



SERVICING COMMUNITIES WITH OPIOID OVERDOSE PREVENTION: LESSONS LEARNED FROM THAILAND



WITH SUPPORT FROM THE GLOBAL FUND TO FIGHT AIDS,
TUBERCULOSIS AND MALARIA AND OPEN SOCIETY FOUNDATIONS

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ACRONYMS

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral treatment
ATS	Amphetamine-type stimulant
BCC	Behavior change communication
CHAMPION	Comprehensive HIV Prevention Among Most-At-Risk Populations by Promoting Integrated Outreach and Networking
CND	Commission on Narcotic Drugs
CPR	Cardiopulmonary resuscitation
CTL	Closing-the-loop
DALY	Disability-adjusted life year
DDC	Department of Disease Control
DIC	Drop-in center
EHRN	Eurasian Harm Reduction Network
EML	Essential medicines list
FAR	Foundation for AIDS Rights
FDA	Food & Drug Administration
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HTC	HIV testing and counseling
IDU	Injecting drug use
ICAAP	International Congress on AIDS in Asia and the Pacific
IHAA	International HIV/AIDS Alliance
M&E	Monitoring & evaluation
MIMS	Medical Information Management System
MIS	Management of information system
MOH	Ministry of Health
NGO	Non-governmental organization
OSF	Open Society Foundations
PEPFAR	President's Emergency Plan for AIDS Relief
PiA	Princeton in Asia
PSI	Population Services International
PWID	People who inject drugs
PWUD	People who use drugs
RTF	Raks Thai Foundation
SCOOP	Servicing Communities with Opioid Overdose Prevention
STI	Sexually transmitted infection
TDN	Thai Drug Users' Network
THB	Thai Baht
TOT	Training of trainers
TRC	Thai Red Cross
TTAG	Thai AIDS Treatment Action Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
USD	United States Dollar
WHO	World Health Organization

Though governments in Thailand come and go, the national commitment to suppression of the illicit drug market has not wavered over the past decade, despite growing international calls for a more balanced approach. Lauded as a leader by some and condemned by others for human rights violations, all in the name of a drug-free Kingdom, various government administrations have pursued aggressive campaigns to rid the country of illicit drugs and provide treatment to all those who have ever used illicit drugs. Unfortunately, international evidence suggests that strategies based on a punitive law enforcement model may cause more harm than good by, for example, fueling the spread of HIV and other blood-borne infections and exacerbating other harms among people who inject drugs (PWID).^{1,2,3}

In Thailand, an estimated 5% of the national population aged 12-65 – approximately 2.5 million people – used illicit drugs in 2007,⁴ with over 40,000 people who inject drugs (PWID). HIV prevalence among PWID in Thailand has remained high, recorded between 25-40%, for more than the past decade.^{5,6} Approximately 30% of a sample of PWID in Bangkok have lived through at least one non-fatal overdose while 68% have witnessed at least one overdose in their lifetimes.⁷

To address some of the health issues faced by PWID, PSI Thailand and local partners have been working together since 2009 to prevent HIV transmission and improve their quality of life. Though CHAMPION-IDU was initially designed as an HIV prevention project supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), an additional opioid overdose prevention

and management component – the Servicing Communities with Opioid Overdose Prevention (SCOOP) project – was integrated in 2013 to address the growing needs of project clients. While a national harm reduction policy was deployed in February 2014, the official document does not refer to overdose prevention or naloxone provision.⁸

Pharmacologically, naloxone is a competitive opioid antagonist, and its rapid blockage of opioid receptors is very effective in reversing opioid drug overdoses, producing rapid onset of withdrawal symptoms. In essence, naloxone rapidly binds to the same receptors in the body that receive heroin and other opioids without creating a ‘high’; because naloxone binds to receptors much more efficiently than opioid drugs, it “kicks out” the opioid drug and reverses the respiratory depression that leads to death from overdose.

In 2012, the Commission on Narcotic Drugs (CND) ratified resolution 55/7 titled *Promoting Measures to Prevent Drug Overdose, in Particular Opioid Overdose*,⁹ calling on all United Nations (UN) Member States to deploy policies and practices to prevent and treat drug overdose. In 2014, WHO published revised guidance and recommendations to address HIV and health of those most vulnerable, notably adding community-based overdose prevention and management with naloxone to improve the comprehensive package of services earmarked for HIV prevention, treatment, care and support among PWID.¹⁰

The current report summarizes almost two years of experience in implementation of a community-based opioid overdose prevention and management



project integrated across the 19 CHAMPION-IDU provinces in Thailand. The report intends to provide more detailed information about overdose prevention and management with naloxone to Thai stakeholders and support further expansion of the SCOOP project. In parallel, the report can be used at the regional level to support advocacy in ASEAN countries to encourage rapid scale-up of this life-saving intervention. Finally, the report is structured to provide external audiences interested in overdose prevention and management with naloxone a project blueprint to adapt and implement in their own localities. Though specific to Thailand, the report concludes on a set of lessons learned that could guide and support other overdose prevention projects.

Since the initiation of the SCOOP project in January 2013, the project management team in PSI Thailand encountered a range of challenges that had to be overcome to make naloxone available to PWID. Initial barriers in procurement forced the management team to address pricing and policy issues with technical assistance from external agencies. Once procurement was completed, additional policy barriers had to be addressed to ensure full compliance with Thai law. In parallel, the capacity of the outreach workforce was strengthened to include overdose prevention and management. Data management systems were deployed, including data recording forms, to indicators and M&E systems with multiple redundancies.

Within 18 months of the two-year project life cycle, 1,575 vials of naloxone were distributed across the CHAMPION-IDU drop-in centers (DIC). In 21

recorded cases, CHAMPION-IDU field workers successfully reversed opioid overdoses using naloxone. At least 148 CHAMPION-IDU field workers and clients were trained to recognize an opioid overdose and respond with emergency care and injection of naloxone. Because of the integration of overdose prevention in behavior change communications (BCC) strategies, it is also assumed that overdose prevention was discussed with each of the 74,852 clients reached by CHAMPION-IDU between January 2013 and June 2014. More importantly, the SCOOP project has empowered and motivated both CHAMPION-IDU field workers and their clients to see the immediate potential of naloxone as a life-saving antidote.

Advocacy efforts also yielded a fragile agreement with health service providers to explore a pharmacy-based distribution model for the prevention and management of overdose with naloxone in the future. The tentative compromise would allow low-threshold access to naloxone while minimizing legal risks for implementing agencies, and would build on the experiences of SCOOP for generating opportunities for continued civil society and community engagement.

However, additional advocacy efforts are needed to ensure that the current outreach-based indirect distribution model is sustained to complement pharmacy distribution. Moreover, all stakeholders involved in improving the quality of lives of PWID should push for changes in policies and regulations to ensure access, ideally so that naloxone ends up in the hands of every person who injects drugs, their families and their communities.

With positive outputs, outcomes and impacts after barely two years of implementation, there is clear potential to expand significantly in the near future provided that the CHAMPION-IDU infrastructure remains in place and that funding support continues for SCOOP. The summary below captures the intrinsic value of the SCOOP project as well as its added value in the context of HIV prevention in Thailand:

SCOOP IS A HIGH IMPACT INTERVENTION

Overdose prevention targets PWID, one Thailand's most marginalized and vulnerable populations; overdose reversals generate high disability-adjusted life-year (DALY) values; administration of naloxone is almost immediate and the impact is visible; naloxone saves lives;

SCOOP IS LOW THRESHOLD

Naloxone is easy to use and trainings are simple; deploying multiple distribution models will increase the number and type of outlets to ensure high coverage; services are available across all 19 CHAMPION-IDU provinces;

SCOOP IS A LOW COST INTERVENTION

Direct negotiations with manufacturers and distributors generated significant savings; additional market competition could drive prices down even further; utilizing existing DIC and peer outreach infrastructure also reduced cost of the intervention; cost sharing model between multiple donors, including private sector, added significant value;

SCOOP IS INTEGRATED

Naloxone is integrated in a comprehensive package of overdose prevention and management services; overdose prevention and management is integrated in the CHAMPION-IDU project which represents the bulk of the national response to health among PWID; CHAMPION-IDU in turn is also integrated in the national package of HIV prevention, treatment, care and support services Thailand;

SCOOP STIMULATES DEMAND

Demand for overdose prevention and management exists in Thailand and SCOOP expanded that demand by raising awareness among field workers, clients and the communities around them;

SCOOP IS INNOVATIVE

A novel service that can attract previously unreached clients with high risk behaviors; stimulate exploration of new policies and implementation models to overcome barriers; project data indicates success after less than two years of implementation;

SCOOP EMPOWERS COMMUNITIES

Project staff enthusiasm and performance has increased; project volunteers have gained confidence and respect from community members; clients are eager to learn more about overdose prevention and have access to naloxone to assist their peers; communities welcome the CHAMPION-IDU across virtually all sites to expand overdose prevention and management using naloxone.

Though SCOOP can be considered a success, additional work remains to be done to ensure sustainability and expansion of the project. Based on SCOOP lessons learned, recommendations have been formulated towards sustainable expansion of a national overdose prevention and management program in Thailand.

INTRODUCTION

“Overdoses happen especially when there is a change in drug supply – due to police raids, changes in suppliers, changes in quality of the drugs – but also after people have been abstinent for a long time.”

– CHAMPION-IDU field worker

Out of the estimated 99,000 - 253,000 deaths related to illicit drug use worldwide, between 70,000 and 100,000 are caused by opioid overdose.¹¹ Globally, overdose is the leading cause of preventable deaths among people who inject drugs (PWID).¹² In 2010, the United Nations Office on Drugs and Crime (UNODC) estimated that 43,000 deaths were directly caused by opioid dependence and 180,000 deaths caused by drug poisoning, resulting in more than two million years of life lost.¹³ However, the tracking of national and global data on opioid overdose mortality is undermined by significant data quality issues and limited mortality data collection at the country level.¹⁴

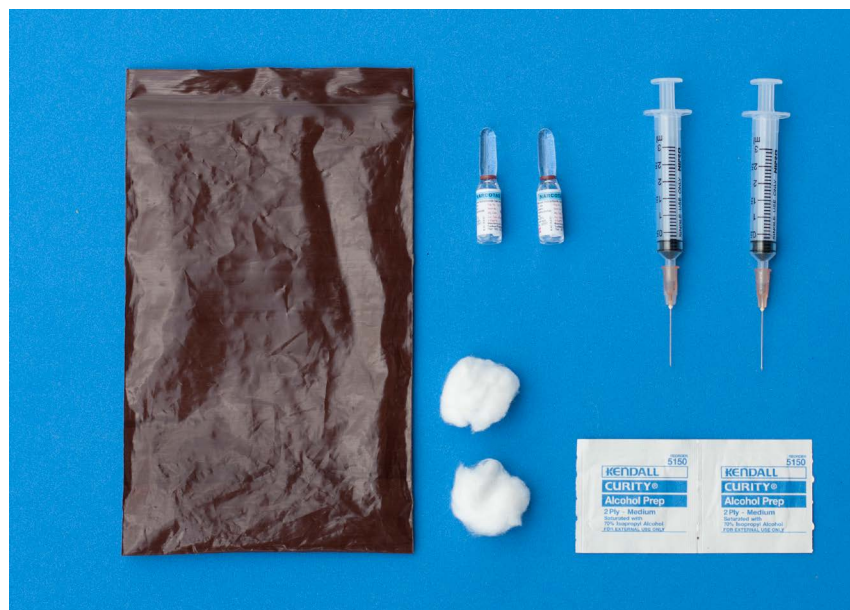
Despite these challenges, it is well recognized that people who use opioid drugs are at considerably high risk of overdoses. For example, a study conducted across 16 Russian cities found that 59% of known heroin injectors had lived through at least one non-fatal overdose in their lifetime.¹⁵ Other studies have identified similar trends in other cities and countries: 83% in Bac Ninh (Vietnam), 41% in Baltimore (USA); 30% in Bangkok (Thailand); 38% in London (UK); 42% in New York City (USA); and 68% in Sydney (Australia).¹⁶

In 2012, the Commission on Narcotic Drugs (CND) ratified resolution 55/7 titled *Promoting Measures to Prevent Drug Overdose, in Particular Opioid Overdose*,¹⁷ calling on all United Nations (UN) Member States to deploy policies and practices to prevent and treat drug overdose. More

recently, WHO published revised guidelines for key interventions among key populations which explicitly recommends the inclusion and integration of overdose prevention and management with naloxone.¹⁸ While global drug control and regulatory agencies have recognized that opioid overdose is preventable, treatable and reversible, many national governments, especially in low and middle-income settings, have yet to deploy measures to support effective programming and service delivery.

In recent years, many drug overdose prevention programs have relied on strategies that have been documented and have proven effective in preventing opioid overdoses. In particular, the administration of naloxone, a clinically recognized antidote to reverse opioid overdose, has been attracting attention beyond the medical community, especially in the context of health and social care responses among people who use illicit drugs. Community-based overdose prevention and management programs using naloxone first began in the USA in the mid-1990s, and quickly led to a significant decline in fatal overdoses.¹⁹ By 2010, there are at least 15 countries around the world that use naloxone in the context of overdose prevention programs targeting people who use drugs (PWUD), their peers, friends, family members and the broader community (including law enforcement) to recognize opioid overdoses and respond using naloxone.²⁰

This report will review the successes and challenges faced by the project partners who have implemented



a community-based overdose prevention project among PWID in Thailand. The report will first provide an analysis of the drug situation in Thailand and situate overdose prevention within a public health framework linked to national HIV responses to explain the synergy with the only national HIV prevention project – CHAMPION-IDU – among PWID in Thailand. These will provide the foundations to explore the operationalization of the project, focusing on the procurement of naloxone and implementation processes and activities, along with the results of the project to date, against a backdrop of the local and national policies and advocacy efforts aimed at sustainable and integrated overdose prevention and management in Thailand. The report will conclude on a set of recommendations to address key barriers to improve accessibility, affordability, integration and sustainability of overdose prevention and management activities in Thailand.

It is expected that this report will be useful at national level to encourage decision-makers, health service providers and health officials to facilitate access to naloxone for community-based organizations while building a more competitive and dynamic market. In parallel, it is hoped that the report can be used at the regional level to support advocacy in ASEAN countries to encourage rapid scale-up of this life-saving intervention. Finally, the authors hope to contribute to a growing body of global literature documenting local efforts to prevent overdose among people who use drugs (PWUD) and assist other organizations in initiating, managing and expanding their own overdose prevention and management projects.

NALOXONE

- Is an effective, fast-acting antidote to opioid overdose
- Is a recognized medicine included in WHO's Essential Medicines List (EML)
- Is a controlled medical substance though it has no counter indications or abuse potential
- Is available in Thailand

DRUGS, PEOPLE WHO USE DRUGS AND OVERDOSE IN THAILAND

“I was lucky! I survived my first overdose but there was no one to help me.”

