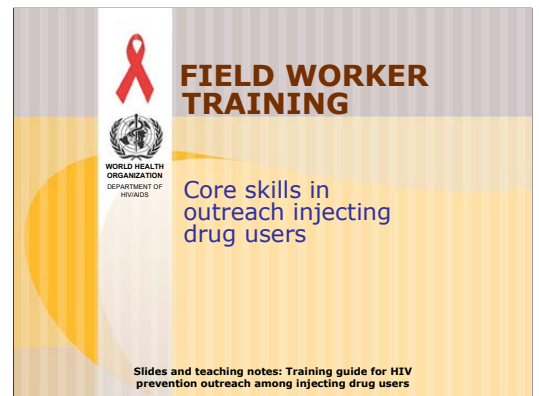


Teaching Notes



See Training guide book for:

Preparation and materials needed for this workshop, overview of sessions, training and learning objectives and key learning points

See CD-ROM for:

Exercises

PowerPoint Slides for other modules

Handouts

Photographs

Videos

Training guidelines book (electronic version)

References

Additional training resources

Teaching Notes

Aim of the course

- To feel confident in **providing outreach** to injecting drug users (IDUs) in **our locality** for HIV prevention

D1.1

Day 1

Session D.1.0. Introduction

Introduce yourself to participants and welcome them, to the training course. Because this is a multi-day course it is important that participants trust one another, so use an Ice-Breaker exercise (some are described in the workshop method chapter) to spend 15 minutes or so helping people to get to know each other.

Slide D1.1: Read the aim of the workshop and read out the outline of the whole course, stating when the breaks will be on the first day.

Let participants know that this is an opportunity for them to learn outreach skills so that they can do outreach work. This is the first time that these materials have been used for training. We welcome their participation and ideas for how to improve the course so that it can be made better for the next class. Evaluations will be filled out at the end of the day for them to give us feedback. As outreach workers they will continue to learn as they do their job. The real classroom is in the communities where they will be working with drug users.

Teaching Notes

Workshop rules

- Arrive on time
- Share honest opinion
- Ask questions at any time
- One person speaks at a time
- Make comments to the whole group
- Listen first before reading
- Use 'cards' for anonymous/embarrassing questions
- Personal information shared will remain confidential

D1.1.1

- We, participants and facilitators, agree to arrive on time for the beginning of each session and after each break
- We will all undertake to honestly state our opinion so we can benefit from frank discussion
- Participants may ask questions freely at any time
- One person speaks at a time: particularly with translation, this is vital; it is also important to ensure that quieter voices are heard in both small groups and plenary sessions
- Comments should be made to the whole group: we undertake not to have side conversations
- We undertake to listen to a person's full opinions or ideas, not react immediately: in this way we can consider what we really think of a new or opposing idea, instead of just reacting to it
- If you are embarrassed or too shy to ask your question in front of the group, you may fill out a card and place it in the box at the back of the room. We will answer these anonymous questions at the end of the day, each day of the course.
- Any personal information shared during the workshop will be kept confidential.
- We will work towards resolving conflicts rather than taking up inflexible positions
- We will discuss ideas or opinions, not the person expressing them
- No smoking in the training room
- No alcohol or drug consumption during the workshop sessions (or at least a lack of intoxication during training)
- We agree to switch off mobile phones while in the training room
- No violence (verbal/physical): people must feel free to express opinions that may not be popular so that we can learn from these opinions.
- Feel free to get up and leave the room to use the restroom or attend to personal needs during the training.

Teaching Notes

Workshop rules (cont.)

- Work towards resolving conflicts
- Discuss ideas, not person sharing them
- No smoking, alcohol or drug use
- Turn off mobile phones
- No violence
- Feel free to get up for personal needs

D1.1.2

Session D.1.1. Self expression: Who am I?

See Exercises on CD-ROM

Session D.1.2. Introduction to organization and programme

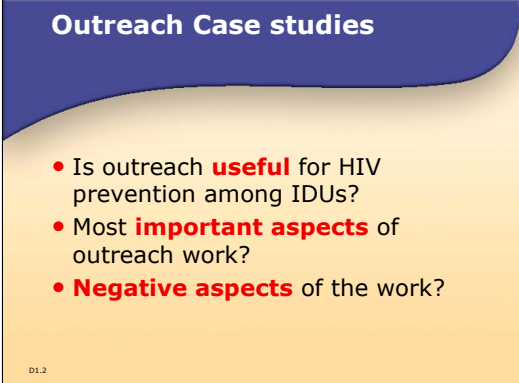
These will need to be written at the local level as they will be specific to the organization operating the outreach programme and the characteristics of the programme itself.

Break

Normally a break would be held at about this point for coffee or tea, and to allow participants to move around and meet one another. It is common practice for such a break to be around 15-20 minutes long.

Trainers should use this time to write out the cards for the exercise in session D1.5

Teaching Notes



Outreach Case studies

- Is outreach **useful** for HIV prevention among IDUs?
- Most **important aspects** of outreach work?
- **Negative aspects** of the work?

D1.2

Session D.1.3. Outreach Case study: outreach programmes

At this point, a guest lecture by an outreach worker can be very effective, especially if the outreach worker comes from the same country as, or a similar country as that of the participants. The guest lecture should be short (about ten minutes), just describing his/her daily work and allowing about 30 minutes for questions from participants. This guest lecture can take the place of the case studies. If there is sufficient time, you may wish to use both case studies and guest lecture to give participants a more complete picture of outreach work.

Slide D1.2: Ask participants to read the case study that you have distributed to them. After ten minutes (to allow them to read it carefully), ask them to form small groups of four to five people. Ask the groups to discuss the following questions:

- Does outreach appear to be a useful method of HIV prevention among IDUs in the country described in the case study?
- What seem to be the most important aspects of outreach work in the case study?
- Are there any negative aspects of the work described in the case study?

These small group discussions should continue for 15 minutes.

Then ask the participants to assemble in the large group again and lead a general discussion about the case study, based on the above questions. Summarize the views of participants on a white board or flip chart. This final discussion should last from 15-20 minutes.

Teaching Notes

HIV transmission among and from IDUs:

- through **sharing** of injecting equipment
- through some drug **preparation processes and rituals**
- through **unprotected** heterosexual (male to female or female to male) or homosexual (male to male) **penetrative sexual act**
- through **HIV-positive mother-to-child transmission (MTCT)**

D1.3 Source: Bell A and Crofts N. HIV risk reduction in injecting drug users. In: Lumsley PR and Gayle H eds. HIV/AIDS Prevention and Care in Resource-Constrained Settings. Arlington, Family Health International, 2002.

Session D.1.4. HIV epidemics among IDUs

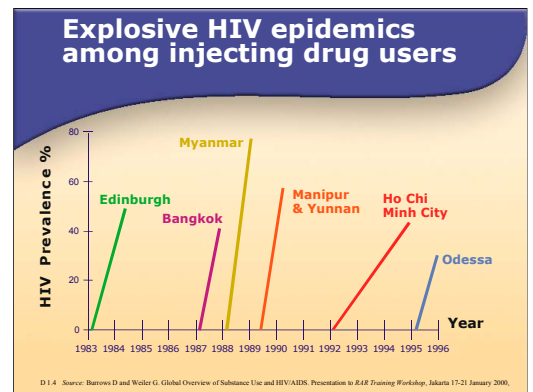
Inform participants that this training course covers a wide range of material, but it is important to put the whole topic of outreach into context.

HIV transmission among and from injecting drug users occurs in several ways:

- The most efficient way that HIV is spread among IDUs is by frequent sharing of injecting equipment (as small quantities of blood, often invisible to the eye, may remain in a syringe and be passed on to the next person who uses the syringe).
- HIV may also be transmitted through some drug preparation processes and rituals associated with injecting drug use (where blood may become mixed with the drug, for example).
- Drug users and sex workers (especially those who also inject) can also acquire and transmit the virus through high-risk sexual behaviours (vaginal or anal sex without condoms).
- IDUs can play a critical role in the spread of HIV into the broader population through heterosexual or homosexual transmission to sexual partners and through mother-to-child transmission (MTCT). For example, in Manipur, 45% of the regular sexual partners of HIV-positive IDUs acquired the virus over a six year period (Panda et al., 2000); and from 1996 to 2001 most of the HIV-positive infants in Ukraine and the Russian Federation were born to mothers who were IDUs or sex partners of IDUs (Dehne, 2001).
- Unscreened blood transfusion can be the most efficient transmission route for HIV. A study among IDUs in Dhaka in 1997 found that 20% of the IDUs were commercial blood donors.
- It also has been observed that many female IDUs get involved in sex work to support their own and/or male partner's drug-use practices while many sex workers get introduced to drug use by their male drug user partners. The study among IDUs in Dhaka in 1997 found that 10% of the male IDUs had experience of male-to-male sex. As the efficiency of transmission of HIV through unprotected heterosexual intercourse can be as much as ten times higher from male to female as from female to male, female IDUs and the female partners of the male IDUs are at greater risk of getting the virus than male IDUs.

The link between sexual transmission of HIV and other sexually transmitted infections (STIs) should also be made here. Emphasize that the prevention of sexual HIV transmission (whether among IDUs or other segments of the population) should be part of a general strategy to reduce the incidence of all STIs.

Teaching Notes



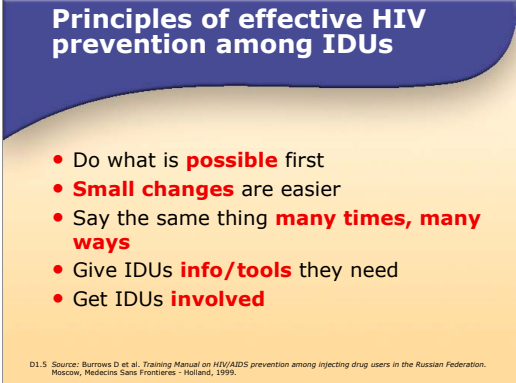
Slide D1.4: HIV can spread very quickly among IDUs. Explosive HIV epidemics among IDUs have occurred in a wide range of areas in the past 20 years, including:

- New York City (United States of America) in 1979, followed by such cities as Edinburgh (the United Kingdom), Bangkok (Thailand), Ho Chi Minh City (Viet Nam), Santos (Brazil), Odessa (Ukraine), Svetlogorsk (Belarus), Moscow and Irkutsk (the Russian Federation) and, in 2001, Narva (Estonia). Explosive spread has also occurred across entire provinces such as Manipur in India and Yunnan in China, and across countries such as Myanmar.

In some areas, HIV prevalence among IDUs has escalated from less than 5% to over 40% in a period of less than 12 months. In Manipur, prevalence increased from under 10% to more than 60% in six months. In Eastern Europe, where the epidemic only emerged in about 1996, 80%–90% of new HIV infections are among IDUs. In 2001, the Eastern European HIV epidemic was the fastest-growing in the world.

- Worldwide, there may be as many as 185 million drug users, equivalent to 4.3% of the population age 15 years and above. The proportion of female drug users ranges from about 10% (e.g. in some traditional Asian societies) to 44% (in the United States of America) of all drug users. It is also estimated that globally there are around 6–10 million IDUs (as of 1999). Even though traditionally women are not as involved in injecting drug use as men, many countries have observed an increasing share of women in the injecting drug use population and, several countries, e.g. in the Eastern European region, reported an increase in female injecting drug use levels, over the last couple of years. In Eastern Europe, where the epidemic only emerged around 1996, 80%–90% of the new HIV infections occurred through unsafe drug injecting practices and the male-to-female ratios of reported cases of HIV have been declining, suggesting that HIV is spreading increasingly among females either via sexual intercourse mainly from the male IDUs to their female partners or females increasingly are injecting drugs and contracting HIV through contaminated equipment, which is more likely.

Teaching Notes



Principles of effective HIV prevention among IDUs

- Do what is **possible** first
- **Small changes** are easier
- Say the same thing **many times, many ways**
- Give IDUs **info/tools** they need
- Get IDUs **involved**

D1.5 Source: Burrows D et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow, Medicus Sans Frontiers - Holland, 1998.

Slide D1.5: Point out to participants that a public health approach has been shown in many countries to lead to effective HIV prevention among IDUs. An effective prevention programme also requires:

- *Do what is possible first*: Emphasis on short-term pragmatic goals (for example, preventing HIV transmission in a specific circumstance) over long-term idealistic goals (for example, overall reduction in harm/risk from drug use).
- *Small changes are easier than big changes*: Establishment of a scale of means to achieving specific goals: for example, a hierarchy of risks (next slide)
- *Say the same thing many times, many ways*: Use of multiple strategies to achieve goals.
- *Give IDUs the tools they need*: Provision of the means to accomplish risk reduction, for example condoms and sterile needles and syringes .
- *Get IDUs involved*: Involvement of people who inject drugs in the planning and implementation of programmes through recruitment of current drug users.

This set of principles is known collectively in some countries as “harm reduction” or “risk reduction”.

Teaching Notes

Risk hierarchy

- **Stop/never start** using drugs
- If you have to use, **don't inject**
- If injecting, **don't re-use or share**
- If re-using, **use own equipment**
- If re-using others' equipment, **clean it appropriately**

D1.6. Source: Burrows D et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow, Medecins Sans Frontieres - Holland, 1999.

Slide D1.6: A typical hierarchy of drug-related HIV risks is as follows. This hierarchy relates only to HIV risk associated with drug injecting. Other hierarchies need to be used for other HIV transmission routes such as sexual transmission and mother-to-child transmission:

- Stop or never start using drugs: if you do not use injectable drugs, you cannot catch infections through needle sharing.
- If you cannot stop using drugs, use them in any way except injecting: if you do not inject drugs, you cannot catch infections through needle sharing.
- If you cannot stop injecting, do not share needles, cookers/spoons or filters with other drug users/ or use new injecting equipment every time: if you use new injection equipment every time, you cannot catch viral infections such as HIV through needle sharing
- If you need to re-use any equipment, use your own injecting equipment every time: if you re-use your own injection equipment every time, you cannot catch viral infections such as HIV (unless someone else has used your equipment without your knowledge).
- If you need to re-use any equipment and you believe you need to use someone else's equipment (needle or equipment sharing), clean needles by an approved method (see *Programme management workshop* guide for details). There is some risk of HIV transmission after needle cleaning, but cleaning in an approved manner will reduce the likelihood of transmission.

Teaching Notes

Elements of effective prevention

- Go **where IDUs** are
- Education from **someone IDUs trust**
- Increased **access to needles and syringes**
- Drug **substitution** treatment
- Supportive **policy, legislation and advocacy**

DL.7 Source: WHO Evidence for Action papers and policy briefs, REF

Slide D1.7:

In 2001–2002 WHO commissioned a series of papers by the world’s leading authorities on HIV among injecting drug users. These are known collectively as Evidence for Action. The papers are being published both as printed documents and online, as they are finished. At the time of this writing, not all of the papers were complete, so make sure that you check the web site (www.who.int/hiv_aids) for these to see if more-up-to-date versions are available. Give participants an overview of the papers available on the web site as well as the web address, and state that this slide and the following slides summarize some of the key findings from these papers.

From the Evidence for Action papers and policy briefs, there is clear evidence that five activities can be highly effective in preventing HIV transmission among IDUs. While each activity seems to have limited effectiveness by itself, when several or all are used at the same time, HIV epidemics among IDUs have been prevented, brought under control and reduced.

The five elements are:

Outreach. Go where the IDUs are. The papers refer to outreach as an approach for contacting drug users in their local neighbourhoods and providing them with education, advice (risk reduction counselling) and the means (skills and/or products such as needles, syringes, bleach, condoms) to change their risk behaviours related to injecting drug use and sex.

Relevant, credible education and information. Education needs to come from someone IDUs trust. This is sometimes called Information Education Communication (IEC) or Behaviour Change Communication (BCC). It forms an important part of outreach work but can also be carried out in additional ways through the use of leaflets, videos, and a wide variety of targeted and mass media.

Increased access to needles and syringes. Specifically, the papers summarize the large body of evidence for needle and syringe programmes (NSP) which sometimes include the exchange of used needles and syringes during the distribution of new needles and syringes.

Drug treatment with methadone and buprenorphine (for users of opioids such as heroin). This has also been shown to be highly effective in preventing HIV transmission among IDUs.

Supportive policy, legislation and advocacy. Last but not the least, it has been also observed that supportive policy, legislation and advocacy can help to reduce marginalization and thus increase access to prevention services for IDUs

Teaching Notes

Community-based peer outreach is most widely used and is also very effective

- **...why?**
- **Least costly**
- **Contributes greatly to preventing HIV infections in IDUs and their sexual partners**
- **A major component of a comprehensive strategy**

D1.8 Source: Needle R, et al. Effectiveness of community-based peer outreach for IDUs: a preliminary report. Paper presented at 13th International Conference on the Reduction of Drug-Related Harm, Ljubljana 3-7 March, 2002.

