

## Fifth Week's Sessions

Fifth week's sessions	Time
Recap of previous session.	15 min
Debriefing experience of training peer group members through the experiential learning cycle – positive reinforcement by recognition.	30 min
Problems faced by a drug user with a focus on social consequences.	30 min
*****	
<i>The following sessions need to be structured depending upon the composition of the group. Discuss the risks associated with the drug(s) used by the group.</i>	
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<b>Opioid users</b>	
Risks associated with opioid use.	
Overdose of opioids – introduction to first aid and transfer to emergency health care.	30 min
<i>Alternate session for injecting drug users:</i>	
Risks associated with Injection Drug Use - Risks associated with non-aseptic injecting in general, risks of direct and indirect sharing.	30 min
Risk reduction (Using bleach – demonstration and practice).	
<i>Alternate session for opioid users:</i>	30 min
Self-assessment of risk.	
Introduction to drug substitution.	30 min
	30 min
<b>Alcohol users</b>	
<i>Alternate session for alcohol users:</i>	
Consequences of alcohol/cannabis use – Risks associated with alcohol use, overdose, consequences of use of spurious alcohol (e.g., methanol).	60 min
Self-assessment of risk.	
Introduction to drugs as deterrents to alcohol use.	
*****	30 min
Winding up:	
<ul style="list-style-type: none"> <li>• Motivation to train peer group members and act as a role model,</li> <li>• Goal setting for service to peer group over the next week,</li> <li>• Goal setting for change in self based on behaviour change communication hierarchy.</li> </ul>	15 min

## Recap and Preliminaries

### **Activity 1: Recap of previous session.**

#### **Objectives:**

- To begin the day with a prayer reinforcing one's limitations,
- To revise the previous week's sessions and correct any misperceptions,
- To sharpen one's presentation skills,
- To develop leadership skills.

**Material needed:** None.

**Time:** 15 minutes.

**Methodology:** Group activity followed by a presentation and discussion.

#### **Procedure:**

1. Request a volunteer to lead the group in the serenity prayer.
2. Request the participants to hold hands and repeat each line of the serenity prayer after the leader.
3. The group members greet each other.
4. The group member who volunteered to recapitulate the previous week's sessions is requested to make his / her presentation.
5. Members clap in appreciation of the presentation.
6. Group members are encouraged to add what is missed/correct any inaccurate narration.
7. The facilitator corrects any incorrect narration, and requests anyone to ask for clarification.

## Debriefing and Recognition

### **Activity 2: Debriefing experience of training peer group members through the experiential learning cycle – positive reinforcement by recognition.**

#### **Objectives:**

- To debrief the experience of each participant in narrating previous week's lesson to his/her peer group members,
- To debrief the experience of each participant in acting as a role model of change,
- To elicit information about change in self or others,
- To give genuine appreciation of the positive role-played by select participants.

**Material needed:** None.

**Time:** 30 minutes.

**Methodology:** Debriefing following the experiential learning cycle.

**Procedure:**

1. The facilitator explains the purpose of this session to the participants.
2. Each member is requested to relate his/her experience in narrating previous week's lesson to his/her peer group members, followed by his/her experience in acting as a role model of change.
3. The facilitator enquires about change in self or others from each participant.
4. The group claps in appreciation of each member's sharing.
5. While debriefing, the facilitator focuses on the feelings generated in the peer volunteer while educating peer groups members and acting as a role model.
6. The facilitator recognises and expresses appreciation for genuine efforts made by selected group members and encourages all to make sincere efforts towards the success of the programme.

### Social consequences of a life on drugs

### **Activity 3: Problems faced by the drug user with a focus on social consequences**

**Objectives:**

- To introduce the participants to problems faced by the drug user (focusing on the substance used by the group) with a focus on social consequences.
- To introduce the participants to risks taken by the drug user and his or her peer group members (focusing on the substance used by the group).

**Material needed:** Blackboard/whiteboard/flip chart with appropriate markers.

**Time:** 30 minutes.

**Methodology:** Mind-mapping followed by discussion.

**Procedure:**

1. Draw a circle with the 'drug user' in the middle.
2. Recapitulate the consequences of drug use from the first week's training.

