



# HIV PREVENTION

among young injecting  
drug users



UNITED NATIONS  
*Office on Drugs and Crime*



Global  
Youth  
Network



This publication is the result of a theme meeting for young people involved in preventing HIV/AIDS amongst young Injecting Drug Users (IDU's) that was organized by the global youth network project in coordination with the Brazilian National Ministry of Health, the National Coordination for HIV/AIDS prevention and the UNODC field office in Brasilia.

**United Nations Office on Drugs and Crime  
Vienna**

# **HIV PREVENTION**

**among young injecting drug users**



**UNITED NATIONS**  
New York, 2004

The Office for Drug Control and Crime Prevention became the Office on Drugs and Crime on 1 October 2002.

UNITED NATIONS PUBLICATION  
Sales No. E.04.XI.20  
ISBN 92-1-148190-2

This publication has not been formally edited.

# Contents

## Contents

Acknowledgements	4
List of participants	5
Abbreviations	7
<b>1. Background and purpose</b>	<b>9</b>
Drug use and HIV/AIDS	9
The specific issues of young IDUs	11
Drug use patterns	14
Transition to injecting	15
Risk behaviour and consequences	18
HIV/AIDS (and other STD's)	20
Specific risk groups	21
<b>2. Step by step—how to build a programme</b>	<b>27</b>
Know the target group	28
Staff	30
Planning and involving youth	33
Community	34
Establishing contact	37
What to provide and how	38
Funding, monitoring and evaluating	56
<b>3. Key principles for HIV prevention</b>	<b>59</b>
<b>4. Resources</b>	<b>63</b>
<b>Notes</b>	<b>65</b>

# Acknowledgements

## Acknowledgements

In coordination with the Brazilian National Ministry of Health, the National Coordination for HIV/AIDS prevention and the UNODC field office in Brasilia, the Global Youth Network project organized a hands-on meeting for young people involved in preventing HIV/AIDS amongst young Injecting Drug Users (IDU's). The meeting was held in Cuiaba, capital of the Mato Grosso province of Brazil from 8-11 September 2001 in tandem with the IV Brazilian Congress on the Prevention of STD and AIDS.

Fourteen representatives from eight countries, from various service organizations working with injecting drug users met with the aim to exchange ideas, to facilitate communication, to develop guidelines and to formulate a set of best practices to prevent injecting drug use, HIV and AIDS among youth. The workshop discussions and proceedings provided the framework for the formulation of these guidelines to prevent injecting drug use and related adverse consequences, in particular, prevention of blood borne pathogens like HIV among drug users and their sexual partners.

In particular we would like to thank Tamara Maman, Dr. Shakuntala Mudaliar of SAHAI Trust (Chennai, India), Christian Kroll, Moruf Adelekan, Stefano Berterame, Giovanna Campello and Gautam Babbar for their work in bringing this guide to fruition. Various people contributed by providing comments and inputs, including UNICEF, WHO, UNFPA and UNAIDS. The Inter Agency Task Team on young people was also involved with the consultations.

The reader will note that the term "harm reduction" is used in some of parts of the publication. From UNODC's point of view, this term is meant to cover those activities aimed at reducing the health and social consequences of drug abuse, an integral part of the comprehensive approach to drug demand reduction, as recognized in the Declaration on the Guiding Principles of Drug Demand Reduction, adopted by the United Nations General Assembly Special Session on the World Drug Problem in 1998.

Within this document, the three following areas of activity are referred to as "harm reduction principles":

- Reaching out to injecting drug users;
- Discouraging the sharing of contaminated injecting equipment by providing sterile injecting equipment and disinfectant materials;
- Providing substitution treatment.

These principles, which were first enunciated in "Principles for preventing HIV infection among drug users" by WHO, together with UNAIDS and the Council of Europe, in 1998, should not be seen in isolation from overall national drug strategies or national AIDS programmes. They are, however, valuable in guiding these national policies and programmes with regard to the specific goal of reducing HIV transmission among injecting drug users. (WHO, 1998: *Principles for preventing HIV infection among drug users*, Copenhagen: WHO Regional Office for Europe).

In addition to the above documents, the guiding policy document of UNODC's current activities in this work area is the ACC-approved document titled "Preventing the transmission of HIV among drug abusers: A position paper of the United Nations System", which was also endorsed as a conference room paper (E/CN.7/2002/CRP.5) at the 2002 meeting of the Commission on Narcotic Drugs (CND).

# List of participants

## **INTERCAMBIOS, ARGENTINA**

### **Diego Santillan**

Corrientes 2548-1° E-1046 Buenos Aires  
ARGENTINA  
Intercam@cvtci.com.ar  
Phone: +54-11-4954 7272  
Fax: +54-11-4954 1333

## **ICON (INDO-CHINESE OUTREACH NETWORK), SYDNEY, AUSTRALIA**

### **Penny Sargent**

School of Public Health and Community Medicine,  
Faculty of Medicine, Wallace Wurth Building,  
University of New South Wales, Sydney,  
NSW 2052, AUSTRALIA.  
Phone: +61-2-9385 2503  
Fax: + 61-2-9385 1526  
<http://home.iprimus.com.au/avwwa/>

## **STEPS TO A POSITIVE DIRECTION, SOFIA, BULGARIA**

### **Anna Pehlivanova**

1504 11 Marim Drinov Str.  
Sofia  
BULGARIA  
Sofianep@online.bg  
Phone: +359-2-986 4954/951 5963/943 3980  
Fax: +359-2-986 4954

## **SÃO PAULO, BRAZIL**

### **Abelardo Furtado, Mendonça Filho**

Av. Conselheiro Nêbias 116 (altos), Santos  
BRAZIL

### **Silvia Fernanda de Paula**

Rua Francisco de Souza Rezende nº 330, Sao Paulo  
BRAZIL  
iepasede@atribuna.com.br  
Phone: +55-13-3223 5624  
Fax: +55-16-638 2745

## **MATO GROSSO, BRAZIL**

### **Isabel Silva Magalhães**

Rua 13 de junho, 802 – Santa Izabel – Cuiabá/MT  
BRAZIL  
jafonsop@terra.com.br  
Phone: +55-65-634 4789

## **RIO GRANDE DO SUL, BRAZIL**

### **Maurício Pereira da Silva**

Rua Vinte e Um, nº 497 Bairro Bom Jesus –  
Porto Alegre/RS,

## **BRAZIL**

Phone: +55-51-3225 3720/ 3231 7114

## **SANTA CATARINA, BRAZIL**

### **Sabrina Iara Tomaz**

Conceição, 613  
bairro: São João-Itajaí-Santa Catarina  
BRAZIL

## **BAHIA, BRAZIL**

### **Josimar Conceição Melo**

CETAD/PRD-  
Centro de Estudos e Terapia do Abuso de Drogas  
Rua Pedro Lessa 123, Canela  
Salvador Bahia  
BRAZIL  
rurebatista@usa.net  
Phone: +55-71-336 3322  
Fax: +55-71-336 7643

## **YOUTH CO, VANCOUVER, CANADA**

### **Sheena Sargeant**

203-319 West Pender Street  
Vancouver,  
British Columbia V6B1TF  
CANADA  
Sheenas@youthco.org  
information@youthco.org  
Phone: +1-614-688 1441  
[www.youthco.org](http://www.youthco.org)

## **INDIA**

### **Eardley Rigley**

### **Shakuntala Mudaliar**

12 Vaidayaram Street  
T. Nagar, Chennai  
600 017  
INDIA  
msuresh@vsnl.com  
Phone: +91-44-433 2285

## **ROMANIA**

### **Adriana Lungu Ancuta**

Adolescent Association Bucharest  
(Adolescentul Association)  
Moise Nicoara street no. 8  
741391 Bucharest – 4 ROMANIA  
Adolesc@itcnet.ro  
asociatia\_adolescentul@excite.com  
Phone: +40-1-132 38017

**YUGOSLAVIA****Jelena Kostic**

Gandijeva 136  
11070 Belgrade  
YUGOSLAVIA

Phone: +381-11-781 622/361 0776

**UNODC VIENNA****Stefano Berterame****Gautam Babbar**

UNODC, PO BOX 500, A 1400, Vienna  
AUSTRIA

Gautam.babbar@unodc.org

Stefano.berterame@unodc.org

<http://www.unodc.org/youthnet>

**UNAIDS****Telva Barros Naiara, Garcia da Costa**

SCN, Q. 02, Bl. A,  
Ed. Corporate Financial Center,  
Asa Norte,  
Brasília DF –  
CEP: 70359-970

**BRAZIL**

naiara@undp.org.br

telva@undp.org.br

Phone:+55-61-329 2195

Fax: +55-61-329 2197

**UNODC BRAZIL****Cintia Freitas****Vera da Ros****Giovanna Quaglia****Nara Araujo**

UNODC-Regional Office

Ministério da Justiça, anexo I

70064-900 Brasília DF

**BRAZIL**

Vera@UNODC.org.br



## Abbreviations

**ACC**—Administrative Committee on Coordination (UN)

**AIDS**—Acquired Immuno-Deficiency Syndrome

**ATS**—Amphetamine Type Stimulants

**CDC**—Centers for Disease Control and Prevention

**CSW**—Commercial Sex Work

**GLBT**—Gay, Lesbian, Bisexual and Transgender

**HIV**—Human Immuno-Deficiency Virus

**ICON**—Indo Chinese Outreach Network, Sydney, Australia

**IDU**—Injecting Drug Use

**IDUs**—Injecting Drug Users

**IEC**—Information, Education, Communication

**NGO**—Non-Governmental Organization

**NSEP**—Needle and Syringe Exchange Programmes

**PLWHA**—People Living With HIV/AIDS

**STD**—Sexually Transmitted Disease

**STI**—Sexually Transmitted Infections

**UNAIDS**—Joint United Nations Programme on HIV/AIDS

**UNFPA**—United Nations Fund for Population Activities

**UNGASS**—United Nations General Assembly Special Session

**UNICEF**—United Nations Children’s Fund

**UNODC**—United Nations Office On Drugs and Crime

**WHO**—World Health Organization

**YMSM**—Young men who have sex with men

Abbreviations

# 1

## Background and purpose

### Drug use and HIV/AIDS

#### *Injecting Drug Use and HIV/AIDS*

The global HIV/AIDS epidemic killed more than 3 million people in 2003, and an estimated 5 million acquired the human immunodeficiency virus (HIV)—bringing to 40 million the number of people living with the virus around the world [1].

Anywhere between a third and quarter of the 40 million people living with HIV/AIDS are in the age group of 15-24 years. Some studies estimate that young people account for as many as half of all new infections [2]. Worldwide, new infections in young people occur at the rate of five per minute.

Today, injecting drug use is acknowledged in 135 countries and it is estimated that more than 3 million users are HIV-positive, whereas in 1992, only 80 countries reported injection drug use, with only 52 reporting HIV infecting among injection drug users. Drug prevalence rates among youth can be three or four times higher than those found among the general population. This includes injecting drug use. Although it was common to say that IDU is less common among adolescents, in some regions the age of IDU has decreased considerably, to include adolescents and children.



## HIV prevention among young injecting drug users

According to an UNAIDS 2000 report, it is estimated that between 5 and 10 per cent of HIV infections have resulted from injecting drug use globally. In some countries and areas however, more than half of reported AIDS cases are attributed to injecting drug use. For example Belarus, China, Italy, Poland, Spain, Russian Federation and Eastern Europe [3].

.....  
**Facts around the world...**

- *In Central Asia, more than 80 per cent of new infections are related to IDUs.*
- *By some estimates, there could be as many as 3 million injecting drug users in the Russian Federation alone, more than 600,000 in Ukraine and up to 200,000 in Kazakhstan. (In Estonia and Latvia, it has been estimated that up to 1 per cent of the adult population injects drugs, while, in Kyrgyzstan, that figure could approach 2 per cent). Most of these drug users are male and many are very young—in St Petersburg, studies found that 30 per cent of them were under 19 years of age, while, in Ukraine, 20 per cent were still in their teens [1].*
- *In parts of China, for example, high rates of HIV/AIDS prevalence have been found among injecting drug users—35-80 per cent in Xinjiang and 20 per cent in Guangdong [1].*
- *According to official estimates, 65 per cent of Viet Nam's HIV infections are occurring among drug users, due to the use of contaminated injecting equipment. Sentinel surveillance in 2002 found that more than 20 per cent of injecting drug users in most provinces were HIV-positive [1].*
- *A report by the national programme for the struggle against AIDS and sexually transmitted diseases in Argentina, revealed that the transmission of HIV between IDUs represents 40 per cent of the total HIV/AIDS cases in the country [4].*

.....  
The most common modes of HIV transmission worldwide remain unprotected sex, unscreened blood and blood products, contaminated needles, and mother-to-child transmission. In many countries of Asia, Latin America, Europe and North America, injecting drug use is the main or a major mode of HIV transmission. With an estimated 12.5 million people injecting drugs across the globe, most being between the ages of 15 and 30, there is a huge potential for further spread of HIV among drug injectors and their sexual partners.

Sharing or use of contaminated injecting equipment or needles is the most efficient way of transmitting HIV. The level of risk is much higher than from unprotected sexual intercourse since HIV infected material is injected directly into the bloodstream.

Since injecting drug users are often linked in tight networks and commonly share injection equipment, HIV can spread very rapidly in these populations through sharing of injection equipment and through risky sexual behaviour.

.....  
*In Manipur, India, the proportion of young drug injectors (median age 25) infected with HIV zoomed from virtually zero in 1989 to 56 per cent within six months and to between 60 per cent and 75 per cent by 2003 [5].*  
.....



There is considerable evidence that public health interventions can change the course of epidemics. HIV/AIDS prevention programmes have helped make drastic changes in whose injecting risk behaviour and also sex risk behaviour. Dramatically lowered levels of HIV infection have often rewarded countries that have worked with young people to reduce risky behaviour.

*“In regions like Eastern Europe . . . we could effectively stop the development of large-scale (HIV) epidemics through strong efforts targeting injecting drug users.”* Peter Piot,  
Executive Director of UNAIDS, June 2001.

### ***Injecting drug use and sexual behaviour***

Drug injectors are at risk of getting infected with HIV virus and spreading the infection to their sex partners through unsafe sex. Injecting drug users can act as a bridge to transmit HIV to non-injectors with which they have sexual contacts. IDUs tend to underestimate the importance of condom use in sexual intercourse and have very low levels of condom use.

Numerous studies have found drug injectors to be disproportionately likely to be involved in the sex industry. Girls, who have sex in exchange for money or drugs, are at high risk for HIV infection and can spread the virus to a large number of people.

In addition to sexual contact between drug injectors and non-injectors, drug injecting may also contribute to an increased incidence of HIV infection through HIV transmission to the children of drug injecting mothers (this is called “vertical transmission”).

HIV is also a risk among drug abusers who do not inject drugs through high-risk sexual behaviour. The impact of many types of psychoactive substances, whether injected or not, including alcohol, are risky to the extent that they are disinhibitors and affect the individual’s ability to make decisions about safe sexual behaviour.

*New epidemics have emerged in Estonia and Uzbekistan, while in Ukraine, more than 250,000 people were living with HIV/AIDS by 2000. Although the epidemic is still concentrated among injecting drug users and their sexual partners, growing prostitution and high level of sexually transmitted infections could, in a climate of jolting social change, cause it to spread rapidly into the general population [6].*

### **The specific issues of young IDUs**

You may be wondering why this manual focuses specifically on young IDUs and why it is important to differentiate young IDUs from others. The reason is that young IDUs are not the same as their older counterparts. We should remember that youth are the adults of the coming years and countries will face economic and social instability if this group becomes the main concentration of HIV/AIDS cases. Various factors make their issues unique and these have raised awareness for the need to have services, which target them specifically.



