

Starting and Managing Needle and Syringe Programs

A guide for Central and Eastern Europe
and the newly independent states
of the former Soviet Union

Dave Burrows

Starting and Managing Needle and Syringe Programs

A guide for Central and Eastern Europe
and the newly independent states
of the former Soviet Union

Written by: Dave Burrows
Edited by: Andrew Preston and Jon Derricott

Written by:

Dave Burrows, Consultant: HIV/AIDS and hepatitis prevention, care and support of injecting drug users. Sydney, Australia. dbsyd@aol.com

Edited by:

Andrew Preston and Jon Derricott
for HIT, Liverpool, UK.

© IHRD 2000

ISBN 1 891385 13 5

Published by:

International Harm Reduction Development

Cover photo:

John Ranard

Further copies of this book may be obtained from:

Open Society Institute
International Harm Reduction Development
400 West 59th Street
New York
NY 10019
USA

Tel: 212-548-0677

Fax: 212-548-4617

Email: ihrd@sorosny.org

Thanks to the international review group who read the drafts of this guide and provided important comments:

Glenn Backes, Director, International Harm Reduction Development (a joint venture of Open Society Institutes and the Lindesmith Center), New York, USA.

Dan Bigg, Board Member, US Harm Reduction Coalition; Needle and Syringe Provision Program Developer for Central Europe; Founder and Manager, Chicago Recovery Alliance, USA.

Judit Honti, Coordinator Central and Eastern European Harm Reduction Network; Founder and Manager, Szeged Needle and Syringe Program, Hungary.

Sujata Rana, Founder, Lifesaving and Lifegiving Society Needle Exchange Program, Kathmandu, Nepal.

Anya Sarang, Trainer, Medecins Sans Frontieres, Holland Harm Reduction; Russian Federation Training Program, Moscow.

Thanks also to:

Tim Rhodes for his recent writings on community action; Franz Trautmann and Erik van Ameijden for information about needle and syringe provision in Amsterdam; Owen Westcott and Shaun Davies from the AIDS and Infectious Diseases Unit, NSW Department of Health, Sydney, Australia for information on needle and syringe programs in Australia; and John Heller from IRHD for helping to get the project finished.

Finally, thanks to Agnes Nagpal of IRHD for her untiring efforts providing reports from needle and syringe provision services in the region.

Preface

Since the mid-1990s, needle and syringe programs have been set up in many countries in Central and Eastern Europe (CEE) and the newly independent states (NIS) of the former Soviet Union.

Although guides exist on how to set up and manage needle and syringe programs, they were written for countries such as Australia, the US, UK, and the Netherlands – which have different histories and patterns of health service delivery.

Financial constraints, different social circumstances and complex planning processes mean that in CEE/NIS setting up a needle and syringe program is a more difficult and complex task – with much of the most important work having to be done before a single needle or syringe is given out.

Starting a program usually involves a team of doctors and/or non-government organizations working together.

With needle and syringe provision in the CEE/NIS region continuing to expand, it became clear that there was a need to share the experience and knowledge of this process that has been gained. This book brings this information together. I hope that in doing so it will make the task of setting up new needle and syringe programs in CEE/NIS easier, and help existing services develop their practice further.

The first chapter of the book, which is available as a separate document, provides an overview of the background to, and need for, needle and syringe programs and is written mainly for policy makers and workers new to the field.

Subsequent chapters give detailed advice on the many tasks that need to be undertaken in order to get, and keep, services running successfully.

The book has been divided so that readers can, if they wish, dip into the book according to gaps in their knowledge, rather than reading it from cover to cover.

For example, an understanding of outreach work, which is described in Chapter 8, is central to the process of setting up and operating a needle and syringe program. Readers unfamiliar with outreach work may therefore want to move to that section, having read the first chapter.

This guide draws on much previously published work, including *The European Peer Support Manual* published by the Trimbos Institute, the WHO/UNAIDS *Rapid Assessment and Response Guide on Injecting Drug Use*, the *New South Wales Needle and Syringe Exchange Program Policies and Procedures Manual*, *The Safer Injecting Briefing*, *The Chicago Recovery Alliance Procedures Manual*, the draft *Asian Harm Reduction Manual* and many evaluation and funding reports from needle and syringe programs. Full details of useful publications are given in the Appendix.

I would like to acknowledge my gratitude to these, and other, authors and organizations for laying the foundations upon which this guide could be built.

Dave Burrows
July 2000

<u>Preface</u>	<u>4</u>
<u>1. Introduction to the HIV epidemic and the role of needle and syringe programs</u>	<u>1</u>
<u>2. Getting support for your needle and syringe program</u>	<u>15</u>
<u>3. Rapid situation assessment</u>	<u>29</u>
<u>4. Service options</u>	<u>42</u>
<u>5. Staffing issues</u>	<u>53</u>
<u>6. Key organizational issues</u>	<u>65</u>
<u>7. Information and education</u>	<u>81</u>
<u>8. Good practice in needle and syringe provision</u>	<u>98</u>
<u>9. Appendix: Useful contacts, websites and publications</u>	<u>112</u>
<u>10. References</u>	<u>114</u>

1. Introduction to the HIV epidemic and the role of needle and syringe programs

Introduction

There is a wealth of scientific research evidence from around the world that both charts the spread of the HIV epidemic among injecting drug users and supports the cost-effectiveness of needle and syringe programs as a measure to prevent and control the epidemic.

This chapter gives a global overview of the HIV/AIDS epidemic among injecting drug users and the role needle and syringe provision has played in its prevention and control, and looks in detail at what is happening in Central and Eastern Europe (CEE) and the newly independent states (NIS) of the former Soviet Union.

It provides a rationale, based on scientific evidence, for the effectiveness of needle and syringe programs in helping to prevent HIV epidemics among injecting drug users, as well as practice examples from the many needle and syringe programs which have already started work in 16 countries in the region.

This chapter may be read as the first part of the complete guide to starting and managing needle and syringe programs, or as a briefing paper for decision-makers at local and national level who have the power to assist in the setting up of needle and syringe provision for injecting drug users.

Additional copies of the book and briefing paper can be supplied by International Harm Reduction Development – the address is at the front of the book.

Prevalence and spread of the HIV virus

Worldwide, more than 58 million people had been infected with HIV by December 1999, with almost 6 million infected in the previous 12 months.¹

The largest upward trend in new HIV cases during 1999 was reported in the NIS, which saw a doubling of the proportion of the population living with HIV.

In 1999, UNAIDS/WHO estimated that the number of people infected in the whole of the NIS/CEE region rose by 33% to a total of 360,000.¹

Transmission through shared use of contaminated injecting equipment is a major cause of its rapid spread in many developing and transitional countries.

For example, in Asia it is estimated that in countries such as Malaysia, Myanmar, Vietnam, China and Kazakhstan at least half of HIV infections are associated with illicit drug injection.

Rapid spread of HIV through shared use of contaminated injecting equipment has also been observed in developed countries, such as Italy, Spain, Scotland and the USA.

In some cities, such as Svetlogorsk in Belarus and Mykolayev in Ukraine, HIV prevalence among injecting drug users rose to more than 55% within one year of first identifying HIV amongst the cities' injecting population:² in a city with 10,000 injecting drug users, this would mean 5500 new HIV infections in a year.

Once an HIV epidemic has become established among injecting drug users, the virus usually spreads quickly to other sectors of the community – first to sexual partners of injecting drug users, then via sexual transmission to the rest of society.

There can also be a link between HIV, sex work and injecting drug use. For example, one Russian study estimated that 80% of HIV-positive women in the Russian Federation were involved in both sex work and injecting drug use.³

The spread of HIV among drug users in CEE/NIS is occurring at the same time as a rapid increase in the prevalence of sexually transmitted infections and viral hepatitis in the general population.

This combination increases the probability of major sexually transmitted epidemics of HIV.

Do needle and syringe programs work?

Needle and syringe provision has been the subject of widespread scientific evaluation over the past 15 years.

These studies have confirmed that needle and syringe programs do not lead to higher rates of illegal drug use or injecting and can:

- Reduce HIV seroprevalence
- Reduce the need to use a needle more than once
- Provide an access point for a large disadvantaged group to health and other services.⁴

US studies have found that needle and syringe provision can decrease HIV-risk injecting behavior by up to 73%.⁵

A study of 81 cities around the world compared HIV infection rates among injecting drug users in cities that had needle and syringe provision with those that did not.

In the 52 cities without needle and syringe provision for injecting drug users, HIV infection rates increased by an average of 5.9% per year. In the 29 cities with needle and syringe provision, HIV infection rates decreased by an average of 5.8% per year.⁶

An international comparison of five cities⁷ which prevented HIV epidemics among injecting drug users for at least five years found that there were three similarities between them:

- Prevention efforts were initiated early, when less than 5% of injecting drug users were infected with HIV
- Outreach was used to build trust between health workers and injecting drug users, to provide information about HIV testing and counseling and drug treatment and to distribute HIV prevention information, needles, syringes and condoms
- Needle and syringe provision was well established and 20–33% of all injectors in each city were regular users of the service.

Needles and syringes were also easily available for sale at low cost in four of the five cities.

In California (USA), the effects of needle and syringe provision were studied over a five-year period.⁸

The needle and syringe program did not encourage drug use either by increasing drug use among current injecting drug users, or by recruiting new or young injectors.

In fact, injection frequency amongst injecting drug users in the community decreased from 1.9 injections per day to 0.7, and the percentage of new initiates into injecting drug use decreased from 3% to 1%.

Australian needle and syringe programs were evaluated in 1991.⁹ It was found that they had saved an estimated 3000 lives in that year at a cost per life saved of approximately US \$200. The savings in HIV treatment costs for that year were estimated to be about US \$150 million.

These effects are not achieved by the distribution of injecting equipment alone.

In most countries, needle and syringe provision has been accompanied by programs to educate drug users about the need to use sterile injecting equipment, and the development of treatment and other services which can reduce drug-related harm.

Cost of the epidemic

An HIV epidemic followed by an AIDS epidemic is both a human tragedy and an enormous economic cost for any country to bear.

In the European Union in 1999, the direct medical costs of treating HIV/AIDS ranged from US \$3444 per person per year in the early stages of symptomatic HIV disease to US \$50,184 per person per year in the latter stages of AIDS.¹⁰ If 5500 people were infected, this would mean costs of between US \$19 million and US \$275 million a year as the disease progressed.

Indirect costs, such as the time each family must devote to caring for a person with AIDS, years of lost productivity, and other factors, mean that HIV/AIDS is undermining development gains in many developing and transitional countries.

In CEE/NIS, the costs of an HIV/AIDS epidemic among injecting drug users can lead to massive problems in the provision of adequate health care to all sectors of society.

The World Bank has found that low-income households are the most likely to be affected by HIV/AIDS.¹¹

Many injecting drug users come from low-income households. When HIV infection leads to illness this brings reduced income from the person with HIV and, often, further economic and social costs associated with families caring for their relatives. This, in turn, leads to further poverty and increased likelihood of other family members engaging in HIV-risk behaviors.

The World Bank recommends that countries with small HIV epidemics should act early to implement prevention programs, and that they should focus on those most at risk for HIV infection: in CEE/NIS countries, this usually means injecting drug users.

Factors that predict an HIV epidemic

Injecting drug use has now been reported in 126 countries worldwide, with 98 of these countries reporting HIV among drug injectors.

After more than a decade of international experience of HIV transmission among injecting drug users, there are a number of epidemiological, geographical, and social factors that are known to contribute to the rapid spread of HIV among injectors. These include:

- The presence of HIV in the population
- A recent and rapid spread of injecting drug use
- Proximity to drug supply routes
- Widespread unemployment and economic dislocation
- Social change
- The regular sharing of injecting equipment among members of social networks
- High levels of mixing between social networks of injectors
- The sale and distribution of drugs in syringes.

Systematic research of HIV-risk behaviors in CEE/NIS is still at the developmental stage, but a large number of rapid assessments based on the World Health Organization (WHO) rapid assessment and response methodology¹² have now been completed in the region.

In most countries where these assessments have been carried out, all of the major risk factors listed above have been observed – often at much higher levels than in Western countries. They are therefore discussed in detail below.

The spread of injecting

In CEE/NIS, with a few exceptions such as Mongolia, there has been a massive and rapid rise in the number of people injecting illicit drugs, particularly in the past decade.

Reasons for the spread and increasing popularity of injecting are complex but include the facts that injecting:

- Offers the most cost-effective way of using a drug – less drug is needed to achieve the same effect than with other methods of administration
- Gives a greater intensity of effect, with more rapid onset
- May be easier to conceal than other, more time-consuming methods of taking drugs
- Is often established as the 'normal' way of taking a given drug
- Is the only way of using some preparations, and there may not be a choice of preparations.

Proximity to drug-trafficking routes

HIV epidemics among injecting drug users occurred along drug trafficking routes in Asia in the late 1980s and early 1990s.

The Asian HIV epidemic among injecting drug users (which has been concentrated largely in the 'Golden Triangle' countries of South-East Asia) is now spreading across India and Nepal, and into the other major opium-producing areas of Afghanistan and Pakistan.¹³

Middle Eastern countries are also finding evidence of emerging epidemics of HIV, spreading largely among injecting drug users. On the other side of the CEE/NIS region, injecting drug users remain the largest group with HIV and AIDS in several Western European countries.

The spread of HIV among injecting drug users in CEE/NIS in the mid to late 1990s also appears to be partly related to the setting up of drug trafficking routes between opium production areas in Afghanistan and Pakistan and the large heroin markets of Western Europe and the USA.

Virtually all Central and Eastern European and Central Asian countries and many newly independent states around the Black and Caspian Seas play a role in the complex web of drug production, refining and trafficking operations between Asia and Europe.

This is likely to increase. The United Nations Drug Control Program (UNDCP) estimated that between 1985 and 1996 illicit production of opium (for heroin production) increased by 300% and coca (for cocaine production) by 200%, and foresaw a further increase in the coming decade.¹⁴

Social change

The CEE/NIS region is 'in transition' from a group of Communist-controlled, centrally planned economies towards a new economic system, the final shape of which, in many cases, is still being formulated.

This transition process has been accompanied by:

- An inability of many governments to pay for services which were regarded as essential under the former system
- Massive unemployment
- High inflation which has reduced real wages for most people still employed
- Difficulties in collecting taxes and widespread corruption.

These have all been significant factors in both the large numbers of people turning to drug use and in the lack of financial resources to address emerging issues such as HIV epidemics.

Related to this 'transition' is the ideological conflict between those who believe that the state has both a right and a duty to intervene in its citizens' sexual and other personal behavior and those who believe that protection of human rights precludes the use of compulsory treatment, imprisonment, and exile for behavior the state views as deviant.

This often leads to conflict between health officials and doctors on the one hand who are concerned with protecting and promoting the health of the whole community, and internal

affairs, militia, police and military forces on the other who are concerned about the effects of drug use on public order.

Unless this conflict is resolved, it is very difficult for effective HIV prevention work to be carried out among injecting drug users.

The complex national and local structures which govern the planning and operation of health services and the absence of community-based or private health facilities and organizations (especially in Eastern Europe and NIS) also present problems in trying to develop new, community-based, HIV prevention services.

Sharing injecting equipment and mixing of injectors' social networks

A World Health Organization study of 12 cities on five continents found a high rate of mobility among injecting drug users, and found that those injectors at higher risk for HIV were more likely to travel.¹⁵

This fact, added to the enormous dislocations and movement of people due to conflicts, unemployment and other social factors, is likely to lead to high levels of social mixing among injecting drug users, and increased opportunity for spread of the virus.

Although drug users in most countries in the CEE/NIS region usually try to keep their own syringes, fear of the police, and other factors, mean that many do not always have their own syringe and may share a syringe and/or needle at least occasionally.

In areas without needle and syringe provision and education programs, needle and syringe sharing is usually at levels above 50%.

Few studies have examined the age of first injection, but there are anecdotal reports from some countries in the CEE/NIS region of injectors aged 12–13 and younger.

This is likely to compound the problems mentioned above, and creates particular problems for HIV prevention as young people are more vulnerable in that they are less likely to have acquired the skills and resources needed to maintain their health.

Sale and distribution of drugs in syringes

Throughout Eastern Europe and Central Asia, the main injectable drugs are prepared in a solution, ready for injection. In some Central European countries, such as Poland, the majority of injecting drug users use drugs that are prepared in this way.

The usual production method for these drugs is for the mixture to be prepared by, and for, a social network of three to five injectors, each of whom brings some ingredients or equipment to the drug preparation process. The process is usually carried out under the 'supervision' of an experienced 'cook'.

The drug is prepared in a cooking pot and is usually distributed to the members of the group by drawing up the liquid into a single (possibly used) syringe which is used to transfer the liquid into each person's syringe.

This practice is known as 'backloading' (when the plunger is taken out of the receiving syringe and the liquid squirted in the back) or 'frontloading' (when the drug is drawn up through the nozzle of the receiving syringe). It is a high-risk activity for HIV and hepatitis transmission when used syringes are involved in the process.

Alternatively, the syringes are dipped one by one into the mixture. These processes are often repeated several times, allowing residual blood and drugs to mix with the liquid remaining in the pot.

In addition, there is evidence from several countries that some 'cooks', their agents, or partners make drugs already drawn into syringes available to people who are not part of their small injecting network either through shooting galleries (a room in which a number of injectors use a syringe in turn) or on the streets.

This is a high-risk way of buying drugs as the syringe may have been used before and contain the HIV virus. This pattern of drug buying and selling leads to much greater mixing of networks, thus increasing the risk of rapid rises in HIV transmission.

In terms of HIV prevention among injecting drug users, it is a concern that these processes carry an inherent risk of HIV transmission and that there are thousands of small, hidden groups preparing drugs in this way, each of which needs to receive HIV prevention messages.

Another public health problem lies in the fact that these production methods result in drugs of varying purity, and there is considerable risk of accidental overdose because of this.

While sale of drugs in solution, ready for injection remains common in this region there was a dramatic increase in the injection of powder drugs, especially heroin, in the late 1990s. However, it was still associated with the sharing of injecting equipment.

It should also be remembered that all of the HIV epidemics among injecting drug users in Western countries have resulted from equipment sharing among the injectors of powder drugs such as heroin, cocaine, and amphetamine.

The HIV epidemic in CEE/NIS

There are already established HIV epidemics among injecting drug users that are a major concern for both national governments and international bodies, such as UNAIDS, in the countries of:

- Ukraine
- Belarus
- Russian Federation
- Poland.

Ukraine

In 1998, UNAIDS estimated the number of HIV-positive people in Ukraine at 100,000.

The rise to this level of infection was rapid. In the years 1992–94 there was an average of only 47 new HIV cases per year. In 1995 this rose to almost 1500, and increased again to 12,228 in 1996, 15,443 in 1997, and 24,000 in 1998.²

Of total infections registered since 1995, official estimates indicate that approximately 50% are associated with intravenous drug injection, although some studies estimate the figure to be nearer 80%.²

Belarus

In 1998, UNAIDS estimated the number of HIV-positive people in Belarus at 9,000. In more than 80% of these cases, transmission of HIV was through shared injecting equipment.²

Belarus also experienced a rapid increase in reported HIV cases from an average of around 15 per year from 1992–95 to more than 700 in 1996, of which 485 were among injecting drug users.²

Russian Federation

The Russian Federation also experienced a rapid rise in the spread of HIV amongst injecting drug users with no recorded cases prior to 1995, three new cases in 1995, 1021 in 1996, 2452 in 1997, and 1655 in 1998.²

The total number of people infected with the HIV virus was estimated by UNAIDS in 1998 at 40,000.²

Poland

Poland has about 12,000 people registered as HIV positive, of whom the majority are injecting drug users. There are likely to be many more who are not registered.

It is estimated that in Warsaw, 60% of injecting drug users are HIV positive.

Emerging HIV epidemics in CEE/NIS

The preconditions for an HIV epidemic exist in many other places in CEE/NIS and epidemics are known to be emerging in both Moldova and Kazakhstan.

In Moldova, reported HIV cases have jumped from an average of under three per year in 1992–94 to seven in 1995, 55 in 1996, 404 in 1997, and 807 in 1998 (of which 85% are among injecting drug users),² and may well continue to rise as they have in Belarus, Russia, and Ukraine.

Prior to the detection of HIV amongst injecting members of the prison population in Temirtau in June 1996, there were just 69 registered cases of HIV in Kazakhstan. Since then, the numbers of HIV tests conducted has increased. Between 1997 and 1998, 736 new cases were reported, of which 88% were among injecting drug users.²

There are reports of HIV in other Central Asian republics, but little evidence so far of rapid HIV spread in Uzbekistan (19 cases by June 1998), Kyrgystan (five cases by June 1998), Tajikistan (four cases by December 1997), or Turkmenistan (one case by December 1997).²

The Eastern European epidemics form an ever-increasing pool of HIV infection which is likely to lead to further spread of HIV among injecting drug users in many other countries in the region. Recent political events in South-Eastern Europe make it impossible to assess the levels of HIV and injecting drug use in that region.

Preventing and controlling HIV epidemics among injecting drug users

The World Health Organization has established a comprehensive framework for action on preventing HIV transmission among injecting drug users (and from drug users to other groups).

The WHO document Basic Principles for Effective HIV Prevention Among Injecting Drug Users¹⁶ strongly supports the development of needle and syringe programs. It states that the principles for effective preventive work among injectors at national and local levels include the provision of:

- Information, communication, and education
- Easy access to health and social services
- Outreach services to injecting drug users
- Sterile injecting equipment and disinfectant materials
- Substitution treatment.

It also clearly makes the point that access to sterile injecting equipment should include arrangements for the confidential provision of:

- Free sterile needles, syringes, and disinfecting materials
- Sales of needles, syringes, and disinfecting materials in pharmacies, low-threshold treatment centers, outreach programs, and other agencies and institutions with non-judgemental attitudes
- Safe disposal of needles and syringes
- Information and advice on safer injecting and HIV risk reduction.

These measures are the essential components of what is known as a harm reduction approach to drug use and HIV.

A harm reduction framework

Harm reduction policies, strategies, and activities acknowledge the grave risks posed to public health by injecting drug use, and are aimed at preventing or reducing the adverse consequences of drug use without requiring drug users to become abstinent.

