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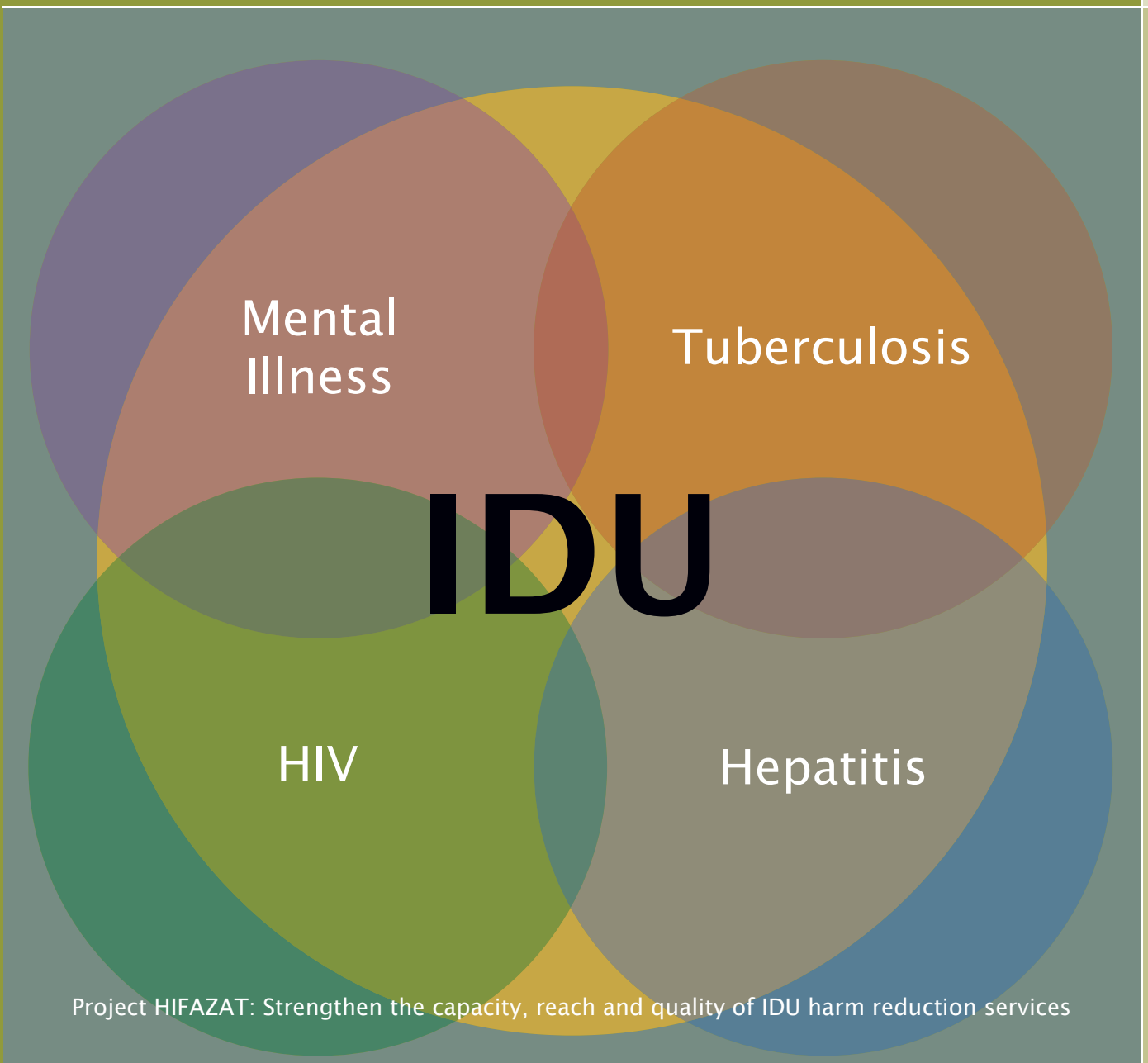
Care and Support for Co-morbid Conditions among Injecting Drug Users



STANDARD OPERATING PROCEDURES

Project HIFAZAT: Strengthen the capacity, reach and quality of IDU harm reduction services

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Standard Operating Procedure Care and Support for Co-morbid Conditions Among Injecting Drug Users

"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

In India, Targeted Intervention (TI) under the National AIDS Control Programme (NACP) framework, is one of the core strategies for HIV prevention amongst injecting drug users (IDUs). Apart from providing primary health services that include health education, abscess management, treatment referrals, etc., the TIs are also designated centres for providing harm reduction services such as Needle Syringe Exchange Programs (NSEP) and Opioid Substitution Therapy (OST). The services under the TIs are executed through a peer based outreach as well as a static premise based approach, i.e., through Drop-in Centres (DICs) which in turn serve as the nodal hubs for all the above activities to be executed.

To further strengthen these established mechanisms under the NACP and to further expand the reach to vulnerable IDUs, 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. In doing so, UNODC supports NACO through technical assistance to undertake the following:

1) Conduct Operational Research
2) Develop Quality Assurance SOPs
3) Develop Capacity Building/Training Materials
4) Training of Master Trainers

It is in this context that a series of seven Standard Operating Procedures (SOPs) has been developed. The present SOP titled 'Care and Support for Co-morbid Conditions among IDUs' is the sixth in the series. It is intended to be a guide for providing care and support to IDUs for their co-morbid conditions within the context of IDU interventions. It also feeds into the broader NACP goals and helps strengthen and consolidate the gains of the TIs towards scaling up of critical services.

This SOP, therefore, has also been developed with a vision to serve as an invaluable tool for service providers engaged in IDU TIs in India to enable them to deliver quality services. 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 was critical towards articulating and consolidating inputs that went into finalizing this SOP.

Acknowledgement

The UN 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 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. HIFAZAT). Project HIFAZAT aims to strengthen the capacities, reach and quality of harm reduction among IDUs in India. It involves providing support for scaling up of services for IDUs through the National AIDS Control Programme.

We would like to acknowledge the invaluable feedback and support received from various stakeholders who include 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 tothe development of this document.

Special thanks are due to the UNODC Project H13 team for their persistent and meticulous efforts in conceptualizing and consolidating this document.

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANM	Auxiliary Nurse Midwife
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
CCC	Community Care Centres
DIC	Drop-in Centre
DOTS	Directly Observed Treatment, Short-course
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HRG	High Risk Groups
ICTC	Integrated Counselling and Testing Centre
ICU	Intensive Care Unit
IDU	Injecting Drug User
IEC	Information, Education and Communication
IV	Intravenous
MSM	Men who have Sex with Men
NACO	National AIDS Control Organisation
NSEP	Needle Syringe Exchange Program
OI	Opportunistic Infection
OST	Opioid Substitution Therapy
ORW	Outreach Worker
PE	Peer Educator
PLHA	People Living with HIV/AIDS
PLHIV	People Living with HIV
SACEP	State AIDS Clinical Experts Panel
SACS	State AIDS Control Society
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TB	Tuberculosis
TI	Targeted Intervention

Contents

1. Introduction

Injecting Drug Users (IDUs) have emerged as a group at high risk for HIV infection and other blood-borne viruses in India, as in other parts of the world. As per the sentinel surveillance conducted by the National AIDS Control Organization (NACO)[1] in 2009, HIV prevalence among IDUs is 9.2%, which is one of the highest among the High Risk Groups (HRGs) in India.[2] The surveillance data shows that HIV infections among female sex workers is declining, but IDUs and Men who have Sex with Men (MSM) are more vulnerable to HIV, with increasing trends observed in many states.[3] It is estimated that there are around 200,000 IDUs in the country. However, the prevalence of injecting drug use and HIV prevalence among IDUs differs from one region to another.

