



UNITED NATIONS  
*Office on Drugs and Crime*

Treatnet  
International network of drug dependence  
treatment and rehabilitation resource centres

# Drug Dependence Treatment: Role in the Prevention and Care of HIV and AIDS



## Preface

## Acknowledgements

The present publication is one of a series of four documents developed under UNODC project GLOH43: Treatnet-International network of drug dependence treatment and rehabilitation resource centres and responds to UNODC's mandate by the Demand Reduction Declaration and the Action Plan for its implementation, to develop and disseminate good practice in the field of drug abuse treatment. During Phase I this project developed an international network of drug treatment and rehabilitation resource centres in all regions, with a view to facilitating dissemination of knowledge and good practices. This document has been produced by members of one of four working group consisting of representatives from Treatnet members and the topics of the documents include: community-based treatment, the role of drug dependence treatment on the prevention and care of HIV and AIDS, Interventions for Drug users in prisons, and Sustained Recovery Management.

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## Disclaimer

Please note that this good practice document is to be further developed in the future. It has been prepared by a professionally and geographically diverse working group with participants from five drug dependence treatment centres as part of UNODC project GLO/H43 "Treatnet – International Network of Drug Dependence Treatment and Rehabilitation Resource Centres".

The views expressed are those of the authors and do not necessarily reflect the policies or views of UNODC. A reference to a document or website does not imply endorsement by UNODC of the accuracy of the information contained therein.

The aim of the review process is to assure comprehensiveness of the document "Drug dependence treatment: Role in the prevention and care of HIV and AIDS" and to ensure its relevance to different sociocultural environments as well as a balanced representation of different perspectives on the issue.

The document will be formally edited at a later stage. We are fully aware that some work has to be done with regards to the consistency of terminology used in this document.

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## Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti Retroviral Therapy
ARV	Anti Retroviral Medication
ATS	Amphetamine Type Stimulants
CDC	Centre for Disease Control and Prevention
SW	Sex Workers
HAART	Highly Active Antiretroviral Therapy
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
MI	Motivational Interviewing
MMT	Methadone Maintenance Therapy
NSP	Needle and Syringe Program
NGO	Non Government Organisation
PLWH	People Living With HIV
SDATC	Shanghai Drug Abuse Treatment Centre
STI	Sexually Transmitted Infection
SMHC	Shanghai Mental Health Centre
VCCT	Voluntary and Confidential Counseling and Testing
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund (formerly United Nations International Children's Emergency Fund)
UNODC	United Nations Office of Drugs and Crime
UNESCO	United Nations Education, Scientific and Cultural Organization

## Chapter One: Introduction

### HIV Infection Overview

Since 1981, nearly 65 million people have been infected with HIV and an estimated 25 million have died of AIDS-related illnesses. An estimated 33 million people were living with HIV at the end of 2007 and an estimated 2.5 million became newly infected in that year. The vast majority of these people are unaware of their status (UNAIDS 2007).

### Injecting Drug Use

Over the past 20 years, HIV infection has become a much more serious risk of unsafe injecting drug use. This risk is for the drug user, his/her spouse or partner and the society at large. It has been estimated that there were 13 million injecting drug users world-wide in 2005, and from 5% – 10% of new HIV infections were attributable to injecting drug use in that year (WHO 2006). Injecting drug use is now estimated to account for one-third of new HIV infections outside the sub-Saharan region of Africa. Use of contaminated injection equipment accounts for 80% of all HIV cases in Europe and Central Asia (UNAIDS 2006). The authors of the UNAIDS Report on the Global AIDS Epidemic (2006) claimed that:

*Fewer than 20% of people who inject drugs received HIV prevention services, with coverage of less than 10% reported in Eastern Europe and central Asia, where drug use is a major driver of the rapidly expanding epidemic. Counterproductive laws and policies in some countries still prohibit pharmacotherapy treatment with buprenorphine or methadone despite their listing on the WHO Model List of Essential Medicines in 2005 (p 15).*

Although HIV risk increases dramatically if drugs are injected with contaminated injecting equipment, non-injecting drug users can also be at risk. For example, risky sexual behaviour whilst intoxicated can elevate risk of infection (Plankey et al 2006).

It should be noted that this document focuses on the prevention and management of HIV. While there is reference to the morbidity and mortality associated with blood-borne viruses such as Hepatitis B and C, more detailed examination will be found in other publications. It goes without saying that any strategies designed to reduce HIV and to manage it more effectively should consider the appropriateness of including additional messages about diseases that drug users may be exposed to.

## Drug Dependence Treatment

A recent WHO/UNAIDS/UNODC policy brief (2004) reported the effectiveness of a wide range of illicit drug treatment modalities in reducing potential HIV transmission. The modalities included:

- Pharmacotherapies (e.g. methadone and buprenorphine),
- Abstinence-based treatment (including skills development, relapse prevention, self help and mutual support); and
- Behavioural interventions (psychosocial support to encourage behavioural and emotional change). These could be part of substitution or abstinence-based programs.

These treatment approaches all have the capacity to reduce drug use in general. They have also been shown to reduce the frequency of injecting and levels of associated risk taking behaviour (WHO/UNAIDS/UNODC 2004).

The authors concluded that 'there is a large body of scientific evidence on the effectiveness of pharmacotherapy vis-à-vis HIV and AIDS and behaviour related to drug use, as outlined below.

- Numerous studies have yielded consistent and strong evidence that pharmacotherapy is associated with substantial reductions in illicit opioid use, criminal activity, deaths attributable to overdoses, and risk behaviour related to HIV transmission
- There is evidence indicating that methadone pharmacotherapy improves the overall health status of drug users infected with HIV
- Pharmacotherapy is more effective than no treatment, placebo and detoxification alone in retaining drug users in treatment and reducing heroin use
- Pharmacotherapy is associated with higher earnings, improved levels of employment and social functioning, e.g. a return to employment and education' (WHO/UNAIDS/UNODC 2004, p1).

In a systematic review, Ritter and Cameron (2005) found there was substantial evidentiary support for needle and syringe programs in terms of efficacy, effectiveness and cost-effectiveness. They have been demonstrated to reduce risk behaviors, including exposure to HIV and increase willingness to enter treatment. There is an argument for including the provision of sterile injecting equipment as part of a comprehensive treatment response. This is acknowledgement that drug dependence is a chronic and frequently relapsing condition that requires pragmatic responses to support drug users to become drug free. There is a need to ensure that they are not unnecessarily exposed to serious harm whilst undergoing treatment. A WHO (2004) report concluded:

*There is compelling evidence that increasing the availability and utilization of sterile injecting equipment for both out-of-treatment and in-treatment injecting drug users contributes*

*substantially to reductions in the rate of HIV transmission (2004, p2).*

### **Challenges**

Despite the overwhelming evidence of the relationship between unsafe injecting drug use and HIV infection and the availability of effective drug dependency treatments, many injecting drug users do not access treatment (for drug use or HIV infection). Injecting drug user populations are often well hidden and even if they desire treatment, fear of stigmatisation, discrimination, family shame or fear of incarceration may prevent them from seeking help. Socio cultural and economic circumstances may predispose or increase the vulnerability of some people to drug use and misuse. It is also the case that in many countries evidence-based prevention and treatment services for drug dependency and HIV infection are not available. Healthcare is often fragmented and limited by legal or regulatory barriers (WHO 2006).

A UNAIDS report on the global AIDS epidemic (2006) highlighted that over 30 countries indicated that stigma and discrimination against people living with HIV remains pervasive. Half the countries submitting reports acknowledge the existence of policies that reduce access and effectiveness of HIV prevention and care measures. Drug dependent people living with HIV and AIDS do not have equitable access to HIV/AIDS treatment, care and support services as a result of multi-level stigma and discrimination and the lack of availability of HIV/AIDS treatment in programs for injecting drug users (WHO 2006).

### **Basic Principles to treat and support drug dependent people living with HIV**

The lack of equitable access to HIV treatment, care and support services for drug dependent people prompted WHO to develop principles and strategies to guide policy makers, treatment planners and service providers to improve access. The principles are listed in the table below.

<b>Basic Principles for Treatment &amp; Social Support of Drug Dependent People Living with HIV.</b>	
<b>Principle 1</b>	<p><b>Human rights of drug dependent people with HIV</b></p> <p>The human rights of drug dependent people living with HIV should be fully respected to ensure their appropriate treatment and psychosocial support. They should not be subjected to stigma or discrimination because of their past or present drug use, health status including HIV, race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, sexual orientation or civil, political, social or other status. This principle forms the core of an ethical and effective strategy for combating both drug dependence and the spread of HIV.</p>
<b>Principle 2</b>	<p><b>Evidence-base for treatment, care and psychosocial support</b></p> <p>The health and social care provided to drug dependent persons living with HIV should be based on salient evidence. Evidence is essential for advocacy, planning and delivery of 'good practice' interventions.</p>
<b>Principle 3</b>	<p><b>Appropriate treatment and psychosocial support</b></p> <p>Drug dependent people living with HIV should have access to appropriate and high quality services, which offer a full range of biological, psychological and social interventions, including drug dependence treatment, HIV treatment and primary health care.</p> <p>These include detoxification and relapse prevention programs, substitution maintenance therapy for opioid dependence, psychosocial care, HIV testing and counseling, antiretroviral therapy, treatment adherence support, post-exposure prophylaxis, treatment of opportunistic infections and co-infections as well as access to harm reduction interventions.</p>
<b>Principle 4</b>	<p><b>Equitable access to HIV care and treatment including antiretroviral therapy (ART)</b></p> <p>Past or present drug use should not pose a barrier to equitable access to all available state-of-the-art HIV treatment and care, including anti-retroviral therapy and psychosocial support. Drug dependent people should be accorded the same treatment, care and psychosocial support as the rest of the HIV-positive population in their country, and their exclusion from such care is medically and ethically indefensible.</p>
<b>Principle 5</b>	<p><b>Supportive environments to enable and facilitate treatment, care and psychosocial support</b></p> <p>Restrictive policies that can impede access to effective treatment and care of individuals suffering from substance dependence and HIV are detrimental both to the health and well being of drug dependent people living with HIV and to the larger community.</p> <p>Supportive environments will maximize the efficacy of the treatment and care such people receive by removing the obstacles that impede appropriate interventions and by creating the conditions, both national</p>

	and local, that foster good practice and maximize the availability, acceptability and accessibility of treatment and care.
<b>Principle 6</b>	<b>Client participation</b> Drug dependent people with HIV should not be just passive recipients of treatment but should fully participate in the planning, delivery, evaluation and monitoring of services.
<b>Principle 7</b>	<b>Participation of community and other stakeholders</b> Community and non-government organizations should be active participants in, and advocates for, the development and implementation of treatment, care and psychosocial support for drug dependent people living with HIV.
Table compiled from - WHO (2006) Basic Principles for Treatment & Social Support of Drug Dependent People Living with HIV/AIDS. Geneva, Switzerland.	

## Report Overview

This report examines the role of drug dependence treatment in the prevention and care of HIV. The aim is to provide evidence and examples of drug dependence treatment and prevention strategies that constitute good practice in this area. It should be noted that many of the strategies outlined in this report also apply to drug use, or problematic, non-dependent drug use. Practical examples have been selected from across the globe to demonstrate that a wide variety of interventions can be implemented in diverse settings (including rural and resource constrained areas).

The report target group is drug treatment service providers and therefore the emphasis has been on the provision of evidence-based, practical information.

**Chapter Two: *Accessible Pharmacotherapy Treatments*** outlines the evidence supporting pharmacotherapies as the most effective treatment for engaging opioid users in treatment, improving their quality of life and reducing the risk of HIV infection and transmission. It is noted that regular counselling, psychotherapy or family therapy provided in conjunction with pharmacotherapy improves treatment effectiveness. This chapter also notes that effective pharmacotherapies are not currently available for other drugs that are frequently injected such as cocaine and amphetamine-type stimulants.

**Chapter Three: *HIV Information, Education and Communication (IEC)*** identifies the important role that IEC plays in preventing the spread of HIV and other blood-borne viruses among injecting drug users. Such strategies are critical given the often very poor understanding that injecting drug users have about HIV and the lack of access they may have to services and products that may provide protection against infection.

**Chapter Four: *Drug Withdrawal Services*** highlights that withdrawal from drugs is only the first step in a recovery process. In what is often described as a chronic relapsing condition, drug withdrawal is not difficult to achieve with the adequate supervision. Staying drug free requires a wide range of support services. An important role of withdrawal services is the opportunity it provides to offer voluntary counselling and HIV testing and ARV therapy.

**Chapter Five: *Psychosocial Supports*** outlines the range of supports that are necessary for the effective treatment of drug dependence and HIV. Family, peer and professional support is associated with better treatment retention and improved treatment outcome.

**Chapter Six: *Antiretroviral Therapy for Injecting Drug Users*** highlights that the availability of antiretroviral treatment has transformed HIV into a manageable chronic illness. The chapter dispels the myth that injecting drug users fail to adhere to ARV therapy.

**Chapter Seven: *Access to Sterile Injecting Equipment*** discusses the research evidence that demonstrates the efficacy of needle and syringe provision for both in and out of treatment injecting drug users. The importance of such programs is highlighted despite acknowledgement that some cultural, political and economic environments make the provision of such services difficult.

**Chapter Eight: *Outreach*** outlines the importance of such services in accessing hidden populations and providing education, support, access to harm reduction services and facilitating access to treatment.

The structure of each chapter provides a brief literature review, a series of good practice principles and good practice examples. The good practice examples are based on the definition of good practice developed by Treatnet and outlined in the table below.

