2 Structure of the Manual

This manual has been devised for people who want to involve drug users in HIV/AIDS prevention activities for their peers. This could be either professionals working in drug or HIV/AIDS service organisations or drug user self-organisations.

In **Chapter 1** we define some terms that will clarify different viewpoints on the work of drug users.

In **Chapter 2** the manual offers tips, hints and considerations on the organisation of peer support groups and activities. This chapter contains material for both professionals and peer leaders.

Chapter 3 is all about what can be communicated to drug users. It contains information on hygienic injecting, alternative ways of using drugs and safer sex techniques.

After having read what can be communicated to drug users, we give you idea's on how to achieve this. **Chapter 4**, therefore deals with the major vehicles of communication - outreach work and training courses. This chapter also consolidates the theory of the previous chapters and transforms them into workable methods.

In the three **annexes** you will find some background information on chasing the dragon, nutrition and surviving in the winter. The annexes also serve as an example of how to communicate in written language. Notably the article on chasing the dragon is an example of a 'life style approach'.

Each chapter begins with a table of contents and has its own independent page numbering.

In recent years there has been a growing acknowledgement that drug users can, and do, contribute to HIV/AIDS prevention. Peer support and peer education can be effective strategies in reducing risk behaviour in injecting drug user (IDU) communities. In different countries peer support or peer education projects have been developed not only by professionals, but also by self-organisations. Efforts have been made to initiate and support drug user self-help groups and self-organisations, especially in the field of HIV/AIDS prevention in IDU communities. One of the reasons for this effort is the finding that HIV/AIDS prevention by regular drug aid services has not been a complete success. There are still drug users who lack information and who simply are not reached by drug aid programmes, or refuse to be reached because of - among other things - feelings of distrust. This distrust is one of the factors that makes peer support seem like a worthwhile attempt to get in contact with drug users who cannot be reached by regular drug aid institutions.

In The Netherlands, peer support in the field of HIV/AIDS prevention for drug users has been based on the work of autonomous drug user self-organisations. ('Autonomous' meaning that these self-organisations were, and are, independent from professional institutions). These organisations began emerging in the early seventies and reached their peak in the early eighties. (The 'Junkiebonden' are a well-known example of this). There have also been other initiatives where drug users (and ex-users), professionals, doctors, social workers, parents of drug users and people that were simply interested in the drug problem worked together.

The approach and contribution of these self-organisations to the drug and HIV/AIDS problem have gained growing recognition. This has resulted in financial support from the Health Ministry and local authorities for some of these activities. In recent years the Health Ministry has funded peer support and peer education projects to assess the merits of this approach.

4 Background of the project

The Dutch National Institute for Alcohol and Drugs (NIAD), in Utrecht, has supported three of these projects. This support included (among other things), the production of a description of the approach and a global evaluation of three of these projects. This information has been disseminated to drug aid services as well as to self-organisations by the national network of the Project 'HIV/AIDS and Drug Use', NIAD . Through this work and receiving requests for information from organisations in other countries we came up with the idea to make this expertise available to the broader public.

A plan was developed to carry out a peer support project in six countries in the European Union that would be funded by 'The Commission of the European Communities'. (The European Peer Support Project - 'Encouragement, development and support of HIV/AIDS prevention by peer support in intravenous user communities'). The project would run from October 1993 until October 1994. The main aim of the project is to encourage, develop and support professional drug aid services and drug user self-organisations and networks to begin (or extend), peer support strategies especially in the field of HIV/AIDS prevention.

Basic elements

The basic elements of this project have been:

- Designing guidelines for safer use and safer sex training courses for (injecting) drug users aimed at causing a 'snowball effect'. (These guidelines were developed by gaining expertise in different countries.)

- Organising 'on the spot' training courses for key persons (drug users and professionals), in six countries in the European Union (England, France, Germany, Italy, The Netherlands and Spain).

- Offering expertise knowledge to local organisations in the participating countries - either as follow-up to the training courses or at request of organisations not involved in the training courses.

- Producing a training manual (in the six languages of the involved countries), which can be used by professionals as well as self-organisations.

1 INTRODUCTION

Peer support as part of a harm reduction strategy

Peer support or peer education are part of a harm reduction strategy. The primary aim of harm reduction is to offer services to ameliorate the living conditions of drug users. 'Getting off drugs' is not unimportant, but secondary to the main issue which is to develop accessible drug aid programmes. The programmes of the Dutch self-organisations are conducted according to this philosophy. In their view, repressive drug policies (such as those defined by criminal law), are inappropriate ways to deal with the drug problem. Accordingly, these policies are mainly responsible for what is called the 'drug problem'.

The concept of 'acceptance' is a basic notion regarding HIV/AIDS prevention methods adequate for reaching drug users effectively. The keynote of the so-called acceptance model is the recognition of the drug user as a human being with the same rights as other human beings. This means that the user has the right to choose how he/she wants to live and if he/she wants assistance. This model offers assistance without formulating prerequisites such as stopping drug use. Offering 'low threshold' drug aid services creates the possibility to reach drug users effectively.

Peer support and peer education fit well into this framework of harm reduction, as has been demonstrated by the work of the self-organisations in The Netherlands. Besides more general political aspects, HIV/AIDS has become a prominent issue in the work of these organisations. One example of this was a syringe exchange program in The Netherlands in 1984, which was carried out exclusively by the MDHG, (an Amsterdam interest group of drug users). Drug aid services at the time refused to carry out syringe exchange because they were afraid of supporting drug use, instead of discouraging it. By 1981 the Rotterdam Junkiebond had started distributing syringes on a small scale to prevent the spread of hepatitis. (This was before the discovery of HIV/AIDS.) This, and other initiatives were important to make safer use an issue among drug users. It had in itself a peer support or peer education effect. The distribution of syringes and needles meant drawing attention to the risk of HIV/AIDS and to the importance of safer use.

It stimulated drug users to talk about these issues, to ask questions, to be frank about their fears, etc. Besides providing information, the emotional aspects of this strategy played an important role at the beginning of the HIV/AIDS epidemic. Drug aid services are sometimes not able to deal effectively with these problems.

Intentional non-intentional influence

This partly non intended effect of syringe distribution shows that peer support does not necessarily mean intentionally influencing one's peers. Peer support is in fact (in a non-intentional way), real, everyday life in the drug scene. Drug users - as with everybody else - copy, judge and criticise the behaviour of their peers. Peer support is therefore not a new approach, it is simply intentionally making use of these everyday influences between peers.

The peer support effects of syringe distribution by drug user self-organisations have shown that different interventions in the drug scene can have - non-intentional - peer support side effects. This snowball effect also occurs with outreach work and training courses that are part of a peer support project. This multiplying effect has been used by many including the 'Boule de Neige' (French for 'snowball') Project in the so-called 'Euregio' region (Belgian-Dutch-German border area).

Self-organisations: self-help - interest group

There are two basic types of self-organisations; a self-help group, or an interest group. In The Netherlands, the central feature of drug user self-organisations has always been that of representing the interests of drug users. Consequently political issues have played a prominent role in their work.

Even within the so-called 'junkiebonden' there has been debate about whether to call themselves a self-help group or an interest group. Their strong emphasis is however on being an interest group and not a self-help group.

According to the junkiebonden, using the term ‘self-help’ implies acceptance of the illness paradigm, which is the ideological base of most drug service organisations. By calling themselves ‘a self-help group’ drug users accept the view that they are sick and need help ‘to cure their addiction’. (For psychologists this could be a clear case of ‘over-adaptation’ or ‘subjection to the aggressor’.)

However, one should not neglect the fact that the work of interest groups always contains an element of self-help; in the sense that people who join are motivated to re-estimate their situation. Being an active member of an interest group is for many drug users a positive experience enabling them to assess their abilities and to foster their self-esteem.

Due to the fact that the target group of the European Peer Support Project are active drug users the choice has been made to focus on the concept of an interest group. This concept entails a broader range of activities and is strongly based on the idea of acceptance.

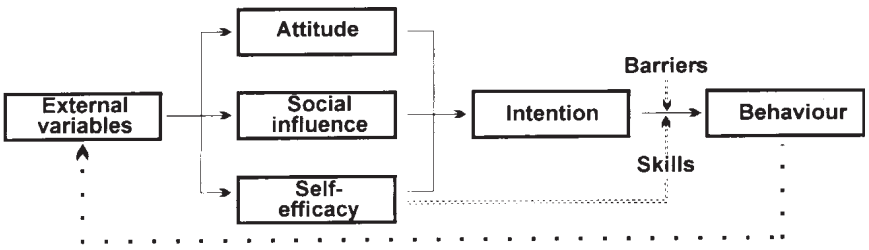
Peer support - peer education

Although the concepts of peer support and peer education have a lot in common, there are important differences. One major difference is that peer education implies and emphasises a disparity between the educator and the educated. In an HIV/AIDS prevention project for drug users based on the idea of peer education, it is the task of the educator to teach other drug users the rules of safer use and safer sex. Within the concept of peer support however, the idea of mutual support is prevailing and is seen as a broader concept than education. The emphasis is more on community and equality. Support does not only mean influencing other drug users towards safer use and safer sex, it can also imply creating better conditions for safer use and safer sex: For example, the distribution of clean syringes and needles. Because peer support entails equality and is a broad ranging concept, it fits well into the work of a drug user self-organisation - especially an interest group. Therefore, the emphasis of the European Peer Support Project is not so much on peer education, but on peer support.

Peer support: knowledge, attitude, etc.

Experience has shown that peer education and peer support do contribute to adequate HIV/AIDS prevention for drug users. 'Inside information', knowledge from personal experience and trust are important features in this approach. HIV/AIDS prevention in the sense of discussing personal matters such as drug use and sexual behaviour require an element of trust. Experience from other peer support activities has shown that social influence on the attitude of drug users to safer behaviour; and self-efficacy by role modelling, are the most important features of a successful peer support project. This means that providing social information plays a more important role than providing mere facts. Being trustworthy and familiar as a peer with the group norms also serves as a basis for attaining reliable information on risk behaviour. (Detailed factual knowledge such as risk of infection by sharing the spoon or the filter has proved to be important information.)

It is worthwhile to look at some important factors which influence behaviour. These factors can be illustrated by means of a model for behaviour change. Like all models, this model is a simplification of reality. It is however useful for clarifying how peer support activities can be initiated and realised. We will briefly describe these factors and provide relevant examples which will indicate how one can influence them by peer support activities.



(Taken from: Kok/Sandfort 1991)

External (outer model) variables

External variables are among other things, demographic factors that cannot (or are extremely difficult) to influence. These include gender, age, race, place of residence etc. In this model we look at factors within a certain demographic context. Another external variable is the political reality.

Examples

Elements of political reality are the drug law, drug policy, public opinion etc. These elements determine drug user's daily life - whether to allow substitution treatment, distribution of syringes etc.

Peer Support action

- Proposing to (local) authorities a plan for a substitution programme.
- Trying to influence public opinion in favour of syringe distribution by demonstrating valid reasons for a harm reduction policy.
- Attracting allies to support this policy - journalists, scientists, politicians etc. (See chapter 2 page 48).

Attitude

Attitude says something about how a person values certain behaviour. Valuing behaviour is weighing advantages against disadvantages, which is not always a logical or rational process. Irrational habits and beliefs also influence the weight of advantages against disadvantages.

Examples

- A clean syringe for each injecting is valued positively because it is hygienic, safe and sharp. Whereas, licking a drop of heroin from the needle after the air has been pushed out is, (although unhygienic and ineffective), valued as positive by many drug users.
- The attitude to condom use is tremendously important. Condom use is valued negatively by many people because they see more disadvantages than advantages to using them. It is difficult to discuss the advantages because most advantages do not give immediate benefit (it's all about avoiding something).

Peer Support action

Try to get a picture of the motives, ideas, beliefs of safer behaviour.
Safer use: Discuss with drug users the advantages and disadvantages of different sorts of injecting practices. **Safer sex:** Discuss the advantages and disadvantages of safer sex practices, (e.g. condom use).
It also should be stressed that the chance of becoming infected and re-infected is relatively high among drug users and their partners.

Social influence

Direct social influence means that the group expects certain behaviour and not doing so can lead to sanctions. Indirect social influence means that norms are internalised and people behave according to the norms as if they are their own rules.

Examples

- Direct social influence: In many countries it is usual to share a marihuana joint with others. Not doing so may lead to an argument.
- Indirect social influence: Smoking heroin by means of chasing the dragon was initiated in The Netherlands by people from Surinam. Now many white Dutch drug users have adopted this behaviour.

Peer Support action

The European Peer Support Manual aims at encouraging positive social influence by peers. If skilled drug using peer supporters offer good examples of proper injecting techniques, other drug users might copy them. Drug users active in a peer support initiative should be influential, trustworthy and a role model. (See chapter 2 page 23)

Self-efficacy

Self-efficacy is the assessment of a person of their possibilities to carry out a certain behaviour. “Will I succeed? Why/why not? Is my success due to myself, my experience, my cleverness, my persistence?” If one is convinced that this is the case, he or she has a high level of self-efficacy. The contrary however, is quite common with drug users. Many drug users have experienced negative judgements by their environment. This influences not only one’s self-efficacy but also one’s self esteem in a negative way. The expression of little self-efficacy can be noted when people complain that things are not going well because of other people.

Examples

- Many drug users have tried several times to kick their habit. The failure to stay drug free influences the decision to try it once again. This means they have low self-efficacy.

- If a drug user has money to buy drugs the dilemma may arise about whether they should first go to the dealer, or first buy clean syringes. If they visit the dealer first they might spend all their money and not keep enough for syringes. If they are determined enough to save money for syringes, they have succeeded and have shown high self efficacy.
- Condom use depends (among other things), on the self-efficacy of the man: Can he keep his penis stiff while putting on a condom? If he doubts this, he might not want to use a condom to avoid a failure.

Peer Support action

Successfully carrying out activities enhances one's self-efficacy. So when it concerns proper injecting, techniques can be discussed and practised the safest way. This can be done intentionally and systematically in an outreach setting. When discussing safer sex options it is often more complicated to practice proper techniques.

Intention

The intention is the actual wish to carry out a certain behaviour. All conditions (positive attitude, supporting social influence and self-efficacy) are fulfilled. Only two things can prevent a person from carrying out a behaviour; barriers and a lack of skills.

Barriers

The lack of necessary means can prevent people from carrying out a desired behaviour.

Example

- In general drug users are willing to use a clean syringe for every new injecting. Unfortunately clean works are not always at hand.

Peer Support action

If someone is going to buy or exchange syringes, he or she should think of their peers as well. It is a good thing to buy or exchange more than one syringe at a time.
If syringes are difficult to obtain because there is no exchange programme, or pharmacies do not co-operate, or the police are confiscating syringes, undertake action for better services or try to influence local police policy (see external variables).

12 Main concepts

(Lack of) skills

It is difficult (and even impossible), for a person to practice safer behaviour if the/she doesn't know what it is. People need to acquire the necessary skills of safer behaviour.

Example

Once people have decided to use drugs in a safer way they need to be aware of all the 'ins and outs' of proper injecting - otherwise they simply cannot do it safely. Making applications for social services such as housing can be pretty difficult. Skills of others are needed sometimes to get things done.

Peer Support action

A more or less permanent point of contention is the injecting practices of other drug users. If the situation is suitable, practical support on proper injecting should always be given. Support on proper injecting can also be organised. An interesting peer support action could be utilising the support of medical staff to provide safer use instructions for drug users.

Basically there are two organisational models of peer support:

❶ Peer support **based in a self-organisation**, for example a drug user interest group; or

❷ Peer support **based in a professional (or voluntary) organisation**, for example a drug aid agency or a health service.

The reality of most peer support projects is that they lie somewhere between these two models. Completely autonomous peer support projects are very rare, and successful peer support projects based solely in a professional organisation are unknown to us. Therefore, most peer support projects have been based on a 'joint venture' of drug users and professionals. However, the basis of these projects is normally by either one of the above mentioned models. These mixed forms can be roughly differentiated into:

- peer support by a self-organisation which is supported by professionals or a professional or voluntary organisation; and

- peer support by a professional or voluntary organisation leaning on the expertise and the work of drug users.

The purpose of this chapter is to shed some light on the different organisational aspects of peer support. The main issues in this chapter are:

- **options and choices** for establishing the organisational fundament,

- **general organisational aspects** of peer support

- relevant organisational aspects and considerations of **peer support based primarily in a self-organisation**

- relevant organisational aspects and considerations for **peer support based primarily in a** professional organisation.

The material used in this chapter is derived from the experiences of different peer support projects.

The aspects discussed in this chapter are designed to enable the reader to compose his or her own specific organisational plan, adapted to local circumstances.

INTRODUCTION

Experience has shown that there are different ways to work with the concept of peer support. Before beginning a new project, thorough discussion should take place regarding the basic alternatives of peer support.

AUTONOMY OR INTEGRATION

The first choice which needs to be made even before a project begins, is the choice between:

- **peer support by a (more or less) autonomous self-organisation; or**

- **peer support embedded in a professional or voluntary organisation.**

HIV/AIDS prevention is in the interest of both drug users and drug aid agencies who represent the community's interest in health care. This common interest however, does not mean that a 'joint venture' is the most appropriate approach. Due to distinct local situations and different views, choices have to be made about whether or not to embed peer support in a professional drug aid agency.

Reasons for embedding peer support in a professional organisation

- To assure the continuity of projects. Most self-organisations of drug users have had problems surviving. The way of life of drug users often appears to interfere with a continual commitment to the job. (A significant part of this is due to the crimination of drugs).

- To ensure professional support for the involved drug users on:
  - a professional level (training in knowledge, methods and attitudes, and supervision of workers)
  - an organisational level (team structure, etc.)
  - a personal level (personal problems, etc.).

- To make the expertise of drug users (drug use techniques, social values, attitudes, etc.), useful within a professional organisation and understood by professionals. Employing drug users also means acceptance and acknowledgement of them as competent members of society.

- To make contacts with drug users who distrust drug aid services.

- To ensure workable contacts with other (professional) organisations such as drug aid, health and social services. This is especially important to facilitate referral.

- To make contacts and remain on speaking terms with police and justice authorities.

- Important conditions for embedding peer support successfully in a professional organisation are:

  – The work of the organisation is based on the concept of harm reduction, i.e. offering 'low threshold' services, without enforcing conditions to stop using drugs etc.

  – The professionals involved have an accepting, non judgmental attitude towards drug use and drug users.

Reasons for choosing an autonomous organisation

- The distrust of many drug users of drug aid services. This distrust cannot simply be taken away by employing drug users. An important reason for this distrust is the sometimes negative attitude of professionals towards the life style and thus, the contribution of drug users. A main issue here can be whether or not drug use is accepted by drug aid workers. HIV/AIDS prevention in the sense of discussing personal matters

- such as drug use and sexual behaviour require an element of trust. For an active drug user it might be difficult to talk frankly to a professional about his way of using drugs if the professional finds drug use unacceptable.

- In view of this distrust, there is the risk that drug users working for drug aid agencies will not be trusted by their peers because they are seen as ‘traitors’ etc.

- The input of drug users in formulating organisational policies can be quite limited in a professional service This can result in a weakening of the motivation of the employed drug users and again can cause feelings of distrust. There is after all, a certain risk that drug users employed by a professional organisation are (or see themselves), as being used as a ‘means to an end’ (to reach the ‘unreached’) or even as an alibi.

- Within the framework of a professional organisation the possibilities to criticise the policies of regular aid services can become quite limited.

- Professional organisations can be less flexible regarding necessary adaptations of their work to the demands of peer support. To co-operate with drug users it may be essential to work outside of the usual ‘business-hours’.

- The position of a drug user as an employee of a professional organisation may raise conflicts with clients. i.e. Drug users may see peer supporters enjoying some privileges they don’t have.

PAID OR UNPAID WORK

The choice needs to be made about whether or not drug users should receive payment for peer support. Once again there are good arguments for both points of view.

Arguments against payment

- Peer support is in the interest of drug users themselves. So, why pay drug users for work, when the work of other interest groups is not paid.

- Paying drug users for peer support can have negative effects. It can undermine their credibility in the sense that drug users who are paid for their prevention work are no longer seen as trustworthy by their peers. This is because their position has changed.

- Furthermore, payment can mean that a drug user looses their independence. They may have to conform to the dictates of a funding organisation and hence be unable to plea for decriminalisation, etc.

- Payment can make a project expensive.

Arguments in favour of payment

- The contribution of drug users to HIV/AIDS prevention is in the general interest of public health. Also, because other healthworkers are paid for their work why would you not pay drug users for the same work?

- In the case of peer support embedded in a professional organisation, it only seems fair that drug users should be paid for their work. Especially if the organisation has made the choice to employ a drug user to undertake part of the implementation of their HIV/AIDS prevention strategy. The employed drug user(s) is then simply an employee like the rest of the workers in the organisation.

- Paying drug users for peer support can have positive effects. Payment can be of importance for the desired continuity and can also be seen as an acknowledgement of the drug user(s) as a competent and professional worker.

The argument that there is no reason to pay for peer support work conducted by drug users as it is in their own interest, does not mean that HIV/AIDS prevention work conducted by drug user self-organisations should receive no financial support. Peer support from within the scene can be a very effective way of addressing the HIV/AIDS threat. It is worth considering supporting and encouraging the work of drug user initiatives, at least by financing the requirements for running an organisation. Often, drug user interest groups are in need of financial backing to pay for such things as an office, office materials, telephone, postage, etc.

Although there are some self-organisations receiving financial support to pay for some of the work performed by drug users, it is usually the professional organisations that can afford to pay users for peer support.

ACTIVE USERS, SUBSTITUTED USERS, EX-USERS

Another important decision which needs to be made is: What type of drug users to involve in your activities? The central questions have always been:

- Are active drug users able to do the job?
- Is substitution/prescription of drugs necessary?
- Should and can ex-users play a role in a peer support project?

There are also options, such as:

- only active drug users.
- only active drug users if substituted,
- only ex-users, or a mixture between these groups.

Why involve active users

The main argument for the inclusion of active drug users in peer support, is that most active users are part of the 'drug scene'. They know what is going on, they are aware of the rules and they generally have frequent contact with their peers, etc. Therefore, they are the most likely to be trusted by and have influence on their peers.

Why not involve active users

Being an active drug user can be like having a full-time job. There is not a lot of time left over to do anything else. Continual commitment to a job therefore, might be asking too much. Hence, solely involving active drug users might cause problems with regard to the desired continuity of a project. Furthermore, sometimes it is argued that active drug users might be too involved in the scene to address confronting issues such as habits or rituals involving risky behaviour.

- Sometimes, drug users might be seen as untrustworthy by their peers, because they are just 'one of them', or alternatively because they are not 'one of them' anymore.

Why involve substituted users

Prescription of substitute drugs like methadone or heroin itself, can contribute to the desired continuity of a project. Sometimes it is even a prerequisite for drug users involved in peer support to use substitute drugs. However, it can also be

argued that substitution lessens the motivation of drug users to assert their interests. Nevertheless, some drug users involved in peer activities would not be able do their jobs without receiving substituted drugs.

- Furthermore, substituted drug users can mediate between non-substituted users and drug services.

Why not involve substituted users?

The main argument against not involving substituted users in peer support, is that substituted users sometimes are not part of the 'drug scene' anymore. That means that they might:

- not share their daily life with other users. They may have lost contact with drug users (especially newcomers) and they may be unaware of relevant information on 'new' drug use trends, actual problems, etc.
- see themselves or alternatively be seen, as 'better human beings'.
- be faced with jealousy, especially when they play the role of peer leader.
- not be seen as trustworthy anymore.
- One thing to keep in mind is that these arguments are more likely to be true in a situation where substituted users are 'out' of the 'drug scene'. It is worth noting that a significant amount of substituted drug users still use some heroin.

Why involve ex-users

- They can contribute to the desired continuity of the project.
- To some extent ex-users can serve as role models for what drug users can reach, i.e. 'being clean', getting a job, being acknowledged as an expert, etc.

- They can draw from their experience to help other IDU's modify their sometimes self-destructive behaviour.

- Many former users view providing a service to the community as a way of maintaining their abstinence. In fact, community service can be a fundamental component of many recovery programmes.

- Many former drug users have established relationships with the treatment system and may be able to provide referral and facilitate access to treatment.

Why not involve ex-users

The arguments against involving ex-users in peer support projects are the same as the ones against involving substituted users. In fact, the risk for ex-users to become alienated from active drug users is even higher than with substituted users. What seems to be crucial is the attitude of the ex-user towards drug use in general: Do they accept or reject it? If they feel they are better human beings than active drug users; or they despise them, (as some ex-users do after therapeutic treatment in trying to protect themselves against a possible relapse). It is evident that they do not fit into the type of self-organisation we are discussing.

- An important consideration of involving ex-users in peer support for active drug users is that it may place them in a 'tempting' situation.

Why a mixed group

A mixed group can result in all the advantages of involving the above listed drug users.

Why not a mixed group

Merging different 'sorts' of drug users can also be a source of conflict in a group where there may be differing interests and priorities. Substituted drug users might for instance take substitution for granted, whereas non-substituted users might believe that the first priority of an interest group is to have a more accessible methadone programme.

EXCLUSIVELY FOCUS ON HIV/AIDS PREVENTION OR NOT

Finally, there is the issue about whether or not peer support should exclusively focus on HIV/AIDS prevention. In the case of funding this may be the primary interest of the financing organisation. There are however reasons to doubt that such an exclusive orientation is very effective in the long term. In order to have a project that is functioning well it is obvious that it has to be 'attractive' for drug users to join. Exclusively focusing on HIV/AIDS prevention is not likely to fulfil this requirement. To keep peer support effective the HIV/AIDS prevention message could be better incorporated into a broader framework of drug users subculture. For example, focusing on health in general or (even broader) in the form of a general interest group.