This approach is based on the pragmatic acknowledgement that, despite years of trying, there are no known effective interventions for eliminating drug use or drug-related problems in any community, city, or country.

In most cultures, adopting a harm reduction approach requires a shift in thinking away from deeply rooted, and understandable, long-term idealistic goals of eliminating drug use and getting all drug users to become drug free.

Harm reduction does not deny the value of helping people become drug free, or the desirability of abstinence as an eventual goal. It simply recognizes that for many drug users these are distant goals and that services to reduce the risk in the interim are therefore essential if personal and public health disasters are to be avoided.

The main characteristics or principles of harm reduction work with injecting drug users include:

- Emphasis on achieving short-term pragmatic goals based on a hierarchy of risk (see below)
- A focus on reducing the harms to the individual and society associated with drug use
- Use of multiple strategies to achieve goals
- Involvement of current drug users in the planning and implementation of programs.

A typical harm reduction hierarchy is as follows:

- Reduce the sharing of injecting equipment
- Reduce the incidence of injecting
- Reduce the use of street drugs
- Reduce the use of prescribed drugs
- Increase abstinence.

Needle and syringe programs are an essential part of the strategy to meet these goals.

Effective promotion of public health

Needle and syringe provision is an essential part of a comprehensive public health approach to HIV prevention.

The preconditions for improved public health are usefully set out in The Ottawa Charter of Health Promotion¹⁷ which identifies five criteria for effective promotion of public health:

- Public policies that promote health
- A supportive environment for those whose health is at risk
- Health services oriented towards preventing health problems
- Community action and support
- Developing personal skills.

The practical implications of these criteria are discussed below.

Government policies which are likely to cause or increase health problems may need to be modified or exchanged for policies that are likely to improve public health.

For example, in many countries, laws present direct obstacles to HIV prevention efforts, especially related to needle and syringe provision, outreach and drug substitution programs.

These laws need to be addressed to ensure that effective HIV prevention can occur.

Drug users are more likely to change their HIV-risk behavior if there is a supportive environment in which health and social injustice are addressed and they have equal access to appropriate health care, prevention and treatment services.

This includes both a supportive physical environment (meeting the basic needs of shelter, clothing, food) and a supportive social environment where drug users are encouraged to consider themselves members of society with equal rights and responsibilities.

Most health services have been established to care for people at the end of their illness, when surgery or major intervention is required.

However, prevention of health problems before they occur and early diagnosis and intervention have been shown to lead to massive cost savings and improved health for the population. Nowhere are these benefits clearer than in the field of HIV prevention.

Health services need to be analyzed and reoriented to ensure that they reach as many drug users as possible with effective HIV prevention services.

When people work together as a community, whether inside or outside the health system, public health measures have a much greater chance of success. Outreach and peer education are key strategies for strengthening community action to reduce HIV risk among injecting drug users.

Drug users are a subsection of society with a sense of community and networks which provide an excellent opportunity for influencing social norms and changing patterns of behavior.

Key groups to target for skills development

While the Ottawa Charter¹⁷ places great emphasis on the social and community aspects of public health, individuals also play a major role in looking after their own health.

In the fight against HIV, four main groups of people need to be targeted for the development of personal skills:

- Injecting drug users
- Sexual partners, families, and friends of injecting drug users
- Doctors and other health/social care workers (such as psychologists, nurses, social workers, etc.)
- Outreach workers and peer educators.

The needs of these groups are discussed below.

Injecting drug users acquire knowledge and skills throughout their drug-using career which assists them in assessing and managing the risks associated with injecting.

Services can intervene to help them to learn how to accurately assess and manage HIV risk by giving accurate information on:

- The HIV risk of injecting and other behaviors
- Needle and syringe use
- Cleaning of injecting equipment
- Condom use
- Gaining access to sterile injecting equipment and condoms
- Drug treatment
- Sexually transmitted disease and HIV treatment services.

Sexual partners need to be able to assess and manage the risk of HIV transmission through sex: this may require training in negotiation techniques and the correct use of condoms.

Developing personal skills for this group also includes providing information on what to do if they witness an overdose and information on drug treatment, sexually transmitted disease and HIV services.

Doctors and other health care professionals need to have sufficient knowledge and skills to counsel injectors and their sexual partners.

The education given to these groups should normally include examination of personal feelings because negative attitudes are often a major obstacle to the effective delivery of HIV prevention interventions to drug users.

Skills development should also cover assessment of HIV risk and early intervention with drug use.

Training for outreach workers and peer educators should include all of the above as well as detailed information on:

- Drug-injecting practices
- HIV transmission and prevention
- Skills for working outside traditional office or clinic environments, such as on streets, in apartments and drug markets, etc.

Needle and syringe provision in CEE/NIS

At the time of writing, needle and syringe programs have been established in Belarus, Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Kazakhstan, Latvia, Lithuania, Macedonia, Moldova, Poland, Russian Federation, Slovak Republic, Slovenia, and Ukraine.

In most countries, only a small number of services have been established so far, and most have not yet been able to reach a majority of injecting drug users in their city or country.

For effective prevention of an epidemic among injecting drug users (or to control an epidemic already underway), UNAIDS estimated that needle and syringe programs need to reach 60–70% of injectors with information¹⁸ and US researchers estimated that needle and syringe programs have to reach at least 20% of injectors with needles and syringes on a regular basis.⁷

This means that larger cities may need several needle and syringe services to prevent the spread of HIV, as well as additional services to cover surrounding smaller towns and rural areas.

Needle and syringe programs in the CEE/NIS region vary widely in their operating practices, depending on local needs and conditions.

Examples of needle and syringe programs

The needle and syringe program based in the Szeged Youth Center (Hungary) is staffed by a group of active drug users and social work students who operate on an outreach basis, offering injecting equipment in parks, drinking places and drug users' apartments.

In Poltava and Mykolayev (Ukraine), non-government organizations (NGOs) run a needle and syringe program with volunteers who receive comprehensive training. They also produce a wide range of leaflets on drugs, HIV/AIDS, sex and the law.

In Odessa, three needle and syringe programs started by the city's AIDS center were later taken over by a NGO; and up to eight other cities are expected to start programs later this year.

In Slovenia, a needle and syringe program was set up with a drug-user representative from the Netherlands to provide group education to injecting drug users on safer injecting and safer sex.

In Prague, the needle and syringe program is operated by a NGO that also provides shower, laundry and coffee-making facilities.

In Penza in the south of Russia, a small needle and syringe program was started by epidemiologists and narcologists from within the city's narcology center, though it later moved to a site more convenient to the area where most of the city's drug users live.

In the Russian Federation, needle and syringe provision has also been established by NGOs in St Petersburg, Yaroslavl, and Volgograd, and by AIDS centers in Pskov, Rostov-on-Don and Novorissisk. More than 20 needle and syringe programs are expected to open in the Russian Federation during 1999–2000.

In Split (Croatia), a program operates every day (including weekends and holidays) to provide injecting equipment not only to drug users in the city, but also from the surrounding rural region and nearby islands.

In the Slovak Republic, the project 'Odyssey' started with six street workers who spend 24 hours on the streets of Bratislava each week offering an outreach service to both injecting drug users and sex workers. Another service providing free injecting equipment is run from a medical center, at which methadone is also dispensed.

In Soroca (Moldova), needle and syringe provision has been combined with a center providing basic medical assistance and psychological counseling for the city's Roma population.

In Lithuania, there is a needle and syringe program in Vilnius (including a mobile service that works with a large Roma population living on the edge of the city) and an outreach program based at the city's narcological service. A drop-in center has been successful in reaching injecting drug users in Klaipeda on the Baltic Sea.

In Kazakhstan, three fixed-site services have started in Temirtau and needle and syringe provision has operated from an apartment where drugs are produced.

Needle and syringe programs operate from AIDS centers in three cities in Estonia and also in Riga (Latvia).

In Poland, needle exchanges have operated for several years in cities such as Krakow, Lublin, and Katowice, often in association with a large drug treatment NGO.

In Sofia (Bulgaria), workers from the needle and syringe program, carrying distinctive bags, move from group to group of injectors in a park in the center of the city, where much drug buying and selling occurs.

In Skopje (Macedonia), the needle and syringe program was started as a non-governmental organization formed by drug users themselves. They have forged links with other organizations to advocate for the legal and civil rights of injectors.

In Belarus, at the time of writing, a needle and syringe program has been running for two years in Svetlogorsk, and new programs are being started in other regional cities such as Mogilu and Babrusk.

2. Getting support for your needle and syringe program

Introduction

Needle and syringe programs cannot be set up and run effectively without the assistance of other individuals, communities, organizations and local authorities.

The experience of establishing and running needle and syringe programs in many countries around the world has confirmed the vital importance of gaining – and maintaining – support from local authorities and communities.

It may be necessary to secure:

- Changes to laws or planning regulations
- Official letters of support from the mayor, city health department and police
- Negotiated formal or informal agreements between police and health facilities.

Forcible closure following pressure from city authorities, police or neighborhood is the likely outcome of opening a service without the powerful support to achieve these things, and forced closure is the most common reason for needle and syringe programs closing down.

So, to make your needle and syringe program both effective and sustainable, you need to ensure the right support is in place.

This chapter is written in general terms and on the basis that needle and syringe program organizers will be aware of, and sensitive to, the social context within which they are working, which includes the:

- Legal framework
- Customs and traditions that exist
- Rules and philosophies of dominant religions
- Political climate and beliefs of the community and of those who hold key posts, such as the Prime Minister and Minister for Health
- The experience of, and attitudes towards, drug users within the wider community.

On that basis it provides advice on recruiting the help the project will need, forming links with other organizations and groups, responding to opposition, getting support for the program base, networking with other services and influencing public policy.

Identifying potential allies

Much of the most important work in setting up a successful needle and syringe program should be carried out before a single needle or syringe is supplied.

The rapid situation assessment (see Chapter 3) is a major part of this essential preparation work.

However, it is also important to identify potential allies who can be influential in determining whether the rapid assessment, and any services that need to be set up as a result of it, will succeed or fail.

‘Power-mapping’

An effective way of creating a list of the most appropriate individuals and organizations with whom you need to forge alliances is to do a ‘power-mapping’ exercise.

To do this take a large sheet of paper and identify your team members in the center. Then place around them every individual or organization which could assist or hinder your team from carrying out the rapid situation assessment (see Chapter 3).

The list of potential allies may include:

- Drug treatment workers/narcologists
- AIDS center workers
- Ex-users and drug users
- Doctors – both GPs and hospital doctors
- Police and internal affairs
- Local Government – mayors and elected officials
- Local politicians
- Health department staff
- Clergy
- Youth workers/youth leaders.

Using connecting lines, map the relationships between people and institutions, showing how the individual team members can access each of the most powerful bodies.

If the map shows that the team does not have sufficient contacts (formal or informal) to reach all of the most important people, then the composition of the team may need to be examined with a view to adding further key people.

It is also a good idea to discuss how best to approach people and to think of arguments that would persuade these potential allies to support the rapid situation assessment and the development of a needle and syringe program.

The people on the list should be consulted regularly and kept informed about developments.

Links with other services and groups

An early step you can take to increase the chances of establishing a successful and sustainable needle and syringe program is to talk with other groups in your city.

Links can be built in formal ways with:

- Official meetings with important people and representatives of powerful organizations
- Presentation of the rapid situation assessment report and your plans to city officials, other services, and the media
- A well-planned official launch or opening of the needle and syringe program
- Address to local police officers
- Project open days for the media, supporters, or neighbors

or with more informal methods such as:

- Private conversations with key individuals to ask whether they would support a new initiative
- Using friendship networks to reach important but hard-to-reach decision-makers
- Producing and distributing general community pamphlets, explaining why the service is being established.

The first links to be made are with other individuals and organizations that are already trying to prevent the spread of HIV or working with drug users.

Such organizations may already be in some form of group or coalition. If not, the needle and syringe program may be the catalyst for the formation of such a group.

These links can be mutually beneficial in a number of other ways. As well as gathering support for the project, you can begin to understand what other organizations do and how they work.

In doing so, you can begin to form referral networks with other helping agencies which will enable them to help their clients access your service, and your clients access theirs.

You may also find that your work has the support of a local charity group whose access to people identified on your 'power map' is greater than your own, or that their experience can help you gain the support you will need.

Together you can identify issues which are common to all of the groups in the coalition and on which you can all work together. Identify the most important issues in your work and seek assistance from other coalition members to achieve them.

Funding is discussed in more detail in Chapter 6, but the issue of support from the important institutions, services and individuals in your city or region is vital when you are seeking funding for needle and syringe provision or want to start a program with existing funding.

Influencing public policy

Needle and syringe programs also have a duty to raise, where possible, the issues of injecting drug use, HIV infection, and the treatment of injecting drug users at city, regional and national level.

A 'selfish' reason to raise these issues is that greater concern by authorities about an HIV epidemic among injectors is likely to lead to greater cooperation from them in allowing you to work effectively, and to ongoing funding for the program. However, there are other, important reasons for raising these issues.

The success of needle and syringe programs is partly dependent on the social and political environments in which they occur. Individual and community behavior (and behavior change) occur within the constraints of the wider social and political environment.

Public health programs therefore require help from those who can influence public policies (for example, government health officials) and local environments that are supportive of risk reduction and behavior change (for example, local residents).

Public policy work can include seeking improvements in the 'service environment' (e.g. the availability and accessibility of HIV or drug-related services), the 'social environment' (e.g. local or community attitudes or responses to drug use), and the 'physical environment' (e.g. housing, areas of drug selling and use).

At the political level it may also be necessary to seek support for changes to laws and public policies: for example, there may be legal restrictions on the operation of non-governmental organizations or there may be laws against giving education to a drug user on how to inject more safely.

There may also be laws against the distribution of condoms, or religious prohibitions to their use.

US researchers have shown that some laws can be very problematic for HIV prevention.¹⁹ Drug paraphernalia laws, in particular, deter injectors from carrying their own injecting equipment.

As a result, drug users who fear arrest for carrying injecting equipment are almost twice as likely to engage in syringe and needle sharing as those who do not fear arrest.

Public policies therefore influence the effects of drug use as well as the effectiveness of public health responses.

Where public policy is preventing effective HIV prevention, the needle and syringe program must lobby for policy change, as well as providing injecting equipment, in order to be as effective as possible.

Cooperation with governments

Public policy work isn't always a battle. Needle and syringe programs are often seen as valuable by governments and religious and social organizations because they can help to access injecting drug users or talk to authorities about the effects of proposed legal and regulation changes on drug use and HIV-risk behavior.

However, programs need to balance the desires of other groups to learn about injectors with the need for confidentiality and anonymity of service users.

Examples of ways in which services can successfully assist governments and other groups include the development of, and involvement in:

- Regional, national, and international networks of needle and syringe programs, harm reduction agencies, HIV or drugs-related agencies
- City, regional, or national AIDS and/or drugs committees
- Training of doctors and health and social workers (both training and qualified) about HIV/AIDS and drug use and the role of the needle and syringe program
- Parliamentary or other political inquiries into drug use, HIV/AIDS, infectious diseases, youth affairs, or social issues
- United Nations or other international committees or organizations attempting to address HIV epidemics and drug use.

Examples of public policy influence

In Szeged (Hungary), the needle and syringe program participates in a range of activities to influence public policy. One of the most important is an attempt to encourage the formation of a city drug committee, committed to harm reduction efforts.

The program worked with the city's chief doctor on a report on the drug situation which was presented to the general assembly of the local government. Accompanying the report was a proposal that the city form a drug committee, reporting directly to the mayor's office, responsible for ongoing reporting of the situation and the development of a city drug strategy.

The service hopes to be represented on the proposed committee, which would follow the recommendations of the Frankfurt Resolution of the European Cities on Drug Policy.

The program believes that a city drug committee formed in this way, with a focus on harm reduction, will ensure the long-term sustainability of the program and encourage the development of other services to assist drug users.

In Odessa (Ukraine), two fixed-site needle and syringe programs were established by the Southern Branch of the Ukrainian AIDS Center in December 1996, together with an outreach program.

The AIDS Center had done as much as possible to gain support for the programs, gaining approval from the Odessa City Council of People's Deputies as well as many other city organizations.

However, in May 1997, two months after the community organization 'Faith, Hope, Love' had taken over responsibility for the programs both fixed-site services were closed by the district sanitary epidemiological department. It was argued by the department that this was because the formal sanitary laws and criteria for this type of facility were not being complied with.

With only the outreach program still operating, the number of injecting drug users accessing the services fell from around 2000 to just 500.

Though the decision to close the centers was not initially opposed by the city authorities, the city administration was persuaded to revise the sanitary criteria and to support the re-opening of the centers.

They were also persuaded to support the establishment of four low-threshold AIDS prevention medical clinics as well as a specific center for teenagers.

Police liaison

Of all the groups that you need to deal with when starting a needle and syringe program, the police are usually the most important. It can be difficult for them to see that the purpose of the program is the promotion of public health and not the promotion of drug use.

Chapter 1 – which is available as a separate booklet – may help them to understand this, as can your discussions with them and your rapid situation assessment report.

The most effective way to develop police liaison is to identify a senior police official who is (or can be persuaded to be) sympathetic to your cause and is at a high enough level to ensure that your rapid situation assessment and needle and syringe program can operate without interference from the police.

If this is impossible, try to find a sympathetic official who is senior to the police officials in your city or region (either through national police structures or through the upper levels of the city or regional administration) who can direct them to cooperate with you.

In either case, try to get a letter from the police confirming that they will support the operation of the program. If they will not go this far, try to at least get a written commitment that they will not interfere with the program's operations.

If you achieve this level of cooperation from the police, you will also need a mechanism to deal with problematic situations. These almost always occur as high-level agreements about police policy on such matters are often not communicated to (or are ignored by) officers on the street who then harass the program workers and clients.

The usual mechanism is to arrange regular meetings at a senior level between police and health (and possibly city) officials or a protocol for calling meetings at short notice if problems arise. If possible, these arrangements should be agreed in writing.

These meetings can be 'sold' as a two-way process, with benefits for the police who can use it as a forum to raise any problems they have with the program, as well as a way for you to raise problems with police behavior.

Much care is needed in balancing a program's relationship with the police and its relationship with drug users.

Evidence of collusion or collaboration with the police – even if thought by the program to be beneficial from a cooperation point of view – can cause enormous credibility problems with its clients.

Communications of this type should always be carried out by an identified person (usually the project manager), who will have to judge the optimum relationship with the police according to local conditions.

Examples of effective police liaison

Drug users in Odessa (Ukraine) did not initially trust the needle and syringe program drop-in centers, because they were afraid that they would be officially registered there.

Mistrust was reinforced by actions of the police, who arrested several drug users at the front doors of the service. There was even an incident in which the police blocked all the centers' exits, forced entry, and searched all the clients inside for drugs!

These serious problems were eventually largely overcome by constant communication with police about the role of the program.

In Skopje (Macedonia), the outreach needle and syringe program 'Healthy Options Project Skopje', known as HOPS, which had operated for one year, was closed in April 1998. This was because the outreach workers had been subject to constant police observation, verbal harassment, interrogations and searches, and confiscation of needles, syringes, brochures and leaflets.

At the time of writing, HOPS has negotiated a specific permit for this work with the police department and is hoping to start the program again.

Police in Krakow (Poland) caused problems for the needle and syringe program by searching the bags of outreach staff, demanding to see their identification each time they went to the main drug-dealing areas, and approaching them while they were giving out injecting equipment, scaring the clients away.

To resolve these problems the program held numerous meetings with police at city, district and local level to address these issues and now provides educational seminars for police on the role and activities of the program.

In Pskov (Russian Federation), the needle and syringe program has good relations with the drug police, ONON.

When the program started, pressure to close it down was applied to local police from senior officers in St Petersburg. However, the local ONON official decided to allow the program to continue to operate.

The needle and syringe program has had few problems with the city and health administration. This may, in part, be because the program does not advertise its activities but relies on word of mouth among injectors to bring new clients to the service – this 'low profile' may have made it easier for officials to support it.

In Vilnius (Lithuania), a meeting with the chief city police commissar and his deputy was sought by the needle and syringe program (operating from the city's Narcology Center).

At this meeting, the role and rationale of the needle and syringe and methadone programs were described and each group stated their attitudes to these services.

It was decided that the police needed to be kept informed of the activities of these programs but would not oppose them. It was also agreed that ongoing communication to deal with any problems that might arise should be between the chief doctor of the narcology clinic and the chief of the Vilnius drug squad.

Police assistance with needle and syringe provision

One very material way that police can assist a program's success is by either approving, or understanding and working with, an identification system for clients of the needle and syringe program.

For example, in Sydney (Australia), all needles and syringes are marked as the property of the needle and syringe program: if police find used needles on a drug user, the user explains that they are taking the needles back to the program and the police will usually allow them to continue on their way.

Both in Australia and elsewhere, some programs use specific cards which state that the user is a client of theirs.

In 1999 a new needle and syringe program in Novorissisk, Russian Federation, was finding it difficult to attract injecting drug users to the service.

Then police searched a user who showed them a card from the AIDS center inviting the user to the needle and syringe program: the police, who had been trained in the new program's operating procedures and ordered by their chief not to interfere with the program's work, allowed the user to go without any further hassles. Two days later, the program was overcrowded with new clients.

The media

Clearly the media can be a very important communication tool, but it is so unpredictable that there is no single right approach to working with them.

In some cities, needle and syringe programs have decided to set themselves up without telling the media because they are sure that, if they did, there would be hostile coverage with the media providing a focal point for efforts to obstruct the program.

These groups often wait for six months or a year, until there are some positive results from the program, before they approach the media and use these to try and gain positive exposure.

In other places groups have talked to the newspapers, radio and TV, and have worked effectively with them to gain public support before starting the needle and syringe program.

Other strategies have included:

- Asking senior journalists and editors in a city or state to attend a meeting where the problems of rapid HIV transmission among drug users and the proposed education interventions are described and discussed
- Selecting one or more journalists who seem 'friendly' to the idea of harm reduction and working with them to provide news stories supporting harm reduction programs.

Each strategy has its risks, advantages and disadvantages: it is up to the coordinating team to decide the best course of action.

However, it should be acknowledged that media exposure is not necessarily something that can be controlled.

