



Supporting community action on AIDS in developing countries



# REACHING DRUG USERS

**A TOOLKIT FOR  
OUTREACH SERVICES**



## WHAT IS THE INTERNATIONAL HIV/AIDS ALLIANCE?

Established in 1993, the International HIV/AIDS Alliance (the Alliance) is a global alliance of nationally based organisations working to support community action on AIDS in developing countries. To date, we have provided support to organisations from more than 40 developing countries for more than 3,000 projects, reaching some of the poorest and most vulnerable communities with HIV prevention, care and support, and improved access to HIV treatment.

The Alliance's national members help local community groups and other NGOs to take action on HIV, and are supported by technical expertise, policy work, knowledge-sharing and fundraising carried out across the Alliance. In addition, the Alliance has extensive regional programmes, representative offices in the USA and Brussels, and works on a range of international activities such as support for South-South cooperation, operations research, training and good practice programme development, as well as policy analysis and advocacy.

This toolkit was developed in line with the International HIV/AIDS Alliance's Good Practice Guide on HIV and Drug Use: Community responses to injecting drug use. It forms part of a series of guides and programming standards which bring together evidence and expertise from our global community-level HIV programming to guide good practice in a range of technical areas. You can find the guide here: [www.aidsalliance.org/publicationsdetails.aspx?id=454](http://www.aidsalliance.org/publicationsdetails.aspx?id=454)



## ABOUT THE COMMUNITY ACTION ON HARM REDUCTION (CAHR) PROJECT

CAHR is an Alliance project that aims to expand HIV and harm reduction services to more than 180,000 injecting drug users, and their partners and children, in five countries: China, India, Indonesia, Kenya and Malaysia.

The project is made possible with support from the Ministry of Foreign Affairs of the government of the Netherlands.

The project involves people who use drugs in the design and delivery of services, and is advocating for the rights of people who use drugs. There is a strong focus on building the local capacity of community based organisations and sharing knowledge about what works.

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Cover photos:  
(Top) Peer educators at Banceuy Narcotics Prison, Indonesia. © International HIV/AIDS Alliance.

(Middle) A beneficiary of a needle exchange in Terengganu, Malaysia. © International HIV/AIDS Alliance

(Bottom) Outreach workers (on the left) provide needles to the client. © International HIV/AIDS Alliance in Ukraine

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The final editing was done by Kathryn O'Neill.

## ABBREVIATIONS

AA	Alcoholics Anonymous
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CBO	Community-based organisation
HIV	Human immunodeficiency virus
KANCO	Kenya AIDS NGOs Consortium
MAC	Malaysia AIDS Council
NA	Narcotics Anonymous
NGO	Non-governmental organisation
NIDA	The National Institute on Drug Abuse
OST	Opioid substitution therapy
PDI	Peer-driven intervention
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary counselling and testing
WHO	World Health Organization

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# INTRODUCTION

Three decades into the HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) epidemic, a decrease in the rate of new HIV infections has been observed globally. However, the sharing of injecting equipment among people who inject drugs – which is the main driver of HIV transmission in Asia, Eastern Europe, the Middle East and North Africa – is becoming a factor for HIV infection in other parts of the world too.<sup>1</sup>

In response to the changing situation, the International HIV/AIDS Alliance launched the Community Action on Harm Reduction (CAHR) project in 2011, funded by the Ministry of Foreign Affairs of the government of the Netherlands. The project aims to expand harm reduction services to more than 180,000 injecting drug users, their partners and children, in China, India, Indonesia, Kenya, and Malaysia.

Partner organisations in these countries – the Kenya AIDS NGOs Consortium (KANCO), the Malaysia AIDS Council (MAC), the International HIV/AIDS Alliance China<sup>2</sup>, the India International HIV/AIDS Alliance, and Rumah Cemara from Indonesia – use a community outreach approach, but have found a lack of information materials on outreach among people who use drugs.

During a capacity-building workshop for CAHR partners in Mombasa, Kenya, held on 8–9 November 2011, Kenyan NGOs and community-based organisations (CBOs) confirmed the need for a guide on outreach among people who use drugs, and suggested topics to be included.

This guide provides tips on how to do outreach work among communities of people who use drugs, in particular among injecting drug users. It includes suggestions on how to optimise the number of clients served by each outreach worker, in order to ensure cost effectiveness.

This is not a comprehensive and detailed manual, but rather a guide on how to start and scale up this type of outreach. For illustration, some examples are provided from Ukrainian NGOs doing community-based outreach. A significant recent decrease in HIV infections among people who inject drugs in Ukraine, as a result of expansion of the harm reduction programme, was acknowledged in the *2010 UNAIDS report on the global AIDS epidemic*.<sup>3</sup>

Recommendations provided in this guide are in line with *Good practice HIV programming standards* developed and published by the International HIV/AIDS Alliance in 2010.

Needle and syringe programmes provided through outreach increase access to clean injecting equipment, condoms, and information about safer sexual and injecting practices for people who use drugs and their sexual partners. When we do this work, we advance the Alliance's standard: "Our organisation promotes and/or provides access to clean injecting equipment, condoms, and information about safe injecting and safe sex for people who use drugs and their sexual partners".<sup>4</sup>

## KEY TO ICONS USED IN THIS GUIDE



### KEY RESOURCE



### EXAMPLE



### KEY MESSAGE



### KEY RESOURCE

International HIV/AIDS Alliance (2010), *Good practice HIV programming standards*. Available at: [www.aidsalliance.org/publicationsdetails.aspx?id=451](http://www.aidsalliance.org/publicationsdetails.aspx?id=451)

1. UNAIDS (2010), *Global report: UNAIDS report on the global AIDS epidemic*, Geneva, Switzerland. Available at: [www.unaids.org/en/](http://www.unaids.org/en/)

2. International HIV/AIDS Alliance China is the CAHR partner at the time of going to print. In 2013 the Alliance will welcome AIDS Care China as a new Linking Organisation, and the work under the CAHR programme will continue with AIDS Care China as the country partner.

3. See note 1.

4. International HIV/AIDS Alliance (2010), *Good practice HIV programming standards*. Available at: [www.aidsalliance.org/publicationsdetails.aspx?id=451](http://www.aidsalliance.org/publicationsdetails.aspx?id=451)



Evidence shows that outreach using peers has been effective in reaching drug users and providing them with the means to adopt safer practices.<sup>5</sup> The guide emphasises the need to involve people who use drugs in outreach, not only as service providers but also in the assessment, planning and evaluation of the intervention. This responds to the Alliance's good practice standard: "People who use drugs participate in our programming and decision-making".<sup>6</sup>

## WHO IS THIS GUIDE FOR?

This guide was written for people setting up outreach projects or services for people who use drugs: project coordinators, outreach workers and their supervisors.

## WHAT IS OUTREACH?

Outreach is a client-oriented and community-based harm reduction method that makes contact with and provides health and social services to people who use drugs in their natural settings or territory.<sup>7</sup> Outreach helps make contact with individuals who are hard to reach, without waiting for them to come to services. It is often referred to as an entry point into the community, or from the perspective of a person using drugs, an entry point to services.

Outreach takes our services out into communities and households where HIV is most directly experienced by people. Because drug use is illegal in most countries, people who use drugs can be hidden from mainstream life, and can be hard to reach with formal health services. Outreach is a method of reaching people who are our concern – in this case, people who use drugs – in order to provide health and support services.



An outreach worker (on the left) visits a client. © International HIV/AIDS Alliance in Ukraine

### KEY RESOURCE

International HIV/AIDS Alliance (2010), *HIV and drug use: community responses to injecting drug use and HIV. Good practice guide*. Available at: [www.aidsalliance.org/publicationsdetails.aspx?id=454](http://www.aidsalliance.org/publicationsdetails.aspx?id=454)

### KEY RESOURCE

WHO (2004), *Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*. Available at: [www.who.int/hiv/en](http://www.who.int/hiv/en)

### KEY MESSAGE

Outreach helps make contact with people who are "out of reach" either because of stigma and marginalisation, or because of lack of resources and limited access to health and social services.

5. World Health Organization (WHO) (2004), *Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*, Geneva, Switzerland. Available at: [www.who.int/hiv/en](http://www.who.int/hiv/en)

6. See note 4.

7. Korf, D.J., Riper, H., Freeman, M., Lewis, R., Grant, I., Jacob, I., et al. (1999), *Insights: outreach work among drug users in Europe: concepts, practice, and terminology*, Lisbon, Portugal: European Monitoring Centre for Drugs and Drug Addiction. Available at: [www.emcdda.europa.eu/html.cfm/index34000EN.html](http://www.emcdda.europa.eu/html.cfm/index34000EN.html)

Harm reduction programmes focus on preventing the harms associated with the use of psychoactive drugs, rather than on preventing drug use itself. Taking into account that many people cannot or do not want to stop using drugs, harm reduction interventions include provision of services and information to keep people healthy and safe.<sup>8</sup> Community-based outreach is an effective approach to deliver harm reduction services and information in a non-judgmental and friendly manner.

## WHAT CAN WE DO WITH OUTREACH?

HIV transmission is one of the greatest harms that result from unsafe injecting. As a harm reduction method, outreach helps us to reach people in order to reduce HIV transmission among people who use drugs and their sexual partners. Using outreach, we can provide people who use drugs with the means to adopt less risky practices and behaviours, including reducing the risk of transmitting or acquiring HIV and other blood-borne viruses related to shared injecting equipment and unprotected sex.

Hepatitis C and overdose are just some of the additional harms that result from unsafe injecting. Our outreach services can prevent hepatitis C transmission, and help to prevent and manage overdose as well.

With outreach, we provide commodities to help people inject safely and practice safe sex. We also provide information and support. People who use drugs need information about HIV, safe injecting, safe sex, and preventing overdose, along with information about where they can get treatment, care and support, and access to justice. When information comes from a trusted source, it is more powerful. Outreach workers are often peers or other trusted members of the community.

Importantly, outreach also helps to bring treatment services to people – either through mobile clinics, or outreach workers educating drug users about available health services and the effectiveness of treatment for HIV or drug dependency, for example. As we aim to scale up access to antiretroviral therapy (ART) and other treatment, outreach is the vital link between people who use drugs – many of whom are marginalised or fearful of using formal health services – and the health care system.



