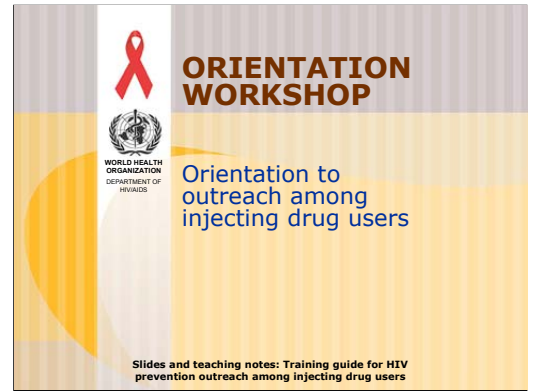


Teaching Notes



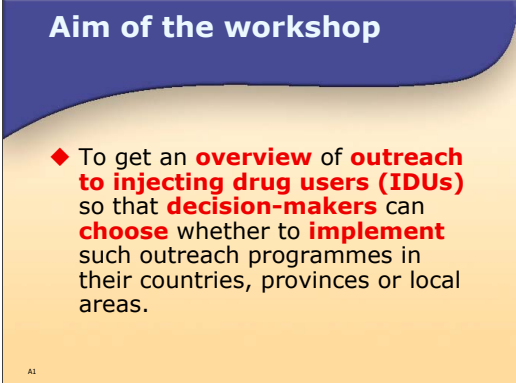
See Training guide book:

- Orientation workshop for preparation and materials needed for this workshop, overview of sessions, training and learning objectives and key learning points.

See CD-ROM for:

- PowerPoint slides for other modules
- Handouts
- Photographs
- Videos
- Training guide book (electronic version)
- References
- Additional training resources

Teaching Notes



Aim of the workshop

- ◆ To get an **overview** of **outreach to injecting drug users (IDUs)** so that **decision-makers** can **choose** whether to **implement** such outreach programmes in their countries, provinces or local areas.

A1

Session A.0. Introduction: Teaching notes

Introduce yourself to participants, allow each participant to introduce himself/herself to the group, stating at least his or her name, their profession or job title and the name of the institution where he or she works (including the city or country if the workshop has a large geographic focus); read the aim of the workshop (Slide A1) and read out the outline, stating when the break will be.

Teaching Notes

Number of countries reporting injection drug use and associated HIV epidemics

	1992	1995	1996	1998	1999
IDU	80	118	121	128	134
HIV/IDU	52	78	81	103	114
% of Total	65	66	67	80	84

A2 Source: Strathdee S. Needle exchange programmes in the 21st century: creating a climate for social change. Paper presented at 12th International Conference on the Reduction of Drug-Related Harm Delhi, 2001.

Session A.1. HIV epidemics among IDUs: Teaching notes

The presentation begins by discussing HIV epidemics among injecting drug users:

Slide A2: the global nature of injecting drug use is explored, with injecting reported in 134 countries in 2000, with 114 of these countries reporting HIV among IDUs. Participants should note that injecting illicit drugs has increased rapidly globally in recent years.

Teaching Notes

Why is injecting spreading?

Complex interaction of factors:

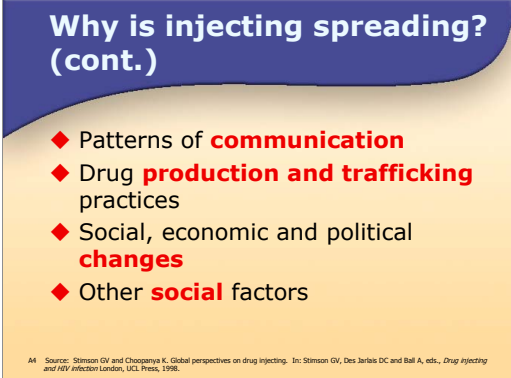
- ◆ **Preference** by drug users
- ◆ **Economic** factors
- ◆ Easier to **conceal**
- ◆ Speed of **drug effect**

A3 Source: Stimson GV and Chooanya K. Global perspectives on drug injecting in Stimson GV, Des Jarlais DC and Ball A, eds., *Drug injecting and HIV infections*, London: UCL Press, 1998.

