‘Positive Prevention’

Resource for training People living with HIV/AIDS (PLHA)

Trainers Manual

(Dec 2006)

Prepared by:
Indian Network for People living with HIV/AIDS (INP+)

Supported by: **DFID India**

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Content

Topic	Training materials	Powerpoint presentation
1. Objectives of the workshop	√ (Pages: 8)	√ (Ppt slides 1-2)
2. Introduction to positive prevention: Prevention interventions for Persons Living with HIV/AIDS	√ (Pages: 9-12)	√ (Ppt slides 3-14)
3. Key strategies in Positive Prevention	√ (Pages: 13-16)	√ (Ppt slides 15-27)
3a. Group work: Key strategies in Positive Prevention		√ (Ppt slides 28-30)
4. Sexuality, sexual health, sexual practices and safer sex	√ (Pages: 17-20)	√ (Ppt slides 31-63)
4a. Group work: Safer sex		√ (Ppt slides 64-69)
5. Sexually transmitted infections	√ (Pages: 21-22)	√ (Ppt slides 70-80)
6. Disclosure, partner notification and couple counselling	√ (Pages: 23-28)	√ (Ppt slides 81-107)
6a. Group work: Disclosure and partner notification; couple counselling		√ (Ppt slides 108-112)
7. Harm reduction with injecting drug users	√ (Pages: 29-32)	√ (Ppt slides 113-131)
8. Substance use, sexual risk and HIV/AIDS treatment adherence	√ (Pages: 33-36)	√ (Ppt slides 132-140)
9. Depression and HIV/AIDS	√ (Pages: 37-39)	√ (Ppt slides 141-150)
Appendix	√ (Pages: 40)	

Participants
The participants for the training course are Persons living with HIV/AIDS and others engaged in providing primary care services for the Persons living with HIV/AIDS. Previous experience of having worked with the Persons living with HIV/AIDS will be helpful and the training can draw on their experiences and the learning can be participatory.

The trainers
The trainers for the course shall be trained Persons living with HIV/AIDS or consultants. This resource guide can be used by them to facilitate the training for the participants. Those who have undergone the training can serve as trainers for future training programs.

Training methods and duration
The training sessions serve to facilitate discussion among the participants and help them to acquire new learning and certain skills. The training process will include:

- Power point presentations
- Activities to facilitate understanding of critical issues
- Skill building in certain specified areas
- Group discussions

The total duration for the training shall be one or two days (6 hours of training per day).

Evaluation
At the end of each training day, the day's proceedings are evaluated by the participants through written feedback on the lucidity of the presentation, quality of the content and the suggestions for improvement. On the final day of the training course, a final written evaluation in a structured format is obtained.

Using the resource guide
The resource guide contains training materials and power point presentations that are to be delivered during the training. It is suggested that the guide is used in a flexible way by the trainers and the necessary local adaptations can be done accordingly.

Supplies and Equipment Needed for Training

LCD Projector and laptop
Diskette or CD of training slides
Dry erase board and markers
Flip Chart
Pens (ink and for flip-chart)
Tape
Handouts:

- Section Handouts
- Multiple copies of role-plays
- Post-Training Evaluation

Tentative Day 1 Plan

Day I:

S.No	Time	Session	Facilitator
1.	9:00 - 09: 05 am	Welcome Address	
2.	9: 05 - 10:00 am	Introduction to the Training Welcome address: Objectives of the Training: Setting up Ground Rules, Expectation from participant, Selecting Volunteers, and Time reporting	
3.	10:00 - 10: 45 am	Introduction to positive prevention: Prevention interventions for Persons Living with HIV/AIDS	
4.	10:45 - 11:00 am	Tea break	
5.	11:00 - 12:00 pm	Key strategies for Positive Prevention	
6.	12:00 - 1:00 pm	Group Work: Key strategies for Positive Prevention	
7.	1:00 - 2:00 pm	Lunch	
8.	2:00 – 3:15 pm	Sexuality, sexual health and sexual practices	
9.	3:15 - 3:30 pm	Tea break	
10.	3:30 - 4: 30 pm	Group discussions: Sexuality, sexual health and sexual practices	
11.	4: 30 - 4:45 pm	Summary & Next day's plan	

Tentative Day 2 Plan

Day 2:

S.No	Time	Session	Facilitator
1.	9: 30 – 9: 45 am	Recap	
2	9:45 - 10: 45 am	Sexually transmitted infections	
3.	10:45 - 11:00 am	Tea break	
4.	11:00 - 12:00 pm	Disclosure, partner notification and couple counselling	
5.	12:00 - 1:00 pm	Role play: Disclosure scenario Discussion	
6.	1:00 - 2:00 pm	Lunch	
7.	2:00 – 3:15 pm	Harm reduction strategies for substance users	
8.	3:15 - 3:30 pm	Tea break	
9.	3:30 - 4: 30 pm	Open session: Questions and answers	
10.	4: 30 - 4:45 pm	Concluding session	

1. Objectives

Training Program Objectives

Preventing HIV in the population
Early identification and treatment of HIV in persons with high risk behaviour
Promoting health amongst Persons Living with HIV/AIDS (PLHA)
Providing prevention-treatment-care and support services for PLHA

Training Workshop Objectives

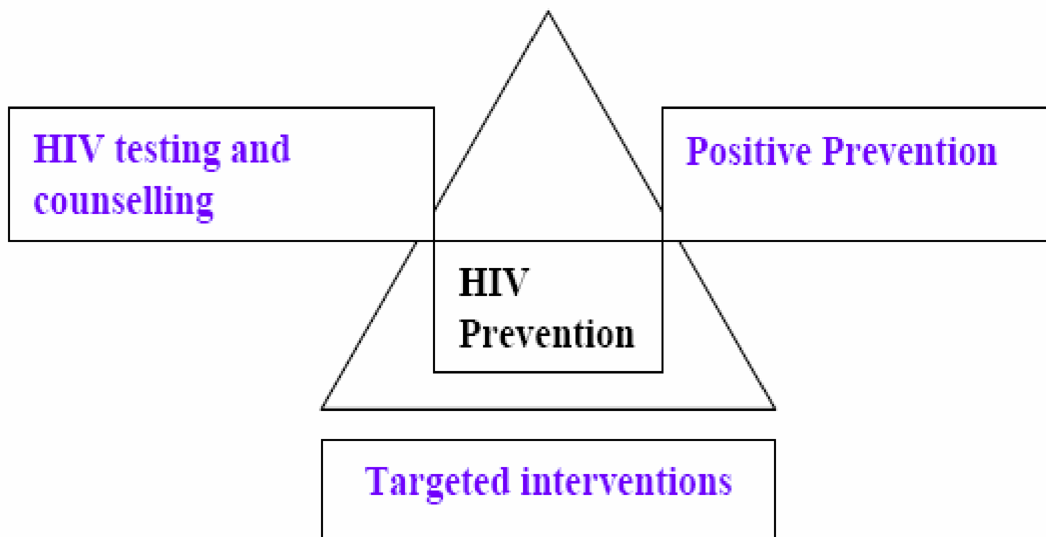
At the end of the workshop, the participants will be able to:

- Understand the concept of positive prevention
- Understand the key strategies of positive prevention
- Understand the contextual factors and challenges in implementing safer sex and safer injecting drug use among PLHA
- Learn how to promote positive prevention strategies among PLHA

2. Introduction to Positive Prevention: Prevention strategies for Persons living with HIV/AIDS (PLHA)

We will address the following in the session:
What are the key components of HIV Prevention?
What is Positive Prevention?
Why positive prevention?

