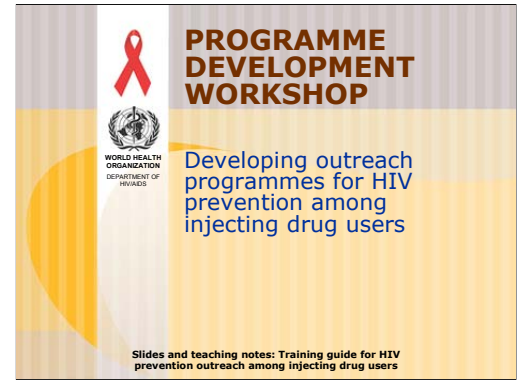


# Teaching Notes



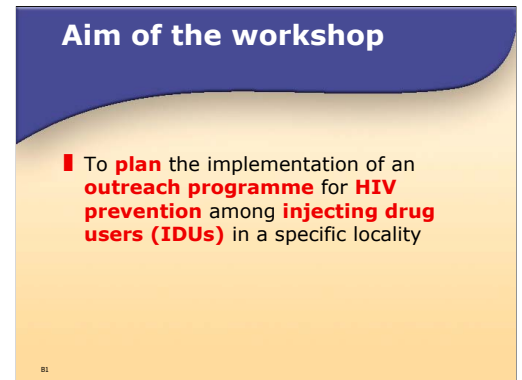
See Training guide book for:

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

See CD-ROM for:

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

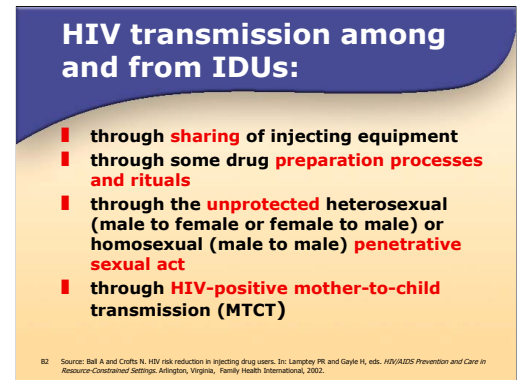
# Teaching Notes



## ***Session B.0. Introduction: Teaching notes***

Slide B1: Introduce yourself to participants, allow each participant to introduce himself or herself to the group, stating at least their name, their profession or job title and the name of the institution where they work (including the city or province if the workshop has a large geographic focus); read the aim of the workshop (Slide B1) and read out the outline, stating when there will be breaks.

# Teaching Notes



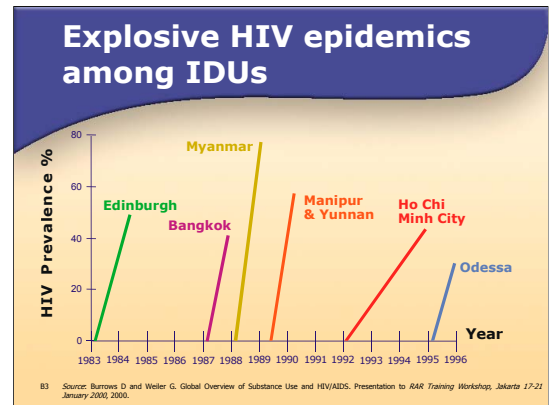
## **Session B.1. HIV epidemics and prevention among IDUs**

Slide B2: HIV transmission among and from injecting drug users (IDUs) 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 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 or male partner's drug use practices or both, 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 as compared to 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 B3: 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 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 spreading increasingly among females either via sexual intercourse mainly from the male IDUs to their female partners and/or females increasingly are injecting drugs and contracting HIV through contaminated equipment, which is more likely.

## Teaching Notes

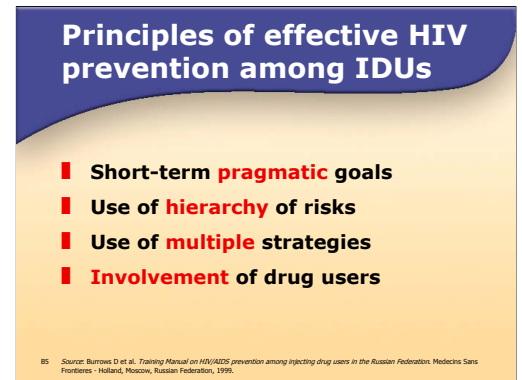
**HIV epidemics among IDUs**

- 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

B4 Source: Graff P. Official AIDS in Russia being ignored. Reuters, 11 February 2002. Burrows D, Holmes D and Schwabe N. HIV/AIDS in the former Soviet Union. AIDS/2001 # 73 February/March 2002. San Jose, CA. National impact of HIV among IDUs on heterosexual transmission in India. Paper presented at the 13th International Conference on the Reduction of Drug Related Harm, Ljubljana 3-7 March. Thailand's response to AIDS: Building on Success, Confronting the Future. Washington, World Bank, 2000.

Slide B4: 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.

# Teaching Notes



Slide B5: 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:

- 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; and
- 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**

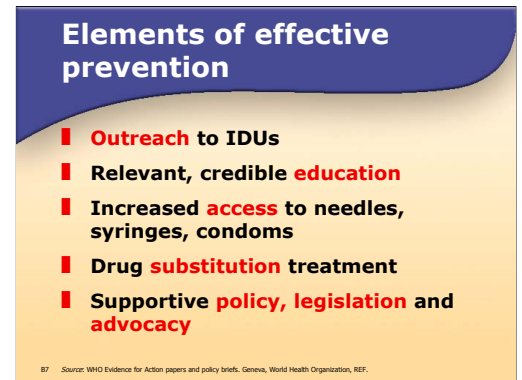
86 Source: Burmes D et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Medecins Sans Frontieres - Holland, Moscow, Russian Federation, 1999.

