TRAINING REPORT

"Hepatitis C and harm reduction for people who use drugs"
3-7 July 2016, Myitkyina, Kachin, Myanmar
Céline Grillon (S2AP) and Marie-Eve Goyer

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Introduction

Since January 2015 MdM-F is implementing a 3 years transversal Program on Hepatitis C (HCV) - in partnership with the French Development Agency – in 6 international mission delivering harm reduction (HR) services for people who use drugs (PWUD) including MdM-F project in Kachin, Myanmar. One of the objective of this program is to strengthen the quality of mission's activities regarding hepatitis C. Pursuing this objective a 5-days training has been organized in Myitkyina, Kachin (Myanmar), from 3rd to 7th July 2016, coordinated by the HCV capacity building officer of MdM-F.

Evaluation of training needs

In March 2016, MdM HCV capacity building officer spent two weeks in Yangon (Myanmar) with the double objective of evaluating mission's training needs regarding hepatitis C and supporting the development of the mission's advocacy strategy. The training needs have been evaluated through meetings with the coordination team (GenCo, Deputy Genco, FieldCo, MedCo) and key members of the team (medical advisor, harm reduction advisor, peer educator) to understand current activities of the mission regarding hepatitis C and the average level of knowledge and skills of different team members (medical doctors, nurses counsellors, health facilitators, peer educators).

The evaluation of training needs assessed the necessity to improve general knowledge on hepatitis C for non-medical staff, develop understanding of HCV prevention, improve the quality of the HCV testing counselling, capacitate the medical staff in charge of hepatitis C assessment especially regarding clinic evaluation and APRI scoring, improve understanding of hepatitis C prevention and care for PWID in the perspective of harm reduction as a holistic approach, develop understanding of the staff of advocacy. Besides, the team expressed great interest in hepatitis C treatment.

Training and learning objectives, agenda

The overall training objective was **to provide participants with relevant skills and knowledge to integrate quality hepatitis C services in their current harm reduction activities**. The specific learning objectives of the training were:

- Ability to explain what hepatitis C is and how it can affects the health
- Ability to explain how to limit progression of chronic hepatitis C
- Ability to identify key components of harm reduction specific to prevention of HCV transmission in PWID
- Ability to classify the different diagnosis test for hepatitis C and explain their results
- Ability to identify adapted content and attitudes for hepatitis C test counselling
- Understanding of what are the new treatments for HCV and what are the treatments for HCV currently available in Myanmar
- Ability to describe elements improving HCV treatment outcomes and lowering reinfection rates for PWID
- Ability to identify key advocacy issues related to access to hepatitis C prevention, diagnostic and treatment for PWID in Myanmar

Training agenda:

<table>
<tr><td></td><td>Sunday</td><td>Monday</td><td>Tuesday</td><td>Wednesday</td><td>Thursday</td></tr>
<tr><td>9:00-9:30</td><td>Welcome coffee</td><td></td><td></td><td></td><td></td></tr>
<tr><td>9:30 - 9:45</td><td rowspan="2">Introduction and presentation of training session</td><td>Learning review</td><td>Learning review</td><td>Learning review</td><td>Learning review</td></tr>
<tr><td>9:45 - 10:45</td><td>Testing and diagnosis</td><td>Counselling</td><td>Treatment of hepatitis C virus</td><td>What is advocacy ?</td></tr>
<tr><td>10:45 - 11:00</td><td colspan="5">Break</td></tr>
<tr><td>11:00 - 12:15</td><td>Whas is hepatitis C ?</td><td>Testing and diagnosis</td><td>Counselling</td><td>Treatment of hepatitis C virus</td><td>Barriers for PWID access to HCV services in Myanmar</td></tr>
<tr><td>12:15 -13:15</td><td colspan="5">Lunch break</td></tr>
<tr><td>13:15 - 14:30</td><td>Natural history of hepatitis C</td><td>Hepatitis C transmission risk related to drug use</td><td>Risk reduction of alcohol consumption</td><td>HCV treatment for PWID</td><td>Advocacy strategy to improve access to HCV services for PWID</td></tr>
<tr><td>14:30 - 14:45</td><td colspan="5">Break</td></tr>
<tr><td rowspan="2">14:45 - 16:00</td><td rowspan="2">Natural history of hepatitis C</td><td rowspan="2">HCV prevention in harm reduction for PWID</td><td rowspan="3">Practical session</td><td rowspan="3">Availability of HCV treatment in Myanmar</td><td>Transfer</td></tr>
<tr><td rowspan="2">Evaluation and conclusion</td></tr>
<tr><td>16:00 - 16:30</td><td>Monitoring</td><td>Monitoring</td></tr>
</table>