What are the key components of HIV Prevention?



A three-pronged approach is important:

1) Prevention activities directed at persons at high risk for contracting HIV (Targeted interventions)
2) HIV counselling, testing, and referral services
3) Prevention activities directed at improving the health of persons living with HIV and AIDS to prevent further transmission (Positive Prevention)

Prevention activities directed at persons at high risk for contracting HIV (Targeted interventions)
The persons at high risk for contracting HIV include:

- Sex workers
- Injecting drug users
- Men having sex with men
- Persons with multiple sex partners
- Persons having unprotected sex

In India, most targeted interventions supported by National AIDS Control Organization (NACO) are targeting persons at high risk for contracting HIV. The behavioral intervention strategies

operate at individual, small-group, and community levels. They are complemented by structural interventions that help to create an enabling environment. The targeted interventions include:

HIV Prevention

- behaviour change communication (BCC)
- control of sexually transmitted infections (STIs)
- voluntary confidential counselling and HIV testing (VCCT)
- harm reduction programmes for injecting drug users (IDUs)
- interventions for prevention of mother-to-child transmission (PMTCT)
- blood safety measures
- infection control in healthcare settings
- structural interventions to alter the environment in ways that promote risk reduction

Behavioral interventions substantially reduce sexual risk among young adults, men who have sex with men (MSM), heterosexual men and women, and injecting drug users. They are also cost-effective.

HIV counselling, testing, and referral services

PRACTICAL POINT = THE THREE C'S
HIV testing should always be

- Only be conducted with **C**onsent, i.e. both informed and voluntary
- HIV testing should be accompanied by **C**ounselling.
- The HIV test result should only be disclosed to the client ensuring **C**onfidentiality of the test result.

Offer of HIV testing and counselling comprises of three steps:

1. Pre-test information and education (group or individual) and provide individual pre-test counselling if requested
2. Informed consent and HIV testing
3. Post test counselling

HIV counseling and testing

- reduces risk among persons who learned that they were HIV seropositive
- increases condom use
- decreases new sexually transmitted diseases (STDs) among HIV seronegative patients

The availability of rapid tests has made it easier to provide HIV testing in a wide range of clinical and nontraditional settings. Rapid tests produce results in 20 minutes and make it possible to give HIV-seronegative and provisional HIV-seropositive test results in a single visit.

Prevention activities directed at improving the health of persons living with HIV and AIDS to prevent further transmission (Positive Prevention)
Interventions targeting PLHA is an important component of HIV prevention and should be promoted.

What is Positive Prevention?

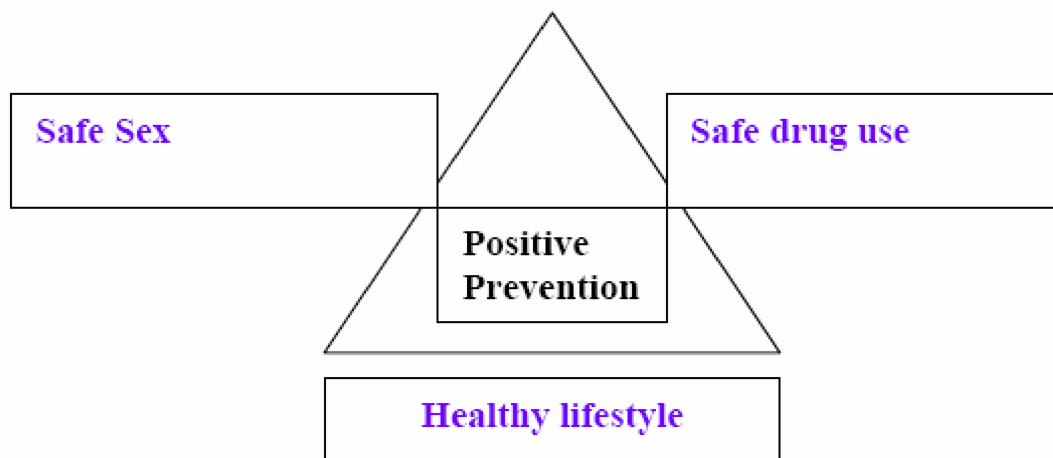
•HIV-positive prevention emphasizes positive choices.

•Positive prevention optimizes the health and well-being of HIV-positive people by
promoting risk reduction activities
promoting healthy lifestyle choices

Is prevention for positives only about sexual behavior? Prevention for positives focuses on two main areas:

1) sexual behavior
2) injection drug use

•HIV+ individuals should practice general prevention for all illnesses – infectious and non-infectious



Aims of positive prevention
•How to avoid infecting others with HIV
•How to avoid getting sexually transmitted diseases (such as herpes, gonorrhea, syphilis, hlamydia, etc.)
•How to avoid other blood-borne illness (for example, hepatitis C and hepatitis B).
·How to remain healthy

Positive Prevention
Why Positive Prevention?

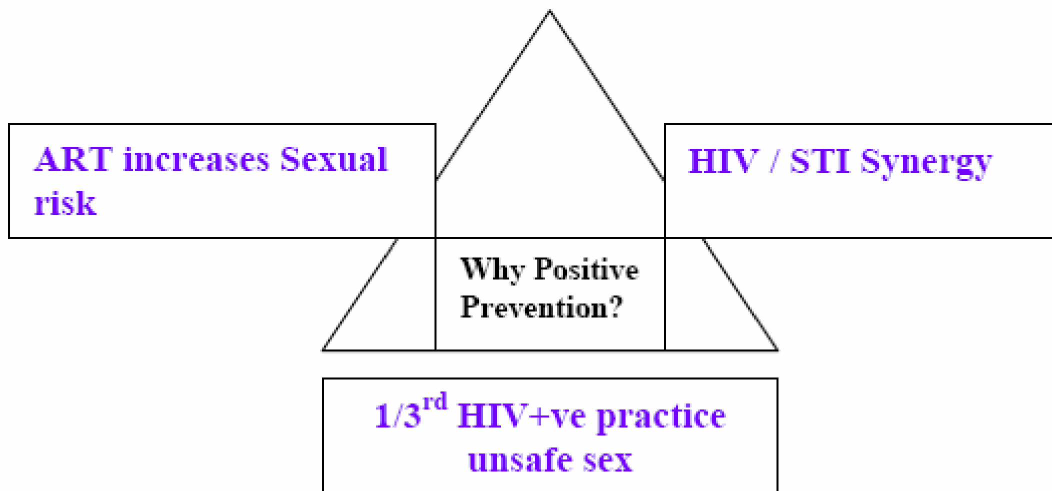
Public health principle
Public health approach to prevention of infectious diseases is to target the infected for prevention efforts.
This is more efficient for preventing HIV transmissions as in every HIV transmission a HIV infected individual is involved.