Slides A3-4: reasons for spread of injecting are complex, including:

Slide A3: Advantages of injecting from the viewpoint of the drug user: economic advantages in that less drug is consumed than in other forms of administration to achieve the same effect; injecting and injecting equipment may be easier to conceal than other drug using practices (e.g. it may be faster to use an injected than a smoked or snorted drug); drug user's preference for fast effects (as injected drugs tend to act faster than drugs taken orally for example, and injectors may enjoy this fast onset of drug effects, known as the "rush"); fads and fashion are also important as injecting becomes a common activity among groups of youth, for example.

Teaching Notes



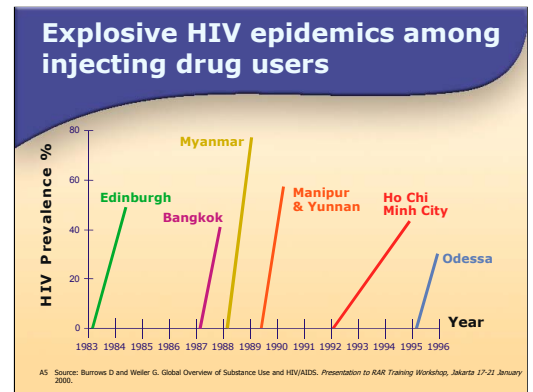
**Why is injecting spreading?
(cont.)**

- ◆ Patterns of **communication**
- ◆ Drug **production and trafficking** practices
- ◆ Social, economic and political **changes**
- ◆ Other **social** factors

A4 Source: Stimson GV and Choppana K. Global perspectives on drug injecting. In: Stimson GV, Des Jarlais DC and Ball A, eds., *Drug injecting and HIV infection* London, UCL Press, 1998.

Slide A4: Social factors are also important, including patterns of communication between and among groups of drug users (that allow transfer of knowledge about techniques of drug use such as injecting); influence of drug production and trafficking practices on the local availability of injectable preparations (as drug trafficking routes change, new populations may be introduced to injectable drugs); and social, economic and political changes (war, civil disturbance and transition to new political, economic or social systems are sometimes accompanied by dramatic increases in illicit drug use and drug injecting).

Teaching Notes



Slide A5: 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 (the 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 in about 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 increasingly spreading among females either via sexual intercourse from mainly the male IDUs to their female partners and/or females are increasingly injecting drugs and contracting HIV through contaminated equipment, which is more likely.

Teaching Notes

HIV transmission among and from IDUs:

- ◆ through **sharing** of injecting equipment
- ◆ through some drug **preparation processes and rituals**
- ◆ through the **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)**

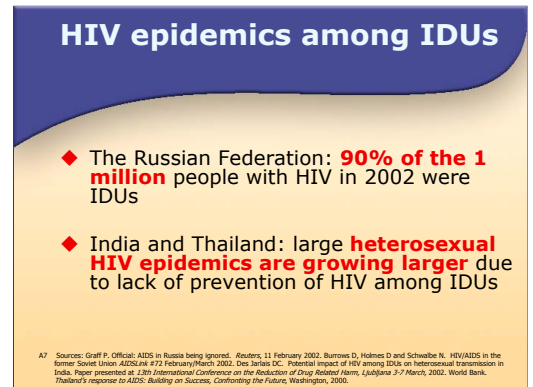
A6 Source: Ball A and Crofts N. HIV risk reduction in injecting drug users. In: Lamprey PR and Gayle H, eds., *HIV/AIDS Prevention and Care in Resource-Constrained Settings*. Arlington, Virginia: Family Health International, 2002.

Slide A6: 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 in 1996– 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 has been also 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 than from female to male, female IDUs and the female partners of the male IDUs are at increased 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



HIV epidemics among IDUs

- ◆ The Russian Federation: **90% of the 1 million** people with HIV in 2002 were IDUs
- ◆ India and Thailand: large **heterosexual HIV epidemics are growing larger** due to lack of prevention of HIV among IDUs

A7 Sources: Graff P. Official: AIDS in Russia being ignored. Reuters, 11 February 2002. Burrows D, Holmes D and Schwabbe N. HIV/AIDS in the former Soviet Union AIDS Care 17(2) February/March 2003. Des Jarlais DC. Potential impact of HIV among IDUs on heterosexual transmission in India. Paper presented at 28th International Conference on the Reduction of Drug Related Harm, Ljubljana 3-7 March, 2002. World Bank. Thailand's response to AIDS: Building on Success, Confronting the Future, Washington, 2000.