– CHAMPION-IDU client

In Thailand, an estimated 5% of the national population aged 12-65 – approximately 2.5 million people – used illicit drugs in 2007.²¹ Although there are no reliable estimates of the number of people who are currently clinically dependent on illicit drugs, national population size estimates indicate that more than 40,000 inject drugs on a regular basis.²² Commonly used illicit drugs include heroin, opium, amphetamines (yaabaa), ice, cannabis and kratom, while licit drugs such as midazolam and other benzodiazepines are often mixed with illicit drugs.²³

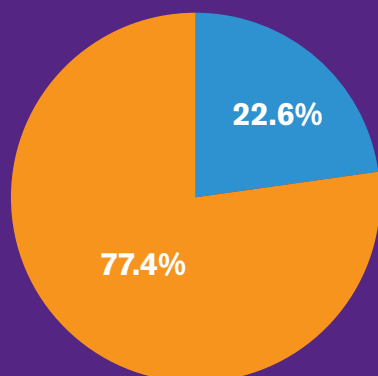
HIV prevalence among PWID in Thailand has remained between 25-40% for over a decade^{24,25,26} with higher rates in custodial settings compared to community settings,²⁷ while hepatitis C infection among PWID in the Kingdom has been recorded at over 90%.²⁸ In parallel, the absence of a harm reduction policy up until February 2014 has stifled HIV prevention service coverage among all PWUD across the Kingdom. Unsurprisingly, Thailand's first overdose prevention and management program was introduced only very recently – in 2010 – and by civil society – through TTAG.

GRAPH 1

Occurrence of Overdose Among PWID by Region (IBBS, 2010)

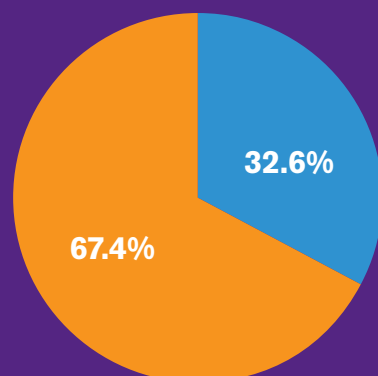
CENTRAL

(Bangkok, N = 409)



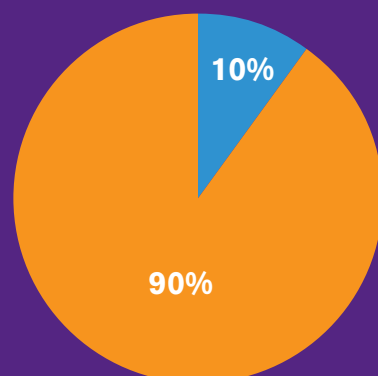
NORTH

(Chiang Mai, N = 150)



SOUTH

(Songkhla, N = 204)



■ Ever had overdosed
■ Never overdosed

Published data about a sample of Thai PWID from Bangkok indicates that approximately 30% have lived through at least one non-fatal overdose while 68% have witnessed at least one overdose in their lifetimes.²⁹ The 2010 Integrated Bio-Behavioral Surveillance (IBBS) results indicate that there is considerable regional variation as shown in Graph 1.³⁰ Data collected through project implementation in Bangkok, Chiang Mai and Narathiwat corroborates the Bangkok-based study and IBBS data, revealing that 27% of respondents had suffered at least one an opioid overdose in their lifetime (compared to 8% in the past 12 months), with an average of two overdoses for each respondent.³¹

In contrast, survey data revealed that respondents who suffered an overdose were generally treated at community level (46%), in hospital or other health care settings (39%) or received no help at all (5%).³² When asked to qualify the type of assistance they received, respondents noted that they were verbally coaxed to wake up (64%), hit or slapped (57%), injected with saline (24%), injected with naloxone (22%), placed in the recovery position (20%), given cardiopulmonary resuscitation (CPR) (18%), and given mouth-to-mouth (14%).³³

"I still see friends in the community injecting salt water or even hitting their friends to wake them from an overdose. I know that it won't work, I learned it from the CHAMPION-IDU training workshop. I tell them to call CHAMPION-IDU when they see someone who is having an overdose."

– CHAMPION-IDU client

Research has also been conducted around the world to reveal the factors associated with opioid overdose. UNODC and WHO have identified four key factors associated with overdoses: opioid availability, combination

use of opioids and other psychoactive substances, lack of treatment options and reduced tolerance due to a recent period of abstinence, because of incarceration for example.³⁴ Peer reviewed studies among PWID indicate that non-fatal overdoses are commonly associated with a prior history of overdose, high intensity drug use (such as poly-drug use), and recent incarceration.³⁵ Project data and academic research from Thailand confirm these trends and further suggest alarming factors positively associated with overdose among PWID. For example, one study revealed a significant correlation between overdose and evidence planting and entrapment by law enforcement.³⁶

As drug policies encourage strict enforcement and prohibition of illicit drugs, many PWID find themselves cycling in and out of prisons, so-called drug treatment centers and other closed settings. With little or no support upon release, the probability of relapse commonly associated with illicit drug use increases, thus placing those individuals at particularly high risk of overdose.

“At least one person from every group leaving the drug treatment center dies [from an overdose]. People are afraid that the methadone dispensed by the doctors will not be enough, so they use their own [drugs] which causes overdose. [...] [We hear reports from clients who say that] their methadone dosing is too low, so they take more [heroin or methadone] and overdose.”

– CHAMPION-IDU field worker ³⁷

In parallel, for many PWID in Thailand who are accessing methadone, dosing is often too low to

completely eliminate the cravings and withdrawal symptoms, and clients resort to using illicit drugs as well to compensate, heightening the risk of an overdose. ³⁸

“In Bangkok, there is a trend of poly-drug use with a large proportion injecting benzodiazepines. As methadone does not reduce cravings for benzodiazepines, people continue to use it and become very prone to respiratory depression.”

– UN official

However, data on overdose in Thailand is scarce – national morbidity and mortality surveillance systems do not recognize “overdose” or “opioid overdose” as a legitimate and acceptable cause of death.³⁹ Indeed, coroners in Thailand usually attribute the cause of death to “heart failure” or “respiratory failure” as opposed to assigning cause of death to a drug overdose.

Finally, project survey respondents identified fear of going to the hospital (being identified as a drug user, being arrested by the police, etc) (56%), potential financial liability for treatment costs (31%), and distance to health service access points (31%) as the key barriers to intervening in the event of an overdose.⁴⁰

DRUGS AND OVERDOSE IN THE CONTEXT OF HIV

“Though NGOs come to offer HIV-related services, I am more interested in the overdose prevention project because that meets my immediate needs.”

– CHAMPION-IDU client



Ample evidence has been published to acknowledge the causal linkages between drug use and HIV and other blood-borne infections like hepatitis C.⁴¹ In the context of the global response to HIV, several international agencies have established important linkages between HIV and overdose prevention.

While both HIV and overdose are serious public health concerns, the UN has recognized the importance of overdose prevention, including the use of naloxone, as a critical component of a national response to HIV among people who use and inject drugs. In March 2012, UN CND resolution 55/7 titled *Promoting Measures to Prevent Drug Overdose, in Particular Opioid Overdose*⁴² was passed, underlining its


...understanding that opioid overdose treatment, including the provision of opioid receptor antagonists such as naloxone, is part of a comprehensive approach to services for drug users and can reverse the effects of opioids and prevent mortality, [...] encourages all Member States to include effective elements for the prevention and treatment of drug overdose, in particular opioid overdose, in national drug policies, where

appropriate, and to share best practices and information on the prevention and treatment of drug overdose, in particular opioid overdose, including the use of opioid receptor antagonists such as naloxone.

A recent discussion paper titled *Opioid Overdose: Preventing and Reducing Opioid Overdose Mortality* has been jointly published by UNODC and WHO, as a result of Resolution 55/7, further acknowledges that people living with HIV were at higher risk of overdose.

Since 2001, UNAIDS, UNODC and WHO have jointly recommended the deployment of a comprehensive range of interventions for HIV prevention, treatment, care and support among PWID.⁴³ In 2014, WHO released new guidelines for consolidated HIV prevention, treatment, care and support for all key populations, including PWID. The revised comprehensive package maintains all essential services and recommends two additional services: pre-exposure prophylaxis for HIV prevention among men who have sex with men and community-based overdose prevention with naloxone among PWID.





People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose. [...] Greater availability of naloxone through community-based distribution could help reduce the high rates of opioid overdose, particularly where access to essential health services is limited for people who inject drugs.⁴⁴

Donors such as PEPFAR and GFATM are increasingly interested in supporting such interventions. PEPFAR recognizes the added value of overdose prevention with naloxone, especially in the context of HIV prevention with people who inject drugs.⁴⁵ Similarly, GFATM's Information Note on Harm Reduction for People Who Inject Drugs expresses clear and unambiguous support for overdose prevention with naloxone:

Overdose remains a primary cause of death among people who inject drugs, even in the context of an HIV epidemic, and overdose prevention and management interventions are particularly important for this population [...] Overdose prevention – including the provision of naloxone [...] should be a core component of “targeted information, education and communication” for people who inject opiates. Overdose impacts directly on HIV-related harm reduction services, and poses particular risk to those released from prison or from drug-free treatment settings. [...] applicants are strongly encouraged to consider low-cost interventions such as provision of OST prior to release from prison, take-home naloxone provision and peer administration for people who inject drugs, peer and staff training in overdose prevention, and the strengthening of overdose responses for emergency health services, and ensure policies and law enforcement practices are supportive to this approach.⁴⁶

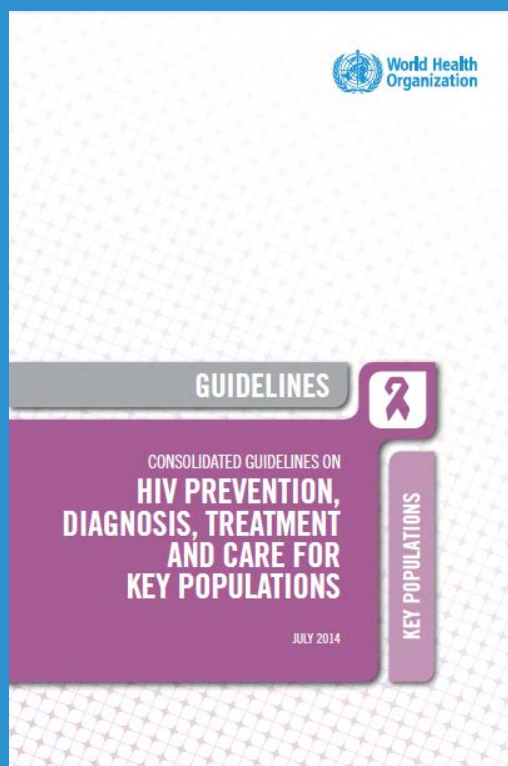
THE COMPREHENSIVE PACKAGE OF INTERVENTIONS FOR HIV PREVENTION, TREATMENT, CARE AND SUPPORT AMONG PEOPLE WHO INJECT DRUGS*

Essential health sector interventions

1. Comprehensive condom and lubricant programming
2. Harm reduction interventions for substance use, in particular needle and syringe programs and opioid substitution therapy and overdose prevention with naloxone
3. Behavioral interventions
4. HIV testing and counseling
5. HIV treatment and care
6. Prevention and management of co-infections and other comorbidities, including viral hepatitis, TB and mental health conditions
7. Sexual and reproductive health interventions

Essential strategies for an enabling environment

1. Supportive legislation, policy and financial commitment, including decriminalization of behaviors of key populations
2. Addressing stigma and discrimination
3. Community empowerment
4. Addressing violence against people from key populations



*WHO. 2014. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.



Why Overdose Matters for HIV

Recognizing the needs of communities already vulnerable to HIV, OSF and the Eurasian Harm Reduction Network (EHRN) have jointly articulated clear linkages between HIV programs and overdose prevention efforts in order to further facilitate implementation of overdose prevention and management, and their integration within national HIV strategies. Essentially, OSF and EHRN underline that overdose prevention and management is necessary for quality HIV programming among PWID for a range of reasons:

1. Among people living with HIV, overdose is a significant cause of mortality, often being the leading cause of death among PWID living with HIV in many countries including Canada, US, India, Spain and France;
2. PWID are at greater risk of fatal overdose if they are living with HIV and/or hepatitis C, due to the associated systemic disease and liver damage linked to HIV/hepatitis C infection;
3. Overdose prevention services connect people who use drugs to HIV prevention, drug treatment, primary health care, and other health and social care services. This linkage has been demonstrated to produce a positive impact on drug use and HIV prevention;
4. Overdose prevention empowers people who use drugs as well as people living with or at risk of contracting HIV. When involved and trained to respond to overdoses, PWID report feeling empowered and useful;
5. Overdose may exacerbate HIV related opportunistic infections and other conditions like pneumonia, pulmonary edema, acute renal failure, rhabdomyolysis, immune suppression and physical injuries;
6. State policies that criminalize and incarcerate people who use drugs and prioritize compulsory drug treatment have been shown to increase the risk of both HIV infection and overdose;
7. Overdose is a serious concern among drug users living with HIV.⁴⁷



Since 2009, PSI's global network initiated projects relating to overdose prevention and management, from implementation and service delivery to documentation of overdose prevention activities and advocacy.

Based on PSI's experiences in Russia, Uzbekistan, Kazakhstan, Kyrgyzstan, Tajikistan, China, and Vietnam and existing efforts to prevent HIV among PWID in Thailand, the PSI Thailand team made a decision in 2012 to incorporate overdose prevention and management programming under the CHAMPION-IDU project. The CHAMPION-IDU overdose prevention project – Servicing Communities with Opioid Overdose Prevention (SCOOP) – currently includes skills building for clients and implementation teams; facilitating access to naloxone across the project's 19 provinces; monitoring and documentation to produce strategic information towards future advocacy efforts; and policy advocacy to overcome implementation barriers. The SCOOP project was developed in order to add value to existing HIV prevention efforts, better meet the needs of the existing target group, attract new clients with new services, while also legitimizing the use of naloxone at community level and mobilizing government support.

CHAMPION-IDU

“If [PWID] think they are alone, and keep themselves isolated from society this means that there is self-stigmatization. If they realize they are not alone they will have confidence. Then accessing services will happen, and they will also be able to learn their rights.”

– DIC manager⁴⁸

In 2008, GFATM awarded a USD 16.6 million grant under Round 8, specifically to reduce HIV transmission among PWID in Thailand over the course of five years.⁴⁹ The grant’s principal recipient (PR) – PSI – has worked in partnership with a range of recipients – including Raks Thai Foundation (RTF), the Thai AIDS Treatment Action Group (TTAG), Alden House, Thai Red Cross (TRC), the Thai Drug Users’ Network (TDN), the Foundation for AIDS Rights (FAR), AIDS Access Foundation, 12D and Ozone⁵⁰ – to meet the needs of over 13,000 PWID. Thai government agencies such as the Department of Disease Control (DDC) and the Bureau of AIDS, Tuberculosis & STI (BATS) under the Ministry of Health (MOH), as well as the Office of Narcotics Control Board (ONCB), the Department of Corrections (DoC) and the Princess Mother Institute on Drug Abuse Treatment (formerly known as the Thanyarak Institute) have also been recipients of GFATM money to reduce HIV transmission among PWID under Round 8.

The Comprehensive HIV Prevention Among Most-At-Risk Populations by Promoting Integrated

Outreach and Networking (CHAMPION) IDU project aims to deliver and strengthen a range of essential health services for PWID by addressing policy and program gaps in Thailand’s response to HIV. For example, through peer-led and peer-operated DIC and outreach-based services spanning 19 of Thailand’s 76 provinces, PSI and its partners have been distributing sterile needles and syringes and other safe injecting paraphernalia, a service still inaccessible through government health service outlets and previously operated on a relatively small scale by civil society partners.