Slide D1.8: The Evidence for Action paper on outreach refers specifically to community-based and peer outreach.

It is referred to as community-based because it is organized to access and reach hidden populations of IDUs in a process of risk reduction in the communities where they congregate (rather than intervening with drug users who attend clinics to access services).

The outreach worker is often referred to as a "peer", or in some programmes as an "opinion leader." In this context, peer refers to someone familiar with the IDU "community": an active or ex-IDU, or a non-injecting drug user or non-user with close links to IDUs, who can be trusted by IDUs, who is preferably from the same gender group as his/her peers, is trained to provide services, and preserve confidentiality.

The paper found that outreach is the most widely used intervention to prevent HIV among IDUs globally, with evidence of outreach programmes to address these issues on almost all continents.

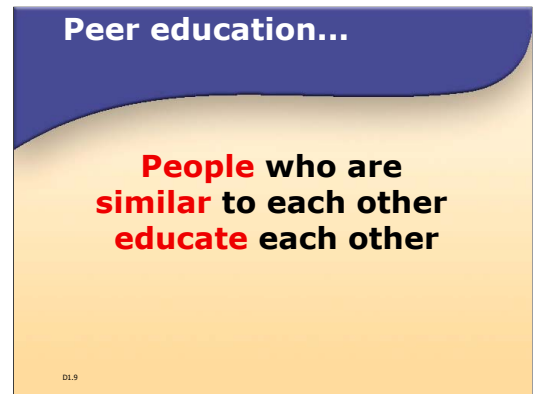
It is the least costly intervention and is often the easiest intervention to begin (compared to large targeted education, NSP or substitution drug treatment programmes).

Several studies have shown that outreach can be effective by itself and that outreach is usually plays a major role in a comprehensive HIV prevention programme among IDUs.

In summary, outreach contributes greatly to the prevention of HIV among IDUs and their sexual partners.

If peer education is an unfamiliar term for participants, you may want to use this slide:

Teaching Notes

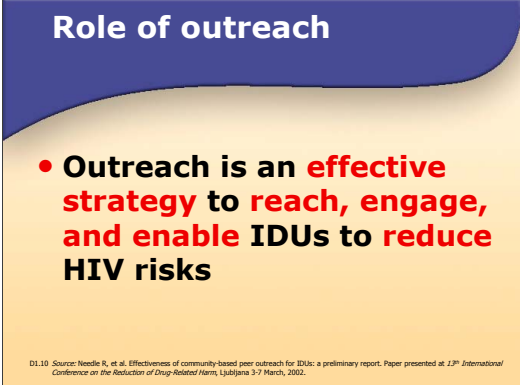


Slide D1.9: Peer education can be defined as: “people who are similar to each other educate each other”.

The key elements of peer education are that:

- the education strategies and messages are specifically for one group or subpopulation (for example, IDUs in a specific locality, of same sex, in some cases of same gender);
- the strategies and messages are developed and used by members of the subpopulation: IDUs
- peer education is based on the widely recognized principle that members of a group or subpopulation are more likely to understand each other and be able to develop useful messages and strategies for people like themselves.

Teaching Notes



Role of outreach

- **Outreach is an effective strategy to reach, engage, and enable IDUs to reduce HIV risks**

D1.10 Source: Needle R, et al. Effectiveness of community-based peer outreach for IDUs: a preliminary report. Paper presented at 12th International Conference on the Reduction of Drug-Related Harm, Ljubljana 3-7 March, 2002.

Slide D1.10: The available evidence clearly shows that outreach is an effective strategy to reach, engage, and enable IDUs to reduce their risks of acquiring and or transmitting HIV. Outreach is most effective when it is linked with other services, especially needle and syringe provision, and when IDUs are provided with explicit information and education, developed with the involvement of IDUs themselves.

Teaching Notes

How to contact IDUs?

- Where would you **find IDUs** in your locality?
- Would you feel comfortable **going to** all these places to talk to IDUs?
- Would you feel comfortable **talking to** IDUs about HIV and drug use issues?
- Do you believe IDUs would **listen to** you about behaviour change?

Session D1.5 Exercise: How to contact IDUs?

Slide D1.11: Split the participants into small groups (at random): Provide flip chart paper and ask each group to appoint one person to write down answers.

Ask each small group to develop answers to the above questions. Tell them they have 20 minutes to answer the questions.

Where would you find IDUs, particularly female IDUs, in your locality? Ask the group to list the various places across all the localities represented in the group.

Would you feel comfortable going to all of the listed places to talk to IDUs? If no, why not? Ask the group to list the reasons why it might be uncomfortable for at least some participants to visit all the listed places.

If you find them, would you feel comfortable talking to IDUs about HIV and drug use issues? If no, why not? Ask the group to list the reasons why it might be uncomfortable for at least some participants to talk to IDUs about these issues.

Do you believe IDUs would listen to you, believe you and follow your recommendations for behaviour change? If no, why not? Ask the group to list the reasons why IDUs might not listen to at least some participants.

After 20 minutes, ask participants to return to their seats and ask one group to give their answers. Ask the other groups to provide any answers which are different from or additional to the first group's answers. This should take about 15 minutes.

Summarize the answers by saying that it is difficult to know where all IDUs may be in any locality, that not everyone is comfortable visiting the places where IDUs might be found and talking with IDUs, and that IDUs may not listen to advice and follow recommendations for changing their behaviour. Research has shown that the effectiveness of this communication with IDUs depends greatly on who is trying to communicate with IDUs and where the communication takes place.

LUNCH

At around this point, break for lunch. Lunch break usually lasts for about one hour, though this may depend on the local culture.

Session D.1.6. Communicating with drug users I

See Exercises on CD-ROM

Session D.1.7. HIV/AIDS Knowledge test

See Exercises on CD-ROM

Teaching Notes

HIV and AIDS

- Human Immunodeficiency **Virus**
- Acquired Immune Deficiency Syndrome...**clinical condition**
- **"HIV does not equal AIDS"**

D1.12 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organizations), 1998.

Session D.1.8. HIV/AIDS knowledge I

This session is best undertaken by a guest lecturer (usually a doctor or other authority with a wide knowledge of medical and social aspects of HIV/AIDS). The information provided here is only suitable for those trainers who feel they have sufficient experience of training on HIV/AIDS topics to answer questions from participants. If you use a guest lecturer, make sure you clearly brief him or her on the topics you want covered and ask the guest lecturer to look through the slides to ensure that all the topics contained in this session are addressed.

(Reference: Notes for this section are based on AFAO 1998.)

Note: Slides in this session should only be displayed AFTER participants have been given the chance to answer each question.

Begin by writing "HIV" on a sheet of flip chart paper and asking participants to tell you what the letters mean and what HIV is.

The answer should be similar to:

HIV is the human immunodeficiency virus. A virus is a microscopic organism which can only survive by living inside the cells of another organism. HIV affects humans and leads to a deficiency in the infected person's immune system: this means the infected person's body cannot protect itself from infection.

Next, write "AIDS" on the flip chart and ask what this means.

The answer should be similar to:

The Acquired Immune Deficiency Syndrome is a syndrome, or collection of clinical illnesses. A syndrome is not a specific disease, but a set of signs or symptoms which occur together, as a direct result of a particular cause. In the case of AIDS, the cause is HIV.

Next write "HIV = AIDS?" and ask does HIV mean the same as AIDS? If not what is the difference?

The answer should be similar to:

HIV damages the body's immune system and renders the body vulnerable to other diseases and infections. The resultant deficiency in the immune system, following the destruction of the cells that fight infection, allows certain opportunistic infections and cancers to flourish. Such infections and conditions are described as 'opportunistic' because common organisms which cause them (for example parasites, bacteria, fungi and viruses) would usually be controlled by an intact immune system. These organisms are often present in the bodies of many people with intact immune systems. When the immune system is damaged, however, these organisms may multiply relatively unchecked, and so cause disease. The presence of HIV in the body is itself not an AIDS diagnosis. It is possible for people to have HIV antibodies for many years, but present none of the clinical symptoms which define AIDS.

Show Slide D1.12

Teaching Notes

Stages of HIV infection

- **Seroconversion illness stage:**
brief and soon after the infection
- **Asymptomatic infection stage:**
can last **months or years**, often **no signs of illness**
- **Symptomatic HIV infection stage**
- **AIDS or late severe HIV disease stage**

D1.13 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organizations), 1998.

Next ask: "What are the stages of HIV infection?"

The answer to this question may be different in different countries (as methods of categorizing people with HIV infection sometimes differ). Trainers should ensure they know the stages generally referred to in their country. Below are the stages most commonly discussed in Western countries:

Seroconversion. HIV infection can occur without a person knowing they have contracted the virus. Some people may experience a short 'seroconversion' illness between two and six weeks after becoming infected; many people do not. The symptoms of the primary illness may be quite non-specific and include:

- notable tiredness and lethargy;
- fever;
- an often characteristic rash;
- diarrhoea; and
- non-specific symptoms often compared to those of flu or glandular fever, such as sore throat or headache.

It is important to note that such symptoms are common to a range of other conditions, both serious and minor. Many people, however, report the experience of seroconversion illness as markedly different from that of having the flu. Nonetheless, symptoms of seroconversion illness are not a reliable indicator of the presence of HIV infection. HIV antibodies usually don't appear until about two or three weeks into this period of primary infection, or about six weeks after initially becoming infected. In the absence of symptoms, but where exposure to HIV is suspected, HIV cannot be reliably excluded until about 12 weeks (three months) after exposure.

Following seroconversion, and in the absence of treatment, there may be a period of many months, or many years, during which damage occurring to the immune system does not manifest itself in outward signs or symptoms. There will be antibodies to the virus present but there may be no other indications of infection. This period is known as asymptomatic infection. During this period, most people look and feel generally well. (Note: It is important to stress that it is generally impossible to tell that a person has HIV during this period without a specialized HIV test.) Some people at this stage may experience a persistent swelling of the lymph nodes.

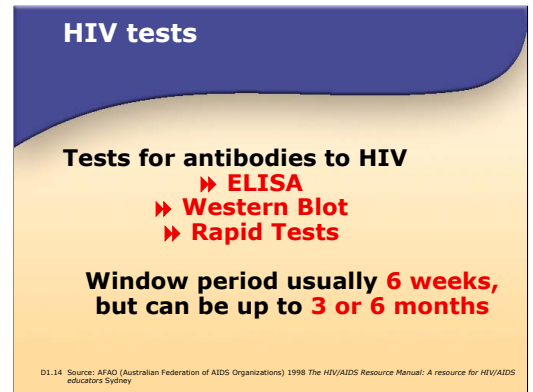
Eventually, in the absence of treatment, symptomatic HIV infection will follow. The period from acquiring HIV to showing symptoms of HIV varies widely between individuals and between countries, but it is often more than five years. Indications of symptomatic HIV infection may include:

- lack of energy;
- fever and night sweats;
- persistent vaginal candidiasis in women;
- diarrhoea for more than one month;

AIDS or late severe HIV disease can manifest itself in a wide variety of ways. There is no universal set of clinical features common to all people with AIDS, nor is the course of HIV infection or disease the same in all individuals.

Show Slide D1.13

Teaching Notes



Next ask: If a person can have HIV for months or years before symptoms occur, how do we know if the person has HIV?

The answer should be similar to:

HIV is detected by tests which look for antibodies to the virus. When a virus enters the body, antibodies are generated by the body to try to kill the virus. HIV antibody status is generally determined by two different blood tests. When one test is positive, and this has been confirmed with a second test, a HIV positive result is recorded.

The standard initial blood test applied to detect the presence of HIV antibodies is called Enzyme-linked Immunosorbent Assay (ELISA). As many patient samples can be tested simultaneously, ELISA is used as the main screening test. A positive blood sample will then be re-tested for confirmation by another test, known as Western Blot. This test is generally considered more labour intensive, and requires significant technical expertise to ensure results are correctly interpreted at the laboratory level. It is not used, therefore, in isolation, or as the initial screening test. Western Blot testing occasionally gives false positive results, some thought to be caused by the presence of other proteins or viruses which produce a cross-reaction to HIV antibodies. The combination of the two tests, however, is generally considered very reliable.

A rapid test for detecting antibody to human immunodeficiency virus (HIV) is a screening test that produces very quick results, in 30 minutes or less. In comparison, results from the commonly used HIV antibody screening test, the enzyme immunoassay (EIA), are not available for one to two weeks.

Both the rapid test and the EIA look for the presence of antibodies to HIV. As is true for all screening tests (including the EIA), a reactive rapid HIV test result must be confirmed before a final diagnosis of infection can be given.

Next ask: What about the window period? What does this mean?

The answer should be similar to:

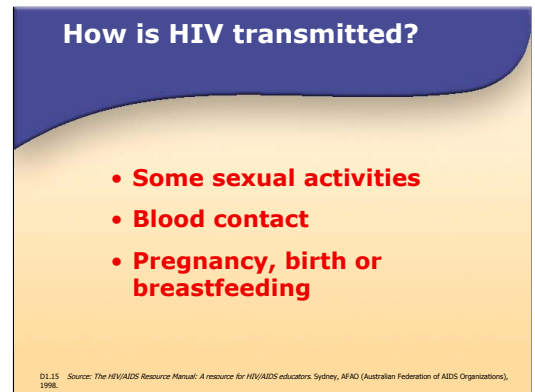
When a person is initially exposed to HIV and becomes infected, antibodies to the virus will not be immediately present. Rather, there is a period of time over which the antibodies will develop. During this so-called 'window period' a HIV test, which relies on the presence of antibodies, may be negative. The amount of time between initial infection and the appearance of detectable antibodies in the blood may vary considerably. In general, antibodies will have appeared within 45 days of infection (about six weeks) but in some cases this may not occur for up to three, and rarely, up to six months following infection. A negative HIV test result therefore does not necessarily mean a person is not infected with HIV. A second test may be necessary, after this 'window period' has elapsed, to exclude the possibility of infection.

Show Slide D1.14

Break

Normally a break would be held at about this point for coffee or tea, and to allow participants to move around and meet one another. It is common practice for such a break to be around 15-20 minutes long.

Teaching Notes



Session D.1.9. HIV/AIDS knowledge II

This session is a continuation of Session D1.7.

(Reference: Notes for this section are based on AFAO 1998.)

Note: Slides in this session should only be displayed AFTER participants have been given the chance to answer each question.

Next ask: How is HIV transmitted?

The answer should be similar to:

HIV has been shown to be transmitted through:

- Some sexual activities
- Blood contact between individuals such as the sharing of injecting equipment
- Pregnancy, birth or breastfeeding

Show Slide D1.15

Teaching Notes

Sexual transmission

- Through **unprotected (no condom) penetrative vaginal and anal sex most efficient**
- Through **oral sex also possible**

D1.16. Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organizations), 1998.

Next ask: How is HIV transmitted sexually?

The answer should be similar to:

The sexual transmission of HIV has been extensively documented from male to male, from male to female, and from female to male sexual partners. There are few case reports of female-to-female transmission. Penetrative anal and vaginal sex without use of a condom is the most common way that HIV is transmitted sexually.

The likelihood of HIV being transmitted during any single episode of sexual contact appears somewhat higher from a male to a female than from a female to a male. The risk of acquiring HIV through unprotected receptive anal sex is greater than the risk posed by receptive vaginal intercourse, in a one-off encounter. Transmission during oral sex is much less likely than transmission during vaginal or anal intercourse, but it can occur.

The risk of HIV transmission associated with a single episode of unprotected intercourse appears to be highly variable and dependent on a number of factors; the risk also increases with multiple episodes of unprotected intercourse. These factors include:

- the viral load of the HIV positive partner (the concentration of virus present in blood and bodily fluids);
- the presence of any genital infection, particularly that which causes skin ulceration or bleeding;
- the type of sexual activity engaged in;
- the risk of that activity causing bleeding or tearing (e.g.. rough sex or anal sex without sufficient lubrication);
- the presence of blood (e.g. menstrual blood); and
- other factors, such as douching or chemical agents, which may cause irritation to skin and mucous membranes.

Show slide D1.16 and Slide D1.17

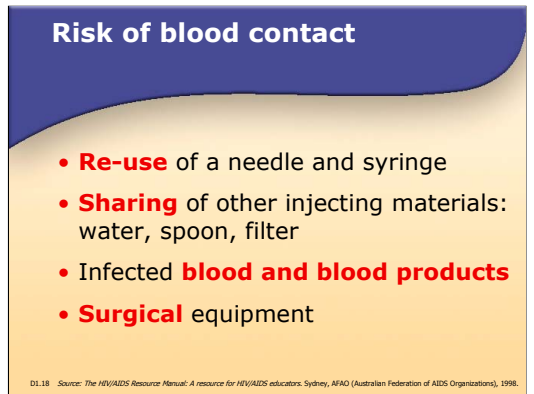
Teaching Notes

Risk of sexual transmission

- **Viral load** of the HIV-positive partner
- Presence of **genital infection**
- **Type** of sexual activity
- Risk of sexual activity causing **bleeding or tearing**
- Presence of **blood**
- Other factors

D1.17 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organizations), 1998.