Slide B6: 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 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 drugs prevention campaigns to drug treatment agencies to outreach workers to IDUs themselves.

# Teaching Notes



Slide B7: 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 this writing, not all of the papers were complete, so make sure that you check the web site ([www.who.int/hiv\\_aids](http://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 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, 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 targeted advocacy.* These approaches have been observed to reduce marginalization of IDUs, thus increasing access to HIV-prevention services.

# 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**

88 Source: Boya A. Effectiveness of drug dependence treatment in prevention of HIV among IDUs. Paper presented at 12th International Conference on the Reduction of Drug-Related Harm, Ujijima 3-7 March, 2002.

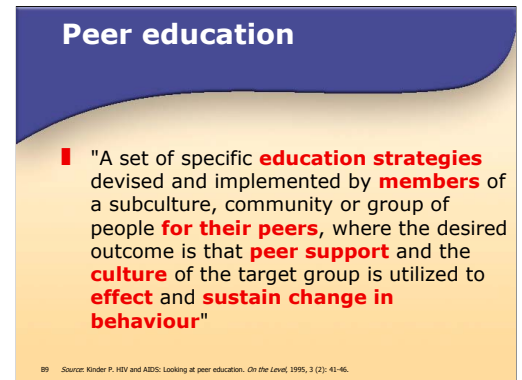
Drug treatment programmes have been found effective in assisting drug users to reduce or stop injecting, especially where substitution drug treatments are used (Ward et al., 1998). Methadone programmes are the most widely used type of substitution drug treatments but others include buprenorphine, pethidine, 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



**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**"

B9 Source: Kinder P. HIV and AIDS: Looking at peer education. On the Level, 1995, 3 (2): 41-46.

Slide B9: 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).

Key characteristics of peer education are that:

- the education strategies and messages are specifically for one group or subpopulation (e.g. IDUs in a specific locality, female IDUs);
- the strategies and messages are developed and used by members of the subpopulation; and
- 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**

B10 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 B10: It must be stressed 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.

# 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?

B11

## **Session B2. Exercise: How to contact IDUs**

Slide B11: 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.

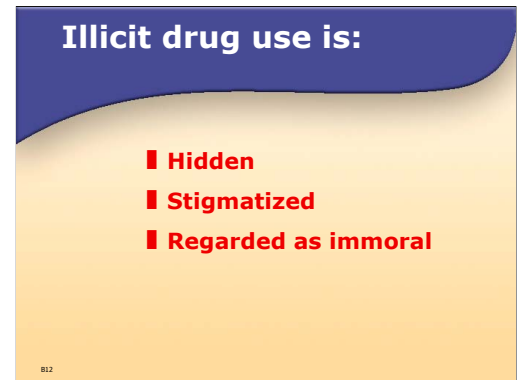
If you find them, would you feel comfortable talking to IDUs about HIV and drug use issues? If no, why not? Ask the group to list the reasons why it might be uncomfortable for at least some participants to talk to IDUs about these issues.

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 also be noted that in many societies and economic contexts where women in general do not enjoy equal rights as 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 B.3. Types of outreach: Teaching notes***

Slide B12:

This presentation starts by examining the characteristics of illicit drug use, particularly drug injecting. Illicit drug use is:

- hidden: it is not usually done openly in front of strangers (as we saw in the previous exercise);
- stigmatized: drug users are seen as different and are viewed negatively by many in society: this can be seen in the treatment of drug users by their families, by health and medical staff, by media, etc. As discussed in the previous slide, in many societies and economic contexts where women in general do not enjoy equal rights as their male counterparts, being a “drug injector” is most likely to expose female IDUs to more stigma and drive them further underground, thus making it harder to reach them; and
- regarded as immoral by at least some groups in most societies: often religious leaders, politicians and others refer to the “evil” of drug use and drug users.

## Teaching Notes

**Drug using behaviour is fluid, changing with:**

- new **technologies**
- impact of **police, narcotics control**, etc.
- changes in drug **selling and using networks**
- changes in **patterns and trends** in drug use

B 13

Slide B13: Drug-using behaviour is also fluid, changing with:

- new technologies: changes in drug manufacture, for example where injectable drugs suddenly become widely available;
- impact of police and social pressures: drug users may be pushed from one neighbourhood to another by constant police raids; increasing rents in an area may force drug users to move to new locations;
- changes in membership of drug selling and using networks: different ethnic groups may become involved; trading sex for drugs may be a phenomena, drug users of different ages may enter or leave the scene; subcultures may take over certain drug sales; and
- changing patterns and trends in drug use based upon availability, price, drug preference and consequences of using particular drugs or drug combinations.

# Teaching Notes

**Outreach to drug users:**

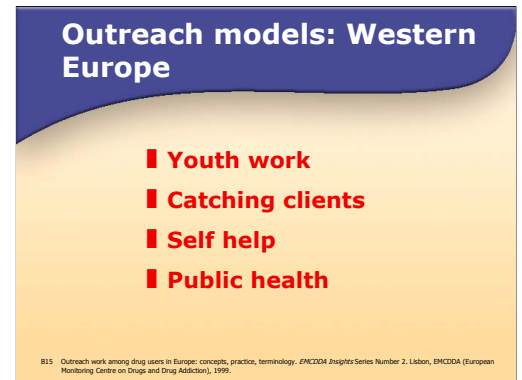
- Started in **1960s** in **Western Europe, North America, then Australasia**
- Outreach to disadvantaged groups (including drug users) in **Latin America** in **1960s and 1970s**

B14 Needle R et al. Effectiveness of community-based peer outreach for IDUs: a preliminary report. Paper presented at the 12th International Conference on the Reduction of Drug-Related Harm, Ljubljana 3-7 March 2002.

