Module 3

Sub module 1: Targeted VCT intervention -Injecting drug users

Sub module 2: Targeted VCT Intervention - Sex workers

Sub module 3: Targeted VCT intervention -Youth and children

Sub module 4: Targeted VCT intervention - Men who have sex with men (MSM)

Sub module 5: Prevention of mother-to-child transmission

Sub module 6: Targeted VCT intervention – Mobile populations

Sub module 7: Targeted VCT intervention – Prisons

Module 3

Sub module 1: Targeted VCT intervention - Injecting drug users

Session objectives

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

- Identify the specific HIV transmission risk behaviours of IDUs
- Appreciate the need to adapt VCT to the specific needs of IDUs

Time to complete sub module

2 hours 30 minutes

Training materials

- PowerPoint presentation **(PPT18)**
- Flip chart, whiteboard or overhead transparencies
- Activity sheet **(AS19)**
- Handout **(HO17)**
- Question box
- Evaluation form collection box

Content

- Social and ethical issues in provision of VCT and care to IDUs
- Summary of the evidence of the effectiveness of VCT for IDUs
- Harm reduction/safe injecting combined with VCT
- Change in IDU clients' sexual risks after VCT
- Challenges relating to VCT sites and injecting drug users
- Challenges for HIV testing in drug treatment facilities
- Counsellor attitudes to working with IDUs
- Psychological impact of HIV on IDUs
- Post-VCT support and care considerations
- Health education and clinical interventions
- Evidence-based counselling interventions

Session instructions

1. *Activity*: Group discussion.
   - Ask the trainees to discuss their responses to the following:
     a. Why do people use drugs?
     b. Why do people inject drugs?
   - Using a flip chart, whiteboard or overhead transparencies, write down the trainee's responses.
2. Lecture with PowerPoint presentation **(PP18).**
3. *Activity:* Hand out to each participant a copy of **AS19.**
   - Ask the trainees to divide into three groups and allocate the activities as follows:
     a. Group 1: Brainstorm key issues and strategies for managing problems presented by IDUs at general VCT services.
     b. Group 2: You have been asked to establish a VCT service for IDUs. What staff training do you need? Consider needs of all levels of VCT staff (reception, blood collectors, counsellors, medical personnel).
     c. Group 3: Design a VCT pamphlet for street users. Include messages about safer sex, safe injecting and their relationship to HIV.
4. Ask the group if they have any questions and remind them about the "question box".
5. Ask trainees to complete an evaluation form and place it in the "evaluation form collection box".

Module 3

Sub module 1: Targeted VCT intervention - Injecting drug users

Session objectives

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

- Identify the specific HIV transmission risk behaviours of injecting drug users (IDUs)
- Appreciate the need to adapt VCT to the specific needs of IDUs

1. Introduction

IDUs inject drugs into veins, under the skin (skin popping), or inject substances intramuscularly (steriod injectors). Drug injecting is often conducted as a group activity between IDUs. A common practice is to use the same injecting paraphernalia syringe, needle, spoon, filter, and/or tourniquet, for all the members of the group. Sharing is also common among regular sexual partners. If one member of the group or a partner in a sexual relationship with a member of the group has HIV infection, and sharing of injecting paraphernalia occurs, the chances of infection spreading rapidly to other members of the group is extremely high. The chances of infection through the injecting route are much higher than sexual route of transmission. Thus, once HIV enters into a social network of IDUs, the spread within the IDU community can be explosive[1].

2. Injecting drug use and HIV in Asia

The UN regional taskforce on drug use and HIV vulnerability concludes that *"Drug users in Asia are highly vulnerable to HIV transmission because of the legal, political, socio-economic, health service and cultural situations in which they live"*.[2] The rates of opioid dependency and injecting drug use vary across countries and cultural settings in the Asian region. Data from regional studies can be found in the appendix at the end of this document.

Confirmed cases of HIV infection and of AIDS among IDUs are continuing to increase throughout the region. Several countries are now facing serious epidemics. The countries with the highest recorded HIV prevalence rates among IDUs are China, India, Indonesia, Iran[3], Malaysia, Myanmar, Nepal, Thailand and Vietnam.

The prevalence of HIV among IDUs has reached 60-90% in some countries within six months to a year after the first cases of HIV infection were detected. In some locations up to 60% of IDUs became infected in the first two years of the commencement of their injecting behaviour. The rates of seroprevalence among IDUs in the region are available in a table in the appendix of this document.[4]

Asian HIV outbreak amongst IDUs in Asia has had several consistent features[4]:

- They have been explosive: HIV prevalence among IDUs in Bangkok rose from 2 to 40% in six months in 1989 with clear links to incarceration

- They have been transnational: The highest prevalence zones in China and India (Yunnan and Manipur states respectively) share their border with Myanmar
- They have spread among the sexual partners of IDUs in China, India, and Thailand
- Given both the inadequate availability of both effective drug treatment and HIV prevention measures among IDU in most countries the epidemics have spread unabated.

A wide range of interventions can be used to reduce HIV-related risks among IDUs. Effective intervention approaches currently employed in some countries include needle and syringe programmes; various forms of outreach work; VCT peer-led education; treatment programmes for both detoxification and longer term maintenance that include opioid substitution pharmacotherapy, safer-sex behaviour change interventions, etc. There is a large and growing body of evidence to suggest that IDUs can and will change their behaviour to reduce their own risk of HIV infection, and to a lesser extent, the risk to others if they are provided access to the services and means of behaviour change they require[5]. This is encouraging to those professionals working in the fields of HIV prevention amongst and from IDUs.

There is significant scientific evidence to support argument that such an epidemic is preventable and/ or reversible if there is the political will to adopt harm reduction strategies such as needle and syringe exchange programmes and peer-led education strategies.

3. Social and ethical issues in provision of VCT care and treatment to IDUs

People who use drugs and especially those that inject drugs often face judgmental attitudes and responses from counsellors and other health workers. Stigmatising and marginalising injecting drug users leaves them feeling alienated, fearful, and out of touch with the support and services they need. This has an adverse impact on HIV prevention care and treatment programmes for IDUs as the target population will not access services they deem as not user friendly.

Legal and ethical factors are also creating challenges for HIV prevention, care and treatment programmes[6] for IDUs. For example, the illegal nature of drug use can drive drug users to hide away from society which effectively cuts them off from services that they desperately need.

In many countries drug taking is a criminal act and punishable by law. Criminalisation of drug taking makes the IDUs hard to reach and can pose ethical and legal issues for the counsellor. This serves as a barrier to the provision of effective VCT as clients may be unwilling to disclose risk factors associated with their injecting drug use and receive appropriate risk assessment, advice and care.

4. The role of VCT and prevention counselling

(i) Access to HIV testing and counselling

VCT programmes have sought to affect changes in HIV/AIDS-related risk behaviour among drug users. IEC has a key role to play in increasing awareness of, and access to, clinics and testing sites where VCT can be obtained. It can also be used to help facilitate learning within the context of VCT, including the steps that need to be taken to reduce both sexual and injection-related risk behaviours.

(ii) Risk reduction counselling

Risk reduction counselling aims to use interpersonal communication to help IDUs clarify their feelings and thoughts in the hope that they will take action to protect themselves and their partners against infection. Individual or group-based risk reduction counselling, and the education and communication that accompanies it, can also assist HIV positive IDUs in relationships to minimise their personal risk behaviours and those of their sexual partners.

5. How effective is VCT in prevention of HIV transmission between IDUs and their partners?

Summary of the evidence of the effectiveness of VCT for IDUs[7]

- Effective models – VCT usually comes as a 'package' linked to peer and outreach services
- Outreach programmes build trust and VCT can be delivered either through outreach or at fixed services centres
- Only effective in behaviour change when there is access to harm reduction services
- Reduction of needle sharing where harm reduction is included and needle exchange is available
- Increased condom use, particularly in HIV-positive clients

A review of the evidence for VCT as an effective component of a prevention strategy follows (Table 1, 2)

Table 1: VCT outcome studies: Reported injecting practices among injecting drug users

Author (year)	Site	Number	Results (in changes in IP)
Casadonte (1990)❖	New York, USA	81	No change in IP following VCT
Magura (1990)❖	New York, USA	48	↓in risky IP following VCT
Nicolosi (1991)❖	Northern Italy	933	↓in risky IP following VCT
Calsyn (1992)❖	Seattle, USA	313	↓in risky IP but no difference between VCT or education group
Desenclos (1993)❖	12 European countries	1456	T-ve ↓in risky IP following VCT cf. UTT+ve less likely to give injecting equipment to others following VCT cf. UT
Watters (1994)❖	California, USA	5644	↓in risky IP following VCT
McCusker (1996)❖	Worcester, Mass, USA	4267 (207)	↓in risky IP following VCT
Colon (1996)❖	Puerto Rico	261	No change in IP following VCT
MacGowan (1996)❖	Connecticut & Massachusetts	674	N/S difference in drug treatment retention in T+ve, T-ve and UT
Des Jarlais (2000)❖	New York City, USA (meta analysis) associated with	>11,000	↓in risky IP following VCT, temporally ↓in seroincidence
Sabin (2000)❖	Multi-centre, USA	1174	No change in IP following VCT

N/S = No significant differences
↑ = Increased
UN = Unaware of HIV status
❖ = N/s / inconclusive studies
↓ = Decreased
T = Tested and aware (of HIV status)
IP = Injecting practice
❖ = Decline in risky behaviour associated with VCT

Source: The impact of voluntary counselling and testing: A global review of the benefits and challenges. http:// ibid. www.unaids.org/publications/documents/health/counselling/index.html p30 and UNAIDS (2001) p31

Table 2 : VCT outcome studies: Reported sexual behaviour among injecting drug users

Author (year)	Site	Number	Results (in changes in IP)
Nicolosi (1991)❖	Northern Italy	933	No change in sexual behaviour following VCT
Calsyn (1992)❖	Seattle, USA	313	No change in sexual behaviour following VCT
Desenclos (1993)❖	12 European countries	1456	T-ve N/S difference in condom use following VCT cf. UTT+ve -condom use following VCT cf. UT
Friedman (1994)❖	New York City, USA	317	T+ve N/S difference in condom use following VCT cf. UT +ve T-ve ↑ condom use following VCT cf. UT –ve T+ve ↑ condom use with non-IDU partner cf. T-ve
McCusker (1996)❖	Worcester, USA	4267	No change in sexual behaviour following VCT
Colon (1996)❖	Puerto Rico	374	↑ condom use and ↓# sexual partners following VCT
Vanichseni (1992)❖	Bangkok, Thailand	601	T+ve ↑ condom use and FP use cf . T-ve and UT
Vanichseni (1993)	Bangkok, Thailand New York	1558	T+ve ↓in risky sex following VCT cf. T-ve and UT

- **A review for VCT as an effective prevention strategy**

Harm reduction/safe injecting combined with VCT

Some studies have found increases in safe injecting practices following VCT. [8]

- In a study of 933 injecting drug users attending a detoxification centre from Milan[9] a preventive intervention based on VCT was associated with a significant reduction in sharing of syringes and unsafe injecting practices compared with risk behaviour in IDUs who had not received the intervention. The latter group showed no change and there was even an increase in sharing of syringes and unsafe injecting practises, despite general information and HIV health education campaigns
- In a small study of IDUs attending a detoxification programme in Long Island, USA, both seropositives and seronegatives had reduced risk behaviour[10]. There was, however, no untested control group for comparison
- A multicentre cross-sectional survey of 200 European IDU recruited in 12 European countries collected data on behaviour and prior knowledge of HIV status. Results indicated that the knowledge of HIV serostatus helped reducing HIV transmission from HIV-positive and negative IDUs to others through safer injecting behaviour[11].
- In a study of 5644 attendees at needle exchange programmes and detoxification centres in California the factor most closely associated with not sharing syringes was having attended VCT[12].

- VCT and needle exchange programmes have expanded substantially in New York. The percentage of IDUs using needle-exchange programmes (NEPs) has risen from 20-54% and those using VCT, from 51% to 81% during 1990-1997[13]. In a meta analysis of studies among over 11,000 IDUs from New York during 1990-1997 it was shown that knowledge of HIV status and attendance at NEPs were associated with less risk behaviour. Using a NEP had an OR (ODDS RATIO)=0.64 (p=<0.001) for sharing at last injection and knowledge of a seropositive status had an OR=0.35 (p=<0.001) for unsafe sex with primary sexual partner. During this time the HIV incidence fell from 4.4 per 100 person years to 0.8 per 100 person years for those at risk. The authors conclude that while there are multiple causes in the process of declining HIV incidence among IDUs in New York there is a clear pattern of increased use of NEPs and VCT, which were temporally associated with a large reduction in HIV incidence

- **Change in IDU clients' sexual risks after VCT**

The majority of studies show a reduction in risky sexual behaviour of IDUs following VCT.

- The aforementioned survey of 200 European IDU recruited in 12 European countries indicated that, IDU who knew that they were HIV-seropositive in comparison with IDU who had never been tested, were more likely to always use condoms [rate ratio (RR) = 3.1; 95% confidence interval (CI), 2.3-4.2]. There was no significant difference among IDU who had never been tested and IDU with a negative test. [11]
- A study among IDU in Bangkok and New York City showed that two factors (i) knowing that one in HIV-seropositive and (ii) talking about AIDS with sexual partners, were most strongly associated with always using condoms with primary partners in both cities. The authors concluded that programmes to prevent sexual transmission of HIV among IDU should provide voluntary and confidential/anonymous HIV counselling and testing, and should facilitate discussions of AIDS and sexual transmission of HIV between IDU and their sexual partners [14,15].
- The impact of an HIV testing and counselling programme on the risk behaviours of drug users was assessed in 981 African American heroin and crack cocaine users living in the US and 144 Puerto Ricans living both in Puerto Rico and the US. Injection risk factors after counselling were independent of HIV test result among African Americans; among Puerto Ricans, a positive HIV test increased the likelihood of shared use of cookers. In both ethnic groups, seropositives were significantly less likely to persist in practising unprotected vaginal sex. Seropositive African Americans were also less likely to continue to practise unprotected oral sex. Since heterosexual relations with an HIV-positive drug user is a major risk factor for sex partners and children, this screening and counselling programme can have a substantial impact on control of the AIDS epidemic in the US [16].
- A study from New York found that seronegative IDUs who had received VCT were more likely to always use condoms than seronegatives IDUs who had not received VCT [17]. However, this difference was not seen among seropositive who received VCT compared with seropositive who were unaware of their status. The authors attributed the similarity in condom use between tested and untested seropositive IDUs to changes in condom use made by IDUs who suspected that they were HIV infected and had thus made changes in their sexual behaviour based on this assumption

These findings suggest that community interventions aimed at providing VCT and thus detecting seropositive IDUs, counselling them about their status and assisting them to reduce the risk of transmitting HIV are effective in reducing the spread of HIV from IDUs to their sexual partner/s.

In most studies changes in behaviour to prevent sexual transmission of HIV are more marked among those who test seropositive than among those who test seronegative. This indicates that seronegative IDUs may be continuing to put themselves at risk from sexual transmission of HIV (particularly if their

sexual partner is also an IDU). Emphasis on providing counselling about prevention of sexual transmission of HIV for IDUs who test negative is important.

• Testing IDUs: Considerations and Challenges

Relating to VCT sites and injecting drug users

1. Intoxication and informed consent
2. Risk assessment - stereotyping
3. Explicit questions and feedback on injecting practice
4. Identified users - Counsellors overly focus on injecting
5. Illegal behaviour - duty to disclose
6. HIV rapid tests - implications for HBV and HCV
7. Lack of information, education and communication (IEC) materials (low literacy)
8. Lack of means to reduce risk (e.g. needle exchange programmes)

HIV testing in drug treatment facilities

1. Mandatory testing for access to drug and alcohol treatment
2. Partners of inmates often denied treatment
3. Poor links to HIV services
4. Lack of VCT and post-VCT care and support
5. Non-disclosure in rehabilitation groups
6. HIV peer support group and discrimination

Psychological impact of HIV on IDUs[18]

HIV positive IDUs and HIV positive controls

- Higher levels of global cognitive impairment[19, 20]
- Higher levels of mood disorders
- Major depression (associated with opioid use)
- Higher levels of suicide attempts and completed suicides
- Complex drug interactions between ARVs, recreational substance use and psychiatric medications

Post-VCT support and care considerations

- Immediate gratification needs
- Group support and clients who are intoxicated (prescribed and non-prescribed)
- Significantly higher risk of suicide
- Misattribution of mood disorders and differential diagnosis
- HIV and drug-related cognitive impairment
- Adherence, discharge care plans, social and economic dislocation

Those diagnosed in late stage disease[21]

- Cognitive impairment (HIV/substance)
- Poor planning ability
- Short-term memory
- Poor impulse control (frontal lobe)
- Disinhibition (frontal lobe)
- Poor frustration tolerance

Counselling requires exploration of constraints and active problem-solving strategies.

Health education and clinical interventions[22]

1. Transmission reduction education—Counsellors need to be aware of all injecting practices and cultural issues relating to use, e.g. shooting galleries, frontloading practices, etc.[23]
2. Harm reduction
3. Overdose prevention and management
4. Treatment options for dependency

Evidence-based counselling interventions[24, 25]

- Structured problem solving
- Exploration of constraints to safer sex/safe injecting
- Motivational interviewing[26, 27]
- Stages of change model
- Brief structured therapy
- Assessment for mood disorders, post-traumatic stress disorder (PTSD), which may underlie both casual and addictive using patterns (referral)
- Suicide risk assessment – high co-morbidity

Case study: integrating needle and syringe exchange with VCT

Shakti Dhaka, Bangladesh – Targeted interventions for injecting drug users, sex workers, transport workers

Shakti provides a broad spectrum of health services to injecting drug users in order to reduce the risk of transmission of HIV and other blood-borne infections; treat ailments relating to injecting drug use and sex work; and to establish an environment conducive to behaviour change.

Outreach workers provide a link between community outreach work and field fixed counselling services community based detoxification camp and a visit to the centres.

When needle and syringe exchange services is offered and condoms are distributed. Referrals and cross-referral occur between those services and VCT occur.

