person bleeds avoid direct contact with the wound. To stop the bleeding place the infected persons own hand over the wound and apply pressure.

If you get a blood splash to the skin simply use a mild soap and water to wash it off. Never use harsh chemicals have this can cause irritation to the skin and allow any virus to pass through the skin. HIV cannot travel through intact healthy skin. Your skin provides a good barrier to HIV.

Washing up plates, cups and spoons can be done in the **normal wash up** and sheets and towels can be washed **normally**. People with HIV **do not** need to have their own cups, saucers, plates or knives or forks.

### How can you provide support?

**Avoiding blame** - Many people blame HIV infected people for getting themselves infected however it is important to remember people that nobody asks to be become infected with HIV. People have unprotected sex, and share needles, for a variety of complex psychological and social reasons. We all from time to time have done things even though we know they are not morally correct or healthy for us.

Knowing something is unhealthy or a risk is not enough. A good example is to think about the number of health professionals that you know who smoke. They know it is dangerous but they continue to smoke for a variety of reasons social, physiological, psychological and behavioral.

### The emotional issues related to caring for someone

Everybody organizes the people in their lives differently. Some keep family members and friends quite separate, rarely providing opportunities for them to interact. Others live in extended families where friends, brothers, sisters, parents and partners all know each other and mix together frequently.

When a person in the family becomes ill parents sometimes compete with the partner or friends of the ill person to try to show who cares for the person the most. Sometimes people blame each other for the person's illnesses *"If only I had worked less and spent more time with him as a boy this would not have happened"*

This is a good time to remember that the ill person needs your care and support and do not need the additional burden of causing stress and arguments in the family. If HIV illness is causing difficulties in your family or personal relationship then seek counselling with a trained family therapist.

### The needs of the person with HIV

One of the most distressing things about living with HIV is the gradual loss of independence that sometimes occurs with illness. As people get sick, they can often experience high levels of anger, frustration and depression. There are several ways you can help to maintain your friend or family member's independence:

- Make sure the person with HIV has as much control over the decisions that affect them as possible. Involve them in all decisions about their care
- If their ability to make decisions becomes impaired, be sure that they are allowed to contribute to the extent they can
- Find out what help they want and what they want to do for themselves.
- With the person's consent get help from the HIV care coordinator who can be contacted through the clinic or hospital where your relative or friend receives treatment.
- Try not to totally take over.
- Take a rest and share the care of a sick person with others.

M04 -T4.2

## When you have been told a family member or friend has HIV



### Information for families and friends



## WHAT IS HIV?

HIV stands for the Human Immune Deficiency Virus. It is the virus that causes AIDS-the Acquired Immune Deficiency Syndrome. HIV is sometimes called the AIDS virus.

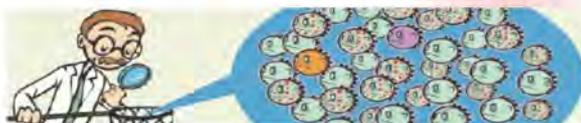
HIV attacks the immune system, leaving people open to developing other infections, which would normally be fought off by the healthy body.

If a person is told that they are HIV positive, this means that they have come into contact with HIV and it has established itself in their body. It also means that they can pass the virus on, through unsafe sex, by needle sharing or by donating blood. HIV infected women may pass HIV to an unborn child, or to her baby during birth and during breastfeeding.

### HIV is not caught through everyday social contact

HIV is a communicable disease, which is it can be passed from one person to another. It is not contagious though, like some other infections- that is; it cannot be passed on through every day social contacts or by careful caring for someone with HIV. HIV is only passed to others by the methods mentioned previously. Caring for a friend or family member with HIV will only put you at risk if you have unprotected sex, or share needles with them or have **direct** contact between their blood and a fresh open wound in your skin.

Many families throughout the world have a HIV positive family member that they share meals with, share bathroom facilities with, and they hug, and kiss their HIV infected friend or family member and do not become infected.



HIV cannot be caught from toilet seats, swimming in pools, sharing meals or drinks with HIV infected people. Mosquitoes cannot transmit the virus from one person to another.

The HIV virus lives and is only able to infect when it is in blood, semen and vaginal fluids.

### Fear of infection

Fear of infection has led to rejection of people with HIV by family members and friends. People sometimes feel less inclined to hug a person or to touch them in a way they used. If you feel uncomfortable about having normal and affectionate contact with a friend or family member with HIV try talking about it with a counselor.

### What happens to people with this infection? Is there a cure?

HIV cannot be cured, however there are now drugs that can help you remain healthy and control symptoms.

Antiretroviral drugs known as ARVs are drugs, which help stop HIV from infecting new cells in your body and destroying the immune system. These drugs are not widely available however Counselor and specialist doctors at the hospital or clinic tell you about these. For people who have had HIV for some time and have a weakened immune system there is a drug that can assist protect the body from infections, this is called prophylaxis.

Other drugs can reduce pain and symptoms such as nausea, diarrhea and skin irritations.

Modifying diet can also reduce symptoms, such as diarrhea, nausea and vomiting muscle wasting and weight loss.

Remember the infected person will rarely experience significant symptoms early in the disease. People can remain well and without symptoms for an average of ten years or more. It is hard to know how long somebody has been infected, just because somebody has only recently been diagnosed does not mean they have just become infected. Many people are diagnosed late in their infection and do not get the benefit of early treatment and care and therefore they may get sick soon after their diagnosis.

With the right treatment, and healthy lifestyle, many people live long productive lives; working, socializing even enjoying intimate relationships.

### Can HIV infected people have sex?

Yes as long as they take precautions. The condom has been proven to be an effective barrier to HIV if it is used correctly. Throughout the world there are many couples where one person has HIV and the other does not. Studies have clearly demonstrated the adoption of safer sex is effective in preventing the uninfected partner getting infected.

Sex is an important part of relationships. As people live with HIV for a very long time it would be unrealistic to think they could not share such intimacy with another person. This topic has been very well researched throughout the world.

Couples can discuss safe sex details with a qualified VCT counselor or with the trained HIV treatment and care co-ordinator.

### Some simple tips protecting yourself when caring for someone who is sick

As we mentioned before HIV is transmitted in blood and it is difficult to contract HIV when caring for someone with HIV. Just a very few special precautions are needed



Positive Health: **Prevention in Care**

# MODULE 05



## Reproductive health and family planning

### Session objectives:

At the end of the training session, trainees will be able to:

- ◆ Identify sexual and reproductive health issues affecting people living with HIV (PLHIV);
- ◆ Facilitate an understanding of how to address contraception for people with HIV;
- ◆ Increase awareness around pregnancy issues and HIV infection;
- ◆ Increase awareness around sexual function and HIV infection;
- ◆ Increase awareness of drug interactions and HIV

### Time to complete module:



2 hours 30 minutes

### Training materials:



1. Activity sheet (AS5.1) handed out during activity
2. Technical Brief (TB05)
3. Tool (T 5.1, T5.2)
4. Overhead transparency sheets or flipchart paper

### Content:



- ◆ Sexual and reproductive health for male, and female sex workers, and substance users
- ◆ Contraception
- ◆ Pregnancy
- ◆ Sexual function

### Session instructions



#### 1. Introduction

- ◆ Ask training participants:
  - What is reproductive health?
  - How is it different from sexual health?

Time  
5 minutes

#### 2. Technical Brief (TB05) and activity sheet (AS5.1)

- ◆ Divide the training participants into three small discussion groups
- ◆ Instruct the participants to read technical brief: sexual and reproductive health (TB05) and Tool (T5.1). **Inform the group points will be awarded for each correct answer from a group.**

75 minutes

- ◆ Debrief the reading by discussion of the following questions with the large group:
  - What is dual protection? Why do we advocate it for HIV positive clients?
  - What is the association between cervical cancer and HIV?
  - What are some key messages we should give all men about PMTCT?
  - What is the association between anal cancer and HIV?
  - What are the risks related to hormonal contraception?
  - What are some of the possible problems associated with the IUD for women with AIDS?
  - What are the advantages of implants for female sex workers?
  - What are key PMTCT interventions used for pregnant women?
  - What is emergency contraception and should it be used?
  - What are some of the disadvantages of promoting female condoms to female sex workers?
  - What are some of the benefits?

[Answers are included in the Technical Brief and Tools]

- ◆ Instruct the small groups to then work through the assigned case studies in the activity sheet

### 3. Case de-brief

45 minutes

De-brief the case activities in detail for each case. Ask each of the groups to present their case and answers to the class. Then after the group presentation, ask the class for additional comments on things the group may not have considered. Correct any misunderstanding in technical information.

### 4. Session recap

10 minutes

- ◆ Ask the group to summarize and discuss the key learning points from the activities.
- ◆ Ask the group if they have any questions and remind them about the “question box”.

## Activity case studies

### Case study 1

Your patient is a HIV positive female sex worker just commencing ART and currently using oral contraception that she buys at a pharmacy. Her regular male partner is also HIV positive and asymptomatic. She is considering having a child, and mentions having a lot of pressure from her family who do not know her HIV status. They also do not know she is involved in sex work.

### For trainers only: Sample responses for case activity

<u>Ask</u>	<u>Screen</u>	<u>Intervene</u>
<p>How do you think your parents not knowing about your HIV is affecting your health and decisions about having children?</p> <p>How does your sex work affect your ability to look after your health?</p> <p>What are your feelings about going to a family planning service to get advice on contraception?</p> <p>Ask the patient what HIV assessment, treatment and care she has received prior to her attendance today.</p>	<p>Screen for barriers to risk reduction</p> <p>How do you practice safer sex with your regular sexual partner?</p> <p>What stops you from being able to use condoms with clients?</p> <p>How do you manage sex work during menstruation?</p> <p>Screen for STI management</p> <p>When was your last STI check-up?</p> <p>What signs or symptoms of STI do you have?</p> <p>What have you done to treat your STI?</p> <p>Have you ever had a Pap smear?</p> <p>When was that?</p> <p>Screen for PPTCT management</p> <p>When did you last have your menstrual period?</p> <p>Have you ever been pregnant or had to terminate a pregnancy?</p> <p>When was the last time you missed taking your oral contraception?</p> <p>What are your feelings about having a child?</p> <p>What are your partner's feelings about having a child?</p> <p>Ascertain patient's comprehension of her HIV health status.</p>	<p>Discuss pros and cons of pregnancy in terms of HIV, her relationships, and work?</p> <p>Options available for preventing parent-to-child transmission of HIV.</p> <p>Contraceptive choices - If pregnancy not desired.</p> <p>Education and information about STI risk for HIV and impact on pregnancy and work.</p> <p>Education on risk for cervical cancer linked to HIV and STI</p> <p>Options for negotiating safer sex with clients or reduced risk behaviors?</p> <p>Options for sex work during menstrual cycle.</p> <p>Refer patient to family planning specialist.</p> <p>Refer patient to necessary HIV physician for further medical follow-up.</p>

## Activity case studies

### Case study 2

Your patient is a male sex worker who occasionally injects amphetamines, recently diagnosed with HIV. He reports that he cannot always get his clients to agree to use condoms. He has not disclosed his HIV status to his wife and does not currently use any contraception with her. He believes she is unaware of his sex with male partners. He also reports he has a regular boyfriend who engages in sex work. He mentions that he is experiencing rectal pain during anal intercourse. He has never had an STI check-up or rectal exam.

### For trainers only: Sample responses for case activity

Ask	Screen	Intervene
<p>How do you think your work and your drug use affect your health now that you know you have HIV?</p> <p>How do you think your wife will react to you when she finds out that you have HIV?</p> <p>Are you aware that having unprotected sex with your wife could result in her becoming infected with HIV and STI?</p> <p>Are you aware that if your partner was to become pregnant that the baby could be infected if she has contracted HIV or STI from you?</p> <p>How do you think your wife will react when she finds out that you have sex with other men?</p> <p>How would unprotected sex with your regular male partner affect your health?</p> <p>Have you disclosed your HIV status to your regular male partner?</p> <p>How do you think a STI could affect your health and your work?</p> <p>Ask the patient what HIV assessment, treatment and care he has received prior to his attendance today</p>	<p>Screen for further STI signs and symptoms.</p> <p>Screen for differential diagnosis of reported symptoms. For example ask</p> <p>Do you use lubricant for anal intercourse? [Is the pain associated with lack of sufficient lubrication?]</p> <p>Do you experience rectal pain at times other than during intercourse?</p> <p>Have you noticed any rectal bleeding?</p> <p>Screen for issues related to partner disclosure. For example ask:</p> <p>What stops you from telling your wife about your HIV?</p> <p>What stops you from telling your male partner about your HIV?</p> <p>Screen for details of barriers to condom use. For example ask the following:</p> <p>What stops you from asking your clients to use a condom?</p> <p>What are the reasons why you and your wife are not using condoms?</p> <p>Screen for potential PPTCT</p> <p>Do you know if your wife is currently pregnant?</p> <p>Is your wife breastfeeding an infant at this time?</p> <p>Screen for drug and alcohol use and dependency.</p> <p>Ascertain patient's comprehension of his HIV health status.</p>	<p>Educate about contraceptive choices - If pregnancy not desired.</p> <p>Options for negotiating safer sex with clients or reduced risk behaviors.</p> <p>Education and information on safer sex, including safer anal intercourse using water-based lubricant.</p> <p>Options for disclosure to wife and regular male partner.</p> <p>Options available for preventing parent-to-child transmission of HIV.</p> <p>Referral or conduct STI check-up, including rectal examination.</p> <p>Offer referral for drug and alcohol management.</p> <p>Refer patient to necessary HIV physician for further medical follow-up.</p>

### Case study 3

Your patient is a female sex worker who leads a chaotic life. Despite having been diagnosed HIV positive for several years she continues to engage in sex work and does not appear to use condoms as she frequently reports with symptoms of STI. She reports using oral contraception inconsistently and admits to having had several illegal pregnancy terminations.

#### For trainers only: sample responses for case activity

<u>A</u> sk	<u>S</u> creen	<u>I</u> ntervene
<p>How does your busy life affect your ability to look after your health?</p> <p>How does constant infection with STIs affect your work? How does it affect your financial situation?</p> <p>How has terminating pregnancies affected your life?</p> <p>Ask the patient what HIV assessment, treatment and care she has received prior to her attendance today.</p>	<p>Screen for STI management referrals</p> <p>When was your last STI check-up?</p> <p>What signs or symptoms of STI do you have?</p> <p>What have you done to treat your STI?</p> <p>Have you ever had a Pap smear? When was that?</p> <p>Screen for PPTCT support referrals</p> <p>What stops you from using oral contraception consistently?</p> <p>When did you last have your menstrual period?</p> <p>Screen for barriers to risk reduction</p> <p>What stops you from asking your clients to use a condom?</p> <p>How do you manage sex work during menstruation?</p> <p>Do you use drugs and/or alcohol to help you manage your chaotic life?</p> <p>Ascertain patient's comprehension of her HIV health status.</p>	<p>Contraceptive choices - If pregnancy not desired.</p> <p>Education and information about STI risk for HIV and impact on pregnancy and work.</p> <p>Education on risk for cervical cancer linked to HIV and STI</p> <p>Options for negotiating safer sex with clients or reduced risk behaviors?</p> <p>Options for sex work during menstrual cycle.</p> <p>Refer patient to family planning specialist.</p> <p>Refer patient to necessary HIV physician for further medical follow-up.</p>

## Positive Health: Prevention in Care

### MODULE 5

## Sexual and Reproductive Health

### Sexual and reproductive health

Sexual and reproductive health is a term that describes many overlapping ideas. They include sexual pleasure, desire, relationships, pregnancy, contraception, sexually transmissible infections and sexual function. People living with HIV share the same range of desires and ambitions as anyone else but these are often dealt with in very different ways because of their HIV status.

In part, this is because many people – including health workers – apply their own values and judgments about what people with HIV should and should not aspire to achieve. For example, some health workers would oppose women with HIV trying to become pregnant and might strongly recommend permanent forms of contraception (sterilization).

### The unmet health needs of FSW, MSW & MSM with female partners

One of the largest groups whose reproductive health needs, also known as RH needs, are not being met is young female sex workers, and MSM with female partners of child bearing age. Evidence of unmet need in this group is seen in the high rates of sexually transmitted infections, or STIs, including HIV; unintended pregnancy; and mortality and morbidity resulting from illegal unsafe abortions in Thailand

Some of the causes of this unmet need include a lack of information and education about sexuality, reproduction, and contraception, as well as limited skills for establishing personal goals, developing strategies, and communicating expectations with partners. Additionally, many individuals from vulnerable populations do not have access to reproductive health services that are prepared to meet the specific needs.

### Reproductive health screening in HIV

Whilst we have discussed the importance of routine STI check-ups for all HIV positive individuals in the Positive Sexual Health module there is a need to highlight some serious sexual health issues further in this module brief.

#### *Cervical cancer and HIV*

One of the major causes of pre-cervical cancer is the sexually transmitted human papillomavirus (HPV). Around 75 percent to 80 percent of women with HIV also have HPV.

Even when the lining of the cervix is infected by the HPV, and therefore having the potential to cause cancer, most of the time the lining will heal without consequences. However, in a very small number of women some cells will undergo changes which, if left untreated, may eventually become cancerous. The stage when the lining is not normal but not yet cancerous is called the precancerous stage, and the abnormal part of the lining is said to contain a cancer precursor.

Women with HIV have a weakened immune system, which allows HPV to survive in the cervix and cause pre-cancerous lesions. Research over the past decade has shown that HIV-positive women are around four times more likely to develop genital lesions and cervical cancer, with 20 percent to 60 percent of HIV-positive women showing signs of pre-cervical cancer.

Studies have found that having lower CD4 (white blood cell) counts and a weakened immune system are risk factors for pre-cervical cancer and cervical cancer.

Additionally, women with HIV are more likely to have a recurrence of pre-cervical cancer and tend to have more abnormal cells in both the cervix and the anus. Antiretroviral therapy was not found to protect HIV-positive women from development of pre-cervical cancer.

Research also suggests that HIV positive women who eventually develop cervical cancer did not respond as well to antiretroviral therapy. Studies that tracked women who started with the same CD4 cell counts when they began antiretroviral therapy found that women who later developed cervical cancer had lower CD4 counts a year after starting therapy than women who did not develop cancer. Currently US CDC HIV treatment guidelines recommend that HIV positive women should receive annual Papanicolaou (Pap) tests to detect precancerous cell changes or early stages of cancer (dysplasia or neoplasia).

### *Anal cancer*

Anal cancer is a form of cancer affecting the anus. The anus includes the external part that you can see, as well as the inch-and-a-half-long end portion of the large intestine that is internal. Anal cancer is seen at much higher rates among gay, bisexual or MSM men with HIV and HPV.

In many countries the incidence of anal cancer has remained high among people with HIV since the introduction of HAART, suggesting that HAART has not had an impact on anal cancer. Anal cancer has become the third most diagnosed cancer among people with HIV. Like cervical cancer in women, anal cancer is usually preceded by pre-invasive lesions called 'anal dysplasia'. If detected early, anal dysplasia can be treated with minor surgical procedures. However anal cancer often goes unnoticed in its early stages, and by the time it is diagnosed people might require chemotherapy and/or radiation therapy and/or surgery.

Signs of anal cancer include itching or swelling of the anus, the presence of a lump, noticing blood in your bowel movements or on toilet paper after wiping, experiencing pain not previously felt during receptive anal intercourse or during bowel movements. The risk of anal cancer rises with age, and predominantly affects individuals who are over the age of 35.

### **Parent to child transmission**

#### *HIV positive women and pregnancy*

A mother can transmit HIV to her child during pregnancy or delivery, or through breastfeeding. The risk of transmission is affected by factors related to the virus, the mother, the delivery

process, the baby, and infant-feeding practices. These factors explain the differing rates of HIV transmission between mother and child in more developed and less developed countries.

During pregnancy and delivery, the mother's health, disruption of the placental barrier, preterm delivery, and hemorrhage are significant predictors of the child's infection. Viral, bacterial, or parasitic placental infections are other factors that increase the opportunity for HIV transmission during this period. Most infants who acquire HIV during delivery have been exposed to maternal blood or cervical secretions that contain the virus. Prolonged membrane rupture and invasive delivery techniques have also been associated with higher risks of mother-to-child transmission (MTCT) during labor and delivery. The risk of MTCT increases if a woman has a higher viral load, which occurs if she becomes infected or reinfected with HIV during pregnancy or if she becomes ill with AIDS.

After delivery, breast feeding is the most significant risk factor. Without treatment, it is estimated that one of every seven infants breast fed by an HIV-positive mother becomes infected through breast milk. The risk of transmission is greater when HIV-positive women do not breast feed exclusively for the first six months, or if complications develop from poor breast feeding techniques (e.g., mastitis, cracked and bloody nipples).

#### *HIV positive men*

Men need information on how to prevent transmission of HIV to their female partners, particularly during their partner's pregnancy and during breast feeding. Whenever men present at health services for HIV tests or HIV care, providers should take the opportunity to ask if they have female partners, and address HIV prevention strategies to reduce parent-to-child transmission (PTCT).

- ◆ Male partners of pregnant women should be explicitly warned about the risk posed to both the mother and the child when they share injecting equipment; or
- ◆ Unprotected sex with other partners who may also have female partners during their partner's pregnancy.

- ◆ Men should also be advised to refrain from such unprotected sex and unsafe injecting while their partner breast feeds.

It is noted that in Thailand like many other South East Asian countries, many MSM have female partners of child-bearing age. It is therefore essential that services offering counseling to MSM explicitly address the issue of preventing MTCT.

It is further recognized that it is important to increase the male partner's involvement in antenatal and postnatal care. Partners should be invited to consultations where appropriate and feasible. Innovations such as "new father" clubs can support the effort to reduce PTCT, and improve family relationships. Just as many antenatal care services offer prenatal classes to women, similar classes can be offered to couples or to prospective and new fathers. It is important that men who are diagnosed HIV-positive are offered support in disclosing their status to their partners. Module 4 offers specific advice on how this can be accomplished.

Men who work during standard clinic hours may not be able to attend clinical and counseling services. The involvement of male partners may necessitate services that have flexible consultation hours and evening information sessions.

### Providing counseling on family planning

HIV-positive women and their partners have the right to choose for themselves whether they want to have children or not. Couples who want to have children should be able to access the medical care and social support they need in order to have safe, healthy pregnancies and healthy babies born without HIV. Information on risk reduction strategies during pregnancy, childbirth and breastfeeding should be made available for HIV-positive people who may consider having babies. In many countries this is now done through prevention of parent-to-child transmission (PPTCT) services that are usually linked to district or central hospitals. NGOs and HIV service organizations increasingly play a central role in raising community awareness of and engagement in PPTCT services.

Equally, in many countries a large number of women first find out they are HIV-positive through antenatal testing programs. While this can be a very stressful time for women, these programs are in place to ensure that HIV-positive women are offered the right care and support during their pregnancy, and all necessary steps are taken to reduce the chances of their baby being infected with HIV

*Despite there being a PMTCT policy, there is still a constant level of infection among pregnant women in Thailand. Authorities don't understand why the number of HIV+ pregnant women does not decline. The focus of the DOH program is not on the reproductive age couple, but focuses narrowly on vertical transmission. This gives rise to repeat pregnancies and more vertical transmission, resulting in warnings from health staff for PLHA to not get pregnant, that their child will be orphaned, that they will both be stigmatized, and that more social problems will result. In fact, the PLHA woman is aware of these consequences but still may want to have a child. In sum, HIV+ women who want to get pregnant are still not well-accepted in Thai society, and counseling services are not well-prepared for this.*

Source: UNGASS Country Progress Report: Thailand, January 2008- December 2009, page 217.

### Key counseling tasks

**Health providers need to address the following:**

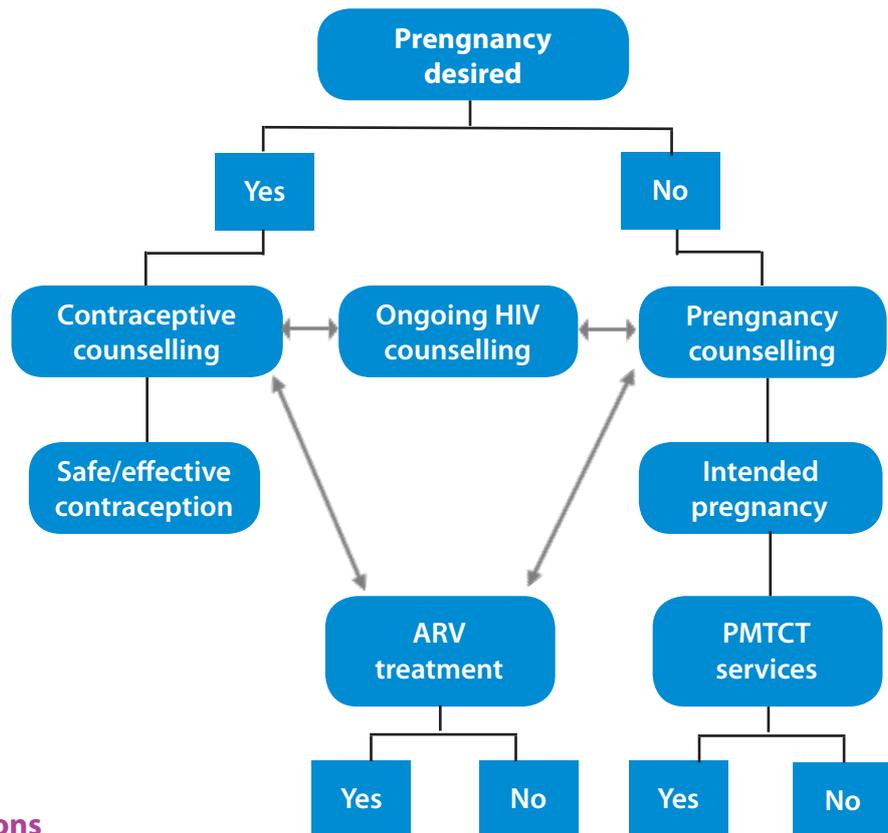
- ◆ Conceiving a baby when one or both partners are HIV-positive
- ◆ Avoiding pregnancy – availability of and access to contraceptives
- ◆ Reducing risk during pregnancy
- ◆ Reducing risk during childbirth
- ◆ Reducing risk during infant feeding
- ◆ Maintaining good health of the mother after childbirth.

## Reproductive health choices for patients with HIV

1. Fertility decision:  
desire pregnancy?

2. Informed decision(s):  
contraceptive  
method? HIV/STI  
prevention?

3. Treatment  
decision(s): ARV  
therapy for self and  
partner?  
PMTCT?



Adopted from: Cates, 2001

### Important considerations

The provider is urged to discuss the following with all patients so the patient can make an informed choice about pregnancy.

- ◆ Availability and quality of local PPTCT services.
- ◆ Availability and quality of local family planning clinics with staff who have been trained in HIV care and support.
- ◆ Opportunities exist for HIV-positive people to discuss reproductive choices. These may exist in HIV treatment centers, family planning centers,
- ◆ Discussing the choices available is an important step for HIV-positive couples who are considering having a baby in order to protect the health of the mother and reduce the chances of HIV transmission to the baby.
- ◆ Some HIV-positive women and their partners find it useful to discuss their questions and thoughts about having babies with other HIV-positive women and their partners. Positive peer support groups can often provide this opportunity.

- ◆ HIV-positive women and their partners need support and information in order to take ARV treatment during pregnancy. Many are worried about the effects of the drugs on the baby. Some HIV-positive women and their partners fear others will find out about their HIV status if they take ARV treatment.
- ◆ Counselors and people who provide information on ARV treatment need to be aware of these issues and be prepared to discuss them with pregnant HIV-positive women.
- ◆ Male partners need to be involved in discussing options for safe conception, pregnancy, delivery and breastfeeding.

*One area of challenge is that the PMTCT program still overly emphasizes the health of the infant. It does not consider the woman's body, her decision options, and pregnancy planning, carrying the pregnancy, or choosing abortion. These decisions need to be based on comprehensive information for the pregnant woman and her partner.*

Source: UNGASS Country Progress Report: Thailand, January 2008- December 2009, page 53.

## Does pregnancy accelerate disease progression?

Based on current research findings, it appears that pregnancy in women with HIV does not accelerate progression of the disease. However, pregnancy often carries serious consequences for infants. Without treatment, about one-third of HIV-infected mothers pass the virus to their newborns during pregnancy, delivery, and breastfeeding. There is only limited evidence to suggest that pregnancy in women with HIV increases the risk of stillbirths and infants with low birth weight.

Nonetheless, for many couples with HIV who choose to conceive, the perceived benefits of having a child outweigh the increased risk of an adverse pregnancy outcome.

## Therapies to reduce transmission

Three positive developments – the impact of ARV therapy on the health and longevity of many people with HIV; the increasing availability of effective means for reducing parent-to-child HIV transmission; and wider availability of support and care services for families dealing with HIV – may encourage women and their partners with HIV to reconsider decisions about sex, relationships, and childbearing.

Helping patients make an informed choice about becoming a parent

Providers are encouraged to talk through the benefits and potential difficulties for parent/parents who wish to conceive in the context of HIV.

The reasons many women and their partners with HIV consider pregnancy include:

- ◆ An intense, emotional need to bear children.
- ◆ Societal, familial, and other relationship pressures to have children.
- ◆ Fear that the children they already have may die.<sup>3</sup>
- ◆ Concern about reduced fertility related to HIV infection.
- ◆ Reassurance that PPTCT programs reduce the risk of having an HIV-infected child.
- ◆ Expectations of receiving ARV therapy and living long enough to see their children grow up.

- ◆ Concern that avoidance of pregnancy might generate suspicion about one's HIV status.
- ◆ Fear that the potential consequences of disclosing one's HIV-positive status to a partner might include violence, abandonment, and loss of finances for children.

## Reasons for taking the decision not to have children

Many HIV positive sexually active women and their partners might not want to bear children and therefore desire contraception. Their reasons to avoid or postpone pregnancy are often the same as those of women who are not infected with HIV: maintaining family economic status, achieving desired family size, and spacing the births of their children.

A woman and her partner with HIV may also want to avoid childbearing for other reasons, such as:

- ◆ Concern that pregnancy will further compromise her health, especially if it is already compromised by HIV-related symptoms. Her partner or spouse may be infected or have already developed symptoms. In the absence of ARV therapy and treatment for opportunistic infections, the length and quality of life may be severely compromised.
- ◆ Fear of transmitting HIV to children she might conceive.
- ◆ Fear of leaving orphans, because HIV infection is likely to shorten her life, particularly without treatment. Parents are naturally concerned about who will care for their children if they are no longer able to do so.
- ◆ Fear that others will be unwilling to care for the family during illness due to HIV-related stigma and discrimination.