Trainers

The training has been mainly prepared by Céline Grillon, MdM HCV capacity building officer (and former MdM HCV advocacy officer) and Dr. Marie-Eve Goyer, medical doctor[1]. When possible, sessions have been prepared and facilitated (in Burmese) by local team, with the support of Marie-Eve.

Participation of the local team :

- Session “What is hepatitis C” : prepared and facilitated by Dr. Hkruzi, medical advisor
- Sessions “Natural history of hepatitis C” and “Testing and diagnosis”: co-prepared and co-facilitated by Dr. Than Min Htike, medical and advocacy coordinator, and Dr. Marie-Eve Goyer.
- During the session “Hepatitis C transmission risk related to drug use” a presentation and demonstration on “drug use in Kachin” has been prepared by Mun Hkaung, peer educator, and Dr. Hein Thu, Harm reduction advisor.
- During the session on “counselling” a presentation has been made by Ja Ring, nurse counsellor.
- Session “Availability of HCV treatment in Myanmar” prepared and facilitated by Dr Than Min Htike, medical and advocacy coordinator.

[1] Dr. Marie Eve Goyer is medical doctor, board member of Médecins du monde-Canada, with a long lasting experience in harm reduction, HIV, OST and HCV. She is also in charge of OST Professional training in Quebec Province and Professor at the University of Montreal. She works on the implementation of supervised injection services and community based Naloxone distribution. Marie-Eve has supported as medical advisor the HR program in Kachin in 2008.

Participants

The participants to the training have been selected following a list of criteria[2] established by the HCV capacity building officer together with the team : Field Co, Med Co, HR advisor, Med advisor.

SL	Name	Position	Base
1	Dr. Hkruzi Ram	Medical Advisor	KCO
2	Dr. Hein Thu	Harm Reduction Advisor	KCO
3	Dr. Yu Yu San	Methadone Advisor	MGG
4	Dr. Phyo Min San	Project Manager	MKN
5	Dr. Saw Ko Ko	Clinic Team Leader	MKN
6	Dr. Myo Min Min Zin	Base Program Officer	HPN
7	Dr. Kaung Nyi Nyi	Medical Doctor	MGG
8	Dr. Nyi Nyi Khin Maung Win	Medical Doctor	HPN
9	Dr. Zar Ni Hlaing	Medical Doctor	MKN
10	Dr. Zaw Lay Naing	Methadone Doctor	MGG
11	Ja Ring	Nurse Counselor	MKN
12	Lu Lu Aung	Nurse Counselor	MGG
13	Ei Ei Phyo	Nurse Counselor	HPN
14	Mun Hkaung	Peer Educator	MKN
15	Swe Hlaing Win	Peer Educator	MGG
16	Phoe Cho	Peer Educator	HPN
17	Zaw May	Health Facilitator	MKN
18	Moon Aung	Health Facilitator	MGG
19	Yaw Nan	Health Facilitator	HPN

Logistics

The training took place in MdM coordination office in Myitkyina, which greatly facilitated logistics such as printing documents, or organizing lunch and tea breaks. Though the training room was tight for the number of participants (22 including trainers) which was not very comfortable and inadequate for exercises/games that require space. Probably for this reason the logistics has been the aspect the less good rated by participants during the evaluation.