Whatever the team decides, it makes sense to discuss early on who will talk to the media and what they will say, and to have some contingency plans should needle and syringe provision suddenly become a major news story.

Sometimes programs get involved in assisting media journalists to interview drug users. But although some have found it useful to engage with the media and develop good working relationships with them, many people, and programs, have also been abused by them (see below).

Because of this, media access to clients should only be allowed when the program staff are very confident that they know the journalists well and can trust them.

One way of attempting to ensure that journalists keep their promises about confidentiality is for staff to get written agreement of their right to see or hear – and veto – the article or broadcast before it is printed or aired.

Positive example of media experience

In Skopje (Macedonia), Healthy Options Project Skopje (HOPS) has successfully described its needle and syringe program and other activities to the general public through the mass media, and has raised many important issues affecting drug users.

The program has been the subject of more than 30 articles in newspapers and magazines and 15 radio broadcasts. It has also assisted in the production of two TV documentaries about HIV/AIDS, drug use and the work of the program.

The organization has received many offers of assistance and messages of support as a result of this media exposure.

Negative examples of media experience

In Penza (Russian Federation), a needle and syringe program assembled a group of current and ex-injecting drug users to be their outreach team.

After media interest was expressed in the program, a television broadcast was arranged in which one of the outreach workers talked about his drug use and the risks of HIV spreading among injecting drug users.

Despite promises not to reveal the worker's identity and to use a masking device to prevent recognition of his face, the broadcast clearly showed his face (which was recognized), and his name and address were published in a newspaper which was referring to the broadcast!

This brought his drug use to the attention of all his acquaintances and his parents, and resulted in all sorts of problems, including abuse and breakdown of relationships. This experience left him – and other outreach workers – much less keen on working for the program.

In St Petersburg, a malicious report in an important newspaper led city authorities to close the mobile needle and syringe program until the program's supporters could persuade the city administration to allow it to continue working.

In 1998 in Sydney (Australia), a photograph was published in a newspaper of a needle and syringe program worker helping a young drug user (incorrectly described as 14 years old) to find a vein in which to inject.

This photograph and subsequent editorials by the newspaper led the state government to close the highly successful program, even though it had been operating for almost 10 years and had wide support in the local area.

Even with this support in place, it took six months of sustained lobbying to have the program re-opened.

Responding to opposition

One of the greatest fears of the public, especially parents or grandparents of young people, police and health professionals, is that a needle and syringe provision is a 'pro drugs' activity that is not compatible with drug law enforcement – which is seen as the only legitimate 'anti-drugs' activity.

It is important to emphasize that your organization is not 'pro drugs', and to separate the moral issue of drug use from the health issue of disease prevention.

Emphasize your role in preventing HIV infection and helping to save the community from disease and the economic and social costs of an AIDS epidemic.

Remember that the very idea of a needle and syringe program can make people very angry or anxious. It will help if you can be patient as you explain the reasons for setting up the program.

Letting people have copies of Chapter 1 of this book, distributing the results of your rapid situation assessment, and referring to any official support that you have – at national and local level – will hopefully calm their fears.

Try to build up the professional profile of the needle and syringe program so that the public in general and staff in other areas know about, and become proud of, this work.

Public meetings

In the UK, Australia and other Western countries it has been found that public meetings have not been a very helpful way of addressing the fears of local communities.

High levels of emotion and rousing speeches have often served to reinforce opposition and to reduce debate and discussion.

Most services have found it more useful to meet individuals on a one-to-one basis to listen to their fears and concerns and to address them directly.

If you are planning a public meeting, the chair should be aware of these pitfalls and plans should be in place to manage the meeting effectively.

Gaining support for a needle and syringe program site

It is also important to develop support amongst people who work or live around any base the program has, as there are examples in almost every country of needle and syringe programs that have been forced to move or close down because of opposition from neighbors.

Many programs are started from within established health structures such as AIDS centers, hospitals or clinics.

This can have many advantages in terms of offering office and storage space, administrative support, communications (phones, fax, email) and so on without great extra expense.

However, many needle and syringe programs which have started in these environments have been forced to move to other premises, or to work within boundaries that make things difficult, because of opposition from other workers in the building.

If you are going to work from within an existing building, it is vital that you spend time gaining support from all the powerful groups and individuals who also work there.

A similar approach is required when needle and syringe programs are set up in other settings.

Indeed, whether the needle exchange program base has residents, shopkeepers or health workers as neighbors, it is important to explain your work to these groups and gain their trust and acceptance.

One useful way of improving relationships with the program's neighbors is to identify their concerns – such as needles and syringes being found on the streets nearby.

If you can incorporate resolving the problems into your work – for instance by organizing regular checks of local areas and collections of discarded needles – it can generate a great deal of goodwill and local support.

Working with other needle and syringe programs

Another important source of support and assistance can be programs which are already established.

Early in the process of designing your program, contact these groups and ask for their advice.

If possible, visit existing needle and syringe programs and spend several days talking with their managers, staff and clients to learn how the program operates and, importantly, how they have overcome any obstacles.

It can also be very helpful to talk to some of the groups that support their work.

There may also be local networks already established or you may wish to help start such a network.

For example, the needle and syringe program in Szeged (Hungary) works together with programs and drop-in centers in Budapest and Pecs as well as the Circle of Hungarian Harm Reduction Activists to exchange information and assist each other in improving their services.

The groups have also worked together on national issues such as proposed changes to the Hungarian legal code related to drug use.

Contacting other services

In the Appendix there are details of how you can find other needle and syringe programs operating in your country or in a nearby country with a similar language.

The Central and Eastern Europe Harm Reduction Network has an email list in English where news and ideas are discussed and a regular newsletter published in English and Russian. This facilitates formal and informal contact between workers in harm reduction services in CEE/NIS (contact details are in the Appendix).

A number of needle and syringe programs have web pages which can be accessed from the Internet (for details see the Appendix).

3. Rapid situation assessment

Introduction

Before investing time and money in policy changes and interventions, it is essential to gain an understanding of the HIV and injecting drug use situation in your local area and to identify the:

- Nature of drug problems and the factors influencing them at a local level
- Adverse health consequences of drug use
- Resources that are or might be available to respond to drug problems
- Interventions which are going to be socially, culturally, religiously, politically and economically appropriate.

A proper assessment of these things should provide a solid foundation for starting a needle and syringe program.

If you are a member of a team where each individual has a specific role and specific responsibilities, then you may want to concentrate on those topics which are most important to your work. But it is important that all members have an overview of all the tasks which need to be completed.

In some locations the circumstances may warrant an immediate start of needle and syringe provision.

However, an assessment of the situation should first be carried out as it will improve both the program's effectiveness and sustainability. This is essential because drug use, and problems caused by it, are diverse and changing.

Because of this there is no single right formula for setting up a needle and syringe program: a proper assessment must be undertaken to enable services to be designed to match the needs.

Rapid assessment and response (RAR)

All modern societies are in a state of dynamic flux and change. In CEE/NIS with regard to drug scenes and HIV spread these changes are both rapid and far-reaching in their consequences.

Rapid assessment and response (RAR) methodology¹² is a set of methods developed by the World Health Organization and UNAIDS in conjunction with the Centre for Research on Drugs and Health Behaviour (UK).

RAR methodology enables you to undertake a rapid situation assessment (RSA) in order to understand and describe the extent and nature of the drug, health and social problems in a given area. It then helps you identify ways in which these problems may be addressed and appropriate services set up.

Rapid situation assessment (RSA)

Rapid situation assessment allows for quick understanding of drug problems that are emerging or rapidly developing and which may be linked with structural and economic features of the country.

The RSA is not an end in itself: it exists to effectively assist cities and regions design appropriate responses to the problems that exist in their area.

To carry out a RSA in your city or region, use the Rapid Assessment and Response Guide on Drug Injecting.¹² Copies of this guide are available in English and Russian from the Open Society Institute in your country or from International Harm Reduction Development in New York (see Appendix for details).

The key advantages of RSA that it is:

- Fast
- Cost-effective
- Relevant and pragmatic

and that it can:

- Use multiple indicators and existing data sources
- Establish an understanding quickly and then refine it in the light of further evidence
- Use the knowledge and opinions of a wide range of people.

Time is very important when tackling rapidly increasing social and health problems, such as HIV epidemics.

The spread of new patterns of drug use and associated problems may occur more rapidly than the time required to undertake conventional research.

A rapid situation assessment differs from traditional research in that it normally takes only a few weeks or months to complete.

It is designed to be inexpensive and is usually carried out by people who are already working in the field (usually practitioners such as narcologists, infectious diseases doctors and NGO workers) rather than researchers.

A single method or source of data cannot describe all aspects of a complex hidden social problem such as illicit drug use. An overview is therefore constructed using different methods and various data sources which individually may only offer a partial and incomplete description.

Existing sources of information are examined before undertaking time-consuming data-gathering exercises (such as surveys).

By using a range of investigative techniques, the RSA examines many different aspects of drug use and HIV infection in order to inform the program and enhance its effectiveness.

Another important feature of rapid situation assessment is that it allows conclusions and hypotheses to be validated or refuted through the collection of data, using a number of different research methods to cross-check results. This cross-referencing is known as 'triangulation'.

The RSA allows for quick understanding and then refinement in the light of further evidence because investigators work 'inductively'.

Inductive analysis works by establishing initial descriptions and hypotheses and checking them against information from a wide range of sources so that they can be confirmed, amended or rejected.

It differs from deductive scientific research in which all information is sought first, then analyzed and a hypothesis devised, on the basis of the full set of data.

Deductive analysis takes much longer to carry out and may be impossible as we may never know all of the data on hidden behaviors such as illicit drug use.

The value of seeking the views and knowledge of a wide range of people lies both in the fact that it begins to break down cultural or political denial of the existence of various drug use and sexual behaviors, and in that it seeks to gather an accurate picture of what is really happening by including drug users and injectors in the process.

The RSA is also an important part of developing local support for the project (see Chapter 2).

Questions a RSA can help answer

The rapid situation assessment will help you to gain an understanding of the:

- Current nature and extent of drug injecting
- Trends in injecting
- Social and geographical distribution of injecting
- Factors that influence the spread of injecting (or its potential to spread)
- Factors that influence the health consequences of injected drug use
- Prevalence of HIV, hepatitis B and hepatitis C infection, overdose and other adverse health consequences
- Sort of injecting and sexual-risk behaviors that injecting drug users are engaging in
- Required policy responses to drug injecting
- Interventions that are needed to reduce adverse health consequences of drug injecting
- Things that are already being done.
- Interventions that it will be possible to implement.

The RSA team

Rapid situation assessment is usually carried out by a team of between three and ten people.

The make-up of the team should allow for a variety of professional and personal perspectives to be used in discovering and analyzing the situation in a given area.

The team should therefore ensure that it is composed of both male and female members, with a wide age range and with different experiences and professional backgrounds.

A successful situation assessment requires the cooperation of many individuals and organizations in a city or region.

For this reason, the RSA team should assemble a list of potential allies who can assist them in gaining access to the necessary information and people so that the various assessment tasks are able to be carried out.

See Chapter 2 for advice on how to identify potential allies and develop support from the local community.

If the existing team does not have access to all the people or information needed, then time should be spent identifying new or different members to join the team.

At the time of writing, around 40 areas in the Russian Federation have completed rapid situation assessments.

Each RSA team was different, varying in size from two to ten people. Members came from a wide variety of backgrounds.

Usually at least one narcologist, one infectious diseases specialist, and one person from a NGO (often an outreach worker) was involved.

Many teams included ex-injecting drug users as members, and some included active injectors.

Some also included representatives from the city administration, sociologists, police, parents of drug users and youth organization or committee members.

It is important for the RSA team to decide how its members will work, both individually and together.

It is important to spend some time agreeing who will do what, where and when, the methods that are to be used, and how information from the team's allies and supporters will be coordinated.

RSA data collection

The team may collect a large amount of information. It is therefore important to Organize a proper filing system.

As you gather this information, you need to manage it carefully as it will soon become very difficult to find specific items if the information is simply piled together in a single file.

Allocate data management responsibilities to one or two individuals. This will allow a filing system to be created quickly, stop researchers filing materials in the wrong place, and allow important materials to be distributed among the RSA team.

The filing system should reflect structure of the final report: it should be divided into sections related to each assessment module. Files should be created which relate to key questions, topics, or information from key people.

Use summary sheets so that researchers can see quickly what information is included in a file.

The summary sheet may cover:

- Key findings
- The methods used to collect the information
- The date(s) on which data was collected
- Details of where and from whom data was obtained.

You need to be very careful with any information that could identify drug users or sex workers who have helped your enquiry. People outside the assessment team – including the police – may gain access (possibly without your knowledge) to the files.

It is recommended that files be kept in a secure place and that false names be used, and no address record kept, for people who could be hurt by disclosure of their drug use or sex work.

Compile an index so that researchers can quickly locate materials, identify gaps in the type of data collected so far, and prioritize areas for further research. This should be updated daily.

Examining existing data

After your team is assembled, your first task will be to consult existing information on HIV and drug use (especially injecting drug use) in your area.

Existing data sources may include:

- Official estimates of numbers of drug users, drug injectors and sex workers
- Number and type of arrests for drug-related offences and sex work offences
- Drugs seized, including analysis of drugs for purity and dilutants
- Drug-use surveys which have already been carried out
- Number and type of hospital admissions for drug-related conditions
- Number and type of admissions to detoxification centers (and waiting lists)
- Number and type of admissions to sexually transmitted disease clinics of injecting drug users (and those thought to have a history of drug injecting)
- Number of people on methadone and other drug substitution programs (and waiting lists)

- Number of known HIV infections among injecting drug users.

Collecting new data

During both the rapid situation assessment and the design and implementation phases of the needle and syringe program, the effective use of outreach methods can help you to find, and effectively communicate with, injecting drug users.

This will enable you to collect a great deal of new information about injecting drug use and HIV/AIDS in your city or region.

The main methods used to collect this new data are:

- Structured interviews or surveys
- Semi-structured interviews
- Observation studies
- Focus groups.

As these are all important methodologies they are addressed in detail below.

Interviews and surveys

An interview involves systematically asking questions of, and listening to, people who have the experiences and knowledge that researchers want to study.

Interviews can be held with individuals (these are often more suited to collecting in-depth information about sensitive issues) or with groups (useful for gathering contextual information about behavior).

Researchers must have:

- Knowledge of local meanings and an understanding of risk behaviors and their health consequences
- Good communication, facilitation and rapport-building skills
- The ability to ask effective questions and to use prompts where necessary.

Questions can be used that gather both fact and opinion.

Questions of fact can normally be addressed by asking closed questions that require a simple 'yes' or 'no' answer or selecting an answer from several previously defined categories, for example:

- Do you use condoms every time you have sex with your girlfriend/boyfriend? yes / no
- How many times a day do you inject? less than once / once or twice / 3 times / more than 3 times.

Questions of fact may also be used for clarification, to allow the researcher to check that they have understood what has been said, whether the response is typical of the person's experience and/or common to other people in the community, and to gather additional information.

Examples of questions of clarification include:

- Were you the only person there at the time?
- Do other people that you know also rinse their syringes with urine?
- Why wouldn't a fixed-site needle and syringe provision work here?

Questions to elicit opinions are usually open-ended questions which encourage the person to state their ideas and beliefs, for example:

- When is it OK to use a syringe that has already been used?

Hypothetical questions may be the most effective way of allowing the researcher to explore situations that the individual has not yet experienced or that are too sensitive to directly explore, for example:

- Let's say that you were able to obtain free condoms. Would this change your behavior?
- If someone wants to buy heroin in this city, where would they go?

Questions that require the person to rank things in order of importance can be useful in allowing the researcher to check the importance or significance of certain factors.

An example of such a question would be:

- In order of importance, what are your greatest fears when you are injecting in an alley?

Whether a survey or semi-structured interview is used, you will need to develop an interview guide.

For a survey, a questionnaire should be used; for a semi-structured interview, a list of the categories, areas, topics or questions that you wish to investigate should be prepared.

In devising an interview guide, it is important to identify appropriate topics and questions and decide on the level of detail you require in the answers. Then, draft the questions and place them in a logical order, as this usually produces better data.

Culturally sensitive questions may need to be addressed towards the end of an interview to allow sufficient rapport to be built up.

Interview guides should try to avoid questions which are:

- Complex or technical – instead, use clear and simple language
- Long or multiple – these can confuse participants and result in their only responding to the parts of the question that they can remember
- Leading – these may result in participants saying things that they think the interviewer will approve of.

Observation studies

Observation can be one of the most useful tools in a rapid situation assessment. Observation simply requires watching, listening and recording.

It may help to concentrate on specific aspects of a situation – normally this would be the most important activities or behaviors being displayed.

The observation may be extended, such as watching an open scene, or a brief glimpse of what is occurring in a specific neighborhood. It may be a planned event such as injectors demonstrating for researchers how they prepare and inject drugs.

The things that might be recorded in an observational study include general observations on:

- Setting – where and when the observation took place, the physical layout, etc.
- Activity – what was happening, and the activities people were involved in
- Event – is this a regular occurrence or is it a special or unusual event?
- The connections between people – how well the people present know one another and the nature of their relationship whether it is social or organised on a commercial basis

and specific observations of:

- People – who was present, what they were doing, why they were there, their age, etc.
- Signs or 'clues' which could provide evidence about meanings and behaviors
- The time, how long things take and in what order they happen
- What people were trying to accomplish.

Focus groups

Focus groups are another important method for generating a lot of useful information quickly and for identifying and exploring beliefs, attitudes and behaviors.

A focus group is a number of individuals who are interviewed together because they have a particular expertise or knowledge relevant to the RSA.

This knowledge provides a focus for discussion or may be used to categorize individual beliefs on a particular topic. The individuals in a focus group need not know one another, although they may do so.

You may need to find key member(s) of the group to be researched to help recruit participants for the focus group.

A focus group is not the same as a group interview.

Focus groups encourage individuals to discuss and explore questions among themselves.

The researchers use this discussion as data. Focus groups are small and usually consist of no more than 6–10 people.

To run a successful focus group you will probably need to provide a:

- Location that is neutral, comfortable, accessible and free of interruption
- Reward to attract participants (e.g. food)
- List of questions or topic areas
- Tape recorder, extra batteries, tapes and labels (optional)
- Blackboard, whiteboard or paper and pens
- Moderator to take part in the focus group and encourage participants to talk about interesting and relevant issues
- Note-taker to observe and record significant verbal and non-verbal details.

Estimating the number of intravenous drug users

It is important to ensure the rapid situation assessment includes some figures that refer specifically to the number of injecting drug users.

This estimate is essential because these are the people who are at most risk, and the ones who you will be trying to attract to a needle and syringe program.

Knowing how many people in the city smoke marijuana or sniff glue may be interesting, but it is not important for designing a needle and syringe program.

However, it is also one of the most difficult aspects of the situation assessment to get right.

The two most commonly used methods to arrive at a reasonable estimate are:

- multiplier techniques
- 'capture–recapture' methodology.

These are explained below.

Multiplier techniques

Multiplier techniques work by making informed assumptions about the proportion of people in a studied population who experience an event in a particular time period (such as an overdose, imprisonment, death) – this is the multiplier – and a benchmark number of such events that are known to occur.

For example, the multiplier might be a number derived from a sample survey in which 20% (one-fifth) of all injectors interviewed said they had been in contact with drug treatment services last year.

The benchmark might be the number of people who have been in contact with drug services in the past year. This number could be accurately calculated, for this example the benchmark figure is 3000.

Using the multiplier (5) and the benchmark (3000), the overall drug-using population size could be estimated to be:

$$5 \times 3000 = 15,000.$$

Capture–recapture

The capture–recapture method involves identifying or ‘capturing’ a sample of drug users who are ‘marked’ in some way (e.g. drug users who are arrested in a given week) to form group n1.

Subsequently, a second sample is identified or ‘recaptured’ in the same way to form group n2.

The number of people from group n1 in the group n2 is calculated and forms group m.

The ratio of people in group n1 to the recaptured sample size can be assumed to be the same as the ratio of the first captured sample to the total population.

This is expressed as:

$$(n1 \div m) \times n2 = \text{total population}$$

Example of capture–recapture methodology

In Dhaka, India, researchers wanted to estimate the total population of street-based sex workers using capture–recapture methodology.

Key members of the group to be studied were recruited to distribute a set of cards containing details of local services and safer sexual practices to each sex worker they contacted during a 24-hour period.

One hundred cards were given out and this represented the first ‘capture’ group, n1 = 100.

Seven days later the same people went to the same site and repeated the exercise. This time they distributed 80 cards. This represented the second ‘capture’, n2 = 80.

As they distributed the cards they asked the sex workers if they had received a card previously; those that said ‘yes’ (20) were the recaptured sample, m = 20.

From this, researchers calculated that the total number of sex workers in the area was:

$$(100 \div 20) \times 80 = 400$$

RSA data analysis

Having collected the data, your RSA team needs to analyze it in order to write a report.

It is important to analyze and present the data in a way that allows others to trust and understand the importance of your findings. Where possible, individual findings should be supported through cross-referencing and 'triangulation'.

For example, you may find from interviews that 40% of injectors report that a friend has overdosed in the past 12 months, from newspapers that ambulance drivers are concerned at the number of overdoses they are called to and from the coroner's office that there is an official report showing an increase in overdose each year for the past three years.

All three data sources confirm that overdose is a large and increasing problem.

The RSA report

Once the analysis is completed it can be assembled into a full report.

This should not only describe individual findings, but also how the findings were made and how they were checked through cross-referencing information or 'triangulation'.

The report should have an executive summary containing the key findings, which will usually include:

- An estimate of the number of injecting drug users in the city or region
- The most significant data on risk behaviors such as needle and syringe sharing and unsafe sex
- Key recommendations.

The completed RSA report – and in particular the executive summary – can be used for a variety of purposes, including persuading people to support the recommendations.

The full assessment and/or the executive summary should be sent to:

- Everyone who has participated in their production
- Potential allies of the needle and syringe program
- Anyone who may have the power to assist in the implementation of the program.

As discussed in the previous chapter, the report will play a key role in the task of developing support for the service.

4. Service options

Introduction

From the information gathered by your rapid situation assessment, you will be able to start to determine what type of needle and syringe provision is most likely to prevent the spread of HIV among injecting drug users in your area.