In parallel with community-based needle distribution through peer outreach and DICs, PSI has enlisted the support of 20 private pharmacies in and around Bangkok through a voucher exchange system. The vouchers, distributed by peer outreach workers to clients, are redeemable for free safe injecting sets at pharmacies displaying the CHAMPION-IDU logo. To date, over 20,000 safe injecting kits have been distributed through CHAMPION-IDU pharmacy outlets.

In addition, the CHAMPION-IDU project teams are providing condoms, behavior change communication (BCC) and education to reduce injecting frequency and risk behaviors, as well as referrals to STI diagnosis and treatment, voluntary HIV counseling and testing (HTC), methadone and antiretroviral treatment (ART).

More recently, PSI initiated an overdose prevention and management project with naloxone linked with the CHAMPION-IDU project, as described in this document. All services provided under the umbrella of the CHAMPION-IDU project are part of the widely endorsed UNAIDS, UNODC and WHO comprehensive package of interventions for the prevention, treatment and care of HIV among PWID.^{51,52}

Throughout the lifespan of the CHAMPION-IDU project, PSI and its partners have been committed to producing strategic information and evidence through rigorous monitoring and evaluation (M&E) as well as innovative research geared towards the development of an enabling program and policy environment for further expansion of harm reduction services in Thailand.

PSI is committed to maximizing health impact among PWID in Thailand by taking local efforts to scale. To achieve project and organizational objectives, PSI is working to strengthen technical capacity of all project staff, improve internal and external communications, actively contribute to advocacy efforts, and become a leader in harm reduction in Thailand.

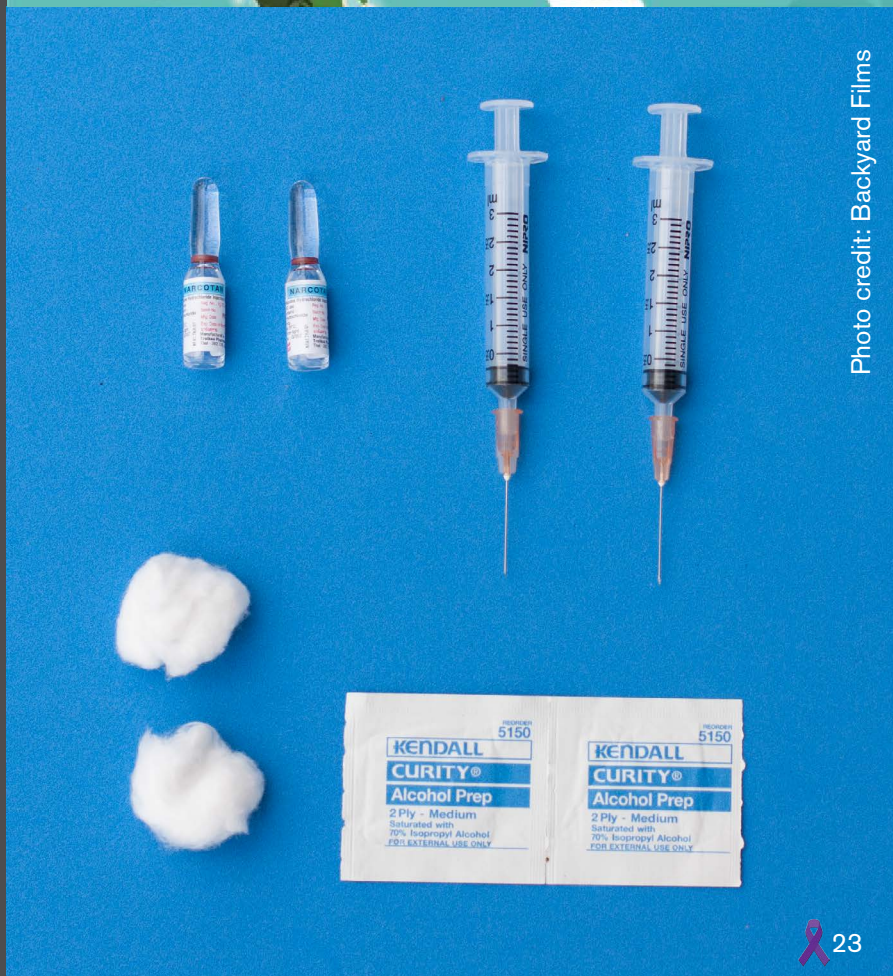


Photo credit: Backyard Films



METHODS

In 2010, The Thai AIDS Treatment Action Group (TTAG) introduced overdose prevention and management as part of their community-based efforts to reduce HIV transmission among PWID and improve their quality of life. TTAG initially facilitated informal skills building sessions with clients of the Mitsampan DIC but over the following three years, TTAG formalized their training curriculum and widened the net to meet the needs of clients at DICs operated by other organizations such as Alden House. In 2012, TTAG, hired the services of an independent consultant specifically to introduce naloxone and develop the necessary capacity to administer the antidote among a core group of harm reduction project field workers. The Chicago Recovery Alliance donated a first batch of naloxone to support the overdose prevention and management Training of Trainers (TOT), hosted by TTAG in October of 2012, for representatives of each of the 19 CHAMPION-IDU DICs who were then tasked to implement local trainings in their respective communities.

Despite the training the consultant could offer, the daunting challenges of sourcing and procuring additional naloxone persuaded TTAG to reach out to PSI Thailand for additional support and to facilitate the purchase of sufficient supplies. With generous support from OSF, a supply chain management consultant, working on a global naloxone market assessment,⁵³ was dispatched to Thailand to assist PSI Thailand staff in ensuring successful procurement, including price and policy negotiations. The International HIV/AIDS Alliance's (IHAA) Technical Support Hub in Phnom Penh,

Cambodia, also supported provision of technical assistance to, amongst other tasks, purchase naloxone on behalf of PSI Thailand for SCOOP under the CHAMPION-IDU project. In parallel with SCOOP, TTAG has continued to invest efforts in policy advocacy to address the regulatory barriers that prevent access, distribution and scale-up.

In June 2013, the PSI Thailand team presented preliminary results of the overdose prevention project at the 23rd International Harm Reduction Conference in Lithuania, focusing on the pricing,



policy and procurement barriers.⁵⁴ In an effort to share lessons learned and transparently document its efforts, the CHAMPION-IDU project partners have agreed to develop this report. An intern from Princeton in Asia (PiA) was assigned to conduct background research including performing a desk review of published literature, conducting focus-group discussions and individual interviews towards an initial working draft.

Starting on 1 September 2013, OSF further supported SCOOP with a small one-year grant aimed at expanding and improving quality of evidence base supporting implementation of overdose prevention and management, including documentation of successes and challenges, operational channels and health impact. The generous support from OSF allowed PSI to set up an integrated data collection system linked to the CHAMPION-IDU management of information system (MIS) database and analyze data to improve project strategies, support advocacy and stimulate policy change. Specifically, project objectives included:

- To document effectiveness and safety of overdose prevention;
- To relate real life experiences of people who have lived through an overdose;
- To advocate for the removal of policy and other structural barriers to direct distribution;
- To integrate overdose programming into national health systems (surveillance, methadone, etc);
- To support behavior change and education of clients as well as government officials and community representatives;
- To generate consensus around a two-year national strategic plan for overdose prevention scale-up.

Under PSI's initiative supported by OSF, quantitative and qualitative data was collected to inform project implementation and policy advocacy. Between September-December 2013, PSI surveyed 299 respondents to obtain quantitative data through rigorous statistical analysis. In February-March 2014, additional qualitative data was collected through six rounds of focus-group discussions with 50 CHAMPION-IDU staff, clients, client family members, and community representatives. In July-August 2014, an additional seven in-depth case studies were collected specifically regarding safety of naloxone and overdose mortality. Additional population data on the survey and focus-group discussion participants can be found in PSI Thailand's Overdose situation among people who inject drugs: A quantitative and qualitative research study from Bangkok, Chiang Mai and Narathiwat published in 2014.

OPERATIONALIZATION OF SCOOP UNDER CHAMPION-IDU

SCOOP PROJECT SUMMARY TABLE

Project Title	Servicing Communities with Opioid Overdose Prevention (SCOOP)
Timelines	1 January 2013 to 31 December 2014
Goal	The project aims to expand and improve quality of evidence base supporting overdose prevention implementation, including documentation of successes and challenges, operational channels and health impact
Sources of Support	<ul style="list-style-type: none"> • PSI Headquarters: Funding for procurement of naloxone • OSF: Technical assistance + funding for documentation and advocacy • IHAA: Technical assistance • GFATM: Funding for CHAMPION-IDU infrastructure
Sites	Bangkok, Chiang Mai, Chiang Rai, Lampang, Mae Hong Son, Nakorn Sri Thammarat, Narathiwat, Nonthaburi, Pattani, Phattalung, Pathumthani, Phayao, Samut Prakarn, Satun, Songkhla, Surat Thani, Tak, Trang, Yala

1. PROCUREMENT

“When our stocks of naloxone ran out, people died.”

– DIC manager

Product: Naloxone

The chemical precursor needed to produce naloxone is the same as that required to produce psychoactive opioid drugs like heroin and morphine. However, naloxone has no psychoactive properties. Pharmacologically, naloxone is a competitive opioid antagonist which reverses opioid overdoses by rapidly blocking opioid receptors, leading to rapid onset of withdrawal symptoms. In essence, naloxone binds to the same receptors in the body that receive heroin and other opioids without creating a ‘high’. Because naloxone binds to receptors much more efficiently than opioid drugs, it “kicks out” the opioid drug and reverses the respiratory depression that can lead to death from overdose. Naloxone is generally injected directly into the muscle or the bloodstream. It is effective within 1-5 minutes and subcutaneous and intranasal administration are equally effective. Naloxone is usually active in the body for 60–90 minutes – a much shorter period than most opioid drugs – highlighting the need for medical attention and supervision even after administration of naloxone.



Photo credit: Backyard Films

Intranasal naloxone is increasingly popular and available across the globe (especially in the US). Intranasal administration potentially provides greater access and reduces risks of needle stick injuries.⁵⁵ To administer naloxone intranasally, an atomizer must be attached to the tip of a syringe filled with naloxone and gently pushed to create a mist that is absorbed through the nasal mucosa. Even though it has a slower onset compared to intravenous or intramuscular administration, intranasal naloxone administration is equally effective and produces comparable results.⁵⁶ Unfortunately, the high cost of the atomizer, sold at approximately THB 600 [USD 20], is a significant barrier to scaling up this aspect of overdose prevention.

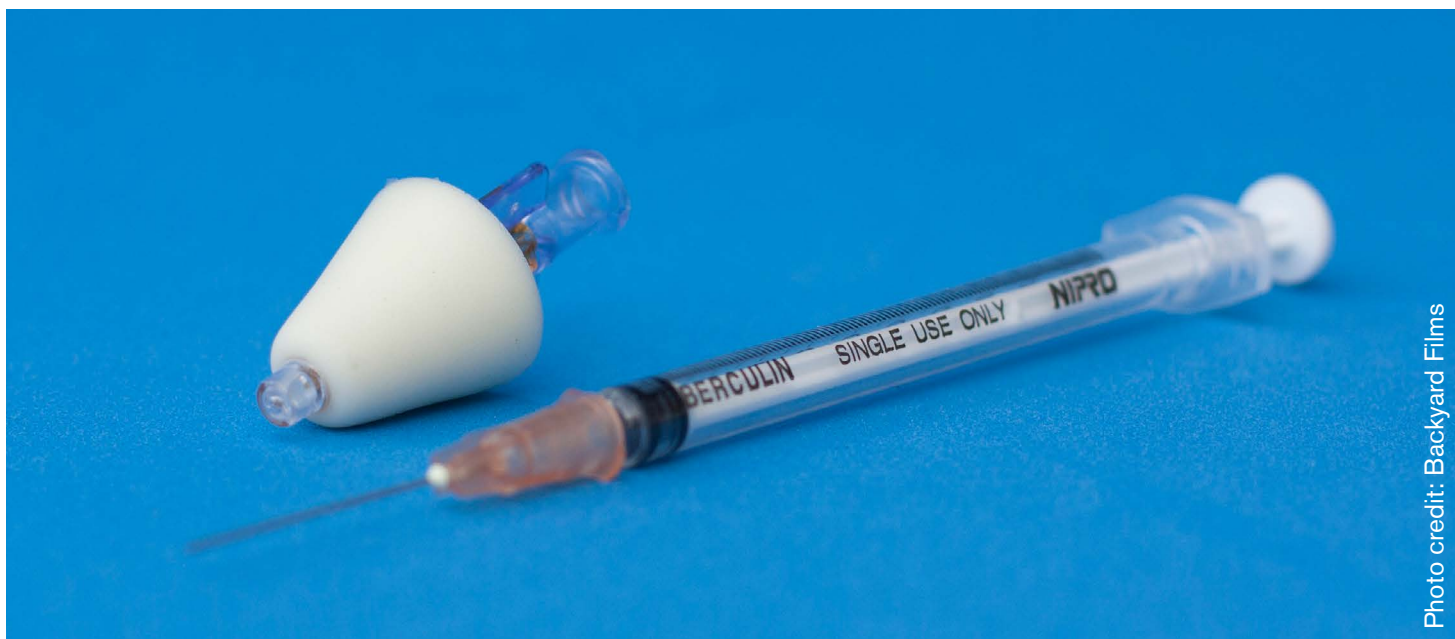


Photo credit: Backyard Films

In Thailand, naloxone is currently only available under the brand name Narcotan through Pinyo Pharmacy Ltd., Part., and manufactured by Troikaa Pharmaceuticals based out of Ahmedabad in India; or through Indochina Healthcare Ltd., supplied by Hospira Australia Pty Ltd. but ultimately manufactured by Hameln Pharmaceuticals based out of Germany. Both products sold in Thailand have a concentration of 0.4mg naloxone hydrochloride in a 1ml glass ampoule.

Though private practitioners can prescribe and administer naloxone directly to their patients, it is most widely available in operating theaters of hospitals where it is used to reverse anesthetic overdoses. Recent data from Pinyo and Indochina indicates that a total volume of approximately 10,000 vials of Narcotan is being sold to hospitals across the country every eight months to prevent accidental overdoses of anesthetics during surgery. Fortunately, such events are very rare and so, significant proportions of naloxone stocks purchased by Thai hospitals exceed their shelf life and must be replaced. In Thailand, many hospitals are not air-conditioned and temperatures can rise above 40°C, considerably reducing shelf life. For example, while Troikaa's product guidelines note a potential shelf-life of 30 months if storage temperature remains at 25°C ± 2°C,⁵⁷ Pinyo's in-country research showed

product shelf life being reduced by up to six months after exposure to 40°C.⁵⁸

In the contractual agreements between Pinyo and Thai hospitals, a clause stipulates that all expired vials of naloxone must be replaced at no cost by the supplier. The combination of high rates of attrition linked to low usage in hospital settings and high temperatures have artificially driven up market prices of injectable naloxone up to THB 246 [USD 8.20] per ampoule, compared to an average international market price of approximately THB 30 [USD 1].

Pricing: Negotiations

When PSI initiated procurement of Narcotan from Pinyo in 2012, the considerable difference between international market prices and that offered locally was an important barrier that had to be overcome. As part of a global market mapping of naloxone manufacturers and distributors it had undertaken, OSF generously delegated an international consultant and supply chain expert to come to Thailand and facilitate the procurement of naloxone for the roll-out the SCOOP project.