- **Peer influence:** Youth are curious and can be easily influenced by peer pressure. They often use or abuse drugs within their peer groups and are often guided by the peer norm, where drugs may be considered normal.

*"At the age of 14 I had friend who tried drugs, so I knew in full detail how drugs are made and used. The very first injection grabbed hold of me and I began to do drugs regularly [7]."* Dima, Belarus

- **Limited awareness:** Young IDUs often have limited education, awareness and knowledge of the HIV virus. Information and communication material that may be available is often not written for young people. They may know little about the drugs, their effects, the risks associated with drug abuse, especially drug injection, safer injecting practices and reducing their risk behaviour. Young IDU have been found to engage in higher levels of needle and syringe sharing than older IDU [8]. A United Nations report released in July 2002 reported that the vast majority of the world's young people have no idea how HIV is transmitted or how to protect themselves from the disease. "Young people actually don't have the proper knowledge to protect themselves. The tragic consequence is that they are disproportionately falling prey to HIV [9]."

*In countries with generalized HIV epidemics, such as Cameroon, Central African Republic . . . more than 80 per cent of young women aged 15 to 24 do not have sufficient knowledge about HIV. In Ukraine, although 99 per cent of girls had heard of AIDS, only 9 per cent could name three ways to avoid infection [9].*

*"For at least four years I was using the needle knowing hardly anything about the kinds of viruses you can catch, in using in unsafe ways [8]."*

- **Unawareness of risks:** Risks to health may be regarded as distant or remote as young IDUs do not experience the complexity and severity of health problems as often as they may be encountered by older IDUs who have injected for longer (abscesses, gangrene . . .). It may be difficult for young IDUs to understand the need for prevention efforts when they have not experienced health problems as a result of their own injection drug use.
- **Limited access to services:** Services are often perceived by youth as unfriendly to young people. Young IDUs are often unaware of the existence of health, social, legal and welfare services that could be of help to them. They may not know how to access these services. Some services are geographically inaccessible to youth. Some countries have waiting lists in health services, and in hospitals—this can lead youth to give up on receiving any help.



- **Lack of confidentiality at services:** Young people, as well as adults in this case, may feel ashamed, fear stigmatization or the lack of privacy and confidentiality when considering approaching treatment services. They may be afraid to make their problem visible, and thus avoid using services. The desire to keep the drug problem discrete results from the strong stigma associated with drug use (and with HIV/AIDS), mentioned under social consequences.
- **Economic instability:** While adult IDUs usually have an income (at least initially), youth often suffer from economic instability, as they are unemployed and often unskilled after dropping out of school. Many youths have to resort to crime or commercial sex work to get money for drugs. Lack of money may also prevent youth from seeking health care, as they may not be able to afford care or medication that they would need to buy.

The recent decades have seen a decrease in the age of initiating drug use. This is a concern, as the age of initiation of injection drug use is important in assessing the severity of the associated risk. Trends seem to indicate that youth are beginning injection at younger ages.

If a youth begins drug abuse very early, some additional problems arise because:

- At younger ages the individual is less likely to understand the consequences of his or her drug use.
- Early onset of drug use is often connected to polysubstance use.
- The longer a person uses drugs, the more severe will be the long-term health related consequences.
- Early onset will often mean school drop out and this will in turn leave few career or job opportunities in the future. Inability to find employment can lead youth to remain on the streets and in the drug-using scene.
- Young girls, who usually have not completed school education, often end up in commercial sex work to get money for drugs or to get drugs directly.

.....  
*In Eastern Europe, the trend in illicit drug use is towards an ever-younger initiation of injecting drug use. "In Ukraine and St. Petersburg (Russian Federation), up to 20 per cent of injecting drug users are teenagers, with the youngest being around 12 years old [10]."*  
 .....

**Social consequences:** Injecting (and non-injecting) drug use also brings social consequences with it. Consequences include dropping out from school, family conflict resulting in having to leave the home, delinquency and social isolation. Since drug abuse is illegal, IDUs usually try to minimize contact with law enforcement agencies and officials. IDU is also stigmatized in most societies, so there is a legitimate reason for the IDUs to hide from society [11]. IDUs are isolated from the mainstream and usually do not come forward for help or information, even when this is available. Also, health services, treatment and counselling services are often designed for adults or addicts. The needs of young people, especially those in the early phases of their "drug careers", so to speak, who often do not even consider themselves addicts, are not catered for.



Even amongst the broader group of drug users, young IDUs have special problems with the law. Their youth, often their status as juveniles and their marginalization often contribute to law enforcement authorities being even more disrespectful, discriminatory and brutal than they would be with drug users in general.

.....

*Many countries in Eastern Europe and the former Soviet Union attempt to control injecting drug use through harsh, inappropriate measures. The police in some countries round up young people suspected of drug use to search for needle marks (known as "tracks") or force them to be tested for HIV. Those who test positive have their drug use and HIV status officially registered with the police. These measures not only have failed to reduce the negative health and social consequences of drug abuse but have forced IDUs further underground, encouraging needle sharing and other risky behaviours [12].*

.....

For these reasons, IDUs are frequently referred to as a "hard-to-reach" population. To maximize the chance of success for HIV prevention, it is important to reach drug injectors in the street and in the places where they congregate, to use former or current drug users as peer educators and to win the cooperation of law enforcement officials so that outreach strategies and programmes are tolerated. These approaches will be discussed in section two.

Finally, UNAIDS [5] emphasise three main reasons to single out young people for HIV/AIDS prevention:

- The special vulnerability of young people to the epidemic. Of all those infected after infancy, at least half are young people under 25.
- Young people account for hundreds of millions of people in the developing world, where the epidemic is concentrated. If HIV prevention in this huge youthful population fails, developing countries will have to face the staggering human and economic costs of vast numbers of adult AIDS cases.
- Working with young people makes sense because they are a force for change. They are still at the stage of experimentation and can learn more easily than adults to make their behaviour safe or to adopt safe practices from the start. Young people can change the course of the epidemic.

### Drug use patterns

Different parts of the world see different patterns of drug use and different trends regarding which drugs are most commonly used. The chart below is not meant to be an exhaustive list of all drugs injected around the world and only provides an indication of the relative popularity of two drug groups. It is essential to remember that increasingly, injected abuse of prescription drugs is also becoming important.



DRUGS INJECTED	REGIONS
Opiates (mainly heroin)	South East Asia East Europe Newly Independent States Central Asia Australia South Asia Some parts of Europe
Cocaine	North America Latin America

Injecting of amphetamine type substances (ATS) is on the increase and youth around the globe are beginning to experiment with new drugs like ketamine. Anabolic steroid abuse is on the increase among youth in developed countries. Other injected drugs include synthetic opiates (morphine, buprenorphine, pentazocine, pethidine), pharmaceutical prescription drugs, notably benzodiazepines, antihistamines and painkillers.

Data on which drugs are being used and which settings they are used in is very important. For example, high-frequency heroin users typically inject three to four times a day with 4-6 hours between injections. On the other hand, high-frequency cocaine users will often inject in a binge pattern, with injections every 15-20 minutes until the drug supply runs out. This binge-type use presents more opportunities for sharing injection equipment and needles.

If drug users inject alone, then sharing normally does not occur (unless someone else previously used the injection equipment). Many drug users, however, use in groups and work together to buy drugs. Then they often consume together as well, dividing the doses among themselves, often using the same needles and syringes. If the equipment is contaminated with HIV, the virus can be rapidly spread among the entire group [11].

## Transition to injecting

Some of the factors that influence the transition to IDU are: More pleasure (tolerance development): Injecting the drug provides a “better trip”, a stronger effect, and a quicker onset of the effect. This is especially relevant when tolerance to the drug begins to develop and the effects are no longer as strong.

*Most started using heroin by smoking or chasing and reported initially being repulsed at the thought of using needles. However, as their tolerance to the drug increased young people found that they were unable to support their use (smoking heroin in its salt form is inefficient and yields a considerably lower recovery rate than when injected). Curiosity about the effects of injecting, including the “rush” also appears to influence some Indo-Chinese young people to start injecting. Finally, peer pressure is an important factor in decisions by some Indo-Chinese young people to initiate injecting drug use. Source: ICON, Australia.*





- **Curiosity:** Injecting is a new sensation and they often aspire for something new and better.
- **Financial considerations:** Injecting is more efficient, it is cheaper than other forms since one can get more pleasure with a smaller dose. These is a very common reason for making the transition.

*"I remember I was unemployed and feeling very bored, so I started to smoke heroin. I continued to smoke the drug until I ran out of money, and then I changed from smoking to injecting." Le Anh Tuan, Viet Nam [7].*

- **Social environment:** Existing IDU in the peer group means they are exposed to injecting drug use. Often group pressure or group norms can be an important cause of the transition.

*"My closest friend never pressured me into taking it because he cares for me and knows how it is like to hang out and stuff, but I know he offered me that day because he saw me depressed and I accepted his offer [13]."*

- **Availability:** The ability to get a hold of the drug, in comparison to other drugs and low prices are also important factors.

*In Asia, the spread of IDU was caused by increased access due to locally produced heroin after the 1960s. Injecting is also associated with the quality and price of available heroin. When there is a decrease in the availability of "pure" heroin, or an increase in prices, the tendency is to resort to injecting in order to produce the desired effect using smaller doses [14].*

- **Personal causes:** Life issues such as family breakdown, emotional disturbance, poverty or other personal issues can lead the drug user to intensify his or her drug use by injecting.
- **Visibility:** Injecting is less visible as it is faster than smoking and does not leave any smell.

*In a study of Indo-Chinese young people, just under half of the interviewed youth reported that it was someone else's idea for them to inject for the first time. About two thirds of participants had been injected by someone else at their first injection. However, there was little evidence of coercion from others.*

*Most initiations "just happened". Only a small number of participants stated they had planned their "first hit" and almost half the sample reported that someone else had purchased the drug the first time that they injected.*

*Ninety per cent had smoked heroin prior to their initiation into injections. A large proportion claimed they were unwilling to return to smoking [8].*



## Trinh's story, Australia

Trinh was fifteen when she first tried heroin. Her family immigrated to Australia from Viet Nam when she was twelve-years-old. Trinh attended a local high school but was not doing well and was experiencing conflict at home. Trinh soon struck up a friendship with Lien, an Australian-born Vietnamese girl in her class. Lien had an older boyfriend, Tuan, who was involved with a local gang that sold heroin in Cabramatta. Through Lien and Tuan, Trinh began a relationship with Cuong, a young man several years older than her.

One night Cuong was not his usual relaxed self and insisted on calling around to Tuan's house before dinner. She was surprised when Tuan pulled out a small package of white rock, broke some off and placed it on a piece of foil and began to heat it with a lighter. Trinh was shocked but also very curious as she watched Cuong, Tuan and then Lien "chase the dragon". Lien asked if she wanted a puff . . . She felt happy and relaxed after smoking although she didn't like the way the smoke stung the back of her throat. Even the sudden and violent retching that made her run to the bathroom had seemed somehow pleasurable and part of the experience. And the best part—none of her problems seemed to matter anymore.

The next time Trinh again felt blissfully happy and relaxed. At this stage she was not aware that smoking heroin could be addictive and knew very little about the drug. One day, Trinh woke up with sore leg muscles and a strange feeling in her stomach. She wasn't sure what it was—maybe she was getting the flu. She continued to smoke the drug, now and then even smoking it alone. Eventually she complained to Cuong who immediately started screaming that her symptoms were caused by heroin withdrawal, calling her a "dumb bitch" and an "addict". Cuong dumped her.

Shattered by the break-up and cut off from her regular supply Trinh sought out Lien and Tuan who by this stage were selling heroin to "Aussies" on the streets of Cabramatta. Trinh helped them find customers and in return they supplied her with heroin. When Lien and Tuan were arrested, Trinh started selling for herself. The first time she saw someone "shoot" she felt repulsed. She felt faint at the sight of the needle and the blood and swore never, ever to use a needle. However, six months later Trinh wasn't selling enough to support her habit. Trinh knew that she wouldn't need as much heroin to satisfy her cravings if she injected but just couldn't bring herself to be like her "customers".

Trinh didn't want to inject that first time. She was "hanging out" with excruciating pains in her stomach and muscles. A junkie had robbed her at knifepoint and taken all her heroin and her money. A regular Aussie customer offered to help Trinh out by buying some heroin from someone else and giving her a small shot. Trinh asked if she could smoke the heroin but Sharon refused, saying that it was a waste. Trinh finally gave in and put her arm out to be injected. Sharon administered the injection and Trinh instantly felt her pains subside, better still she actually felt pleasurably stoned for the first time in eighteen months. Afterwards Trinh felt ashamed about her first injection. She went back to smoking heroin but still wasn't making enough to support her "dos". And now she had a taste of what shooting felt like. Trinh knew that she would have to switch to injecting. She didn't want to but she couldn't afford not to and didn't know where to go for help to quit. Not long after she started injecting regularly, relying on her customers to shoot up for her.



Research conducted in the United States has linked the transition from heroin smoking to injecting with a number of factors, including frequent and heavy drug use, polydrug use and being in a close relationship with an injecting drug user. Social and situational factors such as unemployment, poverty, homelessness, social disruption, incarceration and the influence of social contacts have also been identified as important factors linked to initiation of injecting [8].

### **Risk behaviour and consequences**

It is the risk behaviour of injecting drug users that exposes them to the danger of contracting HIV. Risk behaviour falls into two main categories: injection related risk behaviour and sexual risk behaviour.

#### ***Injection related risk behaviour***

It has been established that young people share injection equipment more often than older drug users and that they perceive less risk in doing so.

The risk of HIV transmission occurs through the following activities:

- Direct sharing/repeated use of needles and syringes for injecting.
- Indirect sharing/sharing of the paraphernalia used for drug injection. This includes:
  - Sharing or using unclean water, cookers or cotton
  - Using used syringe plungers to stir the drug solution
  - Backloading: the drug solution is transferred from one previously blood-contaminated syringe to another. The plunger is removed from the syringe into which the drug will be transferred and the drug mixture is then squirted into the back of the syringe
  - Frontloading: the drug solution is transferred from one previously blood-contaminated syringe to another by removing the needle on the syringe receiving the solution, and then squirting the drug into the syringe's hub or barrel. This is now relatively uncommon, since most insulin syringes used by IDUs do not have removable needles
  - Squirting the drug solution from a previously blood-contaminated syringe into the drug mixing "cooker" or "spoon" and then drawing it into another syringe.
  - Rinsing a used, blood-contaminated syringe in water that other IDUs also use to rinse their own syringes or to dissolve drugs.

"Risky injecting episodes usually took place within specific contexts: late at night or early morning with no access to sterile syringes, when people were 'hanging out' or withdrawing from drugs or during periods of intoxication or binging, particularly when cocaine was involved . . . from the perspective of IDUs [in Cabramatta], backloading is not a 'risk behaviour' but an efficient, equitable and even low-risk method of apportioning drug solution. As one participant noted: 'I don't let the tip touch anything—just in and then out—very careful [15].'"



