Participant Manual

Module 11

Psychiatric Illness, Psychosocial Care and Sexual Health

Treatment and Care for HIV-Positive Injecting Drug Users

asean
USAID FROM THE AMERICAN PEOPLE
World Health Organization
Regional Office for South-East Asia
fhi Family Health International

Module 11

Psychiatric illness, psychosocial care and sexual health

Participant Manual

2007

asean
USAID FROM THE AMERICAN PEOPLE
World Health Organization Regional Office for South-East Asia
fhi Family Health International

The Association of Southeast Asian Nations (ASEAN) was established on 8 August 1967. The Member States of theAssociation are Brunei Darussalam, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam. The ASEAN Secretariat is based in Jakarta, Indonesia.

For inquiries, contact The Public Affairs Office, The ASEAN Secretariat, 70A Jalan Sisingamangaraja, Jakarta 12110, Indonesia, Phone: (62 21) 724-3372, 726-2991, Fax: (62 21) 739-8234, 724-3504. E-mail: public@aseansec.org. General information on ASEAN appears on-line at the ASEAN Website: www.aseansec.org.

Catalogue-in-Publication Data

Treatment and Care for HIV-Positive Injecting Drug Users
Jakarta: ASEAN Secretariat, December 2007

616.9792
1. ASEAN – USAID
2. HIV – Drugs – Modules

ISBN 978-979-3496-63-4 (NLM classification: 503.6)

This publication is available on the internet at www.aseansec.org, www.fhi.org and www.searo.who.int/hiv-aids publications.

Copies may be requested from:

The ASEAN Secretariat, 70A, Jl. Sisingamangaraja, Jakarta 12110, Indonesia. e-mail: public@aseansec.org

and

Family Health International, Asia/Pacific Regional Office, 19th Floor, Tower 3, Sindhorn Building, 130–132 Wireless Road, Lumpini, Phatumwan, Bangkok 10330, Thailand, e-mail: sunee@fhibkk.org

and

HIV Unit, Department of Communicable Diseases, World Health Organization, Regional Office for South-East Asia, Indraprastha Estate, Mahatma Gandhi Marg, New Delhi-110 002, India, e-mail: hiv@searo.who.int

Module 1: Drug use and HIV in Asia: participant manual

Module 2: Comprehensive services for injecting drug users – participant manual

Module 3: Initial patient assessment – participant manual

Module 4: Managing opioid dependence – participant manual

Module 5: Managing non-opioid drug dependence – participant manual

Module 6: Managing ART in injecting drug users – participant manual

Module 7: Adherence counselling for injecting drug users – participant manual

Module 8: Drug interactions – participant manual

Module 9: Management of coinfections in HIV-positive injecting drug users – participant manual

Module 10: Managing pain in HIV-infected injecting drug users – participant manual

Module 12: Continuing medical education – participant manual

Trainer manual: Treatment and care for HIV-positive injecting drug users

Typesetting and Design: Macro Graphics Pvt. Ltd.
Printed in India

Contents

Abbreviations and acronyms

AA	Alcoholics Anonymous
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
ASEAN	Association of Southeast Asian Nations
ATS	amphetamine-type stimulant
BCC	behaviour change communication
CBT	cognitive–behavioural therapy
CDC	Centers for Disease Control and Prevention (US Government)
FBO	faith-based organization
FHI	Family Health International
FSW	female sex worker
HCV	hepatitis C virus
HIV	human immunodeficiency virus
HPV	human papillomavirus
HSV	herpes simplex virus
IDU	injecting drug user
IPT	isoniazid preventive therapy
MSM	men who have sex with men
NGO	nongovernmental organization
NSP	needle and syringe programme
OST	opioid substitution therapy
Pap	Papanicolaou
PEP	post-exposure prophylaxis
PID	pelvic inflammatory disease
PLWHA	people living with HIV and AIDS
PMTCT	prevention of mother-to-child transmission
SNRI	serotonin–norepinephrine reuptake inhibitor
SSRI	selective serotonin reuptake inhibitor
STI	sexually transmitted infection
TB	tuberculosis
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WAS	World Association for Sexual Health
WHO	World Health Organization

Sub-module

11.1

HIV and psychiatric illness

OVERVIEW

Objectives:

By the end of the session participants will be able:

- To describe the various neuropsychiatric conditions associated with HIV infection
- To understand the clinical features of various neuropsychiatric conditions associated with HIV infection
- To know the treatment options for the various neuropsychiatric conditions associated with HIV infection

Time to complete session:

45 minutes

Session content:

- Psychiatric disorders as risk factors for HIV transmission
- Psychological impact of HIV
- Managment of common mental health conditions
- HIV-associated dementia
- Delirium
- Psychotic disorders

Training materials:

- PowerPoint presentation 11.1: HIV and psychiatric illness
- Sub-module 11.1: HIV and psychiatric illness

PSYCHIATRIC DISORDERS AS RISK FACTORS FOR HIV TRANSMISSION

The following psychiatric disorders can facilitate HIV acquisition and transmission:

- Drug use and dependence
  - Injecting drug use
  - Amphetamine-type stimulant (ATS) use
  - Alcohol use
  - Other drug use
- Bipolar disorder
  - Mania
  - Depression
- Chronic mental illness

Injecting drug use has the highest risk for HIV transmission among the factors outlined above. ATS users exhibit increased sexual risk behaviour. Alcohol can facilitate HIV transmission in the following ways: (1) disinhibition due to alcohol; (2) belief that alcohol enhances sexual pleasure; and (3) certain alcohol use settings (relationship between bars and brothels) facilitate risky behaviour. Persons suffering from mania exhibit disinhibition and indulge in pleasurable activities. Persons with depression can engage in risk-taking behaviour. Chronic mental illness is associated with homelessness, a living situation that increases the risk of sexual abuse and exploitation.

PSYCHOLOGICAL IMPACT OF HIV

Primary-care providers should be aware of the specific and general factors that may trigger or exacerbate psychological distress or psychiatric disorders in HIV-infected persons and their families.

Crisis points in HIV-infected drug users include:

- Ongoing psychosocial difficulties associated with drug use
- Learning of HIV-positive status
- Disclosure of HIV or drug using status to family and friends
- Introduction of antiretroviral therapy (ART)
- Time of drug abstinence and withdrawal
- Occurrence of any physical illness
- Recognition of new symptoms or progression of disease (e.g. major drop in CD4 cells, rise in viral load)
- Necessity for hospitalization (particularly the first hospitalization)
- Death of a significant other
- Diagnosis of AIDS
- Changes in major aspects of lifestyle (e.g. loss of job, end of relationship, relocation)
- Necessity of making end-of-life and permanency planning decisions

Exacerbation of pre-existing psychiatric disorders can interfere with the ability to cope with HIV infection. HIV is a risk factor for developing a range of psychiatric disorders including:

- Mood disorders
  - Depression
  - Mania

- Anxiety disorders
  - Generalized anxiety disorders
  - Panic disorders
- Adjustment disorders
- Psychosis
- Substance use
- Organic mental disorders
  - Minor cognitive disorders
  - HIV-associated dementia
  - Delirium

MANAGEMENT OF COMMON MENTAL HEALTH CONDITIONS

Perform an initial comprehensive and annual mental health assessment for all HIV-infected patients (*see* Module 3 on Initial patient assessment).

Depression

Depression is the most common psychiatric co-morbidity associated with drug use.

Risk factors

- History of prior mood disorder
- Prior suicide attempt
- Family history of depression or suicide
- Inadequate social support
- Non-disclosure of HIV status
- Recent loss (occupation, family)
- Multiple losses
- Advancing illness
- Treatment failure
- Hepatitis C treatment with interferon

Clinical features

- Mood symptoms
  - Sadness, crying
- Bodily symptoms
  - Pain
  - Sleep disturbance
  - Easy fatiguability
  - Loss of appetite
  - Loss of weight
  - Constipation
  - Loss of libido
  - Difficulty in concentrating
- Thought symptoms
  - Guilt
  - Pessimism

  - Worthlessness
  - Hopelessness
  - Suicidal ideas
- Behavioural symptoms
  - Lack of interest in pleasurable activities
  - Reduced activity
  - Social withdrawal

Depression is underrecognized, underdiagnosed and undertreated.

A family history of depression is common among persons presenting with major depression. Depression can be both a cause and consequence of substance use. Depression is common during treatment with interferon for hepatitis C; however, 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 pathological depression may be difficult in a person infected with HIV:

- Psychomotor retardation and apathy of AIDS dementia complex may be confused with depression (improve with combination ART).
- Organic mood disorders may also have symptoms similar to major depression (responsive to antidepressant medication).

Patients with depressive symptoms may be at higher 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 or other treatments (e.g. TB treatment). Treatment of depression increases adherence.

Treatment

Antidepressants

- Selective serotonin reuptake inhibitors (SSRIs)
  - Preferred class of drugs as side-effects are minimal
  - Drugs include:
    - Fluoxetine, sertraline, citalopram, paroxetine
- Tricyclic drugs
  - Drugs include: amitryptiline and imipramine
  - Side-effects – anticholinergic
  - Useful in case of neuropathic pain (e.g. amitryptiline)
- Other drugs
  - Mirtazapine in case of severe loss of appetite
  - Bupropion in case of co-morbid smoking

Table1. Common antidepressants

Drug	Daily dose	Possible positive effects	Possible negative effects
Fluoxetine	10–20 mg	Easy administration; non-sedating	Insomnia, agitation, nausea, headache
Citalopram	10–20 mg	Easy administration; less drug–drug interactions	Mild nausea
Amitryptiline	25–150 mg	Useful in neuropathic pain	Anticholinergic side-effects (dryness, constipation, urinary retention)
Sertraline	50–100 mg	Less drug–drug interaction compared with fluoxetine	Insomnia, agitation, nausea, headache

- Venlafaxine serotonin–norepinephrine reuptake inhibitor (SNRI) drug interactions less than many SSRIs

Effective management of depression should include co-management of the substance use disorder:

- Pharmacotherapy (medication) is the mainstay of treatment for major depression.
- A general rule is to start with low doses of any medication and titrate up to a full dose slowly, in order to minimize early side-effects that may act as obstacles to adherence.
- An adequate dose is critical for a good response.
- For the first episode, drugs need to be continued for a minimum of six months.
- Awareness and management of suicidal ideas, wishes or behaviour.

Reasons for referral:

- Presence of psychotic symptoms (irrelevant talk, bizarre behaviour, delusional thinking)
- Severe symptoms that significantly impair functioning of the individual
- Bipolar depression
- Not responding favourably to treatment

Patients often require substantial education about the disease and nature of their depression, encouragement and therapeutic optimism that the treatment will work. Reducing the stigma associated with depression and its treatment is important. This includes working with family members.

- No single antidepressant is better than others 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.
- 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 such as sleep improve within 2–3 days.
- Side-effects usually diminish in 7–10 days.
- Consult a doctor before stopping the antidepressants.

In addition to pharmacotherapy, cognitive–behavioural therapy may be helpful in depressed individuals.

Anxiety

Anxiety is very commonly associated with substance use disorders, particularly during withdrawal from opiates and intoxication with amphetamines. It can also occur as an independent condition.

Clinical features

- Psychological symptoms:
  - Excessive worrying
  - Feeling nervous
  - Fear for no reason, excessive fear in familiar situations
  - Inability to relax
- Physical symptoms:
  - Restlessness
  - Easy fatiguability
  - Difficulty in concentrating or mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance

Treatment

- Relaxation techniques (e.g. Jacobson muscle relaxation technique).
- Supportive psychotherapy (reassurance, explanation, expert advice, suggestions, guidance, ventilation support and facilitating emotional support from key persons).
- Short-term treatment with anti-anxiety drugs (e.g. diazepam 5–15 mg per day, orally for a short span of time along with psychological therapies). Given the risks of misuse of drugs such as diazepam among drug users, the prescription should be limited only to the short term; clients on prescription need to be counselled accordingly.
- For severe cases, refer to a specialist.

Panic disorder

Clinical features

The patient complains of panic attacks, or describes episodes of:

- Chest pain or discomfort
- Depersonalization or derealization
- Dizziness, lightheadedness, faintness or feeling of unsteadiness
- Fear of dying
- Fear of going crazy or losing control
- Hot flashes or chills
- Nausea or abdominal distress
- Numbness or tingling sensations
- Palpitations or accelerated heart rate
- Sensation of choking

- Shortness of breath or smothering sensation
- Sweating
- Trembling or shaking

In the absence of physical illness, four or more of the above symptoms with panic attacks are diagnostic of panic disorder.

Treatment

- SSRIs (fluoxetine, sertraline, citalopram)
- Tricyclics in small doses (amitryptiline, imipramine)
- Benzodiazepines (short half-life benzodiazepines – for example, clonazepam for a short period for acute symptom relief)
- Venlafaxine timed-release formulation can be useful
- Relaxation therapy and cognitive–behavioural interventions

Insomnia

- Insomnia is the inability to fall asleep or waking excessively early.
- It is either primary (no cause) or secondary due to other causes (depression, anxiety, psychosis) and is extremely common in drug users.
- Effective treatment involves treating the cause of the insomnia, which may involve addressing substance use issues.