## Good Practice Statement

Treatnet defines 'good practice' as an umbrella term that encompasses evidence based and promising practices.

**Evidence-based practices** have been studied using appropriate scientific methodology and replicated in multiple geographic or practice settings. These practices produce specific, consistent outcomes and have been documented in scientific journals and frequently manualized.

**Promising practices** have been demonstrated to be effective, using objective measures, in one or more organisations. These practices may be at an early stage and show promise of replication, long-term sustainability and becoming evidence-based practices.

In addition, good practices should display the following features:

- Relevance to local needs.
- Ethical soundness.
- Sustainability likelihood (low cost, cost efficient, integrated, supported), and
- Replicability (sufficiently documented).

## Chapter Two: Accessible Pharmacotherapy Treatment.

### Introduction

Drug dependence is a complex health condition that often requires long-term treatment and care. It is associated with a high risk of HIV and Hepatitis B & C infection when drugs are injected using contaminated injection equipment. Hepatitis B is now a major cause of mortality and morbidity in older drug users. Although many drugs can be injected, there is not yet an effective pharmacotherapy for cocaine or amphetamine use disorders. The evidence-based treatment was developed for opioid dependence only. The objective of drug dependence treatment is the achievement and maintenance of physical, psychological and social well-being through reducing the risk-taking associated with drug use, through reducing levels of drug use, or through complete abstinence from drug use (WHO/UNODC/UNAIDS 2004).

The potential impact of drug dependence treatment on preventing HIV is via:

- Reduced frequency of injecting;
- Reduced sharing of injecting equipment;
- Reduced risk behaviours related to sexual transmission of HIV; and
- Enhanced opportunities for HIV education and medical care (Sorensen & Copeland, 2000).

Simple detoxification, or stopping opioid use is often insufficient. A therapeutic process is required to enhance the likelihood of long-term behaviour change. Detoxification is a first step for many forms of longer-term abstinence-based treatment. Both detoxification with subsequent abstinence-oriented treatment or ongoing pharmacotherapy treatment are essential components of an effective treatment system for people with opioid dependence.

The scientific evidence clearly demonstrates that pharmacotherapy is the most effective option for opioid dependence treatment related to HIV transmission, and the care of drug users living with HIV. Pharmacotherapy (or 'substitution therapy', 'agonist pharmacotherapy', 'agonist replacement therapy', 'agonist-assisted therapy') is defined as the administration under medical supervision of a prescribed medicine with similar action to the drug of dependence. Medicines used in pharmacotherapy can be prescribed either in decreasing doses over short periods of time (usually less than one month) for treatment of withdrawal or for detoxification, or in relatively stable doses over a long period of time (usually more than six months). In either case the

medication allows stabilization of brain functions and prevention of craving and withdrawal.

Globally, the most widely employed pharmacotherapy for illicit drug users is methadone, prescribed in maintenance doses at around 60-80 mg per day (but much higher in some countries – eg. 120+ mg in Ukraine). There is variation between the research evidence and clinical judgement about effective dosing (Trafton et al 2006). This leads to wide variation in dosing regimes around the world. Buprenorphine is a more recent addition to the pharmacotherapies for opioid dependence. Research has shown buprenorphine to be an effective maintenance agent and to have a better safety profile in overdose than methadone and other agonists. The general view is that buprenorphine can be prescribed in higher doses in maintenance treatment without undue sedation. Buprenorphine is also effective for detoxification, producing less severe and protracted withdrawal symptoms than methadone. Another advantage of buprenorphine is that it has a longer half-life than methadone and is capable of less than daily dosing. The research evidence suggests that a doubled dose every two days or a tripled dose every three days are acceptable to clients and do not induce untoward agonist or withdrawal effects.

The combination of buprenorphine and naloxone (Suboxone) was developed to prevent abuse of buprenorphine by injection, and is provided in tablet form for sublingual administration.

Antagonist pharmacotherapy is defined as the administration under medical supervision of a blocking agent, which stops the drug of dependence from having an effect, removing the euphoria and other desired effects. Currently the only antagonist being used in relapse prevention treatment programs for opioid dependence is naltrexone.

### **Literature Review**

- There is strong evidence that pharmacotherapy treatment for opioid dependence is associated with a significant reduction of illicit opioid use, criminal behaviour (Marsch, 1998; R. Mattick et al., 2002; Gowing et al., 2004) and sharing of injecting equipment (Farrell et al., 2005). Data on sex-related risk behaviour change are limited, but suggest that pharmacotherapy is associated with a lower incidence of multiple sex partners or exchanges of sex for drugs or money, but no change, or only small decreases, in unprotected sex.
- Pharmacotherapy treatment has been demonstrated to improve general health and quality of life (Torrens et al, 1997)

- Methadone treatment has been shown to significantly reduce mortality rates compared to clients not receiving methadone (Brugal et al 2005)
- Provision of drug counselling, cognitive therapy, family therapy and other psychosocial interventions in addition to pharmacotherapy treatment improves treatment outcome (McLellan et al 1993)
- Pharmacotherapy reduces HIV transmission and seroconversion (Gowing et al, 2004). This suggests that the reductions in risk behaviours achieved by pharmacotherapy do translate into actual reductions in new cases of HIV infection.
- There is evidence that pharmacotherapy for HIV-positive injecting drug users is associated with better compliance with anti-retroviral treatment and improved health outcomes (O'Connor, Selwyn, & Schottenfeld, 1994; Avants et al, 2001).
- There are fewer complications for pregnant women and their unborn children who are in pharmacotherapy treatment in comparison with those who are not in treatment (Burns et al., 2007).
- Methadone of 60 mg/day or more have been identified as being most effective in terms of retention in treatment and reductions in illicit drug use (Kreek, 2000; Ward et al., 1998).
- The investment in pharmacotherapy is cost-effective in comparison with the costs of later treatment of HIV and related diseases.
- Pharmacotherapy is associated with higher earnings, improved levels of employment and social functioning (WHO, 2004)
- In some countries where methadone is not allowed, naltrexone is the only available pharmacotherapy that might improve chances for relapse prevention and reduced HIV transmission. In addition, naltrexone is an option for clients who cannot use methadone for medical or other reasons (Cornish et al, 1997). However, client acceptance of naltrexone is often poor, resulting in high treatment drop-out. Studies in St Petersburg have shown 42-44% adherence to treatment at six months. Adherence rates may be further improved with depot versions of the drug (Krupitski et al, 2004). For the highly motivated who remain in treatment, outcomes are good in terms of reduced drug use, improved employment and psychosocial status (Gowing et al., 2001).
- Research is underway to develop pharmacotherapy treatments for amphetamine-type substances. Dexamphetamine is the most widely researched, however supporting evidence is poor. Modest improvements have been offset with increased risk of psychosis, continued drug use and diversion of prescribed medication. Trials are now underway to examine the feasibility of modafinil (a novel wakefulness agent) as an ATS substitute (ANCD 2006).

### **Good practice principles**

- The full range of pharmacotherapies should be available in all countries. Access and affordability should be guaranteed. Access to services is a real challenge given the low attendance at traditional services. Service location and design must consider the cultural, social or economic barriers to attendance and implement strategies to address these.
- Pharmacotherapy treatment should be supported by counselling and other psychosocial interventions tailored to meet client needs
- Drug treatment programs should provide opportunities for early diagnosis of other health problems, HIV testing and counselling, psychosocial counselling interventions and referral for additional services as well as HIV treatment, care and support
- The dose and duration of methadone pharmacotherapy should be based on an assessment of the individual client needs (Doses above 60-80 mg per day are better at achieving retention in treatment and reducing illicit drug use)
- People living with HIV should have an open access to long-term pharmacotherapy program and be provided with doses sufficient for well-being without the need for additional use of illicit drugs
- The practice of pharmacotherapy must be guided by research evidence and supported by adequate training and evaluation
- The medications should be administered orally in the form of a tablet or a solution to reduce the risk of infections associated with injections
- Naltrexone should only be administered to highly motivated persons with family support, after 7-8 days of detoxification. Engagement of parents or significant others in the treatment process has been shown to increase treatment adherence and retention.
- Further trials are required to identify medications that could be used as a treatment for cocaine and amphetamine-type substances.

### **Guidelines for establishing pharmacotherapy services**

- Pharmacotherapy programs should clearly articulate the goals of treatment. These might include:
  - To reduce the wide range of harms associated with drug dependence (including overdose, HIV and Hepatitis infections and other health, legal and social problems)
  - To assist clients to stay healthy until, with the appropriate care and support, they can achieve the goal of a drug-free life
  - To reduce the use of illicit and non-prescribed drugs by the individual

- To reduce the duration of episodes of drug use
  - To reduce the chances of future relapse to drug use
  - To reduce the need for criminal activities in order to finance drug use
  - To improve overall personal, social and family functioning
- Pharmacological treatment of opioid dependence is usually provided in a certified, licensed opioid treatment program or a physician's office.
  - Treatment guidelines vary among countries. Some countries have guidelines that require two or more years of proven dependence and several failed attempts at detoxification or rehabilitation. Exceptions are often made in cases of pregnancy, HIV infection or other serious illnesses. Other countries have far fewer barriers to pharmacotherapy access (low threshold services). Clients should have no allergic reactions to methadone or buprenorphine and should be able to attend treatment sessions regularly, especially for medication dosing.
  - For schedules and doses of substitution medicines see *WHO/UNODC/UNAIDS Position Paper - Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention* (2004).  
[http://www.who.int/substance\\_abuse/publications/en/PositionPaper\\_English.pdf](http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf)
  - Provision of pharmacotherapies for people with opioid dependence and HIV must address clinical and psychosocial issues related to both conditions. The combination of opioid dependence and HIV infection can result in specific clinical situations such as:
    - The occurrence of particular HIV-related opportunistic infections
    - The masking of HIV-related symptoms by opioid pharmacotherapies, and
    - Interactions between opioid pharmacotherapies and medications used to manage HIV infection.
  - Those treating opioid dependence in persons with living with HIV need to be aware of these clinical situations. Conversely, those treating individuals with both HIV and opioid dependence need to be familiar with common approaches to the treatment of opioid dependence and related problems.
  - Poor management of opioid dependence may interfere with adherence to treatment regimens for HIV and AIDS, and it is therefore imperative that treatment for opioid dependence is initiated to support adherence

to antiretroviral treatment and medical follow-up. People with both opioid dependence and HIV are often doubly stigmatised. In many countries they are excluded from the provision of antiretroviral treatment in spite of the evidence that individuals with opioid dependence benefit from appropriately administered HIV/AIDS drug treatment. Programs that integrate pharmacotherapies for opioid dependence with HIV treatment and care should therefore be encouraged. Directly observed therapy for opioid dependence also provides an opportunity for the implementation of directly observed antiretroviral therapy as well as therapy for opportunistic infections such as tuberculosis.

- Certain interactions between methadone and antiretroviral medications for HIV and AIDS treatment are known and may have important clinical consequences. Methadone has an adverse interaction with several ARV medications, causing withdrawal. Clinicians need to monitor and adjust doses accordingly. For more information see *WHO, 2006. HIV/AIDS Treatment and Care for Injecting Drug Users. Clinical Protocol for the WHO European Region* [http://www.euro.who.int/document/SHA/WHO\\_Chapter\\_5\\_web.pdf](http://www.euro.who.int/document/SHA/WHO_Chapter_5_web.pdf)
- Research on Buprenorphine suggests that it has fewer and less significant interactions with antiretrovirals than methadone (McCance-Katz et al 2006).
- All pharmacotherapy programs need to address the issue of drug diversion. This might include dispensing seven days per week, monitoring clients to ensure the drugs are taken and urine testing. Failure to put such controls in place has the capacity to undermine confidence in such programs and may lead to decisions to discontinue them.
- All pharmacotherapy programs need to be able to address polydrug use as it is seldom the case that drug users use one drug exclusively. Failure to treat all drug use can seriously compromise treatment outcomes.

## **Conclusions**

Pharmacotherapy for opioid users has proven to be effective in terms of retention in treatment, reduction of drug use, improvement of psychological and social functioning, and reduction of unsafe injecting and sexual behaviours. Treatment outcomes are improved if psychosocial treatments are offered in addition to the pharmacotherapy. It is an effective prevention measure and a proven treatment that minimises the risk of further transmission of HIV. It stabilises the underlying condition for those who are drug dependent and living with HIV. Naltrexone is a potentially effective treatment option for those who are able to adhere to it. Lack of an effective substitute therapy for cocaine and amphetamine-type substances reduces the capacity to engage this growing group of injecting drug users in treatment.

Whilst pharmacotherapy has been demonstrated to be an effective treatment for opioid dependence, it is also important to address the structural drivers that impact drug user's lives and consider other means to aid the recovery process. For example, programs to improve literacy and livelihood skills will assist in the long-term recovery process.

## Good Practice Example

### Methadone Maintenance Treatment as HIV prevention and harm reduction

**Country:** China

**Project Name:**

Methadone Maintenance Treatment Outpatient clinics, Shanghai Hongkou District Mental Health Centre

**Starting Year:** 2006

**Responsible Organisation:**

Shanghai Hongkou District Mental Health Centre, Shanghai, China.

**Background:** In order to reduce HIV infection and other harms related to illegal drug use, the Chinese Public Health Department, Public Security Department, and Food and Drug Administrative Bureau jointly issued the "Community Methadone Maintenance Treatment (MMT) for Opiates Dependence Pilot Project". According to China's HIV/AIDS Action Plan (2006-2010) and HIV/AIDS prevention ordinance, the first MMT outpatient clinic was established in 2004 in Sichuan province. Based on the specific situation, the first MMT outpatient clinic was established in Shanghai 2005. Up to early 2007, there were 5 MMT clinics in Shanghai and more than 300 MMT outpatient clinics across China. The MMT outpatient clinic at Hongkou District Mental Health Centre was established in 2006.