Slide B14: Outreach to drug users originated in the 1960s in the United States of America in response to epidemic levels of heroin use. By the late 1960s, outreach programmes were also operating in several Western European countries targeting drug-using youth (EMCDDA, 1999), and in Australia and New Zealand targeting homeless people and street children, including drug users (KRC, 2002).

Community-based work in Latin America has a long tradition based in experiences of the popular education in Brazil in the 1960s, and social psychology in Chile or social work in Argentina in the 1970s: all of these used outreach methods to some degree. Mexico and the Caribbean have also integrated outreach into their efforts to address different social problems (Needle et al., 2002).

# Teaching Notes



Slide B15: There are a number of community-based outreach models, with considerable overlap and some differences in the organization of outreach work and functional roles and types of outreach workers. Outreach programmes to drug users in Europe can be divided into four types (EMCDDA, 1999):

- *Youth work model*: the original form of outreach in many Western European countries, in which youth workers are employed to seek out “problem youth” and assist them with their problems; drug use is not usually the primary focus of these outreach programmes, but HIV prevention among IDUs has tended to become part of their work in recent years: common in Austria, France, Germany, Nordic countries and Portugal.
- *Catching clients model*: outreach from mainly therapeutic communities and other drug treatment services to encourage drug users into treatment: HIV prevention education is an activity but the primary focus is on helping drug users to quit; common in Nordic countries (particularly Norway and Sweden) and Greece.
- *Self-help model*: where drug users outreach to other drug users about issues of mutual interest, including HIV/AIDS; this type of outreach is most common in the France, Germany and the Netherlands but it is also found in Belgium, Denmark, Italy, Spain, and the United Kingdom.
- *Public health model*: built upon the self-help model, in which IDUs and ex-users work with doctors, nurses, other health workers to reach IDUs and provide HIV-prevention information, often needles, syringes, condoms and other equipment and, in some cases, care and support (including medical treatment) for IDUs: this is the most widely used model across Western Europe.

## Teaching Notes



Slide B16: In the United States of America, there are several models concentrating on HIV prevention among IDUs (Needle et al., 2002). The Indigenous Leader Outreach Model developed in Chicago relies on former and/or current users employed in mobile teams and trained to access, engage and intervene with IDU social networks in the community settings, where members typically congregate (Wiebel, 1993). This model uses insiders who have access to the drug-using community, who know the rules governing the social systems of the streets, who are able to develop trusting relationships with the target population of drug users, and can emphasize a hierarchy of behavioural options to IDUs for the purpose of decreasing the probability of HIV transmission. Individual risk reduction plans are re-negotiated with IDUs periodically to encourage the adoption of increasingly effective measures over time toward the ultimate goal of risk elimination.

The National Institute of Drug Abuse (NIDA) model incorporated the Indigenous Leader Outreach Model, and combined it with features of other models, including the incorporation of pre- and post-test HIV counselling (Needle, Coyle and Cesari 1998; Coyle, Needle and Normand, NIDA, 2000). This model (see Resources in Annex 3) includes two interrelated components designed to facilitate behaviour change among at-risk drug users, including injection and non-injection crack/cocaine users. These include (1) community-based outreach and (2) two sessions of education and risk reduction counselling that are organized around testing for HIV, hepatitis B virus (HBV), and hepatitis C virus (HCV). These two sessions provide pre- and post-test counselling to enable drug users to discover whether they have these viruses and learn about the behaviour changes need to reduce transmission risks.

Another adaptation of the Chicago model is Project SHIELD (Self Help in Eliminating Life Threatening Diseases) in Baltimore, which aims to provide leadership training to active and ex- IDUs to become leaders in their drug-using networks and to assist in changing social norms towards safer behaviours (Sherman et al., 1998). A social network model of outreach from Connecticut, referred to as a Peer-Driven Intervention (PDI), relies on active IDUs, provides them with guidance and direct, per-task monetary rewards to carry out outreach-related tasks (Broadhead, 1998). This model has the same advantages as others described above but differs in the way outreach work is organized and supported. Canada has also used outreach programmes to reach IDUs, usually linked with needle and syringe programmes, and emphasizing the use of active or ex-IDUs as outreach workers.

# Teaching Notes

**Outreach to IDUs for HIV prevention**

- 1980s:** Started in North America, Western Europe, Australasia
- 1990s:** Spread to Latin America, Asia, Eastern Europe
- 2002:** **Very little** outreach to IDUs in **Pacific, Eastern Mediterranean Region, Africa**

B17 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, Lisbon 3-7 March 2002.

Slide B17: Outreach to IDUs for HIV prevention began in the 1980s as a natural progression from the previous work with various types of drug users. Specific programmes to address HIV prevention among IDUs were started (or existing outreach programmes were significantly expanded) very quickly to try to reach as many IDUs as possible with education and information about HIV transmission related to drug injecting. Outreach took different forms in different countries and, in some countries, various models were developed and evaluated (which will be examined in the next two slides).