## Contraception, lifestyle and HIV

HIV positive women and their partners will need assistance in choosing a contraceptive method that suits their specific needs. Some will be in situations where a barrier method is desired in order to protect their male partner/s. Refer to Tool (T5.1), Contraception and HIV. This tool is designed to offer guidance to clients to enable them and their medical practitioner to make an informed contraceptive choice

Sex workers might also be keen to ensure that all of their partners are protected through the use of male or female condoms and water-based lubricant. Others might choose a long-acting or permanent method such as an injectable, implant or sterilization. The advantages and disadvantages of each method will need to be discussed openly with women and their partners wherever possible.

Women on ARV treatment might also learn that they have an undetectable viral load. While the risk of HIV transmission still exists in this situation, some couples may be prepared to change their contraception method to a non-barrier method when they perceive that the risk of transmission has been reduced. The effectiveness of oral contraceptives can be reduced in women taking ARVs such as Nelfinavir, Ritonavir, Amprenavir, Lopinavir/Ritonavir, and Efavirenz.

- ◆ Family planning can also reduce HIV infections among children by helping women with HIV who do not want to have children avoid pregnancy.
- ◆ Women with HIV who are concerned that they may eventually die of AIDS may decide to use contraception to avoid having children who may some day become orphans.

As we have seen, there are many benefits in providing family planning and effective contraception. Unfortunately, there is also a large and growing unmet need for contraception and other family planning services to sex workers, drug users, MSM with female partners and all HIV positive individuals.

**Promote dual contraception  
Encourage clients to consider:**

- ❖ Limitations of a single-method approach
- ❖ Their individual risk of pregnancy
- ❖ Whether partners have HIV or other STIs
- ❖ The negative consequences that may result

### Integrating reproductive health into HIV care support and treatment

Providing integrated reproductive health services that include family planning counselling and access to contraception to women and couples with HIV can improve their lives and those of their families.

- ◆ When family services are accessible, people with HIV experience the same health benefits as others in their communities. Couples can limit the size of their family to the number of children they desire and are able to care for. Women can space their children properly and reduce the risks associated with too many pregnancies or pregnancies spaced too closely.



## Reproductive health and family planning

### Activity Instructions

Timing:

- 15 minutes for reading of technical brief
- 15 minutes for case discussion in groups
- 30 minutes (10 minutes for large group feedback for each group)
- 15 minutes for facilitator debriefing (5 minutes after each group feedback presentation)

1. You will be assigned to three groups: Group 1 will work on case 1, Group 2 will work on Case 2 and Group 3 will work on case 3. You have 20 minutes for your group work. Identify a group facilitator, a group note taker and presenter for large group feedback.
2. Read the Technical Brief (TB 05) and Tool (T5.1)
3. Using the formula Ask-Screen-Intervene
  - a. Ask – What are some questions you could ask this patient to assess their knowledge of the impact of their lifestyle on their reproductive health, and their HIV?
  - b. Screen – Identify questions that will further explore issues that may compromise this patient’s reproductive health, and increase HIV/STI transmission risk and impact on family planning e.g. contraceptive choices or decisions to have children.
  - c. Intervene – What specific messages and realistic strategies would you offer about managing transmission risks, addressing reproductive health issues and family planning strategies (e.g. appropriate choice of contraception, facilitating informed decisions about having children)?

You will need to draw upon information in earlier modules and tools.

4. Prepare feedback on the OHP transparency, or flip chart paper provided in the following format. To save time please record your answers directly onto your OHP transparency, or flip chart paper as they are discussed. Avoid wasting time writing out on paper first and then transferring into the format neatly.

<u>A</u> sk	<u>S</u> creen	<u>I</u> ntervene



**Case study 1**

Your patient is an HIV positive female sex worker just commencing ART and currently using oral contraception that she buys at a pharmacy. Her regular male partner is also HIV positive and asymptomatic. She is considering about having a child, and mentions having a lot of pressure from her family who do not know her HIV status. They also do not know she is involved in sex work.

**Case study 2**

Your patient is a male sex worker who occasionally injects amphetamines and was recently diagnosed with HIV. He reports that he cannot always get his clients to agree to use condoms. He has not disclosed his HIV status to his wife and does not currently use any contraception with her. He believes she is unaware of his sex with male partners. He also reports he has a regular boyfriend who engages in sex work. He mentions that he is experiencing rectal pain during anal intercourse. He has never had an STI check-up or rectal exam.

**Case study 3**

Your patient is a female sex worker who leads a chaotic life. Despite having been diagnosed HIV positive for several years she continues to engage in sex work and does not appear to use condoms as she frequently reports with symptoms of STI. She reports using oral contraception inconsistently and admits to having had several illegal pregnancy terminations.

# Contraception & HIV

Method	How it works and is used	Advantages and disadvantages	Additional information
<b>Temporary</b>			
<b>Male Condom</b>	<p>Prevents semen from entering the partner’s body.</p> <p>Before sexual intercourse begins, a condom is placed over the erect penis; space must be left at the end to collect sperm. After ejaculation, the condom should be held in place when removing the penis so semen does not spill into the partner’s body. Condoms must be thrown away after one use; they should never be re-used</p>	<p><b>Advantages:</b> The latex condom is a relatively inexpensive method and prevents the spread of most sexually transmitted infections, including HIV. When used correctly every time a couple has intercourse, the male condom has a pregnancy rate as low as 2 percent,</p> <p><b>Disadvantages:</b> Male partners must agree to use a condom. In common use, their pregnancy rates are much higher – around 15 percent.</p>	<p>Only water-based lubricant should be used with a condom. Other lubricants will weaken the condom and may cause the condom to break.</p> <p>The male condom does not cover the entire genital area so that it is still possible to be infected with other STI.</p>
<b>Female Condom</b>	<p>Prevents semen from entering the woman’s body and protects male partner from contact with vaginal fluids</p> <p>Before sexual intercourse begins, the female condom is inserted into the vagina. The female condom is like a polyurethane bag with two flexible rings at either end. One of the rings is used to insert the condom into the vagina and hold it in place. The other ring stays outside the vagina.</p> <p>The female condom should be removed immediately after intercourse.</p>	<p><b>Advantages:</b> It provides women with a way to protect themselves if they are with a partner who refuses to use a male condom. and the female condom When used correctly every time a couple has intercourse, has a rate of 5 percent.</p> <p><b>Disadvantages:</b> The female condom may not be widely available and are relatively expensive per piece. In common use, their pregnancy rates are much higher 21 percent for female condom.</p>	<p>The female condom helps to prevent the spread of most sexually transmitted infections, including HIV.</p> <p>Some sex worker may not clean or replace the female condom between clients, possibly creating a reservoir of infection for HIV and STI.</p> <p>The female condom may also be used in anal sex. The inner ring may be removed after insertion.</p>

**Disclaimer** - Specific individual contraceptive advice should be made by a qualified family planning medical practitioner, with full awareness of a patient’s medical history. This brochure is a general guide designed to encourage providers and patients to consider a variety of alternate methods. It is not to be used as a substitute for medical consultation.

Method	How it works and is used	Advantages and disadvantages	Additional information
<b>Temporary contraception</b>			
<b>Oral Contraceptives (The Pill)</b>	<p>Prevents the release of an egg from the ovary (ovulation) and implantation of the fertilized egg in the uterus (if ovulation should occur).</p> <p>The contraceptive pill should be taken daily. Each pill contains a small amount of a female hormone, progestin. If a woman skips taking a pill, she should take it as soon as possible, and take her next pill at the regular time.</p>	<p><b>Advantages:</b> Oral contraception is easy to use and is 95-98 percent effective.</p> <p><b>Disadvantages:</b> Oral contraception (OC) should be used under a doctor's supervision as prescription of OC may be contraindicated for women with history or suspected thrombosis, breast, ovarian or cervical cancer.</p> <p>Possible side effects of taking the pill include reduced menstrual flow, swollen or tender breasts, headaches, slight weight gain and nausea</p>	<p>The effectiveness of oral contraception can be reduced in women taking ARVs such as Nelfinavir, Ritonavir, Amprenavir, Lopinavir/Ritonavir, and Efavirenz.</p> <p>Co-infection with tuberculosis is common among patients with HIV, and Rifampicin speeds up the metabolism of contraceptive hormones, reducing their effectiveness.</p> <p>A theoretical concern also exists that hormonal contraceptive use by women with HIV could increase HIV shedding therefore increasing risk of HIV transmission to an uninfected partner.</p> <p>The pill does not protect from acquiring STI</p>
<b>Contraceptive Injection (Depo-Provera)</b>	<p>An injection of the hormone progestin stops eggs from being released by the ovaries for three months and thickens cervical mucus, blocking sperm from entering the uterus.</p> <p>The hormone is injected into the muscle of the arm or buttocks. The first injection is usually given during the first five days of a woman's menstrual cycle to ensure she is not pregnant. Injections must be repeated every 12 weeks</p>	<p><b>Advantages:</b> This method is 95 to 98 percent effective within 24 hours of the first injection, which is effective for 12 weeks with minimal side effects.</p> <p><b>Disadvantages:</b> Contraception injections should be given only under a doctor's supervision.</p> <p><b>Side effects:</b> menstrual irregularity and irregular bleeding are common. Headache breast tenderness, nausea and increased dizziness have been reported. Other side effects may include: acne, hirsutism, weight gain and long term bone mineral deficiency.</p> <p>Any side effects, however, will continue for some time after effectiveness has ended, lingering until the last traces of the chemicals have disappeared.</p>	<p><b>The effectiveness of hormonal contraception can be reduced in women taking ARVs such as Nelfinavir, ritonavir, Amprenavir, Lopinavir / Ritonavir, and Efavirenz.</b></p> <p><b>Women on ARV therapy</b> need to receive their DMPA injections on time. DMPA injections can usually be given up to two weeks late, but for women on ARV therapy, the potential risk of a sub therapeutic (ineffective dose-level) dose is greatest at the end of the 13-week dosing period</p> <p>Co-infection with tuberculosis is common among patients with HIV, and rifampicin speeds up the metabolism of contraceptive hormones, reducing their effectiveness.</p> <p>A theoretical concern also exists that hormonal contraceptive use by women with HIV could increase HIV shedding therefore increasing risk of HIV transmission to an uninfected partner.</p> <p>The pill does not protect from acquiring STI.</p>

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Method	How it works and is used	Advantages and disadvantages	Additional information
<b>Contraceptive Implant (Norplant)</b>	<p>Prevents the release of an egg from the ovary (ovulation) and thickens cervical mucus, blocking sperm that are released into the vagina during intercourse.</p> <p>Using a minor surgical procedure, six flexible capsules are implanted just under the skin on the underside of a woman's upper arm. Each capsule contains a small amount of a female hormone, progestin, which is also used in oral contraceptives. The hormone is absorbed into the woman's bloodstream very slowly for as long as the capsules remain in place (up to five years).</p>	<p><b>Advantages:</b> The implant is 91 to 99 percent effective in preventing pregnancy. Effectiveness rate is affected by body weight. The method is effective for up to five years and requires no additional action by the user once it is in place. Once the implant is removed, fertility is restored by the next menstrual cycle.</p> <p><b>Disadvantages:</b> Contraception implants should be used under a doctor's supervision.</p>	<p>The <b>effectiveness of hormonal contraception can be reduced in women taking ARVs such as Nelfinavir, ritonavir, Amprenavir, Lopinavir / ritonavir, and Efavirenz.</b></p> <p>Co-infection with tuberculosis is common among patients with HIV, and rifampicin speeds up the metabolism of contraceptive hormones, reducing their effectiveness.</p> <p>A theoretical concern also exists that hormonal contraceptive use by women with HIV could increase HIV shedding therefore increasing risk of HIV transmission to an uninfected partner.</p> <p>The pill does not protect from acquiring STI.</p>
<b>Intrauterine Device (IDU)</b>	<p>The IUD prevents the fertilized egg from implanting in the uterus.</p> <p>A trained medical person inserts the IUD into the uterus with an attached string left hanging into the vagina. The woman should check the string after each menstrual period to make sure the IUD is still in place. IUDs can remain in the uterus for about 5 years.</p>	<p><b>Advantages:</b> The IUD is 98-99 percent effective in preventing pregnancy. Although it is considered one of the easiest contraceptive methods to use.</p> <p><b>Disadvantages:</b> IUD should be used under a doctor's supervision.</p> <p>Possible side effects include cramps, heavier menstrual flow, irregular bleeding and infection</p>	<p>It is not recommended for women who have never had a child.</p> <p>An IUD can be provided to a woman with HIV if she has <b>no symptoms of AIDS</b>. A woman who developed AIDS while using an IUD can continue to use the device. There is a however, theoretical risk that advanced immunosuppression could increase the risk of IUD-related complications, <b>unless a woman is on ARV therapy</b>. A woman with AIDS who is doing <b>clinically well on ARV therapy</b> – meaning that the symptoms of AIDS are controlled by the ARVs – can both initiate and continue IUD use.</p> <p>IUDs do not protect the woman from acquiring STI.</p>
<b>Diaphragm</b>	<p>Prevents semen from passing into the uterus</p> <p>The diaphragm should be inserted within two hours before intercourse. A spermicidal cream is spread in the cap and around the rim. It is inserted in the vagina completely covering the cervix. The diaphragm should be left in for six to eight hours after intercourse. After each use, the diaphragm should be washed with soap and water, dried and stored in its case.</p>	<p><b>Advantages:</b> The diaphragm is only about 82 percent effective in preventing pregnancy.</p> <p><b>Disadvantages:</b> The diaphragm must be kept readily available and used each time intercourse occurs. If the diaphragm is inserted incorrectly, it may not protect against contraception. Diaphragm used with spermicide 6% failure rate in perfect use; 20% failure rate in typical use.</p>	<p>May offer limited protection from STI as it blocks the Cervix an entry point for gonorrhea, and chlamydia. Further studies are in-progress.</p>

Method	How it works and is used	Advantages and disadvantages	Additional information
<b>Permanent contraception</b>			
<b>Male Sterilization (Vasectomy)</b>	<p>Vasectomy is a procedure that blocks the passage of sperm through the vas deferens. Small incisions on either side of the scrotum allow a surgeon to isolate each vas and to cut it.</p> <p>A male should have a physical examination and complete a health history before the surgery..</p>	<p><b>Advantages:</b> Vasectomy is an extremely effective method of birth control.</p> <p><b>Disadvantages:</b> About two percent of males may experience minor complications including bleeding, fever, abdominal pain, or infection.</p>	<p>This method does not provide any protection against sexually transmitted infections or HIV and therefore should always be used with a latex condom.</p> <p>Because he may not be sterile immediately after the surgery, other methods of birth control should be used for the next 20 ejaculations. Strenuous exercise should be avoided for a week after the procedure</p>
<b>Female Sterilization (Tubal Ligation)</b>	<p>Tubal ligation a procedure that prevents a sperm and ovum from uniting. Because fertilization takes place in a Fallopian tube, tubal ligation is designed to block the tubes so that there is no way for a mature ovum to move through a tube to the uterus.</p> <p>Before deciding on a surgical procedure, a female should be fully informed. A general physical exam, including a Pap smear and pelvic exam, is essential. After the procedure, she will be advised to rest for 24 to 48 hours and to resume her normal activity in a few days. Heavy lifting, strenuous exercise, and penile-vaginal intercourse should be avoided for a week</p>	<p><b>Advantages:</b> Sterilization is a highly effective contraceptive method, although a backup contraceptive method should be used until the first menstrual cycle.</p> <p>Failure rate: Female: 0.5% after one year, increasing to 1.85% over ten years</p> <p><b>Disadvantages:</b> Some pain may be experienced for a short time after the surgery at the site of the incision. About two percent of females may experience minor complications including bleeding, fever, abdominal pain, or infection.</p>	<p>This method does not provide any protection against sexually transmitted infections or HIV and therefore should always be used with a latex condom.</p>

**Disclaimer** - Specific individual contraceptive advice should be made by a qualified family planning medical practitioner, with full awareness of a patient's medical history. This brochure is a general guide designed to encourage providers and patients to consider a variety of alternate methods. It is not to be used as a substitute for medical consultation.

Method	How it works and is used	Advantages and disadvantages	Additional information
<b>Other methods</b>			
<b>Emergency Contraception (Morning After Pill)</b>	<p>The emergency contraception pill works by giving the female body a short, high, burst of synthetic hormones. This disrupts hormone patterns needed for pregnancy. The pill affects the ovaries and the development of the uterine lining, making pregnancy less likely.</p> <p>The female partner takes the emergency contraception pill after unprotected sexual intercourse or after sexual intercourse with contraception has failed, for example, the condom has broken during intercourse.</p>	<p><b>Advantages:</b> The emergency contraception pill may be effective up to 120 hours (5 days) after intercourse. But, it is most effective within the first 24 hours. Emergency Contraception reduces the risk of pregnancy by 75 - 89%.</p> <p><b>Disadvantages:</b> The method is much less effective than methods of birth control you use before sex such as condoms or birth control pills.</p>	<p>Depending upon where the woman is in her menstrual cycle, the hormones prevent pregnancy in different ways. It prevents ovulation (the egg leaving the ovary and moving into the fallopian tube). It blocks the hormones needed for the egg to be able to be fertilized. It may affect the lining of the uterus and alters sperm transport, which prevents sperm from meeting the egg and fertilizing it.</p>
<b>Termination of Pregnancy</b>	<p>The term "Termination of Pregnancy" actually refers to any premature expulsion of a human fetus, whether naturally spontaneous, as in a miscarriage, or artificially induced, as in a surgical or chemical termination of pregnancy. Today, the most common usage of the term "Termination of Pregnancy" applies to artificially induced termination.</p> <p>Termination ends a pregnancy by destroying and removing the developing child.</p>	<p><b>Advantages:</b> Termination of pregnancy is 100 percent effective.</p> <p><b>Disadvantages:</b> Termination of pregnancy can lead to physical problems in the woman that range from hemorrhage and infection to sterility and even death. Psychological effects of a termination of pregnancy range from depression and mental trauma.</p>	

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### My partner and I both have and we want to have a baby, how can we protect our baby?

To reduce the risk of HIV being passed from a mother to her baby a combination of three antiretroviral drugs (ARVs) can be provided to the mother during her pregnancy, if the mother is not already on ARV treatment. This can greatly reduce the chance of your baby being infected.

Many doctors suggest that there are important reasons why caesarian section (c-section) is recommended to women with HIV. This involves surgery where the baby is taken out of the mother's body through the mother's abdomen. This surgery is recommended as many babies become infected during natural birth process. Some studies have shown that c-section can halve the risk of passing on HIV if the c-section is performed before the mother's water has broken. After the birth, your baby will be prescribed ARVs and you will be taught how to give your baby the medicine before you go home.

In Thailand the government provides free formula and advises mothers to only feed their babies with this formula. HIV can be transmitted in breast milk. Women are advised against using a combination of breast feeding and formula feeding (called mixed feeding) as this has been shown to increase the risk of passing HIV to the baby. Mixed feeding may damage the lining of the baby's stomach and intestines making it easier for HIV in breast milk to infect the baby but when taking ARVs to prevent mother to child transmission, the risk is reduced and is currently recommended by the WHO.

### Are the mothers ARV treatments safe for the baby?

Most of the ARVs are safe for pregnant women. There are some drugs that could be harmful to your baby such as Efavirenz (Stocrin) or Ribavirin (used to treat Hepatitis C). If you are not on contraception or you think you think you could be pregnant and you are taking those drugs it is important that you talk to your doctor.

### My uninfected female partner and I want to have a baby? Is there any way we can safely have a baby?

An effective way to prevent transmission is sperm washing. This involves separating sperm cells from seminal fluid, and then testing these for HIV before artificial insemination or in vitro fertilization. Sperm washing is a very effective way to protect both the mother and her baby, but it is only available at a few clinics in Thailand

There will always be a risk associated with having unprotected sex with your female partner so you both need to discuss this and make an informed decision. Doctors may advise that you wait until the amount of virus in your blood (viral load) is low or undetectable before you have unprotected sex, and minimize the number of times you have unprotected sex with your female partner by choosing to only have unprotected sex during the time of the month that she is most likely to fall pregnant. You are strongly advised to discuss this with your HIV doctor and your partner.

Men who have female partners who are breastfeeding should use condoms.

### I have HIV, am pregnant and use drugs – what will happen to my baby?

Using drugs not prescribed by your doctor is never a good idea if you are not using contraception or think you are pregnant as the drugs could harm your baby. If you find it hard to give up drugs you need to talk to a drug and alcohol counselor as well as your HIV doctor and your obstetrician. Your baby may experience withdrawal symptoms after it is born and may require special care.

Sharing injecting equipment can bring harmful infections into your body and put your baby at risk of these infections also.

## Contraception, Pregnancy and HIV



Information for men and women



M05-T5.2

### A HIV positive mother can pass HIV to her baby

- Whilst the baby is in her womb
- During birth
- During breast feeding

### HIV positive men should be aware of the following:

- If you have unprotected sex with a female partner you could pass HIV to both the woman and the unborn child.
- If you have unprotected sex with an uninfected female partner whilst she is breastfeeding an infant she could become infected and also infect the baby.

Every woman has the right to have a baby and being HIV positive is no exception. If you are HIV positive or your partner is HIV positive it is important that your decision to have a child is an informed choice. An informed choice means knowing and understanding all of the options available to you and knowing what these options involve.

### Want to avoid pregnancy?

Your choice of contraception should take into consideration your lifestyle, side effects and health issues associated with the contraception. If you take drugs, or have lots of different sex partners you need to protect yourself from getting other infections, and also think about how to protect others from HIV. You should discuss this with a trained health professional, and one who you would feel comfortable telling that you or your partner's have HIV. It is also important that you find a health worker who you could openly talk about your lifestyle issues.

Pregnancy can be prevented in a number of different ways and some methods are more effective than others. No method is absolutely guaranteed other

than to avoid sexual intercourse. It is suggested that two forms of contraception are used. Doctors call this "dual protection"

**Male and Female condoms** – are still the best protection as they protect you from other infections that can make it difficult for your body to fight HIV. However, as condoms can break, especially if used incorrectly. They are not 100% reliable.

**Oral contraceptives** – the effectiveness of oral contraception (OCs) can be reduced in women taking ARVs and so it is important that you let both your HIV doctor and your family planning doctor know what you are taking. It is also important that you do not buy the OCs from the pharmacy without consulting a doctor. The effectiveness of OC is also reliant on you or your partner remembering to take them – that can be difficult if you are leading a busy life, or using drugs or alcohol. Also sometimes if you vomit or have diarrhea your body may not absorb enough of the OC to prevent pregnancy. OCs will not protect you from getting other STIs or transmitting HIV.

**Contraceptive injection** – A hormone is injected into you into the muscle in your arm or buttocks. Injections must be repeated every 12 months. You will not be protected against STIs or HIV transmission, and again as this injection is a hormone, the effectiveness may be reduced when you use certain ARV drugs. It is recommended that you discuss this option with your HIV doctor. However, this is a good contraceptive option for people who are having problems with remembering to take pills, or by women worried they cannot absorb other the OCs because they experience vomiting, or diarrhea.

**Contraceptive implant** – An implant is when a doctor inserts six very small capsules just under the skin on the underside of a woman's upper arm. Each capsule contains a small amount of hormone. However, this is a good contraceptive option for people who are having problems with remembering to take pills, or by women worried they cannot absorb other the OCs because they experience vomiting, or diarrhea.

**Intrauterine Device (IUD)** – A trained medical person inserts a small device into the womb (uterus) IUDs can remain in place for up to 5 years. This method can cause cramps, heavier menstrual flow and irregular bleeding and sometimes infection.

**Other types of temporary contraception include** the use of a diaphragm and spermicide, and very contraceptive gels however these have significantly lower rates of infection.

**Male sterilization (Vasectomy)** – Involves a surgical procedure performed by a doctor, a very effective but permanent form of contraception. Only a small number of men experience any side effects. Most these are minor and short term. This method however does not prevent the transmission of HIV or STI. There are a number of family planning services that provide free male sterilization in Thailand. Ask your counselor or doctor for a referral.

**Female sterilization (tubal ligation of tubal implants)** – Tubal ligation, often referred to as "having your tubes tied," is a surgical procedure in which a woman's fallopian tubes are blocked, tied, or cut. Tubal implants are small metal springs that are placed in each fallopian tube in a nonsurgical procedure (no cutting is involved). Over time, scar tissue grows around each implant and permanently blocks the tubes. Either procedure stops eggs from traveling from the ovaries into the fallopian tubes, where the egg is normally fertilized by a sperm.

Tubal ligation and tubal implants are considered to be permanent methods of birth control for women. They are usually done by a gynecologist. This method does not provide any protection against sexually transmitted infections or HIV and therefore should always be used with a latex condom.



Positive Health: **Prevention in Care**

# MODULE 06



## Maintaining Health and Treatment Efficacy

### Session objectives:

At the end of the training session, trainees will be able to:

- ◆ Assess the need for strategic planning for comprehensive preventative health activities in HIV treatment and care;
- ◆ Identify the interrelationship between ART adherence, nutrition support, dental health care and health maintenance;
- ◆ Identify the interrelationship between ART adherence, nutrition support, dental health care and transmission risk reduction.

### Time to complete module:



3 hours 30 minutes

### Training materials:



1. Technical Brief, TB06
2. Activity Sheets, AS6.1.
3. Tools, T6.1, T6.2, T6.3, T2.1, T.6.5, T6.6, T6.7, T6.8
4. Question box

### Content:



- ◆ Treatment adherence
- ◆ Treatment resistance
- ◆ HIV-related psychiatric conditions and adherence
- ◆ Nutrition and HIV
- ◆ Dental health and HIV

### Session instructions



#### 1. Introduction

Time  
**10 minutes**

- ◆ Introduce the session by asking the trainees to respond to the following question:  
What are issues related to PLHIV maintaining health?
- ◆ Write key words from the trainees' responses on flipchart paper.
- ◆ Explain that this question will be examined further throughout the session.

#### 2. Technical Brief (TB06) and lecture

**90 minutes**

- ◆ Instruct participants to read the sections on treatment and treatment resistance in the Technical brief (TB06) answer from a group.

Ask the following questions to check for their understanding of the reading:

- What level of adherence is required to ensure resistance does not occur?
- What are the key challenges confronting treatment services in relationship to ART?
- ◆ Instruct participants to read the sections on psychiatric conditions in the Technical brief (TB06) and review the tools (T2.1) and (T6.6)

Ask the following questions to check for their understanding of the reading:

- What types of mental health disorders are you likely to see in HIV?
- How might these disorders reduce an individual's ability to adhere to treatment?
- ◆ Instruct participants to read the sections "How can we support substance users?" in the Technical brief (TB06)

Ask the following questions to check for their understanding of the reading:

- List some of the criteria for substance dependence syndrome (addiction)?
- What does drug tolerance mean?
- What are some interventions you would use for a drug user who is in Pre-contemplation stage?
- What are some interventions you would use for somebody in the maintenance use?
- ◆ Again, instruct participants to read the sections on oral health and prevention in the Technical brief (TB06). Ask participants to look at the patient education tool Oral and Dental Problems (T6.8).
  - What is the relationship between poor oral health and treatment adherence?
  - What oral infections can be transmitted to sex partners?
- ◆ Instruct participants to now read the sections on nutrition and HIV in the Technical brief (TB06).
  - How is the diet of a person related to treatment adherence?
  - What are some of the common symptoms of HIV that may need special dietary advice?

### 3. Tools (T6.1, T6.2, T6.3, T6.4, T.6.5, T6.7, T.68)

**30 minutes**

- ◆ Introduce tools T6.1, T6.2, T6.3, T6.4, T.6.5, T6.7.
- ◆ Briefly explain how each tool is used as follows:
  - T6.1 is used to screen patients prior to commencement on ART and is useful to assist in anticipating possible barriers to adherence and facilitate development of strategies to overcome these problems.
  - T6.2 is a cue card that can also be used as a medical record and is used to track and record action you have taken with the patient.
  - T6.3 may be used to provide strategies on how to resolve some common barriers to adherence.
  - T6.4 are a series of patient education leaflets on various issues and should be used in conjunction with verbal information you provide in your pre treatment and follow-up adherence counseling sessions or after the initial entry into care assessment (T2.2)
  - T6.5 This is a patient education brochure about taking ART and adherence
  - T6.6 This is a provider tool to assist with differential diagnosis of mental health disorders
  - T6.7 is a tool that can be used to help explain treatment resistance to patient's
  - T6.8 is a tool we have already discussed that is designed to facilitate discussions between client/patients and their health provider about their oral-dental health problems and HIV.

**4. Activity (AS6.1)****75 minutes**

- ◆ Inform the participants that they will be given a completed screening form based on a patient record. The answers recorded in the form indicate what the patient said. Point out that when they are completing this screening form in their service, they may not directly record the exact words of the patient but, rather summarize. For the purpose of this training exercise, the exact words of the patient have been recorded.
- ◆ Explain that the participants are to do the following:
  1. Individually review the completed form.
  2. Referring to the technical briefs and other training materials, they should prepare answers for the following questions:
    - Is the patient addicted to any substances? Which ones?
    - What other questions besides what appear on this form might help you make a decision about whether the patient has an addiction?
    - What are some strategies you would put into place to assist this patient to remember to take his medication?
    - What are some strategies that might help overcome some of the barriers to adhering to medication?
    - What does this client need to know about drug and alcohol use and treatment?
    - What are the issues related to HIV transmission that need to be discussed with the patient in relation to his treatment?
    - What further screen or referrals would you make for this patient?
    - Which of the educational tools provided in this package would be useful for this patient?
    - How should you address the family beliefs about traditional medicine?
    - What other patient lifestyle choices would you need to investigate in terms of positive health?
    - What other social issues may have an impact on treatment issues or prevention?
    - Would you recommend that this patient start ARV treatment?
- ◆ At the end of 60 minutes, randomly call on a participant to provide his/her answer to a question. When an answer has been provided, ask the other participants for comments and / or additional information. One facilitator should make a list of the correct answers provided, which can later be distributed to all participants.

**5. Session recap****5 minutes**

- ◆ Ask the group to summarize and discuss the key learning points from the activities.
- ◆ Ask the group if they have any questions and remind them about the “question box”.

## Positive Health: Prevention in Care

### MODULE 6

## Maintaining Health and Treatment Efficacy

*Prevention in care should not be restricted to addressing prevention of HIV transmission. Rather it should be conceptualized as offering a strategy for ensuring that an individual knows how to improve or maintain their health.*

This technical brief will review HIV treatment adherence, nutrition and dental strategies to maintain health and the efficacy of treatment.