Slide A7: HIV epidemics among IDUs can cause massive epidemics in countries with high numbers of IDUs, and can lead to expanded epidemics in countries where most HIV transmission is by sexual routes. For example, in the Russian Federation, it is estimated that 90% of the estimated 1 million HIV infections in 2002 were among IDUs. In India and Thailand, studies in 2000–2002 found that the number of people with HIV was increasing partly because there were few interventions to prevent HIV transmission among IDUs.

(Use flip chart or whiteboard to write these figures): If there are 50 000 IDUs in a country, city or province:

- Assuming that no IDUs were infected to begin with, a 50% rise in HIV infections in one to two years means 25 000 injectors become infected.
- If only 50% of these pass HIV to their non-injecting sexual partners, there will be another 12 500 additional people infected.
- Each HIV infection cost between US\$ 50,000 to US\$ 100,000 per year to treat in Western countries when the full set of drug combinations and other medical practices are used (in 2002). Even in Brazil, which in 2002 had among the lowest prices for HIV treatment drugs in the world, these drugs alone (without adding the costs of medical care, hospital treatment, etc.) cost US\$ 2,700 per year (in 2002).
- This means that five to seven years after this epidemic, the costs for treatment in such a population would be more than US\$ 101 million per year just for AIDS treatment drugs alone (even at the lowest prices in 2002), or US\$ 1.8–3.7 thousand million each year (if all medical treatments and Western costs for AIDS treatment drugs are included): unless effective prevention occurs, these costs will simply continue to increase each year.

State that the economic, social and personal costs of HIV epidemics among IDUs are very high and need to be addressed. Because HIV spreads so quickly among IDUs, interventions must be carried out urgently to prevent or reduce massive epidemics of HIV among IDUs.

Teaching Notes

How to contact IDUs?

- ◆ Where would you **find IDUs** in your locality?
- ◆ Where and how would you locate **female IDUs**?
- ◆ 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?

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Session A2. Exercise: How to contact IDUs. Teaching notes

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 following questions. Tell them they have 20 minutes to answer the questions.

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

Where and how would you locate female IDUs?

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 that 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, particularly female 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. It should be also noted that in many societies and economic contexts where women in general do not have equal rights like their male counterparts, being a "drug injector" is most likely to expose female IDUs to severe stigma, thus making it even more difficult to reach them.

Teaching Notes



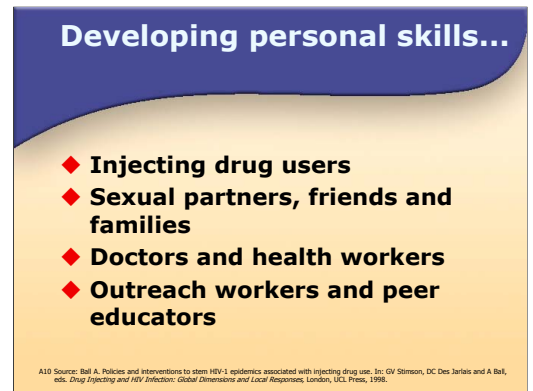
Session A3. Effective approaches to HIV among IDUs: Teaching notes

Slide A9: Effective approaches to HIV/AIDS and injecting drug use need to include a range of public health responses. The Ottawa Charter of Health Promotion is the foundation document of such public health approaches. This slide provides an overview of the principles of health promotion and effective HIV prevention contained in the Ottawa Charter of Health Promotion.

Ball (1998) provides an overview of the ways these five activities are being used to address HIV prevention among drug users:

- Promoting health through public policy: Government policies that are likely to cause health problems or increase health problems need to be exchanged for policies that are likely to increase public health. For example, in many countries, laws present direct obstacles to HIV prevention efforts, especially related to needle exchange, outreach and drug substitution programmes: these laws need to be addressed to ensure that effective HIV prevention can occur.
- Creating a supportive environment: Drug users are more likely to change their HIV risk behaviour if there is a supportive environment in which health and social injustice are addressed and drug users have equal access with other community members to appropriate health prevention and treatment efforts. This includes both a supportive physical environment (meeting the basic needs of shelter, clothing, food and safety specially in case of female IDUs or female peer educators or out reach workers) and a supportive social environment where drug users, both male and female, are encouraged to consider themselves members of the society with equal rights and responsibilities with all other members of the community.

