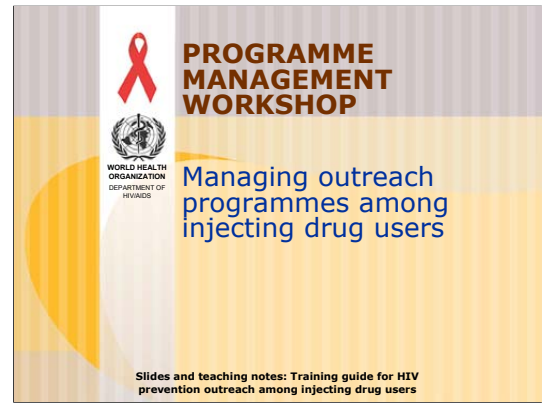


Teaching Notes



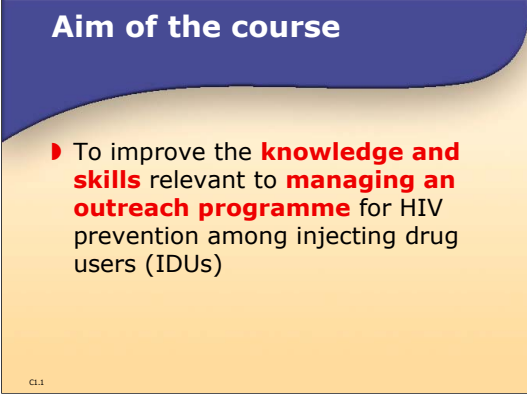
See Training guide book for:

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

See CD-ROM for:

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

Teaching Notes



Aim of the course

- ▶ To improve the **knowledge and skills** relevant to **managing an outreach programme** for HIV prevention among injecting drug users (IDUs)

C1.1

DAY 1

Session C.0. Introduction

Slide C1.1: Introduce yourself to participants and welcome them, to the training course. Because this is a multi-day course it is important that participants trust each other, so use an Ice-Breaker exercise to spend 15 minutes or so helping people to get to know one another.

Either during the Ice-Breaker or after the Ice-Breaker, learn each participant's name, profession or job title and the name of the institution where he or she works (including the city or province if the workshop has a large geographic focus). To remember names and to personalize questions and discussions, trainers often find it useful to write down participants name and certain of their characteristics. Participants should be interested in managing outreach programmes so ask what experience they have of working with IDUs and whether they have already started managing outreach programmes. Read the aim of the workshop and read out the outline of the whole course, stating when the breaks will take place on the first day.

Teaching Notes

HIV transmission among and from IDUs:

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

C1.2 Source: Ball A and Crofts N. HIV risk reduction in injecting drug users. In: Lamptey PR and Gayle H, eds. *HIV/AIDS Prevention and Care in Resource-Constrained Settings*. Arlington, Family Health International, 2002.

Session C.1.1. HIV epidemics and prevention among IDUs

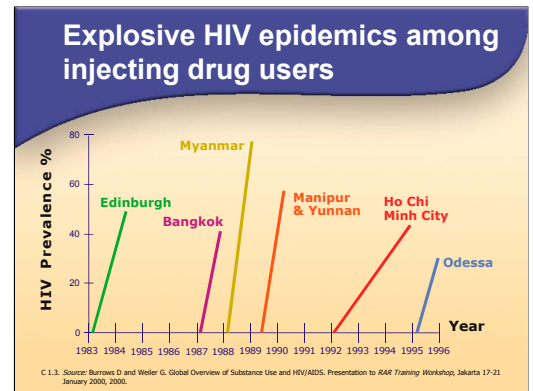
Slide C1.2: Inform participants that this training course covers a wide range of material, but it is important to put the whole topic of outreach into context quickly. Much of the material in this first session should be known to participants but it is useful to revise information on these topics.

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 (since small quantities of blood, often invisible to the eye, may remain in a syringe and be passed on to the next person who uses it).
- HIV may also be transmitted through some drug preparation processes and rituals associated with injecting drug use (where blood may become mixed with the drug, for example).
- Drug users and sex workers (especially those who also inject) can also acquire and transmit the virus through high-risk sexual behaviours (vaginal or anal sex without condoms).
- IDUs can play a critical role in the spread of HIV into the broader population through heterosexual or homosexual transmission to sexual partners and through mother-to-child transmission (MTCT). For example, in Manipur, 45% of the regular sexual partners of HIV-positive IDUs acquired the virus over a six-year period (Panda et al., 2000); and from 1996-2001 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.
- In addition, it has been observed that many female IDUs get involved in sex work to support their own and/or male partner's drug use practices while many sex workers get introduced to drug use by their male drug-user partners. The study among IDUs in Dhaka in 1997 found that 10% of the male IDUs had experience of male-to-male sex. Since 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 a greater risk of getting the virus than male IDUs.

The link between sexual transmission of HIV and other sexually transmitted infections (STIs) should also be stressed 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 C1.3: HIV can spread very quickly among IDUs. Explosive HIV epidemics among IDUs have occurred in a wide range of areas in the past 20 years, including:

- New York City (United States of America) in 1979, followed by such cities as Edinburgh (the United Kingdom), Bangkok (Thailand), Ho Chi Minh City (Viet Nam), Santos (Brazil), Odessa (Ukraine), Svetlogorsk (Belarus), Moscow and Irkutsk (the Russian Federation) and, in 2001, Narva (Estonia). Explosive spread has also occurred across entire provinces such as Manipur in India and Yunnan in China, and across countries such as Myanmar.
- In some areas, HIV prevalence among IDUs has escalated from less than 5% to over 40% in a period of less than 12 months. In Manipur, prevalence increased from under 10% to more than 60% in six months. In Eastern Europe, where the epidemic only emerged in about 1996, 80%–90% of new HIV infections are among IDUs. In 2001, the Eastern European HIV epidemic was the fastest-growing in the world.
- Worldwide, there may be as many as 185 million drug users, equivalent to 4.3% of the population age 15 years and above. The proportion of female drug users ranges from about 10% (e.g. in some traditional Asian societies) to 44% (in the United States of America) of all drug users. It is also estimated that globally there are around 6–10 million IDUs (as of 1999). Even though traditionally women are not as involved in injecting drug use as men, many countries have observed an increasing share of women in the injecting drug use population and, several countries, e.g. in the Eastern European region, reported an increase in female injecting drug use levels, over the last couple of years. In Eastern Europe, where the epidemic only emerged around 1996, 80%–90% of the new HIV infections occurred through unsafe drug injecting practices and the male-to-female ratios of reported cases of HIV have been declining, suggesting that HIV is spreading increasingly among females either via sexual intercourse mainly from the male IDUs to their female partners or females increasingly are injecting drugs and contracting HIV through contaminated equipment, which is more likely.

Teaching Notes

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

C 1.4 Sources: Greff P. Official: AIDS in Russia being ignored. Reuters, 11 February 2002. Burrows D, Holmes D and Schwelbe N. HIV/AIDS in the former Soviet Union. AIDSLink #72 February/March 2002. Des Jarlais DC. Potential impact of HIV among IDUs on heterosexual transmission in India. Paper presented at 23rd 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 C1.4: 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 some 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

Principles of effective HIV prevention among IDUs

- ▶ **Short-term pragmatic goals**
- ▶ **Use of hierarchy of risks**
- ▶ **Use of multiple strategies**
- ▶ **Involvement of drug users**

C.1.5 Source: Burrows D, et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow, Medecins Sans Frontieres - Holland, 1999.

Slide C1.5: Point out to participants that a public health approach has been shown in many countries to lead to effective HIV prevention among IDUs. An effective prevention programme also requires:

- 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**

C 1.6 Source: Burrows D et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow: Medecins Sans Frontieres - Holland, 1999.

Slide C1.6: A typical risk reduction hierarchy for 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 drugs 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**

C1.7 Source: WHO Evidence for Action paper and policy briefs, REF.

Slide C1.7: 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) for these to see if more-up-to-date versions are available. Give participants an overview of the papers available on the web site as well as the web address, and state that this slide and the following slides summarize some of the key findings from these papers.

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

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 substitution treatment, especially 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 also been observed to reduce marginalization of IDUs, thus promoting 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**

C 1.8 Source: Needle R, et al. Effectiveness of community-based peer outreach for IDUs: a preliminary report. Paper presented at 13th International Conference on the Reduction of Drug-Related Harm, Ljubljana 3-7 March 2002.

Slide C1.8: The Evidence for Action paper on outreach refers specifically to community-based and peer outreach.

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

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

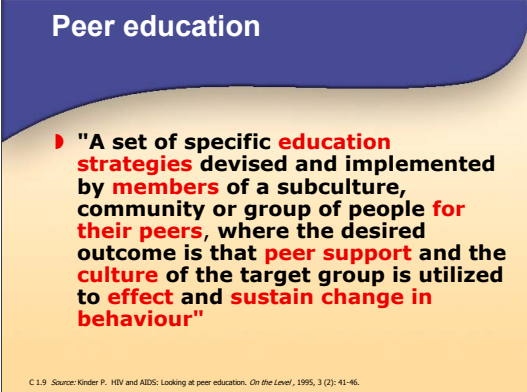
It is the least costly intervention and is often the easiest one to begin (compared to large targeted education, NSP or substitution drug treatment programmes).

Several studies have shown that outreach can be effective by itself and that it 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**"

C.1.9 Source: Kinder P. HIV and AIDS: Looking at peer education. On the Level, 1995, 3 (2): 41-46.

Slide C1.9: 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);
- 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**

C 1.10 Source: Needle RL, et al. Effectiveness of community based peer outreach for IDUs: a preliminary report. Paper presented at 13th International Conference on the Reduction of Drug-Related Harm, Ljubljana 3-7 March 2002.

Slide C 1.10: It must be emphasized 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, developed with the involvement of IDUs themselves.

Teaching Notes

Planning outreach programmes:

- ▶ Aims and objectives
- ▶ Target group and area
- ▶ Assessment of the injecting drug use
- ▶ Human and financial resources
- ▶ Addressing important organizations

C1.11

Session C.1.2. Planning outreach programmes I

Slide C1.11: Inform participants that there are some aspects of managing an outreach programme that need to be planned prior to starting one. These aspects are covered in module B of these Training guidelines. The key activities that should have been completed prior to this training course are:

- setting of aims and objectives for the outreach programme;
- selecting of target groups and target areas for initial outreach work by the programme;
- completion of a Rapid Situation Assessment of the HIV/AIDS and injecting drug use situation in the locality where the outreach programme will operate (using WHO Rapid Assessment and Response methods) or some other assessment of the situation in the locality;
- identification and planning of the type of outreach programme and organizational structure;
- identification of human and financial resources for the outreach programme, and funding secured for starting the programme; and
- contact of important organizations, identification of allies who have subsequently been informed of the outreach programme and identification of potential obstacles.
- Ensure that all participants are aware of these steps. Inform participants that, after the break, they will be asked to develop and present basic outreach plans to the plenary group.

Break

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

Session C.1.3. Planning outreach programmes II

See Exercises on CD-ROM

Teaching Notes

HIV and AIDS...

- ▶ **HIV: Human Immunodeficiency Virus, attacks and gradually destroys the immune system of the body and eventually results in AIDS.**
- ▶ **AIDS: Acquired Immune Deficiency Syndrome is a complex of severe signs and symptoms due to lack of immune response of the body.**

“HIV does not equal AIDS”

C1.12 Source: The HIV/AIDS Resource Manual. A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organisations), 1998.

Next write “AIDS” on the flip chart and ask what this means.

The answer should be similar to:

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

Next write “HIV = AIDS?” and ask if HIV means the same as AIDS. If not, what is the difference?

The answer should be similar to:

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

Show slide C1.12

Next ask: “What are the stages of HIV infection?”

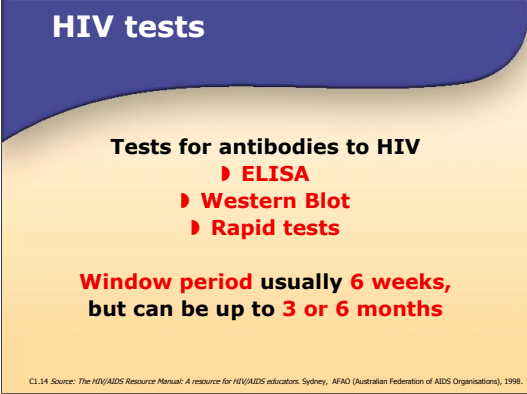
Teaching Notes

Stages of HIV infection

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

Cl.13 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFMO (Australian Federation of AIDS Organisations), 1998.

Teaching Notes



HIV tests

Tests for antibodies to HIV

- ▶ **ELISA**
- ▶ **Western Blot**
- ▶ **Rapid tests**

Window period usually 6 weeks, but can be up to 3 or 6 months

C1.14 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFHO (Australian Federation of AIDS Organisations), 1998.

Show slide C1.14

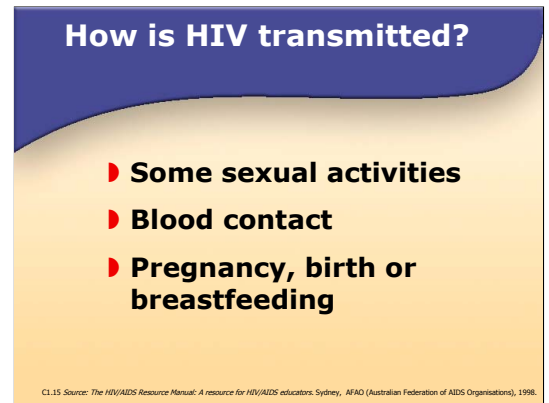
Next ask: How is HIV transmitted?