Reasons for prevention interventions for HIV positive persons
•A third of HIV-positive people have unprotected anal or vaginal sex.

•Significant synergy between HIV and STIs exist. This means that in the presence of STDs, the transmission potential becomes greater among the HIV infected individuals. Reducing the prevalence of STIs in people with HIV will help reduce the spread of HIV itself.

• The availability of antiretroviral therapy (ART) led to a dramatic decline in AIDS-related deaths and a new era in which many persons diagnosed with HIV can expect to lead active and productive lives that extend for decades. The treatment optimism has at times led to unprotected sex.

•Multidrug resistance and HIV superinfection strongly suggests that an increased focus on HIV prevention, directed towards those who are seropositive.



Multiple level interventions are required for positive prevention
Multiple level interventions are required in order that positive prevention is implemented effectively. HIV positive individuals are not a homogeneous population. The HIV positive individuals come from diverse backgrounds of gender, culture and ethnicity. There are subgroups based on a variety of dimensions risk behaviours, sex, sexual orientation, race, geography, norms and values. As there is no “one fix fit all”, we need to develop interventions that target the diversity of populations.

3. Key strategies for Positive Prevention

Principles of Positive Prevention

The five principles of positive prevention **(GEEPS)** are:

Gender dynamics: Be gender sensitive so that interventions address the gender relations and power dynamics between women and men, and recognise that these influence the effectiveness of positive prevention strategies.

Empowerment: Combine strategies to create enabling environments which facilitate the empowerment of people with HIV. Recognise that the behaviour of people with HIV is influenced by the context in which they live their lives and that there will be factors that enable or hinder behaviour change in every situation.

Ethics: Protect and promote human rights and ethical principles, including the right to privacy, confidentiality, informed consent, freedom from discrimination, and the duty to do no harm. Strategies and policies that erode human rights and ethics and create an environment of fear, intolerance and coercion will undermine positive prevention interventions.

Participation: This means it is important to actively involve people with HIV and affected communities in identifying risks and in assessing how best to implement strategies for positive prevention in their situation. PLHA must govern the positive prevention strategies.

Support for sexual needs of positive persons: Interventions need to understand and respond to the sexual and emotional needs and desires that motivate people and adopt 'sexpositive' approaches. Communities must be sensitive to their emotional and sexual needs.

Positive prevention is grounded on five core values:

1. To promote the recognition that people living with HIV/AIDS are part of the solution to the impacts of the disease and should be included in prevention efforts.

2. To encourage the involvement of people living with HIV/AIDS in all aspects of health promotion and prevention activities.

3. To develop health communication and prevention strategies targeted at people living with HIV/AIDS. To promote risk/harm reduction behaviors and activities.

4. To protect and promote human rights and dignity issues for people living with HIV/AIDS including the right to privacy, health care, confidentiality, informed consent, and freedom from discrimination.

5. To ensure programs and services are available, accessible, and relevant to the diverse populations of people living with HIV/AIDS.

Key strategies

1. Promoting voluntary confidential counselling and testing

2. Providing posttest and ongoing counselling for positive people (e.g., safe sex, safe drug use)

3. Encouraging beneficial disclosure and ethical partner notification

4. Providing counselling for sero-discordant couples

Levels of intervention

1. Individual level interventions

2. Couple level interventions

3. Community level interventions

4. Advocacy

Individual level interventions

Voluntary confidential counselling and testing (VCCT) for early identification of HIV infection

Anti-retroviral Treatment (ART) to HIV positive individuals at the appropriate time

Safe sex and safe drug use counselling for PLHA

Preventing mother-to-child transmission (PMCT)

Couple level interventions

Reaching the sex partners through outreach

Couple counselling

Sero-concordant couples

Community level interventions

Peer support groups

Training HIV positive persons as outreach workers

Addressing stigma and discrimination

Addressing HIV related gender violence

Advocacy

Involving people with HIV in decision-making

Advocacy for access to treatment

Legislative reform for addressing stigma and discrimination

Prevention – treatment – care continuum

(1) Increase the number of HIV-infected persons who know their serostatus.
(2) Increase the use of health care and preventive services.
(3) Increase high-quality care and treatment.
(4) Increase adherence to therapy by individuals with HIV.
(5) Increase the number of individuals with HIV who adopt and sustain HIV–STD risk reduction behavior.

1. Increase number of HIV-infected persons who know their serostatus.
Create campaigns to emphasize benefits of early diagnosis of HIV.
Educate to reduce fear of knowledge of serostatus.
Create campaigns to diminish discrimination against HIV-infected persons.
Create campaigns to reduce stigma associated with HIV infection.
Train providers of high-risk persons on benefits and strategies of early HIV diagnosis.
Create campaigns to encourage voluntary HIV testing.
Continue to support anonymous testing.
Make testing venues more responsive to client needs.
Facilitate use of rapid tests.
Increase voluntary testing in health care facilities.
Increase voluntary testing of pregnant women.
Increase voluntary testing in prisons and jails.
Increase voluntary testing among sex and needle-sharing partners of HIV-infected persons.

2. Increase use of services.
Increase links between prevention and care programs.
Improve access to HIV/AIDS care through community-based organizations.
Upon discharge, link prisoners to care and prevention services.
Increase proportion of pregnant women receiving antenatal care.

3. Increase quality care and treatment.
Increase proportion of HIV-infected pregnant women receiving ART.
Educate health care workers and HIV-infected persons about HIV/AIDS treatment.
Monitor and evaluate quality of HIV/AIDS care.
Institute surveillance for effectiveness and side effects of ART.

4. Increase adherence to therapy by individuals with HIV.

Evaluate and implement strategies for increasing adherence, including directly observed therapy.
Monitor adherence to therapy.
Monitor antiretroviral drug resistance.

5. Increase number of individuals with HIV who adopt and sustain HIV–STD risk reduction behavior.
Increase availability of prevention services for individuals with HIV (e.g., counseling, prevention case management, peer opinion leader, small-group interventions).
Develop, implement, and evaluate specific risk reduction strategies for individuals with HIV.
Monitor behaviors and outcomes in individuals with HIV.
Teach health care providers to perform HIV and STD risk assessment for their HIV positive patients.
Increase STD screening, diagnosis, and treatment for individuals with HIV.
Increase delivery of prevention messages to HIV-positive patients by health care workers.
Provide adequate and appropriate substance abuse treatment.