Source: UNAIDS/UNODC/AHRN Preventing HIV/AIDS among drug users – Case studies from Asia 2002 pp25-32

Case study: Integrating prevention, VCT, treatment and care for injecting drug users

SASO-AIDS, Manipur, India, Integrates advocacy, prevention, intervention and home-based care[2]

Founded in 1990 by a group of ex-drug users as a self-help group, it provides prevention, treatment and advocacy for people with HIV. Major activities include: safe injecting and safer sex education; pre- and post- HIV test counselling; home visits for ill clients; free community doctor and clinic providing treatment for opportunistic infections; home detoxification for HIV-positive clients; education, counselling and support for HIV-infected individuals and their family members; referral to drug treatment services, hospital services or VCT services in other locations. The service also offers a telephone helpline, provides and promotes the use of condoms and assesses and treats STIs. Professional staff support self-help groups and volunteer initiatives.

Advocacy work aims to increase levels of support for people with HIV/AIDS and address legal and social barriers to accessing prevention, treatment and care.

Source: UNAIDS/UNODC/AHRN Preventing HIV/AIDS among drug users – Case studies from Asia 2002 pp15-23

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Appendix 1

South and South-East Asia: Size of population and prevalence of IDUs, 2001/2002

Country	City	Population		IDU population			IDUs prevalence (%)	
		MID		Range				
				Low	High	MID	Low	High
Afghanistan	*National*	22 474 000	34 080	23 000	45 500	.15	.10	.20
Bangladesh	*National*	140 369 000	95 000	20 000	170 000	.06	.01	.12
	Central Bangladesh	-	25 000	-		-		
	Chapainawabgonj	-	1 000	-		-		
	Dhaka*	6 164 000	7 650	-		.12	-	
	Northen Bangladesh	-	13 500	12 000	15 000			
	Rajshahi*	507 400	2 000	-		.39	-	
Bhutan	*National*	2 141 000	0	-		.00	-	
Brunei D.	*National*	335 000	3 250	2 500	4 000	.97	.74	1.19
Cambodia	*National*	13 441 000	650	300	1 000	.004	.002	.007
East Timor	*National*	857 000	110	100	120	.011	.011	.014
India	*National*	1 025 096 000	1 602 500	100 000	2 025 000	.15	.009	.19
	Chennai	-	12 500	10 000	15 000			
	Delhi	13 783 000	30 000	-		.21	-	
	Imphal	-	12 000	-		-		
	Kolkata	-	12 500	10 000	15 000			
	Manipur	2 388600	17 500	15 000	20 000	.73	.62	.83
	Mumbai	-	38 000	-		-		
	New Delhi	-	27 500	25 000	30 000	-	-	-
Indonesia	National	214 840 000	515 000	30 000	1 000 000	.23	.01	.46
	Aceh**	3 416 200	2 000	1 000	3 000	.05	.02	.08
	Bali**	2 777 800	4 500	2 000	7 000	.16	.071	.25
	Bangka Belitung**	763 700	270	200	340	.03	.02	.04
	Banten**	7 472 400	6 000	4 100	7 900	.08	.05	.10
	Bengkulu**	1 179 100	600	-	.05	-		
	Botabek	-	10 300					
	Gorontalo**	693 300	240	20	460	.03	.002	.06
	Jakarta	9 373 900	27 500	27 000	28 000			
	Jambi	427 800	4 000	-	.93	-		
	Jawa Tenggah**	28 520 000	15 000	13 000	17 000	.052	.04	.059
	Jawa Barat**	27 912 000	22 150	17 600	26 700	.07	.06	.09

Country	City	Population		IDU population			IDUs prevalence (%)	
		MID		Range				
				Low	High	MID	Low	High
	Jawa Timur**	32 504 000	14 500	14 000	15 000	.044	.043	.046.
	Jogjakarta	-	11 800	7 400	16 200			
	Kalimantan Selatan**	2 597 600	1 650	1 200	2 100	.06	.04	.08
	Kalimantan Tenggah**	1 396 500	95	50	140	.006	.003	.01
	Kalimantan Barat**	3 229 200	1 450	1 300	1 600	.044	.040	.049
	Kalimantan Timur**	1 876 700	1 065	830	1 300	.05	.04	.06
	Lampung**	6 017 600	3 500	2 000	5 000	.05	.03	.08
	Maluku**	1 136 800	1 315	30	2 600	.11	.002	.22
	Maluku Utara**	721 000	1 860	20	3 700	.25	.002	.51
	NTB**	3 369 600	1 500	-	.04	-		
	NTT**	3 268 600	180	60	300	.005	.001	.009
	Papua**	1 648 700	920	40	1 800	.05	.002	.11
	Riau**	2 764 700	5 650	1300	10 000	.2	.04	.36
	Sulawesi Utara**	1 784 800	4 820	40	9 600	.27	.002	.53
	Sumatra Selatan**	6 981 600	11 650	300	23 300	.16	.004	.33
Iran	*National*	71 369 000	166 000	32 000	300 000	.23	.04	.42
Laos	*National*	5 403 000	8 250	5 500	11 000	.15	.10	.20
Malaysia	*National*	21 410 000	190 000	150 000	240 000	.88	.70	1.12
Maldives	*National*	271 000	0	–	.00	–		
Myanmar	*National*	44 497 000	157 000	14 000	300 000	.35	.03	.67
Nepal	*National*	22 847 000	26 200	15 000	37 400	.11	.06	.16
Pakistan	*National*	148 166 000	462 000	54 000	870 000	.31	.03	.58
Philippines	*National*	72 944 000	17 000	10 000	24 000	.02	.01	.03
Singapore	*National*	3 476 000	10 158	315	20 000	.29	.009	.57
Sri Lanka	*National*	18 455 000	19 300	600	38 000	.10	.003	.20
Taiwan	*National*	21 908 135	60 000	–	.27	--		
Thailand	*National*	60 300 000	400 000	38 000	762 000	.66	.006	1.26
	Bangkok	-	36 000	-	-	-	-	-
Vietnam	*National*	77 562 000	130 000	100 000	160 000	.16	.12	.20

: 1991 census population** *: 1990 census population**

Sources: **"Inventory of needle exchange/outreach projects", "Asia update: Critical issues and challenges", "The vaccine meeting. IDU estimates (22/11/01)", "Indonesia national estimates", "UN internal document", "Revisiting the hidden epidemic: A situation assessment of drug use in Asia in the context of HIV/AIDS", "WHO meeting on treatment and psychosocial support : Support guidelines for PLWHA who are substance dependent. Background document number 11. Case study report - Ho Chi Min City, Viet Nam", "Re-estimation of injecting drug user population in Rajshani and ChapaiNawabgonj. SHAKTI", "Injecting drug users interventions. Activity report. March 1998-June 1999. SHAKTI project Care", "HIV and injecting drug use. A new challenge to sustainable human development", "A multicentre rapid assessment of injecting drug use in India", "Rapid situational assessment of injecting drug use and HIV risk in northern Bangladesh. Part 2", "Indonesia: Drugs rampant in SE Sulawesi", "Report on the sero-surveillance and behavioural surveillance on STD and AIDS in Bangladesh. 1998-1999", "Temporal trends on molecular epidemiology of HIV infection in Taiwan from 1988 to 1998" and "The Asian harm reduction network. Supporting responses to HIV and injecting drug use in Asia".**

East Asia and Pacific: Size of population and prevalence of IDUs, 2001/2002

Country	City	Population		IDU population			IDUs prevalence (%)	
		MID		Range				
				Low	High	MID	Low	High
China	*National*	1 274 982 000	1 928 200	356 400	3 500 000	.15	.02	.27
	Hong Kong	6 843 000	12 600	26 300	40 000	.18	.38	.58
	Macau	438 000	473	710	946	.10	.16	.21
	Yunnan*	3 670 000	15 247	-	.41	-		
Fiji	*National*	823 000	131	112	150	.015	.013	.018
Japan	*National*	127 335 000	325 000	150 000	500 000	.25	.11	.39
Korea (Dem. Rep.)	*National*	22 428 000	0	0	0	.00	.00	.00
Korea (Republic of)	*National*	47 079 000	3 000	1 000	5 000	.006	.002	.010
Mongolia	*National*	2 559 000	0	0	0	.00	.00	.00
Papua New Guinea	*National*	4 920 000	7 500	5 000	10 000	.15	.10	.20·

Sources: "The practices and context of the pharmacotherapy of opioid dependence in South-East Asia and Western Pacific Regions", "The vbyeaccine meeting. IDU estimates (22/11/01)", "UN internal document", "Revisiting the hidden epidemic. A situation assessment of drug use in Asia in the context of HIV/AIDS" and "The Asian harm reduction network. Supporting responses to HIV and injecting drug use in Asia".

Module 3

Sub module 2: Targeted VCT Intervention - Sex workers

Session objectives

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

- Identify the specific HIV transmission risk behaviours of sex workers
- Understand the psychosocial issues of sex workers
- Appreciate the need to adapt VCT to the specific needs of sex workers

Time to complete sub module

2 hours

Training materials

- PowerPoint presentation **(PPT19)**
- Handout **(HO18)**
- Question box
- Evaluation form collection box

Content

- Who are sex workers?
- Sex workers and HIV risk
- How are VCT and psychosocial care different for sex workers?
- Service delivery settings
- Prevention counselling
- HIV-infected sex workers
- Sex workers and psychological morbidity
- Outcome data on VCT and peer education for sex workers

Session instructions

1. Activity:
   - Ask the trainees to imagine that they have designed a VCT service that will attract and meet the needs of sex workers
   - Ask them to each suggest one key element to encourage the sex worker to use the service
2. Lecture with PowerPoint presentation **(PPT19)**.
3. Activity:
   - Ask the group to reflect on the presentation you have just made and ask them to share their experiences of working with sex workers
4. Ask the group if they have any questions and remind them about the “question box”.
5. Ask trainees to complete an evaluation form and place it in the “evaluation form collection box”.

Module 3

Sub module 2: Targeted VCT intervention - Sex workers

Session objectives

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

- Identify the specific HIV transmission risk behaviours of sex workers
- Understand the psychosocial issues of sex workers
- Appreciate the need to adapt VCT to the specific needs of sex workers

1. Who are sex workers?

Sex workers encompass a diverse group of people, so it is therefore difficult to generalise about their behaviours and attitudes towards HIV prevention and care. For example, they may be injecting drug users, married women or men, indentured workers (ie. they are coerced into the work and even taken to other countries), college students, unattached minors and may be of all genders (male, female or transgender). They may work temporarily as sex workers or full time. Effective VCT interventions need to recognise sex workers not only as sex workers, but also as partners, wives or husbands, and as parents.

2. Sex workers and HIV risk

Sex workers are especially vulnerable to HIV transmission due to their large numbers of sexual partners and often high rates of other sexually transmitted diseases. In Cambodia, HIV prevalence among female sex workers (up to 38%) was found to be over 14 times higher than among women attending antenatal clinics (2.54%).[1] Sex workers often feel disempowered to negotiate safe sex practices with clients on whom they rely for income. In some cases, sex workers may accept a higher price with men who refuse to use a condom.

Research in Indonesia has shown that the way sex workers negotiate safe sex varies according to the extent of the emotional relationship. While with new clients sex workers may use condoms, with their regular clients or 'lovers', to whom they have developed a kind of emotional relationship, they do not think about using a condom.[2]

In some situations, there is an overlapping risk for sex workers between injecting drug use and commercial sex work. This requires the simultaneous implementation of prevention strategies from two separate disciplines - harm reduction for IDUs and sexual transmission reduction – in recognition of the two sources of risk for the population.[3]

Sex workers have particular needs and VCT and psychosocial interventions should be tailored specifically to ensure effectiveness. It is crucial that VCT services reach this vulnerable population,

both to protect the sex workers from HIV and other STI infections and to prevent transmission to their clients and partners. There is increasing evidence that Targeted programmes to reduce transmission of HIV infection within core groups are feasible, effective and have led to successful risk reduction and decreased levels of infection.[4]

3. How are VCT and psychosocial care different for sex workers?

There have only been a small number of VCT-specific studies among sex workers. Most of these studies have shown that VCT can be acceptable and some result in important changes in sexual behaviour to reduce transmission. However, in some settings economic and social pressures prevent sex workers from practising safer sex. It may also be important to provide VCT and HIV education to clients if condom use is to be increased. Peer-based education programmes have been found to be highly effective for both male and female sex workers.

Although VCT services (as well as other interventions, such as condom provision and screening and treatment of STIs) have been shown to be important and cost-effective, there is still a great lack of provision of specially tailored services for sex workers. [6]

4. Service delivery settings

Different types of sex workers will access VCT and psychosocial services in different environments. There is no single, universal model for providing prevention and care services to sex workers, their clients and partners. The services need to be adapted to different situations.[5]

Assuring anonymity for sex workers is important to encourage them to access the service in an environment where they can feel reassured that their activities, which are often illegal in many countries, will not be disclosed to authorities. For street-based sex workers, outreach services may facilitate access, while for sex workers in venues such as bars and clubs, liaison with venues may be appropriate. In some settings, it can be helpful to integrate services with other health care and community services. It is important for sex workers to have access to sexual health services; however the question of whether it is better to set up special services for vulnerable populations or to integrate STI services into primary health care services remains unresolved.[6]

Particular challenges include designing services and programmes for hard-to-reach, indirect sex workers, such as married women and men, refugees and undocumented migrant workers or brothels which operate in secret. In Ho Chi Minh City in Vietnam, the majority of sex workers do not work in brothels, and as a result are difficult to enumerate or target for prevention.[7] Sex workers are not necessarily a single, identifiable group.

Different service delivery options include:

- Mobile/outreach, i.e. the services are taken to the sex workers or their clients
- Free standing VCT
- STI clinics
- Prisons
- Refugee/migrant detention centres
- Integrated VCT in general health settings
- Drug and alcohol services
- Gay and lesbian health services
- Women's health centres

Family Health International (FHI) recommends that HIV prevention activities among sex workers, their clients and partners, are most effective when the service includes at least the following the key elements rather than information provision alone:

- Information and behaviour change messages
- Condoms and other barrier methods
- Sexual health services[8]

Proven strategies to increase the effectiveness of Targeted services include:

- Use of informal contacts, key informants and "leaders" to access the population
- Peer health promotion and education
- Outreach activities
- Condom social marketing and distribution
- Accessible sexual health services[9]

Examples of Targeted VCT services

VCT services are still limited in Bangladesh. The organisations Sristi (female sex workers) and Bandhu (MSM and male sex workers) have adopted behaviour change messages and activities in their outreach services. They offer condoms, as well as referral in the limited number of VCT services.

In Bangkok, sex workers can receive free testing and treatment from designated government clinics. However, workers must be registered as a sex worker, with these clinics. Most of the workers would rather attend clinics "close to home, but not too close to home", where there may be a breach in confidentiality. Two agencies which provide outreach efforts to both female and male sex workers are EMPOWER and Rainbow Sky. They provide information and behaviour change messages, condoms and referral to a number of reputed clinics that provide a broad range of testing and treatments services.

5. Examples of different service delivery settings to reach sex workers

- *Brothel-based STI services* – In many countries in Asia such as Thailand, Indonesia and the Philippines, commercial sex establishment owners contract private practitioners to visit the brothels to provide regular check-ups and treatment of their employees[10]

- *Mobile vans* – In Tamil Nadu in India, numerous surveys by NGOs have shown that sex workers generally work in areas far away from their homes and prefer to live anonymously in their own neighbourhoods. As neighbourhood clinics would probably draw too much attention, NGOs have looked to set up ambulatory clinic vans so that the sex workers can access STI treatment outside their communities[11]

- *Peer health educators and outreach workers* – In Madras, India, the AIDS Control and Community Education Programmes Trust has started an outreach programme for sex workers in the central railway station area. Peer health educators provide face-to-face prevention information to the sex workers with STI complaints and refer them with a letter to the public hospital for free treatment. The referral letter also helps to ensure the women are well treated by the clinic staff[12]

6. Prevention counselling

Counselling to prevent transmission can cover a range of strategies and activities to convey information and behaviour change messages. The objective is to provide the sex workers with knowledge about HIV transmission and ways to reduce the risk of transmission, for example, through alternative safer sex practices, the use of male or female condoms and lubricants. They also explain how to identify symptoms of STIs and clarify misunderstandings about unsafe traditional practices or beliefs.[13]

Furthermore, counselling can play an important role in developing the communication and negotiation skills of the sex workers to successfully negotiate safe sex practices with:

- Clients
- Personal relationships/partners
- Brothel owners to permit condom usage

In particular, behaviour change messages are important to convey a message about consistent condom use, rather than a judgement based on the extent to which the sex worker is familiar with the client. Some have argued that other relationships of sex workers outside of their professional relationships may be as risky or even more risky for HIV and STI transmission as they have less control and less negotiation possibilities.[14] There is emotional involvement as the relationship becomes more than just a commercial arrangement and sex workers will put aside their professional attitudes and control. Counselling needs to address the needs of the sex worker holistically, rather than solely focussing on their professional sex work activities, e.g. strategies for how a sex worker can negotiate safe sex not only with their clients but also with their boyfriends or long-term clients, who they feel they can trust and may not consider the need to use condoms. Some sex workers may be effective in negotiating safe sex with their clients, but not with their partners with whom they have more intimate relationships.

Peer-based programmes can be highly effective both as an entry point into the affected population and as an effective means to influence their peers through their own experiences. Other examples of creative strategies have included compiling a booklet of responses to a survey of female sex workers about all their questions on HIV and STIs, and training peers as AIDS educators and distributors of condoms.[15] Peer-based programmes will often require some training for the sex workers involved.

7. HIV-infected sex workers

Counselling for HIV-infected sex workers can assist them with:

- Deciding about whether to disclose
- Strategies to disclose their status to partners
- Ongoing support and planning for the future
- Referral to support programmes
- Alternative income-generating projects

Income-generating projects can provide sex workers with an alternative means of income where prostitution is often associated with poverty and lack of other vocational options.

8. Sex workers and psychological morbidity

A significant proportion of this vulnerable population can have a history of mood disorders and personality disorders. These may be associated with substance abuse, or possibly a history of abusive relationships or child sexual assault.

9. Outcome data on VCT and peer education for sex workers

In many countries directing care and support to sex workers has been seen as an important approach in HIV prevention. VCT has been integrated into programmes for female sex workers in Cambodia by MSF. Increased rates of condom use have been reported along with increased attendance for sexual health check-ups.[16]

In the Gambia, however, VCT for sex workers did not result in an increase in condom use.[17] However, there was very high use of condoms before the intervention (89% of women who subsequently tested seropositive reported using condoms before VCT) and this leaves very little room for improvement. Furthermore, the majority of HIV among sex workers in the Gambia is due to HIV-2 and there was a low level of morbidity and mortality due to HIV in the Gambia at the time of the study. Thus the effects of HIV infection may be perceived as being less detrimental than in areas with high morbidity and mortality due to HIV-1.

