
Phase One: Resource and vulnerability mapping, committee of concern, referral network for service provision

Phase one activities deal with creation of an enabling environment for the intervention and flows into phases two and three. It maps the vulnerability of drug abuse related HIV and resources to respond. It sets up the referral network for providing access to services. It mobilises the local community to own the problem of drug abuse and related risks, mobilises key influencers and the lays the ground for sustaining the intervention after project life. A baseline assessment instrument has been designed to document knowledge, attitudes, and practices of current users in phase two. This instrument is translated into the local language, and then by a person not familiar with the original instrument, translated back into English. This translation is compared to the original instrument to test the correctness of the first translation. Key informant interviews and group discussions are carried out with key influencers and stakeholders to get an assessment of the local situation and inform them about the project objectives, activities and implementation arrangements. This facilitates the ownership of the project at the local level. A committee of concern is established at every site.

Objectives of Phase One:

- ◆ To establish a network of key stakeholders in the community to facilitate various activities under the project such as:
 - Establishment of committee of concern
 - Create/strengthen the existing referral system in the community
 - Organise a community meeting and publish the findings of the vulnerability map
- ◆ To create a resource and vulnerability map of the locality in terms of drug abuse and high-risk behaviours among young people and assess the need for outreach.

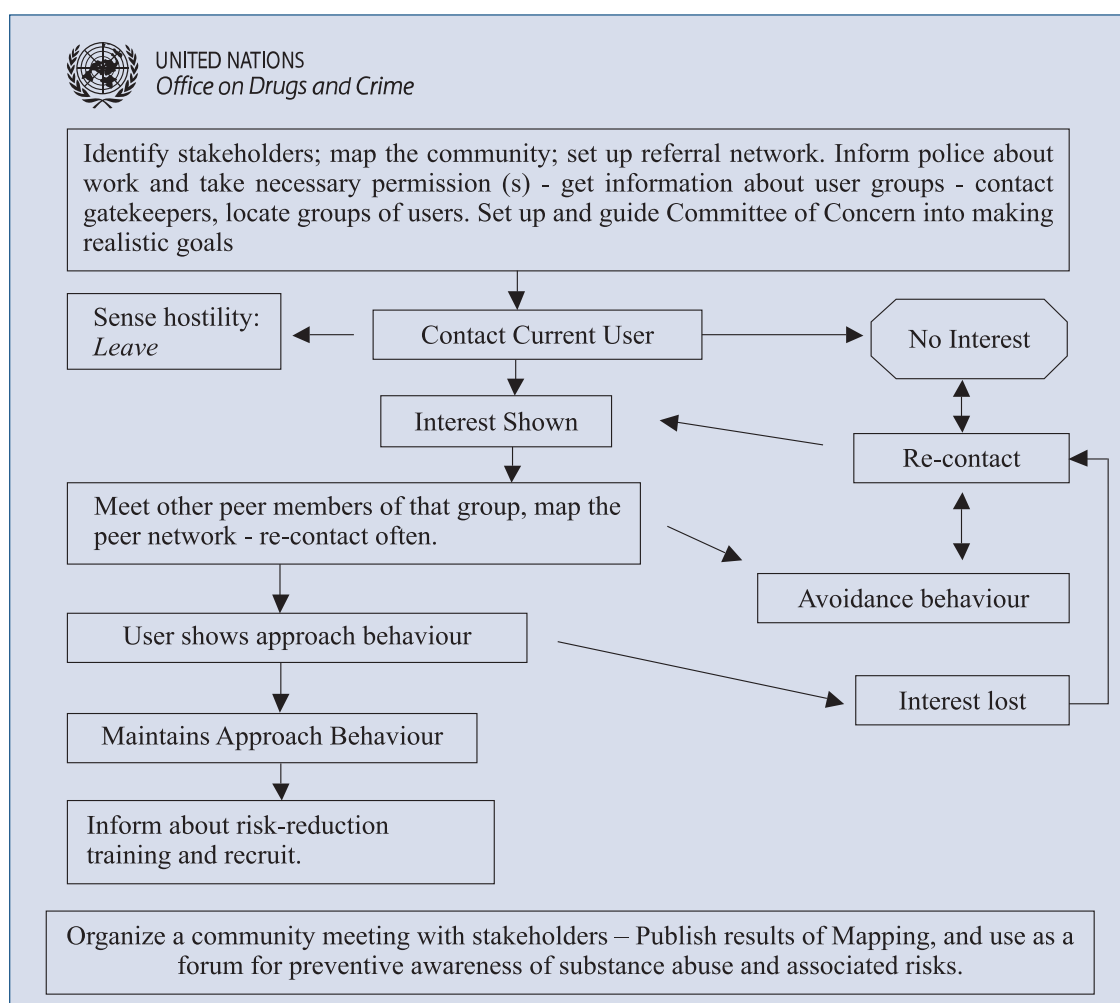
Activities

- ◆ Identify key influencers (stakeholders) in the community and set up a committee of concern (COC). Strengthen the existing referral system in the community or create one.
- ◆ Assess the need for outreach:
 - Vulnerability mapping: Assess the extent and nature of the drug use problems. Decide the locations and geographical area to be covered. Specify populations of drug users to be targeted. Map the members of the peer groups/peer networks (social map). Assess the needs of peer group members and their risk-behaviour. Specify behaviours to be changed. With the help of COC, select indicators of outcome and specific outcomes to be achieved. Readjust the intervention design checking out the following:

- Feasibility of referral to existing services;
 - Feasibility of providing services directly in the community;
 - Possibility of behaviour change in the community through outreach;
 - Possibility of overcoming factors that impede development of services;
 - Feasibility of reaching target population without using peer outreach workers;
 - Are changes in peer group and community norms needed?
 - Prevention materials to be distributed;
 - Health education and advice to be provided.
- ◆ Resource mapping: Assess the resources available to respond to drug users seeking access to services. Establish effective system of referrals between agencies to enable inter-agency referrals.

This phase lasts about three months. It ends with the recruitment of current users for the risk-reduction component of this peer-led intervention. The flowchart of activities is shown below:

Flow chart of activities in Phase One



Mobilising the community

The success of outreach often depends upon on the success of partnership building/networking at the geographical area of intervention and includes correct identification of key influencers, selection of agencies, governmental or non-governmental/community based and networking them to form a Committee of Concern to guide the intervention and sustain the intervention after project life. The outreach service set-up in this intervention must be linked with existing services to widen the range of interventions available in a community.

This component of Phase One looks like the box shown hereunder:

Identify stakeholders; map the community; set up referral network. Inform police about work and take necessary permission(s) - get information about user groups - contact gatekeepers, locate groups of users. Set up and guide Committee of Concern into making realistic goals.

*Committee of Concern*⁸

The Committee of Concern (COC) supports and acts as a prime mover to create an environment for health-seeking behaviour. The COC will have key influencers - opinion leaders, politicians, bureaucrats, local administration and law enforcement personnel, health care service providers, NGO staff, youth groups and leaders, religious leaders and those affected/afflicted by drug abuse and HIV. A Committee of Concern has a chairperson and a small executive committee of six or seven active members, which steer its activities. Though volunteers staff it, its task is to ensure that project activities are implemented smoothly. Simultaneously it will also help to develop referral systems and access to drug abuse treatment.

The COC is formed after successful key informant interviews are conducted as described hereunder. The composition of the COC is left to the local implementing agency handling the peer-led intervention. It is critical to involve law enforcement officials in this committee to counter possible threats from elements in the community who promote drug use and to ensure that law enforcement is made aware of the disorder aspect of drug abuse. It is equally essential to include health care officials in COC to establish a viable referral network for service provision. Those affected or afflicted by substance abuse/HIV need to be included as well as non-formal leaders and influencers in the community. The COC is guided, by the intervention agency in developing realistic expectations from the intervention and explained the relapsing nature of substance abuse disorder. Realistic expectations include not looking for a “magical cure” or a “one-time fix” to deal with the problem of substance abuse. Extreme reactions, such as one-time detoxification camps without adequate rehabilitation measures or violence in dealing with drug pushers, are to be avoided. Involve and guide the COC to develop indicators of risk-reduction and outcome.

⁸ Committee of Concern has been successfully modelled by Project IND/E41 “Community wide drug demand reduction in the North-eastern states of India”, a collaborative project of Ministry of Social Justice and Empowerment, Government of India, and UNODC, Regional Office for South Asia. While IND/E41 modelled the COC at the state/province level, RAS/G23 modelled a COC at the level of a community.