4. Sexuality, sexual health, sexual practices and safer sex

Sexuality and sexual health

Sexuality

- A central aspect of being human & part of personality
- Humans are all sexual beings: feelings & emotions express sexuality
- Sexuality experienced & expressed in different ways: not necessarily involve sexual contact (e.g., fantasy, thoughts, desires)
- Influenced by how we feel about our bodies
- Influenced by how we feel about ourselves in relation to others
- Attitudes & feelings often determined by cultural context, political, legal, religious, historical factors

Sexual orientation

- Heterosexual: sexually attracted to members of the opposite sex
- Bisexual: sexually attracted to members of both sexes
- Homosexual: sexually attracted to members of the same sex (Men who have sex with men report any sexual activity with another man but do not identify themselves according to sexual behaviour)

Why do people have sex?

- Desire for baby
- For love
- Personal gratification
- Personal power
- Marriage

What is sexual health?

Sexual health is a state of physical, emotional, mental and social well being related to sexuality. It is not merely the absence of disease, dysfunction or physical/mental weakness.

Sexual health influenced by various factors:

- sexual behaviour
- attitude
- societal factors
- biological risk
- genetic predisposition
- mental health
- acute & chronic illnesses
- violence

Addressing sexual health requires integrated interventions

- Trained health providers
- Functioning referral system
- Legal, policy & regulatory environment where sexual rights of people respected, protected & upheld

Understanding sexual behaviour helps to protect from sexual risk behaviours

Risks associated with various sexual practices

Receptive anal sex
For the receptive partner - that is, the one into whom the penis is inserted - unprotected anal sex with ejaculation poses enormous risk of infection. Indeed, this form of unprotected sex is by far the most dangerous of all forms of sexual activity. Even without ejaculation, anal sex is considered highly risky, because HIV is present in the seminal fluid known as pre-cum, which is produced just prior to ejaculation.

Insertive anal sex
Anal sex is not as risky for the partner inserting his penis, but there are reported cases of HIV where this was the mode of infection, and so insertive anal intercourse without a condom should also be considered highly risky.

Vaginal sex
During unprotected vaginal sex, HIV can be transmitted from either partner to the other. Transmission from the woman to the man is less likely than from man to woman, but if the woman is having her period this may increase the risk that her partner will be infected.

Oral sex
Unprotected oral sex can also result in the transmission of HIV. Here again, the risks are different for the person performing oral sex than they are for the one receiving it. A man or woman who performs oral sex on a man is generally at higher risk than the man who is receiving the oral sex, but cases of HIV transmission to the receptive partner have been recorded.
Performing oral sex (cunnilingus) on a woman has also been shown to spread HIV, but there have been no proven cases of a woman getting HIV from receiving oral sex. It is generally thought that transmission of HIV is at least ten times less likely to happen during oral sex than during vaginal or anal sex.

Kissing
Open-mouthed kissing leads to contact with saliva. Although HIV has been found in saliva, the amount of virus present is known to be extremely low. There is no evidence of anyone being infected with HIV through kissing.

Other sexual practices
The insertion of fingers or the fist into the anus or vagina does not generally involve any exchange of body fluids, and therefore these activities are highly unlikely to lead to HIV infection. If the skin of the inserted finger or hand has cuts or abrasions, however, there is at least a theoretical risk of HIV transmission from one partner to the other. A much more real risk is that if fingering or fisting is not done with care (and sufficient lubrication), it may cause cuts or tears in the lining of the vagina or rectum - and these microscopic injuries may increase the risk of HIV transmission during later sex play. Even so, there are no recorded cases of HIV infection attributed to fingering or fisting.

Safer Sex

A common question is: "If I'm positive and my partner is positive, then why do we have to practice safer sex?" The important message is safer sex remains important among positive partners. HIV+ people should not have unprotected, penetrative sex (oral, anal, or vaginal) with another person. This includes fisting, handballing, or fingering.

One of these factors is re-infection with HIV. Some new evidence shows that re-infection can and does happen. If one HIV positive person is on therapy and HIV has become resistant to drugs, it's possible for him to transmit the drug-resistant strain to his/her partner, possibly crippling the benefits of ART for the partner.

Finally, it's important to remember that the partner's viral load (amount of HIV in blood) may not relate to the level of virus in semen or vaginal or anal fluids. Therefore, while HIV levels in blood may be undetectable by a lab test, they still may be present in high levels elsewhere (e.g., semen).

When both partners live with HIV, consider these points when discussing safer sex:

- Infections like herpes, hepatitis B among others, remain major concerns. All these are potentially deadly infections in people living with HIV, but they can be prevented, to some degree, through practicing safer sex.

- Re-infection with drug-resistant or more aggressive strains of HIV remains a theoretical possibility. It must be considered when negotiating safer sex between positive partners.

Important fact to consider
The important fact to consider is that having HIV should not be a barrier to sexual relations, so long as those activities are undertaken ***safely with a barrier*** - in the form of a ***brand-new latex or polyurethane condom.***

It is important to recognize that fears can exist on both sides of the relationship, and prospective sexual partners need to talk, openly and candidly, about those fears. The fact that HIV-negative partners fear potential infection is obvious. What may not be as obvious is that HIV-positive partners fear spreading the virus, and they may also fear catching diseases that will further strain their depleted immune systems. In situations where both partners are positive, there is the fear of exchanging different strains of HIV and of passing along other infections.

Overcoming all of these fears can only be accomplished through open communication. The fears need to be voiced, and the risks of various sexual activities need to be assessed, with the partners working together so that they can arrive at a level of security that each can be comfortable with. To do that, both need accurate information on the risk of HIV transmission that is associated with various sexual practices.

Safety guidelines
Latex condoms and plenty of water-based lubricant for vaginal and anal sex is recommended. If one is sensitive (*allergic*) to latex, polyurethane condoms can be used. The female condom is also made of polyurethane. However, polyurethane condoms may have a higher rate of breakage problems than latex.

Access to condoms / dental dams / lubricants is critical for practicing safer sex.

People who have safer sex tend to have a lot of characteristics in common:

- Comfort with sexual identity
- Comfort with drug-free and alcohol-free sex
- Commitment
- Good self-esteem
- Respect for self and others
- Concern about personal health and others' health
- Comfort with intimacy

Ensuring safer sax

- Plan ahead
- Keep safer sex supplies (e.g., condoms)
- Avoid mixing sex with drugs or alcohol

5. Sexually transmitted infections

Sexually transmitted infections (STIs) have been shown to be independent risk factors for the sexual transmission of HIV.
There is synergy between STI and HIV. STIs among HIV positive persons increase the HIV transmission potential to the sex partners.
The shedding of HIV in the semen of HIV-positive individuals is drastically increased in person with urethritis and treatment of urethritis strongly reduces HIV shedding.
Sexually transmitted infections are preventable.
Early identification of sexually transmitted infections is important.
Many STIs are eminently treatable.

