

## 10. RECOMMENDED INTERVENTIONS

A comprehensive strategy that promotes behaviour change is essential to prevent HIV transmission and other negative health consequences from injecting drug use. Using lessons learned internationally, this strategy should aim to keep HIV prevalence low among injecting drug user populations by emphasizing that the sharing of contaminated drug injecting equipment carries the greatest risk of HIV and other blood borne infections. The comprehensive approach should also address issues surrounding sexual transmission among injecting drug users and their sexual partners and encourage drug treatment.

The ability to halt the epidemic requires a three part strategy: (i) preventing drug abuse, especially among young people; (ii) facilitating entry into drug abuse treatment; and (iii) establishing effective outreach to engage drug abusers in HIV prevention strategies that protect them and their partners and families from exposure to HIV, as well as encourage the uptake of treatment and medical care.

Interventions to address injecting drug use and HIV/AIDS need to be compatible with proven public health principles viewing drug dependence as a public health issue rather than only as a law enforcement issue. It is therefore necessary to give injecting drug users options to reduce their risk at various levels focusing on supportive rather than punitive strategies, recognizing that while stopping drug use altogether should be the ultimate goal, intermediate measures are often required to address the immediate needs of drug users and to motivate them to seek treatment.

Research indicates that an HIV/AIDS epidemic among injecting drug users can be prevented, stabilized and even reversed, if responses are based on a sound assessment of the specific drug use situation and the socio-cultural and political context. Taking into account the fact that drug dependence is a chronic, relapsing disorder, policies regarding drug abuse and its health consequences should also address the immediate need to reduce

high-risk behaviours while simultaneously promoting the long-term goal of abstinence.

Interventions should be based on regular assessment of the nature and magnitude of drug abuse as well as HIV infection. These interventions need to build on knowledge and expertise acquired from research including empirical knowledge about the social milieu around which the drug taking revolves.

HIV/AIDS prevention and care programmes for injecting drug users typically can include a wide variety of measures (the “package” approach), all of which should be tailored to the specific needs of injecting drug users so as not to inadvertently increase drug usage. Such messages can range from drug dependence treatment, including drug substitution treatment, outreach (providing injecting drug users with information on risk reduction and referral to services), HIV/AIDS education, life skills training, condom distribution, voluntary and confidential counselling and HIV testing, antiretroviral therapy, access to clean needles and syringes, bleach materials, and referral to a variety of treatment options and interventions for especially at-risk populations such as prisoners and sex workers who inject drugs.

Overall, the package of measures makes a variety of treatment and rehabilitation options available to those who wish to stop using drugs, offering substitution treatment to those who can stop injecting but who are not ready for abstinence-oriented treatment, and reducing risk factors for those injecting drug users who cannot immediately stop injecting.

Drug abuse problems cannot be solved simply by criminal justice initiatives. A punitive approach may drive people most in need of prevention and care services underground. Where appropriate, drug abuse treatment should be offered, either as an alternative or in addition to punishment. HIV prevention and drug abuse treatment programmes within criminal justice institutions are also important components in preventing the transmission of HIV.

A comprehensive coverage of the entire targeted population is essential for prevention measures to be effective in changing the course of the epidemic in the country. It is therefore essential that as many individuals as possible who are 'at-risk' are reached.

Additionally, demand reduction and HIV prevention programmes should be integrated into broader social welfare and health promotion policies and preventive education programmes. Specific interventions for reducing the demand for drugs and preventing HIV should be sustained by a supportive environment in which healthy lifestyles are attractive and accessible, including poverty reduction and opportunities for education and employment. It is desirable to include multi disciplinary activities and provide appropriate training and support to facilitate joint working.

Based on the findings that have emerged from the various studies, the following interventions may be proposed:

### **Recommendation # 1: Reach out to drug injectors and provide services**

The Rapid Assessment Survey of drug abuse employed mapping techniques to identify drug-using locales. With the help of key informants, notably former and current drug users, the RAS research staff were able to recruit drug users, including drug injectors. It is clear from the study that the majority of drug injectors are not in touch with formal services. It was also noticed that the services were not appropriate to the felt needs of the injecting drug users. This could be one of the important reasons why these subjects were not in contact with the treatment centres.

