MODULE 2 PARTICIPANT MANUAL: Contents

Incorporating HIV Prevention into the Medical Care of Persons Living with HIV. MMWR 2003;52(RR-12). Recommendations of CDC/HRSA/NIH/IDSA-HIVMA

Handout 1

Sample Prevention Messages

Condom Use:

- The correct and consistent use of male latex condoms can significantly reduce the risk of STI transmission (CDC). Male and female polyurethane condoms can also significantly reduce the risk of STI transmission.
- Condoms reduce the risk of transmitting HIV, herpes, hepatitis B, Chlamydia, and gonorrhea.

Partner Reduction:

- Having fewer sex partners reduces the risk of exposure to another STI; having fewer drug-sharing partners reduces the risk of exposure to other blood-borne diseases.

Abstinence:

- The only certain means for HIV-infected persons to prevent sexual transmission to non-infected persons are sexual abstinence or sex with only a partner known to already be infected with HIV.
- For injection-related transmission, the only certain means for HIV-infected persons to prevent transmission to non-infected persons are abstaining from injection drug use or for IDUs who are unable or unwilling to stop injecting drugs, refraining from sharing injection equipment (e.g., syringes, needles, cookers, cottons, water, straws, etc.) with other persons.

Disclosure and Referring Partner(s) for HIV Counseling and Testing:

- People who have been exposed to HIV need to know about the exposure so that they can get tested and into treatment if they have been infected.
- The knowledge of one's HIV status allows the individual to take part in prevention efforts through behavioral changes as well as access treatment and support services that may decrease the spread of HIV and reduce morbidity and mortality of HIV infection.

Other STIs Increase Transmissibility of HIV:

- The presence of another STI increases a person's risk of acquiring HIV infection whether or not the STI causes visible open sores.
- Breaks or sores in genital or rectal tissues make it easier for HIV to enter the body during sexual contact.
- STIs can stimulate immune responses in the genital area that increase the HIV transmission risk.
- If an HIV-infected person is also infected with another STI, that person is 3-5 times more likely to transmit HIV through sexual contact.

Reference: MMWR July 18, 2003 / 52(RR12); 1-24, CDC NPIN (www.cdcnpin.gov)

Handout 2

Statements Revealing Beliefs and Attitudes about HIV Transmission

Patients with HIV/AIDS who are involved in risky behaviors often give verbal clues about the reasons for their behaviors:

Statements reflecting misconceptions:

1. My viral load is undetectable (low), so it doesn't matter what type of sex I have with my partner.
2. Every time I go for my HIV clinic visit, they tests for other STIs, so I'd know if I had one.
3. My partner knows about my HIV status and we haven't used condoms in10 years. If he/she still doesn't have it, then he/she must be immune.
4. I only have sex/share works with other people who already have HIV so I don't need to use protection.
5. My partner(s) would ask to use condoms if they wanted to use them
6. I am always the bottom so that I won't be a risk to my partner(s).
7. If I had an STI, I would know. I would have symptoms.
8. STIs are treatable so I don't have to worry about getting something like syphilis.
9. I only share snorting equipment, so there's no risk for giving someone my HIV.

Misconceptions, once identified, can be discussed and the patient can be given correct information.

Statements reflecting greater attitudinal resistance:

1. My partner knows I have HIV and doesn't care if I use condoms.
2. I don't want to live without my partner so it doesn't matter if we give each other something.
3. I don't like how condoms feel - they ruin the moment and interfere with intimacy.
4. I can't maintain an erection with condoms; I can't have an orgasm when I use condoms.
5. My partner/family wants me to get pregnant so that I will leave them a child when I die.
6. Someone gave this to me and never told me – why should I care about others?
7. Everyone I have sex with/share works with is an adult; they know what's out there. If they choose not to use a condom or to share equipment, it's their problem, not mine.
8. My partner doesn't know about my HIV status; how do I start using condoms when we have been together for so many years?
9. My partner might kick me out of the house, break up with me, accuse me of sleeping around, beat me up, etc.
10. My partner says s/he loves me and wants to be close; condoms mess that up.
11. I like to have sex when I'm high – it makes it really powerful.
12. A lot of times I only have sex because I can trade it for my fix or for money to get a dose; if I'm dope sick I don't care who I have sex with or if we use a condom, all I want is to feel better.
13. The only times I feel good about myself are when I have sex/use drugs – otherwise I don't much like myself.

Statements indicating greater resistance to change indicate a need for more in-depth interventions, including referral, use of external/internal resources, and a team approach.