**Notes for the facilitator:**

The facilitator records the responses unchallenged and unmodified in different areas of the board reserved for different areas of concern, knowing that the responses would be in the areas of health, family problems, legal problems, problems with the community, problems of obtaining drugs, etc.

3. With a focus on the area of social and family issues, brainstorming brings out the social consequences of substance use (focusing on the substance used by the group).
4. Keep listing responses on the board according to a pre-determined area for different topics.
5. At the end of the exercise, suggest any social consequence that has not been enumerated by the group.

**Notes for the facilitator:**

Highlight the risk behaviour after a state of intoxication:

- Unsafe driving in a state of intoxication is responsible for a large number of accidents endangering the lives of those driving, those in the vehicle and those outside the vehicle;
- A state of intoxication results in impaired judgment leading to high-risk sexual activity;
- Drug addicts may exchange sex for drugs;
- Drug users often have poor nutrition and health practices that increase risk of disease and infection.

6. Ask for ways health hazards and social consequences can be reduced/prevented (focusing on the substance used by the group).
7. Ask for possible ways of seeking help, and the available health and social welfare services in the community.
8. Ask, ‘how does one work with law enforcement agencies, given that drug use, and possession of drugs by a user is a crime. Drug using paraphernalia, like needles/syringes, can be confiscated and used as evidence against the drug user’.

**Notes for the facilitator:**

Agencies engaged in peer-led interventions are required to seek official sanction from law enforcement authorities before operationalising peer-led interventions. Where agencies have involved law enforcement officials in committees of concern, obstacles to risk-reduction have been minimised.

The following are alternate sessions focusing on the substance used by the group. Select the appropriate section from the alternates provided.

## Alternate A. Sessions for all Opioid users

Overdose of opioids, first aid and getting help

### Activity 4A: Overdose of opioids

#### Objectives:

- To introduce the participants to signs and symptoms of opioid overdose as a likely risk of opioid use,
- To encourage the participants to keep the airway clean and get immediate help,
- To recapitulate the treatment centres available locally to manage opioid overdose.

**Material needed:** Blackboard/whiteboard/flip chart with appropriate markers.

**Methodology:** Mind-mapping followed by discussion.

**Time:** 30 minutes.

#### Procedure:

1. Explaining the purpose of this activity, ask if any participant has seen a drug user who has had an overdose of opioids.
2. Ask if they know how an overdose occurs.

#### Notes for the facilitator:

It is not the intention of this training programme to teach the management of overdose of opioids in any depth, but merely to alert the users into such an eventuality.

It is not the intention of this training programme to train the participants into first-aid techniques like mouth-mouth respiration. The concept can be taught and further training encouraged.

*Unintentional overdose* - Opioid use is characterised by tolerance. This means that the dosage of opioids needs to be increased to get the same effect of intoxication. Many drug users skip doses or switch to another drug when their preferred drug is not available. During this time the tolerance level decreases. The user upon returning to opioid use thinks that the dose taken previously is all right, and takes the dose he/she was used to. This results in an overdose.

3. Brainstorm for signs and symptoms of overdose.
4. Keep listing them on the board according to a pre-determined area for different topics.
5. Complete the list if anything has been skipped.

**Notes for the facilitator:**

Respiratory depression: Breathing difficulty.

Altered level of awareness of self or surroundings.

Unconsciousness: Not responding to painful stimuli.

Pin-point pupils.

Exclude possible head injury causing unconsciousness not caused by opioid overdose.

6. Could the unconsciousness in the drug user be caused by something other than opioid overdose? Look for signs of injury, especially the back, neck and head.
7. Alert the participants to the possibilities of swallowing vomitus by the unconscious person. Turning an unconscious person on the side and cleaning the airway (nose and mouth) could prevent the swallowing of vomitus and improve breathing.
8. Ask the participants whether they know where emergency medical care is available and how they can access this care.
9. Encourage them to ask for as many assistants as possible. An overdose cannot be managed alone.
10. Encourage them to send for expert medical help.
11. Discuss ways to prevent the risk of overdose from occurring.