### KEY MESSAGE

“‘Harm Reduction’ refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption.”<sup>9</sup>



### KEY RESOURCE

IHRA (2010), *What is harm reduction? A position statement from the International Harm Reduction Association*. Available at: [www.ihra.net/files/2010/08/10/Briefing\\_What\\_is\\_HR\\_English.pdf](http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf)

8. International Harm Reduction Association. *What is harm reduction? A position statement from the International Harm Reduction Association*. Available at: [www.ihra.net/files/2010/08/10/Briefing\\_What\\_is\\_HR\\_English.pdf](http://www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf)

9. See note 8.

## DISTRIBUTING COMMODITIES THROUGH OUTREACH

The basic package of commodities we provide through outreach can include sterile syringes, condoms, and alcohol swabs. But depending on risk practices and the needs of people who use drugs, we can also distribute needles, sterile injecting water, cookers or spoons, tourniquets, and filters. Organisations may also provide bandages, cotton wool, disinfectants, bleach solution, vitamins, painkillers like aspirin, ointments for treating wounds and bacterial infections, or drugs to prevent an overdose (for example, Naloxone).



Commodities for distribution during outreach © International HIV/AIDS Alliance in Ukraine

It is recommended to provide sterile needles and syringes in the quantities demanded by people who use drugs without asking them to return used ones, but rather motivating clients to bring them back.<sup>10</sup>

In areas where lemon juice or vinegar is used as an acidifier, the project can offer single-use sachets of citric acid or ascorbic acid, together with education about their proper use, risks of sharing acidifiers, and risks of infections associated with the use of lemon juice or vinegar.<sup>11</sup>

When outreach workers provide services to people using non-injecting drugs, the package of commodities can include foil, individual stems, and pipes for smoking and drugs inhaling. It is also possible to teach people how to make their own equipment for smoking and inhaling.

If the outreach involves exchange of needles and syringes, the outreach workers need a puncture-resistant container. If this is not available, we can use empty plastic water bottles to collect used needles and syringes.

10. Strike, C., Leonard, L., Millson, M., Anstice, S., Berkeley, N., Medd, E. (2006), *Ontario needle exchange programs: best practice recommendations*, Toronto: Ontario Needle Exchange Coordinating Committee. Available at: [www.toronto.ca/health/cdc/factsheets/pdf/needlex\\_best\\_practices.pdf](http://www.toronto.ca/health/cdc/factsheets/pdf/needlex_best_practices.pdf)

11. World Health Organization (WHO) (2007), *Guide to starting and managing needle and syringe programmes*, Geneva, Switzerland: WHO. Available at: [www.unodc.org/documents/hiv-aids/NSP-GUIDE-WHO-UNODC.pdf](http://www.unodc.org/documents/hiv-aids/NSP-GUIDE-WHO-UNODC.pdf).





Puncture-resistant containers © International HIV/AIDS Alliance in Ukraine



Plastic bottle used as container © International HIV/AIDS Alliance in Ukraine

Plastic bottles can also be used for water purification in settings where fresh and clean running water is not easily available. Giving advice to rinse hands and clean injection sites before injecting, outreach workers can supply people with clean water or, if that is not possible, explain how to disinfect water by exposing it in clean plastic bottles to direct sunlight for six hours, keeping the bottles outside, preferably on a rooftop.<sup>12</sup>

12. World Health Organization (WHO) (2007), *Combating waterborne disease at the household level*, Geneva, Switzerland: WHO. Available at: [www.who.int/household\\_water/advocacy/combating\\_disease/en/index.html](http://www.who.int/household_water/advocacy/combating_disease/en/index.html)

The following services can be provided to people who use drugs and their partners through outreach:

- relevant and credible education and information regarding HIV, hepatitis B and C, sexually transmitted infections (STIs), health, and reduction of risks – both injecting-related risks and sexual risks
- clean injecting equipment, and collection of used equipment
- relevant and credible education and information about ART, drug dependency treatment and other treatment services such as for tuberculosis (TB), or treatment of opportunistic infections
- counselling for mental health, drug dependency, access to legal aid, sexual health, relationships, and family planning
- information on access to detoxication, rehabilitation, and care and support services
- referral to health, welfare and legal services
- self-help groups – such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)
- overdose prevention, including Naloxone administration.

If properly trained, outreach workers can be a reliable source of harm reduction information and services, not only to people who use drugs and their relatives but also to others such as people from the local community or neighbourhood where outreach takes place, the police, and representatives from different agencies providing services to drug users. Outreach workers can be opinion-makers and raise awareness of HIV and drug use among communities.

Services targeting the general population are not always sensitive towards people who use drugs. Because drug use is generally illegal, many drug users are afraid to come for services. When planning interventions for people who use drugs, it is important to address these fears by creating a safe environment and using a non-judgmental and supportive approach. It is important to ensure that our services are low threshold, accessible, and responsive to the needs of people who use drugs, both women and men. Although it is not always easy to provide outreach services in a safe environment, it is essential to treat people using drugs in a friendly and respectful manner.



An outreach worker (left) sits with 'Niko' and 'Omar' to provide harm reduction advice in relation to their drug use. Kenya © Nell Freeman for the Alliance



## KEY MESSAGE

Low-threshold services are:

- responsive to the lifestyle of people using drugs
- operating at a convenient time and in a suitable place
- confidential
- imposing few rules on clients
- free of charge.

## PREVENTING AND MANAGING OVERDOSE

Overdose is one of the leading causes of death among people who inject drugs. Overdose may happen when the body cannot handle the amount of a drug or mixture of drugs the person has taken. As a result, the central nervous system is not able to regulate vital life functions. The person may faint, stop breathing, have heart failure or experience seizures. Overdose can be lethal, but in most cases it is not, though there are a number of health harms that could be prevented if the appropriate measures are taken.<sup>13</sup>

Outreach workers can serve as key actors in overdose prevention and management. We may conduct individual and group discussions with people who use drugs to talk about factors that may lead to overdose and to find ways to reduce the risk of overdose.

We can give the following advice to people who use drugs during outreach:

- Understand your tolerance level and pay special attention when it is lower (for example, when you have not been using drugs for a certain period of time or do not have regular access to drugs, when you have gained or lost weight, when you are ill, etc).
- Try not to mix different types of drugs or mix them with alcohol.
- If you are taking any medications prescribed by a doctor, be aware of their interaction with street drugs, because mixing some medications with drugs may cause an overdose.
- Take care of your health: make sure you eat well, drink plenty of water, and get enough sleep.
- Try to buy drugs from one trusted dealer. If you have a new dealer or the supply is unfamiliar, check how strong it is by using a small amount.
- Make sure there are people around when you are using and there is help available if you overdose.

13. International Harm Reduction Association (2010), *Global state of harm reduction 2010: key issues for broadening the response*, London, UK. Available at: [www.ihra.net/global-state-of-harm-reduction-2010](http://www.ihra.net/global-state-of-harm-reduction-2010)

- When snorting or smoking drugs, you have a lower risk of overdose compared with injecting.<sup>14</sup>

While the aim of prevention activities is to reduce the risks of overdose, management means knowing what to do when an overdose has happened. During outreach, we should be able to recognise signs of overdose; identify what type of drugs the person has taken; and provide first aid if needed. We may also raise awareness and provide information on how to respond to overdose to people who use drugs and their family members.

We can try assessing the effects of the overdose in a number of ways:

- speaking louder to see if the person reacts
- seeing if the person responds to pain by slightly pinching the earlobes or pressing the sternum
- checking if the person is breathing by putting your ear closer to the person's mouth and nose, and listening for the sound of breathing while at the same time looking to see if the person's chest is rising.

We can conclude that the person has had an opioid overdose if we notice the following signs:

- the person cannot speak or has fainted
- the person's heartbeat, pulse and breathing are slow
- their lips and/or fingernails are blue and the face is pale
- the body is limp and we can hear choking sounds and croaky breathing.

In the event of an opioid overdose, this is what we need to do:

1. Perform rescue breathing (mouth-to-mouth resuscitation) to get oxygen into the person's lungs. Before doing so, check if there is anything in the person's mouth that may be obstructing their airway.
2. Lie the person in the recovery position (on one side, with one leg pulled up and the head leaning downward).
3. Call for medical help.
4. Administer an injection of Naloxone (opioid overdose antidote) in the person's upper arm or thigh.
5. Assess the situation and repeat steps if needed until the person is awake.

Though a stimulant overdose happens less often than an opioid one, we need to be ready to identify its symptoms as well. The person may faint, stop breathing, have seizures; the heart beats fast and may cause a heart attack or stroke. We can take the steps described above, but it is not necessary to administer Naloxone, as this does not work in the event of a stimulant overdose.<sup>15</sup>



## KEY RESOURCES

Curtis, M. and Guterman, L. (2009), *Overdose prevention and response. A guide for people who use drugs and harm reduction staff in Eastern Europe and Central Asia*. New York: Open Society Institute. Available at: [www.soros.org/reports/overdose-prevention-and-response](http://www.soros.org/reports/overdose-prevention-and-response)

Short videos "how to deal with overdose"

<http://www.youtube.com/watch?v=642Yjvtw-GA>

<http://www.youtube.com/watch?v=U1frPJoW>

<http://www.youtube.com/watch?v=4iZlfQi7Rhs>

14. Curtis, M. and Guterman, L. (2009), *Overdose prevention and response. A guide for people who use drugs and harm reduction staff in Eastern Europe and Central Asia*, New York: Open Society Institute. Available at: [www.soros.org/reports/overdose-prevention-and-response](http://www.soros.org/reports/overdose-prevention-and-response)

15. See note 14.

## WHO CAN BE AN OUTREACH WORKER?

The role of an outreach worker is very important in harm reduction programmes: they bring first-hand information on health, safe injecting, and health and support services, along with commodities such as clean injecting equipment and condoms.

The outreach worker can be either a professional who has been trained in drug use issues or a drug user who has been trained in peer education, HIV prevention and harm reduction.

Trained professionals such as social workers, lawyers, drug and alcohol workers, health educators, psychologists, youth workers, doctors and nurses bring technical expertise – for example, in counselling, treatment, care, rights and laws, health education and other issues. They may also act as advocates for the target population among their colleagues, the general population, and when dealing with the authorities. But often it takes time for them to become trusted in the drug use community and gain access to potential clients; it may also be difficult and unsafe for them to find the places where drug users meet.



