

4. IMPLEMENTATION OF SAFER PRACTICES

The implementation of Safer Practices will be discussed in the following five subsections. The first subsection on 'information and training on Safer Practices' emphasises why training is necessary and what topics can be covered. The second subsection on 'community sensitisation' highlights the importance of creating an enabling environment for the successful launch and managing of Safer Practices. While subsections 3 and 4, respectively, describe 'materials provided through Safer Practices', and 'modes of delivery', the fifth and final subsection focuses on 'other service provisions and access to functioning and affordable health services'.

- I. Information and training on safer practices
- II. Community sensitisation
- III. Materials provided through safer practices
- IV. Modes of delivery
- V. Other services provisions and access to functioning and affordable health services

I) Information and training on safer practices

Adequate information and training on Safer Practices should be provided to the staff to ensure quality delivery of services. Discussions during orientation and training sessions should revolve around a wide range of intervention approaches and not just Safer Practices, which would thus help one to appreciate what a comprehensive intervention programme requires for successful implementation, what such a programme can achieve and what it cannot. Examples of a few such interventions that should feature in the discussions are:

Outreach intervention: Outreach recognises that drug users are marginalised by society and this in turn negatively affects their access to different health care interventions and services. It, therefore, reaches out to drug users with different intervention messages and materials in the communities where they use drugs or gather. Outreach interventions that have employed ex and/or current drug users as Peer Outreach Workers have been able to reach out to those drug users who have never been in any treatment programme and reduce HIV risk behaviour in them. In fact, many of the intervention approaches mentioned here can be carried out meaningfully only when a regular peer outreach is established as a mainstay. Many outreach programmes have provided HIV/AIDS information-education materials, established links with other health care services, including addiction treatment and substitution, and HIV voluntary confidential testing and counselling services (HIV-VCTC). They have been the means for introducing injecting-related risk reduction steps such as sterile needles and

syringes, and condoms for safer sexual practices. For a detailed discussion on Peer-led Community Outreach, read Module 2 in this series.

Network intervention: This intends to work on group norms of drug users by exposing all the members of a network, who were brought in by one of them to a series of group sessions. It is expected that the bond that exists between the members of a group will help them in reinforce each other in observing safer drug-taking practices and because such intervention is targeted towards a group, it will have a better impact in terms of risk reduction than interventions directed towards individuals.

Education of IDUs: This is based on the assumption and some study findings that IDUs who are more aware about the risk of HIV through injecting are better able to protect their own health.

Increasing availability of clean injecting equipment: The basic tenet of this approach is grounded on abundant evidence that not only is awareness required but making other means of behaviour change available (such as sterile syringes and needles) as part of a comprehensive intervention package is crucial to limiting the further spread of HIV among IDUs.

Pharmacological intervention: Two major approaches of pharmacological intervention are: (a) detoxification that aims at treating the physical and psychological discomfort (known as withdrawal) faced by a substance user at the time of stopping drug use through medicines with an ultimate goal of achieving abstinence and (b) substitution treatment where the drug that a user takes is substituted with a similar or identical substance under medical supervision. Substitution may also mean using the same drug but administering it in a different way, for example, sublingual buprenorphine tablets to replace injecting of buprenorphine. Many drug users, through detoxification, can and do achieve abstinence through multiple relapses, as drug use is a chronic relapsing disorder. In the long run, however, it is often difficult to maintain abstinence and many fail. Thus, the second approach – substitution – takes into account the fact that many drug users, consider long-term abstinence a difficult goal to achieve, but still want to protect their health from the risks that might result from continuing drug use and unsafe practices (for a detailed discussion on how to implement substitution treatments, read Modules 4 and 5 in this series).

It is important to appreciate that an injecting drug user who avails of services for Safer Practices may opt at any point of time to switch to other intervention services such as detoxification treatment and his/her choice should always be respected and addressed accordingly. Enrolment of an IDU for Safer Practices should also have similar considerations.

The training workshops dealing with the above-mentioned issues should adopt a participatory training methodology and should be conducted by experienced

trainers. The sessions should address practical issues and enhance the knowledge as well as skills of the participants on the above-mentioned intervention approaches and other related areas. Getting ex-drug users and police officials as resource persons to conduct some of the training sessions often proves beneficial.