Treatment

Teach sleep hygiene approaches:

- Increase daily exercise to at least 30 minutes at moderate intensity (not in the evening).
- Avoid daytime napping.
- Avoid caffeine.
- Reduce alcohol intake.
- Use the bed only for sleeping and sexual activity.
- Use relaxation techniques prior to sleep (e.g. progressive muscle relaxation).
- Develop a regular routine of rising and retiring at the same time each day.

If hypnotics are advised, prescribe only for a short time. Efavirenz (EFV) may disturb sleep in the first few weeks of treatment – this usually resolves.

Cognitive disturbances

Clinical features

Items from a standard mini-mental exam are useful in screening for cognitive disturbances.

- Orientation (name, date, place of examination)
- Registration and recall (three words)
- Language (naming objects)
- General information that may provide additional insight, such as naming the president or prime minister of the country, naming four cities in the country, or naming four countries in the world

At least two of the following symptoms should be present:

- Impaired attention, concentration or memory
- Mental and psychomotor slowing
- Personality changes

Primary-care providers should assess for cognitive disturbances. Rule out other causes, in particular, depression.

HIV-ASSOCIATED DEMENTIA

Clinical features

Dementia is characterized by a reduced level of consciousness with:

- Serious memory problems
- Slowed thinking with trouble in focusing attention
- Reduced speed of information processing
- Impaired executive functioning (e.g. abstraction, divided attention, shifting cognitive sets)

Late manifestations may include:

- Visuospatial difficulties
- Language problems
- Apraxias

The organic contribution to aberrant cognitive disturbance should be considered:

- Substance use related
  - Intoxication, withdrawal, delirium
- HIV-related central nervous system disorders
  - Toxoplasmosis
- HIV-related cognitive impairment
  - A direct result of HIV infection of the brain

Table 2. Stages and characteristics of HIV-associated dementia

Stage	Characteristics
Stage 0 (normal)	Normal mental and motor function
Stage 0.5 (subclinical)	Equivocal symptoms of cognitive or motor dysfunction; no impairment of work or activities of daily living
Stage 1 (mild)	Evidence of intellectual or motor impairment, but able to perform most activities of daily living
Stage 2 (moderate)	Unable to work, but can manage self-care
Stage 3 (severe)	Major intellectual incapacity or motor disability
Stage 4 (end-stage)	Nearly vegetative

Source: Bartlett JG, Gallant JE. *2005–2006 Medical management of HIV infection.* Baltimore, Johns Hopkins University Division of Infectious Diseases, 2005 (http://www.hopkins-aids.edu/mmhiv/order.html).

- Psychiatric disorders
  - Depression
  - Psychosis
- Others
  - Infection
  - Hepatic encephalopathy
  - Electrolyte imbalance
  - Hypoxia
  - Subdural haematoma from head trauma

Treatment

- Rule out treatable (reversible) causes of dementia (e.g. hypothyroidism, chronic subdural haematoma, normal pressure hydrocephalus).
- Rule out pseudodementia (major depression mimics dementia).
- HIV-associated dementia improves with ART.
- Work closely with family members to advise them of the treatment options and prognosis.

DELIRIUM

Delirium is characterized by a fluctuating level of consciousness and:

- Recent onset of confusion
- Difficulty in speaking
- Disorientation in place or time
- Restlessness and agitation
- Reduced level of consciousness

Treatment

- Consider substance use (alcohol)-related delirium and manage accordingly.
- If agitated and not alcohol or drug intoxicated, give low-dose sedation with haloperidol.
- Consider HIV-related illness (if HIV-related, improves with ART).

PSYCHOTIC DISORDERS

- Psychosis is characterized by delusions (false beliefs in the face of evidence against) and hallucinations (the experience of sights and sounds such as voices that are not actually present).
- Drug-induced psychosis is commonly associated with amphetamine intoxication, particularly in chronic amphetamine users.

Clinical features

- Bizarre and uncooperative behaviour
- Irrelevant, often nonsensical speech
- Agitation and violence
- Auditory hallucinations or internal dialogue

Treatment

- Refer to psychiatric services.
- Emergency management of agitation or violence:
  - Administer haloperidol:
    - Medically healthy then haloperidol IM 5 mg once or twice daily.
    - Medically ill, elderly, HIV clinical stage 3 or 4 then haloperidol IM 0.5 – 1 mg once or twice daily.
    - In uncontrollable HIV clinical stage 3 or 4 patient: haloperidol 2 mg and, if no response in one hour, add haloperidol 2 mg. If still not adequately sedated, add diazepam 2–5 mg orally.
    - Haloperidol can be continued orally (same dose) if the patient is cooperative.
  - Side-effects of haloperidol are stiffness, tremor, muscle spasm and motor restlessness. If there is acute muscle spasm, stop haloperidol; maintain airway; give diazepam 5 mg rectally; and refer.
- The management of chronic psychosis in injecting drug users (IDUs) is complex and requires experienced psychiatric care.

REFERENCES AND RECOMMENDED READING

AIDS Education and Training Centres. *Clinical manual for management of the HIV-infected adult*. Newark, New Jersey, USA, AIDS Education and Training Centres (AETC), 2006 (http://www.aidsetc.org).

Bartlett JG, Gallant JE. *2005–2006 Medical management of HIV infection*. Baltimore, Johns Hopkins University Division of Infectious Diseases, 2005. (http://www.hopkins-aids.edu/mmhiv/order.html).

Sub-module

11.2

Psychosocial care

OVERVIEW

Objectives:

By the end of the session participants will be able:

- To identify the psychosocial care needs of IDUs across the continuum of HIV infection
- To discuss the different roles and contributions of members of the care team
- To understand the training requirements of psychosocial care providers

Time to complete session:

45 minutes

Session content:

- Psychosocial care within a medical model
- Psychosocial issues associated with hiv infection in IDUs
- Summary of psychosocial issues across the disease continuum
- Who can provide psychosocial care, and what training do they require?

Training materials:

- PowerPoint presentation 11.2: Psychosocial care
- Sub-module 11.2: Psychosocial care
- Exercise 11.2

PSYCHOSOCIAL CARE WITHIN A MEDICAL MODEL

WHO favours a multidisciplinary approach for the provision of care and treatment for people living with HIV and AIDS (PLWHA) with a substance use history. Such a team includes:

- Clinician (physician or other medical practitioner or specialist, e.g. infectious diseases specialist)
- Medical nurse
- Social worker
- Counselling staff including trained nurse and lay counsellors (including PLWHA)
- Substance dependence specialist(s)

The team should meet on a regular basis to review the status of IDUs under treatment and provide case management. All of the care team should have training and experience with drug dependency issues. Substance dependence needs to be recognized by all care providers, a complex condition that has both metabolic and psychosocial components, and is associated with severe morbidity and a high risk of death.

Social problems, including stigma associated with drug use, discrimination suffered by people who are drug dependent and/or HIV-positive, and the problems their families face, in turn exacerbate drug use and therefore must continue to be addressed at a programme and community level.

Substance dependence (in particular to opioids) is a chronic relapsing condition, which is difficult to control due to compulsive drug use and craving, leading to drug seeking and repetitive use, even in the face of negative health and social consequences. There are a number of medical, psychiatric and social problems common among substance-dependent people, which are important considerations in designing and delivering HIV/AIDS care.

Outreach strategies are a vital component of care. Strong links between the health sector and community-based organizations representing affected groups, and utilizing peer educators and counsellors drawn from these groups can help in addressing some of the community issues impacting care and treatment and transmission reduction.

Linkages between HIV, drug treatment and mental health services

HIV and drug treatment services that do not possess resources to adequately assess and treat mental health problems on site should have the capacity to rapidly refer clients to closely linked mental health services. There should be clearly identified lines of communication between HIV and drug treatment services and mental health services to facilitate care of those with complex needs.

Providing concrete assistance, such as transportation, may increase the likelihood of clients following through on referrals to psychiatric, drug treatment and other types of referral services. Care of HIV-positive drug users with mental health problems is likely to involve multiple service providers. Therefore, communication and coordination among physicians, counsellors and other practitioners involved in a patient's care are essential. Nominating a "service advocate" or "expert patient" may be a useful way of ensuring that such coordination occurs. This role may be played by a trained lay counsellor, a nurse, a social worker or other health professional.

Patients may not always want to divulge information (e.g. that they have a history of mental health problems or that they are already receiving medication from another provider). The establishment of an "expert patient" or "service advocate" may help to ensure that all those involved in patient care are fully informed, with the client's permission, about the patient's treatment status. A

comprehensive treatment plan and an individualized risk reduction plan should be prepared and followed for each patient, and the patient should be actively involved at all levels of service planning. It is important that treatment plan goals are realistic (e.g. immediate abstinence from drugs is unlikely to be a realistic goal for many patients).

PSYCHOSOCIAL ISSUES ASSOCIATED WITH HIV INFECTION IN IDUs

In order to understand what services need to be developed to meet the psychosocial support needs of IDUs living with HIV, we need to discuss the common psychosocial issues that occur across the disease continuum.

The chronic and progressive natural history of HIV infection means that the psychosocial issues confronting both infected and affected individuals change throughout the course of the illness. The psychosocial issues are dynamic and vary at different stages of the disease continuum.

In addition to the issues directly related to HIV, patients may present with a range of issues that are pre-morbid or indirectly related to HIV. For many individuals, becoming infected with HIV re-activates previously unresolved issues such as sexual identity, specific traumatic events such as child sexual assault, or unresolved relationship issues and even guilt about their drug use. Individuals infected with HIV and their significant others such as family, friends or partners can experience profound emotional, social and behavioural consequences. This disease has significant implications for adjustments in family life, sexual and social relations, work and education, spiritual beliefs and needs, and legal and civil rights. Social instability, poverty, psychiatric morbidity, human rights violation, and poor patient–physician relationships characterize many drug users' lives. Newly diagnosed patients recovering from drug dependency are at risk for relapse.

Declining health as a result of HIV disease is a recognized risk factor for relapse into drug use. Physical and psychological stresses associated with HIV, such as pain, decreased functional ability, fatigue and weakness as well as fear, anxiety and grief all serve to increase an individual's risk of resuming substance use.

Certain "milestones" in the progression of HIV present an increased risk of relapse, and clients may need additional support at these times. It is important that staff review a client's treatment plan when one of these milestones is reached. Major milestones include:

- Deciding to be tested and waiting for the results
- Receiving a positive diagnosis
- Developing the first symptoms
- Being diagnosed with AIDS

SUMMARY OF PSYCHOSOCIAL ISSUES ACROSS THE DISEASE CONTINUUM

In order to plan for the psychosocial care needs of IDU PLWHA, it is important to understand the common issues across the HIV continuum.

Post-initial diagnosis: Initial diagnosis of HIV is often accompanied by feelings of shock, anger, disbelief, even denial. A review of the literature suggests that psychological morbidity following diagnosis is usually mild to moderate and of limited duration. While suicide is often discussed and considered in late-stage disease, there is evidence of a bi-modal distribution of suicide attempts. Most research does indicate a bi-modal distribution of suicide across the disease continuum, with peaks in incidence immediately post-diagnosis and up to six months post-diagnosis, and during late-stage disease. IDUs are at increased risk for suicidal ideation and accidental overdose.

Asymptomatic phase: During the second or "asymptomatic" disease phase, clients may present with difficulties related to changes in lifestyle and living with an infectious disease. While no physical symptoms are usually present, some clients may develop health anxiety, misinterpreting minor non-HIV health symptoms as indicators of disease progression. Clients confront issues related to disclosure of status, rejection and discrimination. In endemic areas some clients suffer multiple bereavements, with friends and acquaintances dying from HIV. Within this context of multiple loss, clients may develop anticipatory loss reactions related to their own serostatus. The most prevalent diagnoses provided during this phase of the illness are adjustment disorder, depression, substance use, panic disorder, personality problems and psychogenic sexual dysfunction.

Symptomatic phase: Comparative studies of HIV-negative and HIV-positive asymptomatic persons reveal that individuals experience significantly higher psychological morbidity in the third phase of the disease continuum, the symptomatic disease phase. Higher levels of anxiety, and depression in particular, are noted in this population. Other common diagnoses in this phase include organic brain syndromes such as HIV dementia, HIV minor neurocognitive disorders, delirium related to opportunistic infections (OIs), and substance dependency and use. Mood disorders related to metabolic disturbances, chronic pain and other constitutional illnesses are not uncommon during this period. Individuals may also experience HIV-related sexual dysfunction such as erectile dysfunction or retarded ejaculation. Both conditions may adversely impact on an individual's effective use of condoms.

Acquired immunodeficiency syndrome (AIDS): In this phase of the illness, organic brain syndromes such as AIDS dementia complex, HIV mania and organic mood disorders may be the dominant presenting problems during psychiatric consultations. During this phase clients may experience adjustment disorders related to disease onset, loss of autonomy, grief and loss, and increased suicidal ideation. Psychological assessment and diagnosis demands that the practitioner is able to consider the relative contributions of metabolic disturbance, constitutional illness, pre-morbid conditions, iatrogenic effects and psychosocial factors in mood and behavioural disturbances.