Teaching Notes



Risk of blood contact

- **Re-use** of a needle and syringe
- **Sharing** of other injecting materials: water, spoon, filter
- Infected **blood and blood products**
- **Surgical** equipment

D1.18 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organizations), 1998.

The answer should be similar to:

Blood contact between a HIV sero-positive and a HIV sero-negative person is one of the most efficient means of transmitting HIV. The immediate re-use of a needle and syringe after they have been used by a HIV positive person is an extremely high risk behaviour for the transmission of HIV: the sharing of other injecting materials such as the water with which a drug is mixed, spoon or other device to heat drugs in, and the filter (often a ball of cotton wool) used to filter the drug can also lead to HIV transmission. Infected blood and blood products used in medical procedures can spread HIV very widely, especially where IDUs sell blood to blood banks and the blood screening facility is poor or absent. Some infections have also occurred via contact with invasive equipment used in surgeries such as dental equipment.

Show Slide D1.18

Teaching Notes

Risk of mother-to-child transmission depends on...

- **Viral load** of **HIV-positive mother**
- **Stage** of her **HIV illness**
- **Breastfeeding**
- **Vaginal delivery** (compared with **elective caesarean section**)

D1.19 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators Sydney, AFHO (Australian Federation of AIDS Organizations), 1998.

Next ask: How is HIV transmitted from mother to child?

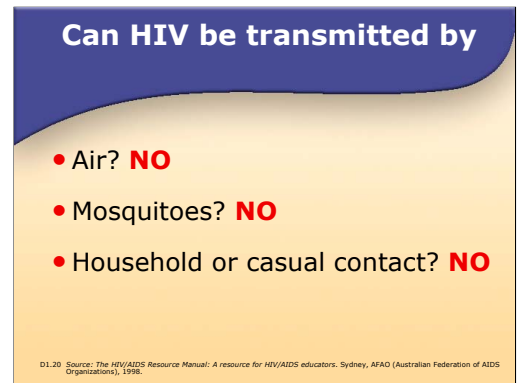
The answer should be similar to:

Studies have found that, without treatment such as AZT or nevirapine, between 8% to 45% of babies born to HIV-positive women acquire the infection. Factors which affect the likelihood of mother-to-infant transmission include:

- the concentration of virus present in the bloodstream of the mother (her viral load);
- the stage of her HIV illness;
- breastfeeding, which has been shown to be a strong risk factor, both in studies of women who became HIV positive after giving birth and in studies of women HIV positive at the time of delivery; and
- vaginal delivery, which, when compared with uncomplicated Caesarian section, slightly increases the risk of infection.

Show Slide D1.19

Teaching Notes



Can HIV be transmitted by

- Air? **NO**
- Mosquitoes? **NO**
- Household or casual contact? **NO**

D1.20 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organizations), 1998.

Next ask: Can HIV be transmitted through the air?

The answer should be: NO

HIV is a relatively fragile virus, quickly destroyed outside the body and outside needles and syringes or other containers. The exact time will depend on factors such as temperature or moisture, but has been estimated at 20 minutes or much less. HIV is also destroyed if it comes into contact with certain chemicals (such as bleach).

Next ask: Can HIV be transmitted by mosquitoes?

The answer should be: NO

HIV is not transmitted by mosquitoes, bed bugs, or other insects. Evidence for a lack of transmission via these insects comes from two areas. Unlike, for instance, malaria, HIV does not replicate inside these insects. If an insect is carrying live HIV, it is because it has recently bitten a person with HIV. Although the insect may carry HIV, it is unable to transmit it. This is because of the extremely minute amounts of blood which could exist on the mouthparts of these insects. In addition, insects do not inject blood, either their own or anyone else's, into individuals; they inject saliva, which works as a lubricant and anti-coagulant. This saliva does not contain HIV.

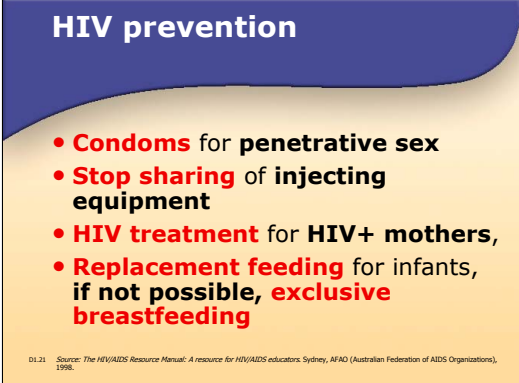
Next ask: Can HIV be transmitted by household or casual contact?

The answer should be: NO

Studies of the household and casual contacts of people with HIV infection have not revealed any risk of HIV transmission. There is no risk of acquiring HIV through the use or sharing of common communal and household objects such as toilet seats, shower facilities, cutlery, glassware or food. There is no risk of contracting HIV through swimming pools.

Show Slide D1.20

Teaching Notes



HIV prevention

- **Condoms** for **penetrative sex**
- **Stop sharing** of **injecting equipment**
- **HIV treatment** for **HIV+ mothers**,
- **Replacement feeding** for infants, **if not possible, exclusive breastfeeding**

D1.21 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators, Sydney, AFAD (Australian Federation of AIDS Organizations), 1998.

Next ask: What are the main methods of preventing HIV transmission apart from in hospitals and clinics?

The answer should be:

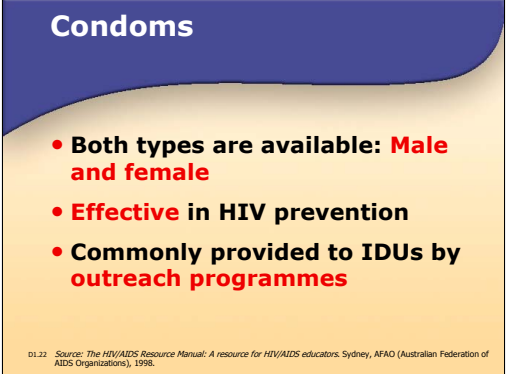
- ✓condoms (both male and female condoms) for penetrative vaginal or anal sex;
 - ✓no transfer of blood between IDUs via needles, syringes or other shared injecting equipment;
 - ✓HIV treatment (such as AZT or nevirapine) for HIV-positive mothers.
- ✓WHO recommends replacement feeding for infants of HIV-positive mothers where it is feasible, acceptable, sustainable, affordable and safe; otherwise exclusive breastfeeding is recommendation and mixed feeding is strongly discouraged as it increases the risk of infection for the infant.

Show Slide D1.21

Session D.1.10. Anonymous questions

See Exercises on CD-ROM

Teaching Notes



Condoms

- **Both types are available: Male and female**
- **Effective in HIV prevention**
- **Commonly provided to IDUs by outreach programmes**

D1.22 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organizations), 1998.

Session D.1.11. Condom demonstration

Before beginning this session, talk to participants about the discussion of topics related to sex. Inform them that these discussions are needed during this course because issues surrounding sexual transmission of HIV must be raised with outreach workers and with IDUs and other clients. Depending on the culture of participants, specific rules or methods may have to be used at this point for discussing topics related to sex. Explain these if they are needed.

Slide D1.22: Inform participants about condoms.

A male condom is a thin sheath of latex or other material designed to fit over the erect penis during sexual activity. A female condom fits inside the vagina. Condoms are designed to prevent the transfer of certain body fluids such as semen between sexual partners. Condoms used during penetrative anal or vaginal sex are the most effective method to prevent sexual transmission of HIV. They are also effective in preventing transmission of sexually transmitted infections and can be used for contraception (preventing pregnancy). They are one of the most commonly distributed prevention materials in outreach programmes to IDUs around the world.

Teaching Notes

Effective condoms

- **Made to standard**
- **'Use by' date**
- **Can be damaged by heat, light, air pollution**
- **Store in cool, dry place**

D1.23 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAD (Australian Federation of AIDS Organizations), 1998.

Slide D1.23: Condoms should be manufactured to a specific standard, which ensures that they do not break easily. They should be packaged with a “use by” date (the date before which they should be used otherwise the condom may become ineffective). Condoms that are not of sufficient quality should not be used for HIV prevention and should not be provided by outreach programmes. If possible, they should also be packaged with brief instructions about their use and with HIV prevention messages. Condoms may be damaged if exposed to heat, light or air pollution. They are best stored in a cool, dry place.

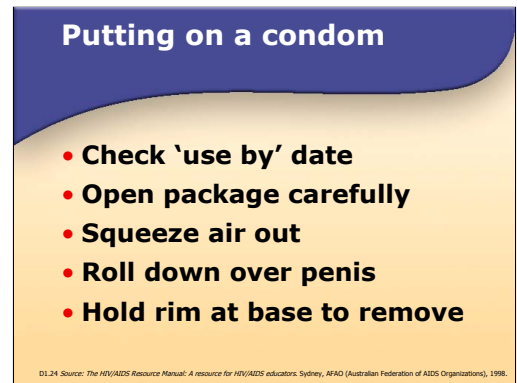
In most countries, condoms are distributed for a variety of purposes by government, NGO or United Nations organizations (such as the United Nations Family Planning Agency). Outreach managers should seek meetings with these organizations to discuss types of condoms that should be distributed through the outreach programme, to consider participating in social marketing of condoms, and to explore whether condoms can be provided for outreach to IDUs either free of charge or at very low cost (by buying together with other agencies). In these ways, quality of condoms can be maximized while costs are minimized.

Male condoms are available in many varieties and sizes and it is important to ensure that any condoms provided by the outreach programme are acceptable to IDUs; this should be done as part of regular monitoring, which will be discussed later. They should only be used with water-based (*not oil-based*) lubricants if additional lubrication is required.

Female condoms consist of a soft, loose-fitting, pre-lubricated polyurethane sheath with two flexible rings. One ring is located at the closed end of the sheath and assists in the insertion and anchoring of the sheath. The second ring, at the open end of the sheath, remains outside the vagina. Female condoms can be used with water or oil-based lubricants.

Both male and female condoms should be discarded after a single use. They should never be re-used as this is likely to lead to weakening of the material and a higher chance of breakage.

Teaching Notes



Slide D1.24: The trainer now demonstrates the correct method of putting on a male condom.

First, the 'use by' date should be checked to ensure that the condom's effectiveness has not expired.

The condom package should be carefully opened with the fingers, not using teeth or scissors.

The condom should be taken out and the closed teat of the condom should be pinched by holding it between thumb and forefinger.

Inform participants that if the penis has a foreskin, it should be pulled back.

The condom is unrolled onto the erect penis (in this case, a dildo or other substitute) until the rim reaches as close to the base of the penis as possible.

Inform participants that after ejaculation, the condom rim at the base of the penis should be held and the penis withdrawn before the erection is lost. This will prevent spillage or leakage of semen.

Leave the slide on the projector.

At this point, split participants into small groups at random. Provide each group with sufficient condoms (about 1.5 per participant to allow for mistakes etc) and a dildo or piece of fruit or vegetable (banana, cucumber, zucchini). Ask participants to demonstrate the use of the condom to the other members of their small group. Ask participants to pay particular attention to mistakes which could result in HIV transmission. Trainers should ensure that all participants carry out the demonstration. About 20 minutes should be allowed for this.

After these demonstrations, bring the participants back to the plenary group and ask how they felt during the demonstrations. If no one says it immediately, ask if anyone felt embarrassed. Inform them that it is common to feel embarrassment at first, but that they will need to become comfortable with demonstrating condom use as they will need to be able to provide these demonstrations with outreach workers and with IDUs. Participants can also be asked to talk about any other safe sex training or educational exercises they have tried, and to demonstrate these for the group.

Encourage participants to take condoms with them.

Session D1.X: Evaluation and close

See Exercises on CD-ROM

Teaching Notes

The term 'drugs' refers to any substance ...

- **In medicine:** with potential to enhance physical or mental wellbeing
- **In pharmacology:** which alters processes of body tissues/organisms
- **In general:** used for non-medical reasons e.g. Illicit drugs

D2.1

Day 2

Session D2.0. Welcome

See Exercises on CD-ROM

Session D.2.1. Who is a drug user?

See Exercises on CD-ROM

Session D.2.2. Drugs and drug use I

(Reference: Notes for this section are based on Burrows, Bleeker and Dillon, 2000 and Burrows et al., 1999.)

Note: Slides in this session should only be displayed AFTER participants have been given the chance to answer each question.

Begin by writing "drugs" on a sheet of flip chart paper and asking participants to tell you what is meant by the word "drugs".

After some discussion, show Slides D2.1 and D2.2:

Slide D2.1: In medicine, the term "drugs" refers to any substance with the potential to prevent or cure a disease or the potential to enhance physical or mental well-being. In pharmacology, the term refers to any chemical agent that alters the biochemical or physiological processes of body tissues or organisms. In common usage, the term often refers to illicit drugs which are often used for non-medical (e.g. recreational) reasons.

Teaching Notes

The term 'substance' refers to any substance ...

that **affects** the way people **feel, think, see, taste, smell, hear or behave**

D2.2

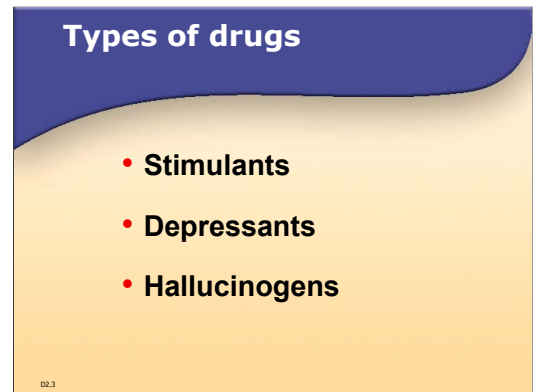
Slide D2.2: A substance is any product that affects the way people feel, think, see, taste, smell, hear or behave (psychoactive substance). A substance can be a medicine, such as morphine, or it can be an industrial product, such as glue.

Next ask: what are some names of drugs? Record them on the flipchart.

Next ask: are all these drugs the same? Are there categories of drugs (in terms of their effects)?

The answer should be similar to:

Teaching Notes



Slide D2.3: Drugs are not all the same. They can be very different in the way they are prepared, in the effects they have on the drug user.

There are three main categories of drugs, based on the effects of drugs on the Central Nervous System (CNS) and on the mind:

- Stimulants such as nicotine (in cigarettes), caffeine (in coffee and tea), amphetamines and cocaine: increase activity of the CNS.
- Depressants such as ethanol (in alcoholic drinks), morphine, heroin, diazepam: slow down activity of the CNS.
- Hallucinogens such as cannabis and LSD (lysergic acid diethylamide) have the ability to produce a spectrum of vivid sensory distortions and also markedly alter mood and thought.

Teaching Notes

A 'dependent' person...

- May develop **tolerance** to certain substance/s
- May experience:
 - Withdrawal**
 - Awareness of compulsion**
 - Narrowing of repertoire (range)**
 - Focus of all interest on drug**
 - Reinstatement or relapse**

D 2.4 Source: Definition of drug dependence, Geneva, World Health Organization, 1964.

Next ask: what is drug dependence or addiction?

There may be no responses or there may be some talk of heroin users being addicted. Inform participants that addiction is difficult to define so that WHO prefers the term "drug dependence" for which there is a clear definition (in DSM-4). Slide D2.4:

Criteria for the diagnosis of dependency are:

1. *Tolerance*. The drug user gets increasingly used to the effects of the drug and it is necessary to increase the dose to achieve the desired effect. A person who has tolerance shows less reaction on given dose of drug than a person who does not have tolerance. The extreme degree of tolerance can be observed with heroin dependency, for example, when a highly dependent person may regularly take a dose exceeding the level which would be lethal for a non-dependent person.
2. *Withdrawal symptoms*. These are clinically observable physical and psychological manifestations that occur if a drug user is deprived of his or her accustomed dose of drug (for example, heroin withdrawal is characterized by physiological reactions such as muscular-joint pains, dysfunction of cardiovascular and gastrointestinal systems).
3. *Withdrawal relief*. This phenomenon is closely connected with the previous topic. A dependent person avoids withdrawal discomfort by taking a dose of the drug.
4. *Subjective awareness of compulsion*. A dependent person realizes his or her compulsion or craving to take the drug. This craving is connected with the necessity of avoiding withdrawal symptoms.
5. *Narrowing of repertoire*. Once dependency is well established, a dependent person takes the drug in an unvarying manner.
6. *Focus of interest*. The drive toward drug-taking gradually becomes the highest priority and all life interests are concentrated around the drug. The circle of his or her interests is narrowed and is determined by finding, acquiring and using the drug (and finding and acquiring the money or other means to acquire more of the drug).
7. *Reinstatement*. A person, who has been off the drug for weeks or months, will tend to relapse quickly into fully established dependence if he or she again uses drugs.