Studies show that in addition to HIV, drug users also face a number of other physical, psychological and social problems. Injecting drug users generally suffer from poor health; conditions such as anaemia, poor nutrition, weight loss, and diseases such as tuberculosis, blood-borne infections such as Hepatitis B and C and mental illness are very common among them.[4] Awareness of these conditions among the IDUs and service providers alike is very low. Even if services are available, IDUs do not come forward to seek treatment due to perceived stigma and actual discrimination. They face a two-fold cycle of stigma and discrimination. First, they are discriminated against because of their HIV positive status, and second, but more important, they are denied services because they are drug users. Though drug treatment services such as detoxification and rehabilitation services as well as opioid substitution therapy (OST) are available, their reach is limited.

Currently, services for IDUs are provided through two distinct approaches: direct and through referrals and linkages (*see* Figure 1). Most of the HIV preventive services are provided by the targeted interventions (TIs) directly, while HIV testing and treatment services are available through referrals and linkages. In addition, most of the treatment services required by IDUs for the co-morbid conditions are currently provided through referrals to other agencies/hospitals providing these services. The TIs working for IDU populations should have excellent networking with these referral agencies to enable smooth access to services.

[1] National AIDS Control Organisation, Annual Report, Department of AIDS Control, Ministry of Health & Family Welfare, 2010

[2] HIV Sentinel Surveillance and HIV Estimation in India 2007 – a technical brief, NACO, Ministry of Health and Family Welfare, Government of India, October, 2008

[3] NACO, Annual Report 2009-10, Department of AIDS Control, Ministry of Health & Family Welfare, 2010

[4] Kumar *et. al.*, 2005

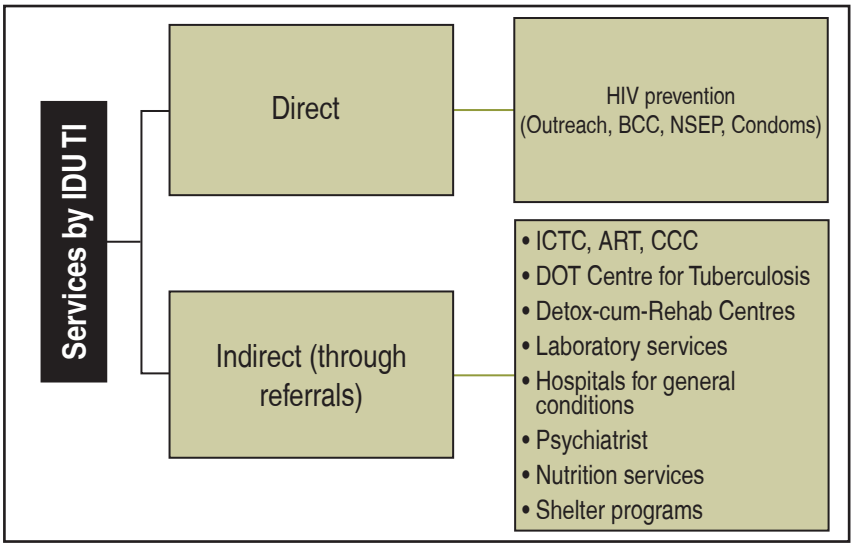

Figure 1: IDU TI service provision

Purpose of Standard Operating Procedure

The purpose of this standard operating procedure (SOP) is to provide an understanding of the care and support services required by IDUs for HIV detection and treatment. In addition, the role of TIs in providing services for a variety of co-morbid conditions is outlined. The SOP provides a set of standardized steps that can be undertaken by harm reduction service providers on managing these co-morbid conditions. Thus, it is intended to be a guide for the provision of care and support to IDUs for their co-morbid conditions. This SOP is for all the staff of TIs, including those involved in providing care and support in outreach and DIC settings for IDUs.

2. Care and Support for HIV Detection and Treatment

Co-morbid HIV infection is very common among IDUs, as seen in the recent NACO Sentinel Surveillance Report.[5] The problem is compounded by the fact that HIV related service uptake among IDUs is very poor. Continuing drug use makes it difficult for IDUs to seek services due to their poor health seeking behaviour. In addition, as mentioned earlier, there is perceived and actual stigma and discrimination among IDUs accessing health-care services. There is also a misconception among service providers that IDUs are more likely to become resistant to Antiretroviral Therapy (ART) medicines than others. However, studies have shown that resistance to ART among IDUs is similar to that among other population groups.

As seen in the flow chart, services for HIV detection and treatment are available in the current context of the National AIDS Control Programme (NACP) through different agencies. It is important to understand that the TI has a role to play at each of the service points. The flow of services for HIV detection and treatment is as shown in Figure 2.

The three service points are discussed below focusing on the role of the IDU TI in each service point.

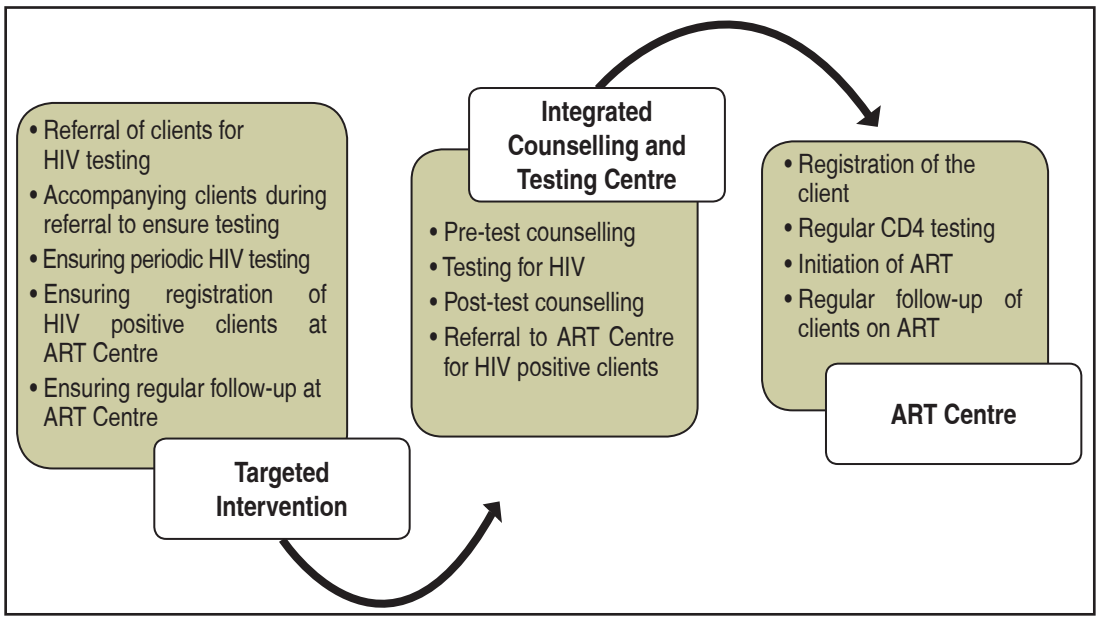

Figure 2: Flow of services for HIV detection and treatment

[5] HIV Sentinel Surveillance and HIV Estimation in India 2007 – a technical brief, NACO, Ministry of Health and Family Welfare, Government of India, October, 2008

2.1 Service Point One: Targeted Intervention

The IDU TI has a major role to play in ensuring that services for HIV detection and treatment are available and accessible to the IDU clients catered to by the TI in a non-discriminatory manner. The following steps should be undertaken by the TI to ensure availability and accessibility of HIV detection and treatment services.