Common sexually transmitted infections

Sexually Transmitted Diseases

- Gonorrhea
- Chlamydia
- Syphilis
- Chancroid
- Trichomoniasis
- Herpes simplex virus (HSV)
- Genital and cervical warts or human papilloma virus (HPV)
- Hepatitis B (HBV)
- Human immunodeficiency virus (HIV)

(Bacterial Vaginosis, Candidiasis may accompany the above)

Diagnosis

Etiological diagnosis of STIs is problematic for primary health care providers. It places constraints on their time and resources, increases costs and reduces access to treatment. To overcome this problem, a syndrome-based approach to the management of STI patients has been developed and promoted. World Health Organization is promoting the syndromic management for sexually transmitted infections. The syndromic management of STIs is based on the identification of consistent groups of symptoms and easily recognized signs (syndromes), and the provision of treatment that will deal with the majority of or the most serious, organisms responsible for producing a syndrome.

STI syndromes

- Male urethral discharge and/or dysuria
- Genital ulcers (GUD)
- Inguinal bubo
- Scrotal swelling
- Abnormal vaginal discharge
- Lower abdominal pain in sexually active women

Questions for STIs	Syndromes
Is there vaginal discharge that is abnormal in colour, odour, amount or consistency? Do you have itching or irritation of the vulva or vagina? Do you have pain during urination?	Abnormal vaginal discharge
Do you have pain in the lower abdomen? Do you have pain during sexual intercourse?	Lower abdominal pain
Is there a discharge from urethra? Do you have pain during urination?	Urethral discharge
Is there any ulcer, sore or blister on your genitalia? Is there discharge, sores or warts in and around the anus? Is there ulcers and other lesions in and around the mouth?	Genital ulcer Consider genital ulcer (syphilis or herpes)
Do you have any of the following: swelling, lumps or ulcers in the groin area?	Inguinal Bubo

Education and counselling on STIs

- Education and counselling for the drug users in private, confidential settings
- Educate that most of STIs can be cured, except HIV, herpes and genital warts.
- Sex with untreated partner can lead to re-infection and treatment of the partner, even if no symptoms, is important to the health of the partner.
- Promote safer sexual behaviour to prevent HIV and STIs.
    - Counsel on safer sex (sexual activity to be limited during treatment)
    - Counsel on consistent condom use with all partners
- Emphasize compliance with treatment
- Examine barriers to prevention, discuss solutions and build skills for safer sex

6. Disclosure, partner notification and couple counselling

Disclosure

What is disclosure?
Disclosure means to:

- To reveal
- To make known
- To make public
- To share
- Other

Disclosure
This is voluntary and based on informed consent. It respects the dignity and autonomy of the affected individuals and maintains confidentiality as appropriate. Disclosure leads
  to beneficial results for the individual people with HIV
  to beneficial results for their sexual and drug-injecting partners and family
  to greater openness in the community about HIV/AIDS.
  to better social support for people with HIV
  to better coping with HIV

Guiding Issues

- Thinking about whether to disclose one's HIV status is a process that can take weeks, months or years

- Disclosing one's HIV status can have valuable as well as serious consequences

- The disclosure process should not be rushed but thought out carefully and systematically

- Supporting this process (before, during, and after disclosure) of disclosure is an essential part of the HIV care

Disclosure terms

- Non-disclosure:
  Client does not reveal status to anyone

- Partial disclosure:
  Client only tells certain people about his/her status

- Full disclosure:
  Client publicly reveals his/her status
  May be to a person or to an organization

- Voluntary disclosure

  Client shares information about his/her HIV status

This may be full or partial disclosure

- Shared confidentiality
  Disclosure upon condition that person will not tell others, unless specific permission given

- Involuntary disclosure

Client's status revealed without his/her approval

What is disclosure counselling?
Structured, confidential conversation between two (or more) people that assists one to work through issues related to HIV disclosure.

Goals of disclosure counselling
1. Promote informed client decisions about whether or not to disclose HIV status

2. Assist in disclosure (if client so decides) with his/her approval

3. Enhance client coping strategies following disclosure

Disclosure Counseling
Advice and support clients who are:
- Not able or ready to disclose
- Thinking about beginning the disclosure process
- Beginning the disclosure process
- Anticipating consequences of disclosure
- Coping with the consequences of disclosure

What should the counselor do before a client discloses her/his HIV status?
Facilitate and help the client about
Who to tell?
When to tell?
How to tell?
Throughout the disclosure process, the client is in control about who to tell, when to tell and how to tell.

Disclosure process: key points
Clients beginning the disclosure process must think about whether or not to disclose in the context of their life situation
–What is best for this person at this time?
–Full disclosure? Partial disclosure? Non-disclosure?

Clients will benefit from guidance and support, which you can and should provide.

Advantages of disclosure

- No burden of secrecy
- Can ask for and receive emotional support
- Easier access to health care and to take medications (don't have to hide them)
- Able to talk about symptoms and worries
- If disclosure to one's spouse/partner, can openly discuss safer sex and family planning choices
- Can share reasons for specific activities (e.g. breastfeeding/replacement feeding)
- Other

Disadvantages of disclosure

- Distancing or outright rejection by partner /spouse /friends
- Possible loss of job
- Children shunned in school
- People believing person is promiscuous
- Discounting the person due to fatal illness
- Assumption that all signs or symptom are HIV-related
- Fear by others for their own safety around the person
- May be at risk of mental and/or physical harm
- Other

Partner notification

Partner notification is based on the informed consent of the people with HIV and, where possible, maintains the confidentiality of the source people with HIV so that their names are not revealed to the partner(s) being notified / counselled. This is extremely difficult to maintain in the context of marital relationships and requires the provision of counselling and support to both partners to reduce the possibility of abuse or discrimination. There are three main accepted methods for undertaking ethical partner notification, all of which are voluntary and confidential, and provided within the context of comprehensive HIV/STI prevention, care and support programmes:

1. Patient referral, in which people with HIV are encouraged to counsel partners regarding their possible exposure to HIV. This is done without the direct involvement of the health worker.
2. Provider referral, in which the people with HIV give their partners' names to a healthcare provider, who then confidentially counsels the partners directly.
3. Contract/conditional referral, in which the health worker of the people with HIV obtains the names of their sexual or injecting partners, but allows the people with HIV a period of time to counsel the partners themselves. If the partners are not counselled within this time period, the health worker counsels the partners without naming the people with HIV source.

Couple Counselling

About a third of HIV positive persons may be engaging in unprotected sex and this is facilitated by several factors –individual, interpersonal, norms and structural issues.

HIV vulnerability among the regular sexual partners

Individual	Knowledge levels	Self-efficacy
Interpersonal Relationship	Trust	Intimacy
	Communication	Negotiation
	Power	Gender
	Priorities	Child
Perception of Social acceptance (Norms)	Condoms in long-term relationships	
	Alcohol and sex	Domestic violence
	Sexual decision-making	
	Health care for women	Help seeking behaviour
Structural	Health care system	Quality and access to services
Broader issues	Poverty	Other concerns

Relationship factors

The sexual transmission of the virus normally requires the participation of at least two people. The sexual relationship is critical for transmission of sexually transmitted diseases, and any risk management should take into consideration the relationship dynamics.