Mental health co-morbidities are common among HIV-infected IDUs. Estimates suggest that between 25% and 50% of drug users also have a co-morbid mental health problem. Some IDUs have a long history of mental illness without having been properly diagnosed or treated. There are some mental conditions, such as bipolar disorder, which may result from the use of substances such as alcohol, cocaine and opioids as a form of self-medication and substitute for effective treatment. A substantial increase in the frequency of major depression and suicide in HIV-positive IDUs is apparent, even above the elevated rates associated with advanced HIV infection and AIDS. The provision of appropriate mental health support is a critical element of both psychiatric (antidepressant therapy) and psychological inputs (cognitive–behavioural therapy, etc.) and an essential component of HIV care and drug treatment services.

WHO CAN PROVIDE PSYCHOSOCIAL CARE, AND WHAT TRAINING DO THEY REQUIRE?

VCT and HIV care counselling

HIV counsellors are drawn from a variety of professional and non-professional backgrounds. In many settings the counsellors providing services are themselves HIV-infected. HIV counsellors are required to recognize and manage complex psychological, social and physical presentations in

their clients. It is imperative that these counsellors receive adequate and appropriate training and that this training supports their work across a variety of clinical and social settings. HIV counsellors throughout the Region have generally only received training in pre- and post-HIV test counselling. Few mental health professionals, including drug rehabilitation counsellors, have received training in HIV-related mental health issues. There is a great need to train mental health professionals, drug counsellors and community lay or faith counsellors to deliver counselling and psychosocial care across the disease continuum.

Family therapy

For many clients, "family" may need to be defined as broadly as possible. Supporting people in recovery from drug dependence is often a principal goal of family therapy. It may also be a useful opportunity to address issues of risk reduction for family members who are not HIV infected and are caring.

Positive peer support clubs

- These may fulfil a wide range of needs: psychosocial support in modifying drug use, providing emotional support to members and offering support for treatment adherence.
- No single organization can provide all the services needed by HIV-infected drug users, especially those with mental health problems. Services should actively refer patients to appropriate specialized outside support groups where their specific needs can be met.
- Support groups may be segregated by gender, sexual orientation and type of drug use, also by stages of recovery from addiction or HIV infection (newly diagnosed; asymptomatic or mildly symptomatic; advanced disease).
- It may be helpful for groups to be time-limited (e.g. some groups may have to be stopped as members die and surviving members may be in a continual process of grief).

Peer educators and peer counsellors also require specific training to enable them to provide care. Too often governments and services rely on "self-help" organizations without providing them with the training or resources needed to function. Positive peer support group facilitators require some basic counsellor training as they have to support members with significant social and psychological problems associated with both HIV infection and substance use and dependency.

Drug dependency recovery support groups

The most common types of self-help programmes are "twelve-step" groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous. These tend to be abstinence-oriented and may emphasize medication-free treatment. Where such groups exist, they are free and easily accessible and offer considerable support to members. They can be helpful for motivated drug users.

Social and legal support: Community involvement and household assistance to mitigate the impact of HIV/AIDS are examples of social support. Providing food support, volunteers for daily duties, orphan support, PLWHA peer support, welfare services and legal support are also part of social support and should be part of a comprehensive care and support package.

Faith-based organizations

Faith-based organizations (FBOs) often play an important role in supporting drug users who have been rejected by families, and require welfare or home-based or palliative care. Basic training

should be provided to enable these organizations and their volunteers to provide services to IDU PLWHA. Such training may include: basic information on HIV transmission and prevention; basic information on HIV disease progression; information on substance dependence; and non-judgemental counselling and helping strategies.

REFERENCES AND RECOMMENDED READING

DiClemente CC, Prochaska JO. Self-change and therapy change of smoking behavior: a comparison of processes of change in cessation and maintenance. *Addictive Behaviors*, 1982, 7:133–142.

Douaihy AB, Jou RJ, Gorske T, Salloum IM. Triple diagnosis: dual diagnosis and HIV disease. Part 2. *AIDS Reader*, 2003, 13:375–382. http://www.medscape.com/viewarticle/460734

Farber EW, McDaniel SJ. Clinical management of psychiatric disorders in patients with HIV disease. *Psychiatric Quarterly,* 2002, 73:5–16.

Goldenberg D, Boyle BA. HIV and psychiatry. Part 1. *AIDS Reader*, 2000, 10:11–15. www.medscape.com/viewarticle/410244_1

Goldenberg D, Boyle BA. HIV and psychiatry. Part 2. *AIDS Reader*, 2000, 10:201–204. www.medscape.com/viewarticle/410281

Horwath MD, Nas SS. Psychiatric manifestations of HIV infections and AIDS. *Psychiatric Times*, 23 November 2005 (13).

International Classification of Diseases (ICD). Geneva, World Health Organization, 1994. www.who.int/classifications/icd/en/

International Statistical Classification of Diseases and Health Related Problems (ICD-10). Second edition. Geneva, Switzerland, World Health Organization, 2006.

Palmer NB et al. Psychiatric and social barriers to HIV medication adherence in a triply disgnosed methadone population. *AIDS Patient Care STDs*, 2003, 17: 635–644.

Strathdee SA, Patterson TL. Behavioral interventions for HIV-seropositive and HCV-seropositive drug users. *AIDS and Behavior*, 2006, 12:1–16.

Yun L, Maravi M, Kobayashi J, Barton P, Davidson A. Antidepressant treatment improves adherence to antiretroviral therapy amongh depressed HIV-infected patients. *Journal of Acquired Immune Deficiency Syndromes*, 2005, 38: 432–438.

EXERCISE 11.2

Case study

One participant will be asked to read this case study out loud followed by discussion among the large group.

Your client is a 22-year-old heroin dependent IDU. He was diagnosed 10 months ago. He was in a drug detention centre at the time of his diagnosis and underwent withdrawal without medication. He was released from detention and was unable to get full-time employment. He does odd manual labour tasks. He has re-established a relationship with his former girlfriend who engages in sex work to support her substance dependence. He reports that he relapsed into heroin use again shortly after he was diagnosed with an HIV-related skin condition. He reports that he frequently coughs up blood and experiences night sweats. His family has rejected him and he lives with his girlfriend in a low-cost rented accommodation. His girlfriend uses oral contraceptives that she purchases herself from a pharmacy. She has not had a recent HIV test; however, she tested HIV-negative nine months ago.

The client reports that he has some minor memory problems, and he appears agitated.

Questions for large group discussion:

1. **What are the key issues for the client?**

2. **List strategies to address each of the issues.**

Sub-module

11.3

Sexual health

OVERVIEW

Objectives:

By the end of the session participants will be able:

- To understand the WHO comprehensive concept of sexual health
- To be familiar with sexual health issues in IDU populations
- To understand the general principles of sexual health care for female IDUs
- To understand the general principles of sexual health care for male IDUs
- To understand the approaches to promoting safer sexual behaviour among IDUs

Time to complete session:

45 minutes

Session content:

- WHO concept of sexual health
- Sexually transmitted infections (STIs)
- General principles of STI management for IDUs
- Talking about sexual health with IDUs
- Sexual activity and drug use
- Sexual health care for female IDUs
- Sexual health care for male IDUs
- Harm reduction for sexual health

Training materials:

- PowerPoint presentation 11.3: Sexual health
- Sub-module 11.3: Sexual health

Key learning points

- IDUs and their partners are vulnerable to sexually transmitted HIV infection.
- IDUs have multiple risk factors for sexual ill health.
- IDUs have high rates of sexually transmitted infection (STI) and are at risk of long-term disease from STIs.
- IDUs are vulnerable to other sexual health problems, such as sexual violence and issues related to their psychosexual and reproductive functioning.
- Offering regular STI screening to IDUs is warranted and is an effective public health intervention.
- Early and effective STI treatment is important in reducing the risk of acquiring and transmitting HIV.
- Early and effective treatment of STIs can reduce the burden of disease in individuals and the population.
- Brief interventions on sexual health behaviours can result in positive behaviour change in IDUs.

WHO CONCEPT OF SEXUAL HEALTH

Sexual health issues of concern for IDUs and their sexual partners are similar to the sexual health issues facing non-injecting populations, except that IDUs' needs for sexual health care are often greater. The sexual health of IDUs is an issue of global concern when considering the relationship between injecting drug use and poverty, socioeconomic development, human rights, public health and political repression. It is easy to overlook the sexual risks of IDUs in preference to the more obvious risks associated with bloodborne virus transmission and the re-use of injecting equipment. However, in Asia, IDUs report multiple sexual partners and are an important conduit of HIV and STI transmission between homosexually active men, sex workers and the general population. Because IDUs tend to have large sexual networks, even a small number of IDUs with HIV can cause a large number of new sexually transmitted HIV infections. Managing sexual health in IDU populations is therefore important, not only for IDUs and their sexual partners, but also for the broader public.

The World Health Organization (WHO) has published a definition of sexual health and has outlined four main criteria for sexually healthy people, which will be used in this module as the reference point for sexual health.

1. Sexually healthy people have accurate sexual knowledge so that they can enjoy happy relationships and satisfying sexual activity.
2. Sexually healthy people know how to avoid STIs, and seek effective treatment if they have symptoms.
3. Sexually healthy people know how to plan for a new pregnancy and avoid unintended pregnancies.
4. Sexually healthy people manage their sexual relationships so that their emotional and sexual needs are met without causing harm to other people.

While much of the focus of sexual health in clinical medicine is directed to the management of STIs, it is important to remember the other aspects of sexual health when providing health care to people who inject drugs. Using the WHO sexual health concept, it is important to note that IDUs are vulnerable to sexual ill-health at all four points.

1. IDUs may not understand the fundamentals of sexual desire, arousal and pleasure for themselves or their partners. For example, male IDUs may have false beliefs about penile size and female pleasure. IDUs may have limitations in their interpersonal communication skills, which can lead to conflict, resentment, and an unhappy, unsatisfying sex life. The association of mental ill-health (depression), substance dependence and sexual abuse or assault (child and adult) is well documented.
2. IDU populations have higher rates of STIs, low rates of consistent condom use, multiple sexual partners, higher rates of transactional sex (both as sellers and consumers), and face barriers to accessing quality sexual health care. This results in significant STI-associated morbidity for the individual, their partners and the community. Male IDUs may attempt to increase the size of their penis and in the process, cause structural and aesthetic damage (injecting oil or silicon into the penis). Female IDUs may suffer chronic pain during sex and pelvic pain due to chronic STIs.
3. Female IDUs may have reduced control over their reproductive health due to power imbalances when exchanging sex for drugs or survival, have poor access to effective contraceptive options, encounter unhelpful health professionals when accessing pregnancy care or contraception, face challenges in caring for a newborn, and perhaps lack a supportive partner (for contraception and pregnancy).
4. IDUs are vulnerable to sexual violence. IDUs can be sexually exploited as well as sexually exploit others. Both men and women IDUs report high rates of exchange of sex for drugs, money or survival. IDUs report high rates of sexual assault by partners, drug dealers, police and others while incarcerated. Due to social marginalization and absence of legal sanction, IDUs are more likely to frequent dangerous venues or areas, and are therefore at increased risk for violence generally.

Indicators of sexual ill-health among IDUs and their partners

- Unplanned pregnancies
- STIs
- Sexual assault (being a survivor and/or a perpetrator)
- Intimate partner physical and/or emotional violence
- Sexual dysfunction due to psychological and biological causes (including drug associated)

End results of sexual ill-health among IDUs and their partners

- Maladjustment and psychological stress, unhappiness and relationship disharmony
- Pelvic inflammatory disease (PID) leading to chronic pelvic pain and pain during sex for women
- PID leads to infertility, ectopic pregnancy, fetal wastage, and other poor pregnancy outcomes
- Disease of the neonate (HIV, syphilis, chlamydia, gonorrhoea)
- Cancers of the cervix, anorectum, vulva and penis due to human papillomavirus (HPV)
- Death due to HIV or cancer
- Significant costs to the community and government

When providing sexual health care to IDUs, it can be useful to ask yourself:

- Does this person have accurate sexual knowledge?
- Does this person have other complicating medical conditions?

- Does this person have interpersonal communication difficulties?
- Does this person have sexual relationship problems?
- Does this person have a mental health condition or diagnosis?

The presenting issue could be compounded by other diagnoses that require the physician's attention. IDUs are more likely to have several co-morbid conditions associated with their injecting drug use, including drug dependence, depression, suicide attempts, chronic viral infections (hepatitis B or C or HIV), liver disease, plus other conditions related to unhealthy injecting technique (abscess, thrombo-embolism, endocarditis, etc.). These conditions are covered in other modules.

Structural determinants of sexual ill-health among IDUs and their partners

- Socioeconomic and other macro factors such as the cultural and legal environment
- Lack of knowledge or an inability to act on knowledge of healthy behaviour
- Lack of access to health services due to structural barriers such as government policy and police harassment
- Nature of the STI such as asymptomatic infection, lack of immunity and inadequate treatment options
- Health provider clinical knowledge and skills, discomfort while dealing with the field of sex or drugs, or unprofessional attitudes towards IDUs or people with STIs.