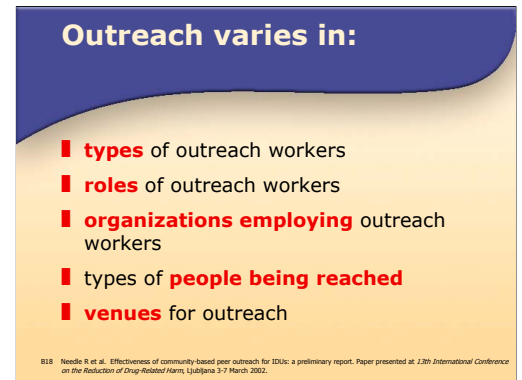
Outreach to IDUs for HIV prevention spread to resource-constrained countries at the end of the 1980s and during the 1990s. It became widespread in Latin America, especially in Brazil and Argentina. Limited outreach developed in Asia and, at the end of the 1990s, a significant number of outreach programmes started in the countries of Central and Eastern Europe. In 2002, there were very few outreach programmes in the Pacific region (except Australia and New Zealand), the Eastern Mediterranean region and Africa (Needle et al., 2002).

**(Trainers: select from the following to provide additional information on your region. The main source for all the below data is Needle et al., 2002.)**

## ***Latin America***

There has been a substantial effort to introduce community-based/peer outreach programmes in Latin America since the early 1990s. The first outreach programme in Latin America was established in Santos, Brazil in 1993 (Bueno et al., 1996). In Brazil, most outreach to IDUs is linked with needle and syringe provision (NSP). For example, the Harm Reduction Programme (HRP) of Porto Alegre was created in 1996 (Kuchenbecker et al., 2000). HRP interventions are mainly based on outreach workers who visit communities searching for IDUs and "shooting-galleries" (places where many IDUs inject together or one after another). Some outreach workers are former drug users. Shooting-galleries and IDU networks are visited weekly by outreach workers who provide information on STD/AIDS sexual and injection drug use-related transmission, needle-exchange kits and condoms, and referral to health and social services. Brazilian outreach programmes and NSPs distributed syringes and provided education and other services to more than 50 000 IDUs in 2002.

# Teaching Notes



**Outreach varies in:**

- **types** of outreach workers
- **roles** of outreach workers
- **organizations employing** outreach workers
- types of **people being reached**
- **venues** for outreach

B18 Needle 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 B18: Outreach varies in terms of types of persons doing outreach (current and/or former drug users, non-drug users, male and/or female drug users), the roles of outreach workers, the amount of time engaged in actual contact with IDUs in high-risk locations, the organizations and sub-components they represent (NGOs, drug users' organizations, health departments), the types of persons being reached (IDUs, non-injection drug users in and or out of drug treatment using various drugs, prisoners and those recently released from prisons, commercial sex-working injection drug users, female drug users, persons living with HIV/AIDS), venues for outreach (tolerance zones or open drug scenes, closed drug scenes, streets, bars, crack houses, storefronts, favelas or shanty-towns, residences) (Needle et al., 2002).

## Teaching Notes

Outreach varies in: (cont.)

- education and information **methods**
- prevention **materials**
- other **services/referrals**

B19 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 B19: In addition, there are differences in the types of education and information provided to IDUs; the means provided to drug users to assist them to change their behaviours (risk reduction information, condoms, bleach, syringes, safe crack pipes, referrals to health and other services) and the types of services provided (or referred to) through outreach. In many countries, outreach workers provide risk reduction information as well as syringes. In some countries, outreach workers provide risk reduction information, and syringes to IDUs (or people living close to IDUs) in neighbourhoods and these people, in turn, provide the materials to other IDUs. Referrals to other services have increasingly become a focus for outreach—these can include referrals to drug treatment, sexually transmitted infection diagnosis and treatment, HIV/AIDS treatment, care and support, and other health, social and legal services (Needle et al., 2002).

# Teaching Notes

**Most outreach programmes:**

- **find and contact** IDUs
- provide **information and education** about HIV/AIDS, HIV testing, drug use and services
- are commonly linked to **NSP, drug treatment** and other programmes

B20

Slide B20: Most outreach work at least involves:

- finding and contacting IDUs: going into the communities where IDUs live, work and buy, sell and use drugs; and
- 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.

## 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. (Such a break usually lasts from 15-30 minutes.)

# Teaching Notes

**Outreach case studies**

- What were the **important steps** in starting outreach?
- What **questions need to be answered** before an outreach programme can begin?

B 21

## ***Session B.4. Getting started: Case study teaching notes***

Slide B21: At this point, a guest lecture by an outreach manager can be very effective, especially if the outreach manager comes from the same country as, or a similar country to, the participants. The guest lecture should be short (about 15 minutes), just describing his/her daily work and allowing about ten 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.

Ask participants to read the case study that you have distributed to them. After ten minutes (to allow them time 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 starting outreach in the locality in the case study?
- What questions need to be answered before an outreach programme can begin?

These small group discussions should continue for about ten 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.

Steps may include a variety of activities but the essential steps and questions are:

- Deciding aims and objectives: a clear view of what the outreach project will try to do
- Deciding target groups and areas: with whom and where the outreach project will work
- Determining whether there a gender component in injecting drug use that area
- Beginning data collection, assessing needs: how the programme developers will calculate how many staff they will need and what types of work outreach workers will do
- Mobilizing resources: Where the project will identify people to staff the project and find funds for it
- Defining the project's relationships with other agencies: how the outreach project will work with police/public security/ interior personnel, health, education, social services, both government and nongovernment

# Teaching Notes

**Clear aims and objectives help in:**

- **Creating** a common ground
- **Devising** strategies for monitoring and evaluation
- **Explaining** and
- **Representing** the project to others

B22 Source: Trautmann F and Barendregt C. European Peer Support Manual. Trimbos Institute/European Commission, 1994. Power R. 1996 Guidelines on community-based peer intervention aimed at drug prevention and harm minimisation Utrecht, London, North Thames Peer Intervention Forum, 1996.