One of the difficulties lies in the fact that in the context of everyday injecting drug use, the HIV risks associated with injection may seem less immediate or important than other risks, such as overdose, vein damage or addiction.

***“You don’t care when you need a dose. The fear of remaining sober and in pain overwhelms any fear of sickness.” Andrei, Siberia [16].***

#### ***Heroin Injecting in India: direct and indirect sharing***

*Transitions from chasing heroin to injecting have occurred among young persons rapidly in Chennai, India. Typically, one young injector takes responsibility for preparing and dividing the drug, usually heroin.*

*The individual responsible for the preparation places it in the cooker (usually a spoon or an alcohol bottle cap), and then, using their syringe (the donor syringe) draws up water and discharges it into the cooker. The drug is then stirred with the syringe plunger until it dissolves. The entire solution is then drawn through a cotton filter and into the donor syringe. The same injector measures the total amount of the drug to determine each injector’s share. Once portions are calculated, the IDU preparing the drug distributes it by skirting all but their share of the solution back into the cooker or directly in to the other injectors’ syringes.*

#### ***Rapid Assessment Report, Chennai, India, 2001 Sexual risk behaviour***

Sexual risk behaviour is common and difficult to change in IDUs. They often do not recognize the importance of safe sexual practices and can become links who transmit the HIV virus to non-injecting populations.

***“Most people I know say ‘Oh, my boyfriend or girlfriend doesn’t have AIDS, because look at her, she’s healthy and wouldn’t do stuff like that’. But people don’t realize that if you have a relationship with someone, you’re sleeping with all the people they slept with. If you don’t use a condom, you might get what all those other people had.” Joretta, 15 [17].***

Risky sexual behaviour includes:

- Vaginal and anal intercourse and oral sex without the use of a condom.
- Having multiple partners.
- Lack of treatment for other STIs which can increase the change of HIV transmission.

High-risk injection and sexual behaviour often go hand in hand. IDUs also often use other drugs such as alcohol, which have been related to high-risk sexual behaviour due to their disinhibiting effect.



Providing sex in exchange for money often supports drug use. In sex work, it is often difficult to negotiate safe sex practices and this is often neglected.

- One-third of female drug users interviewed in Osh, Kyrgyzstan, report that they are periodically or constantly engaged in prostitution to earn their living or to purchase drugs. An estimated 90 per cent of these commercial sex contacts take place without the use of condoms.
- In Tashkent, Uzbekistan, more than half of drug users' sex partners do not use drugs themselves, but practice unprotected sex with their IDU partners [10].
- A study in Brazil among crack users found that 60 per cent of the females worked as prostitutes to buy drugs. The sex workers did not use condoms to protect themselves or their customers [7].

While substantial behaviour changes occur in relation to injection drug use after interventions among IDUs, influencing sexual behaviour is more difficult. The majority of drug injectors are sexually active, partner change rates are relatively high and there is also a high degree of sexual mixing between injectors and non-injectors. Condom use is especially uncommon with regular sexual partners.

Negotiating condom use can be a difficult matter for many girls.

*"It's really a delicate matter; a few [women] do ask. Very few boys don't need to be asked before using it . . . but there are many who would get angry and feel you don't love them or you don't trust them.*

*For some boys, you don't dare offer them a condom. They will immediately feel you play around and that you are cheap [18]."*

### HIV/AIDS (and other STDs)

- HIV infection is the most important and the most serious blood borne pathogen acquired by young injectors. HIV enters the body, attacks, and over time destroys the body's immune system. The immunity to diseases and viruses gets considerably weakened. HIV infection represents the presence of the virus inside the human body. Sometimes, this can go without any symptoms or signs.
- AIDS is the Acquired Immuno Deficiency Syndrome. When AIDS has developed, the body loses its immunity ability and many symptoms appear (infections and cancer can develop). The evolution is progressive, and opportunistic infections eventually lead to death, as there is currently no known cure. However, the increasing availability of Anti Retroviral Therapy (ART) is providing hope that HIV positive people can hope to lead fairly normal lives.

It is also worth mentioning that other injection related health consequences exist and often have more immediate effects. Some of these are listed below, however will not be explained in more detail here.



- Hepatitis B—acute and chronic forms are common among IDUs. A vaccine exists.
- Hepatitis C—a very transmissible virus. High rates exist within IDUs, in many places above 60 per cent of drug injectors are Hepatitis C positive. There is currently no cure for this virus.
- Other STIs such as gonorrhoea, syphilis and genital herpes.

Other consequences of injection drug use can be:

- Overdose—caused by a higher dose than the body can take, this is often fatal. Mixing drugs into “cocktails” can often be dangerous in this sense and lead to overdosing.
- Physical damage—repeated injection can result in scarring and marks on the skin. Loss of access to superficial veins may result in the use of deeper veins that can cause tissue damage. Abscesses are also a common concern for IDUs.

## Specific risk groups

Although youth is the target group we are concerned with in this publication, there are many groups within “youth” which may need special consideration due to their specific issues and problems. It is critical to work on the best way to reach all young people, those in, out of school, or in other programmes or situations.

“Specific programmes may be needed to target women IDUs (especially those who are sex workers); gay and lesbian IDUs; street youth (a large number of whom abuse substances, including injectable drugs); and IDUs of specific ethnicities who are often marginalized such as Roma in Eastern Europe, North Africans in France . . . [19]”

Knowing the target group you are dealing with and knowing which subgroups exist in your area is important for reaching all youth in the most appropriate manner. Some specific groups are listed below.

### *Young girls and sex workers*

There is a special need to consider young women in terms of their vulnerability and especially linked to their access to information [20]. In many countries, young women have far less knowledge about HIV than young men.

Among adolescent drug using girls, sex work can rapidly become a part of life as a means of funding their drug habit. These girls are at high risk of acquiring HIV and can serve as a transmission link of HIV to their casual and regular sexual partners, to their children and to the general population through paid sex. Girls also suffer a high incidence of sexual abuse, rape and victimization.

Condoms are little known or used by young women in developing countries. Their use usually depends on the cooperation of the man, and young women are often embarrassed to suggest using a condom.



Females may need specialized services, such as those for pregnant or parenting adolescents. It has been shown that girls often experience more severe parental rejection and sexual or physical abuse than boys do. Weak family bonds are a precursor to substance abuse in females. Also, some studies indicate that psychiatric profiles of females show higher disturbance among all dimensions [21].

### ***Homeless/street children***

The street environment places street children in especially vulnerable categories. Drug abuse behaviour is widely prevalent. Often, drugs are used as an escape from self-degradation and misery. Services rarely understand the circumstances and specific needs of street children and their accessibility to health care services, particularly those related to drug abuse and HIV/AIDS is severely restricted.

Street populations are prone to experimentation, and therefore are more likely to try injection drug use. Injection may also be a demonstration of “street toughness” that preserves a person’s status on the street.

Besides needle sharing, unsafe sex practices under the influence of substances increases the risk of contracting HIV. Some findings seem to indicate that street children are often intoxicated while having sex with opposite or same sex partners.

A study in South Asia found that street boys become sexually active between the age of 7-9 years. Unprotected sex is common and visits to commercial sex workers are frequent. There is a total lack of awareness and knowledge among street children about the risks associated with drug use/abuse and unsafe sexual practices [20].

.....  
*Studies carried out by CEBRID (Brazilian Center for Information on Psychotropic Drugs) in 1989 and 1993 revealed that up to 90 per cent of the children and adolescents who live on the streets use drugs. This figure was lowest in Rio, where rates were still above 50 per cent [22].*  
.....

### ***Immigrant groups and minorities***

Minority groups, for example immigrants from a different culture, often have difficulty integrating into the new society and can become an isolated group that may breed drug use. In Australia, Indo-Chinese immigrants are a specific group that needs to be dealt with as many problems have lead them to have high drug use rates. Evidence from several studies suggests that Indo-Chinese injecting drug users may be at increased risk of blood-borne viral infection. As a group, they appear to be more socially isolated, have significantly less contact with services and limited knowledge and awareness of blood-borne viruses. Recent studies of Indo-Chinese IDUs have found high levels of needle and syringe sharing [8].



.....  
 To address these issues (cultural differences) ICON uses discrete and sensitive bi-cultural/bi-lingual volunteer workers where possible and all volunteers are required to have a flexible and non-judgmental approach to service delivery and to utilization. Source: ICON, Australia.  
 .....

The Roma are the most vulnerable population throughout Central and Eastern Europe. They live in slum-like houses, have high unemployment levels, poor health care and lack access to public services. There is also strong discrimination against this group.

Given their poverty and lack of access to services, many are at risk of drug abuse and HIV infection. Many Roma are uninformed about the risks associated with needle sharing and unprotected sex [12].

For more information on working with youth belonging to ethnic minorities, refer to the Global Youth Network Project How-to guide on working with ethnic minorities.  
 ([http://www.unodc.org/youthnet/youthnet\\_action.html](http://www.unodc.org/youthnet/youthnet_action.html))

### ***Infrequent injecting drug users***

Infrequent injectors are those who have not yet developed fixed injection patterns, and for the most part they are ignored in prevention and intervention efforts. However, studies of young, recent onset injectors have shown high rates of HIV infection within the first years of injecting. Random injectors may be very vulnerable to HIV, so it would be a valuable effort to target this group.

They are a difficult population to target since they do not fully identify themselves as IDUs and may be particularly afraid of the stigma of being related to a NSEP (Needle and syringe exchange programme). They may not be as easily reached as IDUs through outreach programmes [23].

### ***Young people in prison***

Studies in different parts of the world have indicated that overcrowded conditions, drug abuse and limited availability of adequate services in prisons may adversely affect the health of inmates, including through exposure to blood-borne diseases such as HIV/AIDS.

.....  
 Lara Stemple, Executive Director of the non-profit human rights group Stop Prisoner Rape, reported: "Rape and HIV in prison is 8 to 10 times as high as in the general population [24]."  
 .....

The most difficult problem with respect to HIV and prisons, however, is preventing HIV transmission among inmates while they are in the facility. Of course, the activities that transmit HIV, i.e. unprotected sexual intercourse and the sharing of drug injection equipment, are officially banned in prisons. Nonetheless, even though it is unrealistic to expect prisons,





particularly those that are understaffed and overcrowded and that house large numbers of persons with drug abuse problems, to be completely free of these activities, it is extremely embarrassing for prison officials to publicly admit that these activities do in fact occur. Such denial has been one of the reasons why the distribution of condoms, bleach and sterile injection equipment has been limited within prisons [25].

For young people in prison, there are additional risks considering that they are often physically weaker than other inmates are (youth are not always incarcerated separately from adults) and may be forced to take part in drug related or sexually related activities.

.....  
*Alfreda, an 18-year-old Hispanic female, contracted AIDS while in a youth lock-up in her teens. She is one of many youths who are left only minimally supervised during the night shift in many lock-ups. She describes the sexual environment as one of experimentation and curiosity. "We did it to fight the boredom, to give us something to do," she describes. Alfreda returned from the lock-up to her neighbourhood, where the same problems, (that is, a lack of supervision and knowledge) existed, not only with the psychological scars of incarceration, but also with a physical reminder of her unsafe sexual exploits while in the lock-up [26].*  
.....

Prison populations can not be forgotten simply because they are closed off from society for a certain time. Remember—prison inmates come from the community and will most likely also return to the community.

### **Gay and lesbian youth**

Many studies have concluded that the frequency and variety of drugs used by gay men is greater than that of heterosexual men. For instance, 38.5 per cent of gay, lesbian, bisexual and transgender youth admitted heavy drug use compared to only 22.5 per cent of their heterosexual peers in a study in the United States [27]. The explanation for these findings usually involves the social and emotional isolation. Up to 80 per cent of gay, lesbian, bisexual and transgender youth report feeling severely isolated socially and emotionally [28]. Substance abuse often results from an attempt to manage stigma and shame or to deny their own feelings.

It is important not to assume that homosexuality causes drug or alcohol abuse. When gays, lesbians and bisexuals internalize society's homophobic attitudes and beliefs, the results can be devastating. Society's hatred becomes self-hatred. As a minority group, gays, lesbians and bisexuals are victims of systemic and ongoing oppression. It can lead to feelings of alienation, despair, low self-esteem, self-destructive behaviour, and substance abuse (Nicoloff and Stiglitz, 1987). Some gays, lesbians and bisexuals resort to substances as a means to numb the feelings of being different, to relieve emotional pain or to reduce inhibitions about their sexual feelings.

Substance abuse often begins in early adolescence when youth first begin to struggle with their sexual orientation. When surrounded by messages telling you are wrong and sick for who you are, eventually you begin to believe it. Having to hide your identity and deal with homophobic



comments and attitudes—often made by unknowing friends and family—can have a profound effect on you. In response to this overwhelming oppression and homophobia, many lesbians, gay men and bisexuals use alcohol and drugs to cope.

A subgroup within this group, which has been identified as being at high risk of HIV infection, is young men who have sex with men (YMSM). Among males ages 13 to 19, 41 per cent of AIDS cases and 52 per cent of HIV cases reported to the Centers for Disease Control and Prevention (CDC) in 1997 were among YMSM and YMSM injecting drug users [29].

In a 1996 study, 38 per cent of YMSM reported having unprotected anal sex, and 27 per cent reported having unprotected receptive anal sex [30].

One in four YMSM is forced to leave home because of his sexual orientation, up to half of these youth resort to prostitution to support themselves—greatly increasing their risk for unprotected sex [31]. Perceived invulnerability is characteristic of youth but is especially problematic for YMSM, considering their risk for HIV and their lower rates of safer sex as compared to older gay males

### ***Youth living with HIV/AIDS***

Youth living with HIV/AIDS are a group with very specific needs, which are different from other groups, considering this is a group who has already contracted the HIV virus. This group needs efforts in treatment and care and in reducing stigma related to PLWHA (People living with HIV/AIDS). Issues of this group are discussed in chapter 2, under “HIV positive youth”.

# 2

## STEP BY STEP – how to build a programme

Prevention of the spread of HIV among IDUs uses various strategies. The most recommended way to go about prevention is to provide a comprehensive package of care for injecting drug users.

This section should help you to build up your programme by following the ideas we have brought together here. Remember—this guide is not all encompassing, there is always more information being released and other sources that can help you with specific aspects of your work. This guide should help you get started, but it will not be your ending point!

A comprehensive package [32] should aim to include:

- Provision of HIV/AIDS information and education;
- Access to basic services and primary health care;
- Life skills training and peer education;
- Condom distribution;
- Access to clean needles and syringes and possibly bleach materials;
- Voluntary and confidential HIV testing and counselling;
- Referral for a variety of treatment options.



***“It is not advisable to offer proposals of total abstinence from the start (although that is the final aim)”.*** Projeto de Reducao de Danos de Itajai, Santa Catarina, Brasil.