A project from KwaZulu Natal in South Africa offered counselling and testing to sex workers at truck stops.[18] Although uptake of testing was good, the majority of women did not want a positive result disclosed to them, as behaviour change was very difficult due to economic and social reasons. Following VCT, women also continued with unsafe sexual practices. This project demonstrates the difficulties and social and economic barriers that must be overcome and highlights the limitations that may arise if sex workers alone (and not their clients) are Targeted for interventions.

Two studies among sex workers in the USA report increased condom use and decrease in risky sexual behaviour following VCT. [19] [20]

Projects offering peer counselling for sex workers (without testing) have been shown to be well accepted and provide sex workers information about safer sex and HIV prevention advice. [21]

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Module 3

Sub module 3: Targeted VCT intervention - Youth and children

Session objectives

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

- Appreciate the need to adapt VCT to the specific needs of young people and children
- Identify VCT strategies to reduce the specific HIV transmission risk behaviours of youth

Time to complete sub module

2 hours

Training materials

- PowerPoint presentation **(PPT20)**
- Handout **(H019)**
- Question box
- Evaluation form collection box

Content

- Definitions
- Why target young people?
- VCT services for young people
- Elements of youth-friendly services
- Service issues for young people
- Psychosocial issues for young people
- Children infected by and affected by HIV

Session instructions

1. Lecture with PowerPoint presentation **(PPT20)**
2. *Activity:*
   - Ask the trainees the legal age of consent in each of their countries.
3. *Activity:* Role-play.
   - Divide trainees into groups of four, with one person as the "counsellor"; one as the "client" (a young person aged 15), and two as the "parents"
   - The client is below the legal age of consent to have an HIV test. He has told the counsellor that he wants to have the HIV test but does not want his parents to know he is taking the test. What should the counsellor do?
4. Ask the group if they have any questions and remind them about the "question box".
5. Ask trainees to complete an evaluation form and place it in the "evaluation form collection box".

Module 3

Sub module 3: Targeted VCT intervention – Youth and children

Session objectives

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

- Appreciate the need to adapt VCT to the specific needs of young people and children
- Identify VCT strategies to reduce the specific HIV transmission risk behaviours of youth

1. Definitions

A child is commonly defined to be between 4 and 12 years of age; adolescents, between 12 and 15 years of age; and young people, between 15 and 24 years of age.

2. Why target young people?

Young people encompass a significant demographic of the population who affect HIV trends in any country. Young people aged 15 to 24 years old account for more than 50% of all HIV infections worldwide (excluding perinatal cases) and more than 6,000 young people are newly infected with HIV each day throughout the world.[1] However, only a fraction of them know they are infected. In Thailand, the estimated HIV prevalence rate in 1999 for young women was between 1.53 and 3.11 and for young men between 0.47 and 1.89. In India the figures for young women were between 0.4 and 0.82 and for young men, between 0.14 and 0.58.[2] Sexual activity begins in adolescence for the majority of people and in many countries unmarried girls and boys are sexually active before the age of 15.[3] Yet VCT services are not always designed to target the specific needs of youth.

This represents a missed opportunity not only to provide testing and counselling, but also to provide behaviour change communication about safer practices during a person's formative years. In areas where the spread of HIV/AIDS is subsiding or even declining, it is primarily because young men and women are being given the tools and the incentives to adopt safe behaviours.[4] In northern Thailand, half as many 21-year-old men visited sex workers in 1995 as had done so four years earlier. Of the ones who did visit brothels, far more used condoms than before – 93 % in 1995 compared to 61 % in 1991.[5]

The reasons for seeking VCT services, outcomes and needs can be different for young people. For example, in Uganda and Kenya, research suggested that 20% of the young people who undertook VCT reported they were not sexually active and were possibly seeking VCT simply to have access to information.[6] Access to information about safe sex can be more difficult for youth than adults due to its sensitivity, particularly in cultures and societies where information about sex and sexuality is not considered appropriate to be provided to youth. Young people may rely on their peers to learn about sex, which can result in misconceptions about sex and HIV transmission. Peer influences are particularly pronounced in adolescents and youth. They tend to have a perception of invincibility which can lead

to greater risk taking. Therefore VCT services can play a vital role in providing information and skills to youth to negotiate safe sex, which may not be accessible through the general media or through schools. In Thailand, 40% of those attending the VCT site in Bangkok described themselves as 'students'.[7]

Young people are not a homogenous group and so the principles of other Targeted interventions need also to be applied. Some groups of youth stand at a greater than average risk for HIV/AIDS, for example, men who have sex with men (identifying and non-identifying), injecting drug users, mobile populations, street youth and adolescent sex workers. In many countries, homosexual sex is illegal between men who are less than 18 years of age and therefore young men who have sex with other men may be reluctant to access services.

3. VCT services for young people

Young people have a broad range of HIV/AIDS-related needs, which may be addressed through both VCT and other mutually reinforcing services. Services may be offered in a 'one-stop-shop' as an integrated programme or through developing strong linkages between different services. Young people often do not attend formal health services for their preventive health needs and young women are reportedly much more likely to present late in pregnancy and less likely to deliver in a health facility.[8] There is no one particular best practice model for delivery of VCT services to young people. Some options include:

- Integration into existing health care services (e.g. primary health care, STI clinics and TB clinics) with designated "youth-friendly corners"
- Integration into school and college health care services
- Outreach/mobile with links to fixed site
- Fixed youth drop-in sites with basic services such as showers, café or clothing exchange
- Youth centres
- Mix of peer educator/support workers and youth-friendly adult professionals
- Targeted "tribe" campaigns (soccer, disco, etc)

In a number of secondary and vocational schools in the Bangkok Metropolitan Area "youth corners" have been established, through which students are provided easy access to information on reproductive health, HIV/AIDS, STI and referral to reputable VCT services. After an intensive selection process, a number of teachers are trained in providing counselling services in these areas. Condoms are also available to the students through these youth corners.[9]

In Cambodia, VCT for HIV is currently operational in 21 health institutions, with 50% of provincial hospitals having integrated VCT services. Mass media campaigns on VCT targeting young people have been carried out nationwide. An HIV/AIDS hotline supported by UNICEF and a private telephone company, MOBITEL, provides HIV/AIDS counselling and referral to VCT services through toll-free lines.[10]

4. Elements of youth-friendly services

- Offers a broad array of youth-oriented services, including counselling services and life-skills training. This is to help with peer pressure, self-esteem, negotiation skills, risk-taking and experimentation as related to developing safer behaviours and setting limits
- Provides health education which is non-judgemental and realistic. Asks few questions
- Offers free testing (and condoms). For youth who generally do not have an income, cost can be an important obstacle to accessing services and products

Programme for street children in Phnom Penh

Mith Samlanh is a programme for street children in Phnom Penh that has established referral links to VCT services. The objectives of its HIV/AIDS project include supporting children at risk of HIV/AIDS to remain off the streets and enabling them to protect themselves from being affected by the virus. It also operates a complementary drug use project which seeks to reduce levels of substance abuse and the harmful consequences of abuse among street children. A 1998 study found that 25.5% of street children (N = 250) interviewed had used a psychotropic substance and of these, 47.4% had used inhalants. In a more recent study in 2000 the percentage of street children who had used psychotropic substances had increased to 46.6%.

Mith Samlanh runs a number of integrated activities designed to support street children and provide them with healthy alternatives to living on the streets. These include:

- A medical facility with a doctor and nurse. HIV testing and counselling are conducted and basic care provided.
- Cooking classes leading to cooking in public restaurants.
- Training in other areas, including sewing, hairdressing, electronics, tiling and ceramics.
- A school with several classrooms, a library and 250 students at seven levels.

Source: UNAIDS/UNODC Regional Task Force on Drug Use and HIV vulnerability

- Convenient hours and location (public transport)
- VCT for couples is available
- Assures confidentiality
- Does not require parental consent
- Offers choice between oral/blood-drawn tests
- Enables participation of young people in decision-making, planning and delivery of services. In general, programmes for youth work better when young people help plan and run them as the involvement gives young people a sense of ownership of the programme and helps develop skills such as management, organisation, and decision-making. However, involving youth can be difficult as turnover rates among youthful staff members can be high and legal issues may arise, such as labour laws restricting employment of minors[11]
- Provides referral to other services such as for other reproductive health care, especially for pregnancy prevention and STI treatment

5. Service issues for young people

Most countries have legislation that requires parental or guardian consent before a medical procedure can be conducted on young people who are below the age of consent. This may include HIV testing and therefore affects the nature of services offered to youth. It is important that relevant legislation and any other national guidelines are understood so that the VCT service can make an informed choice about their own policies regarding consent for VCT and disclosure. It is preferable that young people are allowed to provide consent (without parental consent) for VCT, as parental consent is a barrier to uptake of VCT by some young people.[12]

In testing for HIV, ensuring medical confidentiality is essential and the right to confidentiality is recognised by the UN Convention on the Rights of the Child.[13] Other legal considerations for VCT for youth include the mandatory notification of child sexual assault (statutory rape) and those indentured to sex work.

6. Psychosocial issues for young people

Psychosocial characteristics of youth, which can influence the provision of VCT, include:

- Belief in their own invincibility/inaccurate risk perception
- Lack of ability to negotiate safer sex
- Difficulty in disclosing status to parents, partners, etc
- Abuse by health service providers
- Believe these to be the normal tasks of adolescents
- Greater peer influence
- Image-conscious

Young people may react impulsively and the risk of suicide should be considered. Others may feel cheated by life and seek what they see as 'revenge' through rebellion and risky behaviour.[14] It is essential to identify the sources of support for the young person. If parents are to be the main providers of support, they will also need counselling to enable them to cope with their own emotions.

7. Children infected by and affected by HIV

The overwhelming majority of infected children acquire HIV infection through mother-to-child transmission, which can take place during pregnancy; during labour; during delivery; or after birth, through breastfeeding. In the absence of any intervention, rates of mother-to-child transmission of HIV can vary from 15% to 30% without breastfeeding and can reach from 30% to 45% with prolonged breastfeeding.[15] Prevention of mother-to-child transmission is addressed in a separate module of the programme.

All children born to HIV-positive mothers will test HIV positive at birth when the standard HIV antibody test is used. It is only by about 18 months of age that the standard HIV antibody test will be able to reliably reveal whether a child is HIV-infected or not. There are other types of HIV tests that can tell whether an infant less than 18 months old is infected with HIV (for example the PCR test), but this may not be widely available and is expensive. (For more information see Module 3, Sub module 5: Prevention of Mother-to-Child Transmission.)

Until parents find out whether their infant is infected or not, they will feel stressed, worried, anxious, tense, sleepless or easily irritated. VCT services can play an important role in helping parents to decide about whether to inform a child about their own or a family member's HIV status and when to do it. Some considerations are:

- The maturity and health of the child has to be considered
- If the children are very young, they will not understand the stigma and discrimination that can happen because of HIV/AIDS
- The truth can often be less threatening to a child than the fear of the unknown. Sometimes, if the child is not informed, he/she may have suspicions because of overheard conversations or noticing differences at home. Children can often make up their own complicated and incorrect explanations. Avoiding talking to a child about illness in the family may make it easier for the parent to cope, but it can make the child feel anxious, guilty and upset. If the child cannot talk about his/her fears, it can lead to many problems
- If they are adolescents or youths (13-18 years of age), they are reaching an age where they may be likely to become sexually active and will need knowledge and skills to be able to take responsibility for safe sex practices

When informing a child:

- Use language and concepts that are appropriate to their age
- First ask them what they are thinking and discuss what they understand about HIV/AIDS
- Use words, pictures and drawings to explain about HIV
- Be direct and use language they can understand
- Ask them if they have any questions they would like to ask
- Ask them to draw a picture about it. This may help you to understand what they are thinking and their reaction. It is good to talk about their feelings with the family so that the child can feel supported and can understand what is happening. A lot can be learnt about how a child is feeling by listening to them and looking at the pictures they draw

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Module 3

Sub module 4: Targeted VCT intervention - Men who have sex with men (MSM)

Session objectives

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

- Appreciate the need to adapt VCT to the specific needs of men who have sex with men (MSM)
- Explore the barriers to VCT for MSM
- Identify VCT strategies and complementary strategies to reduce the specific HIV transmission risk behaviours of MSM
- Explore strategies to increase access to VCT for MSM

Time to complete sub module

1 hour 30 minutes

Training materials

- PowerPoint presentation **(PPT21)**
- Handout **(HO20)**
- Question box
- Evaluation form collection box

Content

- Definitions
- Why VCT for MSM?
- How to adapt VCT to meet the needs of MSM
- Complementary strategies to reduce the specific HIV transmission risk behaviours of men who have sex with men

Session instructions

1. *Activity:* Agree or disagree.
   - You will need a reasonable amount of space so if you can move the chairs and tables against the wall then do so. If there is no room you may need to go outside
   - Gather the group together and explain the activity. You will read out a series of statements relating to MSM—if they agree with the statement they should run to one end of the room; if they disagree they run to the other end of the room; if they are undecided they can stay in the middle
   - Once everyone is in place ask some of the trainees at each end of the room why they either agree or disagree with the statement you have just read out
   - Some possible statements are listed below but you may wish to make up your own:
     i. Sex between men is wrong
     ii. Counsellors should not ask clients if they have ever had sex with another man
     iii. Health organisations should provide services for MSM
     iv. In our community there are no MSM
   - The statements you choose to read out may depend on your interpretation of the group and their level of sophistication around MSM issues. You may want to ask trainees to pretend they are playing a part, rather than themselves, so that you get a variety of responses and so that people do not feel that they have to express their 'real' opinion
2. Lecture with PowerPoint presentation **(PPT21)**.
3. Ask the group if they have any questions and remind them about the "question box".
4. Ask trainees to complete an evaluation form and place it in the "evaluation form collection box".

Module 3

Sub module 4: Targeted VCT intervention – Men who have sex with men

Session objectives

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

Appreciate the need to adapt VCT to the specific needs of MSM
Explore the barriers to VCT for MSM
Identify VCT strategies and complementary strategies to reduce the specific HIV transmission risk behaviours of MSM
Explore strategies to increase access to VCT for MSM

1. Definition

The term 'men who have sex with men (MSM)' was developed as an overarching term to cover all the different groups and sub groups of men who have sex with men. In part the term MSM can be seen as a reaction to the language that has developed in Western cultures to describe and/or medicalise sexual acts between men, e.g. 'gay', 'homosexual'. Also, the emergence of 'gay culture' in Western societies during the 20th century has encouraged the belief that people are either 'gay' (homosexual) or 'straight' (heterosexual). This may be true for some people in some parts of the world, but for many men, having sex with other men, this is just one part of their sexual life and does not determine their social or sexual identity. For example, the word, homosexual, as it is understood in the West does not have a direct equivalent in Indian languages, even though male-to-male sexual activity is well documented. [1]

MSM can include the following:

- Men who exclusively have sex with other men
- Men who have sex with other men but mostly have sex with women
- Men who have sex with both men and women without any particular preference
- Men who have sex with other men for money or because they do not have access to sex with women, e.g. men in prison, men in the military

Within these groups there may also be sub groups, such as the different sexual roles that men may assume when they have sex with men:

- Men who are exclusively the insertive partner in anal sex
- Men who are exclusively the receptive partner in anal sex
- Men who are both insertive and receptive
- Men who do not have anal sex but practice other activities such as oral sex and mutual masturbation
- Men who assume different roles and practice different activities at different parts of their lives

Some MSM may be highly visible in the community and can include men who dress as women or wear some items of women's clothing. However, other MSM may be completely indistinguishable from non-MSM. Where 'homosexuality' is not visible it is sometimes thought not to exist, however this is probably not the case. In fact, sex between men happens in most, if not all, societies. Public discourses that deny the existence of same-sex activity do not reflect what happens in real life.

MSM communities and behaviours are structured differently in different countries and within different parts of a country. There can be significant divisions between working and middle class MSM as well as urban and rural divisions.

2. Why VCT for men who have sex with men?

In some parts of the world MSM have been disproportionately affected by the HIV epidemic. In countries where such information is gathered, HIV infection rates among MSM are often higher than in the general population. Multiple sex partners, unprotected anal sex and the hidden nature of MSM sexual relations in many communities may all contribute to the prevalence of HIV among MSM.[2] In many countries there is very little data available on whether HIV is transmitted via heterosexual or homosexual intercourse. It is often assumed that where there is sexual transmission, it is heterosexual. If male clients are asked how they contracted HIV they may be more likely to say via heterosexual rather than homosexual contact because of fear of discrimination.

