



DRUG USE AND HIV/AIDS PREVENTION AND MANAGEMENT

Knowledge and
Skills Enhancement
for NGO Staff

Training Manual

June 2004



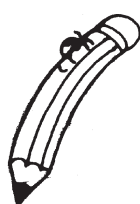
BACKGROUND AND OBJECTIVES OF THE HANDBOOK

The handbook focuses on the link between the spread of blood borne viral diseases and drug use, specifically HIV/AIDS and explores how present approaches to drug treatment services may need to be modified in response to the adverse health consequences associated with drug use.

This handbook is mainly intended for service providers who have worked in the field of drug ‘demand reduction’ under two ongoing programmes known as “Community Wide Drug Demand Reduction in India” and in the north eastern parts of India (Project No. E – 40 and E – 41). The intention of this training handbook is to act as an orientation for them on issues related to drug use and HIV/AIDS.



Readers of this handbook are encouraged to think about, and develop skills that will enable them to deliver HIV/AIDS prevention and care services more effectively. The key objective of this handbook is to reinforce existing capacity while providing new skills to deal with emerging challenges in the fields of HIV/AIDS prevention and care.



Structure of the Handbook

1. Drug Use Scenario

- ❑ Historical context of drug use in India
- ❑ Types of drug use and routes of administration
- ❑ Injecting drug use in India
- ❑ Brief overview of health consequences associated with drug use

2. Basics of HIV/AIDS and Universal Precautions

- ❑ The facts about HIV/AIDS
- ❑ Who is at risk?
- ❑ How can HIV infection be prevented?
- ❑ Stages of infection
- ❑ Window period
- ❑ Universal precautions
- ❑ How can transmission of HIV infection and AIDS be prevented?
- ❑ Post Exposure Prophylaxis (PEP)

3. HIV Counselling and Testing

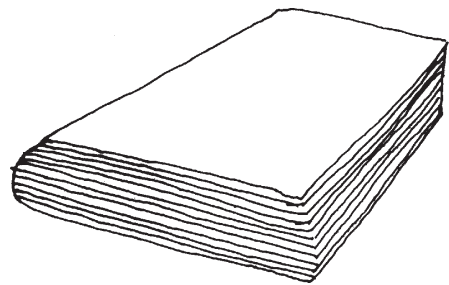
- Components of HIV/AIDS counselling
- Difference between health education and counselling
- What is the importance of counselling before HIV test?
- National HIV Testing Policy
- Steps in pre-test counselling (role plays)
- Steps in post-test counselling (role plays)
- Voluntary counselling and testing as a link between prevention and care
- Partner notification

4. Other Health Consequences Associated with Drug Use

- Overdose management
- Malnourishment and weight loss
- Acute and chronic bronchitis and respiratory disorder
- Tuberculosis management
- Abscesses
- Hepatitis B and C virus

5. Response to Drug Use and HIV Epidemic

- Background
- Stage 1:Prevention through education and awareness
- Stage 2:Intervention
- Stage 3:Treatment
- Condom provision
- Continuum of care
- Human rights issues





DRUG USE SCENARIO

- 1.1 Historical Context of Drug Use in India
- 1.2 Types of Drug Use and Routes of Administration
- 1.3 Injecting Drug Use in India
- 1.4 Brief Overview of Health Consequences Associated with Drug Use

1.1 Historical Context of Drug Use in India

Heroin in Asia¹

Asia has a history of opium production and oral consumption: Opium has been produced throughout South and Central Southeast Asia for centuries. The extracted opium from the opium poppies was fundamentally administered by smoking or inhaling and also ingested by mouth.

“Smoking or inhaling of drugs does not carry a direct risk of HIV transmission.”

The changes in the production and distribution patterns have exposed new populations to opiate use, and led to the introduction of injecting drug use (due to the availability of a high grade of heroin).

Geographically, India lies between two major areas producing opium for illegal markets:

- The South East Asian region of Thailand, Myanmar and Laos in Southeast Asia (Myanmar accounts for 70 percent of the estimated world opium poppy cultivation). The heroin produced in this region is commonly called ‘Number 4’ and is very pure. It is commonly injected, but it can be inhaled as well.
- The South West Asian region of Pakistan, Afghanistan, Iran and Turkey, possesses the largest poppy crop in the region (see Figure 1). The heroin from this area is commonly called ‘smack’ (brown sugar). It is not very pure and is most commonly inhaled, though it can also be injected.
- India is the largest producer of opium for medicinal use; some of this finds its way to the illicit drug trade, because of the potential price difference between government procurement price and the black market price. Conversion of opium to Brown Sugar is a viable and lucrative option for many, especially because it can be made quite simply.

¹ The information in this section has been taken from “ The Manual for Reducing Drug Related Harm in Asia (pp13-15)

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- Asia is witnessing a major epidemic of amphetamine use, with a small percentage of amphetamine users reverting to injecting.

Figure 1: Opium producing illegal markets area.



The Iran-Iraq war and the Russian invasion of Afghanistan also resulted in the routing of increased quantities of heroin through India for both local consumption and trafficking to other places during the late 1970s and through the 80s.

1.2 History of Drug Use in India

These substances (e.g. opium and cannabis) were used for:

- **Medical Purposes** – “India has a vast repertoire of home remedies and folk medicine practices, which use opium and cannabis extensively. Traditional systems of medicine such as *Ayurveda*, *Siddha*, *Unani* or *Tibbi*, also use opium in the form of paste applied for headaches, toothaches, inflammation and swollen joints. Suppositories of opium were used for disorders of the pelvic region; it reduced sensibility during the advanced stages of smallpox, and prevented relapse of malaria fever and controlled diabetes.”

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- **Religious Use** – Cannabis was consumed in Hindu and Sikh temples and at Mohammedan shrines; among fakirs, bhang is viewed as the giver of long life and a means of communion with divine spirit. The Prophet Mohammed (AD 570-632) did not explicitly prohibit the use of cannabis, but alcohol was not permitted; among the high caste Hindus, alcohol was prohibited, but cannabis use for festivals and ceremonies was sanctioned.
 - **Social and Functional Uses** – Various psychoactive substances were used in important social functions. The Rajputs used opium for marriage, for sealing an important business deal, to facilitate catharsis after the death of an immediate family member, for longevity and for enhancing sexual pleasure. They also used opium before engaging in battle and for sealing peace treaties.

“Historical information indicates that on certain occasions, cultural sanction was given to drug use in different parts of the country. This persists even to this day and can be seen in Orissa, Gujarat, Karnataka, Rajasthan and Himachal Pradesh.”

1.3 Injecting Drug Use in India

Injecting drug use has been increasing in India since the mid-late 1980s. This increase was identified in Manipur between 1988-89, in Delhi in 1991 (Sharan Report) and Chennai (earlier Madras) in 1987 (Kumar).

The specific factors causing the diffusion of injecting drug use, however, vary from place to place. Three factors, which interact that lead to the diffusion of injecting drug use are:

- The drug supply which is available in the area (e.g. type, quality, quantity, price and availability).
- Law enforcement activity (such as that arising from the NDPS Act’85 and amended in 88 legislation).
- Characteristics of the drug users (especially their socio-economic status and rising physical tolerance).

The table below attempts to represent how injecting drug use spreads throughout the drug using population.

Table 1: Estimates of the Current Extent of Injecting Drug Use

City	No. of IDUs	% of total opiate users
Chennai	11,000	50%
Delhi	27,000	25%
Imphal	13,000	>90%
Mumbai	6,000	15%

The above table shows that the number of injecting drug users in the metropolitan centers is around the same number of injecting drug users in Imphal, though the percentage of injecting drug users is much lower in each of these centers. It is clear that injecting drug use is not just a ‘problem of the North Eastern states’, as is sometimes thought.



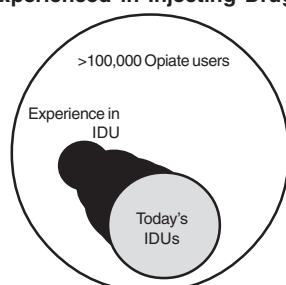
There are some important differences between drug use in the Northeast and drug use in the rest of India. For example, the drugs injected are different.

In Manipur, pure heroin is the predominant drug injected although spasmoproxyvon is injected by some. In other parts of India, a ‘cocktail’ of pharmaceutical drugs is most commonly injected. The cocktail often comprises of buprenorphine (a synthetic opiate), an antihistamine (such as Avil) and a sedative (such as Diazepam) though there are other combinations and drugs which are used. The people who inject this cocktail are mostly smack users before they begin injecting drug use.

Most of the opiate users in Imphal have injecting drug use as their primary mode of drug use. However, this is not necessarily the case, for those who have experience in injecting drug use in the Metropolitan centers. The RSA in both Kolkata and Delhi identified a significant population of drug users who had experience in injecting drug use, but who were not currently injecting. At the time of the assessment only 25 percent of drug users were injecting drug users. It also shows that around 50 percent of the drug users interviewed had experience in injecting drug use, though half of them were not currently injecting. This finding is consistent with Sharan’s experience of service provision in Delhi. The finding can be illustrated as follows:

Figure 2:

A Growing Population of People Experienced in Injecting Drug Use



1.4 Brief Overview of Health Consequences Associated with Drug Use

The World Health Organisation defines health as a “state of complete physical, mental & social well being” and not merely an absence of disease or infirmity. It envisages three dimensions or components of health - physical, mental and social all closely related. A fourth dimension has been suggested to be spiritual health.²

Due to physical, biological, psychosocial environment or multifactorial causation, a drug user is pre-disposed to certain disease conditions³. Apart from these, economics plays a major role in diseases and health seeking behaviour of any one, especially in the case of drug users. The drug users marginalization is often so complete that their health seeking behaviour is minimal.

The health consequences of psychoactive drug use depends on the interaction of two sets of variables – A) Characteristics of drugs and B) Type of consumer.

A) The Characteristics of Drugs

- Pharmacological properties
- Route of administration i.e. oral, snorting, inhalation, and injection
- Whether taken alone or in conjunction with alcohol or other drugs
- Level of purity of the drug and presence of adulterants
- Dosage level

B) Types of Consumer

- Personality of the user
- Intensity or frequency of previous use
- Users pre-existing state of health
- Social and economic circumstances of the user
- Users expectation of drug effect

The existence of so many variables means that different people will have different experiences. Some may have side effects and diseases due to drug use, some may not.

Injecting Drug Users

This group is most vulnerable to both viral and bacterial blood borne infections. The disease spectrum ranges from abscess, cellulites, damage to veins, gangrene, HIV/AIDS, and hepatitis viruses.

Some diseases associated with commonly used drugs.

² Park and Park – Text Book of Preventive and Social Medicine (XI edition)

³ Petten Kofer of Munich 1819 to 1901.

Opiates - (Drugs from Opium Poppy) can cause

- Difficulty in respiration.
- Constipation
- Loss of appetite
- Heroin use nephropathy
- Loss of libido
- Impotence and sterility
- Sleep disturbance
- Psychiatric problems
- Diseases associated with injecting practices
- Diseases associated with inhaling
- Reduction in heart rate and blood pressure
- Loss in immediate or short term and long term memory

Cannabis

- Psychosis
- Constipation
- Respiratory ailments
- Decrease in sperm count
- Loss of memory
- Increase in heart rate

Stimulants (cocaine and amphetamines)

- Increased blood pressure
- Generalized fits
- Cocaine if snorted can cause infections in the nose. The brain is an inhibitory organ. After taking any mood-altering drug the inhibitory control decreases and high-risk behaviour becomes a probability.
- Unsafe sex is an example of high-risk behaviour, which leads to genito urinary diseases (GDU) and STIs.

Summary

Asia has a history of opium production and oral consumption. India lies between two major areas producing opium for illegal markets - the Golden Triangle and the Golden Crescent. India has a history of traditional drug use for medical purposes, religious purposes and social

and functional uses.

Injecting Drug use has been increasing in India since the mid to late 1980's. The drug supply and law enforcement activities (due to the NDPS Act 1985 and its amendment done in 1988), and the characteristics of the drug users are the specific factors causing diffusion of injecting drug use. The RSA in five Indian cities identified a significant population of drug users who had experience in injecting a cocktail of pharmaceutical drugs.

The use of psychoactive substances for pleasure is known from antiquity. However, these substances also produce several health consequences. Two variables interact – the type of drug used and the type of consumer. Injecting drug users are most vulnerable to both viral and bacterial blood borne infections.





BASICS OF HIV / AIDS AND UNIVERSAL PRECAUTIONS

- 2.1 The Facts about HIV/AIDS
- 2.2 Who is at Risk?
- 2.3 How can HIV Infection be Prevented?
- 2.4 Progression of Infection
- 2.5 Window Period
- 2.6 Universal Precautions
- 2.7 How can Transmission of HIV Infection and AIDS be Prevented?
- 2.8 Post Exposure Prophylaxis (PEP)

2.1 The Facts about HIV/AIDS

Human Immunodeficiency Virus

There are two requirements for HIV infection to take place.

Minimum Infective Dose: There must be a sufficient quantity of HIV to allow infection to occur. If the concentration is too low, the possibility of infection does not exist.

Port of Entry: There must be a way for HIV to enter into the body. If any body fluid infected with HIV does not have a path into another person's body, then infection cannot take place.

Dissemination of information for IDUs must be on both injecting practices and on sexual transmission of HIV. IDUs face the same risks and problems of sexual transmission, as do other sectors of the community. The sharing of injecting equipment increases the risk of contracting and transmitting HIV, resulting in the virus being passed onto sexual partners through unprotected sexual intercourse.

The predominant mode of transmission of both HIV and other STD agents is sexual, although other routes of transmission for both include blood, blood products, donated organs, and from infected mother to her child (vertical transmission). Many of the measures for preventing sexual transmission of HIV and other STD agents are the same. There is a strong association between the occurrence of HIV infection and the presence of certain STDs, making early diagnosis and effective treatment of such STDs an important strategy for the prevention of HIV transmission. STD clinic services are important access point for people at high risk of contracting both AIDS and other STDs, not only for diagnosis and treatment but also for education and counselling.

HIV can be transmitted from mother to child. It is important that information on transmission includes details about all the routes of transmission. Often people may be aware of one route of transmission but not of another. IDUs in particular, need to be informed about the risks of infecting their partners through sex and/or unsafe injecting practices and the subsequent risk of infecting a child.