In negotiations with Pinyo, the consultant used a range of tactics and strategies to better understand the current rationale behind the quoted price of

THB 246 [USD 8.20] and address the components in the 'pricing mix' to reduce sales price. Three key strategies had particular influence on the pricing:

- **Volume:** Pinyo was amenable to price reductions provided that PSI make a commitment to a certain volume within a determined amount of time. Eventually, an agreement was reached wherein PSI made a commitment to purchase an initial 1,805 ampoules over an eight-month period and Pinyo accordingly reduced its naloxone sales price.
- **Attrition:** As noted above, Pinyo was bound in contractual arrangements with Thai hospitals to replace expired ampoules at no product cost and when negotiations began with PSI, Pinyo representatives came to the negotiation table with the assumption that this clause would apply as well. The elimination of this assumption also led to a significant reduction in sales price.
- **Manufacturer costs versus distributor price:** After Pinyo provided the initial quote of THB 246 [USD 8.20] to PSI, the consultant negotiated directly with the international manufacturer, Troikaa, to obtain information on their pricing guidelines and clarify PSI's interest in purchasing naloxone for overdose prevention in Thailand in the context of the CHAMPION-IDU project. Events suggest that Troikaa representatives then contacted Pinyo, which also contributed to the reduction in price offered to PSI.

All three strategies used to obtain a price reduction were successful because the consultant had done extensive background research to obtain information and understand the market dynamics and barriers across the supply chain, from the perspective of the manufacturer, distributor and client. The consultant generated bottom-up influences to address concerns and obtain a more favorable price.

However, though those strategies represented areas where trade-offs could be made and pressure applied, one of the most important components to the successful price negotiations was providing Pinyo and Indochina as well as Troikaa and Hospira/Hameln with information about PSI, about the

CHAMPION-IDU project and about SCOOP.

The consultant reported at the conclusion of his assignment that neither naloxone distributors nor manufacturers contacted had any knowledge of the 'community' market for overdose prevention among people who use illicit opioids. As both manufacturers and distributors understood the objectives of the CHAMPION-IDU and SCOOP projects, they became more interested in supporting such efforts, stimulating market competition and corporate social responsibility, which yielded a significant price reduction.

In the end, PSI purchased with its own funding a total of 1,805 ampoules of Narcotan from Pinyo for THB 75 [USD 2.22] per vial, with three scheduled deliveries in 2013 over a period of eight months. In 2014, an additional 1,625 ampoules of Narcotan were purchased from Pinyo at the previously established rate. The OSF consultant thus generated an immediate cost saving of approximately THB 600,000 [USD 20,000] by successfully concluding the price negotiation with one of two naloxone distributors in Thailand. Though the price negotiations have been extremely successful, the price obtained in Thailand is still more than double the international average market price, as noted above.

Policy: Navigation

During the procurement process, PSI discussed the objectives and activities of the overdose prevention project with several external stakeholders and it soon became clear that many policies were in place that could restrict or even prevent the implementation of SCOOP in Thailand. Even after successful price negotiations, it remained unclear whether PSI could legally purchase and distribute naloxone to prevent overdoses among clients of the CHAMPION-IDU project. To assist PSI navigate the complex medical and legal regulatory framework for purchase, use and distribution of medical products, PSI was fortunate to receive assistance from IHAA's Technical Support Hub in Phnom Penh, Cambodia, which generously appointed another consultant to facilitate and complete procurement of naloxone on behalf of PSI by addressing regulatory and policy concerns.

Different Thai laws, policies and regulations had already been identified during the procurement process, including purchasing requirements, authorizations from the government, and legal barriers to distribution. For example, in Thailand, naloxone is classified as an antidote and detoxifying agent under the Medical Information Management System (MIMS) and is included in the Dangerous Drug Category by the Thai Food and Drug Administration (FDA) implying that the medication can only be distributed by a registered pharmacist or medical professional.⁵⁹ Furthermore, at the moment of purchase, PSI had to demonstrate to the supplier that it could satisfy minimum requirements, in accordance with Thai laws on the sale of medical materials:

- demonstrating storage capacity in line with Thai FDA requirements,
- having two medical professional signatories authorizing PSI to distribute a controlled substance, and
- demonstrating a capacity to pay within 30 days.

At no time during the procurement process was PSI required to obtain a prescription or be officially registered with health regulatory agencies. PSI was able to finalize the purchase of naloxone from Pinyo's local pharmacy store in Bangkok on 23 November 2012.

Fortunately, WHO has included naloxone in the international essential medicines list (EML) as has Thailand; naloxone is one of 16 antidotes on the national EML. Medicines included in the list are considered "of utmost importance, and are basic, indispensable and necessary for the health needs of the population."⁶⁰ Furthermore, WHO states that:

*Essential drugs are those that satisfy the health care needs of the majority of the population; they should therefore be available at all times in adequate amounts and in the appropriate dosage forms, and at a price that individuals and the community can afford.*⁶¹

Not only is naloxone included on the EML, it is

included in what is known as the "core" list,⁶² which "presents a list of minimum medicine needs for a basic health-care system, listing the most efficacious, safe and cost-effective medicines for priority conditions. Priority conditions are selected on the basis of current and estimated future public health relevance, and potential for safe and cost-effective treatment."⁶³ In Thailand, all drugs listed in the EML are fully reimbursable under all national health security schemes.⁶⁴

Additional policy barriers that could potentially compromise distribution had been identified. Two regulations in particular had to be addressed before initiating distribution and use of naloxone across the 19 CHAMPION-IDU project sites:

- The Thai Food and Drug Administration classifies naloxone as a Dangerous Drug which implies that it is restricted for distribution by medical professionals – doctors, nurses, pharmacists and emergency responders.
- A national regulation is in place preventing laypeople from performing medical procedures, including injecting others with a pharmaceutical product.

At first glance, those policies and regulations seem to leave little to no room for a peer-driven community-based overdose prevention and management project with naloxone and PSI. Thailand therefore consulted lawyers and medical professionals to ensure the organization's full compliance with Thai laws in order to develop a legal and effective naloxone distribution model. Fortunately, Thailand has a 'Good Samaritan' law that protects and compels those with the means to assist a person in distress, with the threat of punishment for inaction – up to one month in prison and a fine of up to THB 1,000 [\$33].⁶⁵ In parallel, the Declaration of Patient's Rights (1998) states that anyone at imminent risk of death is entitled to receive treatment, with or without informed consent, from medical professionals or laypeople capable of providing assistance.

Thai lawyers informed PSI Thailand that the Good Samaritan laws and the Declaration of Patient's

Rights would protect the peer outreach workers should they be confronted with a client suffering an overdose and administer naloxone. These policies enabled PSI to initiate SCOOP across the 19 CHAMPION-IDU provinces. However, though the law would protect all implementing partners should trained volunteers or staff use naloxone to reverse an overdose, the FDA regulation continues to prevent PSI from directly distributing naloxone to clients. In essence, all naloxone must remain at all times in the CHAMPION-IDU DIC or in the hands of a trained CHAMPION-IDU staff or volunteer (and comply with storage regulations). PSI Thailand could face criminal charges for distribution of a controlled substance should clients directly receive vials of naloxone.



Policies and guidelines from UN agencies support the wide distribution of naloxone throughout Thailand in a cost-effective manner as they aim to improve access to core medicines needed for an effective health care system. Though policy barriers were encountered during the implementation of the CHAMPION-IDU overdose prevention and management project component, those barriers were overcome and addressed in order to initiate the SCOOP project. Before delving into the details of the implementation, the following summary recommendations have been developed based on the experiences under the CHAMPION-IDU project in order to assist other agencies intending to procure naloxone for community-based overdose prevention and management efforts.

Successful procurement of naloxone in Thailand was facilitated by the following factors:

- collecting extensive background information on the composition of the market including manufacturers, distributors, importers, and clients in relation to the product by searching in the registered medicine database;
- inform distributors of the existence of a community-based market for overdose prevention and management with naloxone to generate interest and expand the national market;
- seeking qualified supply chain technical assistance to facilitate and support procurement;
- stimulating competition between in-country suppliers as well as identifying and negotiating hidden costs in order to reduce prices further and align with international market prices;
- obtaining permissions and authorizations for procurement and purchasing;
- balancing price and volume considerations in a long-term procurement strategy supported by sustainable funding;
- building understanding and acceptance about naloxone use in Thailand.

2. IMPLEMENTATION

“Naloxone is like fire extinguishers – it doesn’t matter how many fires a year there are in this building or that building but it is absolutely critical to have them in every building in case a fire does break out and replacement is needed if they reach expiry date.”

– Bureau of the Metropolitan
Administration registered nurse

Training: Developing a professional workforce

In 2010, TTAG noticed a growing number of fatal overdoses and began educating and training the PWID community about overdose prevention and management, including the administration of naloxone. For two years, TTAG worked with local NGOs to inform clients about overdose risks, prevention and management in Bangkok. Unfortunately, naloxone remained out of reach due to financial limitations though hundreds of clients were informed and educated in overdose response. In October 2012, PSI Thailand and all CHAMPION-IDU partners were officially invited to participate in a training workshop on overdose prevention and management with naloxone, a TOT offered by an international expert consultant.



TTAG and PSI Thailand continued to work together to develop a Thai language curriculum to expand training PWID on overdose prevention and management. The curriculum is based on expert recommendations, feedback from the first TOT in 2012, and input from the CHAMPION-IDU team.

The TOT curriculum is designed for a two-day workshop targeting clients and peers and includes both theory and practice modules. At its core, the workshops are divided into three sections: how to avoid and prevent an overdose; how to recognize and identify an overdose when it occurs; and how to respond to an overdose, including how to use naloxone.

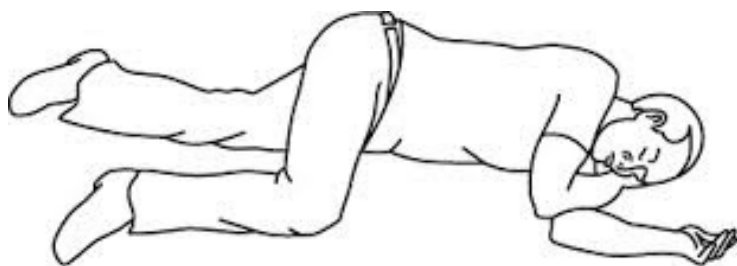
It is noteworthy that the workshops do not solely focus on opioid overdose prevention and management. As the number of amphetamine-type stimulant (ATS) injectors and users in Thailand and in the region continues to rise, CHAMPION-IDU staff have recognized that stimulant overdoses also occur in the community. Though naloxone is ineffective against stimulant overdoses, much like methadone is an ineffective substitute for stimulant drugs, the CHAMPION-IDU training curriculum includes strategies and actions to prevent and respond to stimulant overdoses.

At the end of successful workshops, all participants should be able to understand and explain what happens to the body during an overdose; identify the types of drugs and risks that predispose people to overdose; how to physically recognize an overdose; how to support someone during and after an overdose (providing rescue breathing, administering naloxone, and calling for help); how to discuss overdose prevention and responses with peers and provide training to others, including the how to integrate overdose prevention in CHAMPION-IDU behavior change communication (BCC) strategies.

In summary, workshop participants learned that a person’s propensity to overdose depends on weight, overall health, tolerance to the drug, the route of administration, speed of drug onset, the drug’s potency, and any extended periods of drug abstinence.⁶⁶ Participants are also taught to recognize the physical signs that someone is overdosing. Opioid overdoses compromise the central nervous system and lead to depressed breathing. Telltale signs of an opioid overdose are blue lips and/or fingertips, indicating a lack of oxygenation of the blood. Other signs of opioid overdoses include passing out, throwing

up, choking, gurgling and labored breathing. In the case of a stimulant overdose, also known as overamping, symptoms can include chest pain or a tightening in the chest, high temperature/sweating profusely, often with chills, fast heart rate, racing pulse, irregular breathing or shortness of breath, and convulsions.⁶⁷

Once an opioid overdose is confirmed, participants are taught to use rescue breathing, immediately call for medical help and position the person in a “recovery position”. If naloxone is available, participants are taught to inject the antidote, ideally in fatty tissue or in a muscle. In the case of stimulant overdoses, participants are taught to reduce the body temperature and call for emergency assistance.



Between 1 January 2013 and 31 December 2013, 148 staff, volunteers and clients have been trained by TTAG and PSI across all 19 provinces where the CHAMPION-IDU operates. Participants in the CHAMPION-IDU overdose prevention trainings report a very high level of satisfaction and participants' level of knowledge and attitudes regarding overdose prevention improved by an average of 98% as measured by comparing workshop pre- and post-assessments results.⁶⁸

Model: Erring on the side of caution

PSI Thailand explored several models since the initiation of the project in 2013 to ensure effective distribution, storage and use of naloxone across all CHAMPION-IDU project sites. In the design process, PSI Thailand relied on advice from other PSI countries, including PSI Russia, and colleagues at OSF as well as input from local partners. Three complementary models were explored over the course of the project including indirect distribution through outreach workers, indirect distribution through a pharmacy-based voucher scheme, and

direct distribution to clients, with the latter model being the ideal towards which to strive.^{69,70}

I wish there was more distribution of naloxone and information for clients about how to use naloxone, so they can take it from us and use it. Also, I wish there would be naloxone at the community clinics [...] or in the hands of community health volunteers because they are always available on-call. And community-health volunteers should also be provided with information so that they can understand and help us.

– CHAMPION-IDU field worker⁷¹

It is worth pointing out that in each model, PSI has consistently emphasized that naloxone, though critical, is but one component of an effective overdose prevention and management package. Indeed, under each model below, BCC towards reduced risk behaviors and capacity building on discussing overdose in the community are always integrated and generally precede interventions with naloxone.

Free indirect outreach-based distribution:

Though current Thai regulations prevent direct distribution of naloxone to clients, PSI and CHAMPION-IDU partners initiated the opioid overdose prevention component through trained outreach workers. In the initial phases, even before naloxone was made available, targeted community-based BCC activities were integrated into CHAMPION-IDU to sensitize clients to issues relating to overdose prevention. In February 2013, each DIC was provided with the necessary equipment to store and monitor stocks and field staff and volunteers now regularly carry naloxone during outreach.

[When I do outreach in the community], clients often ask if they can have it [naloxone] or buy it from me. I can't give it to them. We keep them at the DIC or in peer leaders' homes in case someone ODs. They need to be trained before they can have naloxone and only use it when someone is really suffering from an overdose. It's a waste to use naloxone on someone who's just high [but not in danger].

– CHAMPION-IDU field worker⁷²

In addition to DIC and outreach based overdose prevention activities, many clients of the CHAMPION-IDU project have contacted PSI staff and volunteers outside of working hours to intervene as a friend suffered an overdose. In these cases, CHAMPION-IDU representatives have to collect the naloxone at the DIC and make their way to the location of the emergency. Fortunately, many of the CHAMPION-IDU field staff live near the DIC but in some cases, time is a major barrier to reversing an overdose. In such events, if naloxone had been in the hands of clients (direct distribution), the odds of reversing opioid overdoses would be significantly increased.

Someone from the community clinic called me at four thirty in the morning to inform me someone was suffering from an opioid overdose. Because the community clinic doesn't have naloxone, they called me.

– CHAMPION-IDU field worker⁷³

I was with four other people at the time. We panicked when one person overdosed because we didn't know what to do so we shook him and threw some water at him. Back then, we didn't know how to help [people suffering from an overdose] and were panicking. One of us tried to go and get a vehicle to take him to the hospital but we didn't make it and our friend died.

– CHAMPION-IDU client⁷⁴

There is naloxone but it's kept with [CHAMPION-IDU] peer outreach workers. It is not widely available. When someone overdoses, they have to wait for the peer outreach worker to come. There's always a chance that the person will die before the peer outreach worker arrives.