Peer educators at Banceuy Narcotics Prison, Indonesia.  
© International HIV/AIDS Alliance

Active or former drug users often know better how to reach people who use drugs. They may be more likely to understand the language and norms of the local drug scene, to have informal contacts with potential clients, and may be able to build more trusting relationships with people who use drugs than professionals can. Their personal experience of drug use gives them credibility among other drug users and access to high-risk sites. They can also serve as a role model to other drug users. But there are some risks as well. Former drug users have a danger of relapse into drug use, especially during constant contact with active drug users. Outreach workers who use drugs may confront problems with the police, and there are possible difficulties with following the schedule of working hours, so they may require extra support from their organisation.



### KEY MESSAGE

Programmes may greatly benefit from involvement of people who use drugs in their implementation. It helps to reduce prejudice towards drug users, ensures appropriate services, and builds up drug users' ownership of the programme.<sup>16</sup>



### KEY RESOURCES

Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute (2008), *"Nothing about us without us": Greater, meaningful involvement of people who use illegal drugs: a public health, ethical, and human rights imperative*. Available at: [www.aidsalliance.org/publicationsdetails.aspx?id=310](http://www.aidsalliance.org/publicationsdetails.aspx?id=310)

16. Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute (2008), *"Nothing about us without us": Greater, meaningful involvement of people who use illegal drugs: a public health, ethical, and human rights imperative*. Available at: [www.aidsalliance.org/publicationsdetails.aspx?id=310](http://www.aidsalliance.org/publicationsdetails.aspx?id=310)





Suharizal is an outreach worker with people who use drugs and a former drug user, Malaysia  
© International HIV/AIDS Alliance

The programme benefits from the involvement of professionals and people who use drugs in the outreach team as they bring different skills and knowledge, including:

- knowledge and experience of drug use
- counselling and listening skills
- HIV and harm reduction knowledge
- case management skills
- first aid or other health care skills
- specific knowledge in medicine, psychology, social work, law, drug and alcohol addiction, etc
- advocacy skills to involve stakeholders and develop linkages and networks for expanding the range of services
- negotiation skills.

This list is not exhaustive. The mix of knowledge and skills within the outreach team ensures that existing clients receive regular, professional delivery of information and messages, along with commodities. This is also a good option for sharing responsibilities and using different approaches to outreach work.

## WHO ARE WE TRYING TO REACH?

While targeting people who use drugs, harm reduction projects may provide services to more than one population group, such as:

- people who use drugs, including recreational drug users
- injecting drug users, including women who inject
- children and young people who use drugs
- people who prepare and sell drugs to others
- injecting drug users who are involved in sex work
- partners of people who use drugs (those they share injection equipment with as well as sexual partners)



### KEY RESOURCES

Video 'Somebody's mother, somebody's brother'  
[www.youtube.com/watch?v=jwDAiX2dut0&list=UUxsoS3S0BLTFYmGGjN1V6IA&index=3&feature=plcp](https://www.youtube.com/watch?v=jwDAiX2dut0&list=UUxsoS3S0BLTFYmGGjN1V6IA&index=3&feature=plcp)

- migrant or mobile populations
- people in prisons or detention centres
- homeless people who use drugs or those working and living on the streets, including street children.

Some people who use drugs may have different social roles and risk practices that may make them vulnerable at a number of levels.<sup>17</sup> For example, when speaking about a woman as a person receiving HIV prevention services through outreach, she could be a partner of a drug user and/or use drugs herself, she may have children, she may be HIV positive, or she may be involved in commercial sex work. These different factors all define her needs, behaviours and risk factors, and determine the services she may need. That is why it is important for practitioners to identify what sub-groups of people they are going to target in order to propose services based on their needs.




Malaysian AIDS Council partners doing outreach work with injecting drug users  
© Malaysian AIDS Council

## POINTS OF SERVICE

Comprehensive harm reduction projects provide a range of services for clients. Services must be available and accessible to new and existing clients. Therefore, outreach is often combined with fixed sites, drop-in centres or mobile units. Outreach services can act as a link between all service points.

*What is street work/outreach?* A way of reaching people who use drugs that involves visiting clients on their territory along previously chosen routes.

In most cases, outreach consists of a team of two people with a backpack or bag containing sterile injecting equipment, a puncture-resistant container for used needles and syringes (if the project includes a needle-syringe exchange service), information leaflets and other printed media, and condoms and lubricants.



### KEY RESOURCES

To find out more about the needs of specific groups, see: International HIV/AIDS Alliance (2010), *HIV and drug use: community responses to injecting drug use and HIV. Good practice guide*. Available at: [www.aidsalliance.org/publicationsdetails.aspx?id=454](http://www.aidsalliance.org/publicationsdetails.aspx?id=454)

17. International HIV/AIDS Alliance (2010), *HIV and drug use: community responses to injecting drug use and HIV. Good practice guide*. Available at: [www.aidsalliance.org/publicationsdetails.aspx?id=454](http://www.aidsalliance.org/publicationsdetails.aspx?id=454).



Materials at a drop-in centre for people who use drugs. Emei, China © International HIV/AIDS Alliance

The workers visit locations where people using drugs gather along a specific route, and on a specified date and time, which can be previously agreed with clients. Outreach workers make contact with clients and encourage them into more comprehensive services.

**What is a fixed site?** A specific place with a caring and friendly environment, where people who use drugs can receive injection equipment and condoms, dispose of used equipment, and get support and information from project staff.

Fixed sites can be drop-in centres, community centres (chill-out facilities), pharmacies, or specialised voluntary counselling and testing (VCT) centres, which are closely linked to outreach services in the area.

Location, access and environment should be the first concerns when establishing a fixed site. It needs to be convenient for clients, as it is vital that drug users feel comfortable about visiting the site. Needle and syringe programmes at fixed sites are low threshold – they offer a “safe place” to receive clean needles and syringes, condoms and information about HIV, and referral to other services in a friendly atmosphere. They should be responsive to the needs of drug users from different groups and located in places where they live or spend time. They should have opening hours that match the daily patterns of the local drug-using community.

Easy access allows for a quick-stop service for those drug users who may be cautious of greater interaction and education. A fixed site could be located close

to or within a neighbourhood where drug-buying and selling are common, or in neighbourhoods with high concentrations of people who use drugs. It is good when the location for the fixed site is relatively discreet, so that people who use drugs can visit it without being noticed by the police or general public.

It can be helpful to offer additional services at a fixed site, such as voluntary counselling and testing for HIV and other blood-borne viruses, legal services, health care and health services for TB and STIs, family or parental support services, and overdose prevention and management.

Needle and syringe programmes provided through pharmacies are another example of low-threshold services because they are easy to access and are often open longer hours than street outreach or mobile units. They can also be more confidential for people who use drugs, when people are worried that their drug use or HIV status will be assumed by local communities because they are using the local needle and syringe programme.



## EXAMPLE

The first Ukrainian pilot project delivering syringes to people who use drugs through pharmacies started in Kiev in 2007. Following that, the programme was scaled up to other parts of the country. At the initial stage there were some barriers such as prejudice of some pharmacists towards “crowds of drug users coming to the pharmacy for services”. But this attitude

changed after training where the pharmacists learnt communication techniques and the principles of harm reduction, enabling them to communicate effectively with people who use drugs. Outreach workers also train people who use drugs and use the pharmacy-based service on how to collect and bring needles and syringes safely.



A pharmacist is giving out a package with clean injecting equipment to a drug user  
© International HIV/AIDS Alliance in Ukraine

*What is a mobile unit?* A van or a bus that brings a range of health and harm reduction services directly to clients, on the street. Mobile units usually work

regular hours along regular routes, often at night when sex workers are working and when drug users are busy buying, selling and using drugs. Visits to specific destinations can also be requested by clients. We need to consider safety though, and only do night-time outreach when outreach workers have good rapport with clients and people are already familiar with them.

Sometimes mobile units also act as mobile clinics or VCT centres, as they can transport nurses, counsellors and other health care workers along with outreach workers. Specially equipped vans or buses give an opportunity not only to provide needles and syringes to people who use drugs in remote areas, but also medical services such as testing for HIV, STIs, cervical cancer screening, immunisation (for example, against hepatitis B), family planning, and emergency services. Depending on resources available, it is possible to organise screening for TB and even provide dental services. It is good to have a first aid kit in the mobile unit, which should contain Naloxone doses, to provide first aid on the spot and be able to respond in the event of a drug user experiencing an overdose.

A mobile unit usually works best together with outreach services when outreach workers scatter into the area close to the mobile unit's parking space, and invite clients and potential clients to use services. Outreach workers can also identify clients prior to the mobile unit's scheduled arrival and let them know about the services available in the mobile unit.

Mobile units may be more expensive than a fixed site. They need to be purchased and require running and maintenance costs. They also require storage space for supplies. However, mobile units are more flexible and are helpful for reaching large numbers of people in more than one location. It is a very convenient way to get health services to people who cannot come to the health services, or who fear stigmatising attitudes and practices if they do access mainstream health services.

In settings with large numbers of drug users, a comprehensive programme might have a combination of one or several fixed site services, a mobile unit and outreach services. This helps to increase their coverage, especially over large areas, and expands the range of services available to drug users. A combination of different points of service also means clients have more choice and can access services in different locations.



Mobile unit: a bus with two rooms for counselling and medical examination.  
© International HIV/AIDS Alliance in Ukraine



## MODELS OF OUTREACH

Outreach models are based on a combination of approaches that include activities to reduce individual risk and influence the behaviours, beliefs and norms of the networks of people using drugs.<sup>18</sup>

Community-based outreach programmes targeting people who use drugs may vary depending on:

- the types and number of people to reach (injectors or non-injectors, young people, stimulant users, etc)
- the sites for outreach work (streets, residences of people who use drugs, slams, “shooting hotspots”, etc)
- the commodities provided (syringes, needles, condoms, bleach, risk reduction information, alcohol swabs, spoons, cookers, tourniquets)
- other services through referrals
- outreach workers’ roles and responsibilities and the nature of training they receive
- the types of drug users’ sub-groups whom outreach is going to reach
- the organisations involved in service provision (NGOs, government organisations)
- the supervision and management of outreach workers and peer educators; monitoring and evaluation system.<sup>19</sup>

This guide describes four of the best-known outreach models:

- the indigenous leader model
- community-based outreach model
- peer-driven intervention
- secondary needle exchange.

If you want to know about other models, see the World Health Organization (WHO) guide, *Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users* (pp. 28–30).