### Antiretroviral therapy and treatment resistance

'Antiretroviral' (ARV) refers to a medication that stops or inhibits the replication of a retrovirus such as HIV. ART is a complex treatment with multiple medications that once started need to be taken long-term. Studies have shown that an adherence rate of over 95% is associated with controlling HIV replication, which allows an optimal therapeutic response to the medications. The aim of antiretroviral therapy (ART) is to prolong and improve the quality of life by maintaining maximal suppression of HIV replication for as long as possible. Antiretroviral therapy (ART) has reduced HIV morbidity and mortality by 60-90% and improved the quality of life of many PLHIV.

For ART to be effective, a patient must take all prescribed medication regularly and at the same time each day. Some have specific requirements, such as, they must be taken before or after a meal and with a certain fluid.

Sub-optimal adherence to the ART regimen can result in the failure of the prescribed regimen, continued destruction of CD4 cells and the emergence of resistance to the antiretroviral. ARV resistance, in addition to causing regimen failure, will compromise future treatment options and lead to increased risk of mortality.

Non adherence to other medications including STI, TB medications or OI prophylaxis may also result in their diminished treatment effectiveness if they are not taken as prescribed.

Multiple ARVs are used to interrupt the different parts of the life cycle of the virus. A dramatic reduction in viral load (the level of virus in the blood) with resulting arrest in immune damage is achieved by combining at least three drugs from the various classes of antiretroviral drugs into a "cocktail."

### Transmission of treatment resistance

While this was mentioned earlier in Technical Brief (TB03) it is important that we reinforce this with regard to individuals who are on ART.

This three-drug antiretroviral cocktail is called "Highly Active Antiretroviral Therapy" (HAART). Each class of anti-HIV drugs attacks the virus at a different stage of replication while it is growing in the human host lymphocyte cell. The common classes of drugs currently on the market are the nucleoside reverse transcriptase inhibitors such as Zidovudine (AZT), Lamivudine (3TC), Abacavir; the non-nucleoside reverse transcriptase inhibitors such as Nevirapine and Efavirenz; and the protease inhibitors such as Indinavir, Ritonavir and Lopinavir.

### Challenges in ART

- ◆ Side effects of the drugs are common and need to be clinically monitored. Side effects may lead to stopping or changing the drug, or changing lifestyle to reduce illicit drug and alcohol intake in case of liver toxicity.
- ◆ HIV can easily become resistant to ARVs, hence the need to combine different classes of ARVs to treat patients.
- ◆ Most of the ARVs interact with other drugs commonly used in the treatment of opportunistic diseases such as tuberculosis and fungal infections.

This requires adjusting the dosage of the drugs or the discontinuing of ARVs while taking other medication.

- ◆ Most of the ARVs currently available have strict medication schedules or storage requirements. The protease inhibitors, for example, require a very strict time regimen to be effective (e.g. Indinavir every eight hours on an empty stomach). Some require refrigeration (e.g., Ritonavir, Lopinavir). Others need precautions to avoid severe side effects (Indinavir, for example, requires at least 1 litres of water a day to avoid kidney stones; Efavirenz can cause insomnia with vivid dreams, requiring it to be taken only at night). Pregnant women should not use Efavirenz. Medical advances are developing new drugs and drug combinations to make them easier to take with fewer side effects.
- ◆ ARV must be taken life-long if AIDS is to be a manageable chronic illness. It requires a lifelong relationship between client and the healthcare team.

### What is needed to support treatment adherence and minimize treatment resistance?

It is extremely important that clinical services establish a system where they take time to assess and prepare individuals for the chronic long-term treatment needed and to consider the diverse needs of individuals from MARPs.

It may be best to initiate treatment only when the individual:

- ◆ Has emotional and practical life supports e.g. has family members, friends, community volunteers or members of PLHIV clubs to support him or her taking medication
- ◆ Fits his/her treatment regimen into a daily routine;
- ◆ Understands non-adherence leads to resistance and understands resistance can be passed to others through unprotected intercourse or sharing injecting equipment;
- ◆ Recognizes that all doses **must** be taken as prescribed (the correct dose, interval between doses and in the correct way i.e. with or without food);

- ◆ Understands that traditional medicines and special dietary supplements may adversely impact on ART and health and that use of these should be discussed with the treating physician.
- ◆ Feels comfortable taking treatment drugs in front of others i.e. patient has either disclosed HIV status to others, or has a prepared explanation for taking pills;
- ◆ Keeps clinical appointments;
- ◆ Is alerted to “warning signs and symptoms” that warrant seeking medical assessment and treatment, i.e. when to see a doctor;
- ◆ Understands the interaction and side effects of ARVs in combination with illicit drugs and where applicable oral substitution therapies;
- ◆ Knows how to manage common side-effects of the medication e.g. nausea, vomiting, diarrhea etc.

### How can this be facilitated?

At least three preparatory adherence counseling visits to discuss the above mentioned topics should occur prior to starting ART, and continual adherence counseling, after commencement of ART is required. The preparatory visits should be spaced one week apart to allow for short term reinforcement of teaching points about adherence, treatment information, and practice with mock pills/medications. Following the final preparatory visit, the treating physician and nurse counselor should assess patient readiness to initiate treatment.

Session One	Session Two	Session Three
<p>Medical assessment</p> <ul style="list-style-type: none"> <li>Educate client</li> <li>Non adherence and resistance</li> <li>Transmission of resistance</li> <li>High CD 4/ low viral load does not mean no transmission</li> </ul>	<ul style="list-style-type: none"> <li>Update patient on medical status</li> <li>Education about side effects and management</li> <li>“Walk through” of treatment regimen</li> <li>Set “homework practice” run with dummy pills or candy</li> </ul>	<ul style="list-style-type: none"> <li>Assess patient understanding of regimen</li> <li>Review patient experience in “homework practice”</li> <li>Problem solve</li> <li>Contact information taken and follow-up appointment organized</li> </ul>

In addition, to adherence support, the adherence nurse, counselor and/or physician should perform adherence assessment and monitoring. Adherence should be assessed on a basic level at all visits by all members of the multi-disciplinary team.

**What is adherence assessment and monitoring?**

Measuring adherence is problematic as there is no single method to assess adherence accurately. Therefore, multiple approaches are used to assess adherence. Some of the currently used measures are client self-

In summary the key patient messages include:

- ◆ **Correct dose!** e.g. do not increase or decrease without medical consultation
- ◆ **Correct way!** e.g. with/without food interactions with recreational drugs and alcohol.
- ◆ **Every time!** What should be done if a dose is missed, what should be done if the patient has vomiting or diarrhea.

**What kind of support is required after commencement of ART?**

The individual should have a follow-up adherence counseling visit within one to two

weeks and then ongoing adherence counseling should be provided on a continual, regular basis. Adherence barriers can change over time due to changing life circumstances. Adherence levels change with time as patients get accustomed to their treatment, experience side effects,

feel better or worse, or face new challenges. Adherence support needs to change over time as well. Different patients require different levels of ongoing support at different points in time. Ongoing adherence counseling and continuing interactive communication are the keys to providing effective adherence support to the patient taking ART.

report, electronic monitoring devices, pill counts, provider estimation and measurement of medications in the blood stream. All methods have their strengths and weaknesses.

**Psychiatric conditions and treatment adherence**

The presence of psychiatric and neurological disorders poses substantial challenges to maintaining treatment adherence and can limit an individual’s ability to modify transmission risk behavior. Individuals may present at clinical services with a pre-morbid, co-morbid or HIV-related psychiatric disorder.

Time (Years)	0-1	1-2	2-10	3-15	Death
HIV Stage	0 At Infection	I Initial Diagnosis	II Asymptomatic Phase	III & IV AIDS	After Death (significant other)
Mental Health	<ul style="list-style-type: none"> <li>Substance Abuse</li> <li>Pre-morbid disorder e.g. schizophrenia</li> <li>Post-Traumatic Stress Disorder (PTSD) associated with sexual assault and diagnosis.</li> </ul>	<ul style="list-style-type: none"> <li>Acute stress reactions</li> <li>Adjustment disorders</li> <li>Panic disorders</li> <li>Delirium</li> <li>Suicide</li> </ul>	<ul style="list-style-type: none"> <li>Depression</li> <li>Substance abuse</li> <li>Anxiety disorders</li> <li>Personality changes</li> <li>Suicide</li> </ul>	<ul style="list-style-type: none"> <li>HIV Dementia</li> <li>Delirium</li> <li>Psychosis</li> <li>Mania</li> <li>Depression</li> <li>Seizures</li> </ul>	<ul style="list-style-type: none"> <li>PTSD</li> <li>Complicated bereavement</li> </ul>

HIV-related neuropsychiatric disorders are the result of direct or indirect effects upon the brain of HIV or from complications resulting from the individual’s immunosuppression, such as opportunistic or tumors. They include:

- ◆ Depression
- ◆ Personality change

- ◆ Psychosis
- ◆ HIV Mania
- ◆ Minor Cognitive /Motor impairment
- ◆ HIV Dementia

An international study shows that

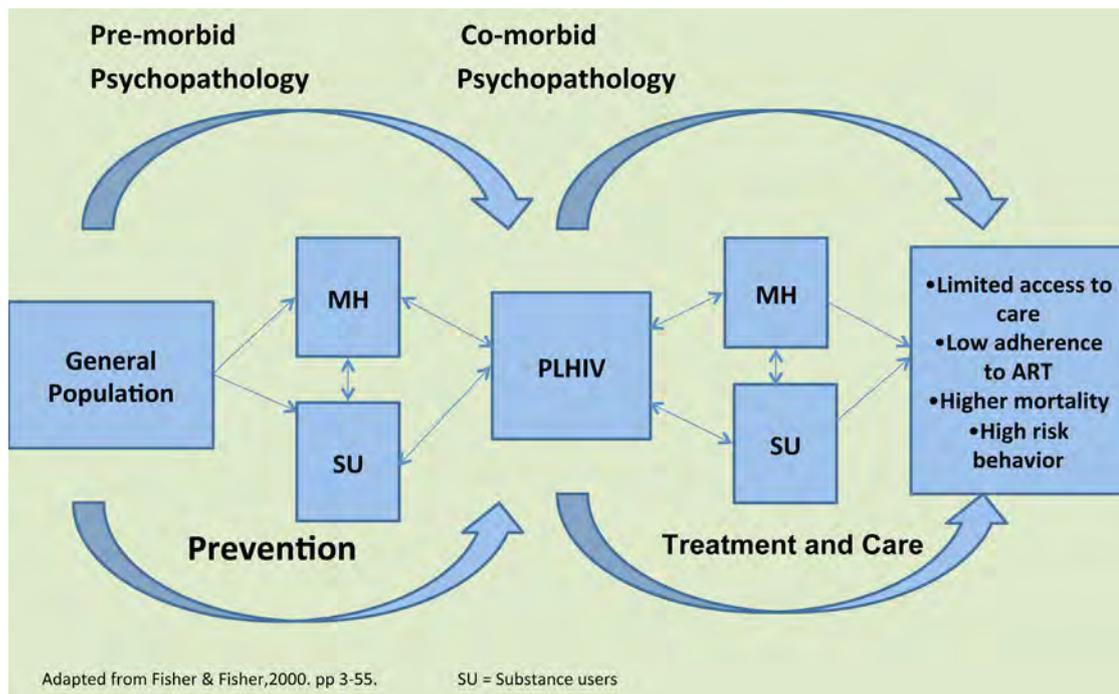
- 10% of HIV-infected patients worldwide are IDUs
- 70% patients with HIV suffer from an acute psychiatric complication during the course of the illness
- 90% of people who have recently been diagnosed with HIV infection suffer from acute stress disorder

Individuals who are on treatment, especially those who engage in substance use should be routinely screened for the presence of these disorders. Difficulties with planning and

scheduling daily activities, attention and memory problems, and poor motivation are common to many of these disorders and may inhibit an individual's ability to adhere to treatment. In HIV-related dementia, psychosis or mania individuals may incorporate the concept of medication into their delusions and refuse to take medication, considering it to be poison. Individuals who experience paranoid thinking may resist the support offered by others. Research indicates that HIV infected children and adult substance users may be more predisposed to these disorders.

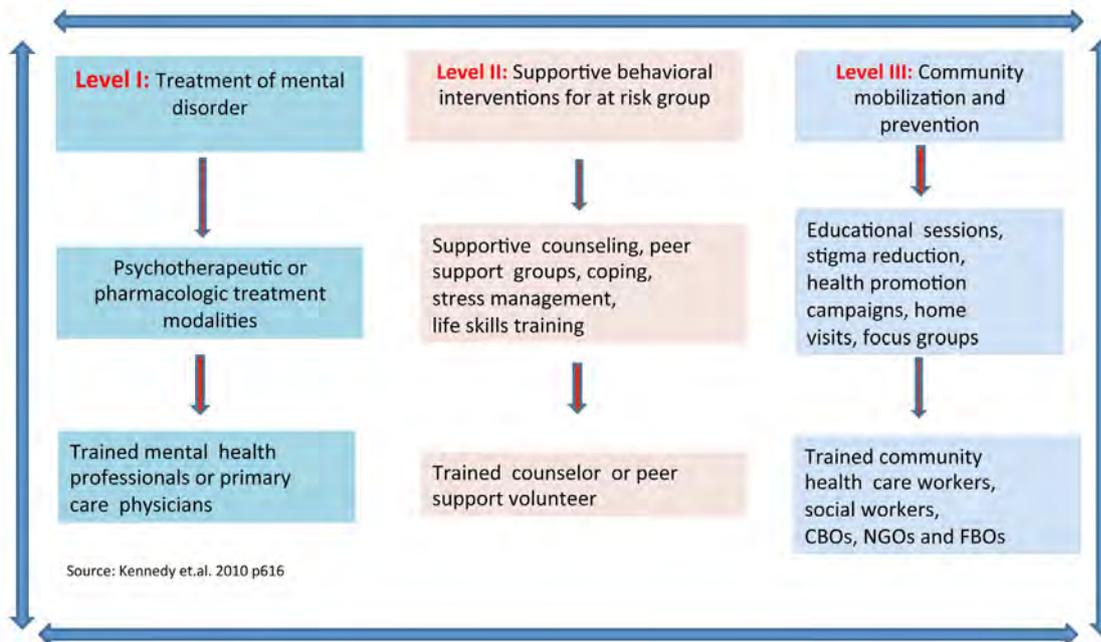
### HIV, mental health and transmission

MODULE 06



An important part of patient support planning is to conduct a routine assessment (T2.1 Case Support Planning), which can assist with screening for these disorders. Medical staff without a background in psychiatry may find the Mental Health Presenting Problem (MHPP) flow charts (T6.1) can assist them to make appropriate referrals or other interventions.

### WHO framework for integrating MHS in HIV/AIDS interventions



### How can we support substance users?

Substance users need a lot of support related to adherence, general health and changing transmission risk behaviors.

Initiation of ART is rarely an emergency and therefore drug and alcohol using individuals should be carefully assessed, well informed, motivated and have had potential barriers to adherence addressed prior to commencement of therapy.

Substance dependency assessment and management is desirable for dependent individuals and controlled substance use (for binge substance users). The case support planning form (T2.1) contains questions about drug and alcohol use. If a patient indicates that they are using drugs and alcohol then the health service provider is advised to complete a more detailed substance use history, or alternatively, quickly screen using The Severity of Addiction scale (SAS) as follows:

### SEVERITY OF ADDICTION SCALE (SAS)

1. Did you ever think your [drug] use was out of control?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
2. Did the prospect of not taking any [drug] make you anxious or worried?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
3. Did you worry about your [drug] use?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
4. Did you wish you could stop using [drug]?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
5. How difficult would you find it to stop or go without [drug]?	0 Easy	1 Quite difficult	2 Very difficult	3 Impossible

A detailed interview would enable the trained counselor or health worker to use formal diagnostic criteria for dependence are outlined in Box 6.1. It is important that counselors and patient support coordinators have an understanding of diagnostic criteria for substance dependency and other substance use disorders. It is suggested that the service provider asks a series of questions consistent with the criteria that appears in Box 6.1 in order to assess the need for a formal diagnosis by qualified clinical psychologist, psychiatrist or medical practitioner should make the formal diagnosis in relationship to substance use disorders. Tool (T6.6) may be of assistance where a patient does not directly disclose use

of drugs or alcohol during routine follow-up, yet displays behavior that is consistent with intoxication or withdrawal from drugs or alcohol.

Individuals who are diagnosed as substance dependent should be offered referral to an appropriate specialist drug and alcohol treatment service. It is important that the substance/s used are identified. This will determine the appropriate referral agency. For example, if a patient is dependent on opioid then it may be appropriate to refer to a methadone maintenance program, however if the patient is dependent on amphetamines a different type of treatment program would be required.

Referral to drug treatment services has been shown to improve treatment adherence. For example opioid dependent patients who have consistent participation in a **methadone maintenance** treatment program have been shown to have a higher probability of HAART use, and a more consistent use of or adherence to HAART.

The following should be facilitated for all substance users where possible prior to commencement on treatment:

- ◆ Stabilized living conditions
- ◆ Dealing with psychiatric disorders (pre-morbid and HIV-related)
- ◆ Stabilization of serious medical conditions

Management of prescribed and non-prescribed drug interactions and adjusting drug doses requires close medical supervision.

Dispensing medication in small amounts at frequent intervals will lead to:

- ◆ Opportunities to detect and address adherence problems before they lead to drug resistance
- ◆ Limited disruptions in or misuse of treatment

Once daily options, low pill burden, and the use of fixed dose combinations (FDC) may be of benefit in this early stage of treatment.

Again it is important to ensure substance users understand that use of illicit drugs and alcohol may complicate their treatment due to complex drug interactions, and also because of other substance use-related health issues such as poor nutrition or substance related illnesses.

Many HIV infected substance users also have hepatitis B or hepatitis C and will require support in avoiding or limiting alcohol consumption. Both infections may complicate HIV treatment by increasing the frequency of ART-liver toxicity.

The Stages of Change model discussed in Module 3 (TB03) can also be used to guide your choice of appropriate interventions for a client who uses drugs or alcohol. An example is provided in a table "Stage specific behavior change interventions" at the end of this technical brief.

### Nutrition and HIV

HIV positive sex workers, drug and alcohol users, transgender and men who have sex with

#### Box 6.1 ICD-10 diagnostic guidelines

A definite diagnosis of dependence syndrome is usually made only if three or more of the following were present together at some time during the previous year:

- ◆ Evidence of tolerance, such that increased doses of the psychoactive substance are required to achieve effects originally produced by lower doses;
- ◆ Physiological withdrawal state when substance use has ceased or has been reduced:
  - as evidenced by the characteristic withdrawal syndrome for the substance, or
  - use of the same (or closely related) substance to relieve or avoid withdrawal symptoms;
- ◆ Strong desire or sense of compulsion to take the substance;
- ◆ Difficulty controlling substance-taking behavior—onset, termination, or levels of use;
- ◆ Progressive neglect of alternative pleasures or interests because of psychoactive substance use—increased amount of time necessary to obtain or take the substance or to recover from its effects; or
- ◆ Persistent substance use despite clear evidence of overtly harmful consequences—depressive mood states consequent to periods of heavy substance use or drug-related impairment of cognitive functioning.

men may need nutritional support due to their lifestyle or concern with body image.

### Food security, nutrition, and food safety

Too often nutrition is ignored in HIV treatment and care. Good nutrition can help boost immune function, manage symptoms, maximize the effectiveness of antiretroviral therapies and contribute to a better overall quality of life. Many individuals from MARPS have poor nutritional status due to lifestyle factors including “living-on-the-street”, drug and alcohol use and often a lack of routine.

Food security and food hygiene are also important considerations for individuals living with HIV. Often HIV positive individuals living in many countries such as Thailand have to cope with muscle wasting and opportunistic infections (OI) linked to unsafe food or water. Even when gaining adequate and safe food is not an issue, many PLHIV experience significant concerns about body shape changes, elevated blood lipids, and other metabolic complications associated with HIV infection.

Frequently in the absence of adequate guidance individuals make inappropriate choices with regard to how to manage weight loss and muscle wasting, common in late stage HIV infection. Many symptoms of HIV illness, e.g. nausea, diarrhea or muscle wasting, can be managed through changes in diet.

It is important that patient support coordinators ascertain whether poor nutritional status of a patient is related to poverty and an inability to purchase sufficient and continuous supply of nutritious food. Many non-government and community based organizations in Thailand offer food to individuals in need.

### Disease progression and nutrition

Often by altering the metabolism, acute or chronic illness (including HIV disease and OIs), and the resulting deterioration in immune response, can increase the HIV-infected individual’s required calorie intake, and need for vitamin, minerals and macronutrients.

Nutritional deficiencies can impair immune function, potentially increasing disease progression. Muscle wasting is a significant issue in HIV. Muscle wasting is the loss of lean

body mass rather than fat. Whilst ART has reduced the incidence of severe wasting, moderate weight loss is still common. Weight loss is associated with nausea, diarrhea, thrush, history of drug use, malnutrition, a CD4 cell count below 200/mm and HIV viral loads above 100,000copies/ml.

**Opportunistic infections (OIs):** Infections such as oral candidiasis (known as thrush), gingivitis (gum inflammation) and cytomegalovirus esophagitis (throat inflammation) can make eating painful and result in an inadequate diet. Various bacterial, viral, fungal and parasitic infections can interfere with proper nutrition. Cancers and mycobacterial illnesses often result in the patient exhibiting muscle wasting. Several OIs cause vomiting or diarrhea, which can lead to poor absorption of loss of nutrients, as well as causing inadequate levels of treatment drugs in the body.

**Malabsorption:** Treatment efficacy is hampered when malabsorption occurs. Clients may not maintain a consistent therapeutic level of treatment drugs and therefore become resistance to medication over a time. HIV or associated infections can damage the lining of the gastrointestinal tract, which can interfere with absorption of nutrients. Some HIV positive people experience specific problems, such as malabsorption, which can impair absorption of fat-soluble vitamins.

*“I am losing weight; I don’t want people to know I have HIV. I have started eating more fatty foods so I can put on weight but my diarrhea seems to be getting worse and I am still losing weight.”*

The comment above highlights a common misunderstanding of how to manage weight loss, muscle wasting and diarrhea. Patient may eat foods high in fats and oils mistakenly believing this will help them regain lost weight. In the example above the patient’s not considering the possibility that increased consumption of fat and oil is possibly exacerbating the diarrhea and that this contributes to further weight loss.

**Inadequate intake of food:** Many sick PLHIV often experience loss of appetite, or may develop the psychiatric disorder anorexia nervosa and fail to respond to dietary intervention.

GI symptoms and medication side effects – nausea, diarrhea, sore mouth or throat, altered sense of taste or smell-can reduce appetite. Inadequate food intake may also be related to inability to afford or shop for food, depression with the common symptom of poor appetite, or simply reflect an inability to prepare food.

**Medication:** ARVs, GI prophylaxis and treatment drugs and other medications can directly or indirectly cause nutritional deficiencies. These deficiencies may be a result of drug-nutrient interactions or drug side effects. Vomiting and diarrhea can lead to dehydration and depletion of nutrients. Loss of appetite, fatigue, and taste alterations can make it difficult to have sufficient intake of food. Antibiotics may kill off beneficial bacteria in the intestinal tract.

Medication may also cause dietary difficulties and indirectly interfere with adherence to treatment. Often medications are needed to be taken on either a full or empty stomach. This often upsets the routine of eating and the routine for medication dosing.

### Nutrition counseling

In the absence of proper counseling many HIV patients may not make informed choices about their diet.

General nutrition advice may be appropriate for individuals who are asymptomatic and well. However, specific advice should be provided to symptomatic patients or those experiencing side effects of ART that may influence dietary decisions. Nutrition assessments and counseling should form part of HIV clinical management. In many countries such as Thailand specifically trained nurses and health educators have provided this information in the absence of sufficient HIV nutritionists.

Patients need specific advice on what to eat and not eat or drink when they experience the following problems, and the advice should be specific to the nature of the problem.

- ◆ Diarrhea;
- ◆ Nausea;
- ◆ Weight loss
- ◆ Low appetite
- ◆ Taste distortion

Patients also require advice about when and what nutritional supplements to take as well

as advice that assists them to plan meals in harmony with treatment medication dosing regimens.

### Importance of dental health and prevention

Research shows that approximately 9 out of 10 people with HIV will get at least one of the common HIV-related conditions like Candidiasis and Hairy Leukoplakia. These may be early signs of immune weakness. Knowing what to look out for will help identify problems before they become more serious and can reduce the risk of losing teeth. Many individuals will have poor dental hygiene and this not only threatens their health but also potentially their ability to adhere to treatment, reduce transmission of STIs and possibly HIV.

Health workers could use the patient education tool (T6.8) to educate and ascertain if patients/clients have any oral-dental problems that may influence transmission.

### Common oral-dental problems

A number of oral/dental conditions are linked with HIV, can affect comfort, appearance, self-esteem, diet and speech, and can make other conditions more serious:

- ◆ **Dry Mouth (Xerostomia)** (pronounced 'Zero-stomia'), or lack of saliva can be caused by HIV, HIV medications, prescribed drugs and recreational drugs, which affect saliva glands. Food can build up between the teeth promoting tooth decay, gum disease and thrush. Without saliva to wash away food, teeth can decay quickly, fillings can break down, abscesses can form and teeth may need to be extracted. A dry mouth can also affect a good night's sleep.
- ◆ **Oral Ulcers (Aphthous Ulcers)** occur on the mucous membranes (mouth surfaces) as open sores. They can make eating difficult and uncomfortable. They are commonly caused by a reinvigorated immune system after commencing anti-retroviral therapy, although a suppressed immune system, medication side effects and injury to the area may also lead to oral ulcers. They may also be a symptom of other viruses.

- ◆ **Clenching & Grinding Teeth.** Stress, anxiety and physical factors like an abnormal bite can cause teeth and gums to become painful, sore and sensitive, and results in wear of the teeth. Some HIV drugs which affect sleep (Efavirenz), mood and anxiety, anti depressant medications, amphetamines and ecstasy can all contribute to teeth grinding.
- ◆ **Thrush (Oral Candidiasis)** is perhaps the most common oral condition in people with HIV. Symptoms include red or white patches and groves on the inside of the mouth. They may or may not cause minor pain. Even a mildly compromised immune system may not keep the fungus in check. Most outbreaks occur when the CD4+ cell count falls below 400. Stress, depression, and antibiotics may also lead to thrush. Early detection and treatment is crucial. Leaving thrush untreated commonly results in disturbed taste, pain, loss of appetite and weight loss. Progression of thrush to the patient's airway or throat is a serious problem.
- ◆ **Oral Hairy Leukoplakia** is a viral infection and a very common HIV oral condition. Symptoms include corrugated or folded white patches on the sides of the tongue or walls of the mouth, with hair-like particles along the folds. The condition is not generally painful or serious and can occur very early in HIV disease, but may indicate increasing risk of more serious illness and patients should be informed to report this to the HIV doctor.
- ◆ **Cold Sores / Herpes Simplex.** As well as sores on the lips, herpes can appear inside the mouth as 'bubbles' on the gums and on the roof of the mouth. It can also appear on the back or sides of the tongue or cheeks, with fever, pain and loss of appetite. They can be small and almost painless, or extensive, persistent and more troublesome.
- ◆ **Herpes Zoster (Shingles)** is a reactivation of the same virus that causes Chickenpox. Outbreaks produce sores on the skin or in the mouth. The sores begin as 'bubbles' and then break and crust over. Treatment should be started as soon as possible.
- ◆ **Angular Cheilitis** is a mixed infection, causing sore cracks in the corners of your mouth. It can occur more if lip-seal is poor because of poorly fitting dentures, mouth breathing or snoring. It can be treated with over-the-counter anti-fungal and anti-bacterial creams such as Daktarin. It is important not to moisten lips by licking.
- ◆ **Gingivitis and Periodontitis:** Gingivitis is a common bacterial inflammation of the gums, sometimes accompanied by bleeding and bad breath. Bleeding gums are the earliest sign of many diseases and should be investigated. (Bleeding may be less obvious among people who smoke).  
  
Periodontal diseases affect the gums, teeth and underlying bone. People with HIV are susceptible to aggressive forms of these conditions. Without proper dental care, severe problems can occur.  
  
Gingivitis can be prevented by regular brushing, using fluoride toothpaste with a soft toothbrush and flossing. Short term use (less than 2 weeks) of an anti-microbial mouthwash containing Chlorhexidine gluconate is sometimes advised in addition to good brushing and cleaning between the teeth. Other mouthwashes, without chlorhexidine, are not usually recommended as the high alcohol content dries the mouth and dilutes the protective film of saliva. Patients should be informed that if they notice any symptoms, it is important that they see a doctor or dentist as soon as possible. Left untreated, Gingivitis and periodontal disease can have serious consequences.
- ◆ **Osteoporosis:** There is increasing concern for the development of osteoporosis (bone thinning) in people with HIV. If bisphosphonate therapies (either oral or intravenous) are suggested to combat this, it is extremely important to ensure that oral infections are treated prior to commencement on bisphosphonate therapy.