Alternate session for 'ever' injecting opioid users:

## **Activity 5A: Risks associated with injecting drug use**

### **Objectives:**

- To understand the terminology associated with injecting drug use,
- To understand direct and indirect sharing,
- To understand risk reduction hierarchy,
- To explore the myths and facts related to HIV.

**Material needed:** Blackboard/whiteboard/flip chart with appropriate markers, syringe and needle.

**Time:** 30 minutes.

**Methodology:** Brainstorming followed by discussion.

### Procedure:

1. Request injecting drug users to demonstrate how they prepare the drug for injection, fill the syringe with the drug and how they inject themselves (or others).
2. Elicit the terminology used locally for the various aspects of injecting drug use .

#### Notes for the facilitator:

Make a special note (for example, as listed in the following page) of the following before the training session :

Drug used: single drug used or more than one drug mixed (cocktail);

Local names of drugs;

Method of preparing the drug for injecting;

Method of sharing prepared drug while loading the syringe;

Method of injecting the drug.

3. Complete the list if anything has been skipped.
4. Recapitulate the first week's session on infection and modes of transmission.
5. Highlight direct and indirect sharing and the potential for harm.

#### Notes for the facilitator:

While pooling their money to purchase drugs, many injectors jointly prepare and share drugs. The process of preparing and injecting drugs and the various items of equipment used provide many opportunities for transmission of HIV and other pathogens. Make a special note of:

Preparing the drug – how is the powder obtained (for example some drug users open a capsule to take out the powder)?

While the participant is demonstrating the preparation and sharing of drug note any direct or indirect sharing.

**Direct sharing:** When the same needle/syringe is used for injecting more than one person.

**Indirect sharing:** When different users having their own syringes load their syringes from a common pool of prepared drug:

- Injectors prepare the drug using common injection paraphernalia, such as cooker, cotton, and spoon that others have used. The prepared drug is contaminated without actually passing a syringe and/or needle from one person to another.

6. Highlight possibility of infection if injection site is not being prepared aseptically.
7. Highlight the probability of sepsis if needle is not aseptic or handled carelessly and contaminated.
8. Highlight risks involved for transmission of disease.

<b>Find out the local names for the following before the session starts:</b>	
<b>Words:</b>	<b>Meaning:</b>
	High on drugs.
“Maal”	
“Dum”, “Ganja”	Cannabis.
C.A.T.	Combination of Calmpose (a brand name of diazepam), Avil (a brand name of chlorpheniramine) and Tidigesic (a brand name of buprenorphine).
P.A.T.	Combination of Phenergan (a brand name of promethazine), Avil and Tidigesic.
Cooker	Drugs like heroin must be dissolved in water and heat is used for this process. The drug is heated in a spoon or a bottle cap, referred to as “cooker”.
Cotton	Some drugs are available as powders or tablets. If the drug has to be injected, it is dissolved in water with other additives to convert it into an injectable form. The drug may not dissolve completely. To remove the sediment it is filtered through a piece of cotton and then injected.
Registering	To ensure that the needle is in the vein for an intravenous injection, the injector pulls back the plunger to see if blood enters the syringe. This is called “registering” and this process contaminates the syringe with blood.
Booting	To make sure that all the drug is completely injected from the syringe into the vein, the injector pulls the plunger many times, drawing the blood and re-injecting it. Booting increases the presence of residual blood in the syringe.
Front Loading	The drug is carefully squirted into the front of each person’s syringe that still has the plunger in it but from which the needle has been detached.
Backloading (Piggy-backing)	A single sterile syringe can be used to draw up equal amounts of the liquid drug that can be carefully squirted into the back of each person’s syringe after the plunger has been removed.
Shoot, Fix, Boost, Run	To inject drugs.
Rig	Syringe, needle.
Track	Injection mark.
Rush	The initial sensation felt when a drug is injected.

**Notes for the facilitator:**

Risks specific to injecting drug users:

- IV users share needles, syringes, drugs and drug paraphernalia,
- The illicit drugs used by injecting drug users often carry bacterial and fungal contaminants.

A variety of other medical complications also occur as a result of injection practice:

- Subcutaneous abscesses (pus formation under the skin),
- Cellulitis (inflammation of the skin),
- Septicaemia (blood poisoning; pus forming micro-organisms are present in blood),
- Endocarditis (infection of heart valves),
- Hepatitis (inflammation of the liver).

