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STAYING SAFE

A Manual to Train Clinical Staff In IDU Interventions



TRAINING MODULE

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A Manual to Train Clinical Staff in IDU Interventions

“Currently ‘Injecting Drug Users’ (IDUs) are referred to as ‘People Who Inject Drugs’ (PWID). However, the term ‘Injecting Drug Users’ (IDUs), has been used in this document to maintain consistency with the term used presently in National AIDS Control Programme”.

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Preface

The success of any strategy to reduce the harms associated with drug use, such as HIV/AIDS, depends on how well it is implemented at the grassroots level. This in turn requires significant training and capacity building of service providers and program implementers who implement the strategies.

In India, Targeted Intervention (TI) under the National AIDS Control Programme (NACP) framework is one of the core strategies for HIV prevention among injecting drug users (IDUs). Primary health services, health education, abscess management, treatment referrals and provision of harm reduction services such as Needle Syringe Exchange Program (NSEP) and Opioid Substitution Therapy (OST) are some of the critical services provided as part of the NACP strategy to reach out to IDUs. The services are executed through peer based outreach and Drop-in Centre (DIC) based approaches.

To further strengthen these established mechanisms under the NACP and to expand the reach to vulnerable IDUs, the United Nations Office on Drugs and Crime (UNODC) in India provides technical assistance to the National AIDS Control Organisation (NACO) through the Global Fund Round 9 Project (i.e., Project HIFAZAT), amongst others, to undertake the following:

- 1) Conduct Operational Research & Diagnostic studies
- 2) Develop Quality Assurance SOPs
- 3) Develop Capacity Building/ Training manuals
- 4) Training of Master Trainers

This manual is part of a series of six training manuals developed by UNODC and has been developed for the training of doctors and nurses of the IDU interventions, whose functions include providing clinical services especially management of abscesses, STIs, and overdose, and ensuring referral linkages. This manual aims to build both knowledge and skills of the clinical staff using participatory and adult learning principles. In addition, a conscious effort has been made to keep the manual interactive through frequent use of group discussions, films and brainstorming exercises so as to enable better learning.

Contributions from the Technical Working Group of Project HIFAZAT which included representatives from NACO, Project Management Unit (PMU) of Project HIFAZAT, SHARAN, Indian Harm Reduction Network and Emmanuel Hospital Association were critical in articulating and consolidating the inputs that helped in finalizing this module.

Acknowledgement

The United Nations Office on Drugs and Crime, Regional Office for South Asia (UNODC ROSA), in partnership with national government counterparts from the drugs and HIV sectors and with leading non-governmental organizations in the countries of the South Asia, is implementing a project titled *“Prevention of transmission of HIV among drug users in SAARC countries”* (RAS/H13).

As part of this regional initiative, UNODC is also engaged in the implementation of the Global Fund Round 9 IDU-HIV Project (i.e. Project HIFAZAT). Project HIFAZAT aims to strengthen the capacities, reach and quality of harm reduction services among IDUs in India. It involves providing support for scaling up of services for IDUs through the National AIDS Control Programme (NACO).

We would like to acknowledge the invaluable feedback and support received from various stakeholders which includes NACO, Project Management Unit (PMU) of Project HIFAZAT, Emmanuel Hospital Association (the Principal Recipient of the grant “Global Fund to Fight AIDS, Tuberculosis and Malaria – India HIV-IDU Grant No. IDA-910-G21-H”), SHARAN, Indian Harm Reduction Network and individual experts who have contributed significantly to the development of this document.

Special thanks are due to the UNODC Project H 13 team for their persistent and meticulous efforts in conceptualizing and consolidating this document.

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARD	Ano-rectal Discharge
ART	Antiretroviral Therapy
ARV	Antiretroviral
AZT	Zidovudine
BCC	Behaviour Change Communication
BID	Twice Daily
BV	Bacterial Vaginosis
CBO	Community-based Organization
CCC	Community Care Centre
CMIS	Computerized Management Information System
CNS	Central Nervous System
CPR	Cardiopulmonary Resuscitation
DAPCU	District AIDS Prevention & Control Unit
DFID	Department for International Development
DFID-TAST	Department for International Development-Technical Assistance Support Team
DIC	Drop-in Centre
DOTS	Directly Observed Treatment Strategy
EFV	Efavirenz
ELISA	Enzyme-Linked Immunosorbent Assay
FIDU	Female Injecting Drug User
FSW	Female Sex Worker
GUD	Genital Ulcer Disease
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
ICD	International Classification of Diseases
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug User
IDU-TIs	Injecting Drug User-Targeted Interventions

IEC	Information Education and Communication
IM	Intramuscular
LAP	Lower Abdominal Pain
LCD	Liquid Crystal Display
LGV	Lympho Granuloma Venereum
LSD	Lysergic Acid Diethylamide
3TC	Lamivudin
MMT	Methadone Maintenance Therapy
MOH&FW	Ministry of Health and Family Welfare
MSJ&E	Ministry of Social Justice and Empowerment
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NGO	Non-Governmental Organization
NNRTIs	Non-nucleoside Reverse Transcriptase Inhibitors
NRHM	National Rural Health Mission
NSP	Needle Syringe Program
NRTIs	Nucleoside/nucleotide Reverse Transcriptase Inhibitors
NVP	Nevirapine
OD	Overdose
OI	Opportunistic Infection
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis
PLHIV	People Living with HIV
PLWA	People Living with AIDS
PPTCT	Prevention of Parent to Child Transmission
PUD	People who Use Drugs
QID	Four Times a Day
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Tract Infection
SACS	State AIDS Control Society
SPYM	Society of Promotion of Youth and Masses
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection

STRC	State Training and Resource Centre
TB	Tuberculosis
TDF	Tenofovir
TI	Targeted Intervention
TID	Thrice in a Day
TSU	Technical Support Unit
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
UNODC ROSA	United Nations Office on Drugs and Crime, Regional Office for South Asia
VCCT	Voluntary Confidential Counselling & Testing
VCT	Voluntary Counselling & Testing
WHO	World Health Organization

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The Training Manual

Introduction to the Manual

This 5-day training manual has been developed in response to the need felt to provide a comprehensive curriculum for training of clinical staff working in Injecting Drug Users' (IDUs) interventions in India. It maps out a complete course for training of health-care professionals in targeted interventions (TIs). This is part of a series of training modules designed in order to build the capacity of doctors and nurses working with IDUs in the TIs. All components of the training module were field tested during a training workshop in Chennai in 2012. The workshop was attended by clinicians and nurses, from different settings such as TIs and medical college hospitals across India. Feedback and comments from the workshop were documented and incorporated during the development of this training manual.

Most of the sessions have been designed to cover a period of 60 to 90 minutes, which includes theory, discussion and/or activities. It is important that the training fosters an environment of learning, and is not just delivered by a person standing in front of a class lecturing about a particular subject. Trainers are encouraged to consider how they will use the training manual to develop the knowledge and capacity of the trainees. Trainees should be encouraged to take responsibility for their own learning experiences so that this process will be sustained long after the training workshop. The trainer should not feel obliged to implement all the activities within the training manual.

Purpose of the Training Manual

The purpose of the training manual is to increase knowledge, skills, confidence and build the capacity of clinicians and nursing staff to respond effectively to the issues of drug use, HIV infection and other public health concerns.

Through a combination of theory and complementary activities, trainees will have an enhanced comprehension of the key topics. The training manual provides an overview of key topics related to HIV prevention and drug use.

Who is the Target Audience?

This manual is aimed at health-care workers working with IDUs and clinical staff from TIs who may be unaware of the rapid gains in knowledge and treatment methodologies that have occurred across the world. The training manual provides evidence based approaches to the provision of services to IDUs.

Design of the Training Package

This package has been designed to develop and clarify the perspective of the participants on their role as clinical staff working in TI projects for IDUs. Most of the sessions have been planned with interactive methods such as brainstorming, problem-solving, discussions, etc. to facilitate the process of experiential adult learning for greater participation and better recall of the core issues.

The package contains the following elements:

1. Manual

The manual has been designed for a 5-day training workshop. This training manual can be used in one of two ways. First, it may be implemented as a complete training package and presented

in its entirety over five days. Alternatively, the trainers may focus on a selection of topics for a particular audience and expand upon the information that has been provided. It is recommended that the trainer read all the topics covered in the training manual from the beginning to the end, in order to gain a better understanding of the subjects and scope of each topic within the workshop.

2. Film DVD

The package contains a set of audio visual tools as listed below:

A documentary film made by SPYM, Delhi which elaborates on issues like Abscess Prevention and Management, Overdose (OD) Management, Safer Injecting Practices and Opioid Substitution Therapy (OST).

3. CD

The CD provides PowerPoint presentations used during other trainings.

4. Annexures

Some additional documents have been provided as annexures to support the training:

Annexure I: Pre- and Post-training Questionnaire containing a battery of multiple-choice questions. The same questionnaire needs to be administered in the beginning of the training programme as pre-training and at the end of the training program as post-training. After administering the pre-training, the analysis should be done immediately so that weightage can be provided for certain sessions as per the current knowledge level of the participants. Therefore, if the analysis reveals that the participants do not have an understanding of – or have less understanding of – a particular aspect, then the facilitator should emphasize on it during the relevant session/s.

Annexure II: Training Agenda

Annexure III: Day-wise Feedback Forms are also provided. Copies are to be given to the participants at the end of each of the first four days (Days 1 to 4) for their feedback on the day's proceedings. It would be helpful to review the feedback forms on a daily basis so as to be able to respond to significant issues, if any, on the topics and issues such as lack of comprehension of important content or perceived lack of applicability.

Annexure IV: Assessment of Drug Dependence

Before the Workshop

A 5-day workshop needs extensive preparation and the facilitator should ensure that the following is done well in advance:

1. Tips for Trainers

- Before each day's training it is recommended that the trainers familiarize themselves with the topics to be covered for that day, by carefully reading the relevant materials. This will enhance understanding of the concepts and points raised on each slide and its correlation to the accompanying text. Depending on the skills of the trainer, and their background, they may wish to include examples or case studies to bring further depth and clarity to the topic being presented.

- Most workshops require more than one trainer. In such cases, it should be ensured that the co-trainers have read all the workshop materials in this package and that they feel comfortable facilitating the workshop on the selected topics from the training manual. A meeting of the trainers before the workshop should ideally be conducted to agree on the agenda and to decide who is going to teach which topic. Some trainers feel more comfortable presenting certain topics than other trainers and for the benefit of the trainer and the trainees, this should be taken into consideration.
- Understand the profile of participants attending the training so that the training can be tailored to suit their requirements. For example, if it is a Hindi-speaking audience then the Hindi animation film will be required; if the participants are a mix of new and senior clinical staff then ensure there is space for the senior clinical staff to share their experience with the new clinical staff.

2. The Venue

The venue used for training can make a big difference to the results of a training program. Multi-day workshops can be held either at central locations to which where participants can travel to each day for training, or they can be held in more isolated venues. The advantage of central venues is that the training may be more convenient for participants (who can return to their homes and families each evening), accommodation may not be needed for participants (except those from outside the area), and the training course would work out to be considerably cheaper to conduct. The advantage of a more isolated venue is that participants are forced to spend more time together, enhancing the likelihood of building up friendships and team spirit. Depending on the type of workshop, venues can also be selected according to their proximity to field activities, so that the participants can visit programs and meet staff.

3. Workshop Logistics

- It is always wise to check that the equipment needed is available and working properly, like projector and laptop to screen the PowerPoint presentations and the film.
 - When organizing the workshop, various arrangements need to be made such as transport for the participants to and from the venue, site visits, accommodation, restroom facilities, catering, social activities, safety and security of personal belongings equipment and materials, emergency medical assistance and so on.
4. Read the NACO Operational Guidelines and training manual completely before the workshop.
 5. Prepare all materials required for the sessions pre- and post-training questionnaire, feedback forms, etc.
 6. If possible, arrange for other films or newsletters/magazines that document best practices on working with IDUs from across the country. These films can be screened during the lunch break or after the day's sessions have ended. Newsletters and magazines could be placed on the side at the training venue and participants could be encouraged to go through them.

Workshop Completion Certificate

It is a good idea to award certificates to all participants on successful completion of the workshop. A small gesture of endorsement or recognition by the organizers helps a great deal to boost the level of participation and motivation both during the workshop and afterwards.

Materials Required During the Training

- LCD projector (for slides) or overhead projector
- Computer with slides or printed overhead slides
- Flip charts, a stand, at least 10 marker pens (various colours)
- Whiteboard or blackboard (plus chalk for blackboard or special whiteboard marker pens if using whiteboard)
- Resource manual for each participant
- Training Agenda
- Pre- and post- training questionnaire
- A notebook for recording information or aspects not documented in the training materials
- Daily feedback forms
- Certificates
- CD-ROM of the training manual including each of the PowerPoint presentations

How to Facilitate

- The workshop trainers or facilitators should be familiar with experiential and participatory forms of learning.
- They should have the ability to ask exploratory/probing open-ended questions and should make it a point to involve all the participants.
- The facilitators should be technically competent to answer various intervention-related questions. The topics included may be adapted to suit local needs and priorities.
- As there are many hands-on sessions, the facilitators would need to be familiar with all those processes so that they can actually demonstrate as well as guide the participants correctly in the field. It will be important at all stages for participants to correlate their classroom teachings with field-level learning and vice versa.

How to Use the Manual

The chapters on each session provide the following information:

1. **Objective:** What the facilitator hopes to achieve by the end of the session.
2. **Expected Outcome:** The outcomes anticipated as a consequence of the session.
3. **Methodology:** The suggested methods and techniques to be used.
4. **Materials Required:** Materials may include flip charts, marker pens, handouts, etc. in addition to any preparation that is required.
5. **Duration:** Approximate time each session will take.
6. **Process:** The step-by-step details of how to conduct the session.

Key Things to Remember as Facilitator

Do

- Be flexible. Scheduling may have to change depending on the need of the participants
- Use different teaching methods to enhance participation and retain interest
- Ensure that teaching materials like hand-outs; charts, etc. are available before the beginning of the session
- Respect participants' local knowledge
- Encourage participants to make presentations
- Remember, this is a participatory workshop and your role is to FACILITATE!

Don't

- Let any one person dominate the discussion
- Speak more than the participants – let the participants brainstorm and discuss
- Allow distractions like mobile phones and chatting among participants
- Make the training a boring experience – intersperse the sessions with energizers/games
- Read out from the PowerPoint presentations – prepare well and use the presentation slides as cue cards to elaborate on the relevant points

Day

1

Session One

Introduction to the Training Program

Session Two

Basics of Drugs

Session Three

Understanding Drug Related Harms and Injecting Drug Use

Session Four

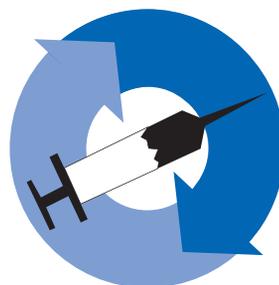
Harm Reduction - Understanding the Principles

Session Five

National AIDS Control Programme

Session Six

Targeted Interventions for Injecting Drug Users



Introduction to the Training Program

OBJECTIVE

To introduce the participants to each other, set ground rules for smooth running of the sessions and record the participants' expectation from the training.

EXPECTED OUTCOME

By the end of the session, participants would:

- Have agreed on the ground rules for the workshop
- Have explored the expectations from the workshop
- Know the agenda for the 5-day training workshop

DURATION

1 hour

SESSION CONTENT

- Ground rules for the workshop
- Expectations from the workshop
- Introducing the training agenda for the workshop

METHODOLOGY

- Discussion
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED

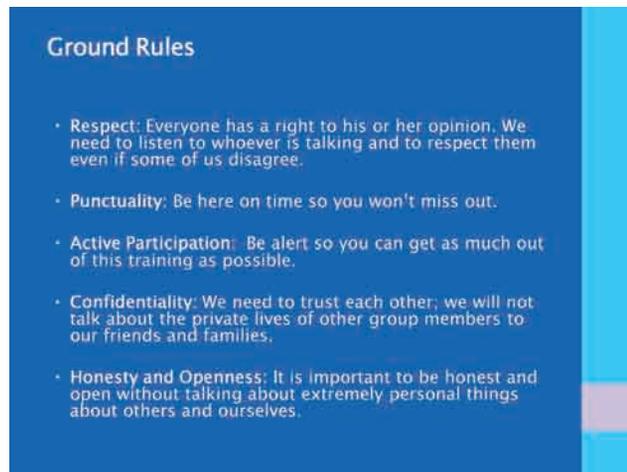
- Projector
- Laptop
- PowerPoint presentation
- Flip charts and markers
- Training agenda: copies for the participants
- Pre-test evaluation: copies for the participants

PROCESS

Step1: Establish ground rules

- Ask participants to decide on the ground rules. Allow the group to brainstorm for a short time.

- Write the ideas on the flip chart, putting similar ideas together or close to each other on the chart sheet.
- Assist the group in making rules by asking questions or giving examples.
- After brainstorming, the group should have consensual ground rules. After the session, the facilitator(s) will rewrite the rules in an orderly fashion on a different flip chart. These rules will be posted during the entire training.
- To reinforce, facilitator will present the slide on ground rules.



Step 2: Expectations of the workshop

- Ask the group to share the expectations they have from this training.
- Write their responses on a flip chart. After getting their responses, review the list and mention which issues will be covered in the workshop and which will not.
- Explain that the issues covered in this workshop were developed through a consultative process involving people who use drugs, service providers, non-governmental organizations, National AIDS Control Organization officials, donor agencies and UN agencies from all the regions of the project.

Step 3: Introducing the 5-day workshop agenda

- Provide the training agenda to the participants and review it with them.
- Introduce the workshop; duration of each day of the workshop; logistics arrangements including breaks during the day, food and location of toilets.
- Invite volunteers from among the participants and assign them the task of noting 'reflections' from the participants at the end of each day of the workshop. Also ensure that volunteers are assigned the role of recapping the previous day's sessions at the beginning of each day. Inform them that this is applicable to all the days of the workshop.

The agenda for the 5-day workshop is included in [Annexure II](#).

Step 4: Pre-training evaluation

- Explain the objective of the pre-training evaluation (the evaluation is not a formal assessment of the participants; rather, it is meant to understand the current level of knowledge of the participants, and reassess the same at the end of the training. This will provide feedback on the possible change as a result of the training program.
- Distribute the pre-training questionnaire and ask participants to complete and return it. The questionnaire is anonymous and does not require the respondent's name or any other identifying information.
- Collect the completed questionnaires and thank the participants.

The pre-training evaluation questionnaire is included in [Annexure I](#).

Basics of Drugs

OBJECTIVE

To help participants understand the various terms associated with drug use, various types of drugs and how they affect the risks of HIV transmission.

EXPECTED OUTCOME

By the end of the session, participants would

- Know various types of drugs used, the routes of administration and the effects of the drugs
- Understand about the various terminologies associated with drug use and their effects such as drug use, abuse and dependence

DURATION

1 hour

SESSION CONTENT

- Types of substances used
- Modes of administration
- Effects of various substances
- Stages of drug use
- Drugs: Use, harmful use, hazardous use and dependence

METHODOLOGY

- Brainstorming
- Discussion
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/whiteboard
- Marker pens

PROCESS

Step 1: Understanding the definition of 'drugs'

- The facilitator initiates the discussion by asking the participants what comes to their mind when they hear the term 'drugs'. He/she notes down the various responses on the whiteboard/chart paper/flip chart and then presents the slides on drugs from the PowerPoint presentation (What is a drug and a psychoactive substance?)

- A drug is also referred to as 'substance' and drug users can also be called 'substance users'.

The term 'drug' is also referred to as 'substance'; and 'Drug users' are referred to as 'substance users'.

- Psychoactive drugs are derived directly from plants or naturally occurring plant processes (tobacco, heroin, cannabis and alcohol) or they can be manufactured in laboratories (benzodiazepines, amphetamines). They can also be manufactured illegally in 'backyard' laboratories. Most psychoactive drugs have a therapeutic effect when used in controlled doses and circumstances with the notable exception of tobacco. Psychoactive drugs produce changes in feelings, mood and cognition by stimulating or depressing the central nervous system (CNS).

What is a drug? What is a psychoactive substance?

- Any substance (with the exception of food and water) which when taken into the body alters its functions, physically and/or psychologically is a drug.
- Any substance which when taken into the body alters the functions of the mind is called a psychoactive substance.

Society has made a distinction between licit and illicit drugs and this in turn impacts upon how drug use is perceived in the community. It is important to acknowledge that the two most widely used psychoactive drugs, resulting in the highest health costs to the community, are the legal drugs: tobacco and alcohol. Drug use occurs along a continuum and any substance has the potential to cause harm. The harms associated with illicit drug use are frequently attributed to factors relating to prohibition: involvement in criminal justice system, marginalization, stigmatization and lack of regulated quality control. Trends over the past two decades indicate that the problems associated with illicit drugs are increasing rapidly.

Step 2: Discussion on types/categories of drugs

- The facilitator then asks the participants to name the drugs that they know, which is noted down on a flip chart. The participants are also asked to mention whether the drugs that they name belong to the category of legal or illegal drugs.



NOTE TO THE FACILITATOR

He/she should make sure to note down the various names under the 3 basic categories of Depressants, Stimulants and Hallucinogens.

- The facilitator continues with the presentation to explain the various categories of drugs, he/she uses the list of drugs mentioned by the participants to help them understand which drugs come under each of these categories.

Categories of Drugs

- Depressants
- Stimulants
- Hallucinogens

- **Depressants** slow down the processes of the CNS, leading to relaxation and sedation. In small doses, they can lessen inhibition and reduce coordination and concentration. In larger doses, they may cause slurred speech, unconsciousness, vomiting and death. The risks are greatly increased when drugs are mixed. Often mixing depressant drugs dramatically increases the effects of these drugs and, consequently, the risk of unconsciousness, vomiting and death.

Depressants

- Depressants slow down the activity of the brain or other body functions.
- Depressants slow down the messages going to and coming out of the brain.
- Bodily functions such as breathing and heart rate are slowed down.
- Depressants may be useful to relieve pain, reduce anxiety and deal with stress.

- Depressant drugs include opioids, alcohol, marijuana, tranquillisers and most volatile solvents (aerosols, solvents, glue, petrol, cleaning fluid, laughing gas).

Depressants (contd.)

- Opioids
- Alcohol
- Benzodiazepines
- Solvents

- **Stimulants** cause arousal by speeding the production of nerve impulses, leading to heightened alertness, excitability and energy. Stimulants increase the heart rate, blood pressure and body temperature. They increase self-confidence and reduce feelings of tiredness and hunger. In large doses they can cause anxiety, panic and paranoia. Although less common than with depressant drugs, there have been deaths associated with the use of stimulants. Mixing stimulant and depressant drugs does not negate the effects of each drug. On the contrary, it is more likely to increase the effects and the risks.

- Stimulants include amphetamines (speed), ecstasy and designer drugs, cocaine and slimming tablets. Nicotine and caffeine are mild stimulants.

- **Hallucinogens** distort the user's perception of reality. Perception may be affected to the extent that user sees or hear things which aren't actually present (visual or auditory hallucinations). The effects of hallucinogens vary greatly.

- Hallucinogens include magic mushrooms, LSD (Lysergic Acid Diethylamide), PCP (Phencyclidine), Ecstasy and Ketamine.

Stimulants

- Stimulants speed up the messages going to and coming out of the brain.
- They can lead to increased body metabolism, elevated heart rate and wakefulness.
- Stimulant users experience increased energy levels, feeling of power and strength.

Stimulants (contd.)

- Amphetamine type stimulants
 - Methamphetamine, Ecstasy
- Cocaine
- Tobacco

Hallucinogens

- Hallucinogens include a range of naturally occurring and synthetic drugs.
- They confuse or mix up the messages that are going into and coming out of the brain.
- Hallucinogen users experience hallucinations and sensory distortion.

Hallucinogens (contd.)

- LSD (Lysergic Acid Diethylamide)
- PCP (Phencyclidine)
- Ketamine
- Certain mushrooms
- Certain cactus plants

Cannabis has the properties of all the three classes of drugs, namely, depressant, stimulant & hallucinogen

- There are various definitions related to the use of substances. A detailed description of these terms can be found on the WHO website. There are two main classification systems for substance use, namely the World Health Organization's *International Classification of Diseases*, Tenth Revision (ICD-10) and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, (DSM-IV).

ICD-10 Diagnostic Guidelines – WHO

A definite diagnosis of dependence syndrome should usually be made only if three or more of the following have been present together at some time during the previous year:

- Evidence of tolerance
- A physiological withdrawal state when substance use has ceased or reduced

ICD-10 Diagnostic Guidelines – (contd.)

- A strong desire or sense of compulsion to take the substance
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination or levels of use
- Progressive neglect of alternative pleasures or interests
- Persisting with substance use despite clear evidence of overtly harmful consequences

Step 3: Understanding abuse and dependence

- **Substance (drug) abuse** is characterized by recurrent and clinically significant adverse consequences related to the repeated use of substances, such as failing to fulfil major obligations, the use of drugs in situations which are physically hazardous, occurrence of substance-related legal problems and continued drug use despite the presence of persistent or recurrent social or interpersonal problems.

- **Substance (drug) dependence:** It is a cluster of cognitive, behavioural and physiological symptoms indicating that a person is continuing to use a substance despite having clinically significant substance-related problems. It is characterized by a strong desire to take the substance, difficulty in controlling use, neglect of other activities in preference for using or seeking the substance, tolerance for the drug requiring larger amounts for the same effect and withdrawal symptoms in the absence of the substance.

Abuse/harmful use

- Maladaptive pattern of use resulting in physical, social, legal harm
- Continued use in spite of negative consequences
The same 40-year old man continues drinking alcohol after the incident

A 'Dependent' Person...

- May experience:
 - Narrowing of repertoire (range)
 - Focus of all interest on drug
 - Awareness of compulsion
 - Craving
 - Loss of control
 - Reinstatement or relapse
- Withdrawal syndrome
- Tolerance to certain substance/s

Source: World Health Organization Geneva: Definition of drug dependence.

- Importantly, the individual has insight into the connection between use and consequences and continues to use the drug despite the legal, health and financial consequences. Drugs are used to alleviate withdrawal symptoms, leading to increased tolerance and withdrawal from family and work.

Drug Dependence

- Drug dependence is a chronic relapsing disorder.
- It is a brain disorder in which biological, psychological and social factors operate.

Additional Notes

Intoxication is a condition that follows the administration of a psychoactive substance and results in disturbances in the level of consciousness, cognition, perception, judgement; affect behaviour, or other psycho-physiological functions and responses. The disturbances are related to the acute pharmacological effects of, and learned responses to, the substance. They get resolved with time resulting in complete recovery, except where tissue damage or other complications have arisen.

The term is most commonly used with regard to alcohol use: Its equivalent in everyday speech is 'drunkenness'. Alcohol intoxication is manifested by such signs as facial flushing, slurred speech, unsteady gait, euphoria, increased activity, volubility, disorderly conduct, slowed reactions, impaired judgement and lack of motor coordination, insensibility, or stupefaction.

Addiction refers to repeated use of a psychoactive substance or substances, to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance or substances, has great difficulty in voluntarily stopping or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means.

Typically, tolerance is prominent and a withdrawal syndrome frequently occurs when substance use is interrupted and life is dominated by substance use over all other activities and responsibilities. The term 'addiction' also conveys the sense that such substance use has a detrimental effect on society as well as on the individual; when applied to the use of alcohol, it is equivalent to alcoholism.

'Addiction' is a term of long standing and variable usage. It is regarded by many as a discrete disease entity, a debilitating disorder rooted in the pharmacological effects of the drug. From the 1920s to the 1960s, attempts were made to differentiate between addiction and 'habituation', a less severe form of psychological adaptation. In the 1960s the WHO recommended that both terms be abandoned in favour of dependence, which can exist in various degrees of severity. Even though the term 'addiction' is not a diagnostic term in ICD-10, it continues to be widely used by both professionals and the general public.

The research and treatment community has found standardized diagnostic criteria useful. Such criteria provide agreement as to the constellation of symptoms that indicate alcohol or drug dependence syndrome and allow researchers all over the world to communicate clearly as to what kinds of disorders are being studied.

Contd...

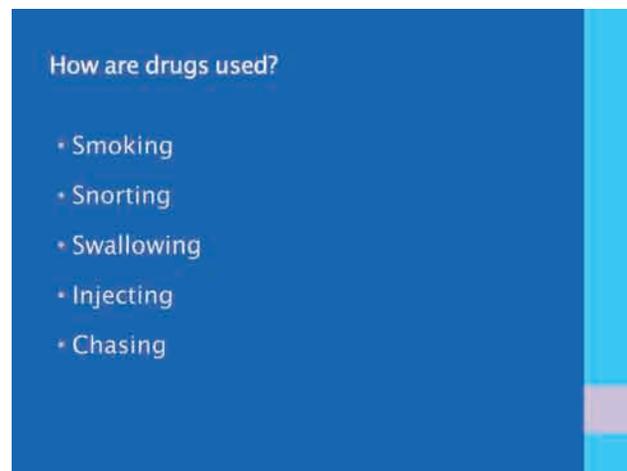
Standardized diagnostic criteria are equally important and useful to clinicians. In the drug and alcohol field, there have been many different ways by which clinical staff might arrive at a diagnosis-sometimes differing among staff within the same program. Although the use of standard diagnostic criteria may seem somewhat burdensome, it provides many benefits: efficient assessment and more consistency in diagnoses, enhanced ability to measure the effectiveness of programs, and provision of services to people who most need them.

The American Society for Addiction Medicine recently defined addiction as a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours.

Step 4: Discussion on other issues related to drug use

- The facilitator then generates the discussion among the participants regarding how the drugs are being used
- Summarize the discussion with the PowerPoint presentation

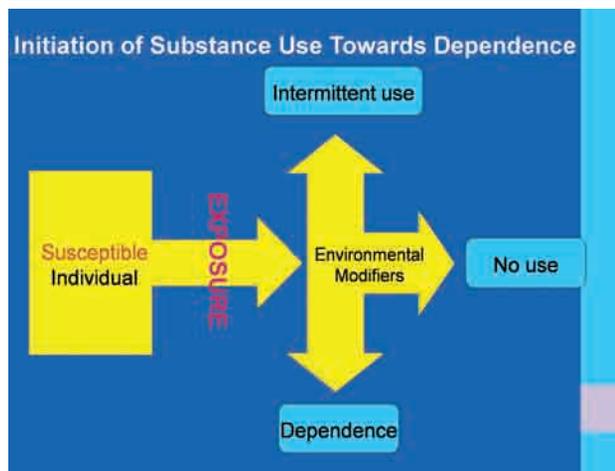
- **Smoked or inhaled:** Tobacco, cannabis, opium, heroin, ATS, glue
- **Snorted/sniffed:** Cocaine, heroin
- **Ingested (swallowed):** Alcohol, opium, cannabis, sedatives (e.g.diazepam)
- **Injected:** Heroin, cocaine, sedatives, ATS, buprenorphine
- **Chased (or “chasing the dragon”):** Heroin



- Some people transit from one route of use to others (from smoking to injecting heroin)
- Some use multiple drugs and multiple routes (e.g., drink alcohol, smoke tobacco and inject heroin)

- Facilitator then presents the slides on progression of drug use

- Drug use, abuse and dependence begin with the initiation of drug use. Initially everyone is an experimental user and then transits to being a social user, using drugs in recreational and social settings. As drugs offer pleasure, the user have a tendency to repeat the use of drugs and look forward to using drugs as often as they can. Once they start using drugs frequently, individuals begin to feel normal under the influence of drugs and feel dysphoric without the drugs. In this stage, they are taking drugs to normalize themselves. Then comes the final stage of compulsive use where they experience significant withdrawal symptoms, physical and/or psychological and have significant craving.



- There are many factors which either protect people from drug use or put people at risk of drug use. It needs to be emphasized that many of these factors are interdependent and either positively or negatively reinforce each other.
- A complex group of agent (substance), host (e.g., genetic) and environmental factors interact with each other for the establishment of substance use disorder.

Risk and Protective Factors

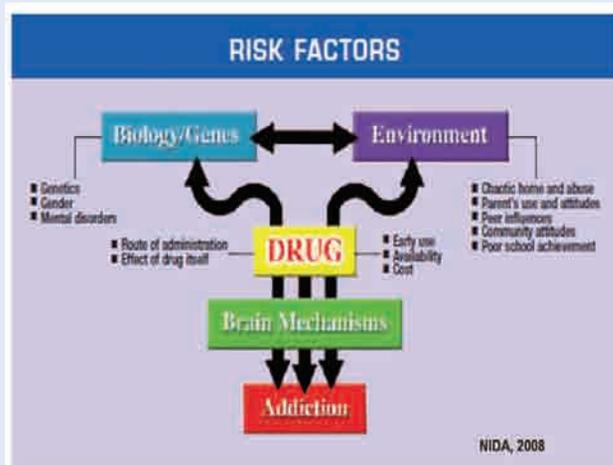
Risk factors	Protective factors
Lack of parental supervision	Parental support and supervision
Drug using friends	Peer norms discouraging drug use
Early aggressive behaviour, externalizing behaviours	Peers who are academically competent
Poor social skills	Positive relationships
Easy availability of drugs	Self control
Family member using drugs	Social and cultural norms for drug use are discouraging
Psychiatric disorder	Earlier intervention for externalizing behaviours
Early use of drugs	
Using drugs in certain methods (injecting)	

Additional Notes

Susceptible individuals include those with a genetic predisposition, victims of child abuse, and individuals with psychiatric pathology including depression and personality disorders, those who experience family disruption including substance-use dependence within the home and those who are socially isolated.

With exposure to a substance, neurological pathways within the brain are modified depending on the substance used. Even a small exposure to a substance can alter brain chemistry. Environmental factors such as poverty, social change, cultural norms, drug polices and drug availability and importantly, peer group culture determine further use of drugs. Social support and integration, perceived control over present situation and economic status also influence the outcome of drug use.

The result is that most individuals either do not continue to use or use intermittently over time. Some individuals use intermittently but heavily when they do use and this is termed substance abuse when there is psychosocial fallout from this pattern of use. A minority of individuals, for various reasons, go on to develop substance dependence, which is generally transient but can be lifelong. It has been estimated that around 2-15 per cent of people can become dependent drug users.



Step 5: Conclusion

- The facilitator concludes the session by highlighting the following:

Key Messages

Any substance which, when taken into the body, alters the functions of the mind (brain) is called a psychoactive substance

Three categories of drugs: depressants, stimulants, hallucinogens

Progression of drug use is over time and goes through experimental, recreational, regular and compulsive use

Drug dependence is recognized by characteristic symptoms such as progressive neglect of other pleasures, craving, withdrawal, tolerance, loss of control and use despite harm

Understanding Drug Related Harms and Injecting Drug Use

OBJECTIVE

To help participants understand the profile of IDUs and harms related to drug use

EXPECTED OUTCOME

By the end of the session participants would:

- Know the various harms related to drug use
- Understand the physiological and psychological factors associated with drug use
- Know the various harms related to injecting drug use.

DURATION

1 hour

SESSION CONTENT

- Drug use related harms
- Injecting drug use related harms

MATERIALS/PREPARATION REQUIRED

- Group activity
- PowerPoint presentation

TRAINING MATERIALS

- Projector
- Laptop
- PowerPoint presentation
- Flip Charts/whiteboard
- Marker pens

PROCESS

Step 1: Group activity and presentation

- The facilitator divides the participants into small groups and provides each group with the name of a drug: heroin, pharmaceutical injections, cannabis or alcohol.

- He/she asks each group to list:
 - ◆ Factors or scenarios where this drug causes the least amount of harm
 - ◆ Factors or scenarios where the most amount of harm occurs
- He/she asks each group to consider that the legal status of their drug has been reversed, e.g., alcohol is now an illegal drug, and to discuss how this would affect alcohol users and alter the harms associated with this drug
- The facilitator then asks the groups to reconvene to a large group and present on:
 - ◆ The positive and negative factors and the implications of legal and illegal status of drugs
 - ◆ The consequences of injecting drugs

Step 2: Presentation on drug related harms and injecting drug use related harms

- Overdose (OD) which occurs when a larger than usual quantity of the drug is ingested, when tolerance has reduced, or when several drugs (including alcohol) are taken in combination.

- **Direct mental effects:** Acute, as in intoxication (for example, amphetamine psychosis), and chronic, as in the long-term effects of some drugs on mental functioning.

- **Harms linked to living conditions:** A further class of harms may be related to, or exacerbated by, the poor lifestyle and living conditions of some drug injectors (inadequate diet, overcrowded or insanitary housing), which increases vulnerability to infections such as pneumonia and tuberculosis (TB).

- **Harms linked to lifestyle conditions:** Problem drug users are more likely to be victims of violence or accidents. Additionally, they may resort to crime or sex work to sustain their drug using habit.