SEXUALLY TRANSMITTED INFECTIONS (STIs)

(*See WHO STI Management Guidelines* 2003 and country-specific Ministry of Health STI screening and treatment guidelines.)

Several studies have demonstrated higher rates of STI in IDU populations. This higher risk of infection is complex and due to multiple factors that increase the vulnerability of IDUs to acquiring STI. Some of these variables are independently associated with both STI and IDUs:

- Multiple sexual partners and low levels of condom use
- Commercial or transactional sex and low levels of condom use
- Male-to-male sex, including men having sex with females and transgenders
- IDU sexual networks have a high prevalence of STIs (therefore chance of acquiring STIs is higher within and between these networks)
- Intoxication may predispose IDUs to vulnerability because of reduced self-efficacy in relation to condom use or other protective behaviours
- HIV and the interactions with STIs (many interrelated factors that increase the transmissibility of both STIs and HIV)
- Reduced access to health services due to cost, distance, attitudes of self and staff
- Antibiotic resistance due to incorrect doses prescribed, or poor compliance, or self-medicating with ineffective treatments
- Use of low dose or ineffective antibiotics as STI prophylaxis may facilitate development of resistance, but also provides a false sense of "protection" from infection
- Drug use is associated with risk-taking in general and social deprivation
- Poor general health and well-being (nutrition, other infections and conditions)

Sites of infection

- Syphilis is a systemic infection and therefore serological tests are required to make a diagnosis.

- *Chlamydia* and gonorrhoea can infect the urethra, throat, anus, cervix and eyes.
- *Trichomonas* can be found in the vagina and cervix, and less commonly the urethra.
- Herpes simplex virus (HSV) can infect the epithelium of the vulva, penis, anus, vagina, cervix and perineum.
- HPV can infect the penis, vulva, anus and cervix.
- Chancroid and lymphogranuloma venereum can infect the anogenital area.
- STIs can infect other parts of the body when the patient is immune deficient.

GENERAL PRINCIPLES OF STI MANAGEMENT FOR IDUs

(Refer to *Sexual health medicine* by Russell, Bradford and Fairley, 2003)

- Use a syndromic-plus approach if laboratory facilities are available.
- Provide treatment at presentation; do not wait for laboratory results if clinical manifestations indicate infection.
- Self-collection of samples (genital and blood) increases the acceptability of and uptake of screening tests.
- Many STIs are asymptomatic, and have periods of "latency".
- A person can have more than one STI at any given time.
- STI always involves more than one person.
- Not treating sexual partners at the same time results in treatment failure due to reinfection. It is therefore good practice to provide effective medication to both the index case and sexual contacts.
- Syphilis can be transmitted through the reuse of injecting equipment with an infected partner as well as through sex.
- Infection with HIV can change the natural course and manifestations of some STIs.
- STIs can be present in more than one anatomical site, depending on which parts of the body have been used for sex (e.g. cervix, urethra, anus, vulva, penis and throat).
- Do consult with your local centre for disease control about local STI epidemiology.

TALKING ABOUT SEXUAL HEALTH WITH IDUs

(Refer to *Discussing sexuality* by Ross and Channon-Little, 1991; and *Sexual health medicine* by Russell, Bradford and Fairley, 2005)

"Adopting a positive and open attitude is the key to success in STI management. In the absence of trust and confidence, it is impossible to address the many sensitive issues related to STI". (WHO STI case management manual, 2002)

Skills needed for health professionals in order to talk effectively with IDUs about sexual health include:

- Knowledge of the biological, psychological and social contexts of sexual behaviour
- Self-care and awareness of the limits of scope of practice and clinical competency
- Non-judgemental and non-censoring attitude
- Demonstrating an openness and willingness to discuss intimate topics.

The image health professionals need to present to IDUs when talking about sexual health includes:

- Confidentiality – assurance of not disclosing their personal information to others

- Trustworthiness – assurance of not informing law enforcement agencies of illegal activity
- Professional – demonstration of safety and not abusing power
- Culturally appropriate and safe
- Empathetic
- Respectful and understanding

IDUs with STI or other sexual health concerns may have the following emotions and feelings. If health professionals are aware of these potential emotions, they can better communicate with IDUs. These emotions include:

- Vulnerability
- Embarrassment
- Guilt
- Anxiety
- Fear a breach of confidentiality or being reported to the police
- Misinformation about STIs in general, but particularly urban myths about painful invasive treatments
- Physical discomfort or pain

Before asking questions of a sensitive nature, ask the patient's permission and warn them that some people find the questions challenging. For example, "Some people find answering questions about their sex life embarrassing, but your sexual health is important and I can best help you when we talk about it openly". It is also useful to explain that you ask all your patients these questions about their sexual health, so that the IDU does not think they are being targeted specifically because of their injecting drug use or sex industry work, but rather, that sexual health is an essential aspect of primary care.

Some general guidelines for asking questions about sexual behaviour include:

1. Encourage affirmative or "yes" answers by asking questions such as: "When was the last time you ..." or "How often do you ...". Avoid asking "Have you ever" (this invites people to answer "no" and you may not get the correct answer).
2. Do not assume that people know what clinical words mean.
3. Do not use a long word when a short word could mean the same thing.
4. Start with the "kind" or easy questions and leave the difficult ones for later, once rapport has been established.

Recall of specific sexual events and associated drug-induced states may not be possible. It may be more useful to talk about the most recent sexual activity and work backwards to the past three to six months. For example:

- "You mentioned that the last time you had sex, the condom broke. Has this happened in the past three months also?"
- "Have you noticed any ulcers or unusual discharge from your penis?"
- "Many people who have been in jail report being sexually assaulted. Has this happened to you?"
- "You said you always use condoms during your sex work, and that is excellent. Do you use them with your boyfriend also? It is often a bit more difficult to use condoms with regular partners."
- "In the past three months have you had vaginal sex when your partner did not use a condom?"

- "Many people have sexual concerns or questions, is there anything you want to ask me or talk about?"

You may not get all the information at the first session – it may take several visits for rapport and trust to be established. Over time, you may find out more details, and can therefore counsel more effectively and ask about the more sensitive issues of forced sex, transactional sex or other problems.

Assumptions about sexual behaviour can be problematic and can reduce providers' professionalism and ability to provide quality care. It is more useful to ask open-ended questions without using labels such as heterosexual, homosexual or bisexual. For example:

- Women IDUs who prefer to have sex with women (i.e. have a lesbian identity) may have a history of sex with men due to rape or sex for money, drugs or survival, or due to a social expectation to marry. Therefore, sensitively asking about sex with men is just as important for women with a lesbian identity as it is to ask about male-to-male sex with men who have a heterosexual preference.
- Men who prefer sex with women may have sex with men for money, drugs or may have been subjected to forced sex. Likewise, some men who have a homosexual identity may have sex with women due to social expectations to marry.
- Many IDUs report sex in exchange for drugs or money. This may occur in a sex industry setting, or through injecting or social networks. Using a label of "sex work" may not assist you in obtaining the information you need to best provide care.

SEXUAL ACTIVITY AND DRUG USE

(Refer to *Sexual pharmacology* by Crenshaw and Goldberg, 1996)

- Many drug effects are context- and dose-related. Drugs do have a different impact in different individuals at different doses and the length of time with use.
- IDUs are also likely to use other mood-changing substances, such as alcohol, marijuana and prescription medications (poly-substance use).
- Opioid users may have reduced sexual desire and activity, but importantly, do continue to have regular sex.
- Methamphetamine or crystal methamphetamine users may have increased sexual activity (but men may have erection difficulties).
- Cocaine users have reduced inhibition with increased desire and increased sexual activity (but may have low desire with chronic use).

SEXUAL HEALTH CARE FOR FEMALE IDUs

These points are not comprehensive, but are of specific relevance when providing care to female IDUs. You may need to refer to specialized sexual health services.

History of sexual violence (vaginal or anal rape)

- If recent, consider **post-exposure prophylaxis (PEP)** for HIV and STI, as well as contraception.
- Also consider PEP and emergency contraception following unsafe sex with a person known to have HIV or STI or when effective contraception was not used.
- Also refer for social and psychological support to an appropriate NGO or the health services.

History of transactional sex (receptive vaginal, anal and oral sex)

- Consider country-specific or WHO screening guidelines for sex workers.
- Encourage testing of anatomical sites – throat, anus, cervix and urethra.
- Encourage condom use with commercial or transactional sex.

Vaginal health

- Douching or using astringents or other preparations can predispose to inflammation and trauma and thus facilitate HIV and STI transmission.
- Recurrent or persistent candidal infections could indicate immune deficiency. Prophylactic antibiotic use and use of douching preparations can also predispose to candidal infections.
- Remember the most common cause of an increased vaginal discharge is not STI but bacterial vaginosis, which requires treatment.
- *Trichomonas vaginalis* infection is an STI and requires treatment (can also be found in the cervix).

Cervical health

- HPV and cervical cancer. Encourage regular Papanicolaou (Pap) smear testing if available.
- Chlamydia and gonorrhoea are cervical infections. Samples for laboratory examination need to come from the cervix, not the vagina.

Herpes simplex virus 1 and 2

- HSV is more prevalent in sex industry workers and people with HIV.
- HSV infection is often sub clinical, but transmission occurs through asymptomatic viral shedding.
- Consider suppressive therapy in those with regular recurrences.

Sexual function

- Low levels of desire and arousal. This could be drug-related, but is also indicative of potential relationship problems and poor general health and well-being.
- Pain during sex. Investigate for STIs, pelvic inflammation, cervical abnormalities or other medical conditions, but may be due to poor male technique, or lack of arousal and lubrication.
- Difficulty in having an orgasm.

Contraceptive needs

- Oral contraceptive pills may not be appropriate due to lifestyle challenges.
- Injectable or implantable contraceptives may be more appropriate, but also encourage condom use with casual or commercial sex.

Menstruation concerns

- If the woman is selling sex regularly, refer to an NGO who can give specific health and occupational advice about working during menstruation.
- Some drugs can change the ovulatory and menstrual cycles.
- Nutrition and general well-being can also impact on and alter hormonal cycles.

Pelvic pain

- Pelvic pain in sexually active women should be assumed to be STI-related pelvic inflammatory disease (PID) and managed as such with immediate, appropriate and effective antibiotic therapy.
- The long-term effects of poorly managed PID can be infertility and chronic pelvic pain.

SEXUAL HEALTH CARE FOR MALE IDUs

These points are not comprehensive, but are of specific relevance when providing care to male IDUs. You may need to refer to specialized sexual health services.

History of sexual violence (anal rape)

- If recent, consider PEP for HIV and STI.
- Also consider PEP following unsafe sex with a person known to have HIV or an STI.
- Also refer for social and psychological support to an appropriate NGO or health services.

History of transactional sex (receptive and insertive anal and oral sex, and insertive vaginal sex)

- Consider country-specific or WHO screening guidelines for male sex workers.
- Encourage testing of anatomical sites – throat, anus and urethra.
- Encourage condom use during commercial or transactional sex.

History of male-to-male sex

- Whether it was for fun or money or drugs
- Whether this happened while incarcerated
- Ensure that he understands about the need for condom and lubricant use for anal sex with all partners – whether he is the insertive or receptive partner

Herpes simplex virus 1 and 2

- HSV is more prevalent in sex industry workers and people with HIV.
- HSV infection is often sub-clinical, but transmission occurs through asymptomatic viral shedding.
- Consider suppressive therapy in those with regular recurrences.

Sexual function

- Low levels of desire and arousal. This could be drug-related, but is also indicative of potential relationship problems and poor general health and well-being.
- Delayed or inability to reach orgasm due to drug use or selective serotonin reuptake inhibitors (SSRIs such as Prozac).
- Use of erection enhancers (Viagra, Cialis, Levitra, Caveject) because of amphetamine use. Inform factually about interactions with the nitrates (recreational and medicinal) and with ARVs.
- Special care with Caveject as it is an injectable.

Penile health

- Risk of HIV and STI acquisition is higher in uncircumcised men.
- In uncircumcised men, this is an additional reason and motivation to use condoms.
- Use of penile size enhancers (oil injections or accessories) can cause inflammation and abrasions and therefore facilitate HIV transmission.
- Penile accessories can cause trauma in the receptive partner and facilitate HIV transmission. Educate about the female anatomy (clitoris as site for female sexual pleasure).

HARM REDUCTION FOR SEXUAL HEALTH

IDUs have many other life stressors and competing risks that can occupy their time and consume their emotional energy. This means that HIV or STIs may not be on their "big worry" list of concerns that require immediate action. IDUs may die from overdose, drug toxicity or violence. The immediate threats to survival dominate the risks posed by an infection that does not manifest itself until later. IDUs have experienced the loss of friends, lovers and acquaintances from these other factors. A "live fast, die young" philosophy may be more prevalent in IDUs and therefore it is difficult to engage with them about future survival or health when they do not expect to live past the age of 30 years (for example).

Engaging with IDUs on life expectations and future plans – whether these plans are about tonight or next year or ten years from now – is the beginning of a process to minimize the harm associated with injecting drug use and sexual behaviour. Studies have highlighted that IDUs can and do demonstrate altruistic behaviour with regard to STI and HIV transmission. Love and sexual intimacy are strong human motivators for life and survival, so that concern for the well-being of their love interest (and children) can be one motivator for reducing sexual risk.