1**. Establishing a system of referrals**

The TI should establish a system of referrals before referring the client to the Integrated Counselling and Testing Centre (ICTC) and ART Centre for HIV testing and treatment. The next Section gives details of how to establish and maintain a system of referrals.

2**. Educating clients on HIV testing**

Before the actual referral, the client should be educated about HIV testing. The education should be done at two levels: at the field level by the outreach worker (ORW)/peer educator (PE) and at the Drop-in Centre (DIC) by the counsellor.

a. **Field level by ORW/PE**

The outreach team should include sessions related to HIV in their discussions with IDU clients. The sessions should be conducted by an ORW along with his/her team of PEs. The sessions can be one-to-one or in a group. The following topics should be covered: Basic facts on HIV; Importance of testing for HIV; Process to be followed for HIV testing; Meaning of positive and negative result; Counselling and other services available for HIV positive clients. The clients should then be referred to the DIC of the TI for further education and referral to ICTC.

b. **DIC level by counsellor**

At the DIC, the counsellor should once again emphasise the importance of HIV testing to the IDU client in a one-to-one setting, address his/her concerns with regard to testing, and finally assure him/her of ongoing support to deal with his/her status.

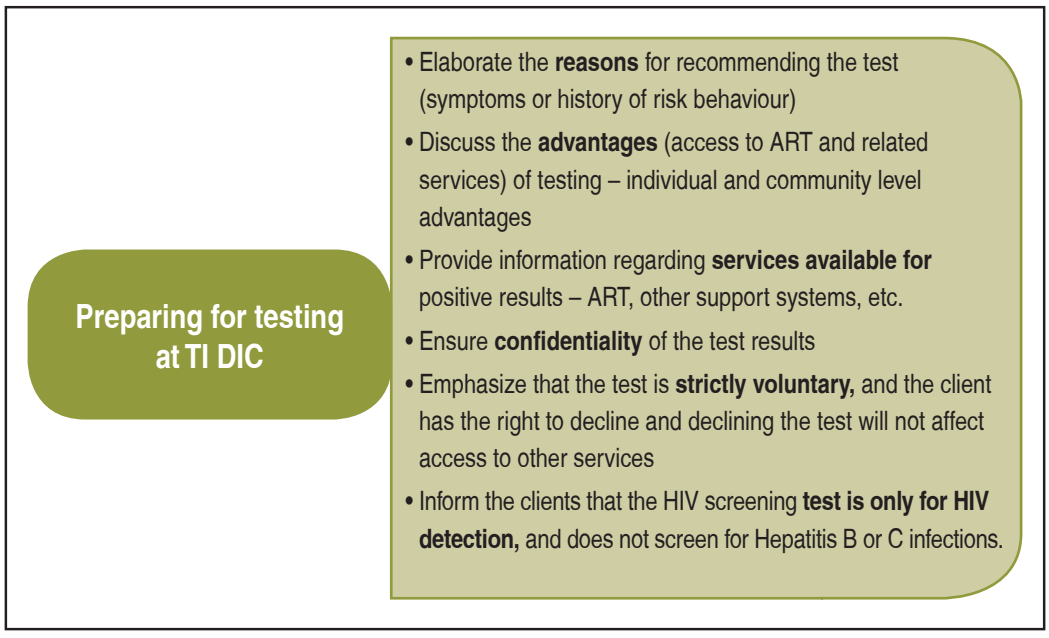

Figure 3: Counselling by TI counsellor before referral to ICTC

3. **Referral of clients to Integrated Counselling and Testing Centre**

The counsellor should use the referral card/slip to refer the client to ICTC. A template of the referral card is provided in Annexure 3. The counsellor should also ensure that the client is accompanied by an ORW or a PE while visiting the ICTC. This is called 'accompanied referral'.

There may be several barriers (which are mentioned below) that prevent an IDU from accessing the ICTC, which the TI staff can address when preparing the IDU for referral to the ICTC:

a. **Fear of getting tested or fear of getting a positive result:** The counselling session should address the client's possible concerns about accessing ICTC.

b. **Fear of police harassment:** The TI staff should conduct advocacy meetings with the local police officers and explain the importance of the TI related activities.

c. **Perceived and actual stigma in health-care settings:** The TI staff should address this with the client and assure him/her of adequate services at the referred health-care centre, as well as have meetings with the ICTC staff beforehand to ensure a non-stigmatizing environment.

d. **Stabilizing drug use to undergo counselling and testing:** The client may be referred for OST services, if indicated and if the client is willing.

e. **Co-morbidities (such as abscess/advanced TB) which make travelling to ICTC difficult:** These co-morbidities should first be managed by the ANM/doctor, after which the client can be sent to the ICTC.

2.2 Service Point Two: Integrated Counselling and Testing Centre

At the ICTC, the ICTC counsellor will initially register the client, followed by a pre-test counselling, and then ask the technician to collect blood for HIV testing. After the test results are received, the ICTC counsellor will then conduct post-test counselling for the client, depending on the results of the test (*see* Figure 4 on next page).

Role of IDU TI in HIV testing

Referral

The TI staff accompanying the client should make him/her aware of what to expect at the ICTC, assist him/her in accessing the ICTC, and introduce him/her to the ICTC counsellor. After the introduction, the TI staff should allow the client privacy so that he/she can interact with the counsellor. The TI staff should ensure that the test results are received by the client, and the client is administered post-test counselling.

The TI staff should inform the client that it is his/her choice whether to divulge the results of the HIV test. The benefits of divulging the results should be communicated to the client by the counsellor of the IDU TI.

Pre-test counselling

Before referring the client for a pre-test counselling session, the IDU TI counsellor should prepare him/her for the test by educating him/her about its significance and implications. When recommending HIV testing and counselling, the counsellor needs to provide the client with the information listed in Figure 3 given in the previous section.