Drug Related Harms

Harms associated with drug use:

- Opioid overdose/ death
- Crime/ theft/ imprisonment/ drug syndicates
- Suicide/ accidental death/ murder
- Sex work
- Financial/ poverty/ community/ legal/ stigma

- **Harmful effects due to drug preparation:** May be caused by contaminants in the drug/s used, or not removed in the process of preparing drugs for injection.

- **Harmful effects due to the route of administration:** Some harms are caused by the route of administration, including infections related to the introduction of bacteria at injecting sites; blood poisoning; and nasal membrane damage from sniffing drugs.

Drug Related Harms (contd.)

Harms associated with injection use:

- Infection
 - Blood-borne infection from shared equipment- hepatitis, HIV, malaria
- Systemic contamination infections - endocarditis, fungal abscess, osteomyelitis
- Local infection from poor hygiene

<p>Injecting Drug Use Related Harms – Needle and the Damage Done</p>  <p>Sharing heroin from same bottle cap ('cooker'), Chennai</p>	<p>Injecting Drug Use Related Harms – Unsafe Injecting Leads to HIV</p> 
<p>Injecting Drug Use Related Harms – Unhygienic Settings for Injecting</p>  <p>Heroin injecting in a public toilet, Chennai</p>	<p>Injecting Drug Use Related Harms - Some Untreated Abscesses in IDUs</p> 

- **Harmful effects related to the social use of drugs – sharing of equipment:** Some harmful effects may arise from the use of drugs in social situations, as when two or more injectors share the same equipment. Infections such as HIV and Hepatitis B and C may be transmitted.
- Whilst we focus on HIV, there are other harms that need to be considered in any harm reduction 'package'. Many harm-reduction projects have now been broadened to include a wider range of adverse health consequences.
- It is important to note that some of the adverse health consequences are not confined to people who inject drugs – for example, 'amphetamine psychoses may be experienced by someone who uses amphetamine orally. It is, therefore, important to understand that the harm-reduction approach is appropriate not only for people who inject drugs, but also for those who use other methods to take illicit and licit drugs, including smoking of tobacco and drinking of alcohol.

Step 3: Conclusion

- The facilitator concludes the session with the following key messages:

Key Messages

Multiple harms are associated with drug use: Overdose, association with criminality, loss of employment, financial problems, marital/family problems and involvement in sex work

Harms associated with injecting drug use include: Acquisition and transmission of bloodborne pathogens, injection-related injuries and infections

Sharing of needles and syringes and unsafe injecting practices contribute to injecting drug-use related harms

Harm Reduction: Understanding the Principles

OBJECTIVE

To familiarize the participants with:

- Establishing a context for harm-reduction strategy, especially in the context of HIV
- Concept of harm reduction
- Hierarchy of injection-related risks

EXPECTED OUTCOME

By the end of the session participants would

- Know about the effective approaches for HIV prevention among IDUs
- Understand the principles of the harm reduction strategy

DURATION

1 hour

SESSION CONTENT

- Effective approaches to control HIV amongst IDUs
- Principles of harm-reduction strategy
- Multiple interventions in harm-reduction approach

METHODOLOGY

- Discussion
- Group activity
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/Whiteboard
- Marker pen

PROCESS

Step 1: Discussion and presentation

- The facilitator begins the session by asking the participants about effective approaches to drug use and HIV

- Efforts to reduce the global demand for drugs have not been very successful, besides being slow, long-term and incremental in their effects. Many demand-reduction approaches are unrealistic in their aims and are not properly targeted. With the emergence and rapid spread of HIV among IDUs in the 1980s, a new and effective strategy was needed which had to be beneficial to drug users as well as their families. It had to attract drug users to the proposed interventions and be capable of retaining them. Since drug users have multiple needs, it is necessary that the approach be able to address these needs.

- The strategy has to be practical in order that it can be implemented in a wide variety of settings. An important component is the effectiveness of the approach in containing HIV infection among the drug using populations and their partners. Finally, the approach should have a public health perspective and benefit not only the users and their families, but society as well.

- Harm reduction emphasizes short-term pragmatic and achievable goals over long-term goals. Efforts to prevent rapid spread of HIV transmission need to be implemented as quickly as possible. The rapid and potentially explosive spread of HIV infection among IDUs must be prevented. HIV prevention among IDUs works best when begun early (HIV prevalence < 5%). It is difficult to contain the HIV epidemic if HIV prevalence escalates above 20%. In order to attract the IDUs who are hidden, it is important to provide need-based services which address their multiple needs. A comprehensive approach containing the effective components may be very useful for the drug users.

What are the effective approaches to drug use and HIV?

- Approaches that are beneficial to drug users, their families and communities.
- Approaches that can be attractive to drug users.
- Approaches that address the needs of the drug users.

What are the effective approaches to drug use and HIV? (contd.)

- Approaches that are practical.
- Approaches that can effectively contain HIV among drug users.
- Approaches that have 'public health perspective'.

Effective Approaches

- Start early (HIV prevalence among IDUs < 5%)
- IDUs need to be attracted (provide need-based services)
- Implement multiple programs such as
 - Outreach
 - Drug treatment such as opioid substitution therapy
 - Needle and syringe programs
 - HIV testing and counselling

- IDUs exhibit several risk behaviours that produce adverse health and social consequences. Providing access to multiple means for behaviour change is critical. IDUs require information, education and effective communication about safer practices for behaviour change. Means for change like needles, syringes, water, cookers, cotton and condoms have to be provided to them. HIV testing and counselling will help them to modify their behaviour as well as encourage them to bring their partners. IDUs have multiple medical and social problems and 'one-stop shopping' would be better for them than fragmented services. IDUs find it difficult to access various services and ways must be found to integrate services. Collaboration between various service providers is critical and efforts are needed for establishing a continuum of care.

- The services must be provided in places and settings that are accessible for drug users. Quality of interventions must be ensured and relates to many issues such as training and competency of staff, dose of interventions and provision of necessary services. Negative attitudes, stereotypes and stigma associated with injecting drug use should be defeated. Humane care of IDUs is critical to the success of interventions targeting drug users. Helping IDUs through drug users and ex-drug users is important.

- Networking with various agencies is essential for sustainability of the interventions. Additionally, this ensures that the various needs of the drug users are addressed as it is difficult to provide all the required services through a single agency.

- It is important to examine the social, legal, cultural and political context with a view to removing the barriers which may exist and prevent safer injecting. Barriers include lack of information, primary health care and drug treatment. Legal barriers such as the criminalization of possession of a clean needle can result in the sharing of common injecting equipment and increase HIV transmission. Drug users want to avoid criminal charges related to possession of clean injecting equipment and therefore may not buy them. Thus, laws to control drug use can inadvertently promote the spread of HIV.

Effective Approaches (contd.)

- Target several risk behaviours at the same time
- Provide access to multiple means for behaviour change:
 - Risk reduction information (media, pamphlets etc)
 - Needles and syringes, cleaning materials, condoms etc.
 - HIV testing with pre and post test counselling

Effective Approaches (contd.)

- Implement programs in various places:
 - Streets
 - Health settings
 - New outlets
- Rely on local drug users and ex users to serve as:
 - Outreach workers
 - Role models
 - Peer educators
 - Advocates

Effective Approaches (contd.)

- Implement programs at several levels for drug users to make and sustain behavioural changes in supportive environment
 - Government policy
 - Legal
 - Health institutions
 - Community
 - Network
 - Individual
- Provide reinforcement education

- The police and law enforcement officials are central players in any response to illicit drugs. The police must be consulted and involved when developing a response to drug use and HIV. It is important to get the police to support harm- reduction programs. There are numerous ways to do this, including involving senior police in early consultations for permission to run a program, educating junior police about the program and what it is aiming to achieve; and using supportive police to educate other police.

Important Things to Consider

- Reaching out to IDUs who are out of treatment
- Providing means for safer practices (sterile injecting equipment, condoms)
- Establishing substitution programs
- Offering counselling, care and support services

Important Things to Consider (contd.)

- Creation of a supportive environment
- Working together with law enforcement and health agencies
- Using a range of approaches

Important Things to Consider (contd.)

- Ensuring adequate coverage
- Undertaking rapid assessments of the nature and extent of the problem

We need to decide, "What is our priority?"

Keeping drug users alive and safe?

Which is the bigger problem?

Preventing Drug Use or HIV/AIDS?

Step 2: Group activity (5-10 minutes)

- The facilitator divides the participants into four groups
- He/she asks the participants to identify the application of harm reduction strategies in everyday life for the protection of the wider community (excluding issues associated with drug use).

The objective of this activity is to make them understand that harm-reduction strategies to promote public health have a long history and are varied.

Step 3: Presentation on Harm Reduction

<h4>Harm Reduction: A Practical Approach</h4> <ul style="list-style-type: none">• Harm reduction is an old concept used widely to promote and improve public health• Examples of harm reduction<ul style="list-style-type: none">• Helmets for motor bikes• Seat belts in cars• Protective gears	<h4>What is harm reduction in drug use?</h4> <ul style="list-style-type: none">• Harm reduction is a public health approach.• Definition of harm reduction: <i>"Policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and their communities".</i> International Harm Reduction Association
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<h4>'Reduction of Harm'</h4> <ul style="list-style-type: none">• Aims to reduce drug related harm to the <u>individual</u> and <u>the community</u>• Hierarchy of goals:<ul style="list-style-type: none">• 'Cure' (abstinence) is ideal• Reducing levels of drug use• Changing high risk behaviours	<h4>A Pragmatic Approach Needed</h4> <ul style="list-style-type: none">• For those individuals who are currently unable or unwilling to stop using drugs, treatment interventions should be directed at reduction of morbidity, disability and death caused by or associated with substance use.• Reduction in risk behaviours associated with drug dependence is an achievable goal. <p>Best for Few vs. Good for Many</p>
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Harm Reduction

Despite continued use, interventions promote health or prevent harms (infections, crime)

Additional Notes

During the presentation make sure following points are covered while discussing the slides with the participants:

- Harm reduction is a public-health approach that emphasizes and places priority on reducing the negative consequences of drug use rather than eliminating drug use or ensuring abstinence. Over the last two decades, harm reduction has become the subject of growing discussion and debate within the drug treatment community and, increasingly, by the media and the general public.
- A primary catalyst for this surge of interest in harm reduction has been the emergence and rapid spread of HIV among drug users through sharing of contaminated injecting equipment.
- Harm reduction is an approach adopted by governments that informs their policy and program response to licit and illicit drug use. It aims to reduce drug related harm to all citizens. As part of this approach drug use is considered a public health issue rather than a law and order or legal issue.
- The efficacy, effectiveness and public health benefits of harm reduction are well proven scientifically. Overwhelmingly, research has confirmed that strategies that are based on harm reduction principles are more effective than approaches focused on abstinence. Within a harm-minimisation approach, it is possible to discourage the harmful use of drugs while still addressing the reality that people will use drugs.

Harm reduction recognizes abstinence as a valid goal or outcome in the continuum of drug use. However, regardless of interventions, some people will continue to use drugs. Harm reduction acknowledges the complexity of drug use and encourages risk reduction in attainable steps. The overall goal is the reduction of drug related harm, both to the community and to individual drug users.

- Presentation on the principles of harm reduction
 - The main characteristic of harm reduction is focus on harms. The fact or extent of a person's drug use is of secondary importance to the risk of harms related to their use. The harms addressed can be related to health, social, economic or a multitude of other factors affecting the individual, the community and society as a whole. The first priority is to decrease the negative consequences of drug use to the user and to others. Among the various harms, the most important from the public health perspective is prevention of infections such as HIV among IDUs. As said before, it is better to initiate HIV prevention interventions early, as once introduced, the infection can rapidly escalate to an explosive epidemic among IDUs, if scaled-up prevention interventions are not in place.

Principles of Harm Reduction

Principle 1: Short-term pragmatic goals

- Strategies to prevent HIV transmission to be implemented quickly. Prevention activities to be undertaken before prevalence of HIV among IDUs is > 5%
- Prevent HIV infection first; long term abstinence and rehabilitation may prove invalid

- Harm reduction programs have a hierarchy of goals, from proactively engaging individuals, target groups and communities to address their most pressing needs. Achieving the most immediate and realistic goals is a priority. While stopping drug use is ideal it may not be possible for many. Hence, not sharing needles and syringes or stopping injecting through appropriate interventions may be more practical.

- No single intervention is sufficient by itself. Different approaches and programs should be considered as complementary rather than in conflict, working at multiple levels from the street or the school (on risk behaviours for HIV transmission) to the provincial and national government (on laws and other elements of a supportive environment for effective approaches to HIV and injecting drug use).

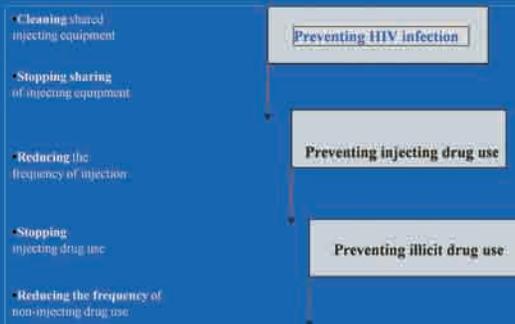
Principles of Harm Reduction (contd.)

Principle 2: Hierarchy of risks

1. Stop, or better still, never start using drugs
2. Stop injecting drugs
3. If injecting drugs, do not share injecting equipment, including needles and syringes, spoons, cotton wool and any materials used to draw up and prepare injection
4. If sharing injecting equipment, ensure that equipment is disinfected after each use

Hierarchy of Harm Reduction Choices

Source: The Health, Risk, Environment and Change, London, Health Education Authority (1996)



Principles of Harm Reduction (contd.)

Principle 3: Multiple strategies

- Harm reduction involves alternative methods
- Different programs to be considered complimentary rather than in conflict
- Information programs informing IDUs of risks
- Establishment of drug treatment and substitution programs

Principle 3: Multiple strategies (contd.)

- Outreach education and peer educators
- Provision of sterile needles and syringes, distribution and disposal programs
- Over the counter sales of injecting equipment
- Counselling and testing for HIV among IDUs
- Access to primary health care
- Removing barriers to safer injecting – laws and police practices
- Targeting special groups: prisoners, ethnic minorities

Multiple strategies of harm reduction also include:

- Early diagnosis and appropriate care of sexually transmitted infections (STI)
- Provision of treatment and care for people living with HIV (PLHIV) with appropriate treatment including
 - ◆ Prophylaxis and treatment of opportunistic infections (OIs)
 - ◆ Anti-retroviral therapy (ART)
- Prevention of mother to child transmission: Some female IDUs or spouses/partners of IDUs might be living with HIV and if pregnancy occurs, the risk of HIV transmission to the child becomes a possibility.
- Care and support for orphans and vulnerable children: Drug using parent/parents may have died as a result of AIDS and/or overdose; may be in poor health to attend to the needs of their children; and/or could be incarcerated as a result of a drug-related crime.
- Reduction of stigma and discrimination towards IDUs: It is widely acknowledged that many IDUs suffer from serious barriers as they are often not treated with dignity and respect as human beings and/or as part of the wider community.
- Marginalized populations such as prisoners, ethnic minorities, women IDUs, and sex workers are sometimes not included in harm- reduction programs and these need to be addressed by those involved in prevention, care and support programs.
- Provision of appropriate and sufficient socio-economic support such as job training and job opportunities for IDUs is crucial to assist them in the reintegration process with society.

- Drug users are not passive recipients of services and must be viewed as vitally important in the prevention of HIV/AIDS. Drug user organizations contribute greatly to the strategic development of harm reduction. IDUs do not trust traditional and mainstream services, and involving peer educators, peer outreach workers and peer networks increases the reach of HIV prevention services to this section of the community.

Principles of Harm Reduction (contd.)

Principle 4: Involvement of drug users

- Current or past drug users can play a vital role in prevention of HIV/AIDS – outreach and peer education
- Drug user organizations contribute to strategic development of harm reduction

Additional Notes

Involving current and ex-drug users in designing, promoting and delivering services to IDUs is an important principle for HIV prevention programs, and is based on the general principles of community involvement. Peer outreach and education programs should be encouraged and used to deliver HIV and other health interventions to other drug users, both in and out of treatment.

Peer Outreach educators have the benefit of personal experience and are perceived by drug users as more trustworthy and credible. Drug-user organizations involve the structured organization of current and ex-drug users, along with other interested individuals, into a group that can represent the interests of drug users, advocate on their behalf, and support and implement HIV and other programs for drug users.

Networks of IDUs provide excellent opportunities for outreach programs to influence peer group and social norms. The members of the network are provided with information and HIV training and are encouraged to disseminate information and HIV prevention materials (such as condoms and sterile injecting equipment) throughout their sexual and drug-using networks. Peer education programs among drug users are effective and social network interventions using peers have been shown to be more effective in reaching and providing more effective HIV education to IDUs.

- Harm reduction principles and practices have been adopted in an increasing number of countries and are pragmatic, humane, effective and holistic.

Harm Reduction: A Summary

Harm reduction principles have been adopted in a number of countries. They are:

- ⇒ Pragmatic
- ⇒ Humane
- ⇒ Effective
- ⇒ Holistic

Step 4: CONCLUSION

- The facilitator concludes the session by giving the following key messages.

Key Messages

Harm reduction is a practical approach with a public health perspective

The abstinence-oriented approach is the best but beneficial to a small proportion of drug users whereas harm reduction is effective for the majority of drug users

Harm reduction measures need to be implemented early (<5% HIV prevalence among IDUs) to control the spread of HIV among IDUs

Harm reduction choices depend on the hierarchy of risks

Harm reduction employs multiple strategies to address the many needs of IDUs

Engaging and involving IDUs in the design, implementation and evaluation of harm reduction program is important

National AIDS Control Programme

OBJECTIVE

To give the participants a clear understanding of the framework of the National AIDS Control Programme (NACP)

EXPECTED OUTCOME

By the end of the session participants would

- Know about the objectives of the NACP
- Understand the IDU strategy in the NACP
- Know about strategy proposed for NACP IV

DURATION

30 minutes

SESSION CONTENT

- Phases of the NACP
- IDU Strategy in the NACP III
- Strategy proposed for NACP IV

SUGGESTED TRAINING METHOD

- Discussion
- PowerPoint presentation

METHODOLOGY

- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/Flip chart
- Marker pens

PROCESS

Step 1: Discussion and presentation on HIV programs in India

- The facilitator begins the session by asking the participants about the history of the HIV epidemic in India

- He/she discusses with the participants what action they think was taken to counter the epidemic.
- He/she takes the participants through the presentation on NACP

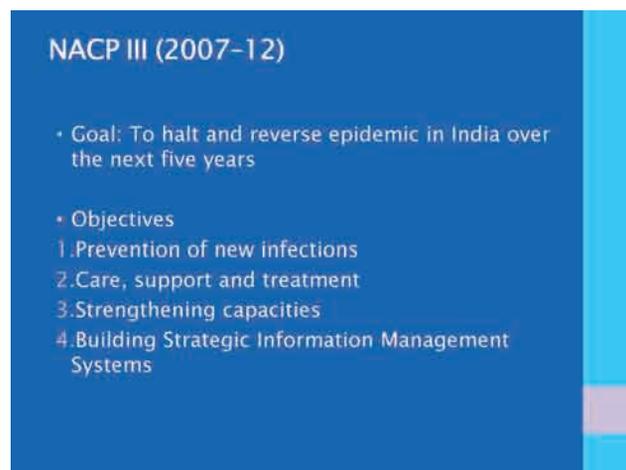
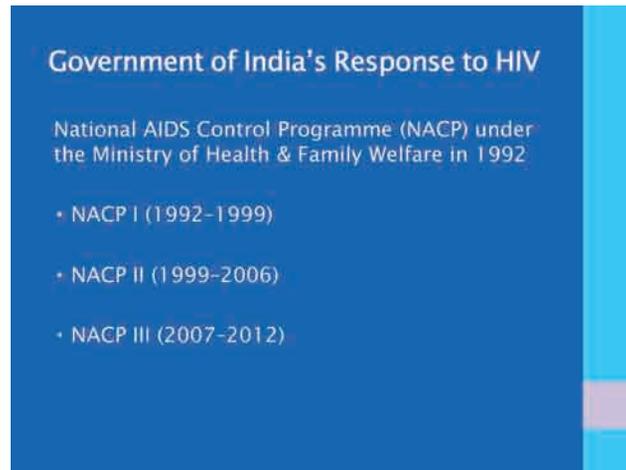
- **NACP I (1992-1999):** As a response to HIV, in 1992, the Government of India launched NACP Phase I to slow down the spread of HIV infection, and set up the National AIDS Control Organization (NACO). The key focus was on blood safety, prevention of HIV among high-risk populations, raising awareness in the general population, and improving surveillance.

- **NACP II (1999-2007):** The aim was to reduce the spread of HIV infection in India through behaviour change while increasing capacity to respond to the HIV epidemic on a long-term basis.

Strong political commitment was shown with the establishment of National Council on AIDS under the chairmanship of the Honourable Prime Minister of India. A decentralised approach was adopted with the creation of State AIDS Control Society (SACS) with involvement of non-governmental organizations (NGOs), civil society partners, private sector and networks of PLHIV. Lessons from the successful NACP II include:

- ◆ Great financial investment for HIV prevention
- ◆ Control, care and support
- ◆ Policies for mitigating the impact of the epidemic on women and children infected and affected by HIV or AIDS
- ◆ Capacity development and technical support for SACS
- ◆ Focused attention on FSWs, IDUs and men who have sex with men (MSM)

- **NACP III (2007-2012):** It was designed to halt and reverse the HIV epidemic in India by 2012 through a four-pronged strategy – preventing new infections in high risk groups and general population through scaled-up interventions; providing greater care, support and treatment to larger number of PLHIV; strengthening the infrastructure, systems and human resources for scaling-up prevention, care, support and treatment programmes at the district, state and national level; and strengthening the nationwide strategic information management system.



IDU Strategy in NACP III	NACP III: Harm Reduction Approach
<ul style="list-style-type: none"> • Objective: <i>Prevent transmission of HIV</i> • Approach: <i>Harm Reduction</i> (National AIDS Prevention Policy, 2002) • Service Delivery <ol style="list-style-type: none"> 1. <i>Targeted Intervention (TI)</i> 2. <i>Delivery by NGOs</i> 3. <i>Provision of services at doorstep of IDU</i> • Service Recipients: <i>IDU and sexual partners</i> 	<ul style="list-style-type: none"> • Aim <ul style="list-style-type: none"> • <i>To keep drug users healthy and productive</i> • <i>To reduce sexual/vertical transmission of HIV in the community</i> • Principles <ul style="list-style-type: none"> • <i>Recognizes the relapsing nature of drug use</i> • <i>Prioritizes addressing the harms caused by drugs as more important than stopping drug use itself</i> • <i>Understands the differing needs of IDUs</i>

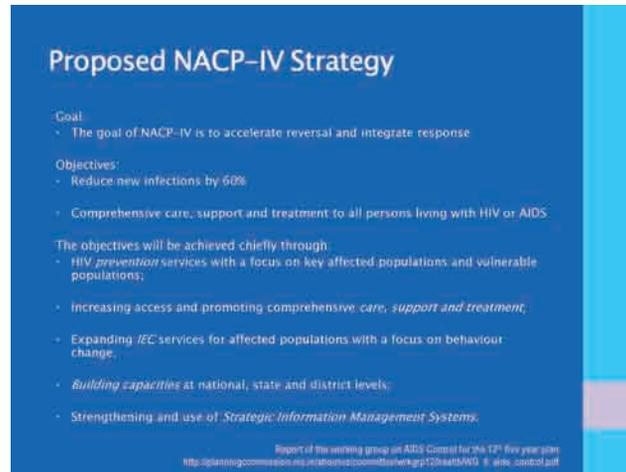
Additional Notes

It has been estimated that there are roughly about 2 lakh IDUs in the country. While the majority of the IDUs are in the North-Eastern states, IDUs are now being seen in other parts of the country also. These include states such as Punjab, Haryana, Uttar Pradesh, Orissa, Kerala, and cities like Mumbai. In NACP III, the objective of setting up IDU interventions is to prevent transmission of HIV. There are many approaches for interventions for the IDUs – supply reduction, demand reduction, etc. However, the approach followed by NACO is that of harm reduction. Harm reduction has been established as the most effective way of preventing HIV among IDUs. This is also endorsed in the National AIDS Prevention and Control Policy, 2002.

The interventions set up would be specifically for the IDUs, and delivered by the NGOs working with the IDU community. The services would be delivered at places where IDUs reside, congregate, hang out, use drugs, or rest. It is well established that relapse following conventional abstinence-oriented treatment is very high and hence harm reduction is essential to deal with drug users in an effective way. The harm reduction approach ensures that the drug users are kept alive and productive till they are ready to adopt conventional abstinence-oriented treatment interventions. The important objective of reducing the transmission of blood borne viruses such as HIV can be achieved very well by adopting harm reduction interventions. More than drug use, *per se*, the adverse consequences related to drug use are more harmful to the individual and the society and the priority is to effectively reduce these. Additionally, harm reduction interventions have multiple components and they address the varying needs of the drug using populations.

Effective program management is ensured through decentralization and technical support units (TSU) to assist SACS of most states in monitoring, supervising and mentoring the TIs. The TSUs also support the newly created cadre of program officers, each supervising the work of 10 TIs while ensuring handholding at field level and encouraging functioning as per the guidelines, as well as addressing gaps at local level. A District AIDS Prevention & Control Unit (DAPCU) is set up to provide management oversight to HIV and AIDS activities in the districts and to work with the district administration and programs provided under the National Rural Health Mission (NRHM) with which the NACP will eventually converge. Working in partnership with networks of PLHIV and other stakeholders, NACP aims to create an enabling environment by addressing issues of stigma, discrimination, and legal and ethical concerns. As the NACP is slated to move beyond addressing risks to addressing vulnerabilities and mitigating the impact of AIDS on the community, it broadens the national response through more sectors and organizations. It is aimed at mainstreaming the work plan of major government and private organizations in modifying their core practices to respond to the challenges of HIV and AIDS.

• NACP-III has laid the foundation for constructing an efficient, effective, evidence-based and comprehensive response for halting and reversing the HIV epidemic. NACO has initiated the planning process for NACP-IV that will build on the achievements so far so as to ensure the complete reversal of the HIV epidemic through combined prevention and treatment interventions. The goal of NACP-IV is to accelerate reversal and integrate response.



Proposed NACP-IV Strategy

- Goal:**
 - The goal of NACP-IV is to accelerate reversal and integrate response
- Objectives:**
 - Reduce new infections by 60%
 - Comprehensive care, support and treatment to all persons living with HIV or AIDS
- The objectives will be achieved chiefly through:**
 - HIV prevention services with a focus on key affected populations and vulnerable populations;
 - Increasing access and promoting comprehensive care, support and treatment;
 - Expanding IEC services for affected populations with a focus on behaviour change;
 - Building capacity at national, state and district levels;
 - Strengthening and use of Strategic Information Management Systems.

Report of the working group on AIDS Control for the 12th five year plan
http://planningcommission.nic.in/reports/commission/12/health/12/health12/12/health12.pdf

Step 2: Conclusion

■ After the presentation the facilitator summarizes the session with following key messages:

Key Messages

NACP, under the Ministry of Health & Family Welfare (MOH&FW), launched in 1992 is currently in its third phase (NACP III: 2007– 2012)

Harm reduction for IDUs has been endorsed and adopted by the NACP

There are about 2 lakh IDUs in the country and services for them are delivered using a decentralized approach through TIs for IDUs

NACP III has laid the foundation for evidence-based, effective and comprehensive response

The proposed NACP IV will build on the achievements and ensure the reversal of the HIV epidemic among IDUs through comprehensive prevention/treatment interventions

Targeted Interventions for Injecting Drug Users

OBJECTIVE

To give the participants a clear understanding of targeted interventions (TIs) for IDUs

EXPECTED OUTCOME

By the end of the session the participants will be able:

- To know the various interventions available under targeted interventions for IDUs
- To know the comprehensive package of interventions for IDUs
- Scale-up and coverage of IDU interventions

DURATION

30 minutes

SESSION CONTENT

- IDU interventions available under TIs
- Comprehensive package of interventions for IDUs
- Scale-up and coverage of IDU interventions

SUGGESTED TRAINING METHOD

- Discussion
- PowerPoint presentation

METHODOLOGY

- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/Flip chart
- Marker pens
- Day 1, Feedback forms (Enough copies to be made for each participant)

PROCESS

Step 1: Discussion

- The facilitator begins the session by introducing the concept of TIs and generates a discussion on why they are required for HIV prevention.

Step 2: Presentation

- The facilitator then shows the presentation on IDU TI and discusses the key points with the participants.

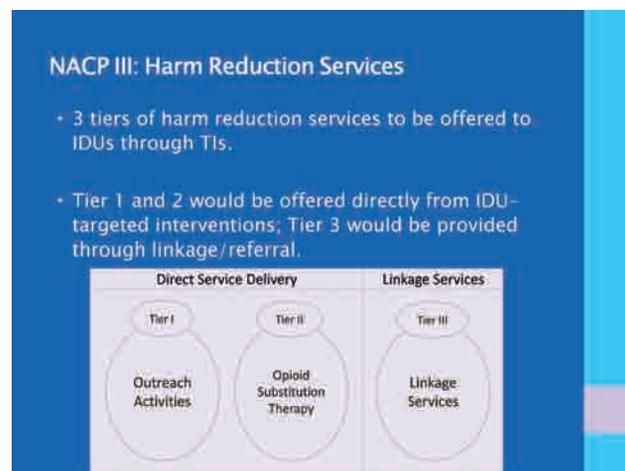
• Though individual interventions such as voluntary counselling and testing (VCT) and NSEP can have an impact in reducing the HIV related risk behaviours and HIV vulnerability among IDUs, it is important to recognize that a combination of interventions is necessary to effectively prevent HIV infections amongst the IDUs. Evidence supports a comprehensive package of biomedical and behavioural interventions as the optimal HIV prevention strategy for halting HIV among IDUs. The technical guide developed jointly by the World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) for countries to set targets for universal access to HIV prevention, treatment and care for IDUs has recommended a comprehensive package of core public health interventions. The prevention package includes the following nine components: 1) Needle Syringe Exchange Program (NSEP); 2) Opioid Substitution Therapy (OST); 3) Voluntary Counselling and Testing (VCT); 4) Anti-Retroviral Therapy (ART); 5) Sexually Transmitted Infections (STI) prevention; 6) Condom programming for IDUs and partners; 7) Targeted Information, Education and Communication (IEC) for IDUs and their sexual partners; 8) Hepatitis diagnosis, treatment (Hepatitis A, B and C) and vaccination (Hepatitis A and B); and 9) Tuberculosis (TB) prevention, diagnosis and treatment. There is strong evidence that these interventions, when implemented in a variety of settings (including a range of closed settings), are effective in reducing risk behaviours, preventing HIV infections, and accessing essential care and treatment services for IDUs.

• NACO is providing eight of these interventions to the IDUs through its harm reduction strategy, but mostly through several service delivery points and not as a comprehensive package through a single door.

- Discussion points for the facilitator while presenting the adjacent slide:

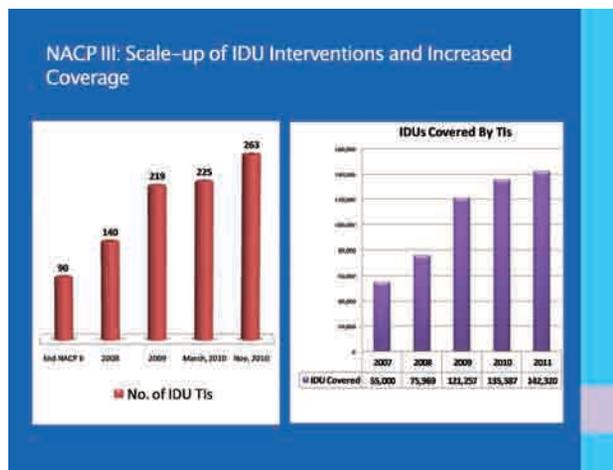
- ◆ Harm reduction services are provided both directly and indirectly.
- ◆ The Tier I services include a package of low threshold harm reduction interventions such as community outreach, peer education, behaviour change communication (BCC), NSEP, waste disposal, condoms and provision of IEC to the sex partners of IDUs.
- ◆ The Tier II service is primarily opioid substitution therapy (OST). HIV prevention strategy is through TIs for some IDUs and includes ownership building and enabling environment. Peer-led interventions by community based organizations (CBOs) and NGOs form the backbone of HIV prevention strategies and exist in both urban and rural areas.

Comprehensive Package for IDUs NACP	
Services	Responsibility
1) NSEP	1) Targeted Interventions (TIs)
2) OST	2) TIs and Government hospitals
3) VCT	3) ICTC
4) Anti-Retroviral Therapy (ART)	4) ART centres - Government
5) STI prevention	5) Clinics and hospitals - Government
6) Condom programming for IDUs and partners	6) TIs
7) Target IEC for IDUs and their sexual partners	7) TIs
8) Hepatitis diagnosis, treatment (Hepatitis A, B and C) and vaccination (Hepatitis A and B)	8) ---
9) TB prevention, diagnosis and treatment	9) TB-DOTS: Government

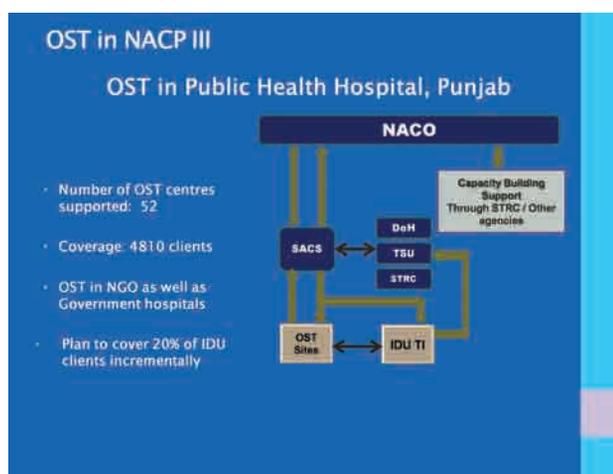


- ◆ The Tier III services link with other health and welfare services and ensure that the multiple needs of drug users are addressed. The TI services are linked to integrated counselling and testing centres (ICTC), Antiretroviral Therapy (ART) centres, tuberculosis (TB) services and addiction related services.

- There has been a significant scale-up of IDUTIs since NACP II. From 90 IDUTIs at the end of NACP II, there were 263 IDUTIs by November 2010. A major scale-up has occurred outside of north-eastern states, in states such as Delhi, Punjab, UP, Bihar and Haryana. The coverage of IDUs through TIs has increased over time and TI coverage of IDUs has been about 80 per cent of the estimated IDUs.



- For expansion of the OST program, it is proposed that the Government hospitals will be involved in implementing OST and they will be linked with IDUTIs located in the vicinity. To determine the operational feasibility of the above scheme, a pilot project is operational in the state of Punjab; five centres (Amritsar, Batala, Jalandhar, Ludhiana and Tara Taran) are implementing OST. Methadone pilot project has been initiated by the UNODC. It is proposed to scale up OST to cover a target of 40,000 IDUs. OST is expected to be delivered through 320 OST sites across India, operated by NGOs and/or governmental hospitals.



Step 3: Conclusion

- The facilitator concludes the session with the following key messages:

Key Messages

The targeted interventions for IDUs are delivered through 3 tiers of harm reduction services. Tier I (Outreach and DIC services) & Tier II (OST) are offered directly through IDU-TIs; Tier III services are provided through linkage/referral.

NACP-III has increased the number of IDU-TIs and expanded the coverage to the majority of IDUs by offering outreach based services and NSEP.

In future, the thrust will be on the scale-up of OST; it is proposed to deliver expanded OST services through Government hospitals in collaboration with NGO-led TIs.

A comprehensive package of services to IDUs is possible through TI services (IEC, NSEP, condom distribution), OST clinics and effective linkages with other services such as ICTC, ART, TB, STI services.

- As this is the last session of Day 1, distribute the feedback forms (Feedback form – Day 1) and ask the participants to provide feedback for the sessions conducted through the day.

Day 2

Session One

Roles and Responsibilities of Doctors and Nurses in IDU TI Programs

Session Two

Assessment and Diagnosis

Session Three

Counselling for Safer Injecting Practices

Session Four

Drug Treatment: Detoxification

Session Five

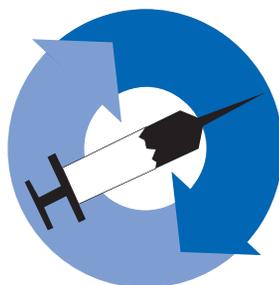
Drug Treatment: Opioid Substitution therapy

Session Six

Sexually transmitted infections: Basics

Session Seven

Prevention of sexually transmitted infections



Roles and Responsibilities of Doctors and Nurses in IDU TI Programs

OBJECTIVE

To make the participants understand the roles and responsibilities of doctors and nurses in IDU TI programs

EXPECTED OUTCOME

By the end of the session the participants would:

- To understand the role of the doctors in IDU-TI programs
- To understand the role of the nurses in the IDU-TI programs

DURATION

30 minutes

SESSION CONTENT

- Role of the doctors
- Role of the nurses

METHODOLOGY

- Discussion
- PowerPoint Presentation

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Flip charts/Whiteboard
- Markerpens

PROCESS

Step 1: Discussion

- The facilitator begins the session by generating a discussion among the participants on the roles and responsibilities of doctors and nurses in IDU TI programs.