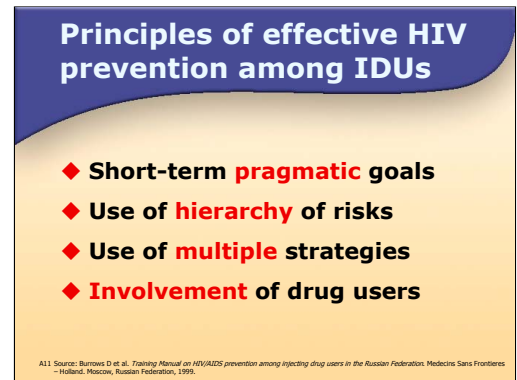
Teaching Notes



Slide A10: Four main groups need to be targeted for the development of personal skills (Ball, 1998):

- *Injecting drug users*: IDUs acquire specific knowledge and skills through their drug-using experience that assist them in assessing and managing the risks associated with injecting drug use. Skills development is needed in assessing and managing HIV risk, including accurate information on the HIV risk of injecting and other behaviours; education on needle and syringe use and cleaning, and condom use, information on gaining access to sterile injecting equipment and condoms and information on drug treatment, sexually transmitted infection (STI) and HIV services, overdose prevention, general health, etc.
- *Sexual partners, families and friends of IDUs*: For sexual partners, this includes the development of ways to assess and manage the risk of HIV transmission through sex, which may include training in negotiation techniques as well as use of condoms, including female condoms. Developing personal skills for this group also includes providing information on what to do in case of an overdose or an abscess, and information on drug treatment, STD and HIV services. Partners, families and friends can also benefit from skills training on providing a support network to help users when they want to quit injecting or to be of assistance should the user become infected.
- *Doctors and other health care workers* (such as psychologists, nurses and social workers). These professionals need to have sufficient knowledge and skills to counsel the above two groups about effective HIV prevention. The negative attitudes of health care workers towards drug users, particularly towards female drug users, is a major obstacle to effective HIV prevention and treatment. This skills development should concentrate on assessment of HIV risk, skills in early intervention with drug use and HIV risk.

Teaching Notes



Slide A11: Point out to participants that the above framework sees outreach workers as vital in effective HIV prevention among IDUs. An effective prevention programme also requires:

- 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 from drug use);
- establishment of a scale of means to achieving specific goals: for example, a hierarchy of risks (next slide);
- use of multiple strategies to achieve goals;
- provision of the means to accomplish risk reduction, for example condoms and sterile needles and syringes;
- 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**

A12 Source: Burrows D et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Medecins Sans Frontieres – Holland, Moscow, Russian Federation, 1996.

Slide A12: 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 use drugs, use them in any way except injecting: if you do not inject drugs, you cannot catch infections through needle sharing.
- If you continue to inject, 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 module C for details). There is some risk of HIV transmission after needle cleaning, but cleaning in an approved manner will reduce the likelihood of transmission.

As this risk hierarchy shows, many different groups and activities should be involved in harm reduction, from drug-prevention campaigns to drug treatment agencies to outreach workers to IDUs themselves.

Teaching Notes

Elements of effective prevention

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

A13 Source: WHO Evidence for Action papers and policy briefs, Geneva, World Health Organization, REF.

Slide A13: In 2001–2002 WHO commissioned a series of papers and policy briefs 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 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 (and 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 paper and policy briefs, there is clear evidence that five activities can be highly effective in preventing HIV transmission among IDUs. Each activity seems to have limited effectiveness by itself but, when several or all are used at the same time, HIV epidemics among IDUs have been prevented, stabilized and reduced.

The five activities are:

Outreach. 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. 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. These approaches have been observed to reduce marginalization of IDUs, thus increasing access to HIV prevention services.

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**

A14 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 Harms, Glasgow 27 March 2002.

Slide A14: 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.

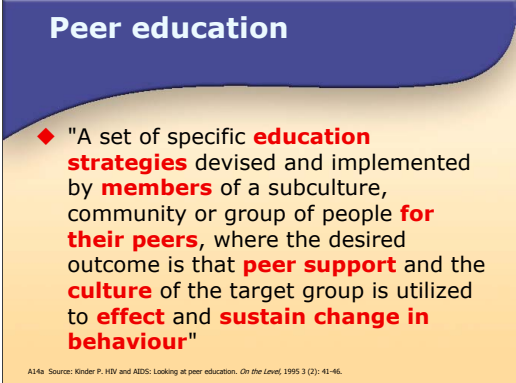
It is the least costly intervention and is often the easiest intervention to begin (compared to large targeted education, NSP or substitution drug treatment programmes).