Next ask: Of the drugs mentioned earlier, which are legal and which are illegal?

Record the answers on a flip chart page divided into two halves headed with "legal" on one half and "illegal" on the other half.

Ensure that the following are recorded (if participants fail to mention them, say them). Under "legal", place cigarettes. Under "illegal" place heroin and cocaine.

Next ask why are some drugs legal while other drugs are illegal? Answers will centre on the idea that legal drugs are less harmful than illegal drugs. Question whether this is so. Some participants will usually be willing to debate this topic. NOTE: This topic can become very complex very quickly, so it should only be discussed at length of trainers feel confident they have extensive knowledge of the legal status and harms associated with various drugs in the locality of the training.

After some further discussion on this topic, show the next three slides one after the other. Note that the legality of a drug is generally due more to traditions, culture, or political or religious factors than to whether a drug is more or less harmful than another drug.

Teaching Notes

Nicotine...a legal drug

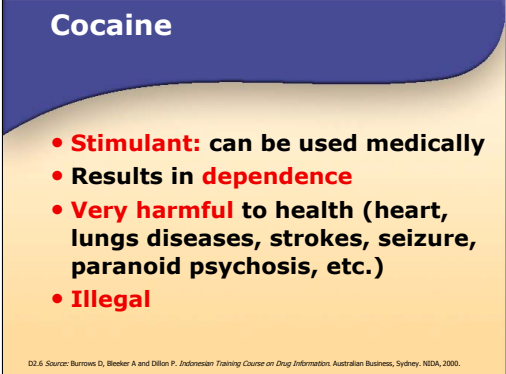
- Pure nicotine can **kill** instantly
- **Stimulant**: no medical use
- Results in **dependence**
- **Very harmful to health** (heart-lung problems...cancer and problems in pregnancy)
- But **'legal'**

D 2.5 Source: Burrows D, Bleeker A and Dillon P. Indonesian Training Course on Drug Information. Sydney, Australian Business, 2000.

Slide D2.5: NICOTINE (Tobacco)

- Cigarettes and cigars are manufactured from tobacco plants.
- Two to three drops of pure nicotine can kill an adult instantly.
- Nicotine is the only drug for which there is no recommended/safe dosage.
- Many smokers feel that nicotine aids their concentration, relieves boredom and suppresses their appetite.
- People easily become dependent on nicotine.
- Withdrawal symptoms include restlessness, insomnia, irritability, mood swings, depression and craving.
- Short-term damage from cigarettes includes chronic coughs, chest infections, breathing problems, asthma, ulcers and bad breath.
- Long-term smoking greatly increases the risk of developing cancers of the throat, mouth, neck and lungs. It also contributes to the development heart disease and circulatory problems.
- Smoking while pregnant can damage the unborn child, and children who breathe their parents' tobacco smoke are more likely to develop breathing problems, infections and asthma.
- Nicotine is not usually injected.
- Nicotine is legal.

Teaching Notes

A graphic slide titled "Cocaine" with a blue header and a yellow-to-white gradient background. It contains a bulleted list of key facts about cocaine.

Cocaine

- **Stimulant:** can be used medically
- **Results in dependence**
- **Very harmful to health (heart, lungs diseases, strokes, seizure, paranoid psychosis, etc.)**
- **Illegal**

D2.6 Source: Burrows D, Bleeker A and Dillon P. Indonesian Training Course on Drug Information. Australian Business, Sydney, NIDA, 2000.

Slide D2.6: COCAINE

- Manufactured from the coca plant.
- Stimulant (similar to amphetamines) though its “pleasurable” effects last a short time.
- It produces sensations of alertness, confidence and well-being.
- Cocaine use can become compulsive and dependent.
- Continued use can lead to paranoia, hallucinations and psychosis (loss of contact with reality); physical effects can include lung and cardio-vascular problems.
- Cocaine is usually snorted but it can be used in other ways including injection.
- Cocaine is illegal.

Teaching Notes

Heroin

- **Depressant**
- Results in **Dependence**
- **Harmful** for health: Infection, clouding of mental function, clogging of blood vessels leading to complications in lungs, liver, kidneys, or brain
- **Illegal**

D2.7 Source: Burrows D, Bleeker A and Dillon P. Indonesian Training Course on Drug Information. Australian Business, Sydney, NSW, 2000.

Slide D2.8: HEROIN

- Heroin is depressant drug.
- It is produced from the opium poppy and is a powerful painkiller.
- People easily become dependent on heroin.
- Initial effects include pleasant euphoric surge, lethargy, nausea and vomiting, itching, shallow breathing and constipation.
- Lethal overdose is a greater risk with heroin than with most other drugs.
- Long-term effects (connected only with the drug) are relatively few, including lowered sex drive and impotence in men, irregular menstruation and infertility in women.
- Most of the other harm related to heroin use is either related to legal and social issues, or are health problems related to injection of heroin (vein collapse, abscesses, transmission of blood-borne viruses such as HIV and hepatitis B and C)
- Heroin is commonly smoked, injected or snorted.
- Heroin is illegal.

Teaching Notes



Next asks: in what ways are drugs used?

The answer should include at least:

- Smoking
- Snorting
- Swallowing
- Injecting (into vein or muscle, sometimes accidentally into arteries)
- Show Slide D2.9.

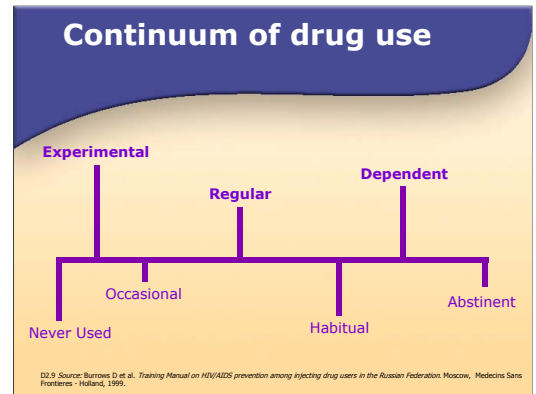
Break

Normally a break would be held at about this point for coffee or tea, and to allow participants to move around and meet one another. It is common practice for such a break to be around 15-20 minutes long.

Session D.2.3. Why do people take drugs?

See Exercises on CD-ROM

Teaching Notes



Continuing....

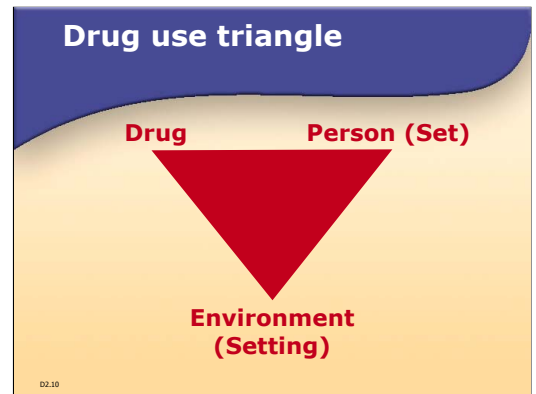
Also talk about changes between these positions on the continuum. For example (point to experimental), inform participants that some people start with a drug like nicotine or heroin and move through all these stages quite quickly towards dependency. But some people, like social smokers, will only smoke a few cigarettes at parties. Then at times of great stress (the end of a relationship, the death of a loved one, loss of a job), they may move further along the continuum (point towards habitual and dependent). This also occurs with illegal drugs. Some people can have a level of control over their drug use, but when they are under great stress they may lose control and head toward the dependent end of the continuum. Others may move quickly through these stages.

Similarly, when people try to stop using drugs, they usually decide they must move immediately from dependent to not using drugs at all (point at dependency then make a large arc with your arm towards the left side of the continuum). This can be extremely difficult to accomplish and often leads to relapse, where they start using drugs again, either occasionally (point to the left end) or they move very rapidly back to dependence (point to the right end). So people can change positions along this continuum quickly and often.

Finally, the same person can be at different points on the continuum when considering their use of different drugs. For example, it is quite common to find a dependent smoker (point to the right end) who is only an occasional drinker (point to the left end). This also occurs with illegal drugs so that some people have a particular drug they usually take, which is called their drug of choice (point towards, regular, habitual and dependent) which may for example be heroin, but they may also take cocaine occasionally (point towards the left end).

The most important point about this continuum of drug use is that IDUs accessed by outreach workers may be at various stages along this continuum and, over time, they may shift back and forth along it. This means that outreach workers need to be prepared for many different situations when talking to the same IDU.

Teaching Notes



Next Ask participants why different people react differently to the same drugs. Someone will almost certainly say “because of the addictive personality”. Usually, at least one participant will deny that people react differently and will say some drugs are addictive and others are not. Usually a debate will begin between those who believe the drug is most important and those who believe the drug user’s personality is most important.

Show Slide D2.10:

Allow the debate to continue for a few minutes, then ask whether anyone has heard of the drug use triangle. In this model (known as Zinberg’s model: Zinberg, 1984), drug problems are seen as depending on three factors:

- The drug: some drugs do appear to have a greater potential for dependence than other drugs (but not everyone becomes dependent even on the most “addictive” drugs such as nicotine and heroin)
- The Set (or person): the specific psychology, physiology and accumulated experiences of the drug user (because some people react violently or become dependent on drugs which cause few problems for others); and
- The Setting (the environment) within which drugs are used: for example, the same level of drug use in one context may not cause the same level of problems as in a different context.

Teaching Notes

Outreach case studies

- What were the important steps in **making contact** with IDUs?
- What **differences** are there when making contact with IDUs in **your locality**?
- Some ways to **assist** making contact in your locality

D2.11

Session D.2.5. Making contact: Case study

Slide D2.11: Ask participants to read the case study that you have distributed to them. After ten minutes (to allow them to read it carefully), ask them to form small groups of four to five people. Ask the groups to discuss the following questions:

- What are the important steps in making contact with IDUs in the locality in the case study?
- What differences are likely to occur between making contact with IDUs in your locality and in the locality in the case study?
- What are some ways your outreach programme can assist its outreach workers to make contact with IDUs in your locality?

These small group discussions should continue for about 15 minutes.

Then ask the participants to assemble in the large group again and lead a general discussion about the case study, based on the above questions. Summarize the views of participants on a white board or flip chart. This final discussion should last about 20 minutes.

LUNCH

At around this point, break for lunch. Trainers should meet during lunch discuss the results of the morning's work and to decide what changes, if any, may be needed in the remainder of the day.

Trainers may also need to prepare cups of water and ensure sufficient supplies of needles and syringes, swabs, spoons, etc. for the injecting and needle cleaning demonstrations in the afternoon.

Teaching Notes

Elements of effective prevention

- **Outreach**
- Relevant, credible **education**
- Increased **access** to **needles and syringes**
- Drug **substitution** treatment
- Supportive **policy, legislation** and **advocacy**

D2.12 Source: WHO Evidence for Action papers and policy briefs, REF.

Session D2.6 Risks related to injecting

Begin the session by stating that needles and syringes will be used several times for demonstrations throughout the afternoon but first it is necessary to know why outreach and other activities have been started and what risks are related to injecting drug use.

Slide D2.12: Quickly revise these points from Session D1.4

Teaching Notes

Community-based peer outreach is most widely used and is also very effective

...why?

- **Least costly**
- **Contributes greatly to preventing HIV infections in IDUs and their sexual partners**
- **A major component of a comprehensive strategy**

D.2.13 Source: Needle R et al. Effectiveness of community-based peer outreach for IDUs: a preliminary report. Paper presented at 13th International Conference on the Reduction of Drug-Related Harm, Ljubljana 3-7 March 2002.

Slide D2.13: Quickly note each of these points which were made in yesterday's presentation and ask if participants have questions on these points.

Teaching Notes

Most outreach programmes:

- **Find** and **contact** IDUs
- Providing **information and education** about HIV/AIDS, HIV testing, drug use and services
- Commonly **linked** to NSP, drug treatment, other programmes

D2.14

Slide D2.14: Outreach is most effective when it is linked with other services, especially needle and syringe provision, and when IDUs are provided with explicit information and education, developed with the involvement of IDUs themselves.

Most outreach work at least involves:

- Finding and contacting IDUs: going into the communities where IDUs live, work and buy, sell and use drugs.
- Providing IDUs with information and education about HIV/AIDS transmission and prevention, HIV testing, HIV disease (especially for HIV-positive IDUs), drug use and the services available to assist IDUs.

Outreach is also commonly linked to (or part of) other programmes such as NSP, substitution and other forms of drug treatment, and other health and social services.

Next, start a discussion among participants about the risks associated with injecting. First, ask what infections and other health problems can occur through sharing injection equipment or through drug injecting? After each discussion, show the related slide.

Teaching Notes

Risks of drug injecting

- **Blood borne infections:** HIV, Hepatitis B and C, syphilis
- **Overdose**
- **Vein damage**
- **Bacterial infections**
- **Loss of limbs/limb function**

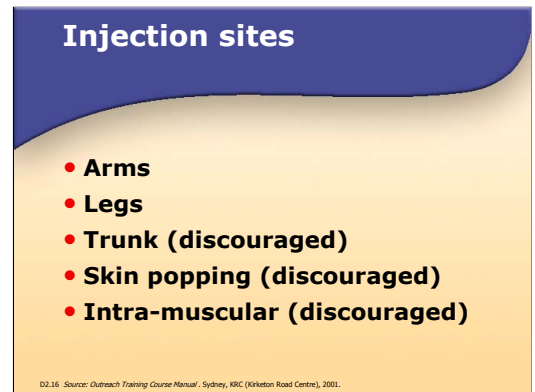
D2.15 Source: Outreach Training Course Manual - Sydney, KRC (Kirketon Road Centre), 2001.

Slide D2.15: Risks of injecting include:

- viral infections: HIV, hepatitis B, hepatitis C;
- overdose, including fatal overdose;
- vein damage: regular injection into the same sites or poor injecting technique can lead to vein collapse;
- bacterial infections, such as endocarditis, abscesses, cellulitis, septicaemia, syphilis; and
- loss of limbs or loss of function of limbs after injection into an artery or nerve.

Next, ask where can drugs be injected on the body.

Teaching Notes



Slide D2.16 Sites of injection include:

- *Intravenous:* Arms: crook of the arm, upper and lower arm, back of the hands, fingers;
- *Intravenous:* Legs: back of the legs, feet;
- *Intravenous:* Penis, breasts, groin, neck (these should be discouraged);
- *Under the skin:* Called skin popping, this should be discouraged; and
- *Muscles:* Called intramuscular, thigh, buttocks and deltoid (these should be discouraged).

HIV transmission risks from shared injecting equipment are common to intravenous and intramuscular use and skin popping.

Next, state that there are rules for the safest (or least risky) ways to inject drugs. These rules have been developed for intravenous drug use, which is the most common type of drug injecting. Distribute Handout D3.

Read through each step, providing additional information as needed.

Session D2.7 Needle and syringe use demonstration

See Exercises on CD-ROM

Teaching Notes

A presentation slide with a blue header and a yellow body. The header contains the text 'Making contact with IDUs: Decide...'. The body contains a bulleted list of seven points. At the bottom left, there is a small source citation.

**Making contact with IDUs:
Decide...**

- **Where to hang around**
- **When to visit a place**
- **When to start a conversation**
- **Who to contact first**
- **Whether to be direct or indirect**
- **What can be offered**
- **When to stop**

D2.17 Source: Trautmann F and Barendregt C. European Peer-Support Manual. Utrecht, Trimbos Institute/European Commission, 1994.

Session D2.8 Making contact with drug users I

Start a discussion among participants about ways to contact drug users. Make it a point that special considerations may have to be taken to contact female drug users, who are usually more stigmatized and hidden.

First, ask what information is needed in order to identify how to make contact. After each discussion, show the related slide.

Slide D2.17: For getting into contact one has to decide:

- *Where to hang around.* At which site, at a distance or near by people, etc.
- *When to visit a place.* Sometimes several visits at different times are needed to discover the best times for regular visits;
- *What is the right moment to make a move.* Do people have time to talk, are they in the mood for a talk, etc.
- *Who to contact first* In every group there is often a leader and it is usually good practice to contact him or her first.
- *What is the right way to approach.* Direct or less direct (see below).
- *What can be offered.* Can a card or pamphlet or condom or needle and syringe be offered?
- *When to stop for a while.* When to give it a break and leave. This may be caused by IDUs starting to use drugs or buy or sell drugs, by tension among IDUs, etc.

Next, ask what outreach workers should do when they go to an outreach area.

Teaching Notes

The slide features a blue header with the text "Their space, their rules...". Below the header, on a light yellow background, is a bulleted list of five items in red text: "Dress appropriately", "Speak appropriately", "Be non-threatening", "Be non-judgmental", and "Obey rules". A small "D2.18" label is visible in the bottom left corner of the slide.