NOTE TO THE FACILITATOR

Make sure the following points are covered during discussion:

- People who inject drugs often have multiple needs and require many services. All services cannot be provided through the TIs and hence the doctor has to offer referral services to the clients.
- A key referral point is the ICTC; and it is important that the doctor is able to motivate and send most of the IDUs and, if necessary, their spouses for VCT services.
- Tuberculosis is an important and common medical morbidity among IDUs and they need to be referred to the TB-DOTS centres for diagnosis and treatment.
- For those who are HIV positive and require treatment, the doctor has to ensure that they are referred to the ART clinics and adhere to the treatment regimen.
- Hepatitis is frequently prevalent among people who inject drugs and hence they need to be referred for liver function tests.
- Referrals to medical and surgical services may be necessary for some proportion of IDUs.
- Depression and anxiety disorders are relatively common and some of them exhibit suicidal behaviour. To get appropriate care, they can be referred to mental health service centres in that location.
- The most important need of the IDUs is management of their drug use. Those IDUs who require and request treatment can be referred to detoxification and drug rehabilitation services.
- There is a possibility of health care workers injuring themselves; and following a needle-stick injury or exposure by accident, they need evaluation by a doctor. Depending on the clinical assessment, the doctor may refer the worker to PEP services for necessary management.

Step 2: Presentation on the role of doctors and nurses

- Use the following presentation to summarize the roles and responsibilities of doctors and nurses in IDU TIs.
- **Role of the doctor:** The medical doctor is the head of the clinical services unit at the TI. He is expected to conduct basic clinical assessment and medical examination of the IDUs. Based on the needs of the clients, the doctor provides appropriate medical care and treatment that can be offered through the TI settings. Abscess is a common medical problem faced by IDUs. and the abscess management is to be provided through the TI settings. Most cases can be effectively managed by the nurse in TI team under the guidance of the doctor. Further, the doctor organizes syndromic management of STIs at the TIs. For common medical problems, the doctor can provide necessary care and treatment; he/she prescribes appropriate analgesics for symptom relief and can give antibiotics in case of infections.

<h3 style="margin: 0;">Role of the Doctor</h3> <ul style="list-style-type: none"> • The doctor is the head of the clinical services at the targeted intervention. • Conduct a basic clinical assessment and medical examination of the clients attending the TI. • Provide basic medical care and treatment for abscesses and syndromic management of STIs. • Prescribe appropriate doses of medications as required by the client (for e.g. analgesics, antibiotics). 	<h3 style="margin: 0;">Role of the Doctor (contd.)</h3> <ul style="list-style-type: none"> • In TIs that provide OST, determine the patient's suitability for OST on the basis of inclusion and exclusion criteria. • Conduct a basic assessment and medical examination of the clients for OST. • Prescribe appropriate doses of OST medication (e.g., buprenorphine) and additional medications as required by the client (for e.g. sedatives), and supervise the dispensing of OST medication doses, if required. • Conduct follow-up with the clients and their family and assess the progress of the client on OST. • Maintain appropriate records as required in the OST clinic.
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<h3 style="margin: 0;">Role of the Doctor (contd.)</h3> <ul style="list-style-type: none"> • Provide referrals to ICTC as well as to other services (e.g., TB services, ART clinics), as and when required. • Referrals to laboratory investigations (e.g., liver function tests) • Referrals to medical and surgical services • Referrals to mental health services • Referrals to detoxification centres • In case of needle-stick injury or exposure, evaluation and referral to PEP. 	<h3 style="margin: 0;">Role of the Doctor (contd.)</h3> <ul style="list-style-type: none"> • Conduct basic health-education sessions for the clients and the family members on drug use harm related issues. • Conduct regular educational classes on health related topics: <ul style="list-style-type: none"> • ART (benefits, adherence, side effects) • STI treatment (treatment completion, consequences of untreated STIs) • OST (benefits, dose and duration, adherence) • Assist in advocacy and other networking meetings.
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- The doctor in charge of the OST uses the inclusion and exclusion criteria to assess whether the client is eligible for OST. For the eligible clients, the doctor takes a complete clinical history, conducts a thorough clinical assessment and medical examination. The doctor inducts the patient on the OST medication (such as buprenorphine) and prescribes the appropriate dose based on the needs of the client. Additionally, he can use other drugs for management of co-occurring conditions (e.g., sedatives for sleep disturbance). Supervision and monitoring of patients is critical for ensuring compliance; hence the doctor is expected to supervise the clients on buprenorphine. He/she is also involved in the follow-up of the clients. Apart from the IDUs, the doctor also interacts with the families of the IDUs to ascertain the progress of the clients and to evaluate the improvement in the quality of their life. As head of the clinical unit, the doctor ensures that the clinical records are kept properly.

<h3 style="margin: 0;">Role of the Nurse</h3> <ul style="list-style-type: none"> • The nurse is in-charge of the day-to-day management of the clinic. • Providing emergency health services in the absence of the treating doctor • Responsible for dispensing the medicines prescribed by the doctor • In OST-TIs, responsible for dispensing OST medication to the clients on a 'daily observed treatment' basis as prescribed by the doctor, following protocols • Maintaining the stock of medicines required in the clinic 	<h3 style="margin: 0;">Role of the Nurse (contd.)</h3> <ul style="list-style-type: none"> • Provide basic health education to the clients and their families • Report early warning signs of adverse effects to the doctor • Maintain the patient related clinical records appropriately
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Step 3: Conclusion

- The facilitator then summarizes the session by giving the following key messages:

Key Messages

- The medical doctor is the head of the clinical team.
- The doctor is responsible for the clinical assessment, examination, diagnosis of medical conditions, treatment of STIs, referral services for ART, TB and mental health services.
- In OST-TIs, the doctor assesses the suitability for OST and provides appropriate dose of OST.
- Health education is required for both the IDUs and their families.
- The nurse provides emergency health services for IDUs in the absence of the doctor at the TI.
- The nurse is responsible for day-to-day management of the clinical services, administration of medicines, maintaining the stock of medicines, OST medication administration, health education for IDUs and their families and maintaining the client records`

Assessment and Diagnosis

OBJECTIVE

To help the participants understand how to conduct comprehensive assessment and diagnosis of persons who use drugs

EXPECTED OUTCOME

By the end of the session the participants would

- Comprehensively assess persons for patterns of drug use, risk behaviours and adverse consequences
- Diagnose the various medical/psychological morbidities exhibited by persons who use drugs
- Understand the ways to deal with drug users

DURATION

1 hour

SESSION CONTENT

- Comprehensive assessment of persons who use drugs
- Diagnosis of substance use related disorder, medical and psychological morbidities
- Dealing effectively with persons who use drugs

METHODOLOGY

- Brainstorming
- PowerPoint presentation
- Discussion

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/Flipchart
- Marker pens

PROCESS

Step 1: Understanding the aims and components of assessment

- The facilitator brainstorms with the participants and asks them to list the reasons for assessment of persons who use drugs.
- He/she summarizes the responses by presenting the following slides:

Aims of Assessment

- To treat any emergency or acute problem
- To confirm that the patient is taking drugs (history, examination)
- To evaluate drug dependence, withdrawals or intoxication
- To assess risk behaviours
- To identify complications of drug use
- To diagnose medical and mental health problems
- To give advice on harm reduction, testing for HIV
- To refer for appropriate care

Assessment of Drug Dependence

A. Drug history

- Reasons for presentation
- Past and current drug use (past four weeks)
- History of injecting and risk of HIV and hepatitis
- Medical history
- Psychiatric history
- Forensic history
- Social history
- Past contact with treatment services
- Other relevant history

Assessment of Drug Dependence (contd.)

B. Examination

- Assessing motivation
- Assessing mental health
- Assessing general health

C. Special investigations with full informed consent

- Generate a discussion among the participants on what issues should be covered while assessing an IDU. Note the responses on the flipchart/Whiteboard. The list of issues to be covered during an assessment is provided in [Annexure 4](#).

Step 2: Discussion on different interventions at an IDU TI

- The facilitator initiates a discussion with the participants on the aim of intervening with the IDUs in a TI setting. After the discussion, the following slide is presented.

Aims of Targeted Interventions

- Reduce the risk of HIV, hepatitis B and C, and other blood-borne infections due to injecting and sharing of injecting paraphernalia
- Reduce the use of illicit or non-prescribed drugs
- Deal with withdrawals and intoxication
- Reduce foetal exposure to drugs
- Assist the patient to remain healthy until he or she can achieve a drug-free life

In many Asian countries, the family, society or the treating doctor decides what outcomes should be aimed for in the treatment process. The client, or drug user, is seldom consulted; it is taken for granted that the family or doctor knows best. It is well established now that treatment outcomes improve when there is a “therapeutic relationship” and clients are “consulted” throughout the treatment process.

- The facilitator asks the participants to list the process of providing the interventions at the TI. He/she then summarizes the discussion using the following points.

Processes of intervention

- *Contact with a person using drugs*: attendance at a DIC (the first major hurdle).
- *Assessment*: Drug use and related problems need careful consideration of living situation, family issues and legal problems. It is important to determine if there is need for urgent medical care.
- *Diagnosis*: Co-existing disorder (psychiatric or medical problems to be evaluated). Referral to a specialist in any or all of these areas may be necessary. Evaluate the presence and severity of dependence on any specific drug and the extent of other drug/alcohol use.
- *Therapy*: Various options depending on client choice, assessment and availability of various therapies.
- *Follow-up and long-term support*: This is probably the most important and the most neglected area because of the skills required, expense of health workers’ time, frustration due to relapse and loss of contact with the patient.
- *Resource map*: Map the nearest secondary and tertiary facilities for drug use treatment, mental health services.

Step 3: Understanding the participants’ attitude towards drug users

- The facilitator asks the participants the following questions: “If someone says, ‘*There’s a drug user*’, what comes to your mind? What does a drug user look like?” (Write the answers down: e.g., thin, long hair, dirty, etc.)
- The facilitator/co-facilitator notes down the responses on a flip chart or blackboard; these can be referred to later in the session. The objective is to explore the participants’ perceptions and feelings and come to a pragmatic and common understanding about people who use drugs.
- The facilitator should then discuss the responses in order to normalize the often negative impression that society harbours about drug users – as egoistic, selfish and self-centred individuals who do not care for anyone else’s feelings.

Additional Notes: Understanding people who use drugs

Just as there are many types of drugs, there are many kinds of people who use drug. If we want to work effectively with drug users, it is important to remember that drug use is a behaviour not an identity. So a person may be an injecting drug user, but could work as a taxi driver, a salesman or a professional. Do we label him an injecting drug user or do we label him by his profession? In HIV work, the terms “drug user” and “injecting drug user” are very commonly used. But these terms only tell us about a person’s behaviour; the fact that they use or inject drugs. These terms do not necessarily tell us anything about what kind of a person they are.

One of the problems related to drug use that people are most often concerned about is drug dependency. The general public’s image of a drug user is that of a person who is dependent on drugs. But this is not always the case. Not all people who use drugs are drug dependent; the majority uses drugs occasionally and recreationally. Even among those who use drugs regularly and have become dependent on them, there are many who integrate their drug “habit” into the rest of their lives.

Not every habitual user is a street “junkie”. People from all social groups and classes may have a drug “habit”. Many people maintain jobs, have families and raise children while being dependent on drugs. The reasons why some people become dependent on drugs, and why some of them experience problems with their dependency are complicated and beyond the scope and intent of this session.

- **Step 4: Presentation on working with drug users**
- The facilitator then takes the participants through the presentation on working with drug users.

Working with Drug Users	Communicating with Drug Users
<ul style="list-style-type: none"> • Build trust with drug users • Take time to build a relationship of trust • Create a relaxed atmosphere by providing incentives • Maintain appropriate confidentiality • Be respectful and professional 	<ul style="list-style-type: none"> • Respect <ul style="list-style-type: none"> • Active listening • Positive attention • Give credibility to their opinion • Empathy <ul style="list-style-type: none"> • Understand their feelings • Give adequate time • Be genuine <ul style="list-style-type: none"> • Be honest • Share thoughts in a caring manner

- While presenting the slides, the facilitator can use the following points for discussion:
 - ◆ It is essential to create a relationship of respect and trust with drug users and their families and social networks. Only through this will you be able to involve drug users in identifying and addressing their own problems.
 - ◆ Any information provided by the patient should be kept confidential. It is essential that such information is not shared with people and agencies who are not directly involved with drug use issues. Drug users are unlikely to share information if they suspect that the information they are sharing may be used against them.
 - ◆ Talking to people about their personal histories is helpful in understanding their vulnerability but may also be painful to the people concerned. Further, drug users are the local

“experts” on drug use issues, and we should respect this knowledge. When drug users are treated with respect and as professionals, they are much more likely to open up and provide much needed insight into the social and environmental issues that affect their lives.

- ◆ *Active listening:* Active listening means to be able to reiterate what has been told and ask further questions. It shows you are attentive, and that the drug users are not just talking to the wind. It also indicates you are thoughtful and concerned about the issues surrounding their lives.
- ◆ *Positive attention:* Do not be distracted by what is going on around you when talking with drug users. Maintain eye contact with them.
- ◆ *Give credibility to their opinion:* By asking their opinions, you are respecting the knowledge of hidden behaviours that exist within drug users. If we treat them as ‘cultural experts’ and give credibility to their opinion, we are reinforcing that they are valuable individuals.
- ◆ *Understand their feelings:* By displaying an understanding of their feelings, you are being empathetic and a good counsellor. Do not show sympathy, but show that you would feel or act in the same way if you were in their situation.
- ◆ *Adequate time:* Because drug users do not speak openly for fear of negative repercussions, your taking time out to listen to them is an indication that you are not judging their behaviour and that you are genuinely interested in their lives and problems, if any.
- ◆ *Be honest:* Drug users will respect your decision if you are firm and clear on the boundaries of your relationship.
- ◆ *Share thoughts in a caring manner:* Someone who does not talk down to the drug users and talks with them in a caring manner is much more likely to be respected and trusted.

Step 5: Summarizing

- Conclude the session with the following key points:

Key Messages

The assessment of people who inject drugs involves history taking, appropriate physical and mental status examination and relevant investigations.

Treatment of people who use drugs is a long-term process and the treatment plan should be made jointly by the clinical team and the IDU.

While working with drug users, the priority is to reduce harms related to drug use.

A user-friendly approach, being non-judgmental, treating the drug users with dignity and respect, and providing positive feedback regarding behaviour changes in them are important.

Counselling for Safer Injecting Practices

OBJECTIVE

To enable the participants to understand safer injecting practices

EXPECTED OUTCOME

By the end of the session the participants would

- Understand the risks associated with injecting drug use
- Know about safe injecting methods
- Know about safe injecting sites

DURATION

1 hour

SESSION CONTENT

- Risks associated with unsafe injecting
- Risk reduction counselling on safe injecting methods
- Safe injecting sites and vein care

METHODOLOGY

- Discussion
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/Flipchart
- Marker pens

PROCESS

Step 1: Discussion and presentation on risks faced by drug users

- The facilitator opens the session by asking the participants about the risks associated with unsafe injecting practices.

- He/she encourages the participants to point out the risks of the various steps and the unhygienic practices involved at each step.
- The facilitator notes down the responses on the whiteboard/chart paper and sums up the discussion with the presentation on risks associated with unsafe injecting.

- Generally, people who use drugs face the following risks: a) buying/procuring an illicit drug puts the risk of being arrested, as drug possession is a criminal offence under the Narcotic Drugs and Psychotropic Substances (NDPS) Act; b) stealing money from their own houses and at times from that of others, or engaging in drug peddling in order to raise money for drug use puts them at risk of being arrested; c) drug intake can result in acute intoxication requiring medical attention; and d) withdrawal states that can be distressing during periods of abstinence from drug use.

The risks can be in multiple domains such as physical (intoxication, withdrawals resulting in severe pains); legal (arrest for drug possession); occupational (inability to be productive due to drug dependence or excessive drug use); financial (spending disproportionate amounts of money on illicit or pharmaceutical drugs); and social (association with other anti-social groups, social withdrawal from usual friends and family). It must be understood that the people who inject drugs are more at risk than those who use oral drugs, as the injecting route of administration carries greater risks and harms than oral drug use *per se*.

- People who inject drugs are often more at risk due to the following factors. First, they have inadequate knowledge related to safe injecting and, more often than not, the information about injecting methods is gathered from their own peer group members. So, if they acquire misinformation, they continue to practice unsafe injecting methods. Second, IDUs are in a hurry while injecting as they fear arrest from police. In addition, when they are in a state of withdrawal from drugs, they are in a great hurry to inject and this keeps them from considering and practising safe injecting methods. Third, the people who use drugs frequently inject in hazardous settings and places. These include abandoned buildings, places near open drainage, public toilets, railway tracks, under bridges and other unhygienic settings. These settings facilitate the transmission of infections.

Risks Faced by Drug Users

- Drug users encounter risks at many stages:
 - Procurement of illicit drug
 - Obtaining money for procurement of drugs
 - Drug intake
 - Intoxications/withdrawals
- Risks are in multiple domains – physical, legal, occupational, financial, social
- Risk faced by an IDU over and above those faced by non-IDUs because of injecting behaviour/route of drug intake

Why do IDUs face risk?

- Lack of knowledge/wrong knowledge
 - Wrong knowledge from peers
- Lack of adequate time for injecting
 - Due to fear of police arrest or severe withdrawals
- Injecting in hazardous places/settings
 - Unclean places such as near an open drain, railway tracks, abandoned houses, etc.

- The IDUs are injecting substances that are not meant to be injected. Heroin and its impure form, 'brown sugar', are injected after preparing a solution from them. Similarly, in north-east India (e.g., Nagaland) and some other parts of the country, capsules of spasmoproxyvon (dextro-propoxyphene) are emptied and a solution is made with the powder and injected. These solutions contain many impurities and cause injection-related injuries and infections. The non-availability of materials to clean the injecting equipment such as cotton swabs and spirits also contribute to unsafe injecting.

Why do IDUs face risk? (contd.)

- Non availability of injectable drugs
 - Injecting impure form of heroin - 'brown sugar'
 - Injecting capsules (S.P.)
- Non availability of materials to clean injecting equipment
 - Cotton swabs, spirits, etc.



- The non-availability of adequate needles and syringes results in sharing of injecting equipment by the drug users. Repeated use of the same needle results in blunting of needle tips and this contributes to injection-related injuries. It is not uncommon for persons who inject drugs to use unclean and unsterile water (e.g., tap water) for cleaning the injecting equipment before reusing the same.

Why do IDUs face risk? (contd.)

- Non availability of adequate needles/syringes for injecting, resulting in sharing and reuse
- Reuse leads to blunting of the needle tip
- Using unclean/non-sterile water for cleaning needle/syringe before reusing



- Ask the participants about the complications arising from unsafe injecting practices.
- Ensure that the following points are covered in the discussion:
 - ◆ Sharing of contaminated injecting equipment (needles and syringes) and other paraphernalia (drug solution, spoons used for preparing drug solution, cotton swabs, etc.) results in transmission of HIV, Hepatitis C and B. Track marks are scars along the veins caused by repeated injecting into the same site.
 - ◆ Bruising occurs when blood leaks from the vein and collects under the skin during the process of injecting. Redness or swelling around the injection site may occur if the vein is missed and the drug is injected into the soft tissue. Urticaria is a "histamine reaction", a direct result of the drug entering the soft tissues. Veins collapse is due to repeated injections at the same site. Other causes include repeated local infections leading to scarring of the vein; trauma to the vein and/or surrounding tissues; use of irritant substances; and using a barbed or blunt needle which tears the vein, damages the valves in the vein and leads to a large amount of scarring. Chronic venous insufficiency occurs due to chronic damage to the veins. The walls of the veins and the valves get damaged so the blood cannot return to the heart as fast as it is pumped. Venous ulcers occur as a complication of venous stasis. Injection sites can have persistent ulcers. Arterial injury results from inadvertent injection into the artery. This is more common when a vein is located close to an artery such as in the groin. Arterial injuries can result in haemorrhage. The inadvertent injection of drugs into the arterial circulation can also result in vascular spasm with loss of distal tissue due to lack of blood flow. This may

be complicated by infection (gas gangrene or tetanus) and muscleswelling (compartment syndrome), which may lead to amputation and renal failure.

- ◆ Cellulitis is a bacterial infection of the skin resulting in the skin becoming red, hot, swollen and tender. Cellulitis and abscesses often occur together. Thrombophlebitis is an infection of the vein wall. It can be an extension of cellulitis or due to an infected clot within the vein. Bacteraemia is the presence of bacteria in the bloodstream. Septicaemia is an established blood infection resulting from bacteraemia. The repeated trauma of venepuncture, local infections and the irritant properties of the injected substance are the main causes of superficial and deep venous thrombosis. Septic thrombosis is responsible for bacteraemia and can lead to the other complications discussed earlier. High-risk locations for the development of complicated embolization include deep venous thrombosis of the iliofemoral and upper limb veins. Embolican lodge in the small vessels of any organ causing tissue damage and infection. Examples include stroke (brain) and gangrene of the fingers and toes. Endovascular infections in IDUs include: infective endocarditis, organ abscesses (brain and liver abscess) and mycotic aneurysms.

- Summarize the complications using the following slides:

Injecting Risks

- Blood-borne infections: HIV, Hepatitis B, Hepatitis C
- Local Infections: skin infections with bacteria/fungus resulting in swelling, or pus collection □ abscess, and a wound □ ulcer
- Loss of veins/sclerosis: due to repeated injecting in the same site, scarring leads to blockage of the vein



Injecting Risks (contd.)

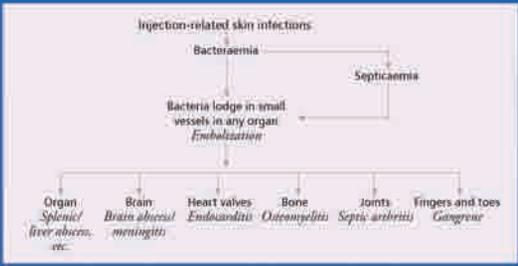
- Scarring of tissues around the injecting site due to seepage of drug outside the vein
- Septicaemia: local infection spreading through blood stream causing generalized infection
- Injection into artery: resulting in gangrene/ necrosis of tissue



Injecting Risks (contd.)

- Infection of internal organs: heart, brains, lungs
- Overdose: injecting more amount of opioids than what can be withstood by the body, leading to symptoms of overdose

Complications



Step 2: Discussion and presentation on risk reduction counselling

- The facilitator asks the participants to recall the session on harm reduction.
- He/she asks some of the participants to summarize what was discussed in the session on harm reduction.

- The facilitator then presents the slides on risk reduction counselling.

- As many drug users are unwilling to give up use of drugs, harm reduction measures are a practical way to reduce the various ‘harms’ associated with injecting drug use. Depending on the stage of the IDU in the harm reduction hierarchy, the interventions will differ.

Risk Reduction Counselling

- Premise of risk reduction counselling: harm reduction
 - Not every IDU is either ready or able to give up drugs instantly
 - Harms continue to be incurred by IDUs till they are ready or able to give up drugs
 - The harms incurred can be reduced in the meantime
- Intervention differs depending on the stage of the IDU in the harm reduction hierarchy

- Different harm reduction strategies are proposed depending on the stage. They range from never starting to use drugs (by prevention interventions targeting the general public) to education on safe injecting practices and providing materials for cleaning (for those persons who inject drugs and are unable to stop sharing injecting equipment).



Risk Reduction Counselling (contd.)

- IDU client is not able to stop sharing:
 - Reasons may range from group behaviour to non-availability of clean needles/syringes when the client has to inject
 - Best way is to educate the client to be prepared for such an eventuality and carry one set of new needle syringes all the time
 - There is NO FOOLPROOF METHOD OF CLEANING NEEDLE/SYRINGES
 - *Something (cleaning) is better than doing nothing (not cleaning)*

Risk Reduction Counselling (contd.)

Recommended method for cleaning N/S:



- Pour bleach into one cup or bottle and water into another.
- Draw up freshly prepared bleach solution into dirty needle and syringe.
- Expel bleach away down the sink (not back into the cup or bottle).
- Repeat steps 2 and 3.
- To remove the bleach, draw up cold water into the needle and syringe.
- Expel water down the sink.
- Repeat steps 5 and 6 two or three times.

Risk Reduction Counselling (contd.)

Points to remember for cleaning the used needle/syringe

- The above cleaning method does not guarantee protection
- Bleach cleaning the previously used equipment should only be a last resort option
- Clean equipment both before and after use.
- Boiling plastic syringes melts them

Risk Reduction Counselling (contd.)

Points to remember for cleaning the used needle/syringe

- Cold water is recommended as warm water may coagulate blood and hence will be harder to expel through the needle.
- Thick bleach is impossible to draw up through a needle.
- Diluted and old bleach may not be effective.
- Using new/clean injecting equipment (from a needle exchange program) is the safest option.

- Some people who inject drugs are unable to stop injecting for the following reasons: First, they may not be motivated to stop injecting as it is an efficient way of administering the drug and getting the maximum effect out of it. Second, the non-injecting mode of administering a substance (for example, chasing heroin) may be expensive and unaffordable. Transition to injecting mode is often due to cost factors, as injecting is the most cost-effective way of administering the drug. Third, over a period of time some IDUs get addicted to injecting; their 'needle addiction' makes them continue with injecting drugs.

Risk Reduction Counselling (contd.)

• IDU is not able to stop injecting but is in a position to avoid sharing:

Possible reasons:

- Not motivated to stop injecting
- Not able to afford non-injectable drugs
- Dependent on injecting

- For those who continue to inject but can avoid sharing, education about the risks of injecting is useful. They can be informed about NSEP and the importance of obtaining sterile needles/syringes for their daily injecting use. They can be linked with the NSEP staff, in particular the outreach staff. It is necessary to emphasize the importance of removing the contaminated injecting equipment from circulation as that would help in prevention of transmission of blood-borne pathogens such as HIV. IDUs can be educated about the risks related to reuse of needles. Information on abscess prevention and overdose prevention are critical for people who inject drugs. While safe injecting is important, the relevance of OST in helping people to stop injecting drugs needs to be underscored. The users must be informed about the OST available in their settings.

Risk Reduction Counselling (contd.)

Counselling: Educate the clients on the following

- Risk with sharing
- NSEP and link up with concerned outreach team
- Returning used N/S
- Risk of reusing used N/S
- How to inject safely, abscess prevention
- Overdose prevention and management
- OST if ready to stop injections; availability of OST in the city/town

- It is necessary to explore the current injecting practices to understand both safe and risky behaviours. While reinforcing the safe practices, it is necessary to point out the risky practices and suggest modification accordingly. The IDU should be able to understand the critical practices that need to be changed. Three stages are identified in which modification of injecting practices can happen: before, during and after injecting.

Risk Reduction Counselling – Safe Injecting

- Explore current injecting practices followed by the IDU
 - Understand the risky and safe practices
 - Reinforce the safe practices followed
 - Point out risky practices for modification
 - Summarize the important practices at the end of assessment as feedback to the client
- Counselling for three stages of injecting
 - Before injecting
 - During injecting
 - After injecting

- Before mixing the drug solution it is important to ensure that a hygienic (clean) and safe place is chosen by the person who injects drugs. A safe place ensures that the IDU is not anxious and can place the injecting equipment and other paraphernalia on a clean newspaper or magazine. Injecting alone is not advised as the presence of others will ensure that there is someone to assist in case of an emergency, such as overdose. Where possible, choose a clean thin bore needle that is less likely to cause injection-related injury. Washing the hands is a good hygienic practice.

Risk Reduction Counselling – Safe Injecting

- Counselling for before injecting
 - Choose a safe place where you are not anxious. Relaxation helps in relaxing the muscles
 - Do not inject alone; injecting in presence of someone else will ensure availability of help in case of overdose
 - Keep the immediate surroundings clean – use a clean newspaper or magazine to lay down the injecting equipment
 - Choose the smallest bore needle possible

- It is important to use sterile water; if it is not available, the use of cooled boiled water is preferred. While preparing the drug solution, clean the spoon by wiping once with a new swab; the drug can then be put on the spoon. Use new sterile injecting equipment to draw up water from the new ampoule of sterile water or cooled boiled water. Add the water to the spoon and mix using the clean blunt end of your syringe. In order to cook drugs such as brown sugar, it may be necessary to add acidifier like vitamin C tablets or lime (citric acid) but ensure that too much is not added as this will hurt the vein. Too much heating is also injurious to the vein.

Risk Reduction Counselling – Safe Injecting

Counselling for before injecting

- Use sterile water; if not use cooled freshly boiled water
- Use an acidifier such as vitamin C tablets or citric acid for dissolving brown sugar □ use small doses of acidifier, as large dose will injure the vein
- Do not heat the drug too much as doing so will cause injury to the tissue where the drug is being injected

- Add the filter to the spoon (sterile cotton ball or bud or cigarette filter ends) to filter the impurities from the drug solution. Only sterile injecting equipment is to be used to mix and divide if the drug is to be used by a group. Draw the solution up through the filter to remove impurities. Do not touch the spoon being used for mixing with the needle tip as the tip get blunt if used in this manner. Remove air bubbles from the syringe before injecting.

Risk Reduction Counselling – Safe Injecting

Counselling for before injecting

- Filters are often used to filter out un-dissolved particulate matters
- Cotton swabs and cigarette butts are often used
- Cigarette filter ends are preferable, as cotton swabs have loose fibres which may enter the injection
- Do not touch the cooker (metal cap; spoon used for mixing and heating) with needle tip, as doing so will make the needle tip blunt.




- It is preferable that one avoids injecting subcutaneously. Cleaning the area before injecting is important. If washing with soap and water is not possible, alcohol swabs can be used. Ensure that alcohol dries up before injecting. Cubital fossa is the best area for injecting.

Risk Reduction Counselling – Safe Injecting

Counselling for before injecting

- Intravenous route preferable to subcutaneous injection
- Clean the area where the drug is to be injected
 - Best way is with plenty of soap and water
 - If not possible, use alcohol swabs
 - Ensure that alcohol dries off before injecting, otherwise the site will not be sterile
- Best area for injecting – cubital fossa (front of elbow)



- IDUs have to be educated about dangerous sites for injecting. Groin veins, neck veins, facial veins, breast veins, penile veins and veins in the hand and legs are to be avoided.

Risk Reduction Counselling – Safe Injecting

Counselling for 'during injecting'

Dangerous sites for injecting

- Groin veins
- Neck veins
- Veins on the face
- Veins of the hand and legs
- Breast veins
- Penile veins



This diagram shows the risk levels of injecting into different areas of the body.

- **Red** – High risk! Avoid! (groin, neck, face, hand/leg, breast, penile)
- **Yellow** – Medium risk! (upper arm)
- **Green** – Low risk! (cubital fossa)

- This slide explains how to differentiate between an artery and a vein, as injecting into the artery is dangerous.

Risk Reduction Counselling – Safe Injecting

Counselling for 'during injecting'

- Differentiating an artery from vein

Artery	Vein
Pulsating blood vessel	Non-pulsating blood vessel
Cannot be easily seen	Seen as a blue vessel
No valves which can be felt	Valves in veins can be felt
Bright red blood oozes out/drawn into syringe	Dark red blood oozes out/drawn into syringe

- If you hit an artery,
 - There will be excruciating pain;
 - The part of body which the artery supplies blood, will become black and die (gangrene/necrosis)

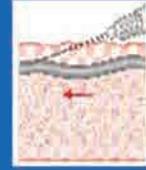
- Educate the IDU about wiping the injection site once with a new swab and placing the tourniquet around the upper arm. The tourniquet should not be left on for too long. IDUs should try not to touch anything that hasn't been cleaned until they have finished injecting.

- The needle has to be put into the arm at a 45-degree angle, with the hole facing up. Blood will sometimes appear in the barrel when the needle is inserted in the vein. Pulling back the plunger, blood should appear. If there is still no visible blood in the syringe, remove the needle and tourniquet from the arm, apply pressure (using a cotton ball) to stop any bleeding and start again. When one is sure the needle is in the vein, loosen the tourniquet and slowly depress the plunger.

Risk Reduction Counselling – Safe Injecting

Counselling for 'during injecting'

- Use smaller bore needle, larger bore needle will damage the vein
- Tie a tourniquet which can be easily released; do not tie the tourniquet tightly; release tourniquet soon after the needle enters the vein
- Hold the needle at 45 degree angle
- Once you hit a vein, stop further puncture and draw some blood in vein to confirm that it has hit the vein; the blood should be dark red in colour
- Administer the drug slowly
- Do not repeatedly push the blood back and forth



- After injecting, remove the needle slowly, keep the arm straight, and apply pressure to the injection site for a couple of minutes (using a cotton ball or tissue).

Risk Reduction Counselling – Safe Injecting

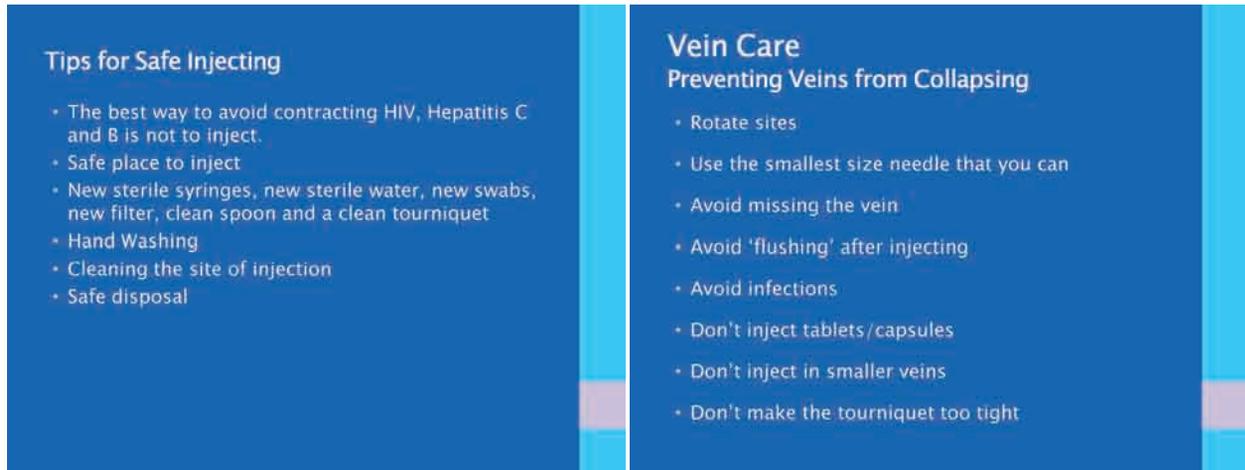
Counselling for 'after injecting'

- Slowly remove the needle from vein
- Immediately apply pressure on the injected site with a dry cotton swab. DO NOT use alcohol swabs
- Apply pressure for at least one minute
- Allow time for injected vein to heal.
- Use another site to inject □ rotate veins

Step 3: Discussion and presentation on care of veins

- Before showing this slide the facilitator asks the participants about vein care.
- He/she writes down the responses on the whiteboard.
- He/she ensures that the following points are conveyed to the participants:
 - ◆ Rotating injecting sites gives the site a chance to heal. If the IDU is running out of veins in the arms, it is time to consider other modes of administering the drug, such as swallowing or sniffing or inhaling the vaporized form (chasing) or sublingually. One should avoid injecting into high risk sites like the neck or groin. Injecting into neck or groin increases the risk of hitting an artery which in some cases can be fatal.
 - ◆ A bigger needle can cause unnecessary damage to the vein.
 - ◆ If the injection leaks into tissue around the vein, it can become painful and swollen, cause abscesses and can drastically shorten the life of veins.
 - ◆ Drawing blood into the syringe and 'flushing' it out after an injection will not increase the amount of drugs in the system at all but will shorten the life of the veins.
 - ◆ The safest way to avoid infections, abscesses and viruses such as Hepatitis C is to always wash the hands and the injection site before and after injecting, and use new sterile equipment.

- ◆ Injecting pills or capsules is particularly dangerous as the chalk from pills or gel from capsules can block blood vessels which can cause loss of circulation to fingers or toes, resulting in possible amputation. In severe cases, it can lead to stroke or heart failure.
 - ◆ If the pressure in the small vein gets too great, it can 'blow up' like a balloon.
 - ◆ Putting a tourniquet on too tightly (should be able to feel a pulse in the arm) can restrict the flow of blood, making the vein thinner and easier to miss.
- The facilitator sums up the discussion by presenting the following slides.