The first question you need to ask is how can the program attract as many drug injectors as possible to its services.

This chapter looks at the service provision options that are available to you and how to design appropriate services to match the equipment and information needs that were established in your rapid situation assessment.

There is nothing mutually exclusive about the ways of working that are described in this chapter. Indeed there are many examples of programs mixing models of service provision using, for example, one fixed site and two outreach services, or a bus and two fixed sites, to provide a comprehensive service to injectors in their area.

Types of needle and syringe program

There are three basic types of needle and syringe program:

- Fixed site – a specific place that injectors can come to collect and dispose of injecting equipment
- Mobile services – using a van or bus, usually with a regular route and regular hours of stopping in several locations
- Outreach/backpack – in which workers travel through the streets or other areas (such as apartments), distributing clean needles and syringes and collecting used injecting equipment for safe disposal.

There is another 'type' of needle and syringe provision, known as activist or 'illegal' needle and syringe provision. These programs have been set up in countries such as the USA which still have laws restricting the provision of injecting equipment and/or advice to injecting drug users.

Each of these types of needle and syringe provision are described in detail on the following pages, with a description of:

- How the services operate
- Reasons for setting up that type of service
- Key planning issues
- Examples of services set up in that way.

Fixed-site services

Of the service options available, fixed-site needle and syringe programs have the fewest organizational difficulties.

The environment of a fixed-site service can be designed to ensure that it is friendly for service users, that staff safety is assured, and that needles and syringes have adequate storage space. It is also easier to offer additional services such as health care, testing for HIV and hepatitis, counseling, etc.

At its best, the site will have different rooms for each of the services offered. Fixed sites are often converted ordinary offices or shops and have a reception area at the front and offices behind.

The reception area can be used as a drop-in social area and for giving out new – and receiving used – injecting equipment, and the rooms behind can be used for storing injecting equipment, counseling, medical assistance, individual and group education staff meetings, etc.

Reasons for setting up a fixed-site needle and syringe program

Fixed-site services are usually set up in response to assessment findings that there is either a fairly open drug scene and/or a large number of injecting drug users in one part of the city.

For instance, if your rapid situation assessment finds that about 10% of the city's 2000 injecting drug users come into an area every day, but that they are in touch with another 30–40% of the city's injectors – you may decide to establish a fixed-site needle and syringe program in suitable premises, such as an old storefront, near to this part of town.

Ideally such a service would be open every day during the period when most drug users are in the area.

Another key factor in a decision to begin with a fixed site may be the availability of space and/or staff in an existing facility.

If this is the case, the issues of accessibility and appropriateness discussed below must be considered carefully.

Key planning issues

Location of any fixed-site needle and syringe program must be convenient, and drug users must feel comfortable about visiting it.

Where and how large the site should be will depend on the results of your situation assessment, which will give you details of the:

- Numbers of people you expect to visit the service
- Districts where injecting drug users live and buy/sell drugs
- Availability of transport (public and private) in your city or region
- Population density
- Services you are able to provide and the number of staff and volunteers you intend to employ.

When considering premises for a fixed-site needle and syringe program, you should look for somewhere that is big enough to house all the services you are going to offer.

A lockable office is needed where reports can be written and the computer, files, cash and other important equipment can be kept. Although many services also use the office for counseling or medical services, this is often inconvenient and causes tension and stress for the staff.

There must also be a lockable store room for the items being dispensed (needles, syringes, condoms, leaflets, etc.) and used needles and syringes.

A further two or three rooms would mean that injecting equipment could be dispensed in more privacy than is possible in an open reception area, and counseling and that health advice could be done in a room with no risk of interruption.

Access is the other major feature of fixed sites that needs to be considered at the planning stage.

Over the years, needle and syringe programs have started in strange places. One opened in anonymous rooms on the third floor of a huge hospital, with no signs, so that drug users had to ask several security guards and nurses where it was.

Such obstacles tend to ensure that drug users do not return to the program and, worse, tell their friends about their experiences, preventing others from visiting.

Access to the service needs to be as simple and quick as possible. Especially at first, injecting drug users are often understandably suspicious about the program, so they will often want to get in and out as quickly as they can.

Once they become more used to the process, and the staff, there will be greater opportunities for interaction, education and provision of other services.

Examples of fixed-site services

In Klaipeda (Lithuania), the needle and syringe program opened in October 1996, one month after the first HIV-positive injecting drug users were identified in the city.

It was started in the city's Addiction Treatment Center, but it was difficult to attract injectors to this location. For six months very few people used it.

So, in May 1997, a separate drop-in center was started in the north of the city, which attracted 450 drug users during the next 18 months (about 10–20% of the estimated number of injecting drug users in the city).

Drug users who attend the drop-in center receive needles and syringes, information and education on less risky injecting, safer sex and healthier lifestyles. The drop-in center has been so successful there are now plans to open another one in the south of the city.

In Prague (Czech Republic), the drug treatment organization, Sananim, operates a contact center to attract injecting drug users in to receive injecting equipment and assistance.

It provides free coffee, showers, laundry facilities, psychological help and referral for drug treatment, assistance with identification cards and referral to a NGO which provides services for homeless people and medical services, including a gynecologist.

The organization also publishes the drug user newsletter Dekontaminace, with writing and graphics by drug users.

The ANKORS needle and syringe program in British Columbia (Canada) includes four fixed sites, as well as a mobile needle and syringe program that makes scheduled stops at selected sites along five routes to provide a service to significant numbers of injecting drug users who live in more isolated parts of the region.

ANKORS initially provides a 'needle exchange kit' to people making a first visit. The kit includes a small number of syringes, a small bottle of bleach for syringe disinfection, alcohol wipes, and a safer-injecting pamphlet. Subsequent visits allow the service's users to exchange dirty needles for clean ones.

Mobile services

Mobile needle and syringe programs normally work from a van or bus.

The vehicle can range in size from a van in which there is a driver in the front and a worker who provides and collects injecting equipment through a door or window at the back, to services which use entire coaches and are more like a 'fixed site on wheels', with a needle and syringe provision at the front and counseling, medical and other rooms at the back.

A mobile service is often more expensive than using a fixed site because it usually involves the purchase and maintenance of a van or bus (a major expense) in addition to office and storage space (as these functions cannot normally be done inside the vehicle).

Mobile services also need secure garaging (to prevent theft, vandalism and attack), fuel, money for maintenance and repairs to the vehicle, insurance and, of course, a driver.

However, these problems can all be solved and mobile services can be extremely useful in certain circumstances.

Mobile services are often easier for local residents to cope with and can prevent, or overcome, opposition focussed on a fixed site, although some may still protest against a needle and syringe program of any type in their area.

Reasons for setting up a mobile needle and syringe program

If your rapid situation assessment finds that there are several geographically distant areas with concentrations of drug users, you are not necessarily faced with a choice between starting two or more fixed-site services (which is often done in very large cities) and a mobile service.

Sometimes mobile services are set up in conjunction with fixed sites. The fixed sites operate in areas close to a large number of drug users and/or with good public transport links, and the mobile unit travels from there to the areas with smaller numbers of drug users.

An example of how a decision was made to set up a mobile service comes from Skopje (Macedonia).

It became clear that the geography of the city and poor public transport were making it difficult for many injectors to access the fixed-site needle and syringe program. This was made worse by police harassment of clients on their way to or from the program, which further discouraged them from accessing it.

The initial response to these problems was to establish an outreach team using active drug users. However, these outreach workers were also regularly harassed by police and found it difficult to carry clean equipment to clients or to return to base with used equipment.

In addition, the intense fear generated among injectors by these police activities put the outreach workers at risk of attack – because of the mistrust the drug users felt towards anyone approaching them. These factors led to a proposal to begin a mobile service in the city.

Key planning issues

There are a number of issues which need to be given careful thought before starting a mobile service. The vehicle is clearly a major planning consideration.

It should really be large enough for two members of staff to sit comfortably in the rear to give out and receive injecting equipment – this is even more essential in cold climates. The sort of vehicle chosen will depend on a number of factors:

- Available funds
- The existence (or not) of other services
- The numbers of people to be served
- The services you need to offer from the vehicle
- Garaging facilities available.

The schedule must be realistic, allowing for traffic and other delays and be carefully planned to take into account such things as times when drug users are likely to use the service.

The schedule should also allow for routine maintenance of the vehicle to keep it in perfect running order, as any breakdowns will leave people without injecting equipment and with reduced trust in the program.

Drivers must be well trained to drive the vehicle, both in the interests of staff and public safety and because even a small accident requiring repairs can disrupt service provision.

Arrangements must be made so that the van can be restocked from lockable, and accessible, store rooms. Office space and administrative support will also probably have to be arranged.

Examples of mobile services

In Volgograd (Russian Federation), a fixed site is augmented by a bus which serves three networks of drug users who live far apart in this city by the Volga river which is 40Km from end to end.

The St Petersburg (Russian Federation) needle and syringe program bus is run by the Voзрастcheniye Foundation. It is specially built to provide a range of services.

Drug users enter through a front door where a booth has been set up with built-in bins that hold needles, syringes, condoms and other equipment as well as a large bin into which drug users place their used needles and syringes.

As they wait, clients can look through many different leaflets which are on display in a rack, taking them away if they wish.

If they want to receive confidential psychological counseling, the bus has a comfortable counseling room and, if medical care is needed (usually treatment for abscesses or other injecting damage), there is a fully equipped medical room. Both rooms are accessed from a central passageway.

The bus is parked in three different areas of the city on different days. The schedule is regular so local drug users know which days and for what hours the bus will park in their area.

One of the first legal needle and syringe programs in the USA was at New Haven, Connecticut, near the site of Yale University.

Because New Haven is a spread-out city, it was decided that a small van should be used to provide mobile access to injecting equipment. The van had two staff on duty at any one time – mainly for safety reasons but also to ensure that workers had someone to talk to while they were waiting for clients.

When the program began operations, each client would enter the van, be seated, answer a set of questions (the program was also part of a research project), give their used equipment, receive needles and syringes and leave.

If the client wanted assistance with any other service, they were advised to go to a centrally located clinic which had been established to help drug users with psychological, social and medical problems. The clinic served as a base for the project, providing office space, a room for meetings, storage for injecting equipment and garaging for the program's van.

Chicago Recovery Alliance (USA) has a combination of mobile sites mostly serviced by a large van, two fixed sites, and four areas where injectors can access clean injecting equipment by contacting outreach staff who have a pager and mobile phone.

Outreach services

At its simplest, outreach involves a person taking a backpack or bag in which there is new injecting equipment, a puncture-resistant bin for carrying used needles and syringes and perhaps some leaflets and going from one apartment where there are injecting drug users to another.

Outreach is so called because it involves a journey into the community to make contact with a network of drug users to see and understand their practices, to gain their trust and to seek their help in preventing HIV transmission.

Outreach has been used in virtually every country where needle and syringe programs have been established. This is because injecting is often largely hidden (even in areas where aspects of drug use are visible there is usually much more that is unseen) and stigmatized.

Outreach methods are therefore often needed to assist the researchers at the rapid assessment stage in uncovering the hidden activities of injecting drug users and to enable the needle and syringe program to reach the groups at risk.

Of the three forms of needle and syringe provision, the outreach/backpack is probably the easiest to start – but it can be difficult to maintain.

The issue of good practice in outreach work is discussed in detail in Chapter 8.

Outreach work with injecting drug users can include a wide range of tasks such as:

Making and maintaining contact with injectors

- 'Snowballing' – the use of existing contacts to introduce and recruit new people to the study or service
- Collecting information on what is going on, what drugs are used, what injectors see as their greatest problems and needs, etc.
- Providing advice and education, for example where to find medical help or anonymous HIV testing
- Referral to other services such as drug treatment agencies, etc.

- Prevention information about health, safer drug use, overdose, safer injecting, safer sex, etc.
- Collecting information so that other services and organizations can be informed about the circumstances and needs of drug users.

Reasons for using outreach

You may decide to use outreach methods to deliver the services if a rapid situation assessment finds, for instance, that:

- Most injecting drug users inject in apartments
- Police efforts are making drug users afraid to congregate
- The population of drug users is spread across the city.

Absence of funding can also be a factor: where little or no funding is available, some needle and syringe programs – including activist needle exchanges in the USA – have decided to begin with an outreach service.

Outreach has also been used in cities such as Kathmandu in Nepal and Calcutta in India where there are small groups of drug injectors in many different parts of the city, and no open drug buying and selling scene.

Often outreach services are set up to complement the work of fixed-site or mobile exchanges when it is apparent that there is a number of injectors who are not making use of the service.

Outreach workers can then go out and make the contacts, and hopefully encourage people into more comprehensive services.

Key planning issues

The advantages of starting an outreach needle and syringe program are obvious: it can be started quickly and at low cost by a very small number of people, or even by one person.

However, there are potential problems and disadvantages that need to be taken into consideration.

The main disadvantage is that an outreach needle and syringe program, by itself, can only be of limited effectiveness because of the limited opportunities for education and other services that occur when transactions are brief and take place in public or non-confidential settings.

Also, additional precautions are needed to ensure the safety of outreach workers, both from some service users and from police.

As discussed above, outreach/backpack services should usually be considered as an adjunct to other services such as a fixed-site or a larger outreach program. Where this is not the case, most outreach needle and syringe programs at least have an office in which there are computers, equipment to make leaflets, storage areas for new and used syringes and so on.

If possible, this should be in a place both where the outreach workers can receive support from other staff and be geographically close to the main areas in which they are working.

Examples of outreach services

The Lower East Side Harm Reduction Center in New York (USA) has a storefront needle and syringe program that is open six days a week for three hours each day, as well as special women-only hours. They provide many other services, including:

- Auricular (ear) acupuncture to assist detoxification six days a week
- Full-body acupuncture twice a week
- Yoga and Qigong classes weekly
- Men's and women's HIV support groups
- Open discussion groups, health groups
- Counseling about drug use
- A mobile medical van for young people on the city's streets.

Outreach needle and syringe provision occurs three times a week, and includes a night-time sex-worker outreach service.

In Pskov (Russian Federation), a group of four to five outreach workers from the city's AIDS Center work in injecting drug users' apartments.

The outreach workers also refer clients to the AIDS Center for hepatitis B vaccination, testing for HIV and hepatitis, and free anonymous medical services.

The Lifesaving and Lifegiving Society (LALS) in Kathmandu (Nepal) was established in 1991 as the first needle and syringe program in Asia run by a non-government organization.

LALS has 20 full-time workers, including 10 community health outreach workers who regularly visit 750 drug users in many areas of Kathmandu, providing injecting equipment and assisting drug users with health and medical issues, housing problems, drug treatments, HIV testing and treatment, etc.

In Odessa (Ukraine), as well as providing written information, volunteers try and talk to all service users about safer injecting and safer drug use, as well as offering counseling and help with other problems.

At the outreach sites, the climate (especially during the cold winter), stress from the streets, and the absence of coffee, tea and privacy mean that it is much more difficult to raise these issues than it is at the drop-in centers.

Communication during outreach is often minimal and frequently limited to referral advice when further treatment or counseling is needed.

Activist or illegal service provision

In this type of program a group, usually comprised of health professionals, ex-users, drug users and/or others, decides – usually in the face of intractable opposition – to defy laws against needle and syringe provision by setting up illegal, ‘underground’ needle and syringe programs.

In the USA, if volunteers from the needle and syringe program are arrested, they plead not guilty to any charges and demand a trial at which the issues of the program’s role in HIV prevention can be discussed, in the hope that media coverage will put pressure on politicians to allow them to operate legally.

This type of program is not discussed in detail here because most countries in the CEE/NIS have no laws against the purchase of needles and syringes, and because most needle and syringe programs have been able to establish themselves legally.

5. Staffing issues

Introduction

Staffing of the needle and syringe program will be central to its success or failure in recruiting service users and giving them the correct advice and information.

Staff may also have a key role to play in maintaining support and respect from other individuals and institutions and supporting each other.

In this chapter the key issues of who should work for the program. The issues around employing paid staff and volunteers, working with active and ex-drug users, job descriptions, recruitment, management and training are all discussed in detail.

The following guidelines are designed to help services get the best out of their staff, provide the best quality service and keep staff turnover to a minimum.

Deciding who should work for the program

Decisions about who you should employ need to be based on an understanding of the local situation, the ability of your organization to employ people from different groups, and what you believe will achieve the most effective results.

You will need to consider how many staff will be needed to operate the project and whether they should be paid or volunteers or a combination of both; and whether they should include non-drug-using staff, current drug users, ex-drug users or a combination of these groups.

Staff costs are often a major component of expenditure, so it is important that staff numbers are minimised, and that few paid staff are involved solely in management as this can often largely be done by people employed at other services, with one person responsible for the day-to-day management of the program.

Paid staff or volunteers

There are advantages and disadvantages to paying needle and syringe program staff.

From the organization's point of view, paying staff adds considerably to the fixed costs of the project.

However, most needle and syringe programs have found that it is difficult (or impossible) to offer an effective service staffed only by volunteers.

The minimum requirement is usually that the service at least has some paid management/coordination.

There are other issues to be considered. On the one hand, paying drug users and ex-users can show that they are a valued and competent member of the HIV prevention team but, on the other hand, payment – in particular of current drug users – can undermine worker credibility and separate them from the networks of (largely) unpaid drug users.

In practical terms, people with no other means of support – including drug users and ex-users – are unlikely to be willing or able to survive and keep working without some payment.

However, in some countries and some institutions, it is impossible to employ active drug users as full staff members.

In addition, needle and syringe programs which have moved from voluntary to paid staff have often found that this increases commitment and work from their staff.

The management of the project needs to weigh up these (and possibly other) factors before deciding on the mix of paid staff and volunteers to be recruited. Most services in the CEE/NIS region, and throughout the world, have a mix of paid and volunteer staff.

For instance in Nikolaev (Ukraine), in 1998, a needle and syringe program started by the charity foundation, Blagodunist, employed a total of 32 people to cover their fixed-site and mobile unit.

Twenty-eight were volunteers who received no salary and there were four salaried staff. Before beginning the program, salaried staff had internships in St Petersburg and Poltava.

Active drug users, ex-users and/or non-users as staff

Another important question is whether or not active drug users and/or ex-users should work for the service.

Active drug users are likely to:

- Be part of the 'drug scene'
- Know where drug use is happening and who is involved
- Be aware of the rules, rituals and other behaviors being practiced
- Have frequent contact with other drug users.

However, the demands of being an active drug user may leave little time to do anything else.

Commitment to working for the needle and syringe program may be impossible due to time demands and unfamiliarity with work norms (e.g. working hours, need for reliability, etc.). In addition, drug users may also be too involved with their peers to address difficult issues such as unsafe injecting or sexual behavior.

These issues can be resolved through employing people who are stabilized on methadone or other substitution therapies (where these are available), and through training and support of the right people.

Ex-users may be more capable of working within typical work structures and can serve as role models for what drug users can aim for (having a job, being acknowledged as an expert).

They can draw from their experiences to help current injecting drug users modify unsafe behaviors, and often have established relationships with the drug treatment system. They may therefore be able to provide advice and referral on treatment as well as build support in treatment agencies for the needle and syringe program.

However, there can be difficulties. Ex-users have, by definition, stopped using drugs so their knowledge of drug-using practices may be out of date and they may have less access to drug users and drug-using locations than active users.

The issue of their personal safety is also important: the constant exposure to drugs and drug users, added to the stresses and strains of the work, can lead to relapse into drug use unless precautions are taken. In particular, they need adequate personal and professional supervision, and a management structure that has contingency plans in place to respond positively to this potential problem.

Furthermore it cannot be assumed that ex-drug users will be empathic and non-judgemental towards current drug users. The realignment of attitudes towards drugs and drug users that they have had to undergo to get, and stay, drug-free can leave them with a harsh, judgemental attitude to current drug users.

This may be important – indeed central – to their own struggle to stay drug free but can lead to conflict, mistrust and credibility problems when they try to communicate with active users. It may not be possible to resolve these problems through training and supervision.

Non-users can be effective needle and syringe program workers, but to do so they may have to overcome mistrust and prejudice from the client group.

If they come from a professional background such as social work, psychology or sociology they may well bring valuable training and knowledge which can assist the program team to work well.

Many programs employ a mixed group of active drug users, ex- and non-drug users.

A mixed group can bring many advantages, including the sharing of ideas, increasing mutual respect and balancing out the differences that they each might have. However, the fact that different groups are working together may be a source of conflict.

People may have different interests and priorities, and there may be problems around status between ex-users and active users or volunteers and paid staff.

The careful and sensible division of tasks with, for instance, drug users doing street outreach and non-users having roles such as liaison with the police and city officials, team management, training, supervision, etc. can help to maximize the benefits and reduce conflict.

Examples of staff mix

In Sofia (Bulgaria), the needle and syringe program work is usually done on foot at parks, cafes and other specific points in the city where drug injectors gather. A team of two paid workers is always used, together with volunteers who are usually either ex-users or current injecting drug users.

In Szeged (Hungary), a group of active drug users and social workers are paid as outreach workers to visit parks, pubs and apartments where injecting drug users meet.

In Odessa (Ukraine), two fixed-site needle and syringe programs operate daily from 9am to 7pm. As well as providing injecting equipment there is distribution of condoms and information on HIV and other infectious diseases.

The centers are staffed by teams of three or four volunteers, who work in shifts. There is at least one drug user and one medical professional on each team.

Workers' job descriptions

Before appointing staff you will need to map out job descriptions for the paid staff and volunteers.

Obviously these will be flexible, but they need to be detailed enough to enable applicants to be clear about what it is you are asking them to do, and to help you draw up a list of necessary and desirable skills for the people you interview.

The program manager/coordinator

Management and coordination of the needle and syringe program will be crucial to its success.

However this is organized, the person in this position will need adequate professional and personal support in order to cope with what will probably be a stressful and demanding job.

The manager will need to have knowledge and skills in the following areas:

- Harm reduction
- Viral transmission
- HIV/AIDS and other relevant health issues
- Promoting safer injecting, drug use and sex
- Outreach work
- Staff management, training and supervision
- Local service provision
- Communication and planning.

It may be possible for a person with a thorough grounding in management and the right attitudes to be given a comprehensive induction program that will enable them to manage staff who have knowledge and experience of working with drug users.