- Within the framework of an approach based on the social influence of drug users subculture, it is possible to develop a 'lifestyle' formula. Mainline in Amsterdam have done this. They produce a 'lifestyle' magazine with HIV/AIDS prevention messages and general information on health for drug users.

Involving people with HIV/AIDS can be of value for raising and discussing HIV/AIDS related issues.

26 General organisational aspects

INTRODUCTION
The focus of this part is on how to organise peer support. The organisational aspects of peer support important for both a self-organisation and a professional organisation will be discussed. For reasons of clarity a distinction has been made between **internal affairs** and **external affairs**.

Internal affairs refers to the organisation of the project or group (setting the aims and tasks, team organisation, etc.).

External affairs refers to the link between a peer support project and the field in which one is operating (contacts and/or co-operation with other organisations and drug users, etc.).

INTERNAL AFFAIRS
In this section, the following aspects are dealt with:

- collecting information
- setting the aims
- selecting the target group(s)
- choosing an approach
- the workers
  - position of 'peer supporters'
  - job description of a 'peer supporter'
  - profile of a 'peer supporter'
  - training and support for 'peer supporters'
  - job description of a trainer/coach
  - profile of a trainer/coach
- evaluation

Collecting information

The starting point is completing an inventory of all the necessary information on the target group(s). This should include information on the living situation/lifestyle of the target group(s) and should encompass the aims of the peer support project. This information is necessary to verify assumptions. It also provides the basis to establish priorities for the target group(s).

Important steps are:

- collecting and reading written information such as:
  - statistical material about the characteristics of the target group(s) (number, age, gender, ethnic background, sero-prevalence, etc.)
  - studies about the living conditions of the target group(s)
  - reports of service organisations (number and 'sorts' of clients, information on services available, etc.)

- identifying key persons (drug users, professionals, police, people living in the neighbourhood, etc.) and collecting information from them. Lastly,

- getting on the street, exploring the situation. (Where does the target group(s) meet? When and where are drugs used? What drugs are used? What are the problems? etc.)

- It is worth keeping in mind that all these sources have their limitations and biases. It is therefore important to check and compare information to ensure a realistic picture of the situation.

When collecting information it is helpful to make at least a rough plan:

- which data is relevant (e.g. how many drug users are HIV-positive, how many inject, how many live on the streets, etc.)

- where is this data obtainable (organisations, on the street, etc.)

- who is collecting what information and where.

Setting the aims

Firstly, it is important to be clear about what one wants to achieve by peer support. Clearly defining the aims of a project is important for different reasons:

- to create common ground for people to join in/apply for a job
- to explain to the 'outside' world what you are aiming at. This is not only important to convince policy makers of the need/urgency of financial support but also useful for public relations activities.
- to have a standard to measure the results of the project. This is important as you will have to prove the results of the project to external agencies, such as policy makers, funding organisations, etc. It is also important for your own organisation to have a clear insight into the results of your work. This is the basis on which one can learn from successes and/or mistakes and improve (if need be) next time.

It is necessary when establishing the priorities of a project (what is most important and what's not as important) that you keep in mind what could be realistically achieved in the actual situation. Global aims like reducing risk behaviour within the target population are not enough. This is especially important for measuring the results at the end of a project. Peer support in the field of HIV/AIDS prevention could for instance aim at:

- increasing knowledge on safer use and safer sex (can be measured by using the information in chapter 3 'Safer behaviour messages')
- creating a more positive attitude towards safer use (e.g. towards smoking or chasing the dragon, instead of shooting up) and safer sex (e.g. towards condom use).

- raising the general health awareness of the drug using community (taking care for injuries, nutrition, etc.)
- changing social norms, attitude and behaviour, etc.

Selecting the target group(s)

A target group(s) can be selected according to:

- priorities within a problem area, e.g. based on an AIDS epidemic profile,
- the reach and limits of present HIV/AIDS prevention programmes, and/or
- pragmatic criteria.

Establishing priorities within a problem area

In the field of HIV/AIDS prevention the target group(s) with the highest sero-prevalence, and the highest incidence of risk behaviour, generally take priority. In order to establish priorities one has to collect information on the current state of the epidemic (an estimate of how many drug users are HIV-positive, or already have AIDS), and on the expected trends of the epidemic. An epidemic profile can be very useful to begin with. Other sources which can be used to obtain this information are:

- sero-prevalence studies
- HIV counselling and testing programmes
- HIV/AIDS service programmes
- knowledge, attitudes, beliefs and behaviour surveys
- the local blood bank
- hospitals, etc.

The reach and limits of present services

In combination with an epidemic profile, data can be collected on which groups of drug users are not successfully reached by present HIV/AIDS prevention programmes. To be more precise, there are drug users:

- who literally are not reached by drug aid services because the main part of HIV/AIDS prevention focuses more or less exclusively on dependent opiate injectors. So-called recreational users, non-dependent drug users, people who are using or injecting substances (other than opiates), and people who are experimenting with injecting drug use, are systematically neglected. Other groups that are sometimes overlooked are women, homosexuals and ethnic minorities.

- who do not have contact with a service anymore

- who do have contact but are not reached by HIV/AIDS prevention.

- who have been exposed to information about HIV/AIDS, and safer use, and safer sex, but without reasonable result. This may be due to:
  - deficient information
  - an inadequate approach, e.g. compiling information during a methadone intake
  - factors or problems on the users side; feelings of distrust, lack of motivation, negative attitude, social norms, lack of resources, etc.

Pragmatic criteria

Experiences with peer support have shown that pragmatic considerations are influential, and moreover useful when selecting the target group(s). It is a fact that the selection of drug users available for peer support (their quality, background etc.) has influence on the target group(s) that can be reached by a project or group.

Although your first option may be to involve drug users who have access to the selected target group(s), you may have to cope with the fact that the number of available and suitable peer supporters is quite limited. However, direct access to the established target group(s) might not be possible. Due to this restriction, the intended reach of a project/group can be limited especially in the beginning. Therefore, existing contacts with available drug users can be extremely useful to establish and initiate access to a network of drug users which can (by a process of snowballing) lead to the establishment of the target group(s).

Choosing an approach

There are two ways of approaching a peer support project; outreach work for the unstructured setting of the street; or training courses for a more structured setting. This manual will concentrate on these two approaches (see also chapter 4 'Methods of delivering').

The choice offered by outreach work or training courses or both, is dependant on different matters such as:

- the target group(s). If you are focusing on so-called 'hard to reach' drug users then naturally outreach work is important for making contact and ensuring that HIV/AIDS prevention messages reach them. Discussing personal matters such as drug use and sexual behaviour are sometimes easier in your own familiar surroundings than in somebody else's space, e.g. the premises of a drug service.

- the aims of the project. If a snowball effect is a key aim of your project, then training groups of drug users and involved workers to pass messages on about safer use and safer sex can be of great value.

- The available workers. The qualifications of the involved drug users and/or professionals (and the availability of professional support) is decisive for what can be done in a project.

- The available resources. This is especially true where there is not enough money to do both outreach work and training courses. Outreach work by peers is generally less expensive and time consuming than organising training courses because of the involvement of professionals. Often the choice for outreach work is made on this pragmatic consideration.

HIV/AIDS prevention by outreach work is normally confined to what could be called 'spontaneous counselling' (short, incidental talks about HIV/AIDS). Whereas, HIV/AIDS prevention by training courses offers the opportunity to deal with issues at length and intensively. These two elements in fact complement each other quite well. The combination of these two approaches can be especially effective. An intensive introduction to HIV/AIDS prevention at a training course can make more impact if it is supported by short, incidental talks. These talks serve as reminders and focus attention on the subject at hand.

The workers

The selection criteria for workers in a peer support project is very important. It is critical to clearly define the job description and job profile of a peer supporter. The job of a 'peer supporter' entails two important tasks. One is the job of a trainer, responsible for the training of the 'peer supporters'; the other could best be described as counsellor or coach of the other 'peer supporters'.

Points for consideration are:

- the position of 'peer supporters'
- the job description of a 'peer supporter'
- the profile of a 'peer supporter'
- training and support of 'peer supporters'
  - professional coaching and training
  - personal support
- job description of a trainer/coach
- profile of a trainer/coach

Position of a 'peer supporter'

Experiences with other peer support projects have shown that there are different options for peer support. These are:

- volunteers (unpaid, possibly receiving reimbursement of expenses)
- free-lance workers
- employees with a temporary position
- employees with a permanent position

The choice of the above options will naturally depend on local conditions and the availability of financial resources. There are however other factors involved, as was outlined in the above section "Paid or unpaid work". Furthermore, a decision needs to be made about what sort of position is most appropriate in view of the abilities and needs of the involved drug users. Permanent employment may be an unrealistic perspective for some drug users because it is asking too much of them. Free-lance work might suit them better and it can foster the first step towards a more continual commitment to their work

- Positions between workers responsible for peer support (which cannot be explained in terms of differences in working hours or performance) can be a source of conflict. This can occur in a professional organisation employing one or more drug users. Professionals have on occasions undervalued the work of drug users by appointing them as volunteers.

Job description of a 'peer supporter'

A job description for peer support by drug users cannot (and should not) be constructed without consulting available drug users. Often in places with smaller drug user populations the choice of suitable candidates is limited. A job description is influenced by the qualities (expertise, skills, strength, etc.) and the ethnic background of available drug users.

When constructing a job description for a peer supporter, it is best to start with a global job description and profile which gives direction to the selection, but is open to adaptations. After having selected a person to perform the job, the job description should be transformed into a more specific description of the tasks.

Important elements of a job description are:

- a clear definition of the tasks, e.g.
  - making contact with the target group(s)
  - HIV/AIDS prevention
  - general counselling
  - advice (in case of problems in the field of housing, work, justice, etc.)
  - referral in case of (serious) psycho-social problems,
  - representing the interests of drug users
  - contribution to the team/organisation
  - participating in internal and external meetings
  - initiating and maintaining contact with other organisations, etc.

- how to do this work (outreach, training courses, office hours, etc.)
- where to do outreach work
- for which target group(s)
- specification of working time (total working hours/hours for different tasks, etc.)
- participating in counselling/training

Profile of a 'peer supporter'

Not every drug user is suitable to perform the job of a peer supporter. A user has to meet certain minimal standards in order create a workable relationship and to gain maximum effect. It is preferable to work with peers from different backgrounds (ethnic/age/gender/drug of preference) as these people can cover different communities. Too many differences however, can also lead to conflicts in a group or organisation.

The following points can be relevant when developing a profile:

- drug use experience (being an active, substituted or ex-user)
- in the case of an organisation employing active drug users, it is important that he/she can control his/her drug use while at work. (Behaviour should be the criteria, not drug use).
- positive attitude towards drug users
- expressing concern for their peers and willing to work towards ameliorating their living conditions
- being able maintain 'professional' distance from the scene

- contacts (with special groups) in the scene
- high status among peers (peer leader)
- position of trust
- maturity (in some cases it might be advisable to look for drug users who are older and more experienced)
- stability (individuals who lead a relatively stable life are likely to stay around for longer)
- having good communication skills, not being afraid to speak his/her mind
- have an interest in HIV/AIDS prevention, the concept of peer support, self-organisation, etc.
- be open and have no prejudices against drug users
- knowledge and skills in the field of outreach work, training courses, etc.
- knowledge of HIV/AIDS

Training and support for 'peer supporters'

Drug users involved in peer support activities generally need training and support. Usually this work is done by professionals, however it is also possible for active or ex-users to undertake this task. In some peer support projects, ex-users who have since become professionals have done this job.

The training and support of professionals is generally conducted by official education institutions. One would expect them at least to have knowledge and expertise on the subjects named below.

As was evident from the previous sections on 'job profile' and 'job description' additional training of peer supporters is desirable and necessary. In reality however, there are few training courses in knowledge and skills that are specially oriented to peer support. Most professionals and non-professionals involved in training and support of `peer supporters' have acquired their knowledge by experience. Coaching and training `peer supporters' entails two different tasks, **professional coaching/training** and **personal support.**

Professional coaching and training

Before beginning work as a 'peer supporter' drug users usually need some training. In most cases they lack necessary knowledge or skills. There are two ways to go about this basic training.

The first way is to specially design tailor-made training courses that meet the needs of a group or individual drug user. The second way to ensure training is to send drug users to an already existing HIV/AIDS prevention training course for drug aid professionals. This second option can be seen as part of a normalising strategy - confirming the capability of drug users to contribute to HIV/AIDS prevention which in turn, fosters their self-esteem.

- It is necessary for drug users participating in training courses to be seen as contributors. Previous experience has shown that drug users have valuable expertise and that their presence has a positive impact.

Sending drug users to a training course for professionals does have disadvantages. Firstly, the barrier to join in a training course with professionals might be too high for some drug users. Secondly, there is the chance that the training course will not meet the special needs of specific drug users. The first disadvantage could be addressed by thoroughly preparing drug users for the course (informing them what the training is like,

passing on the necessary basic knowledge, etc.). The latter could be addressed by providing individual training in combination with a training course. Individual coaching and supervision aiming at acquiring professional knowledge and skills should be part of a peer support project. The combination of individual training and a training course works well for a peer support project.

Important elements of the initial training course and individual coaching and supervision are:

- factual knowledge about HIV/AIDS (and other health problems of drug users), i.e. knowledge on:
  - infection risks, risk behaviour, etc.
  - safer use and safer sex
  - relevant aspects regarding the HIV antibody test (the 'pros' and 'cons' of taking a test, the testing procedure, etc.)
  - some basic medical information (being HIV-positive without being sick, symptoms which can be an indication of AIDS).
  - psycho-social consequences of being HIV positive or having AIDS.
  - referral in case of medical and/or psycho-social problems.

- methods (outreach work, counselling, etc.)

- professional attitude (e.g. re-defining one's own role from drug user to HIV/AIDS prevention worker, participating in consultations and meetings with workers of other professional services and organisations, being able to work with groups, etc.)

- setting realistic aims (not being too ambitious)

- preparing correspondence (writing letters, minutes and reports etc.)

Besides the above, attention should also be paid to:

- evaluation of work performance and achievements (what has been done, the results, etc.)
- developing a work plan, in the short term (per week) and in the long term (for several months).
- exchange of information and co-operation between the different workers.

For enhancing a professional attitude it might be useful to develop a list of guidelines, such as:

- Do not get involved in trafficking drugs or stolen goods.
- Work as much as possible in couples.
- Carry some kind of ID or even business card on you which can be presented to police or other individuals.
- Becoming intimate friends with members of the targeted population should not be forbidden. However, peer supporters need to be aware that this can cause problems if roles become confused and/or conflicting.
- HIV/AIDS prevention workers performing outreach work will be confronted with many day to day problems related to the lifestyle of many compulsive users of illegal drugs. Be clear about referral tasks and possibilities.
- It is likely that outreach workers will become involved in drug users personal problems. Discuss with outreach workers to what extent ‘clients’ can be supported with personal problems.

- ❗ The role of the outreach worker/representative of an interest group needs to be clearly defined and communicated to everyone involved in the 'drug scene' (from drug dealer to squad officer).

Personal support

Besides professional coaching and training attention should also be paid to the personal well-being of involved drug users. If necessary personal support should be given to matters such as:

- practical/material problems (settlement of debts, finding a house, etc.)
- development of a personal perspective (by advice and support in the field of training, education and work, i.e. career planning)
- personal problems (e.g. in personal relationships with partner, family and friends)

The boundary between personal support and professional coaching and training is not always clear. For example, someone's attitude towards a service is influenced by personal experience with that service. In the case of a drug user this attitude sometimes is quite negative. Therefore, the user has to learn to distance him/herself from their negative experience and modify (if necessary) their attitude.

A similar shift of attitude and behaviour may also be necessary for drug users towards their peers. Again their knowledge is based on their personal experience of being a drug user among other drug users. Although this is an advantage for peer support, it can also be conflicting with a professional attitude. For example, while it may be acceptable 'to beat someone up on the street' this aggressiveness is not acceptable when one is involved in peer support activities.

The change towards a more professional attitude may be more

profound for drug users working in a professional organisation than if they worked in a self-organisation. Nevertheless, drug users working in a self-organisation will find it useful and even necessary to be on speaking terms with official agencies, and at the same time be able to maintain some distance from drug users. Peer supporters need to decide upon the priorities of drug users and be able to discern that behaviour such as 'beating up a user' is detrimental to your position of credibility.

- It can be useful to separate professional coaching and training from personal support by having two different people performing these jobs. This will avoid conflicting the interests of employers with the interests of employees. After all, the first is primarily in the interests of the organisation whereas the latter is more concerned with the personal interests of the worker.

Job description of a trainer/coach

Important knowledge and skills for performing the job of a trainer/coach are:

- professional coaching and training of the 'peer supporters' as described above
- monitoring the work of the peer supporters, e.g. in the form of supervision, etc.
- supporting the development of the approach/methods (outreach work, training courses, etc.)
- collecting relevant material for this development
- personal support of the 'peer supporters' as described above

Profile of a trainer/Coach

The following points are relevant here:

- familiarity with a harm reduction strategy

- knowledge of methods (outreach work, training courses, supervision, etc.)
- knowledge of HIV/AIDS
- interest in HIV/AIDS prevention, the concept of peer support, self-organisation, etc.
- maturity
- stability
- good communication skills, not being afraid to speak his/her mind.
- position of trust
- and finally, a positive/accepting attitude towards people using drugs.

Evaluation for internal purposes

There is the need to see what has been done, who has been reached, which steps need to be taken next: If, and how, the chosen approach can or should be developed or modified, etc. This can be done by collecting relevant data about the target group and project. In different peer support projects registration forms have been designed to obtain the necessary information.

Important issues to record can be:

- date
- gender
- age

- ethnicity
- new/repeat contact
- risk assessment, for example
  - way of using drugs, sharing drugs and drug use equipment (syringe and needle, spoon, filter, water; frontloading, backloading, etc.)
  - sexual behaviour (different partners, sex work, etc.)
  - knowledge
  - attitude
  - social norms
- who initiated the contact ('peer supporter' or drug user)?
- how was the contact made (alone, being introduced, etc.)?
- where was the contact made (in which part of the city, on the street, in a pub, etc.)?
- from what information was the contact made, the place visited, etc.?
- what did the contact mean, e.g.
  - introducing
  - advice
  - counselling
  - handing out condoms/syringes and needles/other
  - paraphernalia
  - referral
- was the contact important for development of a network

❗ The data collected for internal purposes can also serve as a basis for external evaluation purposes, proving the value of peer support (see page 37). This is especially important for funding organisations.

One problem with collecting the above data is that it can be time consuming. If filling in a form takes more than five minutes it may not be an appropriate way to gather information. If you choose this method of data collection be sure to develop a form which is quick and easy to fill in. A workable suggestion is to split the registration into two parts, the first part could focus on general information about the contacts made and the second part could concentrate on one specific issue.

Part one therefore would include the first five points listed above, plus information on 'what did the contact mean'. This ensures that you have primarily quantitative information on the reach of the project.

The second part of the registration form can be on different issues such as; changes in the ways drugs are being used or changes in sexual behaviour, etc. After having monitored an issue for a while (two or three months) you can change to another issue. This way of registration provides at least a qualitative indication on certain issues. Separating the recording of information results in quick and easy to fill in forms.

It is evident that for reasons of privacy no personal information (name, date of birth, exact address) should be registered. To avoid a mix up of forms on the same person, codes (numbers or nicknames) can be developed by contact people which correspond to a person. Therefore only the code is filled in on the registration form.

It is worthwhile seeking some professional support when developing a registration form or designing an evaluation. This could be an 'expert' from a university or a social science student in practical training.

EXTERNAL AFFAIRS

A peer support initiative should pay attention to external affairs. External affairs are important for a well attuned local/ regional HIV/AIDS prevention and care policy (which is meeting the needs of drug users), and for being able to refer drug uses successfully to other services.

The following issues will be discussed in this section:

- positioning the project
- public relations
- co-operation with other organisations
- evaluation

Positioning the project

Before beginning a peer support initiative, the position and function of the project in the field of drug and HIV/AIDS prevention/care services should be clear. Positioning the project is closely related to some of the choices mentioned above, such as:

- choosing for peer support either in a self or in a professional organisation
- setting the aims
- selecting the target group(s), and
- choosing an approach.

The position and function of a peer support project needs to reflect the local situation. Therefore, a logical first step would be to make an inventory of:

- the needs of drug users
- what services are available?

- how are these services functioning?
- what services are lacking?
- are the services co-operating, is there a network of services?
- what is the attitude of professionals working at these services towards peer support (supportive or non supportive, etc.)?

This inventory can be completed as part of the above mentioned process of collecting information. Based on this information the position and function of the project should be formulated.

Public relations

Public relations means different things:

- introducing the project
- attaining and maintaining positive public attention towards the project

Introducing the project

A peer support project needs to be introduced to other organisations 'in the field' as well as to the general public. `Other organisations' are not only drug and HIV/AIDS services but also general social and medical services, politicians, policy makers, police and justice officials. This provides opportunities for services to attune and prepare for the needs of your project and enables you to seek support and co-operation from important players.

The following points should be noted when designing a public relations (PR) strategy.

- It is advisable to inform representatives of the most relevant organisations even before the actual start of the project. The above mentioned inventory will provide information on which organisations should be contacted. Generally a personal talk is more effective than sending written

information. In this first contact the aims and the approach of the peer support project can be explained and discussed. This will enable a particular service to prepare themselves for your project.

- Directly before the start of the project relevant organisations should receive a letter with all the important information on the project. This should include; the aims and objectives of the project, the approach of the project, the start date and a contact person, etc.

- In the starting phase meetings can be organised for the members of these organisations to inform them in detail about your project.

Informing the general public usually means informing the media. Often this is done by sending a press release to the media and organising a press conference. If you have an office the press conference can be held there. One benefit of conducting it in an office is that it shows you have nothing to hide, and satisfies the possible curiosity of what a peer support project might look like. If there are media or particular journalists who are sympathetic to the initiative they could be invited for an 'exclusive' interview.

- Be aware of the possible negative effects of publicly 'coming out' as being a drug user and/or being HIV positive. It can have serious implications for the way one is treated by institutions and even family and friends.

If you are starting a project based at a neighbourhood address, it is useful to inform the residents by organising a meeting at your premises. This forum can serve to take away possible feelings of distrust and suspicion. It also provides the opportunity for residents to look around and see what sort of people are involved.

- In some cases it might be better not to publicly launch a project at the beginning. There might be good reasons for initially establishing the organisation and then being able to present some results. This is especially true when you expect your project will meet some resistance.

- One drawback of not 'going public' is that you loose control of information. One inaccurate and/or negative newspaper article based on second hand information can cause negative publicity and hence big problems. Setting the 'picture straight' again is generally very difficult. Moreover, not 'going public' in the first place can create the impression that you have something to hide.

Maintaining good public relations

Public relations is also very important in the later stages of a project. Drug and HIV/AIDS service organisations, as well as media, should receive ongoing information about the project. This could be updates and 'news' about the project and maybe an annual report. `News' could include developments in your organisation/project; the organising of a training course for drug users; starting a new activity (giving out syringes and needles, organising a meeting for sex workers, disposal of used syringes found in the street); political actions against repressive measures and having new people involved/appointed, etc.

One should take good care to create and maintain a positive image of the project. After all, public acceptance can be supportive for your organisation. The information you provide should not be too radical. Giving convincing examples of harm reduction policies in other areas such as alcohol and tabacco use and car accidents can also be helpful.

Generally it is very effective to have good contacts with one or more journalists who sympathise with your work. They can be helpful not only in times of possible conflict but also for providing positive press coverage of your activities on an ongoing basis. If there is a journalis you can really trust, he or she

could even be invited to join a worker performing outreach work. This can be helpful to convince the public of the value of peer support work.

Cooperation with other organisations

Introducing the project to other organisations is the first step towards developing co-operation with them. At this stage suggestions can be incorporated to allow your project to work together with other organisations. Regular consultation could be useful with some organisations for fine tuning policies and creating a basis for satisfactory referral. These consultations should take place on a formal and informal level. Informal talks between individual workers can be very effective for developing or maintaining a local network.

Co-operation with drug and HIV/AIDS service organisations can also be of value to assure necessary professional support. This support can include; the development of methods, supervision of 'peer supporters', lobbying policy makers, politicians, etc.

Co-operation with other organisations is not imperative. If for example, co-operation demands too much conformation, confrontation can sometimes be a better choice. Be aware though, playing the role of 'lonesome hero' can be as ineffective as 'toeing the line'. Therefore, think carefully about which course you choose. Without any co-operation, a peer support project will have minimal chance of surviving. (For more information, see section `Where to find this support', page 48).

Evaluation for external purposes

Evaluation is important for external purposes. The demand exists to prove to the outside world, i.e. politicians, policy makers, other organisations, etc., the effects of peer support. Evaluation is also important for public relations. An experienced researcher is best to externally evaluate a project. Unfortunately this is often difficult as most peer support projects have financial and human resource limitations.

A workable and efficient solution to this problem is to develop/use the registration form that was previously outlined. However, this has limitations when measuring the effects of peer support, as it is restricted to the active period of the project. This is a disadvantage for a project of short duration. Using this method makes it impossible to assess the long term effects of your work, for example, the attitude and behaviour of the target group. A combination of an evaluation during the course of the project and a small effect evaluation (e.g. some interviews with people from the target group) at completion of the project is recommended.