Step 4: Conclusion

- Conclude the session by giving the following key messages to the participants.

Key Messages

IDUs face several risks associated with unsafe injecting, including acquisition of blood-borne pathogens such as HIV, and Hepatitis C & B.

Many drug users are not willing to stop injecting and even refuse to stop sharing of needles and syringes. Yet they can be helped with risk reduction counselling related to safe injecting.

Risk reduction counselling identifies unsafe injecting practices and facilitates the adoption of appropriate safe practices.

IDUs must be educated about the dangerous sites for injecting (e.g., neck and groin veins), and cautioned not to inject pills/capsules.

OST is an important step to prevent or stop injecting.

Safe injecting not only helps in prevention of acquisition and transmission of HIV but also helps in preventing abscesses, injection-related injuries and infections and overdose.

Drug Treatment: Detoxification

OBJECTIVE

To educate the participants on treatment issues related to detoxification

EXPECTED OUTCOME

By the end of the session the participants would

- Understand the withdrawal symptoms of various substances of use
- Know how to provide relief from distressing withdrawal symptoms from specific substances, including opioids, alcohol and sedative hypnotics
- Understand the importance of linking people to comprehensive drug treatment services following treatment for withdrawal

DURATION

1 hour

SESSION CONTENT

- What is detoxification?
- Withdrawal symptoms of various substances
- Management of withdrawal symptoms
 - ◆ Opioid
 - ◆ Alcohol
 - ◆ Benzodiazepine (sedative)
- Linking with drug treatment and rehabilitation services following detoxification

METHODOLOGY

- Discussion
- PowerPoint Presentation

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/Flipchart
- Marker pens

PROCESS

Step 1: Understanding detoxification

- The facilitator begins the discussion by asking the participants about their understanding of detoxification, and why it is needed.
- He/she sums up the discussion by taking the participants through the following presentation.

- Management of withdrawal, or detoxification, diminishes the pain and discomfort the person feels when withdrawing over a short period from the drug of dependence (such as heroin, a sedative or hypnotic or alcohol) by providing medical and psychological support.

Detoxification

Objectives of detoxification:

- Provide safe and humane treatment to enable the individual to remain abstinent during the acute phase of withdrawal
- Facilitate the patient's transition to a drug-free state

Successful detoxification is safely completing the short-term treatment of withdrawal; it encourages treatment retention and participation in long-term management

During the presentation discuss the general principles of drug detoxification services which are as follows:

General principles of drug detoxification services

- Carry out a comprehensive assessment to help with the treatment plan.
- Prepare the patient for the management of withdrawal.
- Provide factual, realistic information about drugs and withdrawal symptoms to alleviate the anxiety and fear associated with withdrawal symptoms.
- Ask the person undergoing detoxification to visit the service site every day during withdrawal management.
- Request a family member to accompany the person, if possible.
- The doctor should advise and direct the prescription of medications used for detoxification.
- Health workers such as nurses are responsible for monitoring withdrawal, dispensing medication and educating the patient on how to manage withdrawal.
- Advise the patient on good nutrition and avoiding dehydration. General vitamin and mineral supplements can be recommended, as many drug users are malnourished.
- Rigorous physical exercise may prolong withdrawal and worsen distress. Warm baths may be helpful.
- Encourage people undergoing detoxification to engage in calming practices such as relaxation exercises and meditation.
- If the patient becomes confused or behaviourally disturbed during withdrawal, arrange for hospitalization to manage the symptoms.

Step 2: Discussion on opioid withdrawal management

- Generate a discussion on the signs and symptoms of opioid withdrawal. Sum up by presenting the following slides:

Opioid Withdrawal

- Sweating
- Watering eyes
- Running nose
- Yawning
- Hot and cold flushes
- Goose bumps
- Tremors (shakes)
- Loss of appetite
- Abdominal cramps
- Nausea and vomiting
- Diarrhoea
- Increased bowel sounds
- Sleep disturbance
- Restlessness
- Generalized aches and pains
- Rapid heart rate
- Elevated blood pressure
- Dilated pupils

Onset, Peak and Duration of Opioid Withdrawal

Drug	Duration of effects	Onset of withdrawal from the last dose	Peak withdrawal effects	Duration of withdrawal
Heroin	4 hours	8–12 hours	36–72 hours	7–10 days
Morphine	4–5 hours	8–12 hours	36–72 hours	7–10 days
Codeine	4 hours	8–12 hours	36–72 hours	7–10 days
Methadone	8–12 hours	36–72 hours	96–144 hours	10–20 days

- The intensity, peak and course of withdrawal can differ between short-acting and long-acting opioids.
- When opioids are stopped, the severity of withdrawal symptoms depends on a number of factors:
 - ◆ **Amount of opioids used daily:** In general, the more opioids ingested daily, the more severe the withdrawal syndrome.
 - ◆ **Duration and regularity of use:** In general, the more intermittent the drug use, the less severe the withdrawal. Consistent use over a longer duration appears to produce more severe symptoms.
 - ◆ **Psychological and individual factors:** Personality and state of mind can influence the severity of withdrawal, as can general physical health and ability to cope with stress.
- Discuss and present the following slides on management of opioid withdrawal.

Management of Opioid Withdrawal

- Both methadone and buprenorphine are listed on the WHO Essential Medicines List.
- They are highly effective in the management of opioid dependency as part of a maintenance regime.
- Evidence of effective opioid withdrawal management also exists for methadone and buprenorphine.
- Opioid withdrawal is not a life-threatening condition, but untreated opioid toxicity can be fatal.

Management of Opioid Withdrawal (Contd.)

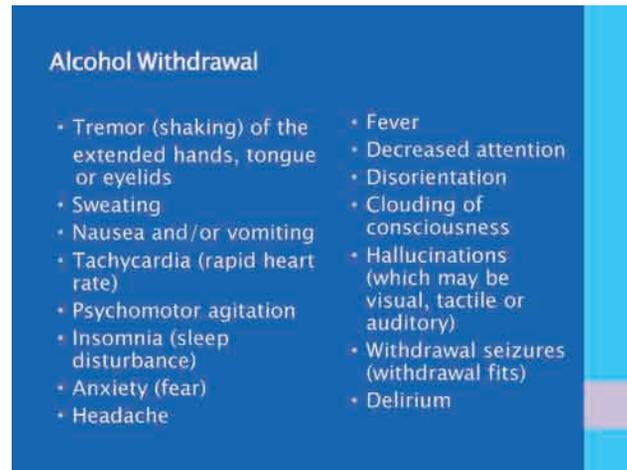
- **Pharmacological treatment**
 - Opioids – buprenorphine, Methadone
 - Non-opioids – clonidine
- **Symptomatic treatment**
 - Pain or muscle cramps – NSAIDs
 - Abdominal Cramps – Dicyclomine
 - Nausea or vomiting – Prochlorperazine, Ondansetron
 - Diarrhea – Loperamide

- Patients should drink plenty of fluids during withdrawal to replace the fluids lost due to excessive sweating and diarrhoea (health workers should be aware of the possibility of compromised renal function). Vitamin supplements can also be provided. For mild opioid withdrawal, supportive care and symptom management suffice. For moderate and severe withdrawal, pharmacological treatment is required.

Step 3: Discussion on alcohol withdrawal management

- Share the PowerPoint presentation and conduct discussion on alcohol withdrawal.

- Patients will often complain of withdrawal symptoms but may not have objective evidence of the same.



Key issues in alcohol detoxification:

- Alcohol withdrawal syndrome is a common medical problem.
- Mortality in alcohol withdrawal can be high (up to 15%).
- Conduct a thorough physical examination, as physical illness markedly increases the chances of convulsions or delirium.
- During detoxification, avoid intravenous fluids unless there are medical indications for this.
- Provide education and reassurance as these are extremely important.
- The patient's symptoms are likely to markedly diminish with any CNS depressant (such as any benzodiazepine) in adequate doses.
- Withdrawal treatment does not usually require an anticonvulsant unless the patient has a seizure disorder.
- Mild-to-moderate symptoms of alcohol withdrawal can be managed on an outpatient basis at the service site; severe symptoms (seizures, delirium) need to be treated in a hospital.
- Longer-acting benzodiazepines (e.g. diazepam, chlordiazepoxide) may be more effective than shorter-acting ones in preventing seizures. They may produce a smoother withdrawal course with less breakthrough or rebound symptoms than shorter-acting agents.
- Check the pulse and blood pressure (BP) regularly.
- Oxazepam/Lorazepam should be used for people with abnormal liver function tests and/or chronic liver disease.
- Intramuscular injection of thiamine/vitamin B complex should be given to prevent Wernicke's encephalopathy and Korsakoff's psychosis.

Step 4: Discussion and presentation on benzodiazepine withdrawal

- Abrupt discontinuation of benzodiazepines in patients who are physically dependent on them can lead to serious adverse medical events, including death. With the short-acting benzodiazepines (e.g. oxazepam, alprazolam, triazolam), withdrawal symptoms typically begin 12 to 24 hours after the last dose and peak in intensity between 24 and 72 hours. Symptoms may develop slowly in persons with liver disease and the elderly, due to decreased drug metabolism. With long-acting drugs such as diazepam and chlordiazepoxide, the withdrawal symptoms peak after five to eight days.

Benzodiazepine Withdrawals	
• Anxiety (fear)	• Postural hypotension (significant reduction in blood pressure due to postural changes)
• Tremors (shaking)	• Seizures (fits)
• Nightmares	• Hyperpyrexia (increased body temperature)
• Anorexia (loss of appetite)	• Delirium
• Nausea	
• Vomiting	

Management of benzodiazepine withdrawal

Persons dependent on benzodiazepines should be regularly monitored for the development of symptoms and complications. The withdrawal symptoms can fluctuate rapidly and health workers must communicate regularly with the person about the symptoms. Patient education and reassurance are necessary.

- The safest way to manage benzodiazepine withdrawal is to gradually reduce the dose. In order to stabilize the person, an appropriate dose of diazepam needs to be given. The calculated dose of diazepam is provided in divided doses to the patient.
- There has to be at least one week's interval between dose reductions in order to make the withdrawal safe and comfortable.

Step 5: Discussion on post-detoxification care and treatment

- Begin the discussion by repeating that effective detoxification includes not only medical stabilization of the patient and safe and humane withdrawal from drugs or alcohol, but also entry into treatment.
- All patients completing detoxification must be connected to after-care psychosocial support services. Following the acute withdrawal phase, protracted withdrawal can last for a few months. This phase is characterized by significant craving for the preferred opioid and a diminished sense of well-being. Relapse is extremely common following detoxification in those not provided with adequate psychosocial support.

All drug dependent persons require long-term care and support and they can benefit immensely with psychosocial interventions, including relapse prevention. Those with moderate to severe opioid dependency and a history of injecting should be considered for opioid substitution therapy with methadone or buprenorphine.

Step 6: Group exercise

- Divide the participants into two to three small groups, depending on the number of participants.
- Have them count off, and then have all the “ones,” “twos,” etc., assemble into respective groups. Tell each group that it will need to assign a person to moderate and another to record and present the discussion.
- Give each group chart papers and markers.
- Ask the participants to brainstorm, based on their knowledge and experience, on the challenges detoxification providers encounter, particularly in providing linkages to treatment.
- Give the participants 10 minutes to brainstorm. Have the recorder write down their responses on chart(s).
- Reassemble into a large group and have each small group present the results of its brainstorming.
- Summarize this exercise by presenting the slide above.
- Conclude the session by giving the following messages.

**Small Group Exercise:
Providing Linkages to Treatment Services**

- Detoxification services are often not long enough.
- Patients are not educated about long term management of substance use disorders.
- The majority of patients do not receive any substance abuse treatment after detoxification.
- Formal linkages don't exist between harm reduction, detoxification and rehabilitation services.
- The rehabilitation services are expensive and unaffordable for many clients.

Key Messages

In general, it is wise to avoid poly-pharmacy to treat opioid withdrawal symptomatically.

Provide effective treatment with opioid medications (methadone or buprenorphine) or clonidine.

Opioid withdrawal is not a life-threatening condition, but untreated opioid toxicity can be fatal.

Whereas mild-to-moderate symptoms of alcohol withdrawal can be managed on an outpatient basis at the service site, severe symptoms (seizures, delirium) need to be treated in a hospital.

The safest way to manage benzodiazepine withdrawal is to gradually reduce the dose.

Drug Treatment: Opioid Substitution Therapy

OBJECTIVES

- To help the participants understand the concepts and benefits of Opioid Substitution Therapy (OST).
- To enable the participants to understand about the two commonly used substitution medications, methadone and buprenorphine.

EXPECTED OUTCOME

By the end of the session, the participants would have:

- A better understanding of the concept of OST
- A better understanding of the benefits of OST
- An increased knowledge about the two commonly used substitution medications, methadone and buprenorphine

DURATION

1 hour

SESSION CONTENT

- What is opioid substitution therapy (OST)?
- Benefits of OST
- Comparison of methadone and buprenorphine
- Doses of methadone and buprenorphine

METHODOLOGY

- Discussion
- PowerPoint presentation
- Screening of film on harm reduction produced by Society for Promotion of Youth and Masses (SPYM), New Delhi

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint Presentation
- Whiteboard/Flipchart
- Marker pens
- Film on harm reduction

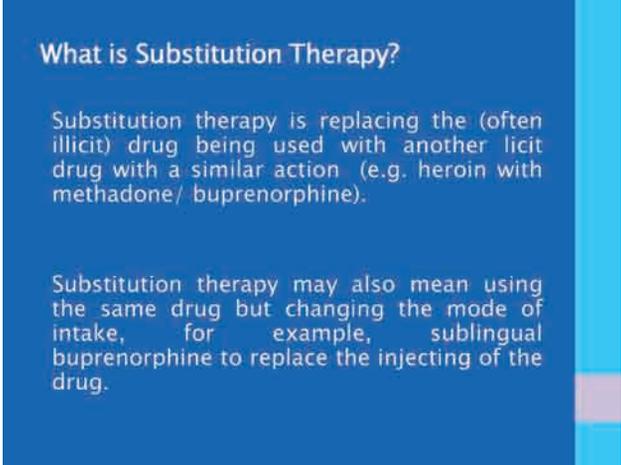
PROCESS

Step 1: Discussion

- The facilitator begins the session by asking the participants the following questions:
 1. What is Opioid Substitution Therapy?
 2. What are the objectives and benefits of OST?
- The facilitator/co-facilitator writes down the responses on the whiteboard and encourages other participants to add points that have been missed.
- Ensure that the following points are covered in the discussion.
 - ◆ OST is a form of medical therapy offered to opioid dependents based on a substance similar or identical to the drug normally used.
 - ◆ Opioid substitution medication is administered through non-injecting route.
 - ◆ An adequate dose of the substituted substance is provided to the user to reduce risky or harmful behaviour associated with the drugs taken by the user such as heroin or injectable opioids.
 - ◆ OST is provided preferably with psychosocial support.
 - ◆ Scientific evidence suggests that OST can help reduce criminality, infectious diseases and drug-related deaths; and improve the physical, psychological and social well-being of dependent users.
 - ◆ Methadone maintenance therapy reduces illicit drug use and criminal activities. Patients stabilized on adequate doses of opioid medication can function normally, hold jobs, avoid crime and violence of the street culture, and reduce their exposure to HIV by stopping or decreasing injecting drug use and drug-related high-risk sexual behaviour.

Step 2: Presentation on OST

- The facilitator then takes the participants through the presentation and stops to discuss the key points with the participants.



What is Substitution Therapy?

Substitution therapy is replacing the (often illicit) drug being used with another licit drug with a similar action (e.g. heroin with methadone/ buprenorphine).

Substitution therapy may also mean using the same drug but changing the mode of intake, for example, sublingual buprenorphine to replace the injecting of the drug.

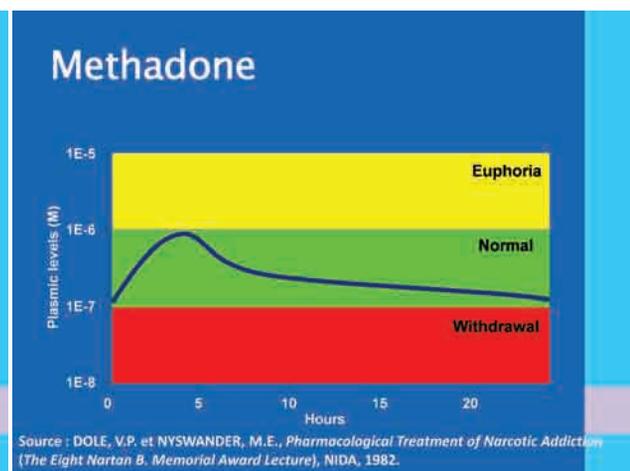
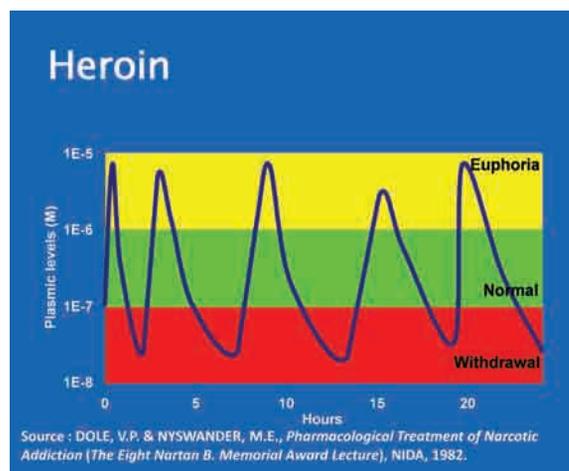
Additional Notes

Opioid dependence is an enduring illness and the abstinence rates following treatment are alarmingly low. The high relapse rates (up to 90-95% of persons who use drugs are unable to achieve drug-free status following conventional abstinence oriented therapy) have nothing to do with being bad or having no will power. It's just that for some people long-term use of illicit opiates changes the brain chemistry in such a way that the brain continues to need an opioid to function properly. While stopping drugs appears a distant and often unachievable goal for many drug users, reducing the risk behaviours associated with drug use is an achievable goal. Therefore, the treatment for drug dependence should aim at reducing morbidities such as blood-borne infections, deaths caused by drug use, and disability associated with opioid use. Such treatment interventions also improve quality of life and prolong the life of the chronic drug user. Management of opioid dependence must be seen the same way as management of diabetes and hypertension - conditions that require long-term treatment, where the treatment interventions, though not curative, are extremely beneficial in reducing/averting the adverse consequences and complications that are associated with these disorders.

- The prime purpose of administering OST is to improve the health of persons who use drugs. The beneficial role of methadone maintenance therapy as well as that of OST with sublingual buprenorphine in HIV prevention among injecting drug users has good scientific evidence to support it. Major observational studies have indicated that methadone maintenance therapy reduces illicit drug use and criminal activities. The cost effectiveness of methadone has been examined and the treatment with it is found to be efficient. There is also an evidence of the safety of opioid substitution medications. The treatment also reduces the number of fatal overdose deaths due to illicit drug use.

What are the objectives of opioid substitution therapy?

- To improve health
- To reduce the incidence of blood-borne viruses
- To reduce crime associated with illicit drug use
- To prevent overdose related deaths
- To improve the functioning of the drug users



- Discuss the benefits of OST with the participants and ensure the following points are covered in the discussion:
 - ◆ The persons who use injecting drugs are at greater risk of acquiring and transmitting blood-borne viruses such as HIV, and Hepatitis C & B. Hence, by transferring persons from an injectable to a non-injectable preparation, the potential for transmission is greatly minimized.

- ◆ Through OST, an illicit drug that the individual is using is being substituted by a licit, medically prescribed and supervised medication. While using an illicit drug, the individual is considered a criminal as he/she normally indulges in criminal behaviours such as petty theft, drug peddling, etc.
- ◆ On replacement with a medically prescribed medication, he/she assumes the role of a 'patient' and engages in health-seeking behaviours. The change in the role status of the individual from 'criminal' to 'patient' changes the associated behaviours from negative, stereotyped criminalized behaviours to positive, health-seeking behaviours. As the patient visits the OST clinic to receive the substitution medication regularly, the contact with the health system enables him/her to seek medical and other help that he/she is in need of.
- ◆ Finally, the substitution is usually from a short half-life drug to a long half-life drug. While on a short half-life drug, the individual has to take the drug three or more times daily resulting in the individual experiencing a 'high' under the influence of the drug (intoxication) or a 'low' due to withdrawal from the drug. Thus the individual spends less time in the normal phase and is dysfunctional. Whereas if the person is on a long-acting opioid such as methadone or buprenorphine, most of the time is spent in the normal phase, as the individual does not experience a 'high' or 'low' during the day; hence the person can be functional throughout.
- ◆ Both methadone and buprenorphine are beneficial in retaining patients on treatment. Clearly, OST is the most attractive treatment option for the opioid dependent users. Both the drugs have been found to reduce the risk behaviours related to injecting drug use and hence serve as HIV prevention options among IDUs. One must understand that OST is a long-term treatment and this provides an opportunity for people to benefit over time. Apart from staying away from illicit drugs and the associated life-style, they are able to remain functional and productive. They are able to take good care of themselves, their health and their families. The burden on the families is greatly minimized and the individual is on the path to recovery. Three things happen with OST which offer significant benefits to the opioid user:
 - a) OST addresses and relieves the withdrawal symptoms effectively.
 - b) OST reduces the craving (intense desire and compulsion to take the drug) associated with drug use
 - c) OST suppresses the further use of heroin or other injectable opioids

- Summarize the discussion by presenting the following slides:



Step 3: Discussion and presentation on methadone and buprenorphine

- Ask the participants about methadone and buprenorphine
- Discuss in detail about methadone and buprenorphine

Additional Notes

- In India, buprenorphine has been available for a long time. For over fifteen years, experience has been gained about the utility of buprenorphine as opioid substitution medication. Methadone, which was taken off the Indian pharmacopeia in 1977, is again being piloted in five centres across three states.
- Both drugs have been approved by WHO/UNODC/UNAIDS as important medications that serve as HIV prevention among persons who inject drugs.
- Methadone is the most employed agent in substitution treatment around the world. Methadone treatment for heroin addicts was first used in a small trial in New York City in 1964.
- The main difference between methadone and buprenorphine is in the mode of administration. Whereas methadone is administered orally (as tablet or methadone syrup), buprenorphine is administered sublingually as it has poor oral bioavailability.
- Methadone remains the most commonly prescribed substitute for heroin in maintenance therapy. Nevertheless, it has limitations like development of tolerance and dependence and potential of fatal overdose. Takeaway doses for patients have resulted in street diversion and occasional poisoning. In addition, there are misperceptions and stigma associated with methadone use. The limitations of methadone treatment apply to some individuals currently receiving treatment and deter others from entering treatment. They include the requirement for daily dosing, side effects for some, and the length of the withdrawal from methadone. Some patients complain of symptoms consistent with mild opioid overdose (such as drowsiness, dry mouth, inability to concentrate) in the first few hours after methadone ingestion. Other unpleasant effects (such as fluid retention, carpal tunnel syndrome) have been reported. Up to a third of methadone maintenance patients experience the symptoms of withdrawal in the second half of the 24-hour dosing interval, that is, it does not “hold” for the entire 24-hour period. More important, however, is the fact that heroin users only have one drug choice in many countries. Choice is a significant determinant of outcome of treatment, and greater choice will improve success rates for treatment.
- Comparative trials have demonstrated buprenorphine to be as efficacious as methadone as a maintenance drug. Studies indicate that high dose buprenorphine is equal in efficacy to methadone as a maintenance agent. One big advantage of methadone is that it is not diverted for injecting whereas buprenorphine, if unsupervised, can be diverted for injecting. Second, methadone is cheaper than buprenorphine. Buprenorphine is a partial agonist and hence does not have toxicity. Death due to overdose with buprenorphine does not occur.
- Buprenorphine is a partial agonist (possesses both agonist and antagonist properties). It is an μ -opioid receptor partial agonist and an opiate receptor antagonist and it binds strongly to μ opioid receptors. Partial agonists exhibit ceiling effects (i.e., increasing the dose only has effect to a certain level). Therefore, partial agonists usually have greater safety profiles than full agonists (like morphine or heroin and certain analgesic products chemically related to morphine). This means that buprenorphine is less likely to cause respiratory depression,

Contd...

the major toxic effect of opioid drugs, in comparison to full agonists like heroin. This should greatly reduce chances of accidental or intentional overdose. Apart from low acute toxicity, it has adequate safety margins for chronic toxicity. Its slow receptor kinetics (tightly binds to the receptors and dissociates from receptors slowly) account for longer duration of action and low levels of dependency. Due its pharmacological profile, the drug is very safe and can be used on alternate days or thrice weekly, reducing the number of clinic visits. Buprenorphine has low abuse potential. Even though abuse has been reported, it is mostly for the parenteral preparations. The withdrawal symptoms are milder and are not distressing like those of heroin withdrawal. The withdrawal symptoms do not appear until 72 hours after the last dose of buprenorphine. Patients administered buprenorphine can discontinue the drug easily. The withdrawal symptoms are mild but can be prolonged after discontinuation due to slow receptor kinesis.

- Run the participants through the following presentation:

Methadone and Buprenorphine

Buprenorphine	Methadone
Partial agonist at μ -opiate receptor and produces only a low level of euphoria	Full agonist at μ -opiate receptor and can produce significant intoxication
Has low dependence potential	Potential to produce significant dependence. As tolerance increases, increased doses are required over time

Methadone and Buprenorphine (contd.)

Buprenorphine	Methadone
At high doses, there is a ceiling effect. The risk of respiratory depression is minimal, except when combined with benzodiazepines, alcohol and other CNS depressants.	Risk of fatal overdose by respiratory depression
Blocks the effects of other opiate agonists	Does not block the effect of other opiate agonists

Methadone and Buprenorphine (contd.)

Buprenorphine	Methadone
Sublingual tablets are effectively absorbed. It is not orally active. Sublingual tablets can be crushed, easily dissolved and injected.	Orally active
Relatively expensive	Cheaper

Potential Benefits of Buprenorphine

- Reduces the use of other opioids
- Keep clients in treatment
- Causes few side effects
- "Partial agonist" – a ceiling effect above which higher doses do not increase activity; respiratory depression unlikely
- Is safe; death from buprenorphine use has not been reported

Potential Benefits of Buprenorphine (contd.)

- Relative low level of physical dependence
- Has only mild withdrawal symptoms
- It is a long acting, so it does not have to be taken daily
- Is a good substitute drug for people with mild to moderate opiate dependency
- Is liked by the clients

Potential Benefits of Buprenorphine (contd.)

When used in opioid substitution therapy for pregnant women with opioid dependence, it appears to be associated with a lower incidence of neonatal withdrawal syndrome.

May be a good option for adolescent opioid dependents.

Dose of Buprenorphine/Methadone

For what?	Methadone dose	Buprenorphine dose
Managing withdrawal symptoms	10-40 mg	Up to 2 mg
Craving	40-80 mg	Around 4 mg
Suppressing further use of heroin/ illicit opioids	> 80 mg	Around 8 mg

Step 4: Explanation and presentation on the process of implementing OST

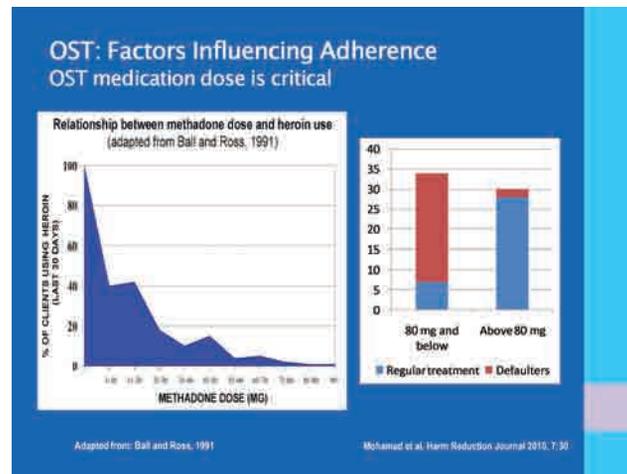
- Explain to the participants the intake process of OST

- The diagnosis of opioid dependence is necessary for offering OST to the individual. The diagnosis is usually made by the assessing clinical team. At present as the program is supported by NACO, only people who inject drugs are considered for OST. Ideally OST should be available for all opioid dependent individuals. Before offering OST, it is necessary to explain about the treatment and its implications to the patient and obtain informed consent. Signing a treatment contract is helpful as it has a positive influence in compliance with the therapy. Involving a family member such as a spouse or mother or sister is helpful in improving adherence to treatment. The decision to initiate and maintain OST is usually an informed decision made jointly by the patient, doctor and often a family member. It is essential to explain the treatment protocols to the patient and provide sufficient time for clarification.

Intake Process

- Opioid dependent individuals: diagnosed by qualified and/or trained physician/psychiatrist
- Informed consent for treatment with buprenorphine/ methadone
- Treatment contract signed
- Involvement of family member (desirable)
- Decision about maintenance with buprenorphine/methadone jointly made by the physician and patient
- Treatment protocols explained clearly

- One of the most important issues in the success and effectiveness of OST is improving the adherence to the therapy.



- Failure to comply with treatment is a challenge and needs to be addressed effectively. In the initial stages, it is important to consider the following factors to promote and maximize treatment participation and retention:
 - ◆ Assess whether OST patients understand the significance of the therapy.
 - ◆ Educate and counsel them about the various benefits of OST.
 - ◆ Stigma and discrimination is another factor that could impede treatment participation and continued attendance.
 - ◆ In the beginning, a peer can provide the necessary support, advice and intensive counselling to the OST patient.
 - ◆ Easy access is another critical issue; the OST patients may need guidance on public and other forms of transport that would help them to access the OST centre regularly.
 - ◆ The operational hours of the clinic need to be flexible in order for the patients to access the clinic regularly. The importance of regular doses should not be underestimated. It has been proved through several research studies that an adequate dose (60-120 mg/day) of methadone is essential to improve treatment retention as well as to reduce further use of illicit drugs.
 - ◆ The attitude of the clinical staff is extremely important. OST clinical staff members, who are user-friendly and non-judgmental, are able to attract and retain drug users in treatment.
 - ◆ Persons who use drugs are very sensitive to criticism and do not tolerate a punitive attitude from the clinical staff members.
 - ◆ Staff members with high morale, tolerance and understanding must be willing to take the extra step to reach out to the drug users and treat them with empathy and concern.
 - ◆ It is necessary for the clinical team to accept drug dependence as a chronic relapsing medical condition that requires long-term treatment with medicine (such as methadone or buprenorphine) as well as psychosocial support.

Step 5: Conclusion

- Conclude the session by giving the following key messages:

Key Messages

OST achieves the following key benefits: shifting from injecting to non-injecting mode; replacing an illicit drug with medically prescribed drug, thus changing the user's status from criminal to patient; and substituting a short-acting opioid with long-acting opioid such as methadone and buprenorphine.

Thus OST reduces injecting related harms; promotes health-seeking behaviour, diminishes illicit drug use and associated criminal behaviour; and makes the person functional and productive.

Dosage: OST addresses and relieves the withdrawal symptoms effectively (up to 2 mg buprenorphine); reduces the craving (around 4 mg buprenorphine); suppresses the further use of heroin or other injectable opioid (around 8 mg buprenorphine).

Adequate dose of substitution medication improves treatment adherence.

Sexually Transmitted Infections: Basics

OBJECTIVE

To educate the participants on the basics of sexually transmitted infections

EXPECTED OUTCOME

By the end of the session the participants will be able:

- To understand the definition of STIs and list the common ones
- To describe clinical features of STIs and diagnose them

DURATION

45 minutes

SESSION CONTENT

- Need for interventions targeting sexual risks among IDUs
- Common STIs and their aetiology
- Major clinical features of the common STIs

METHODOLOGY

- Discussion
- PowerPoint presentations
- Ranking exercise

MATERIALS/PREPARATION REQUIRED

- LCD projector
- Laptop
- PowerPoint slides
- Whiteboard/flipchart
- Chart papers
- Masking tape
- Marker pens
- Cards with risk behaviour written on them:

Three sets of small situation cards should be prepared by the facilitator before the beginning of the session using blank papers. (The various types of risk behaviours should be written on the cards, using one card for each high risk behaviour: HIV-positive penis in HIV-negative butt, HIV-positive penis in HIV-negative vagina, HIV-positive penis in HIV-positive butt, HIV-positive penis in HIV-negative mouth, HIV-positive mouth in HIV-negative vagina/penis, mutual masturbation.)

PROCESS

Step 1: Understanding the Link between Drug Use and STIs

- Begin the session by asking the participants the relationship between drug use and sexual behaviour.
- Discuss with the participants why interventions are required to target sexual behaviour among IDUs.
- Make sure the following points are covered during the discussion:
 - ◆ The relationship between drug use and the level of sexual activity among drug users is phase-specific. In the early phase of drug use, most users report that sexual activity is high, intense and pleasurable.
 - ◆ Following the chronic use of opiates, many report problems with sexual desire and performance. During withdrawal and abstinence, renewed sexual activity is reported. Men do not perceive that they are at risk of infection or that they are placing their wives at risk. As a result, condom use is relatively uncommon with spouses.
 - ◆ The link between substance use and sexual risk behaviour could be understood through the pharmacological effects (e.g., Ecstasy increasing the sexual urges and activity), behavioural disinhibition, user perception about effects, social learning, and use in certain social settings. Understanding the social norms, attitudes, cultural beliefs and social settings is critical to establish links between substance use and sexual behaviour and sexual risk behaviour.
 - ◆ Often there is an overlap between the population of drug users and sex workers. Drug users can be involved in selling sex to raise money for drugs or trading sex for drugs. Certain drugs (cocaine, alcohol and amphetamine type substances) can lead to high-risk sexual behaviour. Sex workers also use drugs and licit substances such as alcohol. A proportion of IDUs are also men who have sex with men (MSM). Thus, there is a significant overlap between the three groups: IDUs, female sex workers (FSWs) and MSM.
- Take the discussion forward using the following PowerPoint slides.

<p>Why do interventions need to target sexual behaviour?</p> <ul style="list-style-type: none"> • Drug users have active sexual life. • Often, they have unprotected sex with regular sexual partners. • OST and abstinence from illicit drugs increase well-being – unprotected sex. 	<p>Why do interventions need to target sexual behaviour?</p> <ul style="list-style-type: none"> • STIs are not uncommon among drug users. • Significant synergy between HIV and STIs. Reducing the prevalence of STIs in drug users will help reduce the spread of HIV itself. • One-third of HIV-positive people have unprotected anal or vaginal sex.
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Drug Use/Sexual Risk

- A considerable proportion of drug users has sex with sex workers.
- Some sex workers use illicit drugs; many use licit drugs.
- A proportion of drug users are MSM.

Low Condom Use among IDUs and their Regular Partners

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graph TD
    A[Knowledge about sex risk low] --- B((Low condom use))
    C[Alcohol and drug use] --- B
    D[Relationship dynamics] --- B
    E[Gender] --- B
    F[Condom skills] --- B
    G[Condom norms] --- B
            
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NOTE TO THE FACILITATOR

- The regular sex partners are at great risk of acquiring HIV from their partners who inject drugs. First, the sexual behaviour of male IDUs is important in the transmission of HIV from them to their female partners. People who inject drugs also exhibit high-risk sexual behaviours, increasing the HIV/STI vulnerability of their sex partners.
- The male latex condom is the single most efficient technology available to reduce the sexual transmission of HIV and other STIs. Despite this, there are several barriers to condom use among the spouses of IDUs.
- Many regular sex partners have unprotected sex with their drug-using husbands to demonstrate intimacy and trust in the relationship. Reluctance to have sex is viewed as rejection of love, and sex is seen as a bonding factor. In the name of commitment, safety is compromised. Insistence on protected sex is interpreted as a suspicion of infidelity.
- Condoms are not perceived to be important as a means of protection against HIV. They are used by couples only at the time of menstrual periods or as a family planning device. Women's economic dependence on men increases their vulnerability to HIV by constraining their ability to avoid risky sex and negotiate safer sex.
- Low social and economic status of women coupled with gender inequality and men's power over women's sexuality contributes to the vulnerability of the regular sex partners.
- There is little interpersonal communication on sexual matters between women and men, and sexual decision-making is influenced by wider perceptions of gender roles and gender inequality. Domestic violence often occurs under the influence of alcohol and substance use.

All these factors together increase the HIV vulnerability of the spouses/regular sex partners of IDUs.

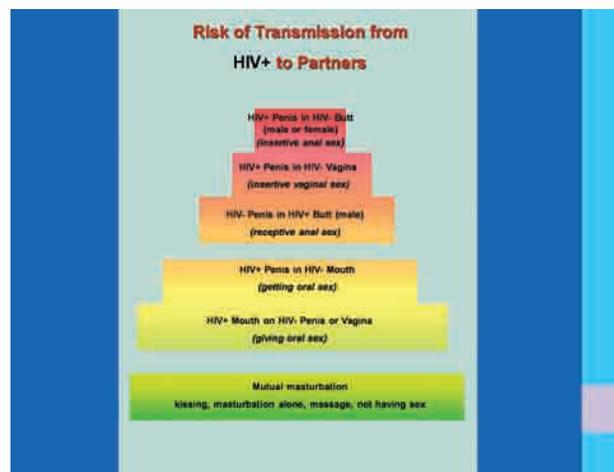
Step 2: Ranking Exercise

- Conduct the following exercise with the participants.