9. What is the risk-reduction hierarchy for injecting drug users?

**Notes for the facilitator:**

*Hierarchy of Risk Reduction Strategies for IDUs*

- Stop using drugs (Enter detoxification and rehabilitation service).
- Stop injecting drugs (If drug taking continues, switch to non-injecting mode of intake).
- If injecting practice continues:
  - Never re-use or share syringes, water or drug preparation equipment,
  - Use only syringes obtained from reliable sources,
  - Use a new, sterile syringe to prepare and inject drugs,
  - Use sterile water to prepare; else obtain clean water from a reliable source,
  - Use a new or disinfected cooker and cotton to prepare drugs,
  - Clean the injection site prior to injecting with a new alcohol swab,
  - Safely dispose off syringes after one use.

10. Explore the myths and facts related to HIV.

**Notes for the facilitator:**

*Risk behaviours:*

Myths and facts regarding risk behaviour must be addressed. One myth is that people affected by HIV can be identified. Reviewing behaviour that place people at risk for HIV/AIDS and discussing personal risks can help determine which risk-reduction strategies may be most appropriate for a particular individual.

## Activity 6A: Risk reduction - Demonstration of using bleach to disinfect a needle/syringe – 3 x 3 x 3 method

### Objectives:

- To demonstrate the use of bleach to clean a needle/syringe – 3 x 3 x 3 method
- To allow the participants to practice using the 3 x 3 x 3 method.

**Material needed:** Syringes and needles (as many number as the number of participants), full-strength bleach, tumblers filled with water.

**Time:** 30 minutes.

**Methodology:** Demonstration followed by a practice session.

### Procedure:

1. Inform the participants if injecting use has to continue, the ideal would be for each user to use a fresh sterile syringe/needle for each use. List out any needle/syringe programme available or enquire whether a medical practitioner would assist in legally purchasing sterile needles/syringes.

### Notes for the facilitator:

*Needle Syringe Exchange Programmes (where legal and available)*

- The primary role of needle-syringe programmes is to distribute sterile injecting equipment to IDUs; and remove used and potentially contaminated injecting equipment from circulation, thereby removing the possibility of further use. Bleach is also provided.
- To provide a point of contact with IDUs for dissemination of IEC material about safe injecting and about prevention of sexual transmission.
- Needle-syringe programs can also become contact and referral points for counselling, primary health care and drug treatment services.

2. Inform the participants that using bleach to clean their syringe and needles does not guarantee safety from HIV. Using other detergents may not be safe for their health.
3. Take a sterile syringe and needle and demonstrate how a syringe is taken out aseptically after inspecting that the package, which contained the syringe, is intact.
4. When a sterile syringe is not available, the 3 x 3 x 3 method may be used to clean a syringe/needle.
5. Fill a syringe from a fresh source of water (if sterile water is not available). Shake the syringe and count for thirty seconds.

### Notes for the facilitator:

It often surprises the participants how long thirty seconds really is. Count aloud:

1. One thousand and one,
2. One thousand and two, and so on.

On the second refill with water, ask the participants to count the seconds in the above manner. This makes the activity fun and gives an experiential realisation of the duration of time required for each step.

6. Discard the water and refill the syringe with fresh water, shake and discard after thirty seconds. Repeat this step a third time.
7. Now fill the syringe with full strength bleach (If liquid bleach is available use full strength. If powder bleach is available, pour a spoon of powder bleach in a tumbler of clean water, and stir. Keep adding bleach a half- spoonful at a time, till on stirring all the bleach does not dissolve and some powder still remains in the glass).
8. Shake the syringe, and count for thirty seconds, and then discard the bleach. Repeat this process two more times.
9. Now fill the syringe with fresh water and repeat steps 5 and 6.
10. The syringe is now ready for a single use.
11. Highlight how this process is not expensive and can save several dangerous health hazards, including HIV, Hepatitis B, Hepatitis C and others.
12. Allow each user to practice using bleach.

### Session for both sets of opioid users

(Note: The session on drug substitution is made available for those sites where this treatment is available).

