



UNITED NATIONS
Office on Drugs and Crime

Regional Office for
South Asia

PREVENTION OF
TRANSMISSION OF HIV AMONG DRUG USERS
IN SAARC COUNTRIES

TD/RAS/03/H13

2

**PEER-LED COMMUNITY OUTREACH
INTERVENTION**

INTERVENTION TOOL-KIT
UNDER TESTING

Intervention Tool-kit
(A set of six modules)

An UNODC ROSA undertaking

For the AusAID supported project 'Prevention of transmission of HIV among Drug Users in SAARC Countries' (Project code- TD/RAS/03/H13)

Module 2

'Peer-led Community Outreach Intervention'

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Excerpts and examples from the Peer-led Intervention Protocol written by the late Dr. H. S. Sethi and his team and developed under the UNODC-ROSA project (TD/RAS/02/G23,) have been used as appropriate in this module.

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Intervention Tool-kit

Module-2

'Peer-led Community Outreach Intervention'



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



Australian Government
AusAID

EXTRACT FROM THE OPENING STATEMENT OF ANTONIO MARIA COSTA, UNODC EXECUTIVE DIRECTOR AT THE 48th SESSION OF THE COMMISSION ON NARCOTIC DRUGS, VIENNA, MARCH 7–14, 2005

"In many countries, the current dramatic spread of blood-borne infections, from HIV/AIDS to Hepatitis C, is aggravating the suffering that comes from the chronic abuse of drugs. As a result, people at risk of HIV, or already infected by AIDS need tangible, targeted, immediate help, before this pandemic evolves into the biggest killer in history ... My office is mandated, via the UN Drugs Conventions, not just to reduce the prevalence of drug abuse, **but also to reduce the harm caused by drugs.**

The best form of dealing with the problem is, of course, abstinence and at UNODC, we've invested substantial resources in prevention and treatment. We are increasing the assistance to populations at high HIV/AIDS risk, and we work with governments so that they can reach people before they join the ranks of the HIV-positive. This is where we can make a significant difference. This is where resources are well spent, as it is always easier to attack a problem before it materialises, or spins out of control.

My office believes that greater attention and more resources should be invested in drug control programmes aimed at checking the spread of blood-borne diseases. These initiatives must not stand alone, but be part of comprehensive efforts aimed at reducing drug use. We unequivocally reject any initiative, well intended as it may be, that could lead to a perpetuation of drug abuse... Governments can, and must **ensure both drug control and HIV prevention.**

As stated by the INCB in its 2003 report: '*... governments need to adopt measures to reduce the demand for illicit drugs taking into account... the drug-related spread of HIV infection. At the same time... prophylactic measures should not promote and/or facilitate drug abuse.*'"

UNODC'S COMPREHENSIVE PACKAGE APPROACH

HIV/AIDS prevention and care programmes for injecting drug users typically include a wide variety of measures (the 'package' approach), ranging from drug dependence treatment, including drug substitution treatment, outreach providing injecting drug users with information on risk reduction and referral to services, clean needles and syringes, and condoms, voluntary counselling and testing, treatment of sexually transmitted infections, antiretroviral therapy, and interventions for especially at-risk populations such as prisoners and sex workers who inject drugs. Such a comprehensive package of measures also usually includes treatment instead of punishment for persons convicted of minor offences, since drug treatment not only constitutes humane, cost effective alternative, but also incarceration usually increases the risk of HIV transmission.

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1. AIMS

The United Nations Office on Drugs and Crime Regional Office for South Asia (UNODC-ROSA) has developed an intervention tool-kit comprising six modules under the project entitled 'Prevention of transmission of HIV among Drug Users in SAARC¹ countries' (Project code - TD/RAS/03/H13). In view of the heterogeneity that exists in the SAARC region with regard to the pattern of drug use (including injecting drug use) as well as HIV prevalence among drug users (Box 1), the project has undertaken this activity to help develop capacity in the region for scaling up HIV interventions among injecting drug users (IDUs) and other opiate users.

Box 1: Drug Use and HIV

HIV prevalence among injecting drug users (IDU) in the region indicates a differential epidemic.

In the past, there has been very high prevalence in certain areas and in certain areas it has escalated rapidly. For example, while there was no prevalence among IDUs in Nepal in 1994, it rose to over 50 per cent over the next five years (Karki and Upreti, 1999). A similar rapid escalation within a short period of 6–12 months was seen among IDUs in Manipur, North-East India, which reported HIV prevalence in the early 1990s of 80 per cent (Sarkar *et al*, 1993). Currently, it is about 40 per cent (NACO, 2004).

Some cities in India - like Chennai, Mumbai and New Delhi that have a concentrated IDU population - have a prevalence rate of over 5 per cent (NACO, 2004) while Kolkata has consistently recorded a low HIV prevalence of around 2 per cent. Bangladesh is also a low HIV prevalence country, with recorded HIV sero-prevalence of 1.4 per cent among IDUs in 2000, although current prevalence rates among IDUs in certain pockets in Dhaka stand at 4.9 per cent (National HIV Serological Surveillance, 2004-2005; Bangladesh- Sixth Round Technical Report- Government of the People's Republic of Bangladesh; National AIDS/STD Program (NASP); Directorate General of Health Services; Ministry of Health and Family Welfare). In Pakistan, although HIV prevalence is still low, the country is vulnerable to an escalating epidemic due to a number of significant risk factors. In terms of the mode of transmission of HIV, heterosexual transmission accounts for a majority of the cases (63 per cent). Even though the male-to-female ratio of HIV infection is 7 to 1, as is expected in the early stages of an HIV epidemic, this could change. Transmission through exposure to infected blood or blood products and male-to-male sex account for 7 per cent and 6 per cent, respectively. Mother-to-child transmission accounts for

The present document is the second in the series of six modules with the following aims:

- ◆ To reduce the HIV vulnerability of drug users (including injecting drug users) and their sexual partners in SAARC countries by facilitating peer-led interventions under project RAS/H13 of UNODC-ROSA.
- ◆ To provide a guideline for designing a 'Peer-led Community Outreach Intervention' among drug users (including injecting drug users) and their sexual partners, for agencies in the SAARC countries that have identified HIV vulnerability among drug users and have decided to initiate or enhance the reach of such HIV/AIDS interventions through a standardised, peer-driven approach.

¹ The South Asian Association for Regional Co-operation

Box 1: Drug Use and HIV

about 3 per cent of cases and IDUs for about 1 per cent. Of concern is that the mode of transmission for the remaining 20 per cent of cases is not known (<http://lnweb18.worldbank.org/sar/sa.nsf/Countries/Pakistan>). There are also countries like Sri Lanka, where HIV is yet to be established among drug users.

A majority of IDUs in the region exhibit high levels of injecting as well as sexual risk behaviours. For example, in a high prevalence area like Manipur, where injecting drug use drives HIV, transmission of HIV from IDUs to their spouses has been established. One study found that close to half (45 per cent) of the wives of IDUs who were HIV positive also had HIV (Panda S *et al*, 2000).

In some areas, the population segments at risk for drug use and high-risk sex overlap. A Rapid Situation Assessment (RSA) carried out in the Maldives (NCB, UNDP, UNESCAP, FASHAN, 2003) revealed that almost half (49 per cent) of drug users were young people. Around 8 per cent reported injecting drug use. Respondents also reported sexual activity at an early age - around a third reported sexual exposure by the age of 15 years and about 92 per cent had a sexual experience in their teenage years. A further dimension of risk behaviour was revealed in the study, where more than one in four respondents who reported pre-marital sex, had had sex with a commercial sex worker.

- ◆ To provide a framework for developing human resources in order to implement peer-led community outreach interventions.
- ◆ To provide a framework for the monitoring of such projects in order to evolve a standardised approach.

2. INTRODUCTION

Though no real data exists, it is estimated by policy planners and service providers that there are roughly over four million drug users in the SAARC region. Chasing (inhaling the vaporised form) of heroin is popular in the region, though transition to injecting has occurred and is rapidly diffusing. It is again estimated that SAARC countries would have about 400,000 IDUs. It needs to be stressed that at present apart from India no survey or size estimation of either drug use or injecting drug use has been carried out in the region. Of concern is the escalation in the abuse of pharmaceutical drugs, including synthetic opiates (like injectable buprenorphine), tranquillisers (diazepam), antihistamines and drug cocktails. The sharing of injecting equipment is common in India, Nepal and Bangladesh and many IDUs in the region also practise unsafe sexual behaviours.