Procedure

- Divide the participants into three groups. Ask each group to pick a set of cards with a behaviour written on it. Ask them to discuss among themselves and then arrange the cards based on how risky they think the behaviour is (low/no risk at the bottom and high risk at the top).

- Once all the groups have completed the arrangement, ask each group to come and present their arrangements. Discuss with them their reasons for placing the cards in a certain order. After all the groups have presented, show the correct order of placement of the cards, as shown in the slides below. During the discussions, make sure the points mentioned below are covered:
 - ◆ As far as possibilities to reduce the harm of infecting others go, being at the bottom of the pyramid is the safest; and as you move up the pyramid, you increase your chances of infecting someone else with HIV. For example, if condoms didn't exist, no sex would mean no risk. The next behaviour on the pyramid that is riskier than no sex is oral sex. Now let's move further up the pyramid. If a man chooses to have unprotected vaginal sex, he is increasing the chance of infecting his partner. At the top of the pyramid, the behaviour that is the riskiest for transmitting HIV is insertive anal sex. All three of these behaviors at the top of the pyramid are very risky.
 - ◆ Men can reduce the risk of transmitting HIV to their sexual partners by changing the type of sex they have. So instead of having anal or vaginal sex, they can move down the pyramid to either oral sex or mutual masturbation.
 - ◆ Using condoms correctly dramatically reduces the risk of transmitting HIV to the sexual partners.
 - ◆ In order to be effective, barrier protection (male and female condoms and dental dams) must be used from the beginning to the end.
- The participants can discuss the risky sexual practices and other erotic/sexual practices that are relatively safer. Ask the participants to name the various sexual practices that they can think of. Encourage them to think about all the practices they have heard of.
- Sum up the discussion by making the following presentation:



Risky Sexual Practices	Other Sexual/Erotic Practices (Partial List)
<ul style="list-style-type: none"> • Anal sex – insertive, receptive (peno–anal intercourse) • Vaginal sex (peno–vaginal intercourse) • Oral sex – Fellatio (Peno–oral sex) • Anilingus (oro–anal sex) or Rimming • Cunnilingus (oro–vaginal) • Fisting – introduction of fist into rectum or vagina • Fingering – introducing finger into rectum or vagina 	<ul style="list-style-type: none"> • Dry kissing • Wet (French) kissing • Sensual touching • Self-masturbation • Mutual Masturbation • Necking • Caressing • Hugging • Frottage • Breast caressing • Breast sucking • Erotic talk • Using sex toys • Sharing fantasies • Telephone sex • Cyber sex • Bubble bath • Water sports • 'Thigh' sex

Step 3: Discussion and Presentation

- Initiate a discussion by asking the participants to talk about various STIs.

Common STIs

<ul style="list-style-type: none">■ Gonorrhoea■ Chlamydia■ Syphilis■ Chancroid■ Trichomoniasis■ Bacterial vaginosis	<ul style="list-style-type: none">■ Genital herpes simplex virus (HSV) infections■ Lymphogranulomavenereum■ Granuloma inguinale■ Human papillomavirus (HPV)■ Hepatitis B
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- Take the discussion forward by using the PowerPoint presentation on STI.

- Some microbes use the sexual route to get transmitted from one person to another.
- Two terms are commonly used, namely, sexually transmitted diseases (STDs) and STIs. A disease usually means that there are symptoms; since many STDs often do not have symptoms (are asymptomatic) and can be diagnosed only through laboratory investigations, the appropriate term is STI.

Basics – STD and STI

- Some microbes use sexual route to get transmitted from one person to another – for replication.
- There is a difference between the terms ‘Sexually Transmitted Disease (STD)’ and ‘Sexually Transmitted Infection (STI)’.
- ‘Disease’ usually means there are some symptoms. But some STIs may not produce any symptoms at all (they may develop later) and can be detected only by blood tests.

- In India, STI is a public health problem of major significance. STIs are transmitted through unprotected vaginal or anal sex, from mother to unborn child or through unsafe use of needles and syringes.
- In settings where laboratory facilities are unavailable for diagnosis of STIs, it is necessary to understand the syndromal level diagnosis of STIs.

Transmission of Sexually Transmitted Infections (STIs)

- Through unprotected penetrative sexual intercourse (vaginal or anal)
- From mother to child
 - during pregnancy (e.g. HIV and syphilis)
 - at delivery (e.g. gonorrhoea, chlamydia and HIV)
 - after birth (e.g. HIV)
 - through breast milk (e.g. HIV)
- Unsafe (unsterile) use of needles or injections or other contact with blood or blood products (e.g. syphilis, HIV and hepatitis)

- Presence of genital ulcer is a category; and this is constituted by syphilis, chancroid and herpes. Urethral/vaginal/anal discharge is another syndrome; chlamydia and gonorrhoea produce discharge. Inguinal swelling syndrome is due to chancroid and bubo. Anogenital warts and molluscum present as genital growth syndrome.

Symptoms or Syndromes

1. Ulcer:
Diseases: Syphilis, Chancroid, Herpes
2. Discharge:
– Urethral or vaginal or anal
– Diseases: Chlamydia and Gonorrhoea
3. Inguinal Swelling:
Diseases: Bubo, Chancroid
4. Growth:
Anogenital warts, Molluscum
5. Other: Pubic lice

- It is to be emphasized that bacterial/protozoal STIs are curable and can be treated with oral drugs or injections. Viral STIs are not curable; and herpes and warts tend to recur again and again.

Treatment

- Almost all bacterial STIs can be treated with drugs or injections.
- Viral STIs are usually not curable. Example: Warts or Herpes come again and again – even after treatment.

Step 4: Presentation on Link between STIs and HIV Infection

- Inform the participants that the next presentation will take them through the interaction between STIs and HIV.

- The link between STIs and the transmission of HIV infection is well established. Specifically, ulcerative STIs facilitate HIV transmission more than the non-ulcerative infections.

- Improved treatment services, based on syndromic STI case management, can substantially reduce HIV transmission in populations with high STI prevalence and HIV incidence. There is a strong epidemiologic association between HIV and other STIs. Some studies have reported two- to five-fold increased risk of HIV among people who have other STIs. The STIs can be asymptomatic, in particular among women. Hence, screening for asymptomatic STIs is critical for control and prevention of HIV among IDUs and their sex partners. Prevention of STIs thus prevents HIV. STIs can increase the viral load in HIV positive individuals, and the increased viral load aids the transmission of HIV.

Interaction between STIs and HIV (contd.)

- STIs increase the HIV transmission:
 - Loss of epithelial integrity – disruption of epithelium provides entry for STI/HIV pathogens
 - HIV viral load is increased in the genital tract in the presence of STIs
 - Recruitment and activation of receptor CD4 cells increases the susceptibility of HIV transmission
 - Immune dysregulation

- STIs are known to enhance the transmission of HIV infection by increasing the susceptibility to HIV in HIV-negative persons and increasing the HIV infectiousness of individuals with dual infection. The shedding of HIV in semen of HIV-positive individuals is considerably increased in persons with urethritis, the treatment of which greatly reduces HIV shedding. In the presence of STIs, the HIV viral load is increased in the genital tract. Recruitment and activation of receptor CD4 cells increases the susceptibility of HIV transmission. Immune dysregulation also contributes to increased HIV transmission.

Treatment

- Almost all bacterial STIs can be treated with drugs or injections.
- Viral STIs are usually not curable. Example: Warts or Herpes come again and again – even after treatment.

Step 5: Conclusion

- Wrap up the session by stressing on the following key messages.

Key messages

People who inject drugs often exhibit risky sexual behaviour.

Among IDUs, unprotected sex with regular sex partners (spouses) is normative. Low condom use is influenced by several factors such as trust and intimacy, inadequate knowledge, power and gender.

All STIs are not symptomatic.

Syndromal level of diagnosis helps in easy recognition of STIs in settings with no laboratory facilities.

There is a synergy between STIs and HIV. STIs, in particular ulcerative STIs facilitate HIV transmission.

Treatment of STIs reduces HIV transmission, and prevention of STIs prevents HIV.

Prevention of Sexually Transmitted Infections

OBJECTIVE

To enable the participants to understand

- Safer sex practices
- How STIs can be prevented

EXPECTED OUTCOME

By the end of the session the participants will be able to:

- Demonstrate correct condom use
- Educate/counsel clients and their partners about the prevention of STIs, in particular the importance of engaging in safe sex
- Understand the various family planning methods

DURATION

45 minutes

SESSION CONTENT

- Condoms: Key to STI prevention
- Prevention of STI
- Family planning methods

METHODOLOGY

- Brainstorming
- Discussion
- PowerPoint presentation

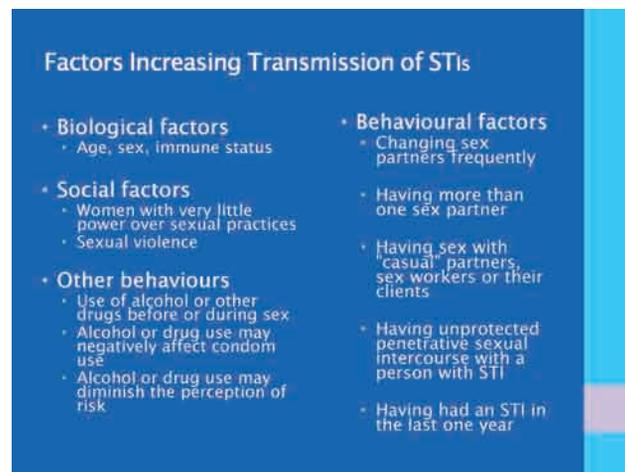
MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/Flipchart
- Marker pens
- Penis model
- Male and female condoms
- Water-based lubricants
- Day 2, feedback forms (Enough copies to be made for each participant)

PROCESS

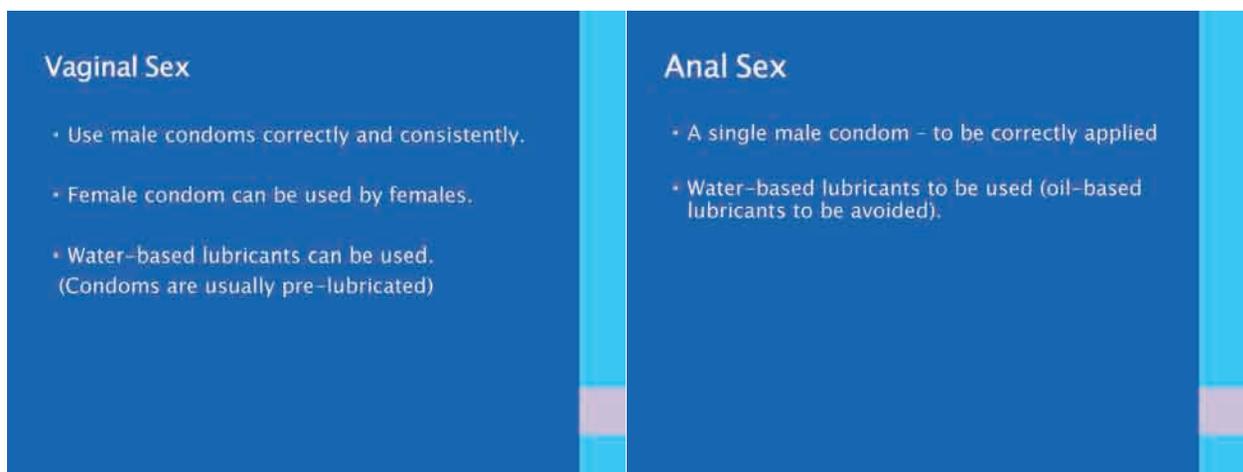
Step 1: Brainstorming and Presentation

- Ask the participants to recall the previous session on the basics of STIs.
- After a quick recap, ask the participants to brainstorm on the factors which facilitate the transmission of STIs and importance of the use of condom.
- As the participants share this information, the facilitator/co-facilitator writes it down on the whiteboard/flipchart.
- Make sure the following points are covered in the discussion:
 - ◆ The vaginal mucosa and cervical tissue in young women is immature, which makes them more vulnerable to STIs. Since the mucosal surface that comes into contact with the infective agent is much greater in women than in men, women can be more easily infected than men. The immune status of the host and virulence of the infective agent affect transmission of STIs.



- Show the adjacent slide to sum up the discussion.

- Briefly explain about condoms with the following slides:
- Condom use is very important for protection from acquiring STIs through vaginal sex. Consistent and correct use of male condoms is a key protective measure. Condoms are usually pre-lubricated; water-based lubricants can also be used with condoms.



Oral Sex (Fellatio)

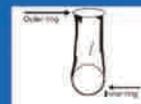
- Oral sex is not absolutely risk-free of HIV infection
- Risk of HIV infection if semen is swallowed?
- Some STDs can be acquired or transmitted by oral sex (warts, herpes)
- Flavoured condoms (strawberry, chocolate) are available for oral sex.

- Discuss about female condoms before presenting the slide on the same.

- The female condom is a thin sheath or pouch worn by a woman during sex. It entirely lines the vagina and helps to prevent pregnancy and STIs, including HIV. At each end, there is a flexible ring. At the closed end of the sheath, the flexible ring is inserted into the vagina to hold the female condom in place. The other end of the sheath stays outside the vulva at the entrance to the vagina. This ring acts as a guide during penetration and it also stops the sheath from moving up inside the vagina. There is a silicone-based lubricant on the inside of the condom, but additional lubrication can be used.

Female Condoms

- A thin, soft, loose-fitting polyurethane plastic pouch-like device
- Lines the vagina with two rings – outer (open end) and inner (closed end)
- Can be used with any type of lubricant



Step 2: Condom Demonstration Exercise

- The facilitator demonstrates the correct use of condoms to the participants. This is followed by a discussion to clarify doubts.
 - ◆ Stress the importance of carrying condoms all the time – the client should never be without one.
 - ◆ Show the expiry or manufacture date and explain that the condom should not be out-of-date, smelly, sticky or hard to unroll.
 - ◆ Explain how to open the package carefully, using the tear-point.
 - ◆ Show the correct side of the condom to roll over the penis, explaining that it will not roll down if placed the other way.
 - ◆ Show how to hold the tip of the condom to press out air, before rolling it all the way down the erect penis.
 - ◆ Emphasize that the condom must be rolled right down to its base.
 - ◆ Explain that the condom should be removed just as the penis begins to lose its erection. The user should hold it carefully at the base and slide it off slowly.
 - ◆ Explain that the patient should tie the top of the condom and dispose of it safely.

<h3>STI Prevention : Objectives</h3> <p>Objectives</p> <ul style="list-style-type: none">• Primary prevention or preventing infection in uninfected clients• Adequately treating the current infection• Secondary prevention, to prevent further transmission in the community• Preventing complications and re-infection in the client	<h3>STI Prevention: Key Methods</h3> <ul style="list-style-type: none">• Protected safe sex• Individual counselling by health care workers<ul style="list-style-type: none">• Risk reduction counselling• Behaviour change• Information brochures• Group discussions to facilitate understanding about prevention of sexually transmitted infections• Early identification and treatment of STIs• Partner counselling and treatment, if necessary
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<h3>Principles of Effective Client Counselling</h3> <ul style="list-style-type: none">• Respect and concern for the safety of clients• Acknowledging clients' feelings, and taking more time with them• Is client centered - tailored messages for different persons• Promote learning through ideas, feelings and actions; through multiple methods• Provide risk reduction messages to all• The clients are advised about preventive measures and use of condoms• Partner education and counselling	<h3>STI Prevention Counselling</h3> <ul style="list-style-type: none">• Explain to the DU/IDU in private, confidential settings about the disease; modes of acquiring and transmitting STIs; prevention and treatment of STIs.• Educate that most of STIs can be cured, except HIV, herpes and genital warts.• Sex with untreated partner can lead to re-infection and treatment of the partner.• Promote safer sexual behaviour to prevent HIV and STIs.<ul style="list-style-type: none">• Counsel on limiting the number of sex partners• Counsel on consistent condom use with all partners• Advise on HIV testing and counselling
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It is necessary for the clinical staff to explain to the injecting drug user about STIs, methods of transmission, prevention and treatment of STIs, and disclosure to the partners. This information should be provided in privacy. Also, the clients need to be assured that any information shared by them will be treated with utmost confidentiality.

Educating the clients that the majority of STIs (except viral STIs such as HIV, herpes and warts) are curable is important. They also need to be educated about the appropriate medicine, adequate dose and duration.

Sex with an untreated partner can lead to re-infection. Hence, all sex should be protected by using condoms.

At every opportunity, the clients should be counselled on safe sex. They should be advised to reduce the number of sex partners and make consistent and correct use of condoms in all sex encounters with all partners.

Wherever possible, the clients should be advised on HIV testing and referred to ICTC.

Step 4: Presentation on Family Planning Methods

- Ask the participants to name various family planning methods they can think of.
- Sum up the discussion by presenting the following slides:

Family Planning Methods	
Family planning method	Key points
Male and female condoms	Correct and consistent use is essential Protection against pregnancy and STIs, including HIV
Combined oral contraceptives	Condoms provide extra contraceptive protection Can be used by women with HIV
Progestin-only pills	Condoms provide extra contraceptive protection Appropriate for breastfeeding women
Injectable contraceptives	Condoms provide extra contraceptive protection Women who are on ART can safely use monthly injectables

Family Planning Methods (contd.)	
Family planning method	Key points
Copper bearing IUDs	Woman at risk of HIV infection, with HIV, with AIDS but on ART and well can have IUD inserted
Female sterilization and vasectomy	Female sterilization and vasectomy do not prevent transmission of HIV
Standard days method	For women with advanced HIV, irregular cycles may be common and hence this method is difficult to use
Emergency contraceptive pill	Effective if taken within 72 hrs of unprotected sexual intercourse. Levonorgestrel 1.5 mg single dose may be used
Spermicides	Women at high risk of HIV infection or with HIV infection, including AIDS, should not use spermicides

A number of family planning methods have been listed in the above slides. Of these, male and female condoms are the most important as they constitute an:

- Effective family planning method
- Effective STI prevention strategy
- Effective HIV prevention measure

Step 5: Conclusion

- Wrap up the session by giving the following key messages:

Key Messages

Factors which facilitate STI transmission: behavioural (e.g., number of partners, frequent change of partners, unprotected sex), biological (age, sex, immune status) and others (drug and alcohol use before sex)

Condoms are the key tool for STI prevention.

Correct and consistent use of condoms with all partners is important to prevent STIs.

STI prevention counselling promotes safe sex, addresses correct treatment of current infection and prevention of re-infection and complications.

Condom is an established method for family planning, an effective STI prevention strategy, and an evidence-based HIV prevention measure.

- As this is the last session of day 2, distribute the feedback forms (feedback from – Day 2) and ask the participants to provide feedback for the sessions conducted through the day.

Day 3

Session One

Management of Sexually Transmitted Infections

Session Two

Basics of HIV

Session Three

Prevention and Management of HIV: The Role of Doctors and Nurses

Session Four

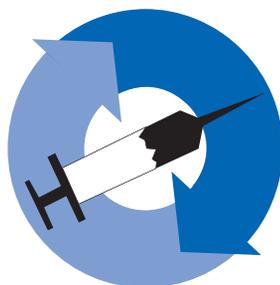
Abscess Prevention and Management

Session Five

Overdose Prevention and Management

Session Six

Co-morbid Conditions among IDUs: Hepatitis and Tuberculosis



Management of Sexually Transmitted Infections

OBJECTIVE

To educate the participants about the management of the sexually transmitted infections

EXECTED OUTCOME

By the end of the session the participants would

- Know how to identify the main features of syndromic case management
- Be able to list the correct drug therapies and dosages for each syndromal diagnosis

DURATION

30 minutes

SESSION CONTENT

- Clinical presentation of STIs
- Treatment based on syndromal diagnosis

METHODOLOGY

- Presentation
- Discussion

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/flip chart
- Marker pens
- STI kits

PROCESS

Step 1: Discussion and presentation on STI symptoms

- Before presenting the slides, the facilitator asks the participants about the signs and symptoms for STIs and records them on the flip chart/whiteboard.
- Share with the participants the signs and symptoms of STIs, and highlight the fact that infection can be transferred to and from any of the organs involved in the sexual acts, i.e. penis, vagina, anus and mouth (lips and tongue).

STI Complaints

Patients with STIs usually have one or more of the following complaints:

- (i) Vaginal or urethral discharge
- (ii) Vesicular and/or non-vesicular genital ulcers
- (iii) Inguinal bubo
- (iv) Lower abdominal and/or scrotal pain
- (v) Genital skin conditions

Vaginal, Urethral Discharge and Burning Micturition

STI	Organism	Symptoms
Gonorrhoea	Neisseria gonorrhoea	Women: Purulent vaginal discharge, dysuria, inflamed urethral opening Men: Purulent urethral discharge, dysuria, infection of the epididymis
Trichomoniasis	Trichomonas vaginalis	Very few symptoms Women: Frothy, foul smelling, greenish vaginal discharge Men: May have a urethral discharge
Chlamydia	Chlamydia trachomatis	Very few symptoms Women: Purulent cervical discharge Men: Common cause of nongonococcal Urethritis
Bacterial Vaginosis	Overgrowth of anaerobes	Vaginal discharge with fishy odour, greyish in colour
Candidiasis	Candida albicans	Women: Curd like vaginal discharge, pruritis Men: Balanitis

Genital Ulcers

STI	Organism	Symptoms
Chancroid	Haemophilus ducreyi	Painful, "dirty" ulcers on the external genitalia Painful enlarged lymph nodes (bubo) in the groin
Lymphogranuloma venereum (LGV)	Chlamydia trachomatis	Small, usually painless papules on external genitalia Buboes in the groin Swelling of the genitals or extremities
Syphilis	Treponema Pallidum	Primary stage: Painless ulcer (chancre) on the external genitalia
Granuloma inguinale	Calymmato bacterium granulomatis	Lumps under the skin which break down to form "beefy" red, painless ulcers
Genital herpes	Herpes simplex virus	Multiple painful vesicles, then shallow ulcers which clear in 2 to 4 weeks Recurrent (multiple episodes) more than 50% of the time

Genital Growths

STI	Organism	Symptoms
Genital warts	Human Papilloma Virus	Single or multiple soft, painless, "cauliflower" growth around the anus, vulvo vaginal area, penis
Molluscum contagiosum	Pox virus	Multiple, smooth, glistening, papules of varying size around genitals
Pediculosis pubis	Pthirus pubis	Small red papules with a tiny central clot caused by lice irritation
Scabies	Sarcoptes scabiei	Severe pruritis (itching) The burrow is the diagnostic sign

- The above slides show the various STIs, etiological organisms and the clinical features of each STI. A number of different organisms that cause STIs give rise to only a limited number of syndromes. A syndrome is simply a group of symptoms a patient complains about and the clinical signs that are observed during clinical examination.

Step 2: Syndromic management

- The key features of syndromic case management are that it:
 - ◆ Is problem-oriented
 - ◆ Is highly sensitive and does not miss mixed infections
 - ◆ Treats the patient at the first visit
 - ◆ Makes STI care more accessible as it can be implemented at primary health-care level
 - ◆ Uses flowcharts that guide the health worker through logical steps
 - ◆ Provides opportunity and time for education and counselling

Syndromic Management of STIs

The syndromic management of STIs is based on the identification of consistent groups of symptoms and easily recognized signs (syndromes), and the provision of treatment that will deal with the majority of, or the most serious organisms responsible for producing a syndrome.

Step 3: Presentation on treatment of STIs

- The facilitator informs the participants that the next slides will take them through the treatment of STIs and the process of counselling.

STI Treatment

- Recommended STI regimens should cure at least 95% of those infected with a bacterial STI.
- Regimens yielding lower cure rates should be used only with great caution since in a setting of unstable susceptibility patterns they may select for resistant strains and rapidly limit their own usefulness.
- Among the anti-microbial agents used to treat STIs, none is specifically contraindicated in drug users/injecting drug users.

STI Treatment (contd.)

- Educate the patients about:
 - Compliance: the need to complete the treatment course
 - Side effects: Possible side effects and ask them to report to doctor/clinic if they experience any adverse effects
 - Treatment failure: Reevaluate and if necessary refer to a specialist STI clinic with laboratory facilities

- The slides below describe the syndromal level management for STIs and the appropriate medicines, dose and duration of treatment.

Treatment of STIs

Syndrome	Disease	Drug
Urethral discharge (Men) <i>Note: Patients should be advised to return if symptoms persist 7 days after start of therapy.</i>	Treat: Gonorrhoea + Chlamydia	Ceftriaxone 400 mg orally as a single dose OR Ceftriaxone 125 mg by i.m. injection as a single dose OR Spectinomycin 2 g by i.m. injection as a single dose + Azithromycin 1 g orally, in a single dose OR Doxycycline* 100 mg orally twice daily for 7 days OR Tetracycline, 500 mg orally, 4 times a day for 7 days
Vaginal discharge (Women)	Treat: Bacterial vaginosis + Trichomoniasis	Secnidazole 2 g orally as a single dose OR Metronidazole 2 g orally as a single dose OR Metronidazole* 400-500mg orally twice daily for 7 days + Tab. Fluconazole 150 mg orally as a single dose
Cervical infection (In high prevalence for gonorrhoea and Chlamydia settings)	Treat: Gonorrhoea (uncomplicated) + Chlamydia	Ceftriaxone 400 mg orally as a single dose OR Ceftriaxone 125 mg by i.m. injection as a single dose OR Spectinomycin 2 g by i.m. injection as a single dose + Azithromycin 1 g orally, in a single dose OR Doxycycline* 100 mg orally twice daily for 7 days OR Tetracycline, 500 mg orally, 4 times a day for 7 days

Treatment of STIs (contd.)

Syndrome	Disease	Drug
Genital ulcer disease (Men and Women)	Treat: Syphilis + Chancroid + Where clinically indicated: Herpes Simplex (HSV-2)	Benazathine penicillin G 2.4 million IU, by i.M. injection at a single session (split into 2 doses at separate sites) OR doxycycline* 100 mg orally twice daily for 15 days OR tetracycline* 500 mg orally 4 times daily for 15 days OR erythromycin 500 mg orally 4 times daily for 15 days OR rifampin 600 mg orally 4 times daily for 15 days + Acetaminophen 1 g orally as a single dose OR Erythromycin 500 mg orally 3 times daily for 7 days OR Ciprofloxacin* 500mg orally twice daily for 3 days OR + Where clinically indicated (women): Acyclovir Pain management: 200 mg five times daily for seven days or 400 mg three times daily for seven days Recurrent infection: As above except for five days

Treatment of STIs (contd.)

Syndrome	Disease	Drug
Scrotal swelling (Men)	Treat: Gonorrhoea PLUS Chlamydia	Ceftriaxone 400 mg orally as a single dose OR Ceftriaxone 125 mg by i.m. injection as a single dose OR spectinomycin 2 g by i.m. injection as a single dose PLUS: azithromycin 1 g orally, in a single dose OR doxycycline* 100 mg orally twice daily for 7 days OR tetracycline, 500 mg orally, 4 times a day for 7 days
Lower abdominal pain (Women)	PID (pelvic inflammatory disease)	Ceftriaxone 400 mg orally as a single dose OR ceftriaxone, 250 mg by intramuscular injection, as a single dose OR PLUS: Doxycycline 100 mg 2 times daily for 14 days PLUS: Metronidazole 500 mg twice daily for 14 days <i>Note: Patients taking metronidazole* should be cautioned to avoid alcohol. Tetracyclines are contraindicated in pregnancy.</i>

- Seven pre-packed STI kits are proposed under NACP III for syndromic management of STIs. These kits are developed based on the *National Guidelines on Prevention, Management and Control of Reproductive Tract Infections, Including Sexually Transmitted Infections*, Ministry of Health and Family Welfare. The SACS is responsible for availability of essential STI/RTI kits/drugs at all designated clinics.

Kit No	Syndrome	Colour of kit	Contents
Kit 1	UD, ARD, Cervicitis	Gray	Tab. Azithromycin 1 g (1) and Tab. Cefixime 400 mg (1)
Kit 2	Vaginitis	Green	Tab. Secnidazole 2 g (1) and Tab. Fluconazole 150 mg (1)
Kit 3	GUD	White	Inj. Benzathine penicillin 2.4 MU (1) and Tab. Azithromycin 1 g (1) and Disposable syringe 10 ml with 21 gauge needle (1) and Sterile water 10 ml (1)
Kit 4	GUD	Blue	Tab. Doxycycline 100 mg (30) and Tab. Azithromycin 1 g (1)
Kit 5	GUD	Red	Tab. Acyclovir 400 mg (21)
Kit 6	LAP	Yellow	Tab. Cefixime 400 mg (1) and tab. Metronidazole 400 mg (28) and Cap. Doxycycline 100 mg (28)
Kit 7	IB	Black	Tab. Doxycycline 100mg (42) and Tab. Azithromycin 1 g (1) NACO, 2007

Step 4: Conclusion

- Conclude the session by giving the following key messages:

Key Messages

The syndromic management of STIs is based on the identification of consistent groups of symptoms and easily recognized signs (syndromes), and the provision of treatment that will deal with the majority of or the most serious organisms responsible for producing a syndrome.

All TIs should follow the national guidelines for STI management and use the seven pre-packed STI kits developed based on the national guidelines. These kits are supplied to TIs by the SACS.

Basics of HIV

OBJECTIVE

To educate the participants on the basics of HIV

EXPECTED OUTCOME

By the end of the session the participants would

- Understand the HIV epidemiology among IDUs and its implications for HIV prevention and treatment among IDUs
- Know about the HIV life cycle
- Learn about HIV testing
- Know about the clinical staging of HIV

DURATION

45 minutes

SESSION CONTENT

- HIV epidemiology among IDUs
- HIV life cycle
- HIV testing
- Clinical staging of HIV

METHODOLOGY

- Discussion
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED

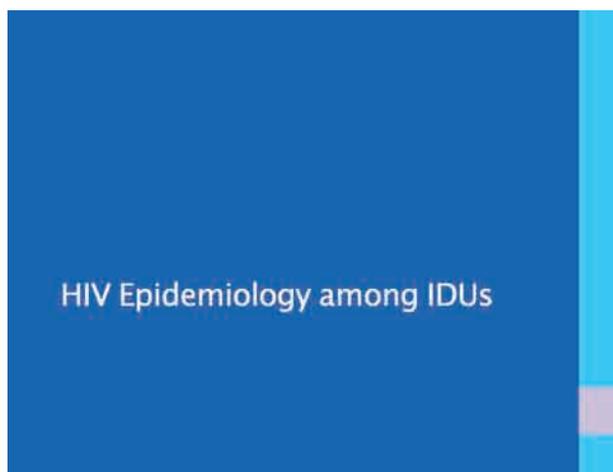
- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/flip chart
- Marker pens

PROCESS

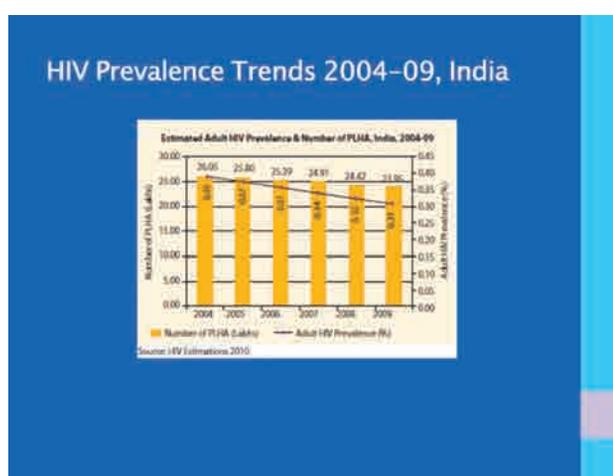
Step 1: Discussion and Presentation on Basics of HIV

- Begin the session by asking the participants about the epidemiology of HIV among IDUs.

- Walk the participants through the PowerPoint presentation on the basics of HIV and conduct a discussion during presentation.

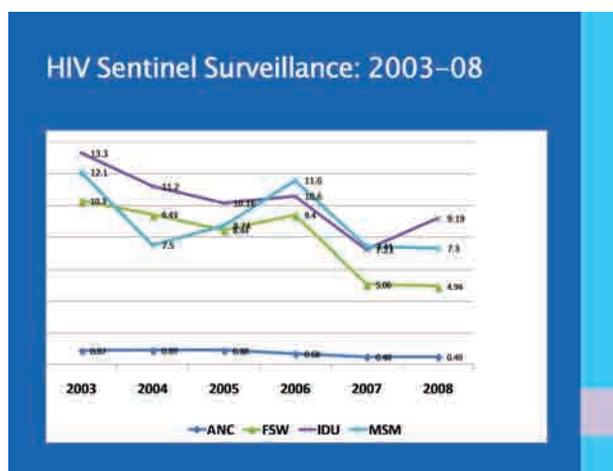


- The number of new annual HIV infections has declined by more than 50 percent during the last decade.
- It is estimated that India had approximately 120,000 new HIV infections in 2009, as against 270,000 in 2000.
- The states of Odisha, Bihar, West Bengal, Uttar Pradesh, Rajasthan, Madhya Pradesh and Gujarat accounted for 41 percent of new infections in 2009.
- The estimated adult HIV prevalence in India was 0.31 percent (0.25%–0.39%) in 2009.



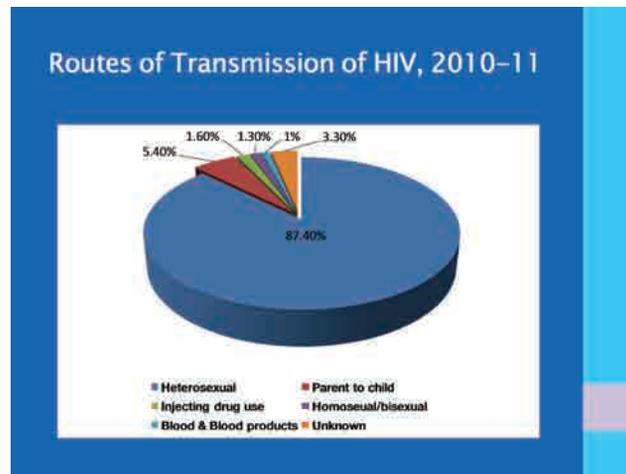
- The adult prevalence was 0.25 percent among women and 0.36 percent among men in 2009. Among the states, Manipur with a high burden of IDUs has shown the highest estimated adult HIV prevalence at 1.40 percent.

- The primary drivers of the HIV epidemic in India are commercial FSWs, unprotected sex between MSM and IDUs.
- It is estimated that there are 12.63 lakh FSWs, 3.5 lakh MSM with high risk behaviour and 1.86 lakh IDUs in India.
- HIV sentinel surveillance over 2003-08 indicates that the HIV prevalence is the highest among IDUs, with 9.2 percent of the IDUs being HIV positive in 2008.



- The overall HIV prevalence among different population groups in 2008-09 continues to portray the concentrated epidemic in India, with a very high prevalence among high risk groups (HRGs)- IDUs (9.2%), MSM (7.3%), FSWs (4.9%) and STI clinic attendees (2.5%)- and low prevalence among antenatal care (ANC) attendees (0.5%).

- Unprotected sex (87.4% heterosexual and 1.3% homosexual) is the major route of HIV transmission, followed by transmission from parent to child (5.4%) and use of infected blood and blood products (1.0%).
- Injecting drug use is the predominant route of transmission in the north-eastern states. Overall in the country, it accounts for 1.6 percent of HIV infections.



- India's HIV epidemic is a concentrated epidemic.
- TIs for groups such as IDUs, FSWs and MSM are the most effective way to control HIV epidemic in the country.
- Effective interventions at the scaled-up level (covering majority of the people in the group) should be mounted before the HIV prevalence among the group reaches 5 percent.
- For example, interventions such as NSEP, OST, outreach-based BCC, condoms and STI treatment should be implemented for the majority of IDUs before HIV prevalence among IDUs reaches 5 percent.

HIV Prevalence: Classification

- High prevalence (Generalized): Where the prevalence of HIV is >1% in general population (like antenatal clinic or PMTCT data) and >5% in the groups such as IDUs, MSM, sex workers
- Moderate prevalence (Concentrated): Where the prevalence of HIV is <1% in the general population but >5% among populations such as IDUs, MSM, sex workers
- Low level prevalence: Where the prevalence of HIV is <5% among the groups such as IDUs, MSM, sex workers

- A combination of NSEP, OST and ART is essential in settings where HIV prevalence is greater than 5 percent.