The answer should be similar to:

HIV has been shown to be transmitted through:

- some sexual activities;
- blood contact between individuals such as the sharing of injecting equipment; and
- pregnancy, birth or breastfeeding;

Teaching Notes



Show slide C1.15

Next ask: How is HIV transmitted sexually?

The answer should be similar to:

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

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

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

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

Teaching Notes

Sexual transmission

- ▶ through **unprotected (no condom) penetrative vaginal and anal sex**
- ▶ through **oral sex** also possible

C1.16 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organisations), 1998.

Show slide C1.16

Teaching Notes

Factors related to sexual transmission

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

C1.17 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFHO (Australian Federation of AIDS Organisations), 1998.

Show slide C1.17

Next ask: How is HIV transmitted via blood contact?

The answer should be similar to:

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

Teaching Notes

Factors related to blood contact

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

C1.18 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFHO (Australian Federation of AIDS Organisations), 1998.

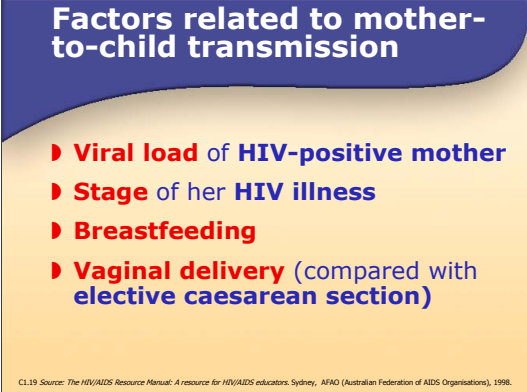
Show slide C1.18

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

The answer should be similar to:

- Studies have found that, without appropriate HIV treatment (with medications such as AZT or nevirapine), between 8% and 45% of babies born to HIV-positive women acquire the infection. Factors that affect the likelihood of mother-to-infant transmission include:
 - the concentration of virus present in the bloodstream of the mother (her viral load);
 - the stage of her HIV illness;
 - breastfeeding, which has been shown to be a strong risk factor, both in studies of women who became HIV positive after giving birth and in studies of women HIV positive at the time of delivery; and
 - vaginal delivery, which, when compared with uncomplicated Caesarian section, slightly increases the risk of infection.

Teaching Notes



Factors related to mother-to-child transmission

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

C1.19 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFHO (Australian Federation of AIDS Organisations), 1998.

Show slide C1.19

Next ask: Can HIV be transmitted through the air?

The answer should be:

NO. HIV is a relatively fragile virus, quickly destroyed outside the body and outside needles and syringes or other containers. The exact time will depend on factors such as temperature or moisture, but has been estimated at 20 minutes or much less (though the time can be much longer when HIV is inside a container such as a syringe). HIV is also destroyed if it comes into contact with some chemicals (such as bleach) and other agents.

Next ask: Can HIV be transmitted by mosquitoes?

The answer should be:

NO. HIV is not transmitted by mosquitoes, bed bugs, or other insects. Evidence for a lack of transmission via these insects comes from two areas. Unlike, for instance, malaria, HIV does not replicate inside these insects. If an insect is carrying live HIV, it is because it has recently bitten a person with HIV. Although the insect may carry HIV, it is unable to transmit it. This is because of the extremely minute amounts of blood that could exist on the mouthparts of these insects. In addition, insects do not inject blood—either their own or anyone else's — into individuals; they inject saliva, which works as a lubricant and anti-coagulant. This saliva does not contain HIV.

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

The answer should be:

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

Teaching Notes

Can HIV be transmitted by...

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

C1.20 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFHO (Australian Federation of AIDS Organisations), 1998.

Show slide C1.20

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

The answer should be:

- condoms for penetrative vaginal or anal sex;
- no transfer of blood between IDUs via needles, syringes or other shared injecting equipment;
- HIV treatment (such as AZT or nevirapine) for HIV-positive mothers and no breastfeeding of their babies.

Teaching Notes



Show slide C1.21

Session C.1.6. Anonymous questions

Provide one 15 x 20cm card to each participant. Ask them to think about everything they have ever heard or read about HIV/AIDS, not only today but in previous months and years. Ask them to think about any question they have ever wanted to ask on this topic. Inform them that this session is called "Anonymous questions" and will attempt to answer any questions participants have: the questions are written anonymously in private and will be answered for all to hear. Ask participants to shield their card in some way (some may want to move to another part of the room for increased privacy), to write very clearly any question they have, make sure they do NOT put their name on the card and bring the card face down to the trainer. Inform them they have about seven minutes to think of questions and they can ask as many questions as they like.

Once the cards have been collected, the trainer (or guest lecturer) turns away from the group and shuffles the card back and forth (to ensure participants cannot read the cards while they are being shuffled). Cards should then be placed face down and the trainer or guest lecturer should pick up each card, read the question and provide an answer. Trainers or lecturers should try to keep answers brief and trainers should consider whether some questions will be answered in later sessions of the training course. Some questions will be sensitive or embarrassing and will lead to laughter but each question should be answered honestly and carefully.

Break

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

Teaching Notes

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

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

C1.22

Session C.1.7. Drugs and drug use

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

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

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

After some discussion, show slides C1.22 and C1.23:

Slide C1.22: In medicine, the term "drugs" refers to any substance with the potential to prevent or cure a disease or the potential to enhance physical or mental well-being. In pharmacology, the term refers to any chemical agent that alters the biochemical or physiological processes of body tissues or organisms. In common usage, the term often refers to illicit drugs, which are often used for non-medical (e.g. recreational) reasons.

Teaching Notes

The term 'substance' refers to...

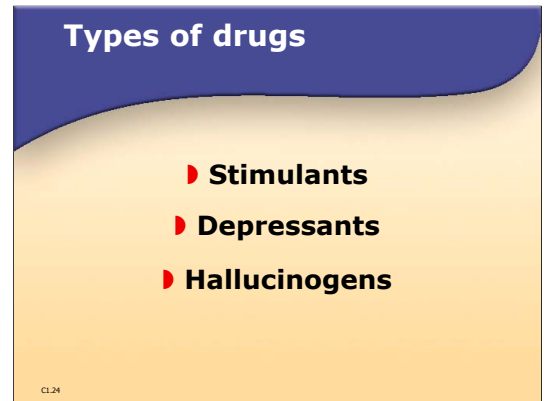
- ▶ Any product that affects the way people feel, think, see, taste, smell, hear or behave.

C1.23

Show slide C1.23: A substance is any product that affects the way people feel, think, see, taste, smell, hear or behave (psychoactive substance). A substance can be a medicine, such as morphine, or it can be an industrial product, such as glue.

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

Teaching Notes



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

The answer should be similar to:

NO. Drugs are not all the same. They can be very different in the way they are prepared, in the effects they have on the drug user.

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

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

Show slide C1.24:

Teaching Notes

A 'dependent' person...

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

C1.25 Source: Definition of drug dependence, Geneva, World Health Organization, 1964.

Next ask: what is drug dependence or addiction?

There may be no responses or there may be some talk of heroin users being addicted. Inform participants that addiction is difficult to define so that WHO prefers the term "drug dependence" for which there is a clear definition (in DSM-4). Show slide C1.25:

Criteria for the diagnosis of dependency are:

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

Teaching Notes

Nicotine...a legal drug

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

C1.26 Source: Burrows D, Benker A and Dillon P. Indonesian Training Course on Drug Information, Sydney, Australia Business, 2000.

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

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

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

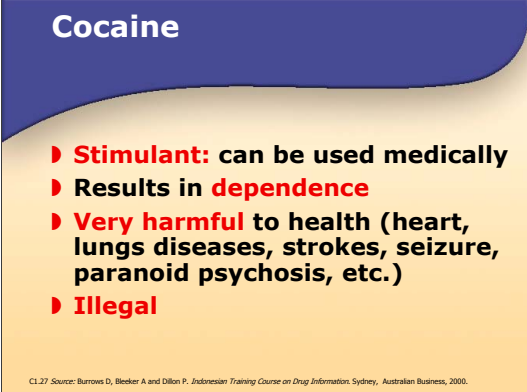
Next ask why some drugs legal while other drugs are illegal. Answers will centre on the idea that legal drugs are less harmful than illegal drugs. Question whether this is so. Some participants will usually be willing to debate this topic. *Note:* This topic can become very complex very quickly, so it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

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

Show slide C1.26: NICOTINE (tobacco) Cigarettes and cigars are manufactured from tobacco plants.

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

Teaching Notes

A slide titled "Cocaine" with a blue header and a yellow body. The text is in red and black. It lists four key points: Stimulant (can be used medically), Results in dependence, Very harmful to health (heart, lungs diseases, strokes, seizure, paranoid psychosis, etc.), and Illegal. A small source note is at the bottom.

Cocaine

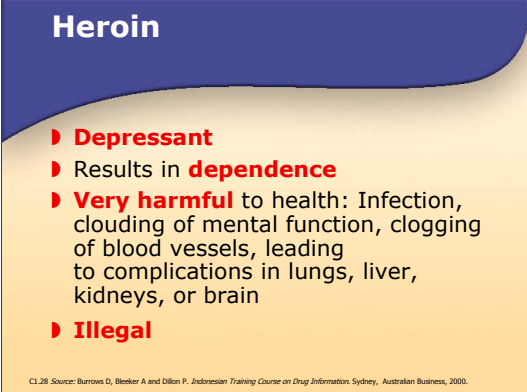
- ▶ **Stimulant:** can be used medically
- ▶ **Results in dependence**
- ▶ **Very harmful to health** (heart, lungs diseases, strokes, seizure, paranoid psychosis, etc.)
- ▶ **Illegal**

C1.27 Source: Burrows D, Beaker A and Dillon P. Indonesian Training Course on Drug Information. Sydney, Australia Business, 2000.

Slide C1.27: COCAINE

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

Teaching Notes

A slide titled 'Heroin' with a blue header and a yellow background. It lists three key points: Depressant, Results in dependence, and Very harmful to health. It also notes it is illegal. A small source note is at the bottom.

Heroin

- ▶ **Depressant**
- ▶ Results in **dependence**
- ▶ **Very harmful** to health: Infection, clouding of mental function, clogging of blood vessels, leading to complications in lungs, liver, kidneys, or brain
- ▶ **Illegal**

C1.28 Source: Burrows D, Benker A and Dillon P. *Indonesian Training Course on Drug Information*. Sydney, Australia Business, 2000.

Slide C1.28:

HEROIN

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

Teaching Notes



Next ask: in what ways are drugs used?

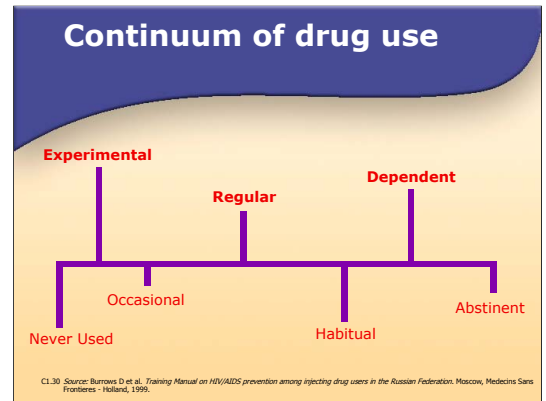
The answer should include at least:

- smoking
- snorting
- swallowing
- injecting

Show slide C1.29:

Next ask: when a drug is used for the first time, do people become addicted immediately? This will normally lead to some debate. Some participants will deny that it leads to addiction. Others will say it does. Most will say it depends on the drug.

Teaching Notes



Show slide C1.30

Use the continuum of drug use to show that there are many places that people can exist on the continuum. For example:

Never used:

- At this point, a person has never used a particular drug.

Experimental:

- A young person who tries his or her first cigarette.
- A person tasting a new cocktail drink.

Habitual:

- An office worker who drinks ten cups of coffee daily.
- A person who smokes 20-30 cigarettes per day.

Dependent:

- An alcohol-dependent person who drinks a bottle of scotch to stave off withdrawal symptoms daily.
- An opiate-dependent person who uses heroin and other substances on a daily basis.

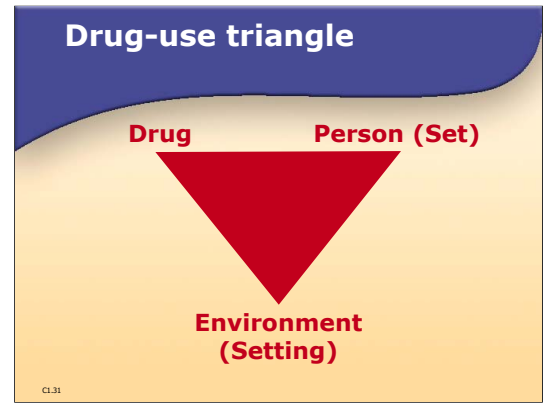
Recreational/ occasional:

- A family who drinks wine with their evening meal.
- A person who smokes a few cigarettes at parties but not at other times

Abstinent/ stopped using:

- At this point, the person has stopped using a drug. This period of abstinence may be long or short, temporary or permanent.