- It should be kept in mind that the influence of drug users on their peers is hard to value in quantitative terms. Solely conducting quantitative research may not make any sense when attempting to assess this effect. This is especially so for measuring the effects of peer support by 'snow balling' (i.e. drug users reached by the project passing on the information to their peers). More qualitative research (field observation, interviews with drug users, etc.) could provide useful material for drug aid services, self-organisations and authorities who are interested in 'new' ways of HIV/AIDS prevention. Quantitative data is very important for funding organisations, policy makers, etc.

- It is also useful to seek some professional support for the development and design of an evaluation for external use. This is especially true if your aim is to acquire some statistical information. Once again this support could come from an 'expert' at a university or from a social science student in practical training, etc.

INTRODUCTION

Although there are similarities between peer support projects organised by professional and self-organisations, there are also differences. Beginning a peer support initiative as a self-organisation requires clarification of some specific organisational aspects. These aspects will be discussed in this section. As stated in the introduction, self-organisation in this manual refers to an interest group.

Important issues in this chapter are:

- defining the interests of one's own group
- establishing an organisation

DEFINING THE INTERESTS

Drug users who form an interest group need to clarify what interests and who's interest they will represent. Keep in mind that the individual interests of one drug user are not necessarily representative of a whole group of drug users.

When starting an interest group this clarification is part of the process of collecting information and setting the aims (see page 16). Collecting information on the local/regional situation can be done by completing an inventory of what drug users see as their needs and problems and what they think could be done about them. This inventory can take the form of a questionnaire. Central issues of the questionnaire could reveal what services they usually deal with and what experiences they have had with these services. The following organisations are important for drug users:

- the drug aid services (social aid, substitution programmes, syringe distribution, etc.)

- other health services (general practitioners, hospitals, etc.)
- other social services
- police
- justice, etc.

Developing an inventory of the experiences of drug users to a particular organisation gauges their feelings of dissatisfaction with the present situation. This for a large part can be attributed to the crimination of drugs. General dissatisfaction is also a motive to begin an interest group. It should be noted that a vague feeling of discontentment is not enough to start and maintain an effective self-organisation.

By using a questionnaire the inventory has a more formal character which is helpful for specifying the actual problems and needs of drug users. As such it can serve as a basis for establishing priorities. It can also have a convincing and motivating effect on the drug users contacted. In that, they can see that something is happening and that someone is taking initiatives to begin an interest group, etc.

- HIV/AIDS is an important topic on the agenda of a drug user interest group. Experience in several countries has shown that drug user self-organisations preferably include HIV/AIDS topics in a broader framework of health, living situation and life style. (The training courses performed in order to complete this manual also revealed that this was the case.) When drug users are asked to name their most important problems - HIV/AIDS is often included as one of the issues. Other issues such as police actions, treatment

by police offices, receiving no methadone, or housing, etc. are usually brought up first. To ensure a solid base for an interest group it is important to pay attention to these problems as well as safer use and safer sex.

ESTABLISHING AN ORGANISATION

Besides the general organisational aspects mentioned above, a number of other things are important when establishing a self-organisation. These are:

- enlisting and maintaining the involvement of drug users
- establishing the 'rules of the house'
- choosing an organisational structure
- professional support

Enlisting and maintaining the involvement of drug users

An inventory of the local problems and needs can be a start to bring people together. Using a questionnaire can interest drug users to join (see the information on outreach work in chapter 4 'Methods of delivering').

In order to enlist the involvement of people, an interest group has to offer them something and be 'attractive' for them to join in. It is crucially important to ensure that the individual motivations and interests of one drug user do not get in the way of the 'collective' interests of all drug users. This is not always easy. It is usually a continuous struggle to ensure drug users pay attention to all problems and not only their own personal problems.

Attention should be paid to the following aspects:

- Very simple things are important to people. Naturally for people to become involved in a project it is important for them to feel at ease. If it is possible, create a place where

people can drop in, have coffee or tea, a chat or a rest, and get the chance to see what is going on, etc. To prevent this place from becoming a room to just hang around in, a motivating approach can be used. For example, after establishing a place for newcomers to meet, you could inform them about the work of the group. It should be made clear to them that people who come along regularly are expected to join in and assist with the work.

- It is important to give people personal attention. Sometimes this can be forgotten with all the work that has to be done. Personal attention can be given in the form of asking how things are, listening to personal stories, showing concern for personal problems, etc. Personal attention is also important as an acknowledgement of someone's work and expertise.

- In order to motivate drug users to participate actively in a group or a project it is important for them to have influence on the policy of the organisation. This point has sometimes been a problem in self-organisations, as initiators of these groups are usually people with strong personalities who find it hard to accept the majority's point of view. Thus, a strong 'leader' is not always an advantage in a drug user group.

- The final crucial step to ensuring the involvement of drug users in a self-organisation is their participation in concrete political actions. Drug users will then see that it is worthwhile to stand up for their own interests. What action should be taken depends on the actual situation, the aims and needs, etc. Essential features for achieving successful political actions are that they are innovative and carried out co-operatively. (Think bigger than, demonstrating in the streets, or corresponding to politicians, journalists etc.).

- A good choice of objectives is vitally important. Our experience has found that it is difficult to find a middle course between long term and short term objectives. It is not enough to concentrate on the political struggle alone. Pursuing long term aims such as 'normalisation' or even 'legalisation' are too abstract and too far removed from the daily life of many drug users.

'Rules of the house'

Self organisations can either have a formal (legally registered) structure or an informal structure. In both cases it is important to clarify the 'rules' of the structure. Written rules and regulations are important for two reasons; to define the rights and responsibilities of the people involved, and to prevent and/or resolve any possible conflicts.

Important points to consider when forming rules and regulations are:

- the goals (see 'Setting the aims', page 16)
- the tasks (see 'Selecting the target group(s)', page 17 and `Choosing an approach', page 19)
- the organisation
  - the workers, (besides the aspects listed in the section 'The workers', page 20), attention should be paid to the selection procedure of drug users
  - the board, in the case of a legally registered organisation. The following have to be defined here:
    - tasks and responsibilities
    - how many board members
    - who can/should be a member of the board
    - an election procedure for board membership
    - maximum period of membership
    - the structure of the organisation (see page 44)

- how to deal with conflicts (e.g. how to install a committee to mediate in case of a conflict)

If you choose to become a legally registered organisation (a foundation or an association) these rules and regulations can be the formal statutes. To fully understand the specific legal provisions and rules it is wise to consult an expert, i.e. a lawyer.

- One important advantage of being a legally registered organisation is that it is easier to raise funds. Usually only registered organisations receive financial support from government and private organisations.

- Being officially registered can also help make your organisation more trustworthy to other people and organisations. Official statutes make clear who you are and what you want.

- It might be helpful to ask non drug users to join the board. One important criteria for their selection is that they should be able to provide relevant support for the organisation. This support could either be professional expertise (e.g. a lawyer, a medical doctor, etc.) or political influence (e.g. a politician, a priest, etc.). (See also the section “Professional support”, page 47). Another necessary criteria for selection to the board is that the person sympathises with the idea of an interest group of drug users.

Choosing an organisational structure

Most organisations have either a horizontal or vertical structure. In a horizontal, i.e. completely democratic organisation, everybody involved has the same say; in a vertical, hierarchical organisation there are distinct levels or positions differing in power, e.g. board/co-ordinator/team. Usually, an organisation is positioned somewhere between these two poles.

If there are different levels or positions it is important to clearly define the following:

- the responsibilities of these different levels (e.g. the board as employer, the co-ordinator and the members of the team as employees)

- the tasks of these different levels (tasks of the employer, tasks of the employees, etc.)

- the influence of these different levels on organisational policy and how this influence is guaranteed (e.g. election procedures, policy discussions, etc.)

- As stated earlier (see page 42), it is important that everyone involved in an organisation has influence on the policy. This will motivate people to participate and contribute to the work of an organisation. The organisational structure of the MDHG (an Amsterdam interest group of drug users), provides a good illustration of how everyone involved can have input into decisions about organisational policy. (The MDHG is an association of drug users.).

The following levels can de distinguished in the organisation of the MDHG:

- the members

- the board

- the team

- sporadically involved drug users

- visitors

Besides a number of registered **members**, all the people involved in the daily activities of the MDHG are counted as members, although some of them are not registered as such.

The **board** formally is the employer. By including drug users and some professionals it also serves as a basis for professional support. Once a year the board is elected by the members of the association.

The **team** includes some paid workers (permanent or part-time) and some volunteers (unpaid, receiving a weekly award and reimbursement of expenses). For both, there is a well defined selection procedure. The paid workers are appointed by a selection panel consisting of members of the board and the team. Volunteers are selected by the team from the sporadically involved drug users who are interested in more commitment.

Sporadically involved drug users are regular visitors to the office drop-in centre of the MDHG and sometimes assist with the work.

Visitors who just come along for a chat, advice, etc.

To assure that these different groups can exercise influence on the MDHG's policy, different platforms have been established for drug users to have their say.

- an annual meeting of the members for a comprehensive discussion of the MDHG policy

- monthly board meetings which are accessible for all members, where the focus is on the extensive line of MDHG work

- a weekly team meeting, where the following topics are discussed:
  - what occurred and what has been completed in the last week?
  - what went well. Why?
  - what went wrong. Why?
  - what can/should be done next week e.g. setting priorities?

- a so-called 'open evening' for anyone interested in the MDHG. After a round in which everybody has shared the 'most important' drug related event of the week an agenda is made up to discuss the most important issues. The result of this discussion is noted and placed on the agenda of the next weekly team meeting.

- a written record of complaints/remarks. Frequent complaints are placed on the agenda of the team meetings as well.

This structure ensures that even drug users not regularly involved in the work of the MDHG have influence on setting priorities.

PROFESSIONAL SUPPORT

In order to provide professional support, two questions need to be answered:

- what type of support is needed? and,

- where to find this support?

What type of support is needed?

Support can either be provided at a material or at an immaterial level.

- At a material level:
  - a **meeting room** can play an important role
    - to allow drug users to drop in
    - to talk with people in a more relaxed atmosphere than on street
    - to prepare some work/actions
  - a separate **office** can be of value, especially if the meeting or drop-in room is becoming too crowded to do office and organisational work
  - **furniture** for the meeting room and the office

- **office material** such as a type-writer or computer, a telephone, a photocopier, etc.
- **money** for office expenses (stamps, stationary, pens etc.), travelling expenses, etc.

- At the immaterial level professional support could mean:

  - expert advice on
    - factual details such as infection risks, safer use and safer sex, treatments and services, legal provisions concerning the organisation etc.
    - the approach (questionnaire, outreach work, counselling, etc.)
    - development of the organisation's policy (e.g. the choice between a confrontation or compromise policy)
  - co-operation with professional organisations (e.g. HIV/AIDS prevention, exchange of expertise, etc.)
  - moral support (positive public relations, defending your initiative, etc.)

Where to find this support

There are different organisations and/or professions who can support and even serve as allies for a self-organisation. These are:

- **HIV/AIDS and drug aid services (and other social services).**
  These services are valuable because they provide expert advice, training, supervision and personal support. They also can offer some support on the material level, for instance by offering office facilities, second-hand office material, etc. Services who have adopted a harm reduction model and who have a positive attitude towards drug user self-organisations are naturally the best to consult for support.

- **medical doctors**
  Can supply necessary medical information on such things as methadone and HIV/AIDS related aspects. They can also be of value for public relations support e.g. to support your organisation's views by 'facts', etc.

- **lawyers**
  Can provide legal information about beginning an organisation. They are also very useful for legal advice and public relations support.

- **scientists or researchers**
  Can support by helping to develop questionnaires, and project evaluations, and for conducting research. They can also 'scientifically' back your organisation's views.

- **politicians/policy makers**
  The support of political parties and policy makers is important for two reasons; firstly for obtaining financial support for running an organisation and secondly, for backing your organisations policy. However, be weary about aligning yourself too closely with one party. Among other things this may cause problems when trying to get a majority vote on relevant issues. Keep in mind that political parties always have their own agenda and can sometimes use a self-organisation to promote their own profile.

- **interest groups/human rights organisation**
  Can be valuable allies but often need to be convinced of the human rights implications of crimination and drug users. Their interests are generally too far removed from the specific interests of drug users. Sometimes they are working on quite abstract, political and ideological levels. Besides moral support they can offer support in setting up an organisation and maybe even office facilities.

- **press/media**
  As discussed in the section “Public relations” (see page 34), positive media coverage can be very valuable in convincing the public, politicians, and policy makers, that the work of a self-organisation is worthwhile. Standing up for your own interests demonstrates that people who use drugs are not necessarily ‘junkies’.

- **church organisations**
  Can be important for some support in the field of finances and facilities. They can also be important for publicity, as they are generally seen as respectable and trustworthy.

- **police/justice**
  Confrontations with police and justice authorities are sometimes unavoidable. For drug users, the police are seen as a natural enemy. However, this is not necessarily so. There are examples of individual police who care about drug users and who are in favour of less repressive policing policies. Sometimes even police authorities are in favour of harm reduction measures. Furthermore, there are police measures which are in favour of drug users. For example, the Amsterdam and Rotterdam police forces are exchanging the used syringes of an arrested drug user when released. It is also important for drug users to examine and think over their sometimes stereotypical picture of the police. Although this picture is understandable, it need not always be true. After all, police are employed ‘to police’. It is worthwhile to try to find allies, at least on some issues. Police and justice officials, if well informed can provide support in the case of problems in a neighbourhood, critics on syringe exchange activities, etc.

- The above listed organisations and people can be allies as well as adversaries. An important condition for support is that the basics of a harm reduction strategy are accepted by the individual or organisation. Public relations work is therefore very important. One should keep in mind that a negative, critical and confronting approach should only be used only when appropriate. In general a positive approach with some convincing developments and highlights in the right direction is more effective. Making compliments and being co-operative is also very worthwhile. Critics and confrontations can be more easily dealt with if you have adopted a positive approach.

- When building up external contacts (see page 48) attention should be paid to where material and immaterial support is available. It is important to explain at length the aims and objectives of the self-organisation and why you have chosen for an approach which involves drug users, etc.

- One possible problem with involving yourself in a network of professional organisations is that they tend to be very institutionalised. Hence, alignment and involvement may result in losing ‘an insiders’ trust and contact with drug users.

64 Peer support based in a professional organisation

INTRODUCTION

Peer support based in a professional organisation is usually developed and embedded in an already existing organisation. Often a professional drug aid service will choose this approach, to reach the 'unreached' because professional drug aid workers have not succeeded in doing so. This situation is quite different from the usual starting point of a self-organisation. Although one will not encounter the same problems a self-organisation has with having to build up from nothing, it can often be harder to change or adapt an already existing organisation to suit a peer support approach.

In this section we will focus on some important characteristics of peer support based in a professional organisation. They include:

- different models, and
- organisational prerequisites

DIFFERENT MODELS

With peer support based in a professional organisation, drug users (active, substituted and/or ex-drug users) are employees of a professional drug aid agency. Their incorporation in a professional organisation can and does vary.

One could choose for reasons of efficiency and organisational support (less expensive overheads, etc.) to base a relatively autonomous project within a professional organisation. This means that the peer support team operates more or less independently from the organisation and decisions about the team policy are made by the members of the team. Another option is to add one or more 'peer supporters' to an already existing team. This would mean that they are then integrated as colleagues in a professional drug aid team.

The actual choice within this range will depend on different factors as both approaches have their drawbacks. Choosing for the second option can result in a better integration of peer support in the work of the organisation and a professional drug aid network. However, this approach limits the influence of drug users on organisational policy more than the first alternative. The 'pros' and 'cons' listed under the heading "Autonomy or integration" (see page 5) can be useful when trying to make a decision about which option to choose.

Furthermore, the choice depends on the local situation. In a small city or region with a small drug using population, employing one or two 'peer supporters' is obviously more adequate (and feasible) than creating a team. The same is true in the case of a small professional organisation.

ORGANISATIONAL PREREQUISITES

Employing drug users within a professional organisation generally requires some adaptations in order to offer them a fair chance to succeed. This is especially true when one is choosing for active drug users as they may need some time and support to get used to working in a professional organisation. Bear in mind that professionals may also need some time and support to accept a drug user as their colleague. This means that the organisation must create conditions for both sides to become acquainted with the changed situation and appreciate the advantages of involving drug users.

In this respect, there are different points which deserve attention:

- support of 'peer supporters' and professionals
- organisational adaptations
- external contacts

66 Peer support based in a professional organisation

Support of 'peer supporters' and professionals

As discussed earlier in the section on 'general organisational aspects' (see page 14), 'peer supporters' tend to need professional coaching and training and personal support. It is advisable to have a fixed arrangement, for example one hour on a specific day every week.

It is especially advisable for peer support embedded in a professional organisation to separate professional coaching and training from personal support. This can be done by having two different people performing these tasks. This will also avoid possible conflicting interests. After all, professional coaching and training of employees is in the interests of the organisation, whereas personal support is important for the individual worker.

An organisation should not expect that professionals will immediately accept involved drug users as their colleagues. Therefore, it is advisable to integrate professional supervision into professional support.

Organisational adaptations

- To co-operate with drug users it may be essential to work outside the usual 'business-hours'. This is important if you want to reach the 'unreached'.

- To assure the influence and motivation of drug users their position should be equal to the professionals in the organisation. This equality is especially important when deciding organisational policies. Drug users 'say' should have the same weight as that of their professional colleagues.

One problem with assuring this equality is that 'peer supporters' will generally be outnumbered by professionals in an organisation. It is therefore recommended to institutionalise

an exchange of expertise on both sides (e.g. a meeting once a fortnight). This would mean that professionals are obliged to take note of the drug users' expertise and vice versa.
Institutionalising this process ensures that this exchange of expertise is in fact occurring.

External contacts

It is useful to inform other co-operating organisations about your peer support activities and 'per supporters' (see "Introducing the project" page 34). This makes the work of 'peer supporters' easier and more effective (e.g. in the case of refferal, expertise knowledge etc.).
Embedding peer support activities in a local or regional network can mean that other orgaisations can utilise the expertise of drug users.

Like the common cold, AIDS is caused by a virus, the Human immunodeficiency virus (HIV). Once you have been infected with HIV there is no cure. However, unlike the virus that causes a common cold, HIV cannot be transmitted through the air. HIV is spread through direct contact with an infected person's blood, semen, or vaginal fluid. It can be transmitted by sharing injection equipment or through sex.

The highest concentrations of HIV are found in the blood, semen and to a lesser extent, vaginal secretions of infected individuals. To contract HIV, the virus must enter your bloodstream.

Persons infected with HIV can look and feel perfectly normal for 6 or more years following exposure. However, during that time they can unknowingly infect other. You can't tell if a person is infected simply by looking at them.

The most effective mode of transmission is blood-to-blood contact. Consequently, someone who shares a syringe with an infected drug user is very likely to become infected.

Sexual transmission is a somewhat less efficient mode of transmission. However, some people have contracted the virus after having sex with an infected individual only once.

If you remember that an infected individual's blood, semen, or vaginal secretions must enter your bloodstream to infect you, it is possible to assess the relative risk of various sexual practices. Any possibility of direct exposure of infected blood, semen or vaginal secretions to your blood is most dangerous. For example, anal intercourse can be very risky because the walls of the rectum are thin and easily torn during intercourse. Any such tears offer direct access for infected semen to enter the bloodstream. Any open sores or cuts on the penis, in the vagina, or anywhere else on the body that come into contact with infected blood, semen or vaginal secretions increase the likelihood of infection. It is also possible for HIV to enter the bloodstream through porous mucous membranes that line the interior of the vagina and penis, but this seems to be a less efficient mode of transmission.

72 Transmission of HIV

The risk of being infected with HIV is relative. It is affected by circumstances, such as open sores, and by specific practices, such a unprotected sex or the sharing of injection equipment.

(Taken from 'The indigenous Leader Outreach Model' by Wayne Wiebel, USA)

INTRODUCTION

Safer use has been the main emphasis of HIV/AIDS prevention directed at drug users. This could be because drug users are generally more interested in safer use related topics. Although these messages are undeniably important, messages about safer sex are just as important for people using drugs.

This section provides an overview of the most important safer use topics. 'Safer use' is often considered by many, 'as safer injecting' we would like to broaden the concept to also include, 'other means of administering drugs'.

CLEANING WORKS

Most people who use heroin in Europe inject it. Other drugs such as cocaine and amphetamines are also injected. The AIDS epidemic has stressed one important rule:

Always use a new needle and syringe for each injection.

And always try to have a spare new syringe and needle available.

What should you do if new syringes are not at hand?

If you know you will use the syringe again, rinse the syringe and needle directly after injection.

- The best thing to do is:
  - Firstly, use a small amount of the drugs in another way i.e. smoking or snorting. (This will counter act withdrawal symptoms.)
  - Secondly, arrange a new syringe.
  - Lastly, use the new syringe to inject the left over drugs.

- The next best thing to do is boiling out the works.

Other alternatives are:

- the bleach procedure.
- the iodine procedure.
- the alcohol procedure.
- As a last resort: Even rinsing with cold water is better than doing nothing.

Boiling out injection equipment

Material required: a stove, pan, water.

Duration: If all equipment is at hand boiling out injection equipment takes about 15 - 20 minutes.

Procedure:

- First, rinse the needle and syringe in cold water 2 times by pulling water up through the needle and flushing it down the drain or toilet.
- Detach (if possible) the needle from the barrel and pull out the plunger. Ensure that there are no air bubbles left. Place all parts in boiling water for at least 15 minutes.
- Allow the parts to cool down before assembling again.
- Before using, rinse the whole syringe another time in cold water.

Advantages:

- The equipment required is simple and harmless.
- This is the only method of cleaning that is 100% effective against contracting most infections including; HIV, Hepatitis B and bacteria and mould. It is not yet clear if it also kills Hepatitis C.
- The spoon (or cooker), can also be disinfected by boiling it together with the syringe.

Disadvantages:

- A failure which often occurs with this method is that syringes are not properly disinfected. This happens because some people think that placing a syringe in hot water for a minute or so is good enough to disinfect it.

- In Europe most drug users shoot up with disposable syringes. These syringes can only be boiled out one to three times: After that the vacuum of the syringe becomes deficient.

- Some syringes perish after being boiled for 15 to 20 minutes.

The bleach procedure

Material required:

- Sodium hypo chloride - NaOCl (household bleach) in the highest available concentration.
- A cup or bowl.

Duration: If all the equipment is at hand, the bleach procedure takes about 6 minutes.

Procedure: **2 x water** **2 x bleach** **2 x water**

- Pre-rinsing: Pull up cold, clean water through the needle until the syringe is completely filled and squirt it down the drain or toilet. Repeat.
- Pull up the bleach through the needle into the syringe, add some air and shake for 30 seconds and squirt out. Repeat this procedure again and don't forget to shake the syringe for 30 seconds.
- Rinsing: Pull up cold, clean water through the needle until the syringe is completely filled and squirt it down the drain or toilet. Repeat.

Advantage:

- The bleach procedure is cheap and quick.

Disadvantages:

- The more traces of blood that remain visible in the syringe, the bigger the chance that the bleach procedure has not been safe. Therefore be sure to pre-rinse well with water and don't forget to vigorously shake the syringe filled with bleach.

- The limited tenability of bleach. In reaction with oxygen, bleach loses its disinfecting quality after three to four weeks.

- Not all European countries believe that bleach is 100% safe for disinfecting.

- Bleach can damage some types of syringes.

For optimum result: Pull the syringe apart after disinfecting and rinsing and place in a bowl of bleach for one hour.

- Shaking a syringe for 30 seconds does not seem very long but in fact it is; especially if someone is in need of drugs. It is therefore recommended to shake the syringe for 30 seconds while you have time and are not in need of a hit.

The iodine procedure

Material required:

- Iodine dilution. Is medically used as a disinfectant for hands, surgical instruments and surgery treatment. A suitable 100 gram dilution contains: 7,5 g poly (1- vinyl-2 pyrrolidine) iodine complex with 10% available iodine (Mw 40000).
- A cup or bowl.

Duration: If all equipment is at hand the iodine procedure takes about 6 minutes.

Procedure: **2 x water** **2 x iodine** **2 x water**

- Pre-rinsing: Pull up cold clean water through the needle until the syringe is completely filled and squirt down the drain or toilet. Repeat.
- Pull up the iodine dilution through the needle and allow it to settle for 2 minutes. Shake syringe well before squirting out. Repeat.
- Rinsing: Pull up cold clean water through the needle until the syringe is completely filled and squirt it down the drain or toilet. Repeat.

Advantages:

- This procedure is relatively cheap and quick.
- Iodine is an accepted and well known substance which is used for disinfecting in surgery treatment.
- There is minimal damage to the quality of the syringe.

Disadvantages:

- The more traces of blood that remain visible in the syringe, the bigger the chance that the hepatitis virus has not been killed.
- People suffering from iodine allergies and/or malfunctioning of the thyroid gland, should only use this method if they thoroughly rinse the syringe with water after disinfecting.
- Iodine leaves yellow stains on your skin and clothes
- ❗ The iodine procedure is not as common as the bleach procedure. The iodine solution mentioned above is approved in Germany as an appropriate substance to disinfect surgery material. A Dutch literature study by the RIVM (National Institute of Public Health and Environmental Hygiene), revealed that there is no research data opposing the use of iodine. Furthermore, iodine is handed out to Swiss prison inmates as part of a first aid kit and used to clean syringes.
- For optimum result: Pull the syringe apart after disinfecting and rinsing and place in a bowl of iodine for one hour.

The alcohol procedure

Material required:

- Medical alcohol (ethanol, isopropanol or n-propanol). Alcohol for consumption is not suitable for this procedure. In the case of an emergency, consumption alcohol which is at least 70 to 80% strong (preferably clear spirits), could be used.
- A cup or bowl.

