

Trainer Manual: Treatment and Care for HIV-Positive Injecting Drug Users



Trainer Manual

2007



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For inquiries, contact The Public Affairs Office, The ASEAN Secretariat, 70A Jalan Sisingamangaraja, Jakarta 12110, Indonesia, Phone: (62 21) 724-3372, 726-2991, Fax: (62 21) 739-8234, 724-3504. E-mail: public@aseansec.org. General information on ASEAN appears on-line at the ASEAN Website: www.aseansec.org.

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Copies may be requested from:

The ASEAN Secretariat, 70A, Jl. Sisingamangaraja, Jakarta 12110, Indonesia. e-mail: public@aseansec.org

and

Family Health International, Asia/Pacific Regional Office, 19th Floor, Tower 3, Sindhorn Building, 130–132 Wireless Road, Lumpini, Phatumwan, Bangkok 10330, Thailand, e-mail: sunee@fhibkk.org

and

HIV Unit, Department of Communicable Diseases, World Health Organization, Regional Office for South-East Asia, Indraprastha Estate, Mahatma Gandhi Marg, New Delhi-110 002, India, e-mail: hiv@searo.who.int

Module 1: Drug use and HIV in Asia: participant manual

Module 2: Comprehensive services for injecting drug users – participant manual

Module 3: Initial patient assessment – participant manual

Module 4: Managing opioid dependence – participant manual

Module 5: Managing non-opioid drug dependence – participant manual

Module 6: Managing ART in injecting drug users – participant manual

Module 7: Adherence counselling for injecting drug users – participant manual

Module 8: Drug interactions – participant manual

Module 9: Management of coinfections in HIV-positive injecting drug users – participant manual

Module 10: Managing pain in HIV-infected injecting drug users – participant manual

Module 11: Psychiatric illness, psychosocial care and sexual health – participant manual

Module 12: Continuing medical education – participant manual

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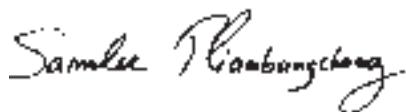
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Foreword

There is a high risk of widespread transmission of HIV in Asia, not only because of the large size of the population and the high burden of sexually transmitted infections but also due to the prevailing risk behaviours and vulnerabilities. The use of heroin and opium as well as cannabis and *hashish* are quite common throughout Asia. Heroin is most commonly used in various countries of the Mekong Basin region, and the favoured method of administration is by injecting. The proportion of those injecting heroin does, however, vary from place to place and in different cultural and social settings. Data suggest that about 50% of heroin users take to injecting once they get over the initial phase of consumption through smoking or inhalation. In the late 1990s, amphetamine-type stimulants had increasingly become a drug of choice in Cambodia, China, Indonesia, Japan, Lao PDR, Myanmar, the Philippines, the Republic of Korea and Thailand.

HIV spreads most rapidly among injecting drug users (IDUs) when injecting equipment is shared between many people – a widespread practice in many countries. In places with a drug culture where IDUs gather at one place to inject, the sharing of one needle between three to even 50 participants can be common. It is not the drug use or even the actual injecting of the drug that causes HIV infection; it is the sharing of contaminated injecting equipment that transmits the virus. In Asia, studies have shown an overlap between sex work and injecting drug use with a substantial proportion of male IDUs buying sex, male and female IDUs selling sex, and sex workers injecting drugs. HIV transmission through injecting drug use has kickstarted the epidemic in many countries of Asia. Half the number of all IDUs in Asia today are infected with HIV and in need of care, support and antiretroviral therapy programmes. However, health-care providers, carers and families often have limited knowledge and skills in managing the health problems of IDUs and, in particular, of those who are already HIV-infected. Therefore, the ASEAN Task Force on AIDS, in collaboration with Family Health International and the World Health Organization Regional Office for South-East Asia developed this set of training modules for clinicians who provide treatment and care, including antiretroviral therapy, for HIV-positive IDUs.

I am confident that physicians in Member countries will find this set of training modules both relevant and useful.



Samlee Plianbangchang, MD, Dr PH
Regional Director

A Message from the Secretary-General of ASEAN

ASEAN is committed to preventing the further transmission of HIV and mitigating the impact of HIV and AIDS, by improving regional responses and enhancing Member Countries' development of people-centred programmes. An important focus of ASEAN's efforts has been in increasing access to treatment and care for HIV-positive injecting drug users (IDUs), who by far are the group most at risk in the transmission of HIV.

As part of this initiative, the ASEAN Task Force on AIDS (ATFOA) has been working closely with the US Government under the ASEAN-USAID HIV and AIDS Cooperation Framework to develop a curriculum to train doctors and health givers in dealing with health problems experienced by HIV-positive IDUs such as hepatitis B, hepatitis C and tuberculosis. Overall, the curriculum identifies critical skills that will be needed by health givers and clinicians in ensuring that HIV-positive IDUs are provided with high-quality treatment.

I would like to congratulate the ATFOA, USAID and all those who had contributed to this outstanding endeavour. This collaboration has put in place a milestone document which will enable ASEAN to carry out its task of preventing HIV and AIDS more effectively. I thank all involved for helping ASEAN forge a caring and sharing community.



Ong Keng Yong
Secretary-General of ASEAN

Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
ALT	alanine aminotransferase (liver enzyme)
ART	antiretroviral therapy
ARV	antiretroviral
ASEAN	Association of Southeast Asian Nations
ATS	amphetamine-type stimulants
CBT	cognitive-behavioural therapy
CDC	Centers for Disease Control and Prevention (US Government)
CME	continuing medical education
DAART	directly administered ART
ddl	didanosine
FHI	Family Health International
HBV	hepatitis B virus
HCV	hepatitis C virus
HIV	human immunodeficiency virus
ICD-10	International Classification of Disease 10 th revision
IDUs	injecting drug users
NGO	nongovernmental organization
NSAID	non-steroidal anti-inflammatory drug
OI	opportunistic infection
OPC	outpatient care
OST	opioid substitution therapy
PCA	patient-controlled analgesia
PLWHA	people living with HIV and AIDS
STI	sexually transmitted infection
TB	tuberculosis
TDF	tenofovir
TENS	transcutaneous electrical nerve stimulator
UDS	urine drug screen
USAID	United States Agency for International Development
WHO	World Health Organization

How to use this curriculum

What you should know before the course

This course is designed for clinicians who provide care and treatment, including ART, for HIV-positive IDUs. As a participant, you should have clinical experience in providing ART before taking the course. It is expected that you will provide care and treatment to HIV-positive IDUs once you have completed this course.

Module structure

The training course consists of 12 participant modules with PowerPoint presentations, a trainer manual and one CD-ROM which contains key references. Most modules are divided into sub-modules. The modules are structured in such a way that they can be used as individual blocks for a single training session and can be combined as needed for training requirements.

This curriculum is not recommended for self-study but for training by trainers.

Training methodology

The overall training approach used in these modules is based on adult learning theory and is a combination of lectures, discussions, small group work, interactive practical exercises and role-plays. It is recommended that this curriculum be delivered by trainers with extensive experience in the content of each specific module. It is acknowledged that this will limit the number of trainers able to deliver individual sessions.

Summary of manual

This manual provides instructions to help trainers present each of the 12 modules in the curriculum.

Adaptation by countries and adoption as a national curriculum

Technical writers from across Asia contributed to the curriculum. Countries should seriously consider adopting the curriculum for use in country-level training programmes. Countries are also encouraged to undertake any adaptation they feel is required for in-country use.

Additions, corrections, suggestions

Do you want to suggest changes to this module? Is there additional information you would like us to include? Please write or e-mail us. We will collect your letters and e-mails, and consider your comments in the next update to this module.

Contact:

Family Health International

Asia/Pacific Regional Office
19th Floor, Tower 3, Sindhorn Building
130-132 Wireless Road, Lumpini, Phatumwan
Bangkok 10330, Thailand
Phone: +662 263 2300
E-mail: sunee@fhibkk.org
www.fhi.org

or

World Health Organization

Regional Office for South-East Asia
Department of Communicable Diseases
HIV/AIDS Unit
World Health House
Mahatama Gandhi Marg
Indraprastha Estate
New Delhi 110 002, India
Phone: +91 11 233 70804
E-mail: hiv@searo.who.int
www.searo.who.int

or

ASEAN

ASEAN Secretariat
70 A, Jalan Sisingamangaraja
Jakarta 12110, Indonesia
Phone: +62 21 724 3372, 726 2991
E-mail: public@aseansec.org

Treatment and care for HIV-positive injecting drug users: Training course schedule

Training course schedule

- The training takes place at *insert name of training centre*
- The schedule assumes strict adherence to the specified break times: 15 minutes each for morning and afternoon tea and 1 hour for lunch.
- You must attend all sessions.

DAY 1		
08.30	09.30	Opening Ceremony
09.30	10.00	Break
10.00	11.00	Expectations review, overview of training agenda
11.00	12.00	Injecting drug use and HIV – Patterns of drug use and regional epidemiology (M1)
12.00	13.00	Lunch
13.00	14.30	Services for HIV-positive IDUs – Comprehensive services and continuity of care (M2)
14.30	14.45	Break
14.45	16.00	Services for HIV-positive IDUs – Closed settings (M2)
16.00	17.00	Country group work
DAY 2		
08.30	08.45	Participant summary
08.45	10.00	Initial patient assessment (M3)
10.00	10.15	Break
10.15	12.00	Managing opioid dependence (M4)
12.00	13.00	Lunch
13.00	14.30	Managing opioid dependence (M4)
14.30	14.45	Break
14.45	16.30	Managing opioid dependence (M4)
16.30	17.00	Country group work
DAY 3		
08.30	08.45	Participant summary
08.45	10.30	Managing non-opioid dependence (M5)
10.30	10.45	Break
10.45	12.00	IDU access to ARVs (M6)
12.00	13.00	Lunch
13.00	15.00	General care of the HIV-positive IDU (M6)
15.00	15.15	Break
15.15	16.30	General care of the HIV-positive IDU (M6)
16.30	17.00	Country group work

DAY 4		
08.30	08.45	Participant summary
08.45	10.00	ARV drugs for the HIV-positive IDU (M6)
10.00	10.15	Break
10.15	12.00	ARV drugs for the HIV-positive IDU (M6)
12.00	13.00	Lunch
13.00	15.30	Selecting a first-line regimen (M6)
15.30	15.45	Break
15.45	16.30	Monitoring IDUs on ART and managing side-effects and toxicities in the first year (M6)
16.30	17.00	Country group work

DAY 5		
08.30	08.45	Participant summary
08.45	10.00	Monitoring IDUs on ART and managing side-effects and toxicities in the first year (M6)
10.00	10.15	Break
10.15	12.00	Long-term monitoring of ARVs: long-term toxicities and treatment failure (M6)
12.00	13.00	Lunch
13.00	15.00	Long-term monitoring of ARVs: long-term toxicities and treatment failure (M6)
15.00	15.15	Break
15.15	16.30	Adherence – Overview and skills rehearsal (M7)
16.30	17.00	Pre-departure briefing on site visits and country group work

DAY 6		
		Site visit
09.00	11.30	Site visit: methadone clinic
11.30	12.30	Travel to next site
12.30	13.30	Lunch in local restaurant
13.30	15.30	Site visit: prison ART programme
15.30	16.00	Return to training centre
16.00	17.00	Site visit debriefing

DAY 7		
08.30	08.45	Participant summary
08.45	10.30	Adherence – Overview and skills rehearsal (M7)
10.30	10.45	Break
10.45	12.30	A drug user's perspective on ART and OST
12.30	13.30	Lunch
13.30	14.30	Drug interactions: ARVs and illicit drugs (M8)
14.30	14.45	Break
14.45	16.00	Drug interactions: ARVs, oral substitution therapy and other medications commonly used to treat PLWHA (M8)
16.00	16.30	Country group work

DAY 8		
08.30	08.45	Participant summary
08.45	10.30	Management of coinfections – HIV/HBV and HIV/HCV (M9)
10.30	10.45	Break
10.45	12.00	Management of coinfections – HIV/TB in IDUs (M9)
12.00	13.00	Lunch
13.00	14.30	Management of acute and chronic pain in IDUs (M10)
14.30	14.45	Break
14.45	16.30	Country group work

DAY 9		
08.30	08.45	Participant summary
08.45	09.30	HIV and psychiatric illness (M11)
09.30	10.15	Psychosocial care (M11)
10.15	10.30	Break
10.30	11.15	Sexual health
11.15	12.00	Prevention for HIV-positive IDUs
12.00	13.00	Lunch
13.00	14.00	Continuing medical education (M12)
14.00	15.00	Country poster presentations
15.00	15.30	Break
15.30	16.30	Country poster presentations
16.30	17.00	Post-course evaluation
17.00	17.30	Closing ceremony

Drug use and HIV in Asia



Objectives:

By the end of the session participants will be able:

- To understand which drugs are used globally and their contribution to mortality and morbidity
- To understand the distinction between licit and illicit drug use
- To be familiar with the patterns of drug use in Asia
- To understand the connection between a change in the pattern of drug use and HIV transmission
- To be familiar with the regional epidemiology of drug use and HIV.