Teaching Notes



Show slide C1.31: Allow the debate to continue for a few minutes, then ask whether anyone has heard of the drug-use triangle. In this model (known as Zinberg's model: Zinberg, 1984), drug problems are seen as depending on three factors:

- The drug: some drugs do appear to have a greater potential for dependence than other drugs (but not everyone becomes dependent even on the most "addictive" drugs such as nicotine and heroin).
- The Set (or person): the specific psychology, physiology and accumulated experiences of the drug user (because some people react violently or become dependent on drugs that cause few problems for others); and
- The Setting (the environment) within which drugs are used: for example, the same level of drug use in one context may not cause the same level of problems as in a different context. In addition, drugs may have very different meanings in different settings: for example, wine is used in some Christian religious ceremonies in a symbolic way, but is also drunk at pubs by people who wish to feel intoxicated.

Teaching Notes

Condoms

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

C1.32 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFHO (Australian Federation of AIDS Organisations), 1998.


Session C.1.8. Condom demonstration

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

Slide C1.32: Inform participants about condoms.

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

Teaching Notes



Effective condoms

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

C1.33 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organisations), 1998.

Slide C1.33: Condoms should be manufactured to a specific standard, which ensures that they do not break easily. They should be packaged with a “use by” date (the date before which they should be used, otherwise the condom may become ineffective). Condoms that are not of sufficient quality should not be used for HIV prevention and should not be provided by outreach programmes. If possible, they should also be packaged with brief instructions about their use and with HIV-prevention messages. Condoms may be damaged if exposed to heat, light or air pollution. They are best stored in a cool, dry place.

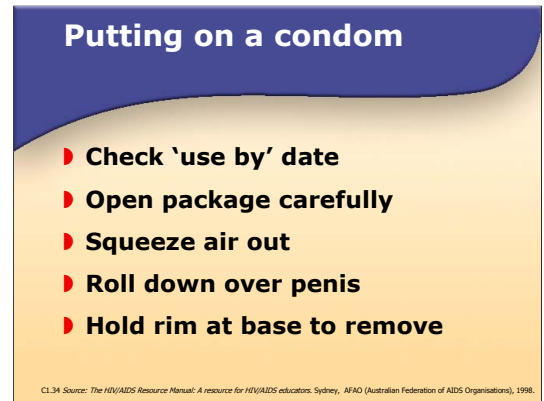
In most countries, condoms are distributed for a variety of purposes by government, NGO or United Nations organizations (such as the United Nations Family Planning Agency). Outreach managers should seek meetings with these organizations to discuss types of condoms that should be distributed through the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

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

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

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

Teaching Notes



Slide C1.34: The trainer now demonstrates the correct method of putting on a male condom.

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

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

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

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

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

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

Leave the slide on the projector.

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

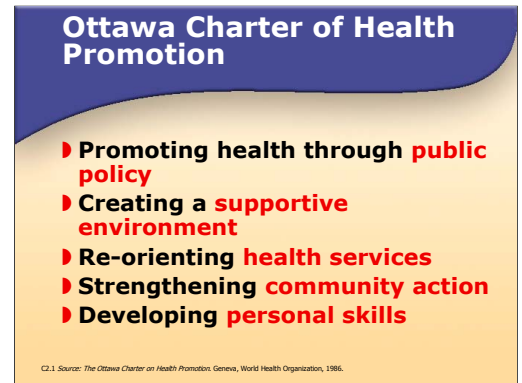
After these demonstrations, bring the participants back to the plenary group and ask how they felt during the demonstrations. If no one says it immediately, ask if anyone felt embarrassed. Inform them that it is common to feel embarrassment at first, but that they will need to become comfortable with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

Encourage participants to take condoms with them.

Session C1.X: Evaluation and close

See Exercises on CD-ROM

Teaching Notes



DAY 2

Session C2.0. Welcome and Session C2.1. Motivation - See module C exercises on CD-ROM

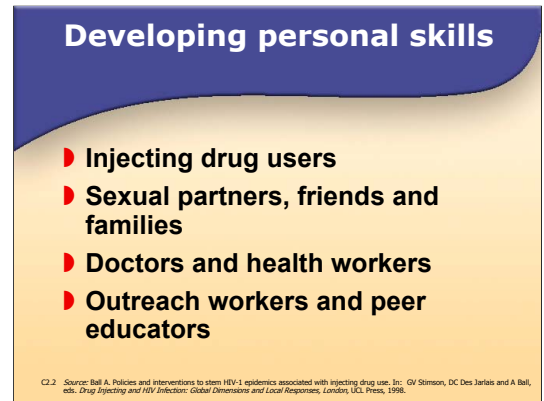
Session C2.2. Effective approaches to HIV among IDUs

Slide C2.1: 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 a supportive social environment where drug users are encouraged to consider themselves members of the society with equal rights and responsibilities with all other members of the community.
- *Reorienting health services*: Most health services have been established to care for people at the end of their illness, when surgery or major intervention is required: prevention of health problems before they occur and early diagnosis and intervention have been shown to lead to massive cost savings and to decrease health problems for millions of people. Health services need to be analysed and re-oriented to ensure that they reach as many drug users as possible with effective HIV prevention: this also means that a wide range of HIV prevention services is needed to reach the diverse group of people who inject drugs.
- *Strengthening community action*: where people work together as a community at the local level, whether inside or outside the health system, public health measures have a much greater chance of success. Outreach and peer education are key strategies for strengthening community action to reduce HIV risk among IDUs: drug users form their own communities and networks, which provide an excellent opportunity for influencing social norms and changing a whole network or community's behaviour. Nongovernmental organizations (NGOs), especially those based in local communities, often take the lead in these activities.
- *Developing personal skills*: While the Ottawa Charter places great emphasis on the social and community aspects of public health, individuals also play a major role in looking after their own health.

Teaching Notes



Developing personal skills

- ▶ **Injecting drug users**
- ▶ **Sexual partners, friends and families**
- ▶ **Doctors and health workers**
- ▶ **Outreach workers and peer educators**

C2.2 Source: Ball A. Policies and interventions to stem HIV-1 epidemics associated with injecting drug use. In: GV Stimson, DC Des Jarlais and A Ball, eds. Drug Injecting and HIV Infection: Global Dimensions and Local Responses, London, U.K. Press, 1998.

Slide C2.2: 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, which 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 developing 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. 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, social workers, etc.): 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 is a major obstacle to effective HIV prevention. This skills development should concentrate on assessment of HIV risk, skills in early intervention with drug use and HIV risk;
- *Outreach workers and peer educators*: These groups need both basic knowledge of injecting drug using practices, HIV transmission and prevention, and skills for working outside traditional office or clinic environments: for example, on streets, in apartments, in drug markets, etc. They also need to know what other services are available for IDUs to ensure appropriate referral. Outreach workers and peer educators can also serve as agents of change in helping to develop the skills of doctors, health care workers, families, partners and friends in promoting harm reduction for IDUs.

Teaching Notes

Elements of effective prevention

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

C2.3 Source: WHO Evidence for Action papers rd policy briefs, REF.

Slide C2.3: Revise these points from Session C1

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**

C.2.4 Source: Needle R, et al. Effectiveness of community-based peer outreach for IDUs: a preliminary report. Paper presented at 13th International Conference on the Reduction of Drug-Related Harm, Lisbon June 3-7 March 2002.

Teaching Notes

Effectiveness of education

- ▶ Effective **prevention**
- ▶ **Sensitization** role
- ▶ Range of **media** used
- ▶ Often combined with **outreach**
- ▶ Credible and familiar **language**

C2.5 Source: Jenkins P and Aggleton P. HIV information, education and communication (IEC) interventions for injecting drug users (IDUs). Paper presented at Global Research Network on HIV Prevention in Drug Using Populations 4th Annual Meeting Melbourne, Australia 11-12 October, 2001.

Slide C2.5: 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 has 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
- ▶ Often **combined with outreach**

C2.6 Source: Wodak A. Evidence for Action: Effectiveness of needle and syringe programmes for HIV prevention among IDUs. Paper presented at 13th International Conference on the Reduction of Drug-Related Harm, Ljubljana 3-7 March, 2002.

Slide C2.6: The Evidence for Action paper on the effectiveness of NSPs (Woday, 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;
- 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 nongovernment 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. 0

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**

C2.7 Source: Boyd A. Effectiveness of drug dependence treatment in prevention of HIV among IDUs. Paper presented at 13th International Conference on the Reduction of Drug-Related Harm, Ljubljana 2-7 March 2002.

Slide C2.7: 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. United States studies, for example, have found that participants in a methadone programme were half as likely to be infected with HIV as drug users on a methadone programme.

Teaching Notes

Role of outreach

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

C2.8 Source: Needle R, et al. Effectiveness of community-based peer outreach for IDUs: a preliminary report. Paper presented at 13th International Conference on the Reduction of Drug-Related Harm, Ljubljana 3-7 March 2002.

Slide C2.8: It must be emphasized 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.

Teaching Notes

Most outreach programmes:

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

C2.9

Slide C2.9: Outreach is most effective when it is linked with other services, especially needle and syringe provision, and when IDUs are provided with explicit information and education, developed with the involvement of IDUs themselves.

Most outreach work at least involves:

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

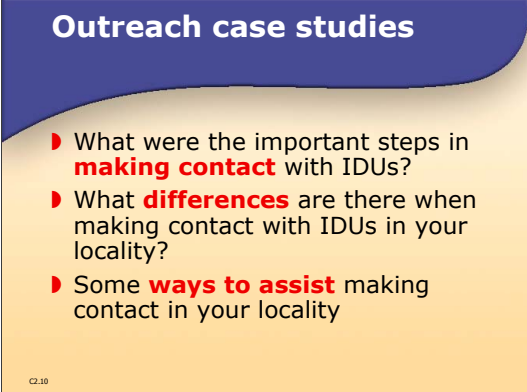
Session C2.3. Arguments for outreach programmes I

See module C Exercises on CD-ROM

Break

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

Teaching Notes



Outreach case studies

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

C2.10

Session C2.4. Making contact: Case study

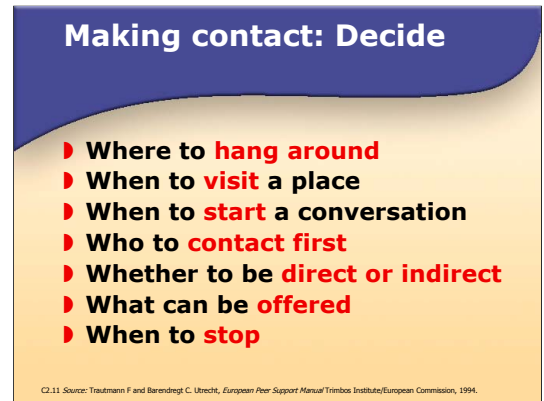
Slide C2.10: Ask participants to read the case study that you have distributed to them. After 10 minutes (to allow them to read it carefully), ask them to form small groups of four to five people. Ask the groups to discuss the following questions:

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

These small group discussions should continue for about 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.

Teaching Notes



Session C.2.5. Making contact with drug users

Start a discussion among participants about ways to contact drug users. First, ask what information is needed in order to identify how to make contact? After each discussion, show the related slide.

Slide C2.11: For getting into contact one has to decide:

- where to hang around: at which site, at a distance or near by people, etc;
- when to visit a place: sometimes several visits at different times are needed to discover the best times for regular visits;
- what is the right moment to make a move: do people have time to talk, are they in the mood for a talk, etc.
- who to contact first: there is often a leader in any group and it is usually good practice to contact the leader first;
- what is the right way to approach: direct or less direct (see below);
- what can be offered: can a card or pamphlet or condom or needle and syringe be offered?
- when to stop—for a while—when to give it a break and leave: this may be caused by IDUs starting to use drugs or buy or sell drugs, by tension among IDUs, etc.

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

Teaching Notes

Their space, their rules

- ▶ **Dress appropriately**
- ▶ **Speak appropriately**
- ▶ **Don't threaten**
- ▶ **Obey rules**

C2.12

Slide C2.12: The main task of outreach work is to go to where IDUs are, to enter “their space” where drug users feel comfortable. This means that the outreach worker needs to abide by the norms or rules that govern this space. The outreach worker should:

- **Dress appropriately:** in some cultures, this means dressing in a similar way to IDUs; in others, it may mean similar dress but slightly different to show that the outreach worker is in the “space” for some reason other than buying, selling or using drugs.
- **Speak appropriately:** outreach workers need to know the “language of the streets”, the words and phrases IDUs use, so that education occurs in a language with which IDUs feel familiar and comfortable.
- **Not be threatening:** IDUs are usually fearful of new people as they may be police (undercover), so outreach workers need to use gestures and non-verbal communication that reassure the drug users that the outreach worker is not a threat to them, or be accompanied by a member of the group of drug users.
- **Obey the rules:** for example, if outreach workers receive a message (verbally or non-verbally) to leave an area because of possible violence or other problems, they should do so directly. It may also mean, women talking to only women and vice versa.

Teaching Notes



Slide C2.13: Two ways of making contact include:

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

Two ways of introduction:

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

One approach is to say:

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

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

Teaching Notes

Gain trust by...

- ▶ Showing that **you are one of them**
- ▶ Always being **honest**
- ▶ Becoming **familiar**

C2.14 Source: Trautmann F and Berendse C. Utrecht, European Peer Support Manual Trimbos Institute/European Commission, 1994.

Slide C2.14: The main task after making contact is to gain the trust of the IDUs, establishing credibility, for example by:

- showing that you are one of them (for example, by referring to your own drug use experience, or sometimes being the same sex as they, especially among female IDUs);
- always being honest (about what you are, what you are able to do, etc.);
- becoming familiar: by returning to the same space several times, talking to the same people on many occasions, trust is built over time.

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

Teaching Notes



Methods and materials

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

C2.15 Source: Trautmann F and Berendse C. Utrecht, European Peer Support Manual Trimbos Institute/European Commission, 1994.