A meta-analysis of successful programmes demonstrated that IDUs who accessed needle and syringe programmes (NSPs) reported fewer incident STI symptoms and were more likely to seek appropriate treatment if they did have symptoms. This was probably due to increased access to health care and exposure to empathetic health professionals who understood the particular health needs of IDUs.

IDUs, like all other populations, equate condom use with reduced intimacy, lack of trust and an absence of love. This means people are less likely (even in the presence of HIV) to want to use condoms with their regular sexual partner. This finding has been repeated many times with different population groups and requires further studies and interventions to discover how to shift the '"condoms = no intimacy/no love" belief system. Using condoms with casual and transactional sex partners will reduce risk for the individual and the population. Other interventions can minimize risk with loved partners where condoms are not used.

Encouraging regular STI check-ups and prompt treatment of STI symptoms is one intervention that can have a large impact on minimizing the harm associated with multiple sexual partners. Ensuring that IDUs with HIV are taking ART (if clinically indicated) will theoretically reduce the chances of transmission to sexual partners. ART when taken correctly does reduce the viral load in the blood and genital fluids and so reduces infectivity.

Promoting male and female condoms as a harm minimization option means more than simply telling IDUs to use condoms. Many people find negotiating and using condoms challenging. Talking about how to make condom use more comfortable and more enjoyable can reduce some of the barriers. Using words like "fun" and "sexy" and "pleasure" may be more effective with people who enjoy risk and excitement, than words like "safe" or "risk reduction". While our aim is "safe sex"

and "reducing risk", these words may not appeal or be heard by the individual who enjoys the excitement of taking risks.

- Applying lubricant to the head of the penis prior to putting on the condom can increase male pleasure (one of the big barriers).
- Using a water-based lubricant on the outside of the condom and applying it to the vagina or anus to be penetrated also increases pleasure.
- Finding male condoms of an appropriate size can increase acceptance.
- If condom slippage is a problem due to condom–penile size differences, men can "tuck" the scrotum into the condom. Covering the testicles with the condom has three benefits: first, some men find this pleasurable; second, it can help maintain an erection; and third, it anchors the condom and prevents from slipping off.

The evidence suggests that the following components need to be included in interventions to reduce sexual risk for IDUs. A multidisciplinary team is required to deliver comprehensive care, including:

1. *Information on how STIs, including HIV, can be transmitted sexually as well as through blood.* It is most effective if this is delivered through peers as well as by health professionals. NGO peers and health professionals can encourage and facilitate IDUs to self-assess their personal risk and vulnerability to STIs and HIV infection.
2. *Involvement of IDU role models or peer educators.* This includes regularly talking with peers about sexual health and safer sexual activities, such as using condoms and enjoying non-penetrative sex. This can be delivered through individual counselling or group activities on how to work out the practical and emotional challenges of implementing changes in one's sex life.
3. *Technical skill development on how to use condoms correctly and maximize pleasure and intimacy.* Such knowledge should also be delivered through peer educators with reinforcement by health professionals. Practising and rehearsing or role-playing can increase the chances of success in the real world.
4. *Referral to and availability of health services for HIV testing and management of STI.* Taking health services to IDUs through outreach programmes increases the access and acceptability of screening and treatment services.
5. *Provision of condoms to IDUs at NSP sites and health services.* Condoms need to be free or at a reduced cost, and available at accessible locations.
6. *Referral to treatment centres for substitution therapy or detoxification.*

Factors determining the likelihood that a person will change their behaviour

- The person must believe that the threat to their health is severe (life-threatening).
- The person must believe that their personal vulnerability to and/or likelihood of developing the disorder is high.
- The person must believe that they are able to do something that will reduce the threat (self-efficacy).
- The response must be effectively capable of overcoming the health threat (i.e. it must work).

REFERENCES AND RECOMMENDED READING

Bogart LM et al. Condom attitudes and behaviors among injection drug users participating in California syringe exchange programs. *AIDS and Behavior*, 2005, 9:423–432.

Bradshaw CS et al. Screening injecting drug users for sexually transmitted infections and blood borne viruses using street outreach and self collected sampling. *Sexually Transmitted Infections*, 2005, 81:53–58.

Crenshaw TL, Goldberg JP. *Sexual pharmacology: drugs that affect sexual function*. New York, W. W. Norton, 1996.

Deany P. *HIV and injecting drug use: a new challenge to sustainable human development*. Australia, UNDP HIV and Development Programme, UNDP Asia-Pacific Regional Programme on HIV and Development, and the Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research, 2000.

Des Jarlais DC, Semaan S. Interventions to reduce the sexual risk behavior of injecting drug users. *International Journal of Drug Policy*, 2005, 16(S):S58–S66.

van Empelen P et al. Effective methods to change sex-risk among drug users: a review of psychosocial interventions. *Social Science and Medicine*, 2003, 57:1593–1608.

Pisani E, Brown T. *AIDS in Asia: face the facts*. Bangkok, Monitoring the AIDS Pandemic (MAP) Network, UNAIDS, 2004.

Rhodes T, Cusick L. Love and intimacy in relationship risk management: HIV positive people and their sexual partners. *Sociology of Health and Illness,* 2000, 22:1–26.

Ross JDC, Radcliffe KW. Why do those using illicit drugs have higher rates of sexually transmitted infection? *International Journal of STI and AIDS*, 2006, 17:247–253.

Ross MW, Channon-Little LD (eds). *Discussing sexuality: a guide for health practitioners.* Sydney, Australia, FA Davis Co., 1991.

Russell D, Bradford D, Fairley C (eds). *Sexual health medicine*. Melbourne, Australia, IP Communications, 2005.

World Association for Sexual Health. 17th World Congress of Sexology, Montreal Declaration, 2005 (http://www.worldsexology.org/index.asp).

World Health Organization. *Guidelines for the management of sexually transmitted infections*. Geneva, WHO, 2003.

World Health Organization, Department of Reproductive Health Research. *Sexual health: a new focus for WHO, progress in reproductive health research No. 67*. Geneva, WHO, 2004.

Sub-module

11.4

Prevention strategies for HIV-positive IDUs

OVERVIEW

Objectives:

By the end of the session the participants will be able:

- To understand the concept of "prevention strategies for HIV-positive IDUs" and their significance
- To understand the key strategies in order to promote safer sex and safer injecting drug use among HIV-positive IDUs

Time to complete session:

45 minutes

Session content:

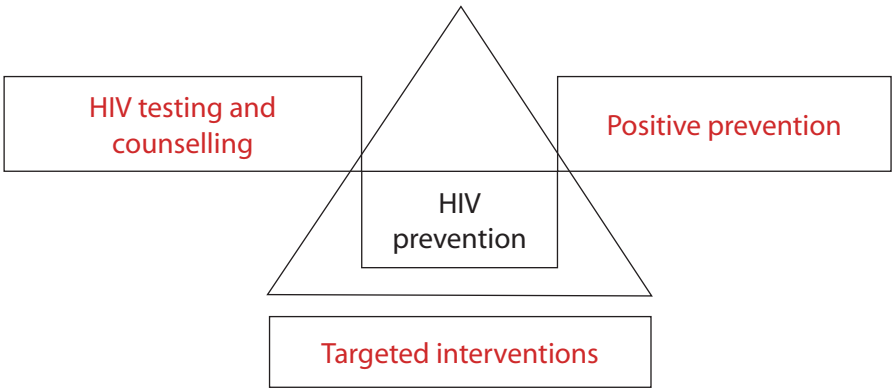
- Prevention strategies for persons living with HIV/AIDS (PLWHA)
- Key strategies for prevention among HIV-positive IDUs

Training materials:

- PowerPoint presentation 11.4: Prevention strategies for HIV-positive IDUs
- Sub-module 11.4: Prevention strategies for HIV-positive IDUs

PREVENTION STRATEGIES FOR PERSONS LIVING WITH HIV/AIDS (PLWHA)

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 (VCT) and referral services
3. Prevention activities directed at improving the health of persons living with HIV and AIDS (PLWHA) to prevent further transmission (positive prevention)

Prevention activities directed at persons at high risk for contracting HIV (targeted interventions)

Persons at high risk for contracting HIV include:

- Sex workers
- Injecting drug users (IDUs)
- Men who have sex with men (MSM)
- Persons with multiple sex partners
- Persons having unprotected sex

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

- Behaviour change communication (BCC)
- Control of sexually transmitted infections (STIs)
- VCT
- Harm reduction programmes for IDUs
- Interventions for prevention of mother-to-child transmission (PMTCT)
- Blood safety measures
- Infection control in health-care settings
- Structural interventions to alter the environment in ways that promote risk reduction

Behavioural interventions substantially reduce sexual risk among young adults, MSM, heterosexual men and women, and IDUs. They are also cost-effective.

HIV counselling, testing and referral services

PRACTICAL POINT = THE THREE Cs

HIV testing should

- Only be conducted with **consent** (i.e. both informed and voluntary)
- Be accompanied by **counselling**
- Be confidential. The HIV test result should only be disclosed to the client ensuring **confidentiality** of the test result.

HIV testing and counselling consists of three steps:

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

HIV counselling and testing:

- Reduces risk among persons who learn that they are HIV seropositive
- Increases condom use
- Decreases the incidence of new STIs among HIV-seronegative patients

The availability of rapid tests has made it easier to provide HIV testing in a wide range of clinical and non-traditional 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 PLWHA to prevent further transmission

Interventions targeting PLWHA are an important component of HIV prevention and should be promoted.

What prevention should be used by for HIV-positive IDUs?

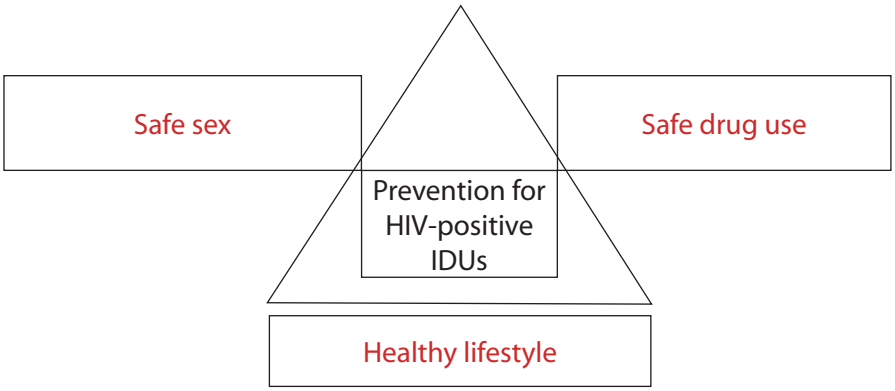
- Prevention among those who are HIV positive emphasizes positive choices.
- Positive prevention optimizes the health and well-being of HIV-positive people by:
  - Promoting risk-reduction activities
  - Promoting healthy lifestyle choices

Is prevention for HIV-positive people only about sexual behaviour?

Prevention for those who are HIV positive focuses on two main areas:

1. Sexual behaviour
2. Injecting drug use

HIV-positive individuals should practise general prevention for all illnesses – infectious and non-infectious.



Aims of prevention for HIV-positive IDUs include:

- How to avoid infecting others with HIV
- How to avoid getting STIs (such as herpes, gonorrhoea, syphilis, chlamydia, etc.)
- How to avoid other bloodborne illnesses (e.g. hepatitis C and hepatitis B)
- How to remain healthy

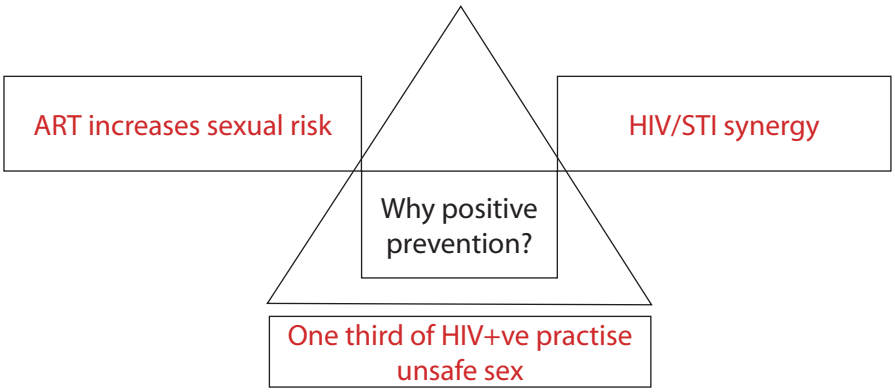
Why is prevention needed for HIV-positive IDUs?

Public health principle

A public health approach to the prevention of infectious diseases is to target the infected for prevention efforts. This is more efficient in preventing HIV transmission because in every case of HIV transmission an HIV-infected individual is involved.

Reasons for prevention interventions for HIV-positive persons

- One third of HIV-positive people have unprotected anal or vaginal sex.
- There is significant synergy between HIV and STIs. This means that in the presence of STIs, the transmission potential becomes greater among HIV-infected individuals. Reducing the prevalence of STIs in people with HIV will help reduce the spread of HIV itself.
- The availability of 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 for decades. Treatment optimism thus generated has at times led to unprotected sex.
- Multidrug resistance and HIV superinfection strongly suggest the need for 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 so that positive prevention is implemented effectively. 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. Since there is no "one fix fits all" solution, interventions should be developed to target the diversity of populations.