**Objectives:** The aims of the program are to:

- Reduce heroin and other opiates use;
- Decrease the transmission of HIV, Hepatitis B, Hepatitis C and other blood borne viruses among injecting drug users;
- Decrease criminal activities; and
- Improve psychosocial functioning through Methadone Maintenance Treatment, counselling, and other related services.

**Process/activities:**

Participants requirements are:

- Required to meet the diagnostic criteria for opiate dependence according the Chinese Classification of Mental Disorder-3 (CCMD-3);
- To be above 20 years old (no age limitations for HIV positive cases); and
- To be resident in Shanghai or live in Shanghai for more than 6 months with a temporary resident card.

Medical doctors will conduct physical examinations to the eligible participants and conduct laboratory tests such as EKG, Chest X-rays, HCV test, HIV test,

liver and kidney function, urine test for drugs, etc. Then MMT will be started after obtaining the informed treatment consent form from the participants. The first methadone dosages are 10-30mg according to the individual's situations, and adjusted to the maintenance dosages (40-80mg) in 3-5 days. Social Workers and staff from CDC will provide counselling and psychosocial support during the methadone maintenance treatment.

**Outcome/achievements:**

Since establishment in 2006, 272 heroin dependent clients have participated in the MMT. Up to the end of June 2006, there were 217 clients (79.6%) still in the MMT, 78.8% (171 cases) were males and 21.2% (46 cases) were females. The majority of the clients (96%) only had junior high school education and the average age was 41.8 years old.

**Lessons and challenges:**

More related departments or systems are needed to work together to diminish the stigma around drug dependence and help drug dependent clients to reintegrate into society.

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## Chapter Three: HIV Information, Education and Communication

### Introduction

With many countries reporting a rise in HIV infection among drug users, information, education and communication (IEC) have an important role to play in HIV prevention and harm reduction among drug users and their sexual partners. The goal of IEC is to provide accurate and credible information to promote behaviour that reduces risk. Although not the focus of this document, it is critical that any IEC strategies incorporate information on other blood-borne viruses, particularly Hepatitis B & C. Both contribute to the mortality and morbidity of drug users globally.

Three factors necessary for successful HIV prevention are good quality information/education, appropriate health services and a supportive environment (Mann, 1993)

The various modalities of IEC delivery are:

- Public awareness campaigns,
- Targeted campaigns,
- Peer network and other outreach services,
- Social marketing campaigns, through health services and Voluntary and Confidential Counselling and Testing (VCCT) programs e.g. hospitals, pharmacies, use of posters placed in strategic sites e.g. colleges, public transport system (underground, trains, bus, taxis), nightclubs,
- HIV antiretroviral treatment adherence campaigns, vital information packs, leaflets and booklets, videos and computer-delivered HIV education and information interventions.

Two practical approaches to IEC are the individual and structural level approaches. Individual approaches focus on change at the individual level, exploring how individual injecting drug users and their partners (either sexual or injecting) can be persuaded to reduce or eliminate known risk related behaviours and/or embrace safer practices.

Structural level approaches aim to change the political, economic, and social and community context in which individuals live their lives. Typically these approaches are outlined in national, provincial and local HIV and related policies. IEC approaches have included structural and environment outreach

work and promote development of safer community structures. IEC approaches have also been used among other systematically disadvantaged, stigmatised and ostracised groups including migrants and refugees, sex workers, sexual minorities and people with disabilities. Examples of projects focussed on these groups are provided in '*Another Way to Learn*' (UNESCO, 2007). The examples highlight the need to reach out of school youth and adults who have failed to complete significant levels of education.

Inclusion of IEC within harm reduction programs can have a significant impact on HIV- related risk behaviour. These harm reduction programs need to provide IEC on:

- Safe sex practice
- Safe injection and vein maintenance
- Needle & syringe programs
- Male and female condom demonstration and distribution
- Awareness of other sexually transmitted and blood borne diseases
- Drug treatment programs including substitution therapies; and
- Availability of VCCT facilities.
- Anti Retroviral Therapy

### **Literature review**

- The evidence of effectiveness of IEC is a complex issue since relatively few good quality evaluation studies have been reported in the international literature.
- To be effective IEC should aim to reach a large mass. Elements necessary for mass-reach media-based interventions to be effective include an emphasis on the positive benefits of changing behaviour, stressing short-term effects and benefits, which are likely to have more of an impact than stressing longer term outcomes (Backer, Rogers, & Sopory, 1992).
- Language, vocabulary and mode of communication are important in ensuring success (Burrows, 2001). Multifaceted and integrated interventions, in which mass media advertising is complemented by in-school programmes and other activities, have been found to be particularly effective in producing health behaviour change (Backer et al, 1992; Perry et al, 1992; Pierce et al, 1990)
- A meta-analysis on the effectiveness of educational programs (Cross et al., 1998) revealed a positive effect of educational program on reducing injecting behaviours, bleach use and injecting equipment-sharing behaviours (with lower but still positive effect on condom use).

- Prendergast et al. (2001) completed a comprehensive meta-analysis of HIV interventions within drug treatment programs. The majority of programs included in the study covered didactic presentation of information, discussion, with some skill demonstration. The results revealed an overall positive effect for harm reduction interventions in the context of drug treatment. Significant changes in knowledge, attitudes and beliefs; sexual behaviours; and risk reduction skills (but not for injection practices) were reported.
- Various studies suggest that mass reach interventions are rarely effective in directly reducing drug use or bringing about reduction in risk-related behavior, although they can be effective in raising awareness and changing knowledge (Don & Murji, 1992; Flay & Burton, 1990).
- The active involvement of injecting drug users in situation and needs assessment, in program development and delivery and in monitoring and evaluation is also crucial for successful IEC (Ball & Crofts, 2001)

### **Good practice principles**

- It is important for a community to start HIV prevention programming as early as possible. Even when HIV is well established, HIV prevention programming can have a significant impact on the further spread of HIV. Early prevention efforts have been successful in maintaining low levels of seroprevalence in many local settings.
- HIV risk reduction in drug-using populations is an achievable goal. One objective of any contact with drug users is to assist them to stop using drugs. However, recovery from drug dependence can be a long-term process and relapse into drug use may occur even among persons in drug treatment. To prevent the spread of HIV, drug users must be encouraged and supported to reduce or eliminate those behaviours that place them and others at risk.
- Effective prevention programming requires a comprehensive range of coordinated services. Drug users and their sex partners at risk for HIV are diverse, and no single prevention strategy will work for everyone. Some individuals often require multiple interventions and an array of prevention services, either concurrently or at different points in their lives. Comprehensive strategies should include community outreach, peer education, HIV testing and counselling, prevention case management, drug treatment and sterile syringe provision. HIV testing must be supported by pre and post-test counselling. The American Centre for Disease control is recommending new technology for rapid, accurate on-site testing. For details see: <http://www.cdc.gov/MMWR/preview/mmwrhtml/mm5624a3>.

- Prevention programs must be based on a thorough, continuing assessment of local community needs and surveillance of drug use and HIV-risk behaviour patterns. Prevention strategies must be adapted to local community needs and resources.
- Prevention services are most effective in reaching at-risk populations when they are available in a variety of locations, provided in a range of service settings and coordinated to enhance impact and avoid duplication.
- Already infected drug users and their sex partners are important target groups for prevention and treatment efforts. They need to be engaged in treatment and informed through IEC of the need for behaviour changes to avoid further HIV transmission.
- Prevention efforts must target individuals, couples, risk networks, and the broader community of drug users and their sex partners. Behavioural norms within a local drug-using community that permit sharing of injection equipment also need to be modified. Relying on opinion leaders in groups can be an effective strategy to influence the drug-using behaviours of risk networks. Behaviour change must be based on sound advice provided through IEC strategies.
- Community-based outreach is an essential HIV prevention strategy and must be directed to drug users in their natural environments. Drug use is usually a covert activity, making drug users and their sex partners difficult to access through traditional health and social service agencies. Peer educators undertaking outreach work who are familiar with the drug use subcultures in their communities have been shown to be particularly effective agents of behaviour change. Peer outreach workers can:
  - Act as referral sources to service agencies and drug treatment facilities,
  - Distribute HIV information and risk-reduction supplies; and
  - Provide skills-building demonstrations, such as syringe cleaning or condom use.
- They serve as opinion leaders who educate and influence their peers to reduce risks for HIV and increase behavioural self-efficacy. The outreach worker should repeat messages of HIV prevention at every contact with a drug user to reinforce how important it is to stop using drugs, or use more safely.
- Prevention interventions must be personalised for each person at risk. Effective prevention requires more than simply passing out information and risk-reduction supplies. Persons at risk must be engaged in a personalised assessment of their own risk behaviours, assisted in identifying barriers to and resources available to help them change their behaviour, and helped to formulate specific and achievable strategies to protect themselves and others.

- Drug users and their sex partners must be treated with dignity and respect and with sensitivity to cultural, racial/ethnic, and gender characteristics. Successful engagement of at-risk populations in interventions requires that they recognise that concern for them is genuine and that they are seen as capable of undertaking behavioural change. Outreach approaches must be socially and culturally appropriate.
- IEC alone is insufficient to achieve widespread behaviour change. Sterile injection equipment must be readily available to IDUs to reduce their need to use injection equipment previously used by other injectors. Individuals are at high risk for HIV and other infections if they share or re-use someone else's syringe and other injection equipment (including cookers, cottons, and rinse water). Research has shown that access to syringe exchange and pharmacy syringe distribution programs, as part of comprehensive HIV prevention programming, is effective in reducing syringe sharing and in preventing the spread of HIV (WHO 2004).
- Interventions targeting injection risk must address sharing needles and syringes, and other injection equipment (including cookers, cotton, water, and drug solutions that have been prepared for injection). Although sharing of other injection equipment is less risky for transmitting HIV than sharing syringes, it presents a potential additional route of infection for HIV and other diseases (e.g., hepatitis B and C) and must be addressed. Sharing drug solutions (drugs mixed with water in preparation for injection) is a significant, but frequently overlooked, HIV transmission risk. Targeted interventions can enable drug users to reduce the risks associated with sharing injection equipment and drug solutions. Many injecting drug users don't have accurate information on which they can modify risky practice. It is the role of IEC to provide such information.
- In addition to offering accurate and up-to-date information on risky behaviours, effective programs focus on enhancing motivation to change behaviour patterns, teach concrete strategies and behavioural skills for reducing risk, provide tools for risk reduction, and offer reinforcements for initial behaviour change. IEC is an important component of such programs.
- Prevention efforts, including IEC, must address sexual transmission risks as well as risks associated with injecting drug use. Many non-injecting drug users and their partners are at risk for HIV infection and its transmission because of unsafe behaviours associated with their drug use, such as engaging in unprotected sex. Both male and female condom demonstration and distribution programmes should be encouraged and sustained. For all sexually active individuals, drug and alcohol use may reduce inhibitions and increase the likelihood of unsafe sexual behaviours.

- Although brief interventions have been shown to significantly reduce HIV risk among substantial numbers of drug users, they are not sufficient as a single, 'one-off' strategy. Sustained and repeated interventions are usually needed. IEC strategies are critical if messages are to be reinforced over a sustained period. The information may need to be continually updated as drug use and harm patterns change. The messages may also need to be reinvigorated on a regular basis to engage peoples' interest in the information provided.
- Sustained, well-designed prevention programs are cost-effective and can lead to substantial reductions in health care and social service costs associated with the treatment and care of persons with HIVDS and other infectious diseases. IEC is a critical component of community-based prevention programs.

### **Conclusion**

Education, information and communication strategies are very important and effective components of community-based prevention programs. With a focus on harm reduction, they play an important role in guiding drug users towards use of VCCT services, harm reduction services and appropriate healthcare services (especially ARV provision and opioid pharmacotherapy). IEC programs must be well supported to reach target groups and to be sustained over a long period of time. To support individual and community behaviour change, IEC must also target policy-makers, opinion formers, religious leaders and community members to ensure that they develop a better understanding of drug users and their needs. IEC alone is an insufficient strategy for achieving significant community level behaviour change. It must be supported by providing a range of harm reduction, drug treatment and other support services.