A good guideline to keep in mind when considering how to go about HIV prevention is a hierarchy of prevention, which can help to set small, achievable steps which can be reached progressively [19]. In a review paper from UNICEF, this typical hierarchy appears:

*“The most effective way to prevent transmission is to never start or to stop using drugs.*

- *If this overall goal is not achieved for a specific individual, the drug user should be encouraged to use drugs in any way except injecting: if you do not inject, you cannot catch infections through sharing drug preparation or injection equipment.*
- *If this goal is not achieved, the drug user should be encouraged to inject with new/sterile injecting equipment every time and to not share preparation equipment.*
- *If this goal is not achieved, the drug user should be encouraged to re-use his/her own injecting/preparation equipment every time: if you re-use your own equipment every time, you cannot catch viral infections such as HIV (unless someone else has used your equipment without your knowledge).*
- *If this goal is not achieved, the drug user should be encouraged to clean needles/syringes and other equipment by an approved method. There is some risk of HIV transmission after equipment cleaning, but cleaning in an approved manner will reduce the likelihood of transmission.*
- *The hierarchy provides small steps which drug users can be encouraged to take to reduce and hopefully eliminate HIV risk behaviours.”*

### Know the target group

From chapter 1 you can probably understand that young people have very special issues and needs that should be considered when wanting to build an HIV/AIDS prevention programme. Remember that due to social isolation and stigmatization, as well as for many other reasons, young IDUs will usually not come forward looking for information or help. For this reason, we need to go out to where the youth are; a process called outreach, which will be explained below. However, to do this, the first thing we need to know is who our target group is.

Some of the basic things that you should find out before you start are:

- The demographics of your target group: characteristics such as age range, gender, social status (are users mainly street youth or students), educational level.
- The extent to which they inject: compared to the use of other types of drug administration.



**Remember:** HIV prevention should begin immediately, even if there haven't been many cases of HIV in the area. The spread of HIV among injectors can occur rapidly—more rapidly than the time it would take to set up a programme in response.

- Injecting behaviour and patterns: What drugs they tend to inject, when and how many times they usually inject, the places where they usually “hang out”. Remember that injecting on the street or public places often escalates the risk. Who they inject with is also relevant: IDUs who use drug with strangers (SW for example) are at increased risk. Also, using with many people and rapid partner changes can spread the HIV infection rapidly.
- If there is a leader in charge of their network: For example, if adults are those in charge, who bring youth in, then a different approach is needed than if it's a network of youth only—in which you should use peers to reach them.
- Their sexual behaviour: How much risky behaviour is there? Who do they have sex with—regular partners or CSW or others? Do they use condoms?
- The HIV/AIDS (and STI) situation in this population: How many people have these illnesses as well as whether support and health services exist in the area and the extent to which IDUs are aware of them.

It may not be so easy to gather all this information. Do not let lack of information stop you from getting started, however keep in mind that the more you know, the more chances you will have to reach your target group. Also remember you can always collect more information once you have got started.

So, how do you get this information [33]?

- Young people involved in your project can tell you about issues that are important to them and trend that they know about. They can also help you gather information from the target group.
- Gathering information directly from the target group is useful; this may be done in informal studies, and interviews in the field.

**Remember:** IDUs may be suspicious of you and not want to talk to you about their activities. It helps to make contact with one or two people and through them reach others. IDUs may not want to admit to sharing needle and syringes. They may understate their risk behaviours.

**“Nobody wants to admit that they do it [share]. How stupid do you look? They know and we know that you're not supposed to share anything, not even a spoon. So you feel like you've done something wrong. I guess you have [done something wrong] but you don't want to admit it cause you know it's wrong too.” Alex [15]**

- Drug treatment services.
- Local authorities on AIDS and health as well as universities may have information that you can use.



- Hospitals and emergency rooms.
- Local researchers in the field can help you with information or references.
- Newspapers and magazines sometimes have articles on HIV/AIDS and other important issues.
- NGO's and other groups already working with the target group or with other groups in the area.
- The police and prisons as well as courts.

This is clearly not an all-inclusive list, and it would be difficult to try and provide such a list, considering different countries and groups can lead to very different conditions, requiring the knowledge of different information. For ideas and tips on getting the information you need, refer to the Global Youth Network publication: *A participatory handbook for youth drug abuse prevention programmes: A guide for development and improvement*. ([http://www.unodc.org/youthnet/youthnet\\_action.html](http://www.unodc.org/youthnet/youthnet_action.html))

For more detailed information on How to conduct a rapid assessment of the situation, particularly with regard to injecting drug users, please see <http://www.who.int/docstore/hiv/Core/Index.html>, a technical guide for Rapid Assessment and Response to HIV/AIDS.

### Staff

Who are the appropriate people to work in HIV prevention projects? What kind of characteristics should they have?

Staff who are going to work in a prevention programme with young IDUs need to have or learn certain characteristics . . .

- They should be open, free of prejudices and stereotypes, and have a non-judgmental position towards drug use. They should be caring, understanding and sensitive. They need to have respect for IDUs, and for their confidentiality.
- They should have a certain level of knowledge on safe injecting and safe sexual behaviour as well as knowledge on HIV/AIDS.
- They should not use technical language, but should be able to reach IDUs on their own level, to work "with them" rather than "for them".
- Outreach workers will need to be available at normal working hours as well as unconventional hours, at which the programme should aim to work as well.

! *Since outreach workers should be reachable 24 hours a day, mobile phones can help a lot. In one case, a project in Brazil was able to negotiate a discount rate with the mobile phone company once they explained that the phones were being used for outreach work.*

- They should have dedication and commitment to the cause.
- There should ideally be outreach workers of both sexes, as some males or females may feel more comfortable talking to someone of the same sex.



Drug Users as well as non-users can be hired as staff, and each group has its advantages and disadvantages.

Using peers to talk to young people is an element that is considered important in developing prevention programmes. Young people are not likely to seek advice from teachers and adults for various reasons, such as finding them untrustworthy. However, youth tend to listen to the experience and the advice of their peers because they present information about drugs without preaching or judging behaviour. For a more in depth discussion of peer to peer strategies and using peer educators, see the Global Youth Network Project How-to guide on using peer to peer strategies in drug prevention. ([http://www.unodc.org/youthnet/youthnet\\_action.html](http://www.unodc.org/youthnet/youthnet_action.html))

### ***Current users as staff***

***“IDUs and PLWHA work as harm reducers, collaborators, help in needle exchange, identify new users and spread the message about the programme.” IEPAS—***

**Instituto de Estudos e Pesquisas em Aids de Santos—  
Projeto “Farmacias na Reducao de Danos” Santos, São Paulo.**

Using current users has the advantage of them knowing the language of the IDUs, they are accepted by the drug users and know their needs.

Peer workers often have personal experience of IDU and can be recruited through NSEP or youth organisations or outreach workers [23].

***“[How do you reach drug users?] By working with other drug users. It is fundamental to have drug users as active participants in harm reduction programmes. In Brazil, of the over 1000 people who work in harm reduction, 70 per cent are drug users. I am convinced that this is the key to the programmes’ successes.” Domiciano Siqueira, Co-ordinator of the Harm Reduction Association of Brazil [4].***

Using peer educators does not only have advantages for reaching the IDUs (by increasing trust and credibility and having an equal level of communication), but is also can help the outreach workers themselves, by giving them knowledge and skills and allowing them to have a meaningful function in the programme.

***“For once, I feel good about myself because of being a peer educator. Though I won’t act like I’m too good, it feels good to know what I’ve learnt. It will also be good to pass it on [8].”***

However it is worth remembering that current users may not have high credibility among peers and may not be reliable.



There may be other difficulties related to using IDUs as staff. In some instances, to some people, it may send out a mixed message if a user is used as a model to give out information about drug use, getting off drugs and preventing disease transmission. Some youth may also prefer to be in touch with someone who has either successfully stopped using drugs or who does not use drugs, to get support in his or her attempts to stop using drugs. Also, there may be some legal issues related to drug users, which have to be considered before starting.

### ***Ex-users as staff***

Ex-users have many of the advantages of current users. They have experience with IDU and may have increased credibility among peers since they have succeeded in becoming clean. However, getting involved in such a programme may be difficult for them and could lead to relapse.

***Telling the story of his drug use gives Diego the strength to be an outreach worker.  
"I began injecting drug when I was 18 years old, but it has been over a year now that I have not injected, it no longer seems like a good idea to me . . . Many times I wake up and I go through the entire day with a syringe on my mind" Diego, Intercambios, Argentina.***

### ***Non-users as staff***

Although it may be difficult for this group to establish a relationship with the IDUs, and although they do not have full knowledge or drug use, there are various advantages of using non-users in the programme.

These may be trained professionals who have a lot of knowledge on HIV and AIDS and this may stimulate discussion, in which the user can talk about his experiences while the staff can bring a more theoretical view.

IDUs may want to speak to non-users about ceasing drug use, and the staff may be their first contact for social re-integration.

### ***Training***

All staff should have basic training so that they are knowledgeable about risk behaviour and risk reduction (both injecting and sexual risks) related to HIV transmission. Staff should be aware of the aims of their interventions and be clear about what their role is and what is expected of them.

Although peer educators have contact with the target group, they need more skills for outreach work.

Staff training should specifically emphasise the reduction or elimination of prejudices and stigma, examining attitudes towards drug injecting and HIV/AIDS.

Confidentiality and other important aspects of work, such as respect and credibility should be covered during training.





## Planning and involving youth

Involving youth in projects relating to youth is a key aspect of making a programme aimed at youth work. Youth know what they like, what kind of information or styles will appeal to them and what they will or will not find interesting. Youth can be involved in all aspects of the programme, from planning and developing the programme to implementation.

“Effectiveness of programmes for young people appears to be enhanced by employment of peer staff (of a similar age or slightly older than the target group) and youth-friendliness of IEC materials, premises and staff: this has included use of youth culture symbols in IEC materials and as posters in premises, involvement of young IDUs in designing and producing IEC materials and in planning and implementing programmes, and staff training to understand the needs and culture of young IDUs [19].”

***“Weekly discussions with young volunteers who are involved in planning and execution.”  
Steps to a positive direction—Initiative for Health Foundation, Sofia, Bulgaria.***

*YouthCO is a “youth-driven” agency. This means that YouthCO works to ensure that the voices of people between the ages of 15 and 29, infected with and/or affected by HIV/AIDS, steer the direction of the organization. At YouthCO, youth are offered the opportunity to voice their opinions on agency priorities, policies, and programming needs. Youth work with each other to identify areas of advocacy and support, and to come up with new and exciting ways to educate their peers. Youth are involved in all areas of agency decision-making and programme implementation—be that within our board of directors, our Staff, our volunteer programmes, and/or within our Membership services. Source: YouthCO, Canada.*

Youth involvement in the organization of these schemes is essential. In Bulgaria, the Touching Reality project trained young people age 14-19. NGO’s provided basic administrative support and preliminary training but otherwise there was a 100 per cent youth involvement policy. A mid-term evaluation showed it is often difficult for NGO’s to let go and let young people express their own ideas in their own language. On the other hand, young people were shown to lack certain skills such as reporting and compiling financial statements and accounts. These essential skills must be included in the training programme if young people are to take complete responsibility for the project [23].

When youth are involved in planning and implementing a programme, they feel a sense of ownership and responsibility towards the project. Not only is their participation beneficial for the project, as they are good sources of information, ideas and feedback, but it is also beneficial for them. Youth can often gain a lot of experience and being involved in a prevention project can help them channel their interests in a useful and safe way, especially youth that are part of the target group.



Youth can be involved at various levels:

- In consultations and focus group discussions to get ideas and collect information;
- Active involvement in implementing projects, (for example being trained to be peer educators or being involved in NSEP);
- Involvement in initiating, designing, and planning the project.

Youth may look and speak differently than the other staff, but this shouldn't be an obstacle. There is a lot to be learnt from youth, especially those that are part of the target group, and your project needs their involvement for success.

**!** *Remember: make sure the youth are clear about their role and their responsibilities and truly involve them and make use of their ideas—let them know that their ideas are important and will be taken seriously and used in the project.*

.....

*The Indo-Chinese Outreach Network in Australia is a street based outreach programme engaging young Indo-Chinese drug users. As well as needle and syringe exchange and condom distribution, education and referrals, and other activities, they also have community development projects, which have included a photo-narrative exhibition and a weekly young women's group: Cabragirlz.*

*Young people are involved in all aspects of the programme, from input in weekly meetings to participating in peer education and harm minimization training programmes, community development and research activities. Peer educators are drawn from the target group.*

*The Cabragirlz project incorporated developmental writing and peer based education as part of the construction of a website on drug-related harms specifically targeting people from Asian backgrounds. ([http://home.iprimus.com.au/avwwa/index\\_frameset.htm](http://home.iprimus.com.au/avwwa/index_frameset.htm)).*

*"The development and administration of the project certainly was not predictable or smooth, but nor were the lives of the participants. Flexibility was crucial. We learned to accept that people will come and go and that "our" expectations are not always the same as participant's expectations. If we are to deliver the best possible outcomes for ethnic Vietnamese heroin users then they need to feel that projects belong to them and that they have a say in their direction [34]."*

.....

## Community

Support from local authorities and communities has shown to be of vital importance. Programmes should be free from police harassment and linked to other services. Police activity attempting to prevent drug selling and buying as well as possession is often devastating to programmes. For example an Australian programme reported 40 per cent less contact with clients after police operations targeted IDUs in the area and around the NSEP site [19].

Look at your aims and try to consider which groups or people could help you or could create resistance to your project. For example, police and law enforcement could be a barrier to



reaching young people. Contact these authorities and talk to them about your project. Offer to run a course on HIV/AIDS education for police for example. Try to come to an agreement on how to encourage the project.

***“All the police stations are informed where the outreach work is carried out, the work is presented to them also by seminars.” Steps to a positive direction—Initiative for Health Foundation, Sofia, Bulgaria.***

At Chennai, a law-enforcement official serves as an advisory board member. By liaising with the law enforcement officials it is possible to carry out the activities with the young drug users in the community. Several workshops on HIV/Drug abuse for the police officials have been conducted.

***“The police are supporting our activities as follows: agreeing on the component of syringe exchange, teaching AA [Adolescent Association] staff how to work with injecting drug users, allowing AA to keep the confidentiality of drug users, collaborating in developing education materials.” Adolescent Association, Romania.***

Not only law enforcement authorities, but also government and authorities as well as the general population may have reservations concerning work with IDUs. Stigma and stereotypes can lead to negative reactions. It is a good idea to build partnerships with the community, to meet with and to involve the community at large when possible. The aims of your programme should be clearly communicated to the community and efforts should be made to allay any specific fears the community may have about your work. It should be explained to the community that your group is not providing drugs or encouraging people to take drugs. Rather, the health benefits of your work should be pointed out.

***“While prevention programmes consisting of AIDS education, condom promotion, needle exchange and drug treatment have proven effective, strong political determination is now needed to apply energetic prevention measures and reach out to marginalized people and their partners [14].”***

***“Since we are dealing with an excluded and excluding client group, we have difficulties in convincing the population of the importance of the work, and the need to see users firstly as citizens and not primarily as users.” Projeto de Reducao de Danos de Itajai, Santa Catarina, Brasil.***

The community may be afraid that their children will come into contact with users or that needles will be left lying around in their neighbourhood for example. If you are creating a drop in centre, for example, you may want to enter into a dialogue with the community explaining to them that



while the number of drug users “hanging around” their area may increase, considering their concerns and dealing with them adequately.

“ . . . There were negative reactions, because people stigmatize drug users. People think that drug users are delinquents or sick people who we must cure, but neither of these ideas is true. There are an enormous number of prejudices against users of illegal drugs and the stereotypes come from all of the institutions of modern society: to the religious, using drugs is a sin, to the courts it is a crime, and to the health care professionals it is an illness. Another misconception that some people have is that by handing out injecting equipment, we encourage drug use. We are not drug traffickers, we are public health agents. I hand out needles because I hope that the person who is injecting does not contract HIV or Hepatitis and that he can be more happy given the choices that he has already made. We have a responsibility to protect lives.”  
Domiciano Siqueira, Co-ordinator of the Harm Reduction Association of Brazil [4].