Duration: If all equipment is at hand the alcohol procedure takes about 6 minutes.

Procedure: **2 x water** **2 x alcohol** **2 x water**

- Pre-rinsing: Pull up cold, clean water through the needle until the syringe is completely filled and squirt down the drain or toilet. Repeat.
- Pull up the alcohol through the needle and allow it to settle for 2 minutes. Shake the syringe well before squirting out. Repeat.
- Rinsing: Pull up cold, clean water through the needle until the syringe is completely filled and squirt down the drain or toilet. Repeat.

Advantages:

- This is a quick procedure.
- Alcohol is very tenable.

Disadvantages:

- Alcohol is not 100% effective at disinfecting everything i.e. tuberculosis.
- Alcohol severely damages the protection layer on inside of the syringe. This will cause the plunger to run stiffly.

For optimum result: Pull the syringe apart after disinfecting and rinsing and place in a bowl of alcohol for one hour.

Once again: The best and safest way is to always use a clean needle and syringe.

PREPARING A SHOT

The following instructions are written for the ideal situation. Where possible alternatives have been given.

- Clean the spoon (or the bottom of a coke can) with water and soap or an alcohol swab.
- Use clean water; cold water from the tap is cleaner than warm water and running water is cleaner than still water.

- Each time you make a new filter (cigarette filter, tampax etc.) make sure it is clean and ensure you have clean hands. The best would be to use a filter for infusion.

- See to it that the liquid in the syringe is transparent and without crumbs (if not; cook, shake and/or filter once again). After a while (or even directly), dirt can cause great problems such as 'the shakes', cardiac diseases, abscesses, embolisms. Also ensure that there are no air bubbles in the syringe.

- For dissolving brown heroin, it is more preferable to use ascorbic acid (Vitamin C) than lemon juice.
  (Taken from L. Synn Stern.)

SELF INJECTING

- Use a new syringe (or at least a new needle), each time you inject. You will avoid infections (HIV, Hepatitis B/C, bacteria), scars, blue spots, clogged or broken needles.

- Choose another spot each time you inject. This means you will have less scars, bruises, abscesses, swellings, withdrawn veins or problems with blood circulation.

- Find the biggest vein possible and try to switch between veins each time you inject. If this is impossible, find a new spot a least 2,5 cm (1 inch) from the spot you last injected.

- Clean the spot with an alcohol swab and wait till the alcohol has evaporated. This is effective and doesn't hurt when the needle is being inserted.

- A tourniquet helps your veins dilate. Use elastic which is easy to loosen e.g. underpants elastic. If you plan to inject in your arm, first let it hang down so that it fills with blood and then apply the tourniquet. Be sure not to tie it too tight or for too long (blood circulation!).

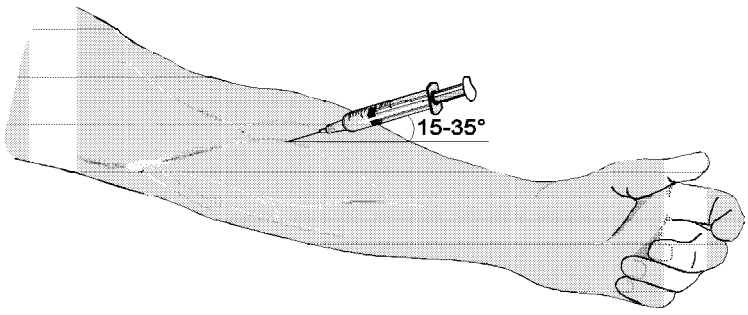
- If you do not succeed in finding a vein, untie the tourniquet, do some physical exercise and tie it once again. Make sure you can loosen the tourniquet before pulling the needle out. For example: Hold one end of

the tourniquet in your mouth: Then if you become too stoned your mouth will fall open and automatically untie the tourniquet.

- Do not forget to remove all the air bubbles from the syringe. Keep the syringe up right and if necessary tap the bubbles out out. Push the plunger carefully until no air is left.

- It is safer to untie the tourniquet before pushing the plunger down. In the case of overdosing (losing consciousness), a tight tourniquet will almost certainly result in losing the part of the body which has been tied off. Unfortunately for many people this is not possible because if they untie the tourniquet they also 'lose' their vein. Therefore, it is always recommended to have someone with you - just in case.

- Insert the needle at an angle of 15· - 35· (in the direction of your heart), with the point of the needle pointing down. This way of injecting means that the needle slides easily into the vein.



- Veins will not roll away if you pull them tight with a finger or the side of your hand: The needle should now be between the tourniquet and the finger/hand that in keeping your vein tight.

- If you see red blood when you pull back the plunger, you are in a vein. If the blood is pink or the plunger has pushed back by itself, you have hit an artery.

If this happens, immediately untie the tourniquet and pull the needle out. Press on the spot with a bandage for at least 5 minutes until you are sure it has stopped bleeding. Hitting an artery can cause serious problems.

- When you know your are in a vein push the plunger down slowly. Check several times if you are still in the vein by pulling back the plunger a little. When injecting cocaine, you will not notice if you are next to a vein. If the needle slips out, untie the tourniquet and choose another spot. (The needle will clog less easily if you pull up a small amount of very cold water.) And don't forget to remove the air.

- When you have finished injecting, untie the tourniquet and pull the syringe out in the opposite direction from the way you inserted it. Apply pressure to the injection spot for a short while (for most people this is until the rush has finished). Preferably this should be done with your arm (leg) held up to prevent possible bleeding underneath the skin.

- If you hit next to a vein or have subcutaneous bleeding, put some ointment (heparin/herodoid), or salted water on the wound and cover with pressure bandages. Missed hits and subcutaneous bleeding can lead to abscesses.

- Don't forget to dispose of your used syringe in a safe way or exchange it for a clean one.
  (Taken from L. Synn Stern.)

DRUG EMERGENCIES

(with contributions from Mainline, Amsterdam and Jan-Hendrik Heudtlass)

Introduction

Death by overdose is an often misinterpreted term. Not many people die from taking too much heroin, or any other drugs, alone. More often drug related deaths are caused by:

- fatal dilutions

- mixing drugs
- choking

Fatal dilution's

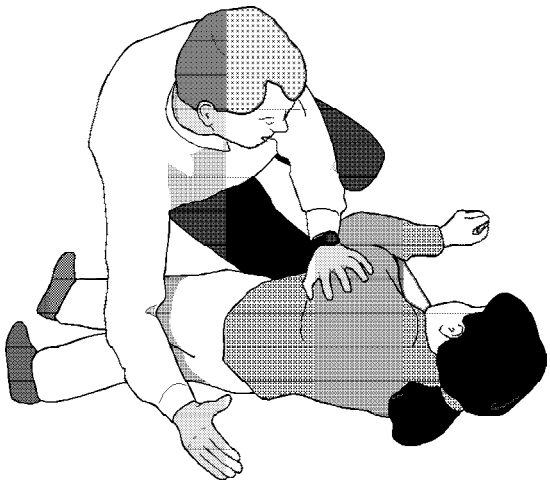
Illegal drugs are (for reasons of profit), often cut with other substances. Sometimes the cutting is more dangerous than the drug itself and this can lead to casualties.

Mixing drugs

Mixing drugs can be dangerous. In the 'opiate scene' it is common to mix opiates with alcohol and tranquillisers. This combination has frequently lead to dangerous situations - of which overdosing is one.

Choking

Choking can occur as a result of mixing the above drugs. If people become unconscious they can sometimes throw up. To avoid choking, clear the mouth and throat (for instance with a handkerchief) and place the person in the recovery position. You should only place a person in the recovery position when their breathing and pulse are stable.



The Vital functions

Somebody who is giving first aid in a drug emergency should not waste time on assumptions and speculations. They should act on what they see, the symptoms:

- consciousness

- breathing
- pulse

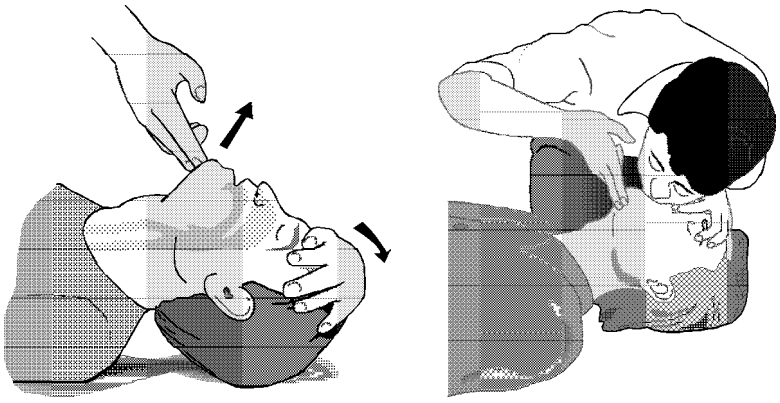
Consciousness is checked by shaking and shouting at a person.

If a person is not conscious, try to wake him/her in any way possible. This can be done by slapping the face, dousing with cold water, squeezing hard right under the collarbone or squeezing the septum of the nose.

Breathing is checked by looking, listening or holding the wet back of a hand close to the mouth/nose. If a person is not breathing start mouth to mouth resuscitation (the 'kiss of life').

Kiss of life

- Clear the mouth and throat of the victim. Lay the victim on his/her back and tilt head backwards.

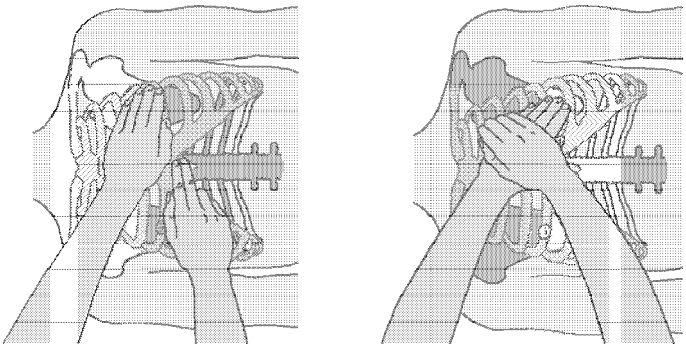


- Squeeze nose, inhale deeply and breathe slowly on the mouth of the victim (3 to 5 times).
- Check if the breast rises. If not, check the position of the victim. If the person starts breathing of their own volition place in recovery position. If not continue mouth to mouth breathing till help arrives. Check the pulse as well.

The **Pulse** is checked by placing two fingers (not a thumb) on the artery in the neck. Check **both** sides. Only begin a heart massage if you can feel no pulse: Ensure that someone calls a doctor.

Heart massage

- Lay the victim on his/her back on a hard surface.
- Place the index finger (pointer) on the end of the breast-bone (above the solar plexus) and the pointer of the other hand close above it. (This is done to measure the correct spot.)
- Make a handball (fist), with your 'first hand' and place it next to pointer on the breast. Then place your 'second hand' over the fisted hand.



- Bend vertically over the victim with your arms completely stretched. Press the breast with short, strong pushes (4 cm), in the direction of the spinal column. Release pressure on the breast immediately but keep hands in the right position.
- Repeat pushes 60 to 80 times per minute.
  If victim is not breathing or has no pulse and you are alone:
- Start with 3 to 5 breathes.
- Then press the breast 15 times. Continue with 2 breathes for every 15 pushes.
- Check the pulse on the artery in the neck after 1 minute. Remember to check both sides!
- If there is still no pulse, continue heart massage. If there is a pulse, continue mouth to mouth breathing until help arrives.

- The kiss of life and heart massage should be exercised before practising. As a peer support initiative, you could organise for somebody from the emergency services or a medical doctor from a drug service to demonstrate these techniques .

Overdosing downers

Heroin and other opiates are sedatives which effect the central nervous system (brain). The central nervous system regulates (among other things) your breathing and heart pulse. When overdosing with opiates the central nervous system slows down and stops the breathing function and eventually the heart function. Other sedatives such as barbiturates, benzodiazepines and alcohol have similar symptoms when overdosing.

High risk situations

- Using drugs when you do not know the quality or purity of them. First try a small dose.
- The use of heroin after drinking alcohol and/or using tranquillisers. A person can easily lose consciousness and throw up. The vomit can clog the throat (see above).
- Using drugs after a 'clean period' or after a period of reduced drug use.
- Using drugs alone; no-one is available to give first aid.
- Using heroine after a treatment with an opiate antagonist (see below).

Characteristics

- Unconsciousness
- Slow breathing
- Slow pulse

What to do

- Check if the person is really unconscious. Shake and shout at the person.
- If the person is unconscious, try to wake him/her by any means possible (see above).

- The moment the person shows a glimpse of consciousness keep him/her awake by forcing the person to walk, talk, respond etc.

- If a person does not become conscious or slips back into unconsciousness again, keep him/her alive with the kiss of life; and if necessary give a heart massage. Ensure someone calls a doctor. A doctor will probably give the person an injection with an opiate antagonist (Narcan etc.).

- ❗ It sometimes happens that a doctor treats an overdose of heroine with an antagonist. An injection with opiate antagonist immediately abolishes the effect of opiates. What could happen then is dangerous: The drug user experiences severe withdrawal symptoms and will leave the hospital to experience them. If he/she gets stoned again, there is an enhanced risk of an overdose. While the effects of the antagonist are wearing off (this takes 2 to 3 hours) the initial dose starts working again. This **plus** the new dose, can easily lead to another overdose.

Overdosing stimulants

Commonly used stimulants in the drug scene are cocaine and amphetamines. On a recreational basis hallucinogenic can also have a stimulating effect. It is also possible to overdose on legal substances such as coffee and guarana. With stimulant overdoses, psychological problems are more apparent than physical problems.

Characteristics

- Psychological symptoms include: panic, fear, unrest, hypersensitivity and aggression.

- The somatic symptoms of a stimulant overdose are: sweating, high body temperature (up to fever), fast or irregular pulse, high blood pressure and erratic breathing.

What to do

- Hallucinogenics: If people show anxiety, approach them quietly. Explain that it is drug related fear that they are experiencing and that it will pass.

- Give them a drink containing some sugar (not coffee or alcohol).

- Cocaine: A commonly used 'street' treatment for cocaine related anxiety is to give a person a little alcohol or a tranquilliser.

- If a person is suffering physical problems call a doctor. If he/she is unconscious, check the vital functions: breathing and pulse (see above).

- Do not place the person in a position with their head down and legs up. What not to do

CHASING THE DRAGON AND OTHER ROUTES OF ADMINISTRATION

Chasing the Dragon

In some countries chasing the dragon has become the most popular way to administer heroin. At first glance, it seems a simple technique, however it does require some practice to do it cost effectively. **(see also: Annex 1 and the video)**

- A portion of heroin is placed on a strip of aluminium foil.

- The underside of the foil is then heated with a modest lighter flame.

- The heroin melts and the released vapours are inhaled through a little tube which is held in the mouth.

- The material required is cheap and easy to obtain. Advantages

- There is minimal risk of overdosing.

- There is no risk of HIV infection. There are small risks of other infections. (If you share the tube you risk hepatitis infections).

- Requires relatively good quality heroin. Disadvantages

- Only brown heroin is suitable.

- It needs some practice to learn to use it cost effectively.
- Some adulteration of heroin can cause irritations in the air passage.
- The effectiveness of chasing the dragon is best,when the heroin is diluted with caffeine.

Snorting and smoking

Chasing the dragon is not widespread in most European countries. This is due to bad quality heroin (generally between 2 and 20% purity) and to the relatively isolated position of the drug culture in society. In these countries the most common alternative for injecting heroin is snorting it.

- Roll some thick paper into a tube or obtain a straw.
- Chip the substance into fine powder; on for instance a mirror.
- Make a line out of the powder.
- Snort the powder through the tube into the nose.

Advantages

- The material required is cheap and easy to obtain.
- This method of administering heroin is less risky than injecting with regard to infections and overdoses.

Disadvantages

- The drugs and the possible substances that the drugs are cut with, can cause irritation to the nose.

In some countries heroin is also smoked in cigarettes. The big disadvantage with smoking it this way is that you lose a lot of heroin. Again, there are health risks associated with what the drugs are cut with.

INTRODUCTION

What is a sexually transmitted disease?

You can contract HIV (the virus that causes AIDS), or a sexually transmitted disease (STD) by having unprotected sex with someone who is infected. As you may have noticed, the inside of the mouth, vagina, anus and penis are lined with a special skin. This lining is called the mucous membrane. Bacteria and viruses that cause disease, live in this lining. When you have unprotected sex they can move from one person's mucous membrane to another person's mucous membrane. And that is all you need for infection to take place.

Other sexualy transmitted diseases (STDs)

There is no cure for AIDS. It is the disease that most people are afraid of. Other STDs occur more frequently than AIDS. The most common are chlamydia, gonorrhoea (the clap), syphilis, herpes, genital warts and hepatitis.

Some STDs (including HIV) may have **no** noticeable (initial) symptoms. Therefore, it is important to have yourself tested if you believe you could be infected. (This is even if you are feeling perfectly OK). Most STDs (including syphilis, gonorrhoea and chlamydia) can be easily cured with medicine. This is providing they are detected early enough. If these diseases are not treated in time, they can cause serious harm to your body. For example, if Chlamydia is left untreated it can cause infertility and make it impossible for a woman to bear children.

Other STDs, such as herpes and genital warts, can be treated but cannot be (completely) cured. These will disappear after treatment but may come back later. This is because the virus that causes them lives in blood; where medicine cannot cure it. There is no medical treatment available to cure a hepatitis B infection. The only way to become well again, is to stay in bed for a considerable amount of time.

(Information taken from: The Soa Stichting, The Netherlands)

MODES OF TRANSMISSION

The easiest way to contract HIV or any other STD is through anal sex (arse fucking) and vaginal sex (intercourse). Unless you are using a good condom these are both 'high risk' activities. A good condom, used correctly, can greatly lower your chances of infection; not only from HIV but also other STDs.

Unprotected anal sex (arse fucking without a condom

This is the most risky activity for becoming infected with HIV and other STDs. The lining of the anus is very fragile. Anal intercourse causes damage to the lining allowing sperm infected with HIV or hepatitis to enter the bloodstream. Other STDs, like gonorrhoea and chlamydia can also be transmitted though the mucous membrane.

Many people believe that only the person being penetrated (being fucked) is at risk of infection. This is not true. The active partner who is penetrating, is also at risk of contracting HIV and other STDs: If the head of his penis comes into contact with a virus or bacteria in the other persons body.

- Never have unprotected anal sex. You can make anal sex safer, by using an extra-strong condom (for arse fucking) together with a water-based lubricant e.g. K-Y Jelly, Sensilube. Even with a condom, anal sex is never completely safe: This is because condoms can break and/or slide off.

Unprotected vaginal sex (intercourse/ fucking without a condom)

Having vaginal sex without a condom is a high risk activity for becoming infected with HIV. If you already have an STD, the chances of becoming infected with HIV are even greater as the virus can enter more easily through open skin (wounds, sores). HIV is also present in menstrual blood. If a woman is sero-positive, the possibility of passing on HIV are higher if you have sex while she is menstruating.

- So our advice is pretty clear: Always use a condom whenever you have anal or vaginal sex.

Fellatio (performing oral sex on a man, blow job, sucking off)

Many people still have questions about the safety of oral sex with regard to HIV transmission. The most up-to-date advice is: As long as sperm does not enter your mouth; you will not come into contact with HIV. One problem with this advice is that it is difficult to know exactly when a man is going to come. Which is why it is preferable to use a condom for oral sex. This is especially important if you have sores in your mouth or if you have bleeding gums.

- Using a condom will also protect you from other STDs such as gonorrhoea, chlamydia, and syphilis. It is almost impossible to contract HIV from licking a man's balls or around his anus. Ensure to look out for scratches or sores (to avoid blood contact). Try also to avoid contact with faeces (shit). This will not give you HIV (unless it contains blood), however, it can give you nasty intestinal infections and diseases.

Cunnilingus (performing sex on a woman, licking, 'going down')

Even if a women is infected with HIV, her vaginal fluids only contain a small amount of the virus. The chances of becoming infected by 'going down' on a woman are therefore, minimal. However, if a woman is menstruating, oral sex is risky. Contact with menstrual blood can pass on HIV. It is best not to perform oral sex on a woman during her period and the few days either side of her period.

The Herpes virus can also be transmitted during oral sex. Especially if a woman (or man) has blisters, sores or scabs (like cold sores) on or around their vagina, (penis) or mouth. If this is the case you should avoid participating in oral sex.

- If you want to be completely safe, use a 'dental dam' for performing oral sex on a woman. It is made from a little sheet of latex rubber that is held over the lips of the vagina during oral sex. Dental dams are sold in sex shops.

Hand jobs (jerking someone off)

You cannot contract HIV from giving someone a hand job. This is because the virus cannot pass through regular skin. If you have an open sore or blister on your hand, place a plaster or band-aid over it before giving someone a hand job.

Finger fucking (in the vagina or anus)

You cannot contract HIV from inserting fingers or hands ('fisting') into the vagina or anus; even if the whole hand is put in. As mentioned earlier, the virus cannot enter the body through regular skin. Fisting is more hygienic if you use a thin rubber glove. Also, be sure to use enough water-based lubricant to prevent damage to the inner lining of the anus while fisting.

Golden showers and scat (piss and shit)

Urine (piss) and faeces (shit) contain very small amounts of HIV. This amount can be a problem if urine or faeces have tiny quantities of blood from liver or kidney infections or from haemorrhoids. These invisible drops of blood can expose you to HIV. Urine and faeces can also transmit other STDs such as gonorrhoea. They can also give you severe intestinal infections.

- You need not worry if you get piss or shit on your hands or your skin; however do avoid getting them in your nose, eyes, mouth, vagina or anus. All these areas are lined with delicate skin (the mucous membrane). Drinking someone else's piss or eating someone else's shit, poses no serious threat of HIV infection; but does pose a threat for contracting other infections.

S/M (Sadomasochism)

Just like with everything else, S/M can be safe depending on what you do. It is important not to cause bleeding, as infected blood and sperm can enter the body more easily.

- If blood gets on the equipment, wash it with soap and water and soak for 10 minutes in 70% alcohol solution before using again. (This solution is for sale in pharmacies).

Sex toys (dildo's, vibrators etc.)

There is minimal chance of contracting HIV through using sex toys - although you should be careful if you want to use them with different partners. Try to use only your own personal sex toys and be sure to clean them well with water and soap after use. If you share your toys with others, ensure you use a condom. If you are using a dildo for anal sex, do not put it into your vagina after it has been in your anus. Transferring bacteria from the anus to the vagina can cause nasty infections.

Massage

No risk activity. Touching and rubbing are completely safe and will not give you HIV or any other STDs.

French kissing (tonque kissing, passionate kissing)

Very small concentrations of HIV are found in saliva (spit). This concentration is not large enough to pose a risk of HIV infection through kissing. French kissing is safe for HIV; but not for herpes. Herpes can be contracted if your partner has cold sores, blisters or scabs on his/her mouth or lips.

Group sex (menage a trois, trios, orgies)

Is group sex risky? The answer, depends on what you do. So read over the list again. And be sure to use a NEW condom each time you have intercourse with same or different partner. Make sure everybody agrees in advance...and watch out for cheaters!

(Taken from: "Safe Sex", The Soa Stichting, The Netherlands)

CONDOMS

General information about condoms

Condoms, if used properly, are a good way to have sex in a safe way. Although they are not 100% safe; condoms can prevent STDs and unwanted pregnancies.

Different types of condoms are available:

With or without lubricant

Many people prefer to use condoms in combination with a lubricant. The chances of a condom tearing or slipping off is smaller if used in combination with a lubricant. Often condoms are packaged with a water based lubricant already on the condom. Condoms which are suitable for anal sex sometimes contain a separate package of water based lubricant.

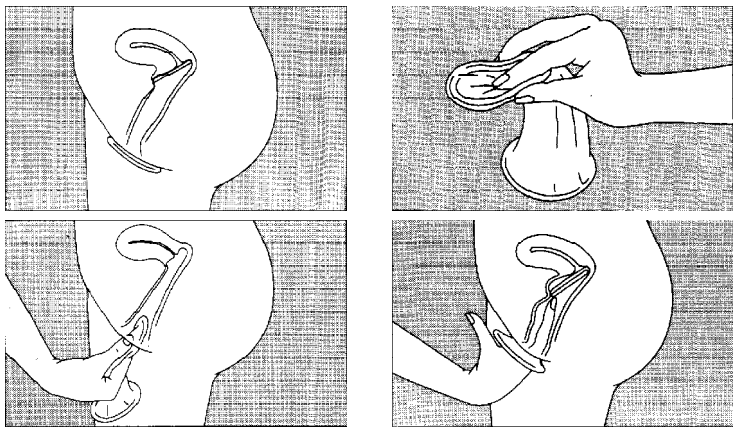
Flavoured condoms

Most of the flavoured condoms on the market have not been designed for vaginal use. Flavoured condoms are not lubricated and are suitable for 'blow jobs' (fellatio).

Female condoms

The female condom is not readily available in all European Union member states; and where available, they are expensive. However, the female condom can be convenient for several reasons. The female condom is marketed under the name

"Femidom". It is inserted into the vagina. A rubber ring inside the condom helps keep the condom in the right position. One advantage of the "Femidom" is that it can be inserted into the vagina a long time before actual intercourse takes place.



Extra strong condoms

Extra strong condoms are often referred to as gay-condoms. This is incorrect because heterosexuals also practice anal sex. Extra strong condoms are specially designed for anal sex; although they are still not 100% safe. The chance of an 'accident' occurring (i.e. a condom tearing), is considerable if the condom has not been used properly. It is best to use these condoms with extra lubricant.