## Good practice examples

HIV/AIDS Prevention, Ukraine
<p><b>Country:</b> Ukraine</p> <p><b>Project Name:</b> HIV/AIDS Prevention among IDUs</p> <p><b>Starting Year:</b> 1996</p> <p><b>Responsible Organization:</b> "Vera, Nadeshda, Ljubov" is a locally based NGO. Funding was provided by UNAIDS, UNICEF, and the Lindesmith Centre.</p> <p><b>Background:</b> During the 1990s Ukraine had the highest proportion of HIV cases in Eastern Europe. Reported cases had increased 200% over the five years period prior to the commencement of this project. The estimated number of the people living with HIV/AIDS was 400,000. Injecting drug use was responsible for 75% of HIV infections. It was estimated that Ukraine had at least 300,000 injecting drug users, all at risk of HIV infection.</p> <p>The project was the first joint pilot project of the National AIDS Committee and UNAIDS in Ukraine. In May 1997, Public Movement "Vera, Nadeshda, Ljubov" of Odessa took over the responsibility for the pilot project. During the project implementation, the "Vera, Nadeshda, Ljubov" gained recognition for using highly innovative approaches and methods.</p> <p><b>Objectives of the Project:</b></p> <ul style="list-style-type: none"><li>• To raise the awareness among drug users on modes of HIV transmission and prevention activities and the development of safer behaviour skills</li><li>• To provide IDUs with individual means of protection such as needles and syringes, disinfecting agents and condoms</li><li>• To develop a supportive social environment, by providing services such as psychosocial and medical support to IDUs.</li><li>• Target Group: IDUs and sex workers</li></ul> <p><b>Methodology:</b> Needle and syringe exchange, condom distribution and provision of information</p> <p><b>Process/activities:</b> Two stationary drop-in centres and one mobile outreach service were set up to provide free and anonymous services to people who inject drugs. The staff included teams of three or four volunteer workers (one with medical training and a person who injects drugs). The service supplied clean needles and syringes, distributed condoms, provided information and counselling on HIV and produced and distributed leaflets. Services were extended to include young men and women who sold sex. Records of attendance at centres together with daily project records provided the evaluation material.</p> <p><b>Results:</b> In the first four months there were 4889 visits to drop-in centres from 1,216 people who inject drugs. Contacts with the outreach service</p>

exceeded contacts within the two drop-in centres. In the first six months 114,000 syringes and 36,000 condoms were distributed. About 3,000 injecting drug users had contact with the service between July and mid-October 1997. Pre and post intervention data showed a high level of risk behaviours among respondents under 25 year old. Only 43% reported using their own needles for injection, and condom use was reported as low as 16%. In April 1997, a new sample of 200 people who injected drugs, recruited at drop-in centres and the outreach post, showed a much lower level of both injecting and sexual risk behaviour post intervention.

**Challenges and achievements:**

This project has remained a community-based project and, despite major external difficulties, has managed to maintain a continuous service. It is run exclusively by volunteers who have other occupations as their means of income. The close involvement of people who inject drugs in program design and implementation ensures a high degree of acceptability. Project activities have had a positive impact on the reduction of risk behaviours. However, unfavourable political and organizational conditions have been a major constraint. This coupled with a shortage of basic resources including syringes and educational booklets and a dependence on volunteer involvement are limiting factors, together with severe financial shortages.

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## HIV Prevention Programs for IDU (HPPIDU), Latvia

**Country:** Latvia

**Project Name:** "HIV prevention programs for IDU" (HPPIDU)

**Starting Year:** 1997

**Responsible Organisation:** G/O AIDS Prevention Centre. Since 2002 a network of HPPIDU formed based on partnership between AIDS Prevention Centre and local municipalities and in some cities NGOs are involved, for instance, NGO, DIA+LOGS" in Riga and SAULES SALA" in Kuldiga.

**Background:** The first case of HIV infection was registered in Latvia in 1987. The first AIDS case was diagnosed three years later. The year 2000 reflects a turning point in Latvia's epidemic, with the number of new HIV cases doubling that of the previous year. Forty percent of HIV cases were under the age of 24. From 1987 to 1997, the majority of HIV infections occurred through sexual transmission, mostly men who have sex with men. In recent years, HIV infection has been primarily due to intravenous drug use. In fact, in 2000, 72% of all the new cases were related to IDU. While the HIV/AIDS epidemic is spreading rapidly in the most vulnerable and high-risk groups of the population, the number of heterosexual transmissions was also growing, indicating that the HIV/AIDS epidemic was spilling over into the general population.

### **Objectives of the Project:**

- Decrease new cases of HIV among IDUs;
- Involve more IDUs in programs;
- Provide information and consultations for IDUs and their families members;
- Exchange syringes, needles, provide IDUs with other materials like condoms, disinfectants;
- Undertake behaviour and prevalence studies;
- Ongoing training program for HPPIDU staff.

**Target Group:** IDUs, IDU's family's members; HIV positive IDU/FM.

### **Methodology:**

- Needle exchange
- Provision of information
- Counselling

**Process/activities:** The program included outreach and stationary services (including one mobile service in Jurmala). Outreach services were staffed by ex-users and social workers, while stationary services employed medical staff, social workers, psychologists and ex-users. Services work on the

principles of low threshold centres.

The AIDS Prevention Centre organised training two days per month in Riga for all Network members.

Behaviour and prevalence studies were undertaken up to one per year in services and in the streets.

Network members in 13 cities collected data using one reporting model. The AIDS Prevention Centre in Riga summarised and analysed the data. Summaries of data were sent back to the cities.

**Results:** Data from 1999 to November 2003 show:

- New clients - 12.676;
- Contacts - 170.129;
- Sterile syringes distributed - 349.629;
- Used syringes returned - 333.861, (used syringes/needles destroyed centrally)

**HIV tests** (Data from The HIV State Register)

In 1999 - 590, HIV +40 (6, 7%); 2000 - 1447, HIV+ 128 (8, 8%), 2001 - 2203; HIV+302 (13, 7%); 2002. - 1178, HIV+ 154 (13,1%), 2003 - data not included

Information/consultations (2002-2003, 11 months) 23.735;

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## The Harm Reduction Centre, Albania

**Country:** Albania

**Project Name:** The Harm Reduction Centre

**Starting Year:** 2000

**Responsible Organisation:** Aksion Plus

**Background:** Statistics on the prevalence of drug use in Tirana are not reliable; however some expert opinion suggests that in 2001 there were approximately 10,000 drug users. The Harm Reduction Centre's records show high-risk behaviour among drug users, mainly sharing of used needles and syringes (74% of those who inject). According to a rapid assessment and response study conducted by UNICEF, there has been an increase of health seeking treatment among IDUs, especially young people in Tirana. Over 87% of all requests for treatment were by heroin users.

### **Objectives of the project:**

- To prevent HIV infection among IDUs
- To undertake research on the drug using behaviour
- Provision of information

### **Methodology:**

- Surveys, questionnaires, rapid assessment of the situation
- Outreach (contacts with drug users, gathering of information, collecting used syringes, condom distribution)
- Publication of brochures, posters and other materials
- Medical assistance and simple medical training
- Referral to other services.

**Process/activities:** The needle exchange program was provided through a drop-in centre and outreach. Approximately 10–15 regular clients and 1-2 new clients visited the centre each day. Besides needle exchange, these clients also benefited from the centre are other services. Contact with new clients was more intense out in the drug scene (especially in certain times of the day and in special locations). The outreach workers contact drug users of different social status such as the Roma community, sex workers etc. They exchanged syringes, provided condoms, leaflets, brochures, and information about the Harm Reduction Centre and generally raised awareness about the harms related to drug use.

In collaboration with the Institute of Public Health, the Harm Reduction Centre launched a vaccination campaign of IDUs against hepatitis B in 2002

The Centre also offered a range of informal activities during the day such as guitar, English, Yoga, painting courses and weekend activities such as

picnics and sports (organized outside Tirana).

**Results:** The Centre's statistics for 2003 showed:

- Approximately 20 syringes distributed in the centre per day.
- Approximately 50 syringes distributed in the drug scene per day.
- Approximately 10 used syringes returned in the centre per day.
- Approximately 5 syringes collected by the out reach workers a day.
- From 2000 to 2003, the Centre contacted approximately 900 Drug users in Tirana.

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## Chapter Four: Drug Withdrawal Services

### Introduction

Withdrawal refers to a group of symptoms or manifestations of variable severity, which occur on cessation or reduction of drug use after a prolonged period of use and/or the use of high doses. Withdrawal symptoms occur as a result of physical and psychological dependence on a drug. Research has shown that relapse is associated with the occurrence of withdrawal symptoms, anxiety about experiencing them, and the absence of care at the time of withdrawal. Thus adequate management of withdrawal manifestations is an essential step for longer-term success in managing substance dependence. Managing withdrawal is often referred to as Detoxification – a set of interventions aimed at managing acute intoxication and withdrawal. Supervised detoxification may prevent other complications that might appear if the client was left untreated. It should be noted that unlike some cases of alcohol and other sedative-type substance withdrawal, opioid withdrawal is seldom life threatening.

For some drug dependent people, detoxification represents a point of first contact with the treatment system and the first step to recovery. It presents a unique opportunity for risk reduction education and early identification of HIV infection. Detoxification programs can provide entry points for highly active antiretroviral therapy (HAART) delivery for AIDS clients.

The main aim of detoxification services is to manage withdrawal in a safe and comfortable environment by medical and non-medical interventions. On its own, medical detoxification is unlikely to be effective in helping individuals achieve lasting recovery. This phase is better seen as a preparation for continued treatment aimed at maintaining abstinence and promoting rehabilitation. It has become clear that detoxification involves much more than simply medically withdrawing a client from drugs. Detoxification, whether done on an inpatient, residential, or outpatient basis, frequently is the initial therapeutic encounter between client and clinician.

Irrespective of the substance involved, a detoxification episode should provide an opportunity for biomedical (including psychiatric) assessment, referral for appropriate services, and linkage to other treatment services. The specific goals of withdrawal management should include symptom minimization, safe management of complications including HIV and other infection diseases, attaining abstinence and promoting motivation for continued drug treatment and rehabilitation. During the period needed for detoxification and stabilization the client should be supported by counselling,

medical treatment and support with every day living problems. A comprehensive management plan should prudently utilize elements of the above-mentioned modalities that can be tailored to the needs of the clients.

### **Literature Review**

- Many studies show that offering detoxification alone, without follow-up to an appropriate level of care, is an inadequate use of limited resources. People who have severe problems that predate their drug dependence – such as family disintegration, lack of job skills, illiteracy, or psychiatric disorders may continue to have these problems after detoxification unless specific services are available to help them deal with these factors. It has been shown that concurrent treatment of psychiatric disorders is necessary to improve longer-term treatment outcomes (Gerstein and Harwood, 1990; Grella et al 2006).
- Effective detoxification includes not only the medical stabilization of the client and the safe and humane withdrawal from drugs, but also entry into treatment/rehabilitation. Successfully linking detoxification with substance abuse treatment/rehabilitation reduces the "revolving door" phenomenon of repeated withdrawals, saves money in the medium and long run, and delivers the sound and humane level of care that clients need (Kertesz et al. 2003). It has been argued that there is a pronounced need for better linkage between detoxification services and the treatment services that are essential for full recovery (Mark et al. 2002, p 3).
- Combining HIV care with drug dependence treatment services (including harm reduction, detoxification and pharmacotherapy) and psychosocial services has been particularly successful. Drug dependence treatment of HIV-infected drug dependent persons has been shown to be effective in reducing the spread of HIV. Drug dependence treatment can improve HIV-infected drug clients' quality of life by increasing their self-esteem, improving their sense of well-being, and helping them develop spiritually. Therefore drug dependence treatment programs should encourage clients to be counselled and tested for HIV infection. If onsite testing is not feasible, programs should develop linkages with HIV testing facilities (WHO Regional Office for SE Asia and the Pacific, 2006).
- Detoxification presents a unique opportunity to intervene during a period of crisis and move a client to make changes in the direction of health and recovery. Hence, a primary goal of the detoxification staff should be to build the therapeutic alliance and motivate the client to enter treatment. Psychological dependence, co-occurring psychiatric and medical conditions, social supports, and environmental conditions critically influence the probability of successful and sustained abstinence from substances. Research indicates that addressing psychosocial issues during detoxification significantly increases the

likelihood that the client will experience a safe detoxification and go on to participate in substance abuse treatment. Staff members' ability to respond to clients needs in a compassionate manner can make the difference between a return to substance abuse and the beginning of a new (and more positive) way of life (NIDA, 1999).

### **Good Practice Principles**

The overarching principles for care during detoxification services are dependent on several standards:

- Detoxification does not constitute drug treatment but is one part of a continuum of care for drug-related disorders. Detoxification is a first step toward recovery and the "first door" through which clients pass to treatment.
- Detoxification services that are appropriate to client needs should be available and easily accessible. It is acknowledged that these services will often be adapted to operate in resource constrained environments.
- Clients must be treated with respect and dignity at all times. Care must be non-judgemental, supportive and confidential.
- The detoxification process consists of the following three sequential and essential components:
  - Evaluation
  - Stabilization and
  - Fostering client readiness for and entry into treatment.

A detoxification process that does not incorporate all three critical components is considered incomplete and inadequate.

- Detoxification programs should be capable of conducting HIV risk assessments and providing basic HIV education and counselling to clients. In addition, they should provide access to HIV testing and pre- and post-test counselling. If programs cannot provide testing and related counselling onsite, they must have formal relationships with other agencies that will provide these services for clients referred by the program.
- Programs must give priority to the admission of HIV-positive clients to try to stop their use of needles and halt the further spread of HIV.
- Every means possible should be used to ameliorate the client's signs and symptoms of withdrawal. When using medication regimens or other detoxification procedures, clinicians should use only protocols of established safety and efficacy. It is important to be aware of any other medications that the client is taking and to consider potential drug interactions.

- All health professionals involved in the care of the client will maximize opportunities to promote rehabilitation and maintenance activities and to link her or him to appropriate substance abuse treatment immediately after the detoxification phase.
- Several groups need special consideration during detoxification because of their specific needs. Such groups include those who are incarcerated, women, adolescents, the elderly, those living with HIV/AIDS and those who have other medical conditions. Specific issues pertaining to treatment in prisons and on discharge are addressed in a companion document in this series '*Drug Abuse Treatment and Rehabilitation in Prison Settings*'.
- Clients are treated with due consideration for their individual background, culture, preferences, sexual orientation, disability status, vulnerabilities, and strengths.
- Detoxification program administrators have a duty to ensure that appropriate training is available to staff.