#### **Out of reach**

Injecting drug users at risk of HIV infection may be out of contact because:

- ◆ Services are geographically inaccessible
- ◆ They fear the consequences of contact
- ◆ They do not seek help or do not perceive the need for it
- ◆ The services are irrelevant to their needs
- ◆ They are marginalised by their lifestyles
- ◆ Services are not proactive in seeking clients

Community-based outreach activities aim to facilitate an improvement in health and the reduction of risk of HIV transmission for individuals and groups who are not effectively reached through existing services. Outreach was conceived of as a means to reach out to people within their own communities or local milieu, outside of the usual service settings.

Recognising the marginalisation of IDUs and their fear of harassment and possible arrest, it is common for IDUs not to trust traditional and mainstream services. Recruiting drug injectors is the first step in organising services for them. The use of peer educators<sup>8</sup> peer outreach workers and peer networks increases the reach of HIV prevention services to the most marginalised and hard-to-reach IDUs, and helps establish trust between IDUs and health services. Community-based outreach has been successfully carried out with the help of indigenous workers in Chennai, Kolkata, Imphal, Mumbai and Delhi. There is an urgent need to expand and enhance the quality of services. Indigenous outreach workers can be trained to carry out effective community outreach with the help of structured training modules and field training.

#### **Community-based outreach**

This involves:

- ◆ Identifying and making contact with target populations in their natural environments
- ◆ Establishing rapport with the target populations
- ◆ Enlisting commitment to behaviour change
- ◆ Providing information about unsafe as well as risk behaviours
- ◆ Strategies to reduce risk behaviours
- ◆ Promotion of safe behaviours

Community outreach has been demonstrated to be an effective method to reduce HIV risk among drug users (Rhodes 1994; Rhodes and Hartnoll 1996; Coyle et al. 1998; Kumar et al. 1998). Community-based interventions must take into account the many pressures on drug users and be cognisant of the types of lives they lead (Power et al. 1995). Lifestyle factors such as employment will lead to different patterns of use and daily routines for drug users. This highlights

<sup>8</sup> Defined for the purpose of this monograph as "a person who is of equal standing with another in a group".

the need for interventions, especially those aimed at encouraging protective strategies and healthy lifestyles, to provide services that are accessible and flexible to the needs of specific groups. Interventions have to be designed that fit into the lifestyles and daily routines of specific target groups.

### **Recommendation # 2: Educate the drug user**

Given the findings, it is evident that priority must be to provide adequate, appropriate, accurate and practical information to IDUs. Prevention of HIV due to IDU is certainly a more urgent public health issue than stopping drug abuse and should as such be prioritised. However, given the organic link between preventing drug abuse and preventing HIV means that pragmatic ways must be found to address both issues in tandem.

### **Recommendation # 3: Encourage drug dependence treatment**

Opiate dependence is an enduring illness and abstinence rates following conventional inpatient treatment are alarmingly low (Kumar 1998). In almost all the places, there is considerable unmet demand for treatment. Many drug treatment services are unattractive, and yet, as the National Survey demonstrates (UNODC and MSJE 2004), the demand for treatment far exceeds supply. The popularity of injectable buprenorphine among opiate dependants signifies the need for treatment with suitable medication.

Treatment services need to be readily available and flexible. Treatment applicants can be lost if treatment is not readily available or readily accessible. Treatment systems need to offer a range of treatment alternatives including pharmacotherapy to respond to the different needs of drug users. They also need to provide ongoing assessments of patients' needs, which may change during the course of treatment. Longer retention in treatment as well as completion of treatment are correlated with reduction in HIV risk behaviour or an increase in protective behaviours.

Drug substitution implies replacing the illicit and/or dangerous drugs with a licit drug of a similar action. It may also mean using the same licit drug but taking it in a different way, for example, sub-lingual buprenorphine

to replace injecting of the drug. The aims of drug substitution are:

- ♦ To switch from an injected to a non-injected substance
- ♦ To reduce the risk of contracting or transmitting HIV/AIDS and other blood-borne pathogens
- ♦ To switch users from black market drugs of indeterminate quality, purity and potency to legal drugs of known purity and potency
- ♦ To minimise the risk of overdoses and other medical complications
- ♦ To reduce hazardous drug use

Data from the five cities of Imphal, Kolkata, Chennai, Mumbai and Delhi indicate that drug injectors favour substitution treatment programmes. Such programmes are found to be beneficial to the drug users in treatment (Dorabjee & Samson 1998; Mudaliar et al. 2001). It is important that drug substitution programmes are organised and supported by the government to ensure proper treatment design for delivery and appropriate dosage; monitoring of the programme to prevent diversion; and sustainability of services. Effectiveness of drug substitution programmes in the HIV prevention strategy has been well established (Metzger et al. 1993; Ward et al. 1998; Gibson et al. 1999; Sorenson and Copeland 2000).