Time to complete session:

1 hour



Session content:

- What are drugs?
- Global drug use
- Drug use in Asia
- Drug production and trafficking in Asia
- How people take drugs
- Drugs that are commonly injected in Asia



Training materials:

- PowerPoint presentation 1: Drug use and HIV in Asia
- Evaluation form



Recommended reading:

- Aceijas C et al. Global overview of injecting drug use and HIV infection among injecting drug users. *AIDS*, 2004, 18:2295–2303.



Session instructions:

- Present the PowerPoint presentation to participants.

Comprehensive services and continuity of care for IDUs



Objectives:

By the end of the session participants will be able to describe the elements of a comprehensive package of services for IDUs including:

- HIV prevention services for IDUs including outreach and needle and syringe programmes
- Drug dependence treatment programmes including opioid substitution therapy (OST)
- Clinical services for IDUs, including primary health care, testing and counselling
- Care and treatment for HIV-positive IDUs, including management of co-morbidities, ART
- Removing barriers that IDUs face in accessing care, treatment and support services
- Continuity of care



Time to complete session:

1 hour 30 minutes



Session content:

- Why is a continuum of services needed for IDUs?
- Defining the essential package – what are the services needed in the continuum?
- Models of service delivery in Asia – examples from the region
- “One-stop shopping” – what is it and why is it recommended?
- Advantages and challenges to delivering “one-stop shopping”
- Staff training and management issues in the delivery of comprehensive services for IDUs
- Other strategies for comprehensive service provision



Training materials:

- PowerPoint presentation 2.1: Comprehensive services and continuity of care for IDUs



Recommended reading:

- WHO/UNODC/UNAIDS. *Policy brief: reduction of HIV/AIDS transmission through outreach. Evidence for action on HIV/AIDS and injecting drug use.* Geneva, WHO, 2004 (WHO/HIV/2004.02).
- WHO/UNODC/UNAIDS. *Policy brief: provision of sterile injecting equipment to reduce HIV transmission. Evidence for action on HIV/AIDS and injecting drug use.* Geneva, WHO, 2004 (WHO/HIV/2004.03).
- WHO/UNODC/UNAIDS. *Policy brief: reduction of HIV transmission through drug-dependence treatment. Evidence for action on HIV/AIDS and injecting drug use.* Geneva, WHO, 2004 (WHO/HIV/2004.04).
- WHO/UNODC/UNAIDS. *Policy brief: reduction of HIV transmission in prisons. Evidence for action on HIV/AIDS and injecting drug use.* Geneva, WHO, 2004 (WHO/HIV/2004.05).



Session instructions:

- Lecture with PowerPoint presentation
- Conduct **Exercise 2.1** – 30 minutes

Ask participants to turn to Exercise 2.1 on page 2 of Module 2. Divide the participants into two groups for discussion for 20 minutes followed by 5 minutes reporting back by each group to the large group.

Group 1

Your group has 20 minutes to write down in bullet points:

- What difficulties do HIV-positive IDUs in your community have in gaining access to HIV prevention, treatment and care services?
- Was anything done to resolve this problem, and if so what was done to help this person?

A representative from the group speaks to the class about their findings (5 minutes).

Group 2

Your group has 20 minutes to do the following:

- Examine the “model” list of service delivery for HIV-positive IDUs.
- Write down which areas are being poorly addressed.
- Select a couple of these areas and suggest practical ways of improving these services.

A representative from the group speaks to the class about their findings (5 minutes).

**Objectives:**

By the end of the session participants will be able:

- To describe the importance of providing treatment in closed settings
- To identify and discuss the range of treatment and care services that are recommended in closed settings

**Time to complete session:**

1 hour 15 minutes

**Session content:**

- HIV transmission in closed settings
- Drug dependence treatment in closed settings
- HIV testing in closed settings (ethics, confidentiality, risks)
- ART for IDUs in closed settings
- HIV and tuberculosis (TB) in closed settings
- Discharge/release programmes
- Prison staff

**Training materials:**

- PowerPoint presentation 2.2: Services for IDUs in closed settings
- Sub-module 2.2: Services for IDUs closed settings
- Exercise 2.2: Case studies – closed settings

**Required reading:**

- WHO/UNODC/UNAIDS. *Policy brief: reduction of HIV transmission in prisons. Evidence for action on HIV/AIDS and injecting drug use*. Geneva, WHO, 2004 (WHO/HIV/2004.05).
- Springer SA, Altice FL. Managing HIV/AIDS in correctional settings. *Current HIV/AIDS Reports*, 2005, 2:165–170.
- Pontali E. Antiretroviral treatment in correctional facilities. *HIV Clinical Trials*, 2005, 6: 25–37.



Recommended reading (contd):

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- Thaisri H et al. HIV infection and risk factors among Bangkok prisoners, Thailand: a prospective cohort study. *BMC Infectious Diseases*, 2003, 3:25.
- Wohl DA et al. Adherence to directly observed antiretroviral therapy among human immunodeficiency virus-infected prison inmates. *Clinical Infectious Diseases*, 2003, 36:1572–1576.



Session instructions:

- Group discussion:
 - ◆ What HIV prevention, treatment and care services are required in closed settings?
 - ◆ What are the barriers to providing opioid substitution therapy in prisons?
- Lecture with PowerPoint presentation 2.2: Services for IDUs in closed settings
- Break up into groups. Read the case studies in Exercise 2.2 and prepare an answer together. Return in 30 minutes.

Initial patient assessment



Objectives:

By the end of the session participants will be able:

- To discuss the principles of drug dependence and psychosocial assessment, describe the concepts of behavioural change and motivational interviewing, and how these relate to initial patient assessment
- To identify drug dependence by performing a drug dependence assessment including the use of the ICD-10 assessment instrument
- To perform a psychosocial assessment and use the Kessler 10 assessment tool



Time to complete session:

1 hour 15 minutes



Session content:

- General skills and principles of assessment
- Drug dependence assessment: objectives; overcoming reluctance; principles of behaviour change and use of motivational interviewing techniques in initial patient assessment; drug use history; ICD-10; physical examination
- Psychosocial assessment: objectives; mental health assessment; Kessler 10; social assessment items
- Social assessment
- Activity 1: Drug dependence assessment role-play
- Activity 2: Using the Kessler Psychological Distress Scale



Training materials:

- PowerPoint presentation 3: Initial patient assessment and drug dependence assessment and psychosocial assessment
- Exercises
- Role-play information sheets
- Annex 1: Sample assessment record for drug dependence and psychosocial assessment
- Annex 2: ICD-10 checklist
- Annex 3: Kessler Psychological Distress Scale

**Session instructions:**

- Lecture with the PowerPoint presentation stopping at Exercise 3.1, Activity 1.
- Conduct **Exercise 3, Activity 1**.
 - ◆ Organize the class into groups of three.
 - ◆ If necessary, explain the principles of conducting a role-play.
 - ◆ Distribute to each group the three role-play activity information sheets.
 - ◆ Ask the group members to decide who will take on each of the roles: patient, clinician and observer.
 - ◆ Ask the class members to read their respective role-play information sheets. Inform the class that they have 15 minutes to conduct the role-play.
 - ◆ After this time has elapsed, ask the groups to stop the role-play and then allow 5–10 minutes for the observer in each group to provide feedback on the assessment and for the groups to discuss this feedback.
 - ◆ Following this, facilitate a class discussion on the activity.
- Continue to lecture with the PowerPoint presentation until you reach Activity 2.
- Conduct **Exercise 3, Activity 2**.
 - ◆ Ask the class to break up into pairs.
 - ◆ Distribute a copy of the K10 assessment tool to each pair.
 - ◆ Ask the class members to read the description of the activity and then decide who will be the respondent and who will be the administrator of the K10.
 - ◆ Allow 10 minutes for each pair to complete the K10 and discuss the process between themselves.
 - ◆ Facilitate a class discussion on the process of using the tool. Points to cover might include: difficulties administering the tool; any difficulties that might arise when using the tool in a clinical context; cultural relevance of the tool; its value in assessing mental health.
- Continue to lecture with the PowerPoint presentation until completion.

Opioid use, opioid dependence and withdrawal syndromes



Objectives:

By the end of the session participants will be able:

- To understand the social, psychological and biological reasons for drug use
- To describe the features of drug use and understand the particular features of opioids and the neurobiology of their use
- To understand the “harms” related to drug use
- To understand and recognize the difference between drug use and dependence
- To understand and recognize the features of the opioid dependence and withdrawal syndromes



Time to complete session:

1 hour 45 minutes



Session content:

- Drug use in society – how it starts and continues
- ICD-10 diagnostic guidelines
- The natural history of opioid dependence and associated harms
- Switching to injecting drug use
- Heroin injection-related harms
- Reduction of harm associated with injecting drug use



Training materials:

- PowerPoint presentation 4.1: Managing opioid dependence: opioid use, opioid dependence and withdrawal syndromes
- Sub-module 4.1: Opioid use, opioid dependence and withdrawal syndromes



Recommended reading:

- **The WHO Evidence for Action Project**
 - ◆ *Evidence for action: a critical tool for guiding policies and programmes for HIV prevention, treatment and care among injecting drug users*
 - ◆ *Methods for assessing HIV and HIV risk among IDUs and for evaluating interventions*
 - ◆ *HIV/AIDS and injecting drug use: information, education and communication*
 - ◆ *Effectiveness of sterile needle and syringe programmes*
 - ◆ *Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*
 - ◆ *Interventions to reduce the sexual risk behaviour of injecting drug users*
 - ◆ *Effectiveness of drug dependence treatment in HIV prevention*

This series has been published in *International Journal of Drug Policy* and is available electronically on the WHO website: http://www.who.int/hiv/pub/prev_care/drugpolicyjournal.pdf

- Centre for Harm Reduction. *Manual for reducing drug related harm in Asia*. Melbourne, Australia. The Centre for Harm Reduction, McFarlane Burnet Centre for Medical Research and Asian Harm Reduction Network, 2002.
- Centre for Harm Reduction. *Revisiting the hidden epidemic: a situation assessment of drug use in Asia in the context of HIV/AIDS*. Melbourne, Australia. The Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research and Asian Harm Reduction Network, 2002 (<http://www.chr.asn.au/resources/libraryservices/docdownload/revisiting/list>).
- Department of Human Services. *Pharmacology of opioids*. State of Victoria, Australia, Department of Human Services, 2004 (see Annex 1).
- WHO/UNODC/UNAIDS. *Evidence for action on HIV/AIDS and injecting drug use: policy brief: reduction of HIV transmission through drug-dependence treatment*. Geneva, WHO/UNODC/UNAIDS, 2004.