– CHAMPION-IDU client⁷⁵

OVERDOSE PREVENTION IN BANGKOK

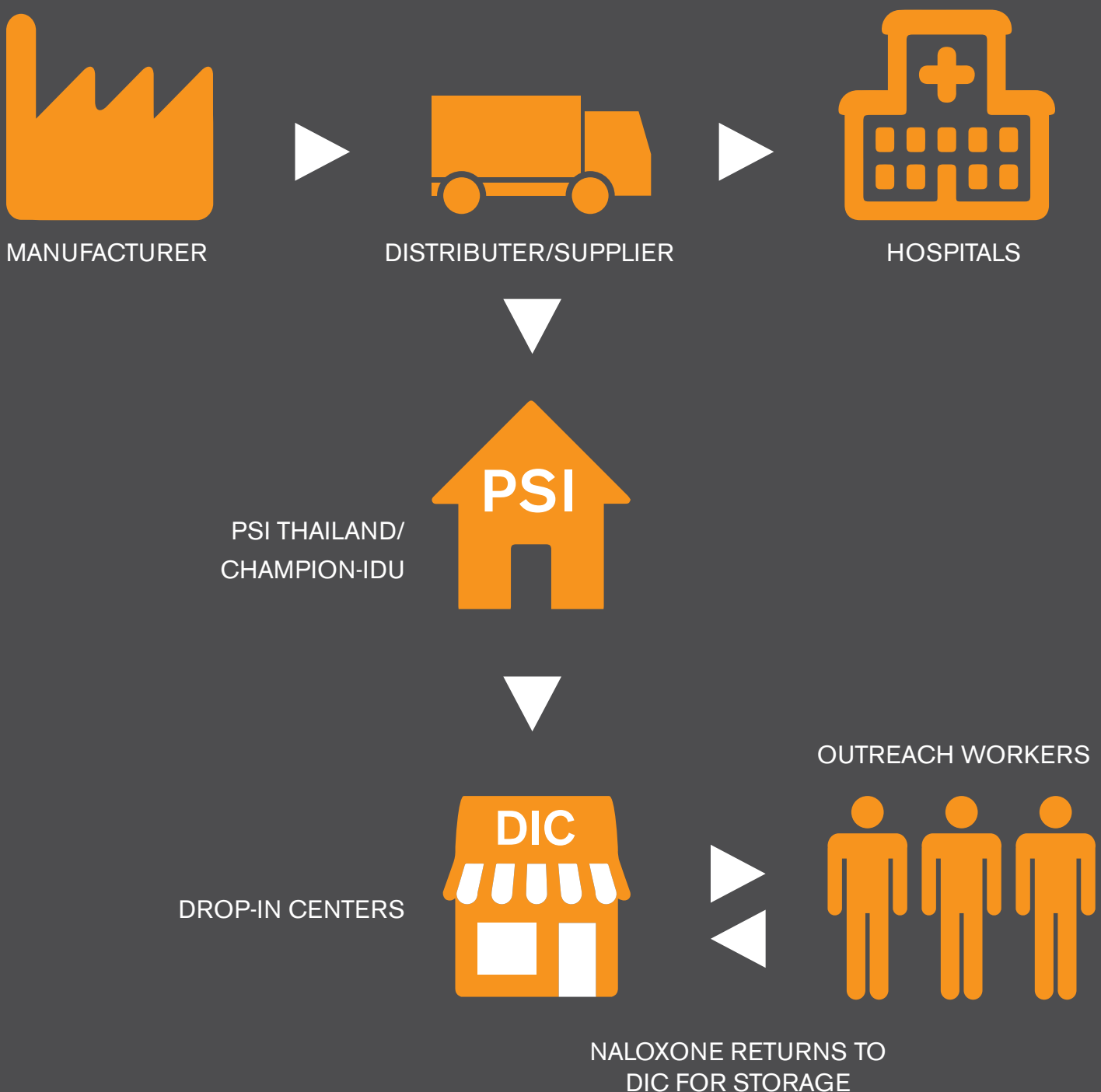
In Bangkok, a high proportion of opioid injectors mix their heroin with pharmaceuticals, particularly Dormicum (midazolam) a short-acting but powerful benzodiazepine, increasing the risk of opioid overdose as the central nervous system is already depressed. Particularly around the Mittsamapan DIC (previously operated by TTAG, now operated by PSI Thailand), outreach teams have noted a high number and frequency of opioid overdoses in the area. In March 2014, one of the PSI peer outreach workers followed his clients as they used drugs, with particular concern for one individual who had just had spent several weeks at the temple to be ordained. The PSI outreach worker approached this client, urging him to be careful with his drug injections, underlining that his tolerance would have changed significantly. Despite the warnings, after the first injection, the client passed out and quickly, the PSI outreach worker recognized the signs of an opioid overdose and administered the naloxone he was carrying. After two intramuscular injections of naloxone, the client regained consciousness but remained under observation for more than 30 minutes.



Photo credit: Voxiton Images

This model has been successful in initiating overdose prevention on a large scale in Thailand. In parallel, the success of the model was predicated on effective introduction to clients and the community around the project sites through sensitization, training and targeted BCC activities. However, policies remain in place that could jeopardize the sustainability of indirect distribution and use by outreach workers, depending on how they are interpreted and applied in practice. Though there are policy protections to cover the CHAMPION-IDU workers, the unclear and contradictory policy environment remains an important hurdle to expanding and normalizing overdose prevention with naloxone.

MOVEMENT OF NALOXONE IN THAILAND



Free indirect pharmacy-based distribution:

With generous support from OSF, PSI Thailand was able to initiate discussions with some of the CHAMPION-IDU pharmacists in key locations, to explore the possibility of distributing naloxone kits – one vial, three needles, three syringes, three alcohol swabs – through a similar voucher scheme as the one already in place to distribute sterile injecting equipment to clients. Essentially, outreach workers would provide clients with vouchers that can later be redeemed for injecting equipment and/or an overdose prevention kit at participating pharmacies. As of August 2014, a total of 20 pharmacies in and around Bangkok were supporting needle and syringe distribution through the CHAMPION-IDU outreach-based voucher scheme. Meanwhile, six new pharmacies have also begun engaging with CHAMPION-IDU in Narathiwat and Pattani provinces as part of an expansion pilot.

Out of the existing partnership between local pharmacies and CHAMPION-IDU implementing agencies emerged an opportunity to address policy barriers that constrained SCOOP. PSI invited pharmacy owners to several discussions in 2014 in order to provide information about overdose and naloxone, sensitize pharmacists to facilitate access to naloxone, and explore mechanisms and channels to improve national management of overdose prevention. An outreach-based voucher distribution scheme allowing clients to directly access naloxone

at local pharmacies with reimbursement through the national health security system would overcome virtually all policy barriers that currently constrain SCOOP.

Unfortunately, though the majority of pharmacists demonstrated interest in learning more about overdose and naloxone, only one pharmacy owner from Bangkok expressed interest in stocking naloxone and expanding the CHAMPION-IDU voucher scheme to include naloxone. All pharmacists expressed concern about the need to deploy a policy mechanism to ensure that a verification system will allow naloxone providers to confirm whether clients have been trained in overdose prevention, management and response.

PSI Russia's three-year overdose prevention project also explored three different distribution models, including one relying on pharmacy distribution. The project team reported that the pharmacy-based distribution model had been successful because it offered a more legitimate and legal channel for distribution as well as a more sustainable mechanism to ensure supply and access.⁷⁶ As has happened in Russia, the pharmacy based distribution option in Thailand would neutralize policy barriers and eliminate the potential legal exposure civil society groups face when implementing life saving activities.



In May 2014, the New York City Police Commissioner and Attorney General announced that 19,500 police officers would be equipped with naloxone, an effort under the Community Overdose Prevention Program to reduce the recent increase in opioid overdose deaths in New York. With estimated costs over USD 1 million, authorities will be relying on money seized from drug raids to finance the project. The overdose prevention and management kit for New York City police officers – valued at USD ~60 per kit – includes two prefilled syringes of naloxone, two atomizers for nasal administration, sterile gloves and basic instructions in a zip bag.⁷⁷ After over 50 TOT sessions in early 2014, more than 1,300 officers were trained with plans to roll out additional trainings to build the capacity of 5,000 officers in 2014-2015. Though police will not be distributing naloxone to PWID in New York City, this innovative model will facilitate access to naloxone during emergencies, much like the indirect pharmacy-based distribution model would in Thailand.

Direct peer-based distribution:

Though indirect distribution has its merits in the short and medium term, the simple fact that PWID are not allowed to carry an antidote that could save their friend's or their own life will always imply that a third party – who is likely not on site – must travel to the location of the emergency to administer naloxone, instead of direct and immediate administration by peers. Direct distribution implies that naloxone is placed directly in the hands of PWID alongside provision of training and sensitization on overdose prevention and management. If such a situation were possible, additional sensitization with the clients' family and relatives would be integrated in the overdose prevention package. Countries like Canada,⁷⁸ China, Tajikistan and the United States have already started exploring direct distribution of naloxone – or “take-home” naloxone – through peers, their families and their social networks.⁷⁹

In Narathiwat province, heroin is abundant, cheap and of high quality. It is not surprising that heroin overdoses are common. PWID in the Sugnai Kolok and Wang districts often congregate in large groups near the river or in abandoned houses to inject drugs. The CHAMPION-IDU outreach workers who operate the overdose prevention and management component there have reported significant frustration at being

called to the scene of an overdose, only to arrive too late and find their client has already died:

If our clients had one or two vials of naloxone under the bridge or in that abandoned house, they could save each other's lives instead of waiting for the CHAMPION-IDU representative to arrive. Some of our friends would still be alive today if naloxone could be distributed directly to clients. [CHAMPION-IDU field worker]

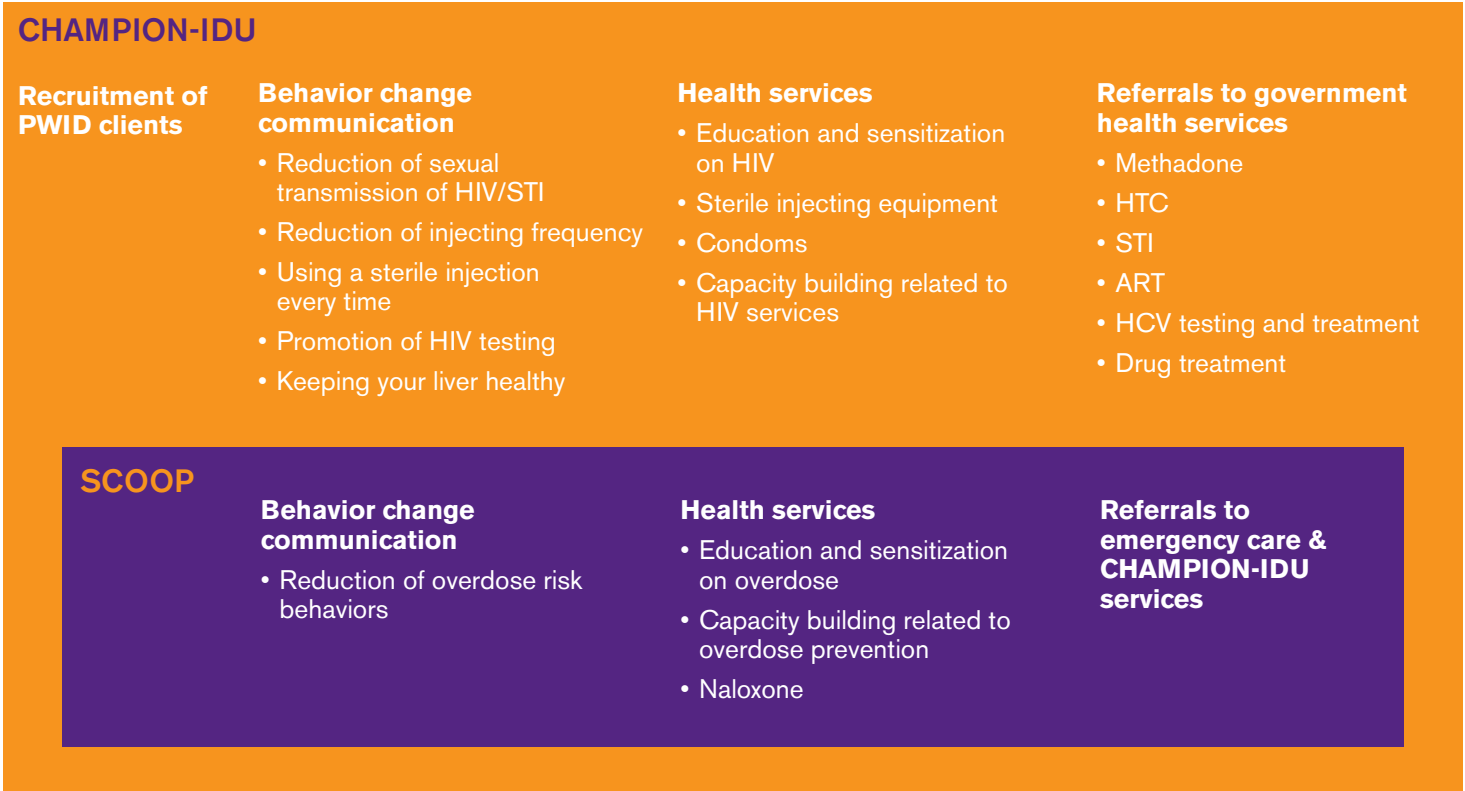
Though the current policy environment does not offer many opportunities to scale-up SCOOP to include direct distribution, PSI has been working with key partners to seek a temporary exemption on humanitarian grounds from the MOH. In Manipur, India, the National AIDS Control Organization under the Ministry of Health relaxed regulations to allow direct distribution of naloxone to trained PWID through targeted harm reduction programs. In Kyrgyzstan, the national government exempted civil society organizations to allow storage and distribution of naloxone through both community- and pharmacy-based schemes.⁸⁰

Though for now only indirect outreach and DIC or pharmacy based distribution can be legally implemented in Thailand, CHAMPION-IDU partners are hopeful that additional advocacy and sensitization efforts will allow progressive scale-up to incorporate pharmacy based distribution, and eventually, direct distribution. Given that all three models have their own strengths and weaknesses, the PSI Thailand team has recognized the complementary value of all three models for simultaneous implementation.

M&E and Documentation: Collecting evidence for action

PSI globally prides itself on collecting data to measure its health impact objectively and PSI Thailand thus invested significant time and resources in developing a robust set of indicators to track progress, adjust project strategies and demonstrate impact while collecting strategic evidence to support advocacy towards a more enabling policy and implementation environment. The generous one-year grant from OSF allowed PSI to develop a rigorous M&E framework in September 2013 that included both quantitative and qualitative indicators (see below) and data collection tools and forms (see Annex 1).

The SCOOP M&E framework was harmonized with the CHAMPION-IDU M&E framework and integrated in the same MIS. The CHAMPION-IDU MIS relies on unique identifier codes (UIC) that anonymizes clients' identities while allowing in-depth tracking over time, by service and by client. The CHAMPION-IDU MIS and UIC systems have been recognized by UNAIDS, UNODC and WHO as a model of best practice.⁸¹ Finally, the data in the MIS and field staff logbooks is triangulated on a monthly basis through the Closing the Loop (CTL) system, a centralized system consolidating MIS, stock management systems and budget/expenditure data to ensure accuracy of results.