2.1 The problem scenario:

The problems in the region regarding injecting drug use and HIV are many:

- ◆ Drug users are a hidden population and are hard to reach.
- ◆ Only a relatively small number of drug users are benefiting from evidence-based interventions.
- ◆ The quality of interventions for injecting drug users to prevent HIV is often poor.

Box 2: Vulnerability of other population groups to drug use and HIV

In India, among FSWs, who have ever used any intoxicating drug, one-third of them had taken some injectable drug in the 12 months prior to the survey (NACO, 2002a).

In a five-city study in India (Delhi, Mumbai, Chennai, Kolkata, and Bangalore), 12.5 per cent MSM respondents reported drug use. Among them, 12 per cent reported injecting drug use during last 12 months of the study (NACO, 2002b).

"The vulnerability of street children to STI/HIV is also an established fact due to consensual and non-consensual sexual contact and injecting drug use. Many of the street children, child sex workers and working children are also into different forms of drug use" (Human Rights Watch, 2004).

- ◆ Many agencies do not have the required technical ability to design and develop appropriate interventions or to properly implement and evaluate their own work.
- ◆ Stigma surrounding injecting drug users and HIV seropositive people is widespread.

Drug injecting may also contribute to an increased incidence of HIV infection through transmission to children of drug-injecting mothers, and through sexual contact between drug injectors and non-injectors (primarily from HIV seropositive IDUs to their sexual partners). HIV risk among drug users does

not arise only through injecting. Many types of psychoactive substances, whether injected or not (including alcohol) are risky to the extent that they affect the individual's ability to make decisions about safe sexual behaviour.

Injecting drug use patterns and associated HIV-risk behaviours are dynamic, and vary between countries, populations and time. Such patterns are determined by a broad range of individual (knowledge, attitude and behaviour) and contextual (social, economic, cultural and political) factors that together establish the conditions for HIV spread (Ball *et al*, 2001).

2.2 Responding to STI/HIV transmission risk between drug users and their sexual partners:

During the last three decades, various risk reduction measures have been found to reduce the STI/HIV vulnerabilities of drug users (including injecting drug users) and their sexual partners.

Risk reduction, in relation to drug use and HIV, aims at interventions that increase risk perception and encourage drug users to sustain changes towards healthy behaviour. It does this by way of simultaneously addressing environmental barriers and improving access to risk reduction supplies and services. These interventions are designed to bring about change at four levels:

1. Individual
2. Interpersonal (between self and other persons in the social network of the drug user, in the drug use and sexual norms of a sub-group)
3. Community (peer opinion, social norms, working together)
4. Socio-political (drug demand reduction policy, HIV/AIDS prevention policy, law enforcement policy)

Box 3: Risk

WHO defines risk in relation to HIV as the probability of contracting HIV. It deals with the person's own perception of probability of getting HIV.

Risk behaviour is defined as "specific form of behaviour, which is proven to be associated with increased susceptibility to a specific disease or ill-health," (in this case, HIV).

Risk behaviour in relation to drug use and HIV/AIDS

Following is an abbreviated list of risk behaviours in relation to drug use and HIV/AIDS:

- ◆ Drug use influencing decisions of safer sex behaviour
- ◆ Injection drug use - the multi-person reuse or sharing of unclean injection equipment and paraphernalia (direct and indirect sharing)
- ◆ Unprotected sex with HIV infected sexual partner

2.3 Outreach:

Outreach is basically reaching out to hard-to-access groups of people with information, supplies and services. In conjunction with STI/HIV prevention, it aims to facilitate the improvement of health and reduction of risk of HIV

Box 4: Defining outreach

"A community-oriented activity with the overall aim of facilitating improvement in health and reduction in the risk of HIV transmission for individuals and groups from particular populations who are not effectively reached by existing or through traditional health education channels".

As cited in Rhodes T, Holland J, Hartnoll R, and Johnson A, 1991, "Hard to reach or out of reach", HIV Outreach Health Education; National and International Perspectives, University of London, Birkbeck College; Hartnoll.

transmission among vulnerable groups having high-risk behaviour who cannot be effectively reached through conventional health education and services. Since HIV/AIDS is often associated with stigma and discrimination, outreach intervention has become an appropriate, widely used and essential approach to make available and accessible HIV/AIDS information, risk reduction supplies (e.g., male and female condom, needle/syringes, bleach, etc.) and services (e.g., treatment of STI/RTI, counselling, drug substitution, etc.) to hidden and hard-to-reach populations.

Box 5: Why outreach?

Outreach is designed to reach hidden populations of drug users in their communities, engage them in a process and provide the means to enable them to reduce their risk of acquiring HIV infection. HIV in IDUs is spread primarily through behaviour related to multi-person reuse (sharing) of contaminated syringes, needles, other drug injection equipment and sharing drug solutions as well as by unprotected sexual intercourse with HIV-seropositive persons (WHO, 2004: 10).

In most countries, a majority of drug users attempt to remain hidden from the authorities especially law enforcement. They often avoid using treatment provided by agency-based services in order to protect their privacy (WHO, 2004: 10).

Drug users who could benefit most from conventional HIV prevention services and drug treatment are the least likely to use these services (WHO, 2004: 10).

It has been found that outreach based services are effective in reaching out-of-treatment injecting drug users, thus not only initiating a process of behaviour change but also inducing behaviour change in the desired direction (Coyle *et al*, 1998).

2.3.1 Types of Outreach:

Based on the definition of outreach given by Rhodes *et al* (Box 4), outreach can be detached or peripatetic.

Detached work is undertaken outside any agency setting. For example, work undertaken on the streets, stations, in pubs and cafes. This may aim either to effect risk reduction change directly (on site) in the community, or aim to facilitate change indirectly by attracting individuals into existing treatment and helping services.

Peripatetic work focuses on organisations rather than on individuals. For example, work undertaken in prisons, needle and syringe exchanges, hostels and youth clubs. Peripatetic outreach places emphasis on broadening the range of people who are reached with health education messages, expanding their knowledge about available services, and training other workers and staff.

2.3.2 Peer-based outreach:

An outreach setting requires entering the world of vulnerable population groups and working with them on their terms. It is not based on value judgements such as 'what is good or bad for them'. In order to address the problem of gaining access to the world of people not in touch with current services, service providers often decide to recruit people indigenous to an area or particular group and then train them as peer-outreach workers. In recent years evidence-based responses have reaffirmed the effectiveness of the most commonly applied form of outreach, which is primarily peer-based. Peer-based outreach not only ensures responses based on current risk practices (as end users are also the service providers) but also enhances the scope of scaling up (qualitative and quantitative reach) and ensures sustainability in terms of the utilisation of services, because it allows participation of the targeted population from the onset of intervention

Box 6: Peer education

Peer education has been used extensively in different settings for the reduction of risk-taking behaviour related to drug abuse and HIV/AIDS. Use of "true" peers i.e. current drug users, for spreading HIV/AIDS prevention message among fellow drug users, however, is a relatively recent phenomenon. As compared with outreach workers, peers have been found to be more effective in recruiting drug users for HIV/AIDS interventions. Numerous definitions of the word "peer educator" are found in the literature. In some instances "peer educators" can be ex-users who are not members of the peer group where an intervention is in place. In other instances, "peer educator" is used for a current user of a peer group who not only delivers an intervention within his/her peer group but an outreach worker for interventions in other peer networks. Research indicates that peer interventions work best when they are part of a larger basket of services.

development. It has been the experience from both developed and developing country settings that 'peers'² form the best 'outreach workers' as they are more acceptable to vulnerable groups such as female sex workers, drug users, transport workers, street children, etc. For the purpose of this module, we would refer to a 'peer-outreach worker' as a member of the same risk behaviour group, which is being targeted. Thus, when targeting an intervention to reach drug users or injecting drug users, 'peers' will be current or ex-drug users.