Session instructions:

- Present Powerpoint presentation 4.1.
- For **Exercise 4.1, Case studies**, break up into small groups and discuss case studies 1 and 2. Each group should choose a speaker who will report back to the class.

Evaluation and treatment of opioid dependence and withdrawal syndromes including OST



Objectives:

By the end of the session participants will be able:

- To understand and recognize the features of opioid intoxication and withdrawal syndromes
- To evaluate clients for treatment and commence withdrawal or maintenance treatment
- To understand the basic components of successful OST.



Time to complete session:

1 hour 30 minutes



Session content:

- Effects of heroin and other opioids
- Effects of opioid withdrawal
- Working with drug users
- Opiate treatment cascade
- Objectives of withdrawal services
- Objectives of substitution maintenance treatment
- Opioid substitution therapy (OST)
- Key features of OST assessment
- Side-effects of OST
- Methadone substitution therapy
- OST in Asia



Training materials:

- PowerPoint presentation 4.2: Managing opioid dependence: evaluation and treatment of opioid dependence and withdrawal syndromes including OST
- Sub-module 4.2: Evaluation and treatment of opioid dependence and withdrawal syndromes including OST



Required reading:

- WHO/UNODC/UNAIDS. *Evidence for action on HIV/AIDS and injecting drug use: policy brief: reduction of HIV transmission through drug-dependence treatment*. Geneva, WHO/UNODC/UNAIDS, 2004 (<http://www.who.int/hiv/pub/advocacy/en/drugdependencetreatmenten.pdf>).

- WHO. *Evidence for action technical papers: effectiveness of drug dependence treatment in preventing HIV among injecting drug users*. Geneva, WHO, 2005 (<http://www.who.int/hiv/pub/idu/drugdependencefinaldraft.pdf>).
- WHO/UNODC/UNAIDS. *Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention: position paper*. Geneva, WHO/UNODC/UNAIDS, 2004 (http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf)



Recommended reading:

- Australian National Council on Drugs. *Evidence supporting treatment: the effectiveness of interventions for illicit drug use*. Woden, Australia, Australian National Council on Drugs, 2001 (http://www.ancd.org.au/publications/pdf/rp3_evidence_supporting.pdf).
- Department of Human Services. *Pharmacology of opioids*. State of Victoria, Australia, Department of Human Services, 2004. (See Annex 1.)



Session instructions:

- Present Powerpoint presentation 4.2.
- For **Exercise 4.2.1, case study**, break up into small groups and discuss the questions for the case study. Each group should choose a speaker who will report back to the class.
- For **Exercise 4.2.2, role-play**, break up into groups of three: one doctor, one patient and one observer. Spend 15 minutes in the role-play conducting a history-taking assessment. After the role-play, discuss among the small group, and then return to the large group for a class discussion of the role-play.

Features of a comprehensive OST programme



Objectives:

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

- To understand the features of an opioid substitution programme and the requirements for additional interventions
- To assess the indications for opioid substitution withdrawal and the support required
- To assess clients for counselling and referral to other treatment and assistance modalities



Time to complete session:

1 hour 45 minutes



Session content:

- Ceasing OST
- Impact of maintenance opioid withdrawal
- Extra requirements of injecting drug users on ART
- Post-withdrawal interventions
- Summary



Training materials:

- PowerPoint presentation 4.3: Managing opioid dependence: features of a comprehensive opioid treatment programme
- Sub-module 4.3: Features of a comprehensive opioid treatment programme
- Annex 1: Pharmacodynamics of opioids
- Exercise 4.3: Case studies



Recommended reading:

- Addy D et al. *Clinical treatment guidelines for alcohol and drug clinicians. No. 1: key principles and practices*. Fitzroy, Victoria, Turning Point Alcohol and Drug Centre Inc., 2000.
- Department of Health Scottish Office. *Drug misuse and dependence: guidelines on clinical management*. Norwich, England, Department of Health Scottish Office, Department of Health Welsh Office, Department of Health and Social Services Northern Ireland, 1999 (<http://www.dh.gov.uk/assetRoot/04/07/81/98/04078198.pdf>).

- National Institute on Drug Abuse. *Principles of drug addiction treatment: a research-based guide*. Bethesda, MD, USA, National Institute on Drug Abuse, National Institutes of Health Publication, 1999 (No. 99-4180) (<http://www.nida.nih.gov/PDF/PODAT/PODAT.pdf>).
- Prochaska JO, Di Clemente CC, Norcross JC. In search of how people change: applications to addictive behaviors. *American Psychologist*, 1992, 47:1102-1114.



Session instructions:

- Present Powerpoint presentation 4.3.
- For **Exercise 4.3, case studies**, break up into small groups.

Case study 1

Discuss the case study. Choose a speaker from each group who will report back to the class.

1. What are the issues within the OST programme and some of the interventions required?

Case study 2

Discuss the case study. Try to identify the issues within the OST programme and some of the interventions required. Choose a speaker from each group who will report back to the class.

1. What more information do you want (history, examination, investigations)?
2. Should a referral be made? Where/when?
3. What psychosocial interventions could be helpful over time?

Case study 3

Discuss the case study. Choose a speaker from each group who will report back to the class.

1. What are the issues within the OST programme and some of the interventions required?
2. What referrals could you make with which psychosocial intervention?

Case study 4

Discuss the case study. Choose a speaker from each group who will report back to the class.

1. What are your thoughts on the management of the OST programme?
2. Which psychosocial interventions might be helpful?

Managing non-opioid drug dependence



Objectives:

By the end of the session participants will:

- Be familiar with common amphetamine-type stimulants (ATS) and their patterns of use in Asia
- Be familiar with symptoms of non-opioid dependence and medications used to deal with these symptoms
- Be able to describe relapse prevention approaches



Time to complete session:

1 hour 45 minutes

Session content:

- Drugs and their effects
- Amphetamine use
- Drug dependence: a chronic “health impairment”
- Treatment interventions
- Co-morbid mental illness
- Treatment of non-opioid drug use



Training materials:

- PowerPoint presentation 5: Managing non-opioid drug dependence
- Exercise 5: Case studies 1 and 2



Required reading:

- Baker A et al. *A brief cognitive behavioural intervention for regular amphetamine users: a treatment guide*. Canberra, Australian Government Department of Health and Aging, 2003.
- WHO. *Systematic review of treatment for amphetamine-related disorders*. Geneva, WHO, 2001 (http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.5.pdf).



Recommended reading:

- Australian Department of Health and Aging. *Management of patients with psychostimulant use problems: guidelines for general practitioners*. Canberra, Department of Health and Aging, Australian Government, 2004 ([http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/content/AC11DD6A037F9ECFCA25717D00811748/\\$File/psychostimnts_gp.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/content/AC11DD6A037F9ECFCA25717D00811748/$File/psychostimnts_gp.pdf)).
- Australian Department of Health and Aging. *Models of intervention and care for psychostimulant users*. Canberra, Department of Health and Aging, Australian Government, 2004 (<http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-publth-publicat-document-mono51-cnt.htm>).
- Australian National Council on Drugs. *Evidence supporting treatment: the effectiveness of interventions for illicit drug use*. Woden, Australia, Australian National Council on Drugs, 2001 (http://www.ancd.org.au/publications/pdf/rp3_evidence_supporting.pdf).
- Australian National Drug and Alcohol Research Centre. *Co-morbid mental disorders and substance use disorders: epidemiology, prevention and treatment*. Sydney, Australia, National Drug and Alcohol Research Centre, University of New South Wales, 2003 ([http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-publth-publicat-document-mono_comorbid-cnt.htm/\\$FILE/mono_comorbid.pdf](http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-publth-publicat-document-mono_comorbid-cnt.htm/$FILE/mono_comorbid.pdf)).
- WHO. *Amphetamine-type stimulants: a report for the WHO meeting on amphetamines, MDMA and other psychostimulants, Geneva 1996*. Geneva, WHO, 1997.



Session instructions:

- Group discussion: white board for dot points
 - ◆ What are the features of the different groups of drugs – stimulants, sedatives, hallucinogens?
- Lecture with PowerPoint presentation 5.1.
- Break up into groups for the case studies. Read the question boxes in the handout and prepare an answer together. Return in 15 minutes.

● **Case studies**

The case studies are used to illustrate the recurring pattern of a dependence syndrome and to provide an opportunity to practise identifying the key features of the diagnosis. Discussing them in groups provides an opportunity to explore the case and express opinions in a small forum.

Case study 1: discussion

The characteristic features of opioid dependence in Ronny include tolerance, withdrawal, continuing to use despite problems, a compulsion to take the drug and difficulty in controlling the amounts taken.

The harms that he is experiencing include psychiatric complications, marital discord and perhaps financial difficulties.

His position in the cycle of change has him taking action or in preparation again, as he has relapsed from previous actions.

Case study 2: discussion

The characteristic features of opioid dependence in Aung include tolerance, withdrawal, continuing to use despite problems, and difficulty in controlling the amounts taken.

The harms that he is experiencing include violence and injury, marital discord, employment problems and financial difficulties. Some options to reduce these harms as an alternative to stopping drug use include relationship counselling and social support for his wife, involvement of an employment advisor to give him some work strategies to assist Aung (anger management, sick leave, etc.) and outreach support during the detoxification to monitor his medication, nutrition and general condition.

His position in the cycle of change has him taking action but there is significant ambivalence so he may just be in contemplation or preparation. His treatment options are limited with his fragile work environment though he would benefit from the engagement in counselling, cognitive-behavioural therapy (CBT) and peer support programmes.

- **Activity 3:** In small groups of 3 or 4, list the potential harms associated with amphetamine use.
 - ◆ Spend 10 minutes brainstorming together. It may be helpful to break down the potential harms into biological, psychological, social and economic harms.
 - ◆ Then discuss in the large group.

**Objectives:**

By the end of the session participants will be able:

- To describe the current access of IDUs to ART programmes
- To explore personal beliefs and preconceptions about IDU access to ART
- To identify some of the barriers restricting access of IDUs to HIV care and treatment programmes including ART
- To understand and describe the evidence refuting some of the commonly held perceptions about IDUs and ART, which currently prevent IDUs from accessing ART programmes
- To begin to explore some of the successful models for providing quality ART to IDUs

**Time to complete session:**

1 hour 15 minutes

**Session content:**

- Epidemiology of HIV infection in IDUs
- Access of IDUs to ART programmes around the world
- Guidelines governing equitable access to ART
- Barriers to accessing ART for IDUs
- HIV Treatment efficacy data
- Adherence, resistance and injecting drug use
- Directly observed ART, IDUs and adherence
- Importance of the ART provider
- Some models that support ART for IDUs
- Recommendations for ART scale-up for IDUs in ASIA

**Training materials:**

- PowerPoint presentation 6.1: IDU access to ARVs
- Sub-module 6.1: IDU access to ARVs
- Photocopies of Exercise 6.1 (Module 6 page 9)
- Blank flipcharts and pens (for co-facilitator to collate responses and summarize major issues about IDUs and ART)



Required reading:

- ARV for injecting drug users: key facts on HIV treatment efficacy coalition ARV4IDUs satellite meeting: HIV treatment for drug users – a realistic goal. XV International AIDS Conference, Bangkok, 2004.
- Availability of ARV for injecting drug users: key facts coalition ARV4IDUs satellite meeting: HIV treatment for drug users – a realistic goal. XV International AIDS Conference, Bangkok, 2004.
- WHO. *Policy brief: antiretroviral therapy and injecting drug users*. Geneva, WHO, 2005 (WHO/HIV/2005.06).
- Wood E et al. Expanding access to HIV antiretroviral therapy among marginalized populations in the developed world. *AIDS*, 2003, 17:2419–2427.