Slide D2.18: The main task of outreach work is to go to where IDUs are, to enter “their space” where drug users feel comfortable. This means that the outreach worker needs to abide by the norms or rules that govern this space. The outreach worker should:

- *Dress appropriately.* In some cultures, this means dressing in a similar way to IDUs; in others, it may mean similar dress but slightly different, to show that the outreach worker is in the “space” for some reason other than buying, selling or using drugs.
- *Speak appropriately.* Outreach workers need to know the “language of the streets”, the words and phrases IDUs use, so that education occurs in a language with which IDUs feel familiar and comfortable.
- *Be non-threatening.* IDUs are usually fearful of new people since they may be police (undercover), so outreach workers need to use gestures and non-verbal communication that reassure the drug users that the outreach worker is not a threat to them
- *Be non-judgmental.* IDUs are discriminated against and frequently treated very judgmentally, which makes them angry and non-receptive and non-responsive. Therefore, to gain their trust and acceptance, it is crucial that they be treated with respect and with a very non-judgmental attitude.
- *Obey the rules.* For example, if outreach workers are told to leave an area because of possible violence or other problems, they should obey quickly. Another example could be that only female outreach workers could reach and talk to a female IDU.

Teaching Notes

Ways of making contact

- **Introduce** yourself
- Be **introduced** by others
- **Indirect:** casual chat
- **Direct:** Introduce yourself and your programme

D2.19 Source: Trautmann F and Barendregt C. European Peer Support Manual. Utrecht, Trimbos Institute/European Commission, 1994.

Slide D2.19: Two ways of making contact include:

- *Doing it on your own.* This can be difficult and may require long periods of outreach workers being present in an area until they feel confident they can make contact with an IDU without problems.
- *Getting introduced by someone.* This is usually easier.

Two ways of introduction:

- Indirectly, by starting some casual chat about the day, weather, mutual friends;
- Or by directly introducing yourself as an HIV-prevention worker, explaining what your task is, and what organization you work for.

One approach is to say:

"We are here because we are concerned about the problem of HIV/AIDS in the community and we want to help reduce further spread of infection." This focuses further discussion on establishing the fact that HIV does represent a clear and present danger in their community. By talking about the problem of HIV/AIDS in the community, the topic of personal threat to IDUs from HIV can be avoided before a relationship of trust and credibility has been established. When AIDS is introduced as a general rather than personal threat, most people are comfortable with listening, discussing, debating or arguing. The objective is to increase HIV/AIDS awareness to the point that IDUs begin to become concerned about what that means to them personally and this transition is a good way to help IDUs to begin considering reducing their own risks for HIV.

Next, ask what the tasks involved in making contact are. Once contact is established, what should you say next? Record answers on the white board or flip chart.

Teaching Notes



Slide D2.20: After making contact, the main task is to gain the trust of the IDUs, establishing credibility, for example by:

- showing that you are one of them (for example, by referring to your own drug-use experience);
- always being honest (about what you are, what you are able to do, etc.);
- becoming familiar by returning to the same space several times and talking to the same people on many occasions. Trust is built over time.

Next, ask what methods or materials can help you to make contact.

Teaching Notes

Methods and materials

- Giving out **condoms/syringes**
- **Collecting** information:
Completing a questionnaire
- **Providing** information:
Giving out leaflets, newsletters
- Organizing **activities**

D2.21 Source: Trautmann F and Barendregt C. *European Peer Support Manual*. Utrecht, Trimbos Institute/European Commission, 1994.

Slide D2.21: Methods and materials to assist outreach work:

- *Giving out condoms/syringes*. This is an excellent way to build trust and should be coupled with educational messages we will discuss this afternoon. But do remember that initially giving out free syringe/needle/condoms can also cause apprehension among the IDUs. So you should be very careful and precise in explaining why you are trying to help them.
- *Collecting information*. You can build trust by asking IDUs to assist you in your work by providing information on drug using practices, etc
- *Completing a questionnaire*. While a questionnaire normally has a research purpose, it can also be used to ensure that IDUs spend some time speaking with the outreach worker
- *Giving out leaflets, newsletters, magazines on topics relevant to IDUs*. These are very useful when time is a major problem (they can be slipped into IDUs' hands or pockets quickly if police or other problems prevent longer talks) and can also be used as the basis for education ("Did you see the page on needle cleaning? What do you think about that?")
- *Organizing activities*. These may range from simple social events to peer education training sessions or the starting of drug-user organizations.

Emphasize that the main task of outreach is to engage IDUs in conversation, to gain trust and develop rapport. The above methods and materials can assist that work, but should not detract from the main task.

Break

Normally a break would be held at about this point. The bleach for the needle-cleaning exercise should be made up during this break. Provide three cups to each group of four participants, two half-filled with water and one half-filled with bleach, together with one needle and syringe. The syringe can be one of those discarded earlier in the day.

Teaching Notes

Safer behaviour

- Providing **situational cue**
- Discussing a **broader framework**
- Engaging in **casual chat**
- Providing **prevention materials**

D2.22. Source: Trautmann F and Barendregt C. European Peer Support Manual, Utrecht.

Session D2.9 Making contact with drug users II

After the break, resume discussion of outreach work and state that, after rapport has been built between outreach workers and IDUs, the topic of HIV prevention in the IDU's life needs to be raised. Ask what some ways of raising this topic are.

Slide D2.22:

How to raise the issue of safer behaviour:

- *Situational cues.* if you notice an abscess, that an IDU has been to hospital or had an overdose, etc., this can make a starting point for talking about risks and ways of reducing risks
- *Incorporate the AIDS prevention message in a broader framework.* for example, you might start by talking about the IDU's health in general or even more broadly about drug use and the drug user's life, before raising issues of safer behaviour
- *An occasional chat like "How are you?" "How are things going?"* This might be enough to get a conversation started in which health will be one subject.
- *The materials and methods mentioned above.* Giving out a syringe can be accompanied by specific safe-injecting messages; a discussion of safer behaviour can start as the result of completing a questionnaire, etc.

Next, state that raising the issue of safer behaviour will most likely lead to a situation in which the outreach worker provides advice to the IDU. This is a type of counselling, sometimes called "outreach counselling" or sometimes included in the general term "outreach education". Outreach counselling has several advantages over more formal methods of counselling and also some disadvantages.

Teaching Notes

Outreach counselling

Advantages

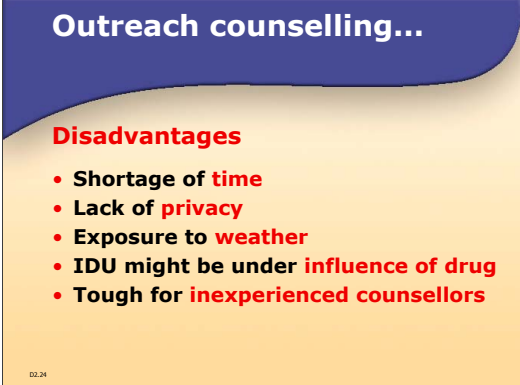
- **Favourable environment**
- **Timing can be flexible**
- **Close to real-life situation**

D2.23 Source: Trautmann F and Barendregt C. European Peer Support Manual. Utrecht, Trimbos Institute/European Commission, 1994.

Slide D2.23: The advantages of outreach counselling include:

- *Environment.* The outreach worker is in the IDU's "space" and the IDU is more likely to feel comfortable with talking there than in an office or clinic.
- *Timing.* Outreach counselling is not dependent on a set agenda of an appointment. The outreach worker can react directly to spontaneous situations, to IDUs' questions, etc.
- *Real life.* The outreach worker is gaining valuable information about the actual living situation, the actual behaviour of IDUs and their friends so that counselling can fit closely with IDUs' lives.

Teaching Notes



Outreach counselling...

Disadvantages

- **Shortage of time**
- **Lack of privacy**
- **Exposure to weather**
- **IDU might be under influence of drug**
- **Tough for inexperienced counsellors**

D2.24

Slide D2.24:

The disadvantages of outreach counselling include:

- *Shortage of time.* IDUs' lives are often busy (and outreach areas may be subject to police and violent activity) so it may be hard to gain their interest for long enough to deal with issues in depth. For this reason, outreach workers should try to visit the same areas on many occasions, talking to the same people on many occasions (as well as talking to new clients).
- *Lack of privacy.* Often outreach workers will find groups of IDUs sitting or talking together. It is sometimes difficult to achieve enough privacy to have frank talks about drug use, sexual behaviour, etc., which is even more important for female IDUs.
- *Exposure to weather.* In some climates, cold or rain can make IDUs unwilling to sit or stand and chat for long periods.
- *Drug effects.* Because IDUs are in their own "space", they are more likely to be affected by drugs and may be less able to understand messages about safer behaviours.
- *Inexperience.* Outreach workers are often not trained as counsellors who can deal with serious issues such as psychiatric conditions, effects of child sexual abuse, etc. A referral network is needed so that outreach workers can help IDUs with serious problems to seek assistance.

Next, state that outreach counselling has several specific aims.

Teaching Notes

Aims of outreach counselling

- Provide accurate **information** about HIV/AIDS
- **Personal risk assessment**
- **Risk-reduction counselling**
- **Motivation to reduce risks**

D2.25 Source: Bell A and Crafts N. HIV risk reduction in injecting drug users. In: Lamptey PR and Gayle H, eds. HIV/AIDS Prevention and Care in Resource-Constrained Settings. Arlington, Family Health International, 2002.

Slide D2.25:

Aims of outreach counselling:

- to provide accurate information about HIV/AIDS transmission and prevention;
- to assist IDUs in carrying out a personal risk assessment: to help them to examine their drug using and sexual behaviour so as to see where they may be at risk of acquiring or transmitting HIV; and
- to help IDUs understand what they can do to reduce their risk, including problem-solving and stress management;
- to motivate IDUs to reduce their risk: both through ongoing counselling and education, and provision of materials such as needles, syringes, condoms (male and female), etc. (where possible).

Next, state that there are some established rules for effective outreach counselling. Provide Handout D5. Ask participants to read the handout in preparation for tomorrow's exercises.

Session D2.10 Needle and syringe cleaning

See Exercises on CD-ROM.

Session D2.X: Evaluation and Close

See Exercises on CD-ROM.

Teaching Notes

Core education messages 1

- Always use **condoms** for **penetrative sex**
- Always **use your own** needle and syringe, spoons, pots, swabs, water, filters, tourniquet
- **Do not share** injecting equipment
- Be aware of **infections and overdose**

D3.1 Source: Burrows D. Starting and managing needle and syringe programs: a guide for Central and Eastern Europe/ Newly Independent States. New York, International Harm Reduction Development/ Open Society Institutes, 2000.

DAY 3

Session D3.0. Welcome

See Exercises on CD-ROM

Session D3.1 Safer-sex arguments

See Exercises on CD-ROM

Session D3.2 Education messages

Inform participants that to be effective, HIV-prevention education messages need to be explicit and targeted specifically at the IDUs in the participants' localities. This means that IDUs need to be involved in developing and disseminating these messages. There is a wide range of education messages for HIV prevention among IDUs, but the most important messages are the following: Slide D3.1: Core education messages for IDUs:

- Always use a condom when having penetrative vaginal or anal sex
- sex.
- You can protect yourself from infection by always using your own:
 - ✓ new, sterile needles and syringes;
 - ✓ mixing water, cups or pots;
 - ✓ spoons or 'cookers' (used to heat powdered drug and mix it with water);
 - ✓ filters;
 - ✓ swabs/alcohol wipes ; and
 - ✓ tourniquet

and never sharing, lending or borrowing them.

- 'Sharing' isn't just using a syringe that someone else has used. It is also using:
 - ✓ a filter.
 - ✓ mixing water.
 - ✓ water cup/container.
 - ✓ spoon

that someone else has used, or passing them on to someone else.

- Always be aware of the risk of:
 - ✓ catching infection from others;
 - ✓ overdose; and
 - ✓ passing infection on to others.

Teaching Notes

Core education messages 2

- Use each needle and syringe **once only**
- Prepare injections on a **clean surface/ clean injection site**
- **Wash your hands** before and after each injection
- **If no new** equipment, **re-use your own**
- **If can't re-use..., clean** by approved method

D3.2 Source: Barrows D. Starting and managing needle and syringe programs: a guide for Central and Eastern Europe/ Newly Independent States. New York, International Harm Reduction Development/ Open Society Institutes, 2000.

Slide D3.2: and, where possible:

- Use each needle and syringe once only
- Prepare injections with clean hands on a clean surface and clean injection site
- Wash your hands before and after each injection.

IDUs should be advised that if they are going to reuse equipment it is much better to re-use their own rather than someone else's. It is also important to advise people who keep syringes for reuse to mark/identify them and keep them in a safe place where they cannot be reached – or used – by other people. The risk that someone else has used their syringe without their knowledge is another important reason for cleaning the syringe again before second use.

If someone else's used needle or syringe is to be used, ensure that it is cleaned. The most effective methods of cleaning needles and syringes to try to rid them of HIV and hepatitis infected blood are:

Teaching Notes

Core education messages 3

Approved cleaning methods

- **2 x water, 2 x bleach for 30+ seconds (shaking), 2 x water**
- **Soak in bleach for several minutes**
- **Boil for 10 minutes**
- **10x with water after and before use**

D3.3 Source: Burnier, D. *Sharing and managing needle and syringe programs: a guide for Central and Eastern Europe/ Newly Independent States*. New York, International Harm Reduction Development/ Open Society Institutes, 2000.

Slide D3.3:

Revise the needle cleaning methods practised yesterday.

Teaching Notes

Other education messages about...

- **Drug manufacture, purchase, preparation, combinations (cocktail)**
- **Vein care and abscess prevention**
- **STIs and sexual practices**

D3.4 Source: Burrows D et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow, Medecins Sans Frontieres - Holland, 1999.

Slide D3.4: Other education messages may relate to:

- *Drug manufacturing.* For example, using blood to change the consistency of home-made drugs is a high-risk activity for HIV transmission
- *Drug purchase.* For example, buying liquid drugs in syringes is a high-risk activity for HIV transmission
- *Drug preparation.* For example, for some types of heroin, citric acid is mixed with heroin during preparation to prevent certain types of infections
- *Combinations of drugs.* This is often referred as 'cocktail' (including alcohol), which causes severe intoxication or specific health problems
- *Overdose and resuscitation.* See Handout D7
- *Vein care.* For example, rotate your injection sites
- *Abscess prevention.* For example, swab the injection site before injecting
- *Other, penetrative and non-penetrative sexual practices.* For example, specific messages may be included about the use of stronger condoms and lubricants for anal sex.

Teaching Notes

Developing new messages

- **Define aim/s with input from IDUs**
- **Research and draft**
- **Check by authority**
- **Focus group/check by IDUs**
- **Re-draft and re-check by IDUs**
- **Produce, disseminate, evaluate**

D3.5 Source: Burrows D et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow, Medecins Sans Frontieres - Holland, 1999.

Slide D3.5: Both the local phrasing of core educational messages and the development of additional messages should be carried out using the following process:

- *Define the aim of the message*, including gaining input from active IDUs about the topic of the messages, language, visual representations: what behaviour do you want to address?
- *Assemble the required information*. Research the topic to discover the latest and most widely adopted messages and information, and draft the publication or message.
- *Have the draft checked by medical or other qualified personnel* to ensure that any medical or other technical information is correct.
- *The draft should then be checked by a group of active IDUs* to provide reactions about the language, illustrations, attractiveness to IDUs, etc. This is often done in a focus group.
- *Re-draft the message or publication*, ensuring the technical aspects are now correct and taking into account the views of IDUs.
- This final draft should again be checked by a group of active IDUs.
- *Finalize the message or publication*, produce it and disseminate it to IDUs.
- *Evaluate the message or publication*. Ask if IDUs have seen it or heard the message, what do they think of it, do they understand it, etc. More formal methods of evaluation will be discussed on Day 5.

Provide participants with Handouts D6 and D7.

Break

Normally a break would be held at about this point

Session D3.3 Communicating with drug users II

See Exercises on CD-ROM

Teaching Notes



Session D3.4 Education strategies

Inform participants that there are many ways to provide HIV-prevention education messages to IDUs. Ask for suggestions from the participants then show Slide D3.6:

Some methods of providing education messages are:

- *One to one.* When an outreach worker speaks with an individual IDU.
- *Group.* This can be when an outreach worker speaks with a group of IDUs on the streets or a place where IDUs congregate or it can be more formal peer education, peer support or peer leader training.
- *Slogans and sayings.* Each time outreach workers are on the streets, they can provide short versions of education messages.
- *Leaflets and booklets.* These can contain larger amounts of information and complex ideas that may require illustrations.
- *Newsletters and magazines.* Regular communication can occur through these media.