Handout 3

Using Stages of Change to Address Barriers Related to Condom Use

There are a limited number of barriers related to condom use for patients who are thinking about changing behavior (in Contemplation Stage). The following are common barriers expressed by patients and strategies you can use to address these barriers.

1. Lack of Availability:

a. **I can't afford to buy them** – Medicaid insurance will pay for male and female condoms if the clinician writes a prescription. **Prescribe**

   Distribute free condoms in your clinic

b. **I didn't have one with me** – discuss circumstances. Where were you? Were you planning to have sex? Who were you with? Has this ever happened before? Discuss with patient – "the time of greatest need to carry a condom is when you are NOT planning to have sex. How do you think you can make sure you have a condom when you have unplanned sex?"

2. Condom Dislike:

a. **I don't like how they feel –** Many males do not like the feeling of latex condoms as the condoms adhere tightly to the glans penis and the rim of the corona which decreases the sensitivity of this area during sex. Some techniques increase the sensitivity, such as:
   - **Put a dollop of lubricating jelly (water-soluble) inside the tip** of latex condom before putting it on. This increases the likelihood that the condom will slide back and forth over the glans/corona and frenulum resulting in greater sensitivity.
   - **Use other types of condoms, such as those with ridges, rings, or nubs**. Again, this increases sensitivity by creating movement of the condom back and forth over the glans/corona and frenulum. You may consider having a few of various types of specialty condoms – for distribution or for demonstration.
   - **Use female condoms.** Female condoms are made of polyurethane, rather than latex. This material is thinner and conducts more body heat. Most men report that it feels more natural than male latex condoms – again because the condom is not adhering to the glans/corona. Female condoms can also be used by the receptive partner during anal intercourse. You may consider having a few of these in clinic with female/male anatomical models to show patients.
   - **Use a male condom made of polyurethane or polyisoprene.** These materials are non-latex, and conduct more body heat, which may improve sensation and pleasure

3. Lack of Negotiation Skills:

a. **I don't know how to bring it up –** Many patients feel that initiating condom use is some type of disclosure about their HIV status. You may suggest other rationale for bringing up condom use. The following are examples:

Handout 3

- **For heterosexual female patients:**
  - I went off my birth control pills for a while and I am using condoms until I can get back on.
  - I don't have any insurance to pay for birth control and I can get these for free.
- **For heterosexual male patients:**
  - This helps me last longer during sex.
  - You are so (hot, beautiful, etc) and I am so excited – this will help me slow it down so I can give you more pleasure.
- **For gay male patients (insertive):**
  - This helps me last longer during sex.
  - You are so (hot) and I am so excited – this will help me slow it down a little.
- **For gay male patients (receptive):**
  - This helps me relax.
  - I want to enjoy you and not have to worry about anything, so lets' get rid of any distractions.

b. **I don't know what to say when they bring up condom use and partner has a negative reaction –** try to learn more about the relationship dynamics. What is the negative reaction the patient is anticipating and from whom? To help the patient develop skills in negotiation of condom use, role-play scenarios in which the patient plays the partner and you play the patient.

4. Condom interferes with sexual performance:

a. **I can't maintain an erection when using a condom –** Refer to options listed in #2 above. If this is not helpful, further assess. Is the erectile dysfunction (ED) with some partners, all partners? Does ED occur at a certain time of day, any time of day?

b. **My partner has trouble having an orgasm if we use a condom** – Refer to options listed in #2 above. Often, a partner may need more foreplay before intercourse. More manual stimulation during intercourse may also help the partner.

5. Condom interferes with the mood:

a. **Using a condom ruins the moment –** Many patients who express this are referring to a reduced sense of intimacy they experience with condom use. They often want to 'feel' and 'taste' raw skin in order to experience intimacy. Ask the patient to think of ways to increase intimacy and feeling/tasting while using condoms for intercourse.

6. Standard condoms sizes do not always fit:

a. **Condoms are available in different sizes –** larger and smaller.
  – Most of the companies that produce condoms have several types, including large and/or small sizes.

b. **Female condoms** – used by the receiver
  – may help if male condom fit is a problem for the male.

Handout 4

Reaching Safer Behavioral Goals

What is a behavioral goal?

A specific action that an individual is willing to try to adopt that can prevent or reduce the risk of STD/HIV transmission

Replacing a higher-risk behavior with a relatively lower-risk behavior may reduce the likelihood that HIV transmission will occur.

What are action steps?