### The indigenous leader model

Projects based on the indigenous leader model developed at the University of Illinois employ indigenous outreach workers acting as key opinion-leaders among their peers. They are considered by people who use drugs as a reliable source of information and can influence the opinions of their peers.<sup>20</sup> The leaders are selected through initial contacts, undergo individual risk assessment, receive basic harm reduction information, and can then spread information further among their peers.<sup>21</sup> The special feature of this model is that the leaders should be really popular among their peers and the selection process involves discussions with people who use drugs to understand whose opinion they trust.

### The community-based outreach model

The National Institute on Drug Abuse (NIDA)’s community-based outreach model widens the role of outreach workers. They serve as role models, educators and advocates, providing services to people who use drugs at the most convenient place and time. Outreach workers provide risk reduction counselling, information materials, and commodities that reduce risks such as syringes, condoms



### KEY RESOURCES

WHO (2004), *Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*. Geneva, Switzerland. Available at: [www.who.int/hiv/en](http://www.who.int/hiv/en)

18. World Health Organization (WHO) (2004), *Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*, Geneva, Switzerland: WHO. Available at: [www.who.int/hiv/pub/idu/idu/en/](http://www.who.int/hiv/pub/idu/idu/en/)

19. See note 18.

20. Rhodes, T. (1996), *Outreach work with drug users: principles and practice*, Council of Europe Publishing.

21. Kitsenko, N. and Volik, A. (n.d.), *Outreach and counselling*, Ukraine. Russian. Available at: [www.aidsfiles.net.ua](http://www.aidsfiles.net.ua)

and alcohol swabs; they also facilitate access to HIV testing and counselling and other medical services. This model includes two informational sessions for clients. The first provides basic information about the prevention and transmission of HIV, hepatitis and STIs, and usually takes place before testing for HIV. The second session, held after the testing, tries to reinforce and support behaviour change and involves discussions around how to reduce risks.<sup>22</sup>

Sometimes, drug scenes (the places where drug users meet) are difficult to access. If there are no obvious places where drug users meet, the drug scene can be hidden and traditional outreach models may not work. This is sometimes the case in Ukraine, where the drug scene changes over time. At present, drug dealing is done mainly by telephone, and injecting takes place in private apartments. In order to reach the target group, secondary needle exchange and peer-driven intervention were introduced.

### The peer-driven intervention model

Peer-driven intervention is an outreach model targeting the social networks of people who use drugs rather than individuals. The aim is to recruit drug users from their networks, and to stimulate discussions on HIV risk reduction with each other. Active drug users are recruited to fulfill outreach tasks in exchange for monetary reward.<sup>23</sup> Peer-driven outreach models are effective in HIV prevention education, less expensive than traditional outreach models, and can be successful in reaching large numbers of drug users from diverse groups.<sup>24</sup> While secondary exchange volunteers just distribute commodities among their peers, people who use drugs and are involved in peer-driven interventions also educate their peers on topics related to HIV prevention and safer drug use.

Peer-driven intervention starts with the recruitment of a small number of people ('seeds') from specific networks of people using drugs: stimulant users, women using drugs, or drug users from one area using the same drug, etc. The 'seeds' receive comprehensive information on HIV prevention as well as training on how to educate peers, which is usually provided by trained NGO staff. They are also interviewed to assess their own risks and receive access to all the services provided by the NGO running the project. After that, the 'seeds' receive three coupons with contact details of the organisation to give to other people from their network, as well as a monetary reward. They recruit other people from their network, discuss risk reduction, pass on information they received during their training, and give out the coupons from the organisation.



### KEY RESOURCES

National Institute on Drug Abuse (2000), *The NIDA community-based outreach model: a manual to reduce the risk of HIV and other blood-borne infections in drug users*, Bethesda, MD, USA: National Institutes of Health. Available at: [archives.drugabuse.gov/CBOM/](http://archives.drugabuse.gov/CBOM/)



### KEY RESOURCES

Broadhead, R. (n.d), *Peer-driven intervention*, University of Connecticut, Center for Health Intervention and Prevention. Available at: [www.chip.uconn.edu/chipweb/pdfs/PDI%20Summary.pdf](http://www.chip.uconn.edu/chipweb/pdfs/PDI%20Summary.pdf)

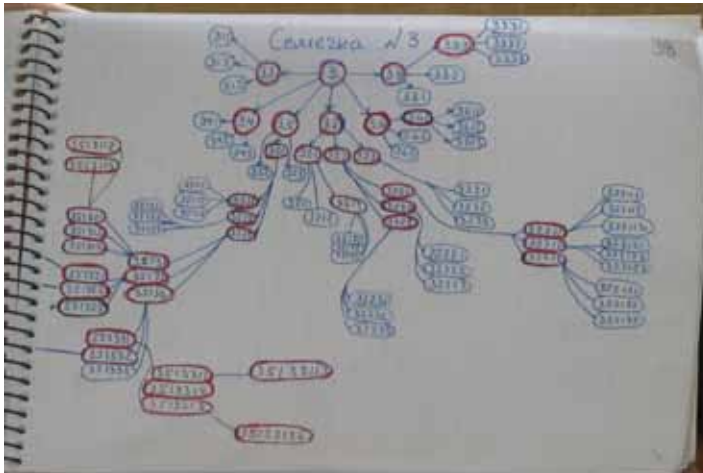
Broadhead, R. S., Heckathorn, D. D., Weakliem, D. L., et al. (1998), *Harnessing peer networks as an instrument for AIDS prevention: results from a peer-driven intervention*, *Public Health Reports*, 113 (Suppl. 1), pp. 42–57.

22. National Institute on Drug Abuse (2000), *The NIDA community-based outreach model: a manual to reduce the risk of HIV and other blood-borne infections in drug users*, Bethesda, MD, USA: National Institutes of Health. Available at: [archives.drugabuse.gov/pdf/CBOM/Manual.pdf](http://archives.drugabuse.gov/pdf/CBOM/Manual.pdf). Page 20.

23. See note 18.

24. Broadhead, R.S., Heckathorn, D.D., Weakliem, D.L., Anthony D.L., Madray, H., Mills, R.J., Hughes, J. (1998), *Harnessing peer networks as an instrument for AIDS prevention: results from a peer-driven intervention*, *Public Health Reports*, 113 (Suppl. 1), pp. 42–57. Page 21

The organisation recruits three individuals as 'seeds', who each receive three coupons to give out to their peers, reaching nine people in total. If those nine people each give out three coupons, the project reaches 27 people.<sup>25</sup> The process continues until there is broad coverage, and it becomes difficult for the project to find new clients in that area.



'Growing seeds' – shows scaling-up of peer-driven intervention that started with just three clients © International HIV/AIDS Alliance in Ukraine



## EXAMPLE

The International HIV/AIDS Alliance in Ukraine piloted the first projects based on the peer-driven intervention model in 2007 and successfully scaled up from five projects in 2007 to 20 in 2011. A total of 2,530 people who

use drugs received HIV prevention services using the peer-driven intervention model during 2011. Many of these people had not come into contact with HIV prevention activities prior to this intervention.

### The secondary needle exchange model

Secondary needle exchange is a model of needle and syringe exchange where people who use drugs receive a large number of clean syringes and needles for distribution among their peers who would not otherwise come to services to access these commodities. Together with needles and syringes, drug users involved in secondary needle exchange may distribute condoms, alcohol swabs and information materials. It is not necessary for a person willing to participate in syringe exchange to be popular among their peers. The main conditions are to be motivated to take part in the programme and have a wide circle of contacts.

This is how you establish a secondary needle exchange intervention:

1. Find volunteers through personal contacts and by visiting sites where people who use drugs meet. It is important to gain the trust of the owner of the site, or to make contact with the most respected people there.
2. Introduce harm reduction principles to volunteers and encourage them to do needle and syringe exchange at the sites. It is advisable to provide regular training for volunteers on HIV, STIs, TB, safer injecting, overdose prevention and management, and safe sex.

25. International HIV/AIDS Alliance in Ukraine (2009), *Model of peer-driven intervention: history, experience, prospects for the future*, Russian. Available at: [www.aidsalliance.org.ua/ru/library/our/equalsforce/pdf/brochure\\_PDI.pdf](http://www.aidsalliance.org.ua/ru/library/our/equalsforce/pdf/brochure_PDI.pdf). Page 22

3. Establish contact with people who use drugs by asking the owner of the site to introduce them to you in order to explain the aims and objectives of the programme, to register project clients, and give them clients' cards.
4. Support the volunteers. Secondary exchange volunteers receive needles, syringes, condoms, alcohol swabs, and information materials from outreach workers, and participate in occasional information sessions or training. It is advisable to provide some rewards to volunteers for their efforts and time (this could be money or vouchers, food, vitamins, or an opportunity to visit training sessions and seminars run by your organisation or others).



## EXAMPLE

In the experience of Ukrainian NGOs, in order to establish effective secondary needle exchange, outreach workers meet secondary exchange volunteers at least once a week. This helps build trusting relationships and to establish contacts with people who use drugs who visit the site.

During the visits, the outreach worker may register new clients and recruit volunteers to participate in secondary exchange, conduct training sessions, bring disposables for distribution, and collect used syringes.

Secondary exchange volunteers' duties include:

- distributing materials received from the NGO
- organising meetings between outreach workers and people using drugs who visit the site
- recording any materials distributed in a simple registration form
- organising collection of used needles and syringes in puncture-resistant containers provided by outreach workers <sup>26</sup>
- maintaining records and submitting simple reports to the NGO: stocks received and distributed, clients served, etc.

## REACHING PEOPLE WHO USE DRUGS

We can reach people who use drugs in their own environment – that is, places where they live, meet, and take drugs, such as:

- places where people prepare and inject drugs, or “shooting hotspots/galleries”
- places where drug users meet: abandoned buildings, building sites, etc
- streets, parks
- railway stations, highways
- construction sites, abandoned houses, ruins
- discos and night clubs, rock concerts
- places where drugs are made and sold
- markets, storefronts
- slums
- pharmacies and clinics
- homes (temporary and permanent) of people who use drugs – although outreach workers need to be trusted to be allowed in
- other places based on information from local agencies: police, health services, drug treatment services, shop owners, etc.

26. International HIV/AIDS Alliance in Ukraine (2011), *A guide to establishing secondary needle exchange as a mechanism for attracting new clients into harm reduction projects*, Russian. Available at: [www.aidsalliance.org.ua/ru/library/pdf/syn\\_instruction.pdf](http://www.aidsalliance.org.ua/ru/library/pdf/syn_instruction.pdf)

It is important not only to find an appropriate location for outreach, but also the best time to do outreach. This could be the hours during which drugs are sold or, for instance, when people using drugs who are also involved in commercial sex go to meet potential clients. It is helpful to discuss the best time and location for outreach with people using drugs from the area where outreach services will be provided to find the most convenient options for potential clients, bearing in mind what is safe and feasible for outreach workers.