Community meetings

Community meetings are used to raise awareness about the substance abuse disorder and its consequences, especially HIV/AIDS. They are used to give accurate information about substance abuse as a disorder, and to give recognition to those who have recovered. This reinforces the message that “treatment works” and that it is worth investing in substance abuse treatment in spite of relapses. The first meeting is used to publish the vulnerability and resource mapping conducted in the community. Subsequent meetings serve as forums for addressing stigma and discrimination by using the family members of those who have recovered to share their relief and benefits from the recovery of their family members, and recognising those who have recovered.

Create/strengthen the existing referral system in the community

Since the drug user needs different kinds of services at different times in her/his drug-using career, a wide range of services need to be tapped and inter-linked. These include health and social welfare agencies.

Health agencies include services for tuberculosis, STI clinics, abscess management surgical set-ups, voluntary counselling and testing centres and detoxification and rehabilitation services. An effort is to be made to contact key individuals in these centres in the government and non-government sectors and reach an understanding as to how the referral to each centre would work. Key individuals also need to meet to establish a “two-way” referral service. Social welfare agencies, micro-credit facilities and vocational training centres in existence are similarly networked as referral centres.

Assessing the need for outreach

The Vulnerability Map

(Extent and nature of drug use problems)

Data (for both vulnerability and resource mapping) is collected through participant observation of drug users and interviews of key informants belonging to four categories:

- ◆ Law enforcement/administration (police personnel, district/town administrative officers, officers from department of narcotics control etc.);
- ◆ Health care service delivery (personnel from government or non-government agencies providing health care services focused on drug abuse / HIV/AIDS prevention, pharmacists/medicine shop-owners);
- ◆ Community members: members of the community who can be regarded as key influencers or opinion makers of the community (such as religious, spiritual or political leaders, senior teachers etc.);
- ◆ Drug users and their family members. (Information from selected drug users is also collected using the knowledge, attitudes and practices questionnaire).

Key Informant Interviews

Key informants provide data on changes in drug use patterns, and on drug users' help-seeking patterns. This is to be done as an ongoing process by field workers/trainers/SSPs and peer outreach workers. The conversational interviews conducted will incorporate the following themes:

Key Informant Interviews from law enforcement agencies

Prepare a checklist before the interview. Collect views and perceptions of:

- ◆ The present drug scene including major drugs of abuse in the region;
- ◆ Changes in trends and patterns of drug abuse including injecting drug use;
- ◆ Profile of drug users including drug abuse in special groups, street children, adolescents, commercial sex workers and their clients etc;
- ◆ Locations where drug use and related activities and high risk behaviours take place;
- ◆ Risk behaviours prevalent amongst drug users with emphasis on sexual risk behaviours;
- ◆ Crimes related to drug use (types of crime, profile of drug users involved in criminal activities and response of the law enforcement and criminal justice systems);
- ◆ Methods of law enforcement operations and organizational framework in which drug control activities takes place;
- ◆ Description of the major activities of the department;
- ◆ Prevention education programs (if any) initiated by the department and response thereto;
- ◆ Opinions regarding what needs to be done to reduce risk-taking behaviour by drug abusers from the law enforcement perspective.

Key Informant Interviews from health care service delivery sector

Prepare a checklist before the interview. Collect information about:

- ◆ Number and types of drug treatment facilities (government, /NGO, outpatient only/ both out- and in-patient, focusing on complete abstinence / harm reduction / abscess management) available;
- ◆ Perception of number and profile of clients using these facilities;
- ◆ Perception of
 - The present drug scene including major drugs of abuse in the region;
 - Changes in trends and patterns of drug abuse including injecting drug use;
 - Profile of drug users including drug abuse in special groups, street children, adolescents, commercial sex workers and their clients etc.
- ◆ Locations where drug use and related activities and high-risk behaviours take place.

Key Informant Interviews from key community members

Prepare a checklist before the interview. Collect information about:

- ◆ Levels of awareness and information about drug use in the community;
- ◆ Levels of awareness and information in the community regarding health hazards of drug use including vulnerability to HIV;
- ◆ Opinions, attitudes, beliefs and perceptions regarding drug abuse and high-risk sex behaviour situation in the community, changes in the patterns of drug use, current programs and policies;
- ◆ Knowledge about the availability of treatment for drug abuse and HIV prevention activities in the community;
- ◆ How the problem should be dealt with at the community level.