The community can be involved in activities of your group such as festivals or activities for world AIDS day. Encouraging participation of community leaders and stakeholders in events can enhance support.

Families of IDUs are also important factors to consider. Often, since IDUs will be contacted on the street through outreach, it will be difficult to have contact to their families, considering that their confidentiality is a high priority for the programme.

However, when possible, involving the family is a positive step, considering that families often have many misconceptions about HIV/AIDS and drug use. They may need information or also referrals to help services and more. They can help youth to learn about safe practices and can help them through withdrawal and treatment if they have knowledge.

***“My mum, she found all my syringes in a big garbage bag and I said I wanted to chuck them but she said don’t chuck them in the bin. Cause they could hurt the garbage men, take them to the exchange [13]”. Helena***

Parents and families, if provided with enough knowledge, could help other families to understand drug use and the needs of their children.

***“Parents talk to parents, ‘Oh my daughter use too much, my daughter use this much’. The parent could educate other parent like the kid being the peer educator [13]”. Thuy***

Youth need and want support from the parents, however this is often not given when the parents find out about their drug use.



*“My family was like any family we had our ups and downs. Using changed a lot of things. The relation with family got bad because of my drug use. I was hardly home to spend happy times with them. But when I’m home we usually fight or argue with my parents or sister and brother. We didn’t get on at all maybe because the drug change me [13].”*

*“Before I used heroin things were ok for me at home Mom and Dad love me. When they find out I’m using Dad stopped talking to me and Mom don’t want me anymore my life just turn up and down [13].”*

Do not forget that in some cases, drug use comes from the home, meaning the parents also use or abuse drugs, and may have contributed to the initiation of drug use. In other cases, problems in the home may have led the youth to resort to drug abuse. In any case, when possible, families should be brought into programme activities.

## Establishing contact

In general, as we explained above, IDUs will not come looking for you, so after you have made some contacts, you have to go to where they are. When you have contact with some people, they can introduce you to others.

Go where they are: this will often be mainly the street, however, other outreach sites can include any place that allows contact such as discos, party’s, bars etc.

*“I work as a harm reduction activist and I do it with joy. I go to the houses of the users, I enter the cuevas—the places where users gather to inject themselves . . . I go and I distribute materials in the street, in an alley. I see that I am doing good . . . ”*  
**Juan, Intercambios, Argentina [4].**

A more friendly approach starts with location and accessibility. Small centres in popular youth districts, with late opening hours are most accessible to youth.

At this point it is important to use the language that the target group uses and have your information in a form they will be able to relate to—don’t use technical language.

Using the peer network is important here to make proper contact and to know how to access and communicate with the group. Having appropriate staff (as mentioned above) can make the first contact easier.

Making contact is a process of building trust, and you need to show you are worthy of their trust, allowing them time to observe your group and see if they can open up to you. You should be responding to their needs, and should adapt accordingly.



**!** Remember: IDUs may be suspicious of you at first. They are accustomed to law enforcement officials and other authorities who can make their life difficult, so they may not want to associate or open up at first. It takes time to build trust.

*“In our first encounters with the community, one person asked us if we were checking in with the police. Of vital importance was establishing a network of drug users in order to generate confidence and trust, which are always fundamental.”* Pablo Cymerman, Intercambios, Argentina [4].

## What to provide and how

### ***Groups still not injecting***

In most cases, individuals move on to injecting after a period of inhaling or snorting the drugs or other forms of non-injecting drug use. Various factors, as mentioned in section one, contribute to the transition to injecting. However, this transition is not inevitable; many drug using groups remain in non-injecting subcultures and never make the transition to injection.

For the non-injecting groups there are various prevention efforts which are important to emphasize:

- Efforts can be made to reduce drug use and encourage abstinence if possible.
- Efforts can also be made to prevent the transition to injection, giving information and life skills as well as alternative activities as preventing measures.
- After the first injection, there is generally a rapid progression to injection as the preferred route of administration. So infrequent injectors are an unstable group and interventions to not have much space or time to be effective [23].
- Even in non-injecting drug users, HIV is a risk, potentially spread through unprotected sexual contact with other drug users who may be injecting or commercial sex workers or other sexual partners who have had sexual contact with HIV positive people.

For drug prevention in general, it is often profitable to use different tools, such as sports or drama, to creatively engage youth in prevention activities. More information on these methods can be found in the Global Youth Network Project How-to guides: “Sport—using sport for drug abuse prevention”, and “Performance—using performance for substance abuse prevention”. ([http://www.unodc.org/youthnet/youthnet\\_action.html](http://www.unodc.org/youthnet/youthnet_action.html))

### ***IDUs***

For preventing the transition to IDU, some points are worth keeping in mind:

- Provide adequate information through education. Have intensive and consistent prevention messages.
- Develop decision-making skills and capacity.



- Use alternative activities, challenges, concerts and music.
- Do not say a blank “no” without explaining further.
- Do not stigmatize abuse.
- Try to comprehend the users and the pressures they may face pushing them towards riskier modes of intake.

*“ To take into account the fact that the community of drug users are very closed, the first thing we did was to contact them, to gain their trust and to keep in touch with them. To enter the community of drug users we hired young former drug users working as social outreach workers. In the first year we made contact with the drug users in an apartment, the accommodation place of drug users or at social worker’s homes. There we: distributed information materials on drug use and safe sex and did syringe distribution and needle exchange. The second year our activities were enlarged: a contact centre for drug users was organized where drug users have meetings support groups and individual counselling, and which is also a fixed syringe exchange place. Outreach was extended to the beach of the Black Sea and three other locations. The target population was also extended to prostitutes who are in touch with drug users.” Adolescent Association, Romania.*

## **Outreach**

*“The core of the strategy is outreach. The outreach approach gives the opportunity to serve as much users as possible and to reach the most ‘hidden’ populations. The network of contacts is extending significantly and allows the messages to reach young people on peer basis.” Steps to a positive direction—Initiative for Health Foundation, Sofia, Bulgaria.*

The basic idea behind outreach is that education and services need to be taken to young people in their milieu, rather than waiting for youth to seek out services. As mentioned before, for various reasons, young IDUs are not likely to seek help on their own, so outreach is a major aspect of work with young injecting drug users. Outreach usually occurs directly in places where the target group spends time—often the street.

Outreach aims to reach young people who are not reached by existing health or information services. It is important in reaching out of school youth and street youth and experience shows that it is not difficult to do, not expensive and a good way to reach those living in vulnerable conditions.

Outreach workers make face to face contact with the target group, learn about them and their needs and develop services appropriate to these needs. This needs time, as the first thing that



needs to be done is build trust. Outreach workers should listen and observe the youth, and not push them to do anything they do not want. Users should not feel pressured to change behaviours, rather they should learn about reducing risky behaviour in a respectful, trustful way. As time passes and trust begins to form, more activities can be suggested and added.

While some types of outreach initiatives chose to focus on information provision others include provision of direct services to IDUs. Information only outreach programmes are few and far between and even where they do exist, they aim to provide effective referral services to service providers. In one sense, outreach is merely a vehicle for provision of whatever is needed by a target audience.

In settings that are hampered by legal restrictions on service provision or where social stigma is particularly high, information provision may be the only effective way of intervening immediately.

Outreach is widely considered the best way to reach young (and old) injectors. In Chicago, a large outreach programme achieved a reduction in risky behaviours from 100 per cent to 14 per cent over four years and the rate of HIV infection fell from 5 per cent to 1 per cent per semester by the last six months of the study [19].

Targeting outreach with young injectors who are not in touch with regular services is critical. Community based outreach 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.

**!** *Remember: confidentiality is essential, especially for building trust. Drug use is illegal, so youth will likely be suspicious of workers reporting them to the police or other authorities. It is important for youth to feel comfortable with the outreach workers.*

.....  
*Some more points to keep in mind [35] . . . Be careful—the drug scene can be violent. Be clear—make sure they know who you are and whom you are affiliated to. Also be sure that they know who you are not affiliated to (for example the police).*

*Develop a pattern—try to have a fixed day and time that you go to a certain area so people know when to expect you.*

.....

Peer outreach is a more specific form of outreach that uses peers to reach out to the target group and through this can be more acceptable to youth. It is also usually a less expensive form. Peers may be especially appropriate for outreach work, as they will better understand the





target group's ways and will possibly be able to communicate with them with more ease. Although they may not have a background in education or helping professions, they have life experience and commitment and can develop good relationships with the young people.

The advantages of peer to peer work include the fact that peers often influence young people. Peer pressure is often considered negative, but in this case peer influence can be used in a positive way. Young people also prefer to learn about sensitive issues from their peers. For example, many young people consider that it is difficult to talk to adults about sex. Adults also have difficulties talking to young people openly about this.

*"It's good because when I was in gaol and these girls were saying shoot up I had a friend who was unsure about it. She asking me do you reckon I should shoot too . . . She goes, "it's Kate's fit (syringe/injecting kit), and you know she doesn't let anyone else use it". She was just unsure about shooting up and I said, even if you clean the fit with bleach it's not ok. I drew her like a picture of the fit which got grooves in it. That's where the blood stays, so when you' wash it the bleach doesn't actually wash out the blood in the grooves. I said that's how you catch HIV or your AIDS, or your Hep C. She was thinking oh, wow, you've actually learned something new, and I found it really good. On the street there's people that ask me and I tell them. Lots of people didn't actually know that by using swabs, spoons, waters that an old fit had touched, you could actually catch the virus. They're like, wow, I didn't know that and they are more aware now." Phuong [13].*

In peer education, active IDUs are trained to educate other IDUs about HIV risks, safer injecting and safe sex. The New South Wales (Australia) department of health defines peer education as "a set of specific education strategies devised and implemented by members of a subculture, community or group of people for their peers. Where the desired outcomes is that peer support and the culture of the target group is utilized to effect and sustain a change in behaviour [8]."

The idea is that IDUs may be distrustful of messages coming from mainstream organizations. Peer education provides an effective and low-cost way to reach these groups. It uses already existing paths of communication to disseminate information and skills.

Peer network interventions reduce the risk behaviours by developing a culture in which IDUs and their peers support each other in risk-reduction efforts. The major goal is to develop a self-maintaining culture in which IDUs and their friends can actively discourage each other from engaging in behaviours such as syringe sharing or sharing other paraphernalia.

For more information on peer to peer work, refer to the Global Youth Network Project How-to guide on using peer to peer strategies for prevention.  
([http://www.unodc.org/youthnet/youthnet\\_action.html](http://www.unodc.org/youthnet/youthnet_action.html))



**!** *Don't forget: outreach should be part of a more comprehensive approach. After relationships are established, activities should be widened and other strategies should be used. (These are discussed below).*

*Another point: outreach workers may be exposed to a significant amount of psychological stress. They may witness IDU deaths or have frustrations due to relapses into sharing. Psychological counselling for outreach workers or supervision with a multidisciplinary team as well as having debriefing sessions is a good idea to avoid problems. Also, having a reward system, not in economic terms, but in an alternative way, may be a good idea to keep the motivation going.*

### **Information**

Young people need to know the facts about HIV/AIDS and about drug use. They need to know how HIV can be transmitted and what risk behaviour is. They also need to know how to reduce their risk behaviour and how to protect themselves from infection.

Information can include:

- What HIV/AIDS is.
- How a person can get HIV/AIDS.
- How a person can avoid getting HIV, including information about injecting paraphernalia and the importance of clean equipment.
- How to use a condom and other safer sex approaches including abstinence and monogamy.
- What services or treatment centres are available to them, (detailed information on voluntary counselling and testing and STI treatment), how to reach them and other information related to partner services.

For this, it is vital that the information you provide is:

**Easy to understand:** Make your brochures and propaganda in the language of use, including slang and street terms.

**Attractive:** Make the information look interesting to them—using pictures or drawings, which appeal to their interests. Use slogans and catchy phrases.

**Short:** Keep information to the point and accurate. Too much information will not be read.

*“Usually I just chuck them away—all the advice and papers. There's too much information—it's always like a whole big piece of paper with a lot of writing [13]”. Hannah*

It is often profitable to use educational materials designed by youngsters or former or current drug users. They can help to make the information more interesting for them.

Different countries developed different styles and messages to adapt to the lifestyle and preferences of their target group.

**YOUTH CO POSTCARDS**

“Space Commando...  
with heat seeking missile...  
Always protects his missile”

**BRAZIL BROCHURE**

“Aids e usuarios de  
drogas injetaveis”

**ARGENTINA STICKERS**

“Yo hago la mia con forro”

***Needle and Syringe exchange programmes***

After making some contact and building a relationship, giving information is not enough. IDUs need concrete services that can help them reduce their risk behaviours. It is not realistic to assume that if they know about the risks of needle sharing, they will immediately go and get themselves their own clean syringes. One of the factors associated with the sharing of injection equipment is the low availability of sterile needles and syringes. Often they do not have money or other means to get sterile equipment and would not go to great lengths to get it. Advice will often be ineffective unless it is supported by the availability of sterile equipment. In light of this, the development of needle and syringe exchange programmes is particularly appropriate for this target group.

The purpose of the Needle Exchange Programmes is:

- To distribute sterile injecting equipment to IDUs; and remove used and potentially contaminated injecting equipment from circulation, thereby removing the possibility of further use. This aims to reduce HIV transmission through reducing sharing of equipment.
- To distribute other equipment used in injecting (such as cookers/spoons, alcohol swabs, cotton, sterile water), and other materials such as condoms.
- To provide a point of contact with IDUs for dissemination of IEC materials about safer injecting and about prevention of sexual transmission.
- To potentially become a contact and referral point for counselling, primary health care, welfare and other services, and drug treatment service.

Equipment offered at the needle exchange sites can include:

- Needles and syringes in varying barrel sizes and needle gauges according to needs of client
- Sterile water
- Alcohol swabs
- Condoms
- Disposal containers (puncture resistant, sealable)
- Risk reduction educational brochures (unsafe sex, unsafe drug use)

Programmes can focus on distribution of needles and syringes or alternatively on exchange. In exchange, new needles are given in exchange for used ones—thus ensuring safe disposal of used equipment. In some cases, clients of the programme can collect sterile equipment not only for



themselves but also for distribution to other IDUs—in effect, they are then working as unpaid peer outreach workers. The rationale for this style of programme delivery is that it increases efficiency, with less pressure on programme staff, and increases reach to populations of IDUs who would not otherwise attend the needle-syringe programme.

***“Having syringes available insures that drug users use clean needles and do not look for used ones . . . It is important that it be clear that having clean syringes available does not create an incentive for people to use drugs.”*** Pablo Cymerman, coordinator  
of the Argentinean Harm Reduction Network.

Reviews of the effectiveness of syringe and needle exchange programme have shown reductions in needle risk behaviours and HIV transmission and no evidence of increase in injecting drug use or other public health dangers in the communities served. Programmes have also been shown to serve as points of contact between IDUs and service providers including treatment programmes. The benefits of NSEP are increased if they include AIDS education, counselling and referrals to treatment [32].

The following factors are important to consider when planning a NSEP:

- Location (for example drop in centres, mobile vans, hospital wards, outreach sites.) The NSEP should access the hidden populations of young injectors and the services should be delivered as close as possible to where drug injectors live or hang out.
- Hours of operation (projects should aim to ensure easy and free 24-hour access to sterile injecting equipment).