## Matching the Intervention to the patient's stage of change

Stage of change	<b>Stage specific behavior change interventions</b> Adapted from HIV Counselling Handbook for the Asia-Pacific. (2010), UNICEF EAPRO, WHO WPRO & SEARO, FHI page 26
<b>Pre-contemplation</b> The patient does not perceive that he or she has a problem or that it is an immediate problem.	<ul style="list-style-type: none"> <li>◆ Find out whether the patient is experiencing life problems such as lack of money or a relationship breakdown.</li> <li>◆ Find out the health impact of the behavior from the patient's perspective.</li> <li>◆ Ask the patient how much drug use is affecting or contributing to his or her problems.</li> <li>◆ Provide personalized information about general health problems resulting from continued drug use.</li> <li>◆ Provide personalized information about the patient's health status and the transmission risk behavior (lack of safer sex practices, unsafe injecting, etc.).            For example: <i>"You seem to be having trouble taking your ART without missing a dose, and I also notice that you come in for frequent STI treatment. How do you think your drug use contributes to these problems? Or a simple health message such as "Because you have not always been able to use condoms this continues to expose your body to other infections. Do you want to continue to experience this problem?"</i> You should provide the patient with basic prevention information.</li> </ul>
<b>Contemplation</b> The patient is seriously considering giving up drugs in the next six months.	<ul style="list-style-type: none"> <li>◆ Acknowledge the patient's ambivalence.</li> <li>◆ Ask the patient what he or she (not the provider) sees as the benefits and problems of continued drug use, and the benefits of and barriers to stopping drug use and unsafe sexual practices.</li> <li>◆ Help the patient to see potential solutions to the various barriers raised (discomfort with condom negotiation, loneliness, common practice among friends, withdrawal symptoms, etc.).</li> <li>◆ Help identify potential resources (e.g. condom negotiation coaching, detoxification facility services, recovery groups, treatment buddies).</li> </ul>
<b>Preparation</b> The patient intends to quit within the next month; has tried to quit in the past year or has made behavioral changes (e.g., tries to use clean injecting equipment or reduce use).	<ul style="list-style-type: none"> <li>◆ Interview the patient to establish why the patient uses drugs (social use, depression, strategy for coping with sex work, etc.); and why and when they do not use condoms.</li> <li>◆ Establish an action start date.</li> <li>◆ Help patient develop awareness of practice of keeping a habit diary, noting issues such as when he or she uses drugs, who with, how much, and when, where and how they use condoms. If the patient is illiterate, interview and do the recording or use low literacy self recording.</li> <li>◆ For substance use, establish degree of substance dependency. Use ICD 10 or other standard diagnostic criteria.</li> <li>◆ Interview the patient about past attempts to stop using drugs or negotiate condom use.</li> <li>◆ Determine the process with the patient, including detoxification, gradual withdrawal, oral substitution therapy in the case of the substance use; steps in initiation, and responding to and managing refusal in the case of condom use negotiation.</li> </ul>
<b>Action phase</b>	<ul style="list-style-type: none"> <li>◆ Help the patient develop a plan of action.</li> <li>◆ Facilitate referrals or preliminary visits to drug treatment services.</li> <li>◆ Support skills rehearsal, e.g., informing partner of wish to enter a methadone program or role play of condom negotiation.</li> </ul>
<b>Maintenance phase</b> The patient is free of drugs or in recovery program for six months.	<ul style="list-style-type: none"> <li>◆ Anticipate and normalize relapse.</li> <li>◆ Anticipate triggers for relapse and plan coping strategies.</li> <li>◆ Support progress, monitor health and highlight positive consequences of changes (e.g., increased condom use during sex; less STIs; improved appearance; improved relationships with partners, families; new friends; better financial situation).</li> </ul>
<b>Termination</b> The patient is 100% confident in all trigger situations.	<ul style="list-style-type: none"> <li>◆ Congratulate the patient and again remind him or her that you are available for follow up.</li> </ul>

1 Aceijas C, Stimson, GV., Hickman, M. Global Overview of Injection Drug Use and HIV infection among injection drug users. AIDS 2004, 19;18 (17):2295-3303

Adewuyi, A.O. Afolabi, B.A, Ogundele, A O. Ajibare, and B.F Oladipo, "Psychiatric Disorders Among the HIV-Positive Population in Nigeria: A control Study." J. Psychosom Res 63, no (2007): 203-6.

## Adherence screening

### Instructions:

Here is a completed screening form. The answers recorded here indicate what the patient said. When you are completing this screening form, you may not directly record the exact words of the patient but, rather summarize. However, for the purpose of this training exercise, the exact words of the patient have been recorded.

1. Individually review the completed form.
2. The following questions will be directed toward you in our class discussion. Plan your answers now.
  - ◆ Is the patient addicted to any substances? Which ones?
  - ◆ What types of questions besides what appear on this form might help you make a decision about whether the patient has an addiction?
  - ◆ What are some strategies you would put into place to assist this patient to remember to take his medication?
  - ◆ What are some strategies that might help overcome some of the barriers to adhering to medication?
  - ◆ What does this client need to know about drug and alcohol use and treatment?
  - ◆ What are the issues related to HIV transmission that need to be discussed with the patient in relation to his treatment?
  - ◆ What further screen or referrals would you make for this patient?
  - ◆ Which of the educational tools provided in this package would be useful for this patient?
  - ◆ How should you address the family beliefs about traditional medicine?
  - ◆ What other patient lifestyle choices would you need to investigate in terms of positive health?
  - ◆ What other social issues may have an impact on treatment issues or prevention?
  - ◆ Would you recommend that this patient start ARV treatment?

## Adherence screening tool

Patient name/code:

Date of Birth:

### Instructions:

This tool is to be used in conjunction with the T2.1 *Case support planning form*.

Tell the patient:

*"Many patients have difficulty taking medication. I would like to ask you some questions that will assist our clinic in planning your treatment. Please consider and answer the questions carefully. I really want to make sure that you get the best treatment we can offer."*

## SECTION 1

**Past experience with medication:**

1. What difficulties have you had in the past with taking medication in the correct dose and at the correct time for the complete prescribed period?

*"I often forget especially when I am out at work. I work in a busy bar on the weekend and often have to drink with clients" "Sometimes I just haven't taken them."*

2. If you had difficulties, what were some of the reasons you could not take the medication as prescribed?

*"Sometimes they make food taste really bad. Once the doctor gave me some pills and they made me feel sick to the stomach so I stopped taking them. Sometimes I found it difficult to swallow the pills."*

When you took medication in the past and had unpleasant side effects like nausea or diarrhea, did you do any of the following (circle YES or NO):

1. Reduce the medication dosage without the doctor's advice?  YES / NO
2. Increase the medication dosage without the doctor's advice? YES /  NO
3. Stop taking the medication?  YES / NO

Additional comments:

1. *"I reduced the medication because it made me feel sick. I think it was too strong."*
2. *"I stopped taking medication because the sore on my penis went away."*

**Attitudes and beliefs about medication (circle YES or NO, or take notes as appropriate):**

1. Do you believe medication is harmful to your body?  YES / NO
2. Do you believe traditional medicine is more effective than prescribed medication? YES /  NO
3. What does your family believe about medication?

*"My family tells me that traditional medicine is better and that I should not take medicine from the clinic because they saw me vomiting and they know a traditional healer who can help."*

4. What about the attitudes and beliefs of close friends, or other people you know with HIV?

*"When some of my friends started taking the medicine it made them feel bad. One friend died shortly after taking the medicine."*

**Daily routine (circle YES or NO):**

1. Do you take meals at regular intervals (same time every day)? YES /  NO
2. Do you ever work through a meal break because you are busy?  YES / NO
3. Do you eat meals with other people at work?  YES / NO
4. Do you eat meals with people at home? YES /  NO
5. Are you worried that if other people see you taking medication they will then know you have HIV?  YES / NO
6. Is there anything in your daily routine or work that would make it difficult to take medication at specific times?

*"I always eat with my friends who are very curious. They would ask me what I am taking if they saw me taking any medicine. It is also difficult to take a break at work."*

**Potential barriers to attending follow-up medical appointments** (circle YES or NO):

1. Do you travel often to other parts of the country/province? YES /  NO
2. Are you able to attend the clinic/hospital during service hours? YES / NO /  Not sure
3. Do you have any problems travelling to the clinic/hospital? YES /  NO
4. There may be other charges for other treatments or tests. Would it be hard for you to pay those extra charges?  YES / NO

**Drug and alcohol use<sup>1</sup>** (circle YES or NO):

1. Are you now using drugs or alcohol?  YES / NO  
If yes, ask which ones (check all that apply):

- |                      |                                     |                           |                                     |
|----------------------|-------------------------------------|---------------------------|-------------------------------------|
| Inhalants / thinners | <input type="checkbox"/>            | Stimulants / amphetamines | <input checked="" type="checkbox"/> |
| Alcohol              | <input checked="" type="checkbox"/> | Hallucinogens             | <input type="checkbox"/>            |
| Marijuana            | <input type="checkbox"/>            | Tranquilizers/ relaxants  | <input checked="" type="checkbox"/> |
| Heroin / opium       | <input type="checkbox"/>            | Smoking                   | <input checked="" type="checkbox"/> |
| Others               | <input type="checkbox"/>            |                           |                                     |

If others, note down which ones:

2. How much of the drugs or alcohol are you using (quantity and frequency)? (Ask about each drug the patient has indicated he/she takes.)

Substance	Quantity & Frequency	Substance	Quantity & Frequency
Alcohol	3-4 cocktails, weekdays 6+ cocktails / beer, weekends		
Ya-Ice	(?) high all weekend		
Sleeping pills	(?) when can't sleep on week-end		
Smoking	6 cigarettes per day		

3. If you are not using drugs or alcohol daily do you ever binge (occasional heavy use)?  YES / NO

**Pregnancy and infant feeding for women** (circle YES, NO, NA):

Some medications should not be prescribed to pregnant women.

1. Are you now pregnant? YES / NO /  NA
2. Have you had a pregnancy test? YES / NO /  NA
3. If not pregnant, are you using contraception? YES / NO /  NA  
If using contraception, please circle which form:

- |                           |                         |         |       |
|---------------------------|-------------------------|---------|-------|
| Intrauterine device (IUD) | Oral contraceptive pill | Condoms | Other |
|---------------------------|-------------------------|---------|-------|

4. Are you breast-feeding an infant? YES / NO /  NA

<sup>1</sup>If the patient uses drugs and alcohol daily, he or she should answer these questions and then more detailed questions about drug and alcohol use.

**Hormone therapy** (for gender reassignment; or menopause)

1. Are you taking any hormones at present YES / NO /

**Steroid Use**

1. Are you taking any steroids for body building  / NO / NA

**SECTION 2****Informal screening for possible HIV related cognitive impairment****Memory and concentration (circle one of the possible answers):**

1. a. How well do you remember what has just been said when somebody is talking to you?

Extremely well      Average, with some small problems     

b. Has there been any change?

Much better      No change     

2. a. How well do you remember events from past years (long term memory)?

Very well      Average, with some small problems     

b. Has there been any change?

Much better            Much worse

3. a. When your family or friends talk to you, can you follow what they say or do you forget what they say even while they are still talking to you?

Follow well            Cannot follow

b. Has there been any change?

Much better            Much worse

**Fine-motor skills (circle one of the possible answers):**

1. a. Do you have difficulty doing fiddly things with your hands (like dropping things or not being able to pick up very small things)?

No problems      Average, with some small problems     

b. Has there been any change?

Much better            Much worse

**Verbal fluency** (circle one of the possible answers):

1. a. Are you having trouble trying to say what you want to say to people (i.e., you cannot find the words or you say the wrong words)?
- |             |   |                          |
|-------------|---|--------------------------|
| No problems | <input checked="" type="checkbox"/> Average, with some small problems | I have a lot of problems |
|-------------|---|--------------------------|
- b. Has there been any change?
- |             |   |            |
|-------------|---|------------|
| Much better | <input checked="" type="checkbox"/> No change | Much worse |
|-------------|---|------------|

**Mood and hallucinations** (circle one of the possible answers):

1. a. Are you easily irritated or frustrated nowadays?
- |             |   |   |
|-------------|---|---|
| No problems | Average, with some frustration and irritability | <input checked="" type="checkbox"/> Really irritable or easily frustrated |
|-------------|---|---|
- b. Has there been any change?
- |             |           |  |
|-------------|-----------|--|
| Much better | No change | <input checked="" type="checkbox"/> Much worse |
|-------------|-----------|--|
2. a. Are you anxious or do you feel nervous nowadays?
- |             |  |  |
|-------------|--|--|
| Not anxious | Only occasional worries like everyone else | <input checked="" type="checkbox"/> Feel very anxious, a lot |
|-------------|--|--|
- b. Has there been any change?
- |             |           |  |
|-------------|-----------|--|
| Much better | No change | <input checked="" type="checkbox"/> Much worse |
|-------------|-----------|--|
3. a. Are you depressed (feel sad, lack motivation) nowadays?
- |               |                                |  |
|---------------|--------------------------------|--|
| Not depressed | No more than most other people | <input checked="" type="checkbox"/> Very depressed |
|---------------|--------------------------------|--|
- b. Has there been any change?
- |             |           |  |
|-------------|-----------|--|
| Much better | No change | <input checked="" type="checkbox"/> Much worse |
|-------------|-----------|--|
4. a. Do you feel manic (extremely active, cannot rest, have difficulty sleeping, talk very fast, spend lots of money without thinking)?
- |            |           |   |
|------------|-----------|---|
| Not at all | Sometimes | <input checked="" type="checkbox"/> A lot |
|------------|-----------|---|
- b. Has there been any change?
- |             |           |  |
|-------------|-----------|--|
| Much better | No change | <input checked="" type="checkbox"/> Much worse |
|-------------|-----------|--|

5. a. Do you ever hear voices or see things that other people say they cannot see or hear?  
(This does not apply when a patient is intoxicated with drugs or alcohol or is in withdrawal.)

Not at all

Sometimes

A lot

- b. Has there been any change?

Much better

No change

Much worse

*Never used to happen*

\_\_\_\_\_  
Nurse / Counselor's name:

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Date:



## Adherence screening tool

Patient name/code:

Date of Birth:

**Instructions:**

This tool is to be used in conjunction with tool T2.1 Case support planning form.

Tell the patient:

*"Many patients have difficulty taking medication. I would like to ask you some questions that will assist our clinic in planning your treatment. Please consider and answer the questions carefully. I really want to make sure that you get the best treatment we can offer."*

### SECTION 1

**Past experience with medication:**

1. What difficulties have you had in the past with taking medication in the correct dose and at the correct time for the complete prescribed period?

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---

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2. If you had difficulties, what were some of the reasons you could not take the medication as prescribed?

---

---

---

**When you took medication in the past and had unpleasant side effects like nausea or diarrhea, did you do any of the following (circle YES or NO):**

1. Reduce the medication dosage without the doctor's advice? YES / NO
2. Increase the medication dosage without the doctor's advice? YES / NO
3. Stop taking the medication? YES / NO

**Attitudes and beliefs about medication (circle YES or NO, or take notes as appropriate):**

1. Do you believe medication is harmful to your body? YES / NO
2. Do you believe traditional medicine is more effective than prescribed medication? YES / NO
3. What does your family believe about medication?

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---

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4. What about the attitudes and beliefs of close friends, or other people you know with HIV?

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---

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**Daily routine** (circle YES or NO):

- 1. Do you take meals at regular intervals (same time every day)? YES / NO
- 2. Do you ever work through a meal break because you are busy? YES / NO
- 3. Do you eat meals with other people at work? YES / NO
- 4. Do you eat meals with people at home? YES / NO
- 5. Are you worried that if other people see you taking medication they will then know you have HIV? YES / NO
- 6. Is there anything in your daily routine or work that would make it difficult to take medication at specific times?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Potential barriers to attending follow-up medical appointments** (circle YES or NO):

- 1. Do you travel often to other parts of the country/province? YES / NO
- 2. Are you able to attend the clinic/hospital during service hours? YES / NO
- 3. Do you have any problems travelling to the clinic/hospital? YES / NO
- 4. There may be other charges for other treatments or tests. Would it be hard for you to pay those extra charges? YES / NO

**Drug and alcohol use** <sup>1</sup> (circle YES or NO):

- 1. Are you now using drugs or alcohol? YES / NO  
 If yes, ask which ones (check all that apply):

- |                      |                          |                           |                          |
|----------------------|--------------------------|---------------------------|--------------------------|
| Inhalants / thinners | <input type="checkbox"/> | Stimulants / amphetamines | <input type="checkbox"/> |
| Alcohol              | <input type="checkbox"/> | Hallucinogens             | <input type="checkbox"/> |
| Marijuana            | <input type="checkbox"/> | Tranquilizers/ relaxants  | <input type="checkbox"/> |
| Heroin               | <input type="checkbox"/> | Opium                     | <input type="checkbox"/> |
| Others               | <input type="checkbox"/> |                           |                          |

If others, note down which ones:

- 2. **How much of the drugs or alcohol are you using** (quantity and frequency)? (Ask about each drug the patient has indicated he/she takes.)

Substance	Quantity & Frequency	Substance	Quantity & Frequency

- 3. If you are not using drugs or alcohol daily do you ever binge (occasional heavy use)? YES / NO

<sup>1</sup> If the patient uses drugs and alcohol daily, he or she should answer these questions and then more detailed questions about drug and alcohol use.

**Pregnancy and infant feeding for women** (circle YES or NO):

Some medications should not be prescribed to pregnant women.

- |   |          |
|---|----------|
| 1. Are you now pregnant?                          | YES / NO |
| 2. Have you had a pregnancy test?                 | YES / NO |
| 3. If not pregnant, are you using contraception?  | YES / NO |
| If using contraception, please circle which form: |          |

Intrauterine device (IUD)	Oral contraceptive pill	Condoms	Other
---------------------------	-------------------------	---------	-------

- |                                      |          |
|--------------------------------------|----------|
| 4. Are you breast-feeding an infant? | YES / NO |
|--------------------------------------|----------|

**Hormone therapy** (for gender reassignment; or menopause)

- |   |          |
|---|----------|
| 1. Are you taking any hormones at present | YES / NO |
|---|----------|

**Steroid Use**

- |  |          |
|--|----------|
| 1. Are you taking any steroids for body building | YES / NO |
|--|----------|

**SECTION 2****Informal screening for possible HIV related cognitive impairment****Memory and concentration (circle one of the possible answers):**

- |    |  |
|----|--|
| 1. | a. How well do you remember what has just been said when somebody is talking to you? |
|----|--|

Extremely well	Average, with some small problems	Forget a lot
----------------	-----------------------------------	--------------

- |                               |
|-------------------------------|
| b. Has there been any change? |
|-------------------------------|

Much better	No change	Much worse
-------------	-----------	------------

- |    |  |
|----|--|
| 2. | a. How well do you remember events from past years (long term memory)? |
|----|--|

Very well	Average, with some small problems	Forget a lot
-----------	-----------------------------------	--------------

- |                               |
|-------------------------------|
| b. Has there been any change? |
|-------------------------------|

Much better	No change	Much worse
-------------	-----------	------------

- |    |   |
|----|---|
| 3. | a. When your family or friends talk to you, can you follow what they say or do you forget what they say even while they are still talking to you? |
|----|---|

Follow well	Average, with some small problems	Cannot follow
-------------	-----------------------------------	---------------

- |                               |
|-------------------------------|
| b. Has there been any change? |
|-------------------------------|

Much better	No change	Much worse
-------------	-----------	------------

**Fine-motor skills** (circle one of the possible answers):

1. a. Do you have difficulty doing fiddly things with your hands (like dropping things or not being able to pick up very small things)?
- |             |                                   |                                   |
|-------------|-----------------------------------|-----------------------------------|
| No problems | Average, with some small problems | I have a lot of problems (clumsy) |
|-------------|-----------------------------------|-----------------------------------|
- b. Has there been any change?
- |             |           |            |
|-------------|-----------|------------|
| Much better | No change | Much worse |
|-------------|-----------|------------|

**Verbal fluency** (circle one of the possible answers):

1. a. Are you having trouble trying to say what you want to say to people (i.e., you cannot find the words or you say the wrong words)?
- |             |                                   |                          |
|-------------|-----------------------------------|--------------------------|
| No problems | Average, with some small problems | I have a lot of problems |
|-------------|-----------------------------------|--------------------------|
- b. Has there been any change?
- |             |           |            |
|-------------|-----------|------------|
| Much better | No change | Much worse |
|-------------|-----------|------------|

**Mood and hallucinations** (circle one of the possible answers):

1. a. Are you easily irritated or frustrated nowadays?
- |             |   |                                       |
|-------------|---|---------------------------------------|
| No problems | Average, with some frustration and irritability | Really irritable or easily frustrated |
|-------------|---|---------------------------------------|
- b. Has there been any change?
- |             |           |            |
|-------------|-----------|------------|
| Much better | No change | Much worse |
|-------------|-----------|------------|
2. a. Are you anxious or do you feel nervous nowadays?
- |             |  |                          |
|-------------|--|--------------------------|
| Not anxious | Only occasional worries like everyone else | Feel very anxious, a lot |
|-------------|--|--------------------------|
- b. Has there been any change?
- |             |           |            |
|-------------|-----------|------------|
| Much better | No change | Much worse |
|-------------|-----------|------------|
3. a. Are you depressed (feel sad, lack motivation) nowadays?
- |               |                                |                |
|---------------|--------------------------------|----------------|
| Not depressed | No more than most other people | Very depressed |
|---------------|--------------------------------|----------------|
- b. Has there been any change?
- |             |           |            |
|-------------|-----------|------------|
| Much better | No change | Much worse |
|-------------|-----------|------------|

4. a. Do you feel manic (extremely active, cannot rest, have difficulty sleeping, talk very fast, spend lots of money without thinking)?

Not at all                      Sometimes                      A lot

b. Has there been any change?

Much better                      No change                      Much worse

5. a. Do you ever hear voices or see things that other people say they cannot see or hear? (This does not apply when a patient is intoxicated with drugs or alcohol or is in withdrawal.)

Not at all                      Sometimes                      A lot

b. Has there been any change?

Much better                      No change                      Much worse

\_\_\_\_\_  
Nurse / Counselor's name:

\_\_\_\_\_  
Signature:

\_\_\_\_\_  
Date:

# Treatment Adherence checklist and summary record form

Patient's name/code.....Medical record#.....

Date of counseling session.....

## Review patient's understanding of HIV/AIDS:

- What is HIV? AIDS?
- Opportunistic infections
- CD4/Viral load
- Patient's understanding of his/her health status
- Effect of treatment
- Need for adherence (explain)

Review barriers to adherence and progress made:

- Poor communication
- Low literacy (e.g., cannot read medication instructions)
- Inadequate understanding of HIV/AIDS
- Lack of social support
- Failure to disclose status
- Mental state
- Travel or work difficulties

Review the treatment program and importance of adherence:

- Drug regimen
- Dummy pill demonstration
- What ART does (e.g., improves immunity, less OIs/ART, but not a cure)
- Relationship between non-adherence and transmission resistance clearly explained
- Side-effects and what to do
- Follow-up visits
- Importance of adherence and consequences of non-adherence

Review interactions with ART and possible treatment resistance

- Alcohol and non-prescribed drug use
- Treatments for sexually transmitted infections
- Use of hormones (e.g. .oral contraception, gender reassignment, hormone replacement therapy)

Review proposed adherence promotion strategies:

- Buddy reminder (discuss role of support person)
- Other reminder cues
- Review the treatment program and proposed adherence promotion strategies for patient with drug or alcohol dependency referred for detoxification or oral substitution therapy

**After patient has commenced treatment refer to items on the reverse side of this form  
Add for ongoing follow-up visits:**

**Review patient's experience with treatment and adherence over the past month**

- Drug regimen and adherence – pill counts, self-reports
- Discuss side effects and actions taken
- Discuss need for continued prevention
- Discuss follow-up plan for next month
- Review patient's goals and success at achieving them

**Explain the need for collection of emergency contact details. Record phone and address details in patient file. Discuss procedures for protection of privacy.**

**Schedule next counseling session and complete appointment card**

**Refer to dispensary or pharmacy**

**Nurse / counselor's signature.....**

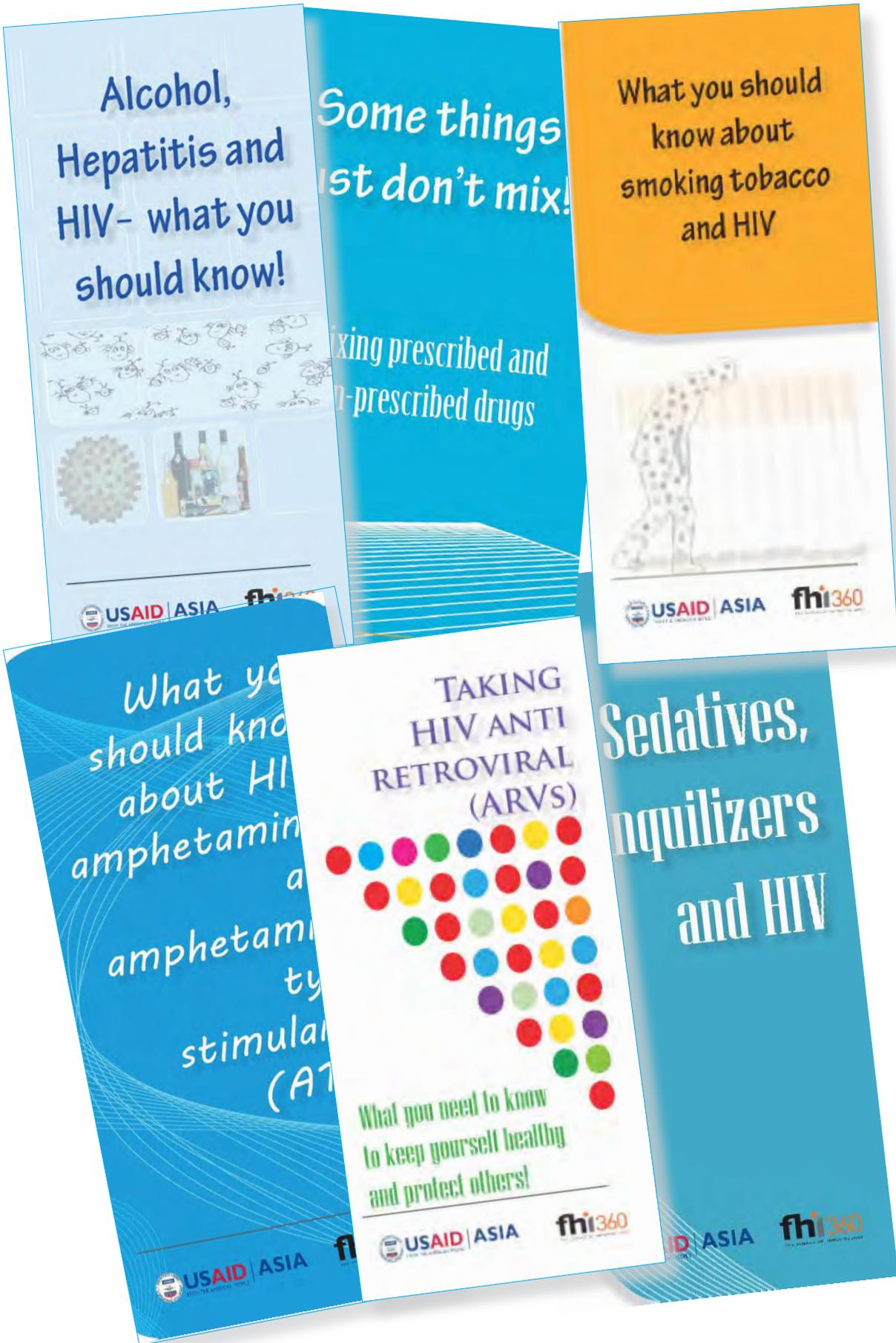
## Practical problem solving for managing common barriers to adherence

Patients may not take their medications for several reasons. Explore the reasons underlying non-adherence and then engage in problem solving those barriers. Problem solving relates to finding out why medications are missed and addressing those reasons. The table below lists some of the common reasons patients cite for missing doses, the possible barriers, and suggestions for problem solving.

Patients' reasons for missing doses	Possible barriers	Problem solving
<b>Forgot to take pills</b>	<ul style="list-style-type: none"> <li>• Travelling</li> <li>• Addicted to alcohol/drugs</li> <li>• Depressive / Psychiatric illness</li> <li>• Living alone and sick</li> <li>• Homeless, no family support</li> </ul>	<ul style="list-style-type: none"> <li>• Plan before travel, take extra pills</li> <li>• Use reminder cues</li> <li>• Address addiction (alcohol and drugs)</li> <li>• Mobile phone/SMS reminder service</li> <li>• Refer for mental health review</li> <li>• Use PLHIV support groups</li> </ul>
<b>Pills do not help; felt better so did not continue</b>	<ul style="list-style-type: none"> <li>• Inadequate knowledge</li> <li>• Incorrect beliefs and attitudes</li> </ul>	<ul style="list-style-type: none"> <li>• Use low literacy visual examples of how ART stops HIV replication and destruction of body's immune system.</li> <li>• Provide scientific information and examples</li> <li>• Enlist family support</li> </ul>
<b>Family said no to medications</b>	<ul style="list-style-type: none"> <li>• Inadequate knowledge</li> <li>• Incorrect beliefs and attitudes</li> </ul>	<ul style="list-style-type: none"> <li>• With client permission counsel family</li> <li>• Foster PLHIV family to family meetings e.g. another family to share their experience of treatment.</li> <li>• Provide scientific information and examples</li> </ul>
<b>Instructions were unclear; did not understand how to take medications</b>	<ul style="list-style-type: none"> <li>• Low literacy</li> <li>• Depression / Psychiatric illness</li> <li>• Alcohol intake / Active drug use</li> <li>• Insufficient time to counsel</li> </ul>	<ul style="list-style-type: none"> <li>• Use treatment schedule with visual aids depicting what pills to take and when</li> <li>• Use dummy pills and repeat instructions</li> <li>• Ask patient to repeat instructions</li> <li>• Enlist family support</li> <li>• Refer for treatment of depression</li> <li>• Address addiction (alcohol and drugs)</li> </ul>
<b>Unable to care for self</b>	<ul style="list-style-type: none"> <li>• Living alone</li> <li>• Unemployed</li> <li>• Has AIDS dementia / mental illness</li> </ul>	<ul style="list-style-type: none"> <li>• Use PLHIV support groups</li> <li>• Register with the home-based care program</li> <li>• Refer to wat (temple) hospice program</li> <li>• Link with community food donation program (e.g. wat)</li> <li>• Enlist family support</li> <li>• Identify a friend who can help</li> </ul>

Patients' reasons for missing doses	Possible barriers	Problem solving
Did not want others to see patient taking medications	<ul style="list-style-type: none"> <li>• Stigma at place of work</li> <li>• Non-disclosure in the family</li> </ul>	<ul style="list-style-type: none"> <li>• Discuss covert ways medication can be taken publicly e.g. vitamin pill or other medication container.</li> <li>• Discuss disclosure strategies for family</li> </ul>
Fear of toxicity	<ul style="list-style-type: none"> <li>• Insufficient preparation</li> <li>• Inadequate knowledge</li> </ul>	<ul style="list-style-type: none"> <li>• Provide scientific information on what to expect and how to manage it</li> <li>• Counsel on risks of non adherence</li> </ul>

# Patient education brochures



### If you have HIV and hepatitis

- Drink little or no alcohol. If you drink no alcohol, there is a better chance that hepatitis medicines will work.
- Avoid alcohol before you start taking hepatitis medicines and during treatment. If you do, there is a much better chance the medicines will work.
- If you can't quit drinking or reduce your drinking before taking hepatitis medicines, talk to your doctor.

### Alcohol dependency (addiction)

If you use too much alcohol, your drinking can get in the way of responsibilities you have at work, university or home, or your relationships with your friends and family. Alcohol overuse can lead to alcoholism, which means your body eventually needs alcohol to feel normal and function like it should.

Alcohol may be a problem for you if?

- Feel bad or guilty or ashamed about your drinking
- Think you should drink less than you do
- Regularly drink more than you intended to
- Lie to other or hide your drinking habits
- Need a drink in order to relax or feel better
- Need a drink as soon as you get up in the morning

- "Black out" or forget what you did while you were drinking

### Common signs that you are becoming dependent are:

- Tolerance**—needing more and more alcohol or drugs to get the same buzz or high
- Craving**—feeling a strong desire or urge to drink alcohol
- Losing control** once you start drinking
- Having withdrawal symptoms** like nausea, sweating and shaking if you don't have alcohol.

Talk to your doctor, counselor or someone you trust about what to do about your alcohol use.