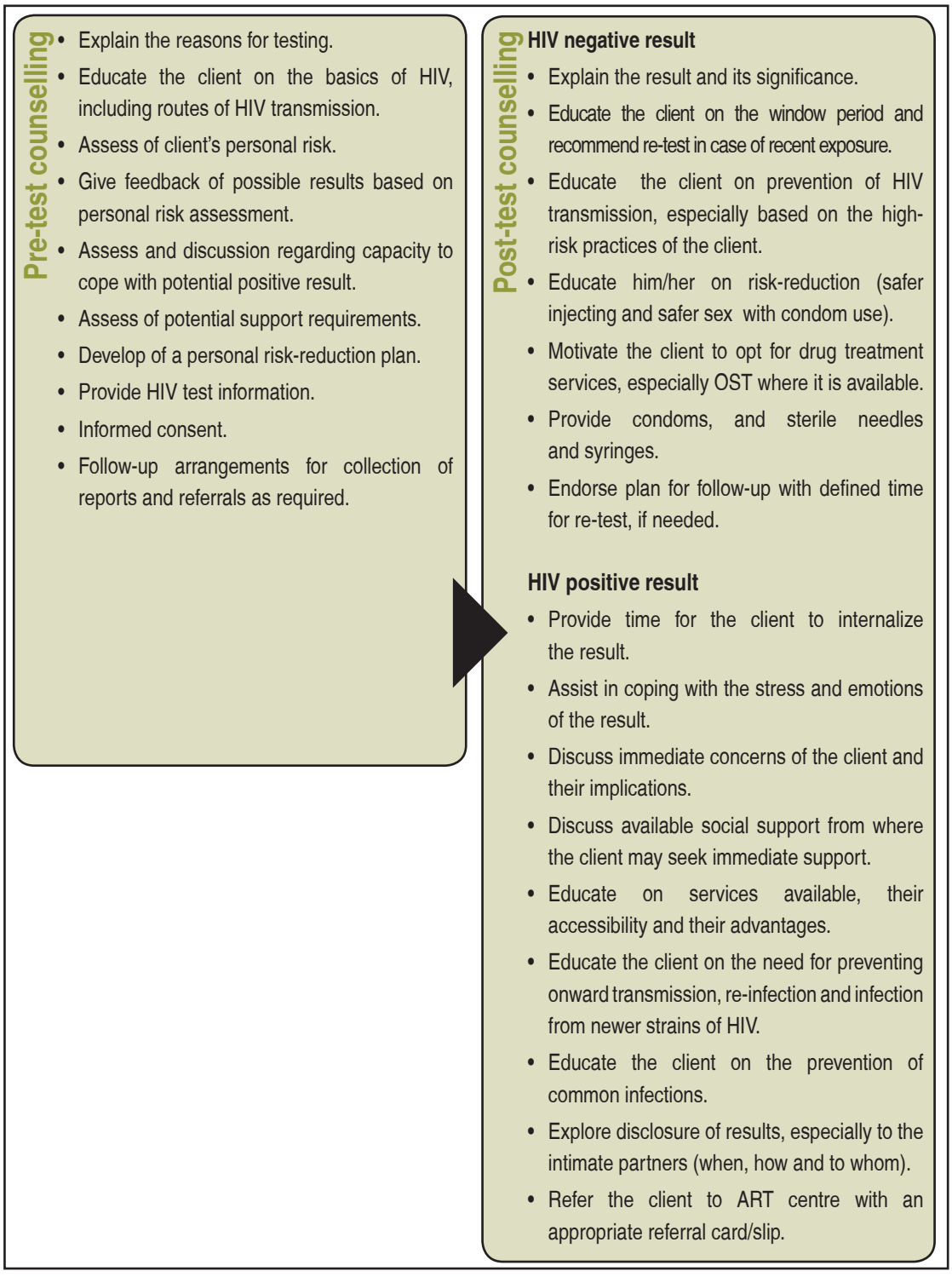

Figure 4. Pre- and post-HIV test counselling by ICTC counsellor

Post-test counselling

IDUs have a lower capacity for dealing with stress, especially when the test result is positive. Care should be taken to ensure that the IDU is not at risk of harming himself/herself by overdosing on drugs or attempting suicide upon receiving the result. Negative results may also lead to overdose when he/she tries to celebrate. The best way to avoid such situations is by conducting a suicide risk assessment in individual counselling sessions. In addition, support from the IDU's family members/peers should be sought if there are indications that the client may

harm himself/herself. Finally, if needed, the services of a mental health expert (psychiatrist/psychologist) should be sought. Peer support is usually helpful in such cases.

The client is within his/her rights to refuse the test results, but the counsellor should make reasonable attempts to ensure that the client receives his/her results and is able to understand its significance.

In case the result is negative, the IDU TI counsellor should:

- Re-educate the client on the window period and recommend periodic re-testing in case of repeated high risk exposure. Educate the client on the prevention of HIV transmission, especially on the client's high-risk practices.
- Educate the client on risk reduction (safer injecting and safer sex with condom use).
- Motivate the client to access drug treatment services, especially OST, where it is available.
- Provide condoms, and sterile needles and syringes.
- Endorse plans for follow-up with a defined time period for a re-test, if needed.

In case the result is positive, the IDU TI counsellor should in addition:

- Assist the client in coping with the stress and emotions of the result.
- Explore disclosure of results, especially to the intimate partners (when, how and to whom).
- Motivate the client for testing and counselling of intimate partners and children.
- Advise on other tests (like liver function, Hepatitis B and C, pregnancy, TB, etc.).
- Advise on referrals for treatment, care, counselling, support and other services, as required (e.g. screening and treatment of TB, prophylaxis for OIs, STI treatment, contraception, antenatal care, OST, Hepatitis B and C screening, and access to supplies of condoms and sterile needles/syringes).
- Assess the risk of violence, drug overdose or self-harm, including thoughts of attempting suicide, and discuss possible measures to ensure the physical safety of clients.
- Provide counselling on positive prevention and positive living.

The Project Manager of the IDU TI should liaise with the ICTC, especially the counsellor, to ensure effective and smooth referral of the IDU client to the ICTC. The Project Manager should look into possible stigma and discrimination issues at the centre and implement strategies to address them. These may involve sensitization programs, in collaboration with State AIDS Control Society (SACS) and other agencies, on harm reduction where ICTC staff members could also participate.

HIV support networks where buffers are required

Government ICTCs may not have enough time to administer the counselling that IDUs who are at HIV risk require. It is therefore, important that networking is done with PLHA groups to provide support and services as may be required by the IDU client. Members from the network may also be engaged to provide accompanied referral to the IDU client, especially if they are established within the TI.

Getting IDUs tested for HIV involves considerations as to how drug use can be managed while undergoing the test. In addition, people with no income and who require drugs are unlikely to allow the time needed

Counselling for HIV positive clients

Advise the IDU client on positive living, with focus on nutrition, adequate sleep and rest, maintaining hygiene, etc.

Most of the clients also use alcohol and are alcohol-dependent. It is important to educate the clients on the harmful effects associated with alcohol and the chances of liver toxicity as a result.

The client needs to be educated that continuing high risk behaviour when he/she is HIV positive will put him/her at a higher risk of increased viral count, co-infection with other diseases (including Hepatitis and STI), and thus early mortality. Risk reduction education must be provided to the client, including injection and sex related risk reduction.

Offer OST, if the client is willing to go for it. OST will help the client in stopping his injections as well as other opioid use. In addition, OST helps in improving physical health, increases access to other services as well as practice positive living. Hence, every client must be motivated to enroll for OST.

The client must be motivated to undergo regular follow-ups at the ART clinic, including regular testing his/her CD4 count.

for HIV testing to interfere with the drug using (including scoring) ritual. Severe morbidity, including infected abscesses or advanced TB, will make it unlikely that a person can travel by public transport. Such conditions should make considerations for fast tracking to OST services essential.

In case a client declines a test, extra care should be taken to see that he/she is not denied access to other services. Helping the client to contemplate the costs and benefits of testing, as opposed to not testing, for HIV should be facilitated with continued education and support to overcome barriers and fears. The client should never feel threatened at any point of time.

2.3 Service Point Three: ART Centre

Not every HIV positive client requires ART, but every IDU client detected as HIV positive should be registered at the ART Centre. This is because the decision to start ART depends on his/her CD4 cell count, the presence of opportunistic infections (OIs), and the presence of other conditions (e.g. pregnancy, hepatitis, etc.). After initial registration, the client will have to follow up regularly in the ART Centre, once in 3 to 6 months.