- Once HIV has entered the body, the immune system initiates anti-HIV antibody and cytotoxic T-cell production.
- It can take from 1 to 6 months for an individual exposed to HIV to produce measurable quantities of the antibody.
- Virus replication accelerates, producing massive viremia and wide dissemination of virus throughout the body's lymphoid tissues.
- An immune response against virus causes some protection but a chronic persistent infection is established.

HIV Life Cycle

- HIV uses the CD4 cell like a factory to reproduce itself
- HIV attaches to the CD4 cell and releases RNA and enzyme on entry
- The enzyme 'Reverse Transcriptase' makes a DNA copy of the viral RNA
- New viral DNA is then integrated into the CD4 cell nucleus using 'Integrase'
- New viral components are then produced, using the cell's machinery. These are assembled together using the enzyme 'Protease' and then released as new viruses
- The host CD4 cell gets destroyed during this process

- HIV specific CD4+ T-cells may be especially susceptible to destruction by HIV.
- The rapid loss of memory helper T-cells and the inability to replace these cells leads to increasing immuno deficiency.

- Explain in detail about HIV testing and ensure that the following points are covered.
 - ◆ HIV antibody test is done through ELISA test or Rapid HIV Antibody test.

ELISA Test:

It is the screening test used when more than 30 samples are tested in a batch. The test requires expensive infrastructure as well as trained technicians. The ELISA tests require a second or third test for confirmation. The test reading is based on colour development in the positive samples. It is objective as it uses a reader for measuring the colour development.

Rapid HIV Antibody Test:

On site and field testing is possible; does not require highly skilled staff to perform the test; requires minimal equipment and reagents; very easy to interpret the results; samples can be obtained by safe finger prick method; and the results can be obtained in less than 30 minutes.

HIV Testing

HIV antibody test

- Elisa (Enzyme Linked Immunoassays) test (up to 3 hours to complete the test and know the results)
- Rapid test (on-site and field testing; test result available in 30 minutes)
- Confirmatory tests
 - Repeat Elisa/Rapid test on the sample, to reduce the possibility of false positivity
 - Western Blot Assay on the same sample (expensive test)

- ◆ **False Positives:** Could be considerably reduced if quality kits are available. The second or third tests for confirmation of the first positive test are performed to overcome the possibility of a false positive.
 - ◆ **Western Blot Assay:** Though it can confirm positivity on the same sample, the test is expensive
- Discuss the importance of HIV testing and counselling with the participants.
 - ◆ Voluntary and confidential HIV testing and counselling should be routinely offered to all IDUs who are at high risk of having HIV infection. While in some situations clients themselves request HIV testing and counselling, health providers are also uniquely placed to routinely offer this service to all those who may be at risk, even when the client has not requested it.
 - ◆ HIV testing and counselling comprises of three steps:
 1. Pre-test information and education (group or individual) and provision of individual pre-test counselling, if requested
 2. Informed consent and HIV testing
 3. Post-test counselling

- The following slide depicts the stages in the natural history of HIV infection.

<h3>Stage of HIV Infection</h3> <ul style="list-style-type: none"> • Viral transmission (2-3 weeks) • Acute retroviral syndrome – symptoms such as fever, rash, lymphadenopathy and sore throat (2-3 weeks) • Seroconversion – after this HIV antibody testing is positive (2-4 weeks) • Asymptomatic chronic HIV infection (about 8 years) • Symptomatic HIV infection / AIDS (about 13 years) 	<h3>Clinical Staging WHO</h3> <ul style="list-style-type: none"> • Primary HIV infection <ul style="list-style-type: none"> • Asymptomatic • Acute retroviral syndrome • Clinical Stage 1 <ul style="list-style-type: none"> • Asymptomatic • Persistent generalized lymphadenopathy • Clinical Stage 2 <ul style="list-style-type: none"> • Moderate (<10%) unexplained weight loss • Recurrent respiratory tract infections • Herpes zoster • Angular cheilitis • Recurrent oral ulcerations • Papular pruritic eruptions • Seborrhoeic dermatitis • Fungal nail infections of fingers
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<h3>Clinical Staging WHO (contd.)</h3> <ul style="list-style-type: none"> • Clinical Stage 3 <p>Conditions where a presumptive diagnosis can be made on the basis of clinical signs or simple investigations</p> <ul style="list-style-type: none"> • Severe (<10%) weight loss • Unexplained chronic diarrhoea > 1 month • Unexplained persistent fever > 1 month • Oral candidiasis • Oral hairy leukoplakia • Pulmonary tuberculosis • Severe presumed bacterial infections • Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis • Unexplained anaemia (<8 g/dl), neutropenia (<0.5 x 10⁹ /L) and or chronic thrombocytopenia (<50 X 10⁹ /L) 	<h3>Clinical Staging WHO (contd.)</h3> <ul style="list-style-type: none"> • Clinical Stage 4 <p>Conditions where a presumptive diagnosis can be made on the basis of clinical signs or simple investigations</p> <ul style="list-style-type: none"> • HIV wasting syndrome • Pneumocystis pneumonia • Recurrent severe or radiological bacterial pneumonia • Chronic herpes simplex infection (orolabial, genital or anorectal > 1 month duration) • Oesophageal candidiasis • Extrapulmonary TB • Kaposi's sarcoma • Central nervous system toxoplasmosis • HIV encephalopathy
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Step 2: Conclusion

- Conclude the session by giving the following key messages to the participants:

Key Messages

In India, HIV prevalence is highest (9.2%) among IDUs as compared to FSWs (4.2%) and MSM (7.3%).

It is essential to mount effective HIV prevention interventions targeting IDUs before HIV prevalence among IDUs reaches 5 percent.

HIV life cycle and its stages help to understand the site of action of anti-retroviral drugs on HIV.

Clinical staging of HIV by WHO – Primary HIV infection

- Clinical Stage 1
- Clinical Stage 2
- Clinical Stage 3
- Clinical Stage 4

Prevention and Management of HIV: Role of Doctors and Nurses

OBJECTIVE

To make the participants understand the role and responsibilities of doctors and nurses in the prevention and management of HIV

EXPECTED OUTCOME

By the end of the session the participants would

- Know how to describe the role of the doctors and nurses within the TIs in providing HIV treatment and care
- Understand the needs of HIV infected individuals attending the TIs

DURATION

45 minutes

SESSION CONTENT

- Comprehensive care of HIV/AIDS
- Benefits of ART
- Hepatotoxicity of some ARVs
- ARVs and opioid substitution medications
- Positive prevention

METHODOLOGY

- Brainstorming
- PowerPoint presentations

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/flip chart
- Marker pens

PROCESS:

Step 1: Brainstorming and Presentation

- Begin the session by asking the participants to brainstorm on various interventions for the IDUs that require care and support for HIV infection at different clinical stages.
- After the discussion, show the adjacent slide.

WHO CLINICAL STAGE 1	WHO CLINICAL STAGE 2	WHO CLINICAL STAGE 3	WHO CLINICAL STAGE 4
PATIENT EDUCATION	PATIENT EDUCATION	PATIENT EDUCATION	PATIENT EDUCATION
POST-TEST AND ONGOING SUPPORT			
PEER SUPPORT	PEER SUPPORT	PEER SUPPORT	PEER SUPPORT
COMMUNITY SUPPORT	COMMUNITY SUPPORT	COMMUNITY SUPPORT	COMMUNITY SUPPORT
ROUTINE CLINICAL CARE	ROUTINE CLINICAL CARE	ROUTINE CLINICAL CARE	ROUTINE CLINICAL CARE
ACUTE CARE	ACUTE CARE	ACUTE CARE	ACUTE CARE
OPIOD SUBSTITUTION THERAPY (OST)			
		ART	ART

- Ask the participants to list the various benefits of anti-retroviral therapy (ART).

- Show the adjacent slide on the key benefits of ART.

<ul style="list-style-type: none"> • Prolongs life, and improves quality of life • Reduces mother to child transmission • Increased number of people go for voluntary counselling and testing • Increased awareness in the community, since more people do the test • Increased motivation of health workers, since they feel they can do more for HIV patients • Less spent to treat opportunistic infections and provide palliative care • Decreased number of orphans

Step 2: Presentation on ART

- Share the presentation on ART and conduct a discussion around it.
- The first line ARV drugs that are available in India are:
 - ◆ **Nucleoside reverse transcriptase inhibitors (NTRIs)** such as Zidovudine (AZT or ZDU) and Lamivudine (3TC).
 - ◆ **Non-nucleoside reverse transcriptase inhibitors (NNTRIs)** such as Nevirapine (NVP); Efavirenz (EFV). Tenofovir (TDF) is also available in the first line drugs.

<p>Nucleoside/Nucleotide reverse transcriptase inhibitors (NTRIs)</p> <ul style="list-style-type: none"> • Zidovudine (ZDV or AZT): 300 mg twice a day • Lamivudine (3TC): 150 mg twice a day (or 300 mg once a day) • Tenofovir (TDF): 300 mg once daily <p>Non-nucleoside reverse transcriptase inhibitors (NNTRIs)</p> <ul style="list-style-type: none"> • Nevirapine (NVP): 200 mg twice daily • Efavirenz (EFV): 600 mg once daily

- The ARV drugs act on HIV by interfering with its reproductive cycle.

- **Nucleoside/nucleotide reverse transcriptase inhibitors (NTRIs):** These prevent the formation of proviral DNA by inhibiting reverse transcriptase enzyme. NTRIs lead to premature termination of the production of the HIV DNA chain; they are competitive inhibitors of reverse transcriptase. They are active against both HIV 1 and HIV 2. NTRIs are recommended as monotherapy, as this will lead to rapid development of resistance.

- **Non-nucleoside reverse transcriptase inhibitors (NNTRIs):** These also prevent the formation of pro-viral DNA by inhibiting reverse transcriptase enzyme. NNTRIs are non-competitive inhibitors of reverse transcriptase; they work to change the conformation of reverse transcriptase, inhibiting it from functioning properly. Unlike NTRIs, NNRTIs do not work in HIV2 infection. For NNRTIs, interaction with some drugs occurs due to induction and/or inhibition of cytochrome P450 enzymes in liver. Protease Inhibitors inhibit maturation of virion through interrupting the protein processing and virus assembly. Fusion inhibitors prevent attachment of HIV to CD4 cells.

Antiretroviral Therapies: Mode of Action

- Antiretroviral drugs (ARVs) act on HIV by interfering with its life cycle.
- Nucleoside/nucleotide reverse transcriptase inhibitors (NTRIs) and Non-nucleoside reverse transcriptase inhibitors (NNTRIs) prevent formation of proviral DNA by inhibiting reverse transcriptase enzyme.
- NRTIs are competitive inhibitors of reverse transcriptase and NNRTIs are non-competitive inhibitors of reverse transcriptase.
- Protease inhibitors inhibit maturation of virion by interrupting the protein processing and assembly of viruses.
- Fusion inhibitors prevent attachment of HIV to CD4 cells.

- A combination of three ARVs [e.g., ZDV (Zidovudine) + 3TC (Lamivudine) + NVP (Nevirapine) or ZDV (Zidovudine) + 3TC (Lamivudine) + EFV (Efavirenz) or Tenofovir (TDF) + 3TC (Lamivudine) + NVP (Nevirapine)] is required to mount an effective response.

- The combination of drugs assists in attacking the HIV virus through different mechanisms and stages of the cycle. It also helps in overcoming or delaying the development of viral resistance.

- The reasons for not adhering to HIV treatment include: stigma and discrimination of being an IDU HIV positive; active drug use; multiple problems interfering with adherence; beliefs and concerns about ART; perception about the health care providers' attitude; perception about health care settings; distance from health care service; and mental health problems such as depression.

- The health care providers can advise the patients on the details of ART medication; the negative role of substance use (including alcohol use) in adherence to ART; and co-morbid disorders like depression. The clinical staff can emphasize the importance of OST in improving adherence. In addition, they can explain about the side-effects.

ART

- As a combination of three antiretroviral drugs, it helps to contain HIV.
- Anti-HIV drugs from different drug groups attack the virus in different ways.
- Combinations of anti-HIV drugs may overcome or delay resistance.

ART: Adherence Support

- Advise on the need for complete adherence to daily treatment
- Motivate and make the patient agree to take ART
- When patient is ready for ART, discuss with the patient and make a plan for him/her
- Assist the patient to develop the resources/support/arrangements needed for adherence
 - Facilitate people who inject drugs to enroll for OST
 - Organize peer support

- The healthcare providers should motivate the patients and make them agree to take ART daily. Make the patients agree to a plan for support by treatment supporter and support groups; agree to a plan to stabilize drug use by starting treatments such as OST.
- Strategies to help adherence:
 - ◆ OST
 - ◆ Abstinence from drugs
 - ◆ Alarms, pillboxes, etc.
 - ◆ Peer support groups

• Among the early and potentially severe toxicities, the most common is hypersensitivity to NVP, which normally occurs within the first few weeks of therapy. A dose titration period of NVP is needed because of its enzyme induction (self-induction) that reduces the NVP levels after two weeks. Therefore, the NVP levels are therapeutic even though you are dosing once daily. Dosing needs to be increased to twice daily to account for self-induction. NVP should be dosed once daily before increasing to twice daily after two weeks to avoid added toxicity.

Early ART Toxicity

The common early and potentially severe toxicities are:

- Hypersensitivity to NVP, which normally occurs within the first few weeks of the therapy.
- AZT-related anaemia and neutropenia, which typically present in the first few months of the therapy.
- Careful clinical and laboratory monitoring is required in the first few months of ART.
- Acute toxicities, if not identified early, can evolve into life-threatening and fatal events.

- AZT-based regimen is recommended only for those patients whose haemoglobin level is more than 8 gms%. If it is less than 8 gms%, it is not recommended. AZT-related anaemia and neutropenia which typically occur in the first few months of therapy need to be monitored.
- Careful clinical and laboratory monitoring is required in the first few months of ART- as many of the acute toxicities, if not identified early, can evolve into life-threatening and fatal events.
- EFV is contraindicated in pregnant HIV-infected women during the first trimester of pregnancy because of concerns of teratogenicity. EFV should be used cautiously in women of child-bearing age unless contraception is assured.

• NVP and EFV cause hepatotoxicity. NVP causes severe toxicity.

• Early NVP hepatotoxicity usually occurs in the first 6-16 weeks (most frequently during the first 6 weeks) of treatment and seems to be a hypersensitivity reaction. It may be accompanied by drug rash, eosinophilia and systemic symptoms, and can progress to liver necrosis and death. It can be minimized by frequent monitoring in the first 12 weeks of therapy, careful counselling to patients, and discontinuing NVP if a patient has clinical symptoms; the SGPT (ALT) is elevated to 5 times the upper normal limits. Late hepatotoxicity occurs in 15 percent of patients and is more common in those with chronic HBV and/or HCV.

ART and Hepatotoxicity

- Nevirapine and Efavirenz can cause hepatotoxicity.
- Of these, NVP is more commonly associated with severe hepatotoxicity and should be avoided if possible in all patients with chronic liver disease and liver dysfunction.
- The NRTIs associated with the liver damage include AZT.

Step 3: Presentation on co-infection with HIV and HCV

- Before sharing the slide on co-infection with HIV and HCV, discuss the following points with the participants:
 - ◆ A public health approach to the prevention of infectious diseases is to target the infected person for prevention efforts (positive prevention). This is more efficient in preventing HIV transmission because in every case of HIV transmission an HIV-infected individual is involved. Positive prevention is required for the following reasons:
 - The availability of ART makes the HIV positive individuals lead an active and productive life for decades. Treatment optimism thus generated, however, has at times led to unprotected sex.
 - A significant synergy exists between HIV and STIs. This means that in the presence of STIs, the transmission potential becomes greater among the HIV- infected individuals. Reducing the prevalence of STIs in people with HIV will help reduce the spread of HIV itself.
 - It is found that about a third of HIV-positive people have unprotected anal or vaginal sex.
 - ◆ Additionally, multi-drug resistance and HIV super-infection strongly suggest the need for an increased focus on HIV prevention, directed towards those who are seropositive.

Co-infected with HIV and HCV

- Health care providers to be knowledgeable about HIV and HCV.
- Provide the patients with information to maintain liver health.
- Counsel the drug users about the transmission of HIV and HCV.
- Consider them for HIV and/or HCV antiviral treatment as needed.
- Counsel about drug interactions and side effects of HCV and HIV treatments.

Step 4: Presentation on OST and ART

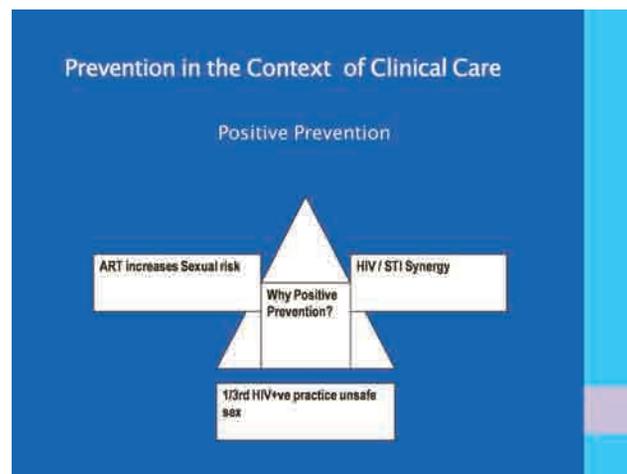
<p>OST and ART</p> <ul style="list-style-type: none"> • People dependent on opioids benefit immensely with OST as it stabilizes their lives. • OST helps to stabilize the drug users and improves adherence to medication, including ART. • OST improves the psychological and social functioning of individuals, a factor that is helpful in treatment retention. • People receiving OST adhere to ART, and this is comparable to adherence by non-drug using HIV positive individuals. • It is imperative that the treatment for drug dependence is initiated with OSMT to support adherence to antiretroviral treatment. 	<p>Methadone and ARVs</p> <ul style="list-style-type: none"> • EFV and methadone <ul style="list-style-type: none"> • EFV can decrease the concentration of methadone in the blood by 60%, resulting in methadone withdrawal • May require a methadone dose increase of 50% • NVP and methadone <ul style="list-style-type: none"> • NVP can decrease the concentration of methadone in the blood by 46%, resulting in methadone withdrawal • May need a methadone dose increase of approximately 15%
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Methadone and ARVs (contd.)

- **AZT and methadone**
 - Methadone increases the blood concentration of AZT (43%)
 - Watch for AZT toxicity: anaemia, myalgia, bone marrow suppression, fatigue, headache and vomiting
- **Ritonavir and methadone**
 - Ritonavir (RTV) decreases methadone levels in the blood by 26-53%
 - Can cause methadone withdrawal

Step 5: Presentation on positive prevention

- Key strategies in positive prevention include the following:
 - ◆ Promoting voluntary confidential counselling and testing
 - ◆ Providing post-test and ongoing counselling for positive people (e.g., safe sex, safe drug use)
 - ◆ Encouraging beneficial disclosure and ethical partner notification
 - ◆ Providing counselling for sero-discordant couples.



It is observed that initiating early ART in sero-discordant couples is the best way to prevent sexual transmission of HIV between them.

Step 6: Conclusion

- Conclude the session with the following key messages:

Key Messages

Comprehensive care and support is required for HIV positive IDUs at different clinical stages.

ART has immense benefits for HIV positive IDUs.

The first line ARVs in India include AZT, 3TC, TDF, NVP and EFV.

A key strategy to help ART adherence is OST.

NVP causes severe toxicity and hence ALT (SGPT) should be monitored in the initial stages.

Buprenorphine has no clinically significant drug interactions with ARVs, whereas methadone dose may need to be increased with NVP, EFV.

Abscess Prevention and Management

OBJECTIVE

To educate the participants on the prevention and management of abscess associated with illicit drugs

EXPECTED OUTCOME

By the end of the session the participants would

- Know the clinical features of an abscess
- Understand the basic measures to prevent abscess
- Have learnt the basic management for abscess

DURATION

30 minutes

SESSION CONTENT

- Definition and clinical features of abscess and cellulitis
- Basic measures to prevent abscess
- Basic management of abscess

METHODOLOGY

- Brainstorming
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/flip chart
- Marker pens
- SPYM film (up to 12 minutes 20 seconds)

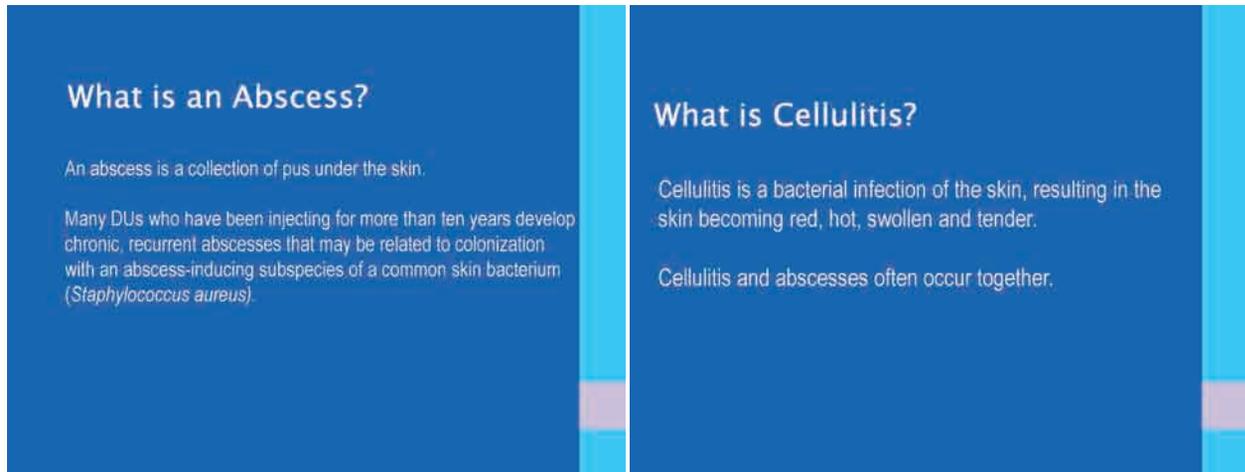
PROCESS

Step 1: Brainstorming

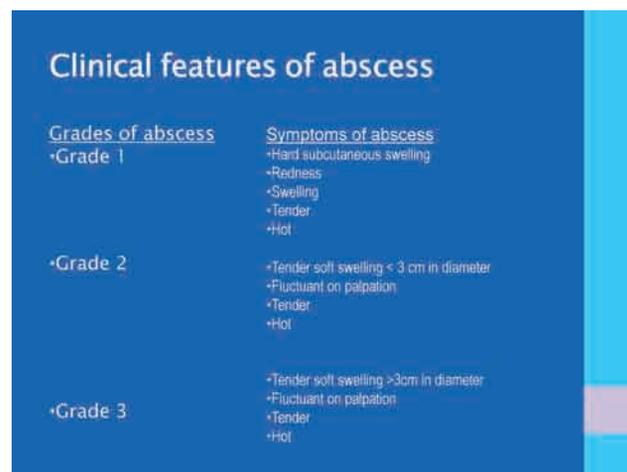
- The facilitator begins the session by asking the participants to think of the common medical problems faced by the IDUs and notes them on the whiteboard/flip chart. He/she also asks the participants about the probable services that are needed to address them.

Step 2: Presentation on abscess prevention and management

- Share the following presentation and conduct a discussion around abscess formation, its prevention and management.



- The abscesses develop over a period of 2-5 days. The clinical features of abscesses of different grades can be easily recognized by the clinical staff. A hard subcutaneous swelling can evolve to tender soft swelling of varying sizes. Abscesses can lead to ulcers. These ulcers can be superficial, deep with involvement of bones (osteomyelitis) or accompanied by gangrene.



- Brainstorm with the participants about the various risk factors for abscesses and preventive measures.

- Present the slides which list the various risk factors and preventive measures.

<h3>Risk Factors</h3> <ul style="list-style-type: none"> • Poor injection technique • Injecting tablets (particularly diverted buprenorphine or dextropropoxyphene) • Injecting frequently • Injecting frequently at the same sites • Using non-sterile injecting equipment • Not cleaning the skin adequately before injecting 	<h3>Risk Factors (contd.)</h3> <ul style="list-style-type: none"> • Injecting "cocktails" (for example, mixtures of benzodiazepines, antihistamines and heroin or dextropropoxyphene) • "Booting" (repeatedly flushing and pulling back during injection) • Resorting to skin popping (experienced IDUs who do not have accessible/ patent veins for injecting resort to "skin popping" – subcutaneous or intramuscular injection) • Being HIV-positive • Having a poor nutritional status
<h3>Preventing Abscesses and Cellulitis</h3> <ul style="list-style-type: none"> • Preventing injecting or transiting injecting drug uses to non-injecting modes of administration (for example, through opioid substitution therapy) • Using clean injecting equipment every time • Maintaining skin hygiene and hand-washing • Reducing the frequency of injections • Ensuring early diagnosis and treatment. 	<h3>Preventing Abscesses and Cellulitis (contd.)</h3> <ul style="list-style-type: none"> • Educate clients on safe injecting methods: <ul style="list-style-type: none"> ▪ Always inject in veins and avoid arteries ▪ Rotation of injecting sites ▪ How to inject safely ▪ Sites where NOT to inject • Outreach staff should distribute alcohol (spirit)/betadine/savlon swabs along with needle/syringe to every injecting drug user. • Refer patients to OST whenever possible.

Step 3: Assessment and treatment of abscesses

- Inform the participants that it is important to recognize that while many abscesses can be managed at the TI level, **the clinical team should be aware of which ones need to be referred to hospitals with surgical facilities for better management.** Decisions relating to use of antibiotics are also important. Relief of pain is necessary, and an appropriate analgesic medication may be used.

<h3>Assessing the Abscesses</h3> <ul style="list-style-type: none"> • Which abscesses/ulcers can be managed at the TI? • Which abscesses/ulcers need to be referred for specialist attention? • Which abscesses are true abscesses that need incision and drainage? • Which abscesses need conservative treatment such as antibiotics? • Which abscesses need antibiotics followed by incision and drainage? 	<h3>Objectives of Abscess Care</h3> <ul style="list-style-type: none"> • To prevent increase in size and other complications through provision of early treatment • To heal the abscess as quickly as possible • To provide appropriate pain relief • To refer complicated cases for appropriate medical treatment
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Treatment of Abscess

- If the abscess is fluctuant or if pus is found on aspiration, the recommended treatment is incision and drainage by a trained doctor (referral to a hospital may be required).
- The wound should be cleaned with alcohol wipes followed by application of povidone solution to cover the wound and at least a three-inch margin around the site.
- Analgesia may be necessary.

Treatment of Abscess (contd.)

- As utmost care is required to perform incision and drainage above major arteries and near joints, referral in such cases is recommended.
- Irrigating the wound with sterile saline can be useful in large and complex wounds.
- Following drainage, the wound should be covered with a bulky gauze dressing to absorb the continued discharge of serosanguineous fluid.
- The packing should be changed every other day and the wound inspected to ascertain whether the skin has broken down or erythema is progressing.

Treatment of Abscess (contd.)

- Antibiotics are usually unnecessary for the treatment of abscesses following incision and drainage.
- In the context of associated cellulitis, an antibiotic is recommended following successful incision and drainage.

Antibiotic Treatment for Abscess

Mode of treatment	Medication
Orally	Erythromycin 500 mg two times daily for 5 days/Cefixime 200 mg 2 times daily for seven days
Injectable	Inj. Cefotaxime 1 gm two times daily for seven days

- Follow-up care can be carried out at the TI. The clinical team should monitor for complications.

Follow-up Care

- Patients should return to have a check-up within 24 hours following incision and drainage.
- Following this, the wound should be reviewed regularly to ensure it has healed without complication.
- If antibiotics have been prescribed, patients should be instructed to complete the full course of medications to reduce the likelihood of development of drug-resistant bacteria.
- Analgesia may be required if pain persists.

- Bacteremia and septicemia are dreaded complications that require immediate medical attention and hence prompt referral to the appropriate hospital is required. Gangrene is another dangerous consequence and should be recognized early and promptly referred to an appropriate hospital.

Complications

Bacteraemia and septicaemia, with the formation of multiple new abscesses ("seeding" of infection) such as in the joints, pleura or other areas



Gangrene (tissue death): darkening of the affected tissue; pungent odour; loss of sensation



Step 4: Screen SPYM Film

Screen the short clip on Abscess Prevention and Management prepared by the Society for the Promotion of Youth and Masses, Delhi.

Step 5: Conclusion

The facilitator summarizes the session by giving the following key messages to the participants.

Key Messages

Abscesses are common among active IDUs; in particular, among those who do not practice safe injecting.

Education on safe injecting practices, which includes the use of clean needles and syringes, is essential in preventing injection-related harm and infections.

OST is one of the most effective interventions to reduce the likelihood of developing injection-related infections among opioid injectors.

While many abscesses can be treated with simple incision and drainage, in rare cases there may be complications and these need to be recognized and referred to the appropriate hospital as soon as possible.

Overdose Prevention and Management

OBJECTIVE

To educate the participants on overdose prevention and management

EXPECTED OUTCOME

By the end of the session the participants would

- Know the risk factors for overdose and their signs
- Understand the preventive measures for overdose
- Have learnt about overdose management

DURATION

45 minutes

SESSION CONTENT

- Risk factors for overdose
- Signs of overdose
- Overdose prevention
- Management of overdose

SUGGESTED TRAINING METHODOLOGY

- Discussion
- PowerPoint presentation

MATERIALS/FLIP CHART REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/flip chart
- Marker pens

PROCESS

Step1:

- Initiate a discussion on the symptoms, risk factors and management of overdose.
- Use the presentation to talk about the above topics at key points and ensure all the points raised by the participants are answered.

Opioid Overdose

Introduction

- IDUs are at high risk of premature mortality, 13 times more as compared to the general population.
- 65% of overdose cases took place at home or at a friend's home.
- A significant number of overdose deaths occurred in people who combined opioid use with alcohol.

Opioids – Action (contd.)

- After continuous use of opioids, an individual develops 'tolerance' for the opioid
 - The individual has to increase the dose to get the same effect
 - Use of lesser quantity leads to development of 'withdrawal' symptoms
- However, tolerance **does not** develop for the respiratory depression effect of opioid



Individual 'at risk' for overdose

Opioid Overdose

- Overdose – Intake of dose in quantity (dose) which is more than the body can handle
 - Individual starts having discomfort
 - Life threatening symptoms appear
 - Individual may die if he/she is not provided adequate medical care

Risks Factors for Opioid Overdose

- Staying away from drugs
 - If the individual has abstained from taking opioids for some period (even as less as 3 days) due to any reason (e.g. imprisonment, detoxification)
- Change in the purity of the opioids
 - In case, the purity of the drug increases, even if the quantity is the same, the individual may have overdose

Risks Factors for Opioid Overdose (contd.)

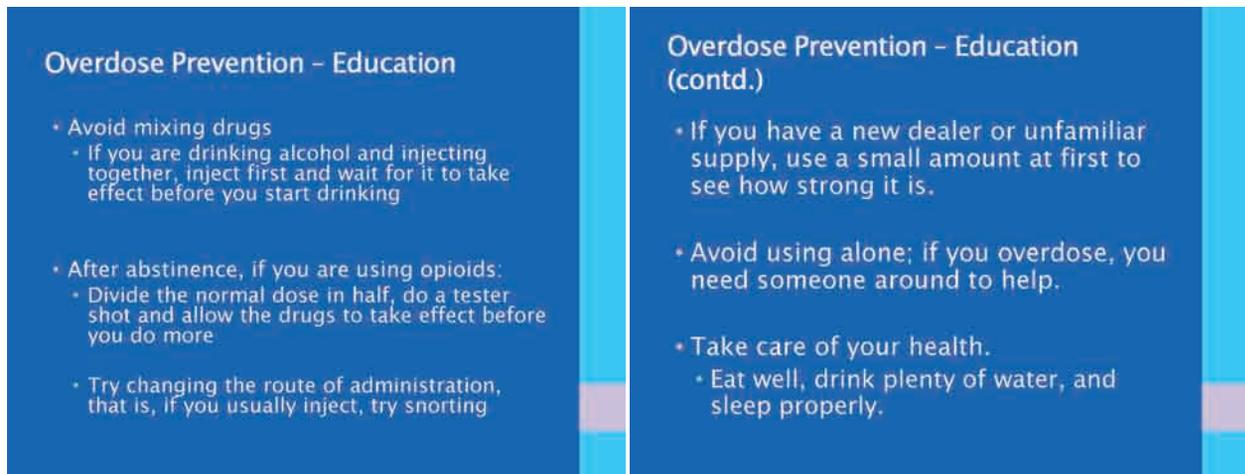
- Mixing different type of drugs
 - If opioids are mixed with alcohol, benzodiazepines which also inhibit the respiratory centre in the brain
- Physical illness or recent infections
 - The individual will not be able to tolerate the same dose, if he/she is suffering from physical illness or recent infections
- Mental health
 - In case of depression, the individual may attempt suicide by overdosing himself/herself

Signs of Opioid Overdose

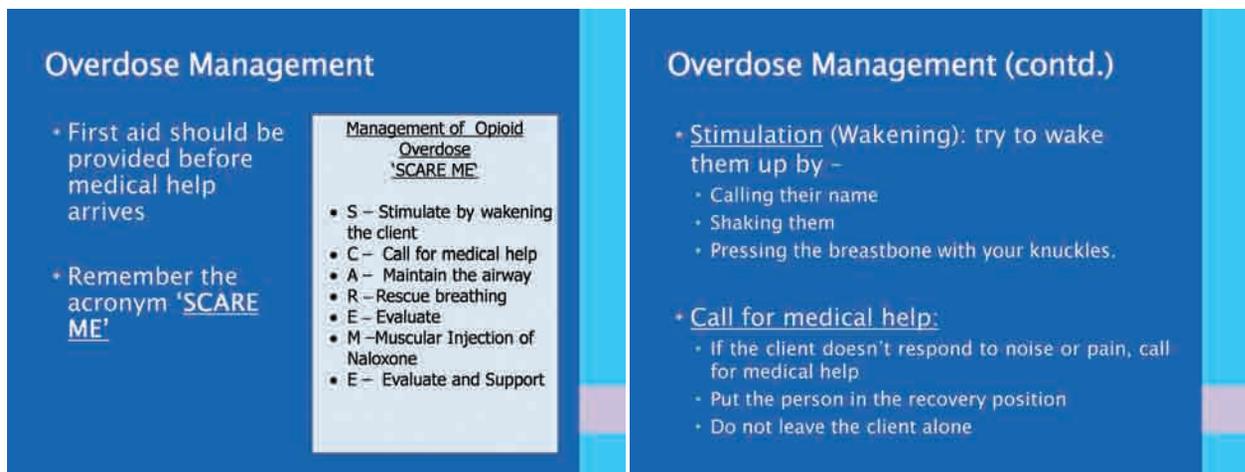
- Presence of the following three symptoms/signs confirms opioid overdose:
 - Coma: a state of unconsciousness, in which a person cannot be awakened and fails to respond normally to painful stimuli, light or sound
 - Pinpoint pupils: constriction of the pupils of eye (the pupils become smaller in size)
 - Respiratory depression: difficulty in breathing, finally leading to stopping of respiration

Other Signs of Opioid Overdose

- Can't be woken up by noise or pain
 - Gaspings, gurgling, or snoring
- Blue or ashy lips and fingernails from lack of oxygen
 - Choking sounds
 - Vomiting
- Slow breathing (less than 1 breath every 5 seconds)
 - Pale face
 - Tired body



- Discuss the facts of overdose with the participants.
 - ◆ High purity of heroin is seldom the cause of death due to overdose.
 - ◆ Mixing of drugs (heroin, alcohol and benzodiazepines) is the most common cause of death due to overdose.
 - ◆ Death due to overdose often occurs several hours after heroin has been taken.
 - ◆ Death due to overdose is less common among new or inexperienced users.
 - ◆ Interventions are possible, as many cases of overdose are witnessed by others.
- Continue the presentation on overdose management.



- An assessment of the patient’s consciousness is necessary and can be done as follows:
 - ◆ Can the person open his/her eyes and respond to their name?
 - ◆ Does the person respond to pain? – Test it by rubbing the patient’s chest with your knuckles or press hard with a pencil in the space between the fingers.
 - ◆ If possible, ask the patient to get up and make him/her walk.
 - ◆ If the person feels sick, has tightness of the chest or is short of breath, seek help immediately.
 - ◆ Detecting respiratory depression in opioid overdose: respiratory arrest with a pulse, pinpoint pupils not reactive to light, snoring giving way to shallow respiration (8 breaths/minute).

- Explain rescue breathing in detail. Ensure that the following points are conveyed to the participants:

- Check if the person's airway is clear.
- If something blocking the airway, make the person lie down on his/her side, clear the airway (mouth) of food/vomit by holding down the chin with one hand (tilt the head back without closing the mouth) and with the other hand use finger/s to remove the object.
- Place the person in the recovery position to make sure that the tongue does not fall back and obstruct the airway.