Early experience from using the SCOOP reporting forms has shown that narrative details recorded in field workers' narrative reports are often very scarce. To enhance the documentation, PSI plans to invest in additional training for DIC managers to enhance their interviewing skills to collect additional details from field workers and if possible from clients, and record the events in the narrative report on behalf of field workers.

CHAMPION-IDU OVERDOSE PREVENTION INDICATORS

	WHAT IT MEASURES	METHOD OF MEASUREMENT	MEASUREMENT FREQUENCY
1. Number of naloxone distributed to peer outreach workers (indirect distribution)	Number of naloxone vials distributed to peer educators who have been trained and certified through TTAG/PSI training course	Tracked through stock reports at each DIC. Using PSI's "Closing the Loop" (CTL) –system to triangulate data from stock log books, the MIS and the budget	Monthly reports
2. Number of naloxone distributed to PWID (direct distribution)	Number of naloxone vials distributed to PWID who have been trained and certified through TTAG/PSI training course. Includes vials received from DICs, peer educators and other distribution outlets	Tracked through stock reports at each DIC., links to UICs of clients. Using PSI's "Closing the Loop" (CTL) –system to triangulate data from stock log books, the MIS and the budget	Monthly reports

Comments on indicators 1 and 2 (distribution of naloxone):

Though PSI is tracking the number of vials distributed, additional data should be collected in the future to better facilitate access to the antidote. Looking upstream, as new distribution models are implemented in conjunction, it will be important to capture which channels clients use to access naloxone through stock management systems. Meanwhile, looking downstream, enhanced data collection should include information on what happens to the naloxone after it's been distributed: number of vials used, broken, lost, abused, expired before use. This data should be collected through periodic (bi-annual) surveys conducted among a random sample of clients.

	WHAT IT MEASURES	METHOD OF MEASUREMENT	MEASUREMENT FREQUENCY
3. Number of field workers trained on first aid to manage overdose	Number of naloxone vials distributed to peer educators who have been trained and certified through TTAG/PSI training course	Program record on trainings; comparison of pre- and post-training test results	Quarterly
4. Increased knowledge of PWID regarding overdose and response	Number of naloxone vials distributed to PWID who have been trained and certified through TTAG/PSI training course. Includes vials received from DICs, peer educators and other distribution outlets	Comparison of pre- and post-training test results	Quarterly
5. Increased knowledge of health service providers regarding overdose and overdose response	Number of health service providers whose knowledge about overdose has increased after receiving training from the project	Comparison of pre- and post-training test results	Quarterly

Comments on indicators 3, 4 and 5 (training on overdose):

The trainings provided to field workers include understanding risk factors for overdose, recognizing symptoms of an overdose, responding properly (first aid, calling for help, administering naloxone). In order to be counted against indicator targets, training participants must show increased understanding in overdose prevention as measured through pre- and post-test results. Those who complete the training and show positive improvements in knowledge and application of naloxone use are certified and receive a naloxone kit to take on outreach in the community. Additional community based workshops take place on a regular basis for clients of the CHAMPION-IDU project, including PWID as well as community members and leaders around each DIC. It should be noted that though PSI designed an indicator for training of health service providers, provision of such training was not part of the scope of the SCOOP project.

	WHAT IT MEASURES	METHOD OF MEASUREMENT	MEASUREMENT FREQUENCY
6. Number of naloxone administration events in response to overdose	Number of times naloxone was used by a field worker	Overdose incident reporting form (OVD_02). Reported through the MIS as of April 2014	Quarterly
7. Number of overdose deaths averted through administration of naloxone	Number of PWID who overdosed who received naloxone and recovered	Overdose incident reporting form (OVD_02). Reported through the MIS as of April 2014	Quarterly
8. Number of fatal overdoses that could have been avoided through direct distribution	Number of fatal overdoses due to unavailability or too late administration of naloxone	Overdose incident reporting form (OVD_02) and overdose incident narrative report (OVD_02.1)	Quarterly
9. Number of times naloxone was misused, leading to documented negative health outcomes	Number of naloxone vials abused by PWID or diverted	Survey or operational research	Bi-annual

Comments on indicators 6-9 (use of naloxone and lives saved):

Documenting the number of overdose cases and lives saved by reversing overdose with naloxone are essential measurements to track the success of overdose prevention. However, to document the effectiveness of distribution models and channels, it will be important to be mindful to collect data regarding any and all fatal overdoses in the community around the DICs that could have been avoided had naloxone been available for administration directly by a friend or family member instead of having to alert a peer educator to the scene. Based on lessons learned from the roll-out of the initial overdose incident reporting form, it has been modified to better capture essential data, i.e. adding specific questions on who administered the naloxone, what was the outcome and why (e.g. dead on arrival of the outreach worker).

Finally, as concerns about abuse or diversion of naloxone are frequently raised by opponents of peer-based/direct distribution of naloxone, surveys should be conducted to investigate whether any such cases do occur even though there is little pharmacological basis to assume any abuse would occur. SCOOP focus group discussions found the concern to be largely hypothetical. However, collecting data to back up the expectation that naloxone will not be abused or diverted will be helpful for advocacy efforts.

	WHAT IT MEASURES	METHOD OF MEASUREMENT	MEASUREMENT FREQUENCY
10. Number of PWID accessing additional harm reduction services after naloxone administration	Number of PWID whose overdose was reversed by naloxone administration who subsequently received or were referred to any new health service. Health services include HTC, ART, diagnosis and treatment of STIs, diagnosis and treatment of HCV, distribution of sterile injecting equipment and condoms	Overdose incident reporting form (OVD_02) and data on service delivery through MIS; the two linked through UIC	Quarterly
11. Reducing frequency of overdoses (BCC)	Number of PWID with lifetime prior overdose with experience of reduced frequency of overdoses following receipt of services from the project	<p>Option 1: Trend analysis of overdose incident reports by project site/aggregated at project level</p> <p>Option 2: Cohort study of PWID who report ever experiencing overdose: base line survey vs. end-line survey</p>	Once per project cycle

Comments on indicators 10 and 11 (behavior change):

Indicator 10 is set to measure the positive impact overdose activities are expected to have improving uptake of other health services. By gaining the trust of the clients and providing a service they see as useful, it opens the door to recruit them to other services and combat the “message fatigue” in HIV-prevention. Indicator 11 would measure long-term impact of the program: improved knowledge about overdose is expected to reduce the incidence of overdoses over time.

Advocacy: Tackling the challenges

Drug policy advocacy has been a mainstay of the CHAMPION-IDU project, often achieving well over 200% against indicator targets set in the project performance framework. This means that a wide range of workers are well-versed in policy negotiation. These skills have been useful since the initiation of SCOOP to ensure community acceptance and even more so after receiving the generous grant from OSF in September 2013. Though there has been overwhelming positive support for SCOOP in the majority of the CHAMPION-IDU provinces, certain obstacles highlighted in this report continue to expose SCOOP, the CHAMPION-IDU project and its implementing partners to significant risk.

In order to transform policy barriers into implementation opportunities, PSI led an advocacy process to mobilize the support of Thailand's health service providers who would assist in swaying policymakers by lending their influence to civil society groups. With the objective of developing a two-year advocacy plan shared between civil society groups and local and national level health service

providers, four meetings were organized across Thailand to consult representatives from the health sector, including doctors, nurses, pharmacists, public health experts and health lawyers as well as civil society representatives mostly from the CHAMPION-IDU project. Over 130 participants attended the meetings, including representatives from the FDA, MOH's DDC and the Princess Mother Institute on Drug Abuse Treatment as well as others.

In general, participants were unfamiliar with naloxone at the outset of meetings and PSI Thailand and TTAG provided all participants with basic facts sheets on naloxone and opioid overdose in Thailand to set the stage for more detailed discussions. After reading the materials and at the conclusion of all four meetings, no health professionals disputed the effectiveness of naloxone as an antidote to opioid overdose. The majority of participants agreed that facilitating access to naloxone among PWID would save lives. However, several reservations were raised regarding Thailand's laws and policies that could expose SCOOP partners to legal sanctions, as described above.



In particular, the national and FDA regulations preventing administration of a controlled substance by laypeople provoked the strongest foundation for opposing implementation and scale-up of SCOOP amongst almost all representatives from the health sector. Despite the presence of a health lawyer underlining that Good Samaritan laws and the Declaration of Patient's Rights protect individuals who inject the antidote to reverse an opioid overdose, strong reservations persisted.

However, representatives from key national agencies noted that an indirect distribution model through pharmacies – with or without civil society's voucher system – could be setup and would fully comply with national regulations. In turn, private sector pharmacists agreed that a pharmacy-based supply chain would eliminate many risks for civil society and facilitate more direct access for PWID. Unfortunately, not all pharmacists agreed with the proposition, raising concerns about encouraging drug use should an antidote be too easily accessible.

In terms of secondary concerns, health service providers who participated in the consultations identified a need to scale-up their own capacity to deal with overdoses. The prevailing attitude among participants was that current capacity was simply insufficient to manage overdose reversals with naloxone. Representatives from the Princess Mother Institute on Drug Abuse Treatment expressed consistent support for overdose prevention integration and suggested including the CHAMPION-IDU training module in the Institute's yearly professional development curriculum.

One of the nurses who participated in the meeting described an event:

A drug user had been dropped off at the hospital and the nurses didn't know what to do. There was an overall panic and such a commotion set in that it disturbed everyone because there was only one doctor to take care of the patients and the person suffering from an overdose.

– Bureau of the Metropolitan Administration registered nurse

When participants discussed national surveillance to track the number of fatal overdoses (and reversals) in Thailand, again the majority of health sector representatives voiced strong and widespread opposition. The majority of participants felt that collecting overdose morbidity and mortality data could be perceived as incompatible with the government's widely publicized objective of completely eliminating drug use in Thailand.

Geographically, the greatest support and interest for implementation and scale-up of SCOOP came from the southern provinces – Narathiwat, Pattani, Songkhla and Yala. Participants there welcomed the CHAMPION-IDU representatives' efforts to improve quality of life of PWUD and PWID and requested continued dialogue and information about SCOOP-related efforts in their areas. In the northern provinces – Chiang Mai, Chiang Rai, Mae Hon Son, Lampang, Phayao, and Tak – there was little opposition to efforts furthering the established CHAMPION-IDU project and participants' attitudes were described as moderately supportive by CHAMPION-IDU project staff. In contrast, in Bangkok and the central provinces, health service providers raised legal, policy, and political concerns to distance themselves from SCOOP. The geographical support for SCOOP was comparable to that received overall for the implementation of CHAMPION-IDU in each region.

In parallel with the consultations, PSI Thailand invested significant resources to provide detailed feedback in a process facilitated by WHO Thailand to revise national methadone guidelines. With several face-to-face meetings between April and December 2013 and rounds of electronic feedback on multiple drafts, PSI Thailand consistently pushed for the inclusion of a section in the national guidelines on overdose prevention. The final version of the guidelines include the following:

Opioid overdose is most common in the first 2 weeks of methadone treatment and less common above doses of 60mg daily. Opioid overdose is most common in poly-substance use with other sedatives (such as benzodiazepines or alcohol). IM naloxone (400mcg) should be stocked at the methadone clinic, as well as available to outreach teams.⁸²

At the close of the OSF grant on 31 August 2014, the advocacy planning process did not yield the expected outputs of a concerted two-year advocacy strategy and detailed regional action plans with clear roles and engagement responsibilities shared between civil society and health service providers. However, the consultations have yielded deep insight into stakeholder positioning vis-à-vis overdose prevention and management with naloxone and SCOOP as well as tentative shared work plans in the North and South. Based on current stakeholder landscape, PSI Thailand is in a strategic position to move forward and support a more concrete planning process. Indeed, the investment in stakeholder mapping has also contributed to a tenuous consensus for potential scale-up of overdose prevention with naloxone through a pharmacy-based model.

The fragile agreement around a potential pharmacy-based model for naloxone distribution in Thailand is an example of how the CHAMPION-IDU partners have identified policy challenges and elegantly leveraged support to transform barriers into opportunities. By relying on key partners such as health lawyers from the Foundation for AIDS Rights (FAR), the discussions around policy barriers led participants to naturally identify pharmacy outlets as a feasible solution compliant with all regulations, while meeting project objectives with opportunities for continued civil society engagement.

However, as noted earlier in the report, the model towards which the CHAMPION-IDU implementation teams are working towards is to end up putting the antidote directly in the hands of laypeople – PWUD, their friends, families and communities.⁸³ Although the project team is proud to have achieved the results recorded to date and plans are underway to support the scale-up of SCOOP through pharmacies, one of the senior-most CHAMPION-IDU managers reports:

The overdose prevention project will only be a success in my eyes once there are multiple channels in place from which people who use opioid drugs can access naloxone. We can't rely just on civil society or just on the pharmacies. If access to this life saving antidote is to become a sustainable reality, we need all sectors involved.

The CHAMPION-IDU partners have defied the odds, working in a policy constrained environment against challenging targets and deadlines, and have setup an overdose prevention and management project with elements of best practices and innovation to better meet the needs of clients. However, much remains to be done for this ideal to become a daily reality for Thailand's community of PWUD. Though the OSF support has ended in September 2014, the CHAMPION-IDU partners have maintained overdose prevention services as well as fully integrated next steps for overdose prevention advocacy in their local CHAMPION-IDU DIC-level advocacy plans.

Provided that the CHAMPION-IDU infrastructure remains in place and fully resourced, the SCOOP project could be easily expanded with a small national investment to fully integrate overdose prevention in national systems through a pharmacy based scheme supported by the CHAMPION-IDU voucher scheme. Unfortunately, funding from GFATM to Thailand under the New Funding Mechanism has been considerably reduced and though in-country negotiations are not finalized, funding for HIV prevention among PWID is likely to be dramatically reduced. In addition, PSI Thailand will no longer be receiving funds from GFATM to support HIV prevention among PWID starting on 1 January 2015. Instead, PSI Thailand's branded network of DICs – Ozone – will register as an autonomous local NGO and take over direct management of operations across all Ozone sites. As such, Ozone will directly manage the majority of HIV prevention sites targeting PWID, in eight of 12 provinces supported by the New Funding Mechanism, implying cessation of service delivery in seven provinces.

Globally, funding for HIV prevention and other health services for PWID is rapidly diminishing.⁸⁴ Current funding indications for Thailand imply significant financial cutbacks which, combined with increased performance expectations, will likely negatively impact quality of services, capacity of workers, and sustainability of the national harm reduction response, including the continuity of the SCOOP project.

THE 11TH INTERNATIONAL CONGRESS ON AIDS IN ASIA AND THE PACIFIC (ICAAP)



During the 11th ICAAP, PSI Thailand and other partners shared responsibility for managing the Drug User Networking Zone in the Asia Pacific Village. With OSF's support, PSI Thailand worked with OSF to promote overdose prevention and management with the support of their mascot, the Naloxone Ninja. Created for the 23rd International Harm Reduction Conference in Lithuania, the Naloxone Ninja is a harm reduction hero fighting to get naloxone into the hands of those who need it most.

The Naloxone Ninja paraded around the Asia Pacific Village between 18-22 November 2013, promoting overdose prevention and management with slogans and key advocacy messages (see Annex 2), with handouts and gifts and photo opportunities. In conjunction with the *Support. Don't Punish.* campaign,⁸⁵ the Naloxone Ninja was a consistent presence in the photo booth setup to promote the international campaign for harm reduction, including overdose prevention and management, and drug policy reform.