Suggested topics for a three-day training workshop are given in (Table 1):

Table 1: Training staff for Safer Practices programme based on Rapid Situation and Response Assessment findings		
Day 1	Day 2	Day 3
Introduction to the workshop Self-introduction by the participants	Recap of the first day Basic communication skills- talking with the community members and assessing their attitudes towards drug users	Recap of the second day Enhancing 'quality' of services- liaison services and linkages with special focus on the regular sex partners of IDUs
Ice-breaking exercise so that participants get familiar with each other	How to hold community sensitisation meetings	Materials to be delivered and modes of delivery in a safer practices programme
Global overview of drug use and injecting drug use followed by drug use scenario in the country	Advocacy with police	Accidental needle stick injury, safe handling of old and used needles and decontamination of the used needles
Sharing of the 'situation and response assessment' findings	How to build trust and rapport with the drug users/ IDUs	Monitoring and quality control (documentation and record-keeping)
Different HIV intervention approaches for injecting drug users and what could be appropriate in the light of the situation and response assessment findings	Dos and don'ts in the field	Planning for site visits where safer practices is operating and support for travel
Basics on HIV prevention and care	Confidentiality, ethical practices and respecting clients' choices	Feed-back of the participants for the 3rd day of training
Feed-back of the participants for the 1st day of training	Feed-back of the participants for the 2nd day of training	

II) Community sensitisation

Community sensitisation remains pivotal to the success of any Safer Practices programme . The three major purposes that it serves are:

- a) Dispelling any misperception that the community at large might have about Safer Practices.
- b) Getting diverse community members on board, including police officials.
- c) Obtaining community support and participation for ancillary services that some of the clients of Safer Practices or the drug-using community in general might require – e.g., community-based detoxification camps (for a detailed discussion read Module 6 in this series).

In fact, all these considerations hold true for any risk reduction activity that aims at reducing the vulnerability of IDUs to contracting HIV³ through a comprehensive intervention approach; otherwise, the community might misperceive elements of intervention such as 'Safer Practices' or 'Substitution Treatment' as efforts towards promoting drug use.

Different members of a community exert different influences on drug trade, individual drug users and their networks. They also play important roles in building community attitudes towards different intervention approaches. The power structure in an area, and the influences that each member in this structure holds, will differ from place to place and that is why there is no 'one size fit all' model for conducting community advocacy. However, the following could serve as a useful checklist on the stakeholders who may need to be approached and sensitised in an area while planning services for Safer Practices and other risk reduction activities:

- Law enforcement officials / police (border security force, if appropriate in an area)
- Government officials in the department that deals with the subject of drug use
- Political leaders
- Church leaders
- Youth club officials
- Community elites

³ The barriers encountered in implementing peer-based outreach to IDUs and how these barriers can be minimised was demonstrated through the Indian Council of Medical Research-World Health Organization (ICMR-WHO) collaborative project during 1994–1996. Launching outreach to the larger community before reaching out to IDUs was found necessary through this work that avoided misperception of the community about outreach-based harm reduction interventions (Hangzo et al, 1997). It was also convincingly shown through this study, (which was carried out in Churachandpur, the southern hilly district of Manipur, a north-eastern state of India having a common international border with Myanmar), that IDUs talked to other IDUs about HIV/AIDS, were capable of initiating HIV/AIDS risk reduction and adopted different modes of cleaning injection equipment such as bleach in order to protect their own health.

- Local NGOs who have been working with HIV and/or drugs since before
- Drug dealers (if possible)
- Local private physicians and hospital doctors
- Local underground pressure groups⁴
- Different donor agencies in the field of drug use and HIV (important for having adequate scaling up at the national level and in turn, impact upon local activities)

The use of either an informal network of friends from the locality (existing from before or developed during assessment of situation and responses) or formal approaches such as extending an invitation to opinion leaders from the community for intervention activities (e.g., official meetings, presentation of situation and response assessment findings, inauguration day of the safer practices project, etc.) helps foster support from different stakeholders and goes a long way in achieving community sensitisation.