2.2 Who is Particularly at Risk?

- Injecting drug users and their partners
- CSWs and their clients
- Men who have sex with men
- STD clients
- Migrant workers
- Long distance truck drivers
- Women of child-bearing age

2.3 How can HIV Infection be Prevented?

- If you know you are uninfected and are sexually active, have sex only with one mutually faithful partner who is also known to be uninfected.
- In all other situations a condom should always be used during sex.
- Women with HIV should seek advice before getting pregnant because they may pass HIV to their babies.
- When you need a blood transfusion, insist on having blood that has been tested for HIV. It is safer when your relatives donate blood for you.
- When you cannot avoid skin-piercing instruments such as blades, needles and syringes insist on having sterilised instruments.
- Do not share needles and syringes in any situation.
- Cover cuts and wounds with waterproof plasters. If you do not have plasters, use a piece of clean cloth to cover the wounds.
- Women should be extra careful as they are more at risk of getting infected with HIV because they have
 - Greater chances of catching the infection during sexual intercourse.
 - Greater chances of needing a blood transfusion because of bleeding associated with HIV infected pregnancy and child-birth.

Box 1: The Important Facts about HIV/AIDS

- A virus named Human Immunodeficiency Virus (HIV) causes AIDS.
- People who are infected with HIV often have no symptoms of diseases for many years and can therefore infect others without realizing that they themselves are infected.
- AIDS refers to specific clinical manifestations seen during the later part of HIV infection when people are ill as a result of opportunistic infections.
- Although many of the opportunistic infections seen in AIDS can be managed, there is presently no cure for AIDS. Most people with AIDS will eventually die.
- The mortality rate is very high. Prior to retroviral therapy, 50 percent of adults died within eighteen months after being diagnosed with AIDS. The survival period for children is less.
- Prevention is at present the only possible cure. NGO workers have an important role in teaching their patients and their colleagues how HIV is and is not transmitted, and how people can protect themselves against the infection.

2.4 Progression of Infection

- Infections and acute sero-conversion illness
- Asymptomatic infection (latency period)
- Early symptomatic illness
- The “full blown” AIDS stage, i.e. opportunistic infections, opportunistic tumors and other AIDS defined conditions.

2.5 Window Period

When a person is infected with HIV, it usually takes about 3 to 6 months for the antibodies to show in a blood test. This period is commonly referred to as the window period. When a blood test detects the presence of antibodies, the person tested is referred to as ‘sero - positive’ or ‘antibody - positive test’. During the window period, an infected person can unknowingly infect others.

Later some of these symptoms may appear

- Dry cough or shortness of breath
- Diarrhoea
- Fatigue, Fever
- Furry white spots in the mouth (thrush)

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- Significant weight loss
 - Skin rashes, swollen lymph glands
 - Lack of resistance to infection
 - Loss of appetite
 - Memory or movement difficulties
 - Night sweats
 - Red or purplish spots on the body

2.6 Universal Precautions

Universal precautions are a set of measures taken to ensure that accidental exposure of patients and health care workers to infected blood is reduced to the minimum. Universal precautions are based on the assumption that all blood is potentially infectious regardless of whether it is from patients or health care workers, regardless of their HIV status, and should be applied in all settings.

Universal precautions consist of four standard practices:

- Safe handling and disposal of containers.
- Safe decontamination of instruments and other contaminated equipment.
- Hand washing.
- Use of protective barriers to prevent direct contact with body fluids.

2.7 How can Transmission of HIV Infection and AIDS be Prevented?

- All blood body fluids, and objects which come in contact with them, must be regarded as infected.
- Health care workers should follow the same principles of cleanliness, sterility, hygiene and precautions, which they have been following for other viruses like Hepatitis B Virus (HBV).
- Precautions must be taken to avoid accidental exposure to areas with broken or cut skin, scratches, rashes, acne, chapped skin or fungal infections.
- Precautions must be taken to avoid accidental splashes on mucous membrane (eyes and mouth).
- All such accidental splashes must be immediately reported to the authorities.
- All contaminated objects must be properly disposed and appropriately decontaminated.
- Hands must always be washed immediately before and after the procedure. Hands

and other parts of the body that have been contaminated with blood should be washed thoroughly with soap and water. Hands should also be washed immediately after removal of gloves.

- HIV is an extremely delicate virus, which can be easily destroyed by simple methods using chemicals such as bleach.
- Wear rubber boots or plastic disposable shoes when the ground is likely to be contaminated.
- It is important to remember that infection control measures are intended to isolate the virus and body fluids, not the patient.

2.8 Post Exposure Prevention and Care

Health Care Workers are normally at a very low risk of acquiring HIV infection during management of the infected patients. However, in spite of a low statistical risk of acquisition of HIV, the absence of a vaccine or effective – curative treatment, makes the health care workers apprehensive. So, it is necessary to have a comprehensive response in place to deal with anticipated accidental exposure.

Most exposures do not result in infection. The risk of infection varies with types of exposure and other factors such as:



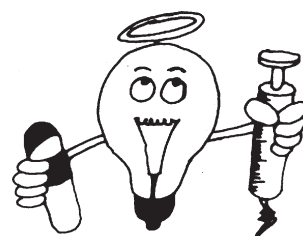
- The amount of blood involved in the exposure.
- The amount of virus in patient's blood at the time of exposure.
- Whether post exposure prophylaxis (PEP) was taken within the recommended time.

Prevention: Needle stick injuries

- Wear two pairs of gloves
- Use caution in handling of containers
- Thumb and index finger of non dominant hand – preventable
- Don't recap needles
- Use disposable needles and syringes

If needle stick occurs: What should be done?

- Don't panic
- Allow wound to bleed
- Wash in soap and water
- Place in disinfectant for 15 seconds
- Inform authorities (i.e. the nodal officer)



The person should be tested at 3 weeks, 3 months, and 6 months. If tested positive, workers may also test patient for Hepatitis B and C and advise workers to use condom for 6 months. No blood/organ donation for 6 months.

No disease in recent times has matched AIDS in terms of social upheaval, and no disease is more misunderstood. Treatment should not be denied on the basis of HIV status. We must treat these patients with the same care and concern we would wish for our families and ourselves.

Blood is the single most important source of HIV infection and risk depends on the following factors:

- Type of exposure, e.g. exposure of intact skin, non-intact skin, mucous membrane or needle stick injury.
- The amount of blood involved in the exposure. Hollow bore needles and canula for intravenous use carry more blood than intramuscular needles.
- The amount of viral load in the patient's blood at the time of exposure.
- Prevalence of infection in the said population.
- Number of exposures in case of needle stick injuries from individuals with unknown sero-status.
- Timely availability of post exposure prophylaxis.

The following should be done if health care professionals are exposed to the blood of the patient:

- Needle sticks and cuts should be washed with soap and water.
- Splashes to the nose, mouth or skin should be flushed with water.
- One should not put pricked finger in the mouth.
- Eyes should be washed with clean water, saline or sterile irrigates.

Summary

Minimum infective dose and port of entry play an important role in transmission of HIV infection. HIV is transmitted by exposure to blood and blood products, or donated organs. Exposure to blood occurs principally from the transfusion from the unscreened blood or from the use of unsterilized contaminated syringes and needles. HIV can be transmitted from infected mother to foetus or infant before, during or shortly after the birth (perinatal/vertical transmission). HIV cannot be transmitted from normal causal contact. HIV infection can be prevented.

There are four stages of HIV infection – infection and acute sero-conversion illness, asymptomatic

infection, early symptomatic illness and the “full blown” AIDS stage, i.e. opportunistic infections, opportunistic tumors and other AIDS defined conditions. Window Period is when a person is infected with HIV but antibodies do not show up in the blood test as it usually takes about 3 to 6 months for antibodies to be produced. This period is commonly referred to as the window period.

Universal precautions consist of four standard practices – safe handling and disposal of containers, safe decontamination of instruments and other contaminated equipment, hand washing, and use of protective barriers to prevent direct contact with body fluids.





HIV COUNSELLING AND TESTING

- 3.1 Components of HIV/AIDS Counselling
- 3.2 Difference between Health Education and Counselling
- 3.3 What is the Importance of Counselling before HIV Test
- 3.4 Components of HIV/AIDS Counselling
- 3.5 National HIV Testing Policy
- 3.6 Ethical Issues in HIV Counselling
- 3.7 Steps in Pre-test Counselling (Role Play)
- 3.8 Steps in Post-test Counselling (Role Play)
- 3.9 Voluntary Counselling and Testing (VCT) as a Link between Prevention and Care
- 3.10 Partner Notification

HIV voluntary counselling and testing has been shown to have a role in both HIV prevention and as an entry point to care. It provides people with an opportunity to learn about and accept their HIV serostatus in a confidential environment. VCT has become an integral part of HIV prevention programmes in many countries, as it is a relatively cost effective intervention in preventing HIV transmission.

3.1. Components of HIV/AIDS Counselling

WHO defines HIV counselling as a:

Dialogue between the client and the care provider aimed at enabling the client to cope with stress and to take personal decisions relating to HIV. Counselling includes evaluation of personal risks of HIV transmission and the facilitation of preventive behaviours.

HIV counselling is recommended for:

- Persons already HIV infected and their families
- Persons wanting to be tested for presence of HIV
- People seeking help because of past or present behaviours
- Persons not seeking help, but who are practising 'risky' behaviours

3.2 Difference between Health Education and Counselling

Counselling in relation to HIV infection and health education of the public is the primary way of (1) reducing resistance to behavioural change (2) helping people adjust to the need

to change behaviour; (3) assisting individuals, families, and communities to use social, medical, spiritual and economic support systems; and (4) reinforcing healthy behaviours which may already exist. (An orientation to HIV/AIDS Counselling, WHO)

Education is an important tool for counselling. Therefore, health education and counselling complement each other.

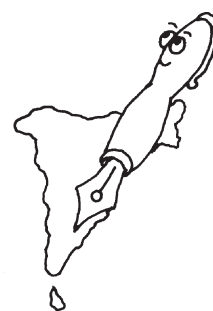
3.3 What is the Importance of Counselling before an HIV Test?

Counselling before an HIV test should provide individuals, who are considering being tested, with the information on the technical aspects of screening and on the possible personal, medical, social, psychological and legal implications of being found either HIV-positive or HIV-negative. Efforts should be made to guide them on the decision as to whether or not they should take the test (informed consent).

3.4 National HIV Testing Policy

Government of India Policy on HIV Testing

- No individual should be made to undergo a mandatory testing for HIV.
- No mandatory HIV testing should be imposed as precondition for employment or for providing health care facilities.
- Adequate voluntary testing facilities with pre and post-test counselling should be made available all over the country.
- Any testing procedure undertaken in the country must be in accordance with and a part of comprehensive HIV control programme.
- Any testing procedure must be undertaken with explicit consent of the patient. Mandatory testing must be discouraged when it tends to identify the individual, except in rare cases.
- Testing procedure must be supported by social and psychological assistance.
- Any procedure for testing must be consistent with a pre decided objective.
- Any kind of mandatory linked testing should be discouraged.
- Transfusion safety should be ensured.

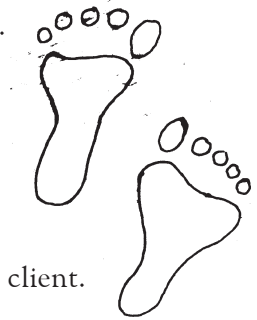


Different modes of HIV testing within Asia are often combined and include: compulsory, voluntary testing, and sentinel surveillance. Successful counselling can be achieved by combining various approaches. Counselling is very often not a one-time event and can occur formally/informally on a regular basis. There are certain steps that need to be followed in the pre and post-test counselling process to make it more comprehensive. This is crucial even if the test results are negative.

3.5 Ethical Issues in HIV Counselling Process

A counsellor needs to understand the importance of the following suggestions

- Do not wait for clients to come to you, go where they are.
- Be non-judgmental in approach.
- Be available when services are needed.
- Do not impose attitudes and beliefs on the client.
- Listen to what the client has to say.
- Try to understand what is the most important issue to the client.



In summary pre-test counselling should

- Determine what the person understands about HIV and AIDS.
- Provide factual information as needed.
- Discuss potential implications of positive and negative test result.
- Explain and obtain informed consent.
- Review the test procedure.
- Assess the person's ability to cope with a positive result.
- Establish a relationship as a basis for post – test counselling.

HIV Testing

HIV testing services should be designated to address the multiple needs and rights of individuals at risk of infection. A more humane and person centred approach to HIV testing could be achieved by moving from HIV testing alone to voluntary counselling and testing where the primary emphasis would be to reach individuals with effective counselling and peer support. Efforts to reduce stigma and discrimination seek to normalize community perceptions on HIV infection and AIDS and make counselling services available to all who seek them, regardless of their willingness to be tested.

Types of Clinical HIV Tests available

- ELISA
- Western Blot



3.6 Steps in Pre-test Counselling (Role Play)

- Solicit informed consent before an HIV test.
- Make the client comfortable by establishing rapport.
- Ascertain reason for the client's visit (referral, STD clinic or voluntary).

- Assure complete confidentiality.
- Elicit knowledge about HIV/AIDS – nature; stages; transmission; prevention; misconception; management of STDs – causes; types; Cure; link between STDs & HIV condom usage – including condom demonstration.
- Fill in gaps of knowledge and identify risk behaviour if any.
- Make the client understand/acknowledge risk associated with behaviour.
- Define linkages (attitudes/values/self image) with behaviour.
- Help clients to define their potential for attitude shifts, behaviour modification and change.
- Clarify and correct doubts and misconceptions.
- Provide the risk reduction information.
- Explain testing procedures.
- Explain meaning and consequences of test result (Positive & Negative).
- Assess coping and support systems.

3.7 Steps in Post-Test Counselling (Role Play)

Steps in post-test counselling for (Positive Result)

- Re-establish rapport and review pre-test notes.
- Find out what the waiting period was. Reveal test result gently.
- Client's understanding of test result checked.
- Facilitating ventilation of feelings and coping with those feelings.
- Explain the difference between HIV and AIDS.
- Ascertain support system – family, friends and relatives and medical.
- Arrange for referral services if required.
- Arrange for screening tests – blood test and chest X-ray.
- Emphasis on a “positive outlook to life”, medication, yoga, good diet and adequate rest. Advise them to seek medical help for early treatment of minor ailments.
- Encourage client to bring spouse/partner and children for counselling.
- Arrange follow up visits, ongoing supportive counselling.



Steps in post-test counselling for (Negative Result)

- Re-establish rapport.
- Review pre-test notes.
- Find out what the waiting period was like.
- Reveal test result.
- Re-assessment of window period.



- Give date for repeat test.
- Review risk reduction information and how to stay negative.
- Work with clients to introduce and sustain their behavioural change.

Steps in post-test counselling for (Indeterminate Result)

- Re-establish rapport.
- Find out what the waiting period was like.
- Reveal test result (inconclusive report).
- Build up motivation for retest.
- Arrange for retest (after 3 months).
- Reinforce risk reduction information.
- Arrange follow up visits.