During the conference, PSI Thailand and TTAG field workers were on site to offer overdose prevention training, as well as naloxone. More than 20 participants were trained and received a vial of naloxone during the conference.

3. RESULTS

"I feel very proud of having saved one of the CHAMPION-IDU clients and those positive lessons learned are very useful in sensitizing communities around our DIC."

– CHAMPION-IDU field worker

Almost two years after the initiation of SCOOP – and despite the full scope of the project remaining constrained by internal and external challenges – significant outputs, outcomes and impact have been achieved. With the objective of demonstrating effectiveness and safety of opioid overdose prevention using naloxone in Thailand, SCOOP has yielded significant results against indicators since initiation in January 2013.

A total of 3,430 vials of naloxone were procured under SCOOP in 2013-2014, and a total of 1,855 vials remain in stock at central and DIC levels. A total of 148 staff, volunteers and clients have been trained and project workers provided with 1,575 vials of naloxone since January 2013. At least 26 vials of naloxone were used by CHAMPION-IDU field workers to reverse 21 recorded cases of opioid overdose since January 2013. In all 21 cases, the client's overdose was reversed and a life was potentially saved. This includes the use of naloxone on four people who since become CHAMPION-IDU clients.

TABLE 1

SCOOP output results against indicators 2013-2014

INDICATOR	RESULTS
1. Number of naloxone vials distributed to peer outreach workers (indirect distribution)	1,575
2. Number of naloxone distributed to PWID (direct distribution)	N/A*
3. Number of field workers trained in first aid to manage overdose	148
4. Number of individuals who show increased knowledge of overdose and overdose response	1,575
5. Number of health service providers who show an increase in knowledge of overdose and overdose response	N/A**
6. Number of naloxone administration events in response to overdose	26
7. Number of overdose deaths potentially averted through administration of naloxone	21
8. Number of fatal overdoses that could have been avoided through direct distribution	No deaths ⁸⁶
9. Number of times naloxone was misused, leading to documented negative health outcomes	0
10. Number of new PWID accessing additional harm reduction services after naloxone administration	4
11. Number of clients provided with BCC on the prevention of overdose ⁸⁷	74,853

* Direct distribution is prohibited in Thailand.

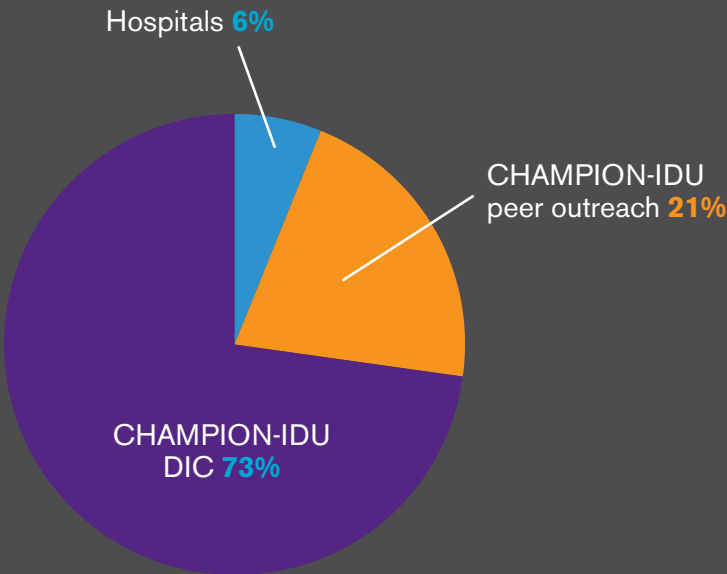
** Building capacity and sensitization of health service providers was not included in the scope of the SCOOP project due to financial constraints. However, the indicator should be proposed for use in the national system to track progress in training health service providers.

The CHAMPION-IDU project infrastructure has offered a solid platform from which to distribute large amounts of naloxone to prevent opioid overdoses across communities in Thailand. It has also offered a workforce pre-disposed to reach those at highest risk of opioid overdose and equipped them with the knowledge and skills to intervene calmly and professionally to provide life-saving assistance. Almost every one of the 180 CHAMPION-IDU field workers was trained in overdose prevention and reversal with naloxone within just a year.

In theory, every client contact with a CHAMPION-IDU field worker should include a discussion on overdose as part of the CHAMPION-IDU BCC strategy. Though no materials or tools have been produced under SCOOP, field staff were encouraged to raise and discuss the issue with their clients to reduce their risks of overdose. Unfortunately, at the time of preparation of this report, no data was available to measure frequency of overdose prevention BCC messaging. However, data from the project survey revealed that 82% of PWID had heard of naloxone and overdose prevention through the joint CHAMPION-IDU effort.⁸⁸ Respondents also listed the sources of naloxone they could identify, as summarized in Table 2, which confirms that CHAMPION-IDU has been very effective in informing PWID about overdose prevention and management with naloxone.

GRAPH 2

Comprehensive HIV Prevention Among Most-At-Risk Populations by Promoting Integrated Outreach and Networking-Injecting Drug Use clients identification of sources of naloxone ⁸⁹



It is clear that – despite significant efforts to deploy data monitoring and quality assurance across results – important data gaps remain. Indeed, output data collected under SCOOP could confirm that 21 lives were potentially saved, whilst over 1,500 vials of naloxone have been distributed.⁹⁰ However, project staff anecdotally report many more cases of overdose and reversals using naloxone than the CHAMPION-IDU MIS, suggesting that many of the project staff and volunteers are not recording data systematically. In parallel, while project results indicate no deaths from overdose during the project life cycle, anecdotal reports from field workers indicate a number of clients have passed away due to an opiate overdose though they may not have been contacted during the emergency. Additional efforts to strengthen data collection should also focus on following up with field workers about lost, broken, confiscated and misused vials, while data about capacity building should be disaggregated by site, by period, and by target audience to allow more in-depth analysis of results.

Despite the limitations, the SCOOP project has also generated notable outcomes. Most importantly, the SCOOP project has added to a growing body of international evidence demonstrating the effectiveness of community-based overdose prevention and management with naloxone (including through this report). Also of critical importance is the demonstration that a community-based overdose prevention and management project with naloxone can comply with national laws and regulations and does not lead to misuse or other adverse effects. The data collected under SCOOP indicates that the project has been successful in both demonstrating effectiveness and safety of overdose prevention and management with naloxone.

In addition to addressing effectiveness and safety concerns, SCOOP led to the establishment of a community-based supply management chain for procurement, storage and distribution of naloxone in Thailand. The project also led to the development of a strong M&E system to track overdose prevention nationally and hopefully integrate overdose in national surveillance systems. Perhaps one of the most surprising outcomes of SCOOP is its impact on the ‘market’, both upstream – by stimulating competition for an unexplored niche – and downstream – by generating demand among PWUD for more overdose prevention services as well as HIV prevention services.

Though implemented for less than two years, we can already estimate the impact of the SCOOP project based on the results presented in this report. PSI globally measures its health impact using the disability-adjusted life year (DALY), a metric developed by the World Bank and WHO to determine disease burden. One DALY equals one year of healthy life lost due to illness or death. For example, a 30-year old CHAMPION-IDU client whose fatal overdose was reversed with naloxone would generate 45 DALYs knowing that 75 is the average life expectancy in Thailand. Following this simplified logic and assuming that the average age of clients whose overdoses were reversed is 30, SCOOP's 21 successful overdose reversals represents 945 years of life saved.

Even on a qualitative level, the SCOOP project under CHAMPION-IDU has generated critical impact that is simply not captured by quantitative M&E tools and systems deployed by implementing partners. Throughout the implementation of the SCOOP project, field workers and clients alike have expressed very high levels of enthusiasm and interest in the overdose prevention component. Project management teams across the majority of CHAMPION-IDU sites have indicated that field workers easily recognize the value of overdose prevention and management:

I've been working with PWID in Thailand for almost ten years now and we keep repeating messages to prevent HIV and we offer them condoms. First of all, they know how to prevent HIV and secondly, they don't need condoms [because very few of them are sexually active]. For the first time, it's like we're offering what they want, what they need!

– CHAMPION-IDU coordinator

While addressing 'HIV fatigue' among clients, the most important benefit seems to be for CHAMPION-IDU volunteers, peers who are actively using or recovering from drug use and dependence with little or no chance of decent employment. For CHAMPION-IDU volunteer peer outreach workers, using naloxone has been a transformative experience:

For years, I have been using drugs so I was cast out by my family and my community. I became an outreach worker under CHAMPION-IDU recently

and could see that I was helping others and that made me feel happy. However, I was still rejected by my family and the community where I now live. After I saved [a CHAMPION-IDU client] from an overdose using naloxone, I was very proud. I never felt proud of myself like this before. Even people in the community know me because I saved [a client] from a heroin overdose.

– CHAMPION-IDU volunteer

For the first time in my life, I feel like I did something positive. I would never have thought that I had the power and capacity to save someone. I'm glad [the client] is still alive and we are now good friends.

– CHAMPION-IDU volunteer

The feeling of empowerment that comes with saving a human life was an overwhelming sentiment that permeated all communications with the project team during the preparation of this report. From clients to central project management teams, the enthusiasm levels of those involved in delivery of this new health service was refreshing and stimulating.

The SCOOP project was designed to meet an immediate emergency need in a community that has disproportionately restricted access to health services. What we found was that we were able to stimulate demand for HIV services through this new service. [...] Testimonies from CHAMPION-IDU clients seem to indicate that we're attracting a new segment of the PWID population. Obviously, this is very exciting for the dedicated staff and volunteers of the CHAMPION-IDU project, and even more so for clients who are looking forward to having the opportunity to use naloxone themselves to save their friends.

– CHAMPION-IDU senior management

After the overdose training, peer outreach workers feel more confident about helping their clients. We are more confident [about providing help] even though we don't know whether the client will pull through. Naloxone is something new which we can easily talk about, share information about and even promote to our clients who haven't heard of the benefits associated with naloxone. We can discuss the positive impact of naloxone with doctors and show them it really helps. It's obvious to us because many of our peer outreach

workers have used it [to] successfully [reverse an overdose] and we are more confident about helping our friends.

– CHAMPION-IDU field worker⁹²

I've seen a lot of my friends die of opioid overdoses over the past decades. So many lives lost uselessly – if I had known that naloxone existed, I could have saved some of them. At least, now that PSI is offering overdose prevention services with naloxone, I expect that my friends lives will be protected. Now that we know about naloxone, we will make sure it is available for us when we use drugs.

– CHAMPION-IDU client

Qualitative survey results indicate that 39% of CHAMPION-IDU workers responded to an overdose, with 58% dealing with the emergency directly in the community compared to 34% in health care settings. Responses included hitting or slapping (73%), verbal coaxing (60%), CPR (37%), placing in recovery position (29%), injecting saline (27%), injecting naloxone (21%), and giving mouth-to-mouth (21%). In parallel, 42% of surveyed CHAMPION-IDU field workers felt confident carrying naloxone (compared to 16% who did not) and 57% felt comfortable using naloxone (compared to 2% who did not).

With positive outputs, outcomes and impacts after barely two years of implementation, there is clear potential to expand significantly in the near future provided that the CHAMPION-IDU infrastructure remains in place and that funding support continues for SCOOP. The summary below captures the intrinsic value of the SCOOP project as well as its added value in the context of HIV prevention in Thailand:

SCOOP IS A HIGH IMPACT INTERVENTION

Overdose prevention targets PWID, one Thailand's most marginalized and vulnerable populations; overdose reversals generate high DALY values; administration of naloxone is almost immediate and the impact is visible; naloxone saves lives;

SCOOP IS LOW THRESHOLD

Naloxone is easy to use and trainings are simple; deploying multiple distribution models as well as increasing the number and type of outlets can be

implemented to ensure high coverage; services are available across all 19 CHAMPION-IDU provinces;

SCOOP IS A LOW COST INTERVENTION

Direct negotiations with manufacturers and distributors generated significant savings; additional market competition could drive prices down even further; utilizing existing DIC and peer outreach infrastructure also reduced cost of the intervention; cost sharing model between multiple donors, including private sector, added significant value;

SCOOP IS INTEGRATED

Naloxone is integrated in a comprehensive package of overdose prevention and management services; overdose prevention and management is integrated in the CHAMPION-IDU project which represents the bulk of the national response to health among PWID; CHAMPION-IDU is integrated in the national package of HIV prevention, treatment, care and support services targeting PWID in Thailand;

SCOOP STIMULATES DEMAND

Demand for overdose prevention and management exists in Thailand and SCOOP expanded that demand by sensitizing field workers, clients and the communities around them;

SCOOP IS INNOVATIVE

A novel service that can attract previously unreached clients with high risk behaviors; stimulate exploration of new policies and implementation models to overcome barriers; project data indicates success after less than two years of implementation;

SCOOP EMPOWERS COMMUNITIES

Project staff enthusiasm and performance has increased; project volunteers have gained confidence and respect from community members; clients are eager to learn more about overdose prevention and have access to naloxone to assist their peers; communities welcome the CHAMPION-IDU across virtually all sites to expand overdose prevention and management using naloxone.

CONCLUSION AND RECOMMENDATIONS

“[The peer outreach worker] thinks the CHAMPION project should play a role in coordinating with government and the public because [the project] work has changed from ‘underground’ to ‘over-ground’ [publicly visible]. If [the community] can accept his work, it can be sustainable: working in public is to prepare for the future.”

– CHAMPION-IDU DIC Manager

Project implementing teams, CHAMPION-IDU and SCOOP clients as well as external stakeholders had much to say about the collective experience of the past two years under this first large-scale project to pilot overdose prevention in Thailand and the strategic approaches that should be leveraged going forward. Though there are many opinions and perspectives on the way forward, SCOOP has established and confirmed that:

- Community-based overdose prevention with naloxone is safe and effective
- Overdose prevention and management saves lives and generates many other benefits for the client and the community
- Overdose prevention with naloxone is a niche market with high demand
- Pre-existing project infrastructure to reach PWID was instrumental to rapid scale-up

SCOOP has also provided various insights into a range of project-related areas that are presented below as lessons learned:

1. Product

- Naloxone, branded as Narcotan in Thailand, is a fast-acting opioid antidote with no psychoactive properties or potential for dependence.

2. Pricing

- Price of naloxone in Thailand was influenced by volume, attrition and by stimulating competition between distributors as well as better collaboration between manufacturers and distributors who were unaware of the 'community' market for the product;
- Despite significant price reductions gained through strategic negotiations, price of injectable naloxone in Thailand remains double the international market price, while atomizers are prohibitively expensive for community-based projects;
- Despite the limitations listed above, the SCOOP project was considered low-cost and cost-effective.

3. Policy

- Significant policy barriers prevent direct distribution of naloxone and national regulations

limit sustainability and stifle scale-up;

- However, the Good Samaritan law and the Declaration of Patient's Rights both protect laypeople administering naloxone responsibly to a person in distress;
- Minimum standards at national level were met (ie storage capacity), but additional more robust standards should be developed to guide implementation.

4. Training

- Partnerships with other NGOs and health service providers are strategically important during the roll-out of training, which has paved the way for service delivery – but additional workshops specifically targeting health services providers are required to improve their capacity to manage and reverse opioid overdoses;
- A combination of theoretical and practical modules based on a culturally appropriate and locally developed curriculum have generated exceptional results in terms of performance and results as well as enthusiasm and attitude;
- Application of knowledge and skills has been without incident or complaints to date, demonstrating the undeniable capacity and professionalism of CHAMPION-IDU field workers;
- Additional tools and materials to support sensitization and capacity building are required, especially to support further integration of overdose prevention with naloxone in regular BCC activities.