Recommended reading:

- Centre for Research on Drugs and Health Behaviour. *Treatment and care for drug users living with HIV/AIDS*. Paper prepared for the UN reference group on treatment and care for drug users living with HIV/AIDS. London, Centre for Research on Drugs and Health Behaviour, Imperial College, 2003.
- Lucas G et al. Directly administered ART in methadone clinics is associated with improved HIV treatment outcomes, compared with outcomes among concurrent comparison groups. *Clinical Infectious Diseases*, 2006, 42:1628–1635.
- Open Society Institute. *Breaking down barriers: lessons on providing HIV treatment to injection drug users*. New York, Open Society Institute, 2004.
- Vlahov et al. Effectiveness of HAART among IDU with late stage HIV infection. *American Journal of Epidemiology*, 2005, 161:999–1012.
- WHO. *Scaling up provision of antiretrovirals to IDU and non-IDU in Asia*. Report produced for the International Harm Reduction Association and WHO. Geneva, WHO, 2004.



Session instructions:

- Introduce topic plus session outline – PowerPoint presentation 6.1.
- **Exercise 6.1, Activity 1:** Individual exercise
- State that this exercise will take 5 minutes. Let participants know that the aim of this exercise is for them to stop and reflect about their individual perceptions about whether IDUs can successfully take ART. Hand out the photocopies of Exercise 6.1 with the following questions on it and space for the participants to write.

1. Do you personally think that active IDUs can take ART successfully?
2. What are the reasons you think active IDUs can (or cannot) successfully take ART?

Let participants know that whatever they write on the piece of paper is confidential and will not be shown or discussed with anyone. Tell them that one of the workshop facilitators will collect and collate the responses, and these will be discussed at the end of the session along with a discussion of what people have learned. Let participants know that once this is done, the slips of paper will be destroyed. (You will need to ask one of the co-facilitators to collect the responses: the number of yes and no answers to question 1 plus a summary of the major issues IDUs can/cannot take therapy on separate flipcharts.)

- Resume PowerPoint presentation
- **Exercise 6.1, Activity 2:** Brainstorm – Why do barriers exist for IDUs to access ART?

Ask participants why they think there are barriers to IDUs accessing ART and ask them to list the barriers. Record the ideas on flipchart paper – ideas may include that IDUs cannot adhere to ART, that ART does not work very well in IDUs, that IDUs often do not access health clinics, injecting drug use is a criminal activity, negative attitudes of health workers to IDUs, ART is expensive, it is hard to treat IDUs with ART as they often have other medical conditions, etc.

Ask the participants to describe their own experiences of treating IDUs with ART.

Ask the participants whether they would like to share their own thoughts about whether IDUs can successfully be treated with ART.

Let the participants know that during this session these barriers will be discussed in much greater detail and that some of the evidence surrounding these controversial issues will be explored.

- Resume PowerPoint presentation.
- **Exercise 6.1, Activity 3:** Group discussion
- Review the collated responses and discuss them with the group. Ask the participants if any of them would like to change their responses after looking more closely at some of the evidence and experiences you have described in the presentation. Ask participants if they have any other questions.

**Objectives:**

By the end of the session participants will be able:

- To outline the health problems common to HIV-positive IDUs and the essential components of healthcare service delivery for HIV-positive IDUs
- To describe the common non-HIV related infections and medical conditions of HIV-positive IDUs including their management
- To describe common opportunistic infections (OIs) and their management
- To outline the difference between primary and secondary OI prophylaxis
- To perform an initial evaluation of an HIV-positive IDU at the HIV clinic

**Time to complete session:**

3 hours 15 minutes

**Session content:**

- Looking after IDUs with HIV
- Common health problems in HIV-positive IDUs
- Comprehensive care models for HIV-positive IDUs
- Initial evaluation of the HIV-positive IDU
- WHO clinical staging system for HIV-infected adults and adolescents
- Management of common health problems in IDUs
- Overdose
- Diagnosis and management of OIs
- Prevention of OIs
- Follow-up visits

**Training materials:**

- PowerPoint presentation 6.2: General HIV care for IDUs
- Sub-module 6.2: General HIV care for IDUs
- Blank flipchart paper and pens
- Exercise 6.2.1: WHO clinical staging exercise
- Exercise 6.2.2: Role-play: Initial clinical evaluation
- Annex 1: Outpatient chart

- Annex 2: Facilitator's checklist
- Annex 3: Clinical staging system of HIV infection in adults and adolescents



Required reading:

- O'Connor PG, Selwyn PA, Schottenfeld RS. Medical care for injection-drug users with human immunodeficiency virus infection. *New England Journal of Medicine*, 1994, 331:450–459.
- WHO. *Chronic HIV care with ARV therapy: interim guidelines for health workers at health centre or clinic at district hospital outpatient*. WHO, Integrated Management of Adult and Adolescent Illness, April 2006.



Recommended reading:

- Hoy J, Lewin S (eds). *HIV management in Australasia: a guide for clinical care*. Sydney, Australia, Australasian Society for HIV Medicine, 2004.
- Bartlett JG, Gallant JE. *Medical management of HIV infection*, 2005–2006 edition. Baltimore, MD: Johns Hopkins University, 2005.



Session instructions:

- Introduce the topic plus the session outline – PowerPoint presentation
- **Activity 1:** Small group work (15 minutes)

Ask the class to break up into four groups and provide each group with two large pieces of blank flipchart paper. Ask each group:

1. To list some of the common health problems among HIV-positive IDUs
2. To outline the ingredients that make up a good model of care for HIV-positive IDU clients

Ask each group to summarize their discussion on the above questions on two separate pieces of flipchart paper.

Ask one group to present their “list of common health problems”. Ask the other three groups to add anything that they may have forgotten.

Ask a different group to present their “model of care for HIV-positive IDUs”. Again ask the other three groups to add anything that they may have forgotten.

- Resume PowerPoint presentation – you will be adding and reinforcing the issues discussed in the group work in slides 5–9.
- **Activity 2:** Individual exercise – WHO clinical staging
Ask participants to use Annex 3 to complete Exercise 6.2.1 – identifying the WHO clinical stage of each of the patients in the case study. This should take approximately 5 minutes. Go through each case study and ask a different participant to volunteer the answer. Ask if anyone has any different suggestions and discuss these as you proceed.
- Resume PowerPoint presentation.
- Tea break (after 1.5–2 hours)
- Resume PowerPoint presentation.
- **Activity 3:** Exercise 6.2.2. Role-play: The initial clinical evaluation of an HIV-positive IDU (30 minutes)

Ask the class to break up into four groups and tell them that they will work together on a role-play of the initial clinical evaluation of an HIV-positive IDU. You will need a total of four facilitators to assist with this session and provide feedback to the groups. Facilitators should use the Facilitator Checklist (Annex 2). Let participants know that each group needs one clinician and one patient. The doctor should make an initial assessment of the client using the Outpatient Care (OPC) Record (Annex 1). The client in each group should use Exercise 6.2.2. The rest of the group should assess the clinical evaluation process and provide feedback and suggestions at the end. Let everyone have a few minutes to study the activity sheets before they start the exercise. Start the role-play. When there are approximately 5–10 minutes left ask the doctors to cease their evaluations and allow each group time to provide feedback and suggestions.

Once back in the large group ask people how things went with this exercise and if they have any questions.

- Resume PowerPoint presentation.
- **Activity 4:** Group discussion: The follow-up visit

Hoa comes back to see you one day later than you planned. Her laboratory tests are back. Her CD4 count is 150 cells/mm³; her Hb is 11.1 mg/dl and her ALT is 75 IU/L. She is HBsAg positive.

What do you need to think about next?

- Resume PowerPoint presentation – close.

The use of ARV drugs for the HIV-infected IDU



Objectives:

By the end of the session participants will be able:

- To demonstrate knowledge and understanding of the overall mechanism of action of antiretroviral drugs (ARVs) and their role in preventing and controlling disease progression
- To describe the ARVs and regimens outlined in the revised 2006 WHO ART guidelines
- To demonstrate a detailed understanding of all the individual ARV drugs included in the 2006 guidelines
- To appreciate and understand the complexity of factors influencing the choice of ARV drugs for HIV-positive IDUs who require antiretroviral therapy (ART)



Time to complete session:

3 hours



Session content:

- Revise how ARVs work
- Review the goals of ART
- Examine the ARV drugs and regimens recommended by the revised 2006 WHO ARV guidelines



Training materials:

- PowerPoint presentation 6.3: ARV drugs for the HIV-infected IDU
- Sub-module 6.3: ARV drugs for the HIV-positive IDU
- Blank flipchart paper and pens
- Exercises 6.3.1–6.3.3



Required reading:

- *2006 Revised WHO guidelines for ART in low-resource settings*. Geneva, WHO, 2006.



Recommended reading:

- Hoy J, Lewin S (eds). *HIV management in Australasia; a guide for clinical care*. Sydney, Australia, Australasian Society for HIV Medicine, 2004.
- Bartlett JG, Gallant JE. *Medical management of HIV infection*. 2005–2006 edition. Baltimore, MD, Johns Hopkins University, 2005.

- Department of Health and Human Services (DHHS) Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents*. 10 October, 2006 (<http://aidsinfo.nih.gov/contentfiles/AdultandAdolescentGL.pdf>).



Session instructions:

- Introduce topic plus session outline – PowerPoint presentation 6.3.
- **Activity 1:** Small group work (10 minutes)

Divide the class into four groups and provide each group with two large pieces of blank flipchart paper. Ask each group to draw on flipchart paper the replication cycle of HIV and where each different class of ARV drugs acts. Ask one of the groups to present their “model” and discuss within the group, correcting any misperceptions that may arise.

- Resume PowerPoint presentation.
- **Activity 2:** Group work – getting to know ARV drugs

Divide the class into four groups and give each group a different exercise (Exercise 6.3.1–6.3.4). Let them know that they have 30 minutes to use what they know and whatever resources they have available to fill in a table summarizing the major features of the ARV drugs that the group has been assigned. This includes:

- ◆ Class of drug
- ◆ How it works
- ◆ Dosing recommendations
- ◆ Food effect
- ◆ Minor side-effects
- ◆ Major toxicity
- ◆ Drug interactions with methadone and buprenorphine
- ◆ Drug interactions with ARVs and other drugs

Once the 30 minutes is up the group needs to present these summarized findings to the rest of the class and discuss together in the group.

- Resume PowerPoint presentation – close.

Selecting a first-line regimen and starting ART

Objectives:

By the end of the session participants will be able:

- To understand the issues that need to be addressed before an HIV-positive IDU can start ART
- To appreciate and understand the complexity of factors influencing the choice of ART regimens for HIV-positive IDUs
- To demonstrate a detailed understanding of all the ART regimens included those in the revised WHO 2006 Guidelines
- To analyse the most important aspects of the clinical and social history of an HIV-positive IDU and choose a suitable regimen for this client.