### Good Practice Example

<b>Project Aware, Stanley Street Treatment and Resources (SSTAR), USA</b>
<p><b>Country:</b> United States of America</p> <p><b>Project Name:</b> Project Aware</p> <p><b>Starting Year:</b> 1989</p> <p><b>Responsible Organisation:</b> Stanley Street Treatment and Resources (SSTAR)</p> <p><b>Background:</b> Project Aware has been offering HIV counselling, testing and referral (CTR) since 1989 as an add-on service to a multi-service inpatient substance treatment facility in Fall River, MA, USA. The testing services are funded by the MA Department of Public Health. For seventeen years, HIV CTR has evolved to meet the need and complexities of working with people at critical risk for HIV, HCV and other STD.</p> <p>As the HIV pandemic started to show significantly in drug treatment clients SSTAR serves, staff needed to be able to offer a way for clients to ascertain their HIV status and support those who tested positive into care and treatment in a culturally competent manner.</p> <p><b>Objectives:</b> To be able to support those in need of care into appropriate level of treatment and to prevent the spread of disease by those who may not accept, acknowledge, and/or know their risk and status. To provide Education, Counselling &amp; Testing in an Inpatient Detoxification Setting</p> <p><b>Process/activities:</b></p>

- Weekly pre-test groups to heighten awareness of HIV and HCV
- Inpatient client centered pre-test counselling sessions that can address multiple concerns
- Post test sessions that support consumer in risk reduction and follow up testing
- Supported referral to additional/alternate levels of care as indicated by the clients' self determined individualized service plan.

**Outcome/achievements:** Currently, Project Aware performs 1,200 HIV tests each year with an 89% return rate.

**Challenges:** Staff training and support are integral to successful programming. Clinical supervision is provided twice each month by an off-site masters' level social worker who specializes in HIV, infectious disease and addiction. Staff turnover is costly. Supporting and maintaining staff in this often repetitive but critical work is extremely important.

**Lessons learned:** Successful programs are non-judgmental and non-punitive in their approach. Confidentiality must be inviolate.

**Cultural or situational issues related to this project:** To provide this service cultural awareness needs to expand far beyond the realm of race and ethnicity. Staff performing this service need to be non-judgmental and credible with individuals from all walks of life. Sensitivity to issues of sexuality, transsexual issues, gender, power dynamics between genders, domestic violence and sexual assault, addiction, relapse, shame, blame and guilt all play a part in the integrity of the process for those at critical risk.

**Evaluative data available related to the project:** Overall data for the state of MA is available in the annual epidemiological report obtainable at: <http://www.mass.gov/dph/cdc/aids/aidsprog.htm>

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## Shanghai Drug Abuse Treatment Centre (SDATC), China

**Country:** China

**Project Name:** Shanghai Drug Abuse Treatment Centre (SDATC): Linkages for HIV/AIDS and Mental Health Treatment

**Background:** SDATC is one department of the Shanghai Mental Health Centre (SMHC). SMHC is the largest and most comprehensive mental health service in China. SDATC includes both inpatient unit and outpatient clinics and has a multifunctional role including clinical, teaching and training, research and prevention, etc.

As illegal drug use and HIV/AIDS epidemics have been emerging in China over the past two decades, there is a shortage of qualified services to provide voluntary treatment for drug dependent populations. In 1997 the Shanghai Narcotic Control Commission and the Shanghai Public Health Bureau approved SDATC. This centre was the first and only government-supported drug treatment Centre within SMHC in Shanghai, China.

**Objectives:** To provide qualified detoxification services and establish linkages for HIV/AIDS and mental health services for people experiencing drug use problems.

**Process/ Activities:** Detoxification is regarded as the first step long-term drug abuse treatment/rehabilitation and SDATC is committed to establishing the necessary links to other treatment and services. Professionals and SDATC staff work as a team to address client's individualised need based on a thorough clinical evaluation including for HIV/AIDS risk behaviours. SDATC's main activities include:

- Providing effective and safe medically monitored inpatient detoxification with methadone tapering and Chinese medicine. The detoxification process consists of a thorough clinical examination and evaluation, stabilising and motivating client readiness for and entry into treatment.
- Employing a wide range of psychosocial interventions, such as Motivation Therapy, group therapy, Cognitive Behavioural Therapy, family intervention to motivate clients toward further rehabilitation.
- Integrating IEC and VCCT into inpatient detoxification services: working closely with professionals from Shanghai CDC to provide HIV/AIDS information, education and communication (IEC) and VCCT for inpatients.
- Establishing links with mental health services. Referring the clients with dual diagnoses to inpatient and outpatient mental health services at the Shanghai Mental Health centre.
- Conducting research projects on drug use and HIV/AIDS related topics

in order to decrease drug use and HIV/AIDS related problems.

- Providing teaching and training programs to professionals in the drug abuse field to disseminate evidence based knowledge and interventions for drug abuse and HIV/AIDS related problems.

**Outcomes:** SDATC has established a good reputation for its service and expertise and has played an important role in the drug treatment field in China. Other governmental and nongovernmental organisations invite experts from the Centre to conduct training and supervision and consult on policy making. The centre has been widely recognised by their clients and their relatives who prefer to seek help through the Centre. The number of drug abuse clients is increasing, with 500 inpatients and 1000 outpatients per year in 2006.

**Challenges:** Well-trained psychologists or social workers are needed to provide psychosocial interventions during inpatient and post-detoxification to promote client rehabilitation.

**Lesson learned:** The therapeutic relationship between staff and client is crucial to establish linkage with further treatment/rehabilitation.

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## Chapter Five: Psychosocial Supports

### Introduction

Psychosocial support is a critical facet of HIV and drug dependence care. It includes a wide range of interventions to enable people to improve functioning while living with the co-occurring diseases. Psychosocial support can help mitigate the effects of the twin epidemic on the affected individuals, their families, and the communities in which they reside. Supports can improve the adherence to medical regimens and can support the person who seeks treatment for addiction, and can improve outcomes in both arenas.

The psychosocial working group of the MacArthur Foundation's Network on Socio-economic Status and Health classified psychosocial supports as *assistance that people receive from others through emotional, instrumental and informational support*. Emotional support refers to things people do that make us feel loved and cared for (e.g. talking, positive feedback); instrumental support refers to the tangible help that others provide; and informational support refers to help that others may give through providing information. (MacArthur Foundation 1998).

Psychosocial care can be provided by professionals, paraprofessionals and non-professionals, including family. The skills required to provide psychosocial care can be taught to non-professionals. Providing such care can be a sustainable, community-based activity that requires few if any outside resources. This will be of utmost importance in under-resourced areas of the world where the monetary and professional human capital to treat the twin epidemics are not readily and consistently available. Psychosocial support for the caregivers themselves is a necessary component for health workers and persons caring for the affected individuals.

There are many forms of psychosocial supports including:

### ***Case Management***

Case management is an active support strategy designed to assist vulnerable people to negotiate health care systems to access the services they need. Individuals living with HIV infection and drug dependence face a complex, often fragmented service delivery system. Case Management addresses the needs of client with addition and HIV disease and helps them to overcome barriers they face in obtaining necessary services.

Effective case management is critical to ensure that individual drug users are assisted to engage in a range of activities and organisations that will help their recovery. It is not just about accessing treatment. To effect lasting change, encouragement needs to be provided and projects funded to address livelihood skills and basic education (literacy, numeracy and writing). These skill development programs can provide drug users with a livelihood and enhance recovery over the long term.

Case management should be flexible to accommodate the particular medical and social needs of clients with different backgrounds and in various stages of health and illness.

The functions that generally comprise case management are:

- Assessment
- Planning
- Linkage
- Monitoring
- Advocacy

The services should reflect a philosophy that affirms a clients' right to a quality life, privacy, confidentiality, self-determination, non-discrimination, compassionate, non-judgmental care and dignity and respect.

### ***Motivational Interviewing***

Motivational interviewing (MI) is a client-centred, directive method of enhancing intrinsic motivation to change by exploring and resolving ambivalence. It is an active, professional support strategy designed to assist people to make positive lifestyle changes. MI has been proven effective in many special populations and in many different treatment settings. It has demonstrated effectiveness in changing the high-risk sexual practices of HIV positive men, in substance abusing populations, and in a variety of settings such as physician offices, substance abuse clinics, and in psychosocial support centres (Miller and Rollnick 2002).

### ***Peer Assistance***

Often, when people experience negative life events, they typically turn to their friends, not professionals for support. Peer Assistance Programs strengthen the support that friends have to offer, increasing a person's ability to find safe and satisfying solutions. Well-trained peers can determine the need for referrals to professionals.

Peer helping is typically characterized by the following components:

- Peers are self nominated or selected by members of their peer group
- Peers are volunteers but may receive some type of compensation
- Peers receive need based, goal directed & experiential skill training from qualified peer leaders
- Peer volunteers are supervised on a regular basis
- Experienced peers are involved in the selection, training, & supervision of other peers.

### ***Peer Support Groups***

Support groups for persons living with HIV provide social, educational and medical supports and benefits. They can reduce physical and emotional isolation and they can empower the person living with HIV. A support group is often the first place they can acknowledge they are infected and where they can meet others who share the same issue. This acknowledgement and ability to share can reduce the power of HIV stigma. Support groups are usually free which makes them a valuable resource where there is no money available for treatment.

### ***Psychosocial Support through Home Visiting***

The Gaborone Declaration on Community Based Home Care (2001) defines psychosocial support through home visiting as:

*“Care given to an individual in his her own natural environment, by his family and supported by skilled social welfare officers and communities to meet not only the physical and health needs, but also the spiritual, material and psychosocial needs.”*

Adults with HIV who have been prescribed ART’s have significantly higher adherence rates if they have home visits by a nurse and a community worker compared with clients who have all medical supervision in a clinic setting (Williams 2006).

### ***Family Psychosocial Support***

Families can play a major role in the recovery of anyone living with the co-morbid diseases of drug dependence and HIV. It is important that recovery programs help families understand the drug dependence and recovery process, and learn about HIV/AIDS. The experiences and needs of the family should also be considered (Daley & Miller, 2001). Families need to take care of themselves during the process. There are groups in many countries that offer family support. In drug dependence treatment there are groups such as Al-Anon and Al-Ateen. HIV treatment centres also often offer family support through caregiver support groups

## **Palliative Care**

According to WHO (1998) Palliative Care is:

*An approach that improves the quality of life of patients and their families facing the problems associated with life threatening illnesses through the prevention and relief of suffering by means of an early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.*

Clients with multiple issues of addiction, HIV, and Hepatitis C have disease courses that are confounded by multiple factors. Palliative care should become a part of care from the point of diagnosis, rather than focussing on the end phase of a course of illness.

## **Literature Review**

- Research shows that providing psychosocial support for this target population improves functioning and quality of life in several arenas. Individuals reporting more satisfying social support were more likely to report a lower level in their HIV-related health symptoms. This indicates that social support is a strong predictor of health outcomes over time, independent of coping style and baseline health status (Ashton, et al, 2005)
- Findings indicate that actively maintaining social support networks and social functioning plays a positive role in maintaining higher levels of physical functioning, and reducing pain and symptoms over time (Lubeck and Fries, 1998)
- A pilot-study examined an alternative support structure, termed a "peer-driven intervention," that served as a functional equivalent to drug treatment for increasing active drug users' adherence to HIV therapeutics. The pilot demonstrates that an alternative social support structure to drug treatment is possible for increasing drug users' adherence to medical care (Broadhead and Heckathorn 1998)
- In a study carried out in Sweden, methadone treatment with added psychosocial support was shown to have the most effective outcomes. Kakko and Svanborg (2003) found that the combination of buprenorphine and psychosocial support was highly efficacious and should be added to treatment options.

## **Good Practice Principles**

- Psychosocial support inclusion in care is critical in ensuring positive client outcomes.

- Communities considering implementing case management programs should first assess the availability of community services relevant to the target population and then evaluate their ability to develop and implement referral systems.
- Psychosocial support for the caregivers themselves is a necessary component for health workers and persons caring for the infected individuals.
- Motivational Interviewing combined with other interventions is feasible and efficacious for improving antiretroviral medication practice, even among drug users.
- Peer Leaders should receive need based, goal directed & experiential skill training from qualified peer leaders, and have on-going supervision.
- Support groups for people living with drug dependence and HIV can provide social, educational and medical benefits.
- Home visiting has increased quality of life and better coping in different disease stages through proper information and material assistance to poor families.
- Palliative care should become a part of care from diagnosis to death, rather than being concerned with the end phase of life.

### **Conclusion**

It is clear through research and good practices that psychosocial supports are important aspects of integrated drug dependence and HIV care. The strategies discussed in this section can be used solely or in combination to promote well-being in the target population. Professionals or volunteers who have been trained in the modality can provide psychosocial supports. They can be provided in a clinic setting, in community centres, or at home. They are particularly well suited to informal treatment settings and resource poor environments. Those who are planning treatment projects would do well to add psychosocial programs to support the projects, as evidence shows that it will strengthen the attendance and adherence to the project.

## Good Practice Example

### **The Partnership Between a Psychological Attention Centre for Alcohol and Other Drugs Users and the Centre of Prevention for Patients Living with HIV/AIDS**

**City / Country:** Santo André, Brazil

**Project Name:** Partnership between the Psychosocial Attention Centre for Alcohol and Other Drugs users (NAPS Ad) and HIV /AIDS Prevention Centre

**Starting Year:** 2002

#### **Background of the Project**

In 2002 the Municipal Health Department of Santo André, in partnership with the European Community (through the Rub-AL Project) developed a research project to map the drug use of women in the sex trade. The project also researched the sexual exploitation and drugs use of teenagers living on the street.

When the study was finished the Health Department decided to maintain and expand the project. Other groups that were included were transvestites, transsexual men and men who have sex with other men. Focus also shifted to include prostitution houses (night clubs where sex is traded).