***“For me, preventing harm to myself means using new needles and never sharing spoons, waters or swabs. But you can’t always be safe. Sometimes the chemist close early or there’s nowhere to get new equipment late at night. Or it might be a public holidays and there’s nowhere to get equipment [13].”***

- Staffing (remember the advantages for peers being involved).

The needle and syringe exchange is often a first contact point, from which information about related services and activities can be offered to new clients.

*Intercambios Civil Association is a programme in Argentina, located in Avallaneda, a poor district in the south surroundings of Buenos Aires City. Outreach workers distribute clean needles, condoms, and safer injection information to three communities with a high rate of injecting drug use and poor access to preventive care or medical treatment. They also develop brochures and stickers containing prevention messages, organize workshops and counselling. Work is based on*



peer education and outreach. Young people are involved as outreach workers and volunteers. They participate in planning, implementation and evaluation of the programme.

Kits contain two syringes, a small bottle of sterile water, a filter, two alcohol swabs, a bottle cap in which to place the drug before injecting, and educational materials about HIV prevention. For example, one of the stickers included in the sterile injection kits handed out to IDUs says: “Loco, take care of yourself. Don’t share syringes [4].”

.....

**“The street setting means that activities are structure according to what is happening on the streets. In addition to NSEP outreach, we might be called to an overdose, hear of an opportunity to access a group of new injectors, be invited to visit a squat or asked to attend to an injury. Service provision in such a setting needs to be flexible and responsive to changing client needs on a daily basis.”** Source: ICON, Australia.

Some sources suggest needle cleaning using bleach as an option for when new needles are not as readily available. This method had various disadvantages—it is time consuming and complicated and evidence has not been encouraging regarding its reliability. In general, this facility should be used only as a last resort [35].

**!** Remember: to start and maintain a NSEP, you need to have a sufficient number of needles and syringes, as well as a sufficient number of condoms (for condom distribution).

### **Condom distribution**

As discussed in chapter one, the lack of condom use is an important factor in HIV transmission within IDUs. Many IDUs practice unsafe sexual activity, rarely using condoms.

Previous programmes had often preached abstinence from sexual intercourse. This option is important, however it does not provide any information or support for the large number of young people who are already sexually active. Strategies must stress the importance of regular condom use, with regular as well as with irregular partners.

Condoms are not always as available as one would expect, and financial barriers also exist. To promote safe sex, condom distribution can help. It can reduce the occasions where an IDU may not have any sexual protection available. Condoms can be distributed together with injection kits or with HIV and AIDS educational material by outreach workers. Also, together with condom distribution, IDUs can be told about the importance of condom use as well as shown how to use condoms properly.

Condom availability is especially important for sexually active youth, for youth that do not know where to get condoms and for youth that can not afford to buy condoms.



Condom promotion may not be as accepted as you would hope. Many people oppose condom use, feeling that they are not at risk of becoming infected and using various reasons to avoid use.

Some issues [33] to be considered:

- Some youth may lack knowledge of how to use condoms correctly. Pictures should accompany instructions and written material should be simple, so the target group can easily understand it. Distribution programmes can include demonstrations. (Insert example of brochures from groups).
- Embarrassment: Make your condom distribution discrete—try to avoid situations where youth will have to explain themselves or be in contact with adults in order to receive condoms.
- Being prepared: encourage young men and also women, to carry condoms with them just in case.
- Reduced pleasure: a common excuse for not using condoms is the belief that condoms diminish sexual pleasure. Encourage young people to make putting on the condoms part of the prelude to sex.
- Myths: some groups believe that carrying condoms means that young people are promiscuous. Use positive peer pressure to promote condoms.

*“People will think she must be having sex with the whole world” (Brazilian girl).*

*“If a girl carried a condom in her purse, I would think she was very bad.”  
(Thai factory worker) [36].*

Do not forget to mention abstinence—just because you are distributing condoms does not mean that you are pushing youth to have sex. Make sure they are aware of their other options.

Drug using women often are involved in commercial sex work and have a power disadvantage in negotiating safer sex. It may be helpful for these women to have access to female condoms.

### ***Some more things to keep in mind while working with young injectors***

“Some of the most important rules of our work are the ethic rules: anonymity, confidentiality, voluntary participation in the programme, friendly attitude to the injectors, and peer approach.” Source: Steps to a positive direction—Initiative for Health Foundation, Bulgaria.

“Of primary importance to ICON’s client group is the need for services to be delivered in a culturally appropriate, discrete and sensitive manner. Confidentiality is of utmost importance when working with young IDU who may still be living at home with their parents.” Source: ICON, Australia.



Some points, other than the ones already mentioned throughout this section, which came up repeatedly in discussion about the best ways to work with young IDUs and ways to improve a project, were:

- Use active listening skills when working with the IDUs.
- Use clear and accessible language, compatible with the educational level of the user.
- Confidentiality and respect should be a part of the main principles of the project.
- Be receptive and show human warmth.
- Have a mix of professionals and peers in the staff. Use a peer approach and use contacts in the community to spread the news about your project.
- Your centre should be a safe place for IDUs. Make sure police will not interfere.
- Be accessible, located in a place comfortable for youth, have long opening hours at late hours, be easy to get to.

**!** *Remember: The users are not always easy to find, and it can be a hard task to gain acceptance from them.*

- *It's not always easy to build trust. Don't forget that IDUs are often trying to keep away from the police and also are distrustful of institutions.*

*It is not always easy to get the users to acknowledge the problem, many do not believe they are at risk.*

## **Youth friendly services**

### *Why YFS?*

Many people ask why should young people have “youth friendly” services? What about old people? What about everyone having “client friendly” services? What is the difference between client friendly and youth friendly services?

It is true that the whole population should have access to services that are responsive to their needs and vary depending on age, gender, socio-economic status, ability, and ethnicity. The ultimate goal is that all services should be “client friendly”. There are however, three pressing reasons why youth friendly services are necessary.

Firstly, adolescence is a period of transition and experimentation. In many countries, young people [37] have sex for the first time and begin to use substances such as, tobacco, alcohol, and illicit drugs. The habits and lifestyles that are established during this period have a profound effect on future health and development. WHO has estimated that 70 per cent of premature deaths amongst adults are largely due to behaviours initiated during adolescence. In addition, many of the lifestyles engaged in during adolescence, such as, unsafe sex and substance abuse can facilitate the transmission of HIV, result in unplanned pregnancy and STIs, and result in long term addictions, or dependency on unhealthy substances. Young people (aged 10 to 24 years) thus need information, life skills and access to services (such as, counselling) to assist them in a healthy transition to adulthood. Young people should be assured of physical and sexual health,



mental and emotional well-being, freedom from exploitation and abuse, skills and opportunities for sustainable livelihoods.

Secondly, young people are an important resource for the future and we need to invest in their health and development so they are able to fully participate and contribute to society. As expressed at the recent United Nations General Assembly Special Session on Children: “Young people are not the sources of problems—they are the resources that are needed to solve them. They are not expenses, but rather investments: not just young people, but citizens of the world, present as well as the future [38].”

Thirdly, young people have rights. They have the right to participate in decisions and actions that affect their lives, and to develop roles and attitudes compatible with responsible citizenship (WHO, 2000). This right builds on Article 24 of the Convention of the Rights of the Child (UN, 1989) which defines practical steps countries must take when they sign and ratify the Convention. To ensure that all children and young people enjoy “the highest attainable standard of health” countries must take measures to reduce infant mortality, develop primary health care, combat disease and malnutrition, provide health information and to develop preventive care services.

After outreach work has been done, one aim could be, if the means are available, to set up a drop-in centre where youth can come to you. After they feel comfortable and have developed a strong enough trust in your project, it would be realistic to expect that they would agree to come to a fixed place at which you are stationed. (This does not mean that outreach work and going out on the streets should stop—but this is an additional aspect of work).

Such a centre should be a contact place, a safe and non-threatening space where they can feel comfortable, and get services not only related to drugs and HIV/AIDS, but to other areas of their life. A drop in centre should be located as close as possible to the area where drug users gather, to increase the probability that they will make use of the place. They should not have to travel much to reach you. Consider what opening hours would be most appropriate considering your target group.

Your centre may include for example:

- Counselling: Youth may want to talk about relationships, family, work or money. (Counselling does not necessarily have to be provided in a centre; it can be given after HIV/AIDS counselling or with the NSEP for example.)
- Vocational information: Your target group may need help finding job opportunities. Your centre could have listings of job openings for example. To complement this, there could be an office with telephone facilities.
- Life skills training: groups could be set up where youth meet to learn and practice life skills.
- Hygiene: IDUs do not always have a place where they can shower, or rest, especially if they are street youth. Your centre could provide such facilities as a rest room, showers and changing rooms. A medical room could also be useful.
- Referrals: A centre could have information about other services, for drug treatment, for HIV testing and counselling, for STD's.





- NSEP: A fixed place can also serve as a needle exchange site, as well as a place for condom distribution.
- Recreation: television, games and other recreational activities could be available.
- Information, education and communication materials (IEC): Of course any fixed place where you are stationed should have information brochures about HIV and AIDS, safe injecting practices, safe sexual practices, treatment services, legal rights and so on.

According to a United Nations inter agency group for South Eastern Europe on youth and HIV, the essential elements of any YFHS are:

- General health (endemic diseases, injuries, TB, malaria).
- Sexual and reproductive health (STI, contraceptives, management of pregnancy, post-abortion care).
- Voluntary Confidential Counselling and Testing (VCCT) for HIV.
- Management of sexual and domestic violence.
- Mental health services.
- Substance abuse (alcohol, tobacco, illicit substances and injecting drug use).
- Information and counselling on a range of issues (sexual and reproductive health, nutrition, hygiene, substance use).

### *HIV testing and counselling*

Voluntary counselling and testing is an important aspect of prevention. Youth, who have become aware of the risks of HIV, through your programme or through public awareness or friends having become sick with AIDS or through any other way, may want to get tested for HIV. Often they will be worried and anxious, especially if they feel they are at high risk of having the virus and need counselling to help them get through this time. Knowledge of the HIV status can help modify behaviours to prevent transmission of the virus. It can also be important to improve the general health and in seeking treatment for opportunistic infections.

Your group can refer IDUs to HIV testing facilities, or can discuss with them the possibilities of getting tested. IDUs should be encouraged to get tested.

The HIV test is a blood test that screens for the presence of antibodies that have developed in response to the HIV. There is a period between infection and when the test can show that a person is infected—this is the “window period” (this can last 2 weeks to 6 months) during which a person will test negative although they do carry the virus.

Counselling before HIV-testing helps young people assess their risk, decide whether to be tested and consider the meaning of the positive or negative test result. The person can also discuss their fears or concerns and it can also help to clarify why taking the test is a good idea (not all individuals will admit to high risk behaviours and may consider themselves out of risk).



Counselling after HIV-testing is also very important. It helps to interpret the results of the test. If they are tested negative, it is a good time to talk about reducing risk—a negative result does not mean that one will never contract the virus. A negative test result must be confronted with the possibility of the person being within the window period. If they have tested positive, they may not immediately understand the meaning of this. They need to be helped and to realize that a positive test does not mean they will die immediately. Remember that AIDS symptoms may take up to 10 year to develop. They can learn to improve their quality of life and be told about possible medical care. They also need to learn how to protect others—meaning how to avoid further spread of the virus.

*“Christine got sick living in the streets and was placed in a hospital where she was tested for HIV. ‘One night I overheard two nurses talking about the young girl in this bed being HIV positive. I opened my eyes and asked her to repeat what she said, and she told me that you are going to die of AIDS soon. I cried all day and all night and kept thinking of suicide.’”  
Christine, Kenya [7].*

The most important aspect of counselling is confidentiality. Young people need to feel sure that unless they give permission, the results of their test will not be disclosed to anyone. You should refer youth to a centre where counselling and HIV-testing can be done. Make sure that testing there is always voluntary and confidential. Remember that places you refer to reflect on your programme—if there is no confidentiality there, youth will lose trust in your project. It is also important for youth to go to youth-friendly services, which are open and accepting to young people.

Young people may also want to talk about a wide range of other problems in counselling. They will likely be facing various problems simultaneously, with family, with money with work and so on . . . Counsellors should be open to them, not judge them and listen to their issues. Health workers, physicians, teachers, social workers or others can provide counselling. They need training to learn all the necessary skills for counseling [33].

### *Drug treatment services*

When there is enough trust and a stable relationship has been built with the IDUs, they can also be referred to drug treatment services. If you recall the prevention hierarchy, you will remember that our main aim is abstinence from drugs. However, you should realize that you can not expect that your target group will be open or willing to go to treatment right away. Some may never agree to attempt treatment. Far from being disheartening, this is a typical example of those difficult situations we all face when working on drug demand reduction issues. How do we gain the trust of our “clients”, be non judgmental and yet nudge them towards seeking treatment is an operational rather than ideological problem, one that demand reduction practitioners confront every day.

Substitution drug treatment: Drug treatment programmes have been found to be effective in assisting drug users to reduce or stop injecting, especially when they are involved in substitution drug treatment (such as methadone or buprenorphine) [19]. Today, substitution treatment is



available for heroin and opiates, but not for cocaine dependence and many other drugs. Substitution therapy provides those with an opioid dependence with a daily dose of methadone (or other synthetic narcotic medication) in an attempt to help them break their addiction. Substitution programmes [35] aim to:

- Reduce the risk of HIV transmission;
- Minimize the risks of overdosing and other complications;
- Switch users from injection to non-injection;
- Reduce polydrug use;
- Reduce crime associated with getting the drug; and
- Provide counselling and treatment to drug users with which contact is maintained.

*“Methadone maintenance insures that the drug user comes to a treatment institute regularly. When they’re here we can offer them tests for TB, HIV, and other medical services. If they have other health problems...we can treat them. This contact is substantial. Their status changes from being illegal and underground to being a part of society.”*

Source: Emilis Subata, Director,  
Vilnius Substance Abuse Treatment Centre, Vilnius, Lithuania [12].

Other, non pharmacological, drug treatment programmes are listed below:

- **Cognitive behavioural therapy (CBT):** focuses on cognitive processes (maladaptive thoughts) and behavioural coping skills. The goal is to diminish factors contributing to drug involvement and promote factors that protect against relapse.
- **Family therapy:** stress the role of the family in developing and maintaining adolescent drug abuse. Many approaches also include peers, school and neighbourhood, based on the idea that extended systems contribute to dysfunctional family interactions. It focuses on inducing a family change.
- **Therapeutic community (TC):** an intensive, 24-hour setting residential treatment model developed for adults, however modifications exist for adolescents. This form of treatment is usually reserved for the most severe abuse problems, with serious negative consequences that require long-term care. The most important characteristics are the use of the community as a therapist and the highly structured, well-defined process of self-reliant operation.
- **Self-help groups:** aim to empower the person to take responsibility and within a group get support to help him or herself get off drugs or stay off drugs. These groups are often recommended as follow up after a more intensive treatment.
- **Motivational interviewing (MI):** a focused method, in which the counsellor guides the client into reaching the desired aim. Although directive, the idea behind MI is to guide the client, but not to coerce them into change. Motivation therapy can also be important, as an early intervention, to raise the patient’s motivation to get treatment. It aims to make the person aware of his need for treatment and often can be carried out in non-traditional settings like hospitals (if a user has come in due to some physical complications).