## ***Session B.5. Aims and objectives: Teaching notes***

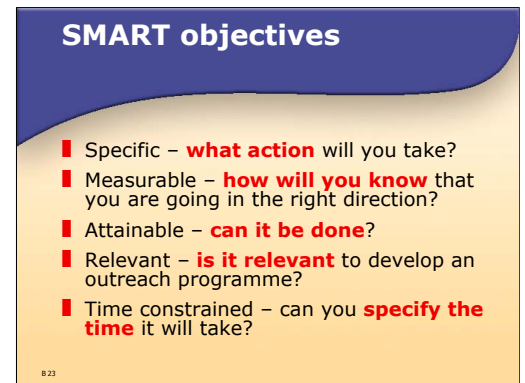
Slide B22: Clear aims and objectives are helpful in:

- Setting common ground for managers, staff and volunteers: if all know the aims and objectives and agree to them, all will work towards common goals
- Explaining the project to people outside the programme: while outsiders may feel uneasy about the activities of the programme, they will be more understanding if they know the aims and objectives
- Devising the subsequent strategies for intervention: clearly defining where you want to go makes it much easier to decide how you will get there
- For evaluation: if you have clear, measurable objectives, evaluation will tell you whether you achieved your objectives.

The aim of most outreach programmes for HIV prevention among IDUs is usually something like:

“To prevent the spread of HIV among and from IDUs in (locality)”

# Teaching Notes

A slide titled "SMART objectives" with a blue header and a yellow background. It lists five criteria for SMART objectives, each with a red square bullet point. The criteria are: Specific (what action), Measurable (how will you know), Attainable (can it be done), Relevant (is it relevant), and Time constrained (specify the time).

**SMART objectives**

- Specific – **what action** will you take?
- Measurable – **how will you know** that you are going in the right direction?
- Attainable – **can it be done**?
- Relevant – **is it relevant** to develop an outreach programme?
- Time constrained – can you **specify the time** it will take?

B 23

Slide B23: Once the aim of the project has been determined, objectives can be developed. The key elements of objectives are that they must be **SMART**:

- **Specific:** The objective should state clearly what the programme is trying to achieve such as “provide education to groups of IDUs” or “contact IDUs and provide needles and syringes,” etc.
- **Measurable:** The objective should be able to be measured fairly easily without massive resources devoted to research and evaluation: a measurable objective might be “to conduct peer education training with 100 IDUs”
- **Achievable** within the available resources: if funds and outreach workers are only sufficient to reach 100 IDUs, then an objective of reaching 1 000 IDUs would not be achievable
- **Relevant:** The objective must contain an activity which is effective in HIV prevention among IDUs and relevant to IDUs: an objective to teach IDUs to bake cakes would not be relevant
- **Time-constrained:** The objective must contain a limit to the time it will take to be achieved, otherwise it is difficult to measure: for example to “reach 100 IDUs in three months” or to “conduct peer-education training for 100 IDUs within one year” are time-constrained.

Examples of SMART objectives are:

- to establish a community advisory committee for an outreach programme within one month;
- to establish an outreach workforce of six trained outreach workers within three months
- to contact 100 IDUs and provide them with information about HIV risk reduction within six months;
- to bring 50% of the female IDUs under the NEP programme;
- to achieve a 25% increase in consistent condom use among female IDUs; and
- to distribute 50 000 needles and syringes to IDUs within 12 months.

The aim and objectives are needed prior to starting an outreach programme but they should be re-examined and discussed with outreach staff after they are recruited.

At this point, split the participants into small groups. Unlike the earlier groups, these should be based on some similarity in the places where participants work. For example, if three to four participants live and work in the same sector of a large city or all come from a small city or district, they should work together. If ten participants come from the same area, split them into two groups of five each. Give each group a sheet of flip chart paper.

Inform participants that they will work in these groups from time to time throughout the day to practice outreach programme planning. They can either plan a hypothetical or a real outreach programme. The most effective method is for participants to plan a real outreach programme but this may not be possible in every case.

# Teaching Notes

**Aims and objectives**

**Draft aim:**  
To **prevent the spread** of HIV among and from IDUs in (locality)

**Questions to be answered:**

- ▶ **Is outreach the most appropriate strategy?**
- ▶ **What are the three main objectives of the programme?**

B24

Slide B24: Ask the participants first to discuss the aim that was mentioned earlier. Do they agree with this aim?

Then ask participants to write the aim of their programme at the top of a sheet of flip chart paper.

Following this task ask participants to answer the following questions:

- Is outreach the most appropriate strategy?
- What are three objectives of the programme?

Give participants ten minutes to write the objectives. Ask participants to rejoin the plenary group. Each group should present its work (in about three minutes each). The aims should not be discussed unless they vary from the draft aim above. Variation is allowed but be careful of double or conflicting aims. The most common conflicting aims are:

- to prevent drug abuse and HIV infection among drug users in our city OR
- to bring drug users into treatment and prevent HIV transmission among IDUs.

These conflicting aims can cause major problems for a programme. Attempts to prevent drug abuse may mean never talking about ways of using drugs, yet effective HIV prevention means that detailed discussions with IDUs about drug injection are needed. To push drug users into drug treatment may mean a coercive approach by outreach staff that will prevent IDUs from trusting and listening to outreach staff.

Objectives should not be discussed at this stage (they are discussed in the next presentation).