The manager/coordinator may well start work before the service opens to take on the numerous administrative tasks, such as drawing up job descriptions for workers and volunteers and being involved in the selection and interview processes.

The job description for the manager or coordinator of the program, in addition to many of the items from the program worker job description below, will probably include:

- Day-to-day management of employees' and volunteers' workloads
- Staff and volunteer recruitment and training
- Monitoring all aspects of service quality
- Management of project funding
- Facilitating project development to defined targets and goals
- Collecting relevant literature
- Personal support of workers
- Facilitating team meetings and other aspects of team/organization
- Representing the organization at meetings.

Needle and syringe program workers

All job descriptions should cover the organizational details of the job such as the:

- Hours to be worked
- Payment (if any) that will be made for the work

- The place(s) of work and the person's base
- Positions of the people to whom the worker reports and is responsible.

It should also describe the specific duties to be undertaken.

The following example of duties is taken from the New South Wales (Australia) Needle and Syringe Exchange Policy and Procedures Manual²⁰ which states that 'all needle and syringe program workers, working under the direction of the project manager, have the following duties:

- Make contact with injecting drug users and supply them with sterile injecting equipment and associated items, safe disposal containers, condoms and lubricant and educational pamphlets.
- Receive from clients, and collect in other ways, used injecting equipment and safely transport and dispose of it.
- Provide information and education to clients on all matters relating to safer drug-use, safer injecting practices, the transmission of infection through sexual and drug use behavior, and the means by which the risk of infection can be minimized or eliminated.
- Provide, upon the client's request, appropriate referrals to other health, welfare and community agencies.
- Participate in the planning and implementation of publicity, promotional and community education activities.
- Assist in the collection and collation of statistics, preparation of evaluation reports, correspondence and other administrative tasks.
- Devise, implement and research new strategies to maximize the effectiveness of the service.
- Staff may also be required to attend meetings, training courses and other activities as directed.
- Train and supervise staff in secondary needle and syringe programs.
- Liaise with police, government departments and community groups.
- Assist in ordering goods, maintaining levels of stock and/or managing the program budget.

Volunteers

In order to fully integrate volunteers into the organization, they too should have job descriptions covering the:

- Organizational details of the job – how many hours they are expected to work, etc.
- Remuneration (if any) that they will receive – such as travel expenses
- Tasks they may be asked to carry out
- Training they will be given/expected to attend
- Supervision they will be given/expected to attend.

Staff recruitment

After you receive funding or appropriate support, and are clear about what you want staff to do and have job descriptions prepared, you can start the process of actually recruiting staff and volunteers for your needle and syringe program.

You may want to make a profile of the essential and desirable attributes you require in your staff. This may include them having:

- A positive attitude towards drug users
- An open attitude to unfamiliar situations
- Knowledge and experience of drug use
- Knowledge about harm reduction, safer drug use, HIV/AIDS and other services for drug users
- The ability to work in an unconventional job
- The ability to control their own drug use
- A suitable level of maturity and emotional stability
- The ability to contact and communicate with the target groups
- Counseling skills
- Office and record-keeping skills.

Examples of staff and volunteer recruitment

In Vilnius (Lithuania), a coordinator was hired who assisted the needle and syringe program organizers to write job descriptions for all the staff.

Potential volunteers from the city's methadone program were assessed and six were selected for a six-session training course. The coordinator was also trained at an international training workshop.

In the process of starting the program, three volunteers were asked to leave. Two were unstable, unreliable and behaved inappropriately and there was a request from the city drug squad to stop employment of a third volunteer due to his involvement in producing and selling drugs.

Chicago Recovery Alliance (USA) uses a structured program to recruit and train volunteers at its needle and syringe program sites.

Volunteers are found through:

- Discussing the idea with clients
- People visiting the Recovery Alliance's informative exhibits at fairs and other gatherings
- People attending their training events
- Recruiting co-workers, friends or family of current volunteers and people who live and/or work in the neighborhood of the particular site
- Advertisements placed in local newspapers
- Volunteer facilitation offices or other appropriate personnel of local schools, social service agencies, and
- community groups.

Staff and volunteer management

Management is probably the key issue in the performance of needle and syringe program staff and affects how well they cope with the work and the length of time that they remain with the organization.

Needle and syringe program work can be very difficult and stressful: volunteers or paid workers may be misunderstood and abused by members of the public, their family, police and even drug users.

If the program workers are paid, they are usually not paid as well as many other people in society.

These factors often contribute to a high rate of staff turnover in needle and syringe programs.

This can cause major problems as each staff member or volunteer leaving means that the organization has to find and train a new person and rebuild relationships with service users.

However, needle and syringe program work can also be very rewarding. A strong sense of pride can be developed within organizations about the work being done, as can a sense of teamwork and mutual support.

Staff are by far the main asset any needle and syringe program has, and they should therefore be encouraged, supported, and treated with respect.

Communication

One of the most important factors in the successful management of people is communication.

There should be established formal and informal mechanisms by which information is shared between the program's workers, volunteers and management.

Team meetings should be held regularly – usually weekly – at a time and place where all team members can attend (even those working shifts or weekends).

Meetings should have a clear agenda and be chaired or led to ensure that all important information is covered and that the team does not become tied up in long discussions on irrelevant issues.

All staff should be encouraged to speak (one at a time) and to discuss any problems they have found in their work or any information they think the others should know. New ideas, services, agencies for referral and changes to the program should also be discussed fully.

These meetings can also be used as the venue for training sessions as well. A staff member or guest speaker can share their expertise on a particular subject by giving a short presentation and having a question and answer session with the team.

Supervision

Supervision should include regular individual sessions of discussion between the supervisor (usually the program manager) and each member of staff.

These meetings should be supportive and cover regular review of their:

- Performance
- Areas of practice that need improvement (if any)
- Training needs
- Relationships with, and feelings towards, individual clients
- Feelings about their work
- Career plans.

Where staff have a current or past history of drug use, supervision may also include:

- Impact of the work on their drug use/abstinence
- Health issues
- Nutrition and basic medical condition.

Because of the nature of the work, and the variety of staff who may be supervised, supervision may also need to cover:

- The impact the work is having on
- the worker's life outside and
- social relationships
- Financial and housing problems
- Personal problems that may impact on the work.

Training

Training and professional development can reduce staff turnover by demonstrating that the organization values them and by reminding workers of the value of their work, and the fact that the program is saving lives and preventing HIV infection.

Professional development is important both for keeping staff and for ensuring adequate management expertise exists for expansion of the program or to replace senior staff if they leave.

Recognition and avoidance of burnout should be the subject both of regular supervision and training sessions.

Volunteer training, in particular, should be highly structured and focused on producing high standards of work – especially if it involves active or ex-injecting drug users.

It should ensure that volunteers understand what they are being asked to do, and that they feel valued by, and important to, the program.

Staff induction

A modular induction program should be drawn up which all new staff must complete.

The first module would normally have to be completed before any clinical work could be done, with further modules having to be completed within a given time period – usually the first three months of employment.

Initial staff training should include:

- Factual information on promoting safer injecting, etc.
- Skills development
- Information on the organization
- Introductions to the other organizations the needle and syringe program works with.

Areas of factual information to be covered should include:

- local relevant information, including local practices of drug preparation and injecting
- Viral infection routes, risks, risk behavior
- Uses of, and transmission risks associated with, every item used in drug preparation and injecting
- The HIV test procedure – pros, cons and limitations
- Basic medical information on infections and treatments
- The anatomy of the circulatory system (to understand the relevant risks of different injecting sites)
- Drugs and drug use and available services.

Skills development should also be included in the staff induction course to ensure competence at:

- Contacting, communicating with and counseling injectors
- Pre- and post-HIV test counseling
- Promoting safer behavior
- Handling and disposal of contaminated injecting equipment
- Dealing with actual and potential aggression and violence.

Information on the organization should include:

- Professional attitude to work and attitude towards drug users
- Boundaries between professional and personal activities
- Confidentiality policy
- Goal setting, work management and planning
- The organization's short- and long-term goals
- Exchange of information in the team
- Record keeping
- Evaluation of achievements
- Time management.

Example of a volunteer training program

Chicago Recovery Alliance (USA) uses a structured program to train volunteers at its needle and syringe program sites.

The first phase is for volunteers who have expressed an initial interest in working for the program to visit one or more sites to observe the program's work in action. This serves as a low-pressure opportunity to get to know about the program without any commitment.

Chicago Recovery Alliance feels that under these circumstances a person can make the best choice as to their level of interest in further participation as a volunteer.

Typically, this informal contact leads to an appreciation for the work and either a willingness to join the team or the insight that the person is not ready to join this work at this time.

If it is agreed that the person should work with the program they enter a formal training phase – this is a period of acquiring knowledge and skills at performing the functions required at the outreach sites.

An individual assessment is made of each volunteer's ability, experience and interests. The content of their training course is based on this background.

Trainees are assessed on the basis of objective measurements of knowledge and observed practice which enables both the volunteer and organization to know when they have the knowledge and skills to work with service users.

This philosophy goes beyond the initial course and addresses the issues of volunteer support and growth.

The Chicago Recovery Alliance involves volunteers in many aspects of the needle and syringe program's work as well as social functions, ensuring that volunteers are offered further training and assistance to gain work.

They also ensure that all volunteers are told of any staff positions that become vacant.

Ongoing training

Staff training is an ongoing process. No matter how busy the service gets, time should be invested in reflection and training.

This may be as simple as the measure, suggested above, of getting guest speakers to attend team meetings, but should also include staff attending conferences and courses, and visiting other services.

Other, easy to implement, training activities include work placements for staff with other services and 'journal clubs' in which members take it in turn to read, present and discuss an article, press cutting or book with their colleagues.

6. Key organizational issues

Introduction

This chapter covers the organizational and planning issues that contribute to the smooth running of the service, such as funding, managing stocks of injecting equipment and policy development.

Establishing service aims

Establishing clear service aims is important. They provide an explanation for people outside the organization about what you are doing and create common ground for the program's staff and supporters.

Service aims also set clear standards against which you can measure the results of your program.

A good example of the use of assessment data to formulate aims and ideas for services comes from the Anti-AIDS Fund in Poltava (Ukraine). From the assessment, the group discovered:

- Places where most drug users lived and congregated
- Gender mix and age breakdown, education level, marital and employment status of injectors
- The most popular types of drugs and the ways these were used
- Factors which increased the risk of HIV transmission during the production, distribution and use of injected drugs
- Drug users' level of knowledge about, and opinions towards, HIV/AIDS and sexually transmitted diseases.

Based on this information, the fund decided to begin a harm reduction program with six main aims, which were to:

- Continue research among injecting drug users to gain a closer understanding of HIV-risk behaviors
- Begin a needle and syringe program
- Produce and disseminate specific information and education materials, based on the above research, to reduce HIV and sexually transmitted disease risk behaviors
- Enhance skills of injectors to protect themselves from HIV
- Increase the disinfection of used injecting equipment
- Provide condoms, enhance skills in safer sexual behavior and ensure appropriate referral to medical services for sexually transmitted diseases.

Funding

The enormous differences between the economic systems and level of economic activity in countries in the CEE/NIS region make it difficult to devise a single set of statements about funding for needle and syringe programs.

However, there are some important rules which apply to the funding process all over the world. The first of these is that a needle and syringe program is not a short-term project, something which is done for six months and then stopped (as sometimes happens with specific HIV education campaigns, for example).

To be effective, needle and syringe programs need to be established, and then expanded, until they are providing equipment to at least 30% of injecting drug users, and educational services to at least 50%, in their city or region. This is a very large task and may take a number of years.

The needle exchanges started in the Netherlands, Australia and the United Kingdom in the mid-1980s and they are all still operating and expanding (except in the Netherlands where there has been a massive reduction in injecting drug use).

Sustainability is therefore a key issue. When you think about funding, you need to think about how the program can be funded initially, as well as in two or five years' time.

Whatever types of funding you decide to seek, it is important to investigate local sources of funding first.

If your needle and syringe program can be funded from local budgets or companies, it is much more likely to continue and become a part of the health services of your city or region, than if you depend on external funding.

In addition, most external funding bodies will only provide funding if there is evidence of some material support from the city or region: this support might include free use of office space, a vehicle, assistance from government staff, office supplies, one or more computers and so on.

This book is produced by International Harm Reduction Development, a joint program of the Open Society Institutes (OSI) of CEE/NIS and the Lindesmith Center (USA). These organizations can assist with initial funding of needle and syringe programs in most CEE/NIS countries (see OSI contact details in the Appendix).

There are also many other funding possibilities. In some countries there are documents which detail funding sources for such projects.

Other potential sources of funding include international organizations such as the United Nations (especially UNAIDS and UN Development Program), European Union, church groups, international charities and humanitarian organizations and the embassies of North American and Western European countries as well as some other nations such as Australia and Japan.

Each funding body has its own rules about how applications should be made, but most ask for some combination of the following:

- Brief statement of the current situation (which you can provide from your rapid situation assessment)
- Statement of the aims of your program
- Detailed description of the needle and syringe program, e.g. type of program, program location, staff numbers, staff roles, program policies, estimates of the numbers of injectors and the number you aim to reach in the first year
- A clear rationale for all aspects of the planned project, for example explanations of service model and locations chosen, staff numbers, etc.
- Some information about the organization which will establish the program and the key staff who will manage and staff it
- How the project will be evaluated
- Full costings and budgets.

Common funding problems

A common problem, that often occurs as a result of success, is underestimating the number of needles and syringes that will be distributed (see below). This can have a dramatic effect on budgets and the ability of the program to continue to function.

For example, one needle and syringe program found that it was giving out so many needles and syringes, condoms and sterile water ampoules that it was in danger of exceeding the total budget for the year.

It was decided to stop giving out sterile water and to concentrate funds on providing clean injecting equipment and condoms until additional funding could be found to enable the program to return to distributing sterile water.

These decisions are difficult to make but they may be necessary to ensure that the needle and syringe program is as effective as possible.

A similar budgetary problem can occur when prices rise suddenly. Programs in the Russian Federation saw imported items rise by up to 50% over six months during the financial crisis of 1998–99.

In some cases, funding bodies will increase their grants to cover these rises, but in others they find themselves unable to do so. Again, the program manager needs to decide whether to reduce services or find additional funding.

Estimating the amount of injecting equipment you will need

Whichever type of program you choose to establish, it is necessary to estimate how many needles, syringes and sharpsafe containers you will distribute in the first 12 months before you can seek funding.

Deciding how many needles and syringes you may need in your first year may be difficult because it can be hard to estimate how much:

- Time will be needed to establish the location of the program, recruit staff, satisfy any regulatory requirements for city authorities, police, etc.
- Time will be needed to find, contact and recruit injecting drug users to the service – in some areas this can be achieved within weeks; in others it can take months or years (especially where there is severe police repression of drug use and/or apartment-based, closed buying and selling drug scenes)
- Seasonal variation there will be in demand for injecting equipment, particularly in more northern countries.

To arrive at a figure you will have to use your rapid situation assessment to estimate:

- The average number of injections for each injector per week – this will have to take into account variation of the range of injecting frequency for different drugs and levels of dependence.
- The proportion of the total population you expect to use the service.
- The numbers of needles and syringes available from other sources – for example, from pharmacies.

All these factors affect your estimates, planning and budgets. The examples below demonstrate the great range that can occur in distributing needles and syringes.

You will need to examine your situation assessment results and think about the difficulties which may prevent you reaching an optimal number of injectors in your first year to decide how many needles and syringes should be included in your first year's budget.

For example if a rapid situation assessment found 10,000 injecting drug users, in a city with an open scene, few predicted obstacles, excellent support from all institutions (including police) and the ability to attract drug users quickly, the program might reasonably expect to be able to provide 100 needles and syringes per user to around 20% (2000) of the city's users in the first year. This would give a projected distribution of 200,000.

However, most cities in CEE will not have such favorable conditions (though all programs should aim for this level of provision after one to two years).

If your assessment found 10,000 injecting drug users, operating in a closed scene, with many predicted obstacles, some support from local institutions and difficulties in attracting drug users to the program, you might reasonably expect to be able to provide around 30-50 needles and syringes per user to around 5–10% (500–1000) of the city's users in the first year.

This would give a projected distribution target for the first year of between 15,000 and 50,000 needles and syringes.

Estimating requirements for other equipment

Similar processes will be needed for estimating the number of condoms and other items you may wish to distribute. Other items may include:

- Leaflets
- Alcohol swabs
- Sterile water
- Other needle and syringe sizes
- Filters
- Tourniquets.

In addition, if you want to provide medical or other services, you will need to estimate how many bandages and other medical supplies will be needed.

Remember to also estimate costs for office supplies, the cost of a computer, modem, internet access, desks, chairs, office rental, a van or bus (for mobile services), bags and identifying stickers or patches (for outreach workers), bins for storing used needles and syringes, and the costs of disposing of used equipment.

All of these estimates need to be made, together with the estimates of staff costs, before seeking funding.

Examples of equipment requirements

In Skopje (Macedonia), the Healthy Options Project Skopje (HOPS) gave out 89,000 syringes and 178,000 needles to 740 injecting drug users in its first year of operation.

This program follows best practice and does not do one-for-one 'exchange', and has no limit on the number of needles and syringes that can be given to clients.

In Frankfurt (Germany), they have a comprehensive needle and syringe program that provides about one million needles and syringes a year to the city's estimated 10,000 injecting drug users, an average of 100 per injector per year.

In Amsterdam (Netherlands), more than 400,000 needles and syringes are provided to about 1250 injecting drug users each year, an average of about 320 needles and syringes per injector per year.

In Klaipeda (Lithuania), after some initial difficulties the needle and syringe program started operating from its own drop-in center and, in its first six months, attracted 450 of the city's estimated 2000–4000 injecting drug users for 3644 visits, giving out a total of 19,000 needles and syringes.

The St Petersburg (Russian Federation) needle and syringe program has distributed 170,000 needles and syringes to 6500 of the city's estimated 65,000 injecting drug users, in 75,000 visits during its first two years.

This program requires a one-for-one exchange: they give out one needle for every needle returned up to a maximum of five needles per person per exchange.

The Australian state of New South Wales has one of the most comprehensive needle distribution systems in the world.

It provides around 10 million needles and syringes to around 30,000 injecting drug users who inject daily (about half of these are opiate injectors half are stimulant injectors) and up to 50,000 occasional injectors each year.

This program is regarded as one of the most effective in the world (the HIV prevalence among injecting drug users in Australia is less than 3%). If it is assumed that the bulk of needles and syringes are used by daily injectors (despite their smaller number), it can be hypothesized that at least six million needles and syringes are needed for the 30,000 daily injectors, which means that the system is providing at least 200 needles and syringes per injector per year.

If each daily injector was given a new needle and syringe for every injection each year (given that Australian heroin users usually inject two to three times a day and amphetamine and cocaine users inject around three to eight times a day), the average number of needles and syringes needed per drug user could be 1000 or more per year.

Australia, a wealthy country, is still expanding its needle and syringe program system to prevent hepatitis B and C infections, but it is important to note that it has prevented an HIV epidemic among injecting drug users by ensuring that around 20% of all injections are carried out using new needles and syringes.

Injecting equipment stock management

One of the most important, and least-mentioned, aspects of needle and syringe provision is the simple logistical issue of ordering, supply and storage.

It is important that all staff have an understanding of stock control issues regarding the physical supply of needles, syringes and other equipment and of needle and syringe disposal.

Record-keeping and monitoring systems need to be kept under review, especially at times when the service is expanding, and ordering systems revised as necessary.

Mistakes in this area can have disastrous effects on the program. In one case in Asia, a needle and syringe program stopped operating for several months when all the injecting equipment ran out. This happened because the manager – who had always been responsible for the ordering – was away.

Local drug users, who were used to getting their needles from the program – and were in a remote area where it was difficult to obtain syringes – began to share injecting equipment. The number of injecting drug users with HIV more than doubled in a short period.

Because needles and syringes are generally available through pharmacies in CEE countries, the effects of such mistakes in planning would not necessarily be so severe.

However, they can affect the rapport that has been built up between program staff and drug users and would be likely to cause at least some increase in equipment sharing.

The way to avoid problems is to have a stock management system and regular stock inspections so that, at all times, the manager of the program knows how many needles, syringes and other products are in stock.

It is important to always have more than enough stock to cope with delays which may be caused by ordering or other problems.

Some organizations have a policy of always having three months' supply of all essential items such as needles, syringes and condoms in stock. The minimum stock level should be reviewed regularly to ensure that it is adequate – especially if the service is expanding.

A further problem in the CEE/NIS region can be the supply of appropriate equipment of adequate quality.

In Skopje (Macedonia), for example, there are periods when the needle and syringe program is unable to acquire good quality equipment, so that clients are faced with a choice of re-using their needles and syringes or exchanging these for new equipment of a lower quality.

Maintaining high stock levels and forming, and maintaining, good relationships with reliable suppliers can help overcome these problems.

Worker and volunteer safety

Safety is an issue that must be constantly uppermost in the minds of staff and management.

Some aspects of the work are inherently dangerous, including the fact that needle and syringe program staff often work:

- In areas which are unsupervised and outside the traditional office/clinic setting.
- With a group who may be vulnerable to exploitation.
- With people who are involved in a violent culture.
- With sharp and potentially infectious products (used needles and syringes and other equipment).

To reduce risk, almost all needle and syringe programs have a rule that staff must work in pairs. This means that one person is never left alone to carry out any work involving needle and syringe provision, outreach, needle disposal, etc.

Staff working in pairs should be encouraged to look after each other, alerting their partner to safety issues as they arise.

If outreach or other program staff are regularly confronted by aggression or violence, further training in preventing and dealing with these situations and self-defense should become a priority.

Hepatitis B vaccination

Hepatitis B vaccination is an essential protection for all members of needle and syringe program staff, including volunteers.

Needlestick injury

Prevention of accidental needlestick injury must be a priority for all needle and syringe staff. The safe handling and disposal of used needles and syringes is an essential component of staff training.

Needlestick injuries should not occur. The risk of infection will vary according to the amount of blood that could have been transferred into the injured person, the length of time any blood on the needle has been outside the body, the temperature etc. However, the risk of infection from a single needlestick injury has been calculated at:

- HIV – 0.3%
- Hepatitis C – 2%
- Hepatitis B – 20%.²¹

These figures are an additional reason why all staff should be vaccinated against hepatitis B. Policies for dealing with needlestick injuries must be in place from the outset.