Instructions for condom use

- Check if you have the right condom:
  - is it for vaginal or anal sex; if you require it for anal sex, use only special, thicker condoms.
  - is it big enough
  - is the brand registered and approved
  - check the expiry date.

- Open the package carefully:
  - not with teeth or scissors. This will avoid tearing the condom.

- Take out the condom:
  - be extra careful if you have long nails
  - make sure you have the condom the right way up (i.e. not inside out).

- The tip (for semen reservoir), should be squeezed so that there is no air left
  - this will decrease the chance of the condom tearing as the reservoir will not come under pressure
  - if the condom has no tip make one yourself by squeezing the air out of the top of the condom (1-3 cm).

- Put the condom on top of the penis and unroll it carefully to the base of the penis
  - wait until the penis is completely hard before putting the condom on
  - when fully unrolled there is less chance that the condom will slip off
  - again, be careful if you have long nails.

- Use only a water based lubricant
  - always use lubricant for anal penetration
    a non water based lubricant will perish the condom. Do
  - **not use** Vaseline, hand cream, body lotion, oil or butter.

- Withdraw the penis carefully, immediately after ejaculating
  - while withdrawing, hold the condom at the base of the penis to avoid it slipping off
  - if you wait too long before withdrawing - the penis becomes soft, the condom slips off and the semen drips out.

- Tie a knot in the condom and dispose of it. Do not flush it down the toilet as condoms can block drain pipes.

Use a new condom each time you start fucking. Never use two condoms on top of one another: This can cause condoms to tear.

TIPS FOR SEXWORKERS
Before you start working try to:

Negotiation with clients

- Set your prices in advance.
- Decide on what you want to do with a client and what you do not want to do with a client.
- Decide on where you want to go (e.g. which parking area or hotel). Do not leave this decision up to the client. Go preferably to a place where others work too.
- Do a wee before you start working. The rubbing of a penis against a full bladder can cause inflammation of the bladder and urinary infections.
- Offer him 'other' sex besides intercourse; such as rubbing his penis between your breasts or thighs. Try to make him horny by talking.
- If he refuses to use a condom try to argue that:
  – it is for his own safety
  – appeal to his masculinity ('with condoms it takes longer', 'condoms are sexy' etc.)
  – it is for your safety.
- Make sure you have a stock of condoms, lubricant and paper tissues.
- Use menthol ointment (for chapped lips) on the inside of your nose. You will smell the client less when you do a blow job and if you are 'dope sick' it will lessen a snivelling nose.

Sex work and drug use

- Try to avoid letting a client know that you use drugs. With this information, a client can tempt you with money and can try to play nasty power games with you.
- Insist on receiving your payment in cash, not drugs. Demanding cash makes you more professional and gives you more control.
- If you inject, try to avoid scars by changing the

injection spot each time. Use new, sharp needles. Rub the injection spot with an ointment such as heparin, Vaseline or haemorrhoid ointment.

- It is difficult to work safely if you are stoned or high (especially on cocaine).

- Do not show a client you are dope sick. Avoid sniffing and snivelling. Put some menthol ointment in your nose.

- Don't forget to pee between jobs; even if you don't have to.

Condoms

- Make sure that you are the one who puts the condom on.

- You can also put a condom on with your mouth. Practise this on a dildo or banana.

- Keep one hand at the base of the penis securing the condom. Your hand can:
  - keep the penis hard
  - ensure that the condom does not roll up and/or slip off
  - keep your labia open, to avoid sores
  - avoid the penis entering your body too deep.

- Take the penis out of your vagina as soon as he has come and hold the condom tight around the penis so that no semen leaks into your body.

(A selection taken from 'Als de weg je werk is' written by L. Synn Stern, issued by GGD Rotterdam).

WHY, WHY NOT?

Different people will be thinking about having an anti-body test for different reasons. It is impossible to give concrete reasons for being tested, however here are some points to consider:

- If you are ill and a doctor feels that this could be due to HIV, being tested will be an important part of finding out what is wrong.

- Do not use the test simply to try and find out whether you should practice safer sex. Safer sex is important for everyone. If you are not infected you should stay so; and if you are sero-positive you should avoid infecting other people.

- If you are in a relationship, discuss with your partner how being tested might affect you both. In the past, some relationships have been destroyed by the knowledge that one person is positive and the other negative.

- Being tested may help, if worry is affecting the quality of your life. However, think carefully about whether or not you will be able to cope with a positive result; and would a negative result really stop you worrying?

- It may make sense to be tested if you are (or intend) to become pregnant. About 13% of babies born to HIV positive mothers are themselves infected. If you wish to become pregnant, or are in the early stages of pregnancy, there may be considerable pressure on you to take an HIV antibody test. Thorough pre-test counselling is essential so that you understand all the advantages and disadvantages of knowing if you have HIV. This counselling allows you to make informed decisions about your pregnancy.

- There is still ignorant and cruel prejudice directed at people with HIV/AIDS and against people who are seen as 'high risk':
  - People with HIV/AIDS are not allowed to enter certain countries.

- Some employees have been sacked for being HIV positive.
- Some people with HIV/AIDS have lost their homes, or faced difficulty in getting accommodation.
- Having a test can have serious implications for insurance and mortgage applications.

- Think long and hard about taking a test. Don't be pressured into having a test unless you have had enough time to decide whether or not it is the best thing for you. Remember that the test is there for your benefit alone and not for anything or anyone else.

- Seek advice from your clinic about early intervention treatment, options and support for people who have positive test results. Recent advances in medical treatment of HIV, mean that some medical practitioners now believe it is worth knowing early if you have HIV.

- For example: It is possible for doctors to monitor how well you are, so that if your health deteriorates to a point which may place you at risk of infections like PCP (a virulent pneumonia), drugs can be prescribed which prevent or significantly delay the onset of infection. If your doctor knows that you are at risk, he/she can diagnose and treat any infections more promptly.

- Some healthy people with HIV who have HIV-induced damage to their immune systems may benefit from anti-viral drugs like AZT. If you only discover that you are HIV positive when you start to become ill - you have missed the option of early treatment.

(Taken from: The Terrence Higgins Trust, UK).

In this chapter, two major approaches of peer support will be discussed:

- **Outreach work**, and
- **Training courses**

Generally most peer support projects range somewhere between these two basic approaches. Outreach work is used for the unstructured setting of the street; and training courses are used for a more structured, indoor setting.

- HIV/AIDS prevention by outreach work normally is confined to what could be called ‘spontaneous counselling’ (short, incidental talks about HIV/AIDS). Whereas, HIV/AIDS prevention by training courses offers the opportunity to deal with issues at length and intensively. These two methods in fact complement each other quite well; and hence a combination of these two approaches is especially effective. An intensive introduction to HIV/AIDS prevention at a training course can get more impact if it is supported by short, incidental talks. These talks serve as reminders and focus attention to the subject at hand.

INTRODUCTION

Outreach work has a lot in common with social work which is based on a harm reduction model. The difference is that the worker leaves the office and 'hits the street'. This means that the worker is meeting people on their own territory and working outside of the normal office-hours model.
Outreach work covers two levels:

- An individual approach aiming at personal behaviour change.

- A group oriented approach aiming at a socio-cultural change.

As these two levels are intertwined in everyday work, we will not deal with them separately in this chapter.

Outreach work can include different tasks:

- **making/maintaining contact**

- **collecting information**
  What is going on, what drugs are used, what problems of the target group have priority, etc.?

- **advice and information**
  Where to find a lawyer, certain services, education, etc.; and also provision of safer behaviour information e.g. concisely repeating the message on different occasions and from different angles.

- **referral**
  To other services, therapeutical programmes, etc.

- **aid and assistance**
  In case of psycho-social problems, when referral is impossible, etc.

- **prevention**
  Information about health, drug use, safer use and safer sex, etc.

- **representing the interests of the target group**
  Informing other services and organisations about the living situation and the needs of the target group(s), etc.

This chapter will focus on two issues:

- **how to make contact**
  As stated earlier, making and maintaining contact with the target group(s) and collecting information about them, are usually linked. Collecting information is in fact the start of establishing contact with the target group(s). (See chapter 2 p 14).

- **counselling**
  Counselling entails providing advice, information, aid and assistance, referral and prevention strategies on HIV/AIDS and other health related issues. This manual will especially focus on prevention strategies.

HOW TO MAKE CONTACT

Making contact is the key point and most difficult part of outreach work. It is in fact a task on its own, even if it does not result in other activities. Outreach work exists after all, to reach the 'difficult-to-reach' or previously 'un-reached'.

One problem with using the term 'unreached' is that it is not very specific. Before going into detail about how to initiate contact it is worthwhile defining what is meant by it. This can be helpful for establishing the target group (see chapter 2).

The 'unreached' can include:

- A person who has never really had any contact with a HIV/AIDS or drug aid service.

- A person who does not have contact anymore with the above services.

- A person who does have contact; but is not reached by HIV/AIDS prevention measures.

- A person who is not reached successfully by HIV/AIDS prevention, due to:
  - deficient information, or
  - an inadequate approach, or
  - factors or problems on the client's side; motivation, attitude, social norms, lack of resources, etc.

Making contact with these target groups is generally much easier for drug users, than it is for professionals. Drug users already know a lot of their peers; they are familiar with the norms and codes of the drug scene and they usually do not encounter the same distrust as professionals, etc. However, even peers have limits in establishing contact with drug users. Their success will largely depend on the 'approachability' of the drug using community. In general you could say that: The more repressive the drug policy; the more difficult it is to approach drug users.

Another major factor here is that the drug using population is not homogenous. There are differences in the types of drugs that are used, the ways of administrating drugs, ethnic background and sexual preferences. These differences can stand in the way of developing contacts. This problem can partly be solved by selecting outreach workers of the same gender or the same ethnic background as the target group(s).

The first steps

Before actually making contact with the target group, it is important to have a vague idea who you want to reach and what you want to achieve. With a broad notion of target group(s) and ideas on the aims of the project; you can take the first outreach steps, i.e. 'taking to the streets' and exploring the situation. Important observations are:

- Where does the target group meet?

- When do they meet?
- Which drugs are used?
- How are they used?
- Where are they used ? etc. (Also see Chapter 2 'Collecting information', 'Setting the aims' and 'Selecting the target group(s)', page 14)

Identifying the meeting places of the target group(s) must be done at various time of the day and night to ensure you obtain a realistic picture of the situation. Involving drug users (or ex-users) in this process will undoubtedly provide you with a lot of valuable information: They will either have the necessary information at hand or they will be able to obtain it from their peers. The gathered information serves as the basis for redefining and choosing the target group (criteria, priorities, etc.). Now contact can be made with the target group. (Through obtaining the above information you probably will have established some contact.)

- One issue with outreach work has always been whether to work in couples or alone. Working in couples has its advantages regarding the safety of the workers. Nonetheless, working as a couple might be less productive than working alone. Working in couples can result in more talks between the workers than with the target group.

Establishing contact entails:

- Visiting the meeting places, observing how people interact, who is a 'leader', etc.
- Begining a conversation; generally it is good to start with a casual chat to get on speaking terms and to create a basis.
- Introducing yourself;
  - explaining what your task is
  - what organisation/group you are working for (you can leave a business card)
  - what you stand for
  - what you can do for the target group, etc.

- Establishing trust and credibility with the target group(s). This can be done by;
  - proving that you are one of them (e.g. by referring to your own drug use experience)
  - always being honest (about who you are, what you are able to do, etc.)
  - offering support in case of problems (only offer what you can fulfil).

It is often a long-term and frustrating enterprise working out how to really make contact and how to actually begin a project. This is especially so if you have to start in a new site or neighbourhood. You have to decide:

- Where to hang out (at which site, at a distance or near by people, etc.).
- When to visit a place.
- What is the right moment to approach people (do they have time, are they in the mood for a talk, etc.)
- Which person to contact first.
- What is the right way to make contact (direct or less direct).
- What can you offer.
- When to stop (when to give it a break and leave).

It is important to distinguish the two ways of establishing a new contact:

- **Doing it on your own.**
- **Being introduced by someone.**

Making a new contact on your own

The first step is to visit the meeting place of the target group. This can be either:

- outdoor, on the street, or
- indoor, in a pub, a youth centre, etc.

Outdoor, on the street

The most difficult point without a doubt is ‘how to start’. Sometimes just ‘hanging around’ for a while can be helpful. This can provide the opportunity for a chance to make contact, to start a casual conversation, to ask a question or be asked what you are doing there. However, just hanging around at a meeting place of the target group can also make people suspicious.

Sometimes it is better to immediately tell them that you are an outreach worker on behalf of a drug aid service, etc.

It can be helpful to develop a schedule to regularly visit a site, starting with shorter visits which can gradually be extended.

- An example of how to make use of an outdoor setting ,if the target group like playing soccer: Is to: 1. join in one of their games , or 2. explicitly invite people to join one of your games, or 3. be in a place where you have seen the target group playing soccer, and encourage them to ‘join in’.

Contact can be established either:

- **Indirectly**; e.g. by starting a casual chat (about soccer, the neighbourhood, etc.). This can develop into a more personal talk, where you can introduce yourself, or maybe you will be asked to introduce yourself

- **Directly;** introducing yourself as a drug aid and/or HIV/AIDS prevention worker;
  - explaining what your task is
  - what you stand for
  - what you can do for the target group, etc.

A direct approach can be quite difficult, however it can be made much easier by using some strategies. Useful instruments for an outreach project can be:

- an inquiry using a questionnaire, e.g. on the needs and/or problems of the target group(s)
- handing out a leaflet which contains information on the project
- handing out a newsletter/magazine
- distributing condoms/syringes
- organising activities (a meeting, sport, music, etc.)

More information on the above strategies for making contact, can be found in this chapter under the heading 'Methods and material to assist outreach work' (see page 20).

Indoor, in a pub or youth centre

It can be easier to make contact indoors than on the street. In public meeting places such as a pubs and youth centres, it is generally easier to legitimise why you are there. You can have a drink, read a newspaper or a magazine, or just sit there and look around. In a meeting place for one specific group, a stranger may be viewed curiously and/or with suspicion. Curiosity can lead to some questions, which give the outreach worker the chance to introduce him or herself.

Indoor, there are some practical things worth keeping in mind, such as:

- sitting/standing at a bar will make it easier to get in contact than sitting alone at a table
- always offer people the chance to avoid/stop the contact

  you can start a conversation about the weather, soccer or an interesting event
- you can join in a game, like pinball, pool, table football, etc.

Furthermore, the strategies outlined above can also be helpful in an indoor setting.

Being introduced by someone

- In an indoor setting it may be somewhat easier to approach someone in a direct way. An example of a direct approach is: An outreach worker visiting a youth centre heard some boys talking 'macho' about sex. He threw some condoms on the table which made them laugh. This was a chance to direct the subject to safer sex.
- This example demonstrates that humour can be an important element in making contact and introducing a serious subject. It also makes clear that an appropriate assessment of the situation is of utmost importance; where you cause laughter in one group you may be beaten up in another. It shows that attitude, intuition and inventiveness are vital. An outreach worker should be able to correctly interpret a situation and find an adequate approach. Therefore personality and finding tactful ways of operating are of major importance.

As soon as the outreach worker has made some contact with people from the target group(s), things can become easier. Making new contacts can be done by being introduced by the people you already know. If people trust the outreach worker they might introduce their friends to him or her.

The first can also be a relatively easy job. If you are an out-

reach worker at a meeting place of the target group (either indoor or outdoor), where you already know some people and you want to make more contact with other people: You can either:

- Join a group with some people you know and start a talk with them. By doing so you generally will be introduced or otherwise you will have the chance to introduce yourself to the people you do not know.

- Explicitly ask one of the people you know to introduce you to people you want to make contact with. You also can ask if people know others who could benefit from information on HIV/AIDS, etc.

Again, your success will depend on an appropriate assessment of the situation.

It can be helpful to visit the meeting places of the target group(s) on a regular basis; i.e. the same time, on specific days. The meeting places of the target group could either be on the street or indoor, in a pub or youth centre, etc. This makes it easier for the target group(s) to find the outreach worker, either for their own needs, or for introducing, or referring a friend to him/her e.g. ‘If you go to this place on Friday at 10 o’clock you can meet him/her’.

Building up contacts can also be facilitated by handing out something to the target group(s). (See also ‘Making a new contact on your own’ page 5).

Being introduced by people you already know is often called ‘snowballing’. The starting point for snowballing can also be a drug agency. The drug users you are meeting there can be interviewed and asked if they can introduce the worker to their peers. If this process is carried out systematically a lot of people can be seen in a relatively short amount of time.

Before initiating outreach work it is worthwhile to find out if this approach is needed. It is wise to examine existing services to see why they do not reach certain groups of drug users. It might be much more cost effective to make existing services more attractive or accessible. Consider alternatives, e.g. needle exchange/distribution can be done by both outreach workers and/or syringe vending machines (if they are strategically placed).

COUNSELLING

Counselling plays an important role within the different tasks of outreach work. Counselling can be providing short advice, information and/or referral. It can also be prevention. In this manual we have concentrated on prevention, although the information we will discuss may also be useful for other tasks. The following issues will be dealt with:

- How to raise the subject of safer behaviour?
- How to discuss the subject of safer behaviour?

How to raise the subject of safer behaviour

Making contact with drug users is one thing; starting a conversation about HIV/AIDS is another. Outreach work is work without a clear agenda and without a well defined structure. An outreach worker is dependent on accidental contacts as appointments are generally difficult to make. However, it is worthwhile to make a plan before you go on the streets; giving thought to which person(s), group(s) and subjects have priority. This can result in some guidelines, which will give you some structure for your work ‘on the streets’.

Working in an unstructured setting has a lot of advantages:

- It can be very effective because you are ‘working’ in the target group(s)’ own environment. You are not dependent on set appointments and daily life in an office. You can respond directly to real life and spontaneous situations and to questions people have, etc.

- Operating in the familiar surroundings of the target group(s) generally facilitates an atmosphere of trust.

- You are obtaining valuable information about the actual living situation and behaviour of the target group(s).

- If people know what your are doing, sometimes they will start talking to you about HIV/AIDS or other health related issues.
- There are various other ways to raise the issue of safer behaviour:

- Looking for openings in either casual or planned contracts. An outreach worker can give a short reminder about safer use when confronted with a drug user having an abscess. Other opportunities are if someone has been to hospital, or someone has had an overdose. Making use of all unexpected situations is very important.

- It will soon become tiring if you only focus on HIV/AIDS prevention when discussing safer use and safer sex with drug users (see chapter 2, page 13). Therefore, it is advisable to incorporate HIV/AIDS preventionmessages in a broader framework of drug users 'subculture', e.g. focusing on health in general, or even in the form of a general interest group.

- If you meet people you know but, haven't seen for a while, questions such as 'How are you ?' and 'How are things going?', may be enough to begin a conversation which also includes issues to do with their health.

- The instruments for making contact which were previously outlined (on page 20) can also be useful here:
  - giving out condoms/syringes
  - colecting information
  - an inquiry using a questionnaire, e.g. what are the needs and/or problems of the target group(s)?
  - handing out a pamphlet which provides information on the project
  - handing out a newsletter/magazine
  - organising activities (a meeting, sport, music, etc.)

More information on ways of making contact with the target group(s) can be found in this chapter under the heading 'Methods and material to assist outreach work' (see page 20).

It is vital to have a broad repertoire of ways to raise HIV/AIDS prevention issues. It is not enough to simply once raise/discuss the issue. Short reminders and repeats of the messages from different angles and approaches can be very effective.

How to discuss safer behaviour

Most counselling occurs in a structured and/or therapeutic setting. However, outreach counselling does not take place in a specific setting, nor does it have a clear structure of well defined roles. An outreach worker has to create a setting for talking confidentially which is dependent on spontaneous opportunities. There are some rules for discussing the subject of safer behaviour.

Attitude and behaviour

- **Do not be judgmental** e.g. condemning risk behaviour as 'stupid or ridiculous' will not change the way a person behaves.

- This also means, **do not ask 'why'?** Posing the question 'why' often shows that you don't understand and therefore you place judgement on the person. Open questions, which invite people to tell **their** story brings about more important information.

- **Do not patronise**. Avoid giving advice about personal matters such as whether a person should be tested for HIV. Also avoid statements on how to behave ('If I were you I would ...'). Try to offer relevant and complete information and also discuss alternatives. Making your own decision about a matter is more important and effective than simply adopting someone else's view. In impersonal or objective matters, advice can be very useful; here are some examples, 'In this case you need a lawyer. You can refer to ...'; 'For getting tested you can go to this doctor/hospital. You first have to make an appointment by phone'; 'You should boil a syringe for 15 minutes and not only flush it with boiling water'.

- **Do not take over the responsibility** of someone else's problems. Try to motivate and support people to solve their own problems by themselves.

- **Listen carefully**. This means do not talk too much and do not interpret. Ensure however, that you have understood correctly what a person is saying by recapitulating what he/she has just said and asking if this is what they meant by it.

- **Stick preferably to the 'here and now'**. What do people feel or think now? What do certain things or emotions mean to people now? What are their possibilities? etc. This approach generally provides more relevant information for realising safe behaviour than discussing the past.

- **Pay attention to emotions**. How and what do people feel? What do certain events mean to them? etc. This can give insight into why people behave as they do.

- **Show that you understand and care by showing interest**. Ask people how they are, how things are going, where have they been? If a person has disappeared for a while, ask their 'mates' where he/she is. If you know where a person is, you could even visit him/her (at home, in hospital, in prison,etc.).

- **Treat people with respect**. For example: Thank people for their information and/or assistance; apologise when you are bothering someone; invite them for a cup of coffee at a cafe or at your office, etc.

- **Do not play therapist or 'shrink'.** It is important to listen carefully and pay attention to what someone is saying. Avoid playing the role of an untouchable, personally uninvolved therapist. Questions like 'Tell me, how does it feel?', 'What does this mean to you?', can raise feelings of aversion, especially when asked in reaction to questions for advice or help. Drug users might know this way of counselling by their attempts to 'kick their habit'. Their experiences with therapeutic treatments are frequently bad.

- Most of these rules are closely linked to the personality and attitude of the outreach worker. It is evident that an outreach worker has to be genuine in his/her care and understanding. Just pretending and using these rules is not enough. It is inadvisable to use the 'jargon or codes' of the target group(s) if the outreach worker does not feel familiar or comfortable with them. An outreach worker has to integrate these 'rules and codes' into his/her own, personal style of behaviour.

❗ To get an understanding of how an outreach worker is developing his/her personal style of working, regular feedback is necessary. This can be done by external supervision and/or by accompanying an outreach worker on the street. As supervision is not based on direct observation of how someone is working, immediate feedback is not possible.

Practical rules

- Try to **find a quiet place** to talk where you have an undisturbed conversation, e.g. a quiet bar or street (where you can sit down), at a person's home, etc.

- **Ensure that a person has time and that he/she feels like talking.** Generally it is obvious if somebody is in a hurry, or in search for drugs, etc. If your aim is a longer conversation you can explicitly ask if someone has time. You can also invite someone to have a cup of coffee with you.

- **Use appropriate language**, i.e. language that is readily understood and accepted. It is important to know/learn the 'jargon and the codes' of the target group(s).

- **Provide consistent, complete and objective information** which offers people choices (see chapter 3). Informing people is not only telling them something, it is also listening to what they have to say. When asking personal questions it is important to state clearly that people don't have to answer if they don't want to. Explain the reason why you are asking this question (so as not to be seen as offensive), e.g. to gain valuable information on the needs of the target group(s).

- **Provide relevant information.** This can be done by a conducting a formal risk assessment:
  - using a form to collect relevant information on level of knowledge (e.g. what do people know about HIV/AIDS?), attitude (e.g. how do people view condom use?) and risk behaviour of the target group members (e.g. do they share their injecting equipment?).
  - explaining the basics of HIV/AIDS (e.g. transmission of the virus, risk behaviour, etc.)

- asking and answering questions
- discussing possibilities to reduce risks, etc.

A formal risk assessment enables both prevention worker and drug user to set risk reduction goals and structure outreach prevention. However, it generally will not be possible to reach all outreach contacts with this formal instrument. For people who cannot be reached by this instrument it is necessary to have a less formal, appropriate variant. This means that you will have to be able to improvise.

- Besides explicitly talking about HIV/AIDS related issues, an outreach worker can also **discuss safer behaviour information that can be 'read between the lines'.** For example; you can talk about other health subjects (e.g. how to survive on the street, how to have a balanced diet.); about drug users life-style (e.g. not only misery, but also having fun and enjoying life). This strategy can be effective to prevent people from being bombarded with HIV/AIDS prevention information.

- **Do not talk exclusively about HIV/AIDS prevention.** Outreach work involves working in the 'daily life' of people. It is therefore, impossible and inadequate to confine yourself only to HIV/AIDS prevention. If you have gained people's confidence they will regularly seek contact with you on other issues besides HIV/AIDS prevention. Most likely their first priority will not be information about safer use and safe sex. They might be more in need of other services. Those needs cannot be denied when working on the streets. If you do, you lose your credibility. Therefore it is important to have knowledge of, and contacts with relevant services (see chapter 2, page 37).

- **Support positive changes in behaviour and attitude**. Supporting changes towards safer behaviour is important to foster self-esteem and self-efficacy (see chapter 1, page 8). This also provides the basis for ongoing change.

- **Do not judge or reject a person if he/she has a negative change of behaviour.**

- **Encourage and support 'snowballing'**
  by simply asking drug users to pass on the information to their peers
  by discussing how this can be done
  by involving drug users in the production and distribution of information.

