
Introducing the Toolkit

Halting the HIV/AIDS epidemic fuelled by substance abuse requires a three pronged strategy: (a) prevention of drug abuse, especially among young people; (b) establishment of effective outreach to engage drug users in HIV preventive strategies that protect them and their partners and families from exposure to the virus, and encourage the uptake of substance abuse treatment and medical care; and (c) provision and facilitation of access to drug abuse treatment.

Interventions for reducing risk behaviour among injecting drug users are critical. However, it is not only dependent drug use or injecting drug use that exposes the user to the risk of HIV/AIDS. There is sufficient evidence that the state of intoxication in early use and harmful use of substances, including alcohol, exposes the user to increased sexual risk taking. An intervention model is needed to address the concerns of all levels of use and to address all drugs of abuse.

In South Asia, on average, the duration of time between dependent drug use and accessing services for the first time ranges between two and ten years. Moreover, the period of time between switching from non-injecting drug use to injecting drug use is decreasing. In some settings, injecting drug use has been reported at the onset of drug use. During this time the substance user is exposed to several health risks, including HIV/AIDS. It is critical that this period of time, providing a narrow window of opportunity for preventing the substance abuse driven HIV epidemic, be exploited to reduce risk-taking behaviour to have an impact on the epidemic.

From several situation assessment studies conducted in South Asia it has been observed that less than 10 per cent of substance users access treatment services. Of these about 10 to 20 per cent achieve abstinence. This leaves about 80 to 90 out of every 100 substance users either not in touch with services or relapsing into substance use after unsuccessful abstinence focussed treatment. Reaching this un-reached, hidden drug using population is impossible without a partnership with current users, using them as volunteers to change social norms among their drug using peer networks.

Peer education has been used extensively in different settings for the reduction of risk-taking behaviour related to drug abuse and HIV/AIDS. The basic premise in using peer group members as peer educators revolves around the belief that young people learn about drug use and sex mainly from their peers. The corollary that these peers can influence social norms in their respective peer group is tested in this intervention model. Use of these “true” peers i.e. current drug users, for spreading HIV/AIDS prevention messages 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.¹

¹ Stocker S. (1999): NIDA notes (research findings): “Among drug users, peers can help spread the word about AIDS prevention” Volume 4, number 5

Peer-led interventions using peer-education for effective outreach offer a useful way to engage young people and bridge the gap between drug users and service providers. Outreach alone, by giving information and materials, does not bring the desired results. A risk-reduction methodology is therefore needed for guiding young substance users to practice and sustain health-seeking behaviour.

Research indicates that peer-interventions work best when part of a larger basket of services and both, outreach as well as peer educator approaches have been described as complementary to each other.

Peer-led intervention toolkit

Among the gaps identified by UN Office on Drugs and Crime, Regional Office for South Asia regarding response to twin epidemics of substance abuse and HIV/AIDS in the region is the lack of a comprehensive intervention toolkit that primarily focuses on community management of risk-reduction among substance users which is culturally adapted to the local settings of use. One gap identified in rapid situation assessments is the lack of an intervention based on a standardised protocol that accesses networks of current substance users and motivates them to get into the treatment net.

This intervention toolkit is an attempt to address these gaps. It provides a detailed description of a comprehensive peer-led intervention. Engaging the community is an important first step. For example, the committee of concern comprising influential stakeholders in the community guides the intervention and adapts the model to the local setting. It ensures that the model is owned by the community and is sustainable beyond project life. This facilitates establishing a referral network for providing services needed by the substance users. Engaging the community also helps in generating awareness aimed at preventing the onset of substance abuse among young people in the community.

This intervention will baseline existing behaviour amongst vulnerable youth, use a peer led intervention to address risk reduction, and disseminate data from research in the region. Once these interventions are set up, the opportunity for conducting rapid assessments at these sites can be achieved for a small additional cost.

Elements in this toolkit go beyond currently available peer-driven models. There is an attempt to make optimum use of recovering addicts and field workers. The model uses current users to influence behaviour change among their drug using peers. Issues like improving self-esteem, dealing with emotions, problem solving, stress management, improving family relationships and recognition by the community has reduced stigma and discrimination in preliminary field trials of this model.

Throughout the intervention, it attempts to bridge the gap between drug users and service providers, laying special emphasis on motivating drug users to seek treatment.

This toolkit consists of three manuals:

- 1. Field Manual:** The present document provides an overview of the whole intervention, including terms of reference of various agencies / personnel. The intervention rolls out in three phases. The first phase maps the vulnerabilities and available responses and facilitates a coordinated response amongst the service providers. Former substance users are engaged to contact current users. The second phase uses an intensive training-based risk reduction intervention amongst current users. These current users are motivated to volunteer as role models, agents of information and change amongst their peer group members; hence the name, peer volunteers. The intervention ends with formation of support groups of current users to sustain risk-reduction practices and facilitates access to treatment services. This manual also contains a questionnaire, South Asia Knowledge, Attitude & Practice in Drug Users (SAKAPiDU), and an instruction manual. This manual provides clear instructions about how to deliver this interviewer-administered questionnaire and how to interpret the responses.
- 2. Manual for Training-of-Trainers:** This manual, for the use of resource persons, uses a participatory training methodology to train trainers (field workers, outreach workers) on risk reduction. It also attempts to build skills and knowledge and change attitudes among trainees. This manual has been tested in five training of trainers' programmes conducted by the project team (during 2004) and is available as a separate publication.
- 3. Manual for training of Peer Volunteers:** This manual, for the use of field workers, also uses participatory training methodology in a more simple, easily understandable manner for training peer volunteers. It focuses on reducing risk-taking behaviour. This manual is available as a separate publication.