An outreach worker (on the right) visits a client.  
© International HIV/AIDS Alliance in Ukraine

It is often not easy to find drug users. Outreach workers need excellent communication skills to enable them to approach people who use drugs and to build trusting relationships with them. Often it is easier to build trusting relationships with a drug user if the outreach worker has an experience of drug use. But knowing some of the ways to establish new contacts can make it easier even for those outreach workers who do not have experience of drug use.

“Cold contacts” is a way of contacting people who outreach workers have never met before. Meeting new people who can benefit from the project requires confidence and a good understanding of the local drug scene. It is important to remember safety when making “cold contacts” though.<sup>27</sup>

During the first contact, people can be reluctant to admit they use drugs. In this case it may be helpful to introduce yourself and the organisation, talk about the services available, and provide contact details of the organisation if the person decides to call for services later. Giving out condoms or information materials can be a good start during the first contact as it does not expose the person as someone who uses drugs.

“Natural contacts” are the ones that you make naturally. They are achieved through building trust with people who use drugs by spending time in the places where they get together<sup>28</sup> and by offering help and support consistently over a period of time. “Natural contacts” are easier to establish when there are peer educators in the outreach team. But even if there are no peer educators, an outreach worker can become a trusted person by taking an interest in the lives of the people they are working with. Asking people only about their drug use and not being interested in their life circumstances is often what police do. Outreach workers need to ensure that their contact with people is not just about drug use,

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27. See note 20.

28. See note 20.



or HIV, but about these issues in the context of a person's life – their family life, housing, general health and well-being, along with their interests, experiences, plans and aspirations.


“Snowball contacts” are often used when peer educators are involved. They help to identify not only individuals but also networks of people who use drugs, such as opiate or stimulant users, young people, and others. With “snowball contacts”, outreach workers are introduced to key representatives of the target population. When the initial relationship is established and the key representative learns that they can trust the outreach worker, and that the outreach worker has something to offer, the representative is asked to escalate the information about services and introduce the outreach worker to their peers.<sup>29</sup> When introducing this approach, it is important to work with people who are trusted by their peers and have a wide circle of contacts. This helps to scale up information about services and makes reaching large numbers of people who use drugs easier. Sometimes, interventions using a “snowball contacts” approach can include incentives (such as money or small gifts) to encourage new clients to access services, as in the example of peer-driven intervention described earlier.

Outreach workers may start by introducing themselves and their organisation, describing the programme and its goal, and explaining why the organisation provides services to people who use drugs, as well as what kind of services the client can expect to receive from outreach workers.

It is important to make regular ongoing outreach contacts with the clients and provide information when and where they may receive outreach services. Together with verbal information on the time and place of outreach, it is good to give the client a card with the address, time, and contact information of the outreach worker or organisation.

Outreach contacts may last just a couple of minutes or sometimes longer depending on how much time the client can spend for interaction with an outreach team and the local context such as presence of the police, weather conditions, time when drugs are sold and bought. Information provided to people who use drugs during outreach may include discussion of risk behaviours and risk reduction strategies, or the provision of information materials such as leaflets, brochures or newspapers that contain information on HIV prevention and referral to other services. Repeated contacts help to build trusting relationship between an outreach team and their clients, which makes it easier to discuss these issues more broadly, and raise other important topics.

The beginning of the conversation is very important because depending on the initial impression we make, the potential client can agree or refuse to receive outreach services. In many cases, outreach workers rely on their experience and communication skills when building a relationship with people who use drugs. Sometimes it is worth discussing topics unrelated to prevention such as weather, music or sports, and then, when contact is established, to start discussing HIV prevention and risk reduction, and the possibility of distributing commodities to encourage safer drug use. There is also a “fast way” of communication when the outreach worker gives out syringes and information, tells people the time and place for outreach, and gives short prevention messages. This is the option when there are too many clients and there is not enough time for longer conversations.



**KEY RESOURCES**

National Institute on Drug Abuse (2000), *The NIDA community-based outreach model: a manual to reduce the risk of HIV and other blood-borne infections in drug users*, Bethesda, MD, USA: National Institutes of Health. Available at: [archives.drugabuse.gov/pdf/CBOM/Manual.pdf](https://archives.drugabuse.gov/pdf/CBOM/Manual.pdf)

29. See note 10.

Outreach uses various ways of contacting people who use drugs. Some of them are described above. We can be creative and can work with local drugs users to develop new methods. New technology opens new opportunities to access people. For example, mobile phones can be used to provide information about services and also to keep in touch with people who use drugs.



## EXAMPLE

An outreach worker from Ukraine told us a story about a call he received late one night from one of the clients of the outreach service, asking to be reminded what to do in case of an overdose. The outreach worker provided on-the-spot information about managing an overdose.

Shortly after, the outreach worker received a text message saying that the person was alive. This example

shows that using mobile phones in outreach can be life-saving. It also shows that the outreach worker had something useful to offer the drug user – information about managing an overdose. When drug users can reach outreach workers easily, and when outreach workers have something to offer, trust-based relationships grow, and our outreach becomes more effective.

## GOOD PRACTICE IN PROVIDING OUTREACH SERVICES

For outreach work to be carried out with clients ethically and effectively, there are some important elements to ensure good practice. Every project coordinator or supervisor in charge of outreach work, and every outreach worker, should follow these good practices:

- gaining the trust and acceptance of the target population by being open-minded, non-judgmental and non-threatening
- ensuring a continuous and flexible service that is easily accessible and based on voluntary involvement of the clients.<sup>30</sup> Projects should be able to change outreach routes, timings, and working hours of outreach workers, depending on the circumstances and needs of the target community
- developing good communication, people skills and the ability to listen to clients to make sure the services offered by a project or organisation match the clients' needs
- ensuring confidentiality and privacy by using anonymous client coding and preserving the confidentiality of any information given by clients to representatives of the organisation or outreach workers
- ensuring confidentiality and privacy by not drawing attention to drug users, and drug using, as we deliver outreach HIV prevention services
- acting as a link between the client and the organisation or other agencies, by providing referral and accompanying the client to services if required
- acting as an inside observer and reporting back on drug users' opinions of the project, along with any changes happening in the local drug scene. This is important for the organisation in order to develop a drug user-centred response that meets the needs of clients and is appropriate to the context. It may also help determine how to expand services by providing new interventions that are requested by drug users such as female condoms, gender-sensitive counselling, hepatitis B and C screening, contraception, pregnancy tests, overdose prevention, and food and personal hygiene packages

30. Svensson, N.P., Homer-Knight, S., Husebye, T., Muerwald, S., and Schaffranek, J. (2003), *Outreach work with young people, young drug users and young people at risk: emphasis on secondary prevention*, Strasburg, France: Council of Europe, Pompidou Group. Available at: [www.coe.int/pompidou](http://www.coe.int/pompidou)

- acting as a key correspondent who collects clients' stories and tracks changes in their lives. This information can be used to prepare case studies that show project achievements or challenges.

Based on these good practices, here are some **dos** and **don'ts** for outreach workers.

DO...	DON'T...
be attentive, open-minded and non-judgmental. Accept clients for who they are and respect their opinion	do any harm – for example, ensure that police/law enforcement staff do not follow outreach workers to clients' homes, and ensure that drug users' privacy is protected
protect confidentiality and privacy	break trust or clients' confidentiality, except in a court of law upon a formal request made by the court
be honest about what can be done for a client, what your project does or does not provide, and how long services can continue	pretend or give false hopes and promises about what the project has to offer, your knowledge, or being the same as the client
listen to what clients say, their needs and feedback on the project and services	lend or take money, drugs or belongings from clients, even temporarily
make sure that you see and are being seen, yet recognise and maintain personal boundaries	buy anything for clients
fulfill rights and respect choices, e.g., voluntary use of services and enrolment into projects	get emotionally or sexually involved with clients
be informal	get into arguments with client, or try to prove them wrong
discuss any problems with the supervisor to find the right solutions – for the client and for the service	try to handle situations you are not trained to handle
be flexible and adaptable to different situations	be biased or give judgmental remarks (e.g., “this guy will never change”) <sup>31 32 33</sup>
refer clients to other organisations or services if their needs cannot be met by the project	
maintain regular contact with the client	
be available	

31. Buning, E. (1993), *Outreach work with drug users, an overview*, The International Journal of Drug Policy, 4(2).

32. Mikkonen, M., Kauppinen, J., Huovinen, M., and Aalto, E. (eds) (2007), *Outreach among marginalized populations in Europe: guidelines on providing integrated outreach services*, Amsterdam, Netherlands: Foundation Regenboorg, AMOC. Available at: [www.correlation-net.org/doccenter/pdf\\_document\\_centre/book\\_outreach\\_fin.pdf](http://www.correlation-net.org/doccenter/pdf_document_centre/book_outreach_fin.pdf)

33. Sethi, H.S., Pant, S. (2006), *Professional boundaries of “acceptable” outreach work*, in *Reducing risk-taking behaviour amongst young drug users in South Asia. Training of trainers' manual for trainers, outreach and field workers* (volume 2), Chapter 17, pp. 119–21, New Delhi, India: United Nations Office on Drugs and Crime (UNODC). Available at: [www.unodc.org/pdf/india/publications/Drug\\_Users\\_in\\_SAsia-TOT\\_Manual/17\\_ProfessionalBoundariesOfAcceptableOutreachWork.pdf](http://www.unodc.org/pdf/india/publications/Drug_Users_in_SAsia-TOT_Manual/17_ProfessionalBoundariesOfAcceptableOutreachWork.pdf)



A nurse measures out methadone at an outreach service at a mosque in Kuala Lumpur, Malaysia. © International HIV/AIDS Alliance

## BUILDING CAPACITY FOR OUTREACH

Skills and knowledge are essential for effective outreach. Many outreach workers are not professionally trained or qualified in HIV prevention or public health. Regular training sessions and workshops, as well as refresher courses, help to equip outreach workers with the skills and knowledge they need. The topics may vary, but there is a minimum of knowledge each outreach worker should have.