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 the next slide:

Teaching Notes



Peer education

◆ "A set of specific **education strategies** devised and implemented by **members** of a subculture, community or group of people **for their peers**, where the desired outcome is that **peer support** and the **culture** of the target group is utilized to **effect** and **sustain change in behaviour**"

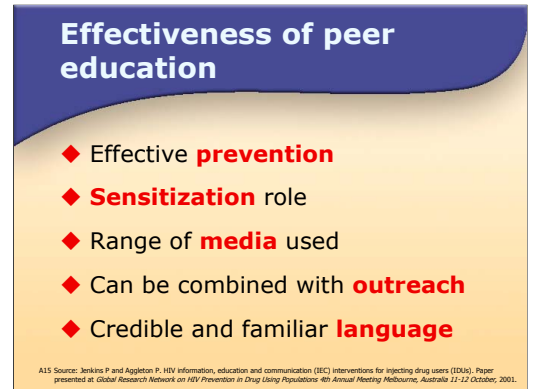
A14a Source: Kinder P. HIV and AIDS: Looking at peer education. On the Level, 1995 3 (2): 41-46.

Slide A14a: Peer education has been defined as: "A set of specific education strategies devised and implemented by members of a subculture, community or group of people for their peers, where the desired outcome is that peer support and the culture of the target group is utilized to effect and sustain change in behaviour" (Kinder, 1995).

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 or female IDUs);
- that the strategies and messages are developed and used by members of the subpopulation; and
- that peer education is based on the widely recognized principle that members of a group or subpopulation are more likely to understand one another and be able to develop useful messages and strategies for people like themselves.

Teaching Notes



Slide A15: The Evidence for Action paper on HIV information, education and communication (IEC) interventions for IDUs (Jenkins and Aggleton, 2001) concludes that such interventions are one component of an effective HIV prevention programme among IDUs. These interventions can sensitize both the population in general and people who inject drugs to the potential risks associated with injection, to the availability of voluntary counselling and testing (VCT) facilities, and to treatment and care options.

IEC approaches also have an important role to play in outreach work, including programmes of peer education. Information about HIV/AIDS-related risks and ways of reducing risk and reducing harm may be made available through leaflets and booklets, as well as by word of mouth. In some circumstances, audio-visual media have been used to good effect, such as in programmes to teach IDUs how to sterilize and clean injecting equipment.

Beyond this, IEC can be used to establish a policy climate supportive of work with IDUs, and sensitive to the approaches that work best. It may do this through high-level advocacy with politicians and political decision-makers, religious leaders and community groups. 'Unpaid publicity' and 'media advocacy' can help create a climate in which HIV/AIDS prevention issues among IDUs can be tackled. IEC interventions such as these, operating at a structural level, can be used to prepare the ground for more focused interventions around IDUs and their needs.

To be effective, IEC approaches (whether free-standing or in combination with other work) require clear and realistic goals. They need to be couched in language that is both credible and familiar, addressing sexual as well as injection-related concerns. Implementation of IEC interventions should be part of a broader programme of work on HIV prevention, risk reduction and harm reduction.

Teaching Notes

Effectiveness of increased access to needles & syringes

- ◆ Compelling evidence of **effectiveness** and **cost effectiveness**
- ◆ Need to **integrate** with other health care services
- ◆ Often can be **combined with outreach**

A16 Source: Wodak A. Evidence for Action: Effectiveness of needle and syringe programmes for HIV prevention among IDUs. Paper presented at 12th International Conference on the Acquisition of Drug-Resistant HIV-1 (AIDS9), 7 March, 2002.

Slide A16: The Evidence for Action paper on the effectiveness of NSPs (Wodak, 2002) notes that most evaluations of NSPs have examined the differences in behaviours between those attending and not attending an NSP: in recent years, this has extended to studies of IDUs before a NSP begins, then of attenders and non-attenders 6–12 months after the NSP begins.

The results have overwhelmingly showed that IDUs who attend NSPs have:

- lower risk behaviours, especially needle and syringe sharing;
- lower incidence of HIV (fewer new cases of HIV each year); and
- lower prevalence of HIV (lower percentage of IDUs with HIV);

than IDUs who do not attend NSPs or IDUs in areas where there are no NSPs.