Treatment options which are available from your local infectious disease hospital or clinic for people who have received a needlestick injury should also be investigated and confirmed in advance of any injury: most treatments need to be started within an hour if they are to be most effective.

If needlestick injury occurs:

- Wash the affected area with cool, soapy water for several minutes.
- Encourage bleeding (by pinching and squeezing surrounding skin).
- Report the incident to the project manager.
- Seek specialist medical advice.

Policy development

Development of policies and procedures is often overlooked during the establishment of needle and syringe programs.

Policies are general guidelines which explain what the program will do, how it will operate and what rules it will follow.

Procedures are more detailed step-by-step guides for doing each task.

All programs have policies and procedures, although in some services they are not written down – usually because the process is perceived as being too time-consuming.

However, the preparation of clear written policies is a useful investment of time. When the whole staff team is involved in the writing process it becomes a useful way of familiarizing staff with difficult issues and of ensuring that everyone is aware of, and works within, the policy.

The finished document can then inform practice, be used for staff training and for establishing credibility to outside agencies such as the police, neighbors, etc.

As circumstances change policies may need to be adjusted or developed. This process can be a useful exercise for the staff team.

Provision and disposal of equipment

There should be practical policies and procedures on the actual provision of injecting equipment, covering issues such as:

- The limit (if any) on the number of needles and syringes provided to each client on each visit – unlimited numbers without insistence on one-for-one exchange is best practice, although at the outset of the project this may not be acceptable to some key people / organizations.
- Safe disposal of needles and syringes in a way that minimizes the risk of accidental needlestick injury to program staff and all other members of the community.

The aim of the policy on safe disposal is to eliminate the handling of used equipment by staff.

It should include getting service users to place used injecting equipment in puncture-resistant disposal bins, use of two pairs of latex gloves if staff have to handle used equipment and ensuring that bins full of used equipment are destroyed in an appropriate way – usually by incineration.

Policies, procedures and rules

A range of staff policies, procedures and rules should be developed for effective management of the project, including:

- A staff recruitment procedure covering job advertisements, interviews, responsibility for final selection, initial training etc.
- An information policy covering how information flows through the program, monitoring processes, log books, team meeting records, etc.
- A staff supervision policy and procedure covering frequency and scope of meetings
- A disciplinary policy and procedure.

It is useful to set clear written boundaries or rules for staff and service users so that everyone knows where they stand.

Rules for program staff are needed to protect the individual and the organization. Typically these would include statements that workers must:

- Carry their work identification and business cards at all times when on duty (these may need to be signed by appropriate authorities to ensure fair treatment of staff by police and others).
- Always work in pairs (especially on the streets or in apartments)
- Not use drugs on the premises or be intoxicated while on duty
- Not be involved in drug dealing
- Not allow personal relationships to interfere with the work of the program
- Follow agency procedure if harassed by police or arrested (this will depend on the specific arrangements you have made with police and other authorities)
- Follow agency procedures if clients are aggressive or violent.

Examples of use of policies and procedures

In Sydney (Australia), all government needle and syringe programs must follow the New South Wales Needle and Syringe Exchange Policy and Procedures Manual, 20 a 40-page document which covers all areas of needle and syringe provision work, including:

- The laws and government regulations related to needle and syringe provision
- Rationale and history of the program in Australia
- Principles of needle exchange work.
- Descriptions of the different types of program
- Aims and objectives of the program
- Data collection and evaluation
- Liaison with police
- Role of needle and syringe program workers
- Safe disposal of used equipment.

In Sofia (Bulgaria), the group which applied for needle and syringe program funding designed their needle disposal policy before sending in the application.

This policy included provisions that the workers would carry special puncture-proof bins with them into which drug users would place their needles, and these would be disposed of in the city's military hospital furnace.

It also included provision that workers would also do a monthly clean-up of areas where injecting drug users had congregated, removing used needles and syringes for incineration in the furnace.

Monitoring and reporting systems

Every needle and syringe program should have a recording system in place to ensure they have accurate data with which to monitor and evaluate the program.

The most important functions of the system are to record:

- Each item of injecting equipment dispensed
- Each item of used injecting equipment collected for safe disposal
- Whether each person is a new client or someone who has previously visited the program.

This allows you to record how many injectors access the service (number of new clients), number of visits (by new or repeat clients), number of needles and syringes given out (with separate categories for all other items such as condoms, leaflets, sterile water, filters, tourniquets), and the number of needles and syringes received for safe disposal.

Return rates

The return rate can also be calculated from these figures by dividing the number of needles and syringes given out by the number received and expressing this as a percentage. For example:

1000 needles given out divided by 600 needles returned gives a return rate of 60%.

Return rates are not the only, or even the most important, information to collect. Evaluating whether you are reaching both male and female injectors, drug users from

different parts of the city and injectors with different drugs of choice etc. is also important: this is discussed below.

The recording form

A typical needle and syringe program recording form would be constructed as follows:

Exchange ID	New (N) Return (R)	District	N&S out	N&S In	Condoms	Leaflets	Other
1BM62	N	2204	10	8	3	SS,IS	Coke?
2PS80	R	4812	3	5	20		Dep
1DB82	R	1032	9	9	8	SS	Medical
2SG75	N	6234	2	0	1	SS,SI	?T

In this form a precise system for coding their clients is used. It is one which is commonly used by services funded by International Harm Reduction Development and the Open Society Institute and/or those involved in epidemiological studies.

The five-character coding system works as follows:

- Gender: 1 male, 2 female.
- First letter of mother's family name.
- First letter of client's first name or nickname.
- Last two digits of year of birth.

This system allows the program to record age, gender and a unique code for each client very quickly and means that service users don't have to remember the ID they have adopted for the program.

However, at least one program has reported that certain marginalized injectors (from Roma groups for example) refuse to give this information for fear that it is possible to identify them from the code and that information may be passed on to police or other authorities.

For this or other reasons, some services use a simpler model in which clients are asked for a nickname, which can be anything except their real name. They should remember and give this name each time they come to the program.

The next question is a straightforward 'Is this the first time you have come to this service?'. If they say yes, they are new (N); if not they are return (R) clients.

They are asked for the postal code of the district where they live: this can also be done in words by using the common names for districts of a city or region.

The form also records how many needles and syringes are given out: this table is for 1ml needle and syringe units.

If drug users in your area normally use separate needles and syringes, you may want to have separate categories for needles out and syringes out; you may also want to record how many are given out of various gauges of needles and sizes of syringes.

'N & S in' records the number of needles and syringes given in by the drug user, and 'condoms' simply records the number of condoms provided.

'Leaflets' records that two different leaflets are provided (one on safer sex and one on safer injecting): this system stops staff assuming that people who are familiar faces at the program have had information when they may not have done, especially if early transactions were hurried.

The 'other' column can be used for several purposes.

For example, 'Coke' records the fact that the client may be a cocaine user (this may be interesting, especially if the program has not usually attracted cocaine users).

'Dep' is a comment that the client seems depressed. Some programs provide a range of counseling and other services and these forms can be used to keep track of the client's moods: a code is useful so that other clients cannot understand these comments.

'Medical' means the client has been referred for a medical service (the actual service, such as treatment of an abscess or a HIV test, needs to be recorded elsewhere to ensure confidentiality); and 'T?' means the client may be interested in drug treatment, so that an outreach worker may discuss treatment options with them.

There are, of course, many other questions that can be asked on these forms.

Log books

Other recording measures, such as log books, should be used from the very beginning of the program's operation.

Log books are particularly necessary for outreach workers, but they can be useful for any type of needle and syringe program.

Log books are usually notebooks issued to each staff member in which they record the important events that occur during their work. These may include:

- Client contact information
- Anything they are told by injectors about drug-using and preparation practices, risk behaviors, trends in drug-using patterns, etc.
- Questions asked by clients (especially any they cannot answer)
- Incidents observed by program staff
- The worker's reactions to things that happen.

Log books can be very useful. They should be brought to team meetings as a reminder to bring up unusual occurrences or points or questions for discussion by the whole team.

By recording the most commonly asked questions, the team can, if needed, receive additional training on these topics, and prepare verbal answers or leaflets.

Information collected in log books about drugs and risks, and about the ways in which the drug scene is changing, can be very useful for monthly, quarterly and annual reports. In addition, notes on the worker's feelings and reactions can be discussed during supervision to monitor problems, safety and risks such as relapse to drug use.

Analysis and reporting

Regular analysis and reporting of this data can help the program identify its strengths and weaknesses.

By checking the percentages of male and female clients, perhaps their ages and the districts where they live, and comparing these with relevant situation assessment results, you can make statements about the injectors who come to the program and, more importantly, those who do not.

This can help determine where more time and effort can be expended to increase effectiveness.

You can provide a brief monthly report on the program by bringing together the:

- Numbers recorded each month
- Main points made in log books (by outreach and/or other staff)
- Comments made in other written forms (such as the program recording form) and from staff meetings – the easiest method is to do a simple count of the number of times an issue or problem is mentioned.

By reviewing monthly reports every three months, you can write a quarterly report which contains accurate statistics, raises the most important issues and how they have been, or will be, addressed.

If quarterly reports are done promptly then the annual report (which is often required by funding bodies and is also useful for maintaining support for your activities) is a relatively simple matter of combining the statistics and important issues from the four quarterly reports.

For example, in Salvador (Brazil), a needle and syringe program opened in 1995 in the district known as Pelourinho. The program worked well for the first year, with constantly increasing numbers of syringes exchanged and condoms distributed to cocaine injectors.

But the introduction of crack into the district was followed by increased police activities, violence associated with the crack trade and fears by outreach workers for their safety on the streets.

The number of syringes supplied fell from 1462 in the second half of 1996 to 64 in the first half of 1997 and to just five in the second half of 1997.

As Tarcicio Andrade writes: 'This experience demonstrates the interrelationships between services and changing climates of drug use. It is critical that programs stay abreast of any changes in local drug-use patterns and adapt rapidly to these changes.'²²

Recruiting service users

It is not unreasonable to think that by opening the needle and syringe program with trained staff and plenty of needles and syringes, injecting drug users will come through the doors in large numbers.

Sometimes this happens, but in most places, you will need to attract drug users into the service.

Drug users are likely to be suspicious of any new service and, for many reasons (such as not wanting to attract adverse publicity), you will probably not want to advertise the service very openly.

For this task, it is often best to return to outreach techniques. Identify places where drug users are likely to be, contact them and tell them about the program and what it offers.

Most needle and syringe programs use cards or leaflets for this purpose as well, so they can give the address of the fixed-site or the places where the mobile service stops or some information about how to contact an outreach worker: this will be discussed in greater detail in Chapter 8.

The staff mix may also be an issue in contacting all groups of injectors. For example an all-male staff may have difficulty contacting female injectors.

As well as outreach, you may also be able to seek potential clients through cards, leaflets or posters displayed in other services which have contact with injectors such as youth organizations and infectious diseases clinics.

You can also adapt the physical environment of the program to attract injecting drug users. If the environment reminds drug users of a hospital or jail, they may be less willing to enter than if it feels welcoming and open.

Program staff should be friendly and helpful and should ensure that injectors are able to access all the equipment they need.

Practice examples of service-user recruitment

In both Rostov-on-Don and Pskov (Russian Federation), new needle and syringe programs were successful in reaching both male and female injectors aged over 25 and using a range of drugs.

However, they had not been able to gain trust among younger injecting drug users.

Both programs decided to try and recruit drug injectors who could work as volunteers to help the program reach this group.

Having identified a large group of Roma injectors in the city, the Pskov team also recruited a member of staff who spoke the Roma language.

In areas where it is hard to gain the trust of injecting drug users, the process of persuading people to use the service can take a significant amount of time and effort.

In Poltava (Ukraine), volunteers from the needle and syringe program started by trying to keep up an almost daily presence in the areas where drug users met with each other.

The appearance of the volunteers was important – they needed to be tidily dressed to show that they were working and not part of the scene, but not so well dressed that their appearance made users feel inferior to them.

Even with all of these advantages, the volunteers (who were mostly ex-users) still often met with rejection, with users standing up silently and moving away when volunteers tried to engage them in conversation.

An important breakthrough was achieved by volunteers finding friends from childhood or from earlier drug-using periods and explaining their work to these individuals. Slowly, in the first two months, the number of injectors spoken to rose to 10, then began to increase rapidly.

In both Poltava and Odessa (Ukraine), needle and syringe programs operate in drop-in centers which are called 'centers of trust', to emphasize that they are safe and welcoming places for injecting drug users.

7. Information and education

Introduction

Provision of information and education is essential if needle and syringe programs are to meet their aim of preventing the spread of HIV and hepatitis.

Workers must keep in mind that every contact with an injector is an opportunity to build rapport and to disseminate information – even if the contact is only for a minute or two.

There are several basic education messages which are used in most places to assist drug users to prevent HIV transmission: these should be repeatedly provided through a range of media.

However, there are several issues to consider when you adapt these messages for an education program or campaign in your city or region:

- Practices – priorities for messages about safer behavior will depend on the important transmission risk factors you discovered during your situation assessment
- Targeting – make sure that you aim the right messages in appropriate ways at each group
- Language – ensure that the language used is acceptable to, and understood by, the target group
- Images – ensure that images are appropriate for the target group: if drug users do not like the images used, they may not read the materials and/or may develop negative perceptions about it and/or your program
- Embedding messages in other issues: by finding out what local injectors are most interested in, you can include HIV prevention messages in materials on these other topics.

It must also be recognized that behavior change in the areas of drug use and sexual health cannot be accomplished simply by giving people lists of do's and don'ts.

Drug injectors need sufficient information about the way their body works, how drugs affect their body, viral transmission, the risks of various practices and advice on how to change to or maintain safer behavior.

Moving to giving more information can be done on a one-to-one basis, in groups or through targeted or mass media public health campaigns.

These different methods are looked at in detail at the end of this chapter.

Basic safer injecting messages

All injectors should be given basic information during their first few visits to the needle and syringe program on safer injecting and avoidance of blood-borne viruses (such as HIV and hepatitis) that are transmitted via used injecting equipment.

Basic safer injecting education includes the following messages.

You can protect yourself from infection by always using your own:

- New, sterile needles and syringes
- Mixing water, cups or pots
- Spoons or 'cookers' (used to heat powdered drug and mix it with water)
- Filters
- Swabs/alcohol wipes and never sharing, lending or borrowing them.

'Sharing' isn't just using a syringe that someone else has used. It is also using:

- A filter.
- Mixing water.
- Water cup/container.
- Spoon

that someone else has used, or passing them on to someone else.

Always be aware of the risk of:

- Catching infection from others
- Overdose
- Passing infection on to others

and, where possible:

- Use each needle and syringe once only
- Prepare injections with clean hands on a clean surface
- Wash your hands before and after each injection.

And, always use a condom when having sex.

In Skopje (Macedonia), the needle and syringe program run by Healthy Options Project Skopje (HOPS) attempts to provide information on the following topics to everyone to whom needles and syringes are provided:

- Safer injecting and safer sex
- HIV/AIDS, hepatitis and sexually transmitted diseases
- Condoms and how to use them correctly
- Safe disposal of injecting equipment
- Different types of drugs and drug-related harm
- Civil rights and other legal issues.

Of course, not all of these topics can be covered in a single brief contact. However, workers can achieve a great deal in a short time through the imaginative use of different communications media such as:

- Educational materials – regular publication of new materials on topics of interest to injectors can create a talking point or can take the place of initial education in those situations where the drug user needs to leave quickly
- Delivering a single message to every service user over a given period – such as having a ‘spoons week’ during which paraphernalia risks are highlighted or safety messages are given about specific issues like high-purity heroin and overdose risk
- Development of short sayings/slogans such as ‘stay safe’, ‘shoot clean’ or ‘look after yourself’ which staff can say quickly to clients during brief contacts (similar to the American use of ‘Have a nice day’).

Such interventions put health and safer injecting ‘on the agenda’ and make it clear that needle and syringe program staff are happy to answer questions or discuss any of this information, if the drug user has time.

One needle and syringe worker summed this up commenting: ‘You need to always look for opportunities to talk about healthy behavior: maybe you see a bandage or a bruise and you ask what happened or you show service users a draft of a new leaflet you are working on, and ask for their opinion on it.’

Slogans and sayings

Constant repetition of the same message has the same effect as an advertising slogan: the words – and the idea or product – stay in our minds.

In Australia, drug users are advised to ‘use a new fit (needle and syringe) for every hit’. This slogan appears on the packaging of some syringes, on business cards for needle and syringe programs and on stickers, leaflets, cards, brochures, posters and booklets.

At Chicago Recovery Alliance, staff are encouraged to develop ‘one-liners’ – quick reminders that staff can say to clients. Here are some examples on the subjects of safer injection, vein care and safer sex:

- ‘One shot, one sterile syringe.’
- ‘Use your own – needles, cookers, filter, water.’
- ‘The cleaner everything is, the better.’
- ‘New paraphernalia + clean hands = safer shots.’
- ‘Different spots – no tracks’ (i.e. visible puncture marks are reduced if you rotate sites).
- ‘Shoot with the flow’ (of blood).
- ‘Release the tie (tourniquet) – before you get high.’
- ‘Knowing your condom is safer than knowing your partner.’
- ‘You can’t tell if someone is infected by looking at them.’

Staff need to be able to convert these short exchanges into longer educational discussions. However, slogans and sayings represent a first step in building a relationship with service users in which they begin to see the program staff as a reliable source of information about reducing the risks of their injecting.

Other key safer injecting messages

Other key areas that may need to be covered are:

- Water that is injected
- Filters
- Tourniquets
- Drug preparation and supply
- Injecting sites and vein care
- Overdose prevention and treatment
- Sexual transmission of disease
- Cleaning used injecting equipment.

These are discussed in detail below:

Water

Water used in the preparation of drugs should, ideally, be sterile. In practice, the risks from bacterial infection from water may not be a major public health problem and the expense of its provision may be prohibitive.

Water that has been boiled in a pan for five minutes is sterile.

Water boiled in a kettle is usually sterile as very few pathogens can survive boiling.

Bottled water (even if it is labelled 'pure' or 'distilled') may contain far more bacteria than tap water.

Filters

Where powdered drugs are prepared for injection, filters (ranging from bacterial filters used in hospitals to cotton wool balls, cigarette filters or tampons) are often used to remove solid particles.

Research from the UK²³ shows that the best type of filter (apart from those used in hospitals) are the separate cigarette filters which are sold for roll-your-own cigarettes.

Filters can represent a significant HIV and hepatitis risk if they are shared, sold or passed on. If a syringe has been returned to the spoon, infected blood is likely to be passed to the filter. All injectors should be made aware of this risk.

Tourniquets

Drug users should be educated to always release the tourniquet once the needle is in the vein and before injecting the drugs, otherwise it will both slow the passage of the drugs to the brain and result in increased pressure in the vein, possibly causing it to split.

If they inject sedatives with the tourniquet on and collapse unconscious while it is still tight, it could cause serious damage to the limb through poor circulation. In extreme cases this could cause gangrene which then has to be surgically removed.

Drug preparation and supply

Your rapid situation assessment may have identified risks in the drug preparation and supply processes. These might include returning to a common vial or pot for a second dose after everyone has taken their first dose.

This is a high-risk activity for HIV transmission – only by each member of the group using a new needle and syringe for each dose can transmission risk be eliminated. With the mix of urgency, intoxication and several people that is often present, this can rarely be guaranteed.

Where people continue to prepare, and share, drugs in this way, encouraging the cleaning of needles and syringes between doses may be a way to reduce the risk of infection.

However, efforts should be directed at getting the injecting community to look at changing the way they use drugs together.

The buying of drugs in syringes is also a high-risk activity for HIV transmission as there is usually no way of knowing whether the drug has been provided in a sterile or a used syringe.

Injection sites and vein care

Discussion about injecting sites and their relative risks is important and useful. Arms are the least risky site for injection. When these have collapsed, injectors should be encouraged to seek alternative ways of using drugs.

If they do continue to inject, the neck and groin should always be avoided because of the high risk of accidentally hitting an artery and/or nerve damage.

Hands, fingers and feet should also be avoided due to the risk of vein damage and infection.

If the veins of the hand or fingers are used, rings should be removed as swelling in the fingers will restrict blood flow below the ring, possibly leading to gangrene and amputation.

Advice about vein care can prolong the life of the veins in the arm and slow, or prevent, the progression to riskier sites. Such advice would include:

- Rotating injection sites
- Avoiding repeated injections into the same site over a short period of time
- Not using blunt needles or substances which irritate the veins as the damage they cause will hasten vein collapse
- Promoting other routes of drug use such as smoking or swallowing drugs.

Overdose and resuscitation

Many injectors have personal experience of overdosing, and have seen others overdose on a number of occasions. Giving injectors information on how to lay unconscious people with their airway clear and so they can't roll onto their back – the 'recovery position' – could save lives.

Many injectors will not call an ambulance to an overdose for fear of the police also attending. If it is possible to negotiate an agreement with the emergency services that this will not normally happen, it could save many lives – especially if knowledge of the agreement can be effectively communicated to the drug-using community.

Sexually transmitted diseases

Although there is an emphasis on the transmission of blood-borne viruses and other infections through shared injecting equipment, the sexual transmission of HIV and other diseases should not be forgotten, especially in areas with a high prevalence of HIV.

Cleaning injecting equipment

When doubt first began to be cast on the ability of cleaning methods to completely clear injecting equipment of blood containing traces of hepatitis and HIV, many needle and syringe programs stopped teaching users how to clean equipment and only promoted the use of a new needle and syringe for every injection.

However, best practice is for the two messages to run side by side, i.e. always use a new needle and syringe but, if you can't, following the advice on cleaning equipment may prevent HIV and hepatitis infection.

Service users should be advised that if they are going to reuse equipment it is much better to reuse their own rather than someone else's.

It is also important to advise people who keep syringes for reuse to mark/identify them and keep them in a safe place where they cannot be reached – or used – by other people. The risk that someone else has used their syringe without their knowledge is another important reason for cleaning the syringe again before second use.

The '2 by 2 by 2' method

Injectors should be advised that all syringes that they think may be reused should be cleaned immediately after first use.