The basic list of topics for training includes:

- outreach and harm reduction
- safer injecting and vein management
- safer sex and condom use (including negotiation skills for safer sex)
- communication and basic counselling skills
- drug-related harms and how to avoid them
- overdose prevention and management
- disinfection
- waste disposal and management of used needles/syringes
- HIV transmission, prevention, screening/testing and treatment
- STI transmission, prevention, testing and treatment (syphilis, gonorrhea, chlamydia)
- hepatitis B and C transmission, prevention, testing and treatment (if available in the country)
- TB transmission, prevention, testing and treatment
- opioid substitution therapy (OST) with methadone/buprenorphine
- first aid
- health and safety at work.



### KEY MESSAGE

Clients may be lost if each outreach worker works individually with his or her own network of clients, and does not transfer knowledge and contacts to other staff members. Continued development, integration, expansion (geographic and programmatic), and improvement of services are essential for a relevant and meaningful project.



## EXAMPLE

Ukrainian NGOs use staff knowledge assessment questionnaires to select additional training topics for outreach workers. Questionnaires can include questions on the basic subjects

listed above, plus additional 'hot topics'. Questionnaires are regularly distributed among staff. They are analysed and used to plan further staff training.

Capacity-building of outreach workers is not limited to training sessions. It may include on-the-job training and supervision from experienced outreach workers, and individual training. Access to self-study resources, such as online learning courses, manuals and regular group discussions on practice issues, can really help outreach workers to build their capacity. Some organisations in Ukraine assist their employees with entering college or university if they wish to obtain a degree relevant to the area of their work.

Group discussions provide outreach workers with an opportunity to discuss problematic cases and share successful examples. They may be arranged for outreach workers from one organisation or from several organisations working in the area. It is also useful to arrange outreach workers' forums at regional and national levels, and give workers the opportunity to take part in conferences so they can make their voices heard and bring practical experience from the field. Capacity-building (including training, and personal and professional staff development) should be an ongoing activity in order to maintain staff knowledge and skills at an adequate level.



## EXAMPLE

The International HIV/AIDS Alliance in Ukraine has developed distance learning lessons on various topics such as HIV, overdose, and tuberculosis. The lessons consist of information on the relevant topic and a short questionnaire to evaluate knowledge. The lessons are sent

to organisations implementing HIV prevention projects with the support of the Alliance Ukraine. Project coordinators are responsible for distributing these lessons among outreach workers, and assessing knowledge levels once the training has taken place.

There are a number of support mechanisms to help ensure that outreach workers who are also active or former drug users receive the help they need from their organisation:

- Establish a self-support group for staff who use drugs facilitated by a harm reduction counsellor from another agency. With an external facilitator, it may be easier for outreach workers to discuss issues related to drug use and personal problems. Effective discussions are based on the principle of confidentiality when group participants are sure the information will not be disclosed to their supervisors or management. These support groups could be run for staff from different organisations.
- Ensure that employees who use drugs are part of a team and participate in events and activities that are in line with the organisation's objectives. That will give them a sense of ownership and belonging to the group.



## KEY RESOURCES

International HIV/AIDS Alliance in Ukraine

*Harm reduction lessons, a distance learning course*

[www.aidslessons.org.ua](http://www.aidslessons.org.ua)

Available in English, Russian and Ukrainian



## KEY MESSAGE

Outreach workers are key people for bringing project services to people who use drugs, and we need to ensure decent working conditions and ongoing support for them.



- Organise events to bring together all staff members. Maybe a group dinner, picnic or something useful for a local community such as clearing used syringes and needles from local streets.
- Encourage staff who use drugs to join or establish networks of drug users' activists and participate in their initiatives.
- Support staff to participate in conferences and workshops and help them to prepare presentations, abstracts and key messages and look for funding to participate in these events.<sup>34</sup>



Malaysian AIDS Council partners doing outreach work with injecting drug users  
© Malaysian AIDS Council

**KEY RESOURCES**

Balian, R. and White, C. (2010), *Harm reduction at work: a guide for organizations employing people who use drugs*, New York, USA: Open Society Foundations. Available at: [www.soros.org/reports/harm-reduction-work](http://www.soros.org/reports/harm-reduction-work)

## ENSURING SAFETY IN OUTREACH

There are two main types of risks related to outreach work, both for the outreach workers and their clients: these include occupational safety risks affecting outreach workers, and risks to people who use drugs (clients) as a result of their interacting with outreach workers.<sup>35</sup>

The risks for people who use drugs during their contacts with outreach workers involve disclosure of their status as drug users when members of the local community or the police see them receiving services from outreach workers. There is also a possibility that information about their health status and behaviour will be known to other people if the outreach workers do not strictly follow the confidentiality principle.

The quality of consultations provided by outreach workers is very important, because if the outreach worker gives clients poor or wrong advice regarding risk reduction and safer practices, there is a possibility of health-related problems and an increased risk of infection. If outreach workers give advice on areas they are not qualified to (for example, medicine or law) this may also lead to serious negative consequences for the client.

34. Balian, R. and White, C. (2010), *Harm reduction at work: a guide for organizations employing people who use drugs*, New York, USA: Open Society Foundations. Available at: [www.soros.org/reports/harm-reduction-work](http://www.soros.org/reports/harm-reduction-work)  
35. See note 18.

Among the safety risks for outreach staff, there could be increased use of drugs by active drug users, relapse by former drug users, and initiation of drug use by those outreach workers who have not been using drugs before. The other possible problem is harassment or negative conduct by the police or local community towards outreach workers.<sup>36</sup>

Outreach workers' duties involve negotiation with different people, dealing with their problems and sharing successes, which can be stressful. This may lead to burnout and decreased motivation to work.

There are safety guidelines to ensure good practice and work performance by outreach workers, and to provide a safe environment for workers and clients alike.

In order to ensure the safety of outreach clients, we need to remember the following:

- Confidentiality is one of the main principles of outreach work, and must be maintained. If you are in any doubt, discuss the confidentiality issue and what it means with your manager, and make sure you read the organisation's ethics policy, seeking clarification wherever necessary.
- You should not give any medical advice or propose any medical treatment if you do not have the relevant qualification. If you believe a client has specific medical needs, it is better to refer him or her to a relevant medical specialist.
- Before doing an outreach visit, make sure you know as much as possible about risk reduction, prevention of HIV, STIs and TB, and have contact information of relevant specialists and organisations so that you can refer clients on where necessary. If you are not sure, it is better to ask colleagues for advice rather than give the client inaccurate information.

These are the staff safety guidelines used by outreach workers of Ukrainian NGOs. Organisations involved in outreach work are advised to consider these staff safety guidelines and adjust them or add more according to their local circumstances:

- Work in pairs. This helps not only to share the workload, but also means there is someone who can help out if any problems arise during visits.
- Make sure the outreach worker's identity as an outreach worker for your organisation is clear. This can be done by wearing a specific uniform or a T-shirt/cap/bag with the organisation's logo. Specially designed T-shirts can also be used to display health promotion messages.
- Gain permission from the police to carry out outreach work and sign an official agreement between the police department and NGO allowing outreach work in the area. Make a copy of the agreement and give it to each outreach worker to show to the police on demand. Introduce outreach workers to police officers controlling specific areas on a regular basis, to avoid conflicts during work. In case of police enquiries during outreach, the outreach workers should be able to introduce themselves, show required documents, and tell officers about the organisation and the programme's objectives.

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<sup>36</sup>. See note 18.

- Meet community leaders to tell them about the programme and gain their support. Introduce the outreach team to the community, stressing that the aim of the programme is to reduce the negative impact of drug use, and provide consultations and information to people using drugs to keep them healthy and safe.
- Make sure the outreach team has a phone whenever they carry out outreach visits and they know what number to call in an emergency. That could be the office number, the manager's number, or a lawyer.
- Ensure that outreach workers have identification cards when they do outreach visits or provide case management services to clients. This should have the name of the organisation, a photo of the outreach worker, and their job title.
- Carefully select each outreach worker and provide sufficient training. Ensure that there is a support system for outreach workers, and avoid isolating them from other staff within the organisation.
- Ensure that any staff members who relapse into drug use receive adequate support: for instance, advice on coping with the work and drug use, or rehabilitation or substitution therapy services.
- Have regular staff or individual meetings, when outreach workers can discuss any difficult situations they encounter.
- Where possible, provide insurance for outreach workers. Advise them to have X-rays once a year if they work in areas of high TB prevalence. The outreach workers must be aware of TB symptoms, and diagnosis and treatment services should be readily available.
- Equip an outreach worker with a first aid kit, rubber gloves for rendering first aid or collecting used syringes, and a face mask if outreach takes place in closed premises.
- Ensure that each outreach worker attends and passes health and safety training before beginning work, and arrange regular refresher sessions.
- Organise activities to prevent staff burnout.



## KEY MESSAGE

Health and safety training may be developed individually by each organisation, depending on the circumstances and characteristics of the target population they work with. This training should include the safety guidelines discussed above, along with a code of conduct for outreach workers.



An outreach worker's safety kit, with disinfectants, plaster and rubber gloves © International HIV/AIDS Alliance in Ukraine

## MONITORING AND EVALUATION

The quality of outreach services needs to be continuously monitored. **Monitoring** is the regular tracking of the main elements of project performance through record-keeping, reporting, observations, and surveys.<sup>37</sup> Monitoring can be internal or external – that is, donor or stakeholder-driven. We need to analyse any results of monitoring and evaluation that we produce, summarise them and share them, with the local community, among staff within the organisation, and among stakeholders and donors. This ensures accountability and transparency of the services we provide.

Outreach workers are actively involved in the monitoring process – they participate in data collection, and the accuracy of their reporting directly influences the quality of overall programme reporting and any decisions made as a result of data analysis.

One of the key indicators to monitor the effectiveness of HIV prevention among people who use drugs is coverage – in particular, of needle and syringe programmes. Coverage is important because it is only by reaching sufficient numbers of people who use drugs on a regular basis that we can have an impact on HIV (that is, reduce or at least stabilise the rate of infections). WHO calculates that we need to reach more than 60% of drug users in a particular site or setting in order to have an impact on HIV.<sup>38</sup>

Outreach workers contribute a great deal towards coverage by reaching people who use drugs and distributing needles and syringes, condoms, and information materials. Every project and organisation is different, and availability of funding often determines the number of staff and client coverage. Nevertheless, organisations may find it useful to plan the workload for each outreach worker in a structured way.