#### **Objectives**

- To minimize the level of vulnerability, illness and risk of the targeted population.
- To increase the access of this population to the health service.
- To reduce illness and death in these populations.
- To minimize social exclusion and preconception.

#### **Activities**

Staff of both Centres jointly provided the following services:

- Orientation about civil right and health
- Nurse consultation service
- Dispensation of material to prevent illness, including condoms (for women and men), needles & syringes, lip protector, lubricant gel, mineral water, coconut water (for nutrition and hydration), honey (for nutrition and to protect the respiratory system), chocolate (for energy), etc.
- Vaccination (hepatitis B; tetanus, measles and rubella)
- Referral to Health net

- Guidance to housing and protection net
- Provision of printed information materials
- Guidance to HIV, hepatitis and other viruses testing services
- Guidance to cancer prevention examination services (uterus and prostate)

### **Beneficiaries**

People in seriously vulnerable individual/social situations who are at risk of drug use, abuse and dependence. These include male and female sex workers (including transvestites, transsexuals, men who have sex with men, women who have sex with other women); teenagers in situations of sexual exploitation; homeless people; people in trouble with the law; and others.

### **Issues dealt with in the case study**

This case study details a service that was developed through a partnership between Psychosocial Attention Centre for Alcohol and Other Drugs users (NAPS Ad) and the HIV /AIDS Prevention Centre for people living with HIV/AIDS. It addressed a population involved in prostitution or sexual exploitation (working in streets and/or night clubs) who were also involved in licit or illicit drug use. The project was designed to minimise the vulnerability, risky behaviour and illness through the systematic actions of engaging, orienting and implementing prevention and treatment strategies. The project engaged peer health workers ('harm reducers') to provide outreach services.

### **Outcome / achievements**

Some data:

- 650 people attended the service between January and December of 2006.
- 500 people were vaccinated during this same period.
- 414 people attended between January and June of 2007.
- There was a 100% increase in attendance to the Municipal DST/AIDS Program
- Drug user engagement improved, as evidenced by attendance of many users in forums, committees, social movements, etc.
- There was an increase in harm reduction action in the erotic show nightclubs, parks of the city and the Municipal Secretariat of Education (Connivance Centres)
- Fifty percent of the program attendees were vaccinated.

### **Lessons Learned**

- The project increased the individual impact of both Centres involved in the project
- Using peer workers increased project capacity, in terms of access,

efficiency and efficacy

- The shared use of material amplified the available resources for each Centre.
- The collaboration between the two health programs raised awareness about each others centre, contributed to network building and provided more effective services for the clientele.
- Shared work produced a sense of joint responsibility and resulted in the provision of better quality services.
- The project demonstrated that with assistance the clientele could improve levels of self care, self esteem and recognition of citizen rights and responsibilities.

#### **Further information**

Status of the project – On going

Source of funding – Governmental funding (Municipality)

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## Chapter Six: Antiretroviral Therapy for Injecting Drug Users

### Introduction

A United Nations General Assembly resolution adopted on 23 December 2005 requested the Joint United Nations Programme on HIV/AIDS to assist in

*“facilitating inclusive, country-driven processes, including consultations with relevant stakeholders, including non-governmental organization, civil society and the private sector, within existing national AIDS strategies, for scaling up HIV prevention, treatment, care and support with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all those who need it.”*

Global estimates suggest that there are over 13 million injecting drug users (Aceijas, et al., 2004) and that 5–10% of all new HIV infections can be attributed to injecting drug use worldwide (WHO 2006). This figure rises to 30% when Africa is excluded.

HIV epidemics are largely driven by injecting drug use in many regions. It is the major or second major risk factor for HIV in seven of the ten UNAIDS regions, comprising 90% of the global population (Wodak and Cooney 2005). HIV prevalence related to injecting drug use has risen dramatically in Eastern Europe and Central Asia (Rhodes and Simic 2005). Injecting drug use is a major factor in HIV epidemics in the Russian Federation, Ukraine and Uzbekistan (UNAIDS 2007). Availability of antiretroviral medicines has transformed HIV/AIDS into a manageable chronic illness. ARV therapy significantly improves the prognosis and quality of life of people living with HIV/AIDS. However, IDUs continue to have poor and inequitable access to antiretroviral treatment, particularly in Eastern Europe (UNAIDS 2007)

### Literature review

- Data from 50 developing and transitional countries showed that at the end of 2004, only 36,000 former or current injecting drug users were receiving antiretroviral treatment. Of these, 30,000 were in Brazil (Aceijas, et al., 2004). An Open Society Institute survey (2006) found that excluding IDUs from treatment is widespread in the following countries:
  - In Central and Eastern Europe and Central Asia it was estimated that IDUs represent over 80% of HIV cases but less than 14 percent of those are receiving ARV.

- In Russia, where approximately 80% of total HIV cases are IDUs, as many as 100,000 people are in need of ARV. Only 5,000 receive it. Many clients receive mono, or bi-therapy rather than the combination of three antiretrovirals that is the global standard of care.
- In Thailand, where government efforts have tripled the number of clients receiving ARV since 2003, few, if any, active drug users have access to HIV treatment.
- In Malaysia, and Vietnam, IDUs are interned for months or years in forced detoxification and rehabilitation centres. Though many IDUs are HIV-positive, few centers offer ARV.
- In Malaysia, IDUs are 75% of all HIV cases but only 12 percent of those are receiving ARV.
- In China the new regulations on HIV/AIDS from March 2006 clearly state that treatment for people living with HIV/AIDS should be available.
- The main reasons for this disparity include misunderstanding about the impact of drug use on treatment adherence, denial of basic supports such as methadone that would facilitate HIV treatment, and stigma in health care settings (International Treatment Preparedness Coalition, 2005; UNAIDS, 2006; WHO, UNODC and Joint UN Programme on HIV/AIDS (2004).
- There are consistent data on adherence of IDUs to ARV therapy. Good adherence to antiretroviral medications by injecting drug users has been demonstrated. With appropriate support IDUs adherence to treatment and treatment outcomes are comparable to those of other clients (Open Society Institute, 2006). Research on HIV-infected IDUs has shown that treatment with antiretroviral drugs is very effective in reducing mortality and increasing survival benefits (Muga et al 2007)
- In reality management of HIV-positive injecting drug users is not significantly different from that of other people living with HIV, and includes clinical and immunological staging of disease, prophylaxis for and treatment of opportunistic infections and ARV therapy. The criteria for initiating ARV therapy in HIV-positive injecting drug users does not differ from general recommendations provided by WHO, the International AIDS Society-USA (IAS-USA), the U.S. Department of Health and Human Services (DHHS), and the British HIV Association (BHIVA).
- On the other hand, a number of studies document the difficulties injecting drug users have in accessing, remaining in and deriving the full range of HIV care as well as the potential for overcoming these obstacles through drug dependence treatment, outreach programs, supervised dispensing of medications and directly observed therapy (WHO, 2005).

- Pharmacotherapy with methadone or buprenorphine allows IDUs to stop or reduce drug use, stabilize their lives, improve their health, increase access to care and retain them in treatment (Open Society Institute, 2004). Importantly, the World Health Organization recently added methadone and buprenorphine to its list of essential medicines.
- High retention rates and good compliance with treatment in pharmacotherapy programs facilitate treatment with antiretroviral medications, either provided in specialised out-patient programmes or in close cooperation with specialised HIV/AIDS hospital units. Long-term pharmacotherapy programmes allow observation of the course of antiretroviral treatment and a better response to side effects. There are numerous potential drug interactions between antiretroviral medications and methadone and other substitute substances. Adaptations of methadone dosages may be necessary. The analgesic properties of opioids may mask early symptoms of serious side effects of HIV medications. A good relationship between doctor and client is essential to deal with these problems.

### **Good Practices Principles**

- Medical care should be accessible to the client and situated in facilities that are part of the general health care infrastructure, free-of-charge and user-friendly with non-judgmental and unbiased staff
- Drug dependence and HIV/AIDS are two chronic medical conditions that require integrated care and long-term treatment strategies
- Medical care should be comprehensive with the maximum possible number of the most needed services available at the one location. Harm reduction programs should be involved in planning HIV treatment for IDUs, in conducting outreach to drug users for HIV testing, counselling and treatment, and in maintaining follow-up with drug users who drop out of care
- Medical care should be offered to injecting drug users at the level of intensity the person can accept so as not to drive the person away from care
- Outreach strategies are a vital component of HIV care with the most effective programs forming strong links with community-based organisations representing affected groups, and utilising peer educators and counsellors drawn from these groups
- Continuity of care is an important consideration when developing medical services and for retaining people in care
- Close attention must be paid to the management of co-morbidities such as tuberculosis, hepatitis B and C, psychiatric illness and drug interactions including opioid pharmacotherapy. The prevention of, and

treatment for these conditions decreases morbidity and mortality and facilitates the enrolment of injecting drug users in comprehensive HIV care.

### **Conclusions**

A comprehensive response to HIV among injecting drug users should combine prevention, treatment and other support services to ensure maximum uptake of services as early as possible. Social services, education, adherence support, opioid pharmacotherapy and other drug dependence treatment are key elements of an effective HIV care program. The response should be realised on both public health and human rights grounds. Policy-makers play an important role in ensuring this by promoting the treatment of HIV-positive IDUs in their country.

## Good practice examples

### Treatment for HIV/AIDS, Brazil

**Country:** Brazil

**Project name:** Brazil Model

**Background:** Brazil has developed a unique response to the HIV/AIDS epidemic. Care, prevention, and human rights are the basis of the Brazilian response. This country provides free universal access to antiretroviral therapy. This was established by Brazilian Federal Law in November 1996. This law states: "HIV-infected people and/or people living with AIDS are entitled to receive, at no cost, all medicines necessary for their treatment, from the National Health System". In 2003, 125,000 Brazilians received free ART treatment, accounting for 100% of the total registered AIDS cases but only 20% of the estimated AIDS cases.

**Objectives:** To provide free, universal access to antiretroviral therapy to HIV-infected people and/or people living with AIDS in Brazil.

**Process/activities:** The Brazilian government has struggled with pharmaceutical companies to lower the price of medications, and has supported the national production of generic drugs, resulting in dramatic cost savings. In 1997, the cost to treat a client for one year was \$4,860. In 2004, the cost of treatment per client was \$1,000 per year. The cost of universal provision of highly active antiretroviral therapy (HAART) accounted for 2.3 percent of Brazil's public health budget in 2003.

Government supported universal access to HAART and harm reduction services are key elements of Brazil's response to the HIV/AIDS epidemic. The Brazilian Ministry of Health has intensified the development of a comprehensive network of free and anonymous Voluntary Counselling and Testing (VCT) units throughout the country. In 2001 there were more than 140 HIV testing units across the country. Special outreach teams were developed to meet the needs of specific populations such as pregnant women, MSM, and IDUs in order to increase access to VCT.

**Outcomes:** In 2001, 424 network facilities had been accredited by the Brazilian Ministry of Health to deliver ARV therapy to PLWHA; 111 of these facilities provided care for 65% of all clients receiving ARVs. In 2004, Brazil had 279 harm reduction programs. The Ministry of Health supports these projects both politically and financially. It is estimated that harm reduction projects reach 40% of the injecting drug users in the country.

The Brazilian Network of Human Rights Advocacy in the Field of HIV/AIDS, developed in 1997, brings together PLWHA, activists, NGOs, and a variety of public institutions working in the area of HIV/AIDS.

**Lessons learned:** The Brazilian model offers important lessons to developing countries as access to ARVs becomes more prevalent, and governmental and nongovernmental institutions continue to develop and

improve programs and policies to ensure that in practice, all PLWHA receive the clinical and psychosocial care and support that they need and deserve.

**Zurce:**

F.I. Bastos , D. Kerrigan, M. Malta, C. Carneiro-da-Cunha, and S.A. Strathdee. Treatment for HIV/AIDS in Brazil: strengths, challenges, and opportunities for operations research. AIDScience Vol. 1, No. 15, November 2001 (<http://www.aidsscience.com/Articles/aidsscience012.asp>)

and ii)

F. Mesquita. Brazil: Giving Injecting Drug Users Access to Highly Active Antiretroviral Therapy as a Response to the HIV/AIDS Epidemic (from Breaking down the barriers. Lessons on Providing HIV Treatment to Injecting Drug Users. New York, International Harm Reduction Programme (Open Society Institute, 2004).

## Integrated Care for HIV-infected IDUs, Baltimore, USA

**Country:** USA

**Project/model:** Integrated care for HIV-infected IDUs, Baltimore

**Background:** The Drug Addiction Treatment Act of 2000 (USA) and the approval of buprenorphine by FDA for the office-based treatment of opioid addiction provided a new opportunity to integrate addiction treatment and medical care for people with HIV. Evidence suggests that an integrated model of care which links substance abuse and HIV treatment, psychiatric care and social support services improves HIV treatment outcomes among drug users. Integrated care facilitates access for complex client population. This model promotes collaboration among medical care providers, psychiatrists, and substance abuse specialists. Importantly, data from randomised controlled trials have suggested that integrating services at a single site may improve both medical and substance abuse treatment outcomes.

**Process/activities:** Research team from Johns Hopkins School of Medicine (Baltimore, USA) conducted a pilot study to determine the acceptability and feasibility of directly administered antiretroviral therapy (DAART) in a methadone maintenance clinic in 2001. Of the 50 subjects enrolled, the estimated three-month retention rate was 78% and the estimated twelve-month retention rate was 54%.

A prospective comparison between 1) the DAART group; 2) clients with a history of drug use, who were receiving methadone maintenance therapy; and 3) clients with no history of drug use was conducted.