There are many other methods such as comics, audio tapes, CD-ROMs, videos, television and radio programmes that can be useful for getting messages to IDUs.

Teaching Notes

One-to-one education can be...

- a part of **outreach counselling**
- provided in **prisons, treatment centres, hospitals**
- also **pre- and post-test counselling**

D3.7 Source: Burrows D. Starting and managing needle and syringe programs: a guide for Central and Eastern Europe/ Newly Independent States. New York, International Harm Reduction Development/Open Society Institutes, 2000.

Slide D3.7:

One-to-one education of IDUs by outreach workers can normally only be done after establishing trust and rapport. Education of this type is normally provided as part of the outreach counselling process described in C2.5.

One-to-one education also occurs within institutional settings such as drug treatment centres, prisons, hospitals, etc., usually as part of a wider range of educational and/or counselling activities. People working in these settings may have to balance the need for education that will assist a drug user to remain as healthy as possible with the need to abide by the operating philosophy of the institution.

Institutions (such as prisons or detoxification units) may have to be educated and persuaded to recognize that the life-saving nature of harm-reduction messages may mean that they have to change their attitude towards discussion about drugs and drug use and sexual behaviour.

One-to-one education also occurs as part of pre- and post-test counselling for HIV or hepatitis antibody tests. Education at these points has been found to be extremely effective in personalizing the issue of HIV or hepatitis and in impressing on drug users the need for safe behaviours. This will be dealt with in greater detail on Day 3 of this course.

Teaching Notes

Group education is useful in...

- **Outreach to groups**
- **Training in peer education, support, leadership**
- **Events-based/targeted activities**

D3.8 Source: Burrows D. Setting and managing needle and syringe programs: a guide for Central and Eastern Europe/ Newly Independent States. New York, International Harm Reduction Development/Open Society Institutes, 2000.

Slide D3.8:

Group education can be provided in a range of settings. Much of it relies on the social networks that drug users form as these can have a positive effect on those members trying to change or maintain safer behaviours. Gender of the groups might be important. Also, groups of men might be found in different places from groups of women. 'Classical group education' takes place with facilitation or information provision by an authoritative figure such as a doctor, epidemiologist, drug treatment worker or NGO worker who has control over the information and education the drug users receive. Unless this person has a clear idea of the educational needs of the group, this type of group education may be ineffective.

Targeting social networks of injecting drug users through peer education, peer support or peer leadership has become increasingly popular in recent years. Some authors have suggested that peer education should not be seen as 'teaching' by a 'good drug user' to change the behaviour of another drug user, but as drug users sharing information with one another on how to inject as safely as possible, given their current circumstances. With this approach, drug users work together to reduce the risk of injecting. This leads to a supportive peer environment in friendship networks, and allows the development of materials for friendly and supportive education rather than lecturing.

Another type of targeted education campaign is based on specific events that injectors are known to attend, such as rock concerts, rave parties and festivals that are aimed at specific subcultures. Activities at these events range from simple provision of leaflets about HIV and drug use to booths where festival participants can come to learn more about these topics and discuss any problems or issues with workers, either through the booth or meeting outreach workers who are moving through the crowds.

Teaching Notes

Slogans and sayings is useful for...

- **Constant repetition of the same message, e.g.**
 - **New fit for every hit**
 - **Different spots = no tracks**
 - **Friends do not share**
- **Specific focus: spoons week**
- **Convert slogans into longer talks**

D3.9 Source: Burrows D. Starting and managing needle and syringe programs: a guide for Central and Eastern Europe/ Newly Independent States. New York, International Harm Reduction Development/Open Society Institutes, 2000.

Slide D3.9: Constant repetition of the same message has the same effect as an advertising slogan: the words – and the idea or product – stay in our minds. In Australia, drug users are advised to 'use a new fit (needle and syringe) for every hit'. This slogan appears on the packaging of some syringes, on business cards for needle and syringe programmes and on stickers, leaflets, cards, brochures, posters and booklets.

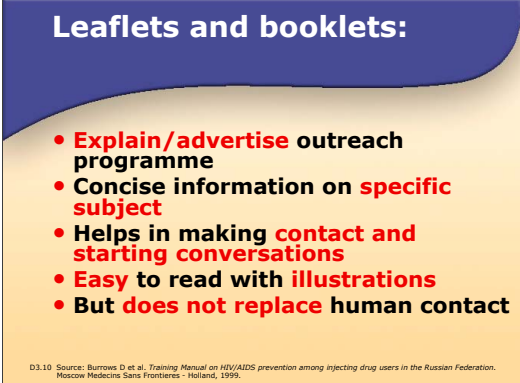
At Chicago Recovery Alliance (United States of America), staff are encouraged to develop 'one-liners' – quick reminders that staff can say to clients. Here are some examples on the subjects of safer injection, vein care and safer sex:

- 'Different spots = no tracks' (i.e. visible puncture marks are reduced if you rotate sites).
- 'One shot, one sterile syringe.'
- 'Use your own – needles, cookers, filter, water.'
- 'The cleaner everything is, the better.'
- 'New paraphernalia + clean hands = safer shots.'
- 'Shoot with the flow' (of blood).
- 'Release the tie (tourniquet) – before you get high.'
- 'Knowing your condom is safer than knowing your partner.'
- 'You can't tell if someone is infected by looking at them.'

Other methods are to have a specific focus for a specific period in which a single message is provided to all outreach contacts over a given period – such as having a 'spoons week' during which risks related to sharing spoons are highlighted. Such interventions put health and safer injecting 'on the agenda' and make it clear that outreach staff are happy to answer questions or discuss any of this information, if the drug user has time.

Outreach workers need to be able to convert these short exchanges into longer educational discussions. However, slogans and sayings represent a first step in building a relationship with IDUs in which they begin to see the outreach staff as a reliable source of information about reducing the risks of their injecting.

Teaching Notes



Leaflets and booklets:

- **Explain/advertise outreach programme**
- **Concise information on specific subject**
- **Helps in making contact and starting conversations**
- **Easy to read with illustrations**
- **But does not replace human contact**

D3.10 Source: Burrows D et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow Medecins Sans Frontieres - Holland, 1999.

Slide D3.10: Leaflets and booklets:

- are useful in outreach work to inform drug users on various issues such as to:
- explain what you are doing and why;
- provide concise information on a specific subject such as needle cleaning or overdose prevention;
- recruit drug users to the service or invite them to specific events such as meetings;
- are useful in assisting outreach workers to make contact with drug users;
- should be easy to read and use pictures or illustrations to provide information in visual as well as text form; and
- do not replace human contact: pamphlets can never replace a face-to-face conversation but can act as a reminder and support for positive behaviour change.

Teaching Notes

Newsletters and magazines:

- **Circular:** contact IDUs to contribute, produce, distribute
- **"Voice"** for drug users
- Regular **updates**
- **Expensive** in time, money, manpower
- May be **controversial** if "voice"

D3.11 Source: Barrows D et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow Medecins Sans Frontieres - Holland, 1999.

Slide D3.11: Magazines and newsletters can assist outreach work in a circular way by making/keeping contact with IDUs through contributions (from IDUs), production (with or by IDUs) and distribution (with or by IDUs). They can be used:

- to provide a voice for drug users to communicate with other drug users: for this reason they are a common tool in drug-user organizing;
- to provide a voice for drug users to inform drug assistance services and policy-makers about their views and their needs: this is another key area of drug user organizing; and
- to inform drug users about health-related issues, including regular updates on changing topics such as HIV treatments.

Magazines/newsletters:

- take a great deal of time to produce: it is better to have smaller newsletters published regularly than large, high-quality magazines produced irregularly; and
- may be controversial if they are used as a "voice" for drug users, because control of the content must be totally or mainly in the hands of the drug users themselves.

Conclude by saying that all these publications and messages should be developed using the process outlined in Slide D3.5. This development process can be used by outreach workers as a way of raising issues related to HIV risk, by showing publications being developed, by asking IDUs for slogans, etc. Effective HIV prevention requires the provision of the same messages in different levels of detail and in different media to reach the same group of IDUs many times over a sustained period of time.

D3.5 Education messages exercise

See Exercises on CD-ROM

LUNCH

At around this point, break for lunch.


C3.6 Site visit/Guest lecture(s) (3 hours)

See Exercises on CD-ROM

D3.X: Evaluation and close

See Exercises on CD-ROM

Teaching Notes



HIV testing...why?

- **Own risk behaviour**
- **Sexual partner's risk behaviour**
- **To make decision about unprotected sex with trusted partner**
- **To decide about pregnancy**
- **To investigate symptoms: e.g. recurring, unexplained illnesses**

D4.1 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFHO (Australian Federation of AIDS Organizations), 1998.

DAY 4

Session D4.0. Welcome

See Exercises on CD-ROM

Session D4.1. Impressions of outreach work

See Exercises on CD-ROM

Session D4.2 Problem-solving with injecting risks

See Exercises on CD-ROM

Break

Normally a break would be held at about this point

Session D4.3 HIV testing and counselling

Start a discussion about HIV testing by asking: Why should people such as IDUs in participants' localities consider being tested for HIV? After discussion, show the Slide D4.1:

There may be a number of reasons for someone to consider being tested for HIV including:

- a person knows, or suspects, that she or he might be at risk of HIV due to, for example, an episode of unprotected sex, sharing drug injecting equipment or occupational exposure;
- having a sexual partner who is HIV positive where issues of unsafe sex arise, or who may be having unprotected sex with other partners;
- making a decision with a regular sexual partner to have unprotected sex (negotiated safety);
- pregnancy; and
- having signs or symptoms (such as recurring unexplained illnesses) that could suggest HIV-seroconversion illness, or an undiagnosed HIV-related condition.

Teaching Notes

HIV testing issues...

- **Where to test?**
- **Pre-test and post-test counselling**
- **Informed consent/confidentiality**
- **Partner or family notification?**
- **Treatment, care and support**
- **Stigma and discrimination**

D4.2 Source: Prevention of HIV transmission among drug users: a training module for field-level activities. Bangkok, UNAIDS Asia Pacific Intercountry Team, 1999.

Next ask: What are the benefits to the individual and society of having a HIV test?

There may be several answers here but it is important to note that an early diagnosis of HIV can mean greater treatment options for the individual in countries where HIV treatments are available to IDUs. HIV therapy has now been shown to be effective in suppressing the replication of HIV in the body, so that early testing and effective treatment can lead to effective prevention of HIV transmission.

Also note that it is not useful to spend a high percentage of prevention resources on compulsory, widespread or repeat testing. This helps governments to know how many people are infected with HIV but, without adequate prevention programmes in place, such information is not helpful.

Next ask: What are the issues to be considered when discussing HIV testing with IDUs?

Slide D4.2: Issues include:

Where to have the test? Many IDUs are unwilling to go to government testing centres or hospitals so several methods are used to overcome this problem. Some programmes provide testing at drop-in centres or in drug-using areas (especially when outreach is carried out using a bus or van). Other programmes encourage outreach workers to accompany IDUs to testing centres or hospitals, providing pre-test counselling (especially if there are concerns that the testing centre/hospital's pre-test counselling is inadequate).

All HIV testing should be accompanied by *pre- and post-test counselling*. This is dealt with in more detail below. It is important to point out that pre- and post-test counselling should be carried out by people who have been trained specifically to do this work.

HIV tests should be carried out with the IDU's *informed consent*: in other words, he or she should understand what the test is, what a positive or negative result may mean, and should agree to having the test. This means that involuntary or forced testing is not recommended. Testing without informed consent and appropriate pre-test counselling represents a significant missed opportunity for HIV education. The impact of interference of toxication and neuro-cognitive impairment, dual diagnosis, mood alteration, etc., should be also taken into consideration as these may have an impact on decision making and coping.

All HIV test results should be *confidential*. Without the agreement of the tested person, no one should be informed of the result. This includes staff of outreach programmes: no other staff or managers should be made aware of a staff member's HIV status unless that staff member chooses to tell the manager and other staff. If an outreach worker informs the manager of his or her status but asks that other staff members not be told, the outreach manager must obey this request.

In some countries, testing is anonymous or de-linked (no record is kept of the names of people together with their test results). In other countries, there are registers of people with HIV and AIDS (including their names and addresses): these records must be carefully handled to ensure confidentiality. Such a registration process is not recommended because it is likely to dissuade IDUs from HIV testing.

An important issue is the *notification* of sexual partners and family if a person receives a positive HIV test result. This is discussed in post-test counselling below. Confidentiality means that the person's HIV status cannot be provided to sexual partners or family by anyone except the HIV-positive person.

Treatment, care and support issues and related issues of stigma and discrimination are important issues to consider. If no treatment is available and no care and support services will accept IDUs, it is questionable whether IDUs will benefit in any way from a HIV test. In situations where a positive HIV result may result in stigma and discrimination (including refusal of medical, surgical or dental procedures; loss of job; harassment and vilification by family and community), it may be in the IDU's interest to recommend against HIV testing.

Teaching Notes

Pre-test counselling

- **Why test is needed**
- **HIV/AIDS, HIV test information**
- **Personal risk assessment and discussion**
- **Implications of positive and negative results**

D4.3 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organizations), 1998.

Next ask: What are the main issues which need to be discussed during counselling *prior to* a HIV test? Slide D4.3:

Pre-test counselling is one of the most powerful weapons in HIV prevention. When a person decides to have a HIV test, he or she is acknowledging a personal risk. This can be the basis of a very personal and specific discussion about risky behaviour and ways to reduce risks. Issues that should be canvassed include:

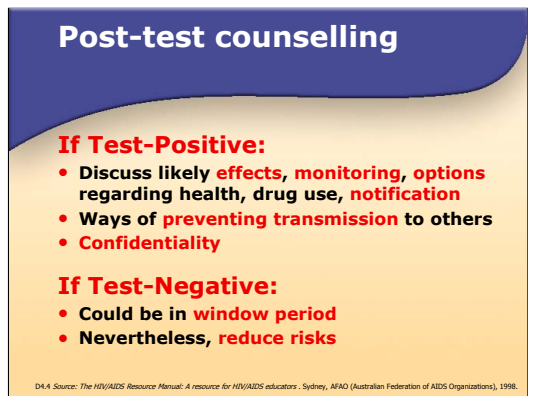
Why a person might wish to be tested: this allows the outreach worker to raise the topic of risky behaviour and to gain an understanding of what general areas of behaviour may be worrying the IDU.

Information about HIV and AIDS and the differences between them. This should include a discussion of the ways HIV is transmitted and effective prevention methods as well as the testing methods (such as the initial and confirmatory tests).

Assessment of any risk factors and behaviours related to the decision. This allows the outreach worker to talk in detail with an IDU about drug use and sexual behaviours that may be risky and to suggest specific ways to reduce these risks

Discussion of the *implications* of both a positive and a negative result. In particular, that a negative result may be an effect of the "window period" so that a second test is needed in about three months with no risky behaviour in between the tests to confirm a negative result. It should also be stressed that a negative result now is no guarantee for the future: that the IDU could have been lucky thus far and future risky behaviour may well lead to a positive result. A positive test result should also be discussed as a possibility, ensuring that the IDU has plans for how to deal with the news (for example, to make sure a friend is available to talk to immediately after receiving the result).

Teaching Notes



Post-test counselling

If Test-Positive:

- Discuss likely **effects, monitoring, options** regarding **health, drug use, notification**
- **Ways of preventing transmission to others**
- **Confidentiality**

If Test-Negative:

- **Could be in window period**
- **Nevertheless, reduce risks**

D4.4. Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organizations), 1998.

Next ask: What are the main issues that need to be discussed during counselling *after* an HIV test?
Slide D4.4:

Post-test counselling should be offered when results are returned. This may include support, or provision of further information, and should be offered regardless of the result. Most people find waiting for and receiving the result very stressful so that many IDUs may not wish to talk about the result immediately. Counselling should be offered at this point and, if the IDU refuses, should be offered again several times. Issues here include:

Positive result:

- the impact on the person's life, how to deal with the emotional impact, who could assist in dealing with these emotional issues;
- confidentiality, stigma and discrimination: explain the IDU's rights under relevant local laws, and suggest ways to deal with discrimination;
- monitoring the immune system and regular medical examinations: the outreach worker should again make the distinction between HIV and AIDS and may offer to accompany the IDU to visit doctors, etc;
- links between HIV care and drugs services and the difficulties this might engender (e.g. inadequate training in both types of services) should be discussed;
- advice on healthy living: nutrition, exercise, emotional support, stress reduction;
- decisions about ongoing drug use: some IDUs decide to quit drugs when they receive a positive test result and outreach workers should be prepared to assist this process;
- dangers of increased substance use or suicide risk as a coping response to emotional distress should also be discussed;
- notification: including whether to notify anyone about the result;
- ways to disclose: to sexual and drug user partners and family;
- responsibility of the IDU to prevent HIV transmission to others including sexual partners and other drug users;
- partner testing: discuss ways and avenues for partner (sexual and drug user) testing; and
- cognitive impairment, dual diagnosis: typically poor planning skills, short-term memory problems, poor impulse control, disinhibition, frustration, tolerance all have an impact specially on coping. Therefore, assessment and subsequent management will be required.
- The outreach workers should also be aware of the within services support and the need to protect the positive or tested IDU from stigma and discrimination from other negative or untested IDUs, say within supportive rehab groups or where they may be being seen to be in receipt of preferential services such as additional medical care or support (thus deductively disclosing their status to others or invoking envy etc).