This usually involves:

- estimating the numbers of drug users who need services in the defined location
- defining demand for services
- distributing the areas and points of service between outreach workers
- assessing the capacity of each outreach worker based on their skills, knowledge and previous experience
- analysing the numbers of people who need services, and resources available, and calculating a cost-effective outreach worker/client ratio
- distributing the planned indicators (targets) by months and service points
- regularly reporting on targets reached and, if they were not achieved, analysing the reasons why.



### KEY RESOURCES

International HIV/AIDS Alliance in Ukraine (2008), *Programme monitoring and evaluation. Practical manual*. Kyiv, Ukraine. Available at: [www.aidsalliance.org.ua/ru/library/our/monitoring\\_reports/pdf/ProgramMEMManualeng.pdf](http://www.aidsalliance.org.ua/ru/library/our/monitoring_reports/pdf/ProgramMEMManualeng.pdf)



### KEY MESSAGE

The term “coverage” is used to describe “the extent to which an intervention is delivered to the target population, that is, the proportion of the target population in need of an intervention who are actually provided with it”.<sup>39</sup>

37. International HIV/AIDS Alliance in Ukraine (2008), *Programme monitoring and evaluation. Practical manual for organizations coordinating and implementing prevention projects among injecting drug users, commercial sex workers, men who have sex with men, prisoners and care and support projects for people living with HIV/AIDS*, Kyiv, Ukraine. Available at: [www.aidsalliance.org.ua/ru/library/our/monitoring\\_reports/pdf/ProgramMEMManualeng.pdf](http://www.aidsalliance.org.ua/ru/library/our/monitoring_reports/pdf/ProgramMEMManualeng.pdf)

38. See note 11.

39. World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC), and the Joint United Nations Programme on HIV/AIDS (UNAIDS) (2009), *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*, Geneva, Switzerland: WHO, p. 13. Available at: [www.unodc.org/documents/hiv-aids/idu\\_target\\_setting\\_guide.pdf](http://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf)



**KEY MESSAGE**

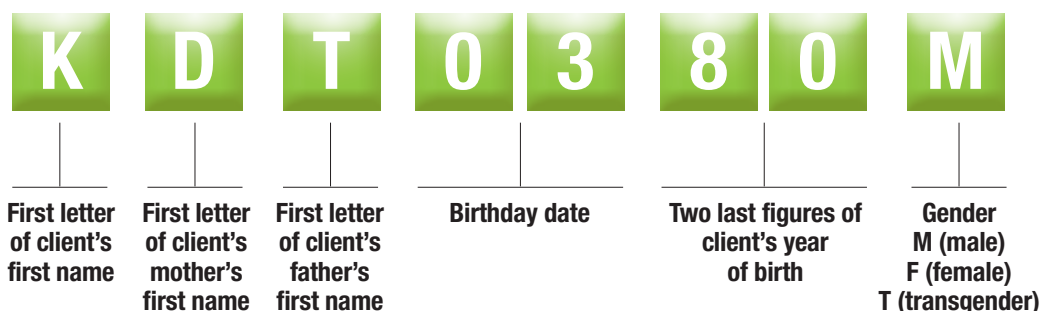
Outreach programmes are feasible and affordable, even in settings with limited resources.<sup>40</sup>

Malaysian AIDS Council partners doing outreach work with injecting drug users © Malaysian AIDS Council

Independent of the numbers to be reached, most NGOs find it valuable to plan ahead and distribute workload among their outreach workers. This helps outreach workers to know their own targets and plan their work accordingly. It also helps the organisation monitor of project performance and the extent to which staff are fulfilling the project’s objectives. And it helps to ensure cost effectiveness. Cost effectiveness comes from reaching as many clients as possible using existing resources – financial resources, number of outreach workers, time spent on outreach, and cost of and need for commodities.

Project coverage is estimated by counting the number of individuals reached by the service over a period of time such as 3 months or 12 months as a numerator, rather than the number of contacts.<sup>41</sup> Every new client receiving services through outreach receives a unique identification number, which ensures accuracy of data collection.

For example, Ukrainian NGOs doing outreach work use a unique code for each client, which is based on the following individual information.



40. World Health Organization (WHO) (2004), *Policy brief: reduction of HIV transmission through outreach*, Geneva, Switzerland: WHO. Available at: [www.unodc.org/documents/hiv-aids/Reduc\\_trans%20outreach\\_eng.pdf](http://www.unodc.org/documents/hiv-aids/Reduc_trans%20outreach_eng.pdf)  
 41. See note 39.



Individual information is inserted by the outreach worker into the clients' cards (shown below) when they first register with the NGO. This system allows the organisation to provide a new client card if it gets lost, and enables the client to receive the whole range of services in any region of Ukraine.



Outreach workers provide regular reporting on the number of clients reached by filling in a daily registration form (see below) noting clients' unique identification numbers, the number of commodities distributed, and referral to other services. If the outreach point is served by a team of two, one outreach worker may fill out the registration form while the other gives out commodities to clients. This may reduce the amount of paperwork and give more time for individual interactions with clients.

A pharmacy worker in Cherkassy, Ukraine explains how the client card enables people who use drugs to obtain clean syringes and other harm reduction materials from pharmacies around the city.  
© International HIV/AIDS Alliance

Daily services register for HIV prevention projects among vulnerable population groups (template)																
Organisation				Sunshine												
Date				15 June, 2012												
Point of service				Friendship Street (street outreach)												
Social worker(s)				John White, Jane Black												
Information on the client				Type of services/commodities provided												
#	Client Card ID	New client (Yes/No)	If a new client, reference number in the journal of registration	Used syringes returned	New syringes provided			Condoms provided	IEC products		Consultation/advice and other services		Referrals			Other comments
					1 ml	2 ml	5 ml		#1 ("Safe injection practices")	#2 ("Safe sex")	#1 (consultation of outreach worker)	#2 (consultation of drug addiction counsellor)	#1 (VCT)	#2 (STI)	#3 (other health care provider)	
1	PLD0479M	No		3	5	0	0	10	Yes	Yes	Yes	No	No	No	Yes	
2	STI0185F	No		0	0	3	0	20	No	Yes	Yes	No	Yes	Yes	No	
3	QI11590M	No		30	30	0	3	5	Yes	No	No	Yes	Yes	No	Yes	
4	TDO1687F	Yes	1035	0	10	0	0	20	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
5	LPP3069M	No		25	0	0	20	10	Yes	No	No	Yes	No	No	Yes	Asked to bring informational materials about stimulant use
6	NDP1283M	No		0	0	3	0	20	Yes	Yes	Yes	No	No	No	No	
7	SAR1892F	Yes	1036	0	0	0	0	20	Yes	Yes	Yes	No	Yes	Yes	Yes	
Total		2		58	45	6	23	105	6	5	5	3	4	3	5	
Total number of the clients served					7			Signature of the social worker(s)								

After filling in the daily registration forms, the outreach workers give them to staff responsible for monitoring, to check the data and transfer it into a database. The database system gives an opportunity to generate reports showing the number of clients served by each outreach worker during a period of time (for example, a week or month), the number of clients served at each site, and the services delivered. If there is no specially designed database system, reports can be generated with the help of Excel. Regular analysis of these reports helps us to identify clients' needs, see what services are lacking, and see if there is a need to change location (particularly if the number of clients has decreased). It is useful for managers to analyse and discuss these reports during regular meetings with outreach workers and look for solutions together as a team.

Outreach workers should carry the following documents in their bags:

- client registration forms (usually a questionnaire for new clients that includes questions about social and health status, risk behaviour, and drug use)
- daily services register (shown above)
- consultation or first aid book (so that consultation notes or first aid provided can be written down)
- referral forms or coupons (printed information with contact details and the name of the specialist the client is being referred to).

This list of documents is not exhaustive, but we need to remember that extra paperwork reduces the amount of time outreach workers spend interacting with clients.



**EXAMPLE**

In Ukraine, the Odessa-based charitable foundation, The Way Home, employs 10 outreach workers and 14 other specialists to provide harm reduction services to more than 12,000 people each year who use drugs. By taking the planned quarterly indicators and dividing them by the number of months, the project managers, in consultation with outreach workers, distribute outreach sites between workers. Depending on the potential client load at each service point, the client targets for each worker are set every month.

At the end of every month, each worker's client target is reviewed using internal monitoring and the results of that month's activities. This allows for changes in the number of clients to be reached and commodities to be distributed by each worker the following month.

In between monthly reviews and internal monitoring by project administration, outreach workers check their own performance and fulfillment of the agreed indicators. If they cannot reach the planned target, they consult their supervisor to make necessary changes to their work schedule.

## INTERNAL MONITORING

Project managers or outreach supervisors do regular internal monitoring to make sure outreach services are provided effectively and according to the fixed schedule. As part of internal monitoring, they may visit outreach sites to carry out observations in order to provide feedback to outreach workers and recommendations on how they can improve their work.

The following areas can be observed by an outreach supervisor or project manager:

- time spent for an outreach
- the number of clients served
- the range and quantity of commodities and informational materials distributed based on their availability in the project
- appropriate data input: registration forms are filled in accurately; new clients are registered and issued with client cards; a unique identification number is assigned to every new client
- communication with clients: outreach workers provide sufficient and accurate information on safer behaviour, prevention of HIV and STIs, and other issues clients are interested in; they communicate in a friendly and engaging manner, but keep personal and professional boundaries
- communication with local community and the police: outreach workers can answer questions about the organisation and the programme; they are responsive to the community
- referral: clients are referred to services provided by the project and are given referral cards; the outreach workers tell them about the whole range of services provided by the project and explain how to receive them
- teamwork: how good is the negotiation within the team; are the roles and responsibilities distributed according to the abilities and skills of each outreach worker
- safety: confidentiality of clients is ensured; the place of outreach is safe enough both for an outreach team and clients; outreach workers have puncture-resistant containers and wear gloves when collecting used syringes; the outreach team has a first aid kit and knows how to use it in case of an emergency; outreach workers have supporting documents to show on demand (identification card, and support letters from the NGO and local police department).

Together with the observation, it would also be good to talk to the clients and ask what kind of services they receive from the outreach worker, how often they receive them, and if they are satisfied with the services received as well as overall negotiations with the outreach team.

It is important that the outreach team is clear about the monitoring procedure and understands that it is an important part of quality assurance processes rather than displaying a lack of trust towards them. It is better for supervisors or managers to give face-to-face feedback to each outreach worker individually, discussing the positive aspects of their work and any areas that need improvement, as well as to discuss what kind of support they need and develop an action plan to strengthen their skills.