Slide C2.15: Methods and materials to assist outreach work:

- giving out condoms/syringes: this is an excellent way to build trust and should be coupled with educational messages we will discuss this afternoon;
- collecting information: you can build trust by asking IDUs to assist you in your work by providing information on drug using practices, etc;
- completing a questionnaire: while a questionnaire normally has a research purpose, it can also be used to ensure that IDUs spend some time speaking with the outreach worker;
- giving out leaflets, newsletters, magazines on topics relevant to IDUs: these are very useful when time is a major problem (they can be slipped into IDUs' hands or pockets quickly if police or other problems prevent longer talks) and can also be used as the basis for education ("Did you see the page on needle cleaning? What do you think about that?"); and
- organizing activities: these may range from simple social events to peer education training sessions or starting drug user organizations.

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

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

Teaching Notes

Safer behaviour

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

C2.16 Source: Trautmann F and Berendregt C. Utrecht, European Peer Support Manual/Timbos Institute/European Commission, 1994.

Slide C2.16: How to raise the issue of safer behaviour:

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

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

Teaching Notes

Outreach counselling

Advantages

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

C2.17 Source: Trautmann F and Berendse C. Utrecht, European Peer Support Manual Trimbos Institute/European Commission, 1994.

Slide C2.17: The advantages of outreach counselling include:

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

Teaching Notes

Outreach counselling

Disadvantages

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

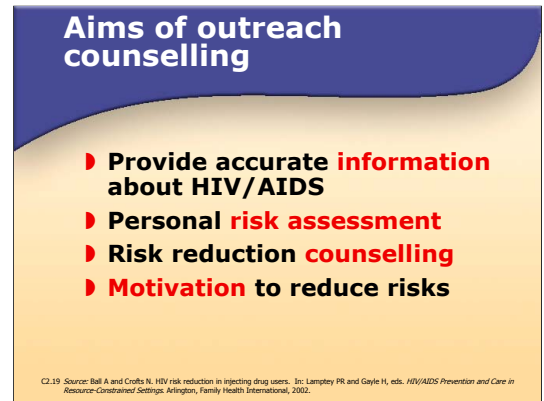
C2.18

Slide C2.18: The disadvantages of outreach counselling include:

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

Next, state that outreach counselling has several specific aims:

Teaching Notes



Slide C2.19: Aims of outreach counselling:

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

Next, state that there are some established rules for effective outreach counselling. Provide Handout C1. Ask participants to read the handout in preparation for the next exercise.

Session C2.6. Communicating with drug users II

See module C Exercises on CD-ROM

LUNCH

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

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

Teaching Notes

Risks of drug injecting

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

C2.20 Source: Outreach Training Course Manual, Sydney, KRC (Kirketon Road Centre), 2001.

Session C2.7. Risks related to injecting

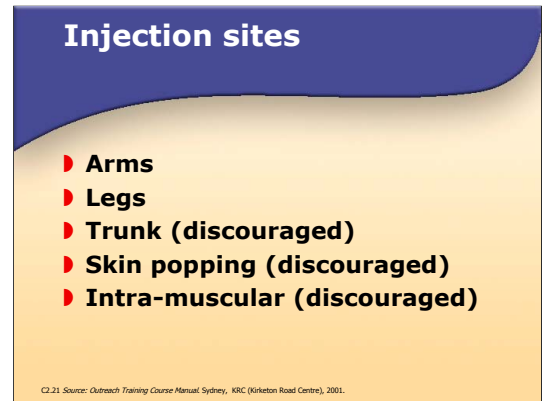
Start a discussion among participants about the risks associated with injecting. First, ask what infections and other health problems can occur through sharing injection equipment or through drug injecting. After each discussion, show the related slide.

Slide C2.20: Risks of injecting include:

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

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

Teaching Notes



Slide C2.21: Sites of injection include:

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

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

Next, state that there are rules for the safest (or least risky) ways to inject drugs. These rules have been developed for intravenous drug use, which is the most common type of drug injecting. Distribute Handout C2.

Session C2.8. Needle and syringe use demonstration

See module C Exercises on CD-ROM

Teaching Notes

Core education messages 1

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

C2.22 Source: Burrows D. *Starting and managing needle and syringe programs: a guide for Central and Eastern Europe's Newly Independent States*. New York, International Harm Reduction Development/Open Society Institutes, 2006.

Session C2.9. Education messages

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

Slide C2.22: Core education messages for IDUs:

Sex: Always use a condom when having penetrative vaginal or anal sex.

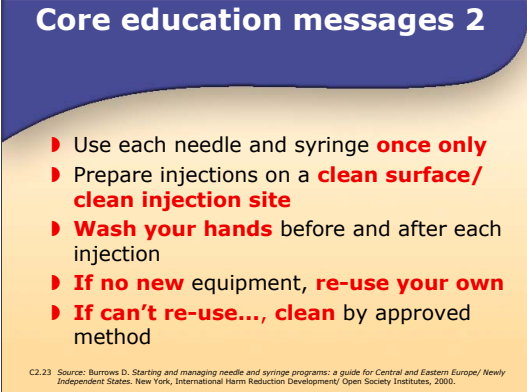
Drug injecting: You can protect yourself from infection by always using your own:

- new, sterile needles and syringes
- mixing water, cups or pots
- spoons or 'cookers' (used to heat powdered drug and mix it with water)
- filters
- swabs/alcohol wipes
- tourniquet
- and never sharing, lending or borrowing them.

'Sharing' isn't just using a syringe that someone else has used. It is also using:

- a filter
- mixing water
- water cup/container
- spoon
- that someone else has used, or passing them on to someone else.
- Always be aware of the risk of:
- catching infection from others;
- overdose; and
- passing infection on to others.

Teaching Notes



Core education messages 2

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

C2.23 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 C2.23: and, where possible:use each needle and syringe once only;

- prepare injections with clean hands on a clean surface and clean the injecting site; and
- wash your hands before and after each injection.

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

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

Teaching Notes

Core education messages 3

Approved cleaning methods

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

C2.24 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 C2.24: The '2 by 2 by 2' method

Injectors should be advised that all syringes that they think may be re-used should be cleaned immediately after first use. They should then be cleaned again before second use.

The best method for cleaning is to use the '2 by 2 by 2 method':

Draw COLD water (sterile or cool boiled is best) into the syringe and then flush it out down the sink or into a different cup. Do this twice.

Then slowly draw bleach into the syringe and shake it for as long as possible: 3–5 minutes is ideal, 30 seconds is the minimum. Flush it out down the sink or into a different cup. Do this twice.

Then draw COLD water into the syringe (as in step 1) and then flush it out down the sink or into a different cup. Do this twice as well.

In addition, you can reduce the chance of infection if you clean the needle and syringe by soaking the parts in either undiluted bleach or a strong detergent/water solution for as long as possible (at least several minutes).

Injectors can also be advised that boiling needles and syringes for 15-20 minutes will also sterilize them (although boiling plastic syringes may lead to distortions of the plastic and leakage).

If they are not going to go through the full '2 by 2 by 2' procedure they should be advised to do anything they can to reduce the residue of blood in the syringe.

In particular, washing the needle and syringe several times (for example, 10 times) immediately after use with cold water before the blood and drug solution have had a chance to dry is likely to flush out most infectious agents.

Failing this, using water or even vodka, wine or beer to flush out the syringe and needle before reuse is likely to reduce the risk a little.

Teaching Notes

Other education messages about...

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

C2.25 Source: Burrows D, et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow, Medecins Sans Frontieres - Holland, 1999.

Slide C2.25: Other education messages may relate to:

- *Drug manufacturing.* For example, using blood to change the consistency of home-made drugs is a high-risk activity for HIV transmission
- *Drug purchase.* For example, buying liquid drugs in syringes is a high-risk activity for HIV transmission
- *Drug preparation.* For example, for some types of heroin, citric acid is mixed with heroin during preparation to prevent certain types of infections
- *Combinations of drugs* (including alcohol). These cause severe intoxication or specific health problems.
- *Overdose and resuscitation:* see Handout C4.
- *Vein care:* For example, rotate your injection sites.
- *Abscess prevention:* For example, swab the injection site before injecting.
- *Penetrative and non-penetrative sexual practices:* For example: specific messages may be included about the use of stronger condoms for anal sex.

Teaching Notes



Developing new messages

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

C2.26 Source: Burrows D, et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow, Medecine Sans Frontieres - Holland, 1999.

Slide C2.26: Both the local phrasing of core educational messages and the development of additional messages should be carried out using the following process:

- Define the aim of the message, including gaining input from active IDUs about the topic of the messages, language, visual representations: what behaviour do you want to address?
- Assemble the required information: research the topic to discover the latest and most widely adopted messages and information, and draft the publication or message.
- Have the draft checked by medical or other qualified personnel to ensure that any medical or other technical information is correct
- The draft should then be checked by a group of active IDUs to provide reactions about the language, illustrations, attractiveness to IDUs, etc. This is often done in a focus group.
- Re-draft the message or publication, ensuring the technical aspects are now correct and taking into account the views of IDUs.
- This final draft should again be checked by a group of active IDUs.
- Finalize the message or publication, produce it and disseminate it to IDUs.
- Evaluate the message or publication: ask if IDUs have seen it or heard the message, what do think of it, do they understand it, etc. More formal methods of evaluation discussed on Day 4.
- Provide participants with Handouts C3 and C4.

Break

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

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

Session C2.10. Needle and syringe cleaning

See Exercises on CD-ROM

Teaching Notes

Provide education messages:

- ▶ **One to one and groups**
- ▶ **Slogans and sayings**
- ▶ **Leaflets and booklets**
- ▶ **Newsletters and magazines**
- ▶ **Other: comics, audio tapes, CD-ROMs, videos, television and radio**

C2.27 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.

Session C2.11. Education strategies

Inform participants that there are many ways to provide HIV prevention education messages to IDUs. Ask for suggestions from the participants then show the next slide.

Slide C2.27: Some methods of providing education messages are:

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

There are many other methods such as comics, audio tapes, CD-ROMs, videos, television and radio programmes that can be useful for getting messages to IDUs. It should be noted that types and locations of IEC messages might be different for women and men.

Teaching Notes

One-to-one education can be...

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

C2.28 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, 2006.

Slide C2.28: One-to-one education of IDUs by outreach workers can normally only be done after establishing trust and rapport. Education of this type is normally provided as part of the outreach counselling process described in C2.5.

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

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

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

Teaching Notes

Group education is useful in...

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

C2.29 Source: Burrows D. Starting and managing needle and syringe programs: a guide for Central and Eastern Europe's Newly Independent States. New York, International Harm Reduction Development/Open Society Institutes, 2006.

Slide C2.29: Group education can be provided in a range of settings. Much of it relies on the social networks that drug users form since these can have a positive effect on those members trying to change, or maintain safer behaviours. Gender of the groups might be important. Also, groups of men might be found in different places than groups of women. 'Classical group education' takes place with facilitation or information provision by an authoritative figure such as a doctor, epidemiologist, drug treatment worker or NGO worker who has control over the information and education the drug users receive. Unless this person has a clear idea of the educational needs of the group, this type of group education may be ineffective.

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

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

Teaching Notes

Slogans and sayings are useful for...

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

C2.30 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, 2006.

Slide C2.30: Constant repetition of the same message has the same effect as an advertising slogan: the words—and the idea or product—stay in our minds. In Australia, drug users are advised to 'use a new fit (needle and syringe) for every hit'. This slogan appears on the packaging of some syringes, on business cards for needle and syringe programmes and on stickers, leaflets, cards, brochures, posters and booklets.

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

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

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

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

Teaching Notes

Leaflets and booklets:

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

C2.31 Source: Burrows D, et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow, Medecins Sans Frontieres - Holland, 1999.

Slide C2.31: Leaflets and booklets:

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

Teaching Notes

Newsletters and magazines:

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

C2.32 Source: Burrows D, et al. Training Manual on HIV/AIDS prevention among injecting drug users in the Russian Federation. Moscow, Medecins Sans Frontieres - Holland, 1999.

Slide C2.32: Magazines and newsletters can assist outreach work in a circular way by making/keeping contact with IDUs through contributions (from IDUs), production (with or by IDUs) and distribution (with or by IDUs). They can be used:

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

Magazines/newsletters:

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

Conclude by saying that all these publications and messages should be developed using the process outlined in C9. This development process can be used by outreach workers as a way of raising issues related to HIV risk, by showing publications being developed, by asking IDUs for slogans, etc. Remember that requesting the view of drug users helps to increase their commitment to safer behaviour and that discussing a leaflet is also passing the message among the target group. Effective HIV prevention requires the provision of the same messages in different levels of detail and in different media to reach the same group of IDUs many times over a sustained period of time.

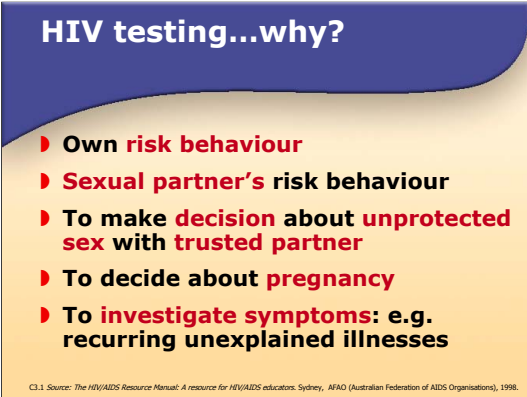
Session C2.12. Slogan exercise

See Exercises on CD-ROM

Session C2.X: Evaluation and close

See Exercises on CD-ROM

Teaching Notes



HIV testing...why?