They should then be cleaned again before second use.

The best method for cleaning is to use the '2 by 2 by 2 method':

- Draw COLD water (sterile or cool boiled is best) into the syringe and then flush it out down the sink or into a different cup.

Do this twice and then:

- Slowly draw bleach into the syringe and shake it for as long as possible: 3–5 minutes is ideal, 30 seconds is the minimum.
- Flush it out down the sink or into a different cup.

Do this twice and then:

- Draw COLD water into the syringe (as in step 1) and then flush it out down the sink or into a different cup.

Do this twice as well.

In addition, you can reduce the chance of infection if you clean the needle and syringe by soaking the parts in either undiluted bleach or a strong detergent/water solution for as long as possible (at least several minutes).

Injectors can also be advised that boiling needles and syringes for 10 minutes will also sterilize them (although boiling plastic syringes may lead to distortions of the plastic and leakage).

If they are not going to go through the full '2 by 2 by 2' procedure they should be advised to do anything they can to reduce the residue of blood in the syringe.

In particular, washing the needle and syringe several times immediately after use with cold water – before the blood and drug solution have had a chance to dry – is likely to flush out most infectious agents.

Failing this, using water or even vodka, wine or beer to flush out the syringe and needle before reuse is likely to reduce the risk a little.

One-to-one education

Giving in-depth information to a service user cannot usually be done 'cold'. One-to-one education usually involves making contact with a drug user and:

- Establishing trust and rapport
- Engaging them in conversation
- Providing HIV prevention education
- Offering to assist them to move towards or, maintain, less risky injecting.

However, it is important to note that one-to-one education in the context of outreach may be different, and depend on the role of the worker.

A drug user employed as an outreach worker may be primarily working with his or her friends and may simply provide clean injecting equipment and basic safer injecting information.

One-to-one education also occurs within institutional settings such as drug treatment centers, prisons, hospitals, etc., usually as part of a wider range of educational and/or counseling activities.

People working in these settings may need to balance the need for education which will assist a drug user to remain as healthy as possible with the need to abide by the operating philosophy of the institution.

Institutions (such as prisons or detox units) may have to be educated and persuaded to recognize that the life-saving nature of harm reduction messages may mean that they have to change their attitude towards discussion about drugs and drug use.

One-to-one education also occurs as part of pre- and post-test counseling for HIV or hepatitis antibody tests. Education at these points has been found to be extremely effective in personalizing the issue of HIV or hepatitis and in impressing on drug users the need for safe behaviors.

Group education

Group education can be provided in a range of settings. Much of it relies on the social networks that drug users form. As these can have a positive effect on those members trying to change, or maintain safer behaviors.

'Classical group education' takes place with facilitation or information provision by an authoritative figure such as a doctor, epidemiologist, drug treatment worker or NGO worker who has control over the information and education the drug users receive. Unless this person has a clear idea of the educational needs of the group this type of group education may be ineffective.

Group education also takes place in institutional settings, where HIV education is often a topic for group discussion in drug treatment centers, jails and so on.

A problem which has been commonly identified with group education in these settings is that institutional policies may not allow full and frank discussion of the various ways that HIV can be transmitted and steps that can be taken to reduce the risk of transmission.

In drug treatment agencies, participants are usually encouraged to believe that they will remain drug-free after they leave the program. Staff sometimes think that there is therefore no need to teach people about HIV prevention while in treatment.

However, it is now widely accepted that the high rate of relapse after treatment means that drug users in recovery need explicit information about safer injecting (and overdose risks) in case they return to injecting drug use.

Group education may also be useful for other members of the community. Needle and syringe program staff often provide talks or seminars for police, drug treatment and hospital staff, people from youth centers and committees, students of social work and other disciplines, and family members of drug users.

The Substance Abuse and AIDS Prevention Fund project in Kiev (Ukraine), though not directly linked to a needle and syringe program, provides training to families of drug users. In its first training cycle in 1998–99, 35 people were trained in four groups for a total of 32 hours. Areas covered included:

- The reasons for adopting a harm reduction approach
- Laws related to harm reduction
- Local programs and possibilities of work in harm reduction
- Medical and social aspects of prevention
- Help and support for the families of injectors
- Successful implementation of harm reduction
- Formation of self-help groups for relatives who want to reduce harm to family members and society.

Some of the relatives who attended the course offered to volunteer for work in harm reduction programs. Drug users interviewed after their family members completed training said they felt a greater:

- Emotional support from their relatives
- Inclusion into the family
- Desire to help spread the idea of harm reduction.

Peer education programs

Targeting social networks of injecting drug users through peer education has become increasingly popular in recent years.

Peer education occurs when the culture of the target group is utilized to effect and sustain change in behavior. Such strategies work best when they are devised with, and implemented by, members of a subculture, community or group.

Some drug-user groups have suggested that peer education should not be seen as 'teaching' by a 'good drug user' to change the behavior of another drug user, but as drug users sharing information with each other on how to inject as safely as possible, given their current circumstances.

With this approach, drug users work together to reduce the risk of injecting. This leads to a supportive peer environment in friendship networks, and allows the development of materials for friendly and supportive education rather than lecturing.

Peer education has been used in many countries and amongst different networks and communities affected by HIV and AIDS.

It is an effective way to promote behavior change for HIV prevention, particularly for young people and for programs attempting to change socially marginalized behaviors.

In a peer education workshop, drug users may learn about HIV transmission and prevention and be given training in how to pass this information on to others.

Examples of peer education initiatives

The needle and syringe program at the Lower East Side Harm Reduction Center in New York (USA) uses interactive education methods in its volunteer training for injecting drug users. At registration the volunteers are taken through a brief course on injection hygiene.

Participants are asked to demonstrate how they perform certain activities, e.g. preparing an injection or cleaning the injection site. Safer injecting information is then given on the basis of what the participant already knows.

This model allows users to identify risks and change behavior in ways that might be missed if the staff simply presented information without understanding how it might be applied.

In Ljubljana (Slovenia), a needle and syringe program operated by a NGO, 'STIGMA', invited a drug-users' organization from Western Europe to assist them in organizing facilitated discussions and training to educate professionals, students and drug users about safer injecting and organizing HIV prevention, harm reduction and peer education.

STIGMA also plans to expand their program to work with other countries in the CEE/NIS region and to enable some Slovenian drug users working on harm reduction to go to the Netherlands to discuss their work and exchange ideas with Dutch drug-user organizations.

Targeted education

Targeted education materials are designed to be read, seen, understood and acted on by specific groups in a society.

Targeted campaigns and programs are used by needle and syringe programs to:

- Raise awareness about the program's services and about HIV/AIDS among injectors
- Attract injecting drug users to the needle and syringe program
- Provide information and education in a way that appeals to injectors, in language and with visual materials they understand and feel they can trust
- Personalize HIV prevention for subpopulations of drug users.

These campaigns use techniques such as:

- Posters
- Public meetings
- Advertising
- Brochures
- Graffiti
- Postcards
- Music
- Radio
- TV or video
- Fridge magnets
- Keyrings
- Syringe packaging
- Newsletters
- Booklets
- Events
- Advertising in specific venues (e.g. festivals) or places (e.g. toilet doors).

The important features of targeted campaigns are that:

- They are explicit in their messages to prevent misunderstanding and confusion (this is the main reason why the mass media cannot usually be used for a targeted campaign)
- Current drug users are involved in all aspects of the campaign
- They use media, language and images that the target group is comfortable with.

The aim of such campaigns is that social networks of drug users begin to develop less risky ways of using drugs as they learn more about HIV/AIDS, and develop and informally enforce community norms about less risky injecting.

Producing materials for a targeted campaign

To produce educational materials for a targeted campaign you should first establish its aims and be clear about what it is you want to communicate.

Campaign aims might include:

- Raising HIV awareness amongst injectors
- Informing drug users about safer sex
- Reducing the incidence of shared needles and syringes
- Attracting injecting drug users to the needle and syringe program or to a meeting.

Having done this you can then begin to develop messages, firstly by noting down the points you want to communicate.

It is then useful to get a group of people together (including service users) and brainstorm all the messages you can use to communicate those points. Having chosen the best messages, decide on the media you are going to use.

Make rough versions of the educational materials, circulate drafts amongst experts and service users, and incorporate their suggestions. Language should always be simple and easy to read, and layout should be as attractive as possible.

The final step prior to production of the final draft and publication is to 'focus test' the materials with a group of people from the target group(s) to get their reaction.

The designer can then produce a finished product ready for the printers.

If your materials need distribution, this should be planned before they arrive from the printer.

All materials and campaigns should have their success evaluated, even if this is done informally.

There are many techniques for evaluation but the simplest are to check:

- Recognition – several weeks or months after distribution, show the material to clients and ask if they recognize it (this tells you what percentage were reached by the campaign)
- That those who remember the material can recall what its main messages were
- Behavior change – after the above questions, ask those who remember the material what effects, if any, its messages had on their behavior.

Newsletters

Another popular form of targeted communication is a drug users' newsletter or magazine. These have been produced by drug users in Australia, India, North America and many European countries. In the CEE/NIS region, they have been produced by needle and syringe programs in the Czech Republic and by the outreach program in Moscow.

These newsletters or magazines can require a great deal of time and staff or volunteer work, but are very popular and cement the program's relationship with injectors in its local area.

Developing and producing this type of publication is also a common method of attracting drug users to work together for HIV prevention, and can be a vital factor in changing social norms towards risky behavior.

The North Eastern AIDS Prevention Program in Melbourne (Australia) offers a wide range of education and information by skilled and non-judgemental staff to clients of the program, health workers and other interested members of the community. They have prepared a free newsletter for clients called 'North Eastern's Greatest Hits' containing relevant, practical and up-to-date articles on topics of interest to injectors.

The program encourages clients to become involved in the production of this newsletter and welcomes contributions from service users. Their annual report says: 'Information works both ways – we provide information but we also like to receive information from our consumers so we can continue to improve and extend our services.'

Event-based campaigns

Another type of targeted education campaign is based on specific events that injectors are known to attend, such as rock concerts, rave parties and festivals that are aimed at specific subcultures.

Activities at these events range from simple provision of leaflets about HIV and drug use to booths where festival participants can come to learn more about these topics and discuss any problems or issues with workers, either through the booth or meeting outreach workers who are moving through the crowds.

Examples of event-based campaigns include work at the annual rock festival on an island in the Danube in Budapest (Hungary), which attracts 250,000 visitors.

It is advertised on MTV and is the largest such event in Central Europe. Two needle and syringe program workers visited the festival in 1997 and found that many of their clients were there without access to clean needles and syringes.

In 1998, the Szeged needle and syringe program, together with the needle and syringe programs in Pecs and Budapest negotiated with the festival organizers to allow an outreach team to provide needle and syringe provision²⁴ hours a day from a tent at the festival.

This was largely successful though it was eventually closed by the city health officer due to concerns about the needle and syringe program staff's ability to ensure a one-for-one exchange policy.

The experience has shown that a more tightly controlled needle and syringe program could be set up at future festivals.

At Kazantip (Ukraine), a three-week windsurfing festival in August each year has become the site of one of the largest and longest rave parties in Eastern Europe, attracting more than 10,000 people to a remote site in the Crimea.

When outreach workers from Moscow visited the festival in 1997, they found high rates of drug injecting and little access to new needles and syringes.

However, because of legal and organizational restrictions, the outreach workers could not start a needle and syringe program at the following year's festival.

Instead they distributed thousands of Russian-language leaflets containing information on the cleaning of needles and syringes. They also provided one-to-one education on HIV prevention and handed out condoms.

Examples of targeted education

In Poltava (Ukraine), injecting drug users work with the needle and syringe programs to write and distribute leaflets and a newspaper. More than 60,000 leaflets have been distributed with information on:

- HIV infection and drugs
- HIV infection and sex
- The needle and syringe program
- December 1 – World AIDS Day
- Drugs and the law
- Sexually transmitted diseases
- HIV/AIDS and the law
- AIDS clinics – what services are available
- HIV/AIDS – general information
- Safer sex
- *The first step* – a leaflet about drug treatment.
- HIV/AIDS – information targeted at children.

Needle and syringe program workers find that clients are always interested in new leaflets so new publications are produced every few months.

The SHARAN drop-in center in New Delhi (India) has several small posters on its walls, providing specific instructions on safer injection, including:

- Always use your own needle and syringe.
- Rotate injecting sites regularly.
- Clean the injecting site with an alcohol swab.
- Dispose of syringes in a safe place.

These posters were designed in English on a computer, then printed on a color printer. Hand written Hindi versions accompany the English posters.

These posters could have been very problematic in terms of negative media coverage, political interference, etc. if they were shown to the general community. However, because the posters are carefully targeted – they are only on display in the SHARAN drop-in center – they are able to provide specific, explicit harm reduction information.

They also demonstrate that information campaigns can be run at a low cost.

One organization has developed a comprehensive system for the development and implementation of targeted education campaigns.

New South Wales Users and AIDS Association (NUAA) is a drug users' organization in Sydney (Australia) which carries out a set of what they call 'Tribes' campaigns each year.

The theory behind these campaigns is that modern societies are so fragmented that most injecting drug users have several groups with whom they identify, so that each individual drug user may be considered to be a member of a complex group of 'tribes'.

By aiming a campaign at the 'tribe', it is possible to reach drug users who do not receive education through other means. To NUAA, a 'tribe' is a group which has a number of things in common, such as having the same:

- Drugs of choice
- Particular slang vocabulary
- Group norms
- Recreational activities
- Appearance (hairstyles, clothes)
- Taste in music
- Area of residence.

The organization invites drug users or people with good contacts with specific groups of drug users to write proposals for funding grants, which are used to provide HIV education and/or injecting equipment to a very specific group of drug users.

Examples of the groups targeted and the campaign materials used include:

- Video, cards and leaflets for gay men in inner-city Sydney who go to gay rave parties
- A motorcycle painted with images and slogans about safer sex exhibited at shows where 'outlaw' motorcyclists are likely to attend
- A set of paintings using traditional materials and methods about HIV/AIDS and drug use for a specific Aboriginal group.
- Murals painted in toilets of drinking places where particular types of rock bands play.
- Workshops for six bands where songs were developed about safer drug use and safer sex, followed by a concert and condom and leaflet distribution in one small area of New South Wales
- Posters and pamphlets for strippers who work in inner-city Sydney clubs
- A video for people over 35 who are still using drugs in a coastal area
- Newsletter for environmentalists who live in forests in remote areas of the State
- A video for transsexual drug users
- T-shirts printed with slogans developed by the members of a 'tribe' of young men living in a public housing estate in an outer Sydney suburb.

NUAA has substantial materials on its Tribes campaigns, including operational documents and evaluation reports.

The organization also publishes a regular magazine and a wide range of educational material. Contact details for NUAA are on the International Harm Reduction Development website – see the Appendix.

Mass media education

It isn't usually appropriate to try and use the mass media for specific safer injecting campaigns.

However, it should be remembered that the mass media is sometimes the main source of general information on HIV/AIDS for drug users, so it is important that, where possible, appropriate messages be provided in these media.

There is more information on working with the media in Chapter 2.

8. Good practice in needle and syringe provision

Introduction

Developing and maintaining high standards of practice should be the aim of all needle and syringe programs.

This involves personnel keeping up-to-date with the literature, networking with other services and reflecting on their practice.

This chapter sets out the principles of good practice in some of the key areas of the work, including promoting change, risk assessment and outreach work.

Ethics

Needle and syringe programs operate in the health field and are bound by the same ethical principles that govern other health workers.

The following set of ethical guidelines can assist needle and syringe program managers and workers to assess any new issue and decide on an appropriate course of action.

It is important that all needle and syringe program staff:

- Accept responsibility for their actions and the consequences of their work
- Are competent and committed to the maintenance of high standards of skill and knowledge
- Are committed to a continuing review of practice and policy, and improvement of the program by upgrading, extending and facilitating services
- Take responsibility for their continuing growth and development relative to their practice
- Have a commitment and obligation to safeguard confidential information obtained in the course of their work
- Are aware of, and conform to, ethical and legal standards of practice in their community and refuse to participate in activities which are unethical or may harm members of the public
- Recognize that their actions affect the lives of others, and are alert to conflicts of interest and clarify these immediately.
- Acknowledge, in all public statements, the limitations of present techniques and knowledge, and clarify whether they are speaking as a private individual or as a representative of the needle and syringe program
- Respect the integrity of clients and safeguard their welfare
- Fully inform clients about the purpose and nature of all interactions and openly acknowledge clients' freedom to refuse to participate in any activity
- Act with due regard to collegial relations and respect the rights, obligations, skills and judgement of colleagues
- Treat colleagues and service users equally, regardless of gender, race, religious belief or sexuality.

Changing behavior

Needle and syringe programs exist to promote safer injecting.

To achieve this it is important that staff are non-judgemental in their approach to service users, and that workers try to understand the reasons why people are engaging in risk behavior, and help them to overcome obstacles to safer injecting, rather than simply telling them what to do.

Since the beginning of the AIDS pandemic, much research has been done into the question of how and why people change their behavior from activities which place them at high risk of HIV infection to those that put them at low or no risk.

Researchers have also tried to understand how programs or campaigns can assist this process.

Factors influencing change

One useful model developed by Kok and Sandfort in 1991 (and described in the European Peer Support Manual²⁴) proposes that people have attitudes and beliefs about themselves – which they describe as their ‘self-efficacy’.

Kok and Sandfort stated that attitudes, beliefs and behaviours are influenced by external social influences such as parents, friends, social networks, sexual partners, media, government and so on. In turn, as members of society, everyone’s actions become part of the external influence on others.

This understanding of the reasons for behavior can be used to systematically analyze an aspect of a person’s intentions or behavior – for example, their desire to stay healthy or to inject drugs without getting infected with HIV.

Where there is a gap between intention and behavior – for instance to inject without risk of viral infection – it may be because skills or resources are needed to overcome barriers to the change.

The needle and syringe program may be able to assist people to overcome some barriers by providing new needles and syringes and other equipment and information.

However, there may be other factors – both personal and external – at work.

Personal factors that influence safer injecting include the user’s:

- Perception of the value of avoiding HIV infection – if injecting drug users are not worried by sharing injecting equipment because they do not understand HIV risks or what infection could mean for them, or do not value their health and life they are unlikely to change their behavior
- Beliefs about whether they are able to change to safer behavior – they may not think it possible having been repeatedly told by relatives and the media that they are incapable of change and of no use to their family or society
- Injecting skills and knowledge of safer injecting techniques – they may always use their own syringe but still engage in other risk behaviors such as buying drugs that are backloaded into their syringe.

External factors include:

- Public policy towards drug users – for example, a repressive policing policy that harasses and intimidates injecting drug users can lead to much injecting being done quickly, under great stress and in circumstances where viral transmission is not a priority
- What ‘everyone else does’.

This last point is important: researchers have found that it is much easier for individuals to adopt and maintain a new behavior if friends change their behavior at the same time.

When a social network tends to do things in the same way, this is called a ‘group norm’ – the normal behavior of the group. Changing the group norms of entire injecting social networks is the ultimate goal of all needle and syringe programs.

Public health programs such as needle and syringe programs need to focus on multiple levels of behavior change, including:

- Individual lifestyles
- Health services
- The immediate community context
- The wider social environment and public policy.

The need to encourage change at all these levels are core underlying principles of an effective response to HIV among injecting drug users, recognized by the World Health Organization in *The Ottawa Charter on Health Promotion*¹⁷ and the WHO/UNAIDS *Rapid Assessment and Response Guide*.¹²

Diffusion of innovations

‘Diffusion theory’²⁵ can be very useful in helping to understand the effects of needle and syringe provision and other HIV prevention interventions.

Diffusion can be defined as ‘the process by which an innovation is communicated among the members of a social system’.

It consists of four main elements:

- Innovation – the idea, practice or object perceived as new by an individual or group
- Communication channels – the means by which messages are exchanged
- The social system
- The time it takes for the innovation to be adopted.

Communication channels can be characterized as either ‘centralized’ or ‘decentralized’.

In centralized diffusion the innovation comes from an expert source transferring an innovation to potential adopters who are less expert (for example, when a surgical technique is taught by a professor to a group of trainee doctors).

In decentralized diffusion there is a high degree of shared information between group members and transfer of information is based on the assumption that the group members are able to manage the diffusion process themselves with little help from professional change agents or ‘experts’.

The diffusion of HIV-risk behavior messages is different in 'distinct population groups' – such as groups of injecting drug users – to that in the general community.

Members of distinct population groups generally:

- Bond together in order to cope with the ostracism and criticism that they perceive from the larger society about their values or beliefs
- Share values and beliefs to a higher degree than the rest of the population
- Bond through frequent interpersonal relationships
- Have the potential to act as powerful agents for or against change, by choosing either to amplify or attenuate communication messages.

In distinct population groups, the social process of diffusion occurs relatively faster than within the general community because:

- Communication is likely to be more frequent
- Communication is characterized by a high degree of trust
- There is less difference between members of distinct population groups.

However, members of distinct groups tend to be selective when deciding whether to adopt innovations which originate from sources outside the target group.

Opinion leaders play a less important role in influencing the attitudes and behaviors of others, so decentralized diffusion approaches will be more effective than centralized diffusion approaches.

Selection and training of change agents is therefore more important than with diffusion in the general community. Members of the target group must perceive the people giving them the message as credible and trustworthy.

Other issues which need to be considered when diffusion theory is applied to public health interventions²⁶ include the necessity to:

- Understand the subculture sufficiently well to be able to make reasonable predictions about which innovations may be accepted
- Design a public health intervention – or innovation – which is acceptable, rather than wait for one to be discovered or introduced in some other way
- Monitor how the subculture uses the innovation, and any changes that result from its introduction
- Be prepared to make alterations to the innovation or the way that it is being introduced, according to the results of monitoring.

Experience of innovation diffusion amongst injecting drug users shows that innovations such as new, less risky drug preparation methods or injecting practices are communicated more effectively when the target group is involved in their creation and dissemination.

Involvement of active injecting drug users in planning and producing educational messages and materials ensures that they are appropriate for the target group.

Systematic risk assessment

Systematic risk assessment questionnaires, which can be completed by workers with individual service users, can be helpful in:

- Raising and discussing risk behaviors in detail
- Informing the worker as to the priorities for safer injecting information.