3.8 Voluntary Counselling and Testing as a link between Prevention and Care

Components of 'Continuum of Care'

- Psycho-social support and ongoing counselling.
- Referral system (medical, psychological-counselling, social support and in some cases financial support).
- Involvement of family/community in providing 'home based care' involving training of family members in areas of diet, treatment of minor symptoms, infection control measures and counselling.
- Treatment of minor ailments/opportunistic infections.
- Prevention of mother-to-child transmission.
- Positive outlook to life.



3.9 Partner Notification

Confidentiality means that the person who conducts the test, reveals the result only to the client. However, sometimes an HIV positive person chooses not to tell her/his partner. Does the spouse have the right to know?

The main arguments in favour of partner notification are:

- The partner of someone with HIV may or may not yet be infected. The risk of infection is very high unless condoms are properly used all the time. The partner has the right to know as it may be life saving.

-
- The partner has the right to know that she or he may already have HIV infection and to seek a test and treatment as needed.

The arguments against partner notification include:

- Patient confidentiality must be ensured, and if this not guaranteed, some people will be deterred from seeking testing and treatment.
- Giving the partner information in the absence of any other support merely creates anxiety and conflict and may do nothing to reduce sexual risk, particularly for women.

UNAIDS – Partner Notification

Recent international consultations have confirmed that the principles of confidentiality and informed consent are not obstacles to effective prevention and care programmes. If employed appropriately, they are not only valid ethical principles, but are also pragmatic tools by which the non-infected and the infected are protected.

There are many reasons for stigma, denial, and discrimination that surround HIV/AIDS. HIV/AIDS is a condition related to sex, blood, death and disease. It may be due to illegal commercial sex, homosexuality and injecting drugs. The fear and taboos associated with these lead to denial, stigma and discrimination.

World Health Organisation encourages the beneficial disclosure of one's HIV/AIDS status. Voluntary disclosure respects the dignity and autonomy of the affected individuals and maintains confidentiality.

- It leads to beneficial results for the individuals, his/her sexual partners and family.
- It leads to greater openness in the community about HIV/AIDS.
- Meets ethical imperatives so as to maximize good for both uninfected and the infected.

Summary

Voluntary Counselling and Testing is the process by which an individual undergoes counselling enabling him or her to make an informed choice about being tested for HIV.

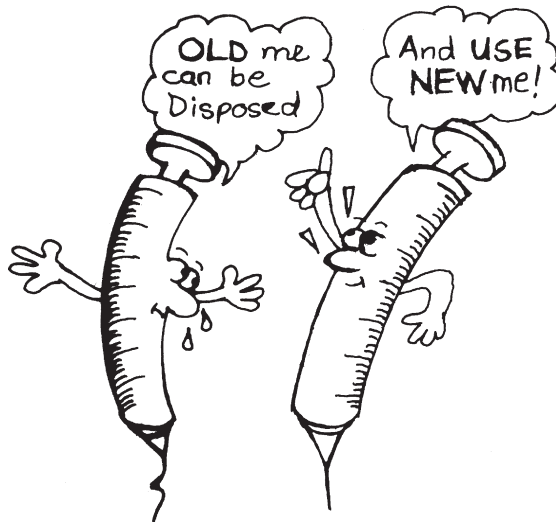
The guidelines for HIV testing and counselling consists of the following:

- Any testing procedure undertaken in the country must be in accordance with and a part of comprehensive HIV control programme.
- Any testing procedure must be with explicit consent of the patient, mandatory

testing must be discouraged when it tends to identify an individual except in certain situations.

- Testing procedure must be supported by social and psychological support.
- Any procedure for testing must be consistent with a pre-decided objective.
- Transfusion safety should be ensured.

Different modes of HIV testing within Asia are often combined and include; compulsory, voluntary testing, sentinel surveillance. Successful counselling can be achieved by combining various approaches. Counselling is very often not a one time event and can occur formally/informally on a regular basis. Certain steps need to be followed in pre-and-post-test counselling process to make it more comprehensive. This is crucial even if the test results are negative.



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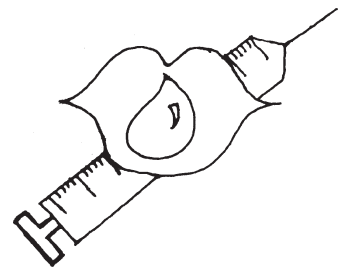
OTHER HEALTH CONSEQUENCES ASSOCIATED WITH DRUG USE

- 4.7 Overdose Management
- 4.8 Malnourishment and Weight Loss
- 4.9 Acute and Chronic Bronchitis and Respiratory Disorder
- 4.10 Tuberculosis Management
- 4.11 Abscesses Management
- 4.12 Hepatitis B and C Virus

4.1 Overdose Management

What is Overdose?

Overdose refers to intake of drugs to get a 'high'. It works by affecting the brain which controls the functions of vital organs such as the lungs, heart and the kidneys. The usage of mind-altering drugs can affect one or more of these critical activities, in addition to making a drug dependent high. For example cocaine speeds up the heart and heroin slows breathing.



If too much of the drug gets to the brain or other organs too fast, dangerous side effects such as unconsciousness, respiratory failure or heart failure might occur - any of which can be dangerous or fatal.

Timely intervention can change a potentially fatal OD into a non-fatal one.

Causes of heroin overdose

- **Lowered tolerance of the individual** - especially on release from prison or relapse from detoxification.
- **Poly drug use** – especially alcohol and benzodiazepines, any combination of several drugs with a respiratory depressant effect will increase the likelihood of overdose.
- **Allergic reaction** – (both, the injection of a) contaminated drug or a purer quality than previously used can cause OD.

Signs and symptoms of heroin overdose

Heroin overdose may be difficult to distinguish from any other cause of unconsciousness. The signs include:

-
- Pinpoint pupils.
 - Cyanosis (bluish tinge to skin) – especially around the lips.
 - Shallow or absent breathing.
 - Person is cold to touch (Hypothermia).

Treatment of heroin OD

Treatment of OD requires that the respiratory depressive effects of the drug(s) be countered as quickly as possible.

Treatment and immediate action could include:

- Insuring that the airway is not blocked with vomit or the tongue.
- Placing the person in the recovery position, attempting to rouse the person.
- Calling an ambulance.
- Giving a CPR (Cardiac massage and mouth-to-mouth resuscitation).
- Naloxone is the drug for counteracting the effects of OD.

4.2. Malnourishment and Weight Loss

Drug addiction is commonly associated with poor health. The user's first priority is to get a fix rather than worry about his food or health. Many drug users are socio-economically disadvantaged and food is often not consumed in sufficient quality or quantity. Most of the drug users are so marginalized and lacking in resources that malnutrition and weight loss is a common phenomenon.

4.3. Acute and Chronic Bronchitis and Respiratory Disorder

It is often associated with long-term smoking and inhalation of fumes from chasing and smoking drugs. Infact, the entire respiratory tract, right from the nose through trachea to the bronchioles of the lungs has such delicate lining and structures that any form of irritant is likely to cause harm.

The drugs that are snorted or inhaled (cocaine, heroin) damage the structure and cause pathological changes in the respiratory system causing bronchitis. The drug users are often prone to pneumonia. The treatment for bronchitis and pneumonia require antibiotics and other drugs, which are costly.

4.4. Tuberculosis Management

Tuberculosis is a classic disease of poverty. Though no drug per se can cause T.B, continuous

drug usage prepares a fertile ground for mycobacterium tuberculosis (the bacteria which causes T.B). This bacteria already exists and is waiting for an individual's immune system to become weak. An undernourished drug user often suffers from a weak immune system. Drug use and its relationship with HIV/AIDS is well established and its relationship with T.B. has also been proven (WHO calls it the deadly duo).

Tuberculosis is a highly infectious disease and is among the top five causes of death in the world (WHO 1999 estimates) and India has a third of this global burden. T.B has a synergistic association with HIV/AIDS, it is usually the first opportunistic infection to afflict a HIV positive person.

Treatment

Complete course of T.B medicine should be taken. The norm should be that if daily course of six to nine months cannot be taken then WHO's DOT (Direct Observed Treatment) should be the strategy implemented. The patient should be given adequate nourishment as the disease itself leads to malnourishment.

4.5. Abscesses

When an injecting drug user misses the vein, he loses the shot. A missed vein shot can get infected and cause an abscess.

What is Pus?

A collection of mainly white blood cells, which produces a proteolytic enzyme causing liquefaction of tissues. These dead WBC and tissue debris form the Pus.



Progression of an abscess

An untreated abscess leads to liquefaction of the tissue which results in Pus formation. The tension within the abscess increases leading to pus discharge from the area of least resistance. If this phenomenon does not occur or the abscess is left untreated the bacteria can enter the blood stream, causing complications.

How does a post injection abscess form?

- Dirty needle misses the vein and leaves contaminants in the tissue.
- WBCs attack contaminants but cannot remove them quickly.
- These WBCs die and crystallize around the infection creating an abscess.
- Repeated injections maintain the area of infection.

- Since the body cannot eliminate infection as fast as it should, WBCs die and the abscess keeps growing.

Treatment

Conservative

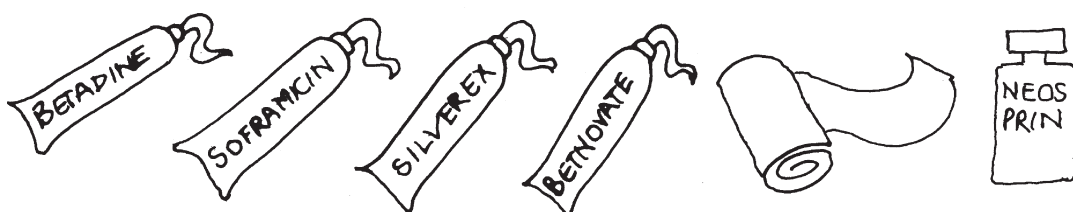
- The abscess should be cleaned with antiseptic solutions like Detol, Savlon etc.
- Magnesium sulfate (Sumag) application / hot fomentation may help.
- The abscess may be bandaged with antibiotic creams like soframycin or betadine.

Surgical

Incision and drainage (I and D) is the treatment of choice but it should be carried out in clean hygienic conditions by a trained person.

Errors in Treatment

If pus is present and Antibiotics are irrationally given, a hard lump called an “antibioma” is formed which makes the abscess a chronic lump.



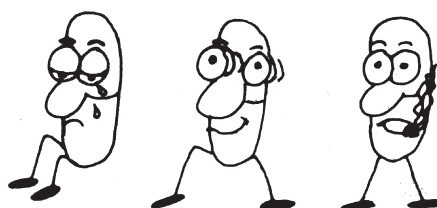
Sterile Abscess

It occurs as a result of injecting crushed tablets and as a consequence of a missed hit. It will often disperse without treatment but overtime a granuloma (benign growth of scar tissue) may be formed around the particles.

4.6. Hepatitis B and C

Hepatitis is the inflammation of liver and is transmitted by several viruses similar to HIV, including:

- Contaminated blood products; using needles contaminated with blood.
- Needle sharing.
- HBV is transmitted sexually (unprotected vaginal, anal sex).
- From mother to child at time of birth.
- HAV can only enter blood stream through food, broken skin or mucous membrane.



Signs and Symptoms of Hepatitis

- Jaundice (yellow colour of eyes, skin, nails, urine etc.)
- Nausea and vomiting
- Vague abdominal discomfort
- Fever
- Clay coloured stools

Even before the era of HIV/AIDS, the group of Hepatitis viruses, non-A non-B and Hepatitis B were recognized as potential risks for injecting drug users. These viruses share in common with HIV the mode of transmission i.e. blood borne and sexual transmission. The Hepatitis B virus is around ten times more infectious than the HIV virus.

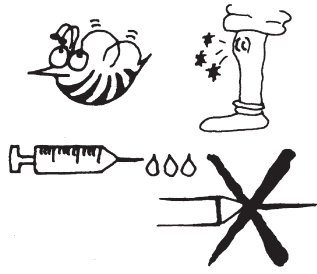
The Hepatitis B virus is a robust virus, which can stay stable on some environmental surfaces for at least 7 days. HBV infection tends to be severe and acute. WHO estimates more than 2 billion people worldwide are infected with HBV. A million people die each year of this virus. 4 million new people are infected every year.

Prevention

- Safe sex
- Safe needle use practices
- Vaccination
- Screening blood before using

Exposure to HBV Virus may be common in certain high-risk groups

- IDU's
- Heterosexual with multiple partners MSM (Men-having-sex-with-men).
- Contacts with family members and sex partners of infected persons.
- Health care and public safety workers who are exposed to blood in workplace.
- Clients and staff in institutions where blood / blood products are used.
- Contaminated and inadequately sterilized syringes and needles.
- Tattoo parlours and acupuncturists.
- Prisoners
- Poor dental care



Hepatitis Infection

Hepatitis C was also called parenterally transmitted non-A non-B hepatitis and was discovered in 1989 using modern genetic engineering techniques. The Hepatitis C virus has never been seen or cultured.

Transmission

- Hepatitis C virus is transmitted entirely by blood-to-blood contact.
- Sharing of not only needles and syringes but also of swabs, spoons and other drug equipment carries a high risk of infection.
- Less than 2 percent of the infection is transmitted through the sexual route and (little conclusive information) is more likely during acute Hepatitis C infection. The mother-to-child infection is not known but appears to be around 10 percent.
- The risks from breast-feeding, are unknown but research is on.
- Blood transfusions/dialysis and poor hygiene by dentists.
- Family toothbrushes and razors.

Diagnosis

Testing Hepatitis C Virus (HCV) is not routine. Diagnosis depends on detecting antibodies to HCV.

- ELISA method
- RIBA method.

The Hepatitis C antibody test usually does not become positive for two to three months after exposure (Window period). The antibody test identifies most people infected with the virus. However, the antibody test does not determine if a person still has the virus and for how long they have been infected. The presence of Hepatitis C antibody does not necessarily mean that there is a current disease.

- Despite absence of HCV, testing of antibodies should be periodically repeated.
- All injecting drug users are recommended the test.

Treatment

Currently no vaccine is available for Hepatitis C. Alcohol consumption should be avoided to reduce further damage to the liver. Trials with interferon and ribavirin are successful in about 40 percent of patients eligible for treatment.

-
- A biopsy must be performed before treatment.
 - Interferon and ribavirin is expensive.

Consequences

It is believed that as many as 85 percent of people initially infected with HCV become chronically ill. This disease progresses over a period of 10 to 40 years with some individuals sustaining liver damage that leads to cirrhosis or liver cancer.