2.3.3 Community-based outreach:

Community-based outreach is organised to access and engage sub-populations such as drug users/IDUs in a process of risk reduction within communities where they congregate rather than intervening with them when they attend clinics in order to access services. Outreach workers can be

current IDUs or non-injecting drug users, former IDUs or former non-injecting drug users or non-drug users who have close links with, and are trusted by, drug users/IDUs. They can be trained to provide services to those drug users they reach out to and engage with, and at the same time maintain client confidentiality. They can assist drug users in understanding their personal risk of acquiring HIV and other blood borne diseases and in identifying the preventive steps necessary to reduce their risk of doing so. They can also provide information on referral to other services drug users may need and be a source of support to those currently using drugs or injecting.

Box 7: Outreach strategies

Outreach primarily uses two strategies:

Persuasive strategies: This uses mediated/interpersonal communications to persuade any target population to modify risk behaviour (through BCC- behaviour change communication). The outreach component can include/encourage formal and informal peer education in their own group. Their skills are further developed by training and are supported by professional/para-professional outreach workers. Education and counselling skills provide support to client groups, use small media to reach target audiences, provide written information, and also use visual/posters/pamphlets as an introductory technique to trigger discussion.

Persuasive strategies also make appropriate use of behaviour change supplies, e.g., needle/syringes, bleach, condoms, etc., and supplement them with information on where they can access services like STD treatment, health care including abscess management, clean needle/syringes, condoms, etc.

² The English-language term 'peer' refers to "one that is of equal standing with another; one belonging to the same societal group especially based on age, grade or status" (Peer Education & HIV/AIDS, Concepts Uses & Challenges, UNAIDS Best Practice Collection, 1999).

Research has shown that the individual drug user's attempt to achieve and maintain behavioural change often depends on whether these changes are endorsed or encouraged by their peer group. Research also suggests that an individual's attempts at, e.g., condom use, are considerably easier when there exists a peer norm which is supportive or accepting of condom use. If "safety norms" exist in the peer group, it makes it easier for individuals within that group to initiate and maintain behaviour change.

By changing behavioural norms and the peer culture of drug users, network-based interventions may provide an opportunity for large-scale and sustainable risk reduction. The use of a network approach may also prove to be cost-effective, since large numbers of drug users can be reached through a multiplier effect generated by the social links among drug users.

Contd. Box 7

Enabling strategies: It implies community development approaches and policy / structural approaches to enable and encourage target population to adopt safer behaviour in a congenial environment. The outreach project can act as a broker or intermediary between structured conditions that cause risky behaviour among target population. The outreach intervention can utilise the services of one / few outreach workers to work like community extension workers as a part of a community development approach. This form of outreach enables target populations to change behaviour by providing opportunities for the individual to attach to community organisations and existing service providing agencies that can provide long-term support.

2.4 Peer-led Community Outreach Intervention:

The Peer-led Community Outreach Intervention under the project 'Prevention of transmission HIV among Drug Users in SAARC Countries' (RAS/H13) is using the community-based outreach and peer-based outreach models to initiate risk reduction. Peer outreach workers, recruited under the project, identify current users (who are then recruited as peer volunteers). Peer volunteers help Peer Outreach Workers to enter into their own drug using networks and then help to extend outreach into other drug users' networks, including reaching out to their sexual partners who could themselves be injectors or non-injectors. The basic philosophy of this intervention is to facilitate the formation of self-help groups through a rights-based approach so that vulnerable population groups can develop their collective ability to fight for their right to access risk reduction services as also to address their other needs.

2.4.1 Key Elements of Peer-led Community Outreach Intervention:

- ◆ Identifying and contacting the target group - rapport establishment and need assessment.
- ◆ Identifying and contacting opinion leaders and community leaders, law enforcement personnel.
- ◆ Contacting and networking with service providers (NGOs, Government and private sector, including individuals).
- ◆ Advocacy and lobbying to create an enabling environment for behavioural change, mobilise community resources for easy availability of risk reduction supplies and services to the target group.
- ◆ Provision of need-based risk reduction information to target group in relation to drug use and STI/HIV, including availability of different services.
- ◆ Transferring risk reduction skills to target group.
- ◆ Need-based referrals to different service providers and follow-up.
- ◆ Documentation and reporting.
- ◆ Assessment and review, based on behaviour change indicators and workplan.

3. WHAT NEEDS TO BE IN PLACE BEFORE INITIATING THE INTERVENTION

There are a few pre-requisites (see Module 1 for details) before implementing Peer-led Community Outreach Intervention. The implementing agency needs to make sure that these pre-requisites are met before the intervention is initiated. In order to understand the current drug use scenario and the needs of drug users, the implementing agency must ensure the involvement of the end users of such services from the onset of the planning process.

The preparedness of the organisation for implementing an outreach intervention may include the following:

Organising and implementing an outreach intervention:

- ◆ **Outreach Management** - Selection of a Manager / Team-leader/ Coordinator, who is going to lead the team of Peer Outreach Coordinators and Peer Outreach Workers. The management also needs to develop a flexible working policy, because 'Outreach' may not have any fixed timing. A written 'minimum code of conduct' for the outreach worker needs to be prepared and shared with the team while delegating tasks. A mechanism to ensure the safety and security of the 'peer outreach worker' while working in the field needs to be developed (e.g., identity card with photograph, staff designation, name of the project, address, phone numbers all duly signed by the head of the agency and/or local police chief. Staff should be advised as to where and when to use it). Other relevant management issues including 'burn-out management' (dealing with stress in outreach staff) should be dealt with while developing the management plan of the outreach project.
- ◆ **Staffing** - Identifying, recruiting and developing a team to implement the outreach project.
 - ◆ Recruitment - the selection criteria for Peer Outreach Coordinator needs to be developed. However, with regard to Peer Outreach Workers and Peer Volunteers who are current users, staffing policies may need to be reviewed or modified, so that ex-drug users and People Living with HIV/AIDS (PLWHAs) can be recruited as part of the outreach team (daily work schedule, absenteeism, health benefits, etc.).

Box 8:

Peer-led Community Outreach Intervention should be guided by the principle of a rights-based empowering approach, so that it endorses the strength and collective responses of end-users towards sustainable behaviour change process. The end-users must be involved in the planning of the outreach intervention so that their active involvement ensures a bottom-up approach of problem solving with due respect to their needs and ability to change.

Box 9: Working procedure and policies

To help managers/ team-leaders/ coordinators in leading and guiding the outreach team so as to adhere to a strategic focus and to achieve the project goal.

- ◆ For all project personnel, roles and responsibilities should be in writing, explained and handed over with a scope of review from time-to-time but frequent change in job responsibilities must be restricted.
- ◆ Outreach team should know the structure and philosophy of the agency/ organisation and how this relates to other agencies.
- ◆ Clear lines of management for Peer Outreach Workers and Peer Volunteers (current users) should be established.
- ◆ Managers should provide Peer Volunteers with a 'code of practice', which should be discussed and agreed upon as a condition of appointment. This must have a gender dimension and gender perspective with regard to staff and clients as well. The code should be reviewed from time to time.
- ◆ Managers should provide Peer Outreach Workers with written procedures on:
 - Safe disposal of injecting equipment (*See Annex 2.1*)
 - Infection control (*See Annex 2.2*)
 - Needle prick injuries (*See Annex 2.3*)
 - Confidentiality (*See Annex 2.4*)
 - Alcohol/other drug use in the workplace (*See Annex 2.5*)
 - Provision of equipment to under-age contacts (Existing laws in most countries view addiction among minors as a serious condition requiring the minor to be in a supportive environment rather than continue to be in the addictive stage. It would be therefore inappropriate and unethical to provide equipment supporting continued drug use to minors. Service providers need to be clearly instructed on this sensitive issue.)

- ◆ Job responsibilities - a written job responsibility needs to be developed and handed over to different team members before project implementation starts.
- ◆ Training - the entire outreach team needs to be trained before execution of the community-based intervention, as STI/HIV outreach is a skilled intervention.
- ◆ Indicators and Monitoring tools - need to be in place before the field implementation starts and training must be imparted to the outreach team on concepts and use of the monitoring tools.