KEY STRATEGIES FOR PREVENTION AMONG HIV-POSITIVE IDUs

Principles of positive prevention

The five principles of positive prevention are:

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

Empowerment: Combine strategies to create enabling environments that facilitate the empowerment of people with HIV. Recognize that the behaviour of people with HIV is influenced by the context in which they live 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: 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. PLWHA 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 "sex-positive" approaches. Communities must be sensitive to the emotional and sexual needs of positive persons.

Positive prevention is grounded in five core values:

1. To promote the recognition that PLWHA are part of the solution to the impacts of the disease and should be included in prevention efforts.
2. To encourage the involvement of PLWHA in all aspects of health promotion and prevention activities.
3. To develop health communication and prevention strategies targeted at PLWHA, and to promote risk/harm reduction behaviours and activities.
4. To protect and promote human rights and dignity for PLWHA, including the right to privacy, health care, confidentiality, informed consent and freedom from discrimination.
5. To ensure programmes and services are available, accessible and relevant to the diverse populations of PLWHA.

Key strategies

1. Promoting VCT
2. Providing post-test 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 serodiscordant couples

Levels of intervention

1. Individual-level interventions
2. Couple-level interventions
3. Community-level interventions
4. Advocacy

Individual-level interventions

- VCT for early identification of HIV infection
- ART to HIV-positive individuals at the appropriate time
- Safe sex and safe drug use counselling for PLWHA
- PMTCT

Couple-level interventions

- Reaching sex partners through outreach
- Couple counselling
  - Seroconcordant 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–STI risk reduction behaviours.

1. Increase the number of HIV-infected persons who know their serostatus

- Create campaigns to emphasize the 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 care providers of high-risk persons on the 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 the use of rapid tests.
- Increase voluntary testing in health-care facilities.
- Increase voluntary testing of pregnant women.
- Increase voluntary testing in prisons.
- Increase voluntary testing among sex and needle-sharing partners of HIV-infected persons.

2. Increase the use of services

- Increase links between prevention and care programmes.
- Improve access to HIV/AIDS care through community-based organizations.
- Link prisoners to care and prevention services both pre- and post release.
- Increase the proportion of pregnant women receiving antenatal care.

3. Increase the quality of care and treatment

- Increase the proportion of HIV-infected pregnant women receiving ART.
- Educate health-care workers and HIV-infected persons about HIV/AIDS treatment.
- Monitor and evaluate the 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 (DOT).
- Monitor adherence to therapy.
- Monitor ARV drug resistance.

5. Increase the number of individuals with HIV who adopt and sustain HIV–STI risk reduction behaviours

- Increase the availability of prevention services for individuals with HIV (e.g. counselling, prevention case management, peer opinion leader, small-group interventions).
- Develop, implement and evaluate specific risk-reduction strategies for individuals with HIV.
- Monitor behaviours and outcomes in individuals with HIV.
- Teach health-care providers to perform HIV and STI risk assessment for their HIV-positive patients.
- Increase STI 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 dependence treatment.

REFERENCES AND RECOMMENDED READING

Centers for Disease Control and Prevention. Advancing HIV prevention: new strategies for a changing epidemic – United States, 2003. *Morbidity and Mortality Weekly Report*, 2003, 52:329–332.

DiClemente RJ, Wingood GM, del Rio C, Crosby RA. Prevention interventions for HIV positive individuals. [Editorial]. *Sexually Transmitted Infections*, 2002, 78:393–395.

Frieden TR et al. Applying public health principles to the HIV epidemic. *New England Journal of Medicine*, 2005, 353:2397–2402.

International HIV/AIDS Alliance. *Positive prevention: prevention strategies for people with HIV/AIDS*. Draft background paper. International HIV/AIDS Alliance, 2003 (http://www.aidsalliance.org/sw9438.asp).

Annex 1

Evidence-based counselling and psychotherapies

Please ensure clients are referred to professional therapists with sound training. Therapists should have received training in the management of substance use disorders and in utilizing specific therapies with substance-using clients.

Cognitive and/or behavioural therapies are psychological approaches based on scientific principles and have been shown to be effective for a wide range of problems. Clients and therapists work together once a therapeutic alliance has been formed, to identify and understand problems in terms of the relationship between thoughts, feelings and behaviour. The approach usually focuses on difficulties in the here and now, and relies on the therapist and client developing a shared view of the individual's problem. This leads to identification of personalized, usually time-limited therapy goals and strategies that are continually monitored and evaluated. The treatments are inherently empowering in nature, the outcome being to focus on specific psychological and practical skills (e.g. in reflecting on and exploring the meaning attributed to events and situations and re-evaluation of those meanings) aimed at enabling the client to tackle their problems by harnessing their own resources. The acquisition and utilization of such skills is seen as the main goal and the active component in promoting change with an emphasis on putting what has been learned into practice between sessions ("homework"). Thus, the overall aim is for individuals to attribute improvement in their problems to their own efforts, in collaboration with the psychotherapist. The effectiveness of cognitive and/or behavioural therapies is supported by evidence from randomized controlled trials, uncontrolled trials, case series and case studies.

Interpersonal therapy is a short-term supportive psychotherapy that focuses on the connection between interactions among people and the development of a person's psychiatric symptoms. Interpersonal therapy was initially developed to treat adult depression. It has since been applied to the treatment of depression in adolescents, the elderly and people with HIV infection. There is a conjoint (couple) therapy for people whose marital disputes contribute to depressive episodes. Interpersonal therapy has also been modified for the treatment of a number of disorders, including substance use, bulimia and anorexia nervosa, bipolar disorder and dysthymia.

Family therapy is a type of psychotherapy designed to identify family patterns that contribute to a behaviour disorder or mental illness and help family members break those habits. Family therapy involves discussion and problem-solving sessions with the family. Some of these sessions may be carried out as a group, in couples, or one on one. In family therapy, the web of interpersonal relationships is examined, and ideally, communication is strengthened within the family.

Motivational interviewing is a therapeutic technique related to decision-making (i.e. aimed at the individual, internal factors). Motivational interviewing is based on Prochaska and DiClemente's Stages of Change Theory, a broad, conceptual model that was initially developed for smokers and has a strong evidence base for treating addictive and entrenched behaviours. The stages of change that are most focused upon in motivational interviewing are *contemplation* and *determination*, the stages at which most people are likely to opt for treatment.

It is important for clients to understand stages of change. If clients understand that the chances of success often increase with the number of attempts, they are more likely to see relapse as a

part of the treatment process and not total failure. Therapists should use interventions that are appropriate to a client's stage of change. Mismatching interventions to stages of change can increase resistance to treatment.

Psychodynamic psychotherapy is a long-term method of treatment, with in-depth exploration of past family relationships as they were perceived during the client's infancy, childhood and adolescence. Emphasis is on the unconscious and childhood experiences. Symptoms and personal difficulties are regarded as arising from deep, unresolved personality or character problems. There is a lack of empirical evidence on whether this form of therapy is effective with substance use problems.

Source: The material provided above was adapted from the following sources.

1) Alliance CBT. *Understanding CBT.* http://alliancecbt.co.uk/cbt.html (accessed on 24 February 2006).

2) Brehm NM, Khantzian EJ. A psychodynamic perspective. In: Washton AM, ed. *Psychotherapy and substance abuse: a practitioner's handbook*. New York, Guilford Press, 1995.

3) Lowinson Jh, Ruiz P, Millman RB, Langrod J, eds. *Substance abuse: a comprehensive textbook*. 2nd ed. Baltimore: Williams & Wilkins, 1992: 106–117.

4) Miller WR, Rollnick S. *Motivational interviewing: preparing people to change addictive behavior*. New York Guilford Press, 1991.

5) WEBMED Online Medical Dictionary
http://www.medterms.com/script/main/art.asp?articlekey=33207

Annex 2

Seven essential elements of sexual health

WHO promotes a comprehensive concept of sexual health, including the elements of pleasure, non-exploitation and social good, with the absence of infection or other medical conditions. It can be paraphrased as the combination of the physical, emotional, intellectual and social parts of sex in a way that makes sex a positive experience, helps us in our relationships, improves the quality of our lives, makes us better people and our society a better place to live. Specifically, WHO outlines seven essential elements or criteria for sexual health:

1. The ability to enjoy and effectively manage sexual and procreative behaviour in ways that are compatible with personal beliefs and identity and congruent with societal core values.
2. Freedom from sexual fears, shame, guilt, inaccurate beliefs and sexual myths that can inhibit sexual expression and damage sexual relationships.
3. Absence of infections, conditions and dysfunctions that interfere with sexual expression and reproductive potential.
4. The conviction that one's personal and social behaviours are congruent with one's gender identity, and a sense of comfort with a range of sex role behaviours.
5. The ability to carry on effective interpersonal relationships with members of both sexes, including the potential for love and long-term commitment.
6. The capacity to respond to erotic stimulation in such a way to make sexual activity – including any activity that is not harmful or exploitive – a positive, pleasurable aspect of one's experience.
7. The maturity of judgement to make rewarding decisions about one's sexual behaviour that do not conflict with one's overall value system and beliefs about life.

Annex 3

Presentation 11.1: HIV and psychiatric illness

HIV and psychiatric illness

Session objectives

- Describe the neuropsychiatric conditions associated with HIV infection
- Understand the clinical features of neuropsychiatric conditions associated with HIV infection
- Know the treatment options for the neuro-psychiatric conditions associated with HIV infection

Psychiatric illness as a risk for HIV

- Drug use and dependence
  - Injecting drug use
  - Amphetamine-type stimulant (ATS) use
  - Alcohol use
  - Other drug use
- Bipolar disorder
  - Mania
  - Depression
- Chronic mental illness

HIV-related psychiatric disorders

- Mood disorders
  - *Depression*
  - Mania
- *Anxiety disorders*
  - Generalized anxiety disorders
  - Panic disorders
- Adjustment disorders
- Psychosis
- Substance use
- Organic mental disorders
  - *Minor cognitive disorders*
  - *HIV-associated dementia*
  - Delirium

(Common psychiatric disorders are underlined)

Depression – risk factors

History of prior mood disorder
Prior suicide attempt
Family history of depression or suicide
Inadequate social support
Non-disclosure of HIV status
Recent loss (occupation, family)
Multiple losses
Advancing illness
Treatment failure
Hepatitis C treatment with interferon

Depression – common clinical features

- Mood symptoms
  - Sadness; crying
- Bodily symptoms
  - Pain
  - Sleep disturbance
  - Easy fatiguability
  - Loss of appetite
  - Loss of weight
  - Constipation
  - Loss of libido
  - Difficulty concentrating
- Thought symptoms
  - Guilt
  - Pessimism
  - Worthlessness
  - Hopelessness
  - Suicidal ideas
- Behaviour symptoms
  - Lack of interest in pleasurable activities
  - Reduced activity
  - Social withdrawal

Treatment of depression: antidepressants

- SSRIs
  - Preferred class of drugs as side-effects are minimal
  - Drugs include:
    - fluoxetine, sertraline, citalopram, paroxetine
- Tricyclic drugs
  - Drugs include: amitryptiline and imipramine
  - Side-effects – anticholinergic
  - Useful in case of neuropathic pain (e.g. amitryptiline)
- Other drugs
  - Mirtazapine in case of severe loss of appetite
  - Bupropion in case of co-morbid smoking
  - Drug interactions with venlafaxine (SNRI) less than that with many SSRIs

Commonly used antidepressants

Drug	Daily dose	Possible positive effects	Possible negative effects
Fluoxetine	10–20 mg	Easy administration; non-sedating	Insomnia, agitation, nausea, headache
Citalopram	10–20 mg	Easy administration; less drug–drug interactions	Mild nausea
Amitryptiline	25–150 mg	Useful in neuropathic pain	Anticholinergic side-effects (dryness, constipation, urinary retention)
Sertraline	50–100 mg	Less drug–drug interaction compared with fluoxetine	Insomnia, agitation, nausea, headache

Treatment of depression

- Pharmacotherapy (medication) is the mainstay of treatment for major depression.
- A general rule is to start with low doses of any medication, titrating up to a full dose slowly, in order to minimize early side-effects that may act as obstacles to adherence.
- Adequate dose is critical to good response.
- For the first episode, drugs need to be continued for a minimum of six months.

Reasons for referral to psychiatric services

- Suicidal ideas, wishes or behaviour
- Presence of psychotic symptoms (irrelevant talk, bizarre behaviour, delusional thinking)
- Severe symptoms impairing the functioning of the individual significantly
- Bipolar depression
- Not responding to treatment favourably

Treatment of depression: patient information

- No single antidepressant is superior in treating HIV-infected patients.
- Patient adherence to regimens is critical.
- Adequate doses of antidepressants offer the best chance for improvement.
- Drugs used to treat depression are not dependence inducing.
- Clinical response takes up to 3 weeks; but symptoms such as sleep improve within 2–3 days.
- Side-effects diminish in 7–10 days.
- Consult a doctor before stopping antidepressants.