Sex, Drug Use and HIV

Substance abuse has tremendous impact on 'sexual risk behaviour' of people. It increases their chances of contracting HIV infection and STDs/ GUDs. The non-using sexual partners of drug injectors may be at increased risk of HIV transmission because unprotected sex is common in relationships between drug injectors and their partners. Further, where people have STD/ GUD, the chances of their contracting HIV/AIDS is dramatically higher.

Summary

Hepatitis is usually caused by a virus which attacks the liver. There are different types of hepatitis – A, B, C, D, E and G. Drug users are more prone to Hepatitis B and C which spreads from one person to another in ways similar to HIV- sharing injecting equipment, having vaginal or anal sex without condom, a pregnant woman infecting her child during pregnancy.

Hepatitis B and C can also be passed on by sharing toothbrushes and razors. Hepatitis infection can be prevented if clean needles and syringes, mixing utensils, filters and water are used every time. Condoms also help preventing hepatitis infection. The intake of pharmaceutical drugs causes abscesses. Dirty needle misses the vein and contaminates the tissue. WBCs attack contaminants but cannot remove them quickly.

If too much of the drug gets to the brain or any other living organ, side effects such as unconsciousness, respiratory, heart failure or seizures might occur. Any of these conditions can be dangerous or fatal. This is called an overdose or OD. Drug use is commonly associated with poor health. It increases the chances of tuberculosis, respiratory, psychological and mental health disorders.





RESPONSE TO DRUG USE AND HIV EPIDEMIC

- 1.1 Background
- 1.2 Stage 1: Prevention through Education and Awareness
- 1.3 Stage 2: Intervention
- 1.4 Stage 3: Treatment
- 1.5 Condom Provision
- 1.6 Continuum of Care
- 1.7 Human Rights Issues

5.1 Background

Drug use treatment varies from strict abstinence based regimen to a public health approach that focuses not only on complete cure but also on reduction of harm to the person affected. Different treatment regimens may be required for different clients depending on their state of health and motivation. Lately the concept of demand reduction and its components, which were adopted in a resolution by the General Assembly on September 9, 1998 (UN document no. A/RES/S-20/3) have given options for innovative approaches to drug treatment and their impact on health of drug users.

Three important components of response to the HIV and Drug related epidemic are:

5.2 Stage 1: Prevention Through Education and Awareness

It is important to know the client before developing any IEC material for distribution. Prevention messages should be based on an understanding of the living conditions of the people. In order to ensure that messages on drug use, HIV/AIDS and STD prevention are effective, a communication plan should be developed. It should include the following:



- Defining the problem (situation analysis)
- Setting the objectives
- Identifying the target audience
- Developing key messages
- Pre-testing messages/materials

- Producing and disseminating
- Implementing the programme

Box 2: Stages of Behaviour Change in an Individual

Stages of Change

First phase

Target people who are not aware of the problem.

Suitable IEC is given and the target people become aware of the problem.

They are now concerned that their behaviour places them at risk.

Second phase

They acquire knowledge about the problem.

They are motivated to act through a perception of risks and benefits that might accrue if they adopt changes in behaviour.

Third phase

They are ready for action through skills acquired to enable change.

They try new behaviour.

They assess the efficacy of changing behaviour and, if successful the behaviour changes are sustained.

Strategies for Developing an Appropriate Awareness Programme

- Give required factual information.
- Messages should not induce fear.
- Avoid stigmatizing of any target group.
- IEC material should draw upon local customs and social practices.
- Services of former drug users should be utilised for disseminating information.
- Integrate HIV related information in a simple and understandable manner.

The Education Package should deal with the following issues:

- HIV/AIDS
- Drug use and addiction.
- Sexual health, safer sexual practices and safe injecting practices.
- Highlighting treatment available in the area.
- Accessibility of the programme by street dwelling population.

Table 2 depicts the Public Health Model of prevention which may be used to limit the dangerous consequences of drug use and HIV due to drug use.

Table 2: The Public Health Model

Prevention level	Description	Activities	Indicator
Primary	Health promotion	Life style change IEC production. Prevention activities.	Drug free life style. Evidence of alternative gainful activity.
	Specific protection	Maintenance therapy/ drug substitution. Needle exchange. Condom distribution.	Behaviour modification through objectively verifiable methods or surrogates. Reduction in abscesses. Reduction in HIV/STD transmission.
Secondary	Early Diagnosis and Treatment	Improved surveillance. Capacity building in BCC. Skills in diagnosis & management of HIV cases (e.g. abscess management, opportunistic infections), Drug Overdose, STD, Detoxification, Substitution therapy.	Increased case coverage. Behaviour change. Decreased morbidity. Reduction in mortality. Better case management. Increased evidence of health seeking behaviour. Increase in voluntary testing.
	Disability limitation	Continuum of care processes. Home based care. Palliative Care Services/ Hospice.	Increased utilization of referral services. Improved care quality.
Tertiary	Rehabilitation	Psychological. Social reintegration. Programmes for widows, orphans & spouses of HIV/AIDS infected.	Increase in numbers accepting drug free state/reduced drug use/ reduced risk (Recoveries). Increase in numbers opting for income generation/ gainful employment/ peer educator schemes. Evidence of non discrimination. Evidence of social/ employment / educational support.

5.3 Stage 2: Intervention

An intervention must clearly define its aims and objectives on the basis of assessment of felt needs, real needs, willingness of the people to take an active part and resources available (persons, skills, materials). In the context of targeting HIV infection in drug using populations, strategies should focus on ways to prevent and reduce the incidence of HIV infection among drug using populations, particularly injecting drug-users.

Reducing the number of injecting drug users in the populations,

The size of drug using population (particularly injecting drug users) can be reduced in the following ways:

- Effective campaigns that reduce the number of people who use drugs.
- Reduce the IDU group by preventing the transition to injecting from non-injecting drug use.
- Targeting new injectors.
- Targeting intermittent injectors.
- Providing substitution and maintenance therapy.

These prevention strategies require the presence of drug treatment services, effective IEC and community outreach measures.

Reducing transmission among injecting drug users

- Drug substitution.
- Promote sterile injecting equipment.
- Providing cleaning agents and information on how and where to dispose.
- Equipment is not available (2 x 2 x 2, bleach and water cleaning).
- Condom provision and related counselling.
- STD treatment.



Reducing transmission from injecting drug users to their partners and the general population

HIV epidemic among injecting drug users can be prevented, stopped and even reversed by implementing programmes that:

- Provide IDUs with information on ways to prevent or minimize the risk of HIV infection.
- Deliver outreach services to IDUs in their own community.

- Ensure ready access to sterile injecting equipment through needle and syringe programmes and pharmacy sales.
- Encourage condom use among IDUs and ensure condoms are readily available.
- Involve IDUs in the planning and implementation of all HIV prevention activities.
- Drug Substitution.
- Promote the adoption of policies and legislations to

Create a supportive environment for implementing HIV prevention programmes.

Decrease the marginalisation of, and discrimination against, IDUs.

This will require quality service delivery and testing facilities along with focused IEC campaigns attuned to gender and sero-status of target groups.

5.4 Stage 3: Treatment

Reducing Injecting Drug use related harm

Reducing the damage caused by drugs can be seen at three different levels. In terms of direct health consequences, the impact of malnutrition, weight loss, tuberculosis and most of all viral diseases on the health of the drug user must be considered. Secondly, direct transmission of these diseases to the sexual partners and their children must be taken into account. Thirdly, we should look at the larger public health impact of diseases that are transmitted to the general populace through the target group of drug users. In this context it is noteworthy that apart from HIV/AIDS, diseases such as tuberculosis and Hepatitis are highly infectious, and when the reservoir of infection in the target group becomes sizeable there is a greater probability of spread of infection into the general population.



While looking at reducing harm the health aspect, the social and economic impact of drug use must all be considered.

The social and economic impact of drug use on the individual, his family and the wider community should receive focus in all demand reduction programmes.

The prevention strategies to stop the sexual transmission of HIV are:

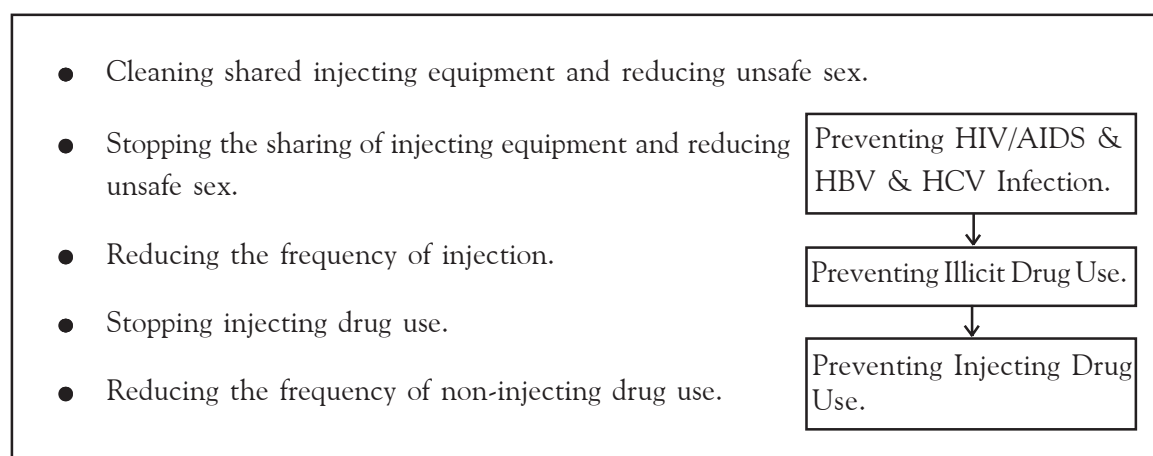
- Reduce the number of sexual partners
- Use condoms
- Be faithful to one partner

- Have non-penetrative sex
- Treat STDs

Overview of damage control choices

Often it is not possible to address the total impact of drug use. Areas and priorities need to be defined according to the needs of the population. We can establish a hierarchy of damage control choices in such a scenario. For example, from a public health perspective we may want to limit the transmission of infectious diseases from target group of injecting drug users, followed by reducing injecting drug use, and then move towards reducing illicit drug use.

Figure 3: Overview of Damage Control Choices

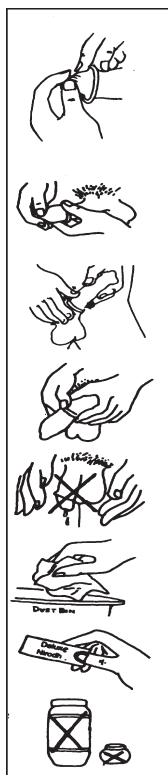


Source : Tim Rhodes, Risk Intervention and Change, London, Health Education Authority (1994)

5.5 Condom Provision

Encouraging condom use is also an important part of a comprehensive intervention.

- HIV/AIDS, Hepatitis B and C are spread through sexual routes. In the absence of condom use drug users may infect their sexual partners and offspring.
- Substance use changes the perception of risk. Often motivation is low and drug users do not actively seek and act upon information given to them through prevention messages, in the sexual context.



Instructions for Condom Use

- Take out the condom from the packet; squeeze the closed end or tip of the condom slightly, between a finger and thumb of one hand to release air.
- With the other hand put the condom on the tip of erected penis and unroll down the length of the erected penis by pushing down the rim of the condom.
- When the rim of the condom is at the base of the penis, penetration can begin.
- Immediately after the ejaculation withdraw the penis while it is still hard, holding the rim of the condom to prevent it from slipping.
- Do not allow semen to spill on hands or other parts of the body.
- Wrap used condom in waste paper before disposing them off safely.
- Always use a new condom each time intercourse is repeated.
- Do not use oil lubricants like Vaseline, oil or cold cream as they may damage the condom.

The distribution of condom is not enough. Condom use should be demonstrated and their disease averting potential should be clearly understood by the client.

Common reasons why condoms are not used by clients include

- They reduce pleasure.
- They are unavailable at the time of sexual contact.
- They are perceived as being of poor quality.

When discussing condom use in the context of low level of motivation among drug users the above-mentioned factors must be addressed and counselling may need to be continuously reinforced over a period of time.

- Condom use is a very good way of preventing HIV/AIDS and other STDs. Clients should also be counselled in the areas of partner reduction and monogamous relationships.
- Condom use and provision must be integrated with information on STD's / GUDs and their treatment, either through the same facility or through referrals. Thus, appropriate mechanisms must be worked out for partner referral, medication and counselling.

Box 3: Types of Communication and Methods for Condom Promotion

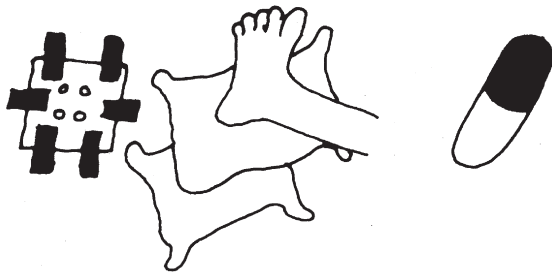
Types	Method	Media
Interpersonal Communication	Home Visit Individual Contact Counselling	Counselling Cards Booklet Kits
Group Communication	Group meeting Group Discussion Demonstration Role Play Workshop Orientation camp Puppet show Street play	Slides Overhead visuals Audio/video Flash cards Flip charts
Mass Communication	Campaign Exhibition	TV/Radio Films' Print Media

Source: Social Marketing of Condoms, USAID - AIDS Prevention and Control Project Voluntary Health Services

5.6 Continuum of Care

Comprehensive HIV/AIDS is a holistic approach to meeting the needs of HIV-positive individuals. These needs are identified and met by different disciplines ranging from medical care to social support. Several studies have been conducted in the region to assess the needs of persons living with HIV and AIDS. One such study from India identified the following list of needs:

- Clinical and nursing care for the ill to alleviate the symptoms of HIV and AIDS.
- Psychological support and counselling of individuals tested HIV positive and their families.
- Financial support or opportunities for employment for persons discriminated against and rejected from employment due to HIV status.
- Assistance to find appropriate housing in a neighbourhood that is sympathetic to HIV positive persons.
- Legal assistance to overcome discrimination at work and in the community.
- Care and support of orphans and widows after the death of the primary bread winner, and
- Information and training in HIV/AIDS care and prevention for care givers at home.



The identification of the needs of individuals and families affected by HIV/AIDS is the beginning of the planning process. To assist in this effort, WHO has developed a manual “Group interview techniques to assess the needs for people with AIDS” (WHO/GPA/TCO/HCS/95.2). Practical steps are outlined to conduct a rapid needs assessment and methods of analyzing data.