## Alcohol, Hepatitis and HIV- what you should know!



M06 - T6.4.1



### Alcohol and sex can be a dangerous combination.

If you have HIV, take extra steps to avoid spreading the virus to others and bringing new infections into your body. Alcohol can affect your judgment when you have sex. You might forget to use a condom, or not stick with a plan to protect yourself.

Some people use alcohol and drugs to increase their sexual enjoyment. If you engage in anal sex you may not remember to use a condom or use a lubricant.

Even, if you remember to use a condom after drinking, drinking too much alcohol can cause loss of erection and that can cause a condom to slip off during sex.

### How will drinking alcohol affect my body's ability to fight infections?

There is no evidence that low to moderate drinking does any harm to people with HIV. However, if you have hepatitis or high levels of blood fats, then you may be advised to stop drinking alcohol or cut down alcohol consumption by your doctor. Alcohol dependency is increasingly common amongst those with HIV with many people using alcohol as a way to cope with the psychological pressure of living with HIV. Heavy drinking will affect your immune system and slow down recovery from infections and may increase disease progression. Research suggests that alcohol can interfere with the normal functions of various parts of our immune system, impairing our body's immune response to all infections.

HIV-positive people who drink heavily, and who are not on ARV drugs tend to have lower CD4 counts (a measure of immune systems health) than moderate drinkers. Why not ask your doctor about what is a safe amount of alcohol for you to drink!

### Alcohol and HIV medications

While, the same difference in CD4 count isn't true for heavy drinkers who are taking anti-HIV drugs, they are **more likely to miss doses of their treatment than those who don't drink.**

Alcohol can also damage the liver and a healthy liver is important for the body to process some antiretroviral medicines effectively. The blood fat increases caused by some anti-HIV drugs can be made worse by heavy drinking.

There are no significant interactions between any of the currently available anti-HIV drugs and alcohol but alcohol can react badly with certain medicines (e.g. rifampicin, rifabutin, metronidazole). It is important to check with your doctor or pharmacist that alcohol is safe to drink with any of the medicines prescribed for treatment of opportunistic infections (OI) that you are prescribed especially

Alcohol can cause vomiting. If you vomit within an hour of taking a dose of your anti-HIV drugs, or any other prescribed medicine, then you should retake the dose.

### HIV, hepatitis C, and your liver

Many people with HIV in Thailand who have HIV also "coinfect" with either Hepatitis B, or hepatitis C. People with hepatitis B or C are at risk of developing a chronic, long-term form of the disease. If hepatitis is not treated, it can lead to liver disease and cancer.

Hepatitis is a lot like HIV—you can fight it by taking medicines and by making smart choices to lead a healthy lifestyle. Heavy alcohol use can speed up the damage to your liver caused by hepatitis. The longer you have hepatitis and continue to drink, the greater your chances of developing liver problems.

**Drugs that interact with methadone to cause excessive sedation and may make you stop breathing and die (especially when first starting methadone):**

- alcohol
- benzodiazepines (diazepam, alprazolam, lorazepam)

**Other drug interactions:**

Methadone can increase the amount of Zidovudine(AZT) in your blood and increase the side-effects of the AZT.

- **Sedatives** (drugs that make you relaxed and sleepy) like Valium (diazepam) can interact with some ARVs and OI drugs resulting in an increase in their sedative effect and possible overdose.

**Anabolic Steroids (used for muscle body building)** at the same as ARVs and OI drugs can cause serious liver problems. This is especially dangerous when you have HIV.

**Ecstasy & Amphetamines**

It is difficult to know what the effect of mixing these drugs with ARVs and OI drugs.

- **Mixing Ecstasy** and some ARVs/OI drugs levels may increase ecstasy dangerously high levels in the body. Some people on ARVs have DIED from taking ecstasy.
- **Mixing Amphetamines** (drugs that speed you up) and some ARVs may also increase amphetamine levels to dangerously high levels and put a great strain on the body.

**Alcohol**

- Chronic (long term) alcohol use can lower levels of many ARVs and damage your liver and other internal organs.



M06-T6.4.2

Some things just don't mix!

Mixing prescribed and non-prescribed drugs



You may have been prescribed a lot of different drugs by your doctor to treat different conditions related to your HIV or STI. You may also use several different drugs that have not been prescribed by a doctor. Buying drugs from a pharmacy without consulting your doctor first or using drugs purchased illegally could create serious complications in your HIV treatment. If you are taking antiretroviral therapy (ART) or OI medications (e.g. for TB, Candida, respiratory and stomach infection or STIs) it can be harmful to use street drugs because the medications can mix together in a harmful way (**drug interactions**).

People with HIV who use drugs that are not prescribed by a doctor are at risk of these drugs mixing (interacting) with their ARVs and OI medications and causing serious health problems and complications. These are called drug interactions.

Mixing drugs and ARVs/OI drugs can cause a number of different complications including:

1. increasing side effects from ARVs;
2. decrease the amount of ARVs in your body so that they no longer work to fight the HIV virus;
3. increasing the risk of harm from drugs including being overly sleepy, coma and even death and;
4. causing excess strain on important organs like the liver and heart – this can make you very sick working because there's not enough of them in your body.

Drug interactions can cause a serious, increase in the level of drugs.

Most ARVs are processed by the liver. Many different types of drugs can damage the liver. Anything, which damages the liver, can be a serious problem for people with HIV.

**Heroin**

When some ARVs and OI drugs mix with heroin, the levels of heroin in the body can decrease so that you don't experience the same high from heroin – it can even cause withdrawal. You should not increase the amount of heroin that you use as this can result in a risk of overdose.

**Methadone maintenance (MMT)**

If you have been prescribed Methadone for treatment of an addiction to Opioid drugs such as Heroin it is important that you discuss this with your HIV doctor. Methadone is a strong drug and can interact with medicines from your doctor as well as over the counter drugs, and illegal drugs and alcohol. It is also very important that you tell your methadone doctor what HIV or STI or if other medications that you are taking.

Drug interactions with methadone can either speed up or slow down the way your body manages methadone - can make your usual methadone dose either too much (sleepy) or too little (withdrawal). If any of your doctors

need to prescribe medications that interact with methadone – your methadone dose may require adjustment.

If you are on any of these medications or a doctor wants to prescribe any of these medications for you, your methadone dose will need to be reviewed.

**Medicines that reduce the effect of methadone and may cause withdrawal:**

- anti-epileptic drugs – carbamazepine (Tegretol), phenytoin (Dilantin) and occasionally sodium valproate (Epilim)
- anti-retroviral drugs – nevirapine and efavirenz
- anti-TB drugs – rifampicin
- cocaine

**Medicines that increase the effect of methadone:**

- anti-depressant drugs – amitriptyline and fluvoxamine
- drugs to treat stomach acidity – dimetidine
- anti-fungal drug – ketoconazole

**Medicines that block the effect of methadone in the brain and can cause withdrawal**

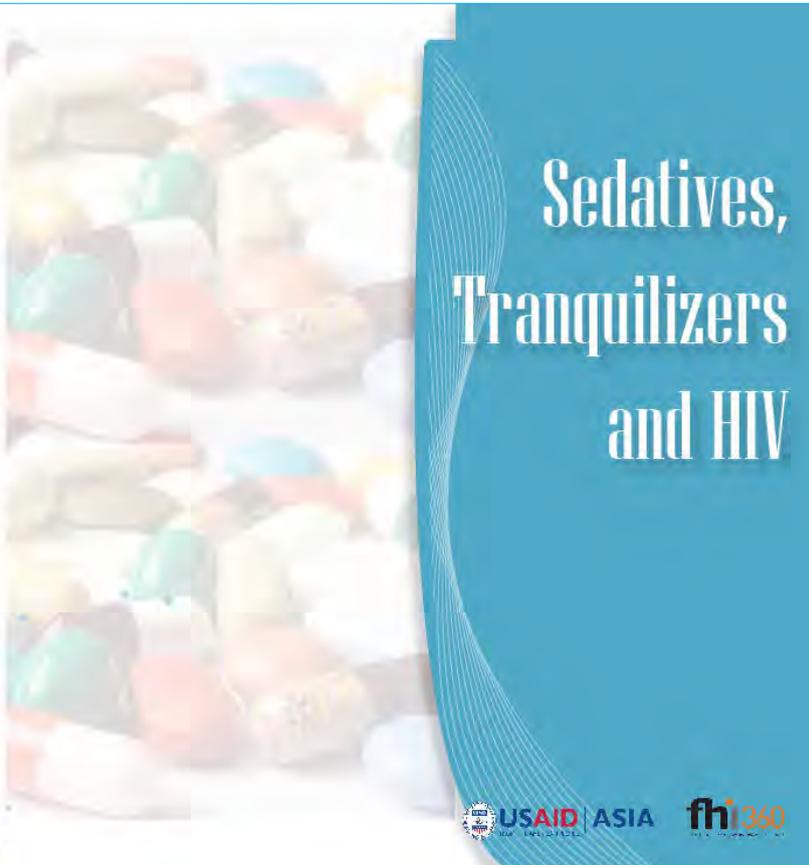
- naltrexone
- buprenorphine

**What are the risks associated with using Sedatives and Tranquilizers when you are taking ARVs?**

Some HIV treatment drugs such as ARVs such as Delavirine and Efavirenz appear to increase the effect of tranquilizers, which can result in extreme drowsiness and breathing difficulties and even fatal overdose. But it does depend on the type of sedatives or tranquilizers that you use. The risk increases if you also drink alcohol while you use ARVs and tranquilizers or sedatives.

It seems that some sedatives or tranquilizers e.g oxazepam, temazepam and lorazepam are actually broken down faster in your body when you take them at the same time that you take your antiretrovirals (ARVs) and this may mean that you do not get the effect of these drugs that is desired. When this happens you may take more of the sedatives or tranquilizers to get the desired effect, and then you are at risk of an overdose. If you use tranquilizers or sedatives it is important that you let your doctor know.

If sedatives or tranquilizers are prescribed by a doctor who does not know that you are taking HIV medication it is important that you discuss this with that doctor, or at least let your HIV doctor know that you have been prescribed these other drugs.



M06 - T6.4.3

The difference between a sedative and tranquilizer is the type of drug used and what it's used for. But they're very often referred to interchangeably because the difference in effect and usage is slight. A sedative is a barbiturate used to treat acute anxiety, tension and insomnia. A tranquilizer is a benzodiazepine prescribed to treat anxiety, acute stress response and panic attacks. There is often not much difference; however mental alertness might be greater with a tranquilizer

Sedatives and tranquilizers slow your brain's activity and cause euphoria, often described as a hazy dream like feeling of happiness... As sedatives or tranquilizers can slow normal brain function, when you first start taking them you'll likely experience:

- ◆ fatigue
- ◆ sluggishness
- ◆ dilated pupils
- ◆ disorientation
- ◆ slurred speech
- ◆ shallow breathing
- ◆ lack of coordination

As your body works to adapt, these effects often disappear. With long term use of sedatives and tranquilizers, tolerance and physical dependency can be expected. Using a sedative and tranquilizer with other substances, especially alcohol, can slow your heart and respiration (breathing) to such an extent that death is possible.

The effects of these types of drugs vary depending to your size (both height AND weight), smaller people need smaller doses and your general health; as well as amount taken. Other things that influence this include: the last time you ate, as tranquilizers are absorbed more quickly into the blood stream when you haven't eaten and will affect you much faster. Whether you are taking other drugs, mixing drugs is always a bad idea as the effects are unpredictable. Long term effects

- ◆ sleeping problems, fatigue
- ◆ loss of motivation, memory loss, confused thoughts
- ◆ depression, anxiety, paranoia, aggression
- ◆ nausea
- ◆ muscle weakness, skin rashes, weight gain, sexual problems, menstrual irregularities, lethargy
- ◆ personality and emotional change.

Sometime drugs are purchased as tablets or capsules and then mixed with a liquid and injected for a stronger and more immediate affect. However, when these drugs are injected, the effects can include:

- ◆ collapsed veins
- ◆ infection, leading to amputation of limbs, damage to organs, stroke and even death

**Sedatives Tranquilizers and Sex**

Some sedatives can cause heightened sexual desire, but the effects can also cause short-term memory loss and decrease the ability to consent to having sex. Some people have been sexually assaulted whilst under the influence of drugs. When this happens people may not remember that they have had sex. Sometimes people may take these drugs unknowingly when their drink has "spiked" with the drug. It is never a good idea to leave your drinks unattended in a bar.

Some people place themselves at risk of getting or giving others HIV as they do not use condoms when having sex.



This places HIV-infected individuals at risk for progression, as well as increasing their ability to transmit the virus during unsafe sex.

**What happens when you stop using stimulants?**

This will depend a lot on what type of stimulant you are using. If regular users stop taking stimulants, they may experience symptoms of withdrawal, which include strong cravings for the drug, irritability, a lack of energy, increased appetite, sleep problems and depression. However, often people may experience more severe symptoms.

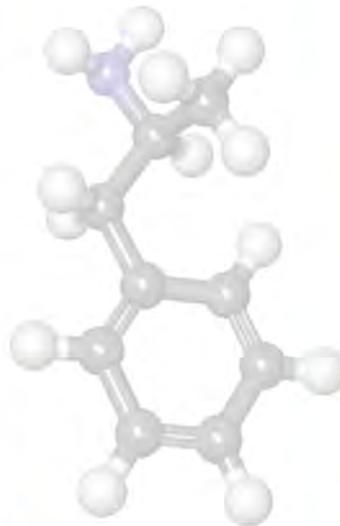
Approximately 1/3 of people who use methamphetamine will experience unpleasant psychotic symptoms including visual or auditory hallucinations. This often occurs as a result of the drug going quickly into the blood and from a lack of sleep.

People who have quit using have experienced a period of time where nothing seems pleasurable. This period can last six to eight months for casual users and two to three years for regular users.

M06 - T6.4.4

**Get help if you want to make changes**

Trying to give up stimulant use may be very difficult to do by yourself. You need medical supervision. Ask your counselor to refer you to a sympathetic, trained doctor who is specialized in working with individuals who would like to modify their drug use or stop using drugs.



*What you should know about HIV, amphetamines and amphetamine type stimulants (ATS)*

USAID | ASIA fhi360

The term ATS covers many different types of substances. Here are just a few that are used in Thailand.

**Methamphetamine**

- Can be sold as powder – bitter tasting crystalline powder easily dissolves in water or alcohol – injected
- Crystalline: smoked form often referred to as “ice”

**MDMA (“Ecstasy”, “XTC” or “E”)**

This is both a stimulant and hallucinogen found in capsule or tablet form in Thailand. Injecting and smoking of ecstasy is not common in Thailand.

These types of drugs generally have the following similar effects;

- A feeling of wellbeing or euphoria
- Increased energy
- Wakefulness
- Alertness
- Reduced hunger
- Increased clear thinking
- Increased feelings of confidence
- Increased sexual arousal
- Increased social confidence
- Improved mood
- Dry mouth and dry lips
- Excessive sweating
- Oily skin or complexion

**Long term effects of stimulants**

- Strokes, seizures and headaches
- Agitation & restlessness
- Depression, anxiety, irritability, anger and psychosis
- Memory loss and attention problems
- Insomnia
- Paranoia, auditory hallucinations, panic reactions
- Suicidal thoughts
- Worn teeth (due to grinding teeth when intoxicated)
- Chest pain, cough and other breathing difficulties
- Disturbance in the rhythm of heart beat, and in some cases heart attack
- Abdominal pain and nausea
- Loss of sex drive
- Muscle tremors

**Injecting** - The risks of HIV and Hepatitis B and C transmission for those who inject stimulants are the same as with any injection drug use. Any sharing of syringes or the various items used in preparing to inject the drug can pass these viruses onto others or can bring other infections into your body.

**Sex & stimulant use**

Many people when using stimulants do not use condoms and may have sex with many different sex partners during a speed run.

Even if they do use condoms, the lengthy and rougher sex that often happens when people have sex whilst using results in a much higher likelihood that the condom will break.

Men or women who have receptive anal sex while on while using the drug are less sensitive to pain responses and may be inclined to have more aggressive sex for longer periods where injury is more likely to occur and the risk of HIV infection is increased.

**HIV progression & stimulant use**

Many HIV experts believe that stimulants have direct effects on HIV as well as on antiviral medications. It is thought that some types of stimulants reduce the effect of HIV medications thus increasing viral replication (growth of HIV in your body).

People who often use stimulants often miss doses of their HIV drugs as a consequence, thereby also increasing viral loads (amount of HIV in the blood).

### How can I stop smoking?

Cigarettes are addictive because they contain nicotine. Many people find that nicotine replacement therapy can help reduce the craving for cigarettes and make quitting easier. Your doctor may be able to prescribe patches, gum, or lozenges which contain nicotine, and there is no evidence that these interact with anti-HIV drugs. You can buy all of them over the counter.

The antidepressant drug bupropion (*Zyban*) has been licensed to help people stop smoking. However, it interacts with anti-HIV drugs of both the protease inhibitor and NNRTI classes, leading to an increasing the amount of Zyban in the blood. **Make sure you tell your HIV doctor if you are thinking about taking bupropion.** The drug also causes side-effects including dry mouth, insomnia, headaches, and fits.

Talk to a doctor about how you can stop smoking.





## What you should know about smoking tobacco and HIV




M06 - T6.4.5

### Does smoking increase the progression of HIV disease?

Smoking, in itself, does not make HIV infection worse. The rate at which HIV disease progresses or the number of CD4 cells lost is no greater in smokers than non-smokers.

However, people with HIV who smoke are more likely to get certain infections and HIV-related illnesses, particularly those affecting the chest. It's known that smokers are approximately three times more likely than non-smokers to develop the AIDS-defining pneumonia PCP. Oral thrush, a common complaint in people with HIV, is also more common amongst smokers. Emphysema, a smoking-related illness, occurs much more commonly in HIV-positive smokers than HIV-negative smokers.

### HIV and smoking-related life threatening diseases?

It's thought that having a long-term illness like HIV might increase the risk of serious heart disease. It's also a well-known fact that smoking increases the risk of heart disease, high blood pressure, and stroke and so smoking when you have HIV is really increasing your chances of heart disease.

It's also a well-established fact that smoking increases the risk of lung cancer. Although relatively rare, lung cancer seems to occur more often in people with HIV. Studies have shown that HIV-positive smokers have an increased risk of lung cancer.

### Taking ARVs and smoking

Some ARV drugs can cause increases in blood fats, and this can contribute to cardiovascular illnesses. If you smoke and take ARV drugs, then your risks might be increased even further.

Stopping smoking (or not starting in the first place) will significantly reduce your risk of developing heart disease and other cardiovascular illnesses. You are most likely to stop smoking and stay stopped if you are motivated.

Individual or group therapy has been shown to help people to stop smoking, and your HIV treatment centre may have a therapy group for individuals who are stopping smoking.

This is not a reason to stop using condoms, but HIV treatments certainly lower the risk of passing on HIV to other people during sex. This might be something for HIV positive people who have a HIV negative partner to consider when thinking about starting HIV treatments. HIV treatments used in combination with other protective factors will definitely lower the risk of passing on HIV.

Remember that you need to protect your body from other types of infections and so using condoms and not sharing injecting equipment is an important way you can protect your own health.

If you have sex without a condom or share injecting equipment with somebody who is not infected, and you have a drug resistant strain of HIV, there is the possibility you could pass on this drug resistant strain of HIV to the other person. That means that that person would have a HIV infection that could be difficult to treat. Some countries up to 10% of people newly infected with HIV have a drug resistant virus.

**What is a superinfection ?**

Somebody who is already HIV-positive can be infected with another strain of HIV that could be drug resistant. This is called superinfection. It is not known how common this is, but you may wish to discuss this with your partner. If you have concerns about this you should discuss this with your HIV doctor.

**Is it true that sometimes these drugs stop working and you get sick?**

With large quantities of new virus copies being made every day inside your body, errors (or mutations) can develop in the new copies. These mutations can change the parts of the virus that drugs are designed to work on causing the drugs to not work effectively. This is called 'drug resistance'. Even when we have taken antiretroviral therapy (ART) and we have a low or undetectable amount of virus in our blood (viral load) HIV can still keep copying itself.

**How I stop this happening?**

You can help prevent this from happening by making sure enough of the ARV drugs are continuously in your bloodstream, preventing the spread of the mutated copies. This is why taking the correct amount of pills, at the correct time, in the correct way is so important.

Regular times must be followed so that drug levels are maintained at an effective working level in the body. Some drugs have guidelines about taking them with or without food, not with alcohol; not with certain other medications such as antacids, or other non-prescribed drugs. This is because the effectiveness of drugs can be reduced. Make sure you know if this applies to your treatment. Ask your doctor, pharmacist, nurse or treatment support officer.

Even though drug combinations are getting easier to follow, some people will still have difficulty with taking their drugs on time. If you find you're missing doses, or taking them at different times, talk to a nurse or treatment counselor about how some strategies to help you remember to take your drugs on time. Set an alarm on your mobile phone or wristwatch. Always have some emergency supply of drugs available in case your daily routine is disrupted and you are prevented from getting home to take them. Sometimes people find it helpful to use a pill box with all of the daily doses in one section. These can be bought in many pharmacies quite cheaply.



**Staying healthy**

Researchers are constantly developing new treatments, new ways of treating HIV and maybe one day they may even find a cure. New therapies and treatments for HIV may be more successful in people who have better health. Taking HIV treatments, as well as a healthy diet, exercise, reducing use of non-prescribe drugs and alcohol and not smoking may allow people with HIV to take better advantage of new developments in HIV treatment and care as they come along.



M06-T6.5

## TAKING HIV ANTI RETROVIRAL (ARVs)



What you need to know to keep yourself healthy and protect others!



**What do they ARVs do?**

When HIV gets into our body it quickly starts making copies of itself and gradually invades our immune system our body's defense against infections. Combination therapy helps to control these copied viruses (called copies) and keep HIV levels as low as possible. The goal of HIV treatment is to lower the level of virus in the blood to undetectable levels.

**Are you worried about starting ARVs?**

People worry about taking HIV treatments because they are concerned about the side effects. Most stories and fears about side effects relate to information about old treatments that are no longer used. In the early days of HIV treatment, people with HIV and their doctors used to wait as long as they could before starting treatments so as to avoid side effects. New treatments are being developed all the time and these new treatments can work more effectively against HIV, often with fewer side effects. These days side effects are usually only experienced at the beginning of treatment, don't last for very long and are easily managed therefore people are starting treatments much earlier than was previously the case.

Starting treatment at the right time can reduce the risk of long term side effects as well as reducing the risk of developing HIV related health issues.

Some people worry about starting treatment because they say once they start they will not be able to stop. If this is a concern to you may want to thinking about some of the benefits of taking the drugs. You may also want to talk to a member of a peer support group about how they have coped taking drugs. Whilst it doesn't make it any easier it is important to recognize that many people in Thailand need to take drugs every day of their lives for o

**What are the benefits of taking HIV?**

- 1. Living a longer healthier life?**  
People who take treatments live longer and healthier lives than people who don't. Treatments stop HIV from replicating or multiplying, reducing the level of HIV in our blood to 'undetectable'. An undetectable viral load allows our immune system to work better. A healthy immune system helps us fight infection and other health issues, so we don't get sick as often and are less likely to get sick.
- 2. Keeping your heart healthy**  
The HIV virus can cause damage to our heart and blood vessels, increasing the risk of high blood pressure, hardening of the blood vessels, stroke (CVA) and other problems relating to

circulation. This is because HIV signals the immune system to send out cells that cause inflammation to fight HIV. As well as fighting HIV, these cells cause damage to the heart and blood vessels. People who take HIV treatment have a lower risk of health issues relating to the heart and blood vessels.

Some older treatments can also cause heart problems by increasing the amount of fats in your blood, like cholesterol and triglycerides. You should ask your doctor about the level of these fats in your blood results. If they are high ask your doctor about diet, exercise and other strategies to bring these levels down. Sometimes switching to HIV treatments will help.

**3. Preventing HIV affecting the way your brain works**

As well as being detectable in our blood, HIV is detectable in our brain, pre-cum and other parts of the body. The longer you live with HIV, the longer your brain is exposed to HIV, putting you at risk of certain HIV related brain issues. Having HIV in the brain can cause tiredness, depression, a quick temper and other problems.

You might find you have difficulty concentrating or are more forgetful. HIV treatments can reduce the amount of HIV in the brain and reduce the risk of these health problems. Many of these health issues are reversible if treated in time.

NB: Not all HIV treatments get into the brain as well as others, and one medication, Efavirenz (Stocrin) can cause side effects like drowsiness. This is usually temporary so talk to your doctor if this side effect continues.

**4. Keep up your energy levels**

The immune systems of people with HIV are constantly fighting HIV and consequently burn up a lot of energy. This can leave people feeling tired and flat, not feeling motivated to exercise thus leading to put on weight. Some people with HIV feel so tired they say they feel like they have the flu.

Treatments take care of fighting HIV which means that your body doesn't need to use up extra energy to fight the virus. Most people find that they have far more energy when they start taking HIV treatments.

When starting HIV treatment for the first time some people can feel tired during the first week while their immune system is getting stronger. This is perfectly normal, so people are encouraged to commence their treatment on days when they don't have any plans or commitments.

**5. Reduce long term inflammation caused by HIV**

HIV causes chronic inflammation. When we have an infection our immune systems release specialized cells that cause inflammation in order to help fight the infection. This is why we get noses get blocked and red when we get a cold or our skin becomes red or bruised if we bump or scratch it. When you recover from a cold, or when your bruise heals, your immune system stops releasing these 'pro inflammatory' cells, and things tend to go back to normal.

With HIV however the immune system recognizes the virus as a chronic, or ongoing, infection requiring these pro inflammatory cells to be constantly released. In the short term, as with a cold, these cells are helpful. Over a long period of time, as with HIV, these cells can cause damage to our heart, kidneys, liver, brain, bones, cause fatigue and problems with digestion, and a range of other health issues. Taking treatments reduces chronic inflammation and the related health issues.

**6. Reducing the chance of cancers developing**

As well as fighting infection, our immune system also fights some cancers. People with HIV are at higher risk of developing some cancers including Kaposi's sarcoma, colorectal cancer, cervical cancer, prostate cancer and melanoma. HIV treatments improve immune function and reduce the rate of these cancers

**I have heard there is a risk of developing diabetes when you take ARVs- is this true?**

Diabetes is becoming a problem for many people in Thailand, not just people with HIV. However if you have HIV you may have some additional risk of developing diabetes. Certain HIV treatments can increase the risk of insulin resistance in people with HIV. This group of drugs is called Protease Inhibitors (PIs). Insulin resistance is a condition whereby our bodies have difficulty using insulin to convert sugar into energy, insulin resistance increases our risk of developing diabetes and diabetes increases the risk of developing heart and kidney related health complications.

If you have a family history of diabetes you should discuss with your doctor whether you should avoid this group of HIV treatments when they choose which combination of ARVs is best for you to take.

**Does taking ARV mean I don't have to use condoms for sex?**

HIV is located in our genital fluids as well as in our blood. Scientists believe that people who are on treatments, have no other STIs and virtually no detectable amount of virus in their blood for at least six months have a reduced risk of passing on HIV to other people during sex.



## Mental health presenting problem (MHPP) flow charts

Work your way down the checklist until you get a positive response. At that point, exit the checklist and refer to the relevant flowchart. The flow charts are designed to be used to facilitate your differential diagnosis and guide you to the relevant clinical diagnostic criteria in either the International Classification of Diseases (ICD 10) or the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or DSM V (In press). Formal diagnosis should be made by a clinical psychologist, or psychiatrist.

No.	Problem	Refer to flowchart
1.	Is the individual confused or disoriented, or is his or her consciousness impaired? Can you identify any factors associated with a physical cause?	Screen for physical cause
2.	Is there evidence of suicidal thoughts or acts? <i>"How do you see the future?"</i> <i>"Do you ever feel that life is not worth living?"</i> <i>"Have you ever thought you would like to end it all?"</i>	Suicidal thoughts or acts
3.	Does the individual hold incredible beliefs, or see or hear things that others cannot see or hear? <i>"Do you ever hear voices when nobody is around?"</i> <i>"Has anything strange been going on around you?"</i> <i>"Has anyone been following you or acting suspiciously near you?"</i>	Delusions or hallucinations
4.	Is the individual agitated, unable to sit still, talking constantly, impulsive, or argumentative? <i>"Has your energy increased a lot lately?"</i> <i>"Have you been feeling very restless lately?"</i>	Agitation or excitement
5.	Is the individual mute, withdrawn, or slow to respond to comments or questions?	Withdrawn behavior
6.	Is the individual's speech strange or difficult to understand?	Abnormal speech
7.	Does the individual report difficulty thinking or concentrating? <i>"Have you been having difficulty concentrating?"</i> <i>"Have you been more forgetful than usual?"</i>	Concentration or memory difficulties
8.	Is there evidence of a depressed mood, or a loss of interest in normal activities? <i>"Have you been feeling sad, depressed, or hopeless lately?"</i> <i>"Have you lost interest in things, or feel that you lack energy?"</i> <i>"Have you felt self-critical or less worthy as a person?"</i>	Depression
9.	Is the individual overly worried or fearful? <i>"Do you have any symptoms of anxiety such as shaking, sweating, palpitations, breathlessness, dizziness, or light headedness?"</i> <i>"Do you worry a lot about everyday problems?"</i> <i>"Do you have any unusual habits, like checking or cleaning more than other people?"</i> <i>"Do you experience upsetting thoughts that you find hard to put out of your mind?"</i>	Anxiety or worry



# Presenting problem 1: Screen for physical cause

**The foremost question to be considered in the assessment of any neuropsychiatric problem is whether or not a physical cause is likely to be responsible for the problem.**

Any of the following symptoms will require immediate medical assessment by a doctor since the symptoms may constitute a medical emergency:

- ◆ Impaired, clouded, or depressed consciousness
- ◆ Recent onset of confusion, disorientation, and impaired memory
- ◆ Periods of complete inactivity during which there is a loss of awareness of surroundings for short periods
- ◆ Fever
- ◆ Diabetes
- ◆ Seizure earlier in the day
- ◆ Signs of head injury or history of recent head injury (within about 2 weeks)

If any of these symptoms are present:

- ◆ Refer **IMMEDIATELY** to a doctor or hospital for medical assessment.
- ◆ Keep the individual under observation while waiting for assessment or transport.
- ◆ Remove sources of stimulation.
- ◆ If the individual is a known diabetic, give sugar solution (e.g., tea with sugar).