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

C3.1 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organisations), 1998.

Day 3

Session C3.0. Welcome

See Exercises on CD-ROM

C3.1. Problem-solving with injecting risks

See Exercises on CD-ROM

Session C3.2. HIV testing and counselling

Start a discussion about HIV testing by asking: Why should people such as IDUs in participants' localities consider being tested for HIV? After discussion, show the Slide C3.1.

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

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

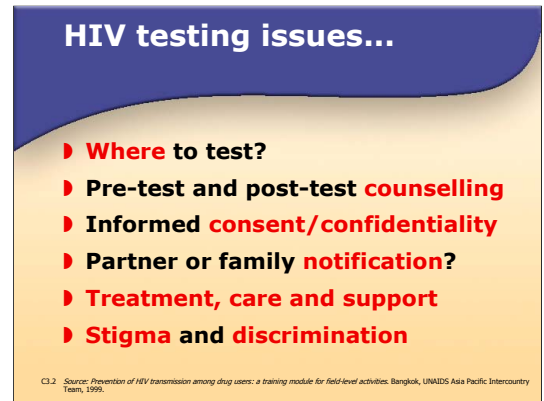
Next ask: What are the benefits to the individual and society of having an HIV test?

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

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

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

Teaching Notes



SlideC3.2: Issues include:

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

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

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

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

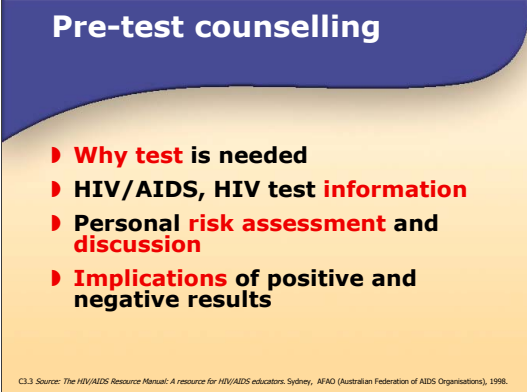
In some countries, testing is anonymous or de-linked (no record is kept of the names of people together with their test results). In other countries, there are registers of people with HIV and AIDS (including their names and addresses): these records must be carefully handled to ensure confidentiality.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

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

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

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

Teaching Notes

A slide titled "Pre-test counselling" with a blue header and a yellow body. It lists four key points in red text: "Why test is needed", "HIV/AIDS, HIV test information", "Personal risk assessment and discussion", and "Implications of positive and negative results".

Pre-test counselling

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

C3.3 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFHO (Australian Federation of AIDS Organisations), 1998.

Slide C3.3: Pre-test counselling is one of the most powerful weapons in HIV prevention. When a person decides to have a HIV test, he or she is acknowledging a personal risk. This can be the basis of a very personal and specific discussion about risky behaviour and ways to reduce risks. Issues that should be canvassed include:

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

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

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

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

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

Teaching Notes

Post-test counselling

If Test-Positive:

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

If Test-Negative:

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

C3.4 Source: The HIV/AIDS Resource Manual: A resource for HIV/AIDS educators. Sydney, AFAO (Australian Federation of AIDS Organisations), 1998.

Slide: C 3.4

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

Issues here include:

Positive result:

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

Negative result:

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

Teaching Notes

Hire active IDUs?

If 'Yes'...why?

- ▶ Part of the "drug scene", contacts
- ▶ Aware of the rules, rituals

If 'No'...why?

- ▶ No time, lifestyle
- ▶ Too involved with peers

C3.5 Source: Trautmann F and Berendse C. Utrecht, European Peer Support Manual/Timbos Institute/European Commission, 1994.

Break

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

Session C3.3. What are the attributes of an effective outreach worker?

See module C Exercises on CD-ROM

Session C3.4. Recruiting and training outreach workers

Inform participants that, before recruiting outreach workers, there are several decisions that need to be made. Outreach workers need to be credible to IDUs in the areas where they work: this may mean that outreach workers are active IDUs, ex-drug users, non-drug users or a mixture of some of these. There are advantages and disadvantages to recruiting from each of these groups.

Slide C3.5: Should active IDUs be recruited as outreach workers?

Yes arguments

- Part of the "drug scene"
- Know what is going on, where it is happening and who is involved
- Aware of the rules, rituals and other behaviours being practised
- Have frequent contact with other drug users

No - arguments

- Being an active drug user is like having a full-time job: little time to do anything else
- Commitment to a job may be impossible due to time demands, unfamiliarity with work norms (e.g. working hours, need for reliability, etc.): this may affect continuity of the project
- Drug users may be too involved with their peers to address difficult issues such as unsafe injecting or sexual behaviour

Teaching Notes

Hire ex-drug users?

If 'Yes'...why?

- ▶ Stability, continuity, role models
- ▶ Draw from experiences, contacts

If 'No'...why?

- ▶ Knowledge may be out of date
- ▶ Judgmental attitude, Relapse

C3.6 Source: Trautmann F and Berendse C. Utrecht, European Peer Support Manual Trimbos Institute/European Commission, 1994.

Slide C3.6: Should ex-drug users be recruited as outreach workers?

Yes - arguments

- Can contribute to the continuity of a project
- Can serve as role models for what drug users can aim for: having a job, being acknowledged as an expert
- Can draw from their experiences to help IDUs modify unsafe behaviours
- Often have established relationships with the treatment system, so they may be able to provide advice and referral on treatment as well as build support in treatment agencies for peer support programmes

No - arguments

- Ex-users have stopped using drugs so they may have less access to drug users and drug using locations than active drug users
- Knowledge of drug use practices may be out-of-date
- May have a harsh judgemental attitude to drug use (caused largely by their fears of relapse), which can cause mistrust and credibility problems
- Often relapse into drug use unless precautions are taken

Teaching Notes

Hire mixed teams?

If 'Yes'...why?

- ▶ Advantages e.g. sharing ideas, increasing mutual respect
- ▶ Division of tasks

If 'No'...why?

- ▶ Conflict?

C3.7 Source: Trautmann F and Barendse C. Utrecht, European Peer Support Manual Trimbos Institute/European Commission, 1994.

Slide C3.7: Should a mixed group of drug users and ex-users (and non-users such as university students) be recruited as outreach workers?

Yes - arguments

- Can result in all of the advantages of using drug users and ex-users
- Can lead to sharing of ideas and increasing mutual respect between drug users and ex-users
- Can lead to division of tasks so that drug users do the tasks they are most suited to (e.g. street outreach, writing messages from drug user to drug user), and ex-users carry out other tasks such as discussing peer support activities with police, health department, drug assistance services

No - argument

Mixed group can be a source of conflict where drug users and ex-users may have different interests and priorities: this sometimes leads to a power struggle: e.g. active users may have feelings of distrust, envy or inferiority towards ex-users and ex-users may despise or feel superior towards active users

Next, state that, after deciding on the composition of the team, there are several further steps needed in recruitment:

Teaching Notes

Recruiting outreach workers

- ▶ Discuss and decide **selection criteria**
- ▶ Find potential **candidates**
- ▶ Devise a **selection process**
- ▶ Draw **contract/work agreement**
- ▶ Pertain **training**

C3.8 Source: Pozer R, ed. Guidelines on community-based peer intervention aimed at drug prevention and harm minimisation. London, North Thames Peer Intervention Forum, 1996.

Slide C3.8: Recruiting outreach workers:

- Selection criteria are needed so that appropriate people are recruited as outreach workers.
- Potential candidates need to be found and informed about the outreach worker jobs.
- A selection process is needed to ensure that candidates are suitable for the job.
- A contract or work agreement is needed to ensure the outreach worker knows what he or she is hired to do, and knows what remuneration and other conditions will be provided.
- Usually, new outreach workers need to be trained to carry out their tasks effectively.

Next, remind participants of the attributes exercise and state that selection criteria should be composed from those attributes. Decisions are needed about what are very important (essential) and what would be useful but are not essential (desirable). Repeat that the most important attribute is credibility among the specific networks of IDUs where the programme will operate. It is also important to note that outreach teams should usually consist of both male and female workers, of a range of ages to ensure that all IDUs can feel comfortable with at least some members of the team.

Participants need to gauge the extent to which the potential outreach worker's knowledge and access to particular networks of drug users match the aims and objectives of the outreach programme. It is also important to gain some appreciation of their role and status in drug user networks, as this may influence their ability to penetrate any given drug scene.

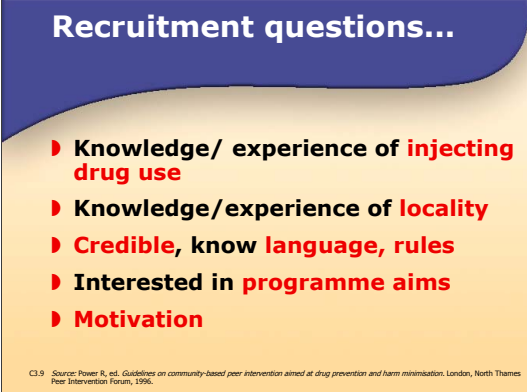
Next, use the flip chart for a brainstorm. Ask where potential candidates may be found for outreach workers. Write the places up as they are called out. If they are not mentioned, add:

- places where drug users congregate;
- drug treatment centres;
- high schools, universities; and
- advertising in selected community and media outlets.

Also, if no one mentions it, state that snowballing can be an effective recruitment method. Once a good candidate is found, he or she can seek out other candidates among friends and acquaintances. Other points of recruitment may include clubs and pubs.

Next, state that a selection process is needed to decide which candidates should become outreach workers. In some cases the recruitment and assessment processes are combined in introductory training sessions, where the programme is described and the role of the outreach worker is outlined. In this model, the assessment process takes place throughout training and continues during the outreach worker's initial involvement with the programme. Supervision sessions can be used to address issues and problems around suitability as and when they arise.

Teaching Notes



Recruitment questions...

- ▶ **Knowledge/ experience of injecting drug use**
- ▶ **Knowledge/experience of locality**
- ▶ **Credible, know language, rules**
- ▶ **Interested in programme aims**
- ▶ **Motivation**

C3.9 Source: Power R, ed. Guidelines on community-based peer intervention aimed at drug prevention and harm minimisation. London, North Thames Peer Intervention Forum, 1996.

Slide C3.9: Other methods include a job interview that might examine:

- Do they have a good working knowledge or personal experience of the target group or target area?
- Are they part of, or knowledgeable of, the social networks that the programme will target?
- Are they credible with their peers?
- Are they conversant with the interests, language and vernacular of the target group?
- Are they interested in the aims and objectives of the programme?
- What is their motivation for joining the programme?

Next, state that terms of agreement or contracts need to be established with clear details about pay and other conditions. It is also vital to provide a list of tasks that outreach workers are expected to perform. Certain policies such as safety policy and discipline and dismissal policy should be in place prior to the employment of staff. Other policies can be developed as the need arises. These work agreements and policies will be described in the afternoon.

Next, state that it is unlikely that many peer recruits will have had any formal training around HIV prevention and related issues. It is therefore crucial that a well-constructed and comprehensive training is provided with the outreach workers being involved in its development. The precise length and content of training will be dependent upon the aims and objectives of the outreach programme, as well as the needs of the outreach workers. The duration and timing of any given training programme will be dependent on factors such as availability of resources, lifestyle and training needs of outreach workers, material to be covered and the aims and objectives of the programme. Training should be compulsory, so that no one is ill-equipped to carry out the programme aims and objectives.

Training programmes can take place over a short period (5-10 days) or a day or half a day per week over several weeks. Shorter programmes can develop skills quickly and enable a programme to start with a trained team. Programmes provided over longer periods can serve to develop group cohesion and begin to instill in outreach workers a habit of ongoing learning.

An important part of peer intervention training is practical work with an experienced outreach worker, where the novice spends some time shadowing and observing the work in action. If the outreach programme has not yet started, it may be possible to gain this experience with another outreach programme located nearby.

Teaching Notes

Training should provide...

- ▶ **Understanding of programme aims**
- ▶ **Knowledge and skills needed for outreach work**
- ▶ **Understanding of legal and ethical issues**
- ▶ **Clarification of expectations and boundaries**

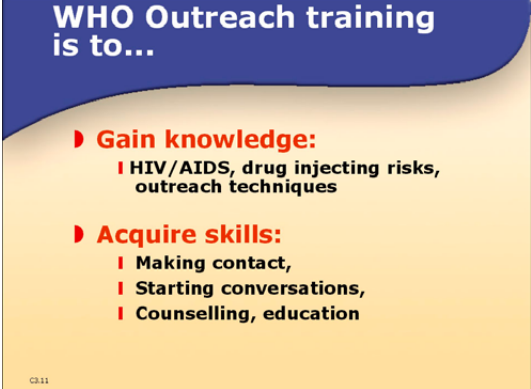
C3.10 Source: Power R, ed. Guidelines on community-based peer intervention aimed at drug prevention and harm minimisation. London, North Thames Peer Intervention Forum, 1996.

Slide C3.10: In general, any peer training programme should aim to equip outreach workers in the following ways. After training, outreach workers should have a:

- clear understanding of the aims and objectives of the outreach programme, including the philosophy of the programme (and, where relevant, its host agency);
- precise knowledge and understanding of the style and nature of the work involved and the type of messages and/or materials to be produced and delivered;
- basic overview of relevant HIV/AIDS and injecting drug use issues, alongside any matters specifically relevant to the programme and the target group;
- basic knowledge of relevant legal and ethical matters related to the programme;
- clear idea of the parameters of their role as outreach workers and the expectations of the programme; and
- clear understanding of the boundaries between their work and the work of other professionals such as doctors or psychologists.