- **Behavioural therapy:** believes that unwanted behaviour can be modified through the demonstration of the desired behaviour and reward of steps leading towards achieving it. Methods include assignments, rehearsal of behaviours, recording and reviewing progress, and using praise and privileges for fulfilling goals.

Several longitudinal studies examining changes in HIV risk behaviours for patients currently in treatment have found that longer retention in treatment, as well as completion of treatment, are correlated with reduction HIV risk behaviours or an increase in protective behaviours [32].



*An important part of ICON's role is to link young people with appropriate services such as detoxification, methadone maintenance, sexual health and chest clinics. Source: ICON, Australia.*



The relationship between HIV treatment and drug treatment is also worth mentioning. One common problem that is encountered with HIV treatment is compliance. It is often difficult to get the person to keep to a strict regime of medication intake. It seems however, that when a person is involved in drug treatment, especially in substitution treatment, where they have to come in to the treatment centre daily to get their dose of substance, it can help to associate the HIV treatment to it. When they are regularly going to get their substitution drug for example, they can at the same time get treatment for HIV. This can enhance adherence to the HIV medical treatment.

### *Life skills*

Life skills are also an aspect to be considered. Although providing or training life skills is not enough on its own, as part of a comprehensive programme, it can be beneficial for youth to learn skills to implement the safer behaviour they learn about as well as improve their functioning in other areas. They often lack skills for use in other areas of life, and your programme can provide a continuum of services, including skills that relate to areas other than drug use. The idea here is to give overall assistance—to help them not only reduce risk behaviours, but eventually also reintegrate into society, have social skills and be able to get jobs.

Of course it is often quite easy to say, include life skills in your intervention but the key is implementing it correctly. When do you provide life skills training? What is the setting? How are specific skills to be introduced? What teaching techniques do we need to use? Questions like these are bound to crop up when you start including life skills in your programmes. For a good explanation of how life skills education must be planned and implemented please consult Skills for Health, WHO 2003, (<http://www.unicef.org/lifeskills/SkillsForHealth230503.pdf>)

Examples of life skills [33] that youth would benefit from are:

- How to discuss safer sex with partners and rehearsal of these skills.
- How to properly use condoms.
- How to identify individuals in the community who they can rely on for support.
- How to recognize and avoid risky situations.



- Problem solving techniques for difficult situations.
- Self esteem building.
- How and where to get help and support.
- How to communicate with others in the community.

Here is an example from the Canadian Red Cross Society [39] of excuses relating to condom use and suggested responses that can be provided or role-played with youth.

IF YOUR PARTNER USES THIS EXCUSE . . .	YOU CAN REPLY . . .
I can't feel anything when I wear a condom.	I know there's a loss of feeling. But there are still plenty of sensations left.
Condoms are unnatural and turn me off.	There's nothing great about disease either.
I'm insulted! You act like I'm a leper.	Not at all. I want it because I care about our relationship.
I love you. Would I give you an infection?	You wouldn't mean to, but most people don't know they're infected.
I'm afraid it will slip off and stay inside me.	Don't worry, I know how to put it on properly so there is no chance it will slip off.

### *HIV positive youth*

Some young people you encounter in your project may already be infected with HIV. Their needs are different but are also very important. They need help making decisions about their lives, they often need to prepare for eventual illness and may need clarification to truly understand what HIV and AIDS means. Safe sex is especially important for this population, to prevent the virus from being passed on to others and to prevent their exposure to other STD's.

HIV positive youth may find it difficult to deal with the fact that they are infected so early in life. They may be confused about their sex life and the risk of infecting others. They may be disconnected from friends due to stigmatization and may not always have support from their own family [5].

***"There have been numerous cases in which people living with HIV have been criminally charged for conduct risking the transmission of the virus . . . But we must be careful to avoid over-reacting based on misinformation and prejudice . . . such situations can lead to a miscarriage of justice and promote stigma and discrimination."*** Marika Fahlen,  
**Director of Social Mobilization and Information at UNAIDS [40].**



## HIV prevention among young injecting drug users

HIV positive IDUs may encounter a double stigma—once due to their drug use, and the second time due to their HIV status. Social stigma must be fought, but we must realize that it won't disappear immediately and we should be aware of the difficulties that these youth may be going through.

.....  
*"Live and let live was the slogan of the two-year World AIDS Campaign 2002-2003, which focused on eliminating stigma and discrimination.*

*Stigma and discrimination are the major obstacles to effective HIV/AIDS prevention and care. Fear of discrimination may prevent people from seeking treatment for AIDS or from acknowledging their HIV status publicly. People with, or suspected of having, HIV may be turned away from health care services, denied housing and employment, shunned by their friends and colleagues, turned down for insurance coverage or refused entry into foreign countries. In some cases, they may be evicted from home by their families, divorced by their spouses, and suffer physical violence or even murder. The stigma attached to HIV/AIDS may extend into the next generation, placing an emotional burden on children who may also be trying to cope with the death of their parents from AIDS. With its focus on stigma and discrimination, the Campaign will encourage people to break the silence and the barriers to effective HIV/AIDS prevention and care. Only by confronting stigma and discrimination will the fight against HIV/AIDS be won [41]."*

.....

HIV positive youth can also become peer educators. This can give them some meaning and a sense of purpose if they are willing to talk to others about their experience.

Youth who develop AIDS and become sick can be visited by the group, and supported through their most difficult times. The programme can also help by reminding them to take medication or shopping for them if necessary, for example. Some youth will not have family or friends to stand by them when they are sick—in this case your programme can be especially important.

**!** *Remember: youth with HIV working in your project may become sick suddenly—be aware of this reality.*



## Mauricio's Story, Brazil

Mauricio, 24 years old, is married and has no children. He was born and lives in Porto Alegre, in Rio Grande do Sul. According to a study by the Ministry of Health, HIV prevalence in IDUs in Porto Alegre is 64.3 per cent, the highest in Brazil (in Salvador for example, the rate is only 6.4 per cent).

Mauricio started sniffing cocaine when he was 13 years old. He didn't use other drugs, not even alcohol, but he quickly moved on to use crack.

Although able to live with his mother at home (who was separated from his father), he lived on the street most of the time, surviving on small thefts.

He continued his use, but meanwhile he "could not feel anything anymore" and wanted something stronger. Sniffing cocaine or crack no longer satisfied him.

When he was 16, he sought out a group he already knew, who were injecting cocaine users. They were all older than he was and he started injecting with them. He injected with them for 2 years before getting sick, at 18 years.

He began having persistent vomiting and headaches. He went to a hospital and was diagnosed with sinusitis. He believes he was a victim of prejudice for being a drug user: why would they attend to a drug user who "is a lost cause" rather than attending to a worker?

His mother and sister supported him and, worried about his symptoms, took him to a private doctor. The exams showed he had meningitis, caused by the tuberculosis bacteria. Referred to the public health system in Porto Alegre, he was cared for and well treated.

He was in a coma for 20 days and after his hospitalization still went through a terrible period, not being able to feed himself and realizing that he was seropositive with a manifesting opportunistic infection. His mother and sister supported him at all times, and without them he "wouldn't have survived". At this point he had to make a decision: he knew he couldn't continue injecting drugs, he wouldn't survive. So he made the decision between life and death. And he chose to live.

As soon as his physical conditions allowed, he found a self-help group for seropositive people. He felt like his life was "useless" and that he would never find a job. In this group (GAPA—support group for prevention of AIDS), he regained his self-esteem, mainly thanks to meeting Andrea, a 39-year-old HIV positive woman working in prevention. They have been married for the last 4 years, supporting each other through treatment.

Through her he got to know the Harm Reduction Project—supported by the National Coordination of STD/AIDS and UNODC under the National AIDS Programme—and did what he had thought impossible: he started working! Through this work he was able to take part in the global network meeting in Cuiaba, in September of 2001.

As for cocaine, he reports never having used again, although using marijuana lightly.

Thanks to antiretroviral treatment, he is doing well and his health is stable.

Currently, he is so strong that he applied for adult studying scholarships that he read about in the newspaper: in December 2002 he will be able to finish his fundamental education [42].



## Funding, monitoring and evaluating

This section will be a short reference to the topic of funding and support, monitoring and evaluating your project, mentioning only some ideas and examples. More information on this topic can be found in the Global Youth Network Project How-to guide on using peer to peer strategies in drug prevention. ([http://www.unodc.org/youthnet/youthnet\\_action.html](http://www.unodc.org/youthnet/youthnet_action.html))

### *Funding and Support*

- Before you start, try to find out what resources you have available to your project. Where could you get funding? What educational materials already exist in this field? What kind of alliances could you make with other organizations?
- Financial support will be one of the key issues when you start your project. Find out which donors may be interested in the work of your project. Try to approach donors early so you have time to present them with your ideas and explain your needs. If your project is linked to other organizations, they may already have donors who they work with.

.....

*Remember to be clear in explaining what the problem is and what your project is proposing. Do not ask for too much money—try to be realistic about what you need and what the donor could provide [33].*

.....

- Funding is often not sufficient, and funding difficulties can make it difficult to sustain a project and professionals may not agree to work for no pay or low pay. You may need to look for cooperation in the private sector or with other countries or international organizations.
- Having voluntary workers is helpful for programmes that don't have a large amount of funding.

.....

***"We function through the largely volunteer effort of our staff. Our outreach work programme began with the support of UNAIDS. Currently it is funded by the National Ministry of Health. Another source of income is a small grant from the International Federation of Catholic Universities." Intercambios, Argentina.***

.....

- Getting support from the government or authorities may not always be easy, as admitting that we must now concentrate on reducing the harmful consequences of drug use rather than concentrating only on abstinence, is often not accepted. Also, not all governments have put HIV as a priority.

.....

***"Fully 40 per cent of all reported AIDS patients in Argentina contracted HIV when they shared syringes in order to inject drugs. This information, collected by LUSIDA (the national programme for the fight against AIDS and sexually transmitted diseases), was critically important in the government's decision to offer official support to harm reduction programmes [5]."***

.....





- Look for competitions or other opportunities to get funding for your project.

*In Argentina, the programme Locos de Sarandi—so named because in the language of the drug users, loco is someone who uses drugs and careta is someone who does not—won a competition organized by the Ministry of Health and got a budget of 30,000 dollars [5].*

### *Evaluation and monitoring*

- Evaluation is important to know if your project is going the way that you had intended or if it needs adaptations. It should allow you to learn from experience and plan for future activities. It may also help to gain more support and funding from the community and other organizations [33].
- Monitoring can be carried out through for example:
  - The number of syringes exchanged;
  - Condoms distributed;
  - Number of IDUs with which the programme came in contact;
  - Number of people trained (outreach workers);
  - Brochures printed and distributed.
- More importantly, it is a good idea to monitor drug and sex behaviours and attitudes. This may be difficult to evaluate, but will provide a lot of information for your programme.
- Also, it is important to monitor how IDUs are perceived by the community to ascertain if the programme is managing to change the negative image that usually surrounds IDUs.
- Evaluations can be carried out by external consultants or through internal agency reports. They can be done through supervisory meetings, conversations with youth involved, surveys, evaluation, outreach workers feedback, outreach workers can keep logs.

*In a research conducted by Fabio Mesquita in the metropolitan area of Santos, it was observed that HIV infection rates lowered from 65 per cent in 1996 to 42 per cent in 1999. Results within the group also showed that in the month of August 2000, 632 syringes were exchanged among IDUs. In the following year, however, (2001), 3,616 syringes were exchanged on average per month, showing a considerable increase between the two years.*

*“The department of epidemiological vigilance, from the secretary of health in Itajai, collected data in various years. They showed a reduction in the number of IDU related new HIV infections from IDU between 1997 and 1999.”* Projeto de Reducao de Danos de Itajai, Santa Catarina, Brasil.

# 3

## Key principles for HIV prevention

### How to build a programme

The most recommended way to go about prevention is to provide a comprehensive package of care, including information and education, life skills training, condom distribution, access to clean needles and syringes, voluntary and confidential HIV testing and counselling, referrals for a variety of treatment options and more.

### Know the target group

It is important to know the group you are working with. Do not let lack of information stop you from getting started, however keep in mind that the more you know, the more chances you will have to reach your target group.

Before you start, try to get as much information as possible about: their demographics, injecting behaviour and patterns, sexual behaviour and the HIV/AIDS situation in their population.

### Staff

Staff who are going to work with young IDUs should be open, non-judgmental, understanding, sensitive and respectful.



Staff can be users, ex-users or non-users. Each group has advantages and disadvantages that should be considered.

Using peers to talk to youth is considered a useful and important method in prevention programmes. Young people are likely to listen to their peers more than to adults.

### **Planning and involving youth**

Involving youth is a key aspect of a programme targeted at youth. They can help design the programme in the most appropriate way.

Youth can, and have been successfully involved in all aspects of programmes, from planning and developing the programme to implementation.

When youth are involved in planning and implementing a programme, they feel a sense of ownership and responsibility towards the project.

### **Community**

Support from local authorities and communities has been shown to be very important. Try to consider which groups or people could help you or could create resistance to your project. For example, police and law enforcement officials could be a barrier to reaching young people. Contact these authorities and talk to them about your project.

The general population may have reservations concerning work with IDUs due to stigma and stereotypes. Try to build partnerships and to involve the community at large when possible.

Since IDUs are often contacted through outreach, it will be difficult to have contact to their families, considering that their confidentiality is a high priority. However, when possible, involving the family is a positive step.

### **Establishing contact**

IDUs will usually not come looking for you, so after you have made some contacts, you have to go to where they are. When you have contact with some people, they can introduce you to others.

It is important to use the language that the target group uses and have your information in a form they will be able to relate to. Using the peer network is important here.

Making contact is a process of building trust, and you need to show you are worthy of their trust.

### **Non-injecting groups**

Prevention efforts in the direction of abstinence, preventing the transition to injection as well as safe sexual behaviour is important for this group. The transition to injection can be prevented.



## IDUs

**Outreach:** This method is one of the most important in working with IDUs, and aims to reach young people who are not reached by conventional services by going to where they are and making contact.

**Information:** Youth need to know the facts about HIV and AIDS and about risk behaviour. Information should be easy for the target group to understand, attractive and short.

**Needle and Syringe Exchange Programmes:** Concrete services like NSEPs are important for IDUs. The idea is to distribute clean injecting equipment to reduce sharing. Location and operation hours are important to consider. This, like other services (i.e. condom distribution, etc.) is also used as an entry point to offer IDUs counselling and treatment options.

**Condom distribution:** Lack of condom use is common within IDUs, so this service is important for sexually active youth. It can promote safe sexual activity by overcoming barriers such as availability and financial issues as well as providing information about proper condom use.

**Other things to keep in mind while working with young injectors:** Anonymity, confidentiality and sensitivity are important. Using active listening skills, clear and accessible language and being accessibly located, are also important for youth.

**Youth friendly services:** When trust has been established with the group, through outreach, IDUs may feel comfortable coming to a drop-in centre where you are stationed. Such a place must be a safe and comfortable place, located near to where injectors gather. Services could include counselling, life skills training, hygiene, referrals, NSEP, information, recreation and more.

**HIV testing and counselling:** Voluntary HIV testing is an important aspect of prevention and it should be encouraged. Counselling before and after the test is vital to help youth understand the meaning of their results and its consequences.

**Drug treatment services:** When a trusting relationship exists, IDUs can be referred to drug treatment services. Remember that abstinence is our highest aim. However, this may not happen very quickly. Various treatment methods are available.