One of the most commonly used injecting risk assessment tools are the injecting risk questionnaires²⁷ (IRQs) developed by the Centre for Research into Drugs and Health Behaviour (London, UK) which enable risk assessments to be carried out either by interview or self completion, both in agency and non-agency settings.

Individual risk assessments should look at all the aspects of a client's behavior that can put him or her at risk for infections and other problems. They may be developed by each program and based on knowledge gained from the rapid situation assessment and subsequent work, including outreach.

Systematic client assessments should be available for workers to assess for:

- Blood-borne virus transmission risk, covering both HIV/AIDS and hepatitis B and C
- Overdose risk
- Other problems related to drug use
- Sexually transmitted disease risk.

Outreach work

Outreach work involves making effective contact with the drug-using population by going out to meet them in their homes or places they congregate.

This is not as easy as it may seem. It is often assumed that if a drug user is not employed or a student, they must have a lot of spare time to sit, talk and discuss their health needs. Experience has shown that, for many injectors, the tasks connected with their drug use mean that they are at least as occupied as many people with full-time jobs.

Time is therefore very important, especially in open scenes, where drug users often only feel able to spend a brief period talking to health workers, in between trying to buy/sell drugs, using drugs, looking out for police, looking out for people to whom they owe money or who owe money to them, talking to friends, making social and business arrangements, etc.

Making first contact

The first step in outreach is making contact with drug users.

First contact is often made through narcological services, HIV/AIDS clinics or infectious diseases hospitals, or other drug-related services (such as NGOs).

These are often good places to contact injecting drug users because they have usually gone there to address health concerns. Although they may not be seeking to stop using drugs immediately, they may be open to harm reduction interventions and are probably part of drug-using social networks.

The first step when making contact with a drug user is usually the same as meeting anyone with whom we want to talk: we start a conversation to find out more about the person, we introduce ourselves, and we begin building trust.

There are some general rules for outreach workers during this first conversation. It is important that you:

- Introduce yourself
- Explain what your task is
- State who you are working
- Explain why the organization is doing this work, and what your rules on confidentiality are
- State what you can do for injectors
- Always be honest.

Honesty is vital during the first and subsequent interviews as drug users are often suspicious. Any dishonesty is likely to cause problems for both the individual worker and the agency they work for in terms of building the trust of the drug-using community.

Outreach in an 'open drug scene'

In some cities there is an 'open scene', where drugs are bought and sold fairly openly on the streets or in some other area.

This is often a good place to make contact with drug users as there may be many injecting drug users in a small space. This means interviews or information distribution can be achieved with a large number of people in a short time.

Below are two examples of outreach work in open scenes.

In a park in the center of Sofia (Bulgaria), many injectors gather each evening, together with many other young people. There are well-lit paths with restaurants and bars in one section of the park and no lighting in the remainder of the park. Users seeking drugs and people selling drugs move from group to group on one of the paths, talking to members of their social networks.

If a drug sale proceeds, the buyer and seller leave the path to conclude the transaction in an unlit area, often returning to have a drink with their friends. This area is an obvious focal point for a needle and syringe program.

Workers, carrying distinctive bags, move from group to group, and injectors come to them asking for needles, syringes and advice.

At the Bird Market in Moscow (Russian Federation), there are many people buying and selling various items. Among them are buyers and sellers of drugs – and police trying to catch them.

There are also outreach workers trying to provide information to drug users.

As Roman, one of the outreach workers, said: 'There is a very short time between the drug user coming into the market, finding the seller, buying drugs and leaving. Police are always watching and trying to catch the user and the seller. Once they have their drugs, users must leave as quickly as possible to avoid being caught. So we try to spot drug users coming into the market and reach them before either the drug sellers or the police. We simply walk past them and slip a brochure into their hand. We always stay in certain places so they can come up and ask us questions as well.'

As these examples show, outreach needle and syringe programs work well if the drug users trust the workers.

It is for this reason that many programs hire active injecting drug users, or ex-users, to provide needles and syringes. Often, when needle and syringe programs are starting, there is an assumption that doctors, social workers, or even police can do outreach work.

However, it is usually very difficult for these groups to achieve rapport and gain the trust of drug users. Drug users have good reason to be mistrustful: if they trust the wrong person they may end up in jail, without drugs, injured or dead.

Outreach in a 'closed drug scene'

In many places, drugs are bought, sold and used very secretly. Drug sellers may work with pagers or mobile phones and drug buyers must be introduced to sellers by people the seller trusts.

These are known as 'closed scenes' and they are very common in CEE/NIS. Below are examples of outreach work in areas with a closed drug scene.

In Pskov (Russian Federation), with a population of 200,000, the needle and syringe program found it difficult to work in a city 'where everyone knows everyone else'. There is no visible drug use in the city and both the interviewing of injectors for the rapid situation assessment and outreach needle and syringe provision had to be done very carefully using snowball techniques – getting existing contacts to introduce workers to new clients.

Most contacts with service users are carried out in apartments. The outreach workers also refer clients to the city's AIDS center for hepatitis B vaccination, testing for HIV and hepatitis, and free anonymous medical services.

In Szeged (Hungary), outreach needle and syringe program workers based at the Youth Drug Center have penetrated a large network of apartments where injectors meet, prepare and inject drugs.

According to the program managers, the Center's staff had at first 'developed a narrow range of contacts with the drug-using population but had little contact with the hidden drug scene'. During its first six months of operation, the outreach team discovered 30 apartments where drug users were living and injecting together.

Outreach in other 'scenes'

In addition to open and closed scenes, there are many places where groups of young people gather to listen to music, drink, etc.

These can also be useful places to try to find injecting drug users. A difficult aspect of working in these scenes is that the outreach worker wants only to reach injectors and does not want to waste time or cause anxiety by addressing non-drug users.

Below are some ideas that have been used to reach injecting drug users in a crowd.

In Amsterdam (Holland), an outreach worker went to a bar every evening when she thought drug injectors might also be there. She always carried a distinctive bag. On the third evening, as she was getting up to leave, she dropped her bag and condoms and needles poured out.

The bar customers helped her gather the contents together and asked why she was carrying all these materials. She explained her role as a needle and syringe program worker and started a conversation with injectors in the bar.

In Sydney (Australia), a needle and syringe program made a poster with simple drawings of scenes of discrimination against drug users (being refused medical treatment, etc.) with the text 'Drug users, has this happened to you? We may be able to help. Call (phone number)'.

The posters were placed in many locations where injectors were thought to gather. When drug users called to complain, they were helped with their problems and told about the program's services.

Examples of good practice in outreach work

The following set of guidelines is based on those drawn up by outreach workers in Poltava (Ukraine) for their work with injectors:

- Ensure privacy – do not speak to an individual on personal topics when they are in a group with their friends.
- Ensure confidentiality – never talk about
- one service user to other service users, even if you know they are friends.
- Try to work with group 'leaders' – they may be harder to speak to but, if they listen, they will tell others.
- Never interfere when service users are 'doing business' related to drugs as their minds will be preoccupied and the reaction of the other person to the intrusion may place the worker in danger.
- Form a genuine relationship with service users – feel free to joke and talk about the weather or local news to help people feel at ease, but don't forget that there must be more to the relationship, and part of the role of the outreach worker is to pass on information and advice.
- Always make the time to go deeply into a problem or issue raised by a serviceuser.
- Outreach workers must know their responsibilities and all articles of the Criminal Code concerning drug users.

During the first conversation or later, you can raise issues of safer drug use and safer sex.

This is sometimes done by outreach workers as a separate activity on its own; it is also usually done by program workers as they give out needles and syringes. It is sometimes also done by people carrying out surveys (for a rapid situation assessment for example), where safer behavior is discussed after the survey is completed.

Methods commonly used to raise the issue of safer behavior include:

- Situational cues – if the user has an abscess, complains of sickness, says they have recently been to hospital or had hepatitis, or a recent HIV test, these are all good points at which to start talking about less risky injection
- Incorporating an HIV prevention message in a broader conversation about the injectors' health in general or the other problems of injectors
- Getting a conversation started – in which health will be one subject – with open friendly questions like 'How are you?', 'How are things going?'

In these types of conversations and, as we saw above in the Moscow Bird Market example, materials can also be very useful.

These might be a business card, a leaflet or sticker, a magazine or newsletter designed for drug users, condoms, etc. They can then be used to start a conversation or, in the case of the Moscow Bird Market, to give drug users something short to read and from which they can ask questions the next time they see the outreach worker.

In Calcutta (India), the Indian Council of Medical Research has established a needle and syringe program and outreach education center staffed by current injecting drug users.

The outreach workers are based at a drop-in center in the inner suburb of Mehidibagan, and provide outreach for two hours each morning and evening, five days a week, with the intervening time spent at the drop-in center.

They provide education about how HIV and hepatitis B and C are spread, and how abscesses can occur, together with prevention information.

In a group interview, the outreach workers said they were better able to understand drug users because of their own drug use: 'If users have a trouble, we know it. Users are happy to talk to us. We love the user... we are one big family.'

Additional services and referral

Needle and syringe programs need to be linked to a range of other services so that when they are unable to address important issues themselves – due to lack of time, finances or expertise – appropriate help is available.

In countries where needle and syringe programs have been effective, access to appropriate services is considered to have been an important factor in their success.

These include:

- Medical treatment – this ranges from first aid to full clinical medical services, and may include a full range of HIV and hepatitis treatments
- Counseling – in most cases, counseling is provided on drug dependence and ways to reduce or stop drug use, but it may also focus on other areas such as relationships, work, finances, food, gambling and sexuality
- Drug treatment – sometimes needle and syringe programs are run as part of drug treatment services but, more commonly, referral processes are used to assist clients to enter treatment when they want this
- Hepatitis B vaccinations for needle and syringe program clients
- Hepatitis A vaccination – this is increasingly being carried out by programs in CEE/NIS because, although hepatitis A is not life-threatening in itself, a death rate of up to 40% has been reported for people who have hepatitis C and then get hepatitis A for the first time.²⁸

Examples of referral systems

In Temirtau (Kazakhstan), a group of needle and syringe programs list their main tasks as establishing trust with injecting drug users and providing them with:

- Psychological support
- Information on HIV prevention
- Informational materials designed in partnership with injectors
- Safer injecting and safer sex training
- Condoms, syringes, disinfectant etc.
- Medical assistance for injectors with abscesses and sexually transmitted diseases.

In addition, a telephone helpline has been set up. This provides support and counseling on the issues of HIV/AIDS, sexually transmitted diseases and drug prevention. The helpline also aims to increase skills and motivation for moving towards safer drug use and sexual behavior, for non-injecting forms of drug use and abstinence. A support group for HIV-positive people and their relatives has also recently been started at one of the needle and syringe program sites.

At Chicago Recovery Alliance (USA) there is a specific procedure for providing referral to other services. The initial contact between the worker and the client must include mutual

agreement on the type of assistance desired and a clear understanding of what the referral source offers.

These two pieces of information form the basis for referral work. The goal will be the positive change(s) sought, not simply access to the referral agency. CRA believes this perspective is crucial because there is more than one way to accomplish the same goals and referral is not always available.

Advocacy

Another area of work in which needle and syringe programs often become involved is advocacy.

In many countries, needle and syringe programs find themselves in the unique position of having daily contact with drug users who have many problems concerning treatment by police, discriminatory medical treatment for everyday illnesses, poverty, homelessness and so on.

These are not issues which most needle and syringe programs can solve by themselves, so program managers and workers need to advocate for better treatment of injecting drug users by a city or region's institutions.

Healthy Options Project Skopje (HOPS) in Skopje (Macedonia) distributes brochures to its clients explaining their civil and legal rights.

The brochures were prepared by the Civil Society Resource Center. The two groups carry out seminars to raise awareness among injectors and state institutions about illegal police procedures and other issues.

In addition, changes to the Macedonian law regarding health insurance threatened to exclude all illegal drug users, meaning injectors would have to pay for all health services, including those related to HIV or hepatitis treatment.

HOPS tackled this problem by addressing an open letter on the issue to the health ministry, politicians and the media. In this way, the needle and syringe program can become a 'voice' for drug users where they traditionally have not been consulted by policy makers.

Promoting pharmacy syringe sales

Because few needle and syringe programs can make equipment available 24 hours a day, seven days a week, drug users should also be able to buy needles and syringes from pharmacies.

In some countries, such as the UK and Australia, free pharmacy-based needle and syringe schemes operate. However, in many countries pharmacies are hostile towards injecting drug users and will not sell them equipment.

Needle and syringe programs may need to educate pharmacies about the necessity of clean needles and syringes being readily available and other aspects of HIV prevention.

Evaluation

Regular assessments are needed to ensure that the needle and syringe program remains effective. In addition to the reports based on the record-keeping procedures described in Chapter 6, you may wish to undertake many other evaluation tasks.

To sustain support for a program, it is often necessary to carry out an impact evaluation to show that it has made a difference in HIV prevention in the city or region. A major problem in CEE/NIS countries is the desire to see very fast results reflected in quick and massive reductions in new cases of HIV.

As discussed, changing behavior is complex and takes time, and a reduction in new cases of HIV will only result after a significant proportion of people practice less risky behaviors, which may take many months, even several years, to achieve.

To evaluate the impact of a needle and syringe program, it is necessary to have a picture of what the situation was like before your program began: this is called a 'baseline'. If you have carried out a rapid situation assessment prior to starting the program, this can be used as a baseline.

Repeating the rapid situation assessment every year or two to see whether there have been any changes either in physical measures such as overdose deaths and HIV/AIDS statistics or in data which shows the levels of various behaviors such as needle sharing, unsafe sex, etc. can be useful.

It is important to be rigorous in interpreting data as there are multiple factors at work and it is difficult to be certain that any changes, good or bad, are directly caused by the work of the needle and syringe program.

9. Appendix: Useful contacts, websites and publications

Contacts

For details of local offices of the Open Society Institute, International Harm Reduction Development and of needle and syringe programs operating in the region, contact International Harm Reduction Development via their head office in New York at:

Open Society Institute
International Harm Reduction Development
400 West 59th Street
New York
NY 10019
USA

Tel: 212-548-0677
Fax: 212-548-4617

Email: ihrd@sorosny.org

Websites

Because websites are subject to constant change it is planned to maintain a list of websites which contain information of interest to people involved in setting up and running needle and syringe programs in Central and Eastern Europe and the newly independent states.

This site can be found on the Internet at

<http://www.soros.org./harm-reduction>

Those publications listed below which are available on the internet can be accessed via links on this page.

Useful publications

Unless stated otherwise all publications are available in English only from bookshops.

Websites listed here (and others that become available following publication of this book) can be accessed via the web address given on p.??.

Burrows D., Rhodes T., Trautmann F., Bijl M., Stimson G., Sarankov Y., et al. (1998). Responding to HIV infection associated with drug injecting in Eastern Europe. *Drug and Alcohol Review*, 17: 453–63.

Available from IHRD, New York in both English and Russian.

Chicago Recovery Alliance Procedures Manual. CRA, USA.

Available on the Chicago Recovery Alliance website, which can be accessed via the link given above.

Derricott, J., Preston, A., and Hunt, N. (1998). *The Safer Injecting Briefing*. HIT, Liverpool. Available from HIT, Cavern Walks, Mathew Street, Liverpool L2 6RE, UK.

Also available on the Internet.

European Monitoring Center on Drugs and Drug Addiction (EMCDDA) (1998). *Annual Report on the State of the Drugs Problem in the European Union*. EMCDDA, Portugal.

Available from EMCDDA, Rua Cruz de Santa Apolónia, 23/25, Lisbon, 1100, Portugal.

Lindesmith Center (1997). *Needle and Syringe Availability*. New York.

Available from International Harm Reduction Development in New York and Open Society Institute offices (see p. 122).

Rhodes, T. (1996). *Outreach Work with Drug Users: principles and practises*. Council of Europe Press, Strasbourg.

Available from the Open Society Institute offices (see p.122) in English, Russian, Bulgarian, Czech, French, Hungarian, Polish, Romanian and Slovene.

Stimpson, G.V., Fitch, C., and Rhodes, T. (1997). *Rapid Assessment and Response Guide on Injecting Drug Use*. World Health Organisation/UNAIDS, Geneva.

Available from the Open Society Institute offices in New York (see p.122).

Stimson, G.V., Des Jarlais, D.C., and Ball, A. (eds) (1998). *Drug Injecting and HIV Infection*. World Health Organization /UCL Press, London.

Trautmann, F. and Barendregt, C. (1994). *European Peer Support Manual*. Trimbos Institute/European Commission, Utrecht. Available in English and Russian from Trimbos Institute.

United Nations Drug Control Program. (1997). *World Drug Report*. World Bank/UNAIDS, Geneva.

World Bank/UNAIDS 1997 *Combating AIDS*. Oxford University Press, Oxford.

10. References

- 1 UNAIDS/World Health Organisation. (December 1999). The AIDS Epidemic Update. Geneva.
- 2 Rhodes, T., Ball A., Fitch C., Stimson G.V., Kobyschka Y., Prokovski V., Burrows D., Berzuchenko-Novachuk M., and Andrushchak L. (1999). The rapid spread of HIV among injecting drug users in Eastern Europe demands rapid assessment and response. *Addiction* 94: 1323–36.
- 3 Smolskaya, T., Momot, O.F., Tahkinova, I.P. and Kotova, S.V. (1998). Behavioural studies and HIV/AIDS prevention policy in Russia, 12th World AIDS Conference, July, Geneva. [Abstract 14191].
- 4 Stimson G.V., Alldritt L.J., Dolan K.A., et al. (November 1998) Injecting Equipment Exchange Schemes: Final Report. University of London, Goldsmiths College. Monitoring Research Group, London.
- 5 Does needle exchange work? Center for AIDS Prevention Studies, University of California. Website: www.epibiostat.ucsf.edu/capsweb/needletext.html
- 6 WHO International Collaborative Group, (1994). Multi-city Study on Drug Injecting and Risk of HIV Infection. World Health Organization, Geneva.
- 7 Des Jarlais, D., Hagan, H., Friedman, S., et al. (1998) Preventing epidemics of HIV-1 among injecting drug users. In: Stimpson, G.V., Des Jarlais, D.C., and Ball, A. (eds) *Drug Injecting and HIV Infection: global dimensions and local responses*. UCL Press, London.
- 8 Watters, J.K., Estilo, M.J., Clark, G.L., et al. (1994). Syringe and needle exchange as HIV/AIDS prevention for injecting drug users. *Journal of the American Medical Association*, 271: 115–20.
- 9 Feacham, R. (1995) Valuing the past... Investing in the Future: Evaluation of the National HIV/AIDS Strategy 1993-94

- to 1995-96. Commonwealth of Australia, Canberra.
- 10 Postma, M., Wiessing, L., Kretzschmar, M., Hartnoll, R., and Jager, H. (1999). Costs of drug-related infectious diseases in EU member states. Paper presented at 10th International Conference on the Reduction of Drug-related Harm. Geneva.
 - 11 World Bank/UNAIDS (1997). *Combating AIDS* Oxford: Oxford University Press, London.
 - 12 Stimson, G.V., Fitch, C., and Rhodes, T. (1997). *Rapid Assessment and Response Guide on Injecting Drug Use*. World Health Organization/UNAIDS, Geneva.
 - 13 Wodak, A., Crofts, N., and Fisher, R. (1993). HIV infection among injecting drug users in Asia: an evolving public health crisis. *AIDS Care*, 5: 313–20.
 - 14 United Nations Drug Control Program (1997). *World Drug Report*. Oxford University Press, Oxford.
 - 15 Frischer, M. (1998). Mobility and the diffusion of drug injecting and HIV infection. In: Stimson, G. V., Des Jarlais, D. C., and Ball, A. (eds) *Drug Injecting and HIV Infection: global dimensions and local responses*. UCL Press, London.
 - 16 World Health Organization (1998). *Basic Principles for Effective HIV Prevention among Injecting Drug Users*. WHO, Geneva.
 - 17 World Health Organization (1986). *The Ottawa Charter on Health Promotion*. WHO, Geneva.
 - 18 Samson, L., Panda, S., Mesquita, F., Ball, A., and Sarkar, S. (1999). Harm reduction for drug-related HIV in developing countries. Paper presented at 10th International Conference on the Reduction of Drug-related Harm, Geneva.
 - 19 Bluthenthal, R., Lorvick, J., Kral A. H., Erringer, E.A., and Kahn, J.G. (1999). Collateral damage in the drug wars: HIV risk behaviours among injection drug users. *International Journal on Drug*

- Policy 10 (1): 25–38.
- 20 New South Wales Department of Health (1997). New South Wales Needle and Syringe Exchange Program Policies and Procedures Manual. DoH, NSW, Australia.
- 21 Short, L.J., and Bell, D.M. (1993). Risk of occupational infection with blood-borne pathogens in operating and delivery-room settings. *American Journal of Infection Control*, 21: 343–50.
- 22 Andrade, T., Lurie, P. and Nunez, M.E. (1999). The effect of a crack epidemic on the NEP in Salvador, Bahia – Brazil. Paper presented at 10th International Conference on the Reduction of Drug -related Harm, Geneva.
- 23 Scott, J., Kennedy, E.J., Winfield, A. J., et al. (1988) Investigation into the effectiveness of filters for use by intravenous drug users. *International Journal of Drug Policy*, 9: 181–6.
- 24 Trautmann, F. and Barendregt, C. (1994). *European Peer Support Manual*. Trimbos Institute/European Commission, Utrecht.
- 25 Rogers, E. M. (1995). *Diffusion of Innovations* (4th edn). The Free Press, New York.
- 26 Friedman, S.R., Des Jarlais, D.C., and Ward T.P. (1994). Social models for changing health-relevant behavior. In DiClemente, R.J., and Peterson, J.L. (eds) *Preventing AIDS: theories and methods of behavioural interventions*. Plenum Press, New York.
- 27 The Centre for Research into Drugs and Health Behaviour (1997). *The Injecting Risk Questionnaire*. CRDHB, London.
- 28 Vento S., Garofano T., Renzini C., Cainelli F., Casali F., et al. (1998). Fulminant hepatitis associated with hepatitis A virus superinfection in patients with chronic hepatitis C. *New England Journal of Medicine* 338(5):286-290.