- Realistic incremental changes that help an individual reach behavioral goals
- Small steps which help the patient start on a path to adopting less risky behaviors

Questions to ask to help develop a risk reduction plan:

- What is your experience with (safer behavior)? What made it work (or not work) for you?
- How would your sexual/drug practices have to change for you to stay safe?
- What would you like to do to reduce your risk of HIV or STDs?
- Who would approve or support you in adopting this behavior?
- What would be the first step in reaching that goal? Second step?
- What could make it difficult for you to complete this step?
- How can you incorporate the step you have identified into your life?
- What could you do to make it easier to take the first step?
- When do you think you will have the opportunity to try this?
- How realistic is this plan for you?

Example:

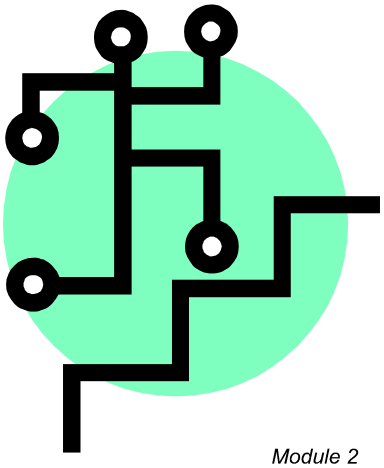
Mike is a, 32 year-old HIV-positive drug user who has always shared injection equipment with his "running buddies." He sometimes uses at home and at other times at his friends' houses.

Goal*: *Use clean works more often

Step 1: I will learn to clean works

Step 2: I will find a needle and syringe exchange program

Step 3: I will keep a stash of clean works at home and will take clean equipment to my friends' houses when I plan to use



Handout 5

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Evidenced-based, Individual-level Prevention Interventions:

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2. Kamb et al. (1998). Efficacy of risk-reduction counseling to prevent human immunodeficiency virus and sexually transmitted diseases: a randomized controlled trial. *Journal of the American Medical Association*, (280), 1161-67.
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Slide 3:

a. Gardner, E. (2011). The spectrum of engagement in HIV care and its relevance to test-and-treat strategies in the clinical setting. *Clinical Infectious Disease*, *52*(6), 793-800.
b. Centers for Disease Control and Prevention (CDC). (2011). Vital signs: HIV prevention through care and treatment-United States. *MMRW*, *60*(47), 1618-1623.

Slide 5: Centers for Disease Control and Prevention (CDC). (2003). Incorporating HIV prevention into the medical care of persons living with HIV: Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. *MMWR, 52*(#RR-12), 1-24.

Slide 6: Centers for Disease Control and Prevention (CDC). (2010). *Establishing a holistic framework to reduce inequities in HIV, Viral Hepatitis, STDs and Tuberculosis in the United States: An NCHHSTP white paper on social determinants of health*. http://www.cdc.gov/socialdeterminants

Slide 7: Centers for Disease Control and Prevention (CDC). *Diffusion of Effective Behavioral Interventions*. http://www.effectiveinterventions.org

Slide 8: Myers et al. (2010). Interventions delivered in clinical settings are effective in reducing risk of HIV transmission among people living with HIV: results from the health resources and services administration special project. *AIDS and Behavior*, *14*(3), 483-492.

Slide 9:

a. Fisher et al. (2004). Clinician-initiated HIV risk reduction intervention for HIV-positive persons: formative research, acceptability, and fidelity of the options project. *Journal of Acquired Immune Deficiency Syndromes*, (37), S78-S87.
b. Richardson et al. (2004). Using patients risk indicators to plan prevention strategies in the clinical care setting. *Journal of Acquired Immune Deficiency Syndromes*, (37), S88-S94.
c. Thrun et al. (2009). Improved prevention counseling by HIV care providers in a multisite, clinic-based intervention: Positive Steps. *AIDS Education and Prevention*, *2*, 55-66.

Slide 17: Smith et al. (2005). Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States. *MMWR*, *54*(2), 1-20.

Slide 18: Cohen, M. (2011). Prevention of HIV-1 infection with early antiretroviral therapy. *New England Journal of Medicine*, *365*, 493-505.

Slide 29: Prochaska et al (1992). *Stages of change in the modification of problem behaviors.* In M. Hersen, P. Miller & R. Eisler (Eds.), Progress in Behavior Modification (Vol. 28). New York: Wadsworth Publishing.

Handout 6

Resources

- High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States. http://www.cdc.gov/hiv/strategy/index.htm
- CDC Factsheet: http://cdc.gov/nchhstp/Newsroom/docs/HD-FOA-media-fact-sheet-508c.pdf
- Effective Behavioral Interventions: http://www.effectiveinterventions.org/
- The National Network of STD/HIV Prevention Training Centers (NNPTC): http://www.nnptc.org/
- AIDS Education and Training Centers National Resource Center: http://www.aidsetc.org/