**Outcomes:** Results indicated that the DAART was associated with high rates of viral suppression in participants. In the six-twelve month time frame, 46% of DAART clients achieved viral suppression, compared to 24% in the drug user methadone group and 38% in the non-drug user group. The intensive intervention was well received by study participants. As well DAART led to changes in the HIV "culture" at the methadone clinic, including, greater dialogue among clients and staff about HIV and its treatment, and greater collaboration between substance abuse providers and medical providers.

**Lessons learned:** DAART programs may differ in terms program principles, staff and delivery. Directly administered antiretroviral therapy is just one of the models to overcome some of the barriers faced by HIV-positive drug users and to provide them beneficial care.

**Sources:** G.M. Lucas. United States, Baltimore: Drug Use and HIV: Effective Models of Integrated Care and Directly Administered Antiretroviral Therapy. From Breaking down the barriers. Lessons on Providing HIV Treatment to Injecting Drug Users. New York, International Harm Reduction Programme (Open Society Institute, 2004)

ii) F. L. Altice, R. D. Bruce. Directly Administered Antiretroviral Therapy for

Injection Drug Users (from Delivering HIV Care and Treatment for People Who Use Drugs. New York, International Harm Reduction Programme (Open Society Institute, 2006)

iii) Integrated Buprenorphine and HIV Care Evaluation and Support Centre's website (<http://www.bhives.org/>)

## Chapter Seven: Access to Sterile Injecting Equipment

### Introduction

The inclusion of needle and syringe programs (NSP) in this paper on drug treatment is based on the evidence that providing a comprehensive and varied range of treatment services is more effective than single or limited strategies in containing the spread of HIV (WHO 2005). NSP play an important role for injecting drug users in and out of drug treatment. For the in-treatment group, there is a large body of evidence that whilst drug treatment such as methadone maintenance is effective in reducing heroin use, needle sharing and sexual risk behaviour, it often does not eliminate such practices (Farrell et al 2005). Access to needles, syringes and condoms remains an important health strategy to support injecting drug users whilst they undergo treatment designed to stabilise, reduce or stop drug use and the associated harms.

While researchers caution about the methodological issues that abound in the NSP evaluation literature, they also report consistent positive research findings regarding the effectiveness and cost efficiency of NSP (WHO 2004; Ritter 2005). The strength of the research evidence prompted the following unequivocal statement by the World Health Organisation:

*'There is compelling evidence that increasing the availability and utilisation of sterile injecting equipment for both out-of-treatment and in-treatment injecting drug users contributes substantially to reductions in the rate of HIV transmission.'*  
(WHO 2004)

A joint statement by WHO, UNAIDS and the UNODC in 2004 was equally clear:

*'Communities or countries threatened by or experiencing an epidemic of HIV infection among injecting drug users should urgently adopt measures to increase the availability and utilisation of sterile injecting equipment and to dispose of used equipment'*

The Declaration of Commitment on HIV/AIDS in June 2006, called for:

*'Expanded access to essential commodities including male and female condoms and sterile injecting equipment...'*

Some countries may be faced with challenges translating these policy commitments into practical programs in unsupportive cultural, political and

economic environments. Even though these constraints may exist it is still important to be aware of the rationale for such programs, have an understanding of the many ways such services are provided and be familiar with the research evidence on which they are based.

### **Literature Review**

It has well established that injecting drug users are vulnerable to HIV and other blood-borne infections as a consequence of sharing needles, syringes and other items used to prepare drugs for consumption. These equipment-sharing practices are estimated to result in 5 to 10% of global HIV infection (Farrell et al 2005).

Recent reviews of the NSP literature can be summarised as follows:

- NSP are highly cost effective as a HIV prevention strategy (Australian Commonwealth Department of Health and Ageing 2002)
- NSP are less effective in reducing HCV (Ritter and Cameron 2005)
- There is no evidence that NSP increases drug use or injecting (Ritter and Cameron 2005)
- NSP can lead to higher enrolment in drug treatment (WHO 2004)
- There is no evidence that NSP leads to increased risk of HIV infection through needle stick injury from publicly discarded needles (Ritter and Cameron 2005)
- There is no evidence that NSP reduce public amenity (increased public disorder or discarded syringes) in the vicinity (Ritter and Cameron 2005)
- There is no evidence of increased crime rates in areas where NSP are located (Ritter and Cameron 2005)
- There is only limited evidence supporting the use of bleach and other disinfectants as an alternative to NSP (WHO 2004)

### **Needle and Syringe Program Settings**

The primary goals of needle and syringe programs (NSP) are to reduce the spread of infectious diseases and establish and maintain contacts with out-of-treatment groups. These programs can take many forms in terms of how they operate and what services they provide. They can be run:

- In association with drug treatment services (integrated or co-located)
- As stand alone primary outlets
- As a secondary service provided by other health and welfare organisations
- On an outreach basis (including foot patrols and mobile vans)

- In special settings such as prisons
- Distributed by pharmacies
- Distributed via vending machines

Services provided by NSP can vary considerably. Some are designed primarily to ensure good access to equipment (needles and syringes, water, swabs, disposal kits or condoms). Others include education, counselling, referral to drug treatment, referral to HIV testing and counselling services, provision or referral to medical care and referral to other health and welfare services. Some services operate on a strict one for one exchange basis, while others are less concerned with return rates.

### **Good Practice Principles**

- Access to sterile needles and syringes is a fundamental component of effective HIV prevention programs
- Effective HIV prevention will incorporate a range of strategies in addition to needle and syringe access
- The need for NSP to prevent HIV among drug users needs to be established after consultation with key groups of drug users, police, health care workers etc to get the necessary clearance and support for establishment and ongoing operation
- Needle and syringe legislation is required to ensure that drug users and workers who make equipment available are not penalised
- If NSPs are to be effective they need to provide extensive coverage. In light of the body of international evidence, small pilot projects to determine the most effective way to introduce the service at a local level should be expanded to maximise this coverage
- NSP should be specifically designed to meet the needs of high-risk sub-groups (such as sex workers and inmates of correctional facilities)
- Needle and syringe programs alone are not sufficient to control HIV infection among injecting drug users
- Bleach and other forms of disinfection are not supported by good evidence and should not be considered as an alternative to the provision of sterile needles and syringes

## Good practice examples

### Needle and Syringe Program as an Integral Component of Drug Treatment

**Country:** Australia

**Project Name:** Turning Point Integrated Needle & Syringe and Drug Treatment Program

**Starting Year:** 1995

**Responsible Organisation:** Turning Point Alcohol and Drug Centre, Melbourne, Victoria

**Background:** The first needle and syringe program was established in Australia in 1986. This was a rapid response to the emergence of HIV in the injecting drug using community. Over 3000 programs now operate across the country in diverse settings, utilising diverse methods (fixed primary needle and syringe sites, distribution by outreach workers, mobile vans, pharmacy distribution and operation within primary health care and specialist drug treatment services). Over 30 million needles and syringes are now distributed on an annual basis (in a country with a population of 23 million). Australian governments have invested \$130 million in needle and syringe programs between 1991 and 2000. Rapid provision of services (education, outreach, drug treatment including pharmacotherapies, needle, syringe and condom distribution) has been credited as the reason that injecting drug users make up only 5% of total HIV infections in Australia.

Turning Point was established in 1994 to provide drug treatment services, research and education and training. Clinical services comprise outpatient and home-based withdrawal services, group and individual counselling, pharmacotherapies (methadone and buprenorphine) and other services. Needle and syringe distribution was considered a critical component of clinical service provision at the time the centre was established 13 years ago.

Needle and syringe services provided. The service operates according to guidelines established by the Department of Human Services in Victoria

<http://www.health.vic.gov.au/drugservices/pubs/needle.htm>

Clients of all ages, whether in treatment at Turning Point or elsewhere, or not in treatment are encouraged to access the on-site service that is provides seven days per week. It is a confidential service. If necessary, clients accessing other treatment services at Turning Point can access the needle and syringe program on the same visit – and frequently do.

**Objectives:** The aim of the program is to minimise the transmission of HIV, Hepatitis B, Hepatitis C and other blood borne viruses among injecting drug users, their sexual partners and children, and from them to the non-injecting community. The program also promotes the safe disposal of needles and syringes; provides links and referrals to drug treatment and other health and

welfare services; facilitates education using peer workers and provides up to date information about drug use issues.

**Process/activities:** The service provides sterile needles and syringes, alcohol swabs, condoms and water-based lubricant, sharps disposal containers and educational materials free of charge (funded by the state government). Sterile water is also available at a small cost.

**Outcome/achievements:** Turning Point has operated the service without incident for the past 13 years. Program monitoring shows that over 120,000 needles and syringes are provided each year to people attending (14,000 visits to the centre). During the period 1999-2003, HIV prevalence of those attending needle and syringe programs in Australia was 1%. In a Turning Point survey of those attending the needle and syringe program (conducted over one month in February 2006) the following was highlighted:

Sex: 73% male

Age: 73% were between 21 and 35 years of age (2% under 18 years)

First time attendees 5%

Recent needle sharing 2.4% of attendees

The efficacy of needle and syringe services operating throughout Australia has been demonstrated (Ritter and Cameron 2005). Australia has a very low HIV infection rate in its injecting drug using community. The investment in needle and syringe programs in Australia has resulted in the prevention of an estimated 25,000 cases of HIV and 21,000 cases of hepatitis C among injecting drug users. The savings to the health system in avoided treatment costs over a lifetime are estimated to be between \$2.4 and \$7.7 billion.

**Source:** Commonwealth of Australia. 2002. Return on investment in needle and syringe programs in Australia. Canberra: Commonwealth Department of Health and Ageing.

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## Needle and Syringe Program, Dhaka, People's Republic of Bangladesh

**Country.** Bangladesh

**Project Name:** CARE Bangladesh's SHAKTI Injecting Drug User Project (SHAKTI Project)

**Responsible Organisation.** CARE-Bangladesh

**Starting Year:** 1998

**Background:** Bangladesh has much lower HIV prevalence than several other countries in South Asia. As of end 2003, the estimated number of people living with HIV in Bangladesh was between 2500 and 15,000. The number of drug users has been estimated at between 100,000 and 1.7 million, with 20 000–25 000 of these being injecting drug users.

There are three needle-syringe programs and related projects in Bangladesh, all established and funded by CARE Bangladesh, as well as a small number of drug treatment programs.

Dhaka, with a population of 12 million is the capital of Bangladesh. The estimated number of injecting drug users is 7,650. Regular behavioural surveillance surveys have identified few HIV positive injecting drug users.

CARE Bangladesh's SHAKTI Injecting Drug User Project (SHAKTI Project) commenced in Dhaka in May 1998. Prior to establishing the project, a rapid situation assessment was carried out, from which it was estimated that there were some 7650 injecting drug users in Dhaka. Other results included:

For injecting drug users, the drug of choice was injectable buprenorphine and other prescription drugs such as diazepam, promethazine, and pheniramine, which are used together with buprenorphine

Over 80% of injecting drug users had shared needles and syringes, 90% had shared other injecting equipment, 30% were homeless, 46% had no education, 84% were ever arrested and 66% were ever jailed.

SHAKTI Project staff, with the assistance of guides, who were active injecting drug users, and other key informants, mapped the city through field visits and observations, identifying 42 drug injecting sites, some of which were also drug selling points.

The project began by training 12 active injecting drug users as peer outreach workers. The five-day training covered a range of topics including;

Educating other injecting drug users on sexually transmitted infections, HIV, and drug-related issues

Offering health services for abscesses and sexually transmitted infections, needle and syringe exchange, and distribution of condoms.

The first drop-in centre was set up in April-May 1998. By June 1998, peer outreach workers had reached 150 injecting drug users and distributed 1753

needles and syringes. By June 1999, the average number of injecting drug users reached daily was 1945 and more than 2200 on some days. A further six drop-in centres had opened. There were 26 peer outreach workers and 20 medicine shop sellers trained, and 160 volunteer peer educators. The program eventually expanded to 11 drop-in centres and 50 peer outreach workers.

In Dhaka, there are 11 drop-in centres, which provide injecting drug users with HIV prevention, diagnosis and treatment services for sexually transmitted infections, and primary health care, mostly treatment of abscesses. Drop-in centres are also used as venues for training peer outreach workers and educators, and for group education of injecting drug users; providing referral to other services such as clinics for more serious medical problems, HIV testing and drug treatment; and providing a safe space for injecting drug users to spend time.

From the Dhaka experience, CARE Bangladesh went on to open similar injecting drug user programs in the northwest Bangladesh in Rajshahi in May 1999, Chapai Nawabganj in March 2001 and Char Narendrar in February 2002.

Needle-syringe programs were not based in drop-in centres after community consultations found that neighbours worried that programs would turn drop-in centres into shooting galleries. Instead these services were provided by peer outreach workers, who use the drop-in centre as a base for collecting outreach supplies, holding outreach meetings, completing monitoring and other forms, and storing used equipment. Used equipment, some 25 000–30 000 needles and syringes, is collected from all drop-in centres once a month and transported to a medical research facility where it is burnt in a medical waste incinerator.

In addition to the 42 sites originally found, some 30 other injecting drug use and selling areas have been identified through mapping the city and interviews with injecting drug users; all these sites are covered by outreach.

The ever-reached figure for the needle-syringe programme was some 3000 injecting drug users in 1998, 8000 in 1999, and 9630 in 2000 with little increase in the figures since. About 70 of the injecting drug users are women (0.8%).