Basic practice guidelines to reinforce the training should also be provided. These will also be discussed in the afternoon.

Teaching Notes



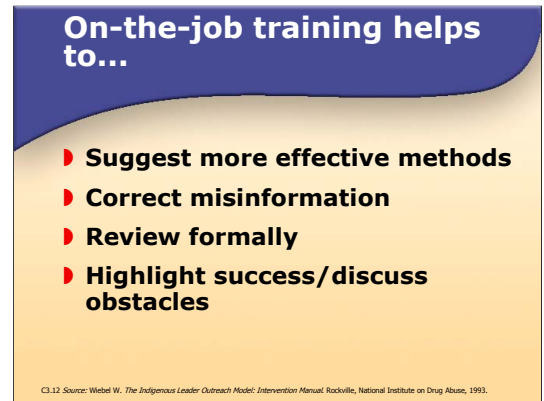
WHO Outreach training is to...

- ▶ **Gain knowledge:**
 - ! HIV/AIDS, drug injecting risks, outreach techniques
- ▶ **Acquire skills:**
 - ! Making contact,
 - ! Starting conversations,
 - ! Counselling, education

C3.11

Slide C3.11: Briefly describe the Field worker training course in this package

Teaching Notes



Slide C3.12: On-the-job training is another important component of training that should be provided both to new staff and to existing staff on a regular basis.

Initial on-the-job training should include a manager or lead outreach worker to:

- accompany outreach teams in the field;
- provide suggestions for improving effectiveness;
- correct misinformation provided by outreach workers;
- conclude each day with a formal review of events and experiences; and
- highlight successes and discuss difficulties and obstacles in a positive, problem-solving way.

Session C3.5. Recruitment role-playing

See Exercises on CD-ROM

LUNCH

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

Teaching Notes



Facilitating management:

- ▶ Define **areas/working hours**
- ▶ List **specific tasks/steps**
- ▶ Set **times for supervision, team meetings, intervision, training**
- ▶ Decide on **work agreements/contracts**
- ▶ Clarify **policies/procedures/ rules**

C3.13

Session C3.6. Managing outreach staff

Management of outreach workers can be difficult. Outreach may occur in places far from the office or clinic where an outreach team is based. Outreach workers may need to work at odd hours (nights, weekends) and in different patterns (a few hours of work followed by a few hours of rest and more work) to contact and communicate with IDUs at times convenient to the clients. Outreach work itself is not like ordinary work: workers need to be flexible so there are often a lack of clarity about targets or outputs of the work. This can cause problems for managers trying to supervise outreach workers, and evaluate and adapt outreach methods used in their programme.

Slide C3.13: To facilitate management, most outreach programmes have developed some set methods of working and some documents to assist outreach workers and managers.

First, areas are defined for outreach work and working hours are established: these can be rigid (such as “visit the main plaza and try to contact IDUs each week night from 17:00 to 19:00) or more flexible (such as “provide 20 hours of outreach per week among IDUs in the southern suburbs of the city”).

Specific tasks are provided for outreach workers. These can be a list of options (contact IDUs, build trust, communicate with IDUs about health topics including HIV/AIDS, distribute condoms”) or a set series of steps. Examples of step-by-step methods are provided in the case studies on Outreach methods in Annex 2.

Set times are arranged for supervision (by the outreach manager), team meetings and for other processes such as intervision (where outreach workers assist each other in solving outreach problems) and ongoing training.

These arrangements and others, as required, are usually formalized in a work agreement or contract between the programme and each outreach worker.

Other useful documents are policies and procedures, and rules of working (including safety issues).

Teaching Notes

Work agreements elaborates...

- ▶ **Training requirements**
- ▶ **Supervision and support**
- ▶ **Tasks, working methods**
- ▶ **Remuneration**
- ▶ **Rules**

C3.14

Slide C3.14: This agreement should be drawn up prior to the outreach worker joining the organization and should be adapted if the role of the outreach worker changes over time. The agreement should clearly state what the programme expects from the outreach workers and what the outreach worker can expect from the programme. It should relate to the aims and objectives of the programme and show the outreach worker how his or her work contributes to achieving those aims.

Specific items that should be covered in any agreement include:

- training requirements;
- supervision and support arrangements;
- tasks and working methods;
- remuneration entitlements;
- project rules (for example, accepted reasons for lateness/absenteeism, circumstances that may result in being dismissed by the programme);
- general conduct rules (including issues concerning sex and race discrimination, the consumption of drugs or alcohol while acting as an outreach worker).

Teaching Notes

Procedures and rules elaborates...

- ▶ **Basic practice**
- ▶ **Unacceptable behaviour**
- ▶ **Security and safety**
- ▶ **Discipline and dismissal**
- ▶ **Other: overdose, forms, meetings**
- ▶ **Balance needed**

C3.15

Slide C3.15: Procedures and rules may all be needed to assist outreach workers in carrying out their tasks effectively and safely. These should start with basic practice procedures and rules that inform outreach workers how to do their work, what behaviour is advisable and what is unacceptable. Due to the many risks that can occur during outreach, safety guidelines should be drawn up prior to the programme beginning operations and these should be adapted and added to as new safety issues arise. Another procedure that should be in place very early is a discipline and dismissal procedure so that there is a transparent process that both managers and staff know and understand to deal with persistent problems. Other procedures that are often useful are guidelines for dealing with overdosed clients; filling in monitoring forms and diaries; procedures for meetings and so on. It is important to balance the need for clear guidelines with the need to do effective outreach work on the streets: procedures should not be so many and so constraining as to interfere with effective work.

Teaching Notes

Unacceptable behaviour

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

C3.16

Slide C3.16: Basic practice guidelines should include the main tasks of outreach work. They should also include rules relating to unacceptable behaviour: these should be developed together with reasons why the behaviour is unacceptable (for example, drug selling by staff may lead to loss of funding and closure of the programme).

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

Teaching Notes

Safety procedures and rules

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

C3.17

Slide C3.17: Safety guidelines should encompass the full range of risks faced by outreach workers. The most important safety advice is that if outreach workers feel unsafe due to verbal or non-verbal signs (chaos, abuse, aggression), they should leave an area immediately. A common safety guideline is that outreach work must always be done in pairs so that if one outreach worker gets into trouble, the other can either help or seek assistance. (Many programmes have this as a basic rule of outreach work.) Safety guidelines should also address handling needles and syringes, and needle stick injuries. They should cover practical issues such as procedures if apprehended by the police and how to deal with aggressive or violent clients.

Distribute Handout C6 with examples of procedures for handling needles and syringes and for dealing with needle stick injury.

Among other tasks, work guidelines should provide a clear idea of the way that supervision, team meetings and intervision (if used) will take place (these will be discussed in Session C3.8).

Teaching Notes

Relapse can be related to...

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

C3.18 Source: *STD/HIV/AIDS Prevention and Harm Reduction: A training manual for Public Security and Justice personnel*. China-UK HIV/AIDS Prevention and Care Project, 2002.

Slide C3.18: Relapse prevention is also a key aspect of management in many outreach programmes. Where ex-drug users are members of the outreach team, most programmes feel a responsibility to assist such outreach workers to maintain their abstinence.

Working among active drug users can be very difficult for ex-users. Relapse can be caused or exacerbated by:

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

Teaching Notes

Relapse can be prevented by...

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

C3.19 Source: STD/HIV/AIDS Prevention and Harm Reduction: A training manual for Public Security and Justice personnel. China-UK HIV/AIDS Prevention and Care Project, 2002.

Slide C3.19: Relapse prevention can be enhanced through:

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

Teaching Notes

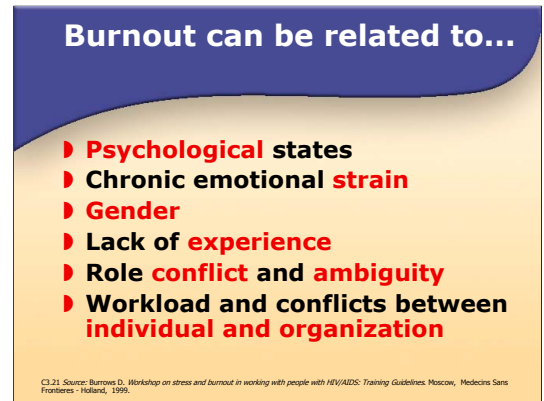


Slide C3.20: While a programme may have rules about drug-use among outreach workers, the manager(s) must work hard to create a supportive, non-punitive work environment so that relapse can be dealt with calmly and effectively.

Some methods of dealing with relapse include:

- Encourage outreach workers to seek help early.
- If relapse is suspected and the outreach worker does not volunteer the information, confront the worker with your suspicions in a calm, non-threatening way.
- If treatment is available and the outreach worker is willing, provide access, referral or treatment.
- Give relapsed outreach workers time off (if possible) to cope with the initial stages of abstinence.
- Work with the outreach worker and a treatment counsellor (if available) to plan the worker's return to outreach work.

Teaching Notes



Slide C3.21: Burnout is related to:

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

Teaching Notes

Burnout can be prevented by...

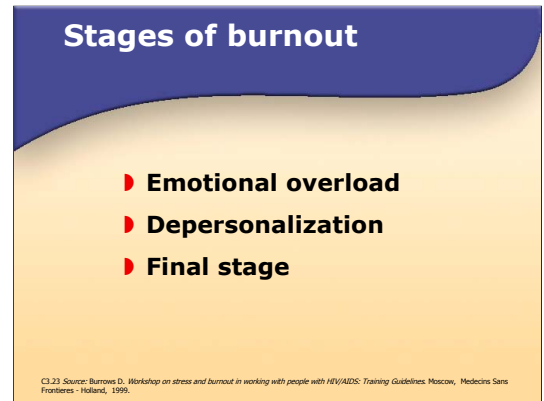
- ▶ **Recognizing stages of burnout**
- ▶ **Personal planning**
- ▶ **Clear, truthful job descriptions**
- ▶ **Realistic expectations**
- ▶ **Supportive supervision and Assistance from other outreach workers**

C3.22. Source: Burrows D. Workshop on stress and burnout in working with people with HIV/AIDS: Training Guidelines. Moscow, Medecins Sans Frontieres - Holland, 1999.

Slide C3.22: Burnout can be prevented through:

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

Teaching Notes



Slide C3.23: Recognizing the beginning of burnout is very important. Each outreach worker needs to look for the signs of burnout in themselves and other members of the team. The stages of burnout are:

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

Session C3.7. Developing outreach rules

See Exercises on CD-ROM

Teaching Notes



Supportive supervision

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

C.24

Session C3.8. Supervision and performance appraisal

Describe the differences between supervision, intervention and performance appraisal.

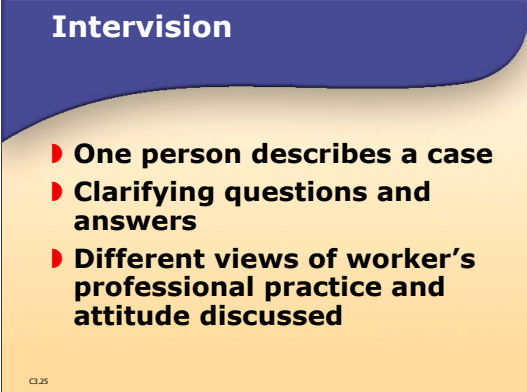
Slide C 3.24:

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

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

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

Teaching Notes



Intervision

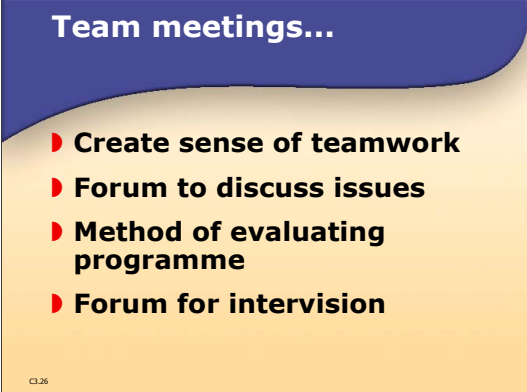
- ▶ **One person describes a case**
- ▶ **Clarifying questions and answers**
- ▶ **Different views of worker's professional practice and attitude discussed**

C3.25

Slide C3.25: Intervision is a learning method that helps outreach workers to learn to analyse situations with clients in relation to their professional attitude. It assists outreach workers to learn about themselves as a professional in situations that are complicated and with a lot of emotional impact. If there is no support system in which it is possible to discuss these situations, it is very likely that outreach workers will react personally rather than professionally. Intervision helps outreach workers to discuss professional issues with each other in a structured way that can lead to solving problems by gaining new perspectives from team members.

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

Teaching Notes



Team meetings...

- ▶ **Create sense of teamwork**
- ▶ **Forum to discuss issues**
- ▶ **Method of evaluating programme**
- ▶ **Forum for intervision**

C3.26

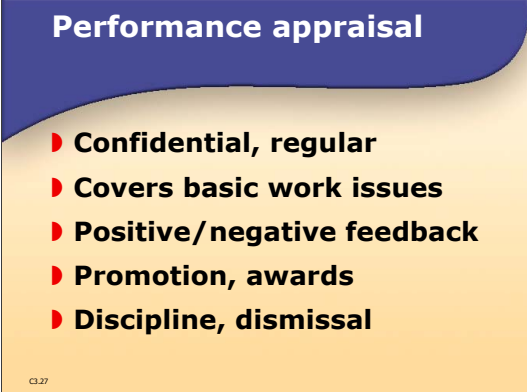
Slide C3.26:

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

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

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

Teaching Notes



Performance appraisal

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

C3.27

Slide C3.27:

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

Appraisal should deal with basic work issues such as:

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

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

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

Break

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

If site visits are planned, the break can be cancelled.