Overdose Management (contd.)

- Airway maintenance
 - Make sure nothing is blocking their airway, and there is nothing in the mouth. If necessary, use your finger to get the stuff out.
- Rescue Breathing and recovery position
 - Put the client in recovery position
 - If the client is not breathing rescue breathing should be done



- Once the airway is clear, roll the person gently onto his/her back.
- Look at the chest and check for rise and fall; listen and feel for breathing. Take no more than 10 seconds.
- Tilt the head back; pinch the nose shut.
- Take a breath, and seal your lips around the person's mouth.
- Give two initial breaths.
- Visualize the 'centre of the chest' and compress at that point (with straight arms locked at the elbow).

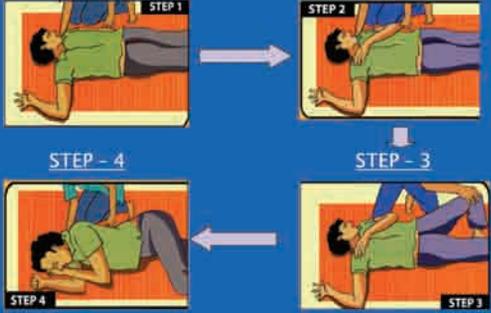
Recovery Position

STEP - 1

STEP - 2

STEP - 3

STEP - 4



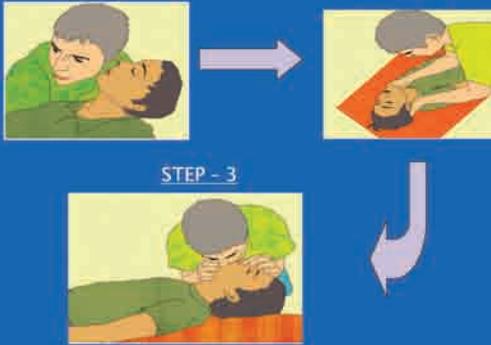
- Maintain a compression-ventilation ratio of 30 compressions to 2 ventilations.
- Do not deliver compressions fast and hard; avoid over-ventilation.
- Shift the person to a hospital as soon as possible in an ambulance.
- All health workers must be trained in cardiopulmonary resuscitation (CPR).

Rescue Breathing

STEP - 1

STEP - 2

STEP - 3



<p>Overdose Management (contd.)</p> <ul style="list-style-type: none">• <u>Muscular injection of Naloxone</u>• Naloxone is a specific antidote to treat opioid overdose• Naloxone reverses the life threatening symptoms caused by overdose<ul style="list-style-type: none">• It wakes you up and makes you breath• It has no effect except in the presence of opioid drugs• It is routinely used in Emergency Medical Services	<p>Overdose Management (contd.)</p> <ul style="list-style-type: none">• Intramuscular (IM, inside the muscles) or Subcutaneous (SC, below the skin) routes may be used (at same doses as mentioned above), if Intravenous (IV) administration is not feasible.• It takes one to five minutes to act, and lasts for 60-90 minutes.• Overdose may return because Naloxone wears off faster than heroin and other opiates.• It is important to continue supporting the person for a couple of hours following overdose.
<p>Overdose Management (contd.)</p> <ul style="list-style-type: none">• Evaluate and Support<ul style="list-style-type: none">• Are they breathing on their own?• Has the breathing started after the rescue breathing?• If not, proceed to the next step.	<p>What not to do while helping</p> <ul style="list-style-type: none">• Don't leave someone who's overdosing alone except if you absolutely must leave the area to call for help; he/she could stop breathing and die.• Don't put him/her in the bath; the person can die.• Don't give him/her anything to drink or induce vomiting; he/she could choke.• Do not make him/her drink salt water, or put salt in his/her mouth. This does not help. On the contrary, he/she may choke.• Do not inject salt water as this is dangerous and can cause sudden death among the clients.

Step 2: Conclusion

- Conclude the session by giving the following key messages to the participants:

Key Messages

Opioid overdose is a common cause of death among IDUs.

There are many factors which place an individual at risk of opioid overdose.

Overdose can be managed in community as well as primary health-care settings with minimal training and expertise.

Naloxone injection can be used to treat opioid overdose.

Educating the IDU clients, their peers and family members can easily prevent overdose and its associated harms, including death.

Co-morbid Conditions among IDUs – Hepatitis and Tuberculosis

OBJECTIVE

- To present an overview on the physical co-morbid conditions among IDUs
- To educate the participants on basic management issues related to physical co-morbidity

EXPECTED OUTCOME

By the end of the session the participants would understand

- The importance of assessing for physical co-morbidities among IDUs
- How to address physical co-morbidity among IDUs

DURATION

1 hour

SESSION CONTENT

- Co-morbidity among drug users
- Physical co-morbidity among IDUs
- Basic management issues related to Hepatitis B & C, as well as Tuberculosis (TB)

METHODOLOGY

- Discussion
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentations
- Whiteboard/flip chart
- Marker pens
- Day 3 Feedback Forms (enough copies to be made for each participant)

PROCESS

Step 1: Discussion – Contextualizing co-morbidity among IDUs

- Begin the session by asking the participants to think back to the session in which they dealt with various harms caused by drugs.

- Ask them to recollect the various physical harms caused due to drug use.
- Inform the participants that this session will focus on physical co-morbidities among IDUs, with focus on Hepatitis B & C as well as TB.
- Walk the participants through the presentation on co-morbidities.

• Presence or co-occurrence of two or more medical (including psychiatric) conditions in the same individual is often referred to as co-morbidity. They can occur simultaneously or one may precede the other. Co-occurrence of drug use related problems and a psychiatric disorder is often called a dual diagnosis.

What is co-morbidity?

- Presence of two or more conditions together in an individual (co-occurrence)
 - The conditions can occur simultaneously
 - One condition can precede another one
- Co-occurrence of mental illness along with drug use problem is called dual diagnosis

- Then present the slide that lists some of the common physical illnesses associated with drug use disorders.

Co-morbidity among Drug Users

- Physical illness
 - Tuberculosis
 - HIV
 - Hepatitis B and C
 - Abscesses
 - COPD and other respiratory illness
 - Systemic infections

• A study done in Chennai revealed that there are a number of physical illnesses that are prevalent among the persons who inject drugs. The rate of physical illness in IDUs is greater as compared to the medical morbidity observed in the general population. The common illnesses are: Hepatitis C, oral candidiasis, TB, anaemia, lower respiratory infections, Hepatitis B, herpes zoster, herpes simplex and cellulitis. A cohort study of IDUs in Chennai also revealed that the mortality rate is high among IDUs; and the common cause of death other than by overdose was AIDS, TB and accidents.

Physical Illness

- Physical illness among IDUs is more common as compared to the general population
- A Study from Chennai conducted in 2005-06 showed increased rates of physical illness
(Solomon et al. 2008)
- The same group also showed that mortality is more in comparison with the following causes: Overdose, AIDS, tuberculosis, accident
(Solomon et al. 2009)

Illness	Prevalence / rate (%)
Tuberculosis	33.9
Lower respiratory tract infections	16.1
Anaemia	22.9
Hepatitis B	11.9
Hepatitis C	94.1
Cellulitis	6.8
Herpes simplex	9.3
Herpes zoster	9.3
Oral candidiasis	43.2

- There are a number of reasons for an increased prevalence of medical morbidities among IDUs. Substance use itself contributes significantly to increased physical illnesses. In some instances, an underlying condition such as pain can be the precipitating factor for drug use in a person.

Physical Illness – Reasons

- Three main factors for increased rates of physical illness
 - Drug use itself may lead to increased rates
 - E.g. smoking may lead to respiratory problems; nicotine and alcohol may lead to cancer; injecting may lead to abscesses, HIV, hepatitis
 - Individual may use drugs due to existing physical illness
 - E.g. person with pain condition may initiate drug use and then become 'addicted' to the drug
 - Some addictive drugs banned today were used earlier to treat physical illness

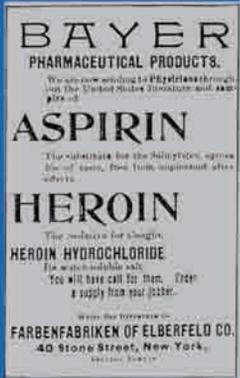
- Some of today's illegal drugs were earlier used and marketed for relief of pain.



Cocaine used in coca-cola as energy drink



Cocaine used to relieve toothache



Heroin used for relief of cough

- A common vulnerability factor can be the reason for both drug use and physical illness.

Physical Illness – Reasons

- Both drug use and physical illness may be caused by overlapping factors leading to both illnesses
 - E.g. genetic factors, stress related factors
 - Drug use and TB may be caused by the individual living in poor socio-economic conditions



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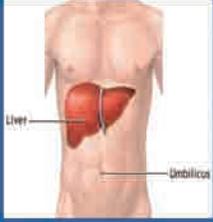
graph TD
    A[Common vulnerability factors] --> B[Drug use]
    A --> C[Physical illness]
            
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Step 2: Understanding Occurrence of Hepatitis among IDUs

- Hepatitis is inflammation of the liver. Liver can be inflamed by toxins, infections and substance use, such as alcohol use.
- The liver performs several functions. It filters and purifies everything we eat and drink, stores vitamins and iron, and helps the blood to clot. Often there may be no symptoms even if the liver is damaged. Some common symptoms of the damaged liver are: fatigue, headaches and pain in the stomach.

Physical Illness – Hepatitis

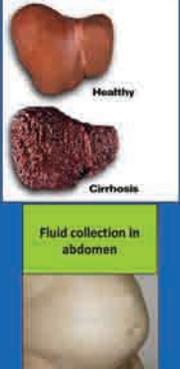
- Liver is a vital organ of the body. Functions include:
 - Processing food for energy conversion
 - Neutralise toxins and other drugs
 - Store iron and important vitamins
 - Process hormones
 - Fight infections
 - Produce important proteins in the body
- Liver can re-grow, if injured



- Chronic inflammation of the liver causes fibrosis, and extensive scarring and re-growth leads to cirrhosis. The end stage of cirrhosis is liver failure that presents with severe jaundice and encephalopathy. Hepatitis C (HCV) is a virus that can harm the liver and produce scarring of the liver. There may be no clinical symptoms. In many HCV infected individuals, the progression of disease could cause significant problems. However, many things can be done to keep the liver healthy if one is infected with HCV.

Physical Illness – Hepatitis (contd.)

- When liver is inflamed chronically, it causes scarring called fibrosis
- Extensive scarring and re-growth of liver leads to cirrhosis
- The end-stage of cirrhosis is liver failure, which leads to symptoms such as jaundice, collection of fluid in abdomen, easy bleeding, toxins entering into blood stream and also brain (encephalopathy) which can make the individual comatose



- There are five types of viral hepatitis: A, B, C, D, and E. While in Hepatitis A and E the mode of transmission is through eating unhygienic food, Hepatitis B is transmitted through unsafe sexual encounter, infected injection and parent-to-child (like HIV). Hepatitis D occurs along with B, and Hepatitis C is primarily transmitted through injecting mode of administration. Hepatitis B & C can lead to chronic infection.

Physical Illness – Hepatitis (contd.)

Type of virus	Route of transmission	Prognosis
A	Eating unhygienic food	Transient; very good prognosis
B	Injection, sexual	Chronic infection
C	Injection, sexual	Chronic infection
D	Occurs along with hepatitis B	Worsens prognosis of hepatitis B
E	Unhygienic food	Poorer than Hepatitis A

- Viral hepatitis
 - 5 types of viral hepatitis: A, B, C, D, E
 - Reaction in liver is the same
 - Degree of damage and persistence of infection depends on the type (summarized in table)

Hepatitis C among people who inject drugs

- Worldwide, most HCV infections are related to injecting drug use, through sharing needles and other drug-injecting paraphernalia. Hepatitis C is easily transmissible compared to HIV. It can live in a syringe for several days to weeks, and it can be transmitted through shared needles and other injecting equipment, such as spoons used for preparation, cotton, water, measuring syringes and ties. The infection can be transmitted through tattooing, sharing infected razors and toothbrushes. Sexual transmission is possible but the chance of transmission through the sexual route is very low. Hepatitis C can be transmitted from parent to child transmission.

Physical Illness – Hepatitis C

Transmission of Hepatitis C

- Sharing of contaminated injecting equipment in majority of cases
 - Other injecting equipment such as spoons, tourniquet, swabs, water in addition to N/S
 - Contamination of hands during mixing of drug
- Transfusion of infected blood and blood products
- Tattooing
- Infected razors and toothbrushes
- Mother to baby (5% chances)
- HIV co-infection increases the risk
- Very low risk through sexual route, (but still chances exist)

- If 100 people are infected with HCV, the virus will be cleared from the body in 25 people; the remaining 75 will develop chronic infection.
- Of those 75 people, 10-20 will develop cirrhosis of liver. Of those 10-20 people, 1-5 will either develop liver cancer needing a transplant or will die.

Physical Illness – Hepatitis C (contd.)

- Chronic: 75% of infected individuals will have chronic hepatitis with presence of virus in body and ability to transmit it to others
 - About 45% do not develop liver damage
 - About 30–40% develop mild liver damage
 - About 10–20% develop liver cirrhosis
 - About 1–5% develop liver failure or liver cancer
- Treatment of Hepatitis C
 - Not everybody requires treatment
 - Success rate is only 30–40%
 - Is currently very costly in India

- Alcohol facilitates the progression of HCV infection to severe liver disease. Other factors facilitating the progression include HIV co-infection, chronic HBV infection, age > 40 when infected and being male.

Factors in Progression of HCV

- Alcohol facilitates HCV progression to severe liver disease
- Other factors
 - HIV
 - Chronic HBV
 - Age > 40 when infected
 - Male

- It is important to provide education to the clients about HCV transmission and counsel them about measures that can be taken by IDUs to protect their liver. Advice on alcohol consumption and treatment for alcohol-dependent individuals is an important step.

Hepatitis C – Counselling Issues	DOs and DON'Ts for Hepatitis		
<ul style="list-style-type: none"> • The TI health provider should: <ul style="list-style-type: none"> • Educate every IDU about the transmission dynamics of Hepatitis C • Stress on using safe injecting equipment (not only N/S, but also others) • Teach the clients how to inject safely • For Hepatitis C infected IDU clients: <ul style="list-style-type: none"> • Instil hope in the client that not every case is fatal • No special diet is required, but if the client is obese, fat foods should be avoided • Alcohol IS STRICTLY prohibited; this message should be strongly delivered to the client <ul style="list-style-type: none"> • If the client has problem of alcohol use, he/she should be counselled accordingly, and if required, should be sent to a de-addiction centre 	<table border="0"> <tr> <td> DOs <ul style="list-style-type: none"> • Stop alcohol • Regular health check-ups • Balanced diet • Regular exercise; stress reduction plan • Drink a lot of fluids • Protect from re-infection • Vaccinate against hepatitis </td> <td> DON'Ts <ul style="list-style-type: none"> • Avoid alcohol, acetaminophen • Foods with high salt, sugar or fat content • High-doses of Vitamins A, D, E or K • Iron supplements unless advised by the doctor • Fumes from paint, paint thinners, chemical solvents, spray adhesives, insect sprays, and cleaners can be harmful to the liver </td> </tr> </table>	DOs <ul style="list-style-type: none"> • Stop alcohol • Regular health check-ups • Balanced diet • Regular exercise; stress reduction plan • Drink a lot of fluids • Protect from re-infection • Vaccinate against hepatitis 	DON'Ts <ul style="list-style-type: none"> • Avoid alcohol, acetaminophen • Foods with high salt, sugar or fat content • High-doses of Vitamins A, D, E or K • Iron supplements unless advised by the doctor • Fumes from paint, paint thinners, chemical solvents, spray adhesives, insect sprays, and cleaners can be harmful to the liver
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- Needle stick injuries are common among health providers as well as IDUs. The greatest risk posed by needle stick injury is Hepatitis B. Wherever possible, IDUs who are not infected and the health care providers working with IDUs should be vaccinated against HBV. There is no PEP available for HCV. PEP guidelines are available for HIV.

HIV, Hepatitis Transmission through Needle Stick Injuries

• HIV	3/1000
• HCV	20/1000
• HBV	300/1000

Step 3: Generating Discussion on Hepatitis C

- The facilitator can use the following frequently asked questions (FAQs) to generate a discussion among the participants on Hepatitis C and clear their doubts.



FAQs on Hepatitis C

Q: What are the functions of the liver?

A: The liver performs several functions. It filters and purifies everything we eat and drink, stores vitamins and iron, and helps the blood to clot.

Q: What are the symptoms of ‘liver disease’?

A: Often there may be no symptoms, even if the liver is damaged. Some common symptoms of a damaged liver are: fatigue, headaches and pain in the stomach.

Q: What is Hepatitis C? What are its symptoms?

A: Hepatitis C virus (HCV) can harm the liver and result in scarring of the liver. There may be no clinical symptoms. In many HCV infected individuals, the progression of the disease can cause significant problems. However, many things can be done to keep the liver healthy if one is infected with HCV.

contd...

Q: How is Hepatitis C transmitted?

A: Injecting drug use currently accounts for most HCV transmissions in the world: needle sharing poses a great risk for HCV transmission. HCV can also be transmitted by sharing of injection paraphernalia such as cookers, spoon and swabs. Within 5 years of injecting, most IDUs become infected with HCV. Sexual transmission of HCV can occur, particularly through sex involving tearing and blood contact.

Q: What are the differences in the transmission of Hepatitis B and C?

A: Both Hepatitis B and C are transmitted by sharing contaminated injecting equipment. HCV is easily transmissible; and even sharing injecting paraphernalia is a risk factor for HCV. In addition, tattooing is an independent risk factor for HCV. Sexual transmission of HBV from infected individuals to their sexual partners through unsafe sex is common. Needle stick injuries result in transmission of HBV.

Q: Is there a vaccine to prevent hepatitis?

A: There is no vaccination against HCV. Hepatitis A and B are vaccine preventable. IDUs who are uninfected should be vaccinated against HBV.

Q: What are the precautions to be taken by people infected with hepatitis?

A: Alcohol is significantly injurious to the liver. Certain drugs harm the liver. These include commonly used drugs such as acetaminophen (paracetamol), a drug used to treat fever and headache. Consult a doctor to know which drugs affect the liver. Proper diet, regular exercise and healthy lifestyle are helpful for persons infected with hepatitis.

Q: How to find out whether the liver is infected with Hepatitis B or C?

A: Liver function tests identify the type and severity of liver disease. Tests are available for detecting whether one is infected with Hepatitis B and C.

Q: Can OST be given to HCV infected people?

A: Persons on OST lead a stabilized life that helps them to adopt a healthy lifestyle. Hence it is beneficial for HCV infected opioid injectors to receive OST.

Q: Is there a treatment for HCV?

A: Yes, there is treatment available for HCV. Drugs like interferon and riboverin are used to treat HCV. Currently, however, the availability of HCV treatment is limited and is not provided in public sector hospitals.

Q: What is co-infection with HIV and HCV?

A: Some people are infected with both HIV and HCV. The ART doctor will guide, with appropriate suggestions, how to manage the patient's co-infection. Depending on the liver functions, the doctor will choose appropriate ART drugs for co-infected individuals. Drugs like Nevirapine and Efavirenz can cause disturbance to liver functions. It is important to completely avoid alcohol and other harmful substances and drugs during treatment.

Q: What is the advice for IDUs co-infected with HIV and HCV?

A: ART delays the progression of HCV liver disease in HCV-HIV co-infection.

- Before wrapping up the discussion on hepatitis, ensure that the following points are highlighted to the participants:
 - ◆ Persons with clinical or laboratory evidence of liver damage should consult a doctor for an appropriate drug regimen (Efavirenz is preferred for patients with significant liver dysfunction. However, it should be used with caution for patients with depression or other significant psychiatric conditions).
 - ◆ The majority of individuals treated with interferon (IFN) exhibit mental health symptoms such as depression. When Efavirenz and interferon are given together, the patient should be assessed for depression regularly.
 - ◆ When AZT and Ribavirin are given together, the patient should be monitored for anaemia regularly
 - ◆ Anti-HCV therapy should be started before the CD4 count falls below 200 cells/mm³.
 - ◆ The anti-HBV activity of 3TC (Lamivudine), a component of NACO first-line ART regimen, offers an advantage in HIV infected patients who are HBsAg-positive.
 - ◆ Hepatic flares on ART start soon after the initiation of ART in co-infected individuals.
 - ◆ Substitution drugs such as methadone may have drug interactions with some of the ART drugs.
 - ◆ Individuals with pathological drinking patterns need to be treated for alcohol use disorders.

Step 4: Presentation on Tuberculosis

- Brainstorm with the participants about TB and how it is transmitted. Provide clarification by presenting the following basic slides.

Tuberculosis among drug using population

Physical Illness – Tuberculosis

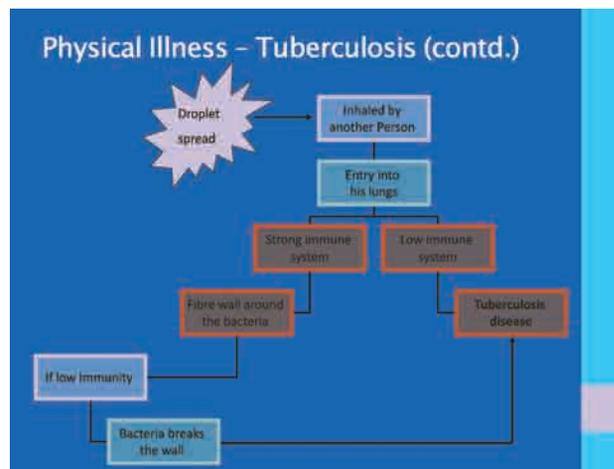
- Tuberculosis (TB) is caused by a microscopic organism – bacteria – mycobacterium tuberculosis
- Can affect any body part
 - Usually affect lungs
 - Other sites: lymph nodes, bone, brain, spinal cord, genital–urinary system, etc.



TB causing bacteria

Physical Illness – Tuberculosis (contd.)

- TB is contagious and spreads through air
 - Transmitted from one person to another through droplets
 - When an infected person sneezes, coughs or talks, tiny droplets of saliva/mucus spread to another person, who can get infected
- If not treated, each infected person with active TB will infect 10-15 persons every year
- TB is not transmitted by touching clothes or shaking hands of an infected person



Pulmonary TB occurs in approximately 85 percent of the patients. Lung lesions can be of the following nature: cavities usually in upper lobes, infiltrates, fibrosis or progressive pulmonary disease. Extra-pulmonary TB occurs in approximately 15 percent of the cases and can occur at any age. Young children and HIV-positive adults are particularly susceptible and many have coexistent pulmonary TB.

- Next, ask the participants to discuss various risk factors of TB, as well as the signs and symptoms of active TB.

Physical Illness – Tuberculosis (contd.)

Risk factors for tuberculosis

- Living with a person who has active TB
- Poverty
- Homelessness
- Nursing home residents
- Prison inmates
- Alcohol dependents

- Injecting Drug Users
- Diabetes
- Certain cancers
- HIV infection
- Health care workers, including doctors and nurses

Physical Illness – Tuberculosis (contd.)

Symptoms of active tuberculosis

- Generalized tiredness/weakness
- Weight loss
- Fever
- Night sweats
- Cough
- Chest pain

- Coughing up of sputum
- Coughing blood
- Shortness of breath
- If other systems involved, symptoms according to the function of the organ
 - E.g. Brain: fits, unconsciousness

- Send two sputum samples to test for TB if any of the following are present: cough for more than 3 weeks, weight loss and sputum production.

- Screen for TB symptoms, if a family member has pulmonary TB. All TB suspects must provide sputum samples for smear microscopy for TB case-detection at TB diagnostic centre under Revised National TB Control Programme (RNTCP). As secretions build up in the airways overnight, an early morning sputum sample is more likely to contain TB bacilli than one taken later in the day.

- Treatment for TB is provided at the TB centre under RNTCP. The treatment is provided under directly observed treatment (DOT). Although the person with pulmonary TB becomes non-infectious within 3 weeks of initiating treatment, a six-month-long treatment is advocated. Two months of intensive treatment with Rifampicin (R), Isoniazid (H), Pyrazinamide (Z) and Ethambutol (E) followed by four months of continuation phase with Rifampicin (R) and Isoniazid (H).

Physical Illness – Tuberculosis (contd.)

- Diagnosis based on
 - Symptom profile and sputum examination
- Treatment
 - Nearest TB centre under RNTCP
 - Directly Observed treatment (DOT)
 - Person becomes non-infectious within 3 weeks of initiating treatment

Treatment of Tuberculosis

- Six month-long treatment
- Two months of intensive treatment with Rifampicin, Isoniazid, Pyrazinamide and Ethambutol followed by four months of continuation phase with Rifampicin and Isoniazid

First Line Anti-TB Drugs				
First-line anti-TB drugs (abbreviation)	Mode of action	Potency	Recommended dose (mg/kg body weight)	
			Daily	Intermittent (3 times a week)
Isoniazid (H)	Bactericidal	High	5	10
Rifampicin (R)	Bactericidal	High	10	10
Pyrazinamide (Z)	Bactericidal	Low	25	35
Streptomycin (S)	Bactericidal	Low	15	15
Ethambutol (E)	Bacteriostatic	Low	15	30

- TB is still a major killer of people with HIV and HIV infected individuals are more at risk of developing active TB. The major concerns relate to drug resistant TB bacilli. Multi-drug resistant TB (MDR-TB) is a form of TB that is difficult and expensive to treat as it fails to respond to standard treatment. Extensively drug resistant TB (XDR-TB) is a form of TB which is resistant to drugs used in MDR-TB.

Physical Illness – Tuberculosis (contd.)

- Other important considerations
 - TB is the leading killer of people with HIV
 - HIV infected people are 20–40 times more likely to develop active TB
 - TB has resurfaced as a global epidemic because of the onset of HIV infection
 - Multi drug resistant TB (MDR-TB): form of TB that is difficult and expensive to treat; it fails to respond to standard treatment
 - Extensively drug resistant TB (XDR-TB): form of TB which is resistant to drugs used in MDR-TB

- Tuberculosis is common in HIV infected as well as HIV non-infected persons who use drugs and people who inject drugs. Studies from India have confirmed that TB is common among IDUs; and the high rates may be due to poverty, homelessness, malnutrition, poor living conditions, low immunity and HIV infection. The early symptoms of TB may be mistaken for other conditions prevalent among IDUs, thus delaying the diagnosis. The weight loss and tiredness can be attributed by the IDUs to general debility. Cough and chest pain may be attributed to chronic bronchitis (as most of them are smokers).

Physical Illness – Tuberculosis (contd.)

- IDU related issues for TB
 - IDUs have a very high rate of TB
 - Reasons are many – poverty, homelessness, poor living conditions, low immunity, poor nutrition, high HIV rates
 - Early symptoms of TB may be mistaken for other conditions. For e.g.
 - Weight loss, weakness or tiredness general debility
 - Cough, chest pain chronic bronchitis associated with co-morbid smoking

- It is important for the health care providers to screen the IDUs for TB by sending them to TB centres. IDUs must be educated about TB; and those with TB must be linked with DOTS centres under RNTCP. Adherence to treatment is essential, and the clinical staff should provide adherence support. OST is an important strategy to help in TB treatment adherence.

Physical Illness – Tuberculosis (contd.)

- During every follow up, symptoms of TB must be positively ruled out
- Baseline screening must be ensured by the counsellor by referral to the physician
- Clients should be educated on signs/symptoms of TB
- Clients with symptoms resembling TB must be referred to nearby DOTS centre
- For those on treatment for TB: counselling for adherence; physically verify whether the client is taking TB medicines or not

Step 5: Conclusion

- Conclude the session by reinforcing the following key points:

Key Messages

- Hepatitis C is the most prevalent infection among people who inject drugs.
 - Hepatitis C is primarily transmitted by sharing needles and other injecting equipment such as spoons used for preparation, cotton, water, measuring syringes and ties; tattooing; sharing infected razors and tooth brushes; and from mother to unborn child.
 - Of the 100 people infected with HCV, a small proportion develops liver cancer, needs a liver transplant or dies.
 - There is no vaccination against HCV.
 - Alcohol and paracetamol facilitate the progression of Hepatitis C.
 - All HCV infected IDUs must be advised to avoid alcohol; treatment must be recommended for people with alcohol dependence.
 - ART delays the progression of HCV liver disease in HCV-HIV co-infection.
 - TB is common among both HIV infected as well as HIV uninfected IDUs.
 - The clinical team must screen IDUs for TB (sputum examination for those with persistent cough >3 weeks who have not responded to conventional treatment).
 - Treatment for TB is through DOTS under RNTCP.
 - Treatment adherence is essential; and OST is an important strategy to help in TB treatment adherence.
- As this is the last session of Day 3, distribute the feedback forms (Feedback Form – Day 3) and ask the participants to provide feedback on the sessions conducted through the day.

Day 4

Session One

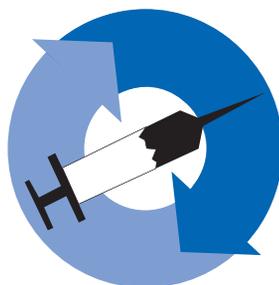
Understanding Co-morbidities/Mental Health

Session Two

Networking and Referral Services

Session Three

Advocacy



Understanding Co-morbidities/Mental Health

OBJECTIVE

To educate the participants on mental health issues among IDUs

EXPECTED OUTCOME

By the end of the session the participants would

- Understand the crisis points in HIV infected IDUs
- Learn about the major psychiatric disorders among IDUs
- Assess suicidal risk among IDUs

DURATION

1 hour

SESSION CONTENT

- Crisis points in HIV infected IDUs
- Major psychiatric disorders among IDUs
 - ◆ Antisocial personality disorder
 - ◆ Depression
 - ◆ Assessment of suicidal risk
 - ◆ Anxiety disorders
 - ◆ Psychosis

METHODOLOGY

- Discussion
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentations
- Whiteboard/Flip chart
- Marker pens

PROCESS

Step 1: Discussion and presentation

- Begin the session by asking the participants to list the various crisis points in the life of an HIV-infected IDU.
- Present the following slides and discuss the crisis situations with the participants. Discuss how these crisis situations can be effectively coped with and what type of psychosocial support needs to be organized to better cope with these situations.
- Ensure that the following points are covered during the discussion.

The general approach to managing crisis situations among IDUs involves the following:

- ◆ Listening: Listen actively to the IDU
- ◆ Providing support: Provide emotional support and organize social support
- ◆ Showing empathy: Show concern for the patient
- ◆ Having a non-judgemental approach
- ◆ Appropriate referral to counsellor or mental health professional

Crisis Points in HIV Infected IDUs

Crisis Points in HIV Infected IDUs

- Learning of HIV-positive status
- Disclosure of HIV status to family and friends
- Introduction of medication
- Occurrence of any physical illness
- Recognition of new symptoms/progression of disease

Crisis Points in HIV Infected IDUs (contd.)

- Necessity of hospitalization
- Death of a significant other
- Diagnosis of AIDS
- Changes in major aspects of lifestyle (e.g., loss of job, end of relationship, relocation)
- Necessity of making end-of-life and permanency planning decisions

Mental Illness

People who inject drugs and those who are opioid dependent commonly have psychiatric co-morbidities. The common psychiatric disorders associated with injecting opioid use (dual diagnosis) are: anti-social personality disorders; bipolar disorder; manic episode; schizophrenia; major depression; and anxiety disorders- obsessive compulsive disorder, and phobia.

Mental Illness

- Mental illness rates more common in drug using population - dual diagnosis

Mental Illness	Rates (%)
Anti-social personality disorder	15.5
Mania	14.5
Schizophrenia	10.1
Depression	4.1
Obsessive compulsive disorder	3.4
Phobia	2.1

National Co-morbidity Study, USA

It is often difficult to tell whether there is a causal relationship between drug use and mental health issues. Drug use itself may cause mental illness (e.g., substance induced psychosis caused by excessive, chronic use of cannabis). Individuals suffering from mental illness may initiate drug use (self-medication hypothesis). For example, individuals suffering from schizophrenia increase tobacco/cigarette consumption to reverse the slowness in thinking due to their illness or due to the medicines used to treat schizophrenia. Both drug use and mental illness may be caused by the same underlying factors (for example, genetic vulnerability, stress related factors, etc.).

Mental Illness (contd.)

- Reasons for increased rates of mental illness:
 - Drug use itself may cause mental illness
 - E.g. cannabis use for a long time is seen to cause psychosis in some
 - Individuals suffering from mental illness may initiate drug use – self medication hypothesis
 - E.g. individuals suffering from schizophrenia increase tobacco/cigarette consumption to reverse the slowness in thinking due to their illness or due to the medicines used to treat schizophrenia
 - Both drug use and mental illness may be caused by the same underlying factors
 - E.g. genetic vulnerability, stress related factors, etc.

Personality Disorder

In personality disorder, an individual’s characteristic and enduring patterns of behaviour deviate markedly as a whole from the culturally expected and accepted range. Such deviation must be manifest in more than one of the following areas: control over impulses and need gratification; interpersonal relationships; inflexible behaviours; emotional response; and cognition.

- The features of antisocial and borderline personality disorder are listed in the slides alongside.

Antisocial or Dissocial Personality Disorder

Features of dissocial or antisocial personality disorder

- (1) Callous unconcern for the feelings of others.
- (2) Gross and persistent attitude of irresponsibility and disregard for social norms, rules, and obligations.
- (3) Incapacity to maintain enduring relationships, though having no difficulty to establish them.
- (4) Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.
- (5) Incapacity to experience guilt, or to profit from adverse experience, particularly punishment.
- (6) Marked proneness to blame others, or to offer plausible rationalizations for the behaviour bringing the subject into conflict with society.

Borderline Personality Disorder

Features of borderline personality disorder

- Disturbances in and uncertainty about self-image, aims and internal preferences (including sexual)
- Liability to become involved in intense and unstable relationships, often leading to emotional crises
- Excessive efforts to avoid abandonment
- Recurrent threats or acts of self-harm
- Chronic feelings of emptiness

Depression

- Depression is under-recognized, under-diagnosed, and under-treated. It is important for providers to consider alternative diagnostic possibilities for depressive symptoms (e.g., acute medical illness, dementia and drug use related conditions). Differentiating appropriate sadness from pathologic depression may be difficult in the person infected with HIV. Psychomotor retardation and apathy of AIDS dementia complex may be confused with depression (improve with combination anti-retroviral treatment). Organic mood disorders may also have symptoms similar to major depression (responsive to antidepressant medication).

Mental Illness – Depression

- Depression is a very commonly occurring mental illness, with great morbidity
- Everyone feels sad at some point of time
- Depression is morbid state of sadness
 - Affects the productivity and normal functioning of an individual

Depression – Symptoms

Symptoms in an individual for at least two weeks leading to difficulty in work OR personal suffering

- Low mood /sadness
 - Varies little from day to day
 - Unresponsive to external situations
- Reduced energy
 - Marked tiredness even after minimal effort
- Decreased activity
 - Psychic (thought level)
 - Motor (physical level)
- Reduced capacity to enjoy
 - Reduced interest in work and pleasure
 - Reduced concentration
 - Thinking becomes muddled and hazy
 - Sleep disturbed
 - Early morning awakening
 - Frequent awakening from sleep
 - Does not feel refreshed

Depression – Symptoms (contd.)

- Loss of appetite
- Reduced self esteem and confidence
- Ideas of guilt
 - feeling that he/she has committed wrong
- Ideas of worthlessness
 - Feeling that he/she does not have any worth
- Ideas of hopelessness
 - Feeling that there is no hope for him/her in this world
- Ideas of helplessness
 - Feeling that no body can help him/her from his/her present condition
- Wishes to die
- Suicidal acts/attempts
 - Feeling that life is not worth living and attempt to end life

- Cases of severe depression should be referred to mental health services.

Assessing Suicidal Risk

- Explain the slide to the participants in in detail.

- Suicidal depressive patients may be helped with hospitalization, specialist care for electro-convulsive therapy and antidepressants. It is extremely important to be vigilant about the patients and the family members need to be educated and counselled about the suicidal behaviour of the patient.

- Refer persons with suicidal ideation to a specialist.

Assessing Suicidal Behaviour

- Assess and document suicidal thoughts and intentions

Have you ever thought of harming yourself?
 Have you had these thoughts recently?
 Have you made a plan?
 Do you think you would ever act on these thoughts?

Closely monitor patients who give answers indicating intention to harm themselves
 Refer to psychiatric services

Anxiety Disorders

Mental Illness – Anxiety Disorders

- Excessive worry and apprehension
- Difficulty in controlling worry
- Associated symptoms
 - Restlessness/nervousness
 - Fatigue
 - Concentration difficulties
 - Irritability
 - Tension
 - Sleep disturbances



Questions to identify anxiety

- Do you often worry or feel nervous?
- Are you often fearful of interacting with other people?
- Do you ever feel jittery, short of breath, or as if your heart is racing?
- Do you ever feel as if you might lose control or fear that you may be “losing it?”