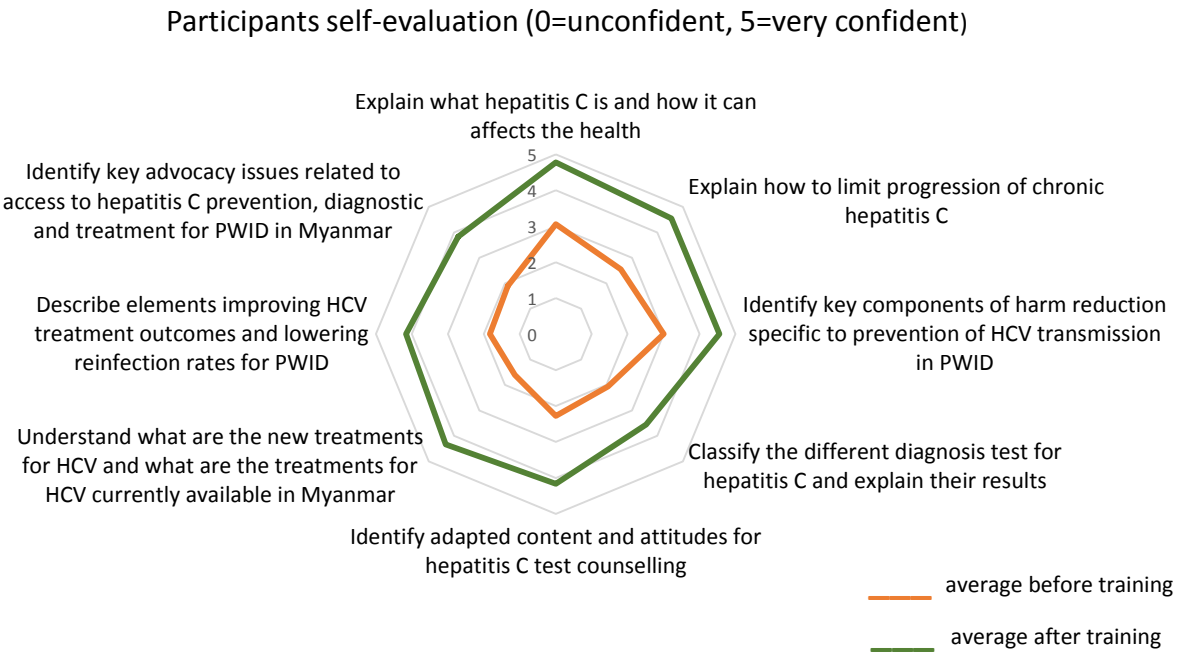
The translation English-Burmese was ensured by Dr Than Min Htike (medCo), and by Dr. Hkruzi (medical advisor) and Dr. Hein Thu (Harm reduction advisor) when Than Min was not available on day 5 or during separated group work. The translation has been one of major challenge of the training, especially on day 5 – due to absence of Than Min and to the specific vocabulary of advocacy that should have needed to be defined and explained. This difficulty has been raised by one participants during final evaluation.

Almost all presentations have been translated into Burmese and handed over to participants on USB stick. Most of translations have been done the evening before and shall be better anticipated next time to avoid stress and tiredness during the training - same thing with exercise materials and instructions.

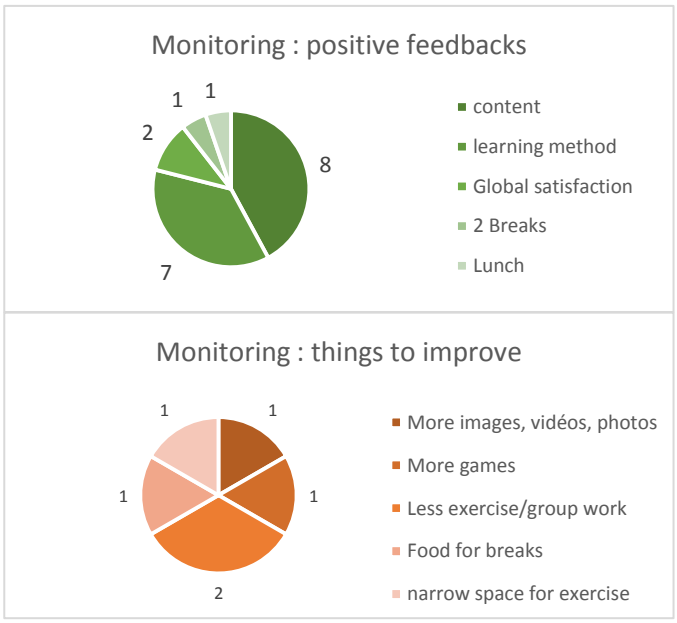
[2] For the list of criteria see the Field Visit Report (March 2016)