### **Recommendation # 4: Establish a hierarchy of risk reduction strategies to prevent HIV among IDUs**

A sample typology could encourage people to:

- ♦ Think before they start using drugs
- ♦ Think before they start injecting
- ♦ Think before they start sharing injecting equipment

As regards the latter point, users should:

- ♦ Never re-use or share syringes, water or drug preparation equipment
- ♦ Use only syringes obtained from reliable sources
- ♦ Use only new, sterile syringes to prepare and inject drugs
- ♦ Use sterile water to prepare drugs; otherwise use clean water from a reliable source

- ♦ Use a new or disinfected cooker and cotton to prepare drugs
- ♦ Clean the injecting site prior to injecting with a new alcohol swab
- ♦ Safely dispose of syringes after one use

User education can be effectively provided by trained peer educators and the content of education should address both drug and sex-related risk behaviour and cover the following points:

- ♦ The nexus between sex risk and drug use;
- ♦ The key contexts of risk behaviour (e.g., who are you using with; where are you injecting; in what state are you injecting, e.g., injecting during withdrawals);
- ♦ Overdose management;
- ♦ Abscess management;
- ♦ Primary health care.
- ♦ Opportunity for seeking drug treatment

Peers should make referrals to services wherever feasible.

### **Recommendation # 5: Develop specific strategies to prevent transitions to injecting**

Findings indicate the potential of non-injecting opiate users – in particular, heroin users – for transiting to injecting. Environmental and structural factors appear to be important in the shift from non-injecting to injecting (Panda et al. 1997; Stimson et al. 1998; Kumar et al. 1998; Kumar et al. 2000). There are very few studies that have examined transitions in detail and not much is known about the prevention of transitions. Most opiate users have used injections at times of scarcity or poor quality to alleviate withdrawal or to get the desired effect. Large-scale provision of treatment with substitution medication is an option to prevent heroin and opiate users from switching to injecting. Again, it would be a useful strategy to include non-injectors for HIV prevention and counselling. Many agencies are treating non-injecting drug users and they may not address issues relating to HIV and other blood-borne pathogens. It will be critical to equip them with necessary skills and training so that they provide HIV information, education and counselling to the drug using populations under their care.

Another approach would be to regulate the availability of injectable pharmaceutical preparations. These drugs are medically useful and critically important for the

treatment of specific conditions (anaesthesia, pain relief in surgical procedures, injuries and cancer) and hence ensuring their availability for rational medical use is equally important.

There is a considerable time lag between the onset of drug use and initiation to injecting. This offers a good opportunity for effective intervention. Interventions that aim at preventing initiation to injecting must be designed, developed and implemented and research in this area should be accorded priority.

A comprehensive strategy involving all stakeholders is required to ensure that non-injectors do not shift to injecting drug use and injectors should finally achieve the goal of abstinence from any form of drug use. Strategies addressing primary prevention with emphasis on community outreach and treatment must be given priority.

### **Recommendation # 6: Strengthen peer-driven interventions**

The networks of drug users engaging in risk behaviours shape the spread of HIV. Peers may influence each other's behaviour through social comparison processes, fear of social sanctions, information exchange, socialisation of new group members, modelling and reinforcement, and through the social interactions that provide opportunities to meet new non-using friends. Peer-driven interventions use peers to provide information, generate peer support and utilise the culture of the target group to effect and sustain changes in behaviour (Burrows 2000). Understanding social influence factors in HIV risk behaviour change (Friedman et al. 1994) may be more important in designing interventions for drug users in India (Hangzo et al. 1997).

There are many models of peer driven approaches. These include the Indigenous Leader Outreach Model - ILOM (Weibel 1993); Community Health Outreach Workers - CHOW Model; the NIDA Community-Based Outreach Cooperative Agreement Program (1991-1998); Personal network based model – SAFE (Latkin et al. 1994; Latkin et al. 1996); the Peer-Driven Intervention PDI (Broadhead et al. 1997); and a peer-leader intervention to promote outreach with HIV risk networks (SHEILD Community Outreach Worker Training – Facilitator's Manual 1997; Latkin 1998).