- ◆ **Materials procurement** - all materials need to be listed and a procurement / production / replenishment plan should be in place before implementation. A suggested list of materials:

- ◆ Materials for Behaviour Change Communication (BCC): to be used for one-on-one and group interactions. They could be, for example, leaflets, small booklets, or flipcharts containing simple messages and visuals using images familiar to local drug users. The topics to be covered could be as under:
 - ◆ basics of HIV/AIDS and its transmission modes
 - ◆ necessary steps for cleaning needle / syringes and their

- appropriate disposal
- ◆ different STIs and their association with HIV transmission as well as information on STI treatment centres where users may go for services
 - ◆ appropriate use of condoms and their disposal and where drug users can access free services
 - ◆ steps for avoiding injection-related injuries and localised infections
 - ◆ messages on living positively with HIV and addresses of Voluntary Counselling and Testing Centres (VCTCs), PLWHA networks, etc.
 - ◆ separate information booklet containing phone numbers and addresses of addiction treatment centres, HIV/AIDS care and support agencies, vocational training centres for youths and ex-drug users, self-help groups such as AA, NA, etc.
 - ◆ additional materials are often required to reach out to sexual partners of drug users and female drug users.
 - ◆ Materials for developing/transferring risk reduction skills: - dildo (wooden/ rubber), a few male condoms for demonstration, a few disposable needle/ syringes, separate glass vials containing water and bleach solution, swabs, etc., should be carried in a 'carry bag' along with BCC materials while conducting outreach.
 - ◆ Materials for Information, Education and Counselling (IEC): Materials should be developed advocating for creation of an enabling environment for the drug users and their sexual partners in the form of literature, A/V aids, visuals, etc. Based on feedback from the outreach workers, identifying local and specific stigma and discrimination related issues around drug use and HIV, further advocacy materials can be developed, or existing materials can be suitably adapted.

Box 9: Contd.....

The above has been provided in the Annex. Copies of the same may be made for distribution.

- ◆ Peer Outreach Workers should contact their manager for help, if needed. Proper contact details should be given, e.g., a phone number where the manager is readily available, as well as adequate money provided (tell POWs to ensure that s/he has it before going out to field, inform account section accordingly).
- ◆ Managers should provide a budget for Peer Outreach Workers' and Peer Volunteers' expenses but it must be made clear to them what these expenses cover and that any expenditure must be accounted for.
- ◆ Managers should see that workers complete a weekly timetable/ workplan of their activities.
- ◆ Peer Outreach Workers and Peer Volunteers should not be 'out' all the time. A work division 70 per cent (exclusively outreach) and 30 per cent (staff meetings, daily feedback, reporting and training) is advisable.
- ◆ Each Peer Outreach Worker should prepare and submit a weekly work plan to the manager and must try to adhere to it.
- ◆ Managers should facilitate and encourage collaborative working with other agencies to avoid duplication.

4. IMPLEMENTATION

This section provides a guideline for the implementation of Peer-led Community Outreach Intervention by agencies in the SAARC region. The agencies should have gone through a Rapid Situation and Response Assessment (RSRA), following the guideline described in Module 1.

The outcome of the RSRA guides the development of an intervention plan. Implementation of Peer-led Community Outreach Intervention is described under five subheads (Box 10)

I) **Planning outreach:** - Each of the Peer-led Community

Outreach Intervention projects must develop an operational plan based on the project objective and goals. The operational plan helps in providing direction to all people involved in the project. In this case, the Peer-led Community Outreach Intervention is primarily intended to reach out to IDUs and their sexual partners. But as heterogeneity prevails in terms of drug-use-related STI/HIV vulnerability in the SAARC region, the project will also reach out to non-injecting opioid users. Each project, in its initial phase, will target 250–300 drug users (focusing on current and potential IDUs) within a geographical domain requiring travel time of not more than one hour from the project office. The strategy for reaching vulnerable populations and the quality of this reach should be reviewed after one year of project implementation.

Based on the RSRA, the project implementation / operational plan may look as follows:

- (A) Goal - 'Prevention of transmission of HIV among Drug Users in SAARC Countries' (Project code- TD/RAS/03/H13).
- (B) Objective - To reduce the transmission of STI/HIV among (mention numbers intended to be reached) drug users (including injecting drug users) and their sexual partners in (name of geographical area and country).
- (C) Duration of the Project.

Box 10: Implementing Outreach

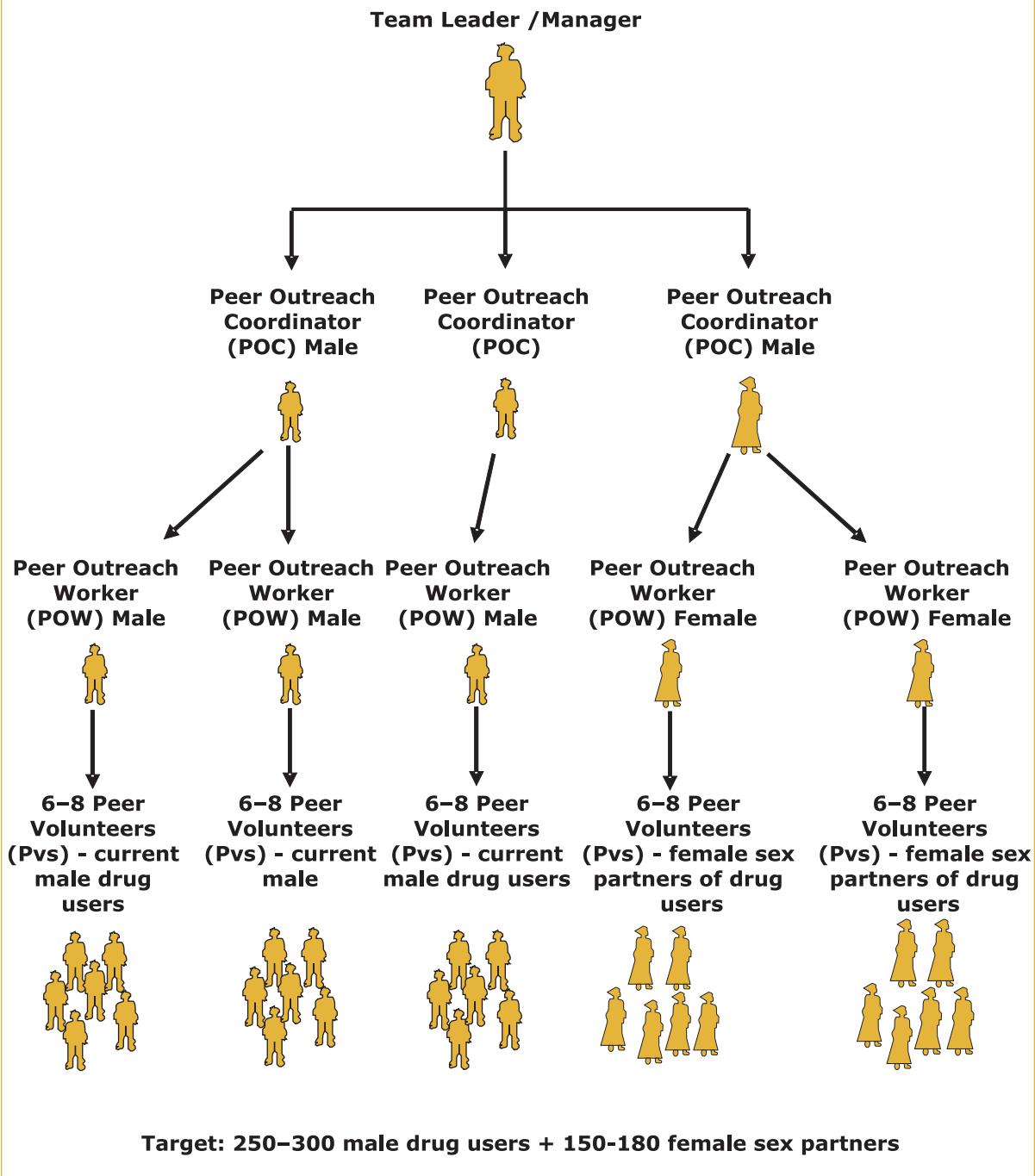
- 1) Planning outreach - Developing operational plans, indicators, reporting formats, material procurements, etc.
- 2) Staffing - Putting the outreach team in place for execution of a Peer-Led Community Outreach Intervention.
- 3) Training - Equipping the team for the job.
- 4) Executing Outreach Intervention - Day-to-day execution of outreach.
- 5) Supervision and Support - Ensuring implementation of outreach intervention as planned by the team and maintaining the team spirit.