Evaluation

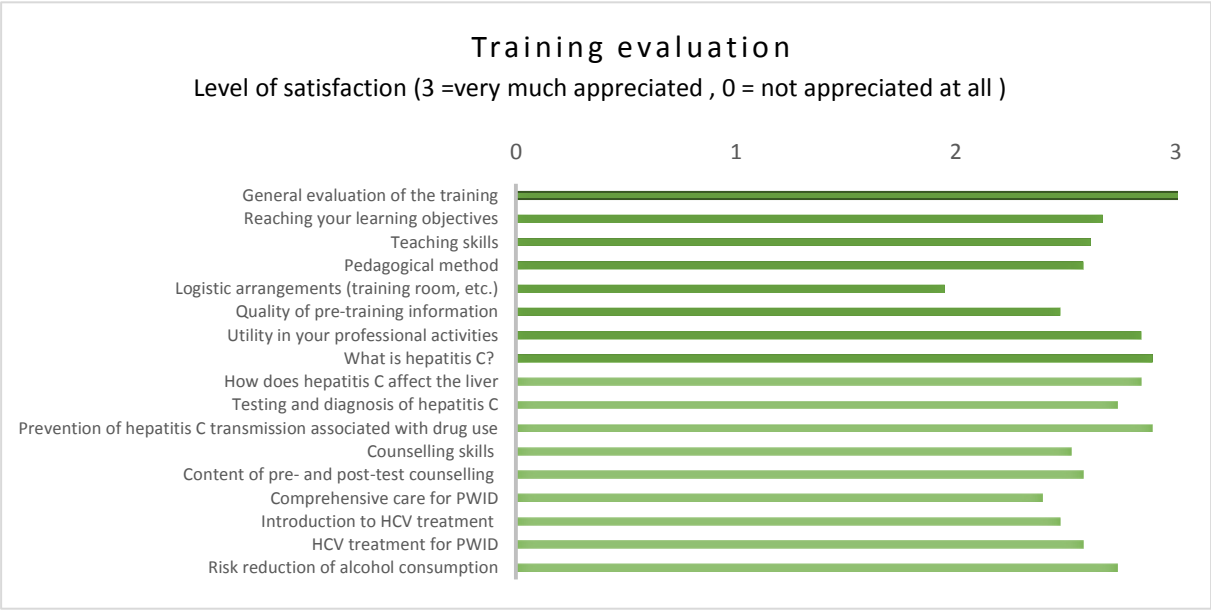
Overall the evaluation of the training has been very positive. The pre- and post-training self-evaluation of participants clearly shows an increase of confidence regarding the different learning objectives. Diagnosis and advocacy are the two objectives with less confidence (average less than 4/5) after the training. Maybe these two learning objective were too ambitious, especially for the participants without medical background concerning diagnosis.



Participants have evaluated very positively the training. During the monitoring carried out at the end of first day, 19 positive feedbacks and only 6 negative feedbacks have been formulated.



During the final evaluation only one aspect (logistic arrangements) have been rated less than 2/3.



Comments

1) In overall the training has been **successful** and **appreciated** by participants and trainers. The group demonstrated **great interest** and **good concentration** and **retention** capacities.

2) The Myanmar team is made of very dedicated participants and contains **strong leaders** and **very good clinicians** (ie. the Moegaung methadone doctor has very strong knowledge on HCV, but also HIV and medicine in general. He speaks very good English and learns very quickly).