In many countries, the repression of MSM is a recent phenomenon – often associated with some or all of the following: laws introduced in the 19th and 20th centuries by colonial rulers; repressive political regimes; and religious fundamentalism. However, these same countries may have a rich and documented history of MSM activity dating back many centuries. Where there is a denial of the existence of MSM, there may be an alarming lack of prevention and care services for MSM. This denial and discrimination against MSM can feed the secrecy in which many MSM live, increasing their risk taking and making it difficult to reach them with HIV prevention interventions.[3]

Developing and implementing interventions for MSM populations may be difficult because of varying definitions and perceptions of gender, sexual roles, stigma, homophobia and internalised homophobia. Due to choice, preference or societal pressure, many MSM have both male and female partners, increasing the HIV risk for their female partners and decreasing the likelihood that MSM identify themselves as MSM.[4]

MSM who have sex with other men for money or favours may be especially vulnerable to HIV. In Thailand the rate of HIV among male sex workers is approximately 14%. In addition to clients, male sex workers in Thailand have sexual encounters with regular and casual, free and commercial, male and female, Thai and foreign partners. There is also a ready mobility among male sex workers and their clients, between different establishments. Some men temporarily move in and out of sex work, not uncommonly returning home for the planting and harvest season. [5]

3. Constraints to MSM programmes

As well as a denial that MSM exists, MSM programmes may be hindered by the following:

- Stigmatisation or criminalisation
- Unreliable epidemiological information
- Difficulty in reaching MSM
- Inadequate or inappropriate health services
- Lack of interest from donors or governments in services for MSM

- Lack of attention in national AIDS programmes[6]
- Fear of being disclosed as an MSM to family or friends can drive men underground leaving them without the skills to negotiate safe sex

4. Barriers to VCT for MSM

- Counsellors are unaware of psychosocial issues affecting MSM
- Health workers and counsellors may even deny the existence of MSM or hold the belief that all MSM are transvestites or transsexual
- Embarrassment of counsellors in talking about MSM sexual activities (or sexual activity generally)
- Lack of knowledge about the sexual practices of MSM
- Disapproval by counsellors of MSM activity, including moral and religious objections
- Internalised homophobia of counsellors who may also be MSM
- Lack of information, education and communication (IEC) materials talking about HIV and MSM for counsellors to distribute to clients
- Unfamiliarity with informal or colloquial language used by MSM

5. Strategies to access MSM

MSMs are not a homogenous group. While some may socialise with MSM friends and identify with MSM communities, others may not have any such affinities. For *all* MSM it is important to have appropriate or 'friendly' HIV/AIDS or STI services where they can obtain accurate information about HIV (and STI) transmission and prevention. Because many health services have traditionally not been welcoming of MSM it may be important to reorient health services so that they are 'MSM-friendly'. Some of these adjustments may be subtle, such as including paintings or posters of attractive men on the walls of waiting rooms and in rooms where clients are interviewed. Other strategies include:

- Outreach programmes by volunteers or professional social or health workers to appropriate locations such as discos, shopping malls where MSM may congregate
- Peer education among MSM – training MSM to conduct peer education
- The promotion of high quality condoms and water-based lubricants and ensuring their continuing availability
- Education for staff from other health services to overcome ignorance and prejudice about MSM
- Advocacy for the abolition of laws that criminalise sexual activity between men
- Anonymous telephone counselling and advice as a first step for MSM wanting to be tested for HIV but who are hesitant to visit a testing centre. (Can provide advice and support over the phone as well as referral to an appropriate service)
- Provision of specially developed IEC materials with information on safe sex for MSM

Some MSM may be easily accessible, especially in cultures where there are visible MSM communities. For example, in the Philippines many MSM work in beauty parlours. However, the sexual partners of these men may be less visible and therefore less accessible for outreach education.

Some MSM may be reached through their female partners who are attending antenatal clinics. For this reason, it can be beneficial if women are encouraged to bring their partners to the VCT service.

Strategy for access to MSM in Thailand

The Rainbow Sky Organisation of Thailand is a relatively new organisation among the HIV/AIDS services organisations in Thailand. Rainbow Sky is a community-based organisation of MSM working for MSM in HIV/AIDS and STI prevention. The initiatives of the organisation have included MSM outreach by peer educators to bars, karaoke, saunas, discotheques, public parks and other cruising areas where men go to meet other men for sex. Outreach workers are able to promote VCT services that have been deemed MSM-friendly. Information cards which contain contact information of the recommended counselling services, including the names of specially trained counsellors, are handed out during the outreach activities. It is not uncommon for the counsellors to accompany the outreach workers in their rounds to gain the trust of MSM and also to be known by both name and face.

The Rainbow Sky Organisation is also linked through its membership to the Social Welfare Unit of Chulalongkorn Hospital, Thai Red Cross Society. Through this linkage, a hotline counselling service has been established with the staff and volunteers of the Social Welfare Unit.

The Rainbow Sky Organisation is currently based in Bangkok but is in the process of expansion to other provinces throughout Thailand.

6. VCT services for MSM

In the first instance, services providing VCT need to acknowledge the existence of MSM activity and develop appropriate protocols. These protocols will be compatible with other aspects of best practices in VCT. In addition, VCT for MSM should:

- Acknowledge the variety of sexual behaviours among MSM and the complexity of relationships with both casual and permanent partners (especially when there are both male and female partners)
- Conduct a sexual risk assessment for HIV and STIs with appropriate checklist including all possible sexual behaviours
- Develop with the client a strategy for disclosing HIV status to both male and female partners
- Address the issue of possible sexual dysfunction which may arise from issues of identity and/or if the client is HIV positive. This may impact on the ability to engage in safer sex
- Address issues related to 'coming out' (disclosing their sexual preferences) as an MSM to family or friends (this may or may not be an issue – can depend on culture, individual, family, etc.)
- Promote condoms for anal and vaginal sex and eroticise safe sex
- Promote other non-penetrative forms of sex for occasions when condoms are not available or as an alternative to penetrative sex
- Explain and provide supporting information on how HIV is transmitted with particular reference to risk factors for MSM and anal intercourse in particular

7. Elements of an MSM-friendly service

- It is anonymous
- It assures confidentiality
- It has staff who do not make value judgements about behaviours – this means all staff, from reception through to nurses, counsellors and doctors

- It provides appropriate education materials in client waiting areas as well as in counselling and doctor's rooms
- It is open at appropriate times such as late at night on at least some nights and on weekends
- It is located in an accessible area, for example, near venues or locations where MSM may go to meet each other or to look for sex
- It provides free or low-cost HIV and STI testing
- It provides free or low-cost condoms and water-based lubricants

Providing HIV/AIDS programmes for MSM in Malaysia

The PT Foundation (formerly known as Pink Triangle Malaysia) was established in Kuala Lumpur in 1987 to provide a supportive environment for gay and bisexual men and lesbian and bisexual women. Its establishment coincided with the emergence of HIV/AIDS and over time, PT developed a range of HIV/AIDS community activities, some of which were financially supported by international donors. These initiatives have included an anonymous telephone counselling service and MSM outreach by peer educators to shopping malls, discos and cruising areas where men go to meet other men for sex. Outreach workers are able to promote the telephone counselling service by handing out cards with its telephone number. The counselling service is staffed by volunteers who receive training over an eight week period by staff of the organisation and other health workers.

PT has never advertised itself as a gay organisation, especially in its early days, as this would have created a media frenzy since MSM issues are highly sensitive in Malaysia (men convicted of sodomy can be jailed for up to 20 years). By focussing attention on its role in HIV prevention and downplaying its MSM programmes, it was able to establish its credibility with the public and the media and is now a highly respected organisation in the community and an integral part of the response to HIV/AIDS in Malaysia.

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Module 3

Sub module 5: Prevention of mother-to-child transmission

Session objectives

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

- Discuss the epidemiological data related to the prevention of mother-to-child transmission (PMTCT)
- Discuss current strategies for PMTCT
- Discuss the importance of VCT on PMTCT programme
- Identify the concepts and skills needed to provide effective counselling to women and their partners for PMTCT
- Discuss strategies for reducing disclosure-related violence
- Describe the integration of PMTCT counselling network into the existing maternal and child heath system

Time to complete sub module

2 hours

Training materials

- PowerPoint presentation **(PPT22)**
- Activity sheet (case studies) **(AS20)**
- Handout **(HO21)**
- Question box
- Evaluation form collection box

Content

- Epidemiology of mother-to-child HIV transmission
- Strategies to reduce MTCT
- Advantages and disadvantages of VCT for prospective parents
- Broadening the scope of VCT in MCH settings
- Psychosocial consequences of HIV among women
- Principle concepts and role of the counsellors in PMTCT
- The process of VCT in PMTCT
- Demands for VCT in PMTCT settings
- Integration of VCT into the existing maternal and child heath system
- Strategies for reducing partner disclosure related violence and VCT
- Working with couples
- Ethical and legal issues for VCT in PMTCT settings

Session instructions

1. Lecture with PowerPoint presentation **(PPT22)**.
   - Review session objectives and PowerPoint Slide #2 (2 minutes)
2. Review epidemiological profile of perinatal HIV transmission and prevention strategies
   - Lecture by using PowerPoint slide # 2 - 20 (18 slides; slide #14 and 15 may be skipped) (15 minutes)

3. Review scope of VCT in MCH settings. Trainer clarifies the advantages of VCT provided for pregnant women in PMTCT programme.
   - Lecture with open discussion by using PowerPoint slide #21 - 25 (5 slides) (5 minutes)
4. Describe "Psychosocial consequences of HIV among pregnant women".
   - Lecture using PowerPoint slide #26 - 30 (5 slides) (10 minutes)
5. Describe specific roles of counsellors in PMTCT settings.
   - Lecture by using PowerPoint slide #31 - 33 (3 slides) (5 minutes)
6. HIV pre- and post- test counselling for pregnant women.
   - Lecture by using PowerPoint slide # 34 - 38 (5 slides) (10 minutes)
7. Disclosure
   - Lecture by using PowerPoint slide #39 - 44 (6 slides) (10 minutes)
8. *Activity:* Case studies **(AS20)**
   - Divide trainees into two groups. Hand out the activity sheet **(AS20)**
   - Overall assignment: To discuss strategies and approaches to provide PMTCT services
   - Group assignment (20 minutes)
   - Trainers/facilitators explain how to do group assignments and facilitate discussion in each group (1 or 2 facilitators per group)
   - Ask the group to prepare a group presentation: 10 minutes each
   - Trainers summarise the key issues for each client and the key strategies that they need to employ (10 minutes)
9. Describe operational issues in implementation of VCT in PMTCT settings. Review lessons learned from PMTCT implementation in Thailand.
   - Lecture by using PowerPoint slide #48 - 56 (9 slides) (10 minutes)
10. Conclusion
    - Trainer concludes the whole lesson learned including need for further training
    - Lecture by using PowerPoint slide #57 (1 slide) (3 minutes)
11. Ask the group if they have any questions and remind them about the "question box".
12. Ask trainees to complete an evaluation form and place it in the "evaluation form collection box".

Case study 1

Last week, a doctor confirmed she was six weeks pregnant. When she told her husband about the pregnancy, he confided that he was HIV positive. He discovered he was HIV positive when he got sick and had to be hospitalised. For this reason she has decided to have an HIV test. She is very upset with her current situation. She is angry with her husband and worried for herself and her unborn child. Her husband has told her that he has visited sex workers. She reports she that most recently had unprotected sex with her husband two weeks ago. She has one close friend to whom she has spoken of her concerns. She states that she is afraid to tell her family for fear of disappointing them. She reports no previous psychological difficulties.

Case study 2

A 23-year-old married woman presents in an advanced state of pregnancy. She is seven months pregnant with signs and symptoms of HIV infection (skin lesions, oral thrush, chronic diarrhoea, and persistent dry cough). She comes from a village and has been brought to the antenatal clinic by a friend. Her husband is away working in another city at the moment. She has had a rapid HIV test today and the results show her to be HIV positive.

She tells you she cannot tell her husband, as he will hurt her. She also reluctantly tells you that in the past when her husband got drunk he used to beat her. She is worried he will leave her. She has one other child who is two years old.

Module 3

Sub module 5: Prevention of mother-to-child transmission

Session objectives

- To review participants' information on the epidemiological data related to PMTCT
- To review and discuss current strategies for the PMTCT
- To describe the importance of VCT on PMTCT programme
- To help participants understand the importance of VCT for both individuals (pregnant women or mothers) and couples
- To help participants understand the aims of pre-test and post-test counselling for pregnant women and the differences in VCT in different settings
- To identify the concepts and impart the skills needed to provide effective counselling to women and their partners for PMTCT
- To describe the integration of VCT into the existing maternal and child heath system

1. Epidemiology of mother-to-child HIV transmission

At the end of 2003, it was estimated that 2.5 million children under 15 years were living with HIV/AIDS and 700,000 children were newly infected in 2003.[1] Most of them will die before they reach their teens.

In Asia the estimated number of children living with HIV/AIDS amounts to more than half a million (Table 1). The vast majority of children with HIV are infected from their mothers in-utero, at the time of labour and delivery, or after birth through breastfeeding (Figure 1). In the absence of interventions, around a third of HIV-positive mothers will pass the virus to their infants through one of these routes.

Most MTCT of HIV occurs at the time of delivery or late in pregnancy. Between one-third and half of infections occur during breastfeeding. Several factors, not all of which have been fully elucidated, influence the likelihood of the baby getting infected, including viral, maternal, obstetrical, foetal and neonatal factors. High maternal viral load, such as at the time of seroconversion or in advanced disease, is considered to be a major factor in transmission.

Table 1: Estimated number of children < 15 yrs. living with HIV/AIDS in selected countries in Asia[2]

India	500,000
China	70,000
Myanmar	23,000
Thailand	18,000
Cambodia	9,000
Malaysia	1,700
Laos	800
Vietnam	600

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2. HIV transmission during pregnancy (Table 2)

In most HIV-infected women, the HIV does not cross the placenta from mother to foetus. The placenta actually shields the baby from HIV. However, this protection may break down if the mother:

- Has viral, bacterial, and parasitic (especially malaria) placental infection during pregnancy
- Gets infected with HIV during pregnancy, developing high viral load at that time
- Has severe immune deficiency associated with AIDS
- Has malnutrition during pregnancy, which may indirectly contribute to MTCT

Figure 1: Estimated risk and timing of mother-to-child HIV transmission

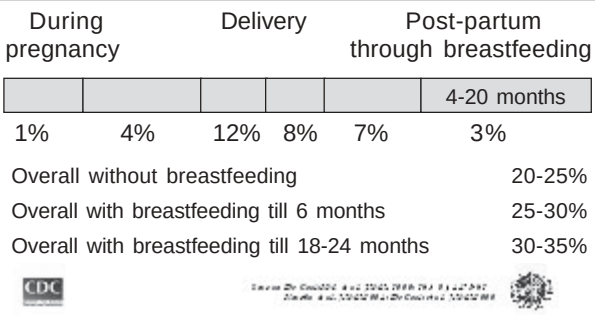


Table 2: Modes of mother-to-child HIV transmission

Risk factors for MTCT

Strong evidence	Limited evidence
Maternal	
• High viral load • Viral characteristics • Advanced disease • Immune deficiency • HIV-acquired during pregnancy • Breastfeeding	• Maternal nutrition status • Vitamin A deficiency • Anemia • STIs • Chorio-amnionitis • Frequent unprotected sex • Multiple sex partners • Smoking • Injecting drug use
Obstetric • Vaginal delivery versus caesarean section • Prolonged rupture of membranes • Intrapartum haemorrhage	Invasive obstetrical procedures • Monitoring • Episiotomy
Infant • Premature • Breastfeeding	• Lesions of the skin and/or mucus membranes (oral thrush) including the gastrointestinal tract

HIV transmission during labour and delivery

Infants of HIV-infected mothers are at a greater risk of becoming infected during childbirth. Most infants who acquire HIV in labour and delivery do so by swallowing, or aspirating maternal blood or cervical secretions. Factors associated with high risk of MTCT during labour and delivery are:

- Long duration following rupture of membranes often in the form of ARM
- Acute chorioamnionitis (resulting from untreated STDs or other infections)
- Invasive delivery techniques that increase the baby's contact with maternal blood, e.g., episiotomy, etc.
- First infant in a multiple birth

3. HIV transmission through breastfeeding

HIV is present in the milk, although the viral concentrations are significantly lower than those in the blood. The risk of MTCT through breastfeeding depends on:

- The pattern of breastfeeding: babies who are exclusively breastfed have a lower risk of being infected than those who are mixed-fed
- Breast pathologies: mastitis, cracked nipples, bloody nipples and other breast infections.
- Breastfeeding duration: the longer it is continued, the higher the risk of transmission
- Maternal viral load: the risk is believed to double, 30% if a woman becomes infected with HIV for the first time whilst breastfeeding
- Maternal immune status, advanced AIDS
- Poor maternal nutritional status

4. Timing of HIV transmission during breastfeeding

- Transmission can take place at any point during breastfeeding.
- About 70% of postnatal transmissions occur within the first 4-6 months.
- HIV has been detected in colostrum and mature breast milk but relative risk of transmission is not established.
- Risk is cumulative (the longer the duration of breastfeeding, the greater is the additional risk). The overall risk of transmission via breastfeeding is 10% over 24-36 months of feeding.

5. Prophylaxis antiretroviral regimens for PMTCT

ARV can reduce the HIV virus concentration in maternal fluid, tissues, and breast milk, which in turn can lead to decreasing risk of infant exposure to high maternal HIV virus during intrauterine, intrapartum and post-delivery. The usefulness of ARV drugs for prevention of mother-to-child HIV transmission was demonstrated in 1994 and has now been adopted as part of the standard care of HIV-infected pregnant women in most countries.

Long course AZT

In 1994 the AIDS Clinical Trial Group 076 (ACTG 076) demonstrated that the use of AZT as monotherapy (given orally 100 mg 5 x daily to pregnant women from 14 weeks to time of labour and given intravenously during labour and to babies orally 4 x daily for 6 weeks and fed on formula) resulted in decreased transmission by 67%. This regimen also referred to as “long course AZT” was then adopted as standard care in HIV infected pregnant women. When this regimen was combined with elective caesarian section the efficacy of prevention of MTCT improved to 98%.

Long course AZT is considered unsuitable for developing countries for the following reasons:

- Course is too long and thus too expensive.
- It is complicated as mothers have to take medication 5 x daily.
- Pregnant women present late to antenatal clinic (ANC).
- Requires the use of intravenous AZT in labour, which is not possible in many facilities in developing countries.
- In the long course, formula is used as babies are not breastfed. This method of feeding is not practical for the majority in developing countries.

Short course AZT

Short course AZT or Thai short course: In 1998 research carried out in Thailand, a developing country, showed that AZT used for four weeks can decrease transmission by 50%. This was considered relatively

Table 3: WHO has introduced a 4-pronged model for PMTCT

Strategy	Key components
Prong I: Primary prevention of HIV infection among women of child-bearing age	• Behaviour change interventions in general population and couples • Information, education and counselling on HIV prevention and care • Better STI management, reduction of unsafe transfusions • Addressing contextual factors that increase women's vulnerability, i.e., stigma and discrimination • Promoting condoms and safer sex practice • Encouraging partner's involvement in safer sex discussions and couples' VCT Providing counselling to either HIV negative or serodiscordant couples has been shown to be a highly effective primary intervention strategy
Prong II: Prevention of unintended pregnancy among HIV infected women	• Increase the number of women who know their HIV sero- status through information, education and counselling on HIV prevention and care, including approach to MTCT prevention. • Step up counselling of women and their partners to enable informed choice with regard to potential future pregnancy. • Promote condoms as a valuable family planning tool. • Set up referrals to family planning and other counselling services as essential ingredients (knowledge of locally available counselling resources is therefore essential). Women who test HIV positive in early pregnancy can make the decision either to continue with the pregnancy or to elect for termination where this is legal and safe.
Prong III: Prevention of perinatal HIV transmission among HIV infected women	• Ensure that HIV positive women have *access to antenatal care system* and PMTCT services. • Provision of *antiretroviral drugs* to HIV infected pregnant women and their newborns with counselling and support for drug adherence. • *Safer delivery* practice. • Counselling and support for *safer infant feeding* practice.
Prong IV: MTCT plus provide care and support for HIV-infected women and their families	• Medical and nursing care: VCT, OI prevention therapy, highly active antiretroviral treatment (HAART) and palliative care. • Psychosocial support: counselling, spiritual support, follow up counselling and community support. • Human rights and legal support: PLHA participation and stigma/discrimination reduction. • Socioeconomic support: material support, micro-credit and food support.

more affordable for developing countries. The regimen is as follows:

- AZT 300 mg 12 hourly orally starting from 36 weeks
- In labour 300 mg 3 hourly until delivery
- No medication given to mother or baby after delivery
- Baby does not breastfeed

As a result of this finding, the UN agencies recommended the use of this regimen for developing countries. Several developing countries through government and the support of UN agencies introduced this regimen as pilot projects. However, there are certain disadvantages to this regimen which are:

- Short course AZT is still expensive.
- Some mothers have premature deliveries and do not benefit from the course.
- Some mothers present very late in pregnancy.
- Some mothers do not attend ANC and deliver at home.
- Multiple pill taking may compromise privacy and disclosure (related to poor adherence and stigma).
- As most mothers tended to breastfeed, the efficacy diminished with breastfeeding.