Anxiety: clinical features

- Psychological symptoms:
  - Excessive worrying
  - Feeling nervous
  - Fear for no reason, excessive fear in familiar situations
  - Inability to relax
- Physical symptoms:
  - Restlessness
  - Easy fatigurability
  - Difficulty in concentrating or mind going blank
  - Irritability
  - Muscle tension
  - Tension headaches
  - Sleep disturbances

Anxiety

Treatment

- Relaxation exercises
- Short-term anti-anxiety drugs (clonazepam, SSRI)
- Supportive psychotherapy

Panic disorder: clinical features

- Subjective symptoms:
  - Panic attacks lasting about 10 minutes
  - Dizziness, faintness, or feeling of unsteadiness
  - Fear of dying
  - Fear of going crazy or losing control
  - Hot flashes or chills
  - Depersonalization or derealization
  - Nausea or abdominal distress
  - Numbness or tingling sensations
- Subjective symptoms:
  - Chest pain or discomfort
  - Palpitations or accelerated heart rate
  - Sensation of choking
  - Shortness of breath or smothering sensation
  - Sweating
  - Trembling or shaking
- In the absence of physical illness, four or more of the above symptoms with panic attacks are diagnostic of panic disorder

Panic disorder

Treatment

- SSRIs (fluoxetine, sertraline, citalopram)
- Tricyclics in small doses (amitryptiline, imipramine)
- Benzodiazepines (short half-life benzodiazepines [e.g. clonazepam] only for a short period for acute symptom relief)
- Venlafaxine timed-release formulation can be useful
- Relaxation therapy and cognitive–behavioural interventions

Management of insomnia

- Increase daily exercise to at least 30 minutes at moderate intensity (not in the evening)
- Avoid daytime napping
- Avoid caffeine; reduce or stop alcohol intake
- Use the bed only for sleeping and sexual activity
- Use relaxation techniques prior to sleep (e.g. progressive muscle relaxation)
- Develop a regular routine of rising and retiring at the same time each day
- If hypnotics are advised, prescribe only for a short time

Mild cognitive disturbance

At least two of the following symptoms should be present:

- Impaired attention, concentration or memory
- Mental and psychomotor slowing
- Personality changes

HIV-associated dementia

Dementia is characterized by a reduced level of consciousness with:

- Serious memory problems
- Slowed thinking with trouble paying attention
- Reduced speed of information processing
- Impaired executive functioning (e.g. abstraction, divided attention, shifting cognitive sets)

Late manifestations may include:

- Visuospatial difficulties
- Language problems
- Apraxias

Treatment of HIV-associated dementia

- Rule out treatable (reversible) dementias (e.g. hypothyroidism, chronic subdural haematoma, normal pressure hydrocephalus)
- Rule out pseudodementia (major depression mimics dementia)
- HIV-associated dementia improves with ART
- Work closely with family members to advise them of the treatment options and prognosis

Delirium

Delirium is characterized by a fluctuating level of consciousness and:

- Recent onset of confusion
- Difficulty in speaking
- Disorientation in place or time
- Restlessness and agitation
- Reduced level of consciousness

Treatment: delirium

- Consider substance use (alcohol)-related delirium and manage accordingly
- If agitated and not alcohol or drug intoxicated, give low-dose sedation with haloperidol
- HIV-related delirium improves with ART

Psychotic disorders

Clinical features:

- Bizarre and uncooperative behaviour
- Irrelevant, often nonsensical speech
- Agitation and violence
- Auditory hallucinations or internal dialogue

Refer to a psychiatrist.

Annex 4

Presentation 11.2: Psychological and social support for HIV-positive IDUs

Psychological and social support for HIV-infected IDUs

Session objectives

- Identify the psychosocial care needs of IDUs across the continuum of HIV disease
- Discuss the different roles and contributions of members of the care team
- Describe HIV-related neuropsychiatric conditions
- Understand the training requirements of psychosocial care providers

Addressing psychosocial needs of IDUs living with HIV

- The psychosocial issues are dynamic and vary across different stages of the disease continuum
- Demands continuous assessment, evaluation and support planning
  - Organic HIV-related mood, cognitive and motor changes
  - Drug use-related mood, cognitive and psychosocial problems (e.g. impulse control)
  - Social and relationship challenges related to HIV infection, drug use and any criminal charges

Activity 1

Brief large group discussion

- What are the key psychosocial support needs of IDUs living with HIV?
- What are the primary barriers to meeting these needs?

Common issues for IDUs – 1

- Confidentiality – IDUs do not "deserve a lesser standard"
- Difficulty accepting diagnosis:
  - Denial related to poor testing procedure
  - Competing health and social problems
  - Self-blame and projected blame
- Disclosure, discrimination and stigma
- Emotional reactions – shock, denial, depression, anger, fear, guilt, depression, anxiety, suicidal thoughts; potential accidental overdose

Common issues for IDUs – 2

- Disease progression and late diagnosis
  - Often illness/deterioration in health at the time of diagnosis
- Changes in physical appearance
  - Impact on how they are treated in the community and in health settings
- HIV represents further loss of control
  - Less power in health settings
  - Now powerless over both addiction and HIV
- Death and dying
  - Confronts motivation for sustained modification of drug use
- Loss and grief
  - Multiple loss – many friends and acquaintances may have died either from HIV or overdose

Common issues for IDUs – 3

- Relationships – partner, family, friends and children – strained by drug use
- Financial difficulties
- Welfare – income/employment/housing
- Accommodation
- Sexual difficulties – drug- and HIV-related
- Employment difficulties/loss of job
- Treatment issues – access, adherence, side-effects

Interventions

- Psychosocial care encompasses a range of interventions that address the social and psychological issues and needs of PLWHA and their significant others.
- Interventions can assist clients to:
  - Develop a support network
  - Experience autonomy
  - Gain a sense of control
- Counsellors or "service organization coordinators" play an integral role in facilitating interventions and care across the HIV disease continuum.

HIV/HCV drug use-related mood disorders

- A substantial increase in the frequency of major depression and suicide in HIV/HCV IDUs
  - Higher rates than PLWHA who do not inject
- The provision of appropriate mental health support
  - Psychiatric (antidepressant therapy)
  - Psychological inputs (cognitive–behavioural therapy, etc.)
  - Peer support
  - Family and partner counselling

Evidenced-based psychotherapies for managing substance use

The following may be used alone or in conjunction with OST and abstinence programmes:

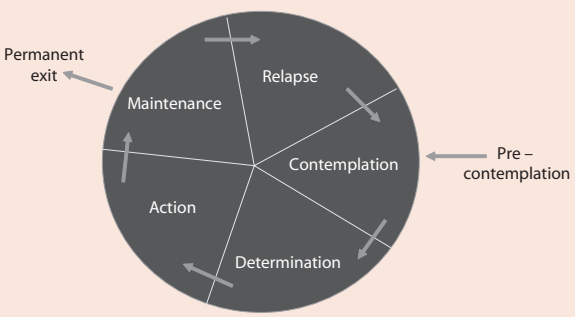
- Cognitive–behavioral therapies (CBT)
- Motivational interviewing – stages of change
- Brief structured therapy
- Interpersonal therapy
- Family therapy

Must be provided by a registered, qualified practitioner

Counselling

- Motivational interviewing
  - Requires specific training and professional distance
  - Development of cognitive dissonance
  - Demonstrated to improve OST impact on heroin use
  - Brief interventions also demonstrated to have impact on:
    - Alcohol use
    - Cannabis use
- May be helpful for adherence
  - Coupled with assertive outreach
  - Phone or SMS reminder for appointments

Stages of change



Source: DiClemente and Prochaska. *Addiction and Behavior*, 1982

Client's stage of change – appropriate motivational strategies for the clinician – 1

Pre-contemplation
The client is not yet considering change or is unwilling or unable to change.

Action
- Establish rapport, ask permission and build trust
- Raise doubts or concerns in the client about substance-using patterns
- Express concern and keep the door open

Client's stage of change – appropriate motivational strategies for the clinician – 2

Contemplation
The client acknowledges concerns and is considering the possibility of change but is ambivalent and uncertain.

Action
- Normalize ambivalence
- Help the client "tip the decisional balance scales" toward change
- Elicit and summarize self-motivational statements of intent and commitment from the client
- Elicit ideas regarding the client's perceived self-efficacy and expectations regarding treatment

Client's stage of change – appropriate motivational strategies for the clinician – 3

Preparation
The client is committed to and planning to make a change in the near future but is still considering what to do.

Action
- Explore treatment expectancies and the client's role
- Clarify the client's own goals
- Negotiate a change (or treatment) plan and behaviour contract
- Consider and lower barriers to change
- Help the client enlist social support

Client's stage of change – appropriate motivational strategies for the clinician – 4

Action
The client is actively taking steps to change but has not yet reached a stable state.

Action
- Engage the client in treatment and reinforce the importance of remaining in recovery
- Acknowledge difficulties for the client in early stages of change
- Help the client identify high-risk situations through a functional analysis and develop appropriate coping strategies to overcome these

Self-help groups

- Narcotics Anonymous/Alcoholics Anonymous
- "Rational recovery"
  - Peer support networks
  - Meet regularly to provide safe social context
  - Self-selection important
  - *Involvement* (versus just attendance) in weekly meetings appears critical
  - Unselected referrals little better than placebo

Peer group support

- The slow establishment of a stable non-drug-using network heralds recovery from dependence.
  - Very difficult to initiate
  - Many become involved in helping other users
    - Peer outreach workers
    - Slow transition from client to staff member of health service
    - High risk of relapse for many years if stays working in drug sector
- Loneliness, boredom and social isolation powerful triggers for relapse

Other critical strategies

- Employment
- Facilitating relationships
- Accommodation

Miscellaneous aids to recovery

Please be aware of the specific cautions

- Learning alternative recreation
- Restoring general health, physique and fitness
- Dental health
- Recovery of libido and sexuality (be aware of HIV-related sexual dysfunction and impact of risk reduction)
- Finding a voice for opinions and peers
  - Writing
  - Public speaking
  - Research
- Spirituality
  - Religion
  - Meditation (screen for depression, neurological disorders)
  - Yoga (screen for motor, neurological impairment)
  - Appreciation of the environment

Why provide psychosocial care and support to IDUs?

- Ethical "duty of care" – avoid concepts of *deserving* and *undeserving* when providing care
- Client perceptions of being *well-supported* by providers associated with:
  - Better patient–provider relationships
  - Improved treatment adherence
  - Commitment to transmission reduction
  - Lower rates of relapse to substance use

Social issues

- The following social issues frequently characterize many drug users' lives and represent challenges to effective HIV prevention, care and treatment:
  - Social instability
  - Poverty
  - Experience of human rights violations
  - Poor patient–health provider relationships

Additional support is required for PLWHA who are incarcerated

- Physical and sexual assault
- Depression
- Suicide
- Unsafe injecting drug use and infection with and transmission of TB, hepatitis B and C, and HIV
- Increased risk of overdose after release from prison
- Breaks in the continuity of medical and psychosocial support
- Release from controlled environment – often to "no or limited" support

Former IDUs often have unique success in:

Educating and motivating current IDUs to take steps to:

- Access effective care
- Prepare patients for possible side-effects associated with ARV drugs
- Support drug adherence

Social and legal support

Community involvement and household assistance to mitigate the impact of HIV/AIDS are examples of social support.

- Food support
- Volunteers for daily duties
- Orphan support
- Welfare services
- Legal support

Faith-based organizations(FBOs)

Throughout the region we see FBOs offer:

- Palliative care to individuals with no families
- Drug treatment services
- Home-based care and buddies
- Re-engagement of families with the IDU PLWHA
- Food distribution
- Transport-to-treatment services
- Pastoral care

Training needs

- Mental health professionals – training in HIV mental health issues
- Drug and alcohol staff – HIV clinical awareness and mental training
- HIV medical and counselling staff – orientation to substance use and dependency
- Caregivers in custodial settings – orientation to drug and alcohol dependency, HIV clinical disease progression, and related psychosocial issues
- Inpatient staff and families, volunteers – managing challenging behaviours and infection control procedures
- Peer support facilitator training

Activity 2

For the case study in Sub-module 11.2, exercise 11.2:

- What are the key issues for the client/patient?
- What strategies would you use to address each of the issues identified?

Care services + linkages = successful treatment of IDU

Four types of interrelated and linked services are crucial in the treatment of substance dependence and HIV/AIDS. These are:

- General medical care and/or infectious disease clinics
- Harm reduction
- Drug dependence treatment
- Psychosocial support

WHO favours a multidisciplinary approach

- Clinician (physician or other medical practitioner – e.g. infectious diseases specialist)
- Medical nurse
- Social worker
- Counselling staff
- Substance dependence specialists (e.g. psychiatrist and/or psychologist and/or drug and alcohol specialist)
- Involvement of PLWHA, especially former drug users

Address both the biomedical needs and psychosocial issues of IDUs

Range of psychosocial support services:

- Support services for adherence to ART
- Psychological support/counselling, group therapy for IDUs and family members
- Peer support groups
- Educational programmes
- Psychiatric services for psychotic disorders or severe depression
- Social services to deal with discriminatory and other issues

Support for families and caregivers

- Counsellors can offer support for partner and/or family disclosure:
  - Client discloses alone:
    - Counsellor rehearses the client in initiating the disclosure and managing partner reactions
  - Client discloses to partner in presence of counsellor
  - Client is present while counsellor discloses
  - Client authorizes counsellor to disclose on her/his behalf
  - Client authorizes a key community member or relative to disclose on her/his behalf
    - Counsellor supports the process by planning with the client

Counselling for disclosure

- Disclosure of HIV status to families and friends may support adherence to treatment and reduce HIV transmission.
- It should be done with the consent of the client.
- However, it may be counterproductive to coerce such disclosure.
- Counsellors can discuss disclosure options, explore barriers to disclosure, and rehearse disclosure strategies with clients.