III) Materials Encouraging Safer Practices

Services for Safer Practices should not be narrowly focused only on sterile syringes and needles. Instead, they should include behaviour change messages and materials for IDUs for safer sexual practices as well. Moreover, the intervention should be comprehensive in nature and should also reach out to the sex partners of IDUs. However, this does not mean building many vertical systems of care. Ideally, the establishment of referral networks is the key. The range of materials that can be delivered through services facilitating Safer Practices, which will contribute to limiting the spread of HIV, within and from drug injectors, and at the same time reduce other morbidities, such as abscesses due to injecting, are:

- Needles and syringes (which size, what type and how many are to be given on a single visit should be based on situation and response assessment findings)⁵

⁴ The north-eastern region of India bordering Myanmar is prone to very high levels of political unrest. The immediate manifestation of this is the presence of various militant organisations claiming to represent ethnic and cultural aspirations. The fiercest of these conflicts exists between the Kukis and the Naga groups. These militant groups seek not just economic control of resources, but also social control of those they claim to represent. They have been known to pass extra-judicial sentences (often manifested in fatal shootings or shooting in the legs as warning) on individuals whose behaviour or stance they deem unacceptable. Hence violence is aimed not only at government structures and members of other tribes and organisations, but also against drug users and peddlers and in some cases those who have been diagnosed as HIV positive (Sharma et al, 2003). Local agencies involved in HIV intervention among IDUs, for example in the state of Manipur, therefore, recognise the local underground pressure groups as one of the key players who need to be brought under the folds of advocacy.

⁵ 'One for one' exchange in street outreach has been insisted upon in most of the settings in South Asia as facilities for safe disposal of used syringes and needles are inadequate. Safer Practices should take care of the disposal of the used and returned syringes and needles either through the existing clinical waste disposal scheme of the municipal corporations or incinerators operating in local hospitals. The outreach worker may sometimes (but not as a norm) need to give sterile syringes and needles without getting back the used ones from the IDUs (as lack of sterile equipment may cause unsafe injecting) and one should always insist on 'return' as a means of ensuring adherence to Safer Practices.

- Alcohol/ iodine wipes in small zip bags
- Condoms
- General health information brochures
- Risk reduction educational brochures covering unsafe sex and unsafe drug use for example safer injection practices, vein care, how to put on a condom properly, overdose-related issues, etc. Use of vocabularies in vogue among IDUs and socio-culturally appropriate and attractive design help in better acceptance of these brochures.

Safe disposal of the used and returned syringes and needles should form an integral part of the responsibility of the services for safer practices as indicated in Box 2 describing 'operation G-21' in Imphal, the capital of Manipur.

Box 2: Safe disposal of the used and returned syringes and needles in Manipur, India (Operation G 21)

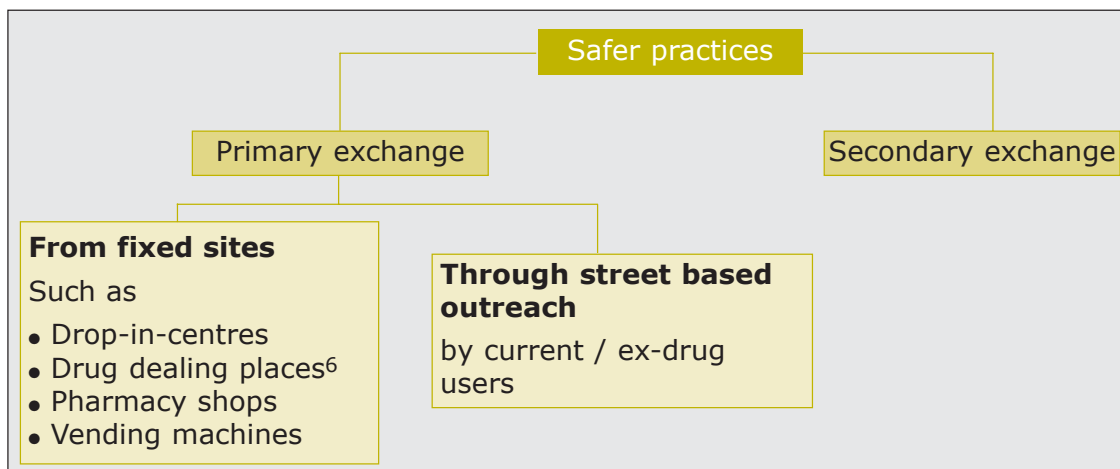
A clean-up drive of used needles and syringes discarded along riverbanks in Imphal (the capital of Manipur), India, took place in September 2001 through Operation G21 (G for Gun - the local slang for syringe; 2=2ml syringes; 1=1ml syringes). Spearheaded by SASO (a local NGO), its objective was to get rid of contaminated injecting equipment dumped along the three marshy riverbank areas in Imphal-North AOC, KR Lane (New Checkon) and Mahabali. Four NGOs are currently working on needle and syringe exchange programmes in these areas.