Setting up an HIV/AIDS Care Programme

Care programme to meet the needs of PLWHAs in hospitals, health centers, the community and the home can be developed by any of the following:

- Health administration
- NGOs/CBOs
- Private health practitioners

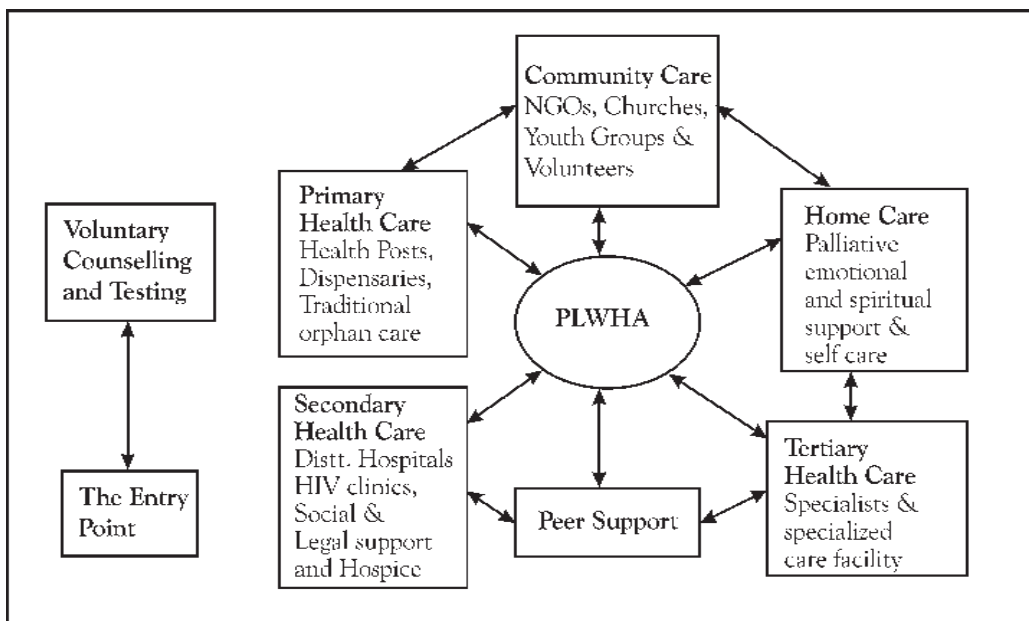
The delivery of comprehensive care across the continuum assumes the following support systems are developed and made operational for care provision to be effective and efficient in an integrated manner:

- Appropriate IEC materials to promote care seeking and de-stigmatise the diseases.
- Community mobilization programme to develop community care programme.
- Partnerships between government agencies and NGOs interacting with health, social and community-based health care activities.
- Referral procedures between hospitals and peripheral health care centers.
- Referral procedures between patients and their families and social support institutions or NGOs.
- Procedures for supervision of staff in health facilities and at peripheral levels including volunteers.

The following are some of the steps that can be taken to develop and implement specific HIV/AIDS care services:

- Step 1 – Obtain an estimate of the extent of HIV illness and AIDS
- Step 2 – Conduct a needs assessment
- Step 3 – Identify existing services and resources
- Step 4 – Mobilise resources
- Step 5 – Define objectives, set priorities and prepare a work plan

Figure 4: The HIV/AIDS Continuum of Care

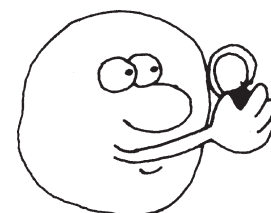


Source : World Health Organisation, Geneva

Developing responses for meeting all these needs requires a multidisciplinary approach as no one discipline can effectively meet the needs as outlined in the example above.

The concept of comprehensive HIV/AIDS care includes the following:

- Voluntary counselling and testing (VCT) facilitates an entry point in the continuum of comprehensive care. Establishing a site where, in privacy, people can come to learn and accept their HIV sero-status allows access to effective care and prevention interventions.
- Clinical management of symptomatic infection with early and appropriate diagnosis and rational treatment, nutritional support, discharge planning and referral to other service providers.
- Nursing care to relieve the physical discomfort of illness, hygiene and infection control promotion, palliative and terminal care, training of family members in home care and preventive education and condom promotion.
- Pre and post test counselling to help individuals make informed decisions on HIV testing. This should also include a supportive and accepting environment in which coping, behaviour change and positive living are promoted and should continue with follow-up counselling for the patient and others so identified.
- Care at home and in the community, including the training of relatives and volunteers in the provision of care, treatment



of common symptoms and palliative care. Promotion of good nutrition, psychological and emotional support, spiritual support and counselling.

- Formation of community support groups to provide emotional support to PLWHAs and their care providers. Opportunities for developing income generating projects could be explored in these groups.
- Eliminating the stigma of HIV/AIDS and developing attitudes in the community towards persons and families living with HIV/AIDS. This includes health care workers in both private and public health institutions.
- Social support or referral to appropriate social welfare services to meet the needs for housing, employment, legal support, and to monitor and prevent discrimination, and
- Partnership-building between various providers (clinical, social, support groups) in order to be accessible through mutual referrals.

Manipur “Continuum of Care” Project

The “Manipur Continuum of Care” project was set up to train interdisciplinary teams of health care workers and NGO volunteers in the provision of comprehensive HIV/AIDS care in three districts. The project was developed in collaboration with the Government of Manipur and international donor organizations. Training modules were developed and an adaptation of the WHO AIDS Home Care Handbook undertaken to take into account the social and cultural context of Manipur. The target group are the drug users. Various local NGOs working with injectible drug users, and support groups of drug users are the key partners in providing care.

Referral systems have been developed to supplement a resource directory in linking the various actors together. The results after a year of starting the project show high acceptability and some success in continuous quality care provision. The support among families and the motivation among NGOs have both been strong. Coordination between the government and NGOs has also been strengthened. This has been achieved despite the lack of supplies in health institutions, stigma and fear of AIDS prevailing within health institutions and communities.



5.7 Human Rights Issues

Box 4: Application of Specific Human Rights in the Context of the HIV/AIDS Epidemic

- The right to non-discrimination, equal protection and equality before the law.
- The right to life.
- The right to the highest attainable standard of physical and mental health.
- The right to liberty and security of person.
- The right to freedom of movement.
- The right to seek and enjoy asylum.
- The right to privacy.
- The right to freedom of opinion and expression and the right to freely receive and impart information.
- The right to freedom of association.
- The right to work.
- The right to marry and to found a family.
- The right to equal access to education.
- The right to an adequate standard of living.
- The right to social security, assistance and welfare.
- The right to share in scientific advancement and its benefits.
- The right to be free from torture and cruel, inhuman or degrading treatment or punishment.

Source: UN International Guidelines on HIV/AIDS and Human Rights

Human Rights Applicable in Case of Drug Use

These rights can be viewed as safeguards against injustice. Following are some basic rights of the accused person.

- The right against unreasonable searches and seizures.
- The right of a person to be informed of his constitutional rights.
- The right to a lawyer during criminal justice proceedings.
- The right to reasonable notice of the nature of the charge against the accused person.

-
- The right to be heard.
 - The right to a fair trial.
 - The right to a speedy and public trial.
 - The right against double jeopardy.

In order to obtain more information, write a letter to your State Human Rights Commission to obtain a copy of the Protection of Human Rights Act.

Summary

Treatment of drug abuse is based on different philosophies and methodologies, varying from abstinence based regimen to a more pragmatic approach that focuses not only on a complete cure but on reducing drug related harm. As HIV transmission among IDUs can spread rapidly, approaches to intervene and obstruct the spread of HIV infection needs to be explored by many countries. Three important steps in creating a response are – prevention, intervention and treatment.



GLOSSARY OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CNS	Central Nervous System
CSW	Commercial Sex Worker
DIC	Drop in Centre
DARCs	Deaddiction and Rehabilitation Centres
DOT	Direct Observed Treatment
GOs	Governmental Organisations
GUD	Gonorrhoea and Urinary Dysfunction
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use
IEC	Information, Education and Communication
MS&J	Ministry of Social Justice and Empowerment
LSD	Lysergic Acid Diethylamide
MDMA	Methylenedioxymethamphetamine
MSM	Men who have Sex with Men (homosexuals)
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NC DAP	National Centre for Drug Use Prevention
NDPS Act	Narcotics Drugs and Psychotropic Substance Act
NGOs	Non-Governmental Organisations
NISD	National Institute of Social Defence
OD	Over Dose
OPD	Out Patient Department
PLWHA	People Living with HIV/AIDS
RRTCs	Regional Resource Training Centres
STD	Sexually Transmissible Disease
TB	Tuberculosis
THC	Tetra-hydrocannabinol
UNAIDS	Joint United Nations Programme on AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

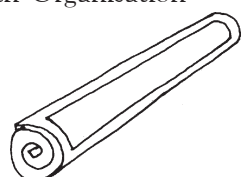
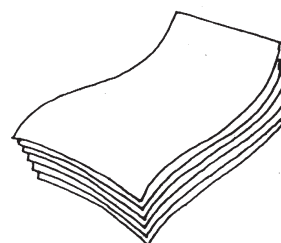


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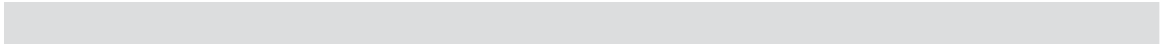
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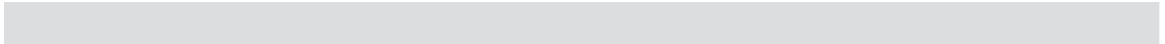


INTRODUCTION

The Ministry of Social Justice and Empowerment, Government of India and the United Nations Office on Drugs and Crime, Regional Office for South Asia commissioned SHARAN to develop this handbook to address high-risk groups and to prevent HIV/AIDS under “Drug Demand Reduction” based activities and programmes.

The Government of India initiated two nationwide projects that were implemented through a network of about 396 NGOs covering almost all drug using points in India, including a separate programme for northeastern states.

This handbook has been extensively used in various training programmes conducted by the National Centre for Drug Abuse Prevention, National Institute of Social Defence and NGOs working in the field of drug demand reduction across the country. It acts as an orientation to service providers on issues concerning drug use and HIV/AIDS. It encourages them to develop skills to deliver HIV/AIDS prevention and care services more effectively.





UNITED NATIONS
Office on Drugs and Crime
Regional Office for South Asia

Ministry of Social Justice
and Empowerment
Government of India



Handbook for NGOs

DRUG USE AND HIV/AIDS PREVENTION AND MANAGEMENT

Knowledge and Skills Enhancement for NGO Staff

Year of publication 2004

A joint publication of

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and

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This module is developed under project AD/IND/99/E40 Community Wide Drug Demand Reduction in India as part of a series of tools for service providers on drug related HIV/AIDS concerns.

(For the National Centre for Drug Abuse Prevention, NISD)

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GUIDE FOR USERS OF THIS MODULE

Resource Person/Facilitator

Expectation from a Resource Person/Facilitator

Suggestions on How to Use this Handbook

Skills Required for a Resource Person

Facilitating Strategy

Description of Different Training Methods

Communication

An Appropriate Intervention

Resource Person/Facilitator

A resource person for this handbook is one who helps participants learn the skills presented in the course material. As a resource person one should:

- Read the module before and work through the contents.
- Plan the schedule for the day taking an account of materials presented in each chapter.
- Develop a strategy on how to work within this framework.

Expectations from a Resource Person

- Demonstrate enthusiasm for the topic covered in the course and for the work that the participants are doing.
- Be receptive to each participant's questions and needs.

The resource person is required to promote a supportive and enabling environment. S/he should have a positive attitude to the questions put up by the participants. Always take enough time with participants to fully answer their questions so that both you and the participants are satisfied.

Some Suggestions

How to encourage interaction: During your presentation, interact at least once with every participant, and encourage the participants to interact with you. Try to know if the participants are having any difficulty or problem, even if they do not ask. If this kind of interest is shown, the participants will feel motivated to interact and actively learn.

How to keep the participants involved: It is advisable to note the main issues to be addressed on the flipchart, at the beginning of a session. The participant should feel that their ideas and questions are understood and recorded correctly.

Ask relevant questions to participants during the presentation to check their understanding and to keep them actively thinking and participating. Special attention is needed for quieter participants in the group who have not spoken before.

Skills Required for a Resource Person

- The ability to listen carefully and creatively, picking out positive aspects and problems, difficulties and tension.
- The ability to see what is happening; to understand non-verbal clues, to monitor the group work objectively.
- The ability to pick implicit messages; to see problems from the point of the participants, to understand their feelings, ideas and values, to focus on structures and roles rather than personalities or competence.
- The ability to define the problem and choose interim intervention and action.
- The ability to provide verbal and non-verbal indicators of encouragement, affirmation, appreciation and caring to assist in a joint search for solutions.
- The ability to confront, to disagree, to stop a process without being rude.
- The ability to invite dialogue, to receive feedback and to be prepared to examine one's own attitudes, values and ideas and to change them, if necessary.
- The ability to include oneself as a model in the group, responding spontaneously, without being idealistic, or posing as an expert.

Facilitating Strategies

- The participants must respect each other's feelings and opinions, even when they do not agree with each other.
- The speaking order should be agreed on by the group so that each participant has a chance to speak.
- Each participant should pay attention to how long they speak and not take up too much time. The facilitator should decide the amount of time allowed per person.
- Each participant is expected to participate and contribute in the discussion. Group members who are uncomfortable will not be forced to speak. They will, however, be encouraged to participate.

Description of Different Training Methods

Some important training methods that can be used in the Manual are described below. The methods described include:

- Games and Icebreakers
- Interactive Presentations
- Group Discussion/Group Work
- Presenting a Case Study – Group Discussion
- Group Application of Module and Group Feedback
- Field Visits

Communication

Communication within a group deals with the spoken, the verbal and the non-verbal, the explicit and the implied message that are conveyed and exchanged relating to information and ideas, and feelings.

Two way communication implies a situation where not only the two parties talk but also listen to each other. It helps in

- Clarification of doubts, confusions and misconceptions.
- Both facilitators and participants understanding each other.
- Feedback exchange.

An Appropriate Intervention

The facilitator needs to decide upon how s/he will help the participants go forward. This conscious act is called facilitating. It includes:

- Encouraging the participants.
- Bringing the group conversation/work to the point.
- Maintaining and peacekeeping.

Module 1 : Drug Use in India

Duration : 60 minutes

No. of sessions : 1 session

Objectives: This module aims to provide participants with a historical context of drug use and production in the region. It informs them of changing trends and patterns of drug use in the country. It introduces the health consequences of changing trends and patterns.

Methodology: The facilitator should use the map and encourage participants to share information and knowledge with the rest of the group.

- Indicate settings for trafficking routes and present information from the module (15 minutes).
- Discussion (15 minutes).
- Local area map to be used to initiate a discussion on specific knowledge of drug use in the area (15 minutes).
- Feedback/Clarification (15 minutes).