Nevirapine

Whilst countries were piloting AZT, research in Uganda (HIVNET) and later in South Africa showed that a single dose of Nevirapine (NVP) given in labour and a single dose given to babies at 48-72 hours managed to decrease the transmission rate by 50% in babies who were three months old and were breastfed. This regimen of single-dose intrapartum/ newborn NVP prophylaxis was considered ideal in preventing MTCT in developing countries for the following reasons:

- It is simple as it is a single drug given at onset of labour.
- It is cheap.
- Some mothers can take the medication if they want to deliver at home.
- Mothers can still breastfeed.

Considerations regarding Nevirapine regimen for PMTCT:

- Drug resistance after single dose was observed in clinical research and needs further investigation.
- When women have not received ARV and risk of transmission is high, benefit of single-dose NVP outweighs the risk of resistance.
- When women receive standard therapy (usually combination ARV), infants receive six weeks AZT, and if elective C/S is possible the benefit of adding NVP seems limited and does not outweigh risk of inducing NVP resistance.

In 2000, the manufacturers of Nevirapine, in partnership with the United Nations system, offered the drug free of charge to developing countries for a period of five years.

Recent studies as for example conducted in Abidjan, Cote d'Ivoire administering combination ARV regimens such as ZDV boosted by single dose NVP in breast feeding populations and Thailand in non-breast feeding populations suggest being more effective at 6-8 weeks post delivery than short-course mono therapy regimens.[3]

6. Breastfeeding and ARVs

Most HIV infected women live in deprived conditions and lack access to clean water and sanitation. This limits their ability to employ safe breast milk substitutes. Research on how to make breastfeeding safer is a high priority. Results from one study suggested that exclusively breastfed children are less likely to acquire HIV than those receiving breast milk and other foods. But these results need to be

confirmed in other settings. Meanwhile, studies are under way to determine whether ARV provided to a mother or infant during breastfeeding period can prevent HIV transmission.

Informed choice on infant feeding choices should be provided to all HIV positive pregnant women. In general, summary of the UN/WHO guidelines on infant feeding are as follows:

- For HIV-negative women of unknown status
  - *Exclusive breastfeeding* should be protected, promoted and supported for six months.
- For HIV-positive mothers
  - *Breast milk substitutes* (formula or sterile diluted animal milk) when replacement feeding is acceptable, feasible, affordable, sustainable and safe, otherwise exclusive breastfeeding is recommended during the first months of life.
  - Breastfeeding should be discontinued as soon as feasible in order to minimise the risk of HIV transmission.
  - Always consider local customs, the individual woman's situation, and the risks of replacement feeding *(which can lead to an increased risk of other infections and malnutrition).*

7. Findings on ARV prophylaxis for PMTCT in limited resource countries

- Higher efficacy of ARV prophylaxis is in non-breastfeeding settings
- Short AP ZDV is effective, but less than long AP therapy
- IP/newborn prophylaxis with ZDV/3TC or NVP can also reduce transmission, although less than with 3-part AP-IP-NB regimens
- Persistent (although decreased) efficacy was seen with short-course AZT and NVP regimens among 18-24 months breastfed infants
- The addition of single-dose NVP may provide added benefit to short-course AZT (need to study NVP resistance)
- When maternal AP/IP ARV are not received, post-exposure infant prophylaxis should be given, but the best regimen is yet to be defined
- The most efficacious regimen among those recommended for prevention of MTCT for women with HIV who do not need ARV treatment is zidovudine (ZDV) from 28 weeks with single dose nevirapine (NVP) at onset of labour for the mother and single dose NVP plus one week ZDV for the infant.
- Alternative but less efficacious regimens include one based on ZDV alone (from 28 weeks of pregnancy and through labour for the mother and for one week for the infant), one using the combination of ZDV plus lamivudine (3TC) (from 36 weeks of pregnancy, through labour and one week postpartum for the mother, and for one week for the infant), and a regimen comprising a single dose of NVP to the mother and to the infant (which does not need to be initiated until labour).
- The selection of the ARV drug regimen should be made at national level, based on issues of efficacy, safety, drug resistance, feasibility, and acceptability.
- A pregnant HIV-positive woman who opts to breastfeed should still be given ARVs to prevent MTCT although the efficacy of the ARV in preventing transmission will be decreased. If short course AZT is used, the efficacy is reduced from 50% in non-breastfeeding to 37% at three months of breastfeeding. With Nevirapine the efficacy at three months of breastfeeding is 50%. In babies who are breastfed for longer, the efficacy diminishes with duration of breastfeeding

8. VCT in the context of PMTCT programmes

8.1. *Why do we need to offer HIV antibody test to particular or prospective parents?*

Advantages of VCT for prospective parents (Table 4)

VCT is an important entry point to other HIV/AIDS services. It provides the opportunity for people to know their HIV status and with quality counselling support it helps them cope with a positive or a negative

Table 4: Advantages and disadvantages of having HIV test among pregnant women

Advantages of having an HIV Test

- Knowledge of the result can reduce stress.
- HIV positive clients can, if they are expecting, make a decision on how to reduce the chances of the baby getting infected through the use of antiretrovirals during pregnancy, labour; chart out options of delivery procedure; and also explore other infant feeding options.
- Positive living
  a. Symptoms can be identified and treated promptly
  b. Clients can also protect themselves from further infection
  c. Clients can improve their health by good sanitation, healthy diet, etc.
- Planning for the future of one's family might be made more easily.
- Making choices about her sexual behaviour and future childbearing.

Disadvantages of having an HIV Test

All the possible implications of a positive test result should be discussed

- Stress and uncertainty: HIV positive clients may fail to handle positive result, e.g. the client might live in anxiety, watching for the development of signs and symptoms of HIV/AIDS or live in fear of maintaining a secret.
- The clients may face stigma if information is shared with family and friends.
- They may find maintaining relationships difficult.
- Clients may find restrictions placed on mortgage and life insurance and job opportunities.

test result. When it is well implemented, VCT services offer the possibility of benefitting the community by "normalising" the existence of HIV/AIDS, thereby reducing stigma and promoting awareness.

Studies from Africa have shown that voluntary (and confidential) counselling and testing is a cost-effective intervention for reducing HIV-related behaviour, particularly when it serves at-risk couples[4]. Experience from Thailand in the early years of the epidemic confirms the value of VCT in contributing to reduction of HIV transmission[5]. In regions seriously affected by HIV, VCT is increasingly being viewed as an integral part of access to comprehensive, essential, quality health care.

In most countries, the majority of the adult population are HIV negative, even in high-HIV prevalence settings. For HIV-negative women, counselling can reinforce the importance of risk reduction such as safe sexual behaviour and can serve as a strong motivating factor to remain uninfected.

For women who are identified before or during pregnancy as being HIV positive, test-related counselling can help them make decisions on further interventions, including ARV prophylaxis and determine options for infant feeding. In addition, it can help HIV-positive pregnant women plan for their future and the future of their families. Such counselling can also help the HIV-positive women take special steps to maintain their health, not infect their sexual partner/s, be linked with support groups and services, and make informed choices about their sexual behaviour and future childbearing decisions. VCT programmes for pregnant women can benefit from the involvement of men. Conflict and violence among couples after HIV disclosure have been shown in some studies. VCT and continuing counselling support can minimise these conflicts, abandonment, and even violence.

In the absence of VCT services, most women have no definitive way to know their HIV status until they fall ill with identifiable AIDS symptoms, or until they give birth to a baby who is diagnosed with HIV/AIDS. But in such cases, the timing for future planning for themselves and their families will be limited.

Disadvantages of VCT for prospective parents (Table 4)

The disadvantage of having the test done voluntarily is that not everyone will be aware or convinced that they are at risk and therefore may not be reached by VCT. Many HIV-positive pregnant women who were infected from their partners/husbands will not be aware of being infected at the time of testing. Many may be unable to cope with the situation. Most people refuse to take the test as they are concerned about confidentiality, and others are afraid that if the results are positive, they may be abandoned or subjected to violence.

Improving uptake of VCT

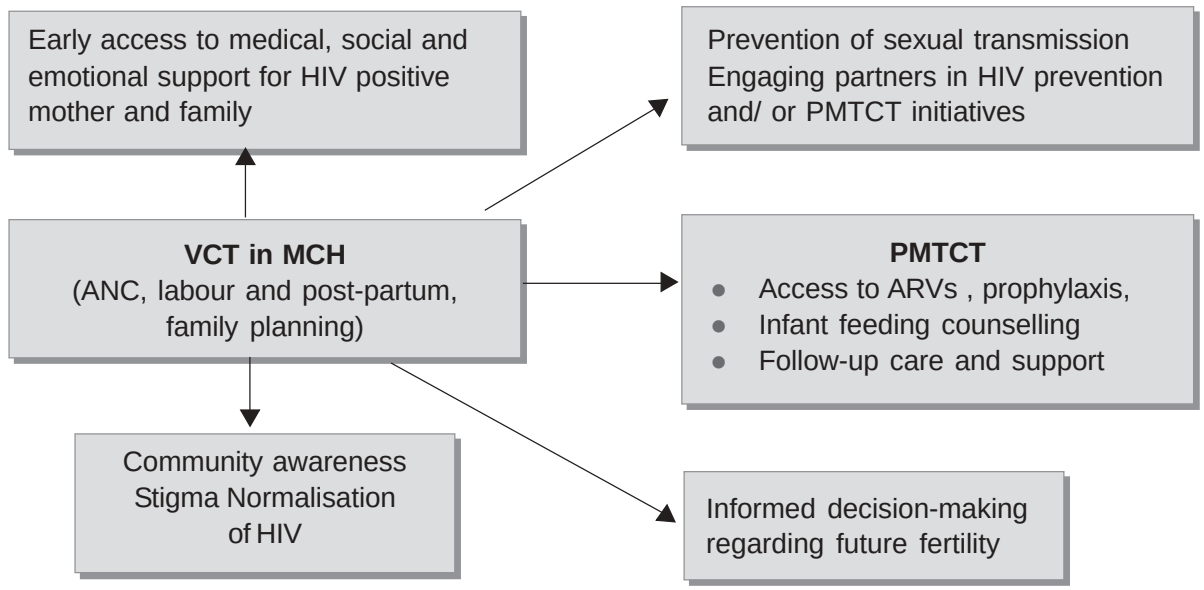
Strategies

- Social marketing campaigns can highlight the benefits of HIV testing to the broader population of women of childbearing age.
- VCT can be promoted in family planning clinics for women, especially those attending to pregnancy.
- Improving the quality of VCT services in ANC services.
- Adoption of "opt out strategies" for VCT services where VCT is offered as part of the routine package of services to women in ANC services. If women do not want to undergo VCT they must specifically decline the VCT component of the service. Where women are required to "opt in" and asked whether they want VCT they are less likely to take up the opportunity.

8.II. *Psychosocial consequences of HIV among women*[7]

1. Women often discover their status by accident, after the spouse or partner or child is already symptomatic and this presents the woman with a double crisis.
2. Women are often wrongly accused of having brought the infection into the family; this often raises conflicts with their spouse and may lead to domestic violence.
3. The woman's infection may be the first indication that she or her partner has had another partner, and disclosure of this within the family unit may be traumatic.

Figure 2: Broadening the scope of VCT in maternal and child health (MCH) settings



4. Fear of social stigma, abandonment and extreme feelings of isolation and loneliness may compel a women to keep her condition secret.
5. Fear of violence may compel a women to keep from disclosing to her partner.
6. Infected women may be extremely concerned about the welfare of their children and underestimate their own needs.
7. Infected women may have tough and often painful decisions about their personal lives. Such decisions include:
   - Care of their children after their own death
   - Whether to take prophylaxis antiretroviral drugs
   - Whether to breastfeed
   - Whether to disclose their HIV status to their partners
   - Whether to avoid pregnancy and contraception options
   - Whether sexual relations should continue and whether condom will be used
8. There are some reports that the incidence of post-natal depression is increased in HIV-positive women.

The emotional reaction of HIV infected women

Women may require counselling assistance to cope with the following psychological reactions:

1. Anger towards the person who may have infected her
2. Grief at her loss of health and status, changed body image and sexuality, the possibility of having to give up having children and of dying and leaving her children alone
3. Guilt relating to how she may have been the cause of her child's illness and may be a burden on her family members in the future
4. Postnatal depression

What cultural and socio-economic factors demand attention?

In a male-dominated society, a woman may be faced with the following challenges:

1. Seek permission of male partner to test
2. Suffer from a lack of protection from HIV (condom use)
3. Suffer from a lack of control over decisions on infant feeding
4. Suffer from a lack of control related to family planning

It is thus evident that the infected woman has many concerns and therefore needs a lot of support from family members, friends, professionals and the community. It is important that the woman is helped to protect herself from getting HIV and therefore from infecting others or facing some of the painful consequences mentioned. One of those likely consequences is transmitting the virus to her unborn child.

8.III. *Principle concepts and role of the counsellors in PMTCT*[8 - 12]

VCT in PMTCT is a dialogue between a client who is a prospective parent and a care provider/ counsellor. The process seeks to serve at least three purposes:

1. Informative:

To ensure that the client has a correct understanding of the facts that will enable him/her to make informed decisions. HIV prevention education should be included as part of routine antenatal care.

a) knowledge and information (basic facts) on HIV/AIDS in pregnancy
b) basic facts on issues of HIV/AIDS, MTCT and modes of transmission
c) the importance of and objectives of VCT for individuals and couples for prospective parents

2. Supportive:

To help the client make voluntary and informed decisions about HIV/AIDS prevention and care and to provide support for the feelings/emotions of the client/clients as needed. Voluntary and informed decisions include:

a) HIV testing
b) Planning pregnancy or termination of pregnancy
c) PMTCT intervention, e.g., delivery options, entering into ARV programmes, infant feeding options
d) Disclosure issues

3. Preventive:

The counsellor increases the client's awareness about measures they can take to protect themselves and others and emphasises MTCT of HIV that can impact future plans:

a) Risk assessment and risk reduction
b) Prevention of re-infection or spread of infection
c) Assisting the client to understand their role in PMTCT starting from where the client is
d) Drawing of future plans, including working with individuals, couples, and families by putting emphasis on working with the client, not for the client

8.IV. *Skills needed to provide effective VCT*

To be able to develop the required basic and specific skills, a counsellor should be guided by certain principles. These principles promote the purposes (aims) of counselling, and guide the conduct of the counsellor and the help given. These principles have been reviewed in Module 2, sub module 2: "Counsellor attitudes and values"

8.V. *The process of VCT in PMTCT* [8 - 12]

A detailed discussion of pre-HIV test counselling should be covered in pre-test counselling sessions as discussed in Module 2, sub module 5.3. The following outlines some of the issues specific to VCT in the context of preventing mother-to-child transmission.

Pre-test counselling of an individual client

1. To provide routine education/counselling about the HIV test for pregnant women by individual counselling, brochures, videos, or group class and give the following messages:
   a. Causes of HIV/AIDS and how it is spread.
   b. Anyone can get HIV infection. Women especially may not know they are at risk.
   c. HIV testing is recommended for all pregnant women regardless of whether a woman thinks she is at risk.
   d. Highly effective treatment and MTCT prophylaxis options are available for HIV positive women to protect the foetus from acquiring HIV and for their own health.
   e. If a woman is HIV negative during pregnancy, she can learn ways to prevent getting the infection in the future.
   f. All information about HIV testing and the results are kept confidential.
2. To carry out risk assessment and provide the individual with necessary risk reduction information
3. To discuss the tests and to spell out what is meant by being positive, negative, discordant, indeterminate results and window period
4. To ensure that any decision to take the HIV tests is fully informed and voluntary
5. To provide the necessary preparation for those who will have to face the trauma of a positive result
6. To explore with client the advantages and disadvantages of knowing one's HIV test results (Table 4)

7. To present options available if the pregnant woman tests positive
8. To discuss the importance of PMTCT intervention and highlight the increased risk of transmission associated with new infections.
9. To allow the client to make a decision about having an HIV test. The client, if ready, may go for the test and on the other hand may decide not to have the test after weighing the advantages and disadvantages
    a. Explain the procedure for HIV testing
    b. Length of waiting time for the results and how client will cope
    c. Amount of blood to be taken
    d. Confidentiality, the use of numbers and not names
    e. Discuss when to come back for results - book an appointment for them
10. To help the client identify support systems, including encouraging the partner to come for testing

Post-test counselling of an individual client

Aims of post-test counselling

1. To give the client his or her HIV test results
2. To deal with any emotional reactions resulting from the HIV test results
3. To support the client in any informed decisions made pertaining to risk reduction, including PMTCT issues

Post-test counselling involves one or more sessions. Once again there is need to realise that individuals are different and may have different concerns during the counselling sessions.

Informing the client of the result

1. Recap on pre-test and assess the client's readiness to receive the HIV test result by asking, "Do you still want to get your HIV test results?"
2. The result of the test, whether positive or negative, should be given promptly. Clients are usually very anxious to hear their results.
3. The result should only be given if the counsellor has proof (laboratory report) in front of him/her. This is important for two reasons:
    a. to avoid confusion or mix-ups
    b. as proof to the client who may wish to see the result in writing

A detailed discussion of result provision is included in Module 2, sub module 5.4. All of the material contained therein should be considered when providing VCT to expectant mothers or HIV-positive mothers. There are a number of specific issues that need to be considered in providing results to HIV infected women who are pregnant or have recently delivered a child. These are discussed further herein.