Session C3.9 Site visit/ Guest Lecture(s)

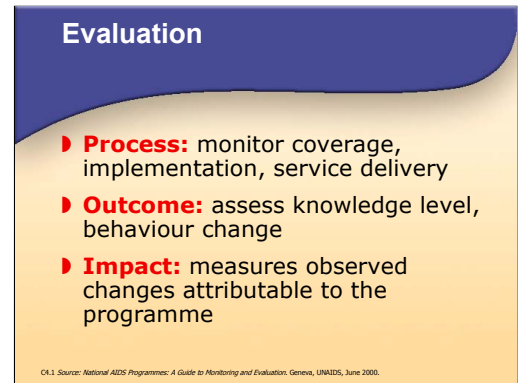
At this point, a visit should be paid to a working outreach programme if possible. Alternatively, outreach workers, IDUs or ex-drug users can be invited to give guest lectures to the participants. (See *Tips for trainers* about methods to be used with site visits and guest lecturers.)

If it is impossible to provide a site visit or guest lecture by the above groups, carry out a set of exercises using the *Case studies on Outreach methods* (in Annex 2) and the videos included in this package to give participants a clear picture of the reality of outreach work

Session C3.X: Evaluation and close

See Exercises on CD-ROM

Teaching Notes



Evaluation

- ▶ **Process:** monitor coverage, implementation, service delivery
- ▶ **Outcome:** assess knowledge level, behaviour change
- ▶ **Impact:** measures observed changes attributable to the programme

CA.1 Source: National AIDS Programme: A Guide to Monitoring and Evaluation, Geneva, UNAIDS, June 2000.

DAY 4

Session C4.0. Welcome

See Exercises on CD-ROM

Session C4.1. Impressions of outreach work

See Exercises on CD-ROM

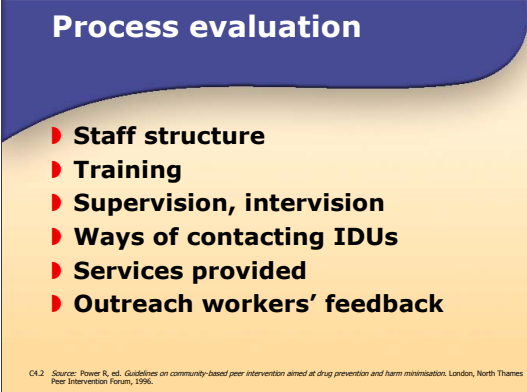
Session C4.2 Evaluation and monitoring

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

Evaluation is a collection of activities designed to determine the value or worth of a specific programme, intervention or project. Evaluation can be divided into three main components: process evaluation, outcome evaluation and impact evaluation:

- Process evaluation indicators relevant to outreach programmes involves the assessment of the programme's content, scope or coverage, together with the quality and integrity of implementation.
- If the process evaluation shows progress in implementing the programme as planned, then the outcome evaluation is warranted. The outcome evaluation measures HIV-related knowledge, risk perception, behaviour change, etc.
- However if outcome evaluation indicators show that behaviour is changing, then it is time to do an impact evaluation. It demonstrates that any observed change in the target population can be attributed to the programme. True impact evaluation, able to attribute long-term changes in HIV infection to a specific programme, are very rare. Rather, monitoring impact indicators such as HIV prevalence or adult deaths, taken in conjunction with process and outcome indicators, are considered to be sufficient to indicate the overall impact.

Teaching Notes



Process evaluation

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

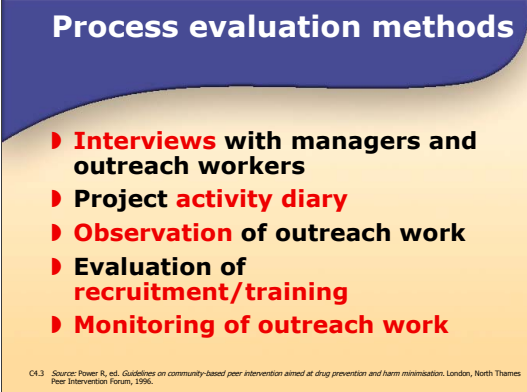
C4.2 Source: Power R, ed. Guidelines on community-based peer intervention aimed at drug prevention and harm minimisation. London, North Thames Peer Intervention Forum, 1996.

Slide C4.2: Process evaluation describes and monitors the way in which programmes operate. This is necessary in order to examine what strategies and methods are most appropriate in delivering the intervention. Process indicators relevant to outreach programmes include the following:

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

Recording changes in the programme.

Teaching Notes



Process evaluation methods

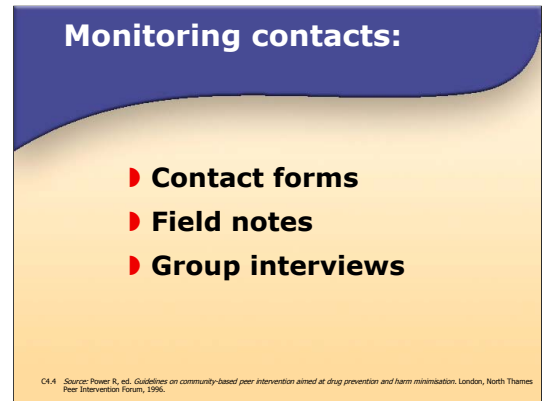
- ▶ **Interviews with managers and outreach workers**
- ▶ **Project activity diary**
- ▶ **Observation of outreach work**
- ▶ **Evaluation of recruitment/training**
- ▶ **Monitoring of outreach work**

C4.3 Source: Pozer R, ed. Guidelines on community-based peer intervention aimed at drug prevention and harm minimisation. London, North Thames Peer Intervention Forum, 1996.

Slide C4.3: Process indicators can be collected in a numbers of ways using both questionnaires and interviews. The methods of evaluation chosen will be dependent on the availability of project resources. Some aspects of the evaluation will be best conducted by an independent evaluator. Examples of process evaluation methods include:

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

Teaching Notes



Slide C4.4: A key aspect of any process evaluation of peer intervention is to describe the nature and extent of contacts made by outreach workers. This helps to monitor how effective outreach workers are in gaining access to the target population. However, collating accurate information on the nature and extent of contact may be difficult since outreach workers are expected to do much of their work away from the direct observation of managers. Detailed below are a number of possible methods of obtaining indicators on the nature and extent of contacts:

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

Group interviews: Outreach workers can be asked to discuss their work in a group interview

Teaching Notes

Aims of outcome evaluation:

- ▶ **Assess changes**
- ▶ **Decide if programme objectives have been achieved**

C4.5 Source: Power R, ed. *Guidelines on community-based peer intervention aimed at drug prevention and harm minimisation*. London, North Thames Peer Intervention Forum, 1996.

Slide C4.5: Outcome evaluation has two main aims. First, to assess the changes of the programme and second to ascertain the extent to which project objectives have been achieved.

Intermediate measures of outcome might include raising knowledge and awareness of ways to prevent viral infection. Intermediate outcome measures appropriate to outreach will largely be determined by the aims and objectives of the programme.

Teaching Notes

Intermediate outcomes:

- ▶ **Increase in IDUs' knowledge about programme, injecting risks, HIV/AIDS**
- ▶ **Changes in injection and sexual behaviour**
- ▶ **Sustained momentum of programme**

C4.6 Source: Power R, ed. Guidelines on community-based peer intervention aimed at drug prevention and harm minimisation. London, North Thames Peer Intervention Forum, 1996.

Slide C4.6: Intermediate outcome measures

- A pre-defined number of leaflets and other prevention materials distributed among the target community
- Diffusion of knowledge about the programme
- Increased knowledge among the target population on drugs and HIV/AIDS and changes in injection and sexual behaviour
- Sustained momentum of the programme

Teaching Notes

Impact evaluation

- ▶ Reduced levels of drug problems, change in norms towards safer drug use among IDUs
- ▶ Reduced HIV prevalence

C4.7 Source: Power R, ed. Guidelines on community-based peer intervention aimed at drug prevention and harm minimisation. London, North Thames Peer Intervention Forum, 1996.

Slide C4.7: Impact evaluation

- Reduced levels of drug problems among the target population
- A change in community norms towards safer drug use and injecting practices
- Reduced levels of HIV, other blood-borne viruses and STIs in the target population

Teaching Notes

Monitoring – feedback - change

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

C4.8 Burrows D (in press) A Best Practice Model of Harm Reduction in the community and in prisons in Russian Federation. Final Project Report. World Bank, Washington, Moscow.

Slide C4.8: Requirements of IDUs need to be carefully and regularly investigated, to ensure that the services (or referrals) provided through outreach match the clients' needs. One method of doing this is to use a process of constant monitoring, feedback, adaptation of services and further monitoring. In such a feedback loop:

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

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

Session C4.3 Evaluation and Monitoring Exercise

See Exercises on CD-ROM

Break

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

Session C4.4 Power mapping

See Exercises on CD-ROM

Teaching Notes



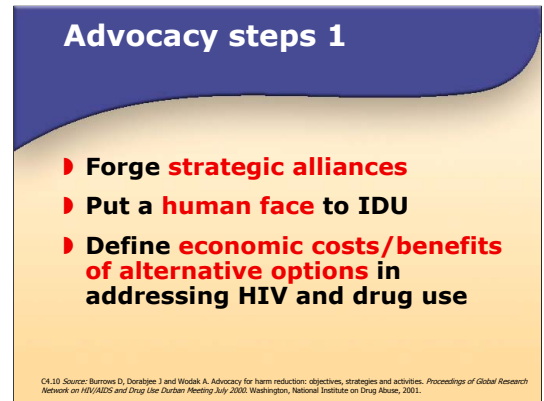
Session C4.5 Advocacy for outreach programmes

Outreach programmes and other effective approaches to HIV prevention among IDUs have been subject to problems in many countries, caused by opposition to their introduction and ongoing existence. These negative experiences can take many forms but have included:

Slide C4.9: Opposition to outreach and other effective approaches (often labelled harm-reduction programmes):

- Opposition from political parties (and politicians), clergy, elderly people and others to outreach and other harm reduction measures as too liberal (calling instead for jail and other punishment of drug users)
- Negative media descriptions of outreach and other harm reduction programmes, often focussing on the provision of needles and syringes to "hopeless junkies" while ill "good" people are not able to access appropriate medical care
- Opposition from the police to outreach and needle and syringe provision (NSP) in particular as an activity that may undermine social order and interfere with police efforts to harass and arrest drug users
- General perception of IDUs, especially HIV positive IDUs as "guilty" (responsible for their own infection) and as dangerous carriers of disease to be avoided, as opposed to "good" HIV-positive people who acquire infection through infected blood or from mother to child.

Teaching Notes



Slide C4.10: Advocacy methods for outreach and other harm reduction programmes include:

Forge strategic alliances

- Map possible allies; identify key stakeholders.
- Identify obstacles to common work with allies.
- Identify common areas of interest.
- Implement formal and informal liaison between allies (formal liaison includes regular reports, meetings, open days; informal liaison may be dinner or a drink together).
- Include diverse groups as allies to increase the allies' impact on policy.
- Build service linkages and networks for regular information-sharing, shared training and advocacy activities.

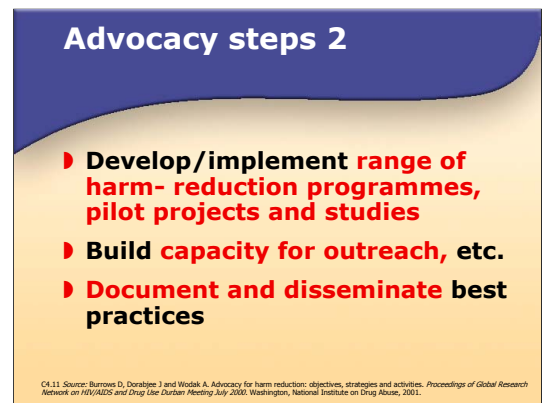
Put a human face to injecting drug use

- Use a humanitarian approach in all programmes to get an empathic response from and towards drug users.
- Identify diplomatic, articulate, pragmatic spokespeople among IDUs and assist groups of IDUs to identify and nominate spokespeople.
- Offer training, support, mentoring: e.g. for many IDUs, sitting in long committee meetings is foreign and difficult, yet these meetings may have a major impact on harm reduction services.
- Support IDU groups.
- Encourage and facilitate IDUs' participation in normal social activities.

Define economic costs/benefits of alternative options in addressing HIV and drug use

- Identify, summarize and disseminate research that shows the costs in the numbers of HIV and AIDS cases likely to occur among IDUs if no action is taken, and social and economic costs of infections (including costs of HIV treatments), compared to the costs and effectiveness of outreach and other harm reduction programmes.

Teaching Notes



Slide C4.11: *Develop and implement a range of harm reduction programmes, pilot projects and studies*

- Mobilize resources to initiate pilot/informal/formal interventions.
- Implement as wide a range of programmes as possible.
- Evaluate and document pilot projects and harm reduction programmes, especially concentrating on processes of starting and operating the project/programme (for use in ongoing improvement), and on their impact on risk behaviours (as an advocacy tool to argue for ongoing funding, expansion and/or replication).
- Carry out Rapid Assessment and Response (RAR) training and implementation to gather baseline data for evaluating interventions, and to raise awareness among politicians, key stakeholders, community, etc.