- **Do not force people to continue talking.** Do not ignore the implicit, unspoken signals that may force someone to continue talking against their will. Do not explicitly force people to talk e.g. 'Wait a minute, I want to ask you another question? Indicators for stopping (or not beginning) a talk can be:
  – if the conversation 'loses it's flow', e.g. if people stop asking questions or barely respond to your questions
  – if people are becoming restless
  – if people's attention is diverted frequently, e.g. if they start talking with somebody else or change the subject.

  If you want to talk further, you can try to make an appointment and/or let them know you will be back to continue your discussion.

METHODS AND MATERIAL TO ASSIST OUTREACH WORK
Outreach work can be assisted by using some useful 'tools'

These tools include:

- giving out condoms/syringes

- collecting information

- conducting an inquiry by means of a questionnaire
- a pamphlet
- a newsletter/magazine
- organising activities

Distributing material and conducting an inquiry, invites the target group(s) to talk with the outreach worker.

- The commercial sector has shown us how important it is to keep communicating with your potential clients. This means establishing a steady relationship between product and client. In this respect there is not much difference with way services are conducted in the public health sector.

Prevention materials can be anything that draws the attention of the target group(s). Materials are always more effective when they can be utilised by the target group(s). Therefore, ensure that prevention materials support the goals you are aiming at. For example; to stop injecting drugs, to stop the sharing of injecting equipment and disinfecting used needles. Prevention materials should also meet the needs of people you are aiming at. Do not distribute 1ml barrel syringes if people are using 2ml ones.

Distribution of syringes, needles and condoms

- Talking about HIV/AIDS risk reduction alone is not enough. It should be accompanied by materials. When providing HIV/AIDS prevention in an outreach setting it can be very effective to distribute syringes, needles and condoms. Handing out prevention materials should be accompanied by talking about HIV/AIDS prevention. Handing out prevention materials should create an atmosphere which allows a person to start talking about HIV/AIDS or the materials handed out.

- Distribution of needles and syringes and other injecting equipment can be an effective way to penetrate injecting drug user (IDU) communities. If it is illegal to carry syringes without prescription, bleach and other legal injecting equipment can be distributed.

- Distributing needles, syringes and condoms makes it immediately clear what you stand for. It also shows that you have an accepting attitude towards people who use drugs.

- It is recommended to provide other materials as well as the basics, e.g. alcohol swabs, filters and ascorbic acid to dissolve brown heroin. Some outreach prevention projects only supply the basics.

- Before choosing to distribute syringes and needles make sure you choose the preferred type and size. It is better is to have a range of different types and sizes available. Different people have different needs. The same reasoning applies for condoms.

- It is also useful to strategically place containers for used syringes and needles. From a public order point of view syringe/needle containers are important because less syringes will be found on the street.

- Distributing syringes and needles can be used as a prompt to begin a discussion about preparing drugs for proper injecting. The distributor should possess the ability to assess whether the situation is suitable to start such a conversation.

- ❗ Make sure that people who distribute syringes and needles carry some kind of ID which can be used in case of police harassment.

- ❗ In cities where the accessibility to injecting equipment is relatively easy, syringe and needle distribution is a means to make contact with drug users. If drug users become dependent on outreach workers who distribute needles something has gone wrong. Outreach workers should make ef-

forts to enable drug users to take care of their own health and not make them 'doubly dependent'. Keep in mind the classic metaphor 'do you give the hungry man a fish or do you teach him to fish?'. However, in cities where the distribution of injecting equipment is limited the distribution conducted by outreach workers is vitally important.

- ❗ As mentioned earlier, HIV/AIDS is a narrow basis to establish an interest group. This is also so if you relied on the distribution of syringes and needles for contacting and maintaining valuable relationships with drug users. For example: In The Netherlands only 30 to 40 % of the opiate users, 'shootup'. So for the majority of dependent users distributing syringes and needles is useless. Additional strategies are therefore required.

Collecting information

An important task for people working 'on the street' is collecting information. Collecting information is a means to make contact with people. It also legitimises outreach workers to continue their work 'on the street', even in 'bad times' when they meet only a few people. Collecting information includes three main goals:

- describing the drug scene
- assessing the needs of drug users
- identifying short falls in the drug treatment system

Describing the drug scene

It is necessary for outreach workers and peer supporters to know what is happening in the drug scene. If this is done systematically, valuable information can be obtained. Observation is the keyword here. A standard observation form could be used to collect data. Subjects to be observed could be:

- What drugs are used?
- How are they used?

- Who uses drugs? Ethnic backgrounds?
- Where do people live?
- What do they do during the day?
- How do they get money?
- Where do they inject drugs?
- Who do they inject drugs with?
- How do they relate to each other?
- Is there a social hierarchy in the network?
- What are the norms and values relating to high-risk behaviour?

- Consider making observations about the frequency drug users use certain services and the way they experience these services (see 'Conducting an inquiry by means of a questionnaire').

- Observation forms should be quick and easy to fill in, and not take more than 5 minutes a day. Consequently not all issues can be covered in one observation form. We suggest dealing with one subject for a limited period and then changing to another one. (see chapter 2, page 26 'General organisational aspects').

Assessing the needs of drug users

The basic principle in assessing the needs of drug users is to listen to what they have to say. Outreach workers should be open minded to the stories and complaints of drug users. A lot of needs are easily assessed by just observing drug users daily life; scoring drugs, being homeless, malnutrition, medical treatment etc.

- Outreach workers should list the problems they encounter in the streets. Listing problems and needs should be done as systematically as possible (see above).

- In the framework of peer support, drug users can make an inventory of the needs of their peers.

- People 'in the streets' are not always used to making their needs known in a structured way. Part of the skill of being an effective outreach worker and peer supporter, is interpreting and classifying the needs and problems of drug users.

- The needs of drug users can vary. Drug users in methadone treatments have different needs to that of homeless drug users. Different needs also require different types of action. Some needs require immediate action e.g. medical treatment other needs require a long term policy e.g. making substitution treatment available.

Identifying shortfalls in the drug treatment system

A needs assessment of the drug treatment system ought to result in concrete action towards the services who should be meeting these needs.

Interest groups have several tools for action available:

- publishing a report of the results of the needs assessment

- meetings with policy and decision makers

- raising media awareness by press releases and public actions

- organising a workshop

- or a combination of the above tools.

- If a needs assessment has been carried out systematically it is easier to discuss these needs with local politicians and drug agencies (see 'Conducting an inquiry by means of a questionnaire').

Raising an awareness is one thing, changing policy is another; and far more difficult. Be conscious of the fact that accomplishing real change demands more than just one action. Defending your interests is a long term strategy. Set realistic goals

and be satisfied with small achievements. These small achievements can contribute to the continuity of the self organisation/ peer support initiative.

Conducting an inquiry by means of a questionnaire

An effective way to contact drug users in their own environment is to use questionnaires which form an inquiry. In the Netherlands drug user self organisations in various cities have carried out research by means of questionnaires. The use of questionnaires by drug user self organisations has two aims:

- gaining insight in the theme studied (see need assessment)
- getting known as a (self)organisation in the scene.

Asking for information shows that you take people seriously; that you are dependent on the information they provide.

The results of the inquiry can be the basis of a change in the local drug policy.

The effect of an inquiry can be an increased consciousness on the subject that has been dealt with. For example: If a study is done on people's experience with methadone programmes, people will become aware of the way they are treated.

Questionnaires should collect the basic demographics of the target group(s). This includes: age, gender, nationality, residence, level of education, source(s) of income. The questionnaires should be completed anonymously. If anonymity is not guaranteed it is likely that you will obtain false data or no co-operation at all (chapter 1).

Inquiries can be conducted on a range of subjects. Some big issues for drug users are:

- methadone treatment

- syringe and needle exchange
- police actions

Obviously, big issues are important as the results can have political impact. However they demand very precise preparation and a complex analysis of the data. This usually requires an experienced organisation. For some self organisations it is recommended to examine smaller issues first, such as:

- the use of filters
- how injecting equipment is cleaned
- how needles and syringes are disposed of, or
- ask people to try the femidom and report their experiences

- Preferably the questionnaire should be designed in conjunction with a researcher or somebody else with compatible skills.
- Everyone involved in using the questionnaire should be instructed on the structure and content of the questionnaire. It is also important to discuss possible difficulties which may arise during the interview.
- Limit the time for collecting data to a set period. Keep in mind that the analysis of the collected data takes the same amount of time as collecting the data. Again, the support of experienced people will be very helpful.

Pamphlets

Pamphlets can be used in outreach work to inform drug users on different issues. They should assist you in making contact with drug users and also help you to make yourself known in the drug scene.

The general rule is that they should be easy to read; using pictures increases the readability of a pamphlet. A pamphlet should always name the organisation or project who produced it. If the name is always the same and the information is useful and credible, the pamphlets and the person who is handing them out, will gain the confidence and trust of the target group.

Pamphlets can be used for the following:

- announcing the foundation of a self organisation/peer support initiative
- when a self organisation/peer support initiative has found a place to meet
- when organising activities or actions for and with drug users
- ❗ Making contact in the drug scene is a difficult job which requires skill and time. Using pamphlets can ease the establishment of contacts. Ensure that you don't fall into the trap of allowing pamphlets to replace human contact. If this occurs, pamphlets are not serving their purpose. Pamphlets can never replace a face to face conversation.

Magazines/ newsletters

A magazine can be an extra helpful tool if it becomes known in the target group. Distributing a new edition and having new copies with you, helps to make contact with people you don't know, but who do know the magazine.

Before choosing to publish a newsletter you should be clear on what the goals are. For example; is the newsletter:

- A voice for drug users to communicate to other drug users. Keeping people updated on activities is an important topic.
- A voice for drug users to inform drug workers, policy makers and the police. It is important for drug users to express their point of view.
- To inform drug users about health related issues. Information is the key word.

In reality newsletters will include more than one of the objectives mentioned above. However it is worthwhile to define the primary objective. This will help people to choose the right angle when writing an article or doing an interview.

Informative material, especially if it is lifestyle oriented can be effective, as the work of Mainline in The Netherlands has shown. Among other things, Mainline produces a professionally designed magazine in which HIV/AIDS prevention information and general information on health for drug users is incorporated into a 'life-style' formula. In 'Mainline' (the magazine) you can find articles on street life, prostitution, falling in love, services for drug users, different ways of using drugs, life stories and a comic strip. Nearly all the articles are based on and/or reflect the experiences of drug users. The magazine is distributed to drug users personally on the streets. This is where contacts occur and information is exchanged about health problems, or confidential matters such as safer use and safer sex. This mutual exchange of information, means that Mainline not only gives out information to drug users but it also obtains information from them. This 'street information' is one of the strengths of the articles in the 'Mainline' magazine.

This example clearly demonstrates, that outreach work is important for getting the message across. Discussing personal matters such as using drugs and sexual behaviour, is often easier in your own familiar surroundings than in someone else's space, e.g. the premises of a drug service.

A newsletter or magazine can in various ways assist outreach work by:

- making/keeping contact with the target group(s) through distributing the newsletter or magazine
- collecting information for an article
- raising a subject by referring to an article
- a readership study

- ❗ Issuing a magazine on a regular basis is an enormous job. Ensure to adapt the size and frequency of a newsletter or a magazine to the capacity of an organisation. It is better to publish a small newsletter which is issued regularly, than a fancy magazine which is only published every now and then.

Organising activities

Organising activities for and with drug users can be a tool in establishing a credible self organisation/peer support initiative. Activities can be divided into two main area's: leisure and interest related issues.

Interest related issues

Interest related issues need ongoing attention. Organising special meetings is important to inform volunteers, peer supporters and other drug users. Consider inviting experts e.g. medical doctors, lawyers, epidemiologists, policy makers. Topics which can be discussed in special meetings include:

- legal rights
- epidemiological update
- medical subjects (hepatitis C)
- changes in the law etc.

A successful meeting depends on how well it has been organised. A meeting will be well attended by drug users if the self organisation/peer support initiative has a certain status in the drug scene, and if the issue(s) to be discussed is relevant. A strategy for reaching as many people as possible is important. Consider the use of pamphlets in combination with 'snowballing' (see 'Being introduced by someone').

Leisure

In general less attention is paid to leisure activities. Working for drug users interests and on HIV/AIDS issues can make people forget that having fun is important. Fun activities can be important for volunteers and peer supporters. Think of sports and/or tournaments such as chess, table football, darts etc.

Before organising an activity, ensure people are interested in participating.

Cultural activities can include benefit gigs of bands who are sympathetic to HIV/AIDS and drug use. Inevitably large amounts of money will be involved in such events, therefore, consider co-operation with other organisations.

- Drug users have different backgrounds and preferences. It is possible that some people will only want to put energy into defending the common interests of drug users and will not be interested in organising leisure activities.

INTRODUCTION

This part of the manual reflects a considerable part of the experience the editors have had conducting training courses in different European countries. Training courses are distinct from outreach work, by the fact that they take place indoor and have a well defined structure. However, the issues that are dealt with in training and outreach work are similar.

Two levels of training courses can be organised in the framework of peer support.

- Training small groups of drug users about safer use and safer sex, possibly resulting in a snowball effect
- Training drug users about safer use and safer sex **and** as 'peer supporters' involved in a project.

Both training courses have their own perspective. The first type is usually for drug users who do not initially intend to become active peer supporters on behalf of a self organisation, or a peer support project. However, our experience shows that a training course can have an impact on both the participant and his/her peers. It is not hard to imagine that a training course will be discussed with friends and peers. This is where the snowball starts 'to roll'. In our opinion this type of training course can be organised and conducted by both professionals and drug users.

The latter type of training course demands a broader peer support framework. These kinds of training courses are usually conducted as a starting point for peer support activities. It can be valuable to invite professionals to participate. Professional support is therefore facilitated.

This type of training course can also fit into already existing drug user activities. For example; it can be organised for drug users who want to become seriously involved in a drug user peer support initiative. It is needless to say that in these courses, attention should be paid to the organisational aspects of peer support, safer behaviour messages and lastly, delivering the message to the target group(s).

In training courses the emphasis should not only be on knowledge about safer use and safer sex, but also on attitude, social norms and self-efficacy. To ensure that more than factual knowledge is communicated, it is important that training sessions are interactive. Participants should not be taught, but stimulated, or even provoked to take part in the discussions. Therefore, we have chosen exercises which are based on active participation. The role of the trainer is basically to guide the discussion and to ensure that accurate information is provided and nothing is missed.

This manual presents exercises on three major peer support subjects: safer use, safer sex and organisation of peer support. These exercises need to be integrated into the general framework of a particular training course. This framework includes:

- introducing the participants
- explaining 'why' there is a need for the training course
- outlining the programme
- providing regular breaks etc.

GENERAL CONSIDERATIONS WHEN ORGANISING A TRAINING COURSE FOR DRUG USERS

This framework has not been discussed in this manual. We assume that the basic knowledge on how to conduct a training course is present, or at least, easy to obtain.

- Invite potential participants well in advance. People have to get used to the idea of being invited to attend a training course. The background of the training course should be discussed and explained. An official letter emphasises that their presence is appreciated.
- In the mean time, keep people informed about the development of the training course.
- Do not stop motivating people to attend the training course until they have actually arrived.

- Invite more people than you in fact want to train. Due to the illegality of drugs, people are sometimes forced to do other, more urgent things.

- Training non-substituted drug users can be of great value. However it is even harder to get these people to a training course due to their daily needs. Consider temporary substitution during the training course.

- The number of people to be trained should not exceed 20.

- It is better to organise a training course in three afternoons, than to organise a training course which takes an entire day.

- It is important to take the level of skill and experience of the participants as a starting point when conducting a training course.

- Keep in mind that the gender, sexual orientation and ethnicity of a trainer can play an important role.

- Give a small present to the participants as an appraisal for their presence.

- Consider paying people for their presence. This is because they could have been out on the street making money, instead of attending your training course.

- Consider giving people a diploma after the course.

- Always end a training course with an oral/written evaluation. Including information on, what have they learnt, what was lacking, suggestions for improvement etc.

- Choose a room for the course close to where people live or 'hang out'. The room will have a higher 'psychological' accessibility.

- Organising a training course for drug users can become more valuable if some kind of follow-up activity is organised.

Almost all of the exercises presented in this manual have been used in training courses with drug users. The key to a successful training course is the active involvement of the participants by taking their knowledge and experience as a starting point.

SAFER USE EXERCISES

Introduction

Proper injecting is a skill which is not learned overnight. A skill is learned and improved by practise i.e. writing. For injecting drug users injecting is an important skill. Unfortunately, some drug users have not learned the skill correctly, or are not always capable (due to difficult situations) to practice proper injecting according to hygienic standards.

The exercises in this manual aimed to improve drug users injecting skills. Some of the exercises are designed to develop HIV/AIDS prevention skills in an outreach setting.

Each exercise should be valued whether it is suitable for the local situation. Where necessary, trainers should adapt the exercises to local needs.

The video tape which is enclosed with this manual has been designed to show **only** to drug users and to people working with drug users. DO NOT PUBLICLY BROADCAST THE VIDEO. We have enclosed the video because we believe it is necessary to have an example of 'proper injecting'. The injecting sequence is shown in full, without any comment. In some of the following exercises we suggest you show a part of the video.

Safer Use 1
Excercise with video

This exercise uses a part of the video with the complete proper injecting sequence. The trainer can choose from:

a shot of heroine with detachable needle
a shot of cocaine with non-detachable needle.

Objectives:
❶ **Introducing the subject of safer use**
❷ **Showing the correct self injecting sequence.**

Duration of exercise: 15 to 30 minutes

Number of participants: Minimum 4, maximum 20

Material needed: European peer support video
Video equipment

Exercise outline:

- Show the video.
- Ask for comment afterwards. Focus on the different ways participants inject and the possible hygienic mistakes made by the actor.

Variation:
If you are not using the video

- You can ask one of the participants to show how he/she prepares a shot and how he/she would inject it.
- The other participants watch carefully and provide comments afterwards.

Safer Use 2
Exercise with video

This exercise uses the last part of the video in which the complete chasing the dragon sequence is shown (see also Annex 1)

Objectives:
❶ **Introducing 'chasing the dragon' as an alternative way of taking heroin.**
❷ **Discussing safer use techniques.**

Duration of exercise: 15 to 30 minutes

Number of participants: Minimum 4, maximum 20

Material needed: European peer support video
Video equipment

Exercise outline:

- Show the 3rd part of the video.
- Ask for comment on this way of taking drugs.
- Discuss the opinions of 'chasing the dragon'

Safer Use 3
'in case of...'

Every injecting drug user is interested in injecting drugs quickly and efficiently. To be successful in doing so, certain conditions must be fulfilled:

- **all equipment must be at hand**
- **veins should be easy to inject**
- **the drug user should have the skills to inject properly**
- **being undisturbed and comfortable**

Unfortunately these conditions are not always fulfilled. It often happens that the conditions are unfavourable at the very moment that drugs are available. For drug users it is extremely handy to have a repertoire of alternatives available which can limit the harm due to unfavourable circumstances.

Objectives:
1. **How to respond effectively to unfavourable circumstances for proper injecting.**
2. **Drug users share the improvising skills they have for proper injecting.**

Duration of exercise: 30 to 60 minutes

Number of participants: Minimum 4, maximum 20

Material needed: Copies of the 'in case of...' list (see next page) Pen and paper

Exercise outline:

- The trainer splits the group into two groups (A and B) or in couples.
- Each group is given some unfavourable circumstances which they have to respond to as if it were a real life situation.
- After some time, the group should come together again and discuss several of the responses.

On the following pages you will find a list of unfavourable factors and possible alternatives for safe injecting.

SAFER USE 3

(Copy sheet)

'IN CASE OF...'
(a selection)

A	no clean needles are available
B	no bleach is available
A	no fresh tap water is available
B	a shot of cocaine and the needle clogs
A	a shot of heroine and the needle clogs
B	the syringe has a bad vacuum (piston/plunger leaks)
A	the needle has a wire-edge (burr)
B	no drugs and 10 clean needles and syringes
A	no spoon is available
B	no fresh cotton is available
A	no alcohol swab is available
B	the plunger cannot be pulled back any further
A	you notice you hit next to the vein (bubble)?
B	you have difficult veins; hard, rolling, deep laying
A	you do not have a quiet place of your own.
B	you have an abscess
A	you hit an artery

IN CASE OF... SOME ALTERNATIVES

- **no clean needles are available**
  - boil it out for 15 minutes
  - clean it with bleach
  - take the drugs by chasing the dragon
  - snort the drugs

- **no bleach is available**
  - boil it out for 15 minutes
  - chase the dragon
  - snort the drugs
  - clean it carefully with anything else (cola, alcohol etc.)

- **no fresh tap water is available**
  - use mineral water
  - or boil water for 15 minutes

- **one portion of drugs, one clean syringe, one used syringe and two persons willing to share the drugs equally.**
  - boil out the used syringe or clean it with bleach
  - both chase the dragon
  - one person divides the drugs into two equal portions, the other chooses

- **one portion of drugs, two persons each with a used syringe of their own and willing to share the drugs equally.**
  - boil out the used syringes or clean them with bleach
  - or second best: rinse your own syringe well
  - one person divides the drugs into two equal portions, the other chooses

- **a shot of cocaine and the needle has clogged.**
  - stop injecting, put the liquid back on the spoon, remove the clot, add some cold water, put on a new needle, or use a new syringe and needle
  - to unblock the needle: warm the needle with a lighter to expand it
  - pull up some fresh cold water and shake the syringe

- **a shot of heroine and the needle has clogged**
  - stop injecting, put the liquid back on the spoon, put on a new needle, or use a new syringe and needle.

- **the syringe has a bad vacuum (piston/plunger leaks)**
  - take a new syringe
  - make the rubber of the piston wet and try again

- **the needle has a wire-edge (burr)**
  - sharpen it on a match-box and clean it with a lighter flame.

- **no drugs and 10 clean needles and syringes**
  stupid question
  try to make some money with it.

- **no spoon is available**
  - prepare the bottom of a tin (e.g. coke can), clean it with a flame

- **no fresh cotton is available**
  - use the filter of a cigarette
  - use whatever else is available such as; an alcohol swab, the lining of a coat etc.
  - use no filter; carefully tip the spoon and keep the residue at the other end from where you draw up.

- **no alcohol swab is available**
  - clean injection spot with water and soap
  - clean it with water only
  - do not clean it.

- **the plunger cannot be pulled back any further**
  - stop injecting, untie the tourniquet, place half the contents of the barrel back on the spoon, or in a second syringe, then let your arm hang down; tie off again and
  - look for another vein.
  - take a second syringe

- **you notice you hit next to the vein (bubble)?**
  - cover it with wet bandages
  - smoothly massage the bubble

- **you have difficult veins; hard, rolling, deep laying**
  - learn to chase the dragon
  - ask someone to help you

- **you don't have a quiet place of your own**
  - find a friend with a quiet place
  - public toilet. Be aware of public toilet doors that open inwards. If you overdose, you will fall against the door and nobody will be able to open it to help you.

- **you have an abscess**
  - make a compress of wet bandages
  - see a doctor as soon as possible.

- **you hit an artery**
  - untie the tourniquet immediately and pull out the needle press on the spot with a bandage for at least 5 minutes, until you are sure it has stopped bleeding.

(Alternatives contributed by drug users of HKPD, Vlissingen, the Netherlands and from Oxford, UK)

Safer Use 4
negotiation skills

Apart from different individual 'technical' problems (as was outlined in exercise 2), drug users can run into situations where problems have to be sorted out with other drug users. This exercise raises the subject of solving problems together.

Objective:	**To prepare drug users for high risk situations.**
Duration of exercise:	30 to 60 minutes
Number of participants:	Minimum 4, maximum 20
Material needed:	A flip chart to write down reactions/solutions Marker pens

Exercise outline:

- The trainer splits the group into small groups of about 5 people.
- Each group gets one or two high risk situations (giving different groups the same situation might lead to an interesting comparison).
- The participants are asked to sort out the safest solution.
- In a plenary discussion the solutions found are compared and discussed.

HIGH RISK SITUATIONS:

- Two people and 1 gram of cocaine. It is 10.00 PM you are at someone's house and you have only one syringe. How do you both get a 'hit' and not become infected?

- One portion of drugs, two people with a used syringe of their own and are willing to share the drugs equally.

- Two people and 1/2 gram of heroine. It is 8.00 am and both of you are suffering withdrawl symptoms. The pharmacist opens at 9.00 am and you do not have any needles.

- Three friends take a good shot of heroine, all with their own clean needle. Everyone gets really stoned for a while. They then want to take another 'hit' but are not sure whose syringe is who's.

- Fifty drug users in prison. One syringe available.

- Let the participants bring in a high risk situation which has been solved in a safe way.

- Let the participants bring in a high risk situation which could not be solved 100% safely.

Safer Use 5
outreach situations

Outreach workers and drug users conducting HIV/AIDS prevention, run into situations where drug users are practising self injecting. It is a question of the right timing to raise the proper injecting issue. In this exercise we try to find out what a third person (friend, a relative, health worker) can do to improve proper injecting. By means of discussion and practice several situations for proper injecting are reviewed.

Objectives:
- ❶ **Discuss the right timing to raise the subject of proper injecting in outreach situations.**
- ❷ **Discuss how to support drug users with proper injecting.**
- ❸ **Exercising practical support**

Duration of exercise: 30 to 60 minutes

Number of participants: Minimum 4, maximum 15

Material needed: The European peer support video
Video equipment
A tourniquet.

Exercise outline:

- Show one of the injecting parts of the video.
- Ask participants, “If you were in the same room as the drug user, **when** and **how** would you start a conversation about safer use?”.