3) The main challenges were:

   - **disparity of participants** as there were as well managers, doctors, nurses, health facilitators (HF) and peer educators (PE). This was a challenge regarding establishment of training objectives and content of the sessions as we don't expect the knowledge and skills from doctors, counselors and prevention team. In addition, the **strong hierarchy** in Myanmar setting led to disparities in the chance to speak between participants. In overall **2-3 participants were dominating group discussions**.

     We addressed these challenges by organizing 3 **sessions separated between doctors and non-doctors** on day 1 (natural history of hepatitis C), day 2 (tests and diagnostics) and day 4 (treatment). Moments where the group is separated by profession helps having a **more focused content** and assures that **everyone feels free to participate**. This has been very useful, although some disparities still remained within the groups[3]. It could be improved by **creating subgroups** that will favor everyone's participation and by **giving specific attention** of the trainers **to those participants who have more difficulties**. To avoid that always the same participants have the chance to speak, during presentations trainers can **address their questions to specific participants** rather than to the group in overall.

     Another way to overcome the challenges of disparity between participants is to use **various pedagogic modalities** in order to **maintain attention** - the **theoretical/masterful presentations should be reduced as much as possible**.

[3] Between senior doctors and junior doctors; and between nurses, HF and PE.

- the issue of language and **translation** (see above "logistics") has also led to that some presentations have not been translated and to that the participants more skilled in English dominated the group discussions. This can be improved by identifying strong translator (at least 2) and by translating the training slides prior to the training.
- the sessions were globally **too long** for the time scheduled and we were often late. This can be improved by reworking the training plan and designing sessions of 1h30 instead of 1h15 ;
- except for a couple of sessions, training has been delivered by doctors whose **presentations and vocabulary was very medical** – leading to some difficulties for non-medical participants to easily understand and appropriate content. Attention shall be given for next time to : **summary key points of each presentation on a final sum-up slide**, **explain the medical terms that are used with simple words and use images/comparisons for non-medicals to better remind** ;
- The **great number of participants** (19) that made it more difficult for trainers to manage group dynamic and ensure everyone participate.

4) The **day 5 on advocacy has been less successful**, most probably due to lack of connection with participants' professional duties.

5) Due to staff handover and lot of work to do, there was **no one from the coordination team** - except the medCo who is leaving the program. This has led to a lost opportunity to build upon the work done during the training to develop further program activities and advocacy. Key ideas that emerged from group work on HCV prevention are attached in appendix.

6) The **pedagogical method that included consolidation exercise and games was very effective and enjoyed by participants**. Attention should be given for next trainings to include even more space for participants to practice the content. The session on counselling, who included the use of inductive learning method has also been very effective, if possible it would be good to further develop the use of inductive method.

7) Specific comments to each session are attached in Appendix 2

Appendix 1: review of training sessions and recommendations

By Marie-Eve Goyer (adds by Celine Grillon)

Day 1 content:

1. What is hepatitis C
    a. This is the only place in the training where HCV is put in the context of the other hepatitis and more emphasis should be made on the viral hepatitis so that participant are able to understand HCV in it's broader context and remember that HCV rarely comes alone
2. Natural history of HCV

a. The graphic made by MDM on HCV natural history is very helpful and a plastic poster should be left after the training as a reminder
    i. The difference between acute HCV and chronic HCV symptoms seemed unclear at first for most of the clinical team
b. In a medical setting as the Kachin project, emphasis should be made on interpretation of liver test and on cirrhosis

3. HCV history and physical exam (for doctors)
    a. As we had a very strong medical team in Myanmar, this section was very helpful since history and physical exam are tools easily available!
        i. This training led to the finding that clinical doctors are NOT examining newly diagnosed HCV patients and are only prescribing test so that the Apri score can be done. This means missing a lot of cirrhosis for clinicians and history and physical exam should be undertaken for every HCV patient.
4. Review exercise for session 1 and 2 (for prevention team)
    a. The exercise has been very appreciated by the team and allow for clarifications of some content that was not understood