- Anxiety that is pathological occurs in two forms. In one, anxiety is more or less persistent (generalized anxiety), whereas in the other it occurs in discrete attacks (acute anxiety attacks).
- In persistent anxiety, the person usually presents with fear of unknown origin, a sense of tremulousness, palpitation, racing of heart and profuse sweating (evident with a handshake with an anxious person). Depending on the cause, the duration of anxiety may vary.
- In acute anxiety, the attacks typically arise suddenly, span over minutes and symptoms reach a crescendo rapidly. In addition to extreme anxiety, the patients experience tremor, palpitations, excessive sweating, difficulty in breathing, light-headedness, nausea and altered sensations. The duration is generally brief.

Treatment for Anxiety

- Relaxation techniques (e.g., Jacobson muscle relaxation technique)
- Supportive psychotherapy (reassurance, explanation, expert advice, suggestions, guidance, ventilation, support and facilitating emotional support from key persons)
- Pharmacotherapy
- Antidepressants are useful for management of anxiety.
- Benzodiazepines, if prescribed, are to be taken only for a short period of time (Diazepam 5 to 15 mg per day, orally for a short span of time). It is better to avoid benzodiazepines for treatment of generalized anxiety. Benzodiazepines should not be used in response to the minor stresses of everyday life. Alcohol and CNS depressants potentiate the effects of benzodiazepines. Driving should be avoided.
- Patient education is critical for effective management of generalized anxiety.
- For severe cases, refer to specialist.

Sleep Problems (Insomnia)

Insomnia is associated with:

- Complaints of poor memory and concentration
- Irritability
- Prone to accidents at work
- Underperformance at work, or educational problems in young people
- Psychosocial difficulties
- Impairment
- Reduced quality of life
- More frequent use of health services due to general ill health
- Chronic dependence on hypnotic medication and sometimes alcohol as a (ineffective) means of 'sleeping' better.

Sleep Problems (Insomnia)

Presenting complaints

- Difficulty falling sleep
- Recurrent waking during night
- Feeling unrefreshed (i.e. easily exhausted or fatigued despite sleep)
- Falling asleep at inappropriate time during the day

Sleep Hygiene

<p>Measures Used to Improve Sleep Hygiene</p> <ul style="list-style-type: none"> • Arise at same time each day. • Limit daily time in bed to 'normal' amount (6-7hr). • Discontinue drugs that act on CNS such as caffeine, tobacco, alcohol, opioids and stimulants. • Avoid day time napping. • Exercise in the morning and remain active through out the day. • Substitute television watching in the night with light reading and listening to music. 	<p>Measures Used to Improve Sleep Hygiene (contd.)</p> <ul style="list-style-type: none"> • 20 minute warm body bath near bedtime • Eat regularly as per schedule, avoid large meals during night • Evening relaxation routine • Comfortable sleeping conditions • Spend no longer than 20 minutes awake in the bed • Use the bed only for sleep and sex
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Step 2: Conclusion

- Conclude the session by giving the following key messages to the participants:

Key Messages

There are increased rates of psychiatric disorders among IDUs.

Depression can be recognized; and suicidal risk assessment should be done in IDUs with depression.

Insomnia is a common problem and teaching sleep hygiene in TI settings is useful.

Networking and Referral Services

OBJECTIVE

To enable the participants to understand the objectives of establishing referrals/networking, and the process of building linkages

EXPECTED OUTCOME

By the end of the session the participants would

- Know the multiple needs of IDUs
- Understand the importance of referral for various services

DURATION

30 minutes

SESSION CONTENT

- Multiple problems faced by IDUs
- Referral linkages

METHODOLOGY

- Discussion
- PowerPoint presentation
- Activity

MATERIALS/PREPARATION REQUIRED

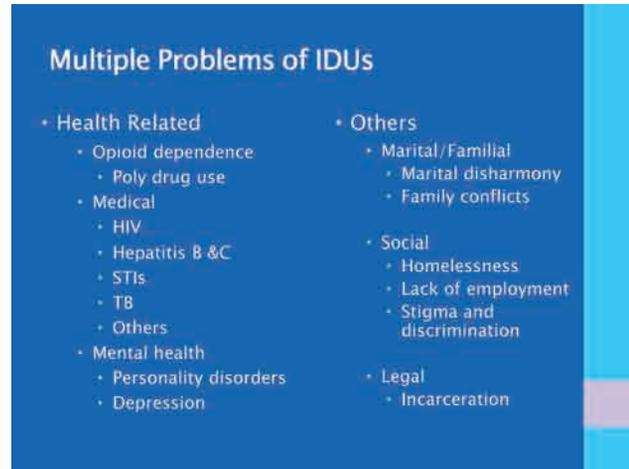
- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/Flip chart
- Marker pens

PROCESS

Step 1: Ask the participants to recall the session on harms related to drug use, and list the multiple problems faced by drug users. While noting down the responses, arrange the problems under various headings as shown in the following slide.

Multiple Problems of Drug Users

- Ask the participants which among the listed problems can or cannot be taken care of in the IDU TI where they work. List them separately on a chart paper. Then, ask them how these services can be provided. In this manner, lead them to the concept of referral systems.
- Now ask the participants whether a simple referral to various services would be enough, and why they think so. Emphasize the following points:
 - ◆ Mere referrals would not help, as most of these referrals would not be honoured.
 - ◆ As the clients are IDUs, the referred agency may not be sufficiently interested/caring to provide services. A strong networking would be required to establish a successful referral system.



Networking for Good Referral System

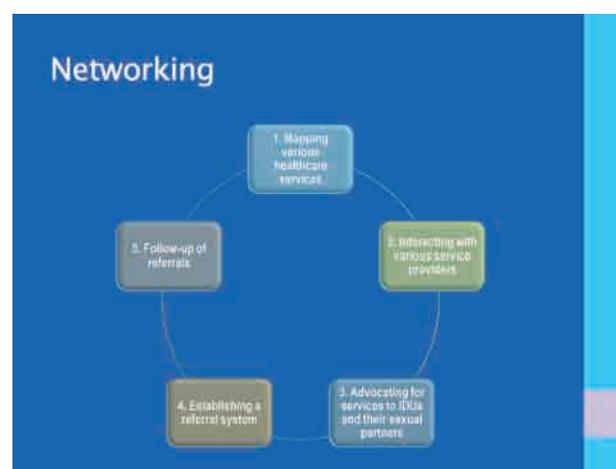
The facilitator should make use of the following notes to explain the Slide:



NOTE TO THE FACILITATOR

The importance of strong referral systems cannot be overemphasized. An inventory of local services for referral relevant to the needs of persons who are injecting drug users should be conducted by the TI team. The staff should be aware of all the services so that they can pass on this information on to the patients attending the TI. Relevant services include most health and welfare agencies, including those providing emergency services. Contact details of the agencies providing such help should be readily available to the peer workers to facilitate referral. It is better to establish formalized linkages with the other services through a memorandum of understanding.

An assessment of opioid dependent individuals should reveal the various needs of the IDUs. After assessing the needs, it is important to prioritize the needs and arrange for linking with most needed services. As drug users feel marginalized, they would be more comfortable if accompanied by peers while accessing such services. Also, since many conditions require long-term help, follow-up with these agencies is important. The peers need to ensure that the drug users continue with the advice, care and support provided by these agencies.



Referral Linkages

• The key services for which referral linkages need to be established include: Integrated Counselling and Testing Centre (ICTC); ART centre; community care centres (CCC); tuberculosis treatment services (TB-DOTS); STI/reproductive health services; maternal and child care services; health services such as secondary and tertiary care hospitals; opioid substitution therapy programs; drug use treatment facilities (detoxification and rehabilitation); and nutritional support.



Step 2: Activity

- The facilitator discusses with the participants various measures that need to be taken in order to ensure that drug users’ needs are addressed adequately.
 - ◆ Brainstorm with the participants and ask them to list all the problems that the drug users encounter. Tell the participants to list the problems in the order of priority.
 - ◆ Ask them how these problems can be effectively addressed.
 - What can be done at the individual level? (e.g., positive living; reduce smoking, exercise)
 - What can be done at the family level? (e.g., food, cooperation by the family)
 - What can be done at the peer support level? (e.g., emotional and social support)
 - What can be done at the Methadone Maintenance Therapy (MMT) clinic? (e.g., common medical problems)
 - What requires attention in a specialized clinic or agency or service? (e.g., TB, depression, disability, social welfare)
- Ask the participants to list the names of the agencies/services in their geographical location that have the potential to offer services for IDUs.

Name of the Agencies

Type of Services Offered

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- ◆ Ask the participants to list the barriers and obstacles in accessing these services.
- ◆ Ask the participants to brainstorm on the ways to ensure that referral linkages are effectively made and list them.
- ◆ Ask the participants how they would ensure follow-up with these services
- The facilitator elicits responses from the participants on all of the above, clarifies them and concludes by summarizing on the flip chart.

Advocacy

OBJECTIVE

To enable the participants to understand the importance of advocacy in the context of IDU TI, and their role in conducting advocacy with various stakeholders

EXPECTED OUTCOME

By the end of the session the participants would have developed an understanding of the basics of advocacy, its relevance in relation to IDU TI, and their role/responsibility in conducting an advocacy program.

DURATION

1 hour

SESSION CONTENT

- Need for advocacy
- Benefits of advocacy
- Role of clinical staff in advocacy

METHODOLOGY

- Discussion
- PowerPoint presentation

MATERIALS/PREPARATION REQUIRED

- Projector
- Laptop
- PowerPoint presentation
- Whiteboard/Flip chart
- Marker pens
- Day 4, feedback forms (enough copies to be made for each participant)

PROCESS

Step 1:

- Begin the session by recapturing the highlights of the session on referral and networking.
The following points should be covered:
 - ◆ IDUs have multiple needs
 - ◆ All of these cannot be fulfilled/provided through an IDU TI alone

- ◆ Many services required by IDUs are available in the general community settings
- ◆ Strong networking is required to ensure that these services are available to IDUs easily
- ◆ Advocacy is an essential element for ensuring a strong network with other agencies
- Next, brainstorm with the participants on the possible barriers IDUs face to access various services. Ensure that issues such as stigma and discrimination, harassment from the law enforcement agencies and other local groups, etc. are covered. Conclude by mentioning that advocacy plays a very important role in removing some of these barriers.
- Share the presentation on Advocacy with the participants.

What is Advocacy?

- Organized effort to influence decision-making
- Action directed at changing approach of an individual/institution/group
- Process to persuade all influential individuals/groups/organizations through dialogue to adopt an effective approach to an issue

Need for advocacy in IDU Context

- All services cannot be provided by an agency alone
 - Services of many other agencies required
 - Other agencies may not be sensitive to IDU needs
- Negative Labelling:
 - IDUs often looked upon as 'criminals' /bad elements
- Reluctance among IDUs:
 - Not ready to access general health/tailored services freely due to perceived and actual stigma
- Community resistance
 - TI services for IDUs (esp. NSP) are opposed by general community and police

ADVOCACY enables to overcome the barriers, helps the IDUs in accessing services freely, and reduces stigma and discrimination in the society.

Advocacy – Benefits

Advocacy benefits both service providers and the IDU clients

- Service providers
 - Enables them to implement programs without any interference/hassles from stakeholders
- IDU clients
 - Enables them to access needed services without fear of stigma/discrimination and ridicule

What to Advocate for?

To ensure that the following services are provided to IDUs

- HIV prevention (including NSEP & OST programs)
- Access to general health services
- Treatment of HIV positive IDUs
- Care and support for HIV positive IDUs
- Access to other needs, e.g. clothing, shelter, food, etc.

Characteristics of Advocacy

- Advocacy is successful if it is:
 - Based on the foundation that all people have equal human/fundamental rights
 - Focused on a particular issue/problem
 - Concerned with rights and benefits of IDUs
 - Concerned with ensuring that institutions/organizations/individuals work the way they should

Characteristics of Advocacy (contd.)

- Advocacy is successful if it is:
 - Relevant to the social, cultural and political context of the society
 - Planned and executed with active involvement of the IDU community

'Advocacy ultimately raises issues and forces the community to change the way it thinks/behaves with IDU'

Step 2

- Generate a discussion on the various steps to be undertaken for advocacy efforts (analysis, strategy, action/reaction, evaluation).
- Using the slides below, describe the various steps in advocacy.

Steps in Advocacy

1. Analysis
2. Strategy
3. Action (and Reaction)
4. Evaluation

Step 1 : Analysis

- The need for advocacy may arise in different situations:
 - During the initial phase, services may not be adequately accessed by the IDU
 - After initial successful uptake, there may be a sudden decline in the access of services by the IDU
 - During routine service delivery, the program staff may come across reports of discrimination/harassment of IDUs

Step 1 : Analysis (contd.)

- In each of the above situations, the staff should conduct an analysis of the problems, e.g. why are IDUs not accessing services; are the reports of harassment being noted by staff too; and so on
- The analysis can be done by the PM along with his staff, IDUs and key members from the general community who are sympathetic to the cause

Step 1 : Analysis (contd.)

- Once it is agreed that there is a problem, the next step is to define the problem:
 - What are the barriers?
 - Who is creating the barriers?
 - Why are there barriers?
 - Nature of the barriers

Step 2: Strategy

- Once the problem is defined, the next step is to formulate a strategy:
 - Describe the situation
 - Define the objectives of advocacy
 - List out intended (target) audience
 - List out key activities to implement
 - Develop timeline for each activity
 - Develop indicators to evaluate the planned activities and the outcomes

Step 3: Action

- Collect information on facts and figures related to the problem, e.g. number estimation of IDUs, prevalence of HIV among IDUs, national and local HIV scenario, policies and programs of the government, and so on
- Tailor the information according to the knowledge and understanding of target audience
- Present information in brief, dramatic and memorable fashion

Step 3: Action (contd.)

- Incorporate human interest stories/anecdotes
- Emphasize urgency and priority of recommended action
- Specify desired action clearly
- Respond rapidly to other views and be flexible
- Focus on policies, not individual behaviour
- Messages delivered should be consistent across various audience groups
- Remember that the desired outcome will not be immediate – so repetition is important

Step 3: Action (contd.)

- Identify other partners with similar issues and form a coalition to advocate together
- Organize media coverage to publicize appropriate events
- Plan events and involve credible spokespeople
- Advocate at different levels to create maximum impact – address meetings with various authorities to get desired change
- Advocacy should be repeated if there is a change in authority/managing agencies

Key Targets/Audience

- Law enforcement agencies
- Religious leaders/FBO
- Community leaders
- General community in/near project area
- Media
- Health sector – (Govt and private): Health workers, organizations providing health care, and health administrative agencies

Key Targets/Audience (contd.)

- Politicians
- Agencies providing social services
- Pharmacies
- NGOs working with drugs and HIV
- NGOs not working with drugs and HIV
- Families of peers
- Diverse unofficial groups (i.e., drug dealers, peddlers, pushers)

Step 4: Evaluation

- Evaluation should be carried out at regular intervals to assess the outcome/output of the advocacy
- Evaluation should be based on the indicators defined in the strategy phase

Step 4: Evaluation (contd.)

Evaluation should answer if:

1. The action plan and strategy is working and if not, is there a need to change the strategy and approach
2. There are gaps in strategies adopted
3. New members/groups need to be brought in for effective advocacy
4. Advocacy at a large scale needs to be carried out and availability of resources for the same

Step 4: Evaluation (contd.)

- Evaluation should finally answer if the advocacy has:
 - changed the perception of the target audience on issues related to IDUs
 - enabled the IDUs to access and utilize services freely
- The whole process should then be documented for dissemination to other agencies

Step 3: Role of Clinical Staff in Advocacy

- Hold a discussion with the participants on the following:
 - ◆ Various agencies where clinical staff can play a major role in advocacy
 - ◆ The steps that can be undertaken in conducting an advocacy program

Advocacy: Role of Clinical Staff

- Key role of agencies which provide healthcare services
 - ICTC, ART, Medical and surgical units, emergency, psychiatry, drug treatment centres, etc.
- Assist the TI in providing the following information:
 - Drug use as a chronic medical illness
 - Understanding various drugs used by IDUs and complications related to their use
 - Importance of HIV prevention programs
 - Need for long term treatment for drug use problems

- Present the slide.

Step 4: Conclusion

- Conclude the session with the following key messages

Key Messages

- Advocacy is the process of seeking support from allies, groups, networks and stakeholders to influence decision making and adopt effective approaches to meet the needs of IDUs and their sex partners.
 - Advocacy is the key to an enabling environment for IDUs to access available HIV prevention and related services.
 - Advocacy helps program staff to implement their projects without undue interference from the local community.
 - Regular advocacy in a project helps reduce stigma and discrimination.
 - Advocacy is successful if it is planned and executed with active involvement of the IDU community.
- As this is the last session of Day 4, distribute the feedback forms (Feedback Form – Day 4); and ask the participants to provide feedback on the sessions conducted through the day.

Day 5

Session One

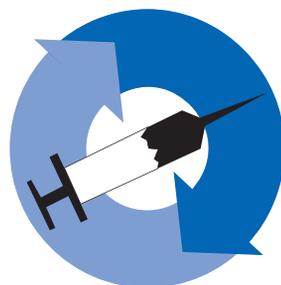
Field Visit to TI

Session Two

Debriefing after the Visit to TI

Session Three

Conclusion and Evaluation



Field Visit to TI

OBJECTIVE

- To get first-hand exposure of how an IDU project functions
- To interact with various members who are implementing the TI project, and understand the various roles/responsibilities of different staff
- To understand the role of clinical staff in various activities of the IDU TI project.

EXPECTED OUTCOME

By the end of the session the participants would have an understanding of an IDU project and its daily functioning

DURATION

5 hours

METHODOLOGY

- Field visit
- Interaction with field staff
- Discussion

MATERIALS/PREPARATION REQUIRED

The facilitator should select field operations that will allow the participants to interact with the staff as well as IDUs. Also, ensure that the staff of the selected TI shares 'best practices' with the participants.

PROCESS

Briefing on the Field Visit

- Inform the participants that they will be visiting an IDU TI, and out there they will be interacting with the clients in the DIC, the project staff and the doctors.
- Ask them to do the following:
 - ◆ Understand the settings of the TI in relation to what they have learnt in the session on TIs.
 - ◆ Ask questions or clarify their doubts regarding the functioning of the TI from the various project functionaries with whom they would be interacting.
 - ◆ Understand how the IDU community can be involved in the implementation of the program
 - ◆ Find out about the strategy of the TI for creating an enabling environment and dealing with structural issues.
- Divide the participants into 4-5 smaller teams and visit the field with the concerned ORW and PE so that the community members are not intimidated by a single large group.

Debriefing after the Visit to TI

OBJECTIVE

- To consolidate the learning from the field visit
- To ensure that correct observations are made by the participants during the field visit

EXPECTED OUTCOME

By the end of the session the participants have an understanding of an IDU project and its daily functioning

DURATION

1 hour

METHODOLOGY

Discussion

PROCESS

Feedback after Field Visit

- On returning from the field visit, briefly take the feedback on the following in order to assess the participants' learning.
 - ◆ What kind of services did they see being offered at the DIC?
 - ◆ What kind of IEC or BCC was being used in the field as observed by them?
 - ◆ What did they notice in terms of client confidentiality being maintained?
 - ◆ What kind of equipment did they see being used? Did it help them to understand their classroom sessions any better?
 - ◆ What were the challenges that were being faced by the field staff at the TI? What kind of strategy was being used by the field staff to overcome these challenges?

Conclusion and Evaluation

OBJECTIVE

- To help the facilitator and participants assess the knowledge acquired and change in attitude after the workshop
- To conclude the training program

EXPECTED OUTCOME

At the end of the session, the participants would

- Clarify their doubts, if any
- Provide comments, suggestions or inputs
- Give feedback on the workshop – methods and content

DURATION

1 hour

METHODOLOGY

- Clarifications on questions from participants
- Comments, suggestions and inputs from participants
- Feedback on the workshop

MATERIALS/PREPARATION REQUIRED

- Before the session, ensure that adequate copies of the questionnaire (given in [Annexure 1](#)) for conducting the post-training evaluation are available. The answers to the questions are also provided therein.)
- Feedback forms – Day 5
- Training feedback forms

PROCESS

Step 1: Post-training

- Remind the participants that at the beginning of the training workshop they had answered a questionnaire
- State that the 5-day training has added to their knowledge and has enhanced their skills in working on outreach for IDUs.
- Inform the participants that before concluding the workshop they need to answer the same questionnaire again

- Distribute the questionnaire – one for each participant. Give them 15 minutes to complete it, at all times ensuring that they participants are answering individually and not with assistance from their peers.
- Collect the filled-in questionnaires and thank the participants.

Step 2: Conclusion

- Encourage some of the participants to say a few words about their experience at the workshop and their learning.
- Thank the participants for their active participation in the workshop.
- As this is the last session of Day 5, distribute the feedback forms (Feedback Form – Day 5) and ask the participants to provide feedback on the sessions conducted during the day.

Annexures

1. Pre- and Post-training Questionnaire
2. Training Agenda
3. Day-wise Feedback Forms
4. Assessment and Diagnosis – Issues to be covered

Pre- and Post-Training Questionnaire

Instructions: Please choose the correct response or responses from the options provided.

Remember: There may be more than one correct option!

1. **Cannabis (Bhang, Charas, Ganja, Hashish) is a**
 - a. Depressant
 - b. Stimulant
 - c. Hallucinogen
 - d. All of the above

2. **What would be the first step of harm reduction that you would advise an active IDU?**
 - a. OST
 - b. Deaddiction
 - c. Reduce number of sharers
 - d. Use non-injecting drugs

3. **What should one do in case of needle stick injury?**
 - a. Wash the injured site with soap and water
 - b. Suck or lick the injured site
 - c. Begin PEP within 72 hours
 - d. Both a and c

4. **What are some of the unsafe injecting practices?**
 - a. Injecting in veins
 - b. Injecting in neck and groin
 - c. Rotating injecting sites
 - d. Sharing needles, syringes and other injecting equipment

5. **IDUs who can be considered for OST should:**
 - a. Be dependent on opioids
 - b. Have an established history of severe side-effects to buprenorphine
 - c. Be able to provide informed consent
 - d. Both a and c

6. What are the routes for transmission of Hepatitis C?

- a. Sharing of contaminated injecting equipment
- b. Mosquito bite
- c. Eating unhygienic food
- d. Transfusion of infected blood and blood products

7. How can you prevent abscess formation?

- a. By avoiding the sharing of needles
- b. By keeping injecting area clean
- c. By knowing the steps to inject correctly
- d. All of the above

8. What is NOT a symptom of overdose

- a. Dilated pupils
- b. Cyanosis
- c. Vomiting
- d. Respiratory depression

9. Which of the following statements are TRUE about the third phase of National AIDS Control Programme (NACP III) in India?

- a. The goal of NACP III is to contain the epidemic of HIV in India
- b. NACP III commenced in the year 2005
- c. The emphasis of NACP III is on prevention
- d. About 50% of all the high-risk groups will be covered under NACP III to halt the HIV epidemic in India

10. What is the prevalence rate of HIV among Injecting Drug Users (IDUs) in India?

- a. 0% - 5%
- b. 5% - 10%
- c. 10%- 15%
- d. >20%

11. Which of the following is NOT a criterion for diagnosing drug dependence?

- a. Evidence of tolerance (i.e. need to take a higher amount of drug)
- b. Withdrawal symptoms in the absence of drug
- c. Poor social and occupational performance due to indulging in substance use
- d. Use of an illegal substance

12. Which of the following is TRUE?

- a. Receptive oral sex is riskier than receptive vaginal sex
- b. Insertive vaginal sex is riskier than insertive anal sex
- c. Insertive vaginal sex is riskier than receptive vaginal sex
- d. Receptive anal sex is riskier than insertive anal sex

13. Which one is TRUE for anti-retroviral treatment?

- a. One should start ART before the CD4 count goes below 200
- b. One should start ART irrespective of the CD4 count
- c. One should start ART before HIV testing if one has an STI
- d. One should start ART as soon as possible after being tested positive for HIV

14. Which of the following is TRUE?

- a. HIV positive IDUs are not fit candidates for ART
- b. IDUs on OST find it difficult to adhere to ART
- c. IDUs on OST are best suited for ART
- d. IDUs on OST are more prone to opportunistic infections

15. All of the following statements regarding opioid substitution therapy (OST) are true, except:

- a. OST can be used in the treatment of all kinds of drugs, including alcohol
- b. OST is substitution of one opioid with another opioid of known purity and potency
- c. The benefit of OST goes beyond mere stopping of injecting/drug use
- d. OST should generally be given for a longer period of time

For Facilitator: Answers to Pre- and Post-training Questionnaire

1. d	6 a and d	11. d
2. c	7. d	12. d
3. d	8. a	13. a
4. b and d	9. c	14. c
5 d	10. b	15. a

Annexure 2 Agenda for Training of Clinical Staff in IDU Interventions

Time	Topic	Session
DAY ONE		
9.00 a.m.– 9.30 a.m.	Registration of the Participants	
9.30 a.m.– 10.15 a.m.	Inaugural Ceremony	
10.15 a.m.–10.30 a.m.	<i>Coffee/Tea break</i>	
10.30 a.m.– 11.15 a.m.	Introduction to the Training Program	Session 1
11.15 a.m.–12.30 p.m.	Basics of Drugs	Session 2
12.30 p.m.– 1.30 p.m.	Understanding Drug Related Harms and Injecting Drug Use	Session 3
1.30 p.m.– 2.30 p.m.	<i>Lunch break</i>	
2.30 p.m.– 3.30 p.m.	Harm Reduction – Understanding the Principles	Session 4
3.30 p.m.– 4.15 p.m.	National AIDS Control Programme	Session 5
4.15 p.m.– 4.30 p.m.	<i>Coffee/Tea break</i>	
4.30 p.m.– 5.30 p.m.	Targeted Interventions for Injecting Drug Users	Session 6
5.30 p.m.– 5.45 p.m.	Feedback – Day 1	
DAY TWO		
9.00 a.m.– 10.00 a.m.	Roles and Responsibilities of Doctors and Nurses in IDU TI Programs	Session 1
10.00 a.m.–11.00 a.m.	Assessment and Diagnosis	Session 2
11.00 a.m.– 11.15 a.m.	<i>Coffee/Tea break</i>	
11.15 a.m.– 12.00 noon	Counselling for Safer Injecting Practices	Session 3
12.00 noon– 1.00 p.m.	Drug Treatment: Detoxification	Session 4
1.00 p.m.– 2.00 pm.	<i>Lunch break</i>	
2.00 p.m.– 3.00 p.m.	Drug Treatment: Opioid Substitution Therapy	Session 5
3.00 p.m.– 3.45 p.m.	Sexually Transmitted Infections: Basics	Session 6
3.45 p.m.– 4.00 p.m.	<i>Coffee/Tea break</i>	
4.00 p.m.– 5.00 p.m.	Prevention of Sexually Transmitted Infections	Session 7
5.00 p.m.– 5.15 p.m.	Feedback – Day 2	
DAY THREE		
9.00 a.m.– 10.15 a.m.	Management of Sexually Transmitted Infections	Session 1
10.15 a.m.– 11.00 a.m.	Basics of HIV	Session 2
11.00 a.m.– 11.15 a.m.	<i>Coffee/Tea break</i>	
11.15 a.m.–12.30 p.m.	Prevention and Management of HIV: The Role of Doctors and Nurses	Session 3
12.30 p.m.– 1.15 p.m.	Abscess Prevention and Management	Session 4
1.15 p.m.– 2.15 p.m.	<i>Lunch break</i>	
2.15 p.m.– 3.45 p.m.	Overdose Prevention and Management	Session 5
3.45 p.m.– 4.00 p.m.	<i>Coffee/Tea break</i>	
4.00 p.m.– 5.00 p.m.	Co-morbid Conditions among IDUs – Hepatitis & Tuberculosis	Session 6
5.00 p.m.– 5.15 p.m.	Feedback – Day 3	
DAY FOUR		
9.00 a.m.– 10.45 a.m.	Understanding Co-morbidities/Mental Health	Session 1
10.45 a.m.–11.45 a.m.	Networking and Referral Services	Session 2
11.45 a.m.– 12.15 p.m.	<i>Coffee/Tea break</i>	
12.15 p.m.– 1.30 p.m.	Advocacy	Session 3
1.30 p.m.– 2.30 p.m.	<i>Lunch break</i>	
2.30 p.m.– 4.30 p.m.	Questions and Answers	
4.30 p.m.– 4.45 p.m.	<i>Coffee/Tea break</i>	
4.45 p.m.– 5.00 p.m.	Feedback – Day 4	

DAY FIVE		
9.00 a.m.– 12.30 noon	Field Visit to TI	Session 1
12.30 p.m.– 1.00 p.m.	Debriefing after the Visit to TI	Session 2
1.00 p.m.– 2.00 p.m.	<i>Lunch break</i>	
2.00 p.m.– 3.00 p.m.	Conclusion and Evaluation	Session 3
3.00 p.m.– 3.45 p.m.	Closing Remarks/Clarifications/Comments	
3.45 p.m.– 4.00 p.m.	<i>Coffee/Tea break</i>	
4.00 p.m.– 4.30 p.m.	Valedictory Session	

Annexure 3

Feedback Form – Day 1

Session	Particulars	Feedback			Remarks*
					
		Good	Ok	Poor	
Overall response to sessions					
1	Introduction to the Training Program				
2	Basics of Drugs				
3	Understanding Drug Related Harms and Injecting Drug Use				
4	Harm Reduction: Understanding the Principles				
5	National AIDS Control Programme				
6	Targeted Interventions for Injecting Drug Users				

Most useful topics

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Topics not found very useful

.....

Any other comments

.....

Please comment on the duration, content and methodology

Feedback Form – Day 2

Session	Particulars	Feedback			Remarks*
					
		Good	Ok	Poor	
Overall response to sessions					
1	Roles and Responsibilities of Doctors and Nurses in IDU TI programs				
2	Assessment and Diagnosis				
3	Counselling for Safer Injecting Practices				
4	Drug Treatment: Detoxification				
5	Drug Treatment: Opioid Substitution Therapy				
6	Sexually Transmitted Infections: Basics				
7	Prevention of Sexually Transmitted Infections				

Most useful topics

.....

Topics not found very useful

.....

Any other comments

.....

Please comment on the duration, content and methodology

Feedback Form – Day 3

Session	Particulars	Feedback			Remarks*
					
		Good	Ok	Poor	
Overall response to sessions					
1	Management of Sexually Transmitted Infections				
2	Basics of HIV				
3	Prevention and Management of HIV: Role of Doctors and Nurses				
4	Abscess Prevention and Management				
5	Overdose Prevention and Management				
6	Co-morbid Conditions among IDUs – Hepatitis and Tuberculosis				

Most useful topics

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Topics not found very useful

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Any other comments

.....

Please comment on the duration, content and methodology

Feedback Form – Day 4

Session	Particulars	Feedback			Remarks*
					
		Good	Ok	Poor	
Overall response to sessions					
1	Understanding Co-morbidities/ Mental Health				
2	Networking and Referral Services				
3	Advocacy				
4	Questions and answers				

Most useful topics

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Topics not found very useful

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Any other comments

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Please comment on the duration, content and methodology

Feedback Form – Day 5

Session	Particulars	Feedback			Remarks*
					
		Good	Ok	Poor	
	Overall response to sessions				
1	Field Visit to TI				
2	Debriefing after the Visit to TI				
3	Conclusion and Evaluation				
4	Clarifications/comments				
5	Valedictory session				

Most useful topics

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Topics not found very useful

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Any other comments

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Please comment on the duration, content and methodology

Annexure 4

Assessment and Diagnosis – Issues to be Covered

A. Drug history

i. Reasons for presentation

- In crisis: overdose (incidental or accidental, both), financial/occupational crisis, physical health, relationship/family problems, loss of control over use, etc.
- May have been brought in by a concerned parent, relative, spouse, employer, friend or a social worker
- May want help for drug dependence and be motivated to change their behaviour
- Usual source of drugs not available
- May be referred by another medical practitioner
- May be suffering from mental illness (psychiatric co-morbidity)
- May be pregnant
- May be referred by police

ii. Past and current drug use (past four weeks)

- The age at starting of drug use (including alcohol and nicotine)
- Types and quantities of drugs taken (including concomitant alcohol and other drug use)
- Frequency of use, including routes of administration
- Experience of overdose
- Periods of abstinence (what helped to abstain for a long time)
- Triggers for relapse
- Symptoms experienced when unable to obtain drugs
- Cost of drug and alcohol use
- Symptoms of dependence
- Drug-funding activities
- Social network

iii. History of injecting and risk of HIV and hepatitis

- Past history
- Reasons for change to injecting
- Source(s) of needles and syringes
- Needle-sharing behaviours including lending and borrowing injecting equipment/paraphernalia
- Does the patient know how to inject safely?
- How does the patient clean the equipment before and after use?
- How does the patient dispose of the used equipment?
- Knowledge of HIV, hepatitis B and C issues and transmission
- Use of condoms

iv. Medical history

- Complications of drug use – abscesses, thromboses, viral illnesses, respiratory problems
- Hepatitis B and C status, if known
- HIV status if known
- Last menstrual period
- Operations, accidents and head injury

v. Psychiatric history

- Any psychiatric consultations?
- Any history of overdose? (accidental or deliberate)

vi. Forensic history

- Any outstanding criminal charges?
- Past and present contact with the criminal justice system?
- Past sentences in jail/prison?

vii. Social history

- Family situation
- Employment situation
- Housing situation
- Financial situation including debts

viii. Past contact with treatment services

- Previous efforts to reduce or stop taking drugs
- Contacts with doctors, community services, drug treatment and rehabilitation centres
- Previous admissions for rehabilitation, how long they lasted and the cause of any relapses

ix. Other relevant history

- Drug and alcohol use in partner, spouse and other family members
- Impact of drug use on other aspects of the patient's life

B. Examination***i. Assessing motivation***

Is the client motivated to stop or change their pattern of drug use or to make other changes in their life?

ii. Assessing mental health – coexisting psychiatric problems***iii. Assessing general health***

- General – anaemia, nutritional status, dentition and overall hygiene
- Skin – needle marks, tattoos, skin abscesses, scabies and open wounds
- Route specific – smoking (asthma)
 - injecting (abscesses, cellulitis)
- Sharing needles, syringes and injection equipment – Hepatitis B and C, HIV and other blood-borne infections

- Drug-related
 - Side-effects (e.g. constipation)
 - overdose (e.g. respiratory depression)
 - Withdrawal (e.g. irritability)

C. Special investigations with full informed consent

Haematological investigations

- Haemoglobin, complete blood picture
- Liver function tests (LFT)
- Tests for HIV, Hepatitis B and C
- Venereal Disease Research Laboratory (VDRL) test for syphilis
- X-ray chest (if indicated)

Further Reading Material

1. Guterman L & Curtis M (2009). *Overdose Prevention and Response: A Guide for People Who Use Drugs and Harm Reduction Staff in Eastern Europe and Central Asia* (English). USA: Open Society Institute. http://www.ihra.net/files/2010/08/20/Overdose_and_Prevention_Response.pdf
2. Harm Reduction Coalition. *Getting off right. A safety manual for injection drug users*. Harm Reduction Coalition, New York.
<http://harmreduction.org/wp-content/uploads/2011/12/getting-off-right.pdf>
3. International Harm Reduction Association (2010). *The Global State of Harm Reduction 2010*.
<http://www.ihra.net/contents/245>
4. National AIDS Control Organization (2008). *Practice Guidelines for Substitution Therapy with Buprenorphine for Opioid Injecting Drug Users*. Ministry of Health and Family Welfare, New Delhi.
http://www.nacoonline.org/upload/Publication/NGOsandtargettedIntervations/Bupenorphine_Practice_Guidelines.pdf
5. National AIDS Control Organization (2008). *Refresher Training Module for ART & CCC Counsellors*. Ministry of Health and Family Welfare, New Delhi. http://www.nacoonline.org/Quick_Links/Publication/Treatment_Care__Support/Refresher_Training_Module_for_ART__CCC_Counsellors_January_2009/Facilitator_Guide
6. Strathdee SA, Hallett TB, Bobrova N, Rhodes T, Booth R, Abdool R, Hankins CA. (2010). 'HIV and risk environment for injecting drug users: the past, present, and future'. *Lancet*. 2010 Jul 24;376(9737):268-84.
7. World Health Organization (2007). *Guide to starting and managing needle and syringe programmes*. World Health Organization, Department of HIV/AIDS, Geneva.
http://www.who.int/hiv/idu/Guide_to_Starting_and_Managing_NSP.pdf
8. United National Office on Drug Control Regional Office for South Asia. *Prevention of Transmission of HIV among Drug Users in SAARC Countries: Project H13 Intervention Toolkit*. United National Office on Drug Control Regional Office for South Asia, New Delhi.
http://www.unodc.org/india/en/prev_h13_modules.html