Capacity-building

- Involve national and international “experts”, where appropriate: sometimes, governments and media that are not interested in a local harm reduction programme’s views, will listen to an “expert” from the capital city or from another country.
- Use networks; visit other harm reduction programmes; swap staff between programmes; encourage anyone interested in setting up a programme to spend one to two weeks studying the way a similar programme works in the same or a nearby country.

Document and disseminate best practices

- Encourage a culture of regular reporting (including distributing forms with standard questions for regular reporting, developing and using monitoring tools).
- Publish/present best practices, including choosing the most appropriate medium (which may include scientific/research papers, newsletter, workshops/seminars, video).
- Identify, collate, summarize and disseminate relevant existing research.

Teaching Notes



Slide C4.12: *Segment targets for advocacy*

- Politicians
- Health bureaucrats
- Neighbours (people living near a harm reduction programme)
- Law enforcement
- Mainstream health workers and organizations
- Media
- Religious leaders
- Community leaders
- Education bureaucrats and teachers
- Social services
- Pharmacies
- NGOs within and outside the drugs and HIV field (e.g. TB organizations)
- Diverse unofficial groups (e.g. drug dealers)

Develop specific advocacy tools to influence key players

- Participate in training in advocacy and lobbying.
- Identify target groups.
- Identify gaps in information/education.
- Identify appropriate arguments, situations, media.
- Publish and disseminate.

Engage with media

- Write press releases, hold press conferences to make media aware of harm reduction programmes, philosophy.
- Disseminate relevant existing research to media.
- Identify and work with experienced, sympathetic journalists, producers, etc.
- Understand the way media functions (so that presentation of press releases or invitations to media briefings attract positive media attention).
- Recognize when not to use media (when certain media are regularly hostile or sensationalist).
- Develop and implement media policy (who can speak, on what topics, what major points to get across, how journalists/photographers can access harm reduction sites, protection of clients).
- Work with all levels of media from local to national and, if needed, international.

Teaching Notes

Advocacy steps 4

- ▶ **Work to ensure drug treatment is safe, attractive, cost-effective and evidence-based**
- ▶ **Fund-raising**
- ▶ **Build local, national and regional networks**

C4.13 Source: Burrows D, Dorajine J and Wodak A. Advocacy for harm reduction: objectives, strategies and activities. Proceedings of Global Research Network on HIV/AIDS and Drug Use Durban Meeting July 2000. Washington, National Institute on Drug Abuse, 2001.

Slide C4.13: *Work to ensure drug treatment is safe, attractive, cost-effective and evidence-based*

- Raise awareness of need for and effectiveness of appropriate drug treatment within public health, human rights and harm reduction frameworks.
- Identify treatment gaps and develop and implement programmes to fill gaps.
- Initiate referral networks or start programmes in health and social services including housing, employment, welfare, legal services, etc.

Fundraising

- Identify targets with funds.
- Identify appropriate arguments, situations, methods of accessing individuals and organizations.
- Develop relationships between agency heads and key individuals in funding bodies.
- Develop standard format proposals.
- Submit multiple proposals often.
- Anticipate shortfalls, plan future funding needs early.

Build local, national and regional networks

- Use existing networks to discover information on funders, resources, information and education sources, relevant research, participate in training.
- Contribute to current networks to allow others to learn.
- Develop new networks at every level (from local to international) for information sharing, assisting with advocacy and lobbying, and consortium building for contracts.
- Funding is required for compensation of outreach workers, salary for coordinator/manager, outreach materials and training.
- Relations with police and other authorities are crucial.

Teaching Notes

Advocacy with police 1

- ▶ **Involve senior police officers in planning and development**
- ▶ **Obtain cooperation from the police to implement the programme**
- ▶ **Organize meetings of police and community leaders**
- ▶ **Visit police station and police officers**

C4.14 Source: Prevention of HIV transmission among drug users: a training module for field-level activities. Geneva, UNAIDS Asia Pacific Intercountry Team, 1999.

Some methods of establishing good relations with Police/Public security/Internal affairs include:

Slide C4.14:

- Involve senior police officers in planning and development of the outreach programme.
- Obtain cooperation from the police to implement the outreach programme.
- Organize meetings of police and community leaders (see Community advisory groups below).

Visit police station and police officers in the areas where outreach teams will work.

Teaching Notes

Advocacy with police 2

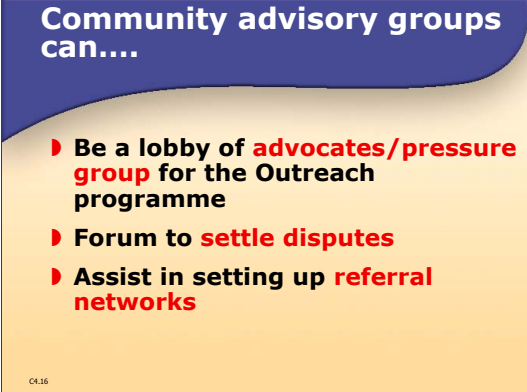
- ▶ **Educate junior level police on the aims of the programme**
- ▶ **Use supportive police officers as peer educators**
- ▶ **Include HIV/AIDS education in police training course**
- ▶ **Offer to provide training**

C4.15 Source: Prevention of HIV transmission among drug users: a training module for field-level activities. Geneva, UNAIDS Asia Pacific Intercountry Team, 1999.

Slide C4.15:

- Educate junior level police on the aims of the programme
- Use supportive police officers as peer educators.
- Include HIV/AIDS education in police training course.
- Offer to provide this training.

Teaching Notes



Community advisory groups can....

- ▶ Be a lobby of **advocates/pressure group** for the Outreach programme
- ▶ Forum to **settle disputes**
- ▶ Assist in setting up **referral networks**

C4.16

Slide C4.16: Community advisory groups (CAG) or Boards can be useful for outreach programmes. The CAG can provide a forum in which the outreach manager can explain the programme to influential people in the locality. It can also be a powerful advocacy tool if members become convinced of the value of outreach work. It can help to settle disputes between various agencies and assist in setting up referral networks. It should include influential members of the local community, including community and religious leaders and teachers, senior doctors, politicians and so on.

Session C4.6 Advocacy arguments

See Exercises on CD-ROM

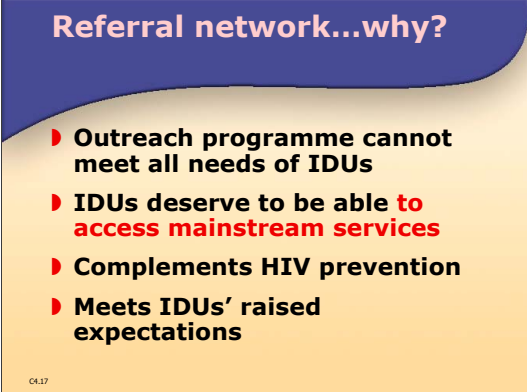
LUNCH

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

Session C4.7 Developing a referral database

See Exercises on CD-ROM

Teaching Notes



Referral network...why?

- ▶ Outreach programme cannot meet all needs of IDUs
- ▶ IDUs deserve to be able to access mainstream services
- ▶ Complements HIV prevention
- ▶ Meets IDUs' raised expectations

C4.17

Session C4.8 Setting up a referral network

Inform participants that there are several reasons why referral networks are needed for outreach programmes:

SlideC4.17:

- Outreach programmes cannot meet all needs of IDUs due to the variety and the number of needs that require specialist attention.
- Outreach programmes are often small with small staffs by comparison with the full complement of government and nongovernment health, legal, social and welfare organizations in a locality.
- IDUs are members of society so they should be able to access mainstream services.
- Agencies in a referral networks can aid HIV prevention by providing HIV information to IDUs that attend their services; and HIV prevention is likely to be ineffective if other needs of IDUs remain unmet. For example, if IDUs are homeless or have painful abscesses, these are likely to be more pressing issues than using a clean needle and syringe for every injection.
- The final reason is possibly the most important. As outreach workers build trust and identify IDUs' needs, encouraging them towards safer behaviours, IDUs will ask for assistance of many types. If outreach workers are not able to either provide the required assistance or provide referral, IDUs will start to mistrust the outreach workers.

Teaching Notes

Slide C4.18: Steps in setting up referral network...

- ▶ Determine **IDUs' needs**
- ▶ Determine **available services**
- ▶ **Negotiate** with each agency
- ▶ Set up **simple database**
- ▶ **Train** outreach workers

C4.18

Slide C4.18: The steps in setting up a referral network are:

- Determine IDUs' needs in the outreach area.
- Determine what services are available from which agencies.
- Negotiate with each agency about client characteristics, methods of access, etc.
- Record the agencies and services in a simple database.
- Train outreach workers in use of the referral database.

The first two steps were demonstrated in the previous exercise but emphasize the need for ongoing discussions with IDUs at the local level about their needs and how these needs are met. This should start with team meetings reporting the conditions in which IDUs live and the problems they face and should continue, if possible, through the completion of questionnaires about their problems. Outreach workers can assist in completing these questionnaires, building trust and credibility for outreach staff. In an ongoing way, the feedback technique referred to earlier can be used to gather information about IDUs' needs, discuss it at the team meeting and gain action to fill gaps in services and to meet new needs of IDUs.

Teaching Notes



Potential referral agencies:

- ▶ Youth organizations
- ▶ Hospitals, drug treatment centres, hospice,
- ▶ ANC and maternity clinics
- ▶ Social services, churches, volunteers
- ▶ Charity organizations, clothes and food donors
- ▶ Homes for children, shelter for women
- ▶ Care facilities
- ▶ Legal and welfare NGOs

C4.19 Source: Prevention of HIV transmission among drug users: a training module for field-level activities. Geneva, UNAIDS Asia Pacific, Intercountry Team, 1999.

Slide C4.19:

In addition to the agencies mentioned in the previous exercise, here are some agencies to consider for a referral network are:

- hospitals, ANC and maternity clinics
- treatment centres
- social services
- churches
- volunteers
- clothes and food donors
- charity organizations
- home for children, shelter for women
- hospice care facilities

After determining the needs and the resources available at the local level, decide whether there are any gaps in services. This will be useful in the next step, negotiation.

Teaching Notes



Negotiation....

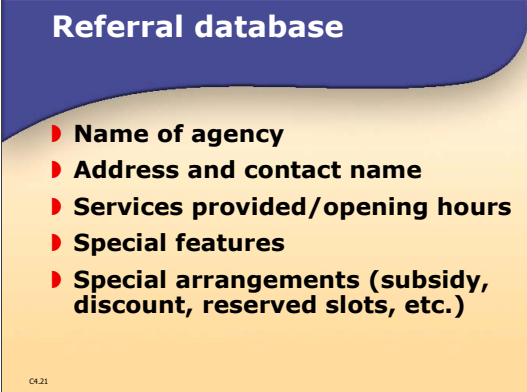
- ▶ **Meet agencies**
- ▶ **Introduce outreach programme**
- ▶ **Discuss needs and how agency can meet**
- ▶ **Listen carefully**
- ▶ **Negotiate access for IDUs**
- ▶ **Get written agreement**

C4.20

Slide C4.20: Negotiation is the most difficult step in setting up a referral network. Negotiation usually requires several steps:

- Visiting each agency is usually the best method of starting negotiations but, if time is constrained, you may decide to hold a meeting or open day to which other agencies are invited; if other agencies are represented on the CAG, this may also be a good forum in which to begin negotiation.
- Introduce yourself and your programme, providing its aims and objectives, target groups and target areas, and its rationale (international evidence for the effectiveness of outreach, etc.)
- Discuss the needs of IDUs that your programme has discovered and ask whether some of these needs can be met by the agency.
- Listen carefully to the agency's explanation about which clients they accept, what services they provide, their opening hours, their requirements.
- Try to negotiate access to the agency's services for IDUs in your locality: discuss ways that outreach staff can work with the agency's staff, ways of collaborating, roles of the programme and the agency.
- If possible, get written agreement to accept referrals from the outreach programme.

Teaching Notes

A slide titled "Referral database" with a blue header and a yellow background. It lists five items with red arrowheads: Name of agency, Address and contact name, Services provided/opening hours, Special features, and Special arrangements (subsidy, discount, reserved slots, etc.). A small "C4.21" label is in the bottom left corner.

Referral database

- ▶ **Name of agency**
- ▶ **Address and contact name**
- ▶ **Services provided/opening hours**
- ▶ **Special features**
- ▶ **Special arrangements (subsidy, discount, reserved slots, etc.)**

C4.21

Slide C4.21:

The negotiation process is ongoing, adapting to the changing needs of IDUs and to agencies opening, closing, expanding, contracting. As agencies are visited, record details of the agency in a simple database that has:

- name of the agency
- address
- contact persons
- services provided
- opening hours
- special features such as people they will accept or not accept
- special arrangements resulting from your negotiation such as IDUs can attend if accompanied by an outreach worker; HIV tests are free if referred by the outreach team, etc.

This database should be provided to each outreach worker, and use of the database should become part of the local training process for new workers. Outreach workers should be encouraged to visit the various agencies in the database to gain a clearer picture for themselves of what agencies might be best suited to their clients' needs.

Teaching Notes

Gaps in services...

- ▶ **Identify** the gaps
- ▶ Discuss with agencies
- ▶ Decide if **feasible** and **important** to address those gap
- ▶ Undertake **collaborative** projects

CA.22