Day 2 content:

1. Review learning
    a. Every morning review learning sessions really allows the trainers to notice what has been retained and adjust the training of the day accordingly. It is a good warm up for the rest of the day
2. Testing and diagnosis
    a. There is a real issue about doing antibodies for HCV without having access to confirmation tests. This leaves the team (and the patient) with uncertainty and with a very complicated post-test counseling to do.
    b. Starting from here, a strong image or metaphor should be chosen to help the team explain and the patient understand the difference between antibodies and viral load. This image should follow during the training and be used during the counseling section.
    c. To my understanding, HCV mono-infected patients or IDU non-infected with HIV don't have access to HBV vaccination in MDM Kachin program. If feasible, that would be a great addition.
    d. If the topic of Apri score and fib-4 is covered, there should always be a practical and interpretation exercise afterward
    e. The WHO continuum of care for HCV was really helpful to position HCV testing within a broader perspective. This graph was used during the whole training.
        i. Maybe a MDM version of this graph could be useful for further trainings.

3. HCV transmission risk related to drug use
    a. This section of the training, where a peer explains the different steps leading to the use of a specific drug (how they find it, prepare it, inject it, mix it, etc.) is not only very useful for the rest of the team that has rarely heard about it, but also a very empowering moment for the peers.
    b. On a programmatic issue, this points out so many places where prevention could take place or is failing. Prevention messages and initiatives can be reviewed and updated according to this presentation. The coordination team should be present for this presentation.
        i. Ex. Users are breaking old needles to place them into the lighter used for inhaling amphetamines
4. HCV prevention in harm reduction for PWID

a. After doing a brief theoretical presentation, the team was divided and each team had to answer the following questions. (the highlights of their answers are summarized in Appendix 2).

Day 3 content:

1. Counselling skills
    a. A role play where a «bad and a good counselor» was played by a member of the training team (and not a local staff) was done and very helpful so that participant would feel free to comment what went wrong and to realize how counseling skills can make the whole difference.
    b. This is really the issue here for the MDM team, this is to say being able to put theoretical notions in practice
2. Pre and post HCV test counseling
    a. The theory is also very well known here, but counselors tend to stick to it so that they have trouble adapting to patient needs and reality. In this MDM project, the patient needs to adapt to the counselor when it should be counselors who adapt to their patients.
3. Alcohol counseling
    a. A theoretical session was made on alcohol counseling, but would probably be more interesting if made during practical sessions where counselor would have to do alcohol counseling with a fake patient.
4. Practical session
    a. This section, which summarizes the whole day, is a must and more time should be allowed to it. This is really where we see what was understood and how to implement it in reality

Day 4 content:

1. Treatment of HCV
2. HCV treatment of PWID
    a. This session, where issues regarding adherence, risk of re-infection and access to care for PWID really allows to discuss the stigma around drug use, also very present in MDM team. For example, one member of MDM staff said that the general population should be treated before PWID.
        i. As Kachin team is a young and changing one, this highlights the importance of clarifying MDM core values for the staff and making sure they are well preserved.
3. Availability of HCV treatment in Myanmar

Day 5 content:

1. What is advocacy
    a. In a large group setting like Myanmar, this presentation was too theoretical and poorly understood
    b. This session lack connection with participants' professional duties and was too far away from the overall content of the training (reaching the learning objective of understanding methodology and key tools of advocacy would need one or two fool days in itself)
2. Barriers for PWID access to HCV services in Myanmar
    a. Participants were divided into several groups, half of participants worked on access to HCV prevention and the other worked on access to HCV treatment. Main barriers identified were : price and unavailability of treatment, stigma attached to drug use,

priority given to general population over PWIDs, limited public funding, limited access to OST

b. For each specific barrier we worked on translating the issue into advocacy objective (ex : limited public funding -> the government allocate a specific budget line for HCV treatment in national budget)