Cost effectiveness has also been studied and NSPs were found to be:

- low-cost in terms of each infection averted; and
- low-cost in terms of life years saved compared to other interventions for viral diseases.

NSPs have been found to be most effective when they are integrated with other forms of health care, either within a set of government or nongovernmental services from a single provider or as part of a referral network of services.

NSPs in many countries are combined with education and outreach programmes to attract IDUs with needles and syringes and other prevention supplies, and provide education on HIV and related topics in areas where IDUs live and congregate.

Teaching Notes

Effectiveness of drug substitution treatment

- ◆ Effective in HIV **prevention**
- ◆ **Reduces** injecting & drug use
- ◆ Can be **combined** with other services to assist in HIV treatment, care and support
- ◆ **Referral** often occurs **from outreach**

A17 Source: Booy A Effectiveness of drug dependence treatment in prevention of HIV among IDUs. Paper presented at 23th International Conference on the Reduction of Drug-Related Harm, Lisbon 3-7 March, 2002.

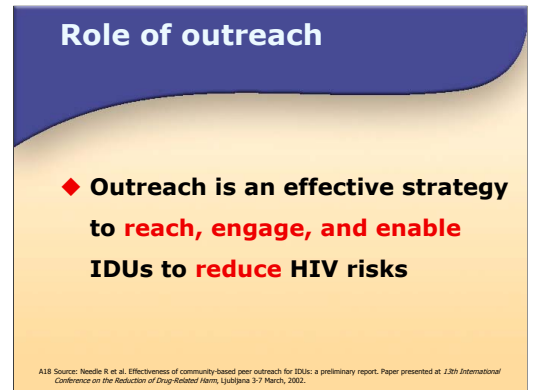
Slide A17: Drug treatment programmes have been found to be effective in assisting drug users to reduce or stop injecting, especially where substitution drug treatments are used (Ward et al., 1998). Methadone programmes are the most widely used type of substitution drug treatments but others include buprenorphine, pethidine, heroin, morphine and tincture of opium. Substitution therapy was developed with several objectives:

- to establish contacts between heroin users and social services;
- to prevent illicit drug distribution;
- to prevent the increase in crimes, associated with heroin use; and
- to assist in social adaptation of drug users.

Methadone and other substitution therapies have more recently been found to be very effective HIV-prevention measures. A United States study, for example, has found that participants in a methadone programme were half as likely to be infected with HIV as drug users on a methadone programme.

Methadone therapy has also been reported to be effective and safe in treating female IDUs even when they are pregnant, lactating and/or HIV positive.

Teaching Notes



Slide A18: It must be underscored that, where effective action has been taken to prevent or control HIV epidemics among IDUs, no single element has been found to be effective on its own. Successful prevention has been achieved through comprehensive prevention programmes, based on community development principles, operating in supportive environments that include access to social welfare and primary health care. But 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.

Most studies of outreach to IDUs for HIV prevention were carried out in developed countries. However, there is a growing literature being reported in languages other than English and from developing countries. The evidence is compelling; the findings are consistent despite variation in characteristics of types of outreach workers, places where outreach is conducted, time and components of the programmes.

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 that are gender responsive and developed with the involvement of IDUs themselves.

Break

Normally a break would be held at about this point for coffee or tea, and to allow participants to move around and meet each other. It is usual for such a break to be around 15–20 minutes in duration.)

Teaching Notes

Outreach case studies

- ◆ **Is outreach useful** for HIV prevention among IDUs?
- ◆ Most **important aspects** of outreach work?
- ◆ **Negative aspects** of the work?
- ◆ Would an outreach programme be useful and achievable in **your locality**?
- ◆ If yes, **why**? If no, **why not**?

A19

Session A.4. Outreach case study/ Guest lecture: Teaching notes

Slide A19: 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?
- Would an outreach programme to prevent HIV among IDUs be useful and achievable in your locality? If yes, why? If no, why not?