The Resource Map

(Extent and nature of services for drug use/HIV/AIDS prevention)

Secondary Data:

Locate by relevant geographical distribution:

- ◆ Identification of services that the drug users need/access:
 - Nearest deaddiction services: detoxification centres/ drop-in centres/ rehabilitation centres/etc run by governmental/non-governmental/community based organisations;
 - Nearest public health services: STI/maternity clinics, TB treatment centres, VCT services;
 - Number of beds in inpatient services/ location of services / key personnel/ training needs of these services;
 - Sentinel surveillance sites for HIV detection;
 - Law enforcement agencies;
 - Legal services;
 - Free housing facilities, e.g. shelters;
 - Developmental programmes dealing with poverty alleviation, food and agriculture, etc;
 - Occupational/vocational training services;
 - Schemes of assistance by the government for non-governmental organizations;
- ◆ Identify existing social structures/governmental structures:
 - Listing of key stakeholders/informants in each area;
 - Village/town/district committees/religious leaders/community leaders;
 - Identify existing interventions in drug abuse and HIV/AIDS prevention being carried out by governmental/international organizations/non-governmental organizations/religious organizations/humanitarian relief organizations;
- ◆ Identify factors that facilitate the development of services.

Primary data:

- ◆ Identify availability of and use of services and patterns of service delivery and factors that facilitate development of services in the community;
- ◆ Identify key informants;
- ◆ Interview key informants;
- ◆ Study inter-agency referrals.

Getting information about the drug using networks / locations:

Using the above mentioned techniques, the locations where drug users congregate to procure/use drugs are identified. Necessary permissions are obtained from the law enforcement authorities for the project activities. Once the locations are identified the peer outreach workers (POWs) start visiting the places and observe the drug users' behaviours.⁹ The information is collected through 'participant observation' technique. This implies becoming a part of peoples' lives to the extent that it is practically, legally, and ethically possible and, while interacting with them, observing their behaviours and conversations. Data from observations and conversations is recorded in field notes¹⁰ from recall after the researcher has left the social situation. The peer outreach workers note down their observations in a specified format at the end of the day (they are discouraged from making notes at the site itself as it may arouse suspicion and hostility among drug users).

Field notes

Date and day of the week

Time

- ◆ Description of the location (only in the notes for the first visit).
- ◆ Number of people present at the location.
- ◆ Brief Description of the activities taking place including any drug use observed.
- ◆ Number of drug users engaged in conversation.
- ◆ Number of drug users persuaded to attend the interview session with the field worker/ SSP/trainer.
- ◆ Number of drug users referred for treatment / helped in seeking treatment.
- ◆ Any other significant event, which took place during the day.

During the field visits peer outreach workers also make attempts to build a rapport with the drug users. If the drug user is sensed as displaying approach behaviour¹¹, an attempt is made to establish a working relationship with other members of the group and mapping the entire network of users (size of the network, a profile of the network members, relationships, etc.).

⁹ Different times of the day/day of the week may be required to successfully contact drug users.

¹⁰ Field notes are an extremely important monitoring mechanisms in this intervention design.

¹¹ User who is friendly, is easy to talk to, and is consistently approachable when re-visiting the community.

Safety of the outreach team

While establishing contact with drug users, it is very important that appropriate security precautions are taken at any point, if the POWs sense hostility they should leave the site. Working in pairs also helps POWs resisting the temptation to relapse into drug use. The intervention agency is responsible for providing immediate attention to a POW who has relapsed.

Ethical considerations in engaging current users as peer volunteers

Outreach teams are likely to reach greater numbers of hidden drug users if they consist of full-time peer outreach workers who have the responsibility of coordinating and supervising a small team of peer volunteers. This is likely to be more cost effective than relying on the outreach contacts made by full time outreach workers alone. Peer volunteers may provide information about the locations where drug users collect/assemble. However, to obviate exposure to higher risk behaviour of another peer group, this intervention has designed the service component of a current user/peer volunteer recruited and trained to contact and educate **only** his/her own peer group.