3. Building advocacy strategy to improve access
    a. Participants were divided into groups and had to develop an advocacy strategy to address one of the advocacy objective identified in the morning.
    b. Among other ideas were identified the following activities :
        i. To tackle stigma attached to drug use and HCV : talk to community leaders for them to integrate PWIDs to community/social activities, MdM staff should not discriminate PWIDs, inform PWIDs on HCV (IEC, health session), link PWID with business, community communication awareness campaigns on hepatitis C – especially on world hepatitis day and world aids day – posters, Q&A, visit of DIC, collaborate with other organizations…
        ii. To improve access to OST : organize a party with celebrities to attract decision makers, in a hall with on the walls posters and photos explaining the issues linked to limited access to OST, identify community representatives to testimony and speak out for PWIDs, write a report/gather data/do a survey, show the situation of people who had methadone and whatis their current status
        iii. To advocate for budget allocation for HCV : write a budget and submit to international donors (GF), write a report on the need to allocate budget for HCV treatment and share with MOH, Minister of Finance/budget, MEP, discuss with MEPs, do a petition, organize a demonstration in front of Parliament
4. Transfer session: participants have been asked to identify things they would like to change in their professional practice after the training, challenges that may occur and possible solutions. Some of the changes that have been identified and shared by participants are attached in Appendix 3.

Appendix 2: outcomes of groups work on how to improve harm reduction services to prevent hepatitis C

- **WHO ARE THE PWID WE DON'T SEE?** (and why we don't see them?)
  - For many user there are transportation cost issues
  - Coming to the DIC often means divulgating your status to the community
  - People who are not IV drug user don't want to come to the DIC
  - Many users are not afraid of HCV and HBV

  In our actual MDM program, what could we do to reach more PWID?
  - ➢ mobile visit to areas not covered including mobile medical team, and mobile testing
  - ➢ better communication through I&C communications
  - ➢ advocacy meeting
  - ➢ hire female peer workers

- **WHAT IS THE SITUATION OF YOUNG INJECTORS IN KACHIN**?
  - students, especially high school and university
  - migrant workers (field mines)
  - users that are living and using drug within a specific group
  - most of them needing help of others for injecting before arriving in MDM
  - very poor education and awareness about HCV

  In our actual MDM program, what could we do to reach more young injectors? How should we adapt our services and counseling to them?
  - ➢ Providing health education in school
  - ➢ Raising community awareness through: Church, quarters, youth camps

- **WHAT IS THE SITUATION OF WOMEN PWID?**
  - These women face even more discrimination and are seldom seen in DIC

  In our actual MDM program, what could we do to reach more women PWID? How should we adapt our services and counseling to them?
  - ➢ need to know more where they live, how they use drugs
  - ➢ have female peer, active IDU in MDM
  - ➢ develop specific, comfortable place for women in DIC
  - ➢ making sure that women can avoid cueing for methadone

- **HOW ARE MDM PEERS INVOLVED REGARDING HCV?**
  - Peers are involved in NSEP, distribution and collection
  - Peers are involved in adherence for HIV
  - Peers are involved in distribution of I&C material

  HOW CAN WE IMPROVE PEER INVOLVEMENT REGARDING HCV?
  - ➢ train all peers for HCV knowledge
  - ➢ participating in the review all HR activities for strategy, involve Moegaung peer
  - ➢ increase awareness on HCV for peer and community
  - ➢ facilitate peer to peer education
  - ➢ advocacy meeting : to get access to confirmation testing at the national level

Appendix 3: outcomes of the Individual Action Plan

During the last session of the training we asked participants to identify things they would like to change in their professional duties after the training, eventual challenges that may occur and possible solutions. Below are listed some of the changes that have been identified and shared by participants.

List 5 changes you will make in your professional practice following this training	For each change identify potential difficulties	.. and possible solutions !
HCV symptoms assessment, follow up/monitoring of patients ≥ F2		
Share updated information on HIC in the DIC, train peers		
Do more effective counselling Involve more in health education sessions		
Training and awareness raising of other organization and self-support network		
HBV screening and vaccination for HCV+	HBV stock limited	Ask donors to support HBV vaccination
HCV RNA confirmation (send blood samples to Yangoun)