In general:

- What kind of situations are most suitable for starting a conversation about safer use with drug users on the street? Or As a drug user, when do you definitely not want to be disturbed by a talk about safer use?

- What kind of introductions are appropriate to raise the safer use subject e.g. the weather, police harassment, availability of needles etc.

Technique:

- An explicit peer support action is to help each other find good veins. Participants look for good injecting veins on their neighbour's arms. Roll up the sleeves and examine your neighbour's arms carefully.

- Correctly using a tourniquet is essential for many drug users. Participants practice the correct and incorrect use of a tourniquet. The results are watched closely (veins coming up, going down). This exercise is particularly interesting if done by people with difficult veins.

- Question: What can be done to make veins come up?
  - if there is no tourniquet available
  - if it is cold and veins are deep down

Safer Use 6
where to inject

Objectives:
- ❶ **Participants look critically at their injecting technique.**
- ❷ **What alternatives do participants use for intravenous injecting (for example intramuscular and subcutaneous injecting).**

Duration of exercise: 30 to 45 minutes

Number of participants: Minimum 4, maximum 15

Material needed: Copies of a drawing of the human body (see next page).
A large (A3) copy of the drawing for use in the plenary. (Using a mannequin is even better.)

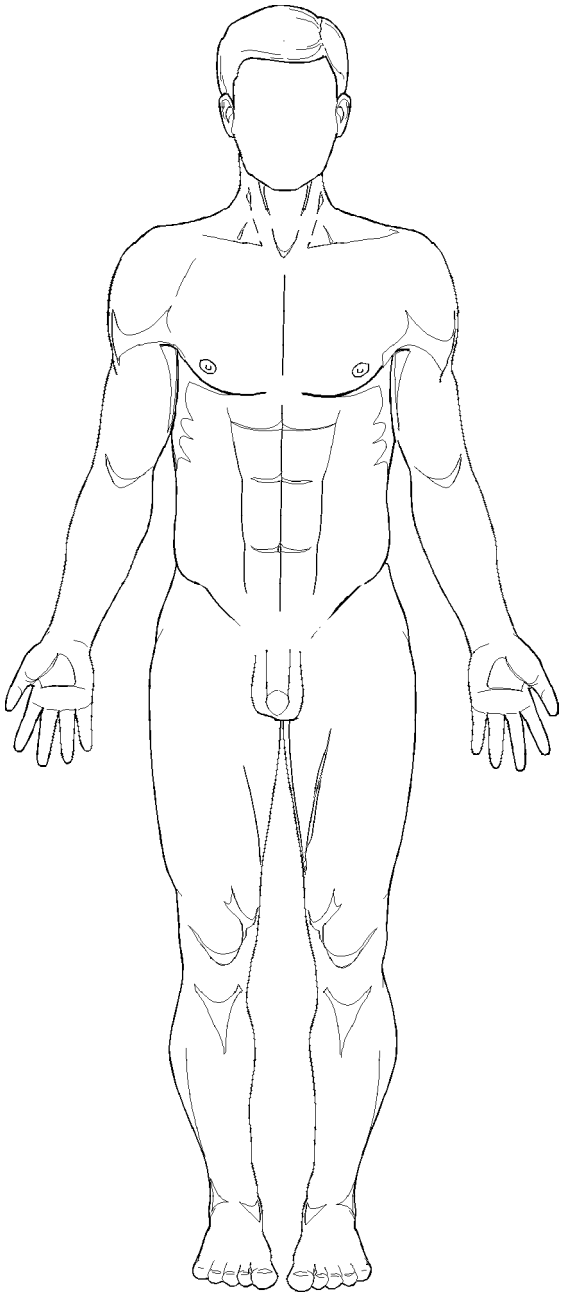
Exercise outline:

- The trainer splits the group into small groups of two to four people.
- Each small group receives a copy of the 'copy sheet'.
- Ask participants to judge and mark possible injecting spots on the copy sheet according to the following standards, (allow 20 minutes):
  1=well suitable
  2=only in an emergency
  3=risky
  4=never
- In a plenary session the small groups present their work. On the large drawing of the human body the correct standard is marked.

SAFER USE 6

(Copy sheet)

where to inject



Please judge and mark the possible injecting spots according to the following standards:

1 = well suitable
2 = only in an emergency
3 = risky
4 = never

SAFER SEX EXERCISES

Introduction

Safer sex is an important topic because it can prevent the transmission of HIV. Research has revealed that safer sex is a badly practised behaviour; especially among heterosexuals. In 1994, in many western European countries, the highest incidence of new infections with HIV is among heterosexuals. Drug users often find it easier to talk about safer use than safer sex. Sex is generally a hard topic to discuss.

General considerations

- In some situations it is recommended to avoid a group of mixed gender.
- Agree with the group to be respectful towards participants' sexual orientation.
- The trainer should not be inhibited to talk freely about sex and sexuality.
- Consider involving a second trainer of the opposite sex.
- When using a dildo, choose a colour which is appropriate to the group. Do not offend coloured people by using a white dildo.
- It is widely experienced that people are reluctant to practice the 'condom technique' on a dildo. This emphasises the need to conduct exercises which encourage people to practice using condoms. We suggest using other, less intimidating, 'phallic' objects as well.
- The exercises in this part of the manual deal with safer sex in various ways. We have begun with some exercises which aim at making sex a subject of discussion. After that the safer sex part comes in. Our experience has shown that this is an effective way to train.

Safer sex 1
Dirty words

Objectives:
- ❶ **Participants discuss sex in order to make them more comfortable with the subject.**
- ❷ **Making clear that different language is used for different people.**

Duration of exercise: 15 to 30 minutes

Number of participants: Minimum 4, maximum 15

Material needed: Pens, paper, flip-chart

Exercise outline:

- Give all participants a pen and paper and ask them to write down as many words possible for the male genitals; medical words, dirty words, pet names etc. (Allow 5 minutes).
- Write down the results on the flip chart. The person who came up with the most words is the 'winner'.
- Repeat this procedure; but with words for the female genitals.
- Discuss the results afterwards and ask participants which words can be used for different categories of people, e.g. parents, children, partner, peers.

Safer Sex 2
Sexual or not

Objective: **Make participants conscious of the impact different words can have on different people.**

Duration of exercise: 30 to 45 minutes

Number of participants: Minimum 6, maximum 20

Material needed: List of words, participants sheet, pens.

Exercise outline:

- Preparation: Compose a list of words suitable for the group (see: example list below).
- Make copies of the participants sheets (see next page).
- Distribute participants sheets.
- Read out aloud the words on your list and ask participants to write them down in the columns which they think is right (no discussion).
- Split the group into two, or even more smaller groups, and ask participants to compare and discuss the results.
- In order to unite the group again, compose a list of words on which everybody agrees.

Example list of words

to hug	exciting	to lick
horny	sucking	to rub
security	sensitive	toys
kissing	tenderness	partner
warm	tickle	confidence
dick	fuck	dark
scratching	surrender	ecstasy
caressing	smell	sharing
safe	hold tight	

Write down the words mentioned in one of the columns.

SEXUAL	NOT SEXUAL

SAFER SEX 2

(Copy sheet)

Sexual or not
Participants sheet

Safer Sex 3
Sex education

Most people have not learned to speak freely about sex, and therefore, safer sex. It is vitally important to talk about safer sex because of HIV/AIDS. This exercise makes clear to everyone that it is 'normal' that we feel shy talking about sex. We have never been taught to do it. In this exercise the plenary discussion is limited in order to maintain privacy.

Objectives:

❶ **Introducing the issue of safer sex in a non threatening way.**
❷ **Making clear that most people's sex education was not very good and therefore it is valuable to discuss this subject.**

Duration of exercise: 15 to 30 minutes

Number of participants: Minimum 6, maximum 21

Material needed: None

Exercise outline:

- Split the group into small groups of threes.
- Each participant in these smaller groups has a maximum of 3 minutes to tell the other two participants about their sex education. Key questions are: when did it happen, who did it, and what were you told?
- After participants have told their history, the general outcome is briefly discussed in a plenary session.

Safer Sex 4
Safe or not?

Objectives:

❶ **Catalogue to what extent participants have knowledge of safer sex techniques and supply lacking information**
❷ **Raise awareness regarding the fact that safer sexual practices outnumber risky ones**

Duration of exercise: 30 to 45 minutes

Number of participants: Minimum 6, maximum 20

Material needed: 3M post-it memo-blocs (the little yellow self-adhesive sheets)
Pens
4 flip-chart sheets of a naked man and woman
1 flip-chart sheet with safe/unsafe

Exercise outline:

- Split up the group into two or more smaller groups.
- Supply each group with a post-it bloc, a pen and the instruction to write down as many as possible variations on making love (e.g. techniques, positions, acts) they can think of. One variation per sheet. Sheets should be stuck on the table for the time being. (Allow 10 minutes.)
- Stick the 4 prepared flip-chart sheets on the wall. On the flip-chart the naked front and back of a man and woman are pictured.
- The participants have 5 minutes to put the post-it sheets on the parts of the body where they think a certain variation belongs.

- Then stick the 5th flip-chart sheet on the wall. This sheet has to two columns: one with safe and the other with unsafe.

- Allow each participant to take some attached post-it memo's and read aloud the variation. The participant should then stick the sheet in the right column.

- To conclude, discuss the result and provide additional information if necessary.

Safer Sex 5
Merry go round

Objectives:
- ❶ **Participants experience talking about intimate sexual subjects.**
- ❷ **Participants experience posing intimate questions.**

Duration of exercise: 30 to 60 minutes

Number of participants: Minimum 12, maximum 30.

Material needed: Cards with questions.

Exercise outline:

- Preparation: Copy the questions on the **following pages** onto cardboard and cut into cards.
- Form an inner and outer circle with the group. Ensure that each circle has an equal number of people. Participants should sit in pairs, face to face.
- Give the people in the outer circle a pile of cards.
- The participants in the outer circle, ask a question from the cards to the person sitting opposite; but only if he/she would have answered the question him/herself. (Allow 5 minutes.)
- The outer circle moves two places and the procedure is repeated. (Allow 5 minutes.)

- Depending on the available time and the number of participants the procedure can be repeated again.
- The pairs change chairs (inner circle becomes outer circle).
- The new outer circle moves one place and the questioning starts again.
- Some experiences can be exchanged in a plenary session.

SAFER SEX 5

(Copy sheet)

Questionnaire 1/5

1. Do you think you are 'good' in bed?	2.Did you ever play 'doctors and nurses or any other forbidden games?
3. Do you think there is a difference between what men and women experience during making love?	4. Do you talk occasionally about your sexual experiences?
5. Do you communicate what you like to your partner when you are making love?	6. Have you ever been afraid of your sexual feelings?
7. What does promiscuity mean to you?	8. Do you feel that your ideas about sex are further developed than your behaviour?
9. Do you have sexual dreams?	10. Have you ever wondered how your parents make love? And how your children make love?
11. In a movie you see an extended scene of homosexual love making; what does that do to you?	12. Do you sometimes punish your partner by refusing sex?

SAFER SEX 5

(Copy sheet)

Questionnaire 2/5

13. Do you like to be touched, caressed?	14. What do you prefer: to tempt or to be tempted?
15. Do you tell your children about your sexual feelings?	16. Do you know what makes you horny?
17. Do you fuck during your period?	18. Do you consider it a sign of weakness to look for help for a sexual problem?
19. Have you ever had a fight about sex?	20. What do you think about extra-marital relations?
21. Should people stay together for the 'sake of the kids'?	22. What do pornographic photo-graphs and films to you?
23. Do you only fall in love with people who are in love with you?	24. Have you ever been afraid that you were homosexual?

SAFER SEX 5

(Copy sheet)

Questionnaire 3/5

25. Have you ever kept a relationship/affair secret from your parents and/or partner?	26. In what way do you like to be hugged most?
27. Do you day dream a lot?	28. Do you like body fragrance?
29. Have you ever been afraid that you or your partner was pregnant?	30. What was your most unpleasant sexual experience?
31. What do you think about oral sex?	32. If your partner wanted anal sex, would you do it?
33. Are you satisfied with your 'sexual equipment'?	34. Do you know and do you like your partner's taste?
35. Do you 'checkout' good looking people from the same sex?	36. If your partner had another lover, how would you react?

SAFER SEX 5

(Copy sheet)

Questionnaire 4/5

37. How do you feel if a person of the same sex feels attracted to you?	38. Were you hugged a lot by your parents? Do you hug your children a lot?
39. Can you accept that your partner does not want sex without feeling rejected?	40. Whatt do you think of the taste of your partner's genitals?
41. How often do you masturbate?	42. Can you show your affection as well with your body as with words?
43. Does somebody's voice have a sexual impact on you?	44. What do you think of vibrators and other sex-toys?
45. Do you get jealous easily?	46. What does the size of your penis or your breasts means to you?
47. Do you see your partner's need for independence as a rejection of their relationship with you?	48. Do you ever go somewhere to meet sex partners?

SAFER SEX 5

(Copy sheet)

Questionnaire 5/5

49. Tell something about your homo-sexual experiences?	50. Which sexual position do you prefer and why?
51. Why do you fuck?	52. Do you think you are as sexy as other people?
53. Where you desired as a baby and of the desired gender?	54. Have you ever felt exploited in a sexual relationship and have you ever exploited someone?
55. Have you ever had sexually transmitted disease?	56. For men: Have you ever been to a prostitute? For women: What do you think if your partner visited a prostitute?
57. Have you ever fucked without contraception?	58. Have you ever pretended that you were coming?
59. What fantasies do you have when you make love?	60. Do you masturbate occasionally in your partner's presence?

Safer Sex 6
Instructions for condom use

Objective: **Participants practice providing instructions on condom use and experience the obstacles that they can be confronted with.**

Duration of exercise: 30 to 45 minutes

Number of participants: Minimum 4, maximum 16

Material needed: Several dildo's (or other phallic objects)
Different types of condoms.
Instructions for condom use.

Exercise outline:

- Preparation: Photocopy the instructions for condom use on the following page.
- Split up the group into pairs and give each pair a condom and a dildo (or a dildo look alike).
- One participant teaches the other how to use a condom. (Allow 5 minutes).
- Bring the group together for an inventory of the reactions.
- Distribute the instructions for condom use and allow participants to read them carefully.

- The same pairs should sit together again, however this time the exercise is conducted the other way around, i.e. the other person with a new condom, provides a condom instruction lesson according to the recently read instructions. (Allow 5 minutes)

- To conclude, allow participants to respond to the instructions given and stress the obstacles one can face while demonstrating the use of condoms.

SAFER SEX 6

(Copy sheet)

Instructions for condom use 1/2

Instructions for condom use

- Check if you have the right condom:
  - is it for vaginal, oral or anal sex; if you require it for anal sex, use only special, thicker condoms.
  - is it big enough?
  - is the brand registered and approved?
  - check the expiry date.

- Open the package carefully:
  - not with teeth or scissors. This will avoid tearing the condom.

- Take out the condom:
  - be extra careful if you have long nails
  - make sure you have the condom the right way up (i.e. not inside out).

- The tip (for semen reservoir), should be squeezed so that there is no air left
  - this will decrease the chance of the condom tearing as the reservoir will not come under pressure
  - if the condom has no tip make one yourself by squeezing the air out of the top of the condom (1-3 cm).

- Put the condom on top of the penis and unroll it carefully to the base of the penis
  - wait until the penis is completely hard before putting the condom on
  - when fully unrolled there is less chance that the condom will slip off again, be careful if you have long nails.

- Use only a water based lubricant
  - always use lubricant for anal penetration
  - a non water based lubricant will perish the condom. Do **not use** Vaseline, hand cream, body lotion, oil or butter.

SAFER SEX 6

(Copy sheet)

Instructions for condom use 2/2

- Withdraw the penis carefully, immediately after ejaculating. While withdrawing, hold the condom at the base of the penis to avoid it slipping off
  - if you wait too long before withdrawing the penis becomes soft, the con-dom slips off and the semen drips out.

- Tie a knot in the condom and dispose of it.
  - Do not flush it down the toilet as condoms can block drain pipes.

Use a new condom each time you start fucking. Never use two condoms on top of one another: This can cause condoms to tear.

Safer Sex 7
Condom relay race

Objective: **Participants practice in a 'gamesome' way the use of condoms.**

Duration of exercise: 10 to 20 minutes

Number of participants: Minimum 6, maximum 12

Material needed: Dildo's
Condoms,
Written instructions for condom use

Exercise outline:

- Instruct participants on how to use a condom.
- The written instructions are used as the 'Royal' standard, see copy sheet exercise 6.
- Split the group equally in half.
- Give each participant two condoms (one as a spare).
- Participants should stand in a line.
- The first person of each group is given a dildo and has to put the condom on it and take it off, in the proper way. Then the second person can start to do the same procedure.

- The group that finishes first is the ‘winner’.

Remarks:

- The trainer can decide to appoint referees to judge the participants actions.
- If a participant makes a mistake he/she should start again.
- The ‘winning’ group should receive a small prize.

Safer Sex 8
The safer sex debate.

People use all kinds of pretexts for not using condoms. The aim of this exercise is to discuss the pretexts and provide valid counter arguments.

Objective: **Discussing the 'pro's' and 'con's' of using condoms.**

Duration of exercise: 30 to 45 minutes

Number of participants: Minimum 6, maximum 20

Material needed: Two case scenarios (see following pages)

Exercise outline:

- Split the group into two; one group 'pro' condom use the other 'contra' (against) condom use.
- Each group is handed out the participants sheet (see following pages).
- The groups prepare their assignments. (Allow 10 minutes.)
- The group comes together again and sits face to face. The 'contra' condom group first provides reasons why people should use condoms. The 'pro' group is given the possibility to respond. The 'pros' and 'cons' are discussed in pairs as much as possible.

SAFER SEX 8

(Copy sheet)

The safer sex debate participants sheet 1/2

Write down the arguments for condom use and keep in mind that your partner will probably not agree with you.

Short stories PRO condom use

"You have been 'checking out' a gorgeous guy/girl for the past few weeks. Finally, you both have met and 'fallen in love'. After an EXITING night out you find yourself in bed wanting to fuck. You want to use a condom but you are not sure how to raise the subject. The last thing you want is to say is that you are HIV positive. Convince your partner to use a condom".

"You are having your period (it's the first day, so lots of blood). It is your last night in Amsterdam and your final chance for romance with the sexy man you met in the hotel. You know he has a history of drug use and a regular partner with high risk behaviour. It's 1.30 in the morning and you have only one hour before he has to return home to his fiancee. There are no condoms available. What do you do?"

"After months of heavy quarrels about money and drug use with your partner, the situation has become unbearable and you leave the house. You are lucky to find a place to sleep at one of your friends' houses. After being his guest for a week, he wants you to have sex with him in 'payment' for rent. When you are in bed with him it appears that he does not want to use a condom".

SAFER SEX 8

(Copy sheet)

The safer sex debate participants sheet 2/2

Write below the arguments against condom use and keep in mind that your 'partner' probably will not agree with you.

Short stories CONTRA condom use.

"You have been 'checking out' a gorgeous guy/girl for the past few weeks. Now you both have met and 'fallen in love'. After an exciting night out you find yourself in bed and wanting to fuck. You hate condoms and you are not going to use them because you are not HIV positive. Then your partner proposes using a condom. Explain why you don't want to use it".

"You and your girlfriend have been using drugs for the past 10 years. Your girlfriend works 'on the street' and is making enough money to supply both of you with drugs. She has kept you from becoming 'dope sick'. One night she suddenly says that she wants to use condoms. You are surprised because condoms are only for clients. You refuse. "

ORGANISATION EXERCISES

Introduction

"Why should drug users organise themselves?" Drug users should organise themselves to defend their interests and inform policy makers and drug agencies of what they are. Too often drug users are treated as criminals, victims or mentally ill patients, instead of people with the same rights and responsibilities as 'non drug users'. The AIDS epidemic has demonstrated the importance of information to curb the spread of HIV. Taking preventative measures should recognise drug users as human beings and take into account a drug users' lifestyle. It is important for drug users to break the stereotypes and confront policy makers, drug workers etc. with a positive and combative attitude.

This manual only supplies a thumbnail of ideas about organising drug users for legal purposes and defending their own interests.

Organisation 1
Drug users' place in society

This exercise can be used as an introduction exercise in a training course with drug users. The exercise begins with 'brainstorming' the experience one has as a drug user. The second part, assesses people's opinion and can sometimes make people hesitant about coming forth with information. Our experience shows that in the beginning many associations are valued negatively, however this later develops into an awareness that is valued. Even negative terms such as 'dealer' have positive sides as well.

Objectives:
1. **Orientation on drug users' place and image in society.**
2. **Identify drug users awareness of the role and importance of drug related issue's.**

Duration of exercise: 30 to 60 minutes

Number of participants: Minimum 4, maximum 20.

Material needed: Flip-chart
Marker pens

Exercise outline:

- The group brainstorms on associations with the word 'junkie': "What associations do you have on the word 'junkie'?"

- After having listed the groups associations, the trainer asks the group to value each association as positive or negative. Experience shows that it takes too long to work through the entire list. The trainer can choose some key association to work on.

- Continue with the associations until people are really aware that issue's which are valued negatively by society do have positive sides for drug users.

Remark:

- At the same time one is discussing drug users' place in society, one is reflecting drug users' self esteem.

Organisation 2a
Inventory of problems

Organisation exercises 2a and 2b are in fact one exercise. They have been separated because experience has shown that it is best if some other exercises are done inbetween 2a and 2b. If possible spread the exercise over two days.

The exercises are basic self-organisation exercises. They aim to transform ordinary complaints into concrete actions to be undertaken by a self organisation. The work carried out in the frame work of this exercise provides concrete examples of the theory in chapter 2 of this manual.

This exercise is best to be done in combination with 2b.

Objectives:
- ❶ **Identifying all kinds of problems people experience in day to day life.**
- ❷ **Taking the first step towards expressing these needs.**

Duration of exercise: 15 to 25 minutes

Number of participants: Minimum 4, maximum 20.

Material needed: Flip chart
Marker pens

Exercise outline:

- Simply ask participants to come up with all the kinds of problems drug users are confronted with in daily life. Write all problems and items mentioned down on the flip chart.

- **Variation.** Mention some big issue's in advance and use them as a guideline for the inventory of problems e.g. homelessness, price of drugs, substitution, HIV/AIDS, needle exchange etc.

Organisation 2b
Working out the inventory

This exercise is best done in combination with exercise 2a.

Objectives:
❶ **Examine a particular problem.**
❷ **Prepare steps towards solving the problem.**

Duration of exercise: 60 to 90 minutes

Number of participants: Minimum 4, maximum 20.

Material needed:
Pens Paper
A table (to write).

Exercise outline:

- Preparation: The inventory (from exercise 2a), has resulted in a list of drug-related problems. Before continuing, problems of the same nature should be clustered. Make clusters which are comprehensive and down to earth. Also prepare an assignment for each cluster.

- Present the clusters with problems to the participants.

- Let participants vote for their cluster (try to balance the number of people in each cluster). For each cluster the trainer(s) has worked out an assignment. There are examples of clusters and assignments on the **next page**. We assume that if somebody votes for a specific cluster that he/she has something to contribute to this subject.

- The formed groups split to work out the assignments. Each group appoints a spokesperson.

- After 30 to 45 minutes of working on an assignment, the group is brought together again to present and discuss the results.

Variation:
The first part of this exercise (2b) involves the trainer(s) preparing the clusters.

- The clustering can also be carried in collaboration with the participants immediately after the inventory.
- Besides clustering the problems, an initial estimation of priorities can be made.
- The problem is assessed to see whether or not it should be tackled by a self organisation.
- And if 'yes' is the answer; Can a self-organisation do this alone. or does it need support from a sympathising organisation?

EXAMPLES OF CLUSTERS
with assignments

- **Methadone**
  Design 5 basic 'rights and obligations' for clients of substitution programmes. Work-out a maximum of 5 steps to implement these rights and obligations at an existing programme.

- **HIV-testing**
  Make a plan for a 'black book' about HIV testing in hospitals.

- **A voice for drug users**
  Design a table of contents for the first two editions of a newsletter of a local drug user self-organisation. (Who will make the illustrations, who will write a guest-column).
  Think hard about who this newsletter is targeting, drug users, or non-drug users, or both?

- **The attitude of drug workers**
  Design a training course for drug workers concerning 'street-life' and drug use.
  Prepare the agenda for a meeting with the programme co-ordinator to discuss the course rules.

- **Police harassment**
  Develop a strategy to make contact with the police chief without getting 'into trouble'. Prepare an agenda for the meeting.

- **Accessibility to clean injecting equipment**
  Organise a public demonstration of how needle exchange occurs.
  How do you obtain free needles? How do you organise drug users to come and exchange syringes? How do you inform the press? How do you plea for a greater variety of needles at the exchange programme?

Chasing the dragon

(from Mainline, special edition VIIIth International Conference on AIDS Amsterdam, July 1992)

Two-thirds of all heroin users chase the dragon. Yet little is known about it. Does the aluminium foil give off harmful fumes? What happens when the dope is cut with something else? And how much dope do you lose when you chase the dragon? The views of some users, a doctor and a laboratory analyst.