Depending on the CD4 count, viral load and OIs, the client may or may not need ART immediately. Till the time they require ART, the clients will need an array of services including treatment and care. If provided correctly and adhered to properly by the client, it can delay the initiation of ART, subsequent development of resistance to ART medication and help delay the progression of the disease, thereby reducing AIDS-related mortality.

PLHAs who do not need ART (or are not medically eligible for the initiation of ART) should be counselled to maintain healthy/positive living and should be linked to care and support services. The IDU TI counsellor plays an important role in providing counselling services. In addition, the PEs and ORWs of the TI should link the IDU client to a HIV positive support group, if such a support group exists in TI. Alternatively, linkage with a positive network in the city/district should be established, and the IDU client should be linked to the network.

Antiretroviral Therapy

Antiretroviral therapy medicines cannot eradicate HIV infection from the human body, but can delay the progress of the disease, prolong lifespan, and improve the overall quality of life. The optimum time to start ART is before the patient becomes unwell or presents with the first OI. As per the existing guidelines, ART medicines are initiated when the CD4 counts are below 350 cells/mm^3.

An important issue is to ensure that the clients initiated on ART medicines continue to take them on a daily basis (ART adherence). Non-adherence leads to drug resistance requiring the client to be moved from one regimen to another, thus limiting future treatment options. The TI counsellor in collaboration with the ART/ICTC counsellor plays a crucial role in this matter. As the TI has a good rapport and contact with the IDU client, the role of the IDU TI staff in ensuring adherence becomes much more crucial.

Though the exact number of IDUs on ART is not known, anecdotal evidence suggests that many IDUs do not have access to ART due to a number of reasons. In addition, IDUs may also be stigmatised and discriminated against by service providers, including those providing ART. It is also seen that there are misconceptions among service providers on the provision of ART. The misconceptions include:

- IDUs are poor candidates for ART treatment due to poor adherence.
- IDUs do not do as well as non-IDUs on ART.
- IDUs must be clean of drugs before initiating ART treatment.
- IDUs are seen as being non-compliant with the instructions given by the ART team, and hence it is a waste to start ART for them.

- Adherence to ART among IDUs is similar to non-IDUs. A large cohort study of more than 6000 patients across Europe in 1999 has found no difference in adherence between IDUs and non-IDUs.
- Studies have shown that even without special support or other services such as OST, IDUs have been able to show adherence rates of over 65%.
- The response to ART shown by IDUs is similar to non-IDUs in terms of the decrease in viral load or increase in CD4 counts after starting ART.
- Similar to other treatment strategies for IDUs, satisfaction of the IDU with the treatment provider is a greater predictor of ART adherence; willingness to start ART is associated with the patient's trust in the physician.
- HBV and HCV have limited impact on HIV disease progression. As per the latest ART guidelines, IDUs with active Hepatitis C are initiated on ART, irrespective of their CD4 count levels
- All IDUs who are medically eligible for ART should receive care and treatment as per the national guidelines.
- The criteria for initiating ART among IDU patients are the same as with other patients with HIV.
- Non-availability of OST or active use of illicit drugs should not bar access to ART for those in need of it.
- Provided with adequate support and easy accessibility, IDUs can adhere to ART and have outcomes similar to those of HIV patients not using drugs..

The IDU TI should make efforts to sensitize ART service providers on issues related to IDUs. A mechanism for regular interaction between the ART service providers as well as the IDU TI staff should be established and followed. Such interactions can be organized on a quarterly-basis through networking meetings. Some of the facts stated in the box can be used to address the myths/misconceptions among the ART service providers..

Homeless clients will require support to keep their "green" cards, provided as identity cards for ART services, safe. Some states offer additional support for the green card, so it is important to ensure that they are kept safely. Case histories are important for the selection of ART "regimens". The table in Annexure 2 provides a list of side effects of ART medicines, which should be explained to the clients. It is important to monitor the CD4 count to see the effectiveness of ART in reducing the load of HIV virus in the system. If the impact on the viral load is less, it is an indication that the regimen may need to be changed.

3. Care and Support for Co-morbid Conditions

IDUs suffer from a number of co-morbid conditions, some of which are life threatening. These include conditions such as TB, Hepatitis B and C. In addition, issues such as mental illnesses, poor nutrition, and poor social support including homelessness affect the IDU population, which contributes to both increased morbidity and mortality. Annexure 4 provides factsheets on TB, infective hepatitis (Hepatitis B and C) as well as some common mental conditions.

People living with HIV (PLHIV), due to their weakened immune system, become especially vulnerable to OIs. Prevention and treatment of OIs is an essential part of care for PLHIV. Some of the common OIs are Herpes, Pneumonia, candidiasis etc. Tuberculosis is the most common OI affecting more than 60% of PLHIV. Comanagement of TB and HIV infections is a challenging issue, complicated by concerns such as drug interactions, adherence and pill burden. People living with HIV (PLHIV), due to their weakened immune system, become especially vulnerable to OIs. Prevention and treatment of OIs is an essential part of care for PLHIV. Some of the common OIs are Herpes, Pneumonia, candidiasis etc. Tuberculosis is the most common OI affecting more than 60% of PLHIV. Co-management of TB and HIV infections is a challenging issue, complicated by concerns such as drug interactions, adherence and pill burden.

3.1 Addressing Co-morbid Conditions Among IDUs

In a TI setting, much of the focus is on ensuring that HIV prevention services are delivered to the IDU clients. However, for many IDUs, HIV may not be the most problematic issue that they are facing. They may be more concerned with other issues, including management of their drug problem, nutrition, shelter, and other physical conditions including TB and hepatitis. Addressing these other conditions will help in ensuring better uptake of HIV prevention services, which remains the focus of the NACP.

In such a case, it is important that the TI makes the services client-centric in order to improve the delivery of HIV prevention services. A number of services for these conditions are often available in the city where the TI operates. Establishing linkages with these service agencies/providers will help the TI in ensuring that these services are available to their IDU clients (Figure 5).

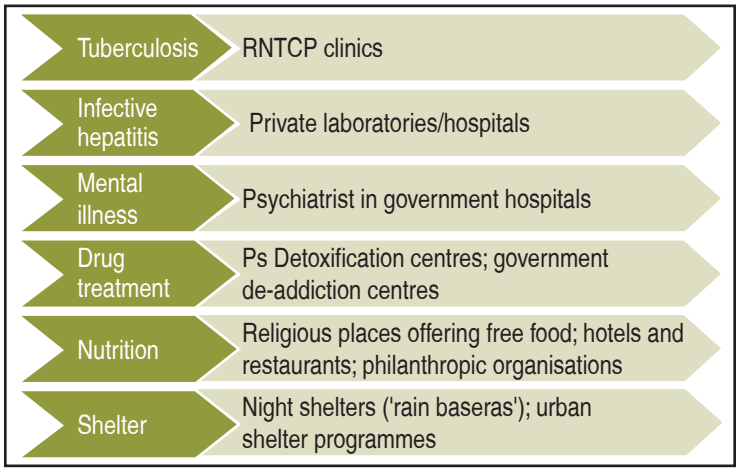

Figure 5: Sources of referrals for various co-morbid conditions among IDUs

3.2 Operationalizing Referrals and Linkages

Referral linkage mechanisms should be formally established with the agencies mentioned above. The following steps need to be taken for establishing the referral linkages.

Step One: Mapping the service agencies

During the mapping of hot spots, service agencies which are important for referrals (mentioned above) should also be mapped. The distance of these agencies from the hot spots/DIC should also be noted. Those agencies which are near the hot spots/DIC should be selected for establishing referral linkages.