Time to complete session:

2 hours 30 minutes



Session content:

- Principles of treatment and care for HIV/AIDS in IDUs
- Selecting a first-line regimen: general principles
- Clinical criteria for starting ART
- Baseline clinical assessment
- Issues impacting the choice of ART regimen in IDUs



Training materials:

- PowerPoint presentation 6.4: Selecting a first-line regimen in for HIV-infected IDUs
- Sub-module 6.4: Selecting a first-line regimen for HIV-infected IDUs
- Exercises 6.4.1 and 6.4.2



Required reading:

- *Revised 2006 WHO guidelines for ART in low-resource settings.* Geneva, WHO, 2006.
- *Draft WHO guidelines on HIV care/ART for IDUs.* Geneva, WHO, 2006.



Recommended reading:

- Hoy J, Lewin S (eds). *HIV management in Australasia; a guide for clinical care*. Australasian Society for HIV Medicine, 2004.
- Bartlett JG, Gallant JE. *Medical management of HIV infection*. 2005–2006 edition. Baltimore, MD, Johns Hopkins University, 2005.



Session instructions:

- Introduce topic plus session outline – PowerPoint presentation 6.4.
- **Activity 1:** Large group discussion (10 minutes)

What factors do we need to take into consideration when choosing a first-line regimen for HIV-positive IDUs?

Ask the participants to think of some of the issues they will need to consider when choosing an ART regimen for HIV-positive IDUs. If they have trouble thinking of issues try to get them to subcategorize them into: (1) adherence issues; (2) co-morbidities; and (3) co-treatments and drug interactions. Reinforce what they have discussed as you talk about slides 8 and 9 and explain how these factors influence the clinical assessment and preparation that has to occur before an individual can start ART.

- Resume PowerPoint presentation.
- **Activity 2:** Small group exercise (30 minutes)

Ask the class to break into four groups. Ask each group to complete Exercise 6.4.1 for the two first-line ART regimens assigned to their group. They should list the advantages and disadvantages related to:

- ◆ Adherence factors
- ◆ Co-morbidities – hepatitis B and C, TB, pregnancy, psychiatric illness, alcoholism
- ◆ Co-treatment interactions – hepatitis B, hepatitis C, TB, methadone, buprenorphine

When the group reassembles after 15–20 minutes ask each group to briefly present the profile of the two regimens that they examined.

- Resume PowerPoint presentation.
- **Activity 3:** Small group exercise (30 minutes)

Ask the class to break up into four groups and complete Exercise 6.4.2. Each group should try to examine all four case studies and discuss the following:

- ◆ Outline your first preferred ART regimen for this client.
- ◆ Why did you choose this regimen?
- ◆ What would be an alternative to this regimen?
- ◆ What other things do you need to consider?
- ◆ What are the major issues you would need to counsel and educate each patient on for this regimen?

When the group gets back together go through the case studies one by one and discuss as a group. Answer any questions that arise.

- Resume PowerPoint presentation – summarize and close.

Monitoring IDUs on ART and managing side-effects and toxicities within the first year



Objectives:

By the end of the session participants will be able:

- To outline “what to expect” for someone on ART in the first six months of therapy
- To understand the routine monitoring processes that should be carried out for all HIV-positive IDUs on ART, including the difference between routine monitoring and monitoring that is required when a toxicity arises
- To understand the impact of OST on routine monitoring and the drug interactions, side-effects and toxicities commonly associated with taking ART and OST together
- To demonstrate the ability to deal with minor side-effects common in individuals starting first-line ART
- To demonstrate an understanding of the management of major side-effects in an individual taking first-line ARV drugs during the first year of treatment
- To understand when and how to switch ARV drugs in the first-line regimen in the event of toxicity.



Time to complete session:

2 hours



Session content:

- What to expect in the first six months of ART
- Immune reconstitution inflammatory syndrome (IRIS)
- Routine monitoring of first-line ART
- Management of adverse events on a first-line regimen
- Management of serious toxicities within the first year of ART
- Drug substitutions due to toxicity
- Safely stopping ART to avoid the development of resistance



Training materials:

- PowerPoint presentation 6.5: Monitoring IDUs on ART and managing side-effects and toxicities within the first year
- Sub-module 6.5: Monitoring IDUs on ART and managing side-effects and toxicities within the first year
- Blank flipchart paper and pens



Recommended reading:

- Hoy J, Lewin S (eds). *HIV management in Australasia; a guide for clinical care*. Sydney, Australia, Australasian Society for HIV Medicine, 2004.
- Bartlett JG, Gallant JE. *Medical management of HIV Infection*. 2005–2006 edition. Baltimore, MD, Johns Hopkins University, 2005.
- *HIV clinical resource*. Office of the Medical Director, New York State Department of Health AIDS Institute in collaboration with the Johns Hopkins University Division of Infectious Diseases (<http://www.HIVGuidelines.org>).



Session instructions:

- Introduce the topic plus session outline – PowerPoint presentation.
- **Activity 1:** Large group discussion (10 minutes)
Ask the group the following question, “What do you expect in the first six months of ART?”. Reflect on the previous session and ask the group to think about the implications of the “usual timing of side-effects and toxicities” on routine monitoring.
- Resume PowerPoint presentation.
- **Activity 2:** Small group work – case studies on minor side-effects (20 minutes)
Ask the participants to break up into small groups and complete Exercise 6.5.1. Let the participants know that the people they started on ART in the last session are now returning with some side-effects that they need to manage. Ask them to examine and discuss each case study in their groups and then document the following:
 - ◆ Which ARV drug do you think is responsible for this presentation?
 - ◆ What is your differential diagnosis for this presentation?
 - ◆ How would you exclude other causes for this presentation?
 - ◆ What advice will you give the client to help minimize the impact of these symptoms?
- Resume PowerPoint presentation.
- **Activity 3:** Small group work – case studies on major toxicities within the first year of ART (30 minutes)
Ask the class to break up into small groups and complete Exercise 6.5.2. Let participants know that the people they started on ARV drugs have successfully had their “minor” side-effects managed but are now returning with additional problems that they need to manage. Ask them to examine and discuss each case study in their groups and then document the following:
 - ◆ Which ARV drug do you think is responsible for this presentation?
 - ◆ What is your differential diagnosis for this presentation?
 - ◆ How would you exclude other causes for this presentation?
 - ◆ What changes would you make to the ART regimen?
 - ◆ What advice will you give the client to help adjust to this new regimen?
- Resume PowerPoint presentation – summarize and close.

Treatment failure, second-line therapy and long-term toxicities



Objectives:

By the end of the session participants will be able:

- To demonstrate an understanding of resistance and its role in treatment failure, including the role of adherence and missed doses in creating drug resistance
- To evaluate when it is necessary to put a client on second-line therapy
- To demonstrate an understanding of the side-effects and major toxicities of second-line ARVs and how to manage these when they arise
- To understand the routine monitoring processes that should be carried out for all HIV-positive IDUs on second-line ART, including the difference between routine monitoring, monitoring of OST and monitoring if a toxicity arises
- To demonstrate an understanding of the long-term toxicities of both the first- and second-line ARVs including how these impact on lifestyle and adherence.



Time to complete session:

3 hours 45 minutes



Session content:

- Treatment failure and resistance
- Initiating second-line therapy
- Managing toxicities on second-line therapy



Training materials:

- PowerPoint presentation 6.6: Treatment failure, second-line therapy and long-term toxicities
- Sub-module 6.6: Treatment failure, second-line therapy and long-term toxicities
- Flipchart paper and pens
- Exercises 6.6.1 and 6.6.2



Recommended reading:

- Hoy J, Lewin S (eds). *HIV management in Australasia: a guide for clinical care*. Sydney, Australia, Australasian Society for HIV Medicine, 2004.
- Bartlett JG, Gallant JE. *Medical management of HIV infection*. 2005–2006 edition. Baltimore MD: Johns Hopkins University, 2005.
- *HIV Clinical Resource*. Office of the Medical Director, New York State Department of Health AIDS Institute in collaboration with the Johns Hopkins University Division of Infectious Diseases (<http://www.HIVGuidelines.org>).



Session instructions:

- Introduce topic plus session outline – PowerPoint presentation.
- **Activity 1:** Group discussion (20 minutes)
Review the side-effects (minor and major) of each of the individual second-line ARV drugs (ddI, ABC, TDF, LPV/r, IDV, SQV, ATZ, fos-APV, NFV). Group them into the following:
 - ◆ Minor side-effects and when they are likely to occur
 - ◆ Major toxicities that are likely to occur within the first year of second-line ART (and when they are likely to occur)
 - ◆ Interactions with OST
 - ◆ Longer-term toxicities
 - ◆ Reviewing toxicities and side-effects – What are the important aspects that need to be monitored when an IDU client is on second-line ART?
- Resume PowerPoint presentation.
- **Activity 2:** Group work (30 minutes)
Ask the class to break up into small groups and complete Exercise 6.6.1. Let the participants know that their clients are coming back after several years and that some of them have problems. Ask them to examine and discuss each case study and then document the following:
 - ◆ What diagnoses would you need to exclude before you diagnose treatment failure?
 - ◆ What is your preferred second-line therapy?
 - ◆ What are some alternatives to your preferred second-line therapy?
 - ◆ What baseline and additional tests will you need to add to your routine monitoring repertoire?
 - ◆ What major side-effects and toxicities will you tell the client about?
 Ask each group to present one case to the class and discuss together as a group, and answer any questions and clarify any issues that arise.
- Resume PowerPoint presentation.
- **Activity 3:** Small group discussion: case study on major toxicities within the first year of ART (15 minutes)
Ask the class to break up into small groups and complete Exercise 6.6.2. Let participants know that Dave, whom they started on second-line ARV drugs, now has additional problems that they need to manage. Ask them to examine and discuss the case study in their groups and then document the following:
 - ◆ Which ARV drug do you think is responsible for this presentation?
 - ◆ What is your differential diagnosis for this presentation?
 - ◆ How would you exclude other causes for this presentation?
 - ◆ What changes would you make to the ART regimen?
 - ◆ What advice will you give the client to help him adjust to this new regimen?
- Discuss the case during the group discussion.
- Resume PowerPoint presentation – summarize and close.

Adherence: overview and skills rehearsal



Objectives:

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

- To define treatment adherence
- To discuss the challenges to ensuring adherence among IDUs
- To describe different adherence implementation strategies that can be used with IDUs
- To conduct a client interview to explore the barriers experienced by an individual in maintaining treatment adherence
- To calculate and report on a client's adherence to medication



Time to complete session:

Part 1 – 1 hour 15 minutes

Part 2 – 1 hour 45 minutes



Session content:

- Overview
- Establishing an adherence programme
- Community – clinic – provider collaborations
- Key elements of patient preparation
- Treatment and adherence programme
- Assessing and facilitating the patient's understanding of HIV
- Managing individual barriers to adherence
- Ongoing counselling and monitoring of adherence



Training materials:

- PowerPoint presentation 7.1a: HIV drug resistance and adherence
- PowerPoint presentation 7.1b: Adherence: counselling overview and skills rehearsal
- Sub-module 7.1: Overview and skills rehearsal
- Exercise 7.1
- Tools 1–9 in Annexes 1–9



Session instructions:

- Give PowerPoint presentation 7.1a: HIV drug resistance and adherence.
- Give PowerPoint presentation 7.1b: Adherence: counselling overview and skills rehearsal.
- **Activity 1:** Group activity 15 minutes
Ask all the participants to stand.

Ask them to think about times in their lives when they have been prescribed medication and inform them that they can sit down only if they have always taken medication exactly as prescribed.

Ask those who remain standing to consider an occasion when they failed to comply with the instructions or complete a course and to think about why this happened.

Ask each person to give their reasons for non-adherence.