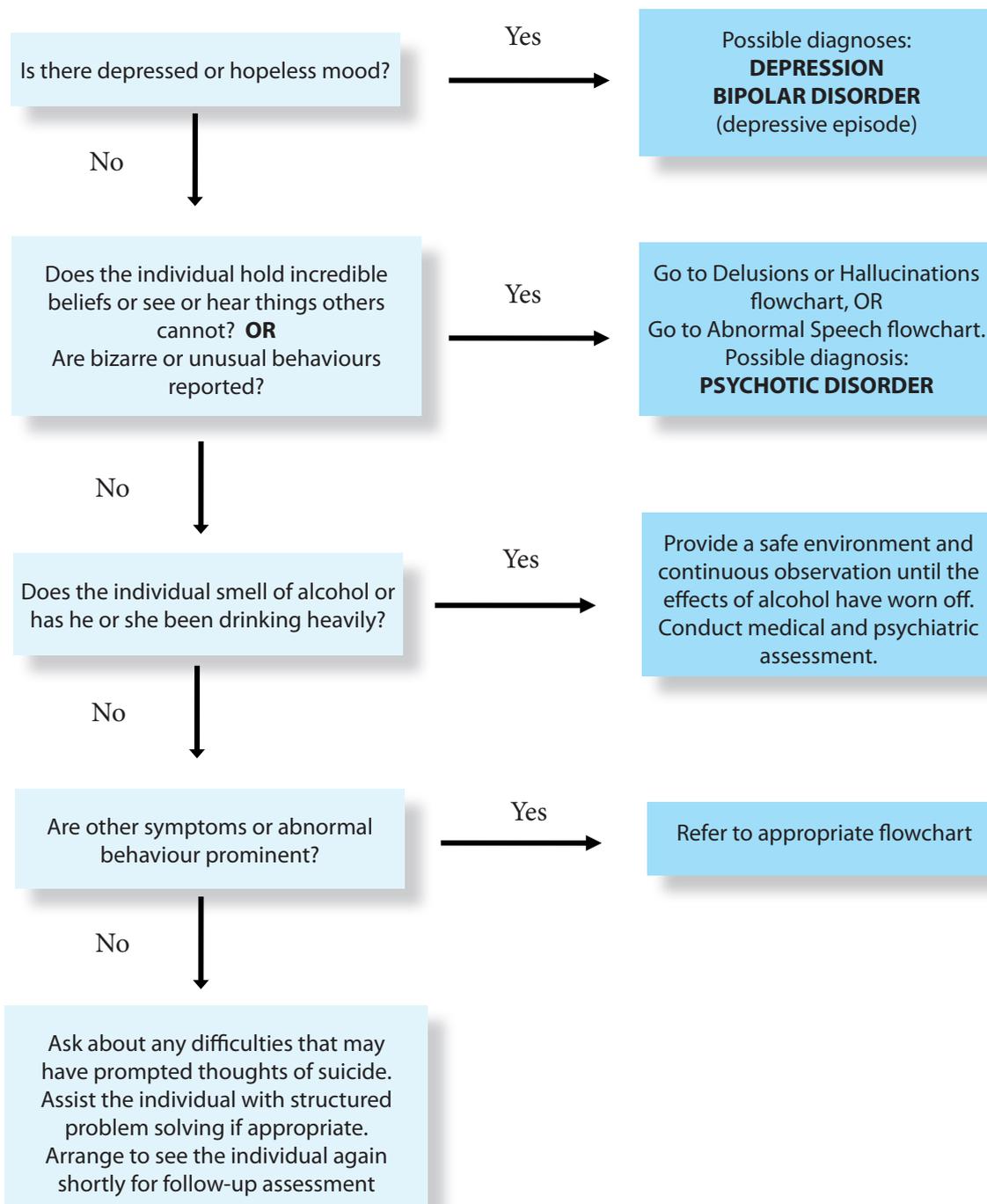
Possible diagnoses: **Delirium related to either an opportunistic infection (brain or systemic), toxic effects of medication, or other medical condition.**

## Presenting problem 2: Suicidal thoughts or acts

### Assess suicide risk

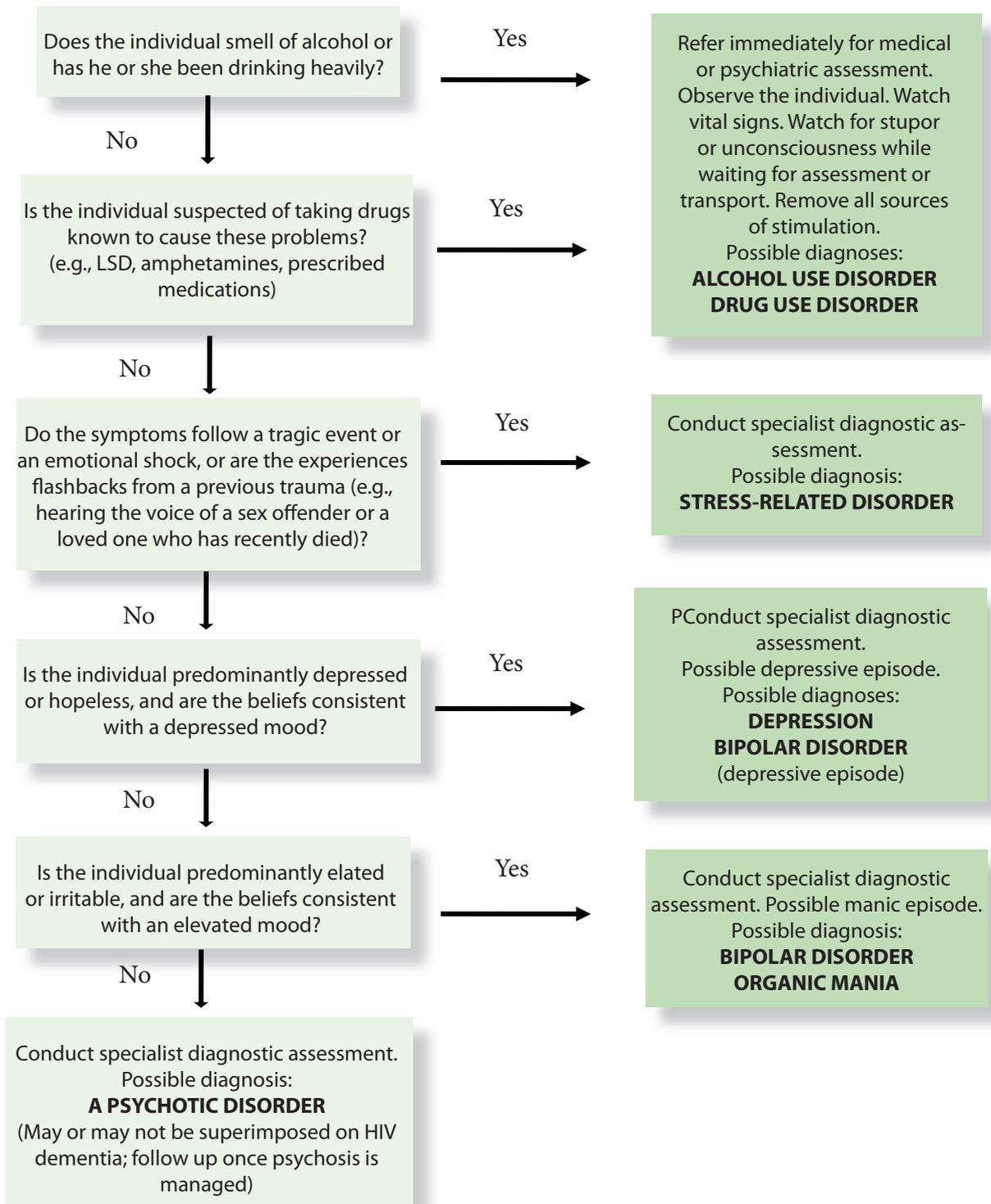
If suicide risk is apparent, seek diagnostic consultation with a specialist.

Assess for other symptoms or abnormal behaviors. In particular:



## Presenting problem 3: Delusions or hallucinations

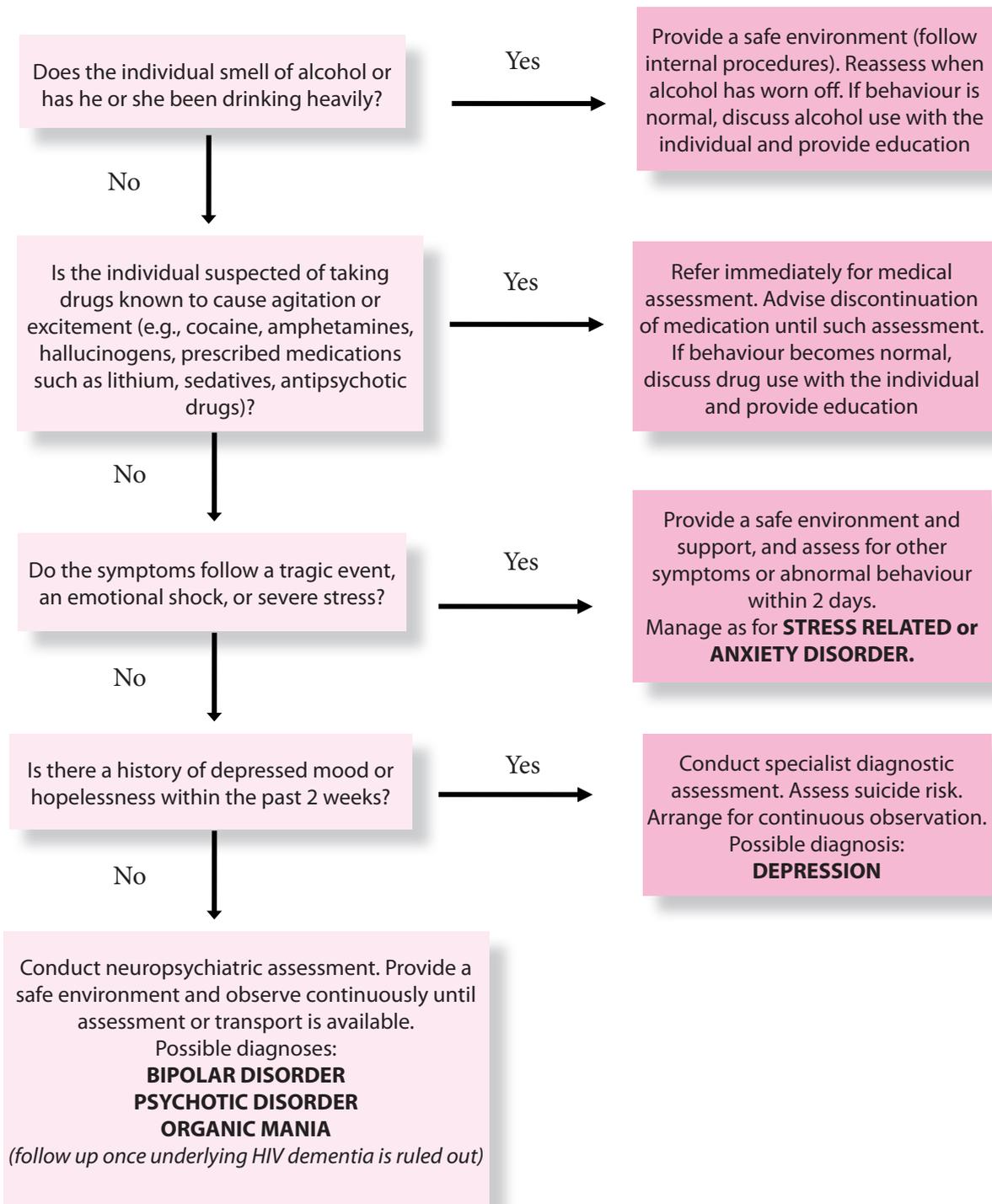
The individual holds incredible beliefs or sees and hears things others cannot.  
*Could the condition be due to a physical cause? (See Presenting Problem 1)*



## Presenting problem 4: Agitation or excitement

Agitation refers to observable and excessive motor activity that is associated with the experience of inner tension. The activity is usually non-productive and repetitious (e.g., an inability to sit still, pacing, hand wringing).

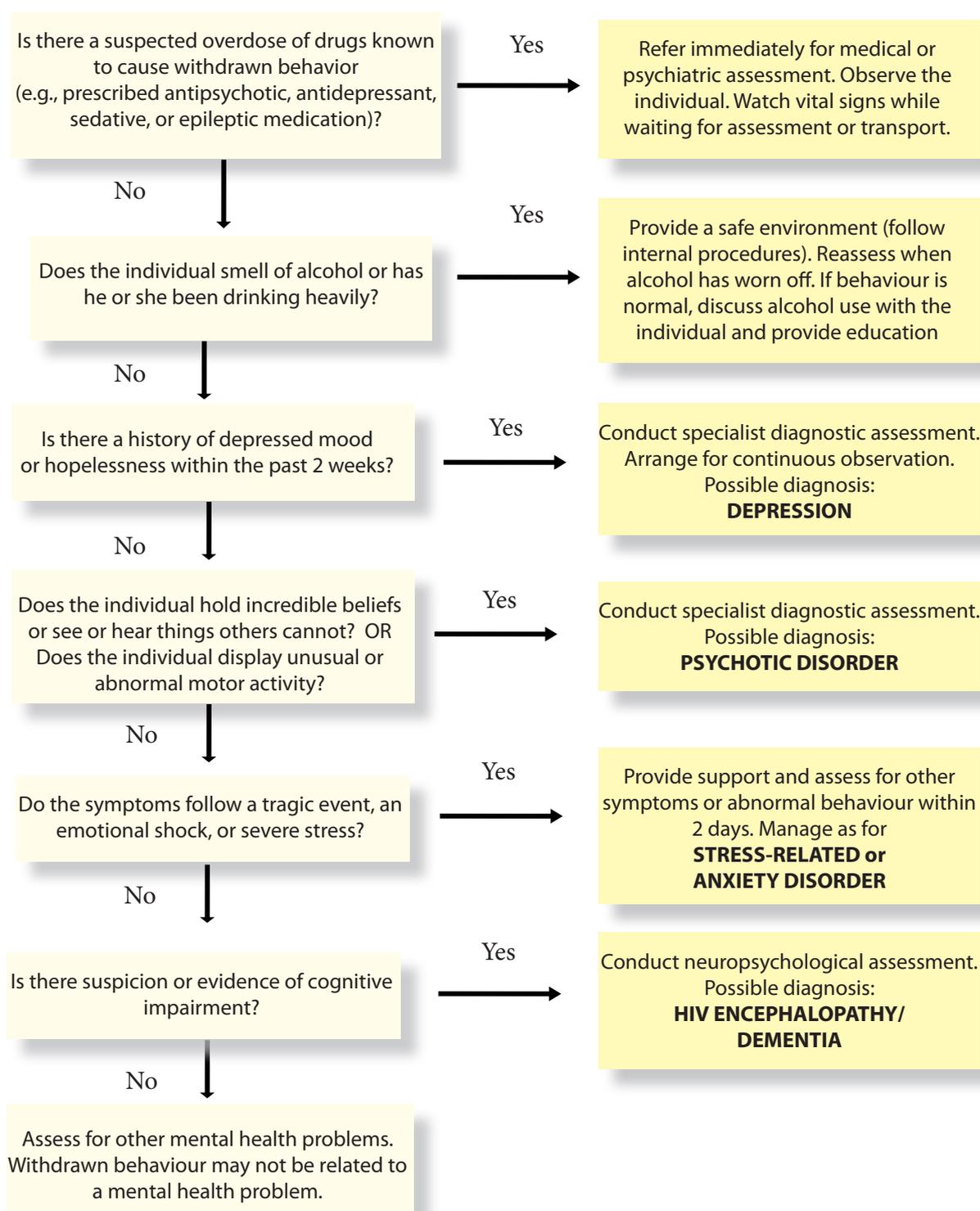
*Could the condition be due to a physical cause? (See Presenting Problem 1)*



## Presenting problem 5: Withdrawn behavior

The individual is slow to respond to commands and questions. (Individuals who are quiet because they are anxious, angry, or intimidated by a new environment are excluded).

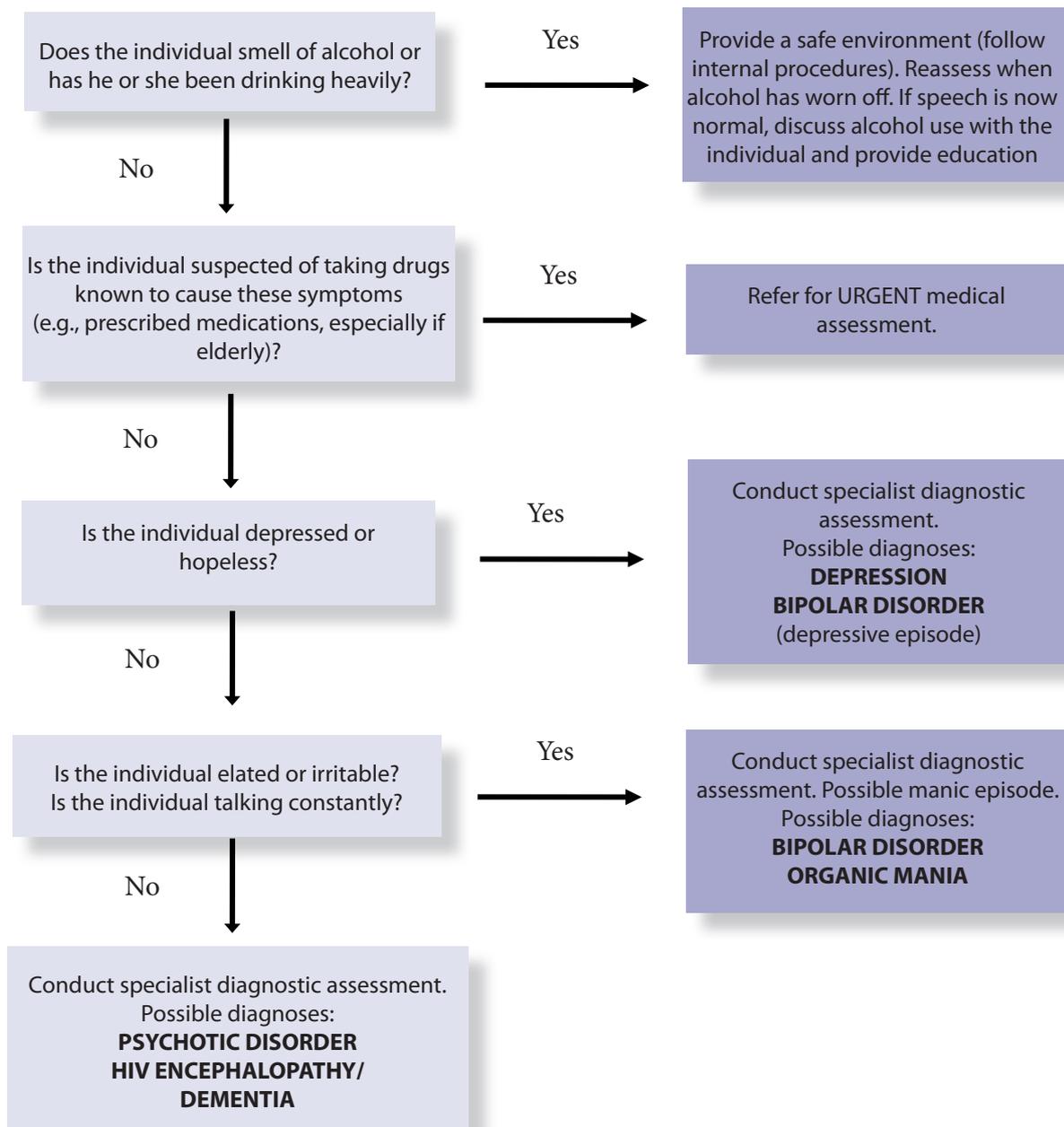
*Could the condition be due to a physical cause? (See Presenting Problem 1)*



## Presenting problem 6: Abnormal speech

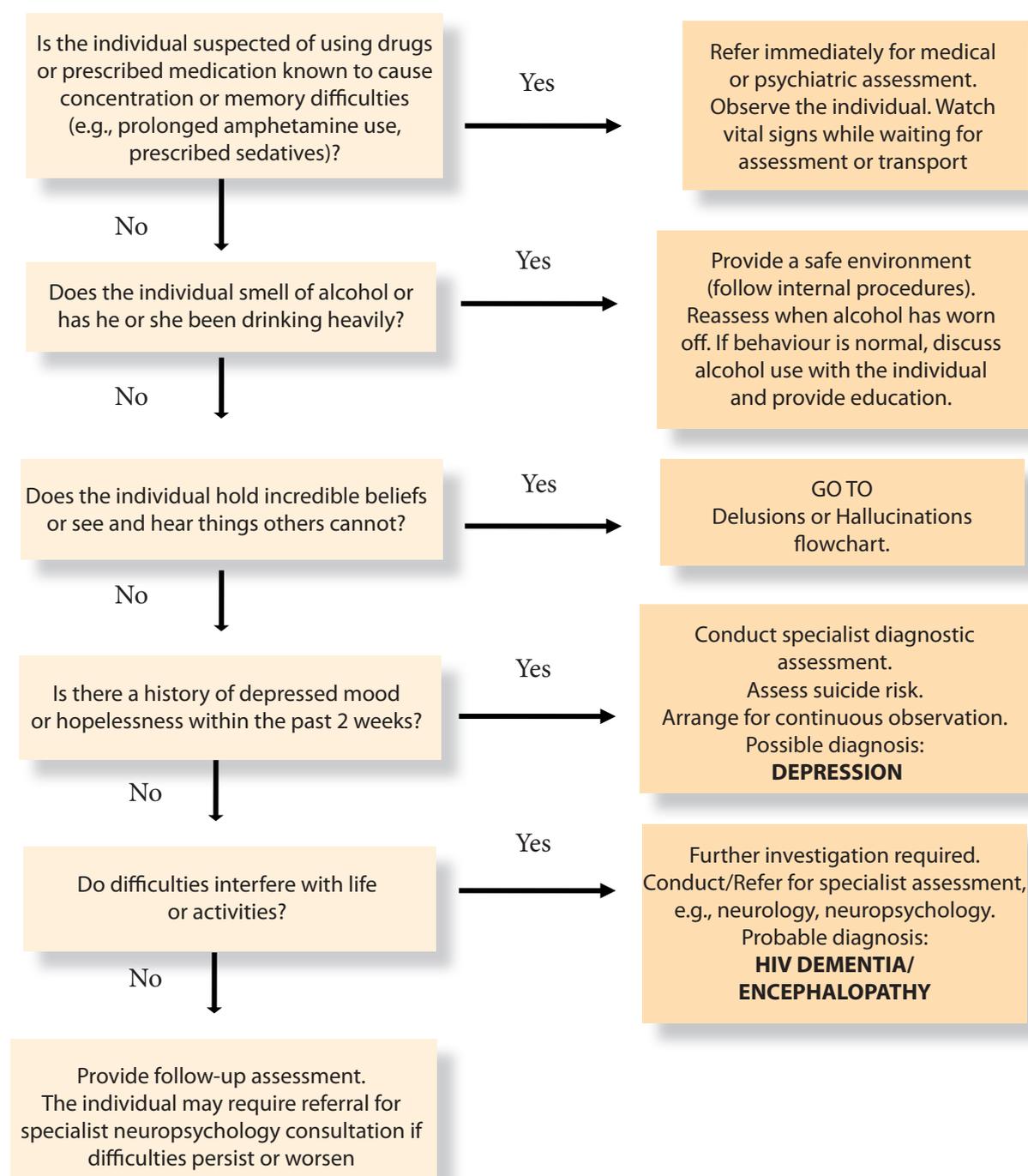
Recent onset of speech or sounds that do not make sense.

*Could the condition be due to a physical cause? (See Presenting Problem 1)*



## Presenting problem 7: Concentration or memory difficulties

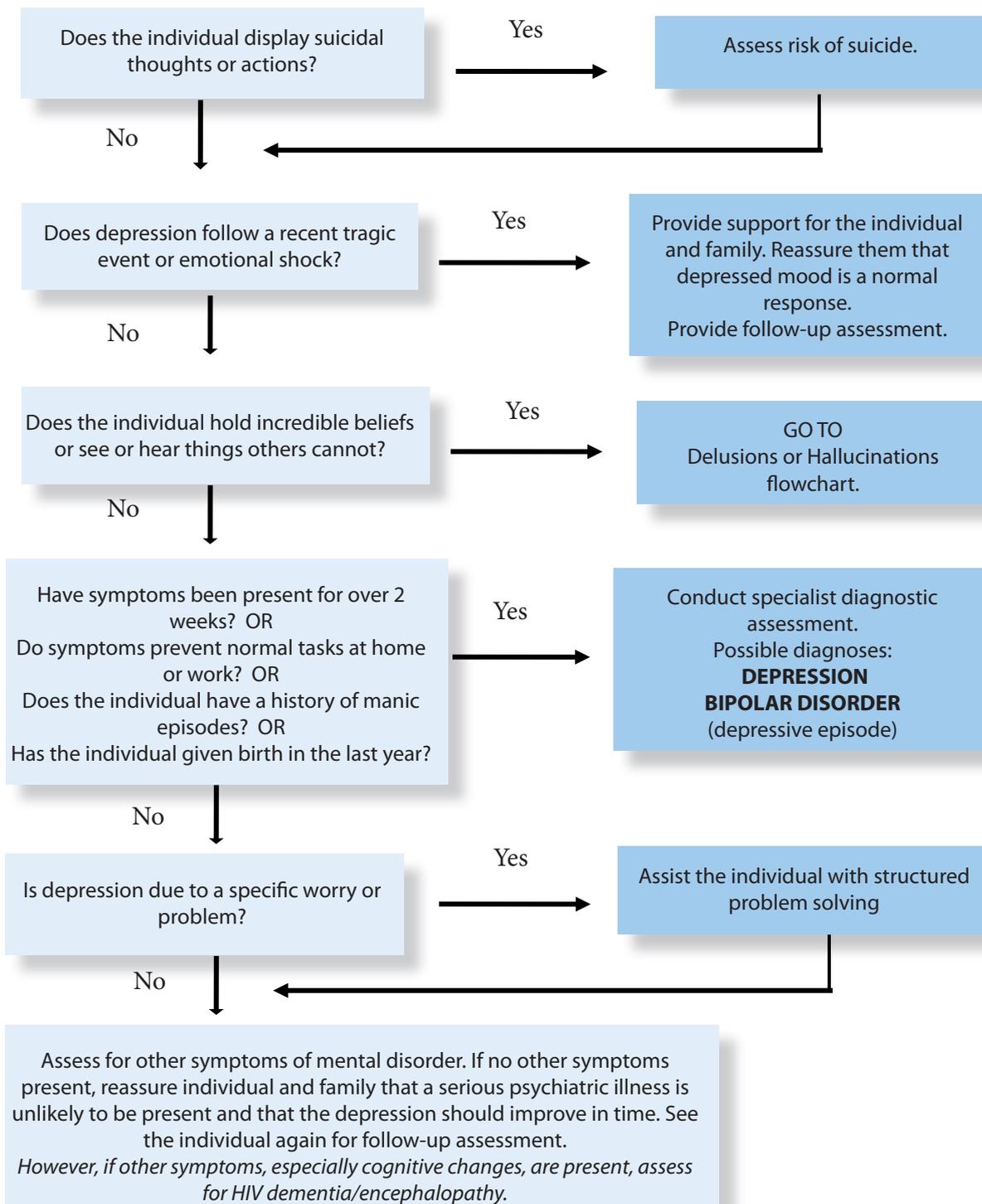
Could the condition be due to a physical cause? (See Presenting Problem 1)  
Check again if the concentration or memory difficulties had a sudden onset.



# Presenting problem 8: Depression

Marked by sad or hopeless mood; loss of interest in normal activities; feelings of worthlessness, sin, or guilt; sleep or appetite disturbances; many symptoms with no apparent cause.