Giving positive results

1. Give space/time to express emotions.
2. Check the client's understanding of the meaning of the result. (Explain that a positive HIV test means that she has HIV infection even though she may feel well and have no symptoms).
3. Discuss and support the client's feelings and emotions, and assess her level of social support, e.g.,
    a. What are your plans for the rest of the day?
    b. Where are you going to from here?
    c. Do you have someone that you can talk to about the diagnosis?

4. Revisit PMTCT for the available interventions to reduce the risk of transmission to her foetus
   a. Transmission of HIV from mother-to-child can be prevented
   b. Assist the mother to make informed decisions. The issues that would be raised are whether or not an infected pregnant/mother should:
      - Use prophylaxis antiretroviral drugs to prevent her baby from becoming infected
      - Select feeding options, as well as explore pros and cons of breast milk and breast milk substitutes
      - Make delivery plans with the obstetrician
      - Practice safe-sex to reduce the likelihood of re-infections

Counselling women to make informed choice requires deep understanding of the social issues, compassion, knowledge of the household situation, the ability to communicate complex concepts, and the ability to emotionally support women in a decision that affects them, their children and their entire family.[13]

5. Discuss living with an HIV positive condition through a healthy lifestyle:
   a. Avoiding further risks of infection with other viral strains: For some, self-protection is a stronger motivator for safer sex than the need to protect others; for others, the responsibility to avoid spreading the virus is itself the critical motivator. Both contribute to HIV prevention.
   b. Screening/treatment for STIs
   c. Nutritional support, exercise, and stress management
   d. Prompt medical attention with early treatment for opportunistic and HIV/AIDS related infections
   e. The referral for medical care and social services

6. Consider whether the father or sexual partner will be informed and tested.
7. Disclosure and other supporting issues with subsequent counselling sessions on the HIV positive status also provide an opportunity to protect sexual partners and to plan for the future from an informed position - deciding on marriage and on child bearing, and preparing children and family for the progression of disease and death.

Giving negative results

1. Recap on pre-test.
2. Give space/time to express emotions/feelings.
3. Check the client's understanding of the meaning of negative result.
4. Explain the possibility of a false negative test if she was recently infected and the antibody has not had time to develop (window period). A repeated HIV test may be needed if she is at risk.
5. Discuss the importance of remaining HIV negative and assist the client to explore future risk reduction options so that they can maintain a negative status in view of the high risk associated with new infections.
6. Alert about support and subsequent counselling sessions.

Giving indeterminate results

1. Check understanding of meaning of result by the client and fill in the gaps.
2. Discuss with the client the need to get re-tested and send sample to the laboratory.
3. Discuss support and subsequent counselling sessions.

8.VI. Demand for VCT in PMTCT settings

Demand for and uptake of VCT's services in PMTCT programmes varies widely within and between countries. In many places in Africa, demand for VCT is low when services are first introduced. In

Table 5: Utopian framework for VCT within ANC/MCH service delivery

Pregnant women
who access antenatal services
who deliver within a health facility with a HCP present (incl. TBA)
who receive health education and pre-test counselling for HIV
who consent to HIV testing
who receive results and post-test counselling
who test HIV positive
who test HIV positive and are offered ARVs for PMTCT
who test HIV positive and take ARVs and
who receive dose for baby within an efficacious time frame
Mother, baby pairs are offered comprehensive follow-up care, and support
Mother-baby pairs access comprehensive follow-up care and support

PMTCT programmes, it is not unusual for fewer than half of all eligible women to accept pre-test counselling, go for testing, and to return for their HIV test results, even when ARV drugs are available for PMTCT [5, 6, 14].

Data on the demand for VCT in Asia are higher than in African countries. Acceptance rates among antenatal women in the well-established Region 7 PMTCT pilot programme in Thailand, and the Calmette Hospital PMTCT pilot project in Phnom Penh, Cambodia, were 93% and 85% respectively[9, 15, 16]. A newer PMTCT site in Myanmar reported acceptance of only about 30%[5]. Seroprevalence, economy and culture may influence the rate of acceptance.

Low demand of VCT has been attributed to a variety of factors [9]:

- Lack of VCT facilities and HIV test kit supplies (including testing cost and payment)
- Low awareness of the availability of VCT services
- Low awareness of the potential benefits of VCT
- Lack of confidence in the quality of VCT services (including adequate time frames and skilled counsellors, women must believe that undertaking VCT is useful and safe, that confidentiality is respected, and that tests yield a “true” result.)
  - Stigma associated with a positive HIV test result
  - Length of time required to wait for the test result
  - Insensitive treatment by health providers
  - Insufficient links to care and support for those found to be HIV positive

Reasons for not being tested among pregnant women are as follows[17]:

- Not perceiving herself at risk (55.3%)

- Having been tested recently (39%)
- Test not offered or recommended (11%)
- Adverse consequences rarely mentioned
- Others: older age, third trimester initiation of prenatal care, higher education attainment

Acceptance of HIV testing among pregnant women

- Pregnant women are likely to accept HIV testing when it is offered (IOM, 1999: 75-86% of pregnant women accepted voluntary HIV testing)
- Attitudes of counsellors: Where counsellors understand and support the benefits of VCT/PMTCT interventions, uptake by women attending ANC is higher
- Reasons commonly cited for acceptance of HIV testing:
  - Belief that knowing one's HIV status during pregnancy can benefit both mother and baby
  - Strong providers endorsement for prenatal testing

Experiences from Thailand

Experiences from Thailand during the implementation pilot PMTCT programme in Region 7 during 1998-1999 prove that VCT is a major part of the programme success. Improvement of VCT facilities including training for counsellors, supply of HIV test kits for poor women free of charge, laboratory capacity with fast reporting, and supply of AZT and formula substitute to prevent transmission have been identified as the key components of a successful programme. The data showed acceptance of VCT in the antenatal care clinic had increased from less than 80% in the first 6 months to more than 90% in the last 6 months of programme implementation [16]. These experiences have been used as benchmarks for the national expansion in 2000. Recent data from Thailand national Perinatal HIV Intervention Monitoring System, 2002, show that 97.9% clients in ANC accepted HIV testing and so did 97.1% of woman delivering.[21, 22]

8.VII. Integration of VCT into the existing MCH system [9, 18]

Significant advantages of offering VCT services to women in MCH or antenatal setting include:

1. Making VCT a routine MCH service (offered to every MCH client) can help reduce the stigma associated with both VCT and HIV infection.
2. VCT offered at MCH clinics may be more acceptable to women than walk-in centers that serve both men and women.
3. VCT services based in antenatal clinics can reach a high percentage of pregnant women, especially when offered as routine services.
4. Pregnant women who are not aware of their individual or partner's risk will have a chance to assess themselves via VCT process.
5. Continuing services of MCH system can support the integration HIV/AIDS programme such as PMTCT, treatment of STD and other infections, family planning, nutritional support, and subsequent referring to other medical care.
6. Access to safe abortion (where this is legal) and counselling to ensure informed decision making and consent by the woman, should be part of the services.

Reducing the time and cost of HIV pre-test counselling in centres with large client numbers

Individual pre-test counselling can be time consuming and may not be feasible for services with large client loads. An alternative to individual counselling is to conduct group information sessions prior to pre-test counselling. In these sessions basic information about HIV and its transmission can be provided along with information on transmission risk reduction strategies, the test procedure and the general advantages and disadvantages of the test. This group information giving then reduces the time the counsellor has to spend with an individual. Individual counselling can be conducted to ascertain individual risk, assessment of individual preparedness for results and individual issues impacting on transmission risk reduction.

Opt in or opt out testing system

Opt-in services = VCT services require women to choose and consent to be tested
Opt-out services = antenatal women are offered VCT routinely and they are tested unless they specifically decline or do not consent

Because some programmes in Africa were experiencing very low uptake of testing, they have developed a model of "opt-out testing". In addition, in very-high-HIV-prevalence settings, such as in Botswana (where 45% or more of women coming for ANC are HIV positive) governments are also offering short-course ARV prophylaxis for women who are offered testing but decline. The impact of this strategy on VCT and other PMTCT interventions is unknown and requires research and documentation in the future.

VCT at the time of delivery - what are the issues?

While it is best if women receive VCT through MCH services during the antenatal period, many women appear for delivery without having received antenatal care from that facility. Even though HIV-positive women present themselves in labour without receiving antenatal care and miss their opportunity to be offered antenatal ARV prophylaxis, some MTCT prevention programmes, i.e. NVP single dose in labour for mother and single dose for baby are still possible.

In response to this, applying VCT for rapid HIV testing in labour in many settings has been developed and implemented. Pre-test counselling needs to make sure that pregnant women understand why VCT is important for their babies and confirm they are ready to make a decision about testing. Rapid HIV testing is used for preliminary diagnosis. Policy on offering ARV prophylaxis is varied in different programmes. Some programmes offer ARV based on preliminary HIV diagnosis by approved rapid test because of high sensitivity and specificity with low false positive (~1%). Pregnant woman need to make choices for themselves and their babies to take medication if her rapid test is positive. Post-test counselling can be completed after HIV infection is confirmed, most likely in the postpartum ward.
Such programmes are implemented in many countries, for example, the Calmette Hospital MTCT Prevention Project in Phnom Penh, Cambodia; Thailand (PHIMS data); a large public hospital in Pune, India, and a rural district in Tami Nadu, India. In the latter cases, the hospitals have many rooms and this can increase VCT coverage and uptake significantly. This approach is not without its critics, who maintain that women are not capable of giving truly informed consent at this time and are not fully receptive to counselling.

8.VIII. Partner disclosure related violence and VCT

The individual benefits that women may receive from sharing HIV test results with their partners need to be balanced against the potential risks that a woman may face when she discloses.

Table 6: Potential benefits and risks of HIV serostatus disclosure to sexual partners

Potential benefits	Potential risks
• Increased opportunities for receiving social support • Improved access to necessary medical care • Increased opportunities to discuss HIV risk reduction with partners • Increased opportunities to carefully and thoughtfully plan for the future	• Loss of economic support • Blame • Abandonment • Physical and emotional abuse • Discrimination • Disruption of family relationships

Counselling strategies to reduce partner disclosure related violence

Fear of violence is a major barrier for disclosure of HIV status by women to male partners. This may be a justified fear.[19] In one study, 42.6 % women reported one occasion of partner violence per lifetime and 32.2 % of them, one occasion of violence with their current partner. Another study found that Indian men who abused female partners both sexually and physically had higher incidence of extramarital sex and incidence of STIs.[20]

1. Encourage discussion prior to presentation for testing.
   a. Social marketing of VCT and PMTCT in communities could target couples and encourage such discussion.
   b. Counsellors facilitate couple discussion prior to testing (See session VIII).
2. Create opportunities for sexual histories of couples to be undertaken separately. This not only ensures accurate risk assessment but also offers the counsellor an opportunity to foresee potential relationship difficulties that may arise from disclosure of an HIV positive result.
3. Assessment: In addition to engaging in the standard process of disclosure counselling it is important to assess the couple's history and potential for violence, preferably at both pre- and post- test counselling sessions. This should be done with the women in an interview separate from her partner and reassurance must be given about confidentiality. Figure 3 shows suggested questions to assess potential disclosure related violence.
4. Where the threat is less tangible and there is little to suggest a real threat but the client is still anxious, encourage couple disclosure of results with counsellor.
5. Develop a "disclosure plan" with the client and include planning for an aggressive response.
6. Maintain a referral directory of welfare agencies offering support to women, e.g. shelter from domestic violence.

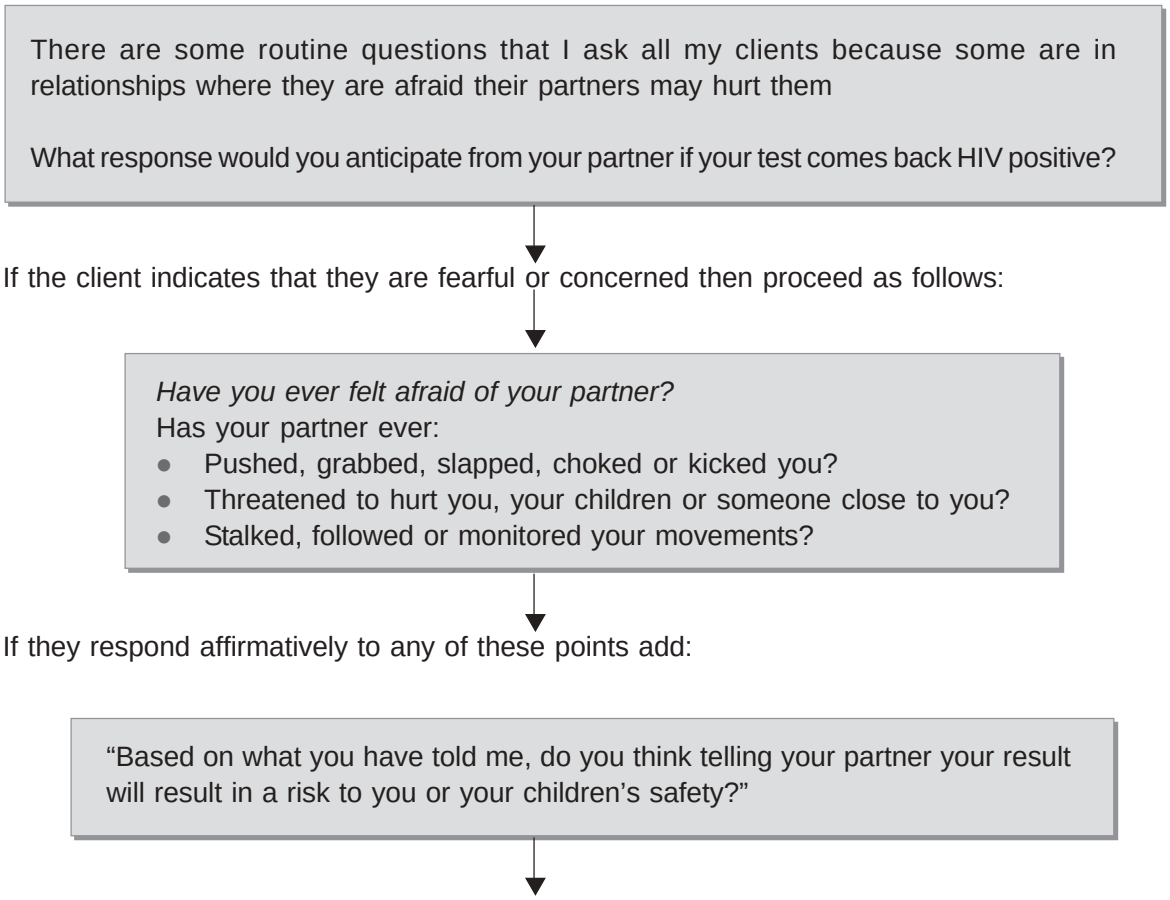
8.IX. Working with couples

The women's partner's HIV status is a critical part of the family's decision-making framework. Involving the partner in the HIV test-related counselling can help ensure that he is supportive of his partner's dilemmas and choices related to HIV, infant feeding, and family planning. Clients coming for HIV/AIDS counselling should be encouraged, but not forced, to come with their partners or as couples. Counsellors need to have some knowledge about how to work with couples.

Rationale for couple counselling

- Some people seek counselling as a couple because they recognise that their problems are rooted in their relationship rather than being attributable to individual issues

Figure 3: Suggested questions to assess potential disclosure related violence



- A change in either partner's sexual behaviour is bound to affect the other partner
- When couples work together in partnership and support they are bound to succeed better in what they want to do than if one partner is in the dark
- Disclosing HIV results to the other partner, which is usually a difficulty for most couples, is better handled if both agree to be seen as a couple
- Couples are better able to cope with such decisions as whether or not to get pregnant, terminate a pregnancy, and breastfeed the baby if they are seen and supported together

Guidelines for working with couples

1. Build up a relationship.
   - Create a conducive and trusting relationship with the couple. Follow exactly the same procedures for preparation and establishing a relationship but ensure that you establish a relationship with both
   - Let them know that there will be equal 'air space' for both of them
   - Let them know that everyone's opinion is important
   - Let the dominant-looking partner start, especially if it is the husband, as this may influence how their action is implemented once they get home

- Pay much attention to both their verbal and their non-verbal communication
- If asked whether you are married, tell the truth; if you are not married, add that you are trained to work with couples
- Try politely to draw out the silent partner of the couple, to share their feelings and options
- Do not judge or take sides
- Keep your values, prejudices and beliefs aside and work with those of the couple

2. Check understanding of HIV/AIDS. Avoid letting one person dominate the conversation.
3. Explain the process of testing and the meaning of testing results—both positive and negative.
   - Discuss at length the concept of getting results: How do they want to get their results? No one will be given the results of the other, either they get their results together or separately then negotiate a way of informing the other. Ideally, it would be good to get the results together. At this point also mention:
   - The possibility of having different results (discordant results) e.g. husband is positive and wife is negative or vice versa and the possibility of HIV negative during window period
   - What will it mean to them if they do not get the same result?
   - Ask each one for the meanings and how they will cope
   - How will they protect themselves?
   - What will be the advantages of knowing their status as a couple? Any disadvantages?
   - Who else might be affected by the outcome of her/his test? If clients are pregnant women and their partners, discuss prevention of parent- to-child HIV transmission issues and availability of PMTCT interventions
4. Check willingness to have test done.

8.X. Ethical and legal issues for VCT in PMTCT settings

It is the pregnant woman's absolute right to choose, on the basis of full information, whether or not to take advantage of the intervention. The controversial issue for VCT in PMTCT setting is whether the pregnant woman has the right to refuse VCT since her baby should have the right to receive HIV prevention under PMTCT intervention programme as well.

Humans are social beings whose behaviour and mental health are influenced by culture. Counsellors must acknowledge and take into account the client's socio-cultural environment. A client's perception of his/her circumstances and capacity to deal with challenges owe a lot to socialisation. Cultural factors to be considered include social norms, values, and morals.