Step Two: Establishing contacts with the service agencies

After identification of the service agencies, a senior member of the TI, which may include the Project Manager or the counsellor, should visit it. The key person and the contact person in the agency should be identified during the initial visit, and the objectives and purpose of establishing such linkages should be explained to them. Finally the details of the agencies in terms of their address, phone numbers, timing of operation, etc. should be collected.

Step Three: Preparing a referral register

A referral register should be prepared in the TI DIC using the information collected from Step Two above. The register should contain:

- Name of the agency
- Name of the contact person
- Address of the agency
- Time of operation
- Distance from the TI DIC

The information from the register should be displayed prominently on the DIC notice board as well as the counsellor's room. If possible, a copy should also be given to all the staff of the TI.

Step Four: Conducting a networking meeting

A meeting should be organized by the Project Manager of the TI in which the key persons of the referred agency should be invited to the TI DIC. During the meeting, the Project Manager should explain the nature of clients who are provided services through the TI, the goals and objectives of the TI, the nature of services provided, modalities of providing services, etc. Finally, support should be solicited from the referral agency and areas of mutual benefit (increased service uptake by the clients) should be stressed upon.

Once the linkages with the referred agencies are established, a system of referrals should be followed using appropriate and approved referral slips, ensuring accompanied referrals and mechanisms for checking whether the referrals are honoured. This is done by collecting the referral slips from the referred agencies. The referrals duly made should be entered in the referral register maintained for the purpose. This register should be maintained by the TI counsellor.

Step Five: Referral analysis

Every month, the Project Manager should go through the referral records and analyse the referrals made in the previous month. In addition, he should get feedback from his staff as well as the IDU clients on whether there are any barriers in accessing services in the referral agency. The achievements with relation to referrals should be discussed in the staff meeting, and a consensus should be reached on the challenges faced, if any.

The barriers/challenges for successful referrals should be addressed by the Project Manager through

subsequent networking meetings. If required, the senior NGO functionaries, Project Officers overseeing the supervision/monitoring of the TIs, or the District AIDS Program Officer/SACS Officers should be roped in to address any significant barriers to treatment access.

3.3 Supporting IDU Clients for Co-morbid Conditions

The IDU TI should prioritize the clients and services. Clients without any co-morbid conditions can be managed by providing outreach and DIC based services. For those with co-morbid conditions, referrals along with outreach and DIC based services are required.

Apart from referrals, the IDU TI staff should also follow up with the client to ensure that he/she has gained an understanding on the co-morbid conditions that he/she is suffering from. The counsellor and the outreach staff should regularly enquire with the client whether he/she is adhering to the treatment recommended by the referred agency. This is especially important for conditions such as TB and mental illness. In case of Hepatitis B, if the client is not Hepatitis B positive, Hep B vaccinations should be considered. (This is also important for the staff working in the IDU TI settings).

The intervention logic flow chart (Figure 6) provides a glimpse of the various service points of importance for the IDU clients.

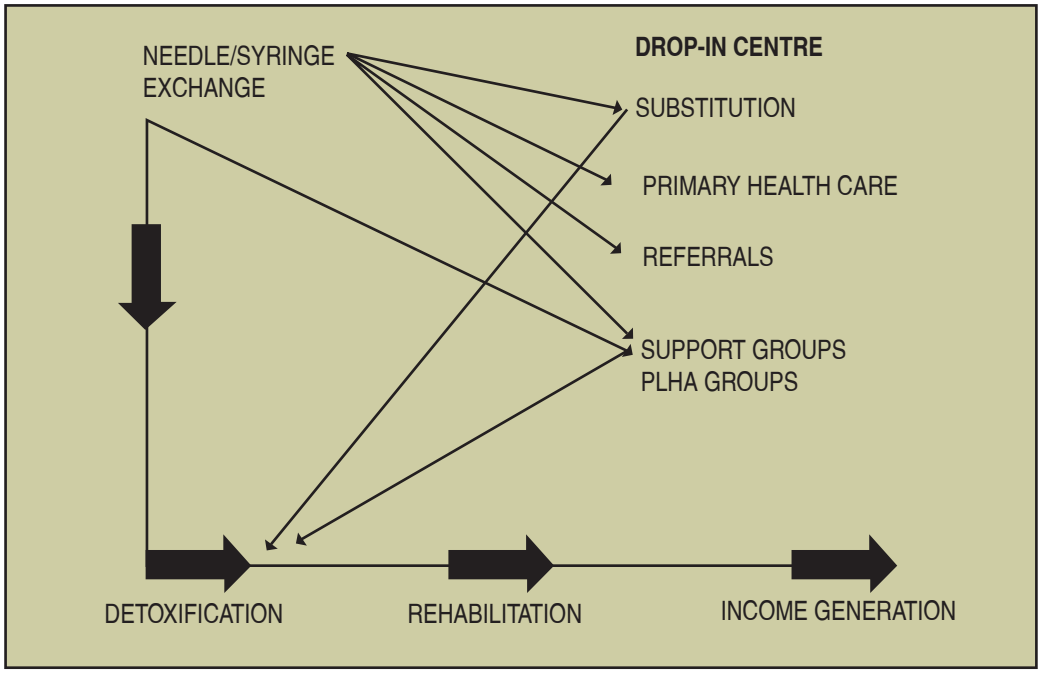

Figure 6: Intervention logic flow chart

4. Summary

Injecting drug users face a number of conditions due to their use of drugs through the injecting route. HIV is an important condition for which the TI has to take a number of steps to ensure that the client undergoes testing for HIV detection and subsequent ART medications, if found positive and eligible.

Addressing the HIV condition alone is not enough, as the client's felt need may be more weighted to other conditions that he/she suffers from. These conditions, such as TB, Hepatitis B, Hepatitis C, mental illness and other psychosocial conditions not only contribute to increased mortality and morbidity themselves, but also determine the outcome of HIV illness and treatment. As the TI is often the first point of contact for a majority of IDUs, the TI should ensure that effective referral and linkages are established with appropriate agencies.

Annexure 1: Guidelines on Initiation of ART in Adults and Adolescents (November 2011)

WHO Clinical Stage	Recommendations
HIV infected adults & adolescents (including pregnant women)	
Clinical Stage I and II	Start ART if CD4 count< 350 cells/ mm^2
Clinical Stage III and IV	Start ART irrespective of CD4 count
For HIV and TB co-infected patients	
HIV and HBV/HCV co-infected – without any evidence of chronic active Hepatitis	Start ART if CD4 count < 350 cells/ mm^2
HIV and HBV/HCV co-infected – with documented evidence of chronic active Hepatitis	Start ART irrespective of CD4.

Clinical Staging of HIV by WHO

Stage 1

- Asymptomatic
- Persistent generalized
- Lymphadenopathy

Stage 2

- Unexplained moderate weight loss (<10% of presumed or measured body weight)
- Recurrent respiratory tract infections (sinusitis, tonsillitis, otitis media, pharyngitis)
- Herpes zoster
- Angular cheilitis
- Recurrent oral ulceration
- Papular pruritic eruptions
- Seborrhoeic dermatitis
- Fungal nail infections

Stage 3

- Unexplained severe weight loss (>10% of presumed or measured body weight)
- Unexplained chronic diarrhoea for longer than one month
- Unexplained persistent fever (above 37.5oC intermittent or constant for longer than one month)
- Persistent oral candidiasis
- Oral hairy leukoplakia
- Pulmonary tuberculosis

contd...