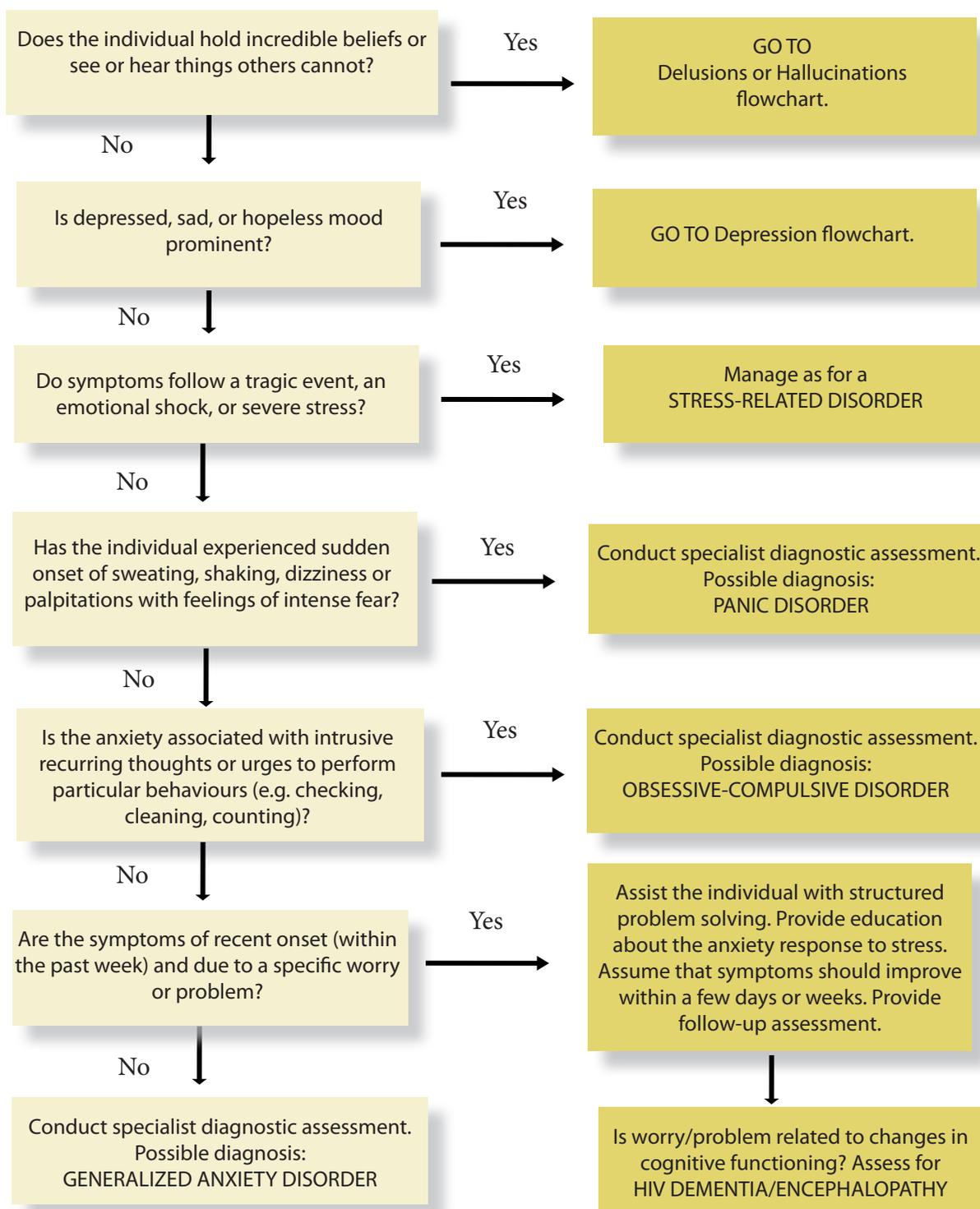
Could the condition be due to a physical cause? (See Presenting Problem 1)



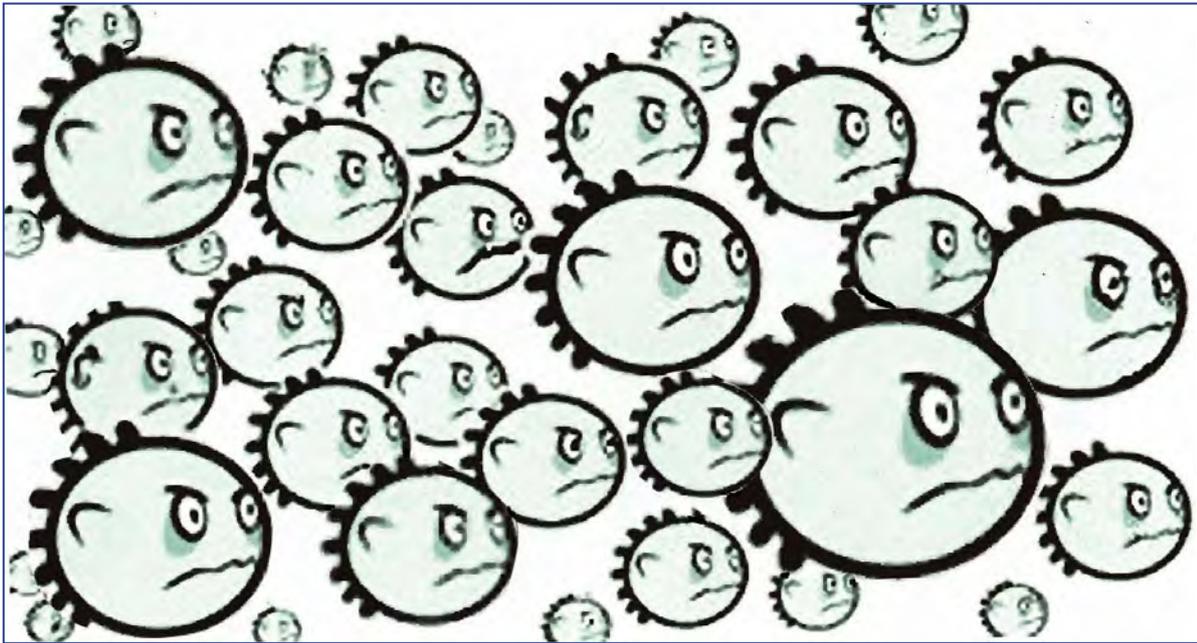
## Presenting problem 9: Anxiety or worry

Expressed fear; excessive worry; symptoms of anxiety such as shaking, palpitations, breathlessness, light-headedness.

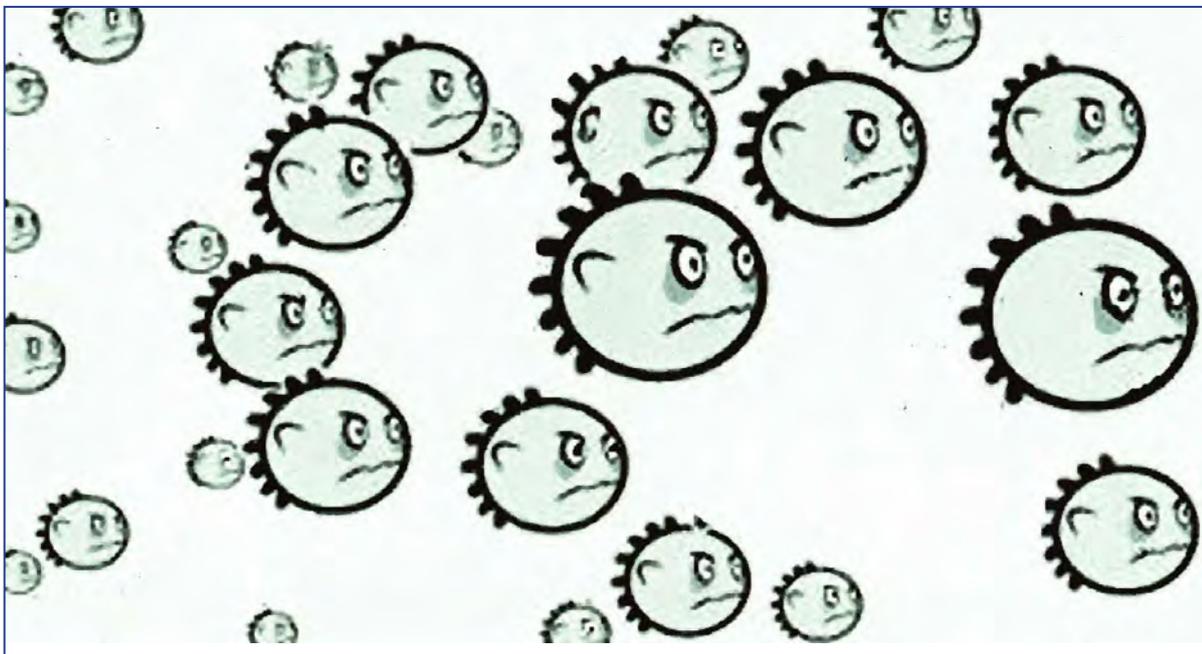
*Could the condition be due to a physical cause? (See Presenting Problem 1)*



## Explaining treatment resistance<sup>1</sup>

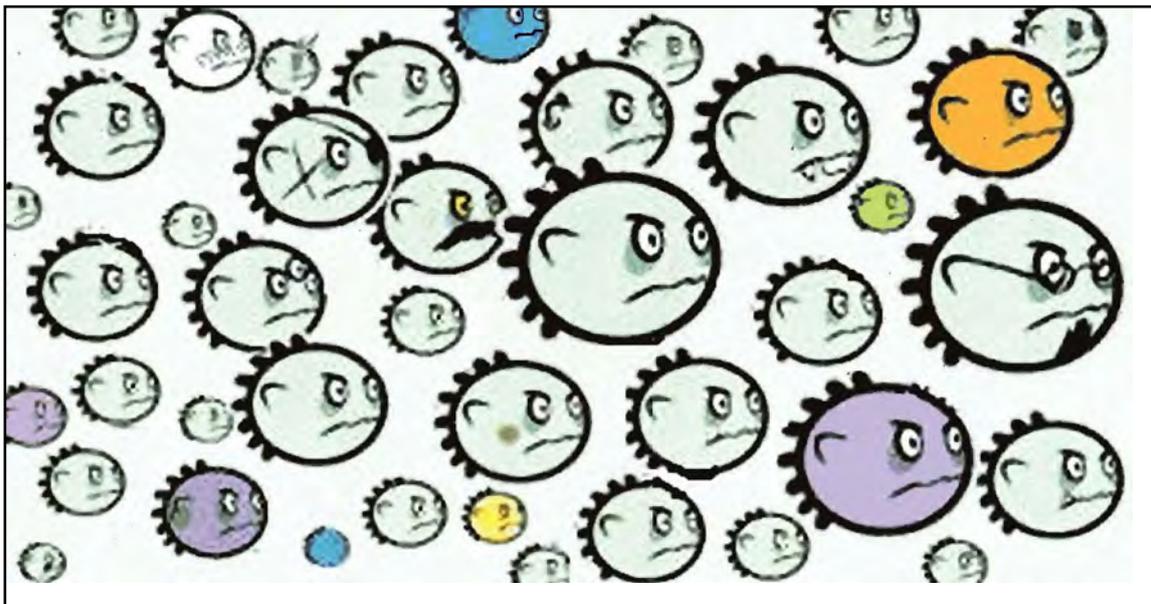


After HIV enters a person's body, it infects the person's immune cells (our body's defense against infections these cells are called CD4/CD8 cells and macrophages) and rapidly starts making copies of its self.

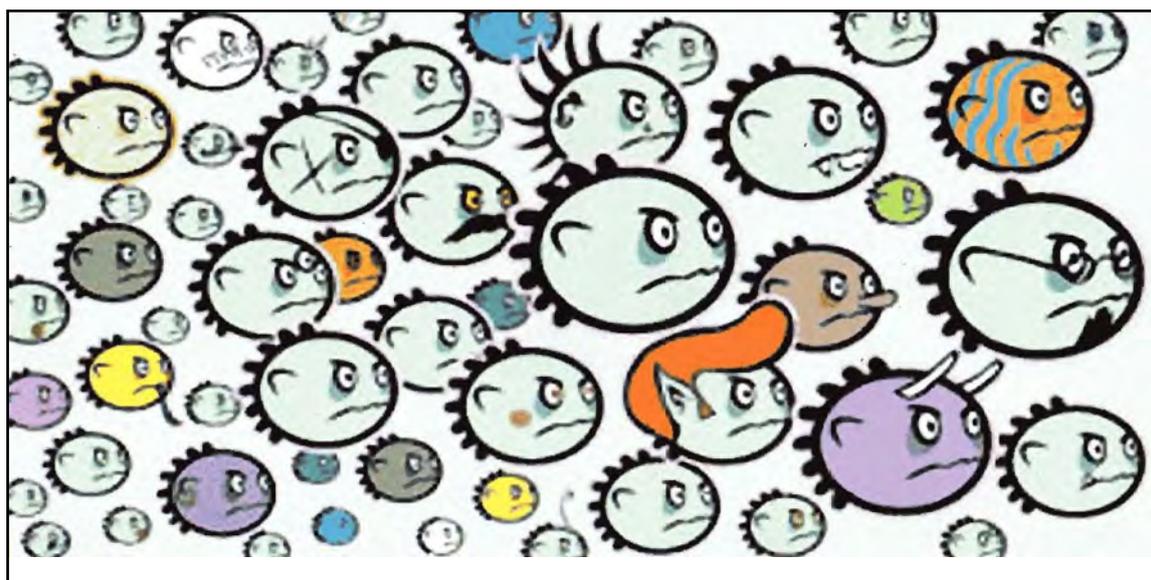


In order for your ARVs to work you need to have a specific amount of the ARVs in your blood all of the time. If you take the right dose of your medications at specified time intervals, HIV cannot easily make copies of itself. If it cannot make copies of itself then the number of copies of HIV in your body will decrease in time but not entirely disappear.

<sup>1</sup>Illustrations adapted from the illustrations *Checking for Resistance*. (2009) *The Body*. <http://www.thebody.com/content/art46023.html>



If you do not take your medications at the right time after your last dose, or the correct amount of ARV, HIV will begin to mutate (change, become deformed and stronger). These could be called "rogue" copies.



Over time, mutated "rogue" HIV copies can make up a larger and larger percentage of the HIV copies in your body. These "rogue" copies are not effectively kept under control by the ARV. This is called drug or treatment resistance.



Your doctor may be able to offer you a special test called an ARV resistance to take closer look the ARVs ability to control HIV in your body to see whether it's developed "rogue copies" of HIV or mutations. If you have these rogue copies you may need to be put onto other ARVs. It is possible that this treatment resistance can be sexually transmitted or transmitted by sharing injecting equipment or from mother to child during pregnancy, delivery or during breastfeeding.

## Oral health and sexual transmission

**Herpes**



**HPV**



**Oral hairy leukoplakia – EBV**



**Combination Lesion:  
HSV and CMV**



**Oral warts Secondary  
to HPV**



**Erythematous candidiasis,  
hard & soft palte**



Source: [http://www.hivdent.org/\\_picturegallery/\\_picturegallery.htm](http://www.hivdent.org/_picturegallery/_picturegallery.htm) accessed 01 December, 2011

Positive Health: **Prevention in Care**

# MODULE 07



## Integration of prevention in treatment and care

### Session objectives:

At the end of the training session, trainees will be able to:

- ◆ Identify key responsibilities in integrating prevention into treatment and care.
- ◆ Identify key strategies for incorporating positive prevention into clinical services.

### Time to complete module:



2 hours 30 minutes

### Training materials:



1. Technical brief (TB07)
2. Activity Sheets, AS7.1, AS7.2
3. PowerPoint presentation (PPT07) – for activity only
4. Flipchart paper or overhead transparencies and markers
5. Special preparation: Print pages 3 and 4 of the Session Plan. Double sided copy and keep aside, do not include it in the participant package .This can be handed out to participants during the activity debrief.
6. Question box

### Content:



- ◆ Placement of positive health in the healthcare setting
- ◆ Service provider responsibilities
- ◆ A holistic approach

### Session instructions



#### 1. Introduction

Time  
10 minutes

- ◆ Start the session by asking the training participants where prevention in treatment and care should be placed in clinical services.
- ◆ Randomly ask a number of participants to give suggestions based on the services in which they work.

#### 2. Technical Brief (TB07)

20 minutes

- ◆ Ask participants to read Technical Brief 07, Integrating positive prevention into clinical services, in their technical brief folder.

**3. PowerPoint Presentation (PPT07)****15 minutes**

- ◆ Start the session with the presentation of PowerPoint PPT07.
- ◆ Stop and ask questions about participant experiences in applying Ask-Screen-Intervene and in working with marginalized individuals.

**4. Small Group work****45 minutes**

- ◆ Divide the training participants into 3 small groups. The groups should be composed of participants from the same or similar provider services.

**Instructions, Part I** (15 minutes)

- ◆ Show the PowerPoint slide "Positive Prevention Teamwork."
- ◆ Tell the groups that they will discuss and decide how positive prevention can be incorporated across their services and decide what staff members have responsibility for which different strategies in prevention in treatment and care. They should think about the process of ask-screen-intervene and how it can be applied to staff member responsibilities. Refer to the technical brief (TB07) to review health and social issues in prevention in treatment and care to determine strategies.
- ◆ Instruct the groups to select a discussion facilitator, and documenter from within their groups. Since the groups will be asked to present their findings, they should also choose a presenter.
- ◆ After providing these instructions, hand out activity sheet AS7.1 to all participants and flipchart paper or overhead transparencies to each group. Then tell the groups to begin their discussion.

**Instructions, Part II** (15 minutes)

- ◆ Show the PowerPoint slide "Service Flow."
- ◆ Tell the training participants to continue working in their small groups. Instruct the groups to now map out the flow of treatment services and the positive health strategies across these points of service and to identify opportunities to ask, screen and intervene. Then, the groups should choose one service point, other than the one in which group members normally work, and identify a key message that should be given as part of the intervention at that point.
- ◆ Hand out activity sheet AS7.2. Then, explain that the blank chart is provided as an example. Their maps should reflect the steps in their services in general.

**5. Small Group Presentations****45 minutes****Instructions**

- ◆ Ask each small group to present its discussions on community outreach and service provision. (5-10 minutes for each group). In the group's presentation, the presenter should include an example of an opportunity to ask, screen and intervene and provide a sample message that should be given as part of the intervention at the group's chosen point of service.
- ◆ After each presentation, allow the other groups an opportunity to make additional comments and suggestions. (5 minutes)
- ◆ Handout the prepared copies of pages 3 and 4 of the Session plan, which are the answer sheets for the activities.

**6. Session recap****15 minutes**

- ◆ Ask the group to summarize and discuss the key learning points from the activity.
- ◆ Briefly discuss what will be the first step for them in integrating prevention in care and treatment in their services.

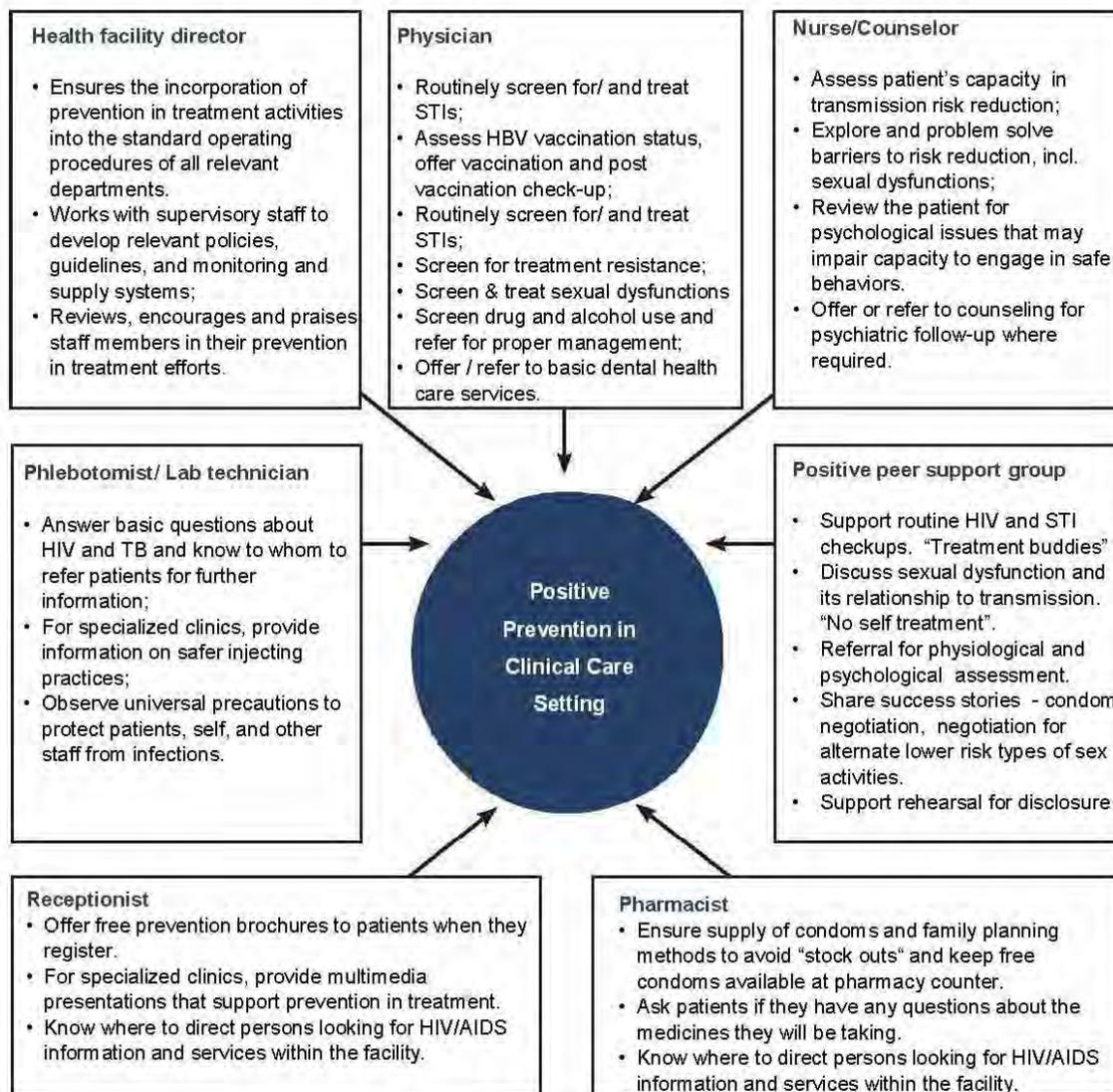
# Positive Prevention – Everybody’s responsibility

## Instructions:

Work in your small group and decide what staff members have responsibility for which different strategies in prevention in treatment and care. You should think about the process of ask-screen-intervene and how it can be applied to staff member responsibilities. Refer to the technical brief (TB07) to review health and social issues in prevention in treatment and care to determine strategies.

Sample:

### Ask - Screen - Intervene



<sup>1</sup> Adapted from “Where Prevention in the Healthcare Setting Happens” in Integrating HIV Prevention in the Care Setting: health manager’s Guide. (2007) Family Health International (FHI).

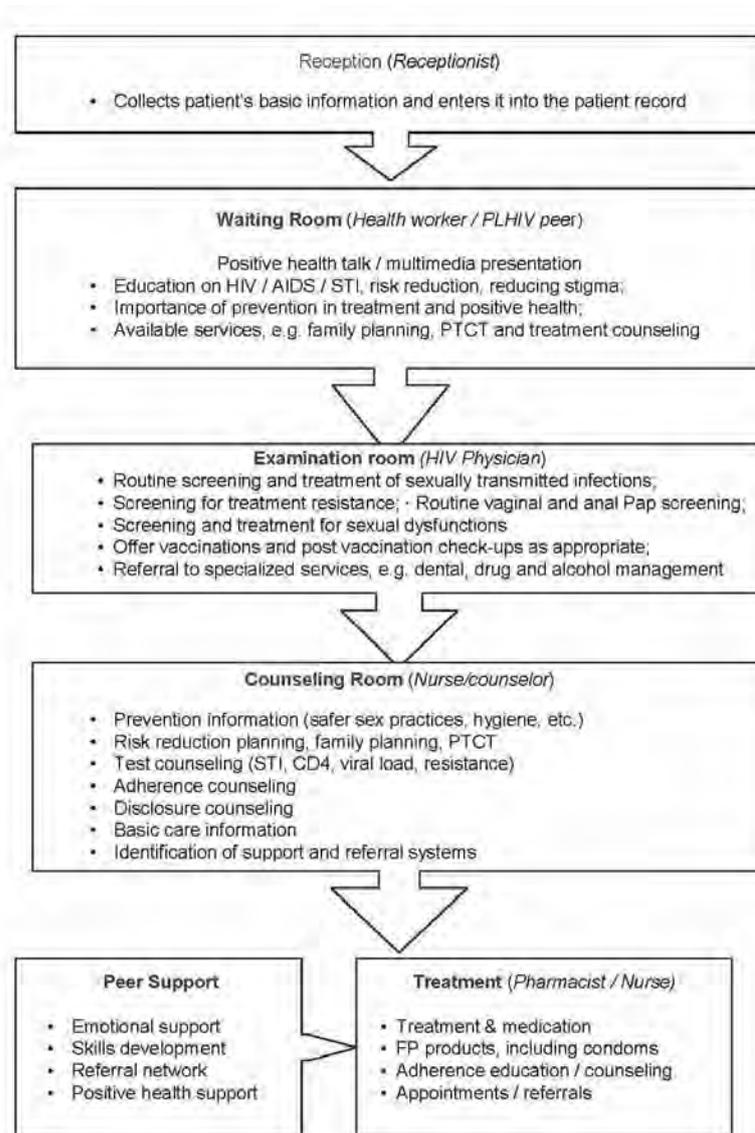
# Positive Health strategies across treatment services

## Instructions:

Work in your small group to map out the flow of treatment services and the positive health strategies across these points of service and to identify opportunities to ask, screen and intervene. Then choose one service point, other than the one in which you normally work, and identify a key message that should be given as part of the intervention at that point.

Sample:

## Ask - Screen - Intervene



2

Note: The steps in service provision may vary from clinic to clinic. In some clinical services, for example, the patient will meet with the nurse/counselor before seeing the HIV physician. In others, the patient may see the nurse/counselor both before and after examination.

<sup>2</sup>Adapted from "A typical example for integrating HIV Positive Prevention Strategies in the existing counseling process" in Positive Prevention Counselling: A Training Course for HIV / AIDS Counselors, Trainer's Guide. (2007) Ministry of Health - ACP, Kampala – Uganda

## Positive Health: Prevention in Care MODULE: 7 Integrating Positive Prevention into Clinical Services

### HIV Prevention in the care setting

Until recently, prevention efforts have primarily targeted persons at risk of HIV infection, rather than those living with HIV. Most of these efforts—such as peer education and condom distribution—take place outside of health facilities. Prevention, however, is extremely important, regardless of a patient’s HIV status. Clinic visits offer opportunities that are often missed to reach both negative and positive persons.

People living with HIV (PLHIV) require knowledge and support so they can protect others from infection, protect themselves from HIV reinfection, and avoid other sexually transmitted infections (STIs). PLHIV come to health facilities for a variety of reasons: they come for the introduction or maintenance of ART treatment or prophylaxis for opportunistic infections, and reproductive and antenatal care. All such visits are opportunities to support and reinforce prevention behaviors, yet prevention is rarely discussed on these occasions.

Persons of unknown HIV status also visit health facilities. Unfortunately, in comparison to other health needs, few go specifically to seek HIV testing or other HIV services. To reach vast numbers of people of unknown status, healthcare providers simply cannot wait to be asked for HIV services; they must actively offer them at every opportunity.

### Placement of Positive Prevention in the Healthcare Setting

HIV prevention is an appropriate part of any healthcare intervention as people need to receive HIV prevention messages from many sources. Ideally, each healthcare encounter with

a patient provides another opportunity to explore possible HIV risks, educate about HIV prevention, and advise about reducing risks and getting tested.

Most health service administrators and managers must prioritize, however, in selecting services in which to integrate HIV prevention. The services they choose should be those that serve people who are at highest risk of having or transmitting HIV. Resources can then be focused on developing a comprehensive prevention plan for integrating prevention into care for these services through the use of staff training, educational materials, supervision, and ongoing assessment.

### Strategies for promoting HIV prevention in the treatment and care setting

Prevention and care are interdependent components in the response to HIV and AIDS and are often intrinsically linked. Effective use of highly active ART, for example, appears to lower the chance that an HIV-positive person will transmit the virus to an uninfected partner. Likewise, knowing that care and treatment options are available may persuade more people to get tested and encourage more open discussion about HIV prevention.

Primary strategies to promote HIV prevention in care settings include opportunities to promote prevention with positives and provider-initiated testing and counseling. These strategies are based on the principle of taking advantage of routine encounters between patients and providers. This brief suggests areas for reinforcing prevention in the treatment and care setting, which includes general counseling; access to condoms; and screening or management of STI s.

## Prevention with positives

HIV-positive persons need prevention support to reduce transmission to uninfected persons and reduce their own risk of co-infection from different HIV strains or strains resistant to ART. HIV-positive persons also require protection from other sexually transmitted diseases, including gonorrhea, chlamydia, syphilis, genital herpes, human papilloma virus (HPV), and hepatitis.

## Provider-initiated testing and counseling

A provider-initiated testing and counseling strategy seeks to normalize HIV testing by encouraging providers to offer tests routinely within health services, rather than obligating patients to ask for tests. The strategy is not meant to replace stand alone counseling and testing services; instead, it encourages providers to assume a more proactive role and reach out to people who may never seek out testing. Provider-initiated counseling is especially important in high-prevalence settings, where opportunities to promote HIV prevention during routine care are frequently missed.

While all encounters in health facilities present potential opportunities for provider-initiated testing and counseling and other prevention services, three of the most critical opportunities involve TB, STIs, and pregnancy. TB care services provide an excellent opportunity to promote HIV prevention because of the high rates of HIV-TB co-infection. Centers offering STI diagnosis and treatment also present prime opportunities for prevention because persons with STIs are at higher risk for HIV. And, pregnancy-related visits present rare opportunities to reach out to an entire family, since men frequent health centers less often than women, and pregnancy may be the only time in a woman's life that she accesses comprehensive health services.

## Behavior objectives for prevention in care

Strategies help explain how a program intends to reach a population, and behavior objectives explain what a program wants the population to do. A comprehensive prevention in care

program recognizes that providers' actions can influence what patients do. So while the focus of prevention in care is primarily to promote specific patient behaviors, promoting provider behaviors that support patients is also very important.

## Why integrate prevention in care?

Every day, during routine care, health workers have numerous opportunities to promote HIV prevention. The healthcare setting is ideal for enhancing the effectiveness of community prevention efforts and reinforcing individual behavior change. The recent push to increase access to treatment for PLHIV worldwide is bringing more people into clinics, where health workers have excellent opportunities to promote prevention among those who are HIV positive. As ART becomes more available, people of unknown status are more likely to access testing services.

In summary, the following are some good reasons to promote prevention in the care setting:

- ◆ In every case of transmission, one person was HIV positive. To prevent new infections, providers must know how to support infected and non-infected persons to reduce risk and stop transmission.
- ◆ HIV prevention is efficient: stopping infection avoids illness, lost productivity, and higher healthcare costs. Solid prevention programs result in earlier detection of illness, which, in turn, reduces hospitalizations and takes some of the care burden off clinical staff. Thailand cannot afford to respond to the epidemic with treatment programs alone.
- ◆ Prevention and care are synergistic. Knowing that care is available is likely to encourage more people to accept testing, and treatment-seeking provides an excellent opportunity to discuss prevention. The sum of the two is greater than either activity alone.
- ◆ Patients who seek care are open to learning how to maintain their health and avoid further illness. The care setting provides unique opportunities for healthcare workers and patients to

discuss prevention. When people come for medical care, they are attending to their health. This is often a window of opportunity for strengthening their understanding of their personal risk of getting HIV and advising them on how to stay healthy.

### Prevention opportunities

Whenever possible, positive prevention efforts should take a holistic approach to HIV prevention and address a wide range of health and social issues. There are numerous opportunities to ask, screen and intervene across different points in treatment and care. It is never redundant to repeat care messages that you think another healthcare provider may have already provided. However, not every positive prevention program will be able to include all these components from the outset. Services need to work with people living with HIV in their community to tailor programming to meet their changing needs.

### Testing

Detecting HIV infections, especially new HIV infections, can help to prevent HIV transmission. People who are newly infected have significantly higher levels of virus in their blood and genital tracts (acute infection) and so they may be more likely to transmit HIV to partners. Because they are newly infected, they may also be unaware of their HIV status. Identifying HIV early allows a person to make more informed decisions about their own and others' health — to access treatment, practice safer sex, use drugs in a safer way, etc. Research does show us that the majority of people who know they have HIV take steps to prevent transmitting HIV to others.

### Supporting a healthy approach to sex

Positive prevention is not just about promoting the use of condoms but also about promoting and supporting healthy sexual relationships for people living with HIV.

### Promoting positive sexual health

Sex is an important part of our lives. It is therefore essential that service providers need to be able to talk openly about sex in a straightforward and non-judgmental way.

This will help to create an open dialogue, which will allow the service provider to understand the person they are talking to, what kind of sex they are having and if they are using condoms. Promoting safer sex within this dialogue is an important part of any positive prevention program. Not all people choose to have vaginal or anal sex but find fulfilling sexual expression in many other ways so it is good to be able to talk knowledgeably and frankly about different kinds of safer sexual activity. Because safer sex can mean different things to different people, it is important that service providers understand the sexual behaviors of their patients so they can ensure that messaging is tailored and relevant to the people they work with.