- (D) Strategy - Risk reduction approaches (information, supplies, services, referrals) through Peer-led Community Outreach Intervention to be implemented by Peer Outreach Coordinators, Peer Outreach Workers and Peer Volunteers (who are current users).
- (E) Activities: Content of the intervention will depend on the objectives of the outreach programme.

Must be done before actual intervention starts at the community level.

- Recruitment of staff
- Training of staff - induction as well as in-service training.
- Developing BCC/IEC materials - materials can be developed / adapted based on vulnerability and situation assessment data. Materials must be reviewed regularly.
- Outreach work - to *provide direct* service to drug users (including IDUs) and their sexual partners through Peer-led Community Outreach Intervention in the community setting targeting locations and times where risk practices are taking place. May also be at specific settings like 'prisons', 'refugee camps' 'work settlements', etc. Each Peer Volunteer starts the work by going back to his/her own group and gradually expands to reach out to other networks or groups within a specific geographical location.
- Providing and improving access to risk reduction information - with the help of needs-based BCC materials for one-to-one and small group interaction (separately for drug users, IDUs and their sexual partners).
- Identifying potential partners, establishing rapport with and sensitising other local agencies providing risk reduction supply and services.
- Establishing these referral linkages to ensure an uninterrupted and easy supply of risk reduction material, e.g., condoms, needle/syringes, bleach, etc.
- Transferring risk reduction and negotiating skills to those most vulnerable for safer injecting and safer sexual practices, appropriate use of injecting equipment, method of cleaning before every injection, appropriate disposal; appropriate use of condom and its disposal, negotiating skills: to avoid sharing (injecting equipment and/or paraphernalia), to avoid switching back to injecting, to avoid poly drug use, to avoid sex without condoms, to establish rights for services including care, etc.
- Establishing needs-based referral linkages for improving access to risk reduction services - e.g., STI treatment, drug substitution services, VCTC, drug de-addiction, care and support (counselling, primary health care, abscess management, treatment of opportunistic infection and ART).
- Environmental intervention (creating an enabling environment) - to improve a client's access to services, to reduce stigma and

Box 11



discrimination, to establish their right to access and utilise conventional development and welfare services.

- At the community level - with families, CBOs, other identified stakeholders, influencers and service providers.
- At the district level - police, excise and other law and enforcement agencies.
- At the state / province level - political parties, departments, ministries, etc.

- Helping vulnerable/ infected/affected population group to form self-help groups (collectives) to support each other, expand and sustain intervention on their own.
- (F) Project management
- (G) Monitoring and evaluation (indicators, tools, mechanisms - who, when, how, what).
- (H) Detailed activity plan for one year
- II) **Staffing-** The Outreach Team could comprise of 1 Team leader / Manager, 3 Peer Outreach Coordinators (at least one female), 5 Peer Outreach Workers (at least two females), and 40 to 60 Peer Volunteers (who are either current drug users or their sexual partners). Each project will target at least 250–300 drug users and 150-180 regular sexual partners of drug users (since roughly 60 per cent of drug users in the SAARC region are married and are currently sexually active). Each drug-using client should be reached at least every alternate day, i.e., each Peer Outreach Worker will reach out to 20 to 30 clients each day through the identified Peer Volunteers who are leaders of their respective drug user groups. The project should decide on recruiting a mix of male and female Peer Outreach Workers and Outreach Coordinators to reach out primarily to male drug users and their female sexual partners. The same field workforce can be adjusted for additionally reaching out to female drug users, if identified, and the male sexual partners of male drug users. Recruitment should be done on the basis of a pre-decided selection criteria, which obviously will include the 'drug use/recovery' background of the Peer Outreach Coordinators and Peer Outreach Workers.

III) **Training** - The capacity development of the team will primarily focus on the following issues, which can be modified based on a quick 'Training Need Assessment' to be carried out by the training team/ mentor:

- ◆ HIV epidemic among IDUs - basics of HIV/AIDS and vulnerability of drug users and their sexual partners.
- ◆ What can be done to address the problem - concepts of risk reduction approach and behaviour change intervention.
- ◆ How to contact IDUs and out of treatment drug users - concepts of outreach in relation to STI/HIV prevention and care.
- ◆ Outreach skills - condom demonstration and negotiation skills
- ◆ Monitoring an outreach intervention, developing tools for monitoring.

(For a tentative training schedule, see Annex 1 and the 'Facilitator's Guide on *'Conducting Training on Rapid Situation & Response Assessment and Initiating Peer Led Intervention'* developed by the UNODC-ROSA Project 'Prevention of Transmission of HIV Among Drug Users In SAARC Countries'. For additional information, look in 'Workshop Manual, *Training Guide For HIV Prevention Outreach To Injecting Drug Users*, Department of HIV/AIDS, WHO 2003').

A separate training can be organised for Managers/ Team Leaders and Outreach Coordinators on planning, managing and implementing Peer-led

Box 12: An example of a 'Code of Practice' for Peer Outreach Workers/ Peer Outreach Coordinators

- a. Field staff (Peer Outreach Workers / Outreach Coordinators) should provide a weekly timetable of their proposed activities and should ensure that their manager knows where they are. In the event of any change to any activities/ arrangements, or in the event of sickness, workers will contact their manager immediately (Peer Outreach Workers / Peer Outreach Coordinator's absence from field without appropriate arrangements will have a detrimental effect in programme implementation).
- b. Field staff should carry an identity card with a photograph, which should state who and what they are, who they work for, and the name and telephone number of their manager.
- c. Field staff should attend supervision meetings with their manager at least every 2 weeks.
- d. Field staff should liaise with a variety of helping agencies in the district in order to be well informed about all available services and networks.
- e. Field staff should know and act within the laws on alcohol, drugs and prostitution, particularly regarding conspiracy, incitement, technical possession, joint possession and obstruction.
- f. Field staff should not use or obtain any illegal or illicit drug for themselves or for anyone else, particularly during work.
- g. Any advocacy work undertaken by Peer Outreach Workers/ Peer Outreach Coordinators should be discussed and agreed with the team including the Team Leader.
- h. Field staff should adhere to their agency's workplace policies and procedures.
- i. Field staff should discuss with their manager any difficulties arising from their working situation or any difficulties in interpreting any part of the code of practice.
- j. Confidentiality: The agency or organisation must develop a Confidentiality Policy for the HIV/AIDS intervention programme (e.g., coding, preservation of records, access and sharing of client's personal information, disclosure of HIV sero-status, etc.)

Community Outreach Intervention, which should also cover a few sessions on 'Training Methods' in order to identify and develop future trainers.

IV) Executing Outreach Intervention - The agency should develop an annual activity plan and work schedule. The Project Manager/ Team Leader will help the team to develop the field work schedule, reporting formats, duty timing (based on Peer Outreach Worker's feedback), etc. It is very useful and always helps if each worker develops his/ her own weekly/ bi-monthly work plan based on annual activity plan developed by the agency. A 'resource map' of the area including location and distribution of the target population helps in deriving the outreach points, developing strategies to reach them and evolving mechanisms (advocacy, referral networking) to link them with information, supplies and services. During the initial phase of intervention, the team should be able to generate a list of clients who need to be reached. This list must include a basic profile of each client. This information should be kept confidential at all times and it is therefore essential that the project develops a Confidentiality Policy for the outreach project.

V) Supervision and Support:

- ♦ Managers/ Outreach Coordinators, who have the primary responsibility of supervision and support, must remind themselves that flexibility, maintaining transparency and

accountability in decision-making along with the spirit of working as a team, is absolutely essential for better implementation of the outreach project. The Peer Outreach Coordinator/ Worker will be the Field Supervisor and the Manager/ Team Leader will have the overall responsibility of the project. The Manager/ Team Leader will not get into the details of day-to-day functioning.