Unprotected sex between the HIV positive persons and their sexual partners is not uncommon. Research studies point to the importance of understanding the social meanings people attach to condom use and unprotected sex, the influence of power and control in sexual and relationship negotiation, the contextual factors influencing perceptions of 'sexual risk acceptability' and sexual norms in relationships.

The social meanings of unprotected sex in long-term relationships – Trust and intimacy

Many people are having unprotected sex with their partners to demonstrate intimacy and trust in the relationship. Reluctance to have sex may be viewed as rejection of love and sex is seen as a bonding factor. In the name of commitment, safety is compromised. Condom is not perceived to be important in protecting themselves and it is used between couples only at the time of menstrual periods. The acts of using and of not using a condom come to have symbolic value in people's relationships. This is particularly the case when some PLHA perceive unprotected sex to be a normal feature of heterosexual relationships, particularly when these are long term.

Sexual communication and negotiation

'Sex is not talked about but only done' summarizes the lack of communication between the regular sexual partners in our settings. Safer negotiations are rare occurrences in the heterosexual relationships. The women have to be imparted necessary skills training in communication, assertion to negotiate for safe sex.

Gender and power in sexual negotiation

The power and control in the sexual relationship is predominantly with the men. Some women also fear that they will lose the partners if they insist on protected sex, since this may interpreted as an indication that the woman has been unfaithful to her partner or believes that her partner has been unfaithful to her or she is unwilling to have sex as he has AIDS. Of particular concern is the plight of women experiencing domestic violence, which often happens under the influence of alcohol. However small the problem is, the recommendation of condom use in such relationships is extremely difficult and even may be dangerous. Research also highlights that power and control in sexual relationships is unevenly distributed by gender. Women may often find it difficult to initiate or negotiate condom use in relationships. Some studies have found women's attempts to initiate condom use to result in emotional coercion towards unprotected sex and the threat of violence from their male partners, and in some cases physical violence is reported to have occurred as a consequence. Effective HIV prevention efforts will need to change gender-based relational norms to support women's role in practicing safer sex.

Sex and sex risks are not a priority in the couple relationship

Everyday life is difficult with many practical problems. Money is the most important factor and ever increasing demand for money leaves the household in total disruption. Frequent quarrels, many unsuccessful hospitalizations, health problems, legal problems and aggressive behaviour complicate the relationship and often render it dysfunctional and disharmonious. Hence sex and sex risks are not the priorities. Sex at times symbolizes that things are apparently normal. The HIV positive person may indulge in sex to prove that everything is okay with him and the wife often agrees for sex in the idea that the act will help him. At times, the spouse may desire to become pregnant, militating against the use of condoms. Discussing sex and sex risk within the relationship is often complicated by these factors.

Social norms surrounding condom use in long-term relationships

The social norms influence the sexual risk behaviour. Condom use within the relationship is considered to be non-normative as most women and men wondered as to why they should be using the condom, as they were men and women. 'Condoms are to be used with sex workers and outside of a long-term relationship and not with regular partners and spouses' is the opinion reflected by most men and women.

Alcohol and sex

At present, it is also normative to be aggressive under the influence of drinks and drugs. Changing the sexual norms and the norms relating to drug/alcohol use and sex risk is important to achieve significant behaviour modification to produce an impact on the HIV epidemic in our settings. Only the disinhibitory effects of alcohol do not adequately explain the association

between alcohol use and sexual behaviour. The norms surrounding alcohol use is important and the general belief is that alcohol enhances sexual pleasure and alcohol use is often linked to sexual activity. Such norms favour use of alcohol before sexual activity. Safety is a negotiated action between the partners and the interpersonal interaction towards safer sex is negatively influenced by alcohol use.

Couple counselling has to address all the above issues.

7. Harm reduction for injecting drug users

What is harm reduction?

Harm reduction

- Harm reduction is an old concept but is now used widely to promote & improve public health

There are many examples of harm reduction, in many areas of life
Example: Compulsory wearing of helmets

Helmets do not prevent motorbike accidents
- But when accidents occur, helmets ↓ mortality & injury

Compulsory helmet legislation *does not condone bad driving*
- admits accidents occur attempts to ↓ negative effects of such incidents

Helmets complement other efforts to ↓ accidents
(Driver education, improved roads, law enforcement)

Defining harm reduction among drug users

- Principal element: reducing harmful consequences of drug use without *necessarily* reducing drug consumption

- Major harmful consequences include BBVs:

  ⇒ HIV/AIDS, Hepatitis B & C

- Other harms include:

  ⇒ Social costs of drug use
  ⇒ Economic costs of drugs use
  ⇒ Legal aspects
  ⇒ Criminalisation

Aims of harm reduction

To keep drug users alive, well and productive until treatment works or they mature out of their drug use
To protect the community from crime and sexual/vertical transmission of HIV

Short term goals HIV prevention; reducing harms associated with drug use) leading to long term results of abstinence.

What are the principles of harm reduction?

Principle 1: Short-term pragmatic goals

- Efforts to prevent HIV transmission implemented early and quickly:

- Before prevalence of HIV among IDUs > 5%

  - First goal: prevent HIV infection
  - Second goal: long term abstinence & rehabilitation
  - Achieving the first goal is crucial as the second goal may be unachievable

Principle 2: Hierarchy of risks to avoid HIV infection

1. Never start using drugs, assistance to stop using
2. Encouragement/assistance to stop *injecting* drugs
3. If injecting drugs, do not *share* equipment
 - including needles & syringes, spoons, cotton wool, any materials used to draw up & prepare injection. Always use own equipment.
4. If sharing injecting equipment, ensure equipment disinfected between each use

Principle 3: Multiple strategies

  - Harm reduction involves multiple alternative methods

- Different programs considered complementary rather than in conflict

  - includes *effective* abstinence-based programs

Conflict between approaches only on basis of effectiveness – harm reduction is *evidence-based*

Multiple strategies

1. Community outreach
2. User Education
3. Network based approaches
4. Strategies to prevent sexual transmission
5. HIV testing and counselling
6. Provision of sterile injection equipment
7. Substance abuse treatment
8. Interventions in criminal justice system
9. Environmental and structural interventions

Principle 4: Involvement of drug users

  - Current or past drug users play vital role in prevention of HIV/AIDS - outreach & peer education

- Increase validity and credibility of programs among IDUs

- Drug user organisations contribute to strategic development of harm reduction

HIV prevention: Multiple strategies

Community outreach

Community based outreach involves:

- Identifying and making contact with drug users in their natural environments;
- Establishing rapport with the target populations;
- Enlisting commitment to behaviour change;
- Providing information about unsafe as well as risk behaviours;
- Strategies to reduce risk behaviours;
- To promote safe behaviours.