### Activity 7A: Self-assessment of risk and introduction to drug substitution

#### Objectives:

- To allow participants to assess their own risk behaviour,
- To discuss relapse into drugs after treatment,
- To provide knowledge of drug substitution as a interim measure to detoxification and rehabilitation,
- To provide information regarding where this treatment option is available,
- To introduce the concept of support groups for maintaining risk-reduction behaviour.

**Material needed:** Presentation given below made on an OHP slide / flip chart.

**Time:** 30 minutes.

**Methodology:** Interactive lecture.

**Procedure:**

1. Allow each participant to assess his / her own risk behaviour
2. Ask the participants as to their idea of an ideal treatment for substance use.

**Notes for the facilitator:**

While the ideal treatment of substance abuse is to give up all drugs through a process of detoxification followed by rehabilitation, some substance users may either not wish to opt for this treatment or may have relapsed several times after undergoing abstinence oriented treatment.

3. Ask participants to share their experience of having undergone treatment and relapse.
4. Enquire into the factors responsible for relapse. Ask, ‘does relapse start with the first use of drugs after a period of abstinence or does relapse start in the mind?’
5. Introduce drug substitution.

**Notes for the facilitator:**

Methadone maintenance has been practised in Nepal. Buprenorphine maintenance has been practised in India. However, at present, Methadone is not freely available in Nepal, while buprenorphine is expensive in India.

The cost of treatment of substance abuse may not be affordable by all. Attempt a parallel between cost of daily substance use with its consequences and cost of treatment for substance abuse.

6. Explain the following while reading out the suggested slides below, making sure that the participants have understood the terms.

Suggested matter for preparation of presentation on drug substitution:

**What is Drug Substitution?**

Drug substitution is replacing the drugs the user is taking with a similar drug. It may also mean using the same drug but taking it in a different way, for example, sublingual buprenorphine to replace injecting the drug.

### **Objectives of Drug Substitution:**

- To lessen the risk of contracting or transmitting HIV / AIDS,
- To switch users from illicit drugs of indeterminate quality, purity and potency to licit drugs of known purity and potency,
- To minimize the risk of overdoses and other medical complications,
- To switch from an injected to a non-injected substance,
- To reduce hazardous drug use e.g. sharing injecting equipment, poly-drug use,
- To reduce the motivation and need for addicts to commit crime,
- To maintain contact with drug users,
- To provide counselling, referral and treatment,
- To help drug users stabilize their lives and reintegrate with the general community.

### **Delivery:**

#### *Methadone:*

- Methadone is prescribed to eligible opioid dependents after an assessment by a doctor,
- Can be administered in a doctor's office,
- Within optimal doses, the toxicity is less – dosage is to be prescribed by a doctor, and can be collected from a pharmacy,
- Methadone can be administered on a long-term basis,
- Successful withdrawal from methadone is possible,
- Can be administered by a doctor, a pharmacist or a nurse.

#### *Buprenorphine*

- Buprenorphine is prescribed to eligible opioid dependents after an assessment by a doctor,
- Can be administered in a doctor's office,
- Thrice a week dose is as good as daily dose for considerable number of opiate dependents.

2. Ask the participants for any clarifications. Encourage the participants to seek further information from a substance abuse treatment specialist.
3. Introduce the concept of support groups necessary to maintain risk-reduction behaviour.

## Alternate B: Sessions for alcohol/cannabis users:

### Activity 4B: Consequences of alcohol/cannabis use

#### Objectives:

- To provide knowledge about alcohol / drug use and its relationship to HIV,
- To recognize alcohol / drug use as high risk factors in HIV transmission,
- To sensitive participants to the issues related to HIV and drugs and recognising the need to intervene.

**Material needed:** Two bowls with facts written on slips of paper (Sets A and B)

#### Set A:

- Spurious alcohol/alcohol containing methanol can damage the eyes and cause blindness.
- Heavy alcohol / cannabis use can reduce the number of white blood cells which are responsible for fighting infection leading to reduced immunity level.
- Those clinically diagnosed as alcoholics appear to be more prone to bacterial infections and certain forms of cancer.
- The individual's vulnerability to being infected with HIV increases if exposed to the virus.
- In those already infected with HIV, alcohol can speed up the course of the disease.