- ◆ As mentioned earlier, each worker must have access to written job responsibilities and training should be provided to her/ him to carry out the job. The Managers/ Team Leaders, along with field staff, should be able to develop 'working procedure and policies' (Box 9) and 'code of practice' (Box 12) for all the team members.
- ◆ Managers/ Team Leader/ Coordinator should provide regular supervision for all outreach at least once every two weeks (extra time to Peer Outreach Workers). Supervision is vital and should not be put off or given low priority.
- ◆ Supervision is a two-way process and provides an opportunity for encouragement, for a review of activities, for setting new targets and priorities, and for addressing any issues relating to the job.
- ◆ Managers/ Team Leaders should be aware that, in order to work effectively, Peer Outreach Coordinators will be the direct supervisor-in-charge of the outreach team and they, along with the Peer Outreach Workers, may have contact with people engaged in illegal activities and, therefore, must sometimes operate at odd hours and in places quite different from the other service staff in the organisation. They should be sensitive to this issue and offer appropriate advice and guidance for workers in this situation, to ensure their safety and security.
- ◆ Managers/ Team Leaders should ensure that there is a time for fostering team building and mutual support from others working in the agency/ organisation and that there are opportunities for Peer Outreach Coordinators/ Workers and Peer Volunteers to contribute to and benefit from the work of the larger team.

Box 12: Contd.....

Peer Outreach Workers/ Peer Outreach Coordinators should adhere to their agency's policy on confidentiality

Peer Outreach Workers/ Peer Outreach Coordinators should not disclose the identity of a contact to any other person outside their agency or give information that would help identify a contact to any other person unless permission is given by the contact.

It must be acknowledged that the Peer Outreach Workers/ Peer Outreach Coordinators can share confidential information about clients with their Manager. The manager must also adhere to confidentiality norms.

Information given by a contact about other contacts will not be divulged to others.

Exceptions to the above may be made where a life is at immediate risk. At the discretion of the manager, exceptions may also be made in respect of children at risk from abuse or neglect, or where an Outreach Worker is in a difficult legal position with the state law enforcement or judiciary in relation to her/ his outreach work.

5. MONITORING AND QUALITY CONTROL

Monitoring is essential to ensure that the intended project objective is achieved within the given time frame, and whether planned activities are followed up and carried out. It is also essential to have some mechanisms in place so that any Peer-led Community Outreach Intervention accomplishes the 'behaviour change' intended among the targeted population group.

Any Behaviour Change Intervention (BCI) in a population group should attempt to document the process of implementing it (**Process Indicators**) as well as measure changes (**Outcome Indicators**) that might have taken place due to such an intervention. Both process and outcome indicators can and should be measured by quantitative as well as qualitative data.

Qualitative Monitoring

For qualitative monitoring, 'field notes' (recording exact verbatim, exact description of a situation happening on the ground) play a great role. While linking BCI with behaviour change as cause and effect, it seems difficult without definite exclusion of possibilities of other influences. The list below is suggestive. Agencies implementing outreach intervention should develop a complete list through participatory brainstorming.

Qualitative Indicators - Process:

- ◆ What did the target population not find 'okay' with the existing BCC materials, what changes did they suggest and finally, what changes were incorporated through the intervention programme?
- ◆ Has the target population taken part in further modification of BCC materials as felt appropriate?
- ◆ What does the qualitative record-keeping (field notes) reflect with regard to the target group's opinion on the quality of services (timing of service provision, attitude of different categories of providers, efficacy)?
- ◆ What does the qualitative record-keeping reflect in terms of the opinion of the target group on whether the communication mode and message, supplies and services of BCI was changing itself according to the community's needs?
- ◆ What changes in the quality of lives were perceived by the target group members (this is an indirect indicator of empowerment of target group, which in turn helps in positive behaviour change)?
- ◆ How many target group members were involved in different stages of intervention programme development (an indicator of how participatory the BCI and other components of the programme had been)?
- ◆ What were the decision-making positions held by members of the target group (an indirect indicator of empowerment)?

Qualitative Indicators - Outcome:

- ◆ Documenting changes in risk perception and safer practices through log book entries or focus group discussions
- ◆ Documenting changes in utilisation of different risk reduction services through service-delivery records, field observations documented in personal diaries, log entries by Peer Outreach Workers and Peer Volunteers.

Quantitative Monitoring

For quantitative monitoring, one can use either already available secondary data (also called historical data) or baseline data can be generated during initiation of the programme. Compiled data available from research agencies can be a good starter, if they can define the situation both in quantitative and qualitative terms. A new study for generating baseline data may unnecessarily delay the whole process of implementing or quick scaling up of the intervention. Indicators need to be adjusted based on the vulnerability assessment carried out among the targeted population group.

- ◆ What proportion of the target group had myths about HIV/AIDS before the programme and what is the status after one year?
- ◆ How many injecting episodes are safe - before and after intervention?
- ◆ How many drug users/ IDUs have been referred to and used 'Safer Practices' services?
- ◆ How many IDUs have switched over to oral use, with or without a substitution programme?
- ◆ What was the treatment seeking status before, and in which way has it changed after programme implementation?
- ◆ How many drug users/ IDUs are seeking STI treatment (in relation to the above)?
- ◆ What is the reduction of STI cases among drug users/ IDUs and their sexual partners?
- ◆ What proportion of drug users/ IDUs is 'always using' condoms with commercial sex workers and unknown sexual partner, before and after one year of the intervention programme?
- ◆ What proportion of commercial sex acts was protected particularly in the case of female or male drug users/ IDUs (who are in commercial sex), before and after one year of the intervention programme?
- ◆ What proportion of IDUs (both male and female) is capable of and are using condoms with their regular partners?

Some Important Reminders

- ◆ Personal details of the members of the target group along with identifiers do not serve as any monitoring indicator of public health importance. NGOs should avoid recording them, as this is unethical.
- ◆ Collecting huge amount of information just for information's sake, the utility of which is not clear either to the implementing or external monitoring agency, not only wastes time but also compromises the quality of intervention. Lessons learnt from many such programmes is 'only collect information that has practical applications in measuring the progress towards objectives and helps in appropriating improving the intervention further'.

6. CHECKLIST FOR MENTOR/S

While following a monitoring system (based on checklists) helps in improving the quality of work, the consultant/ mentor should, in addition, pay attention to the following issues:

- ◆ Have those members been included in the **advisory/ steering committee** who could play an important role in **fostering support** to the intervention once the situation and response assessment comes to its completion?
- ◆ Has the **participation of drug users** in every stage of the assessment been ensured?
- ◆ Are the **trainees** getting enough opportunity to raise concerns, ask questions and clarify their doubts during training?
- ◆ Has the **safety of field workers** been adequately ensured in the field? It should also be ensured that the respondents are not endangered because of involvement in the assessment.
- ◆ Are the field workers introducing themselves and the work they propose to do in and with the community, **ensuring confidentiality, voluntary participation and obtaining informed consent** before undertaking any primary data collection from a participant or a group of participants?
- ◆ Are the rules of '**not buying articles or accepting gifts from respondents**' and '**not raising false hopes in the community**' being followed during fieldwork?
- ◆ Have **linkages been forged with health care outlets and addiction treatment centres** where respondents can be referred in case the necessity arises?
- ◆ Upon receipt of the report submitted by field workers, based on their personal diaries and 'log entries', **is feedback being provided to the field workers** by appreciating achievements as well as suggestions to address any gaps in intervention?
- ◆ What is the **reporting mechanism from the field** to the central coordinating office?

7. COSTING IN TERMS OF MANPOWER, MATERIAL AND TRAINING

A suggested sample of costing heads is given below:

Human resource (all full time)	Material	Training	Subtotal	5% contingency	Grand total
One Team Leader	Desktop PC with printer	5 day training			
Three Outreach Coordinators (Two males and one female)	BCC materials				
Five Peer Outreach Workers (three males and two females)	Movement & support in the field for outreach work				
One account cum administration officer	Office rent				

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9. ANNEXURE 1

Tentative Training schedule on "Community-based Peer Outreach"

Day 1

Time	Session	Objective	Method
9.30 AM– 10.30 AM	Welcome and Introduction	To understand what the training is all about and to enhance relationship among the participants	Icebreaker Game
10.30AM – 11AM	Tea		
11 AM–11.30 AM	Basics of HIV /AIDS: Regional and national scenario, HIV epidemic among IDUs	To make the participants understand situation of HIV/ AIDS and vulnerabilities of IDUs	Individual work, Plenary discussion, Multimedia, Didactic
11.30 AM – 12.30 Noon	Responses to IDU related HIV epidemic	To make participants understand about what works and what does not work in STI/HIV intervention	Didactics, plenary discussion
12.30 Noon – 1 PM	Risk practices and vulnerabilities to STI/HIV	To make participants understand on STI/HIV vulnerability of specific population group	Case studies and group discussion
1 PM –2 PM	Lunch		
2 PM –3.30 PM	Effective approaches to HIV prevention among drug users (including IDUs)	To have a clear understanding on risk reduction approaches	Didactic, group work
3.30 PM – 4 PM	Tea		
4 PM – 5 PM	Behaviour change intervention	To make participants understand the approach and process of behaviour change	Case studies and group work, didactic
5 PM – 5.15 PM	Summing up and collecting feedback of the day	Assess the effectiveness of day's input.	