# Teaching Notes



## **Session B6. Target groups and areas: Teaching notes**

Slide B25: Once the primary aim of the outreach programme has been determined the main target for the work should be identified. This may be:

- a generic group, such as young people or working women;
- a specific group with particular attributes, such as IDUs who are not in touch with established services, female IDUs, IDUs who are also sex workers, etc;
- a generic area such as all schools or youth clubs in a locality; and
- a specific area such as a venue where drug users meet to buy, sell and consume drugs.

Outreach programmes can and have focused on a wide range of target groups and areas. In practice, a programme may focus on more than one group and in more than one specific location.

But most outreach programmes start by defining a very specific target group and area of operation. This assists the programme in beginning on a small task, which can be later expanded. Programmes that start with the objective of reaching all IDUs in a city of 10 million people often fail because their target group and area of operation are too large. It is better to specify as closely as possible the initial target group and area.

In determining the target for the project we may already be aware of a particular group or locality that might benefit from the outreach programme. On the other hand, it may be beneficial to conduct a brief needs assessment to determine the shape and structure of the target group or arena. In general, it is advisable to conduct some form of preliminary research in order to ensure that the outreach programme meets the needs and profile of the target. It is also useful to visit other outreach programmes to discuss what they found to be successful or unsuccessful.

At this point, split the participants into the same small groups as in the previous session. Ask the participants to re-examine their objectives. Ask them to think about the target group and area of operation for their outreach programme and to refine their objectives if needed, remembering all the elements of SMART objectives: specific, measurable, achievable, relevant and time-constrained.

Then ask participants to write the aim of their programme at the top of a new sheet of flip chart paper and to rewrite their objectives, ensuring that they are SMART. Give participants ten minutes to write the objectives. Ask participants to rejoin the plenary group. Each group should present its work (in about three minutes each).

# 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 **verify** that these statements are true?

B26 Source: Burrows D, et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Medische Sans Frontiers - Holland, Moscow, Russian Federation, 1999.

## ***Session B.7. Generating knowledge about hidden populations: Teaching notes***

Slide B26: 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; and
- 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. These methods of verification are covered briefly in the next section.

# Teaching Notes

**Principles of RAR**

- **Speed** with which the entire process is completed
- **Cost-effectiveness** of the entire process
- Collection of **existing data and new information**
- Utilization of **multiple data sources**
- **Investigation and induction** through
  - ▶ Wide consultation
  - ▶ Examining relevance to programmes
  - ▶ Deciding on adequacy of information

B27 Source: Burrows D. et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Medicine Sans Frontiers - Holland, Moscow, Russian Federation, 1999.

## **Session B8. Collecting data and assessing needs: Teaching notes**

Before beginning an outreach programme, participants need information about injecting drug use and HIV/AIDS in their localities. This information is normally generated through an assessment.

WHO recommends the use of a recently developed set of tools called RAR-IDU: Rapid Assessment and Response for injecting drug use. A manual for RAR-IDU is available on web sites in Annex 3 in a range of languages. Make sure you visit the sites and know what languages are currently available.

Start by simply writing "Rapid Assessment and Response" on a flip chart or whiteboard. Then ask participants what they think this means. After hearing their ideas, emphasize the three key words:

- "rapid" means it must be done quickly to address rapidly changing epidemics of HIV among IDUs;
- "assessment" means that the research processes are to be used for designing interventions; RAR is not pure science, but applied science; and
- "response" means that the assessment is linked immediately with the response, intervention, outreach programme, etc.

Slide B27: The principles of Rapid Assessment and Response are:

- **Speed:** The spreading of injecting drug use and related HIV problems may occur more rapidly than the time required to undertake conventional research. RAR differs from traditional research in that it normally takes only a few weeks or months to be completed.
- **Cost-effectiveness:** RAR is designed to be inexpensive and is usually carried out by people who are already working in the field (often not as researchers but as practitioners).
- **Exploitation of existing data:** New data gathering exercises (such as surveys) are undertaken only where the existing sources of information are inadequate.

# Teaching Notes

**Basic assessment methods**

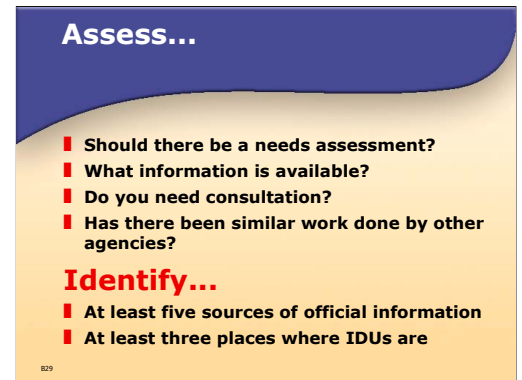
- Collect **existing** data
- Go to **places** where drug users are
- Identify and collect information from **key persons**

B28 Source: Trautmann F and Barendregt C. European Peer Support Manual. Utrecht, Trimbos Institute/European Commission, 1994.

Slide B28: In some cases, the need for an outreach programme is understood and government officials believe that a programme is urgently needed. In these cases, an outreach programme can begin almost immediately, though WHO recommends that RAR methods are used within the first six months of establishing the programme to ensure that it takes into account the many factors influencing HIV among IDUs in the locality. To begin a programme, at the very least, to start an outreach programme, you will need to:

- Collect and read existing data such as written information:
  - statistical material about characteristics of the target group(s) (number, age, gender, ethnic background, seroprevalence, etc.)
  - studies about the living conditions of the target group(s),
  - reports of service organizations (number and `sorts' of clients, information on services available, etc.)
- Identify key persons (drug users, professionals, police, people living in the neighbourhood, etc.) and collect information from them, and of course
- Go on the street, explore the situation to determine:
  - where the target group meets
  - when
  - what drugs are used
  - how they are used
  - where they are used, etc.