Negative result:

- It is important that a negative result is not seen as "evidence" that the IDU is not or cannot be infected by HIV. Stress again that a negative result may be an effect of the "window period" and that future risky behaviour may well lead to a positive result. Remind the IDU that if s/he is really not infected with HIV, it becomes then even more important to practice safer injection and safer sex behaviors so that s/he continues to remain uninfected.

Session D4.4 Communicating with drug users III

See Exercises on CD-ROM

LUNCH

At around this point, break for lunch.

Teaching Notes

Relapse among outreach workers...

Returning to drug use or starting to use drugs while doing outreach work

D4.5 Source: STD/HIV/AIDS Prevention and Harm Reduction: A training manual for Public Security and Justice personnel China-UK HIV/AIDS Prevention and Care Project, 2002.

Session D4.5 Referral

See Exercises on CD-ROM

Session D4.6 What other agencies do

See Exercises on CD-ROM

Break

Normally a break would be held at about this point for coffee or tea, and to allow participants to move around and meet one another. It is common practice for such a break to be around 15-20 minutes long.

D4.7 What will my friends say?

See Exercises on CD-ROM

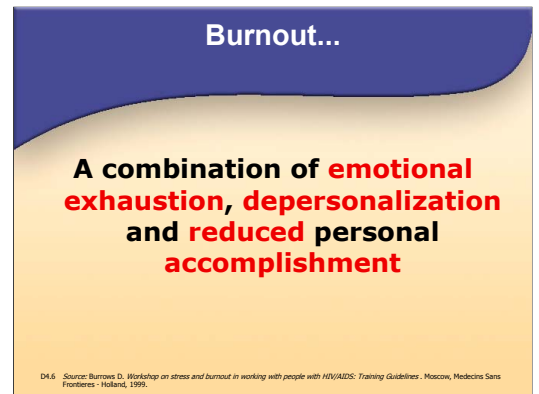
Session D4.8 Relapse and burnout prevention

Inform participants that relapse and burnout are among the most important problems often faced by outreach workers. First, give the meanings for the terms relapse and burnout.

Slide 4.5:

Relapse means returning to drug use. In this session, relapse is also used to mean drug use while working as an outreach worker (for both active IDUs and non-IDUs).

Teaching Notes



Slide D4.6:

Burnout means a combination of:

- emotional exhaustion: not being able to continue to care whether IDUs are well or not, if they live or die;
- depersonalization: inability to respond to IDUs as people, but simply treating them as problems or cases; and
- reduced personal accomplishment: feeling that the job is a chore and worthless.

Teaching Notes

Relapse can be related to...

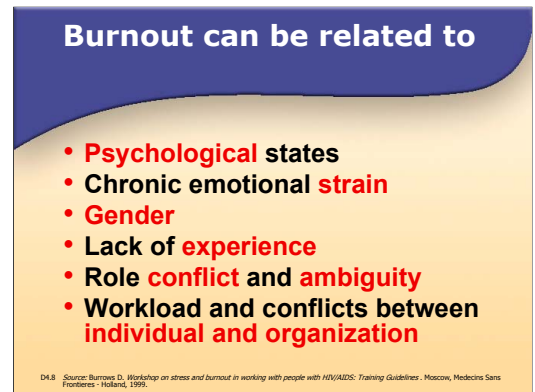
- **Psychological states**
- **Proximity to drug use, drug-using places and drug users**
- **Physical pain**
- **Sudden acquiring of cash**
- **Difficult/unfamiliar situations**

D4.7 Source: STD/HIV/AIDS Prevention and Harm Reduction: A training manual for Public Security and Justice personnel - China-UK HIV/AIDS Prevention and Care Project, 2002.

Slide D4.7: Relapse can be related to:

- psychological states: especially stress, depression, anger, loneliness, boredom, desire to celebrate;
- proximity to drug use, drug using places and drug users (especially friends);
- physical pain;
- sudden acquiring of cash; and
- entering difficult or unfamiliar situations.

Teaching Notes



Burnout can be related to

- **Psychological states**
- **Chronic emotional strain**
- **Gender**
- **Lack of experience**
- **Role conflict and ambiguity**
- **Workload and conflicts between individual and organization**

D4.8 Source: Barrow, D. Workshop on stress and burnout in working with people with HIV/AIDS. Training Guidelines. Moscow, Medecine Sans Frontieres - Holland, 1999.

Slide D4.8:

Burnout is related to:

- *psychological states*: especially stress, depression, anger;
- *chronic emotional strain*: particularly true in dealing extensively with other people, especially those who are troubled or having problems;
- *gender*: sometimes it is difficult for a man to feel comfortable doing outreach to a woman IDU (and the reverse is true);
- *experience*: lack of experience is often associated with high stress (especially in situations where large numbers of IDUs with a range of needs are encountered by untrained staff): this is also one of the reasons that youth is often linked to high levels of burnout;
- *role conflict and ambiguity*: this arises when staff are unsure what they are meant to do with IDUs: what does the organization expect of them? what does the IDU expect? Conflict between these expectations increases stress;
- *workload*: low and high workload can each contribute to stress, especially when the needs of IDUs are diverse and unmet; and
- conflicts between individual desires/needs and organizational demands: the conflict between what staff may want to do or think it is right to do and what is allowed within the structure of the organization.

Teaching Notes

Relapse can be prevent by...

- **Organizational rules**
- **Individual preparation**
- **Appropriate supervision**
- **Assistance from other outreach workers**
- **Reward openness**

D4.9 Source: STD/HIV/AIDS Prevention and Harm Reduction: A training manual for Public Security and Justice personnel. China-UK HIV/AIDS Prevention and Care Project, 2002.

Slide D4.9: Relapse prevention can be enhanced through:

- appropriate organizational rules and individual preparation for outreach work;
- appropriate supervision; and
- promoting and rewarding openness: outreach workers should never fear that admitting relapse will result in immediate dismissal.

Encouraging outreach workers to assist each other in preventing relapse.

Teaching Notes

Burnout can be prevented by...

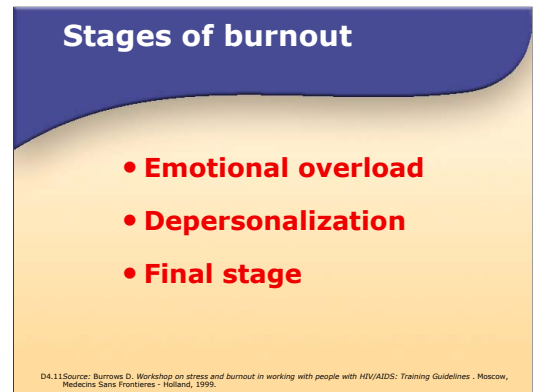
- **Recognizing stages of burnout**
- **Personal planning**
- **Clear, truthful job descriptions**
- **Realistic expectations**
- **Supportive supervision and Assistance from other outreach workers**

D4.10 Source: Burrows D. Workshop on stress and burnout in working with people with HIV/AIDS: Training Guidelines - Moscow, Medecins Sans Frontieres - Holland, 1999.

Slide D4.10: Burnout can be prevented through:

- recognizing the stages of burnout;
- personal planning;
- use of clear and truthful job descriptions;
- realistic expectations of outreach workers; and
- appropriate supervision and assistance from other outreach workers.

Teaching Notes

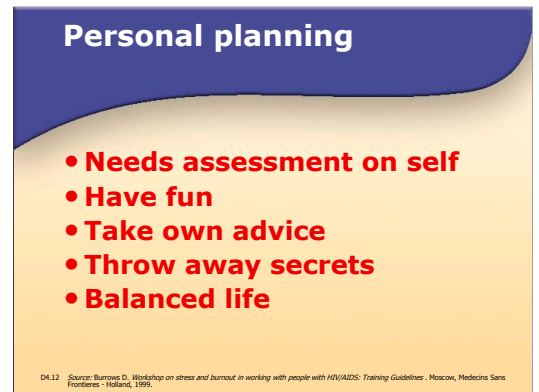


Slide D4.11:

Recognizing the beginning of burnout is very important. Each outreach worker needs to look for the signs of burnout in themselves and other members of the team. The stages of burnout are:

- *Emotional overload*: the feeling that the outreach worker is overwhelmed by the emotional demands imposed by others, leading to emotional exhaustion.
- *Depersonalization*: To deal with this emotional exhaustion, the outreach worker tries to detach completely from clients and treats clients as a category or a disease rather than as a person: this detachment eventually leads to serious emotional problems both at home and work: this stage is categorized by negative attitudes towards clients and other team members and “not giving a damn” about the job.
- *Final stage*: Eventually, these negative feelings are turned onto the self, leading to guilt and distress, overwork, depression, increase/re-uptake of drug use, even suicide in extreme cases. Once burnout reaches this final stage, the outreach worker often has to leave the organization or even stop doing this type of work for months or years to allow himself or herself time to recover his or her emotional balance.

Teaching Notes



Slide D4.12: Each outreach worker has to look after himself or herself. Some ideas for avoiding burnout are:

- Do a needs assessment on yourself: what are your needs and how are you addressing those needs at present?
- Have fun: do not take work (or yourself) too seriously.
- Take your own advice: do what you advise your clients to do: eat well and regularly, avoid or control drug and alcohol use, stay healthy, relax, get some exercise.
- Throw away your secrets: make sure you have friends with whom you can talk about stressful events (and about the world outside of work).
- Balance your life as much as you can: make sure that you do things other than just work.

Issues related to job descriptions, expectations, supervision and team meetings will be dealt with tomorrow.

Session D4.9 My list of relapse triggers

See Exercises on CD-ROM

Session D4.X: Evaluation and Close

See Exercises on CD-ROM

Teaching Notes

Generating knowledge

- **Put together** pieces of the puzzle
- **Describe** the picture
- **What statements** would **you** **make** about **HIV** and **injecting drug use** in your city?
- **How** would you **check** that these **statements are true**?

D5.1 Sources: Burrows D, et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Medecins Sans Frontieres - Holland, Moscow, 1999.

DAY 5

Session D5.0 Welcome

See Exercises on CD-ROM

D5.1 Generating knowledge about hidden populations

Slide D5.1:

Participants are given a piece of a jigsaw puzzle. There are two jigsaw puzzles in all. Participants are asked to walk around the room to find other pieces of their puzzle. Eventually two groups form around the two photographs. Participants are then asked to:

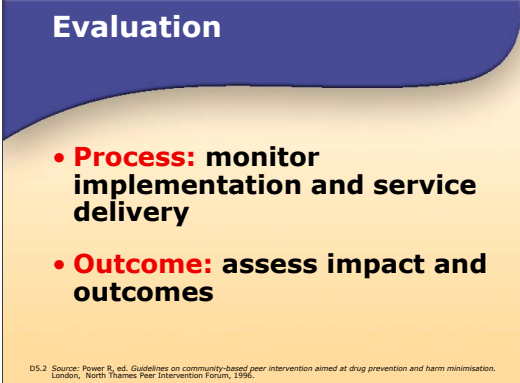
- Put together the pieces of the puzzle.
- Describe the picture formed by the pieces.
- Answer the following questions:
- If this picture were taken in your city, what statements would you make about HIV and injecting drug use in your city?
- How would you check that these statements are true?

The plenary group re-forms and discusses the exercise and the results. In the group discussion, concentrate on pointing out the assumptions that participants have made. For example, if they say, "this photograph shows that injecting drug use is widespread in this city", you can say "but this may be the only IDU (or group of IDUs) in the city". Also concentrate on ways to verify their statements. Use this discussion to lead into the next session on evaluation. Ask questions like:

- How will you know if your outreach work is successful?
- How will you know if you have helped IDUs in your locality?

Remind participants that these questions need to be answered not just for the sake of research, but to ensure the outreach programme's survival and to give outreach workers a sense of their own usefulness to prevent burnout.

Teaching Notes

A graphic titled "Evaluation" with a blue header and a yellow body. It lists two bullet points: "Process: monitor implementation and service delivery" and "Outcome: assess impact and outcomes".

Evaluation

- **Process:** monitor implementation and service delivery
- **Outcome:** assess impact and outcomes

D5.2 Source: Power R, ed. Guidelines on community-based peer intervention aimed at drug prevention and harm minimisation. London, North Thames Peer Intervention Forum, 1996.

Session D5.2 Evaluation and monitoring

Begin by noting that evaluation and monitoring are important to ensure that the programme achieves its objectives, and to help adapt the organization's activities to meet the needs of IDUs in changing circumstances. It is important to evaluate outreach programmes to assess how efficient and effective they are as a means of reducing HIV risk behaviours among IDUs. Designing an evaluation strategy is a key element of any outreach programme. Ideally this strategy should be in place before the programme begins. Ongoing evaluation of programme activities can assist and inform the development and modification of the programme.

Slide D5.2: Evaluation of outreach programmes can be divided into two main components. These are process evaluation and outcome evaluation. The first aims to monitor implementation and service delivery. The second aims to assess the impact and outcomes of the intervention. Both process and outcome evaluation should include an assessment of cost effectiveness of the programme.

Teaching Notes

Process evaluation

- **Staff structure**
- **Training**
- **Supervision, intervision**
- **Ways of contacting IDUs**
- **Services provided**
- **Outreach workers' feedback**

D5.3 Source: Power R, ed. Guidelines on community-based peer intervention aimed at drug prevention and harm minimization. London, North Thames Peer Intervention Forum, 1996.

Slide D5.3: Process evaluation describes and monitors the way in which programmes operate. This is necessary in order to examine which strategies and methods are most appropriate in delivering the intervention. Process indicators relevant to outreach programmes include the following:

- Staff structure: numbers of staff and titles allotted to different tasks
- Training: description of the content and organization of training sessions; number of outreach workers trained; number retained and number of drop-outs
- Supervision, intervision: description of structures in place for post-training supervision
- Delivery of the intervention, including different contacting strategies: "cold contacting" and/or extending recruitment through peer networks and numbers and types of contacts made
- Prevention services provided through outreach: injecting kits, condoms, information leaflets, etc.
- Outreach workers' feedback on efficiency and effectiveness of project management and supervision.

Teaching Notes

Process evaluation methods

- **Interviews with managers and outreach workers**
- **Project activity diary**
- **Observation of outreach work**
- **Evaluation of recruitment/training**
- **Monitoring of outreach work**

D5.4 Source: Power R, ed. Guidelines on community-based peer intervention aimed at drug prevention and harm minimisation. London, North Thames Peer Intervention Forum, 1996.

Slide D5.4: Process indicators can be collected in a numbers of ways using both questionnaires and interviews. The methods of evaluation chosen will be dependent on the availability of project resources. Some aspects of the evaluation will be best conducted by an independent evaluator. Examples of process evaluation methods include:

- interviews with outreach managers at different points in time, to assess perceived difficulties and problems as well as achievements;
- project activity diary where staff record time spent on different aspects of their work;
- interviews with outreach workers concerning perceived needs, experiences, opinions and involvement in the intervention;
- observation of outreach work;
- evaluation of recruitment and training; and
- monitoring of outreach workers, including the proportion of outreach workers who retain an interest and involvement in the programme.

Teaching Notes



Slide D5.5: A key aspect of any process evaluation of peer intervention is to describe the nature and extent of contacts made by outreach workers. This helps to monitor how effective outreach workers are in gaining access to the target population. However, collating accurate information on the nature and extent of contact may be difficult since outreach workers are expected to do much of their work away from the direct observation of managers. Detailed below are a number of possible methods of obtaining indicators on the nature and extent of contacts:

- *Contact forms*: Outreach workers fill out a short form on each contact they make. Such a form would elicit some demographic information, description of where, why and how the contact took place and what advice/information was given out or what activity was involved.
- *Fieldnotes*: All outreach workers keep a field diary, which would be completed after each outreach session. They would be advised to record information about where they were, who they contacted and to describe any factors they think may have influenced the efficiency and effectiveness of their work (for example, too many police in the area to talk with contacts).
- *Group interviews*: Outreach workers can be asked to discuss their work in a group interview.

Teaching Notes

Monitoring – Feedback - Change

- **Monitor situation and operations**
- **Feedback at team meetings**
- **Management agrees to changes**
- **Outreach workers implement changes**
- **Ongoing monitoring**

D5.6 Borrowed D (in press). A Best Practice Model of Harm Reduction in the community and in prisons in Russian Federation. Final Project Report World Bank, Washington/Moscow.