5. Model

- Indirect distribution of naloxone through CHAMPION-IDU outreach and DICs has been very successful as a first step to train the workforce, sensitize communities, and reach clients with a lifesaving antidote though structural limitations due to regulations delays emergency responses in the community;
- Indirect distribution of naloxone through pharmacy outlets would overcome many of the barriers that civil society groups face when implementing overdose prevention with naloxone to rapidly scale-up access, potentially supported by a voucher scheme;
- There is currently broad and tenuous support, including from key national stakeholders, for potential expansion of SCOOP through a pharmacy-based model;

- Direct distribution is in high demand across the 19 CHAMPION-IDU project sites and would imply peer-based emergency responses, though national regulations currently prevent such a model;
- Other distribution models exist in other countries that should be explored, including emergency first responders, law enforcement, and families of PWUD;
- Though many models are possible, it is worthwhile that higher impact will be achieved when multiple distribution models and channels ensure a sustainable, low-threshold supply of naloxone to those most at risk.
- Currently, the sustainability of SCOOP is intimately interlinked with the continued presence of the CHAMPION-IDU infrastructure – disruptions in CHAMPION-IDU funding could significantly compromise continuity of the SCOOP project;
- In order to reinforce SCOOP's sustainability, additional efforts need to be invested to further integrate overdose prevention in national systems.

6. M&E and documentation

- The development of quantitative and qualitative indicators to track progress has been essential to support ownership at local level, implementation strategies at organizational level, obtain permissions from national authorities, and advocate for an enabling policy environment;
- Efficient systems have been deployed with multiple layers of oversight to ensure accuracy and quality of data collected – although internal capacity gaps often have led to incomplete data and have increased the burden of work and fatigue among field workers;
- Additional data points should be collected to track naloxone after distribution, follow-up with clients and staff more regularly, and track effectiveness of BCC interventions.

7. Results

- Community-based overdose prevention with naloxone is effective, saves lives and generates high health impact;
- Throughout the duration of the SCOOP project, not a single adverse event due to misuse of naloxone was recorded – confirming that naloxone administration by trained laypeople is safe;
- The level of empowerment and interest shown by project workers and clients was an unexpected impact of SCOOP that further stimulated demand for additional health services, including overdose prevention and HIV prevention;

8. Advocacy

- A stakeholder mapping analysis has shown that health service providers are perceived as gatekeepers to expanding SCOOP – health service providers who oppose community-based overdose prevention with naloxone can significantly hinder progress while those who support can facilitate expansion;
- The advocacy efforts under SCOOP have yielded a positive but fragile agreement to explore pharmacy-based distribution in the future, although health sector representatives have requested more information about overdose prevention as well as technical support to better equip overdose respondents with adequate skills and knowledge;
- Additional advocacy efforts are required to ensure a plurality of distribution models to ensure low threshold access to naloxone for PWID in Thailand, especially continued advocacy towards a peer-led community-based direct distribution model.

Based on the lessons learned above, the following top line recommendations have been formulated towards sustainable expansion of a national overdose prevention program in Thailand:

Recommendations for Thai civil society

- In order to maximize impact of overdose prevention and management, with or without naloxone, implementing agencies should segment PWID populations, and more selectively focus on people recently released from compulsory drug treatment programs, prisons and other closed settings;
- Explore different overdose prevention and

management implementation models to ensure integration in national systems and maximize access and impact;

- Continue and strengthen the integration of overdose prevention and management in BCC strategies with support of inter-personal, group and media-based communication tools;
- Additional efforts are needed to scale-up effective M&E, particularly in the field, with more in-depth and more long term data tracking as well as with strengthening of documentation skills to capture lived experiences and best practices;
- Significant support can be leveraged from private sector pharmaceutical companies to invest and provide technical assistance in overdose prevention, harm reduction and HIV prevention as well as in achieving advocacy goals;
- Show pride in what SCOOP has accomplished and share results of the project with communities, donors, policymakers and government representatives and other key stakeholders involved in improving quality of lives of communities in Thailand;

Recommendations for Thai government health agencies

- Ensure the sustainability of SCOOP by investing in the continuity of the CHAMPION-IDU project, which represents one of the only national-level large-scale platforms to reach PWID in Thailand;
- Review regulations on the classification of naloxone, on injecting others with controlled substances, on the distribution of naloxone in the community, and on the certification of community health workers;
- Provide an official exemption to allow implementation and expansion of direct naloxone distribution under SCOOP;
- Support a pilot project, with national funding, to evaluate the effectiveness and safety of direct distribution;
- Build capacity of health services providers, especially those directly providing services to PWUD, in order to effectively and confidently respond with naloxone to opioid overdoses;
- Include “drug overdose” in possible causes of

death in coroner’s reports to better estimate the burden associated with such emergencies and design more effective interventions to reduce the frequency and negative impact of overdoses;

- Integrate data points in national surveillance systems such as the Integrated Bio Behavioral Survey (IBBS) or other epidemiological monitoring system;
- Include overdose prevention with naloxone in the national harm reduction policy as an additional high-impact, low-cost service to improve the lives of PWUD and PWID;
- Continue to work with civil society, particularly drug user groups, in the implementation of opioid overdose prevention with naloxone;
- Promote best practice in overdose prevention and management with other communities and networks of PWUD;

Recommendations for donors and UN agencies

- Ensure the sustainability of SCOOP by investing in the continuity of SCOOP and in the broader CHAMPION-IDU project which provides one of the few national level large-scale channels to reach PWID in Thailand as well as other community-based efforts to address overdose;
- Support SCOOP by providing technical support and facilitating the development of an enabling environment for the development and deployment of guidelines on overdose prevention with naloxone based on international best practice;
- Support the engagement of civil society groups and government agencies in the implementation of innovative solutions to real health issues, in implementation and expansion of programs that lead to measurable expansion in markets and further increase demand for health services;
- Facilitate expanded national dialogues and engagement involving private sector pharmaceutical companies to leverage their support through commercial and corporate social responsibility mechanisms and to generate additional savings through coordinated pooled procurement.

ANNEX 1: SCOOP DATA COLLECTION FORM

SITUATION REPORT

Site/DIC: _____

Month/Year: _____

**Even if no incident, please inform*

Number of people who received OVD screening:

Male: _____ Female: _____

Ever seen or been involved with OVD situation?

No: _____ Yes: _____ Number of times: _____

Ever rescued those who experienced OVD?

No: _____ Yes: _____ Number of times: _____

For people who received screening in this month, indicate NO or YES if they ever experienced OVD in their lifetime (number of OVDs and percent):

No: _____ Yes: _____ (If yes) Number of times: _____ Percentage: _____ (< 100 is safe, > 100 caution)

For people who received screening in this month, indicate NO or YES if they ever experienced OVD in the past 6 months (number of OVDs and percent):

No: _____ Yes: _____ (If yes) Number of times: _____ Percentage: _____ (< 100 is safe, > 100 caution)

**If # of incident higher than lifetime, it strongly advised to be cautious.*

Number of Naloxone bottles distributed (please cross check with inventory report):

No. of bottles used: _____ Percent of survivors (used/survived): _____ (Near 100 is safe)

What kind of substance was used before OVD?

- ☐ Alcohol
- ☐ Stimulant (ex. Crack [ice], Mate [yaba])
- ☐ Benzodiazepine: Midazolam Diazepam
- ☐ Opium: Heroin, opioid substance
- ☐ Methadone: bought from black market
- ☐ Other (please be specific)
- ☐ Not sure/Can't remember

Where have you experienced OVD?

- ☐ Own house/Welfare motel/Apartment
- ☐ Someone else's house (friend or acquaintance)
- ☐ Street corner or public area (corner of building, toilet)
- ☐ Outdoors (such as a park, bush, etc)
- ☐ Mosque, graveyard, or temple
- ☐ Drug market
- ☐ Other (please specific)

Number of referral to rescue team or ER from a hospital:

Referred: _____ None: _____

Overall reasons of referral are:

Overall reasons of no referral are:

LIFE AFTER

Survived: _____ Died: _____

REPORT BY _____

DATE _____

INCIDENT REPORT

Day/Month/Year: _____

Org.: _____

Name or UIC: _____

**Peer or staff to assist in selecting answers*

Gender:

Male: _____ Female: _____ MSM/TG: _____ Age: _____

Have you ever heard about OVD?

No: _____ Yes: _____

May answer more than one choice by placing an X in designated space:

In the past 6 months, what types of substances have been used?

- ☐ Alcohol
- ☐ Stimulant (ex. Crack [ice], Mate [yaba])
- ☐ Benzodiazepine: Midazolam Diazepam
- ☐ Opium: Heroin, opioid substance
- ☐ Methadone: bought from black market
- ☐ Methadone : dispense for substantive therapy
- ☐ Other (please be specific)

Degree:

Where do you currently use substance(s)?

- ☐ Own house/Welfare motel/Apartment
- ☐ Someone else's house (friend or acquaintance)
- ☐ Street corner or public area (corner of building, toilet)
- ☐ Outdoors (such as a park, bush, etc)
- ☐ Mosque, graveyard, or temple
- ☐ Drug market
- ☐ Other (please specific)

Degree:

Who is normally present or nearby when using drug?

- ☐ Other drug users
- ☐ Family members
- ☐ Married couple or boy/girl friends
- ☐ Non drug user friends
- ☐ Stranger or someone you just met
- ☐ No one

Degree:

If this person has never experienced OD pleas skip below and sign your signature.

Have you ever seen or been involved with OVD situation either with yourself or a friend?

No: ____ Yes: ____ Number of times: ____

Have you ever rescued those who experienced OVD?

No: ____ Yes: ____ Number of times: ____

Have you ever experienced OVD in your lifetime?

No: ____ Yes: ____ Number of times: ____

In the past 6 months, have you experienced OVD?

No: ____ Yes: ____ Number of times: ____

If Yes, please give more information:

When was your latest OVD experience? Day/Month/Year: _____

If this person has never experienced OD please skip below and sign your signature.

What kind of substance was used before OVD?

- ☐ Alcohol
- ☐ Stimulant (ex. Crack [ice], Mate [yaba])
- ☐ Benzodiazepine: Midazolam Diazepam
- ☐ Opium: Heroin, opioid substance
- ☐ Methadone: bought from black market
- ☐ Other (please be specific)
- ☐ Not sure/Can't remember

Degree:

Where have you experienced OVD?

- ☐ Own house/Welfare motel/Apartment
- ☐ Someone else's house (friend or acquaintance)
- ☐ Street corner or public area (corner of building, toilet)
- ☐ Outdoors (such as a park, bush, etc)
- ☐ Mosque, graveyard, or temple
- ☐ Drug market
- ☐ Other (please specific)

Degree:

FOR STAFF OR PEER ONLY

Does client/you use Naloxone? No: ____ Yes: ____ Number of times: ____

During the client's OVD, what did you or others do to try to help this person (other than Naloxone injection)?

- ☐ Call rescue team or ER from a hospital.
- ☐ Accompany client to hospital
- ☐ Prepare for CPR (Sleep on one's side and clear throat)
- ☐ Did CPR (Cardiopulmonary resuscitation)
- ☐ Wake up by hitting, showering, putting some ice on him, shaking or smashing his body.
- ☐ Inject water or normal saline
- ☐ Call and shout his name to wake him up
- ☐ Do nothing
- ☐ Other (please specific) _____

Referral to rescue team or hospital: No: ____ Yes: ____ Reason: _____

If yes, please specify health setting: _____

Referred: ____ None: ____

Overall reasons of referral are:

Life after: Survival: ____ Death: ____

Signature: _____

Date submitted: _____

Team leader acknowledgment: _____

Date of review: _____

Suggestion: Frequency of interview should be conducted every 6 months.

In case any client just exp. OVD, please use this form to interview as soon as possible when he/she is in good condition

*** Collect report every month, it may require in urgent situation*

ANNEX 2:

ADVOCACY

MESSAGES

“Naloxone will provide a ‘safety net’ that will only encourage people to use more drugs or use drugs in riskier ways.”

This hasn’t been the experience of naloxone distribution programs. Naloxone puts opioid users into withdrawal – which is not a pleasant feeling – and it takes away the positive effects of the drugs. Research has actually shown that people who received overdose training with naloxone reported less drug use after the training. Participation in naloxone programs is also associated with less syringe sharing.

“Drug users won’t be able to recognize an overdose or respond appropriately.”

Research studies demonstrate that drug users can indeed recognize an overdose and respond correctly. In fact, after training, they are as competent in overdose response as doctors. And the good news about naloxone is that, if a victim doesn’t have opioids in their system (if they are unconscious for some other reason) naloxone will have no adverse effect.

“Naloxone will discourage people from seeking drug treatment.”

Actually, experience shows that naloxone program participants may be more likely to access treatment. Naloxone is a resource that drug users want. By providing it, harm reduction programs can get people in the door and build relationships with them. This may lead to other health benefits like HIV testing and treatment, wound care, psychosocial counseling, and perhaps even drug treatment when the person is ready.

“Providing naloxone will send the message that we condone drug use.”

Providing naloxone will send the message that you value the person and care whether they live or die. This can be powerful and affirming, and can build a relationship of trust that can lead to other positive changes. Many methadone treatment and other drug treatment programs are now providing naloxone training.

“Receiving naloxone will make the victim violent, and I’m concerned for my safety.”

Receiving naloxone can put someone into withdrawal, but if not given an excessive dose, and treated kindly upon waking up, they usually will not be violent. Reports of violence are extremely rare in situations where a friend, family member, or peer administers naloxone. Reports of violence in ambulance and hospital settings may have more to do with fears about punishment and ill-treatment of drug users by some medical professionals.

“What if someone tries to sue me for giving them naloxone?”

This seems like a far-fetched concern, but it’s one we sometimes hear. Some groups have asked drug users to sign forms, following overdose trainings, saying that they give others permission to give them naloxone in an overdose emergency. You may also encourage participants to write out an “overdose plan” and share it with loved ones. These plans detail how they want people to respond in the event of an overdose. For the most part, people are not going to be mad at someone for saving their life.

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- 91 WHO has yet to develop and release a model to estimate the number of DALYs generated from successful overdose reversals using naloxone. However, though the logic used in the example above is aligned with the definition, the calculation is deliberately simplified for the sake of argument: it is likely that Thai PWID would have a life expectancy that is significantly below the national average that would reduce the actual number of DALYs generated by SCOOP.
- 92 PSI Thailand. 2014. *Overdose situation among people who inject drugs: A quantitative and qualitative research study from Bangkok, Chiang Mai and Narathiwat*.
- 93 Excerpted from "Advocates' Responses to Common Criticisms of Lay Distribution" at <http://naloxoneinfo.org/sites/default/files/Advocates%20to%20Common%20Criticisms%20of%20Lay%20Distribution%20.pdf>.

Naloxone

An antidote to overdose from heroin and other opioids

naloxoneinfo.org is a website for harm reduction service providers and advocates to find the tools necessary to get naloxone into the hands of those who need it.

Tools on the website will help you:

- Find out where to get naloxone
- Start a naloxone distribution program
- Train staff, outreach workers and drug users to use naloxone
- Advocate for naloxone access in your country
- Apply for funding from international donors like the Global Fund to Fight HIV, TB and Malaria

VISIT: NALOXONEINFO.ORG TWITTER: #NALOXONE

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