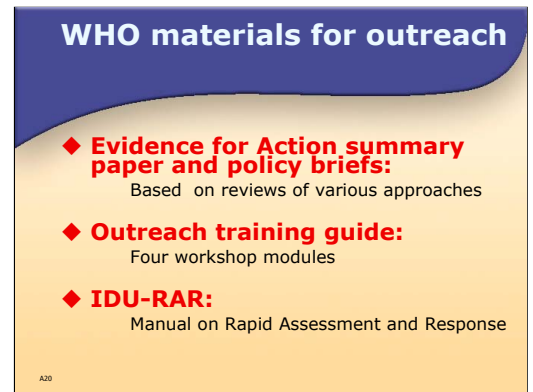
These small group discussions should continue for 15–20 minutes.

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. Allow a few groups to talk generally about the first three questions, but concentrate on the final two questions. Summarize the views of participants on a white board or flip chart. This final discussion should last from 15–20 minutes.

If participants state that outreach would NOT be useful, ask for further details. The usual reasons given for outreach not being useful are:

- Participants' localities have no IDUs or not many IDUs or have no HIV among IDUs. You can answer this by referring back to the slides used in A1, showing that injecting is increasing rapidly throughout the world, and the exercise in A2, showing that injecting drug use is often hidden and it may be difficult to discover the number of IDUs, particularly female IDUs and their risk behaviours.
- There is no need for outreach because health care workers (or police or drug treatment workers or political parties or churches) are so vigilant in looking after all members of society that IDUs can be reached by through clinics and other services without the need to go on the streets and do outreach work. Again, remind participants of the exercise in A2 and ask if they are sure that all these IDUs in different parts of their localities are in touch with services. Inform them that even in very rich countries in North America and Western Europe, outreach work is considered vital because services are unable to reach all IDUs, particularly the female IDUs.

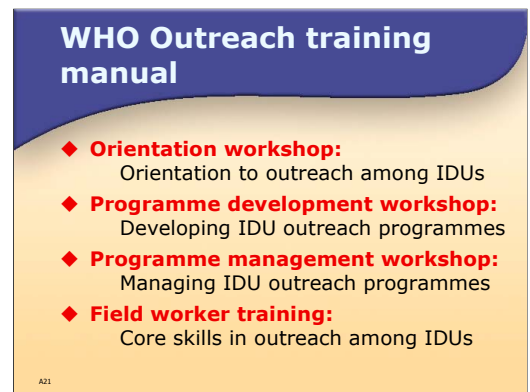
Teaching Notes



Session A.5. Action plans for outreach: Teaching notes

Slide A20: Show participants examples of WHO and other documents related to development of outreach programmes and explain where these documents can be accessed. Describe the Evidence for Action materials in detail, providing details of web addresses and other ways that participants can access these materials (including the CD-ROM of the Outreach training guidelines).

Teaching Notes



Slide A21: Explain that the participants have completed the first of four modules in the WHO Outreach training guidelines, which are designed to assist in starting and managing outreach programmes. Provide an overview of the other modules and the overall Outreach training guidelines resources. Explain that the guidelines are available as a book and CD-ROM. The book contains an overview of the modules, and each module referred to in the book corresponds to a PowerPoint file on the CD-ROM. Each PowerPoint file contains both a set of slides that can be used in training workshops and courses, and a set of training notes explaining how to use the slides. The CD-ROM also contains the references list for all information contained in the book and the PowerPoint presentations, and other resources that may be useful in training, including case studies, evaluation forms, templates for agenda outlines, handouts and so on.

The modules are arranged in a sequence to assist the training of a wide range of participants, depending on their training needs.

- *Module A: Orientation to outreach among injecting drug users* is a half-day workshop for decision-makers, AIDS/ Drugs/ Health Ministerial/ Departmental staff, politicians, researchers, programme developers, outreach trainers. This module provides evidence for the effectiveness of outreach programmes and assists decision-makers to plan the introduction and development of outreach programmes.
- *Module B: Developing outreach programmes for HIV prevention among injecting drug users* is a one-day workshop for programme developers and outreach trainers. This module provides assistance to those individuals who are interested or involved in developing outreach programmes and may be the initial managers of such programmes.
- *Module C: Managing outreach programmes among injecting drug users* is a four-day workshop for programme developers, outreach trainers and outreach managers. This module is designed to be used with people who have never managed an outreach programme, but can also be useful as additional training for current managers and outreach field supervisors.
- *Module D: Core skills in outreach among injecting drug users* is a five-day workshop for outreach workers, designed to be delivered either in a large-scale training exercise (where several outreach teams come together) or to individual outreach teams. This module is designed for initial training of outreach workers but may also be used as a resource for ongoing training and revision among experienced outreach workers.