Slide D5.6: Needs of IDUs have to be investigated carefully and regularly to ensure that the services (or referrals) provided through outreach match the clients' needs. One method of doing this is to use a process of constant monitoring, feedback, adaptation of services and further monitoring. In such a feedback loop:

- All operations of the programme are continuously monitored to search for problems, and the situation of IDUs is monitored to discover new issues that are not currently being addressed: team meetings are the usual venue for discussing these issues.
- Regular reports on this monitoring feed into management at an appropriate level for decision-making, but managers need to involve team members (and active IDUs, where possible) in this decision-making.
- Management decisions on ways to address problems or new issues are made quickly, and fed back to staff and are implemented quickly.
- Ongoing monitoring continues to check whether the new ways of working are effective or whether new issues are again emerging: this is discussed at the following team meetings and the process begins again.

This process ensures an ever-growing evidence basis for each activity and leads to an ongoing improvement in services.

Outcome evaluation is usually carried out later in the outreach programmes and outreach managers should ensure that outreach workers are involved in these processes.

Session D5.3 Evaluation and Monitoring Exercise

See Exercises on CD-ROM

Break

Normally a break would be held at about this point for coffee or tea, and to allow participants to move around and meet one another. It is common practice for such a break to be around 15-20 minutes long.

Session D5.4 What are the attributes of an effective outreach worker?

See Exercises on CD-ROM

Teaching Notes

Supportive supervision

- Keep it confidential and regular
- Can be with individual or group
- Address problems/fears/mistakes
- Be positive, constructive
- Prevent burnout/ reduce stress

D5.7

Session D5.7. Supervision and performance appraisal

Begin by referring to yesterday's session on relapse and burnout. Ask participants to recall that accurate job descriptions, realistic expectations of outreach workers, supervision and assistance from other members of the outreach team are important for preventing relapse and burnout. Job descriptions are set by the outreach organization so they are not covered here but both the job description and the outreach manager's attitude towards outreach work should be based on a realistic assessment of how much can be achieved within the locality. Unrealistic expectations can cause problems both for evaluation and for burnout. This session examines supervision, intervision and the use of team meetings. Describe the differences between supervision, intervision and performance appraisal.

Slide D5.7: Supervision can be carried out by the outreach manager and/or members of the outreach team, and/or an external supervisor. If the budget permits, an external supervisor, coupled with team meetings, tends to provide the best method of supervision. In this process, each outreach worker is able to discuss the difficulties and obstacles of their work in an environment in which they can admit to mistakes, fears and problems: these discussions should be confidential and should be held regularly. Where an individual supervisor is used, his/her role is to listen, allowing the worker to talk at length about these issues, to highlight successes and assist the worker to see the positive effects of his/her work, and to encourage the use of stress reduction techniques.

Where group supervision occurs in a team meeting, it should be separated from the other tasks of the team meeting (for example, a specific, regular period of time should be set aside for supervision). In these sessions, outreach workers should be encouraged to discuss the issues as above and other team members should contribute their own fears/mistakes, etc. and, if possible, offer constructive suggestions from their experience. This serves to create a sense of teamwork, contact with the project and also offers opportunities for outreach workers to express concerns when experiencing difficult practical or emotional issues in their work. It also provides the opportunity to monitor and evaluate the intervention. Supervisors might also need to be aware of different problems that different-sex outreach workers might have. Group meetings of workers might sometimes benefit from being single-sex.

Supervision should also deal with possible changes that are needed to outreach operations, the outreach worker's role and so on. It should include issues the outreach worker wants to bring up such as safety issues and feelings of discomfort. It should also be used as a mechanism for helping to prevent burnout and relapse to drug use (for ex-users). As necessary, a facility should exist for outreach workers to be referred for specialist counselling and support.

Teaching Notes

Intervision

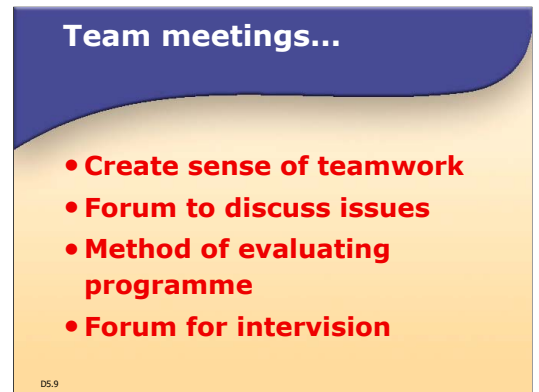
- **One person describes a case**
- **Clarifying questions and answers**
- **Different views on worker's professional practice and attitude discussed**

D5.8

Slide D5.8: Intervision is a learning method that assists outreach workers in learning to analyse situations with clients in relation to their professional attitude. It assists outreach workers to learn about themselves as a professional in situations that are complicated and with a lot of emotional impact. If there is no support system in which it is possible to discuss these situations, it is very likely that outreach workers will react personally rather than professionally. Intervision assists outreach workers in discussing professional issues with one another in a structured way that can lead to solving problems by gaining new perspectives from team members.

An intervision session normally considers only one or two cases, with an outreach worker bringing up a problem he or she has faced/is facing. Other outreach workers ask further questions and together they try to define the problem and to examine the outreach worker's professional work and attitude, offering ideas on how aspects could be handled differently.

Teaching Notes



Slide D5.9:

Note that team meetings can be used for a wide range of tasks (as shown above). They are therefore vital to any outreach programme and are usually held at least weekly. Their main role is to:

- Help create a sense of teamwork between outreach workers
- Be a forum in which problems can be discussed and potential solutions offered by other team members, as well as discussing possible changes to procedures, operating hours, etc.
- Be a method for regularly evaluating the outreach work and suggesting and agreeing changes to operations to better meet the needs of clients
- Be a forum for intervision.

Team meetings are usually held weekly and should be compulsory and paid for as part of the outreach worker's job.

Teaching Notes

Performance appraisal

- Confidential, regular
- Covers basic work issues
- Positive/negative feedback
- Promotion, awards
- Discipline, dismissal

D5.10

Slide D5.10:

Performance appraisal of outreach workers is usually done by the outreach manager. This appraisal should concentrate on both the professional work and personal development of outreach workers. This process should also be confidential and carried out on a regular basis.

Appraisal should deal with basic work issues such as:

- Are the outreach tasks being carried out in a satisfactory way?
- Are sufficient hours being spent in outreach with clients?
- Are there any complaints from clients about the outreach worker?

It should provide positive and negative feedback as needed. Many outreach manager forget to tell outreach workers when they are doing a good job: this can lead to increased stress and burnout. Also, by providing positive feedback, managers can motivate their staff to strive towards more effective and efficient work. Ceremonies, certificates and other awards can assist this process.

It should also be the main mechanism for the discipline and dismissal process. Issues identified in appraisal for improvement should be noted and taken up at the next appraisal session. If significant improvement has not occurred, the discipline process should begin. Appraisal may need to become more regular when problems are identified with an individual outreach worker.

Session D5.6 Team meeting role play

See Exercises on CD-ROM

LUNCH

At around this point, break for lunch.

Teaching Notes

Difficult clients:

- Aggression/threats/violence
- Impulsiveness
- Verbal abuse
- Sexually inappropriate actions, etc.
- Lack of responsiveness
- Inability to appreciate concern
- Inability to take responsibility

D5.11 Source: Outreach Training Course Manual, Sydney, KRC (Kirketon Road Centre), 2001.

Session D5.7 Working with difficult clients

(Notes for this section are from *Outreach Training Course Manual*, Sydney, KRC - Kirketon Road Centre, 2001)

While many IDUs will be happy to meet outreach workers and will appreciate the assistance that they can provide, some IDUs can be very difficult to work with. In this session, some of the most common types of difficult client behaviour are discussed together with some ideas about how to deal with them.

Slide D5.11: Some of the behaviours that outreach workers find most difficult to deal with from clients include:

- aggression
- threats of physical violence
- impulsiveness
- verbal abuse
- sexually inappropriate gestures, suggestions, actions
- lack of responsiveness to treatment or slow change
- inability to appreciate concern for them
- inability to take responsibility for their own behaviour/actions

Teaching Notes

Dealing with difficult clients:

- **Setting boundaries and limits**
- **Set limits early**
- **Don't break service policies and procedures**
- **Do not personalize**
- **Be consistent**
- **Automatic limits for some clients**

D5.12 Source: Outreach Training Course Manual, Sydney, KRC (Kirketon Road Centre), 2001.

Slide D5.12: General ways of dealing with difficult clients include:

- Setting boundaries & limits. It is important to have a clear sense of your personal limits, of where you end and other people begin. Only give extra time, after hours contact numbers, etc. when it is necessary, not because of wanting to be liked, or difficulty setting limits, or fear of the client's aggression, etc.
- Set limits early. This will reduce misunderstandings in terms of boundaries, limits, and inappropriate behaviours and make it easier to contain difficult behaviours.
- Do not break service policies and procedures to calm a client. While this may seem easier in the short term, it can be damaging and counterproductive in the long run. Instead, explain the policy to the client, and stand firm on the rules.
- Do not personalize the client's behaviour. Most of the time another person's difficult behaviour is not about you. When someone else is being difficult, it is always a reflection of his or her innermost state. Even if you provoke or upset someone, it is not what you have done, but rather what you bring up in him or her.
- Be consistent across situations, workers, and clients. Use the same strategies, guidelines, boundaries, and limits, etc. across the different situations in which you encounter the client. Discuss difficult clients with your colleagues, so that you can all be consistent in your approach.
- Certain limits should automatically be put in place for more difficult clients: For example, these clients should not be seen in isolated settings or during "off hours". Help should be readily available in case a client becomes aggressive or threatening.

Teaching Notes

Dealing with angry clients I:

- Use **active listening**
- **Identify the key problem**
- **Do not take personal offense**
- **Allow the client to speak**
- **Do not debate**

D5.13 Source: Outreach Training Course Manual, Sydney, KRC (Kirketon Road Centre), 2001.

Slide D5.13: General ways of dealing specifically with angry clients include:

- Use active listening. Mirror back what is being said and ask for confirmation and clarification: "What I am hearing you say is that.. ..Is that right? Is there more?" This simple technique performs the valuable functions of gathering correct information, and of allowing the client to feel heard.
- Identify the key problem, misunderstanding or failure that may have put the relationship with this client on the wrong track. Determine if there is anything that you can do to alleviate the problem. If there is, do it.
- Do not take personal offense. If the client is critical of you or the service you work for, do not take it personally. Offer the client the opportunity to talk to someone in a supervisory position.
- Allow the client to speak. If the client is upset, but not verbally or physically aggressive, allow him or her to speak, to ventilate their anger. He or she will release their frustrations and often feel better.
- Do not debate. If the client is complaining of bad service or of rules or procedures, etc. do not engage in a debate even if you know the client's perspective is incorrect. Be careful not to get defensive, as this can inhibit your ability to hear what is really happening, and will only upset the client more. Discuss the issues raised with the client at another time, when the client is calm, and can hear what you have to say.

Teaching Notes

Dealing with angry clients II:

- **Do not accept** verbal abuse or aggressive behaviour/ threats
- **Pause** to regain balance
- **Build islands of understanding**
- **Apologize** if needed

D5.14 Source: Outreach Training Course Manual, Sydney, KRC (Kirketon Road Centre), 2001.

Slide D5.14: More ways of dealing specifically with angry clients include:

- *Do not accept verbal abuse or aggressive behaviour/threats.* If someone is using overly offensive language, is engaging in threatening behaviours, or is out of control emotionally or is attacking you personally, you do not have to accept this behaviour. You can ask the client to leave the service, you can leave the area, call your supervisor to assist, call other colleagues to assist, or call the police. There will be times when the best strategy is to simply walk away.
- *Learn to pause to regain balance.* It is OK to say something like "I need to think this through." And this may be the best way to regain your composure when things get derailed.
- *Build islands of understanding.* When mutual confusion occurs, frequently summarizing the facts that you and the client both agree on and understand can be helpful.
- *Apologize if needed.* The key word here is empathy. If you discover that somehow you have offended the client, or inadvertently given incorrect information, etc. it is appropriate to apologize to get past a mistake and on to a solution. Most clients will accept an apology, it diffuses anger and frustration, and it shows that you are listening and care about the client.

Teaching Notes



Slide D5.15: General ways of dealing specifically with aggressive clients and potentially violent situations include:

Prevent.

- Look for: signs of frustration, changes in voice pitch and content. Be particularly alert if these signs are present and the potential aggressor has an audience, because he or she is less likely to back down if there is an audience present.
- Try to get other people who do not need to be in the vicinity to leave the area.
- Do not shout back.
- Take note of where your escape routes are, and keep them between yourself and the potential aggressor. Try not to get in a situation where the potential aggressor is blocking your escape routes.
- Pay attention to early signs.
- Always remain vigilant - to others' behaviour, to your behaviour, and to situational indicators.
- Think defensively.
- Respond immediately to danger signals.

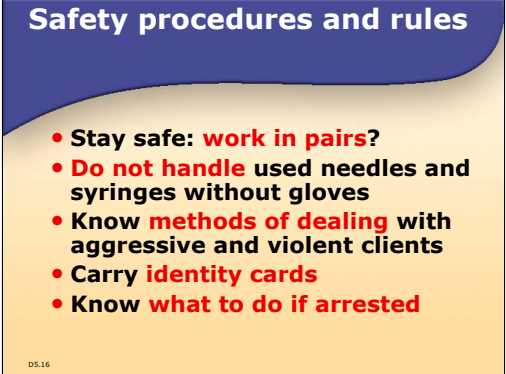
Control

- Keep own behaviour in control, to reduce the chance of escalating the situation.
- Adopt non-threatening body posture.
- Always back off and keep a buffer around your own body space.
- Do not stand front on, stand side on. This is less threatening, and you are better balance if hit or pushed.
- Do not clench your fists - keep hands open in front of you.
- Do not stare/glare - intentionally increase blink rate and maintain sympathetic eye contact.
- Try to stay calm.
- Consciously slow down your breathing and check posture.

De-escalate.

- If the person is already acting aggressively, give them the message "I am listening and I want to help". Offer help as appropriate.
- Use open-ended questions.

Teaching Notes



Safety procedures and rules

- **Stay safe: work in pairs?**
- **Do not handle used needles and syringes without gloves**
- **Know methods of dealing with aggressive and violent clients**
- **Carry identity cards**
- **Know what to do if arrested**

D5.16

Session D5.8 Developing outreach rules

Ask participants to form groups based on their outreach programme(s). Group members should be the same as the outreach teams in which they will work. Ask each group to develop a list of outreach rules. Ask them to keep the rules to those that are essential. Give them 30 minutes to do this.

Then ask the participants to form the plenary group and for each group to read out its list of rules with comments from other participants about whether the rules are too liberal or too restrictive. Stress the need for balance between the need for rules that are important for safety and for the sustainability and effectiveness of the programme, and the need for flexibility that will allow outreach workers to carry out their tasks.

After the draft rules are read out, show slides D5.16 and D5.17 as examples of rules that might also be considered. Distribute Handout D10 (on CD-ROM) as an example of a procedure that should be adopted for picking up used needles and syringes and dealing with needlestick injury.

Then ask participants to return to their small groups and to make any changes they think are necessary. Allow about ten minutes for this. Inform participants that these rules should be checked with their outreach managers and, when agreed, they should be placed in a prominent place in the outreach office so that all outreach workers read and remember them.

Teaching Notes

Unacceptable behaviour

- **Selling/dealing drugs**
- **Selling project materials**, e.g. needles, syringes, condoms
- **Using drugs** (in case of active drug-user peer educators) **during outreach**
- **Theft**
- **Violence, sexual manipulation**
- **Pretending to work**
- **Not completing forms, attending supervision, etc.**

D5.17

Basic practice guidelines should include the main tasks of outreach work. They should also include rules relating to unacceptable behaviour: these should be developed together with reasons why the behaviour is unacceptable (for example, drug-selling by staff may lead to loss of funding and closure of the programme).

With IDUs, ex-drug users and people regularly exposed to drug-use, many situations can occur that can lead to problems or even closure of the programme if they are not addressed. For example, most programmes have a strict rule that no outreach worker can sell to or buy drugs from clients. Another common rule is that theft by an outreach worker is grounds for discipline and (in some cases) dismissal. Another may be that violence or sexual manipulation by an outreach worker towards another worker, manager or client will lead to suspension or dismissal.

Break

Normally a break would be held at about this point for coffee or tea, and to allow participants to move around and meet one another. It is common practice for such a break to be around 15-20 minutes long.

Session D5.10 Follow-up and networking

See Exercises on CD-ROM

Session D5.X: Evaluation and Close

See Exercises on CD-ROM