- Severe bacterial infections (e.g. pneumonia, empyema, pyomyositis, bone or joint infection, meningitis, bacteraemia)
- 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)

Stage 4

- HIV wasting syndrome
- Pneumocystis pneumonia
- Recurrent severe bacterial pneumonia
- Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration or visceral at any site)
- Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)
- Extrapulmonary tuberculosis
- Kaposi's sarcoma
- Cytomegalovirus infection (retinitis or infection of other organs)
- Central nervous system toxoplasmosis
- HIV encephalopathy
- Extrapulmonary cryptococcosis including meningitis
- Disseminated non-tuberculous mycobacteria infection
- Progressive multifocal leukoencephalopathy
- Chronic cryptosporidiosis
- Chronic isosporiasis
- Disseminated mycosis (extrapulmonary histoplasmosis, coccidiomycosis)
- Recurrent septicaemia (including non-typhoidal salmonella)
- Lymphoma (cerebral or B cell non-Hodgkin)
- Invasive cervical carcinoma
- Atypical disseminated leishmaniasis
- Symptomatic HIV associated nephropathy or symptomatic HIV associated cardiomyopathy

Source: NACO, 2011

Annexure 2: Monitoring Patients on 1st Line ART for Failure

The principles of monitoring patients on first line ART are:

- **Clinical monitoring and staging** at each visit as per NACO guidelines
  - Do clinical staging at each visit: Use the T staging for clinical events (*see* Table 4).
- **Immunological monitoring:** Ensuring that routine monitoring laboratory tests are done e.g. CD4 count every six months.
- **Adherence support and monitoring** to ensure >95% adherence
  - Check for progress of improvement at each visit and check weight
  - **Screen for TB:** Ask for symptoms and signs of TB e.g. fever, weight loss, night sweats, haemoptysis
  - Determine if Cotrimoxazole is required or not, based on CD4 count

Table 1: National ART Regimen

National ART Regimen	Regimen	Remarks	To be made available at
Regimen I	Zidovudine + Lamivudine + Nevirapine	"Preferred regimen"	All ART centres
Regimen I (a)	Stavudine* + Lamivudine + Nevirapine	For patients with Hb< 8 gm/dl	
Regimen II	Zidovudine + Lamivudine + Efavirenz	Preferred for patients on anti-TB treatment and Hb> 8gm/dl	
Regimen II (a)	Stavudine* + Lamivudine + Efavirenz	For patients on anti-TB treatment and Hb< 8 gm/dl	
Regimen III	Tenofovir + Lamivudine + Nevirapine	For patients not tolerating ZDV or d4T on a NVP-based regimen	Refer to SACEP for decision. Drug supply mechanism to be decided
Regimen III (a)	Tenofovir + Lamivudine + Efavirenz	For patients not tolerating ZDV or d4T on a EFV-based regimen	
Regimen IV	Zidovudine + Lamivudine + Lopinavir/Ritonavir	For patients not tolerating both NVP and EFV, and Hb>8gm/dl	Centres of Excellence
Regimen IV (a)	Stavudine + Lamivudine + Lopinavir/Ritonavir	For patients not tolerating both NVP and EFV and Hb<8 gm/dl	
Regimen V	Tenofovir + Lamivudine + Lopinavir/Ritonavir + Zidovudine	Preferred	
Regimen V (a)	Tenofovir + Lamivudine + Lopinavir/Ritonavir	For patients with anaemia Hb<8 gm/dl	

Annexure 3: Referral Card

Form H: Referral Slips

1 **(Slip for Facility/Referral Center)**
Name of the Project/TI
Address

Client I.D. No.: _____ Slip Number:
Referred to which type of Facility: _____
Name of the Facility: _____
Address of the Facility: _____
*Referred by (Name): _____
Date of Referral: _____
Reason for Referral: _____
Syphilis Results: _____
Name of the accompanying person (if any): _____

(Signature of the TI staff-in-charge) (Signature of the staff-in-charge of the referral centre)

2 **(Slip for NGO/TI)**
Name of the Project/TI
Address

Client I.D. No.: _____ Slip Number:
Referred to which type of Facility: _____
Name of the Facility: _____
Address of the Facility: _____
*Referred by (Name): _____
Date of Referral: _____
Reason for Referral: _____
Syphilis Results: _____
Name of the accompanying person (if any): _____

(Signature of the TI staff-in-charge) (Signature of the staff-in-charge of the referral centre)

3 **(Slip for Client)**
Name of the Project/TI
Address

Client I.D. No.: _____ Slip Number:
Referred to which type of Facility: _____
Name of the Facility: _____
Address of the Facility: _____
*Referred by (Name): _____
Date of Referral: _____
Reason for Referral: _____
Syphilis Results: _____
Name of the accompanying person (if any): _____

(Signature of the TI staff-in-charge) (Signature of the staff-in-charge of the referral centre)

*Referred by: ORW, PE, Counselor, ANM, Project Manager.

Annexure 4: Factsheets on Co-morbid Conditions

FACTSHEET ONE: TUBERCULOSIS

Tuberculosis (TB) is caused by bacteria *Mycobacterium tuberculosis*. TB usually affects the lungs, but it can affect any organ system of the body, including the lymph nodes, genito-urinary tract, bone, brain, spinal cord, skin, etc. TB is contagious and spreads through the airvia droplets coughed or sneezed by a person infected with active TB. If not treated, each person with active TB infects 10 to 15 people on an average every year.

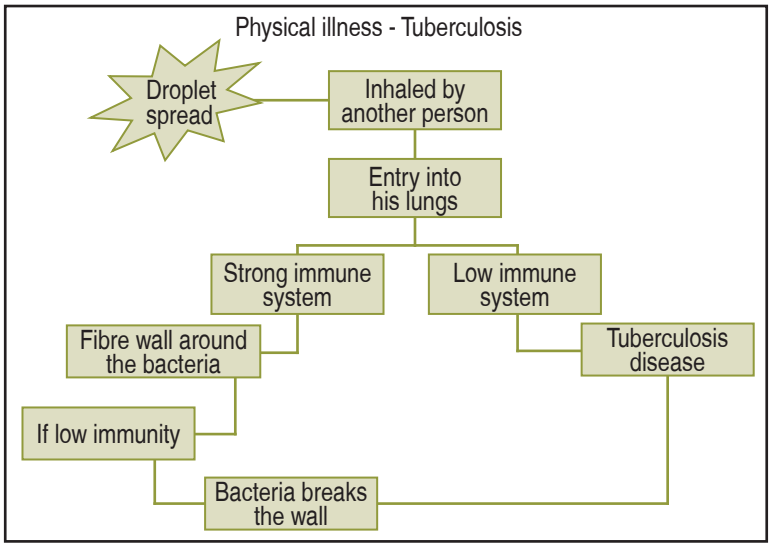

Figure 7: Spread of TB

Certain groups of individuals are at higher risk of contracting TB. These groups include the poor, the homeless, prison inmates and those infected with HIV. Injecting drug users have high chances of getting TB, as many of them have a history of homelessness, and poverty as well as incarceration. Also, drug use itself leads to a lowered immune response, increasing the chance of contracting TB.