User Education

Hierarchy of Risk Reduction Strategies for IDUs

- Stop using drugs
- Stop injecting drugs
- If drug injecting continues:
    - Never reuse or share syringes, water or drug preparation equipment
    - Use only syringes obtained from reliable sources
    - Use a new, sterile syringe to prepare and inject drugs
    - Use sterile water to prepare drugs; otherwise use clean water from reliable source
    - Use a new or disinfected cooker and cotton to prepare drugs
    - Clean the injection site prior to injection with a new alcohol swab
    - Safely dispose of syringes after one use

User education is best done with the help of peers. Network based interventions reduce the risk behaviours of IDUs and other persons at risk by developing a culture in which IDUs and their peers support each other in risk-reduction efforts.

Strategies to prevent sexual transmission

In order to make the interventions have desirable impact on the sexual behaviour, the following issues have to be addressed:

- Interventions have to be designed with the target populations.
- Strategies should consider the determinants of sexual transmission
- Consistency of condom use with regular partners should be stressed.
- STIs should be assessed early and treated appropriately and adequately.
- Extent of sexual activity while a person is intoxicated

Provision of sterile injection equipment

Needle-syringe programs have several objectives, whose relative importance can be seen hierarchically:

- The primary roles of needle-syringe programmes are to distribute sterile injecting equipment to IDUs; and remove used and potentially contaminated injecting equipment from circulation, thereby removing the possibility of further use
- Needle-syringe programmes also distribute other equipment used in injecting (such as

cookers/spoons, alcohol swabs, cotton, sterile water), and other materials such as condom

- To provide a point of contact with IDUs for dissemination of IEC materials about safer injecting and about prevention of sexual transmission
- Needle-syringe programs can also become contact and referral points for counseling, primary health care, welfare and other services, and drug treatment service

Substance abuse treatment - Substitution treatment

The aims of drug substitution are

- To lessen the risk of contracting or transmitting HIV / AIDS
- To switch users from black market drugs of indeterminate quality, purity and potency to legal drugs of known purity and potency
- To minimize the risk of overdoses and other medical complications
- To switch from an injected to a non-injected substance
- To reduce hazardous drug use e.g. sharing injecting equipment, polydrug use, injecting crushed / filtered tablets
- To reduce the motivation and need for addicts to commit crimes to support their drug habits and keep them out of dangerous environment like prisons
- To maintain contact with drug users
- To provide counseling, referral and treatment
- To help drug users stabilize their lives and reintegrate with the general community

A variety of drugs can be used for drug substitution. Methadone and Buprenorphine are the common drug used as substitution drugs.

Benefits of substitution treatment

- Maintains a majority of clients in treatment.
- Improves the clients' physical well being.
- Incidence of HIV, Hepatitis B, C and Tuberculosis decline.
- The criminality reduces significantly.
- The clients' quality of life improves

Structural interventions

Legal and policy changes

Conclusion

Harm reduction provides an alternative approach & framework to deal with IDU problems
Harm reduction principles have been adopted in a number of countries. Shown to be:

⇒ Pragmatic	⇒ Effective
⇒ Humane	⇒ Holistic

Harm reduction: a public health approach assisting in the control of HIV infection among IDUs.

8. Substance use, sexual risk and HIV/AIDS treatment adherence

Substance use and sexual risk

What are the common substances used in India?

Tobacco (Cigarettes, Paan Paaraag, Zardha and Bidis)
Alcohol (Country liquor, Arrack, Toddy, Beer, Whiskey, Rum, Vodka, Gin, Wine)
Cannabis (Ganja, Hashish, Charas, Bhang, Marijuana, Grass, Pot, Indian hemp, Weed)
Opioids

Opium
Heroin (Brown sugar, Smack)
Synthetic preparations (Inj. Buprenorphine, Dextropropoxyphene, Inj. Pentazocine, Inj. Morphine, Inj. Pethidine)

Sedatives (Sleep pills)

Diazepam, Alprazolam, Nitrazepam

Inhalants

Glue

Hallucinogens

Plant derived (mushrooms), or synthetic (e.g. LSD).

Stimulants

Cocaine and the synthetic preparation such as amphetamine type stimulants (ATS) – e.g., ecstasy

Others

Antihistamines (Chlorpheneramine maleate; Promethazine)

Why do people use drugs?

Enjoyment: for the pleasurable effects, for fun; for sexual pleasure
Lifestyle: peer pressure
Forget: to alleviate misery, poverty and disadvantage
Self-medication: to relieve feelings of fear, anxiety and depression
Pain relief: to relieve physical symptoms of pain
Tradition: as part of symbolic or religious ceremonies

What are the levels of drug use?

Experimental: Single or short-term use that is motivated by curiosity or a desire to experience new feelings or moods
Recreational: Controlled use in social settings
Circumstantial: Use in situations where specific tasks are performed or freedom from pain is sought
Intensive: Major doses daily
Compulsive: Persistent frequent high dose producing psychological and physical dependence

What is the relationship between substance use and sexual behaviours and sexual relationships?

Substance use plays a very important role in the spread of the **H**uman **I**mmunodeficiency **V**irus. Substance use continues to increase with many newer dangerous drug use patterns. Most people use one or more drugs and use alcohol and other psychoactive drugs excessively.

The relationship between substance use and sexual behaviour can be understood in two ways: *pharmacologically* and *socially*.

The pharmacological effects of the substances taken need to be understood (as these often aim to increase an individual's sexual pleasure).
The belief, attitude, expectation and perception about the effects of drug is also important.
Socially, it is important to understand how users perceive their consumption as affecting their relationships.
Key issues might involve negotiation in relationships, or sexual relationships where sex is directly exchanged (traded off) for substances.

Why do substance users engage in sexual risk behaviour?

This requires taking into account *structural factors* such as the impact of economic factors on patterns of commercial sex work among users, as well as *social and cultural factors* like the effect of the individual's health beliefs, risk perceptions and knowledge about different risk behaviours.

What is the relationship between alcohol use and sex risk?

Alcohol use is often associated with risky behaviours, including sexual risk behaviour.
Factors facilitating sex risk:

Norms surrounding use (It is normative to use alcohol)
Beliefs about the effects of alcohol (Alcohol relieves tension, pain, drowns depression)
Settings of use (the links between sex selling places and drinking venues)
Pharmacological property of alcohol can contribute to the increased risk (disinhibition).

Alcohol is often associated with sexual behaviour. Some studies have also found alcohol use to be associated with a higher likelihood of unprotected sex and a higher average in the number of sexual partners. The inconsistent use of condoms has been associated with alcohol use among a variety of groups – including young people, heterosexual adults, and men who have sex with men – in a variety of settings and countries. Some studies illustrate that those who use alcohol most frequently use condoms least consistently. Other studies associate inconsistent condom use with the use of alcohol in combination with other substances, as well as with lifestyle more generally. In some cases, there is evidence which associates alcohol use with being HIV-positive. For example, a survey in South Africa among mine workers, sex workers and the general population, found that alcohol consumption was associated with HIV incidence in both men and women.