### Communication skills

Negotiating sex and HIV disclosure are important elements of safer sex. People need to feel comfortable talking to their sex partners about their HIV status and the type of sex they want. This type of communication and negotiation skill may need to be taught and practiced. Positive prevention programs may be able to help people develop the skills they need to disclose their HIV status and to negotiate safer sex with their partners.

### Condoms

Using a condom for vaginal or anal sex is the most effective way of reducing the risk of transmitting HIV and other STIs. While many people living with HIV take steps to ensure that their partners are not infected with HIV by using condoms during sex, others choose not to use condoms. Sex workers, for example, may believe that they were infected by a client. They may therefore think that because the client who infected them showed little concern about their health and wellbeing, they need not be concerned about the health and wellbeing of others. When a client or other partner does not insist on using a condom, they may assume that that partner also has HIV. Traditional safer sex messaging about condom use may not be effective among marginalized individuals.

### Risk reduction counseling

For many people living with HIV, there are only limited opportunities for support and counseling services to help them maintain healthy sexual behaviors. After an HIV-positive test result, people should receive counseling

on safer sex and/or safer drug use to help prevent HIV transmission. This may, however, be only a one-time opportunity. Positive prevention programs can fill the gap and provide counseling services and psychosocial supports on an ongoing basis. These services focus on preventing HIV transmission through motivational interviewing and risk reduction counseling that also addresses factors affecting someone's ability to participate in safer behaviors, such as depression, substance use, low self-esteem and other mental health issues, disclosure of HIV status, relationship and sexuality issues.

### **Sexually transmitted infections**

Having a STI increases a person's chance of transmitting and getting HIV. For people living with HIV, having an STI can be more serious because the STI may progress more rapidly, symptoms may be more severe, and it may be more difficult to treat than in those who are HIV-negative. Therefore, positive prevention programs may want to also incorporate strategies to prevent STIs, including encouraging regular STI testing.

### **Erectile problems**

Many men will experience problems getting or maintaining an erection (known as erectile dysfunction) at some point in their lives. There are many possible reasons for erectile dysfunction. Erectile dysfunction can be the result of personal factors such as stress, anxiety, depression, alcohol or drug use, or hormone imbalances. HIV itself, certain opportunistic infections, or the side effects of certain anti-HIV drugs can also contribute to erectile dysfunction. Finally, some men cannot maintain an erection after they have put on a condom, so they may choose not to use condoms.

Men experiencing erectile dysfunction may feel uncomfortable discussing their sexual problems. Positive prevention programs can offer an arena in which men can talk about their erectile problems. Positive prevention programs could also refer patients to specialized healthcare providers or counselors to help determine the cause of their problem and possible solutions.

### **Supporting reproductive health**

Prevention in care programs could play a role in informing HIV-positive people of their

reproductive options and in working to dispel myths about the risk of transmission during conception and delivery. Many women with HIV would like to have children. With the proper treatment and care, an HIV-positive woman can have a healthy pregnancy and a healthy baby. Many people, including some healthcare providers, do not realize that mother-to-child transmission can be prevented. This lack of knowledge can lead to stigma and discrimination for women who choose to get pregnant. This can make it difficult for HIV-positive people to know who to trust or know where to go to talk about their desires for a child.

To reduce the risk of transmission between sero-discordant couples during conception, there are medical interventions that can be performed at specialized clinics e.g. sperm washing. Although these interventions are not currently widely accessible across Thailand, more and more fertility clinics are accommodating the needs of people with HIV who wish to have children.

### **Reducing stigma and discrimination**

For positive prevention strategies to work effectively, issues of HIV stigma and discrimination must be addressed. People living with HIV may choose not to disclose their HIV status to sex partners out of fear that they will be rejected or even face verbal or physical assault. This can make it difficult to negotiate safer sex options. Stigma and discrimination can also prevent some people living with HIV from seeking healthcare and support services. It is of the utmost importance that all positive prevention programs declare and demonstrate from the outset their commitment to equality and freedom from discrimination for everyone regardless of HIV status.

Much of this HIV stigma and discrimination arises from ignorance of how HIV is transmitted. Increased education about how HIV can (and cannot) be transmitted is needed to help remove the often irrational fears that some people have of HIV.

### **Treatment support**

Since the advent of highly active antiretroviral therapy (HAART) in the late 1990s, HIV has become a manageable chronic condition. People living with HIV can now expect to live longer, healthier lives. However, the decision to

begin treatment can be a difficult one to make.

HAART works by reducing the amount of HIV in the blood, which allows the immune system to rebound. This leads to improved health for the individual. A lower viral load may also make someone less infectious. However, it is important to note that the virus will always be present in the body so people should be counseled to continue to use condoms or practice other kinds of safer sex and unsafe injecting practices even if they have an undetectable viral load.

Treatment with HAART is only beneficial when people take their prescribed medications consistently and at the right times. This is known as adherence. Adherence can become challenging when people need to take medications in private, when travelling, or when they experience unpleasant side effects and illness from the medications. Interventions could include providing information about HAART, suggesting strategies for overcoming these difficulties, and educating people so they know how important adherence is to the success of their treatment.

### Emotional support

People living with HIV who experience depression or other emotional issues may have a poorer quality of life and may be more likely to engage in risky sexual behaviors. Therefore, positive prevention programs need to promote not only the physical, sexual and reproductive health of people living with HIV but also their emotional health.

For example, the rate of depression among people living with HIV has been estimated to be from two to six times greater than that among the general population. There are many reasons why people may feel depressed or stressed, such as financial or health worries, the break-up of a relationship, or worries about work. Changes in emotional health can make people who usually have safe sex engage in unsafe sexual practices. For example, some people may find it hard to negotiate condom use because they fear being rejected by their partner. Furthermore, some people may use drugs or drink alcohol to help them deal with an emotional issue, which can, in turn, increase the likelihood that they will have sex without using a condom.

Positive prevention programs could incorporate counseling aimed at helping people work through these issues and, hopefully, enable them to develop strategies that can help them negotiate safer sex with their partners.

### Pulling it all together

First, any service provider planning to deliver a positive prevention program must define what positive prevention means for that service and agree on the values and principles. People living with HIV should be actively involved in making these decisions. Once the values and principles have been agreed upon, program planning can commence. This should be based on the needs and priorities of people living with HIV in the community.

Developing a positive prevention program or building on an existing one has two advantages. It can improve the quality of life of people living with HIV and aid in reducing HIV transmission in the community. However, these programs should be positioned within a broader range of combined prevention interventions that also targets HIV-negative people. No single intervention can be effective on its own.

### Final Note

The traditional approach in positive prevention is to emphasize the individual's responsibility to protect the larger community from HIV infection. The messages that support this responsibility are often ineffective because the marginalized individuals are often stigmatized by the community they are asked to protect and often lack the choice or means to protect themselves from HIV.

Prevention messages for individuals from marginalized groups are more effective when they stress the health and social benefits to the individual rather than stress the obligation of PLHIV to protect others.

Protect yourself and in doing so you also protect others.

i Ickovics JR, "Bundling" HIV prevention: Integrating services to promote synergistic gain. *Prev Med.* 2008 March; 46(3):222-225.

ii Brenner BG, Roger M, Routy J-P, et al. High rates of forward transmission events after acute/early HIV-1 infection. *The Journal of Infectious Diseases.* 2007, 195(7): 951-959.

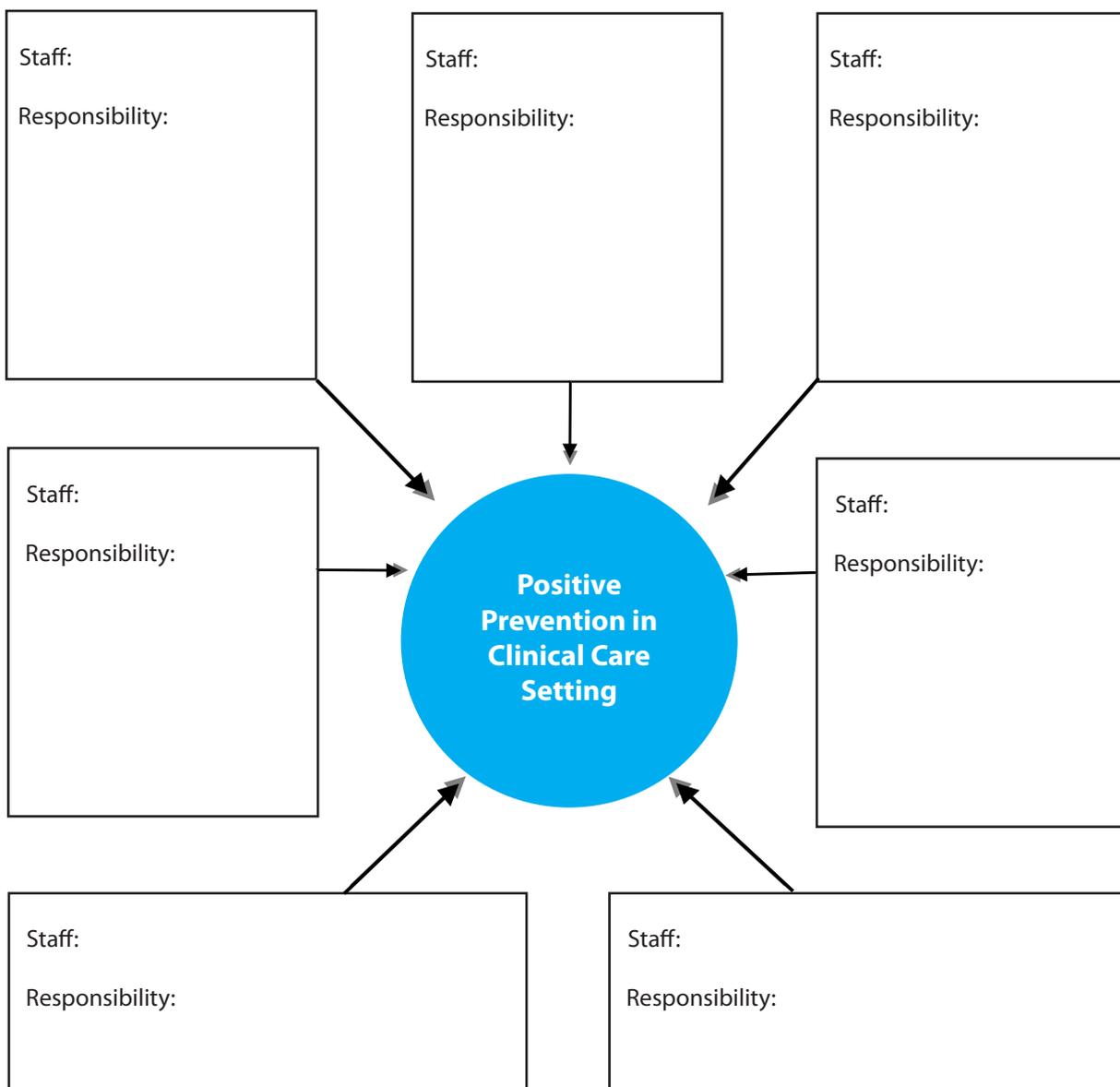
iii Rabkin JG, HIV and Depression: 2008 Review and Update. *Current HIV/AIDS Reports.* 2008; 5(4):163-171.

## Positive prevention: Everybody's responsibility

### Instructions

Work in your small group and decide what staff members have responsibility for which different strategies in prevention in treatment and care. You should think about the process of ask-screen-intervene and how it can be applied to staff member responsibilities. Refer to the technical brief (TB07) to review health and social issues in prevention in treatment and care to determine strategies.

### Ask - Screen - Intervene



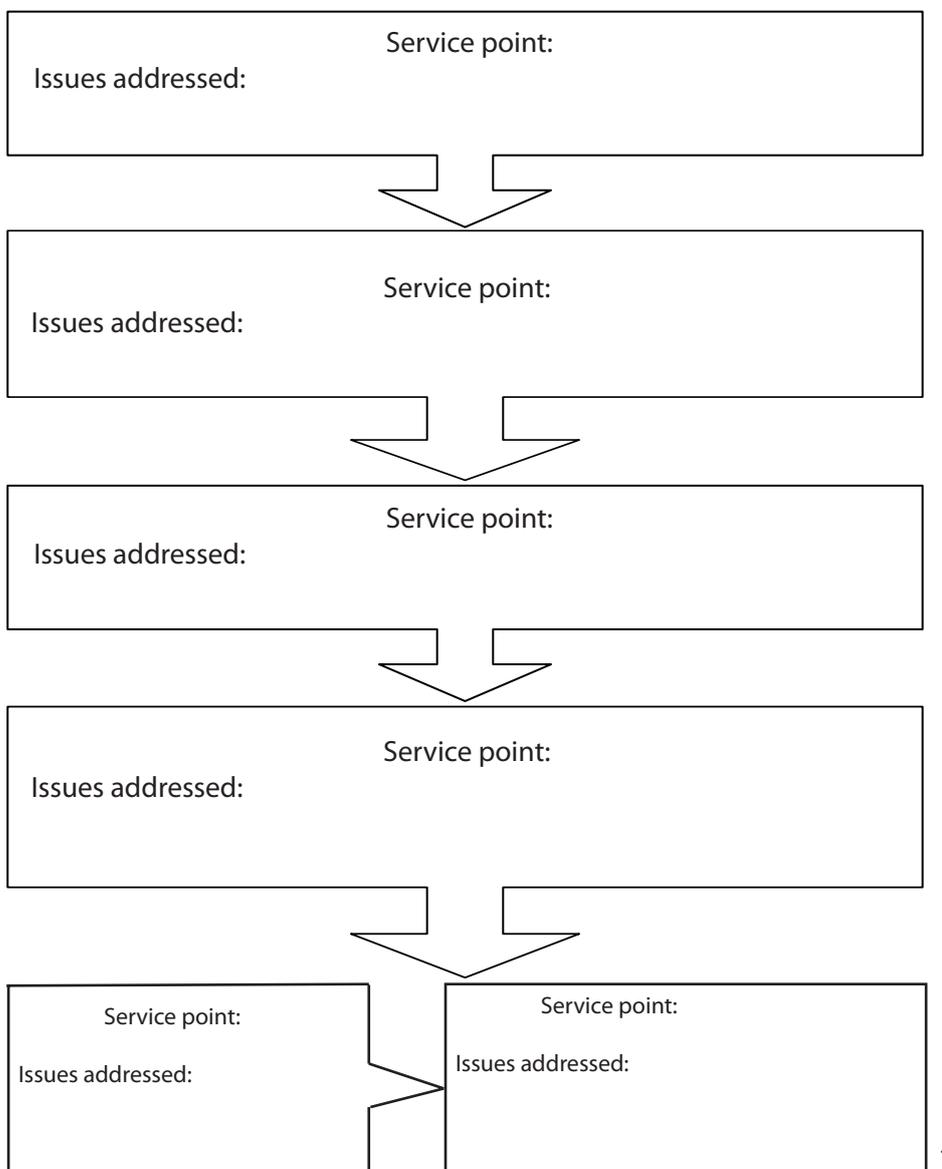
Adapted from "Where Prevention in the Healthcare Setting Happens" in *Integrating HIV Prevention in the Care Setting: health manager's Guide*. (2007) Family Health International (FHI).

## Positive health strategies across treatment services

### Instructions

Work in your small group to map out the flow of treatment services and the positive health strategies across these points of service and to identify opportunities to ask, screen and intervene. Then choose one service point, other than the one in which you normally work, and identify a key message that should be given as part of the intervention at that point.

### Ask - Screen - Intervene



[The chart is provided as an example. Your map should reflect the steps in your service.]

<sup>1</sup> Adapted from "A typical example for integrating HIV Positive Prevention Strategies in the existing counselling process" in Positive Prevention Counselling: A Training Course for HIV / AIDS Counselors, Trainer's Guide. (2007) Ministry of Health - ACP, Kampala - Uganda.



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THE SCIENCE OF IMPROVING LIVES

**Integrating Positive Prevention into Clinical Services – Activity slides**

### Primary Prevention Teamwork

What are the responsibilities of each staff member?

**Health facility director**

- Ensures the incorporation of prevention in biomedical activities

**Physician**

- Routinely screen for and treat STI

**Nurse/Counselor**

- Assess patient's capacity in transmission-risk reduction

**Phlebotomist/Lab technician**

- Answer basic questions about HIV

**Positive prevention in Clinical Care Setting**

**Positive peer support group**

- Support referral for disclosure

**Receptionist**

- Offer prevention brochures to patients

**Pharmacist**

- Ask patients if they have any questions about the medicines they will be taking

**Think:  
Ask  
Screen  
Intervene**

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MODULE 07

### Service Flow

How are positive health strategies placed across all points of service?

```

graph TD
    A[Reception (receptionist)] --> B[Waiting Room (Health worker / PLHIV peer)]
    B --> C[Examination room (PHV/Physician)]
    C --> D[Counseling Room (Nurse/Counselor)]
    D --> E[Peer Support]
    D --> F[Treatment (Pharmacist/ Nurse)]
    
```

**Think:  
Ask  
Screen  
Intervene**

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Positive Health: **Prevention in Care**

TRAINING  
EVALUATION



## Post-exam and course evaluation

### Pre- / Post – Course Knowledge Assessment

1. Can treatment resistance be sexually transmitted?
  
2. Not all clients who are in the acute infection phase will have symptoms of seroconversion illness. However, when a client presents himself to a VCT service and receives a negative result, what are some of the things we should be screening for:
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  
3. What are some things a VCT service could do to reduce treatment delay or failure attend post-diagnosis treatment and care service?
  
4. Often individuals from marginalized populations may not have a vested interest in protecting a community. Therefore, how should we rephrase prevention messages?
  
5. What is one explanation that we could give to clients as to why HIV can still be transmitted with a normal CD4 count and undetectable viral load?
  
6. What is one reason we can give to clients for screening and recommending vaccination for Hepatitis B virus?

7. What is the relationship between sexual dysfunction and HIV transmission?
8. Alcohol is affecting a client's adherence to ART. The client has acknowledged that he is drinking too much and has told you that he is ready to stop drinking altogether (preparation stage). What are some practical things that the counselor/nurse/doctor could do to help him?
9. List five HIV disclosure options:
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_
10. A female sex worker working irregular hours and is required to drink in her work. As we promote dual protection, what would be the most effective contraceptive options for the client?
11. What is one of the concerns with anal HPV in men with HIV?
12. What should we tell our clients about alcohol, ART and HIV co-infections?



## Anonymous evaluation

**Please circle the most appropriate response.**

1. The training improved my knowledge of key information and strategies to use in promoting Positive Health and Prevention to MSM, TG, SW and substance users living with HIV.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Comments: \_\_\_\_\_

2. The training gave me practical skills to provide Positive Health and prevention counselling in HIV treatment and care settings with MSM, TG, SW and substance user client/patients.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Comments: \_\_\_\_\_

3. The training methods used were helpful in developing practical skills.

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	2	3	4	5

Comments: \_\_\_\_\_



4. On a scale of 0–10, to what extent has your knowledge of the following areas changed as a result of the training? Indicate your response by placing a cross on one of the numbers.

- ◆ Module 1: Key information and strategies for prevention of HIV transmission during HIV Acute infection.

0	1	2	3	4	5	6	7	8	9	10
/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../
Not at all					A little			A lot		

- ◆ Module 2: Key strategies to employ for post diagnostic case support planning.

0	1	2	3	4	5	6	7	8	9	10
/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../
Not at all					A little			A lot		

- ◆ Module 3: Key information and strategies to positive sexual health in MSM, TG, SW, and substance users

0	1	2	3	4	5	6	7	8	9	10
/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../
Not at all					A little			A lot		

- ◆ Module 4: Key information and counseling strategies to support HIV disclosure & support disclosure of sexuality.

0	1	2	3	4	5	6	7	8	9	10
/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../
Not at all					A little			A lot		

- ◆ Module 5: Key information and counseling strategies for family planning, reproductive health for HIV positive SW, MSM, TG and substance users.

0	1	2	3	4	5	6	7	8	9	10
/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../
Not at all					A little			A lot		

- ◆ Module 6: Key information and counseling to support the maintenance of health and treatment efficacy among HIV positive SW, MSM, TG and substance users

0	1	2	3	4	5	6	7	8	9	10
/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../
Not at all					A little			A lot		

- ◆ Module 7: How to integrate HIV prevention into clinical service delivery

0	1	2	3	4	5	6	7	8	9	10
/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../	/...../
Not at all					A little			A lot		



5. What did you find were the three most useful parts of the training?

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6. What did you find were the three least useful parts of the training?

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7. List three changes you could make in your work after this training.

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8. Is there any other information you would like to have included in this training?

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Positive Health: **Prevention in Care**

# GLOSSARY



# Glossary

<b>Adherence</b>	The extent to which a patient takes his/her medication according to the prescribed schedule (also referred to as 'compliance').
<b>AIDS</b>	Acquired Immune Deficiency Syndrome. The most severe manifestation of infection with the human immunodeficiency virus (HIV).
<b>AIDS Defining Conditions</b>	Numerous opportunistic infections and neoplasms (cancers) that, in the presence of HIV infection, constitute an AIDS diagnosis. Persons living with AIDS often have infections of the lungs, brain, eyes and other organs, and frequently suffer debilitating weight loss, diarrhea, and a type of cancer called Kaposi's sarcoma.
<b>Antiretroviral. Drug (ARV)</b>	Antiretroviral (ARV) Drug used to fight infection by retroviruses, such as HIV infection.
<b>Antiretroviral Therapy (ART)</b>	Antiretroviral Therapy (ART). A treatment that uses antiretroviral medicines to suppress viral replication and improve symptoms.
<b>Asymptomatic</b>	Without symptoms. Usually to describe a person who has a positive reaction to one of several tests for HIV antibodies but who shows no clinical symptoms of the disease.
<b>CD4 Cells</b>	A type of T cell involved in protecting against viral, fungal and protozoal infections. These cells normally orchestrate the immune response, signaling other cells in the immune system to perform their special functions. Also known as T helper cells.
<b>Combination Therapy</b>	Two or more drugs or treatments used together to achieve optimum results against infection or disease. For treatment of HIV, a minimum of three antiretrovirals is recommended. Combination therapy may offer advantages over single-drug therapies by being more effective in decreasing viral load. An example of combination therapy would be the use of two nucleoside analogue drugs (such as lamivudine and zidovudine) plus either a protease inhibitor or a non-nucleoside reverse transcription inhibitor.
<b>Continuum of prevention</b>	The term 'continuum of prevention' refers to a complement of HIV information support, and services that responds to the evolving behaviors, risks, vulnerabilities, and opportunities of individuals as they progress through various stages of their lives.
<b>Dual protection</b>	Dual protection strategies are intended to prevent both unintended pregnancy and sexually transmitted infections, including HIV. The term refers most often to dual method use through the use of male or female condoms combined with other contraceptive methods such as birth control pills or intrauterine devices.

<b>Efficacy</b>	The maximum ability to produce a result, regardless of dosage. A drug passes efficacy trials if it is effective at the dose tested and against the illness for which it is prescribed.
<b>Highly Active Antiretroviral Therapy (HAART)</b>	Highly Active Antiretroviral Therapy (HAART) is the name given to treatment regimens recommended by leading HIV experts to aggressively suppress viral replication and progress of HIV disease. The usual HAART regimen combines three or more different drugs such as two nucleoside reverse transcriptase inhibitors and a protease inhibitor, two NRTIs and a non-nucleoside reverse transcriptase inhibitor or other combinations.
<b>Human Immunodeficiency Virus (HIV)</b>	Human Immunodeficiency Virus (HIV). The virus that weakens the immune system, ultimately leading to AIDS.
<b>HIV Antibody Test</b>	If positive, the results of this test indicate that the person has been exposed to HIV and has developed antibodies to the virus after the window period of up to 12 weeks has passed.
<b>HIV-negative</b>	A person who is HIV-negative shows no evidence of infection with HIV on a blood test (e.g. absence of antibodies against HIV). Synonym: seronegative. The test result of a person who has been infected but is in the window period between HIV exposure and detection of antibodies will also be negative
<b>HIV-positive</b>	A person who is HIV-positive has had antibodies against HIV detected on a blood test. Synonym: seropositive.
<b>International Classification of diseases (ICD-10)</b>	The ICD is the international standard diagnostic classification for all general epidemiological, many health management purposes and clinical use. The tenth revision, ICD-10, was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as from 1994.
<b>Immunodeficiency</b>	Breakdown in the ability of the immune system to resist or fight off infections or tumors when certain parts of the immune system no longer function. This condition makes a person more susceptible to certain diseases.
<b>Incidence</b>	The number of new cases within a specific period of time.
<b>Maternal Antibodies</b>	Antibodies passed from mother to fetus during pregnancy. Diagnosis of HIV through antibody testing for infants under 18 months may detect maternal antibodies.
<b>Medical Observation</b>	Medical information or concern that a healthcare worker has and can be used as a starting point for discussing the patient's ongoing risk (sexual) or other concerns you want to raise with a patient.
<b>Nucleic Acid Amplification Test (NAAT)</b>	Nucleic-acid-based tests amplify and detect one or more of several target sequences located in specific HIV genes.

<b>Nutritional support</b>	Nutritional support aims at ensuring adequate nutrition and includes assessment of the dietary intake, nutritional status, and food security of the individual or household, offering nutrition education and counseling on how to ensure a balanced diet, mitigate side-effects of treatment and infections, and ensure access to clean water, and providing food supplements or micronutrient supplementation where necessary
<b>Opportunistic Infections (OIs)</b>	Illnesses caused by various organisms, some of which usually do not cause disease in persons with healthy immune systems. Opportunistic infections common in persons diagnosed with AIDS include Pneumocystis carinii pneumonia; Kaposi's sarcoma; cryptosporidiosis; histoplasmosis; other parasitic, viral and fungal infections; and some types of cancers.
<b>Polymerase chain reaction (PCR)</b>	A laboratory method to find and measure very small amounts of RNA or DNA. It is used as the "viral load" test to diagnose HIV in infants and to measure the level of HIV RNA in the blood of infected persons.*
<b>Person/people living with HIV (PLHIV)</b>	"Person/people living with HIV". The term reflects the fact that an infected person may continue to live well and productively for many years.
<b>Parent-to-Child-Transmission (PTCT)</b>	The term 'parent-to-child transmission' is a more inclusive terms preferred to 'mother-to-child transmission' in some countries (see 'mother-to-child transmission') because it is less stigmatizing to women and may encourage male involvement in HIV prevention. A more inclusive term is 'vertical transmission' (see 'vertical transmission')
<b>Prevalence</b>	The number of cases at any time during the study period, divided by the population at risk.
<b>Prophylaxis</b>	A treatment that prevents disease or stops it from spreading, e.g. vaccination
<b>Rapid Test</b>	HIV blood, saliva, urine, or vaginal secretions test that yields same day results.*
<b>Resistance</b>	The ability of an organism, such as HIV, to overcome the inhibitory effect of a drug, such as AZT or a protease inhibitor.
<b>Risk</b>	Risk is defined as the risk of exposure to HIV or the likelihood that a person may become infected with HIV.
<b>Risk Reduction</b>	Risk reduction is a method of decreasing risk on a continuum with the goal of eliminating risk. Risk reduction acknowledges that behavior change happens in small incremental changes and that often it is difficult or impossible to always eliminate all risk. Further risk reduction perspective acknowledges that relapses to risk behaviors are common, expected and part of behavior change.

**Screening**

Screening for HIV status for employment purposes may involve assessment of risk-taking behavior, asking questions about tests already taken or about medication, and HIV testing.

**Seroconversion**

The development of antibodies to a particular antigen. When people develop antibodies to HIV, they 'seroconvert' from antibody-negative to antibody-positive. It may take from as little as one week to several months or more after infection with HIV for antibodies to the virus to develop. After antibodies to HIV appear in the blood, a person should test positive on antibody tests. See "Window Period".

**Sexual and reproductive health services**

Sexual and reproductive health services include, but are not restricted to: services for family planning; infertility services; maternal and newborn health services; prevention of unsafe abortion and post-abortion care; prevention of mother-to-child transmission of HIV; diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer, and other gynecological morbidities; promotion of sexual health, including sexuality counseling; and prevention and management of gender-based violence.

**Sexual orientation**

The term 'sexual orientation' refers to each person's profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different, the same, or both sexes.

**Side Effects**

Medical problems that result from ARV drug toxicities. Common side effects include: nausea, diarrhea, peripheral neuropathy, lipodystrophy, hepatitis, pancreatitis, and lactic acidosis.

**Sexually transmitted infections (STI)**

Sexually transmitted infections (STI) are spread by the transfer of organisms (bacteria, virus, fungi) from person to person during sexual contact.

**Stages of Change Model**

The Stages of Change Model was originally developed in the late 1970's and early 1980's by James Prochaska and Carlo DiClemente. The idea behind the SCM is that behavior change does not happen in one step. Rather, people tend to progress through different stages on their way to successful change. Also, each of us progresses through the stages at our own rate. Each person must decide for himself or herself when a stage is completed and when it is time to move on to the next stage.

The stages of change are:

- ◆ Precontemplation (Not yet acknowledging that there is a problem behavior that needs to be changed)
- ◆ Contemplation (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change)
- ◆ Preparation/Determination (Getting ready to change)
- ◆ Action/Willpower (Changing behavior)
- ◆ Maintenance (Maintaining the behavior change) and
- ◆ Relapse (Returning to older behaviors and abandoning the new changes)



<b>Surveillance</b>	The ongoing and systematic collection, analysis, and interpretation of data about a disease or health condition. Collecting blood samples for the purpose of surveillance is called sero-surveillance
<b>Testing</b>	HIV testing is pivotal to both prevention and treatment programs. The three Cs continue to be the underpinning principles for the conduct of all HIV testing of individuals. Testing must be: confidential, accompanied by counseling, and only be conducted with informed consent, meaning that it is both informed and voluntary
<b>Transgender</b>	A transgender person has a gender identity that is different from his or her sex at birth. Transgender people may be male to female (female appearance) or female to male (male appearance). It is preferable to describe them as 'he' or 'she' according to their gender identity, i.e. the gender that they are presenting, not their sex at birth.
<b>Voluntary counseling and testing (VCT)</b>	Voluntary counseling and testing (VCT) is a client-initiated HIV testing and counseling process.
<b>Viral Load</b>	In relation to HIV: The quantity of HIV RNA in the blood. Research indicates that viral load is a better predictor of the risk of HIV disease progression than the CD4 count. The lower the viral load the longer the time to AIDS diagnosis and the longer the survival time.
<b>WHO Staging System</b>	A classification of the clinical stages of HIV disease developed by the World Health Organization.*
<b>Window Period</b>	The window period is a common term used for the time between the initial HIV infection (the acute infection) and the development of a measurable immunologic (or antibody) response to the infection. During this period, a person infected with HIV could still have a negative HIV test result. The window period varies from person to person and can range from as little as two weeks to as long as three months.





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