Brief Contents: Asia has a history of opium production and oral consumption. India has a tradition of drug use for medical purposes, religious purposes and social and functional uses. Geographically, India lies between two major areas producing opium for illegal markets:



- The South East Asian region of Thailand, Myanmar and Laos in Southeast Asia (Myanmar accounts for 70 percent of the estimated world opium poppy cultivation). The heroin produced in this region is commonly called 'Number 4' and is very pure. It is commonly injected, but it can be inhaled as well.
- The South West Asian region is the area of Pakistan, Afghanistan, Iran and Turkey. The heroin from this area is commonly called 'smack'. It is not very pure and is most commonly inhaled, though it can be injected as well.
- India is the largest producer of opium for medicinal use; some of this finds its way to the illicit drug trade, as there is a huge price difference between government procurement price and the black market price. Conversion of opium to Brown Sugar

is a viable and lucrative option for many, especially because it can be made quite simply.

- Asia is witnessing a major epidemic of amphetamine use, with a small percentage of amphetamine users reverting to injecting.

Injecting drug use has been increasing rapidly in India. This group is most vulnerable to blood borne infections both viral and bacterial. The disease spectrum ranges from abscess, cellulites, damage to veins, gangrene, HIV/AIDS, hepatitis B and C.

Figure 1: Opium Producing Illegal Markets Area



Module 2 : Response to the HIV and Drug Related Epidemic

Duration : 135 minutes

No. of sessions : 3 sessions

Objectives: The objective of this module is to introduce participants to possible responses to the HIV/AIDS and drug use epidemic. It introduces them to ways of reducing the transmission of blood borne viruses among drug users and their sexual partners.

Methodology: Facilitators should try to assess the level of knowledge the participants have and make the session interactive by asking questions.

- Introduction of the module (15 minutes).
- Discussion related to level of knowledge (15 minutes).
- Specific information on Condom Provision/STIs (15 minutes).
- Discussion and Workshop Exercises (15 minutes).
- A presentation by different groups of participants as to how they can use the module (1 hour).
- Feedback on presentation by the groups (15 minutes).

Brief Contents: The components of a response to HIV and drug related epidemic are:

Stage 1: Prevention through education and awareness

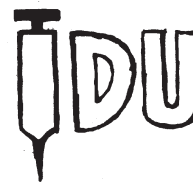
Stage 2: Intervention

Stage 3: Treatment

An intervention must clearly define its aims and objectives on the basis of assessment of felt needs, real needs, willingness of the people to take an active part and resources available (persons, skills, materials). In the context of targeting HIV infection in drug using populations, strategies should focus on ways to prevent and reduce the incidence of HIV infection among drug using populations, particularly injecting drug-users (more details in communication brief).

Reducing transmission among drug users

- Information dissemination amongst the drug using community on prevention techniques.



Reducing the number of injecting drug using populations

- These prevention strategies require the presence of drug treatment services, effective IEC and community outreach measures.

Reducing transmission from drug users to their partners and the general population

- Condom provision, STD treatment, and AZT/Nevirapine to reduce perinatal transmission, Confidential and accessible testing services to make high-risk groups aware of their sero status so that they can take action to prevent onward transmission as well as protect from co-infectants.

This will require the presence of quality service delivery and testing facilities along with focused IEC campaigns attuned to gender and sero- status of target groups.

Reducing drug use and HIV related harm

Reducing the damage that drugs cause can be seen at three different levels

- In terms of direct health consequences, we must consider the impact of malnutrition, weight loss, tuberculosis and most of all viral diseases on the health of the drug user.
- Secondly we must consider the direct transmission of these diseases to the sexual partners and their children.
- Thirdly, we should look at the larger public health impact of diseases that are transmitted to the general populace through the target group of drug users.
- In this context it is note worthy that apart from HIV/AIDS, diseases such as tuberculosis and hepatitis are highly infectious, and when the reservoir of infection in the target group becomes sizeable there is a greater probability of spread of infection into the general population.

The prevention strategies to stop the sexual transmission of HIV are:

- To reduce the number of sexual partners
- To use condoms

- To be faithful to one partner
- To have non-penetrative sex
- To treat STDs

Condom Provision

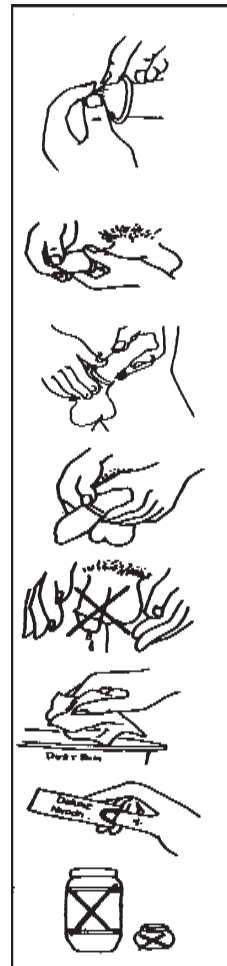
Encouraging condom use is also an important part of a comprehensive intervention.

- HIV/AIDS, hepatitis B are spread through the sexual routes. In the absence of condom use drug users may infect their sexual partners and offspring.
- Substance use changes the perception of risk. Often motivation is low and drug users do not actively seek or act upon information given to them through prevention messages, in the sexual context.

The distribution of condoms is not enough. Condom use should be demonstrated and their disease averting potential should be clearly understood by the client.

Instructions for condom use

1. Take out the condom from the packet; squeeze the closed end or tip of the condom slightly, between a finger and thumb of one hand to release air.
2. With the other hand put the condom on the tip of erected penis and unroll down the length of the erected penis by pushing down the rim of the condom.
3. When the rim of the condom is at the base of the penis, penetration can begin.
4. Immediately after the ejaculation withdraw the penis while it is still hard, holding the rim of the condom to prevent it from slipping.
5. Do not allow semen to spill on hands or other parts of the body.
6. Wrap used condom in waste paper before disposing them off safely.
7. Always use a new condom each time intercourse is repeated.
8. Do not use oil lubricants like Vaseline, oil or cold cream as they may damage the condom.



Module 3 : Other Health Consequences of Drug Use

Duration : 75 minutes

No. of sessions : 1 session

Objectives: The NGO workers will be able to understand other health consequences of drug use, which will help them improve their ongoing programme/activities by addressing these consequences.

Methodology:

- Assessment of participant's level of knowledge/belief about the other health consequences (15 minutes)
- Presentation as per contents of this module (30 minutes)
- Presentation by participants on how the module can be used (15 minutes)
- Clarification and feedback (15 minutes)

Brief Contents:

Overdose

Overdose refers to drugs taken to get a “high”. It works by affecting the brain, which controls the functions of important vital organs like the lungs, the heart, the kidneys etc. The usage of mind-altering drugs can affect one or more of these critical activities, in addition to making a drug dependent high. For example, cocaine speeds up the heart and heroin slows breathing. If too much of the drug gets to the brain or other organs too fast, dangerous side effects such as unconsciousness, respiratory failure or heart failure might occur - any of which can be dangerous or fatal.

Timely intervention can change a potentially fatal O.D into a non-fatal one.

Causes of Heroin Overdose

- **Lowered tolerance of the individual**-especially on release from prison or relapse from detoxification.
- **Poly drug use** – especially alcohol and benzodiazepines, any combination of many drugs with a respiratory depressant effect will increase the likelihood of overdose.

-
- Allergic reaction – both, the injection of a contaminated drug or a purer quality than previously used can cause O.D.

Treatment and immediate action could include:

- Insuring that the airway is not blocked with vomit or the tongue.
- Placing the person in the recovery position, attempting to rouse the person.
- Calling an ambulance.
- Giving a CPR (Cardiac Massage and Mouth-to-Mouth Resuscitation).
- Naloxone is the Drug for counteracting the effects of OD.

Malnourishment and Weight Loss/Respiratory Disorder

Drug addiction is commonly associated with poor health. The user's first priority is to get a fix rather than worry about his food or health. As many drug users are socio – economically disadvantaged, food is often not consumed in sufficient quality or quantity. Most of the drug users are so marginalized and lacking in resources that malnutrition and weight loss is a common phenomenon.

Tuberculosis

Tuberculosis is a classic disease of poverty. Though no drug per se can cause T.B but continuous usage prepares a fertile ground for mycobacterium tuberculosis (the bacteria which causes T.B). This bacteria is already all around and is waiting for an individual immunity to become weak. An undernourished drug user often suffers from a weak immune system. Drug use and its relationship with HIV/AIDS is well established and its relationship with T.B. has also been proved (WHO calls it the Deadly Duo).

Tuberculosis is a highly infectious disease and is among the top five causes of death in the world (WHO 1999 estimates). India has a third of this global burden. T.B has a synergistic association with HIV/AIDS, it is first opportunistic infection to afflict a HIV positive person. T.B is becoming more dangerous because an increasing number of multi drug resistance strains of the bacteria are coming up.

Treatment

Complete course of T.B medicine should be taken, the norm should be that if daily course of six to nine months cannot be taken then WHO's DOT (Direct Observed Treatment) should be the strategy implemented. The patient should be given adequate nourishment as the disease itself leads to malnourishment.

Acute and Chronic Bronchitis

It is often associated with long-term smoking and inhalation of fumes from chasing and smoking drugs. Infact the whole of the respiratory tract, right from the nose through trachea to the bronchioles of the lungs has such delicate lining and structures that any irritant is likely to harm.

The drugs which are snorted or inhaled (cocaine, heroin) are definitely going to damage the structure and cause pathological changes in the respiratory system causing bronchitis. The drug users are also prone to pneumonia. The treatment for bronchitis and pneumonia require antibiotics and other drugs, which are costly.

Abscesses

When an injecting drug user misses the vein, he loses the shot. A missed vein shot can get infected and cause an abscess.



Progression of an Abscess

If the abscess is left untreated there is going to be more liquefaction of the tissue leading to more pus formation. The tension within the abscess will increase leading to pus discharge from the area of least resistance. If this phenomenon does not occur or the abscess is left untreated the bacteria can enter the blood stream, causing complications.

How does a post injection abscess form?

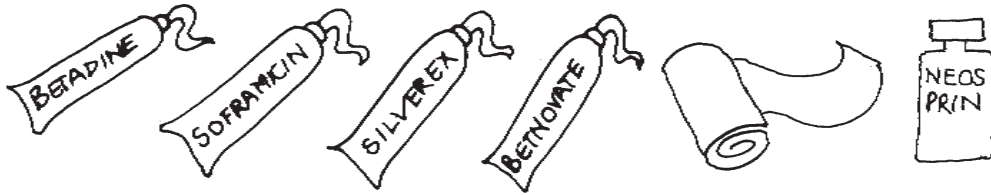
- Dirty needle misses the vein and leaves contaminants in the tissue.
- WBC attack contaminants but cannot remove them quickly.
- These WBC die and crystallize around the infection creating an Abscess.
- Repeated injections maintain the area of infection.
- Since the body cannot eliminate infections as fast as it should do, more WBC die and the abscess keep **growing**.

Treatment – Conservative

- The abscess should be cleaned with antiseptic solutions like Detol, Savlon etc.
- Magnesium sulfate (Sumag) Application / Hot Fomentation may help.
- The abscess may be bandaged with antibiotic creams like soframycin or betadine.

Surgical

- Incision and drainage (I and D) is the treatment of choice but it should be carried out in clean hygienic conditions by a trained person.



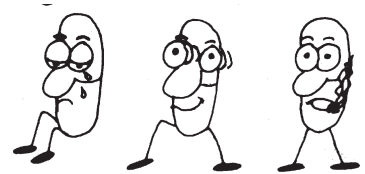
Sterile Abscess

It occurs as a result of injecting crushed tablets and as a consequence of a missed hit. It will often disperse without treatment but overtime a granuloma (benign growth of scar tissue) may be formed around the particles.

Hepatitis B and C

Hepatitis is the inflammation of liver and is transmitted in much the same manner as HIV through:

- Contaminated blood products; using needles contaminated with blood.
- Needle Sharing
- Sexual Transmission (Unprotected Vaginal, Anal Sex)
- From mother to child at time of birth
- The virus can only enter blood stream through broken skin or mucous membrane



Signs and Symptoms of Hepatitis.

- Nausea and vomiting
- Vague abdominal discomfort
- Fever
- Jaundice (yellow colour of eyes, skin, nails, urine etc.)
- Clay coloured stools

Even before the era of HIV/AIDS, the group of hepatitis viruses, non-A non-B and hepatitis B were recognized as potential risks for injecting drug users. The mode of spread of these

viruses and HIV is the same. They are both transmitted through the blood or through sexual contact. The Hepatitis B virus is around ten times more infectious than the HIV virus.

The Hepatitis B virus is a robust virus, which can stay stable on environmental surface for at least 7 days. HBV infection, tends to be severe and acute. WHO estimates more than 2 billion people worldwide are infected with HBV. A million people die each year of this virus. 4 million new people are infected every year.

Prevention

- Safe Sex
- Safe needle use practices
- Vaccination
- Screening blood before usage

Exposure to HBV Virus may be common in certain high-risk groups

- IDU's
- Heterosexual with multiple partners MSM (Male having sex with male)
- Contacts with family members and sex partners of infected persons.
- Health care and public safety workers who are exposed to blood in workplace.
- Clients and staff in institutions where blood / blood products are used.
- Contaminated and inadequately sterilized syringes and needles.
- Tattoo parlours and acupuncturists.

Hepatitis infection

Hepatitis C was also called parenterally transmitted non-A non-B Hepatitis. Hepatitis C was discovered in 1989 using modern genetic engineering techniques. The Hepatitis C virus has never been seen or cultured.

Transmission

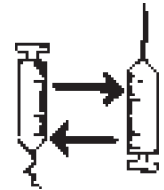
- Hepatitis C virus transmission is entirely by blood-to-blood transmission.
- Sharing of not only needles and syringes but also of swabs, spoons and other drug equipment carries a high risk of infection.

-
- Sexual Transmission (little conclusive information) is more likely during acute Hepatitis C infection. The mother to child infection is not known but appears to be around 10 percent.
 - The risks from breast-feeding are unknown but a lot of research is on.

Diagnosis

Testing HCV is not routine. Diagnosis depends on detecting antibodies to Hepatitis C virus.

- ELISA method
- RIBA method.



The Hepatitis C antibody test usually does not become positive for two to three months after exposure (Window Period). The antibody test identifies most people infected with the virus. It, however, does not determine if a person still has the virus and for how long they have been infected. The presence of Hepatitis C antibody does not necessarily mean that there is a current disease.