An involvement in substance use may often overlap with an involvement in commercial sex work. Estimates of the proportion of substance users involved in female sex work, and sex workers involved in substance use vary widely. A recent study at Chennai supported by WHO

indicate high levels of alcohol use among sex workers and the clients of sex workers. Clients' alcohol use has emerged as an important determinant of condom use.

Amphetamine type stimulants (ATS)

In some settings, ATS is being used in India. There are a number of issues specific to ATS use.

Sexual risk-taking behaviour

- ATS use s associated with sexual risk taking behaviour
- ATS use is often associated with youth, who are more likely to engage in sexual risk behaviour
- ATS use often occurs at entertainment venues and likely use 'sex-on-premises' venues
- Sex workers may also use ATS

Substance use and HIV/AIDS treatment

Is use of ART associated with decreased or increased risk of transmission of HIV infection?

Viral load is strongly related to the risk of HIV transmission and hence ART reduces risk of transmission. But the viral loads are variable in blood and semen at different times.

Treatment optimism: Some persons on ART come to believe that since it is a manageable disease, they can indulge in unprotected sex.

What is the role of substance use in adherence?

Adherence to antiretroviral therapy is vital for the success of the treatment. This is influenced by persistent alcohol and substance use.

Lifestyle instability: Substance users lead a chaotic lifestyle and instability is accentuated by the following:

co-morbid disorders like depression
antisocial personality disorder
patterns of use
levels of drug dependence
emotional and income circumstances

It is desirable to deal with these issues before commencing the therapy.

Combining drug abuse treatment and HIV treatment: Where feasible, an integration of drug treatment programs (opioid substitution treatment) with HIV treatment involving the direct observation of therapies for the management of both dependence and HIV infection among IDUs is recommended.

Alcohol use affects liver
HIV treatment dosage regimens: Drugs with less hepatotoxic (harmful effects on liver) effects are preferred considering the co-occurrence of Hepatitis C infection among IDUs. In many

settings majority of injecting drug users get infected with hepatitis C within six months of initiation to injecting.

Alcohol use impairs liver function and should be completely avoided in Hepatitis C infected individuals.

9. Depression and HIV/AIDS

Depression

Depression is not simply normal sadness, being moody or just a low mood, but a serious illness. It causes both physical and psychological symptoms. A depressive disorder is an illness that involves the body, mood, and thoughts. It affects the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things. A depressive disorder is not the same as a passing blue mood. It is not a sign of personal weakness or a condition that can be willed or wished away. Depression is the most common psychiatric comorbidity associated HIV.

What are the risk factors?

- History of prior mood disorder
- History of substance abuse
- History of anxiety disorder
- Prior suicide attempt
- Family history of depression or suicide
- Inadequate social support
- Nondisclosure of HIV status
- Multiple losses
- Advancing illness
- Treatment failure

What are the symptoms of depression?

- Depressed mood
- Lack of interest in pleasurable activities
- Psychological symptoms
  - Crying spells
  - Low self esteem
  - Pessimism
  - Helplessness
  - Hopelessness
  - Worthlessness
  - Suicidal ideas and wishes
- Physical symptoms
  - Reduced energy levels
  - Reduced motor activity
  - Loss of appetite
  - Constipation
  - Loss of libido

Depression is under-recognized, under-diagnosed, and under-treated.
Family history of depression is common among persons presenting with major depression. Depression is common among substance users. Depression is common during treatment with interferon for hepatitis C, though this usually resolves after treatment is completed.

It is important for providers to consider alternative diagnostic possibilities for depressive symptoms (e.g., acute medical illness, dementia, substance-use related conditions)

Differentiating appropriate sadness and adjustment issues from pathologic depression may be difficult in the person infected with HIV.

How do we diagnose depression?

Questions to assess depression
During the past month:

- Have you experienced little interest or pleasure in doing things?
- Have you felt down, depressed, or had thoughts of hopelessness or worthlessness?

Assessment for suicidal risk

- Assess and document suicidal thoughts and intentions
  - Have you ever thought of harming yourself?
  - Have you had these thoughts recently?
  - Have you made a plan?
  - Do you think you would ever act on these thoughts?
- Closely monitor patients who give answers indicating intention to harm themselves
- Refer to psychiatric services

How do we manage?

- Pharmacotherapy is the mainstay of treatment for major depression.
- Drugs used to treat depression are not dependence inducing (not addictive).
- Drugs take some time to produce a clinical response (up to 3 weeks); but symptoms like sleep improve within 2-3 days.
- Side effects usually diminish in 7-10 days.
- Drugs need to be continued for a minimum of six months. Consult doctor about stopping the drugs.
- No single antidepressant is superior in treating HIV-infected patients as a group.
- Patient adherence to regimens is critical.
- Those who take adequate doses of antidepressants have the best chance of improving.
- Reducing the stigma associated with depression and its treatment is important in the treatment process. This includes working with family members.
- In addition to medicines, psychological therapies are beneficial for depressed individuals.
- Depressed individuals must avoid or reduce intake of alcohol and other substances of abuse.
- For severe cases, refer to a psychiatrist.

Depression increases the transmission potential of HIV

Patients with depressive symptoms may be at increased risk for transmission of HIV infection due to increased likelihood of engaging in high-risk behaviours. HIV infected drug users with depression are less likely to adhere to ART treatment or other treatments (e.g., TB treatment). Treatment of depression increases adherence.

Stress and HIV/AIDS

Psychological distress may be associated with HIV progression. This area has not been researched well. But reducing stress in PLHA may improve the quality of life of them.

*Dealing with stress (**REST**)*

- **R**est
- **R**elaxation
- **R**ecreation
- **R**eassurance, positive suggestions, ventilation, support, guidance
- **E**xercise, regular physical activity
- **E**at balanced diet
- **E**arly identification of underlying disorders (e.g., depression)
- **S**hare your feelings with significant others
- **S**upport groups
- **S**ubstances to be avoided (alcohol, tobacco, drugs)
- **T**raditional therapies: Yoga and meditation

Appendix
HIV prevention interventions for different populations at risk

Population	HIV Prevention Interventions
Unaware of serostatus; behavioral risk of infection	Provide current, essential HIV-related information Encourage voluntary HIV counseling and testing among those at increased risk, including anonymous testing Reduce stigma of HIV disease and services
Recently tested HIV negative; no apparent behavioral risk of infection	Educate to provide HIV prevention messages to family, friends, partners
Recently tested HIV negative; behavioral risk of infection	Offer intensive individual or small-group counseling Develop community-level interventions Establish linkages to STD, substance abuse, mental health, hepatitis, and social services as needed Provide prevention case management for those at highest risk Develop structural interventions (e.g., sterile syringe access)
Tested HIV positive	Provide intensive prevention services Offer partner counseling and referral services Establish linkages to STD, substance abuse, mental health, hepatitis, and social services as needed Provide prevention case management Develop structural interventions (e.g., decrease discrimination)

Source: Janssen et al, (*Am J PublicHealth.* 2001; 91:1019–1024)