Support for families and caregivers

- Specific advice on how to manage challenging client behaviour
- Many of these present challenges to inpatient care and treatment (e.g. short-term memory problems, agitated wandering)
- Staff and family can be provided simple ways to prompt memory and redirect attention

Caring for PLWHA with challenging behaviour

- Need to educate staff, caregivers and families about:
  - The organic nature of these conditions (HIV/HCV or drug use, or treatment-related)
  - How to respond in an adaptive manner to these challenges

Annex 5

Presentation 11.3: Sexual health

Sexual health

Session objectives

- Understand the WHO comprehensive concept of sexual health
- Be familiar with sexual health issues in IDU populations
- Understand the general principles of sexual health care for female IDUs
- Understand the general principles of sexual health care for male IDUs
- Understand the approaches to promoting safer sexual behaviour among IDUs

WHO definition of sexual health

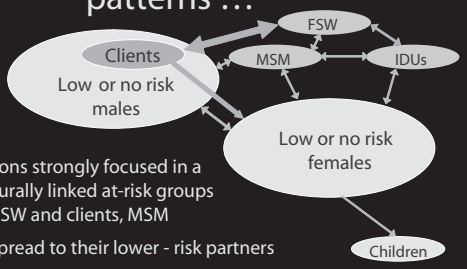
Sexually healthy people:

- Have accurate sexual knowledge so they can enjoy happy relationships and satisfying sexual activity
- Know how to avoid STIs, and seek effective treatment if they have symptoms
- Know how to plan for a pregnancy and how to avoid unintended pregnancy
- Manage their sexual relationships so that their emotional and sexual needs are met without causing harm to other people

Sexual health of IDUs

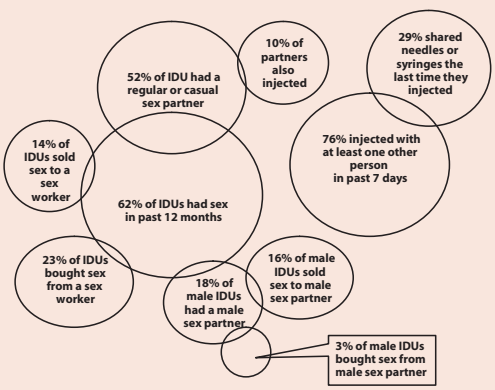
- Sexual health issues for IDUs and their sexual partners are similar to those faced by non-IDUs
- Sexual health services for IDUs provide a public health benefit
  - IDU populations have a high prevalence of HIV
  - IDUs are sexually active
  - Sexual health services can:
    - Increase consistent condom use
    - Reduce rates of STIs
    - Reduce unintended pregnancies among female IDUs and female partners of male IDUs

Asian epidemics all follow similar patterns …



- New infections strongly focused in a few behaviourally linked at-risk groups - IDUs, FSW and clients, MSM
- And then spread to their lower - risk partners

Population interactions: IDUs in Cebu have a great deal of sexual and drug use contact with other groups



Source: Department of Health, the Philippines, 2005.

Sexual health – four areas of vulnerability – 1

1. May not have accurate sexual knowledge

2. IDU populations are vulnerable to higher rates of STIs
   - Higher rates of selling sex (to buy drugs)
   - Male IDUs buy sex
   - Low rates of consistent condom use
   - Multiple sexual partners
   - Intoxication may increase risky behaviour
   - Barriers in access to quality STI services

Sexual health – four areas of vulnerability – 2

3. Female IDUs have less control of their reproductive health
   - Exchanging sex for drugs
   - Poor access to effective contraception
   - Stigma – barrier to accessing contraception and antenatal care
   - Lack of supportive partner
4. Male and female IDUs are vulnerable to sexual violence
   - Exchanging sex for drugs or money
   - IDUs report high rates of sexual assault by partners, drug dealers, police and other prisoners (when in prison)
   - More likely to be in dangerous venues and areas

Indicators

Indicators of poor sexual health among IDUs and their partners

- STI
- Unintended pregnancy
- Sexual assault
  - Survivor
  - Perpetrator
- Physical or emotional violence with partner
- Sexual dysfunction – including drug-related

End results

End results of poor sexual health among IDUs and their partners:

- Relationship problems and stress
- Pelvic inflammatory disease (PID)
  - Chronic pelvic pain and pain during sex
  - Infertility
  - Ectopic pregnancy, poor pregnancy outcome
- Neonatal health problems (syphilis, HIV, chlamydia, gonorrhoea)
- Cancer related to HPV (cervix, anorectum, vulva, penis)
- Death due to HIV or cancer
- Significant costs to community and government

Higher rates of STIs

Bacterial STIs

- Gonorrhoea
- Chlamydia
- Syphilis
- Chancroid
- Donovanosis
- Lymphogranuloma venereum

Higher rates of STIs

Viral STIs

- Herpes simplex
- Hepatitis B
- Hepatitis A
- Hepatitis C
- Human papillomavirus
- Molluscum contagiosum
- Human immunodeficiency virus

Higher rates of STIs

Other STIs

- Protozoa trichomoniasis
- Fungi candidiasis
- Infestations pubic lice and scabies

General principles of STI management for IDUs

- Syndromic-plus
- Treat when presents
- People can have more than one STI
- STIs can be present in more than one part of the body – cervix, throat, anus, urethra
- STIs always involve >1 person – treat partner
- Syphilis can be transmitted through injecting equipment
- Self-collection of samples may ↑ uptake

Sexual health care for female IDUs – 1

- History of sexual violence (vaginal or anal rape)
  - Post-exposure prophylaxis (PEP)
  - Emergency contraception
  - Counselling and support
- Sex work (receptive oral, vaginal, anal sex)
  - WHO or national STI guidelines
  - STI screening (throat, cervix, anus)
  - Condom use
- Contraceptive needs
  - Oral contraception may be difficult
  - Injectable or implantable
  - Condom use

Sexual health care for female IDUs – 2

- Vaginal health
  - Douching→ inflammation→ facilitate transmission of HIV and STIs
  - Recurrent candidiasis
    - Immune deficiency
    - Self-administered prophylactic antibiotics
  - Vaginal discharge is normal
  - Abnormal vaginal discharge – bacterial vaginosis
  - Trichomoniasis is an STI
- Cervical health
  - Regular Papanicolaou (Pap) smears (HPV and cervical cancer)
  - Cervical infections – chlamydia and gonorrhoea

Sexual health care for female IDUs – 3

- Herpes simplex 1 and 2
  - More common among sex workers and PLWHA
  - HSV → subclinical
  - Transmission through asymptomatic viral shedding
  - Suppressive therapy for those with regular episodes
- Pelvic pain
  - STI-related PID

Sexual health care for male IDUs – 1

- History of sexual violence (anal rape)
  - **PEP**
  - **Counselling and support**
- Sex work (receptive oral, vaginal, anal sex)
  - **WHO or national STI guidelines for male sex workers**
  - **STI screening (throat, anus, urethra)**
  - **Condom use**
- History male-to-male sex (insertive or receptive)
  - **Condom use**
  - **Lubricant**

Sexual health care for male IDUs – 2

- Herpes simplex 1 and 2
  - More common among sex workers and PLWHA
  - HSV → sub clinical
  - Transmission through asymptomatic viral shedding
  - Suppressive therapy for those with regular episodes
- Penile health
  - Risk of HIV and STI higher in uncircumcised men
  - Added motivation to use condoms
  - Penile size enhancers? inflammation and abrasions?
  - Penile accessories can cause trauma in receptive partner

Sexual health services for IDUs

- Information on STIs and HIV – peer educators as well as health professionals
- IDU peer educators employed to work in sexual health
- Condoms at all IDU programme sites
- Skills development in how to use condoms correctly
- STI screening, diagnosis and treatment
- HIV counselling and testing (same day results)
- Referral to drug treatment services

Annex 6

Presentation 11.4: Prevention strategies for HIV-positive IDUs

Prevention strategies for HIV-positive IDUs

Session objectives

- Describe the significance of prevention strategies targeting HIV-positive IDUs
- Understand key prevention strategies for HIV-positive IDUs

HIV prevention strategies

- Interventions for persons at high risk for contracting HIV
- HIV counselling, testing and referral services
- Interventions for persons living with HIV

Source: CDC *MMWR Weekly*, June 2, 2006, 55: 597–603.

Prevention targeting persons living with HIV

- HIV-positive prevention emphasizes making positive choices.
- Positive prevention optimizes the health and well-being of HIV-positive people by:
  - Promoting risk reduction activities
  - Making healthy lifestyle choices

Prevention for HIV-positive IDUs

- Prevention for HIV-positive IDUs focuses on two main areas:
  1) Sexual behaviour
  2) Injection drug use
- HIV-positive individuals should practise general prevention for all illnesses – infectious and non-infectious

Key objectives of prevention strategies for HIV-positive IDUs

- How to avoid infecting others with HIV
- How to avoid getting sexually transmitted diseases (such as herpes, gonorrhoea, chlamydia, etc.)
- How to avoid other bloodborne illnessess (for example, hepatitis C and hepatitis B)
- How to remain healthy

Public health principle

Public health approach to prevention of infectious diseases is to target the infected for prevention efforts.

This approach is more efficient in preventing HIV transmissions.

Why prevention interventions for HIV-positive persons?

- One third of HIV-positive people have unprotected anal or vaginal sex
- Significant synergy between HIV and STIs – reducing the prevalence of STIs in people with HIV will help reduce the spread of HIV itself
- ART increases well-being
- Development of multidrug resistance and HIV superinfection

Source: DiClemente RJ, Wingood GM, del Rio C, Crosby RA. *Sexually Transmitted Infections*, 2002.

Sexual risk behaviour

Diverse array of biological, developmental, relational, social, psychological, cultural and environmental influences underlie the adoption and maintenance of sexual risk behaviour among HIV-positive persons.

Multiple-level interventions

- HIV-positive individuals are not a homogeneous population
- Subgroups based on a variety of dimensions (risk behaviours, sex, sexual orientation, race, geography, norms and values)
- Target the diversity of populations
- Consider the context in which interventions take place

Key strategies: counselling

- Promoting confidential voluntary counselling and testing (VCT)
- Providing post-test and ongoing counselling for positive people (e.g. safe sex, safe drug use)
- Encouraging beneficial disclosure and ethical partner notification
- Providing counselling for serodiscordant couples

Key strategies: levels of intervention

- Individual-level interventions
- Couple-level interventions
- Community-level interventions
- Advocacy

Individual-level interventions

- VCT
- ART
- Safe sex and safe drug use counselling
- Preventing mother-to-child transmission (PMTCT)

Couple-level interventions

- Reaching sex partners through outreach
- Couple counselling
  - Seroconcordant 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/STI risk reduction behaviour

Treatment and Care for HIV-Positive Injecting Drug Users

The "Treatment and Care for HIV-Positive Injecting Drug Users" training curriculum is designed for clinicians who provide treatment and care, including ART, for HIV-positive injecting drug users. The training curriculum consists of a trainer manual, 12 participant manuals, and a CD-ROM with PowerPoint presentations and reference articles. Topics covered in the curriculum include:

Module 1: Drug use and HIV in Asia
Module 2: Comprehensive services for injecting drug users
Module 3: Initial patient assessment
Module 4: Managing opioid dependence
Module 5: Managing non-opioid drug dependence
Module 6: Managing ART in injecting drug users
Module 7: Adherence counselling for injecting drug users
Module 8: Drug interactions
Module 9: Management of coinfections in HIV-positive injecting drug users
Module 10: Managing pain in HIV-infected injecting drug users
Module 11: Psychiatric illness, psychosocial care and sexual health
Module 12: Continuing medical education
Trainer manual

The ASEAN Secretariat
70A, Jl. Sisingamangaraja
Jakarta 12110
Indonesia
Phone: +62 21 724 3372, 726 2991
E-mail: public@aseansec.org

World Health Organization
Regional Office for South-East Asia
Mahatma Gandhi Marg
Indraprastha Estate, New Delhi - 110002
India
Phone: +91 11 233 70804
E-mail: hiv@searo.who.int
www.searo.who.int

Family Health International
Asia/Pacific Regional Office
19th Floor, Tower 3, Sindhorn Building
130-132 Wireless Road, Lumpini, Phatumwan
Bangkok 10330, Thailand
Phone: +662 263 2300
E-mail: sunee@fhibkk.org
www.fhi.org

ISBN 978 979 3496 63 4
978 979 3496 63 4