# Teaching Notes



**Assess...**

- Should there be a needs assessment?
- What information is available?
- Do you need consultation?
- Has there been similar work done by other agencies?

**Identify...**

- At least five sources of official information
- At least three places where IDUs are

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Slide B29: At this point, split the participants into the same small groups as in the previous session. Ask the participants to re-examine their objectives. Ask them to think about the outreach programme they are designing. Ask them to answer the following questions:

- Should there be a needs assessment or other form of preliminary research to help identify the most appropriate target group and target area for the programme?
- What research or background information is available to help define the situation of drug use and HIV/AIDS in the locality?
- Are there any groups or agencies that should be engaged, consulted, involved or informed, concerning the intention to work with the target group or in the target area?
- Is similar work being conducted in the area and if so will the proposed programme duplicate this or (possibly collaboratively) improve the range of services available?

Then ask participants to plan an assessment (if one is needed), including at least five sources of written or official information and three places where they would be likely to meet drug users in their locality. Give participants 20 minutes to write these sources and places on their flip chart sheets. Ask participants to rejoin the plenary group. Each group should present its work (in about three minutes each).

# Teaching Notes

**Resources needed:**

- **Human resources:** recruitment, training, supervision
- **Funding:** workers, supervisors, managers, materials
- **Linkages:** relevant authorities, other services

B30 Needle R et al. Effectiveness of community-based peer outreach for IDUs: a preliminary report. Paper presented at 22th International Conference on the Reduction of Drug-Related Harm, Ljubljana 3-7 March 2002.

## ***Session B9. Identifying and mobilizing resources: Teaching notes***

Slide B30: Community-based outreach is well suited to resource-constrained settings because it is the least costly of the range of effective interventions for HIV prevention among IDUs. At its simplest, outreach can be done by virtually anyone with very few resources: anyone can go into the community to make contact with a network of drug users to see and understand their practices, to gain their trust and to seek their help in preventing HIV transmission. However, effective behaviour change among IDUs tends to occur when outreach programmes invest resources in training and developing human resources (outreach managers, outreach workers, peer educators and volunteers), and in educational and prevention materials to be distributed during outreach.

The most significant resource constraints on effective outreach work tend to be human. It is difficult to find people who are willing to undertake outreach work among IDUs. This reluctance may be caused by fear (of IDUs as outlaws, as “drug-crazed” and therefore physically dangerous; or of drug-using places as “lawless”, dangerous places), the stigmatization of IDUs as people unworthy of assistance (which can lead to stigmatization of people who work with IDUs), the low pay and status of most outreach workers, and/or the association with IDUs as fellow-workers. Training, supervision, compensation, gender, safety and security of outreach workers are critical issues.

Outreach programmes tend to be most effective when peer educators are involved. Peers may be IDUs or ex-users, preferably of same gender identity, or in other ways similar to the IDUs being targeted by outreach programmes. In many countries, this may mean that peer educators are illiterate or less formally educated than health care workers. As outreach workers (whether they are peer educators or not), they face a wide range of questions from IDUs so their knowledge has to cover topics related to HIV/AIDS, injecting and other forms of drug use, abscesses and other medical conditions, overdose, basic first aid, and the network of services available to IDUs at the local level. They also need to know how to find IDUs, make contact, build trust and communicate with them. Training is needed both for new outreach workers and, through regular updates, for all outreach workers. Content of this training needs to be determined by examining what types of outreach workers are being employed and ensuring training is suited to their needs. Funds, technical resources (such as trainers, training materials, training venue) are therefore needed for effective outreach programmes to start and be sustained. (See modules C-D in these Training guidelines.)

# Teaching Notes

## Important issues regarding resources...

- Where do you to **find staff**?
- **How many** workers/ manager(s) do you need?
- How much do **wages** cost?
- Is there **office space** free or is there rental cost?
- Are there **material** costs?
- **Total** costs?
- Is there an advance idea about the **bottom-line** budget from the funder?

At this point, split the participants into the same small groups as in the previous session. Ask the participants to think about resources needed for the outreach programme they are designing. Ask them to answer the following questions:

- Where will you find people who may be willing to work in the outreach programme as managers and outreach workers?
- How many outreach workers will be needed at the beginning: encourage participants to consider starting with a small programme?
- How many people will be needed to manage the programme and supervise outreach workers?
- What will be the gender distribution among managers, supervisors, outreach workers and peer educators?
- How much will wages cost for these people for one year (total)?
- Can an office (and store room) be provided by another service (at the beginning of the programme) to hold outreach training sessions, feedback and team meetings? If not, how much would such an office cost for one year?
- Will the outreach programme distribute anything (needles, syringes and educational materials, etc.)? What is an approximate cost for these materials for one year? (Remember that this cost is usually considerably higher than the staff costs: for this exercise, ensure that the materials figure is at least double the staff wages figure.
- Add the three figures to give a rough estimate of how much the program would cost for one year.

Give participants 20 minutes to write these figures on their flip chart sheets. Ask participants to rejoin the plenary group. Each group should present its work as a flip chart sheet, just showing the places to find outreach workers and the figures. The number of outreach workers should be no higher than ten and one person is normally all that is required for the management/ supervision role for ten outreach workers. Do not be too worried about the total sums of money required. Inform participants that this exercise will need to be done back in their locality after assessing exactly what is needed and how the programme can begin. But discourage very large sums as it will be unlikely that such sums can be found quickly.