**Evaluation** helps to understand if the intervention was effective and if it succeeded in achieving its planned objectives. But in outreach programmes, the aim of evaluation is not only to validate results, but also to improve services provided in the project. Evaluation results are used to modify and improve services to ensure that people who use drugs benefit the most from them. In addition, we communicate evaluation findings with stakeholders to inform them about the progress of the project, or any problems we identified, as well as the development of future projects to scale up outreach services.

Outreach workers can be involved in programme evaluation through participation in research and data collection as interviewers or focus group facilitators. They can also assist in the development of methodology and advise on any problematic areas that need to be studied.

On a day-to-day basis, outreach workers can ask clients if they are satisfied with services provided, including whether the schedule and place of outreach is convenient for them. They can also discuss any changes in the local environment such as the drug scene, and the attitudes of the police and community towards needle and syringe exchange programmes and people who use drugs. This important information, gathered by outreach workers and communicated to project managers, can guide decisions that are made to improve the programme.

## STARTING OUTREACH SERVICES

Starting outreach activities can be simple and affordable. Here are some tips on how to set up and implement outreach work:

### 1. Situation assessment


At the stages of planning and project development, we need to begin with a needs assessment and situation analysis. In order to advance the Alliance's good practice programming standard "People who use drugs participate in our programming and decision-making",<sup>42</sup> we use participatory approaches to assessing need and planning services. A participatory assessment and response approach provides opportunities for people who use drugs, their family members and community stakeholders to engage in discussions and decision-making on needs and services, and mobilises people to take action.<sup>43</sup>

Here are some examples of how participatory approaches can be used while planning outreach services:

- **Daily activity chart:** this presents how people spend their time during the day<sup>44</sup> and can be used to identify the best time for outreach.
- **Mapping:** shows people and places within a geographical location and helps us to understand what would be the best place for outreach, what services are already available in the area, and what are the gaps in service provision.<sup>45</sup>

 **KEY RESOURCES**

European Monitoring Centre for Drugs and Drug Addiction (2001), *Guidelines for the evaluation of outreach work: a manual for outreach practitioners*, Luxembourg, Belgium. Available at: [www.emcdda.europa.eu/publications/manuals/outreach](http://www.emcdda.europa.eu/publications/manuals/outreach)

 **KEY RESOURCES**

For step-by-step guidance on a participatory assessment and response approach, see the International HIV/AIDS Alliance's tool (2003), *Developing HIV/AIDS work with drug users: a guide to participatory assessment and response*. Available at: [www.aidsalliance.org/publicationsdetails.aspx?id=88](http://www.aidsalliance.org/publicationsdetails.aspx?id=88)

42. See note 4.

43. International HIV/AIDS Alliance (2003), *Developing HIV/AIDS work with drug users: a guide to participatory assessment and response*, Brighton, UK: International HIV/AIDS Alliance. Available at: [www.aidsalliance.org/publicationsdetails.aspx?id=88](http://www.aidsalliance.org/publicationsdetails.aspx?id=88)

44. See note 43.

45. See note 43.

Assessment activities should not stop once the project is developed and ready to start. When assessment continues throughout project implementation it helps to identify gaps between clients' needs and project services, and can stimulate changes in the project which benefit clients and service providers alike. Drug scenes and drug use practice change quite often and regular assessment helps keep the organisation and its staff "on track" with these changes.

## 2. Partnerships

Because of budget constraints it is often difficult to provide a wide range of services for people who use drugs, and this can be resolved through establishment of the referral system. Partnerships with other organisations – including grassroots and community-based initiatives, service providers, government agencies, NGOs, private companies and businesses, and international organisations working in the area – will ensure a viable referral system for clients.

Coordination of harm reduction programmes with other services and agencies working in the area of project implementation is considered to be good practice, which refers to the Alliance's good practice standard: "The programmes targeting people who use drugs are part of a local network of services and programmes".<sup>46</sup>

Situation assessment results can show us what services people who use drugs already use and what services are lacking in the area. This can tell us what agencies we need to contact in order to establish partnership for clients' referral. The types of agencies we need to make an agreement with will depend on clients' needs and the local situation. It might be useful to sign a written agreement with the organisations we want to work with, detailing precisely what their role would be and who are the key people responsible for the activities.

The following organisations are potential partners for outreach work:

- Regional and local police departments: we need their support in order to start outreach activities, and can offer to train their staff on HIV and harm reduction.
- Local administration/local government: local governments often determine what happens "on the streets". Local crime prevention plans, environmental health, local planning laws – these are all examples of policy that might have an effect on our ability to do outreach. Local government support helps us to establish partnerships with other governmental and non-governmental organisations.
- HIV, STI and TB clinics, in order to refer people for testing and treatment.
- Other NGOs and CBOs providing services to people who use drugs in the area: if they already provide outreach services, we need to agree the locations of our outreach sites to avoid duplicating services, and if these organisations provide services that we do not, we can agree to refer our clients to them.
- Organisations providing other services needed by people who use drugs such as shelter, food, clothes, etc.

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46. See note 4.





NGO staff providing services at the drop-in centre for people who use drugs.  
© International HIV/AIDS Alliance in Ukraine

**KEY RESOURCES**

International HIV/AIDS Alliance (2007), *The health journey. Understanding the dimensions of care and treatment for people with HIV: a community-centred methodology*. Available at: [www.aidsalliance.org/includes/Publication/Health\\_journey\\_web.pdf](http://www.aidsalliance.org/includes/Publication/Health_journey_web.pdf)

There are different opportunities for partnerships with other organisations that may include, for example: establishing joint registration systems so that clients can receive services from several organisations by showing their registration card; arranging joint events such as ‘clean the streets’ days to collect used syringes, or organising HIV awareness events; developing and implementing joint projects to introduce services that were not previously provided.

### 3. Site identification

Situation assessment results will help to identify sites for outreach work and the best time for outreach. Outreach workers who live in the area where outreach will take place may also use their personal knowledge and experience to identify the places where people who use drugs meet. Based on this information, a schedule for outreach work can be developed. Though it is good to fix the dates and times when outreach will take place, it is important to revise the schedule if evaluation results show that the number of people receiving services on this site is decreasing and the local drug scene has changed.

### 4. Approaches to service provision

Situation assessment results will guide us to select the right model of service provision. At this stage we will know what sub-groups of people we want to reach, what is the best way to reach them, what kind of commodities and services they need, and what would be the best outreach model to provide outreach services.

When selecting the right model, it is good to read information on how to use it and talk to others within the organisation who have experience in using it. This will help us to understand not only its advantages but also any drawbacks and possible risks. The best way would be to look at the model critically and see what needs to be adapted to our setting and situation in order to make it work.

### 5. Development of the workplan

Even if we already have a project plan, it would be useful to develop a detailed plan for the provision of outreach services. This will give us an idea of how many outreach workers we need, the composition of the outreach team, and individual staff duties. The workplan may show the working hours of the outreach team that includes the outreach itself, paperwork, meetings and training sessions in the office, and other activities such as case management and self-study.

The workplan would include monitoring and evaluation activities to help us assess whether we have reached our objectives.

## 6. Staff recruitment and training

Staff recruitment and training may start at the stage of situation assessment. Outreach workers may help us to conduct the assessment, identify the sites of outreach, and develop a model of service provision.

Training for outreach workers should be a continuous process through the entire project. At the start they should receive training on outreach and harm reduction, prevention of HIV and STIs, and safety rules. When starting outreach, we also need to know about services provided by the project and information about other organisations working in the area, documentation required, how to fill in the necessary forms, and why the accuracy of data gathering and reporting is so important. The other areas of training described in the section on capacity-building may be carried out later on. If outreach workers are part of the assessment team, they would need training on participatory assessment methodology as well.

It would be advisable to pair up experienced outreach workers with less experienced workers so that they can learn from each other. Alternatively, a new outreach worker could spend the first few weeks with the outreach supervisor or manager until he or she is confident in performing their work.

## 7. Procurement of commodities

During the situation assessment, we should identify what commodities people who use drugs need. Sometimes they will name a specific brand of commodity they prefer. But if we are not sure about the brands or size of commodities (for example, syringes or bottles of injecting water) it would be useful to buy a small amount, give out to people for “testing”, and then receive their feedback. When buying big amounts of commodities we would need to think about the storage place and the person responsible for the warehouse. This could be one of the project staff who would give out commodities to outreach workers, keep the documentation in order, and check stock levels.

We do not need to follow these stages in this sequence; some of them can be started at the same time or earlier if required.



Malaysian AIDS Council partners doing outreach work with injecting drug users © Malaysian AIDS Council

## IN SUMMARY

- Outreach helps make contact with individuals who are out of reach, without waiting for them to come to services, and provides health and social services directly to the target community.
- Through outreach we can provide people who use drugs with the means to change their risk practices, including reducing the risk of transmitting or acquiring HIV and other blood-borne viruses related to shared injection equipment and unprotected sex.
- When planning interventions for people who use drugs it is important to provide low-threshold services, create a safe environment, and use a non-judgmental and supportive approach.
- Involving people who using drugs in programme design, implementation and evaluation helps to build their ownership of the project and ensures that services respond to their needs.
- To maintain staff knowledge and skills at an adequate level, continuous capacity-building of the organisation, including training, and personal and professional staff development, is very important. With proper and regular training, outreach workers are a reliable source of harm reduction information for people who use drugs, their families and local communities.
- Collecting data on client needs, available resources, changes in drug use or drug users' needs, and satisfaction with services –gathered continuously throughout project planning, implementation, and monitoring – will ensure that services respond to current needs of clients and the changing situation.
- Clear monitoring and evaluation procedures and guidance on how to fill in project documentation can help outreach workers deliver accurate reporting and reduce the amount of time they spend on paperwork, which means more time for interacting with clients.
- Safety guidelines and regular staff training may reduce possible risks for clients and outreach workers during outreach.
- Outreach workers are key to bringing project services to people who use drugs, and we need to ensure that they have decent working conditions and the ongoing support they need to fulfill their role.



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Supporting community action on AIDS in developing countries

# A TOOLKIT FOR OUTREACH SERVICES

**“CRIMINALISATION OF PEOPLE WHO  
USE DRUGS CAN MAKE THEM HARD  
TO REACH. PEER-DRIVEN OUTREACH  
SERVICES ARE ESSENTIAL TO KEEP  
PEOPLE HEALTHY AND SAFE.”**

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