- ◆ Record their responses on an overhead transparency or on a whiteboard or on a large piece of flipchart paper.
 - ◆ Remark that clients have the same difficulties. There are many reasons that contribute to non-adherence. Information provision clearly is not enough. Even health workers who had information still did not adhere to their treatment.
 - Continue PowerPoint presentation until **Activity 2**. This is a brief large group discussion (5 minutes).
 - ◆ What are the limitations of directly administered ART (DAART) in methadone clinics?
 - ◆ What are the limitations or issues related to community DAART?
 - Continue PowerPoint presentation until you reach Activity 3.
 - **Activity 3:** Ask the large group the following with regard to each question. What type of questions are these? Respond to each question. What are the problems with asking these questions:
 - ◆ "Do you take your medication as the doctor told you to?"
 - ◆ "Do you know what to do if you have diarrhoea or vomit when taking medication?"
 - ◆ "You always do take your medication, don't you?"
 - Continue the PowerPoint presentation until you reach Activity 4.
 - **Activity 4:** Ask the group to review Tools 1-7 in Annexes 1-7.
 - **Activity 5:** Large group discussion
 - ◆ What are the strengths and weaknesses of "pill counts"?
 - ◆ What are the strengths and weaknesses of "self-reports"?
- Take a break before resuming the session.
- **Activity 6:** Ask participants to read the case study on page 14.

Activity 6: Case study

- A 22-year-old female bar worker has been told by the doctor that she needs to start ART for HIV. Nobody at home or at work knows that she has HIV. She lives with her family.
- She leads a busy life. She looks after her widowed mother and younger sister during the day and works at the KTV bar in the evenings. At the KTV bar, she sometimes has to drink with the clients. She usually eats with the other girls in the bar at night.
- She injects amphetamine to help her feel awake (crushed pills). She injects when she has a lot of work on the weekend. She has increased the frequency of her injecting and her best friend worries about this.
- She has lost a considerable amount of weight and reports that she does not feel like eating.
- She has taken medication in the past for sexually transmitted infection (STI) but did not complete the course. She stopped taking medication when she felt better. She also tended to avoid getting up in the night to take medication. She has started taking some traditional herbal medicine. She has been told that traditional medicines can extend life and are better than the chemicals that doctors prescribe.
- She has problems remembering things lately and also has hallucinations at times (heard things others say they cannot hear). Sometimes she feels like she has plenty of energy to the extent that her friends find it unusual.
- She does not know if she is pregnant. She has missed one menstrual period.

Explain to the large group that the task is to develop an **adherence support plan**. This is done by identifying key barriers and developing specific strategies for each barrier.

- ◆ In the large group “brainstorm” the **barriers to treatment adherence**. Write each barrier on a white board or overhead transparency.
 - ◆ In the large group discuss how these barriers might affect the patient’s future adherence to ART.
 - ◆ Review the “Barriers Support Tool” (Tool 8).
 - ◆ Discuss **strategies** for how the patient might overcome these barriers to adherence.
 - ◆ What other issues might be of concern in this patient’s case? Would you refer her for further work-up by other health and community service providers? Who would you refer her to?
- **Exercise 7.1.2: Role plays: Activity 7:** Divide the class into pairs (cases on following page): For each pair, assign one person to be an A and one to be a B. There are two cases (two rounds of role-play) – case 1 and case 2.
A is the counsellor in case study 1; B is the patient.
B is the counsellor in case study 2; A is the patient.
Ask participants to turn to Exercise 7.1.2 in their manuals. Each participant should read the case study in which they are playing the role of patient.
A receives case study 2.
B receives case study 1.

	Counsellor	Patient	Who reads the case study sheet
Case study 1	A	B	B
Case study 2	B	A	A

Only the participant playing the patient gets to read the case study for that particular round. The **counsellor** should **NOT** read the case study before the role-play round.

Counsellor instructions: Assume your patient is HIV positive. Introduce yourself to the client and explain that your role is to tell them a little about HIV treatment and adherence. Practise eliciting information about the patient and support the client in addressing the barriers. You may use the “interview form” to assist you.

Patient/client instructions: Introduce yourself to the counsellor; indicate the gender and the age of the client you are playing. It is up to the skill of the counsellor to retrieve the information from you. Try to make the role-play as realistic as possible.

Timing for each role-play:

- ◆ 20 minutes total for the two role-plays (10 minutes each role-play)
- ◆ 5 minutes for role-play team debriefing with patient and counsellor
- ◆ 15 minutes for large group debriefing on each case scenario

Large group debriefing: Debrief case by case. Starting with case 1, what were the key barriers to adherence in each case? What strategies could be put in place to address these barriers? What referrals do you need to make for the patient?

- ◆ The goal of the activity is **to identify the possible barriers to adherence in each specific case scenario.**
- Conclude the session with the final PowerPoint presentation.

Activity 7: Case study 1

(To be distributed to the patient and observer ONLY; the counsellor should NOT read this prior to the role-play exercise.)

You are a 26-year-old restaurant manager. Nobody at your restaurant knows you have HIV. You work long hours and are at the restaurant for around twelve hours a day. When you go home, you eat meals with your family. Only your wife knows you have HIV. Your widowed mother lives with you and your two children. Your wife and one of your children have also been diagnosed HIV positive. Your wife is well and your child currently has no symptoms.

When you were given medication in the past you often forgot to take it because you have so many responsibilities at work. You often failed to complete the course of medications. Often, you reduced the dose when you had side-effects such as nausea.

You have been sleeping badly and you are becoming a bit forgetful. You feel quite depressed (sleeping but waking early in the morning, lack motivation) and have to force yourself to get out of bed. You have no appetite.

You believe HIV will kill you. You are not sure that you can afford to take all your medications. The doctor told you that ART is free but the doctor said you need to take other drugs to prevent something called OIs.

Activity 7: Case study 2

(To be distributed to the patient and observer ONLY; the counsellor should NOT read this prior to the role-play exercise.)

You are a 26-year-old male who was diagnosed with HIV/AIDS four years ago. You have used heroin in the past. You have been on ART in the past, but often missed doses because of diarrhoea, and then stopped the medications completely because of a side-effect (burning pain in the hands and feet). Your last CD4 count was 110 cells/mm³.

The doctor now wants to start you on a new ART regimen. You take traditional herbal medicines every day to protect your liver. You work as a peer educator for an organization for PLWHA. You have many different doctors (western and Chinese) telling you different things about your medications. In addition, your friends are telling you to enrol in a new trial to study herbal medicines in treating HIV. You travel frequently because of your duties to do outreach work for other PLWHA.

In the course of your work you encounter other IDUs. It would be easy for you to access heroin and when you feel under pressure it is very tempting. Especially lately you sometimes think of using heroin again as you are starting to feel agitated, restless and have difficulty sleeping. Your friends say you are "too active"; they make jokes about you talking too much and too fast. Your doctor seems to think you are using again but you are not.

**Objectives:**

By the end of the session participants will:

- Have an insight into the issues and problems facing HIV-positive IDUs accessing health-care services and taking ART
- Understand what needs to be in place in order to establish an accessible ART programme for HIV-positive IDUs.

**Time to complete session:**

1 hour 45 minutes

**Session content:**

Participants seat themselves in a circle. Four HIV-positive IDUs make short contributions followed by a general discussion, questions and answers. Examples of questions IDUs can be asked to address include:

- Have they had any difficult experiences getting access to treatment and care?
- Have they had any good experiences getting access to treatment and care?
- Was it easy/difficult to be accepted for ARVs?
- What has their experience of taking ARVs been like?
- What are some of the factors that make adherence difficult?
- If they could ask doctors to do one thing differently, what would it be?

Session preparation:

- This session needs to be organized ahead of time. Course organizers should contact a local NGO working with IDUs and discuss the training course, its objectives, this session and its objectives. It is strongly recommended that IDUs who are willing to participate in this session are paid for their time (both for the preparation of and participation in this session).
- Translators should be organized if required.
- Confidentiality and privacy must be respected. It is up to the individual to share and say what they wish to.
- The session facilitator should organize a preparation session of 2–3 hours to discuss with HIV-positive IDUs what they will say in the group.



Session instructions:

- This session needs to be carefully facilitated.
- Ask participants and speakers to form a circle.
- Explain the ground rules for the session. Write them on a flipchart:
 - ◆ Explain that this session is for the benefit of the clinicians attending the training course. They will have the opportunity to listen to an IDU's perspective on ART, adherence, resistance, side-effects, changing regimens, etc.
 - ◆ Participants will follow the directions of the facilitator.
 - ◆ All participants are expected to respect the speaker's confidentiality and privacy.
 - ◆ All interactions will be respectful.
 - ◆ No questions regarding personal drug-using habits will be permitted.
 - ◆ If a speaker does not want to answer a question, they are not expected to answer it.
- The facilitator introduces each speaker and the organization they represent (if relevant).
- Each IDU speaker speaks for 5–10 minutes followed by 10 minutes of questions and answers.
- The facilitator invites questions from the audience and supports the individual speakers by managing questions and discussions with the group, including managing any challenging behaviours from participants such as judgemental remarks or inappropriate or denigrating questions.

Interactions between illicit drugs and ARVs



Objectives: By the end of the session participants will:

- Understand the mechanisms of drug interaction
- Be familiar with and able to use the standard table of interactions between illicit drugs and ARVs
- Be able to make clinical decisions using information on interactions between illicit drugs and ARVs



Time to complete session:

1 hour



Session content:

- Interactions between illicit drugs and ARVs
- Case study exercises to familiarize participants with the standard drug interaction tables



Training materials:

- PowerPoint presentation 8.1: Interactions between illicit drugs and ARVs
- Sub-module 8.1: Interactions between illicit drugs and ARVs
- Evaluation form



Session instructions:

- Introduce the topic plus session objectives – PowerPoint presentation.
- Ask the participants to turn to Sub-module 8.1 and explain the drugs that are listed and the information each column contains.
- Use the PowerPoint slides as a basis for the case study discussions.

Interactions between ARVs, opioid substitution therapy (OST) drugs and other medications commonly used to treat PLWHA



Objectives: By the end of the session participants will:

- Be familiar with and able to use the standard table of interactions between ARVs and OST drugs
- Be familiar with and able to use the standard table of interactions between ARVs and other medications commonly used to treat PLWHA
- Be able to make clinical decisions using information on interactions between ARVs, OST drugs and other medications commonly used to treat PLWHA



Time to complete session:

1 hour 45 minutes



Session content:

- Interactions between ARVs and drugs used for OST
- Case study exercises to familiarize participants with the standard drug interaction tables
- Interactions between drugs commonly used to treat PLWHA and methadone and ARVs



Training materials:

- PowerPoint presentation 8.2: Interactions between ARVs, OST drugs and other medications commonly used to treat PLWHA
- Sub-module 8.2: Interactions between ARVs, OST drugs and other medications commonly used to treat PLWHA



Session instructions:

- Introduce the topic plus session objectives – PowerPoint presentation.
- Ask the participants to turn to Sub-module 8.2 and explain the drugs that are listed and the information each column contains.
- Use the PowerPoint slides as a basis for the case study discussions.