# Teaching Notes



**Important organizations:**

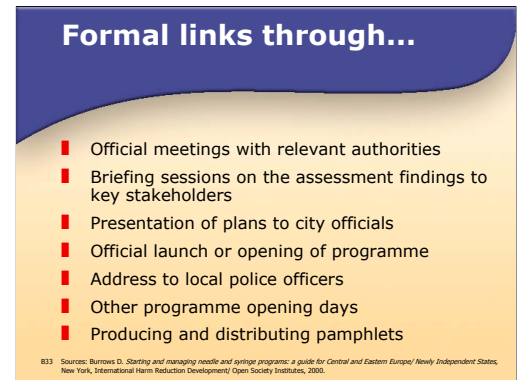
- Health Department and Police/Public Security/ Narcotics Control/ Internal Affairs Department
- Nongovernmental organizations (NGOs), Community-based organizations (CBOs), Women's organizations
- Drug treatment centres (government, private, NGO, etc.)
- AIDS/ other health centres and hospitals
- Local administration
- Religious institutions
- Youth organizations

B32 Sources: 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, 1999.

## ***Session B11. Relationships with other agencies: Teaching notes***

Slide B32: As participants found in the previous exercise, there are many important groups and individuals that can assist or obstruct outreach work. This list gives some ideas but the full list needs to be developed for each locality individually. There are many ways to work with other individuals and groups to start an assessment or outreach programme. An early step is to talk with other groups in the locality who may be interested in HIV/AIDS or drug use.

# Teaching Notes



**Formal links through...**

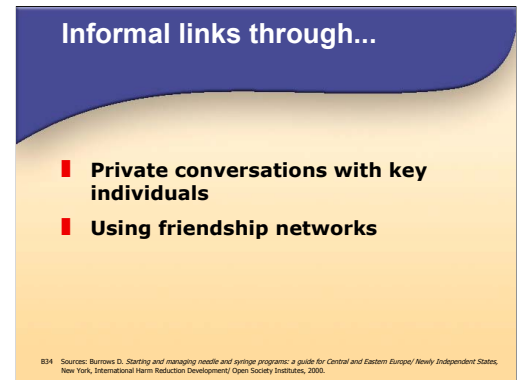
- Official meetings with relevant authorities
- Briefing sessions on the assessment findings to key stakeholders
- Presentation of plans to city officials
- Official launch or opening of programme
- Address to local police officers
- Other programme opening days
- Producing and distributing pamphlets

B33 Sources: 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 B33: Links can be built in formal ways with:

- official meetings with important people and representatives of powerful organizations;
- presentation of the assessment or programme plans to city officials, other services, and the media;
- a well-planned official launch or opening of the programme;
- an address to local police officers;
- a programme of open days for the media, supporters, or neighbours; and
- production and distribution of general community pamphlets, explaining why the programme is being established.

# Teaching Notes



Slide B34: or with more informal methods such as (OH B30):

- Private conversations with key individuals to ask whether they would support an assessment or programme
- Using friendship networks to reach important but hard-to-reach decision-makers.

The first links to be made are with other individuals and organizations that are already trying to prevent the spread of HIV or working with drug users. These links can be mutually beneficial in a number of ways. As well as gathering support for the assessment or programme, understanding can be increased about what other organizations do and how they work. In doing so, referral networks can begin to form.

# Teaching Notes

**Links with police/narcotics control:**

- Most **important group** in terms of initiation and continuation of programme
- Try to obtain a **directive official letter** of cooperation
- Develop a formal **mechanism for resolving disputes**
- Take special care in **balancing relationships:** police/narcotics control and IDUs
- **Avoid "Collusion"**, it can be disastrous for programme credibility

B35 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 B35: Of all the groups that must be dealt with when starting an assessment or programme, the police are usually the most important. It can be difficult for them to see that the purpose of the programme is the promotion of public health and not the promotion of drug use. The most effective way to develop police liaison is to identify a senior police official who is (or can be persuaded to be) sympathetic to the assessment or programme and is at a high enough level to ensure that the assessment and programme can operate without interference from the police.

An alternative is to try to find a sympathetic official who is senior to the police officials in the locality (either through national police structures or through the upper levels of the city or regional administration) who can direct them to cooperate with the assessment or programme. In either case, a letter from the police confirming that they will support the operation of the assessment or programme should be obtained if possible. If the police will not do this, a written commitment should be sought, saying that they will not interfere with the assessment or programme's operations.

Even after achieving this level of cooperation from the police, a mechanism is also needed to deal with problematic situations. These almost always occur as high-level agreements about police policy on such matters are often not communicated to (or are ignored by) officers on the street who then harass the assessment team or outreach workers and clients. The usual mechanism is to arrange regular meetings at a senior level between police and health (and possibly city) officials or a protocol for calling meetings at short notice if problems arise. If possible, these arrangements should be agreed in writing. These meetings can be 'sold' as a two-way process, with benefits for the police who can use it as a forum to raise any problems they have with the assessment or programme, as well as a way for you to raise problems with police behaviour.

Much care is needed in balancing a programme's relationship with the police and its relationship with drug users. Evidence or even the appearance of collusion or collaboration with the police, even if thought by the programme to be beneficial from a cooperation perspective, can cause enormous credibility problems with an outreach programme's clients. Communications of this type should always be carried out by an identified person (usually the programme manager), who will have to judge the optimum relationship with the police according to local conditions.

At this point, split the participants into the same small groups as in the previous session. Ask the participants to think about resources needed for the outreach programme they are designing.

# Teaching Notes

**WHO materials for outreach**

- **Evidence for Action summary paper and policy briefs:**  
Based on reviews of various approaches
- **Outreach training guide:**  
Four workshop modules
- **IDU-RAR:**  
Manual on Rapid Assessment and Response

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