Operational issues: Factors influencing sustainability of effective VCT in PMTCT settings

Epidemiologic:

- The stage of the HIV/AIDS epidemic
  - Degree to which the epidemic has moved from initial high risk groups to the general population of women of reproductive age: HIV seroprevalence among pregnant women
  - Cost-effectiveness in low HIV prevalence settings

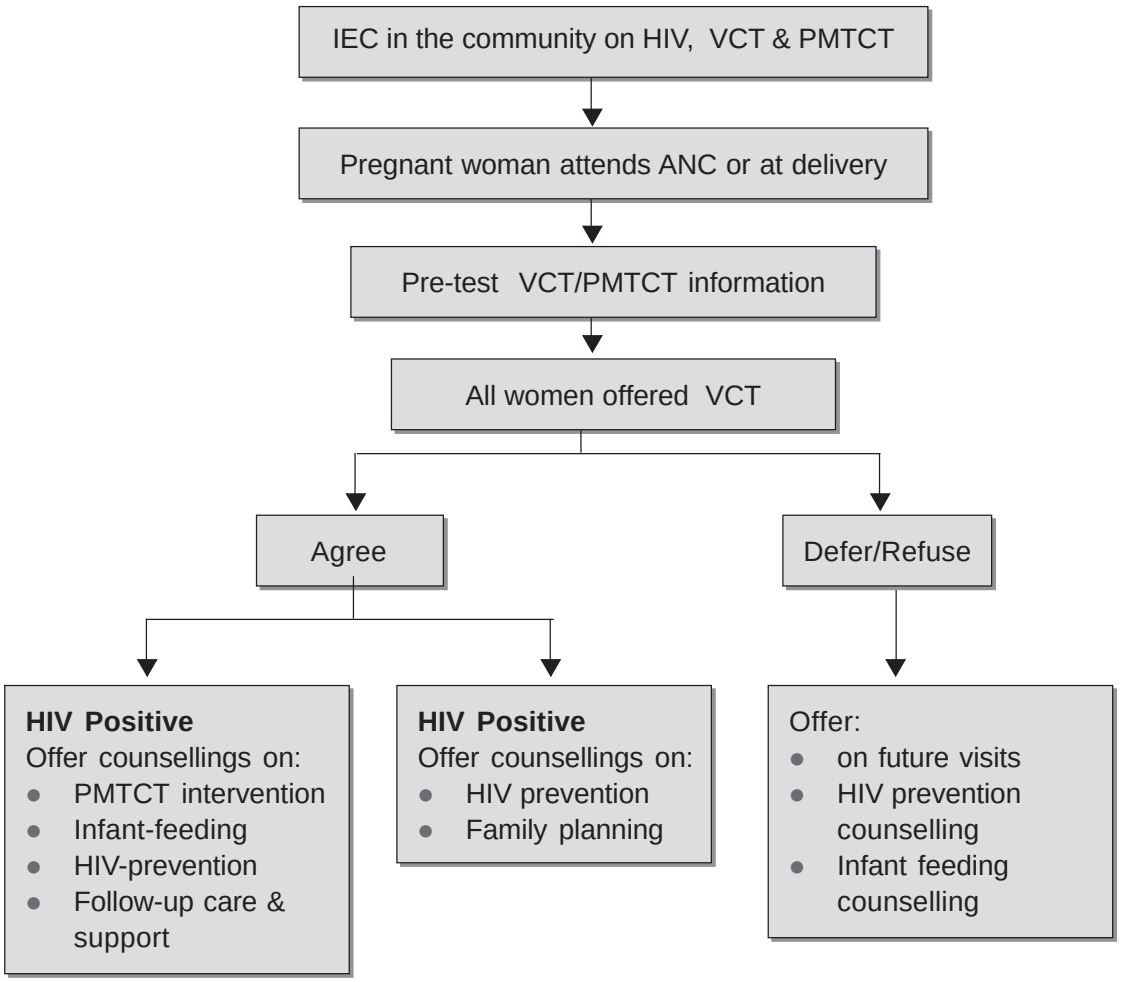
Political:

- Government and political will and commitment to preventing MTCT
- The degree to which these policies are monitored and enforced
- The level of funding available for MTCT and supporting interventions
- Supportive laws and policies to protect HIV-infected persons from discrimination

Health and related system:

- The status of existing MCH coverage and quality, HIV and MTCT prevention activities
- The availability, quality, use of health services and the health system's readiness to deliver MTCT interventions (including human resources/capacity and infrastructure)
- The availability of appropriate system for voluntary and confidential testing and counselling for HIV in the existing health services
  - VCT model: "Opt out" rather than "opt in"
  - Group versus individual pre-test counselling and implications for scaling up
- HIV test kit availability, quality control for VCT and testing method
  - Rapid test: same day testing = higher coverage
- Existing health worker training through pre-service and in-service channels
- Attitudes of counsellors
- Availability of ARV for prevention of MTCT
- System related to infant feeding:
  - Degree of support for a range of infant-feeding options and women's choice
  - Promotion of infant formula as policy may have a negative impact on uptake of VCT
  - Level of implementation of the Baby Friendly Hospital Initiative (BFHI)
- Availability, quality, and reach of family planning services

VCT within ANC services



Health-related practice:

- Attitudes of counsellors towards VCT and PMTCT
- Attitudes towards family planning and family planning acceptance rates
- Common obstetrical practices by traditional birth attendants, midwives, obstetricians, etc.
- Infant feeding attitudes and practices

Community and family:

VCT social marketing can be utilised to overcome negative community attitudes.

Conclusion

Because of recent advances in both antiretroviral and obstetrical interventions, pregnant women infected with HIV who know their status prenatally can reduce their risk for transmitting HIV to their infants. This session explains the importance of VCT for both individuals (pregnant women or mothers) and couples regarding prevention of their babies from getting infected with HIV. In addition, aims of pre-test and post-test counselling for pregnant women and the differences between VCT-PMTCT and VCT in other settings (i.e. STD, IDU group, anonymous clinic, etc.) are clarified. The guidelines in this handout are intended to identify the concepts and impart the skills needed to provide effective counselling to women and their partners for PMTCT and to describe the integration of VCT into the existing maternal and child heath system. These recommendations underscore the importance of HIV infected pregnant women (and their health-care provider) knowing their status to protect their own health and reduce the risk for transmitting HIV to their infants.

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Module 3

Sub module 6: Targeted VCT intervention – Mobile populations

Session objectives

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

- Demonstrate an understanding of HIV/AIDS issues affecting mobile populations
- Demonstrate an understanding of the relationship between HIV/AIDS and migration
- Identify HIV/AIDS prevention and support strategies for mobile populations

Time to complete sub module

2 hours (optional in the 12 day programme)

Training materials

- PowerPoint presentation **(PPT23)**
- Activity sheet **(AS21)**
- Handout **(HO22)**
- Question box
- Evaluation form collection box

Content

- Migration
- Assessing vulnerability to HIV/AIDS
- Clinical issues and relationship to HIV transmission
- Key counselling interventions
- Mandatory testing and human rights
- HIV/AIDS counselling and education programmes for migrant workers
- Follow-up with migrant workers

Session instructions

1. Lecture with PowerPoint presentation **(PPT23).** During the presentation ask participants questions to keep them involved actively in the presentation. Ask participants whether they have any questions.
2. *Activity:* Activity sheet **(AS21)**
   - In the proposed activity participants break up into small groups of three or four. The trainees are given the following scenario:
     - You have been made aware that members of the local community are being recruited to work on a dam building project in a neighbouring country. As part of the recruitment process, potential employees are being tested compulsorily for HIV and receiving no pre-or post-counselling. Those who receive a positive result are told they are no longer eligible for employment and not referred to any health or welfare agency for care or support
   - Ask participants to come up with a list of strategies that may be utilised to help alleviate this situation, e.g. offering VCT, building a partnership with the recruiting agency, offering education and resources to potential migrants
   - This part of the activity should take no more than 10 minutes
   - Groups should then present their strategies to the whole group for a brief discussion
3. Ask the group if they have any questions and remind them about the “question box”.
4. Ask trainees to complete an evaluation form and place it in the “evaluation form collection box”.

Module 3

Sub module 6: Targeted VCT intervention - Mobile populations

Session objectives

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

- Demonstrate an understanding of HIV/AIDS issues affecting mobile populations
- Demonstrate an understanding of the relationship between HIV/AIDS and migration
- Identify HIV/AIDS prevention and support strategies for mobile populations

1. Introduction

Migration and mobility have increased over the past several years and are likely to continue to increase as:

- Land and air transport become more readily available
- Economic imbalances between communities push people to move in search of better lives or to survive
- Closed societies and borers such as in Eastern Europe and China open up
- Wars continue to displace people
- Organised migration and trafficking continue to flourish

AIDS and migration are two of the crucial social issues facing today's changing world. Traditionally, migration has been viewed as a rational and informed choice for individuals seeking improved living conditions. However, as one study observes:

> "The suggestion that movement represents an entirely rational course of action that is taken in response to a reasoned and well informed judgement about conditions elsewhere is questionable. Very often people move more in obscure hope than definite expectation of finding a better life elsewhere. Some simply end up moving from one environment of poverty and exploitation to another."[1]

Understanding the poverty and economic transitions often associated with migration and mobility helps us understand why "migrant populations are at a higher risk than the overall population for poor health in general and HIV infection in particular."[2] Contributing factors to HIV vulnerability may include the following: limited access to health services; health services which are not well versed in the traditions and practices of migrants; limited exposure to public health campaigns around HIV/AIDS.

Mobility and migration are not in themselves risk factors for HIV transmission but can create conditions in which people are more vulnerable.[3]

2. HIV vulnerability

There are several different categories of migrants. These include:

- Those who choose to migrate to another country to seek a better quality of life
- Those who are forced to migrate to escape disruption and turmoil in their home country (refugees)
- Those who migrate from one part of their home country to another (often for economic reasons but not always for economic reasons only)

Migrants and mobile populations may have limited or unreliable information on the country or province they are relocating to. They may also have inaccurate information on the actual migration process. For example, if the process is organised by a commercial agent, that agent may exaggerate the speed and ease of the process and the migrant may be unprepared for the stresses involved.

Migrants can frequently experience breaches of human rights and, while there are some international and regional laws that protect the rights of migrants and mobile people, these may be only partially applied. The International Guidelines on HIV/AIDS and Human Rights, issued by the Office of the United Nations High Commissioner for Human Rights and UNAIDS, state that:

> "There is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status…In considering an entry application, humanitarian concerns, such as family reunification and the need for asylum, should outweigh economic conditions."[4]

The scale of numbers and the variable levels of commitment among governments to universal principles of human rights directly impact on the treatment of migrants. Currently, there are 150 million migrants who live and often work outside their country of citizenship. In China there are considered to be 100 million people who regularly migrate from one part of the country to another. On the Thai / Myanmar border there are also significant migration flows. Internal migration is also a significant issue in countries such as India and Indonesia.

Assessing vulnerability to HIV/AIDS

Often migrant populations in foreign countries are living in a legal vacuum, having no stay or work permit from the host country and living in constant fear of deportation. Contact with official government agencies increases the fear and encourages suspicion not only of government organisations and officials but also of NGOs. The economic situation of migrants gives them limited choice for appropriate employment and therefore they may be locked into unfair employment contracts arranged in the country of origin. They are often vulnerable to exploitation, including sexual exploitation. To provide migrant populations with services to prevent HIV infection and care for those living with HIV/AIDS requires innovative and culturally sensitive approaches and confidentiality.[5] If migrants are fearful of deportation or detainment they will be reluctant to approach services that cannot guarantee confidentiality.

Women and girls face particular migration issues. Their employment opportunities may be restricted and their ability to negotiate improved working conditions, limited. The trafficking of women for sex and bonded sex work clearly has implications for HIV vulnerability.

The following questions can help to assess the vulnerability of migrants and mobile populations to HIV infection. They may be useful questions to ask when developing programmatic responses.

Choice: Did the immigrants leave their country of origin voluntarily?

Cultural affinity: What is the difference between the host culture and the country of origin?

Intention: Do migrants intend to stay in the host country?

Length of stay: Migrants may stay from short periods of time through to several generations. Each type of stay requires a different approach.

Legal status: The legal status affects the access to health and welfare services and the immigrant's whole relationship to the State.

Needs of the host country: Some countries welcome migrants and see them as an integral part of their nation building process. Others see them as merely providing a short-term service or as taking work away from the country's citizens.

3. Programmatic responses

The needs of departing migrants and those already present in the host country require a range of programmatic responses, including access to VCT. Counselling can be seen as one component in the continuum of care which, ideally, is available to migrants. Counsellors providing VCT and other support for migrants and mobile populations need to be able to link with other services and to understand the broader programme and infrastructure issues affecting these groups. An effective response to the needs of migrants will be one which is inclusive and operates at a range of levels:

- Legislation and policy development to ensure human rights protection
- Advocacy and social marketing
- Community educators and outreach workers
- Rapid testing technology
- Counselling inclusive of VCT
- Referral networks, social services
- Appropriate treatment
- Integrated treatment and prevention services

This multi-level response may also need to be multi-country. Inter-country co-operation to prevent the spread of HIV is of critical importance and can take place at a variety of levels. No matter at what level we work, or at what level our organisation is placed, all of us can forge links with organisations and structures in other provinces and countries. For example, if you are aware that clients or communities that you work with are migrating, either legally or illegally, to specific countries, then you can make links with equivalent organisations in those countries and develop joint programmes providing pre-departure and post-arrival support (See CARAM model below).

Building partnerships with other organisations is important in both government and non-government sectors. With limited resources it is necessary to ensure that services are linked with other service providers and that policies are compatible across the services. For example, if you are working with illegal immigrants it is important that the other organisations you may refer your client to have a good track record in working with this kind of client group. This is even more important if the client is already HIV positive.

Regional conferences such as the International Conference on AIDS in Asia and the Pacific (ICAAP) held every two years and other regional meetings are good places to forge links with other organisations in other countries and get to know the personnel in those organisations. There are also regional networks such as the Asia Pacific Council of AIDS Service Organisations (APCASO) http://www.apcaso.org, where you can find key contacts in different Asian countries. Or you can use email discussion lists such as SEA-AIDS to form links with other organisations.[i] Forming links in other countries (as well as your own) helps to strengthen referral networks and potentially increase access to social services for clients. It also provides an information source where you can find out more about the conditions in the country that your client is migrating to, or has migrated from.

Indonesia— HIV vulnerability and migration

The key factor is the *behaviour* of some mobile groups that places them at a higher risk of infection. This relates to mobility being selective of young adults, especially men, and it often involves separation from partners and release from traditional constraints on behaviour, especially sexual behaviour. The growth of a commercial sex industry in locations where there are concentrations of these movers adds to the higher levels of vulnerability of these locations. Accordingly, it is possible to identify 'hot spots' where there are concentrations of migrant workers and an associated commercial sex industry, where there is often a greater risk of infection and prevalence rates above the national average. Such hot spots can include transit areas, workplaces employing large numbers of migrant workers, ports and harbours, cities and towns, mining, lumber industry, plantation and construction sites, especially those in remote areas, transport routes and stops and border crossing points. There is clearly a pattern in many cases of mobile people being more likely to engage in high-risk behaviour (especially sex with a CSW) than is the case with less mobile groups. The relationship between mobile groups and the commercial sex industry is crucial.

Source: Population mobility and HIV/AIDS in Indonesia, Graham Hugo, UNDP 2001

As migration can be a fluid process of mobility, "to be effective, HIV/AIDS responses must address the particular needs and vulnerabilities of mobile people at each stage of the mobility process and in a variety of geographical locations."[6] The different stages of migration can be identified as:

- Pre-departure
- Migration
- Adaptation period
- Settled
- Remigration

Pre-departure

At the community level there is a need to create awareness of the whole migration process and the risks involved (STIs and HIV). Pre-departure programmes can include information on reproductive health, HIV/AIDS, information on airport and border procedures, government and non-government services for migrants in receiving countries and cultural briefing. VCT should be offered along with appropriate support (see CARAM case study below).

[i] To subscribe to SEA-AIDS send a blank message to join-sea-aids@healthdev.net or go to http://www.hdnet.org/

Migration

The process of migration may be brief or extended. During this process, there may be a strong risk of sexual exploitation for women, girls and boys. Those recruited for sex work may be moved from one area to another on a frequent basis to work in different communities. Undocumented travellers are at significant risk as they may have less control over their own circumstances and travel arrangements. Detention centres for those detained during migration may have poor infection control and a lack of access to HIV prevention tools. It may be necessary to develop programmes with a variety of organisations and agents in order to gain access to migrants and provide education services.

Adaptation

Migrants are especially vulnerable during this early period. This is a period when migrants may be least visible and have the lowest level of access to health and welfare services, especially if they are illegal or involved in indentured labour. Outreach education, peer education programmes and drop in centres for migrants can all be used to build individual and community capacity among migrants but other innovative and labour-intensive interventions may also be required. For example women who have been trafficked as sex workers may face huge challenges in this period. They may be forced into behaviours which are unsafe and with which they are unfamiliar. Clients or managers may insist on not using condoms. Outreach programmes need to build strong links with managers as well as women and girls.

Settled

UNAIDS recommends special programmes for migrants based on the observations that migrant groups tend to have sexual partners and form liaisons within their own group – therefore the greater risk is internal.[7] However, the vulnerability of the migrant can vary greatly during this period and the breaking down of traditional norms may result in changes in behaviour and increased risk levels. Again, interventions need to reflect the changing needs of the target group.

Remigration

Remigration may also be a period of increased vulnerability. Individuals have gone through personal and cultural changes and these changes may put them at odds or variance with their home community, which may lead them to greater risk activities. This may be especially so if they are rejected by the home community which may be the case if they are perceived to be HIV positive. If the returning migrant *is* HIV positive they will also have to face issues of disclosure to partners and family as well as other issues. Services need to be non-judgemental and confidential. Broader education with the community may be necessary to increase local knowledge of HIV transmission and how to provide care and support for people with HIV/AIDS.

4. Issues in service provision for migrants and mobile populations

Clinical issues and relationship to HIV transmission

- Poor self-esteem and lack of motivation to protect
- Post-traumatic stress disorder, depression and adjustment disorder
- Drug and alcohol use and related transmission risk behaviour
- Detainment – risk factors

Key counselling interventions

- Assessment, referral and management of mood disorders
- Drug and alcohol use and harm reduction management for dependency

- Problem solving individual constraints to safer behaviours
- Role-play and planning for disclosure of risk and/or HIV status
- Family therapy and couple counselling
- Managing rejection and referral to support agencies

Mandatory testing and human rights

From the research carried out by CARAM (Coordination of Action Research on AIDS and Mobility, Asia) we have learned that most migrant workers do not even know that they are tested for HIV when they intend to migrate. Counselling of those taking the test is never done and migrant workers are only rarely told about the results. Such practices show very clearly that the tests are used for receiving countries to be able to exclude certain people from migration. The tests are not used for the benefit of the individuals. It is time to discuss this at the levels of the government if we believe such practices are acceptable.