**Objectives:**

By the end of the session the participants will:

- Understand the epidemiology of viral hepatitis/HIV coinfection
- Understand the influence of viral hepatitis on progression of HIV
- Understand the influence of HIV on progression of viral hepatitis
- Understand the approach to HCV and HBV treatment in the context of HIV infection
- Understand the approach to HIV treatment in the context of viral hepatitis, including how to choose an appropriate ART regimen and monitor liver function
- Understand the importance of preventing bloodborne virus transmission in coinfection
- Understand the limitations of hepatitis management in resource-limited settings

**Time to complete session:**

1 hour 45 minutes

**Session content:**

Consider both HCV/HIV and HBV/HIV coinfection:

- Epidemiology
- Natural history
- Effect of HCV on HIV progression
- Effect of HIV on HCV progression
- Treatment of HCV in HIV coinfection
- Treatment of HIV in HCV coinfection
- Summary

**Training materials:**

- PowerPoint presentation 9.1: HIV/HCV and HIV/HBV coinfections in HIV-infected IDUs
- Sub-module 9.1: HIV/HCV and HIV/HBV coinfections



Session instructions:

- Group discussion

Hepatitis is common among IDUs across Asia – what are the barriers to treatment or prevention of worsening liver disease in your practice? List the barriers on flipchart paper. Key issues to be covered in this discussion include:

- ◆ Cost
 - ◆ Lack of awareness among health staff of the impact of hepatitis
 - ◆ Lack of awareness among IDUs of hepatitis and that their main concern is about HIV
 - ◆ Lack of knowledge of health staff of the interactions between ART and hepatitis
 - ◆ Alcohol abuse
 - ◆ Lack of an available vaccine
- Give the PowerPoint presentation.
 - Provide feedback and discuss.

Management of HIV/TB coinfection in IDUs



Objectives:

By the end of the session participants will be able:

- To describe the epidemiology of TB among IDUs and PLWHA
- To use the WHO guidelines to prescribe co-trimoxazole prophylaxis in HIV-infected patients
- To describe care and treatment interventions for HIV-infected IDUs with active TB
- To appropriately use ART in HIV-infected IDUs with active TB



Time to complete session:

1 hour 15 minutes



Session content:

- Care and support for HIV-infected individuals with active TB
- Co-trimoxazole preventive treatment and HIV-associated active TB
- Principles of antiretroviral therapy



Training materials:

- PowerPoint presentation 9.2: Management of HIV/TB coinfection in IDUs
- Sub-module 9.2: Management of HIV/TB coinfection in IDUs
- Exercise 9.2.1: Case studies 1, 2, 3



Recommended reading (available free at the WHO website: <http://www.who.int>):

- WHO. *Antiretroviral therapy for HIV infection in adults and adolescents in resource-limited settings, towards universal access: recommendations for a public health approach*. Geneva, WHO, 2006.
- WHO. *Guidelines for co-trimoxazole prophylaxis for HIV-related infections in children, adults and adolescents in resource-limited settings: recommendations for a public health approach*. Geneva, WHO, 2006.
- WHO. *TB/HIV: a clinical manual*, second edition. Geneva, WHO, 2004.
- WHO WPRO. HIV/tuberculosis coinfection. *HIV/AIDS Antiretroviral Newsletter*, 12 October 2005.



Session instructions:

- Lecture with the PowerPoint presentation for 45 minutes leaving time for questions and answers.
- Case studies (45 minutes with time for questions and answers): can be presented as a PowerPoint presentation to the entire group. The case studies can also be discussed in smaller group sessions using either the PowerPoint presentations or Exercise 9.2.1 in the participant manual.

Managing pain in HIV-infected IDUs



Objectives:

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

- To be familiar with the general principles of pain management
- To discuss pain management approaches for IDUs in different treatment settings including opioid substitution therapy (OST), and inpatient and outpatient settings
- To identify treatment options for the management of acute and chronic pain among IDUs



Time to complete session:

1 hour 30 minutes



Session content:

- General principles of pain management
- Acute pain management
- Chronic pain management
- Different treatment settings: IDUs on pharmacotherapy
- Different treatment settings: inpatient and outpatient
- Examples of treatment options
- Treatment options: examples of risk management strategies



Training materials:

- PowerPoint presentation 10: Managing pain in HIV-infected IDUs
- Module 10: Managing pain in HIV-infected IDUs
- Exercise 10



Session instructions:

- Introduce the session.
- **Activity 1:** Large group discussion (PowerPoint slide 3): Give participants the following scenario and ask them to describe their immediate reaction and what they would do:

A very thin young man comes to your clinic complaining of chronic leg pain. He is agitated, aggressive and impatient, and he demands pain killers. You notice he has track marks.

The aim of this exercise is to identify myths and misconceptions regarding pain relief among IDUs. Write key misconceptions on a white board and refer back to them during the presentation.

- Give the PowerPoint presentation.
- **Activity 2:** Large group discussion – two case studies (Exercise 10.1)
- Trainers should refer to the notes below for key points that need to be covered in the discussion.

Notes for trainers on key points to be covered in the session:

The following sections outline the key points in each of the sections in the text provided. These key points should also complement each slide in order.

Introduction

- IDUs have higher rates of injury and trauma, which cause pain problems.
- Chronic opioid users have tolerance to the effects of opioids and can also develop hyperalgesia.
- IDUs may develop withdrawal and craving symptoms during treatment, further complicating the management.
- A good Internet reference is: <http://www.iasp-pain.org>. This is the web address for the International Association for the Study of Pain; it contains an excellent pain classification, definitions of various syndromes and other valuable information.

General principles of pain management

- Review the patient's current symptoms and take the history of prior treatment.
- Review the diagnosis and previous medical evaluations. Perform or repeat diagnostic testing as needed to confirm the cause of pain and rule out the need for surgical or other treatments. This will ensure that the diagnosis is correct and shows the patient that the medical care provider is taking his/her complaints seriously.
- Analgesic treatment starts with the WHO "analgesic ladder" approach.
- When pain is not sufficiently controlled, consider analgesic combinations (e.g. opioid plus NSAID) and other adjunctive medications (e.g. some antidepressants and anticonvulsants work well in neuropathic pain).
- Always engage non-pharmacological strategies (e.g. transcutaneous electrical nerve stimulator (TENS) machine, heat packs, massage, physiotherapy, meditation, etc.).

Acute pain management

- Prompt treatment with effective doses (consider possible tolerance issues) usually facilitates the development of a better therapeutic relationship.
- Provide regular dosing with an appropriate analgesic dose (may need opioid plus NSAID) for special interventions such as regional anaesthesia (e.g. nerve block), opioid infusions via patient controlled analgesia (PCA), special drugs such as ketamine, etc.
- Whenever possible, coordinate with other specialists (e.g. anaesthetist/pain management and addiction medicine specialise, psychiatrist, social worker, etc.) and always with the family.

Chronic pain management

- Always start by reviewing the diagnosis and past treatment history (ask what has worked and what has not worked).
- Formulate a treatment plan incorporating functional restoration and stabilize drug use (i.e. attend to both the patient's drug problems and analgesic management concurrently).

- Never use short-acting or parenteral analgesics: long-acting, oral medications are always recommended (e.g. a comprehensive methadone programme).
- Provide a strategy for pain “crisis” times (e.g. relapsing migraine headache or an episode of “breakthrough” pain).
- Whenever possible, adopt a multidisciplinary team approach (involve other health professionals).
- Consider a “treatment contract” which should be regularly reviewed. The treatment contract may include:
 - ◆ Agreement on a regular schedule for follow-up appointments
 - ◆ A schedule for refill of chronic pain medications
 - ◆ A limited number of doses of medicine for breakthrough pain per refill period
 - ◆ Agreement that the patient will not acquire pain medication from any other source
 - ◆ Agreement that management of the pain medication is the responsibility of the patient and that no replacements will be given for lost or stolen medicine
 - ◆ Pledge that the patient will continue addiction treatment as recommended by the health-care provider
 - ◆ Agreement on the use of a urine drug screen (UDS)
- Manage any potential drug-related risks (ask if the patient is still injecting, if they have “lost control” of their use of analgesic tablets, etc.).

Different treatment settings – IDUs on pharmacotherapy

- Patients on methadone may have both the dose and the dosing interval increased or have morphine (high doses) added.
- Buprenorphine may also be increased by dose and dosing intervals or be stopped and an alternative opioid used (e.g. fentanyl).
- Naltrexone tablets should be stopped if opioids are to be used (note: when the naltrexone effect wears off, the patient’s tolerance to opioids will dramatically decrease); implants and depot formulations cannot be removed but are “overridden” by high-dose morphine (or methadone) treatment.

Different treating settings – inpatient and outpatient

Outpatient treatment

- See the patient regularly and engage the family and others (e.g. the pharmacist).
- Small amounts of medication are given at a time (e.g. daily supply); monitor.
- If available, do a UDS and examine the patient (look for active needle marks). Be mindful of the home situation (do children have access to drugs?).

Inpatient treatment

- Usually high opioid doses are used to both contain the pain and any potential drug craving or withdrawal that could emerge.
- Manage risks, provide support for the nursing staff, engage other specialists when available.

Treatment options – some examples

- NSAIDs or paracetamol given regularly (strict)
- Smooth muscle relaxants (e.g. for “colic”)
- Skeletal muscle relaxants (e.g. for muscular spasm)
- Tramadol (intermediate potency opioid; long-acting formulation)
- Anxiolytics and antidepressants (the latter may also help in neuropathic pain)

- Adjunctive medications: anticonvulsants, ketamine, etc. (e.g. neuropathic pain)
- Local anaesthetic infiltration, regional nerve blocks, etc.

Risk management strategies

- Restrict the amounts of medication provided; monitor use.
- Consider dose “supervision” (by the pharmacist).
- Maintain regular contact with the patient (examine; take UDS) and communicate with the family/others (pharmacist, nursing staff, etc.).
- Use IV access only when absolutely necessary.
- Ensure safe storage of any medication taken home (especially if there are small children at home).
- Consider home visits (outreach).

Summary

- Undertake a thorough assessment and formulate a treatment plan.
- Provide prompt analgesia with appropriate dosages.
- Regularly review the patient and enlist others to assist in ongoing monitoring of the patient.
- Try to avoid parenteral drugs and IV access if at all possible (otherwise closely supervise the situation).
- Analgesics: preferably use oral, long-acting formulations, particularly in patients with chronic pain.
- Manage the pain and addiction problems concurrently and always consider risk management strategies.

Case study 1

A 29-year-old male IDU with a past history (seven years ago) of a motor vehicle accident and low back injury (prolapse of L5/S1 intervertebral disc) is subsequently seen by an orthopaedic surgeon; surgery is not advised but the patient complains of severe pain so morphine tablets are prescribed. The patient returns to his general practitioner; as time progresses, he complains of increasing pain so that the general practitioner provides a further increase in dosage. Eventually, the patient claims to have lost the prescriptions and requests repeat prescriptions. The general practitioner then refers him to see you for an opinion on further management. When you examine the patient, you find active (i.e. recent) needle track marks. The patient states he cannot walk much further than 50 metres and can no longer work or manage most home duties. Discuss the approaches to management.

Discussion

Key points to be drawn out in the group discussion

- The opioid dose has escalated (tolerance) without apparent evidence of progressive disease.
- Diversion to self-injection is occurring.
- The patient may have “lost control” over his medication and potentially be at risk of overdosing himself.
- Is the patient taking this medication home and are there children at home? Are there other IDUs in the home environment who may use some of his supply?
- Consider transferring this patient to a methadone maintenance programme.

- The methadone programme should encompass both pain management and drug rehabilitation goals.
- Improving the patient's functional capacity is the most important pain management goal (improving the drug problem at the same time).
- Emphasize the Importance of a treatment plan, often involving patients signing an agreement (treatment contract) with regular reviews; regularly monitor the drug use situation and utilize UDS (if available).
- Avoid the patient's total focus on analgesic treatment for chronic pain management and instead encourage other treatment alternatives (e.g. physiotherapy, exercise, stretching).
- Adopt a multidisciplinary team approach (whenever possible).