#### Set B:

- Alcohol reduces the inhibition and leads a person into high risk sexual activity. One who hesitates to make sexual overtures to a new partner or visit a sex worker may do so with less hesitation under the influence of alcohol.
- Alcohol acts as a depressant, affects perception and motor coordination, which interferes with the sexual act. In desperation to experience satisfaction the user may attempt other forms of sexual activity like anal sex. The poor coordination could further discourage condom use as the user may find it difficult to use a condom.
- Alcohol impairs the ability to process negative consequences of an action. There is a tendency to overlook risks. Even one who uses condoms routinely may not do so under the influence of alcohol. The user may pressurize or force the other to have sex when the other is unwilling.
- Heavy use of alcohol over a period of time impairs sexual performance. After giving up alcohol, a person wants to engage in sexual relationship but is doubtful whether he will be able to perform. In order to avoid failure in front of spouse, the user may visit sex workers to check his virility.

**Time:** 60 minutes.

**Methodology:** Group activity – true/false followed by corrections/amendments by group members/facilitator.

**Procedure:**

1. Divide the number of participants into two groups.
2. Have a bowl where the facts from Set A and Set B are written on slips of paper.
3. Allow each group to pick up two slips from bowl A.
4. Allow five minutes for each group to reflect on the facts.
5. Ask each group to read out one fact and then say true/false.
6. Ask the other group if they agree/disagree.
7. Correct the information if it is inaccurate/incomplete (Refer to the first week's session on infection/immune system, when necessary).
8. Repeat steps 3 to 6 till all the slips have been discussed.
9. Allow each group to pick up two slips from bowl B.
10. Repeat steps 4 to 9 till all the slips have been discussed.
11. Ask the participants what they learned from the above exercise.
12. Ask each participant if anything that happened in this session is unclear.
13. Ask the participants how they will apply this new learning in their lives.

**Activity 5B: Self-assessment of risk and drugs available as deterrents to alcohol use**

**Objectives:**

- To allow participants to assess their own risk behaviour,
- To provide knowledge of drug available as deterrents to alcohol use,
- To provide information regarding where this treatment option is available for maintaining sobriety.

**Material needed:** None.

**Time:** 30 minutes.

**Methodology:** Interactive lecture and discussion.

**Procedure:**

1. Ask each participant to assess his / her own risk behaviour.
2. Ask the participants as to their idea of an ideal treatment for substance use.

**Notes for the facilitator:**

While the ideal treatment of substance abuse is to give up all drugs through a process of detoxification followed by rehabilitation, some substance users may have relapsed several times after undergoing the ideal treatment.

3. Ask participants to relate their experience of having undergone treatment and relapse.
4. Ask what factors were responsible for relapse. Ask, ‘does relapse start with the first use of drugs after a period of abstinence or does relapse start in the mind?’
5. Introduce the concept of drugs prescribed by physicians as a deterrent to alcohol use.

**Notes for the facilitator:**

Disulfiram is available in select substance abuse treatment centres.  
Naltrexone is available in select substance abuse treatment centres.

6. Inform the participants where drugs as deterrents to alcohol use are available and to seek further information from substance abuse treatment specialists in these centres.

## Winding up

**Graded goal setting:**

1. Motivate peer volunteers to train their peer group members and act as role models.
2. Motivate peer volunteers to get their HIV status checked at the nearest VCT centre.
3. Reinforce the concept of graded goal setting as a method of behaviour change.
4. Goal setting for service to peer group over the next week: obtain a commitment from each participant to play the role of a person with a mission to reduce risk-taking behaviour in at least four peer group members and sharing today’s lesson with all persons in the peer group.
5. Goal setting for change in self - based on behaviour change communication hierarchy: obtain a commitment from each participant to reduce risk-taking behaviour in himself / herself.
6. Encourage those that have begun trial behaviour change to sustain the changed behaviour and recognise those that have sustained behaviour change.
7. Ask someone to volunteer to recapitulate the day’s sessions at the beginning of the next week’s training.
8. Form a circle with every one holding hands. Bid good-bye with the phrase: “keep coming back”.