- Generalized tiredness or weakness
- Weight loss
- Fever
- Night sweats
- Persistent cough
- Chest pain
- Coughing up of sputum (material from the lungs) and/or blood
- Shortness of breath

The diagnosis of TB is based on symptoms, along with microscopic examination of the sputum (for detecting the presence of TB causing bacteria) and other investigations such as chest X-rays and skin tests (Monteux skin test). The duration of treatment depends on the organ involved, as well as the resistance to the medicines prescribed. In the case of pulmonary TB, the duration of treatment is 6 months. The patient becomes non-infectious (i.e. not able to infect others with TB) within three weeks of starting treatment. The medicines to treat TB are dispensed as DOTS i.e. "Directly Observed Treatment, Short-course", which is the internationally recommended strategy to treat TB. This ensures increased adherence to the treatment, and aims to decrease TB-related morbidity, prevent TB deaths, and decrease TB transmission.

Multidrug-resistant TB (MDR-TB) is a form of TB that is difficult and expensive to treat and fails to respond to standard first-line drugs (such as isoniazid and rifampicin). Non-compliance to the standard first-line drugs is the most common reason for the development of MDR-TB.

Tuberculosis is more commonly associated with PLHIV and **is a leading cause of mortality among people with HIV.** HIV weakens the immune system, increasing the likelihood that an individual will become infected and develop active TB. People who are HIV-positive and infected with TB are 20 to 40 times more likely to develop active TB than people not infected with HIV.

FACTSHEET TWO: INFECTIVE HEPATITIS, INCLUDING HEPATITIS B AND C

Hepatitis, simply means, inflammation of the liver (Hepato=liver; itis= inflammation). The liver is one of the body's vital organs. Some of the main functions of the liver include processing food to convert it into energy, neutralizing toxins and other drugs entering the body, storing iron and other important vitamins, fighting infections and also producing important proteins.

The liver is inflamed if it is affected by toxins or attacked by organisms from outside. The common causes of hepatitis include alcohol, other chemicals, and viral infections. There are five types of viruses causing hepatitis, which are labelled Hepatitis A, B, C, D and E. The mode of transmission and the severity of infection depend on the type of virus that has infected the liver. The table below depicts the mode of transmission as well as the severity of infection of the different types of hepatitis viruses on human body:

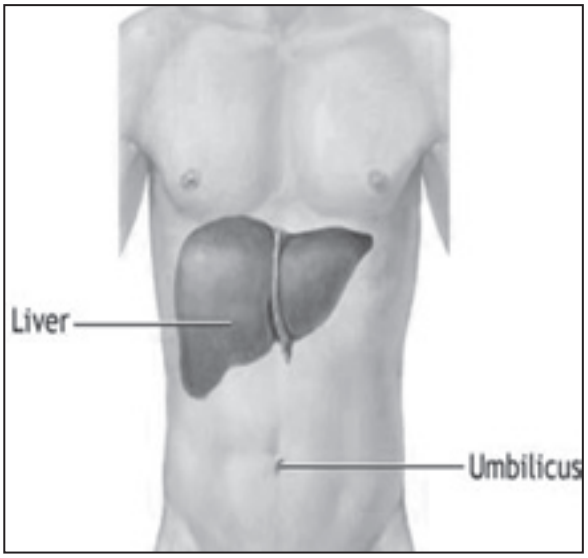

Figure 8: A sketch of the liver in the human body

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 only	Worsens prognosis of Hepatitis B
E	Unhygienic food	Poorer than Hepatitis A

Figure 9: Mode of transmission and prognosis of different types of hepatitis viruses

Hepatitis B

Hepatitis B is transmitted through contact with infected blood or body fluids including saliva, semen, vaginal secretions, and breast milk. The virus can be transmitted through sexual activity, unsafe injecting practices, sharing contaminated objects that pierce the skin (such as needles, tattoo equipment, body-piercing equipment, acupuncture equipment and razor blades), sharing toothbrushes, and from infected mother to her baby.

The acute illness usually lasts from 1 to 3 weeks, but it may also continue for several weeks. Most adults (95%) recover completely from Hepatitis B, and only 5% develop chronic Hepatitis B. About 25% of those with chronic hepatitis develop serious liver disease, including cirrhosis and liver cancer.

Hepatitis C

Hepatitis C infection is a major concern among IDUs. Globally, it is estimated that at least 50% of the IDUs are infected with Hepatitis C in 49 of the 57 countries, where data for HCV was available. In India, the prevalence of Hepatitis C among IDUs ranges from 5–93%.

Transmission of Hepatitis C

In the majority of the cases, Hepatitis C is transmitted through contaminated injecting equipment. Among IDUs, Hepatitis C is transmitted due to the practice of sharing contaminated needles and syringes. Transmission can also occur during the process of drug preparation and injecting, through the sharing or re-using of other contaminated injecting items such as mixing spoons, swabs, water, needles, syringes, syringe plungers and tourniquets; hands and surfaces used for mixing can also become contaminated, which can be a source of transmission

The Hepatitis C virus is also transmitted through the transfusion of infected blood or blood products when a person undergoes blood transfusion. In addition, invasive procedures such as tattooing, body piercing, and acupuncture can cause Hepatitis C, if contaminated equipment is used in the procedure. Though the Hepatitis C virus is also found in other body fluids, the concentration of the virus is too low for it to be transmitted through these body fluids. Hepatitis C can also be transmitted from infected mothers to their babies, though the risk is only 5%. The chance of transmission of Hepatitis C through the sexual route is very low, though the possibility exists.

Stages of Hepatitis C infection

- Acute infection: Soon after being infected with the Hepatitis C virus, some individuals experience symptoms of a liver infection called “acute hepatitis”. The symptoms include fatigue, loss of appetite, muscle aches or fever.
- In 25% of the patients, the virus is cleared from the body without medical intervention within 2–6 months of infection.
- The remaining 75% of the patients move to the next stage of infection called “chronic hepatitis”. It is estimated that among those with chronic Hepatitis C: about 45% do not develop liver damage; 30-40% develop mild liver damage; 10-20% develop liver cirrhosis and 1-5% develop liver failure or liver cancer. The symptoms of liver cirrhosis include weakness, loss of appetite, weight loss, jaundice, and breast enlargement in men, appearance of a rash on the palms, tendency to bleed easily, and spider-like blood vessels on the skin. Liver cirrhosis may result in gradual liver failure characterized by increased jaundice, collection of fluid in the abdomen, enlarged spleen, low haemoglobin and difficulty in blood clotting. Finally, confusion and coma may occur.

Diagnosis of Hepatitis C

Hepatitis C is diagnosed by a number of blood tests and liver biopsy:

- Liver function test to detect liver enzymes in the blood
- ELISA test to detect Hepatitis C antibodies in the blood
- Viral load test to detect the presence and amount of HCV in the blood
- Blood test to detect the genotype of HCV
- Liver biopsy to estimate the degree of the liver damage and the stage of the disease

Treatment of Hepatitis C

Not everybody requires treatment for Hepatitis C infection. The need for treatment depends on the outcome of the tests that are listed above. Given below are the treatment options for those who need it:

- Pegylated Interferon: given as subcutaneous injections once a week.
- Ribavarin: an antiviral agent, given orally and to be taken daily.

Usually a combination of treatments is given. The duration of treatment depends on the genotype of the virus, and ranges from 24-48 weeks. Both Pegylated Interferon and Ribavirin produce a number of side effects. Not everybody who undergoes treatment is successfully cured of the virus; the success rate is only 30-40%. Currently, the treatment is very expensive, and patients may require more than one cycle of treatment to be completely cured.

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Notes