Migrant workers are also frequently tested while staying in the receiving country, for example when they have to extend their work permit. In Malaysia and the Gulf States, a positive test provides a reason for policy makers to send migrant workers back home to their countries. Here again we are confronted with the use of HIV tests for authorities, but not for the protection of individuals."[8]

Mandatory testing for HIV is not recommended by UNAIDS or WHO. However, if mandatory testing is being carried out on potential or arriving migrants this increases the importance of developing appropriate interventions which can lessen the impact of this testing and prepare migrants for such an action, should it occur.

A study of former migrant workers in the Philippines found that testing positive for HIV was likely to render workers "unfit for work" abroad permanently. If they are found positive overseas they are usually deported immediately and the psychological and emotional impact is manifested in the form of depression and mental anguish.[9]

The case study below from CARAM describes a situation where workers from Bangladesh are recruited through formal mechanisms to work in Malaysia. The SHISUK – CARAM project works closely with diagnostic centres where potential migrants are tested for a range of diseases, including HIV. Testing is compulsory if the workers wish to proceed with their applications. CARAM does not support compulsory testing but sees the importance of working closely with the diagnostic centres to increase the level of service and support for migrants.

Case study - HIV/AIDS counselling and education programme for migrant workers[ii]

Implemented by SHISUK – CARAM Bangladesh

SHISUK (Shikkha Shastha Unnayan Karzakam) and CARAM (Coordination of Action Research on AIDS and Mobility, Asia) have developed a specific strategy to work with migrant populations.

This strategy includes education sessions for migrants, including information on:

- Basic facts on HIV/AIDS
- Information on HIV test and consequences
- Counselling on safer sex practices

[i] For more information on this project and other resources for HIV/AIDS and migrant populations go to http://caramasia.gn.apc.org/2 For more information and other resources for HIV/AIDS and migrant populations go to http://caramasia.gn.apc.org/

- How to use condoms and condom demonstrations
- The importance of maintaining continuous contact with their families at home
- How to refer HIV positive migrants working abroad to support organisations
- Provision of educational materials and newsletters

The programme assists migrants with the migration process. Counsellors and outreach workers help potential migrants complete the necessary forms and negotiate on their behalf with stakeholders. Additionally, they refer migrants to other related services.[iii] For those who are diagnosed HIV positive, the programme arranges for additional tests and provides HIV positive counselling in collaboration with professional counsellors. Finally, SHISUK is developing a strong network of legal aid organisations, STI service providers, and HIV specialised physicians to further support migrant workers.

Follow up with migrant workers

The HIV/AIDS Counselling and Sexual Education Programme established a follow up mechanism so that behaviour change communication can be extended even after the workers leave for their destinations. First, workers at the diagnostic centre are provided a set of communication kits that includes passport, bag, writing pad, prepaid envelopes, pens, condoms and other useful items. Relevant messages and SHISUK's address are printed on all these materials.

Once the counselled migrant workers go back to their home communities (the period of time between recruitment and migration may be up to six months), SHISUK communicates with them by post. This follow-up communication is used to get them for further feedback,[iv] to remind them about counselling issues and to encourage to share information with others.

SHISUK also identifies individuals to work as peer educators through this process, based on their interest and their capacity to deliver information. Selected migrants are then invited for peer training programme (SHISUK is organising three residential trainings of three days each) on how to disseminate information in their home communities and to work as peer educators among other migrants in the receiving countries. The outreach workers make visits to identified geographical areas to interact with the selected migrants and their community.

SHISUK provides the list of peer educators to counterpart organisations such as Tenaganita (CARAM Malaysia) in the receiving countries for post-departure follow-up. In the case of a country where there are no organisations that work on migration issues, SHISUK is trying to establish a mechanism for working with existing migrant groups. Peer educators work on a voluntary basis, although they are paid conveyance for attending trainings, workshops and organising peer meetings in their locality before departure.

[ii] Most of the migrant workers come from rural backgrounds. They make several trips to the capital as part of the process of migration process; many of them face severe problems in securing safe accommodation. SHISUK sometimes refer them to the existing boarding houses but has done very little work in this area.

[iv] After the medical check up, the migrants are counselled. After this, it takes 3-6 months to fly overseas for the job. As the counselling session is not long enough to address all the issues in detail, these issues are raised in the follow up sessions and the migrants are reminded about the key issues and they are also asked to visit SHISUK's information desk before departure. Many of the migrant workers come to visit information desk and also wrote back to SHISUK with further queries.

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Module 3

Sub module 7: Targeted VCT intervention – Prisons

Session objectives

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

- Demonstrate an understanding of issues affecting the management of HIV/AIDS in prisons
- Identify HIV/AIDS prevention and support strategies for prisons

Time to complete sub module

2 hours (optional in the 12 day programme)

Training materials

- PowerPoint presentation **(PPT24)**
- Activity sheet **(AS22)**
- Handout **(HO23)**
- Question box
- Evaluation form collection box

Session instructions

1. Lecture with PowerPoint presentation **(PPT24).** During the presentation ask trainees questions to keep them involved actively in the presentation.
2. *Activity:* VCT in prison activity **(AS22)**
   - Ask trainees to design a flowchart of potential counselling, prevention and referral activities for prisons.
   - They should consider the following:
     - How could a prisoner access VCT in a confidential manner?
     - How could results be provided to prisoners (including calling up a prisoner to deliver results)?
     - Who would have access to medical records? How can you ensure security?
     - Different ways HIV awareness and prevention activities could be carried out.
     - How could you organise medical attention for a prisoner with a serious HIV-related condition?
     - How could you manage pre-discharge VCT and prevention education?
     - How might you manage issues relating to a prisoner diagnosed as HIV positive and disclosure of their HIV status to a spouse or regular sexual partner?
3. Ask the group if they have any questions and remind them about the “question box”.
4. Ask trainees to complete an evaluation form and place it in the “evaluation form collection box”.

Module 3

Sub module 7: Targeted VCT intervention - Prisons

Session objectives

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

- Demonstrate an understanding of issues affecting the management of HIV/AIDS in prisons
- Identify HIV/AIDS prevention and support strategies for prisons

1. Introduction

Prisons and detention centres are some of the most difficult sites in which to carry out effective HIV/AIDS prevention and to provide appropriate care and treatment for people with HIV/AIDS. Worldwide, most societies give low priority to public health issues in prisons. This is unfortunate as prisons can be very efficient sites for the transmission of blood borne or sexually transmitted viruses such as HIV. If prisoners or detainees become infected with HIV during incarceration this only increases the potential for the spread of HIV in the broader community as most prisoners are likely to have relatively short term sentences and then return to the community.

Despite high levels of security and physical removal from everyday life, prisons are not vacuums. The same behaviours that might put people at risk in the outside world, such as unprotected sexual intercourse and injecting drug use, also occur in prisons. However, the conditions under which these behaviours take place in prisons may place inmates at greater risk than if carried out in the outside world.

Limited research has been carried out on risk behaviours of prisoners in Asia.

2. Prisoners and mental health

In a review of psychiatric surveys of general prison populations in Western countries it was found that of 22,790 prisoners, 3.7% of male inmates had psychotic illnesses, 10% had a mental disorder and 65% had a personality disorder, including 47% with antisocial personality disorder. Among women 4.0% had psychotic illnesses, 12% had mental disorders and 42% had a personality disorder (PD), including 21% with antisocial personality disorder. Prisoners were several times more likely to have psychosis and a mental disorder and about 10 times more likely to have antisocial personality disorder than the general population.[1]

In Thailand a study of 230 female and 758 male inmates in Bangkok Metropolitan and Bangkwang Central prisons found the following prevalence of psychiatric disorders: current psychosis 3.4%, major depression 10%; current manic episode 1.4%; generalised anxiety disorder 6.6%; and dysthymia 4.3%.

Dependence on amphetamines among inmates was as high as 26.2% and alcohol dependence 12.2%.[2]

3. Rates of HIV in prisons

The rates of HIV in prisons may or may not reflect what is happening in the rest of the community.

In the United States where the AIDS epidemic has a long history in comparison to some Asian countries, the AIDS rate in state and federal prisons is five times higher than that in the general US population.[3] There are no accurate figures on HIV prevalence since not all arrestees need to declare their HIV status. But the number of HIV positive cases in correctional institutions is rising at a rate faster than for the general US population.[4]

In Thailand rates of HIV infection are also higher in prisons than in the general population. A study conducted in the large Klongprem Central Prison in Bangkok indicated a 10% HIV infection rate among inmates. In 1997, among inmates hospitalised, 41% were infected with HIV, TB being the most common opportunistic infection.[5]

A study in India of 240 male and 9 female jail inmates confined for various crimes in a district jail near Delhi were screened for sexually transmitted and blood-borne diseases, including HIV, syphilis hepatitis B and C viral infections, skin diseases, etc. The inmates were aged 15-50 years. One hundred and seventy four of them were not aware of AIDS. On examination 28 of the 240 (11.6%) had active hepatitis with or without a history of jaundice in the previous two years, 25 (10.4%) active pulmonary tuberculosis (TB) and 11 (4.6%) had syphilitic ulcers on the penis. Three males (1.3%) were found to be Western blot confirmed HIV-1 positive while 28 (11.1%) men and two (22.2%) women were positive for HBsAg. Out of the three HIV-positive persons, one was an intravenous drug user (IVDU), second was a drug addict and frequent CSW visitor while the third had contracted HIV through homosexual contact.[6] Although HIV infections were low the study suggested the conditions existed in the prison to promote the spread of HIV between inmates.

Prisoners or detainees may already be practising high risk behaviours or be vulnerable to HIV prior to detention. Injecting drug users, sex workers, migrants/refugees and men who have sex with men may be more vulnerable to HIV infection than other groups (depending on the context) and also more vulnerable to detention or arrest. For example, injecting drug users are often over-represented in prison due to the use of an illegal substance and also the relationship between use of illegal drugs and drug-related theft. In Thailand the number of persons incarcerated for narcotic offences increased five-fold during 1992-1999, from 12,860 to 67,440.[7] A study in Nepal indicated that 28% of 95 inmates who agreed to in-depth interviews were injecting drug users and 75% always shared needles.[8]

4. HIV transmission in prisons and detention centres

Transmission of HIV may occur through the following:

- Sharing of injecting equipment
- Sexual transmission through the following ways:
  - Inmate to inmate, consenting
  - Inmate to custodial staff, consenting/coercive
- Inmate to inmate, sexual assault
- Tattooing “blood brother” or group rituals with blunt instruments
- Poor infection control in custodial medical settings

A recent study in Thailand found that HIV infection was associated with risk injecting both before and after prison: injection of methamphetamine before detention, sharing of needles while in holding cells and borrowing needles in the period directly after release from prison.[9] An earlier Thai study with a cohort of 1209 injecting drug users concluded that "drug use while being incarcerated is a strong risk for HIV infection in Bangkok IDUs."[10]

Sharing of injecting equipment

If there is injecting drug use in the community, then there is likely to be injecting drug use in prisons. While IDUs may not inject in prisons at the same rate as in the outside community, they do share injecting equipment more and sterilise it less because of scarce resources. Injecting equipment in prisons may be made out of whatever is at hand or can be smuggled or brought into the prison. The Thai study referred to above indicates very high rates of sharing of equipment while in holding cells prior to incarceration.[11]

Sex

Numerous studies as well as anecdotal information confirm that there is sexual activity in prisons between inmates and between inmates and custodial staff in prison. One study reports that 73% of inmates in Brazil admitted to male-to-male sexual activity while in prison. Another reports levels of between 6% and 12% in Australian and Canadian prisons.[12] A recent study from Agodi prison in Ibadan, Nigeria, reports that 71% of younger inmates and 29% of older inmates had male-to-male sex whilst in prison. Only 7.8% reported using condoms although 96% knew HIV was transmitted by sex.[13]

Prison authorities in many countries are reluctant to discuss or acknowledge the relatively high levels of sexual activity in prison. Research projects on HIV and prisons are also often reluctant to ask questions about the sexual practices of prisoners while in custody and only collect information on pre- or post-prison activity.

Tattooing and other blood-to-blood practices

Unsupervised tattooing is likely to occur in prisons. A lack of access to sterilised equipment can mean that tattooing or blood brother rituals lead to the transmission of HIV (and other blood borne viruses).

Poor infection controls in custodial medical facilities

Medical facilities within prisons and detention centres may be understaffed and poorly resourced. As a result there may be poor infection control procedures and therefore an increased risk of transmission of HIV and other blood-borne viruses.

5. Key strategies for care and prevention

The WHO guidelines on HIV infection and AIDS in prisons[14] provide a comprehensive set of strategies for testing, prevention and care in prisons. The guidelines reflect human rights concerns as well as an understanding of behaviour change principles and prevention and care interventions that have been successfully utilised elsewhere. However, although these guidelines reflect best practice it is only realistic to acknowledge that they are not universally applied and in some cases, not applied at all. The following represent some key strategies drawn from the WHO guidelines which could be applied to improve care and decrease transmission in prisons.

VCT offered at entry and pre-release

"Compulsory testing of prisoners for HIV is unethical and ineffective, and should be prohibited."[15]

Ideally, prisoners should be tested for HIV voluntarily. They should enter into an informed consent. However, informed consent in prisons is very rare and many prison officials consider that the very nature of incarceration takes away the right of a prisoner or detainee to make their own decisions about HIV testing.

The counsellor needs to review the existing policy and practice within the facility with regards to HIV testing and work with the facility's management to develop a testing policy which incorporates as many best practice features as possible. If HIV testing is not voluntary, it is still important to introduce pre-and post-test counselling to accompany the testing process. If testing is not carried out at all, then the option of pre-release VCT may be an appropriate strategy. Consideration needs to be given to issues of confidentiality – a contentious issue in prisons. If outgoing prisoners are found to be HIV positive, can confidentiality be assured?

Peer education programmes

The principle of peer education is that the effectiveness of educational interventions may be increased, especially for some groups, when peer educators are used to deliver education. Prisoners usually have a high degree of mistrust of authority so are therefore likely to distrust information delivered by prison staff. Peer education programmes for prisoners have been shown to be effective in conveying accurate information on HIV/AIDS, increasing knowledge and encouraging behaviour change. However such programmes can pose a threat to the authority of custodial staff because they are seen to empower prisoners. It is extremely important to establish a good working relationship with all levels of prison management but particularly with custodial staff as they may ultimately be responsible for whether or not peer education programmes can proceed.

Well-living programmes for prisoners

Prisoners or detainees need to be able to access information on healthy living as well as resources to maintain quality of life. This can include information and advice on healthy eating, quit smoking programmes, the impact of illegal drugs and other medications, primary health care, support groups, detoxification programmes, exercise programmes, education opportunities and other options which support prisoner well-being.

Access to condoms

Prison authorities often fear that by providing condoms for prisoners they are acknowledging that sex takes place in prisons and are seen to be promoting sex between prisoners or between prisoners and guards. Condoms have been available in Canadian prisons since 1992 and in a 1998 report of a survey of 20 European countries' prison systems, the authors report that "condom availability has become widely accepted."[16] There is no evidence to suggest that the availability of condoms increases the level of sexual activity.

Condoms should be located in a discrete, accessible place.

Injecting drug use

Because of the relationship between crime and both legal and illegal drug use, many prisoners may have-drug related problems. These can include addiction to drugs such as heroin, amphetamines

and alcohol and physical or mental problems as a result of drug use. Strategies to respond to drug related problems could include demand reduction (methadone, treatment for mood disorders, motivational interviewing) and harm reduction (cleaning equipment, information on safe injecting, clean injecting equipment).

Provision of injecting equipment

The distribution of sterile needles and syringes to prison inmates takes place in several European prisons with no reports of increased drug use.[17] It is unlikely that in countries where there are no pre-existing needle and syringe exchange programmes that they will endorse the distribution of clean equipment in prisons even if it is likely to reduce the transmission of HIV and other blood-borne viruses such as hepatitis C. However, this should not limit health care workers and their agencies in lobbying for such initiatives. There is now good data available to indicate the effectiveness of providing new injecting equipment in reducing the spread of HIV through injecting.

Distribution of full strength bleach and safe using education

Prison authorities who do not condone the distribution of new injecting equipment to inmates may feel more comfortable with making bleach available for disinfecting injecting equipment. Although the cleaning of injecting equipment is not 100% effective in killing HIV in needles and syringes, cleaning is nevertheless a viable and practical option to reduce levels of risk through sharing. Cleaning interventions need to be accompanied by accessible and appropriate information on safe injecting. IEC materials produced for prisoners need to take into account low literacy levels.

Health management in prisons

> "All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality." [18]

One strategy which may be effective in improving the management of HIV/AIDS in prisons is to bring prison health systems under the control of government health authorities. Medical services available in prisons are often of variable standard and exempt from health department guidelines and policies. Issues of importance in this area are:

- Ownership of medical records
- Increased access to post-release care
- Increased uptake of VCT
- Decrease in punitive action related to risk-taking behaviour
- Decrease in stigmatisation

6. VCT in prisons

Interventions

- Pre- and post- HIV test counselling
- Training and supervising peer educators
- Education and training of custodial staff in HIV prevention (but not to conduct VCT, see below)
- Suicide risk reduction and psychological referral
- VCT for management of occupational exposure
- Pre-release counselling: risk reduction, partner disclosure, treatment referral
- Condom and safe injecting demonstration

Points to consider

- Utilise counsellors or other trained personnel from external organisations. Corrective services personnel, especially those working within the prison are not appropriate for conducting VCT on those in detention
- Counsellors need to build partnerships with key stakeholders before initiating activities. Without the support of prison staff and management, interventions are likely to be shortlived and unsustainable
- Conduct risk assessment for HIV and STIs with appropriate checklist, including all possible sexual behaviours and possible non-sexual exposure such as sharing injecting equipment
- Provide client with appropriate IEC materials describing HIV transmission routes and prevention techniques. The counsellor should go through the materials with the client
- Telephone counselling service may be appropriate if detainees are allowed to make outside calls

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