It started off as a rage in Hong Kong early in the fifties. It got called chui lung, which means chasing the dragon. Because the spiralling smoke looks like a dragon's tail. The fumes are inhaled through a small tube. In Holland smoking heroin only started to become popular in the seventies when the main supply of heroin came from China. That's why chasing the dragon has become known as 'chinezen' (Chinesing) in Holland. A good two-thirds of all users in Amsterdam take their heroin Chinese-style.
Carlos has been chasing the dragon right from the start, fift een years ago now. "I came to Holland from Surinam and was taken in by an aunt. I spent a lot of time with my two cousins. Smoking grass, and hanging around the streets a bit. One of my cousins had a chromium-plated convertible Chevrolet in perfect condition. Those were the days, man! All the dope you wanted, beautiful women, and evenings dancing in Marcanti. Both my cousins were users already, so I asked them once could I try it, chasing the dragon. One thing led to another.
I've never done anything else but smoke it, earlier on in cigarettes as well, but usually on foil. There aren't that many Surinamers who shoot up, I only know a few. It's much more common with Dutch kids. They often begin with the needle."
Joop began with the needle. "I was six-teen when I had my first shot. After two weeks I could fix without any help. I didn't think of smoking the dope. I didn't even smoke cigarettes. I only started doing that a few years later." For ten years Joop shot up. First only heroin, later on coke and cocktails as well. A year and a half ago he stopped injecting and started chasing the dragon instead. "It was my veins, you see. I didn't have easy veins to start with, but in the end I didn't have any left that I could use. I always shed a lot of blood, and of course I went on trying, because you want your hit no matter what it costs. Certainly if you're on coke. I stopped with coke first, because that just got completely out of control. A couple of months later I stopped shooting up. I hadn't had that blissful flashout for years anyway. Chasing the dragon suits me better. It's also better for my health."

Extra filter
Chasing the dragon is less of a health risk than mainlining. When you shoot up everything goes straight into the blood-stream: not just the heroin, but also any-thing it's been cut with and any other toxic substances. Using a swab of cotton wool can give you a degree of protection against most of these substances, but a lot can still come

through the needle itself and so go straight into the blood. In any case all soluble elements and anything that is extremely small, bacteria for in-stance. It's the shit and bacteria that comes with the shot that cause all the misery that many mainliners experience: abscesses, the shakes, blood poisoning. Chasing the dragon means that no toxic substances can get into the blood-stream directly. You have an extra filter, your lungs. The inhaled heroin fumes enter the lungs via the air passages. And the pulmonary blood vessels absorb the heroin. Only after that does it enter the blood-stream. Many people ask: even if those toxic substances don't all enter my blood-stream directly, aren't they just as damaging for my lungs?
"I've never come across a lung problem that was only caused by smoking heroin," says doctor Krish Kanhai. He has been working for eight years for the Health Authority as a doctor specialised in drugs and he is quite clear on possible risks for the lungs of smoking heroin. "Don't get me wrong, it isn't healthy. Smoking is always bad for the air passages, whether it is tobacco, marihuana or heroin." He stashes his pack of cigarettes and continues. "The fumes of some substances that are present in the dope can cause the air passages to contract. The air passages can also become irritated. All this together can lead to bronchial complaints. A lot of people get an increased production of phlegm. Heroin suppresses the tickle in the throat, which means you don't cough up all that phlegm. This causes it to accumulate lower down and this can lead to pneumonia. But that's not something you get easily. Only if someone already has poor health or has been sleeping out-side in the cold or doesn't look after him-self properly, do you get problems like that. This doesn't come from chasing the dragon but from other reasons."
It's a different matter when someone already has lung problems. "Chasing the dragon can be dangerous for someone who has a tendency to bronchial asthma. It can give you a severe attack. I know two people who choked to death during an attack like that." But in general Kanhai does not regard chasing the dragon as a health risk: "In any case it is safer than shooting up."

White chocolate
The foil is to someone who smokes what the works are to the mainliner. Only it is less complicated. A syringe must have a sterile wrapping, a good rubber and a sharp needle. With foil you don't have to be so careful. As long as the foil is metal and can be heated well and gradually. In practise a roll of kitchen foil is the best. The thicker the better. "When I don't have any foil," Carlos says, "I buy it on the street from hustlers who sell it or from a fish stall. And sometimes I buy chocolate. Some brands of chocolate also have good silver paper. Galac's white chocolate, for instance, the kind without the rice. It's often bought just for the wrapping. That's why in places where people chase the dragon you often see bars of chocolate lying around. In case of need I sometimes use the foil in cigarette packs. First you have to burn off the paper and the foil is very thin. You can burn holes in it easy as anything. But when in need it will do."
First of all the piece of aluminium foil is made completely smooth. For instance with a piece of toilet paper. Then the dope can move freely round the foil. Some people

heat the foil a little before they put the heroin on it. This burns up the thin plastic layer on the foil. The plastic is there to prevent the foil from rusting and to make it easier to roll out. With its normal household use you don't have any problems with the plastic but inhaling burnt plastic is bad for your health. "Of course smoking plastic is harmful," says doctor Kanhai. "The same goes for the fumes of aluminium that has been burned through being heated too long. It is better let the plastic burn off the foil first."

A taste of the grave

Chasing the dragon has another plus point. People who smoke heroin can more easily tell the quality of their dope. Joop: "When you chase the dragon you can first try out a little bit and taste it to test whether you've got good stuff. When you mainline it's different. You dissolve the dope, fix a shot and all at once you've got it in you."

Good quality dope melts when you heat it, turns into a light brown oil and can move easily around the foil. Carlos: "If it leaves a trail of little black specks, then you're okay." When the oil sets it turns into a resin-like substance. The resin should be hard as glass and transparent. "It's also a good tip to take the drop of resin from the foil and hold it up to the light. If it comes easily off the foil without crumbling and if you can't see any impurities when you hold it up, then you can assume your dope is good." You can also tell good dope from the taste you get when you smoke it. "Some people say it's a taste that's bitter and sour at the same time. Other people say it tastes like putty. I think it has an unpleasant taste, a taste of the grave, but at least it's one you can recognise out of a thousand," Carlos says. "But the main test is whether you get stoned from it or not. And you can tell this with the first puff. If you don't feel any-thing with the first puff, then it's shit."

Skill

Not all kinds of heroin lend themselves easily to chasing the dragon. You'd think that Chinese heroin from the Far East would be the best to smoke. Because of the name and because Chinese heroin dominated the market at the time when chasing the dragon became popular in Holland. But it turns out that 'Turkish' heroin from countries like Pakistan and Afghanistan is more suitable. This kind of heroin is prepared in a different way from the Chinese. It only dissolves after some lemon juice or ascorbic acid has been added, but it makes an easier smoke.

H. Hauser from the forensic laboratory in Rijswijk came to the same conclusions. He did research into chasing the dragon. He placed different sorts of heroin and heroin cut with other substances on some foil and heated the samples with a lighter. In two seconds the temperature rose to six hundred degrees centigrade. Hauser collected the fumes and checked out the amount of heroin contained in each sample. The percentage of heroin in the fumes turned out to depend mainly on the kind: there is three times as much heroin in the fumes from Turkish heroin as there is in the Chinese. What the dope was cut with also proved to have a great influence on the quantity of heroin in the fumes. Cutting it with caffeine produces positive results: it increases the ease with which one can smoke the heroin. Caffeine already starts evaporating at a hundred degrees and one might say that it takes everything else with it. After heating a mixture of Turkish heroin and caffeine sometimes as much as three-quarters of the heroin remains in the fumes. All other ingredients (paracetamol, mannitol, strychnine, lactose and glucose) that the heroin is cut with diminish the proportion of heroin in the smoke. When heroin is cut with noscapine (which is a by-product of careless preparation of the heroin) the percentage of heroin in the fumes is a third less.
In theory it's possible that someone will get more stoned from chasing the dragon with weak heroin that has been cut correctly than with much stronger heroin that has been cut with bad ingredients. The way in which it is heated is also very important for the effect. Heating it too quickly means more gets lost. The more skilful you are in smoking it, the more you get.

To each his style

"You have to learn to chase the dragon," says Joop. "I've noticed that I have a completely different style from Carlos who has been smoking much longer than me. You see, he smokes in a way that's very painstaking. He makes a tiny flame and succeeds in sucking in almost all the smoke. He can spend hours over one packet. I'm different. I'm much greedier and so I lose a lot of smoke. That's why I've lined the inside of my tube with aluminium foil. After I've smoked there's always a bit of red deposit left. That is pure dope that I haven't absorbed. I keep this foil for the next morning. First of all I heat up the deposit till it turns into a drop and then I smoke it.
"It suits me perfectly. It's more healthy and I get more pleasure out of my dope. I take longer over a packet and I still feel good. I am also more sociable. Smoking together is much more sociable than shooting up together, isn't it? You also feel more inclined to give some away. Compare it with someone who sits sociably at the bar and treats everyone to a round. That's totally different from someone sitting in the toilet on the sly and tossing back the contents of a hip-flask. I don't think of myself as a junkie any more, but as a user."

John-Peter Kools

(L. Synn Stern)

General advice:

No matter what drugs you use or do not use, the body requires nutrients from a wide range of sources and plenty of fluids to maintain and repair itself.
Vitamin-pills can supplement a poor diet, but cannot take the place of proper nutrition. Try to eat several servings from each of the four food groups daily. These are;

1. breads, cereals, pasta, rice and other grains
2. meat, poultry, fish, eggs, beans and nuts
3. fruits and vegetables
4. (butter)milk, cheese, (ice)cream, yoghurt, and other dairy products.

Take care that all meat, poultry (chicken, turkey, quail, etc.) fish and eggs are thoroughly cooked before you eat them. Meat can be eaten “pink”, but must be at least warm on the inside to insure that any bacteria is totally destroyed. Pork and poultry must be cooked white all the way to the bone.

Fresh fruits and vegetables have more nutrients than frozen ones; and frozen ones have more than those from jars or cans. Eat your fruit and vegetables either raw or lightly steamed to get the most nutritional value from them. Or try frying them quickly in a little oil or butter. Boiling reduces the amount of vitamins, but if you save and drink the water they are cooked in, you can get back some of the lost nutrients.

Fluids are essential to the body’s ability to maintain and repair itself, and many drug users do not get enough fluids. Most nutritionists recommend that you drink at least eight glasses of water a day. Juice, herb tea, lemonade or milk can substitute for water. Drinks which are high in caffeine (coffee, strong tea, cola) or alcohol (including wine and beer), take away as much fluid from the body as they bring. This does not mean you shouldn’t drink coffee of beer. It simply means that when you are figuring your fluid intake, don’t count these beverages.

Cigarette smokers, whether or not they use other drugs, are usually unable to absorb vitamin C from their foods as well as non-smokers. Therefore, people who use tobacco should make an effort to get extra vitamin C in their diet. (For injectors, this will pay off in less bruising and quicker healing of injection sites.) Foods like oranges, lemons, limes, grapefruit, tomatoes, broccoli, peppers and brussel sprouts are good sources of vitamin C.

Heroin and other opiates:

The biggest problem with opiate drugs is their constipating effect. Insuring that you get enough fluids and roughage usually helps. This means drinking at least eight glasses of water per day and eating several servings of whole grains (brown bread, whole wheat pasta, bran cereal, brown rice), and fruits and vegetables each day. The only exception to this rule is bananas which (although a fruit), can cause constipation rather than prevent it.

Speed, cocaine and other stimulants:

These drugs are dehydrating, and very effective appetite suppressants. It is important to remember to eat and drink when using stimulants, even if you don't feel like it. A good tip is to have small sips of cold beverages, and little bits of cold, calorie-rich foods (like ice cream and milk shakes) throughout the day. This is better than trying to choke down a full hot meal. For stimulant users, insuring proper fluid intake is essential to good health. This way you avoid the cramping muscles and skin rashes which can accompany a long speed run, and the tooth decay which does not have to be automatically associated with speed.

Problems:

Fever/Nausea

- If the smell of food/drinks produces nausea, stay away from the kitchen when anything is cooking, and eat/drink your nutrients cold.
- Eat small amounts regularly throughout the day, and do not drink more than a few sips at the time during your meals.
- Try eating crackers, dry toast or dry cereal immediately after waking.
- Do not lie down for more than two hours after eating.
- Avoid fats. Instead try eating yoghurt, boiled eggs, oatmeal, or mashed potatoes.

Constipation

- Drink! Here is where celon irritants like caffeine and stimulants can help.
- If you use both stimulants and opiates, use your stimulant drugs first and wait with the opiates until you move your bowels - this may only take a few minutes.
- Get some exercise. Even walking a few extra blocks can stimulate a sluggish bowel into action.
- Try hot baths or hot compresses on your bottom.
- A diet rich in whole grains, raw fruit and vegetables can prevent a recurrence.

Diarrhoea

- Try the B.R.A.T. diet: bananas, rice, applesauce and toast, or eat plain boiled noodles, fish, gelatine, and baked or boiled potatoes.
- Replace lost fluids. Drink at least eight glasses of water or weak herb tea daily.
- Avoid caffeine (cola, coffee, tea), stimulants (speed, cocaine), fats, spicy food, whole grain foods and raw vegetables.

Loss of appetite

- Make every mouthful count. Try drinking milk, cocoa or juice instead of coffee, tea or water. For extra calories, add powdered milk to soups, cereal and bever ages; peanut butter, cheese or honey to your sandwiches, and top cereal, rice, noodles or potatoes with sour cream, butter, cheese, sauces and gravy.
- Eat several small meals, or even mouthfuls, instead of trying to sit through a heavy dinner.
- Eat whatever you want, whenever you want it. If you want spaghetti for break fast and toast for dinner - fine! Just keep eating and drinking.

Acid indigestion or gas

- Avoid fats and oils (margarine, butter, mayonnaise, salad dressing, cooking oil, doughnuts, fried foods, potato chips, most desserts, peanut butter), sausages, eggs, nuts and dairy products.
- Do not chew gum; this just fills your belly with more gas.
- Avoid onions, garlic, cabbage, broccoli, cauliflower, carbonated beverages (in cluding cola and beer), beans and spicy foods.

5 ANNEXES

(leaflet by MAINLINE, Amsterdam)

Winter time. It is cold. Rain, ice and wind attack the body. Sometimes fingers and toes can freeze at four degrees centigrade and because of alcohol and drug use some people don't always notice. Instead of shivering with chattering teeth they have the idea that they are warm. Without noticing it, you can become super cold and loose consciousness. Tips for surviving the winter.

Clothes
Put on all the clothes you can find - everything counts - the more layers, the more warmth. This includes (fingerless) gloves, pullovers, coats, socks, hats, T-shirts etc. Clothes and shoes should not be too small, and above all they should not be wet. If you cannot find enough clothes, you can place newspapers under your coat.
Only put gloves on when your hands are warm. If they are cold you should warm them first. This can be done by holding them under an armpit.

Hot liquids
Drinking hot tea, hot soup and hot chocolate are good ways of staying warm. They heat the inside of your body and prevent your fingers, toes, nose and ears from freezing. Drinking a lot is important - but it should be hot drinks.

Wetness
Wetness and dampness are disastrous when it is cold. So take care to avoid getting wet. Look for shelter when it rains or when there is a frost or snow. Flick snow off immediately. Take off wet socks and clothes and let them dry somewhere. You are better off being without socks if your socks are wet.

Places to sleep
If you are forced to sleep outside, try to find a warm, dry and above all, wind free place. Concrete or dry wood make good underlays. Don't lie on or against metal, it will make you cold. As a windscreen use cardboard boxes, full waste disposal bags or shelves. Foam rubber is probably the best material to use as an underlay - cardboard is generally too cold to lie on because it absorbs dampness.
When sleeping outside make yourself as small as possible; place your hands near your chest or between the legs. Keep your hat and gloves on and pull as many clothes or blankets as you can over yourself. If you are too cold don't lie down for too long - try to find a better place. If you don't succeed, ensure that you don't lay down too long. Walk around a little each time you wake up. Don't walk too fast because sweating makes you even colder. If there are two of you, lie down close to each other. If you are afraid that you will freeze without noticing it, agree that you will wake each other up.

Freezing

White and senseless fingers, toes, nose or ears are symptoms of congelation. Ensure they are warm as soon as possible. Frozen fingers can be warmed under your armpit. For frozen toes it is best to start walking slowly. If your nose is frozen, place your hands around it . And for frozen ears, pull your cap down so that they are covered. Find a warm spot as soon as possible. Once fingers and toes have been frozen they can easily freeze again.

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COLOPHON

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of AIDS prevention by peer support
in intravenous drug user communities'
supported by the **European Commission**

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'IN CASE OF...' (a selection)

A no clean needles are available

B no bleach is available

A no fresh tap water is available

B a shot of cocaine and the needle clogs

A a shot of heroine and the needle clogs

B the syringe has a bad vacuum (piston/plunger leaks)

A the needle has a wire-edge (burr)

B no drugs and 10 clean needles and syringes

A no spoon is available

B no fresh cotton is available

A no alcohol swab is available

B the plunger cannot be pulled back any further

A you notice you hit next to the vein (bubble)?

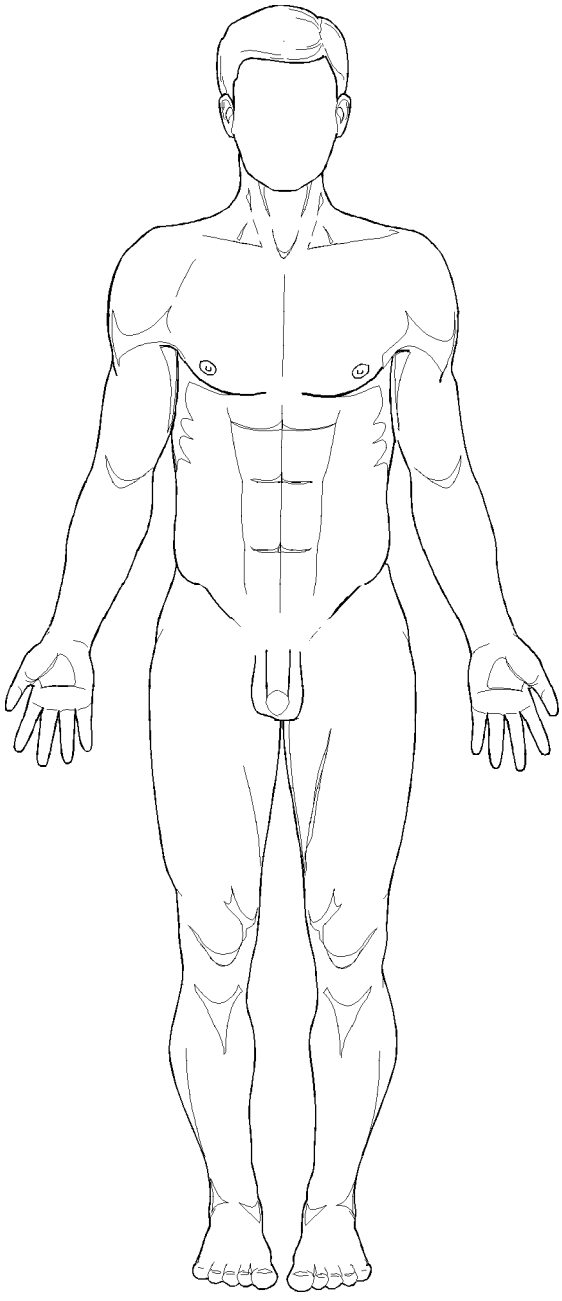
B you have difficult veins; hard, rolling, deep laying

A you do not have a quiet place of your own.

B you have an abscess

A you hit an artery

where to inject



Please judge and mark the possible injecting spots according to the following standards:

1 = well suitable
2 = only in an emergency
3 = risky
4 = never

SAFER SEX 2

Sexual or not

participants sheet

Write down the words mentioned in one of the columns.

SEXUAL	NOT SEXUAL

1. Do you think you are 'good' in bed?

2.Did you ever play 'doctors and nurses or any other forbidden games?

3. Do you think there is a difference between what men and women experience during making love?

4. Do you talk occasionally about your sexual experiences?

5. Do you communicate what you like to your partner when you are making love?

6. Have you ever been afraid of your sexual feelings?

7. What does promiscuity mean to you?

8. Do you feel that your ideas about sex are further developed than your behaviour?

9. Do you have sexual dreams?

10. Have you ever wondered how your parents make love? And how your children make love?

11. In a movie you see an extended scene of homosexual love making; what does that do to you?

12. Do you sometimes punish your partner by refusing sex?

13. Do you like to be touched, caressed?

14. What do you prefer: to tempt or to be tempted?

15. Do you tell your children about your sexual feelings?

16. Do you know what makes you horny?

17. Do you fuck during your period?

18. Do you consider it a sign of weakness to look for help for a sexual problem?

19. Have you ever had a fight about sex?

20. What do you think about extra-marital relations?

21. Should people stay together for the 'sake of the kids'?

22. What do pornographic photographs and films to you?

23. Do you only fall in love with people who are in love with you?

24. Have you ever been afraid that you were homosexual?

25. Have you ever kept a relationship/ affair secret from your parents and/or partner?

26. In what way do you like to be hugged most?

27. Do you day dream a lot?

28. Do you like body fragrance?

29. Have you ever been afraid that you or your partner was pregnant?

30. What was your most unpleasant sexual experience?

31. What do you think about oral sex?

32. If your partner wanted anal sex, would you do it?

33. Are you satisfied with your 'sexual equipment'?

34. Do you know and do you like your partner's taste?

35. Do you 'checkout' good looking people from the same sex?

36. If your partner had another lover, how would you react?

37. How do you feel if a person of the same sex feels attracted to you?

38. Were you hugged a lot by your parents? Do you hug your children a lot?

39. Can you accept that your partner does not want sex without feeling rejected?

40. Whatt do you think of the taste of your partner's genitals?

41. How often do you masturbate?

42. Can you show your affection as well with your body as with words?

43. Does somebody's voice have a sexual impact on you?

44. What do you think of vibrators and other sex-toys?

45. Do you get jealous easily?

46. What does the size of your penis or your breasts means to you?

47. Do you see your partner's need for independence as a rejection of their relationship with you?

48. Do you ever go somewhere to meet sex partners?

49. Tell something about your homosexual experiences?

50. Which sexual position do you prefer and why?

51. Why do you fuck?

52. Do you think you are as sexy as other people?

53. Where you desired as a baby and of the desired gender?

54. Have you ever felt exploited in a sexual relationship and have you ever exploited someone?

55. Have you ever had sexually transmitted disease?

56. For men: Have you ever been to a prostitute?
For women: What do you think if your partner visited a prostitute?

57. Have you ever fucked without contraception?

58. Have you ever pretended that you were coming?

59. What fantasies do you have when you make love?

60. Do you masturbate occasionally in your partner's presence?

Instructions for condom use

Instructions for condom use

- Check if you have the right condom:
  - is it for vaginal, oral or anal sex; if you require it for anal sex, use only special, thicker condoms.
  - is it big enough?
  - is the brand registered and approved?
  - check the expiry date.

- Open the package carefully:
  - not with teeth or scissors. This will avoid tearing the condom.

- Take out the condom:
  - be extra careful if you have long nails
  - make sure you have the condom the right way up (i.e. not inside out).

- The tip (for semen reservoir), should be squeezed so that there is no air left
  - this will decrease the chance of the condom tearing as the reservoir will not come under pressure
  - if the condom has no tip make one yourself by squeezing the air out of the top of the condom (1-3 cm).

- Put the condom on top of the penis and unroll it carefully to the base of the penis
  - wait until the penis is completely hard before putting the condom on when fully unrolled there is less chance that the condom will slip off
  - again, be careful if you have long nails.

- Use only a water based lubricant
  - always use lubricant for anal penetration
  - a non water based lubricant will perish the condom. Do **not use** Vaseline, hand cream, body lotion, oil or butter.

- Withdraw the penis carefully, immediately after ejaculating. While withdrawing, hold the condom at the base of the penis to avoid it slipping off
  - if you wait too long before withdrawing the penis becomes soft, the con-dom slips off and the semen drips out.

- Tie a knot in the condom and dispose of it.
  - Do not flush it down the toilet as condoms can block drain pipes.

Use a new condom each time you start fucking. Never use two condoms on top of one another: This can cause condoms to tear.

The safer sex debate
participants sheet

Write down the arguments for condom use and keep in mind that your partner will probably not agree with you.

Short stories PRO condom use

"You have been 'checking out' a gorgeous guy/girl for the past few weeks. Finally, you both have met and 'fallen in love'. After an EXITING night out you find yourself in bed wanting to fuck. You want to use a condom but you are not sure how to raise the subject. The last thing you want is to say is that you are HIV positive. Convince your partner to use a condom".

"You are having your period (it's the first day, so lots of blood). It is your last night in Amsterdam and your final chance for romance with the sexy man you met in the hotel. You know he has a history of drug use and a regular partner with high risk behaviour. It's 1.30 in the morning and you have only one hour before he has to return home to his fiancee. There are no condoms available. What do you do?"

"After months of heavy quarrels about money and drug use with your partner, the situation has become unbearable and you leave the house. You are lucky to find a place to sleep at one of your friends' houses. After being his guest for a week, he wants you to have sex with him in 'payment' for rent. When you are in bed with him it appears that he does not want to use a condom".

The safer sex debate
participants sheet

Write below the arguments against condom use and keep in mind that your 'partner' probably will not agree with you.

Short stories CONTRA condom use.

"You have been 'checking out' a gorgeous guy/girl for the past few weeks. Now you both have met and 'fallen in love'. After an exciting night out you find yourself in bed and wanting to fuck. You hate condoms and you are not going to use them because you are not HIV positive. Then your partner proposes using a condom. Explain why you don't want to use it".

"You and your girlfriend have been using drugs for the past 10 years. Your girlfriend works 'on the street' and is making enough money to supply both of you with drugs. She has kept you from becoming 'dope sick'. One night she suddenly says that she wants to use condoms. You are surprised because condoms are only for clients. You refuse. "