Sex, Drug Use and HIV

Substance abuse has a tremendous impact on ‘sexual risk behavior’, which increases people’s chances of contracting HIV infection and STDs/ GUD’s. The non-using sexual partners of drug injectors may be at increased risk of HIV transmission because unprotected sex is common in relationships between drug injectors and their partners. Further, where people have contracted STD/GUD, it increases their risk of contracting HIV/AIDS dramatically.

Treatment

Currently no vaccine is available for Hepatitis C. Treatment consists of avoiding any further damage to the liver. Trials with interferon and rebetron are go on.

Consequences

It is believed that as many as 85 percent of people initially infected with HCV become chronically ill. This disease will progress over a period of 10 to 40 years with some individuals sustaining liver damage that will lead to cirrhosis or liver cancer.

Module 4 : HIV / AIDS

Duration : 90 minutes

Session : 2 sessions

Objectives: The NGO workers will be able to integrate and develop strategies for preventing HIV transmission in their ongoing programmes and activities. They will be able to understand the importance of universal precautions.

Methodology: The facilitator should try to encourage all participants by using interactive games and group discussion for disseminating information on HIV/AIDS and the implementation of universal precautions.

- Assessment of participants level of knowledge/belief and an exploration of myths and misconceptions about HIV/AIDS (30 minutes).
- Presentation about modes of transmission and prevention by the facilitator (30 minutes).
- Presentation by participants on how the module can be used (15 minutes).
- Clarification and feedback (15 minutes).

Myths and misconceptions about HIV/AIDS should be addressed during this session. In this context a set of index cards (paper cut outs of the photocopied sheet) with common beliefs on HIV/AIDS can be distributed to each participant. In turn, each reads the cards and evaluates whether the statement is a myth or a fact.

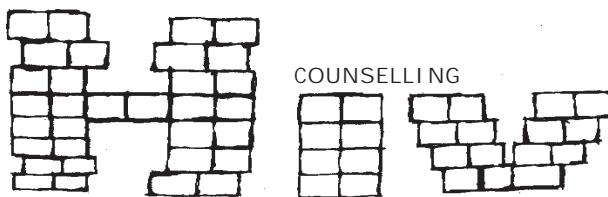
Brief Contents: Minimum infective dose and port of entry play an important role in transmission of HIV infection from person to person. HIV is transmitted by exposure to blood, blood products, or donated organs. Exposure to blood occurs principally through the transfusion of unscreened blood or use of unsterilized contaminated syringes and needles.

HIV can be transmitted from infected mother to foetus or infant before, during or shortly after the birth (perinatal/vertical transmission). HIV cannot be transmitted by casual contact. HIV infection can be prevented.

Facts about HIV/AIDS

Blood and blood products/needles and syringes

- HIV is transmitted by exposure to blood, blood products, or any donated organ (parenteral transmission); exposure to blood is principally through the transfusion of unscreened blood or use of unsterilised contaminated syringes and needles.
- HIV can live between 30 seconds to one minute when exposed to air. However, inside a needle, HIV is not in direct contact with air and can live for longer periods of time.



Mother to Child Transmission

- The overall risk of HIV transmission from an infected woman to her foetus in utero or during delivery is about 30 percent. This on an average can range from 6 percent to 70 percent.
- HIV can be transmitted by breast-feeding from an infected mother to a new born child (10 percent - 15 percent).
- Risk can be lowered significantly with AZT treatment.

Heterosexual or Homosexual Transmission

- HIV can be transmitted from an infected person to his or her sex partner (man to woman, woman to man and man to man).
- In general only 0.1 percent to 1 percent of sexual exposure leads to transmission. Yet, sexual intercourse is the most frequent mode of transmission world wide and in India.

HIV does not spread through the following:

- It is safe to have normal casual contact.
- Through drinking water or eating food from the same utensils used by an infected person.
- You cannot get HIV by living with people with HIV or AIDS.
- Hugging, touching or kissing.
- Caring and looking after people with HIV or AIDS.

-
- Getting bitten by an infected person.
 - Use of the same toilets as people with HIV or AIDS.
 - Sharing telephone instruments, computers etc.
 - Sneezing and coughing.
 - Getting bitten by a mosquito that has already bitten an infected person.

HIV Infection can be Prevented

- If you know you are uninfected and are sexually active, have sex only with one mutually faithful partner who is also known to be uninfected.
- In all other situations a condom should always be used during sex.
- Women with HIV should seek advice before getting pregnant because they may pass on the HIV to their babies.
- When you need a blood transfusion, insist on having blood that has been tested for HIV.
- When you cannot avoid skin-piercing instruments such as blades, needles and syringes insist on having sterilised instruments.
- Do not share needles and syringes in any situation.
- Cover cuts and wounds with waterproof plasters. If you do not have plasters, use a piece of clean cloth to cover the wounds.
- Women need to be extra careful as they are more at risk of getting infected with HIV.

They have:

- Greater chances of catching the infection during sexual intercourse
- Greater chances of needing a blood transfusion due to bleeding associated with HIV pregnancy and child birth.

There are four stages of HIV infection – infection and acute sero-conversion illness, asymptomatic infection, early symptomatic illness and the “Full Blown” AIDS stage, i.e. opportunistic infections, opportunistic tumors and other AIDS defined conditions.

When a person is infected with HIV, it usually takes about 3 to 6 months for the antibodies to show up in a blood test. This period is commonly referred to as the window period.

Module 5 : Universal Precautions

Duration : 120 minutes

Session : 2 sessions

Objectives: The objective of the module is to increase safety in the workplace for people working with groups at risk.

Methodology: The facilitator may use 5-6 case scenarios to determine precautions already in use and precautions that may be taken. It may also be useful to determine the barriers in implementing universal precautions.

- Assessment of universal precautions already in use in the participants working environment (30 minutes)
- Presentation of case scenarios (30 minutes)
- Group discussion on the presentation (30 minutes)
- Discussion on how the participants can use information in the module in their working environment (15 minutes)
- Clarifications and feedback (15 minutes)

Brief Contents: Universal precautions consist of four standard practices – safe handling and disposal of containers, safe decontamination of instruments and other contaminated equipment, hand washing, and use of protective barriers to prevent direct contact with body fluids. To make sure that each participant understands the concept, importance and implementation of universal precautions, some case scenarios can be presented for group discussion.

The following table explains some of the barriers for effective implementation of universal precautions in health care settings.

Selection of Protective Barriers		
Types of exposure	Protective barriers	Examples
Low risk		
● Contact skin	Gloves helpful but not essential	Injections
● No visible blood		Minor wound dressings
Medium Risk		
● Probable contact with blood	Gloves	Insertion or removal of intravenous cannula
● Splashing unlikely	Gown and aprons may be necessary	Large open wounds dressings
High Risk		
● Probable contact with blood	Gloves	Major surgical procedures
● Splashing and uncontrolled bleeding	Waterproof gown	
	Eye wear	
	Mask	

Module 6 : Counselling

Duration : 195 minutes

No. of sessions : 4 sessions

Objectives: The objective of this module is to help the participants understand the implications of HIV testing and the importance of pre-and-post test counselling as it relates to PLWHAs.

Methodology: The session facilitator should organize role-plays and present case scenarios of counselling in general and pre and post-test counselling.

1. Role Play (Pre-test counselling) (30 minutes)
2. Role Play (Post-test counselling for Positive result) (45 minutes)
3. Role Play (Post-test counselling for Negative result) (45 minutes)
4. Role Play (Post-test counselling for Indeterminate result) (30 minutes)
5. Clarification and feedback (15 minutes)
6. Discussion on how the participants can use this information in their working environment (30 minutes)

Brief Contents: Voluntary Counselling and testing is the process by which an individual is enabled to make an informed choice about being tested for HIV.

National HIV Testing Policy:

- Any testing procedure undertaken in the country must be in accordance with, and a part of a comprehensive HIV control programme.
- Any testing procedure should be with the explicit consent of the patient. Mandatory testing must be discouraged except in exceptional situations.
- Testing procedure must be associated with social and psychological support.
- Any procedure for testing must be consistent with an initial objective.
- Transfusion safety should be ensured.



Different modes of HIV testing within Asia are often combined and include; compulsory, voluntary testing, sentinel surveillance.



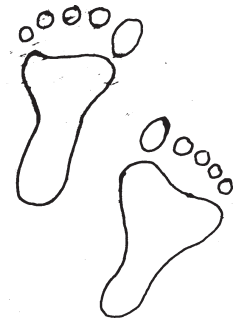
Successful counselling can be conducted by combining various approaches. Counselling is very often not a one-time event and can occur formally/informally on a regular basis.

Counselling before the test should provide individuals, who are considering being tested, with the information (Informed Consent) on the technical aspects of screening and on the possible personal, medical, social, psychological and legal implications of being found either HIV – positive or HIV – negative.

There are certain steps that need to be followed in pre-and-post-test counselling process to make it comprehensive. This is crucial even if the test results are negative.

HIV counselling is recommended for:

- Persons wanting to be tested for presence of HIV
- Persons already infected with HIV and their families
- People seeking help because of past or present behaviours
- Persons not seeking help but who are practising 'risky' behaviours



The main arguments in favour of partner notification are:

- The partner of someone with HIV may or may not yet be infected. The risk of infection is very high unless condoms are properly used all the time. The partner has the right to know as it may be life saving.
- The partner has the right to know that she or he may already have HIV infection and should seek a test and treatment as needed.

The arguments against partner notification include:

- Patient confidentiality must be upheld, and if this not guaranteed, some people will be deterred from seeking testing and treatment.
- Providing information to the partner in the absence of any other support merely creates anxiety and conflict and may do anything to reduce sexual risk, particularly for women.

Module 7(a): Communication with Clients

Duration : 120 minutes

No. of sessions : 2 sessions

Objectives: The objective of this module is to enhance communication skills among the participants. These will help them improve their care giving relationship with the target group.

Methodology:

- Introduction of communication skills mentioned in the module (15 minutes).
- Presentation of various communication skills and techniques (30 minutes).
- Discussion on specific situations where participants are of the view that communication needs to be enhanced and improved (30 minutes).
- Discussion on how participants can use information in their working environment (30 minutes).
- Feedback and Clarification (15 minutes).

People who use drugs do so because very often, they are unable to stop. The necessity to use drugs often leads them to behave in a socially unacceptable manner. The user often suffers from guilt and shame. A non-judgemental approach that respects the user as a human being generally has been found to work well in establishing relationships.

Tips to help establish relationships/break the ice.

- Welcoming a person with a warm smile.
- Offering a cup of tea or a cigarette/bidi.
- Listening attentively.
- Maintaining eye contact.
- Maintaining a neutral body language.
- Spending time with users in their environment.
- Being supportive instead of coercive.

The facilitator should try to look into the history of atleast one client, to know his family

background, when and how he started drug use, is he married or single, does he have a regular or irregular companion. (keep this suggested exercise as informal as possible). Exchange places with clients to gather socially and culturally appropriate information on designing or incorporating new components in an ongoing intervention.

Brief Contents: Communication is the key to form effective and viable relationships with various groups concerned with the project. It ranges from the simplest form of communication i.e. one to one, person to person, to making presentations, designing education and information material to spread awareness as well as for mobilising groups of people with information inputs.



Communication itself is a dynamic and interactive exercise, which, if followed with an open mind can lead to upgrading the information level in the community in general, especially affected groups, and the caregiver himself.

The important aspects need to be addressed are:

- Clients
- Members of the communities where the NGO is starting work
- Donor agencies
- Communication for education and awareness.
- Communication within the organisation, so that the work is focussed and effective.
- The media, which could help in communicating information and spreading awareness.

Communication with the client

- Apart from being a drug user and being stigmatised, the client may also be a rag picker, rickshaw wallah, pickpocket, petty thief or commercial sex worker. They could be dirty in appearance with sores at injecting areas, **but above all he or she is a human being and needs to be treated as such.**
- Normally drug users are very sensitive people and communication with them should be on an even keel - it may be counter-productive if they feel they are being looked down upon.
- The communication should be need based, and in response to the requirements of the client. For instance, if the client is at the stage of needle exchange it would be pointless to talk to him about detoxification. It might be more appropriate to discuss safe ways of injecting.
- The communication should be consistent.

Module 7(b): Communication with Clients

Duration : 60 minutes

No. of sessions : 1 session

Objectives: The objective of this module is to enhance communication skills among the participants, which will help improve their care giving relationship with the target group.

Methodology:

- Introduction of communication skills mentioned in the module (15 minutes)
- Administration of client intake form (45 minutes)

Administration of Risk Assessment Form:

Interviewer:

Date of Interview: __/__/__

Serial No.:

Diagnosis Information

- Name:
- Identification No:
- Date of entry into programme: __/__/__
- Age: _____ years
- Sex: _____ (Male / Female/Other)
- Current Address:
House No, street: _____ Locality: _____
- Place of Origin: _____ (state?)
- Current Marital Status: _____ (single/married /separated/divorced/widowed)
- Religion: _____ (Hindu, Muslim, Christian, Sikh, Jain, Atheist)
- Education: _____ (illiterate/primary/secondary/college/professional)
- Occupation: _____ (student/unemployed/driver/daily wages/white collar/self employed)

Drug Use History

- At onset: _____ (name first drug used?)
- Age at onset: _____ years
- Opioids used from onset till today (Mark 'Y' for yes and 'N' for no) and mention the corresponding 'route of administration' (Oral, Smoking, Chasing, Sniffing, Injecting)
 - (a) Opium: _____ Route: _____
 - (b) Brown sugar: _____ Route: _____
 - (c) Heroin (white): _____ Route: _____
 - (d) Diazepam (calmpose): _____ Route: _____
 - (e) Buprenorphine (tidi'/norphin): _____ Route: _____
 - (f) Fortwin: _____ Route: _____
 - (g) Phenargan: _____ Route: _____
 - (h) Avil: _____ Route: _____
 - (i) Pethidine/morphine: _____ Route: _____
- Average amount of opioids used per day: _____ grams/ml/vials (in the last 6 months)
- Money spent per day on opioid use in the last 6 months: Rs. _____ .00
- Source of drug money : _____ (earnings/from family/loans/ragpicking/begging/illegal means)

Drug Injecting History (Last 6 months)

- Injecting Drug User (I.D.U.): _____ ('Y' for yes and 'N' for no)
- Age at onset of injecting: _____ years
- Types of drugs injected (Mark 'Y' for yes and 'N' for no)
 - (a) Brown sugar:
 - (b) Heroin (white):
 - (c) Diazepam:
 - (d) Buprenorphine (tidigesic'/norphin):

- (e.) Fortwin:
- (f.) Phenargan:
- (g.) Avil:
- (h.) Pethidine/morphine:

- Total amount injected per day (IM/IV/Both): _____ vials/ml
- Specify each of the 'cocktailed' opioids and the amount injected (in 1 day)
 - Opioid 1: _____ amount injected: _____ grams/vials/ml
 - Opioid 2: _____ amount injected: _____ grams/vials/ml
 - Opioid 3: _____ amount injected: _____ grams/vials/ml
 - Opioid 4: _____ amount injected: _____ grams/vials/ml
- Number of cocktails (fixes) injected per day: _____

Risk Practices (in the last 1 month)

- Sharing of needles or syringes: _____ ('Y' for yes / 'N' for no)
- No. of sharing partners: _____ partners
- No. of sharing episodes/occasions: _____ times (total can be a rough estimate)
- Sharing Behaviour: _____ (regular/occasional/never)
- Cleaning of injecting material: _____ ('Y' for yes / 'N' for no)
- Method used for cleaning of injecting material: _____ ('Y' for yes and 'N' for no)
 - (a) Water:
 - (b) Spit/saliva:
 - (c) Cotton: _____ s
 - (d) Piece of cloth:
- Aware of risk of sharing syringes/needles: _____ ('Y' for yes / 'N' for no)

Sexual History (last 6 months)

- Pre-marital sex: ____ ('Y' for yes / 'N' for no)
- First sexual exposure: _____ (Specify; man/woman/eunuch)
- Age: _____ years
- No. of partners in last 6 months (include spouse):
- No. of visits to commercial sex workers in last 6 months:
- Use of condoms in last 6 months ('Y' for yes and 'N' for no):

If yes;

With primary:

Other partners:

Last sexual encounter:

Awareness of STD's & HIV/AIDS

- Knowledge about STD's: _____ ('Y' for yes / 'N' for no)
- Source of information: _____ (Print media/TV/fliers,leaflets etc./NGO's/ Govt. hospital/Pvt. Clinics)
- Knowledge about HIV/AIDS: _____ ('Y' for yes and 'N' for no)
- Source of information: _____ (Print media/TV/fliers,leaflets etc./NGO's/ Govt. hospital/Pvt. Clinics)
- Knowledge that condom protects: ____ ('Y' for yes and 'N' for no)

Incarceration History

- Ever been in prison: _____ ('Y' for yes and 'N' for no)

1 year before entry into programme

- No. of times in prison : _____ times
- Duration (for each time in prison)
 - (a) _____ days
 - (b) _____ days

(c) _____ days

(d) _____ days

After entry into programme

- No. of times in prison : _____ times
- Duration (for each time in prison)
 - (a.) _____ days
 - (b.) _____ days
 - (c.) _____ days
 - (d.) _____ days

Detoxification/treatment

- Ever been to detox/treatment : _____ (*'Y' for yes and 'N' for no*)

1 year before entry into programme

- No. of times in detox/treatment : _____ times
- Duration (for each time in detox/treatment)
 - (a) _____ days
 - (b) _____ days
 - (c) _____ days
 - (d) _____ days

After entry into programme

- No. of times in detox/treatment : _____ times
- Duration (for each time in detox/treatment)
 - (a.) _____ days
 - (b.) _____ days
 - (c.) _____ days
 - (d.) _____ days

Medical History

One year before entry into programme

- Respiratory problems (Please specify): _____
- Tuberculosis: _____ ('Y' for yes and 'N' for no)
- If 'yes'; status: _____ (treated/not treated/ under treatment)

Mark 'Y' for yes and 'N' for no

- Jaundice:
- Abscess:
- Fever for more than 1 month:
- Diarrhoea lasting for more than 1 month:
- Ulcer over genitalia:
- Pus per urethra (burning urination):
- Small warts (cauliflower growth) over genitalia:

After entry into programme

- Respiratory problems (Specify): _____
- Tuberculosis: _____ ('Y' for yes and 'N' for no)
- If yes, status: _____ (treated/not treated/ under treatment)

Mark 'Y' for yes and 'N' for no

- Jaundice:
- Abscess:
- Fever for more than 1 month:
- Diarrhoea lasting for more than 1 month:
- Ulcer over genitalia:
- Pus per urethra (burning urination):

Module 8 : Communication with Members of the Community

Duration : 80 minutes

No. of sessions : 2 sessions

Objectives: This module aims at disseminating the basic skills for conducting community meetings and focus group discussions for situational assessment.

Methodology:

- Presentation of the module (15 minutes).
- The participants can be divided into groups and given specific topics. One participant can play the role of the facilitator of the group (30 minutes).
- Discussion on how the participants can use these techniques in their working environment (15 minutes).
- Feedback and clarification (20 minutes).

Brief Contents:

Focus Group Discussion

A moderator or facilitator guides a number of small groups, who share similar characteristics, through a discussion of a selected topic, allowing them to talk freely and spontaneously. The group may be members of the target population or different types of key informants such as law enforcement people, health care providers/workers, and drug users, PLWHAs etc.

Sensitizing communities and gaining support for interventions is crucial if they are to succeed. Protecting clients against possible harassment from law enforcers is also very important. One good way is to seek out the relevant authorities and explain to them what the intervention is and the rationale behind it

Steps to conduct a FGD

- Arrange the location so that the group will sit in a loose circle. This setting allows everyone to see and hear what is going on.
- The moderator should sit with the participants, but observers can sit anywhere.

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- Try and ensure that the location is as quiet and as free of interruptions as possible.
 - Welcome participants warmly and when assembled introduce yourself and your organisation. Explain why the FGD is taking place. Give an outline into what is expected, and reassure members why people are taking notes. Stress confidentiality.
 - Allow participants to briefly introduce themselves. Discuss the first topic slowly and coax participants into talking.
 - Be a good listener and cultivate the habit of asking “why” and “how”.
 - When the first FGD is over, summarise the key issues and ask questions. See if anyone has anything they want to add.

Module 9 : Communication with Donors and Other Helpful Agencies

Duration : 80 minutes

No. of sessions : 2 sessions

Objectives: The objective of this section is to develop and enhance communication skills, which help deal with the donor and other useful agencies.

Methodology: The session facilitator should encourage participants to develop a common strategy.

- Presentation of the module (15 minutes)
- The participants can be divided into groups and given a specific topic. One participant can make a presentation on behalf of the group (30 minutes)
- Discussion on how the participants can use these techniques in their working environment (15 minutes)
- Feedback and clarification (20 minutes)

Brief Contents: Presentations are an important tool for communicating the nature and effectiveness of the work carried out on the project. In the case of presentations to key stakeholders, it may provide an introduction to the problem and a background to the objectives of the interventions carried out.

Groups will have to communicate a great deal of information in a short period. They will need to be selective and clear.

Stress the following points:

- The sequence must be clear.
- Visual aids should contain only a few words and figures, not whole sentences or long complicated figures.
- Figures should when necessary be “rounded”. They are unlikely to be completely accurate in any case, and it is not necessary that they should be – this is not an audit.

-
- Calculations must be correct.
 - Groups should not present or discuss general views on the project. Presentations must focus on the particular and on the analysis of data.
 - The timing will be strictly enforced; groups should perhaps practise their presentations to ensure that they are not too long.

The facilitator should try to identify some issues for the group - exercise. The group will then present their work and all participants will act as representatives of donor agencies. The presentation should be timed for 15 minutes, with 10 minutes for questions

Module 10: Developing and Communicating an Appropriate Awareness Programme

Duration : 80 minutes

No. of sessions : 2 sessions

Objectives: To develop IEC material which has its genesis in the community and the prevalent culture and social traditions of the region. Messages so developed would eventually be more effective in creating awareness around issues of drug use and HIV.

Methodology:

- Presentation of the module (15 minutes).
- The participants can be divided into groups and given a specific IEC tool for the group (30 minutes).
- Discussion on how the participants can use these techniques in their working environment (15 minutes).
- Feedback and clarification (20 minutes).

Brief Contents: It is important to know the clients and their context before developing any IEC material for distribution. Prevention messages should be based on an in-depth understanding of the context in which the target group is living. In order to reach people with messages about drug use, HIV/AIDS, and STD prevention, a communication plan should be developed. It should include the following steps:

- Give required factual information.
- Messages should not be fear-inducing.
- Avoid stigmatising any target group.
- Culture and local traditions need to be adapted in the development of materials and preventive education efforts.
- Former drug users are a very credible medium for disseminating this information.
- Integrate HIV related information in a simple and understandable manner.
- The education package should deal with the following issues:

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- Hepatitis.
 - Drug use and addiction.
 - Sexual health and safer sexual and injecting practices.
 - Highlight treatment available in the city.
 - State how street dwelling population can access the overall programme.

Get the group to design a poster or leaflet, using simple materials and with culturally appropriate symbols and content.

Module 11: Communicating with the Media on HIV Related Issues

Duration : 90 minutes

No. of sessions : 2 sessions

Objectives: Media coverage will enhance the visibility of NGOs and help them be recognized. It will disseminate information among the public about NGOs activities, and services. Media will help generate public support, increase fundraising or membership, and stimulate free and informed discussion on the issues NGOs are dealing with. Enlisting media support breaks down barriers and will generally help remove stigma, motivating many persons at risk to come forward to seek help.

Methodology:

- Presentation of the following steps (60 minutes).
 - Making contact:** Zero in on the person at the paper or TV/radio station to find out who is interested in or covers your area of work.
 - Providing information:** A well-worded, concise press release is a must but usually not enough to elicit the response you desire. In fact the manner in which the journalist prefers his information should be catered to.
 - Establishing rapport:** The objective is to have a long-term relationship. Whenever they are required to write, they would need your urgent co-operation.
 - Tailoring information:** The media has its own way of looking at the issues which are of concern to you. For instance, they would want to write on human interest stories.
- Organising an exposure tour of the project area and the project activities for media person (Site visit).
- Clarification and feedback (30 minutes).

Brief Contents: There are many benefits of a good media coverage; the workers in the field feel appreciated, and clients who are featured bring the topic to the fore, thus reducing the stigma attached to seeking help and spreading more light on the real issues concerned.

The media is a powerful tool in furthering objectives of NGOs working in the field of drugs and HIV.

Module 12: Human Rights Issues Related to PLWHAs and Drug Users

Duration : 175 minutes

No. of sessions : 3 sessions

Objectives: This module's objective is to sensitise participants that drug users and PLWHAs are human beings and need to be treated with respect and dignity. They also have rights as ensured in the constitution. It is essential that participants, specially those involved with providing treatment services have the right attitude towards service users. It is essential to remove the stigma surrounding drug use and HIV. This is important to enable the marginalized section of society to access treatment.

Methodology: In the beginning of the session facilitators should ask each participant about how they view drug users and PLWHAs. After highlighting human rights of drug users and PLWHAs, a group discussion should be initiated so that participants may be able to change their perception about drug users and PLWHAs.

- Each participant shares her/his views on how she/he perceives drug users and PLWHAs (approximately 1 hour).
- Presentation of Human Rights of PLWHAs and Drug users (30 minutes).
- Presentation of case scenarios of violation of human rights (15 minutes).
- Group Discussion (15 minutes).
- Feedback/Clarification (15 minutes).
- A discussion on how the module can be used by the participants (30 minutes).

Brief Contents:

Rights for People Living with HIV/AIDS

- The right to non-discrimination, equal protection and equality before the law.
- The right to life.
- The right to the highest attainable standard of physical and mental health.
- The right to liberty and security of person.
- The right to freedom of movement.
- The right to seek and enjoy asylum.

-
- The right to privacy.
 - The right to freedom of opinion and expression and the right to freely receive and impart information.
 - The right to freedom of association.
 - The right to work.
 - The right to marry and to found a family.
 - The right to equal access to education.
 - The right to an adequate standard of living.
 - The right to social security, assistance and welfare.
 - The right to share in scientific advancement and its benefits.
 - The right to be free from torture and cruel, inhuman or degrading treatment or punishment.

Human Rights Applicable in Case of Drug Use

These rights can be viewed as the rules of the game and as safeguards against injustice. Following are some basic rights of the accused person.

- The right against unreasonable searches and seizures.
- The right of a person to be informed of his constitutional rights.
- The right to a lawyer during criminal justice proceedings.
- The right to reasonable notice of the nature of the charge against the accused person.
- The right to be heard.
- The right to a fair trial.
- The right to a speedy and public trial.
- The right against double jeopardy.



UNITED NATIONS
Office on Drugs and Crime
Regional Office for South Asia

Ministry of Social Justice
and Empowerment
Government of India



Training Module for NGOs

DRUG USE AND HIV/AIDS PREVENTION AND MANAGEMENT

Knowledge and Skills Enhancement for NGO Staff



List of the Regional Resource and Training Centres (RRTCs)

REGION	NAME OF THE RRTC	CONTACT PERSON	STATES INCLUDED
South Zone	TTK Ranganathan Clinical Research Foundation, IV, Main Road, Indira Nagar, Chennai –600 020 Tamil Nadu	Dr. Ms. Shanthy Ranganathan, Honorary Secretary, Tel: 044-24918461 / 2491 2948 / 2441 6428 Fax: 044-28117150 E-mail: ttrcrf@md2.vsnl.net.in	Pondicherry, A.P., T.N., Kerala, Karnataka and Lakshadweep
East Zone	Vivekananda Education Society, 25/1A, Diamond Harbour Road, Arcadia, Kolkata – 700 034, West Bengal	Mr. C.G. Chandra Secretary, FAX: - 033-468 0364 Tel: - 468 0365, 468 1550 E-mail: chandra@cal.vsnl.net.in chandanchandra@hotmail.com	West Bengal (except Darjeeling) A&N Islands, Orissa, South Tripura
	The Calcutta Samaritans, 48, Ripon Street Kolkata – 700 016, West Bengal	Mr. Vijayan Pavamani Honorary Director Tel. 033 – 2229 5920/2229 9731 FAX 033- 2217 8097 E-mail: rrtccalsam@vsnl.net	Jharkhand, Bihar, Sikkim, Darjeeling
West Zone	Muktangan Mitra, Alandi Road, Mohanwadi, Yerawada, Pune 411006	Dr. Anil Awachat Secretary Tel. 020-6697605 Tele-Fax: 020 – 565 9407 E-mail: muktangan@vsnl.net	Goa, Maharashtra, Chattisgarh, M.P. (excluding Gwalior), Daman & Diu, Dadar & Nagar Haveli, Gujarat
North Zone	Society for Promotion of Youth & Masses (SPYM), B4/3054, Vasant Kunj New Delhi – 110 070	Dr. Rajesh Kumar Executive Director, Tel. 011-2689 3872 Fax. 011-2689 6229 E-mail: spym@vsnl.com	Gwalior, Uttar Pradesh, Rajasthan, Delhi, H.P., J&K, Haryana, Punjab and Chandigarh, Uttaranchal
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