All of these models have been seen to be effective in reducing risk towards HIV among drug users. Given the use of drugs in groups among friends, peer-driven interventions offer the most efficient way of reaching out to the vast majority of drug users in India.

### **Recommendation # 7: Provide primary health care for drug injectors**

Drug users have multiple medical problems and referring them to specialist services and providing appropriate primary medical care are important interventions. Drug treatment services could provide treatment for abscesses, sexually transmitted diseases and tuberculosis. Liaison with other medical services (e.g., Directly Observed Treatment-DOT) is useful. Drug abuse treatment programmes should provide assessment for HIV/AIDS, hepatitis and other infectious diseases, and counselling to help drug users change behaviours that place them or others at risk of infection. Attention should be paid to drug users medical care needs, including on-site primary medical care services and organised referrals to medical care institutions. An integrated "one-stop-shop" service model, incorporating drug treatment, HIV and other blood borne pathogen prevention, sexual health, tuberculosis and general health linked to a hospital service with HIV specialist capability, is recommended.

### **Recommendation # 8: Reduce risky sexual behaviour among drug users**

Sexual behaviour among drug users and the link between drug use and sex risk is often ignored. Improved treatment services, based on STI case management can substantially reduce HIV transmission in populations with high STI prevalence and HIV incidence (Grosskurth et al. 2000). Partners are important in risk management (Rhodes and Cusick 2000) and HIV prevention interventions targeting sexual partners have to be integrated into a comprehensive HIV intervention strategy for injecting drug users. In order that the interventions have desirable impact on the sexual behaviour, the following issues have to be addressed:

- ♦ Strategies should consider the determinants of sexual transmission
- ♦ Consistency of condom use with regular partners should be stressed

- ♦ STIs should be assessed early and treated appropriately and adequately
- ♦ Sex work and drug use among women injectors need to be specially addressed

### **Recommendation # 9: Voluntary HIV counselling and testing**

Low levels of risk perception about acquiring and transmitting HIV and HIV testing clearly demonstrate the need to focus on this crucial area. Integration of voluntary counselling and testing (VCT) for HIV into existing programmes for IDUs, including primary health care, drug treatment, drug counselling services and needle-syringe programmes is urgently required. With proper safeguards to ensure confidentiality, pre- and post-test counselling can be provided in conjunction with most other services for IDUs, and most service provision staff — including peer and outreach workers — are capable of being trained to do so. Psychosocial interventions have been found to substantially reduce both injection and sex-related risk behaviours (Gibson et al. 1998).

### **Recommendation # 10: Design interventions for special populations**

Women drug users are usually excluded from existing programmes and developing special programmes that focus on their felt needs is an important priority in some settings. Similarly, prison-based interventions must be initiated and enhanced. Given the numbers of IDUs in prison settings and the numbers of at-risk and infected individuals, this setting is a crucial venue for HIV- and hepatitis-related interventions and services. Providing a range of health and drug and HIV prevention and care interventions, similar to those available in the outside communities, to inmates not only benefits them and their overall health, but also can improve the health of the communities to which the vast majority of inmates return.

### **Recommendation # 11: Ensure that the approach is comprehensive**

HIV prevention programmes targeting injecting drug users can help IDUs reduce risk behaviours significantly (Stephens et al. 1993; Slobada 1998; Ball et al. 1988; Drucker et al. 1998; Ball and Crofts 2002). What is required to contain the HIV epidemic among drug users

in India is the adoption of a comprehensive approach integrating the above-mentioned key strategies.

General steps for preventing or stopping such HIV epidemics include:

- ♦ initiating HIV prevention interventions early in the epidemic;
- ♦ implementing multiple interventions and intervention strategies (e.g., public health, community development) at multiple levels (e.g., individual, community, national);
- ♦ implementing interventions in multiple settings (e.g., streets, drug-using venues, drug treatment services, prisons);
- ♦ targeting multiple risk behaviours (e.g., drug use, injecting equipment and drug sharing, sexual behaviours);
- ♦ providing access to multiple means for behaviour change (e.g., risk reduction information, encouraging safer practices, condoms, voluntary HIV counselling and testing, drug dependence treatment);
- ♦ reducing obstacles to accessing prevention and treatment services (e.g., affordable, convenient, user-friendly, confidential); and
- ♦ recognising that populations at risk are in various stages of readiness to engage in an intervention and therefore there is a need to create opportunities for repeated exposures.

A public health response should aim to bring all these elements together and support their implementation through the efforts of government, civil society, and drug using communities.