Day 2

Time	Session	Objective	Method
9.30 AM – 10.30 AM	Contacting drug users - conducting outreach	To make participants understand the need of knowing basics of outreach	Lecture and group exercise
10.30 AM – 11 AM	Tea		
11 AM – 1 PM	Community-based peer outreach	To bring clarity on intention and elements of the intervention	Group exercise
1 PM – 2 PM	Lunch		
2 PM – 3.30 PM	Planning outreach by the outreach team	To bring clarity on roles & responsibilities to carry out outreach	Individual exercise and Group Exercise
3.30 PM – 4 PM	Tea		
4 PM – 6 PM	Outreach Skills	To learn the basic skills in conducting outreach	Role plays, plenary discussion

Day 3

Time	Session	Objective	Method
9.30 AM – 10.30 AM	Basic communication skills	To learn the basic communication skills required for facilitating behaviour change	Role play, group work, didactic
10.30 AM – 11 AM	Tea		
11 AM – 1 PM	Motivation	To learn how to motivate the clients for behaviour change	Learning by doing
1 PM – 2 PM	Lunch		
2 PM – 3.30 PM	Negotiation	To learn how to empower the clients on shifting from risk to safer practices	Learning by doing
3.30 PM – 4 PM	Tea		
4 PM – 5 PM	Dealing with outreach environment	To learn how to identify and sensitise Stakeholders	Group exercise and field visit

Day 4

Time	Session	Objective	Method
9.30 AM – 10.30 AM	Stigma, marginalisation and attitudes	To understand the issues of stigma, marginalisation and attitudes	Case studies
10.30 AM – 11 AM	Tea		
11 AM – 1 PM	HIV testing and related issues	To make the participants understand the indication and ethical aspect of HIV testing, its implication on prevention and care	Case study, group work, lecture presentation
1 PM – 2 PM	Lunch		
2 PM – 3.30 PM	Legality, rights and ethics	To understand the underlying issues while working with specific population group	Case studies
3.30 PM – 4 PM	Tea		
4 PM – 6 PM	Burnout management	To learn how to manage oneself while working with behaviour changing process	Learning by doing, case studies

Day 5

Time	Session	Objective	Method
9.30 AM – 10.30 AM	Team Building	To learn how to sustain focus of a team and develop its working environment in an effective way	Learning by doing
10.30 AM – 11 AM	Tea		
11 AM – 1 PM	Counselling	To understand basics of counselling	Didactic
1 PM – 2 PM	Lunch		
2 PM – 3.30 PM	Counselling (contd)	To learn more on counselling skill.	Role playing
3.30 PM – 4 PM	Tea		
4 PM – 6 PM	Reporting	To be able to have the basic skill of reporting on outreach works	

10. ANNEXURE 2

Annex 2.1 Safe Disposal of Injecting Equipment

Definitions of Infection Control:

1. Dispose of rinsing water immediately.
2. Dispose your fit in a sharp-safe or in a child-roof, puncture-proof container such as a glass jar.
3. Dispose swabs, filters, and opened water ampoules by placing them in the sharp, safe.
4. Alternatively, place items for disposal first inside one plastic bag and then another, and then in the rubbish bin.
5. Clean up any surface blood spills and wipe up with soapy detergent water.
6. Wash your spoon with soapy detergent water or wipe it once with a new swab.
7. Tourniquets need washing too.
8. When you have cleaned up, wash your hands thoroughly with soap and warm water.
9. If you can't wash your hands, use new swabs to clean them thoroughly.
10. Rub them in one direction, not backwards and forwards, to avoid putting the dirt and bacteria back on again.



What should one do if one injects at home:

- ◆ Obtain a sharps container (from a needle & syringe outlet) to hold your used material; and
- ◆ When your container is full, secure the lid and deliver it to a needle & syringe outlet, or a Sharps Drop-Off Point.



Sharps drop-off points

What should one do if one injects away from home:

- ◆ Place all your injecting material in a sharps bin/ chute in a public toilet or any other place that has a sharps bin; or
- ◆ Place all your injecting material in a sharps container and deliver it to a needle & syringe outlet or a Sharps Drop-Off Point.

Sources: <<http://www.vicaids.asn.au/content/ContentPage.asp?SectionID=41>>

<http://www.nowaste.act.gov.au/__data/assets/pdf_file/12477/disposalsafe.pdf>

Annex 2.2 Infection Control

Definitions of Infection Control:

Measures practiced by healthcare personnel in healthcare facilities to decrease transmission and acquisition of infectious agents (e.g., proper hand hygiene, scrupulous work practices, use of personal protective equipment (PPE) [masks or respirators, gloves, gowns, and eye protection]; infection control measures are based on how an infectious agent is transmitted and include standard, contact, droplet, and airborne precautions.

1. DEMARCATON OF AREAS

Define the hospitals/wards/clinics into

1. Clean area
2. Unclean area

Clean area

This area is be demarcated in the clinic/hospital/ward for activities such as preparing injections, IVs, and medications, i.e. sterile ointments and dressings that need to be clean.

Unclean area

This area needs to be demarcated in the clinic/hospital. ward for activities that are the place for storing items that have been used and can be source of infection if not handled properly. The items that are required to be placed here are used items such as nebulizers and thermometers before cleaning and disinfection and any other items contaminated with blood or body fluids. Such items also include laboratory specimens waiting to be picked up. Items identified for the unclean area should never be placed in the clean area or areas where they can touch new, clean, or sterile items.

2. PROCESSES FOR EQUIPMENTS

- ◆ Use only disinfected instruments.
- ◆ Keep all the used instruments/equipment in a deep covered tray properly labeled.

i. Disinfection process

Pre-cleaning

- a. Clean all the used instruments using detergent.
- b. Use thick rubber gloves while cleaning.
- c. Wash and clean the rubbers gloves and dry them.

Boiling

- a. Use a deep vessel
- b. Spread cotton cloth at the bottom of the vessel and place the equipments over it.
- c. Immerse the sponge holder with a string tied to it.
- d. Dip the equipments fully under water
- e. Boil for 20 minutes after reaching boiling point.
- f. After boiling first pull up the sponge holder and hold only the handle.
- g. Take out the cloth from the boiler and spread it over the disinfected instrument trays.
- h. Take out the instruments with the sponge holder and place it on the disinfected trays.
- i. Disinfect the trays and the lids with boiling water
- j. Properly label each tray
- k. Always keep the trays covered

3. Infectious Waste Management & Disposals

1. Disposal of sharps

- ◆ Do not recap sharps before disposal.
- ◆ Don't bend or break needles
- ◆ Never place used sharps on tables, beds, furniture
- ◆ Put used sharps immediately into a sharps container
- ◆ Dispose of sharps at the point of use in a leak proof puncture-proof container for sharps only e.g. thick cardboard box, thick plastic box, or a glass container,
- ◆ Make sure the container for collecting the sharps are covered
- ◆ Change the container once they are 3/4th full

Sources: <<http://www.cdc.gov/NCIDOD/SARS/guidance/core/word/app2.doc>>

3. Infectious Waste Cont.....

- ◆ Avoid handling, emptying, or transferring used sharps between containers since needle-sticks can occur.
 - ◆ All the containers having sharps should be sealed properly before disposal
 - ◆ If proper set-up for waste disposals are not available encapsulate (seal and pack in a sealed manner that is not likely to be easily opened) and then discard by burying deep)
2. **Colour coded bins-** the bins should be placed nearest to the source waste generation. Use red, blue and yellow bins with similar colour plastic bags fitted in the bins for disposing used items
- ◆ **red bin** for infected materials (cotton, gauze, bandages, gloves, vaginal pads etc. exposed to body fluids) sharps (needles, razors, blades, needle destroyer content in sealed boxes)
 - ◆ **yellow bin** for vials, ampules, plaster casts, etc. (non-infected).
 - ◆ **Blue bin** for general waste
3. **Transportation.**
- Tie the bags, label it and dispose it as follows – red and yellow bag to be disposed in the central disposal unit of the hospital or burnt the blue bag dispose it with the general waste.
- If disposed in the central hospital waste the bags should be labeled as follows:
4. Date
 5. Contents
 6. Approximate weight
 7. Source of generation
 8. Destination
1. **Final disposal**
- If in a resource deficient setting the wastes should preferably be burnt
- Burn in the following procedure:
1. Dig a big pit with dimension of 1mt x 1mt x 1mt., and collect the soil around the pit
 2. Dig the pit in a demarcated area of the clinic/hospital and making sure for not frequent use.
 3. Put some barricade around the pit.
 4. Burn the contents and cover it with 3-4 cms of soil.
 5. When 3/4th filled, cover the pit with soil, with soil covering an extra one foot above the ground level.