According to BODAR, around 120 injecting drug users had undergone treatment in detoxification camps between January 2000 and November 2002. The Drug Treatment Hospital can treat a further 1,020 people per year; however, the hospital caters to all dependent people, including heroin smokers and alcoholics. The number of injecting drug users treated at the hospital is unknown.

**Source:** This case example was taken from: Burrows, D (2006) *High Coverage Sites: HIV Prevention Among Injecting Drug Users in Transitional & Developing Countries*. UNAIDS Best Practice Collection.

**Evaluation:** A research project was conducted to determine the impact of

the needle and syringe program in Dhaka, Bangladesh. The National HIV Sero-surveillance data among IDUs (2000 -2002) was extrapolated using a mathematical modelling technique. The model predicted that the intervention may have reduced the incidence of HIV among IDUs by 90% (95% CI 74–94%), resulting in an IDU HIV prevalence of 10% (95% CI 4–19%) after 8 years of intervention activity instead of 42% (95% CI 30–47%) if the intervention had not occurred.

The authors concluded that the analysis highlights the potential for rapid HIV spread among IDUs in Dhaka, and suggested that the intervention may have substantially reduced IDU HIV transmission. They also warned that there was no room for complacency. Sustained and expanded funding for interventions in Dhaka and other regions of Bangladesh are crucial to maintaining the low HIV prevalence.

**Source:** Foss, A, Watts, C, Vickerman, P, Azim, T, Guinness, L, Ahmed, M, Rodericks, A and Jana, S., (2007) Could the CARE-SHAKTI intervention for injecting drug users be maintaining the low HIV prevalence in Dhaka, Bangladesh? *Addiction* 102 (1), 114–125.

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## Chapter Eight: Outreach

### Introduction

Outreach provides health related services and information to target populations who otherwise might not receive services due to geographic isolation or mistrust of institutional services or medical professionals. Outreach is an essential component of prevention and early intervention for drug using individuals who are not in treatment and who are at risk of HIV and other communicable diseases.

Innovative outreach strategies have been developed by a wide array of service providers as a way to engage and retain underserved individuals. Outreach programs include home visits, street outreach and mobile services (e.g. vans, buses). Special populations such as women and adolescents, racial and ethnic minorities and individuals released from prison facilities can benefit from outreach services. It is important to have outreach programs that address and engage individuals on their own terms, and in their cultural context.

In the European Union, four general aims of drugs outreach work have been defined at national policy levels:

- To identify and contact hidden populations;
- To refer members of these populations to existing care services;
- To initiate activities aimed at prevention and at demand reduction; and
- To promote safer sex and safer drug use.

A select few countries adopted an additional national policy: to identify the needs and perceptions that drug users have with respect to existing drug care services, and to relay this information to those services as feedback. This emerging role of outreach could greatly enhance the effectiveness and co-ordination of drug care services.

Harm reduction and the stages of change model of behaviour change are two theoretical frameworks used by several projects that are based on this client-centred outreach approach. According to Westermeyer (1999) a definition of harm reduction is that:

*The health and well-being of the individual is of primary concern; if individuals are unwilling or unable to change addictive behaviour at this time, they should not be denied services. Attempts should be made to reduce the harm of their habits as much as possible (p1).*

Effective outreach service provision must be based on the acknowledgment and acceptance that some people are not ready to give up high-risk behaviour. Making connection by helping them in other ways can reduce harm and open the door to further intervention.

The trans-theoretical model (Prochaska, 1997) posits that health behaviour change involves progress through six stages of change: pre-contemplation, contemplation, preparation, action, maintenance, and termination. Ten processes of change have been identified for producing progress along with decisional balance, self-efficacy, and temptations. One of the most striking results to date for stage-matched programs is the similarity between participants reactively recruited who reached us for help and those proactively recruited whom we reached out to help. This model is especially helpful when designing outreach programs to active users.

According to Korf et al. (1999)

*Outreach work in the drug field is a proactive method used by professionals and trained volunteers or peers to contact drug users. Its aims are to inform them about the risks associated with drug taking, to support them in reducing or eliminating such risks, and/or to help them improve their physical and psychosocial circumstances through individual or collective means. (p.85)*

Buning (1993) takes a similar view and considers the tasks of outreach to high-risk drug users to include reaching the unreached; assisting drug users in avoiding major health risks; linking people with other organizations. Outreach workers also have the capacity to provide their organization and policy makers with information regarding patterns of use, prevalence and high risk, AIDS related behaviour.

## **Literature Review**

- Accumulated evidence strongly indicates that outreach-based interventions have been effective in reaching out-of-treatment IDUs, providing the means for behaviour changes and inducing behaviour change in the desired direction. The findings provide sound evidence that participation in outreach-based prevention programs can lead to lower HIV incidence rates among program participants (Coyle, Needle et al, 1998)
- A study conducted in Philadelphia, USA investigating a community-level HIV prevention program for women, examined predictors of exposure to print media and community outreach. The study assessed the relationship between exposure to the intervention and condom use behaviour. The results revealed that the print media campaign reached the largest number of women. However, women at the highest risk did not have high rates of exposure to print media, but had greater exposure to outreach. An important finding of this analysis

was that outreach was successful in reaching a different portion of the target population and that exposure had differential effects on the condom use behaviour of particular segments of the target population (Walls et al 1995).

- A study in Denver, Colorado, USA, examined the financial impact of outreach workers on health care systems and policies. A longitudinal repeated measures design was used to assess the return on investment of outreach conducted by workers employed by Denver Health Community Voices. The data provided evidence of economic contributions that outreach workers made to a public safety net system and informed policy-making regarding program sustainability (Whitley, 2006).
- Morse, Calsyn et al (1996) describe a model of outreach predicated on developing a trusting, meaningful relationship between the outreach worker and the target population. They explain five common tasks inherent in this model of outreach (establishing contact and credibility, identifying people with mental illness, engaging clients, conducting assessments and treatment planning, and providing ongoing service). Other issues discussed include, responding to dependency needs and promoting autonomy, setting limits while maintaining flexibility and resistance to treatment and follow-up service options. While the paper described outreach to a homeless, mentally ill population it could well be transferable to an addicted HIV infected population.

### **Good Practices Principles**

- Outreach workers need the following basic competencies to be effective:
  - An understanding of outreach from a practical and theoretical perspective
  - An understanding of drug dependence
  - An understanding of disease and wellness in the context of drug use, especially as it relates to injecting drug use, HIV, Hepatitis and sexually transmitted infections
  - An understanding of how to engage hard-to-reach populations
  - An understanding of appropriate intervention strategies
  - Resources for client support, and
  - An understanding of how to support ourselves (the persons providing outreach and community education services).
- Outreach strategies need to be aimed at and address and engage individuals on their own terms, in their cultural context, and in their normal environment.

- Harm reduction and the stages of change model of behaviour change are two theoretical models that promote good outreach practices.
- It is important to provide help and information that will aid individuals with their immediate needs such as food and housing before addressing their health care needs.
- Outreach data should be used to inform policy and to identify the needs and perceptions that HIV positive drug users have with respect to existing care services, and to relay this information to those services as feedback.

### Conclusion

Outreach strategies to reach drug-using persons who are at risk of HIV need to be part of a community's continuum of care. Outreach workers need to be trained and supervised, and are very often effective when they come from the community they are trying to serve. Basic needs of an individual often should be addressed before their health needs. Harm reduction strategies along with the Stages of Change Model are effective in outreach programs. Outreach data should be collected not only to meet the needs of service provision, but also to inform policy makers about existing services and new areas of need that should be addressed.

### Good practice example

#### Reaching Young Drug Injectors Through Outreach and Peer Support

**Country:** Russian Federation

**Project:** Harm reduction – Moscow: Reaching young injecting drug users in the community and in hospitals through outreach work and peer support

**Responsible Organisation:** Médecins Sans Frontiers with Mainline (Amsterdam) and with the Netherlands Institute of Public Health and Addiction, Trimbos Institute, Utrecht.

**Starting Year:** 1996

**Background:** In 1996, when the project was founded, the first outbreaks of HIV infection among injecting drug users were reflected in the official statistics. Five cases had been reported in 1995, but 666 cases were reported in 1996. By November 1996 the number of diagnosed HIV cases reported among the Russian population of 147 million was 2,015 (UNAIDS and WHO, 1998, p5). Based on epidemiological surveillance studies, the number of adults and children living with HIV/AIDS at the end of 1997 was estimated at 40,000 (UNAIDS and WHO, 1998) and, two years later, at 130,000 (UNAIDS, 2000).

This project was one of the first projects undertaken in the Russian

Federation on HIV prevention among injecting drug users and is revolutionary in so far as it is based on the principle of peer support, which embraces education on HIV prevention for drug users provided by experienced and trained drug users who undertake outreach work. This principle has enabled drug users to play a decisive role in the activities of the project and shape its policies from the outset. Programs of peer education and outreach work were the only option suitable for the Russian Federation in 1996, since needle exchange programs or methadone maintenance for drug users were prohibited.

Funding was provided by Médecins sans frontières. The project uses the administrative and logistical structure of the Moscow office of Médecins sans frontières—Holland.

**Objectives:** The overall purpose of the project was to increase knowledge regarding the modes of HIV transmission and the prevention of infectious diseases among young injecting drug users in Moscow (i.e. those aged 15 to 25 years). The specific objectives of the project were:

- To reach the young injecting drug users of Moscow by means of peer support and outreach work
- To disseminate information and educational materials among this group
- To raise awareness of HIV and other drug-related risks and to stimulate safer behaviour by means of peer education.

**Process/activities:** An outreach team of former drug users was recruited and given training based on the European Peer Support Manual (Trautmann and Barendregt, 1994). The project staff:

- Provided outreach in the major drug-dealing area in the city and later two of the country's largest hospitals in Moscow.
- Conducted information forums for clients in the narcological hospitals, covering all relevant topics of HIV prevention. A memorandum of understanding was developed between the hospitals and the project's program coordinator.
- Provided counselling and distributed information materials and condoms through outreach work among drug using sex workers in Moscow.
- Produced a series of brochures, issued under the logo "Protect yourself" and adapted from international experience. The brochures dealt with HIV, hepatitis B and C, vein care, overdoses, legal issues, detoxification and drug treatment.
- Established contacts with health professionals in Moscow, enabling the project to use their expertise in the creation of educational material.
- Held indoor seminars for injecting drug users twice a month, and both peers and the programme psychologist provided counselling for HIV-

positive injecting drug users.

- Documented work and monitored closely any new developments in local drug use.
- Advocated for the human rights of injecting drug users and promoted the project's experience through the mass media (e.g. interviews with Russian and foreign newspapers and on television) and through personal contacts with officials and decision makers.

The non-government organization - Mainline provided ongoing consultation by means of email, for example on how to choose outreach sites, manage outreach teams and work in a mixed team of active, former and non-injecting drug users.

**Outcome/output:** In 1997, the first year of the program, the outreach workers documented that they reached about 10,000 injecting drug users and disseminated 20,000 leaflets and condoms.

In 1998 and 1999, providing peer education on safer injecting habits and safer sexual behaviour, and providing lectures on HIV prevention at the narcological hospitals was the main focus. Consequently, the number of injecting drug users reached by the team increased by between 50 and 250 per month. In the first six months of 2000 - 1,050 new contacts were made.

Compared with the high number of contacts made with injecting drug users, the rate of referrals to medical institutions, detoxification programs, rehabilitation centres and HIV testing facilities remained low. This was due to the lack of anonymous services and the fact that most injecting drug users were afraid to contact official structures because they didn't want to be registered as drug users. Recently, more anonymous testing facilities have become available.

Harm reduction – Moscow became a model for the HIV preventive activities carried out in other cities. Its information leaflets have been copied, reproduced and distributed and experience of the project and its staff provide valuable information during practical training workshops throughout the Russian Federation.

The program received broad attention from the Ministry of Health and the Russian mass media, and stimulated awareness and discussion of the subject of HIV and injecting drug users among both professionals and the general public.

**Evaluation:** The project was subject to regular internal evaluations. Four times a year, its consultant organization, Mainline, conducted on-site project monitoring and evaluation.

In 1998 and 1999, epidemiologists of Médecins sans Frontières conducted two behavioural surveys among injecting drug users in the streets and in narcological hospitals. The 1998 survey found that most injecting drug users continued to share injecting equipment, however the most recent survey confirmed that injecting drug users are aware of HIV and that they report

less sharing of equipment than before. Also, based on outreach workers' observations, drug users' perceptions about sharing are changing and it is increasingly being considered "shameful" behaviour.

There is a need to monitor behavioural changes and to determine the extent to which they can be attributed to the work of the project.

**Challenges:** By providing AIDS education through peers and by stimulating safer behaviour, the project attempts to contribute to slowing down the rate of HIV epidemic among injecting drug users. Because it is one of only two programs in a city with over 10 million inhabitants, its impact is clearly limited. The project staff promoted the idea that the large-scale implementation of a comprehensive program on HIV prevention, including peer support outreach, was urgently needed in the city and in the Russian Federation in general.

**Lessons learned:** The most important lesson learned is that, without the involvement of drug users themselves, there can be no ongoing behavioural change and effective HIV prevention among that group. It is crucial to implement HIV preventive activities on the basis of the peer support principle, involving people from the drug-using community.

The project team has realized the importance of maintaining a systematic and regular exchange of information among the various HIV preventive programs operating in a city, among the various cities and even among countries, including the discussion of various topics.

It is crucial to link HIV preventive activities to, and incorporate them into, the existing health-care structures by means of ongoing exchange of information between governmental structures and non-governmental organizations.

Those working with the drug-using population must be engaged in advocating adequate services for drug users, informing the wider community of the developments in HIV prevention, protecting human rights and combating stigmatisation of the target group.

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