**Life skills:** As part of a comprehensive programme, it can be beneficial for youth to learn skills to implement the safer behaviour they learn about as well as improve their functioning in other areas.

## HIV positive youth

Their needs are different but are also very important. They need help making decisions and may need clarification to truly understand what HIV and AIDS means.

Safe sex is especially important for this population; to prevent the virus from being passed on to others and to prevent their exposure to other STD's.

HIV positive IDUs may encounter a double stigma—once due to their drug use, and the second time due to their HIV status.



### **Funding and support**

Financial support will be one of the key issues when you start your project . . . look for donors and organizations that would like to be involved.

Getting support from government and authorities may also not be easy, but should be worked on.

### **Evaluation and monitoring**

Don't forget to evaluate your programme . . . you want to know if you are going in the right direction.

You can look at number of syringes exchanged, how many IDUs you have been in contact with, and many other indicators. More importantly, try to get information on injecting, sexual behaviour and attitudes towards drugs.

# 4

## Resources

### Some Useful Internet Sites Dealing with Drug Use and HIV/AIDS

**UNAIDS:** <http://www.unaids.org>

**WHO HIV/AIDS Department:** <http://who.int/health-topics/hiv.htm>

**WHO Substance Abuse:** [http://who.int/substance\\_abuse/](http://who.int/substance_abuse/)

**UNODC—Demand Reduction:** [http://www.odccp.org/drug\\_demand\\_reduction.html](http://www.odccp.org/drug_demand_reduction.html)

**The Journal of the American Medical Association: JAMA HIV/AIDS Resource Center:**  
<http://www.ama-assn.org/special/hiv/>

**American International Health Association:** <http://www.aiha.com/english/health/hiv.htm>

**Amfar: American Foundation for AIDS Research:** <http://www.amfar.org/>

**Harm Reduction Coalition (US):** <http://www.harmreduction.org/>

**CDC—Centre for Disease Control and Prevention (statistics on HIV/AIDS):** <http://www.cdc.gov>

**Family Drug Support (Australia):** [http://www.fds.org.au/main\\_news.html](http://www.fds.org.au/main_news.html)

**HIV InSite:** <http://hivinsite.ucsf.edu/>



**European Center on AIDS:** <http://www.ceses.org/aids.htm>

**European Monitoring Centre for Drugs and Drug Addiction:** <http://www.emcdda.org/>

**Asian Harm Reduction Network:** <http://ahrn.net/>

**Advocates for Youth:** <http://www.advocatesforyouth.org/>

**Centre for Harm Reduction (Australia):** <http://www.chr.asn.au/>

**Drug User Organisations International (Netherlands):** <http://www.drugusers.org/>

**International Harm Reduction Development (US/CEE):** <http://www.soros.org/harm-reduction/>

**Methadone Maintenance: Guide for Physicians (US):**

<http://www.caas.brown.edu/ATTC-NE/pubs/OBOT/>

**Narcotics Anonymous:** <http://na.org/index.htm>

**The Lindesmith Centre Online Library (US):** <http://www.lindesmith.org/library/lib2.html>

**UNDP Regional Programmes on HIV/AIDS in Asia/Pacific:** <http://www.hivundp.apdip.net/>

**Centre for Research on Drugs and Health Behaviour, Department of Social Science and Medicine, Imperial College on Science, Technology and Medicine, London:**

<http://www.med.ic.ac.uk/divisions/64/about.asp>

**Drug Abuse Treatment Outcome Studies:** <http://www.datos.org/>

**Dragon Whispers and Cabragirlz project, Australia:** <http://home.iprimus.com.au/avwwa/>



## Notes

1. AIDS Epidemic Update, December 2003, UNAIDS.
2. Young People and HIV/AIDS, A UNICEF Factsheet, February 2002.
3. Report on the global HIV/AIDS epidemic, June 2000, UNAIDS, Geneva.
4. Fluk, H. (2001) **Syringes to go: A program in Avellaneda to use drugs without risks.** Buenos Aires, Sunday, April 8 2001. <http://www.pagina12.com.ar/2001/01-04/01-04-08/pag21.htm>
5. UNAIDS (1999). **Young People and HIV/AIDS: UNAIDS briefing paper.** Listen, Learn, Live! World AIDS campaign with children and young people. Geneva.
6. **Fact Sheet on An overview of the HIV/AIDS epidemic,** UNGASS on HIV/AIDS, June 2001.
7. UNAIDS, UNODC. (2000) **Drug Abuse—HIV/AIDS: A devastating combination.**
8. Maher, L., Sargent, P. et al. (2000). **Sharing Knowledge to Protect our Community: A pilot program for research, risk reduction and peer education with Indo-Chinese drug users.** Research Development Monograph, No.1, 2000. UNSW Centre for International & Multicultural Health (University of New South Wales).
9. UNAIDS Press release 2 July 2002, New York/ Geneva. **Major UN study finds alarming lack on knowledge about HIV/AIDS among young people.** <http://www.unaids.org/whatsnew/press/eng/pressarc02/index.html>
10. UNAIDS Press Backgrounder, 12 May 1999, Kiev. **Structural collapse sets the scene for the rapid spread of HIV/AIDS among young people in Eastern Europe.**





11. Des Jarlais, D.C., Dehne, K., and Casabona, J. (2001). **HIV surveillance among injecting drug users.** *AIDS*, 15 (suppl 3): S13-S22.
12. Open Society Institute, International Harm Reduction Development (2001). **Drugs, AIDS, and Harm Reduction—How to slow the HIV epidemic in Eastern Europe and the former Soviet Union.**
13. Dragon whispers and Cabragirlz homepage: [http://home.iprimus.com.au/avwwa/index\\_frameset.htm](http://home.iprimus.com.au/avwwa/index_frameset.htm)
14. Economic and Social Commission for Asia and the Pacific (ESCAP), UNODC regional centre for East Asia and the Pacific, UNAIDS Asia Pacific Intercountry Team. **Injecting Drug use and HIV vulnerability: Choices and Consequences in Asia and the Pacific.** Report of the Secretary-General for the special session of the general assembly on HIV/AIDS.
15. Maher, L. (2002). **Don't leave us this way: ethnography and injecting drug use in the age of AIDS.** *International Journal of Drug Policy*; 311-325.
16. Wines, M. **Easy Heroin Drops a Viral Bomb on Russia's Irkutsk.** *International Herald Tribune*, Tuesday, April 25, 2000.
17. UNAIDS, UNICEF, (1998). **Young people's voices on HIV/AIDS: A communication for development workshop**, 16-19 November, 1998, New Delhi, India.
18. Uwakwe, C.B.U., A.A. Mansaray, and G.O.M. Onwu. (1994). **A Psycho-educational program to motivate and foster AIDS preventive behaviours among female Nigerian university students.** Final technical report, women and AIDS research Program (unpublished). Washington DC. In: Weiss, E. Whelan, D. and Gupta, G.R.-International Center for Research on Women (ICRW). (1996). **Vulnerability & Opportunity: Adolescents and HIV/AIDS in the developing world.** Findings from the Women and AIDS research program. Washington.
19. Burrows, D. and Alexander, G. (2001). **Walking on Two Legs: A developmental and emergency response to HIV/AIDS among young drug users in the CEE/CIS/Baltic's Regions. A Review Paper.** Prepared for the UNICEF regional office for CEE/CIS/Baltics, Geneva.
20. UNODC ROSA (Regional Office for South Asia). **Drug use and HIV vulnerability—towards a regional strategy for young people.**
21. Ellis, R.A., O'Hara, M. and Sowers, K.M. (2000). **"Profile-based intervention: Developing gender-sensitive treatment for adolescent substance abusers."** *Research on Social Work Practice*, 10 (3): 327-347.
22. Noto, A.R., Nappo, S., Galduroz, J.C.F., Mattei, R., Carlini, E.A., III **Levantamento sobre o Uso de Drogas entre Meninos e Meninas em Situacao de Rua de Cinco Capitais Brasileiras.** Centro Brasileiro de Informacoes sobre Drogas Psicotropicas—CEBRID, 1-97, 1993.
23. Defty, H. (2002). **Infrequent injecting drug users: research and interventions with young people at risk of HIV, with special focus on CEE/IS and the Baltics.** Internship assignment, UNAIDS Vienna.
24. Mitchell, S., (2002). **Prison Rapes Spreading Deadly Diseases.** Originally published by *United Press International*, July 26, 2002. [http://www.vachss.com/help\\_text/archive/prison\\_rapes.html](http://www.vachss.com/help_text/archive/prison_rapes.html)
25. G. Medley, K. A. Dolan and G.V. Stimson, **"A model of HIV transmission by syringe sharing in English prisons using surveys of injecting drug users"**, presentation at the Eighth International Conference on AIDS, Amsterdam, July 1992. In D.C. Des Jarlais, S.R. Friedmann. (1993). **Critical issues regarding AIDS among injecting drug users.** *ODCCP Bulletin on Narcotics*, Issue 1 -004. [http://www.odccp.org/odccp/bulletin/bulletin\\_1993-01-01\\_1\\_page005.html#nu05](http://www.odccp.org/odccp/bulletin/bulletin_1993-01-01_1_page005.html#nu05)
26. Carbone, D.J., (2001). **Under Lock and Key: Youth Under the Influence of HIV.** *Body Positive*, May 2001, Volume XIV, Number 5. [http://www.thebody.com/bp/may01/feature\\_02.html](http://www.thebody.com/bp/may01/feature_02.html)



27. Safe Schools Coalition of Washington. **Safe Schools Anti-Violence Documentation Project: Third Annual Report.** [s.l.]: the Coalition, 1996. In: Advocates for Youth: The facts: Lesbian, Gay, Bisexual and Transgender Youth—at risk and underserved.  
<http://www.advocatesforyouth.org/publications/factsheet/fsglbt.htm#6>
28. Hetrick-Martin Institute. *Lesbian, Gay, and Bisexual Youth.* [Fact File] New York: The Institute, 1992. In: Advocates for youth: The facts: HIV/STD prevention and Young Men who have sex with men.  
<http://www.advocatesforyouth.org/publications/iag/ymsm.htm#15>
29. Centers for Disease Control & Prevention. U.S. HIV and AIDS cases reported through June 1997. *HIV AIDS Surveillance Report* 1997; 9(1):1-39. In: Advocates for youth: The facts: Young Men who have sex with men: at risk for HIV and STDs. <http://www.advocatesforyouth.org/publications/factsheet/fsyngmen.htm#4>
30. Valleroy L, et al. *HIV and Risk Behavior Prevalence among Young Men Who Have Sex with Men Sampled in Six Urban Counties in the USA.* Presented to the 11th International Conference on AIDS. Atlanta, GA: CDC, 1996. In: Advocates for youth: The facts: Young Men who have sex with men: at risk for HIV and STDs. <http://www.advocatesforyouth.org/publications/factsheet/fsyngmen.htm#4>
31. Macieira M, Messina S. The invisible minority: lesbian and gay youth. *PSAYNetwork* 1994; 2(1):7-8. In: Advocates for youth: The facts: HIV/STD prevention and Young Men who have sex with men.  
<http://www.advocatesforyouth.org/publications/iag/ymsm.htm#15>
32. United Nations. (2000). **Preventing the transmission of HIV among drug abusers: A position paper of the United Nations System.** Annex to the report of the eighth session of ACC subcommittee on drug control.
33. World Health Organization, Commonwealth Youth Programme and UNICEF. (1995). **Working with young people—a guide to preventing HIV/AIDS and STD's.** London, Commonwealth Secretariat.
34. Higgs, P., Maher, L., Jordens, J., Dunlop, A., & Sargent, P. (2001). **Harm reduction and drug users of Vietnamese ethnicity.** *Drug and Alcohol Review* 20, pp 239-245.
35. Asian Harm Reduction Network (2000). **Prevention of HIV transmission among drug users: a training module for field-level activities.** UNAIDS Asia-Pacific Intercountry Team.  
<http://ahrn.net/powerpt/index.html>
36. Weiss, E. Whelan, D. and Gupta, G.R.-International Center for Research on Women (ICRW). (1996). **Vulnerability & Opportunity: Adolescents and HIV/AIDS in the developing world.** Findings from the Women and AIDS research program. Washington.
37. The UN defines young people as aged 10 to 24 years, adolescents as 10 to 19 years and youth as aged 15 to 24 years.
38. Paraphrase of the Message from the Children's Forum, delivered to the UNGASS on Children by child delegates—Gabriela Azurdy Arieta and Audrey Chetnut on 8 May 2002.
39. **Youth and AIDS; Workshop Guide** The Canadian Red Cross Society, 1991. In: World Health Organisation, Commonwealth Youth Programme and UNICEF. (1995) **Working with young people—a guide to preventing HIV/AIDS and STD's.** London, Commonwealth Secretariat.
40. UNAIDS Press release 10 July 2002, Barcelona. **Avoid using criminal law for HIV, says new UNAIDS report.** <http://www.unaids.org/whatsnew/press/eng/pressarc02/index.html>
41. UNAIDS World AIDS Campaign 2002-2003. [http://www.unaids.org/wac/2002/index\\_en.html](http://www.unaids.org/wac/2002/index_en.html)
42. Courtesy of the Harm reduction programme of Porto Alegre City, Brazil, in cooperation with UNODC field office Brazil. (2002).



Today HIV/ AIDS is one of the biggest challenges facing the world. The risk of getting the virus is particularly high for young injecting drug users, who are isolated, marginalized and often lack access to even basic prevention services This publication focuses on reaching out to young drug abusers with information, services and structures that are appropriate to their needs and how Civil Society at large can contribute.

# HIV PREVENTION

كيفية الحصول على منشورات الأمم المتحدة  
يمكن الحصول على منشورات الأمم المتحدة من المكتبات ودور التوزيع في جميع أنحاء العالم. استعلم  
عنها من المكتبة التي تتعامل معها أو اكتب إلى: الأمم المتحدة، قسم البيع في نيويورك أو في جنيف.

如何购取联合国出版物

联合国出版物在全世界各地的书店和经营处均有发售。 请向书店询问或写信到纽约或日内瓦的联合国销售组。

## HOW TO OBTAIN UNITED NATIONS PUBLICATIONS

United Nations publications may be obtained from bookstores and distributors throughout the world. Consult your bookstore or write to: United Nations, Sales Section, New York or Geneva.

## COMMENT SE PROCURER LES PUBLICATIONS DES NATIONS UNIES

Les publications des Nations Unies sont en vente dans les librairies et les agences dépositaires du monde entier. Informez-vous auprès de votre libraire ou adressez-vous à: Nations Unies, Section des ventes, New York ou Genève.

## КАК ПОЛУЧИТЬ ИЗДАНИЯ ОРГАНИЗАЦИИ ОБЪЕДИНЕННЫХ НАЦИЙ

Издания Организации Объединенных Наций можно купить в книжных магазинах и агентствах во всех районах мира. Наводите справки об изданиях в вашем книжном магазине или пишите по адресу: Организация Объединенных Наций, Секция по продаже изданий, Нью-Йорк или Женева.

## CÓMO CONSEGUIR PUBLICACIONES DE LAS NACIONES UNIDAS

Las publicaciones de las Naciones Unidas están en venta en librerías y casas distribuidoras en todas partes del mundo. Consulte a su librero o diríjase a: Naciones Unidas, Sección de Ventas, Nueva York o Ginebra.

Printed in Austria  
V.04-54807—August 2004—800

United Nations publication  
Sales No. E.04.XI.20  
ISBN 92-1-148190-2