Case study 2

A 34-year-old female IDU who has been drinking in the afternoon (smells of alcohol) presents to the emergency department after being hit on the right side of her body by a passing car. On examination, she is found to have a compound fracture of the right humerus and multiple fractured ribs. She is distressed and demanding pain relief; she has old venous scarring from previous injecting drug use on both forearms. She is referred for orthopaedic surgical treatment and the anaesthetist called in. The patient's past history of being an IDU is noted and a family member who arrives later, informs that the patient had a naltrexone implant inserted two months previously and that she [the patient] had subsequently stopped injecting heroin (a UDS is therefore requested). However, the patient has been drinking heavily at times and occasionally using amphetamines and you are asked to advise on inpatient management.

Discussion

Key points to be drawn out in the group discussion

- If patient is intoxicated currently, she may be at risk for aspiration, particularly during an anaesthetic procedure.
- The patient may be alcohol dependent and her drinking history needs to be clarified; prophylactic treatment for alcohol withdrawal may need to be considered. The patient may have hepatitis C infection and be drinking heavily, and therefore at risk of underlying liver disease.
- A UDS can help corroborate the history later but may not help in the immediate management (e.g. may confirm recent use but not chronic use).
- Important to liaise with the anaesthetist, pain management team and other staff (multidisciplinary team approach).
- Advise that naltrexone blood levels would be expected to be low (although therapeutic) and can be "overridden" by high morphine doses (e.g. via morphine infusion [PCA]).
- Consider the possibility of using regional anaesthesia (e.g. brachial plexus block); also consider the possibility of intercostal blocks for the pain due to the fractured ribs.
- Apart from the potential problem with alcohol (mentioned above), may need to consider whether she is dependent on amphetamines and thus may have craving symptoms that emerge during the first couple of days in hospital: effective analgesic cover should generally contain the situation.
- Need to have daily contact with patient and provide support for nursing staff and others (try to enlist support from the family if possible).

HIV and psychiatric illness



Objectives:

By the end of the session participants will be able:

- To describe the various neuropsychiatric conditions associated with HIV infection
- To understand the clinical features of various neuropsychiatric conditions associated with HIV infection
- To know the treatment options for the various neuropsychiatric conditions associated with HIV infection



Time to complete session:

45 minutes



Session content:

- Psychiatric disorders as risk factors for HIV transmission
- Psychological impact of HIV
- Management of common mental health conditions
- HIV-associated dementia
- Delirium
- Psychotic disorders



Training materials:

- PowerPoint presentation 11.1:HIV and psychiatric illness
- Sub-module 11.1:HIV and psychiatric illness



Required reading:

- AIDS Education and Training Centers. *Clinical manual for management of the HIV-infected adult*. Newark, New Jersey, USA, AIDS Education and Training Centers (AETC), 2006 (<http://www.aidsetc.org>).



Session instructions:

- Lecture with PowerPoint presentation for 45 minutes with time for questions and answers.

**Objectives:**

By the end of the session participants will be able:

- To identify the psychosocial care needs of IDUs across the continuum of HIV infection
- To discuss the different roles and contributions of members of the care team
- To understand the training requirements of psychosocial care providers

**Time to complete session:**

45 minutes

**Session content:**

- Psychosocial care within a medical model
- Psychosocial issues associated with hiv infection in IDUs
- Summary of psychosocial issues across the disease continuum
- Who can provide psychosocial care, and what training do they require?

**Training materials:**

- PowerPoint presentation 11.2: Psychosocial care
- Sub-module 11.2: Psychosocial care
- Exercise 11.2

**Session instructions:**

- Lecture with the PowerPoint presentation stopping at Activity 1.
- **Activity 1** (5 minutes only): Psychosocial care needs of infected IDUs, their partners and families
Discuss:
 - ◆ What are the key psychosocial support needs of HIV-infected drug users?
 - ◆ What are the primary barriers to psychosocial care experienced by IDUs?
- Continue to lecture with the PowerPoint presentation until you reach Activity 2.
- **Activity 2:** Large group case discussion (15 minutes): Case support planning; identifying client needs and planning psychosocial care plan for the client
 - ◆ Ask participants to turn to Exercise 11.2.
 - ◆ Ask one participant to read the case study out loud.
 - ◆ Discuss the key issues for the patient.
 - ◆ Discuss strategies to address each of the issues identified.

Case study

Your client is a 22-year-old heroin-dependent IDU. He was diagnosed 10 months ago. He was in a drug detention centre at the time of his diagnosis and underwent withdrawal without medication. He was released from detention and was unable to get full-time employment. He does odd manual labour tasks. He has re-established a relationship with his former girlfriend who engages in sex work to support her substance dependence. He reports that he relapsed into using heroin again shortly after he was diagnosed with an HIV-related skin condition. He reports that he is frequently coughing up blood and experiences night sweats. His family has rejected him and he lives with his girlfriend in a low-cost rental accommodation. His girlfriend uses oral contraceptives that she purchases from a pharmacy. She has not had a recent HIV test; however, she tested HIV negative nine months ago.

The client reports he has some minor memory problems, and he appears agitated.

Trainer's notes for debriefing group exercises

Key issues – Case 1	Strategies – Case 1
Relapse into heroin use	<ul style="list-style-type: none"> ● Assess the level of motivation for detoxification and rehabilitation using counselling such as motivational interviewing. ● Referral, with client consent, to drug treatment service
Partner on oral contraception, engaging in sex work and using heroin	<ul style="list-style-type: none"> ● Couples counselling – including HIV testing of partner and discussion regarding HIV transmission risk reduction for couple and external sexual and injecting partners ● Assess partner's motivation and willingness to seek treatment for substance dependence. ● Referral as couple for substance dependence if partner agrees (if both undertaking substance treatment together it is more likely to be successful) ● Referral for pregnancy screening and family planning (implant instead of oral contraceptives)
Clinical signs and symptoms	<ul style="list-style-type: none"> ● Assess client's clinical follow-up needs. Make appropriate referrals if client is not currently receiving treatment and care for dermatological conditions and cough. ● Refer both for STI assessment.
Family rejection	<ul style="list-style-type: none"> ● Suggest a family meeting to the client to resolve outstanding family issues. Offer to facilitate the meeting.
Unable to get employment	<ul style="list-style-type: none"> ● Refer couple for welfare assistance.

**Objectives:**

By the end of the session participants will be able:

- To understand the WHO comprehensive concept of sexual health
- To be familiar with sexual health issues in IDU populations
- To understand the general principles of sexual health care for female IDUs
- To understand the general principles of sexual health care for male IDUs
- To understand the approaches to promoting safer sexual behaviour among IDUs

**Time to complete session:**

45 minutes

**Session content:**

- WHO concept of sexual health
- Sexually transmitted infections (STIs)
- General principles of STI management for IDUs
- Talking about sexual health with IDUs
- Sexual activity and drug use
- Sexual health care for female IDUs
- Sexual health care for male IDUs
- Harm reduction for sexual health

**Training materials:**

- PowerPoint presentation 11.3: Sexual health
- Sub-module 11.3: Sexual health

**Session instructions:**

- Lecture with the Powerpoint presentation for 45 minutes with time for questions and answers

Prevention strategies for HIV-positive IDUs



Objectives:

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

- To understand the concept of “prevention strategies for HIV-positive IDUs” and their significance
- To understand the key strategies in order to promote safer sex and safer injecting drug use among HIV-positive IDUs



Time to complete session:

45 minutes



Session content:

- Prevention strategies for persons living with HIV/AIDS (PLWHA)
- Key strategies for prevention among HIV-positive IDUs



Training materials:

- PowerPoint presentation 11.4: Prevention strategies for HIV-positive IDUs
- Sub-module 11.4: Prevention strategies for HIV-positive IDUs



Recommended reading:

- Frieden TR et al. Applying public health principles to the HIV epidemic. *New England Journal of Medicine*, 2005, 353:2397–2402.



Session instructions:

- Lecture with the PowerPoint presentation for 30 minutes with time for questions and answers.

Continuing medical education



Objectives:

By the end of the session participants will:

- Be familiar with key Internet web sites that can be used for continuing medical education (CME), downloading resources and searching for information
- Be familiar with key regional and international listservs to which they can subscribe to receive regular e-mail bulletins on issues related to drug use, HIV and care and treatment



Time to complete session:

1 hour



Training materials:

- Internet tour

Preparations:

- Open Internet explorer.
- Open "Favourites" and go to "Organize favourites". Create a new folder labelled "CME".
- Click on each of the sites listed in Module 12 and save them in the CME folder in "Favourites".
- Trainers should be familiar with each site and the sections listed for each site in Module 12.



Session instructions:

- Connect to the Internet, which is shown on an overhead screen so that all participants can view the web page.
- Open the CME folder.
- Go through each web site and explain the key features of the site and the information available.
- Refer participants to the section on listservs. Ask participants who are currently subscribing to particular listservs to describe the benefits and features of these.

❖ **Services for IDUs in closed settings:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Initial patient assessment:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Opioid use, opioid dependence and withdrawal syndromes:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Managing non-opioid dependence:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **IDU access to ART:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **General care of the HIV-positive IDUs:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **ART for the HIV-positive IDU:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Selecting a first-line regimen and starting ART:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Monitoring IDUs on ART and managing side-effects and toxicities within the first year:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Treatment failure, second-line therapy and long-term toxicities:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Adherence: overview and skills rehearsal:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Adherence: a drug-user perspective:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Interactions between illicit drugs and ARVs:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Interactions between ARVs, opioid substitution therapy (OST) drugs and other medications commonly used to treat PLWHA:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Site visit – prison ART programme:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Site visit – methadone clinic:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Management of coinfections – HIV/HBV and HIV/HCV coinfections:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Management of coinfections – HIV/TB coinfection in IDUs:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Managing pain in HIV-infected IDUs:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Services for IDUs – psychosocial care:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Services for IDUs – sexual health:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

❖ **Continuing medical education:**

0	1	2	3	4	5	6	7	8	9	10
/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....	/.....
Not					A little					A lot
at all										

7. What did you find were the three most useful aspects of the training programme?

8. What did you find were the three least useful aspects of the training?

9. List three changes you could make to your work practices as a result of this training.

10. Is there any other information or material you would like to have been included in this training?

11. Do you have any other suggestions for changes to the training?

Treatment and Care for HIV-Positive Injecting Drug Users

The “Treatment and Care for HIV-Positive Injecting Drug Users” training curriculum is designed for clinicians who provide treatment and care, including ART, for HIV-positive injecting drug users. The training curriculum consists of a trainer manual, 12 participant manuals, and a CD-ROM with PowerPoint presentations and reference articles. Topics covered in the curriculum include:

Module 1: Drug use and HIV in Asia

Module 2: Comprehensive services for injecting drug users

Module 3: Initial patient assessment

Module 4: Managing opioid dependence

Module 5: Managing non-opioid drug dependence

Module 6: Managing ART in injecting drug users

Module 7: Adherence counselling for injecting drug users

Module 8: Drug interactions

Module 9: Management of coinfections in HIV-positive injecting drug users

Module 10: Managing pain in HIV-infected injecting drug users

Module 11: Psychiatric illness, psychosocial care and sexual health

Module 12: Continuing medical education

Trainer manual

The ASEAN Secretariat

70A, Jl. Sisingamangaraja
Jakarta 12110
Indonesia
Phone: +62 21 724 3372, 726 2991
E-mail: public@aseansec.org

World Health Organization

Regional Office for South-East Asia
Mahatma Gandhi Marg
Indraprastha Estate, New Delhi - 110002
India
Phone: +91 11 233 70804
E-mail: hiv@searo.who.int
www.searo.who.int

Family Health International

Asia/Pacific Regional Office
19th Floor, Tower 3, Sindhorn Building
130-132 Wireless Road, Lumpini, Phatumwan
Bangkok 10330, Thailand
Phone: +662 263 2300
E-mail: sunee@fhibkk.org
www.fhi.org

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