Annex 2.3 Needle Prick Injuries

Definition

Exposure of the skin or mucous membranes to blood or other body fluid from any patient.

What Every Worker Should Know	Prevention: Needle Stick Injuries
<p>How to Protect Yourself From Needlestick Injuries</p> 	<ul style="list-style-type: none">◆ Wear two pairs of gloves◆ Use caution in the handling of containers◆ Thumb and index finger of now dominant hand preventable◆ Don't recap needles◆ Use disposable needles and syringes
<p>If needle stick injuries occur: What should be done?</p> <ul style="list-style-type: none">◆ Don't panic◆ Allow wound to bleed◆ Needle sticks and cuts should be washed with soap and water◆ Splash to the nose, mouth or skin should be flushed with water◆ One should not put pricked finger in the mouth◆ Eyes should be washed with clean water, saline or sterile irrigates.◆ Place in disinfectant for 15 seconds◆ Inform authorities/supervisor	
<p>Health care workers should take the following steps to protect themselves and their fellow workers from needle stick injuries:</p> <ul style="list-style-type: none">◆ Avoid the use of needles where safe and effective alternatives are available.◆ Help your employer select and evaluate devices with safety features.◆ Use devices with safety features provided by your employer.◆ Avoid recapping needles.◆ Plan for safe handling and disposal before beginning any procedure using needles.◆ Dispose of used needles promptly in appropriate sharps disposal containers.◆ Report all needle stick and other sharps-related injuries promptly to ensure that you receive appropriate follow-up care.◆ Tell your employer about hazards from needles that you observe in your work environment.◆ Participate in blood borne pathogen training	

Sources: <<http://www.cdc.gov/niosh/pdfs/2000-135.pdf>>

Annex 2.4 Confidentiality

What is Confidentiality?

Within the context of professional ethics, observing the principle of confidentiality means keeping information given by or about an individual in the course of a professional relationship secure and secret from others. This confidentiality is seen as central to the maintenance of trust between professional and service-user.

The obligation to maintain confidentiality does not normally end with the individual's death. Confidentiality is owed equally to mature and immature minors, and adults who lack the capacity to make decisions for themselves. It applies to all forms of transmission; verbal, written, digital, manual or hardcopy records, videos and illustrations etc. – wherever they can be identified with a specific individual.

Disclosure to others	Disclosure with consent	Disclosure of information to other professionals
<p>Disclosure of information about an individual to others will constitute a breach of confidentiality only if that information was previously unknown to the recipient.</p> <p>Confidentiality applies to personal information.</p> <p>General information may be disclosed without breaching confidentiality. For example where relatives are already aware of an individual's condition or diagnosis, an explanation of the possible options for that patient does not breach confidentiality but revealing an individual's views of those choices would do so.</p>	<p>The principle of confidentiality can be waived with the consent of that individual and in practice, an obligation to maintain confidentiality would often work against their interests if it could not be so waived.</p> <p>The consent given must be informed but the definition of what constitutes informed consent is ethically and legally complex. Correct application of the principle confidentiality to professional behavior will therefore require a complimentary understanding of informed consent and the principles of confidentiality and informed consent can be usefully taught together.</p>	<p>The confidentiality owed to person within the doctor-patient relationship covers disclosure to other health professionals.</p> <p>Information should only be shared with health professionals who need access in order to fulfill their own duty of care to the patient. Data circulated for other purposes than the duty of care to the individual to whom that data relates should be done either with their consent or in an anonymised form (see below for further information on anonymising data).</p>

Sources: <<http://www.prs-ltsn.leeds.ac.uk/ethics/documents/confidentiality.html>>

Circumstances in which confidentiality might be breached for ethically or legally justifiable reasons include:

- Cases in which the professional knows or suspects that an individual is acting illegally.
- Cases in which the professional knows or suspects that an individual is harming others*.
- Cases in which the professional knows or suspects that an individual might harm others* in future.
- Cases in which the professional knows or suspects that an individual is harming themselves.
- Cases in which the professional knows or suspects that an individual might harm themselves in future.

Source: <<http://www.prs-ltsn.leeds.ac.uk/ethics/documents/confidentiality.html>>

Annex 2.5 Alcohol/Other Drug (AOD) Use in the Work Place



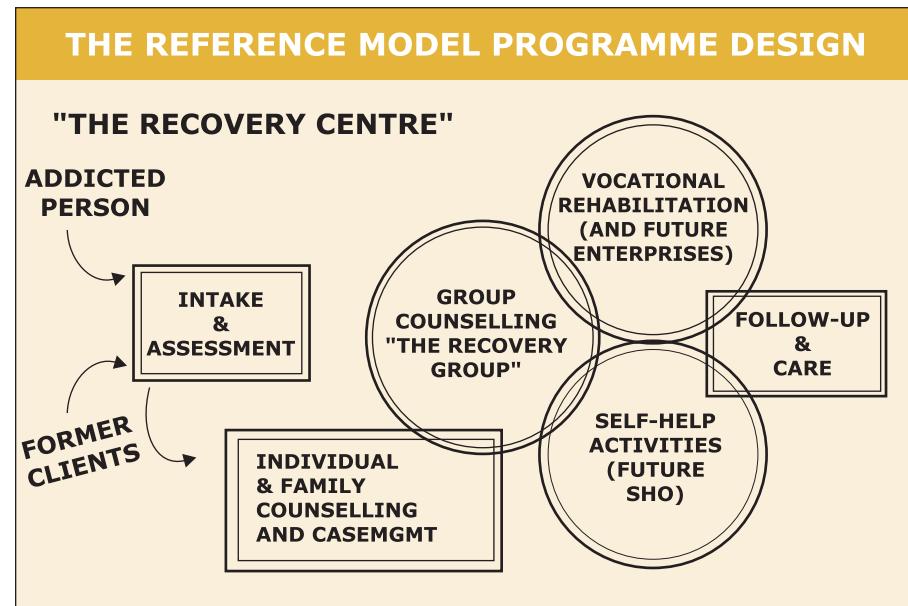
Commonly Noticed Tel-tale Signs of ALCOHOL/OTHER DRUG (AOD) USE Related Problems among Employees at Workplace

1. Taking off from work the day following salary day
2. Reporting sick or coming late during the first week of the month
3. Strained interpersonal relationships
4. Irritable and uncooperative attitudes
5. Deteriorating health – frequent complaints of stomach upset, ulcer, abdominal pain, sleep disturbances and psychological problems like anxiety and depression
6. Impaired productivity and efficiency

Assistance Strategies will include:

1. Procedures for identifying addicted employees (behavioral and other indicators).
2. Ways of initiating a dialogue with substance using employees to discuss the problem and offer help.
3. Guidelines for a series of offers of assistance, followed by warnings and conditions for disciplinary action where the user is unresponsive.
4. Measures to provide counseling (to the individual and/or family).
5. Procedures for referring addicted employees to a rehabilitation facility.
6. Rules concerning costs of treatment and leave in case of hospitalization.
7. Processes to assess treated cases and determine fitness for resumption of duty after treatment.
8. Regulations regarding relapses.
9. Rules for dismissal on grounds of AOD use.

Source: UNDCP ILO GOI EC Project AD/IND/94/808, Publication; 1994



Source: UNDCP ILO GOI EC Project AD/IND/94/808, Publication; 1994



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