Teaching Notes

Slide A22: About the WHO IDU-RAR manual...

- ◆ **Methods** for rapidly assessing injecting drug use
- ◆ Helps to **identify sources of data and key areas** of assessment
- ◆ Guides to develop **action plans** for intervention implementation

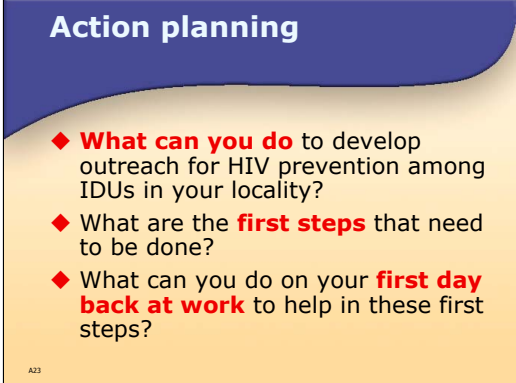
A22

Slide A22: Also talk about the uses of IDU-RAR. Rapid Assessment and Response (RAR) is an action research approach that consists of three main components: assessment methods and sources of data; key areas of assessment; and the development of action plans for intervention implementation. The IDU-RAR outlines the use of multiple methods (both qualitative and quantitative, including approaches to sampling, key informant interviews, focus groups, observations and focused surveys) in conjunction with multiple data sources (including a variety of existing data sources) to undertake assessment of the local and country context, the extent and nature of drug injecting, the extent and nature of health consequences and risk behaviour associated with drug use, the situational and contextual factors influencing risk reduction, and the need for effective intervention and policy development. The IDU-RAR is also provided on the CD-ROM of the Outreach training guidelines.

Explain to participants that all of these materials can only be used after a locality has made the decision that HIV prevention among IDUs is an important and useful activity, and that outreach is an effective method of starting HIV prevention among IDUs.

It is possible that the people who can make such a decision are in this training workshop. However, it is likely that some decision-makers who are important in each locality, are not attending this training workshop. They will need to be persuaded that outreach is an important and effective activity in each participant's locality. In this final session of the workshop, participants are asked to develop individual action plans for their own localities about what they will do to begin development of outreach programmes.

Teaching Notes



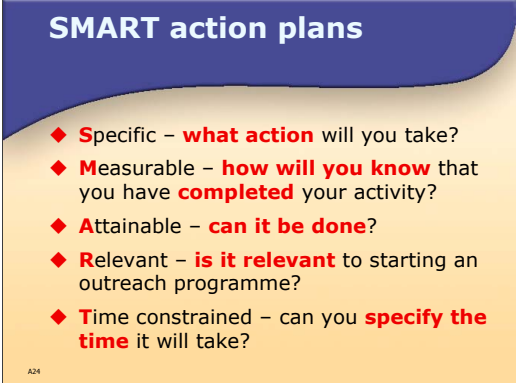
Action planning

- ◆ **What can you do** to develop outreach for HIV prevention among IDUs in your locality?
- ◆ What are the **first steps** that need to be done?
- ◆ What can you do on your **first day back at work** to help in these first steps?

A23

Slide A23: Inform participants that you want them to write individual action plans according to the above list, and that you want the action plans to be SMART.

Teaching Notes



SMART action plans

- ◆ **Specific** – **what action** will you take?
- ◆ **Measurable** – **how will you know** that you have **completed** your activity?
- ◆ **Attainable** – **can it be done**?
- ◆ **Relevant** – **is it relevant** to starting an outreach programme?
- ◆ **Time constrained** – can you **specify the time** it will take?

A24

Slide A24: Give examples of SMART action plans:

- Next Thursday, I will meet with the head of the police in my city to provide him/her with Evidence for Action materials on HIV prevention among IDUs.
 - In the first week of next month, I will hold a meeting in my city with representatives of these organizations (with the specific names of all the organizations) to discuss our city's response to HIV and IDUs; I will give out copies of the Evidence for Action papers and policy briefs and I will give a presentation based on the slides in A1.

It should take about 15 minutes to explain what materials are available and how to write individual action plans.

Ask each participant to take a sheet of paper and decide what he or she personally can do to develop outreach for his/her specific locality. The plans should be short (no more than three actions) and should be achievable within four weeks.

After 20 minutes of writing, ask each person to read his/her plan to the group.