Operation G21 was needed because of the growing negative sentiment of the community towards needle and syringe exchange programmes as reported by service providers and drug users. The general public felt that the place had become a dumping ground for contaminated 'sharps' disbursed by agencies and pharmacies located nearby. "If you are giving out needles/syringes which are irresponsibly disposed around me after being used by drug users, I don't like your work out here," voiced an alarmed resident. Field visits confirmed the report.

(Source: AHRN 2002)

IV) Modes of Delivery

Different modes of carrying out Safer Practices can be diagrammatically represented as follows:



Secondary exchange is defined as making sterile needles and syringes available to the IDUs, irrespective of their contacts with a regular 'fixed site' or 'peer outreach based' Safer Practices programme (primary exchange). The IDUs who are the receivers of sterile needles and syringes from a regular exchange programme serve as secondary exchangers for IDUs who are not in touch with regular exchange programmes. Attempts are also made to identify 'designated exchangers' (mostly current IDUs) in places where Safer Practices are not legal or there is community opposition to visible exchange sites that it feels will promote drug use⁷.

V) Other service provisions and access to functioning and affordable health services

After trust and credibility builds between the safer practices service staff and the IDU community, linkages with other services that appear necessary could be developed. Some linkages that appear imminent soon after initiating the programme are:

⁶ In Rajshahi, the northwestern district of Bangladesh bordering India, outreach workers by ensuring supply of sterile syringes and needles and return of the used ones practically turned the drug dealers' thatched huts into safe injecting rooms. Previously, the dealers used to inject different clients who bought injection ampoules of buprenorphine from them with the same syringe and needle until the needles turned blunt.

⁷ The Centre for Social Research and Development (CSRD), an NGO in Calicut in the south Indian state of Kerala, faced community opposition in some areas against opening fixed safer practice sites and also against initiating street-based outreach. The major concern of the community at large was that 'safer practice' would condone drug use. However, the field organisers of CSRD in those areas could identify current users who appreciated the risk of unsafe injecting in spreading HIV and other blood-borne viruses and also saw an increase in injecting drug use in the recent past in their own localities. These current IDUs expressed their willingness to the project field organisers to keep a stock of sterile syringes and needles with themselves that they could deliver to the local IDUs in need of new syringes and needles. "These secondary exchangers expected no monetary remuneration and a secondary safer practice thus got initiated in the northern part of Kerala- a low HIV epidemic state in India. This is an example of how community opposition to safer practice forced a local NGO to find innovative ways to reach out to IDUs with sterile syringes and needles..." [an excerpt from the assessment report prepared for State Management Agency, Kerala and Kerala State AIDS Control Society (KSACS)].

- i) Abscess management and treatment for common illnesses,
- ii) Referral for drug treatment (detoxification followed by abstinence),
- iii) Treatment for tuberculosis,
- iv) Investigation and treatment for sexually transmitted diseases,
- v) HIV counselling and testing,
- vi) Mental and physical health care services,
- vii) Legal help, and
- viii) Social services such as vocational rehabilitation of IDUs or schooling for children of IDUs.

While abscess management, and syndromic treatment for STDs can be offered at the drop-in-centres (DICs), it is important to establish referral networks for the other services mentioned above. However, the stigma attached to injecting drug users demands that 'accompanied referral' is conducted during the initial years of referring IDUs to other service outlets rather than using just a referral slip. A social worker should accompany an IDU who is in need of these services. DICs can also take part in HIV pre-test and post-test counselling whereas the already existing laboratories in government hospitals could be used for HIV testing.

The idea is to use as many existing services as possible through referral linkages rather than establishing parallel vertical systems of service delivery so that a bridge is finally built between the 'marginalised hard-to-reach population of IDUs' and the 'mainstream service providers', and IDUs in the long run can then access services from different institutions on their own.

DICs can offer more than just safer practices, such as 'space for counselling', 'consultation with physicians', 'hanging out place for drug users (due to recreational facilities that are made available like television or playing carrom)'. They offer 'directly observed therapy' (DOTs) for tuberculosis and 'room for informal and formal interaction between Safer Practices staff and injection drug users'. Thus, the location of DICs should be strategically selected so that a larger number of drug users may access these services. The 'opening hours' and the 'user-friendliness' of the DICs are two other closely linked issues that will determine the effectiveness of a DIC.