Guidelines for BCC:
Enhancing content and strategies for Harm Reduction Service Provision

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DFID FUNDED: HIV/AIDS PREVENTION WITH DRUG HARM REDUCTION IN PAKISTAN PROJECT
FUTURES GROUP
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Foreword

The use of drugs is a behavioural issue. This behaviour is associated with problems at various levels and dimensions. One of these problems with catastrophic potential is the spread of HIV through injecting drug use and/or un-safe sex.

The DFID-funded HIV/AIDS Prevention with Drug Harm Reduction in Pakistan (HAPDHRP) Project is being implemented by Futures Group in all four provincial capitals of Pakistan as a part of the Enhanced HIV/AIDS Control Programme of the Government of Pakistan. NGOs have been contracted to provide Harm Reduction (HR) services in these cities based on a comprehensive service package prescribed by the Steering Committee of the project.

The provision of HR services heavily depends on strategies and activities aimed at behavioural change in the drug users. The NGO service providers working through the HAPDHRP Project are doing excellent work and have demonstrated high motivation and dedication. A need existed to streamline the mechanisms and strategies employed by the NGO service providers to form a Behaviour Change Communication (BCC) framework. This framework should illustrate good practices and propose the means to address the weaknesses so that solid and need-based BCC which complements and strengthens the Harm Reduction services can be provided.

Aahung was selected by the Steering Committee of the HAPDHRP Project to undertake this assignment and has produced this document in response
to the BCC needs of HR service provision in Pakistan. The participation and support of the Technical Working Group and the partner NGOs, who have been heavily involved in the production of this document, is acknowledged.

We believe that this first attempt at developing a streamlined approach to BCC for HR service provision is an important contribution to our common goal of preventing the spread of HIV in Pakistan. We understand that this effort is not a panacea for our BCC needs, but will serve as a good starting point for operationalising and strengthening our approach to BCC for the prevention of HIV/AIDS.

It is with this spirit that the National AIDS Control Programme and Futures Group present *Guidelines for BCC: Enhancing content and strategies for Harm Reduction Service Provision*.

Dr. Simon Azariah  
Project Director  
**Futures Group Europe**  

Dr. Asma Bokhari  
National Programme Manager  
**National AIDS Control Programme**

Lahore, 15 September 2004
Acknowledgements

Although a thorough national and international literature search was conducted for the preparation of these guidelines, the emphasis was on grounding the document in the current realities by collecting the best practices of the various organizations within the project. This gave the Aahung team an opportunity to interact with a large group of dedicated and experienced professionals as well as a large number of their clients.

We would like to thank Dr. Asma Bokhari of the National AIDS Control Programme and Dr. Simon Azariah of the Futures Group for their technical support, guidance, and insight into HIV/AIDS and harm reduction in Asia.

We appreciate the tremendous graciousness and hospitality shown by the partner organizations and in particular Dr. Manzoor from Dost Foundation Peshawar, Mr. Ali from Nai Zindagee Quetta, Mr. Noman from Nai Zindagi Lahore, Mr. Naveed from Caritas Lahore, Mr. Tariq from Al-Nijat Karachi, and Mr. Joe from Marie Adelaide, Karachi.

Finally, but most importantly, we are grateful to all the clients who spoke to us openly about their lives and experiences even though we had nothing to give in return.

We are extremely pleased and happy to dedicate these guidelines to all those users who were brave enough to make a decision to change against all odds and to those users who are next in line!

Shazia Mohammed
Habib Ahmed Afser
Aahung
Karachi, 15 September 2004
List of Abbreviations

AIDS          ACQUIRED IMMUNE DEFFICIENCY SYNDROME
BCC           BEHAVIOUR CHANGE COMMUNICATION
DU            DRUG USER
HAPDHRP       HIV/AIDS PREVENTION WITH DRUG HARM REDUCTION IN PAKISTAN PROJECT
HBV           HEPATITIS B VIRUS
HCV           HEPATITIS C VIRUS
HIV           HUMAN IMMUNE DEFICIENCY VIRUS
IDU           INTRAVENOUS DRUG USERS
IEC           INFORMATION EDUCATION AND COMMUNICATION
IV            INTRAVENOUS
M&E           MONITORING AND EVALUATION
NACP          NATIONAL AIDS CONTROL PROGRAMME
NGO           NON-GOVERNMENTAL ORGANIZATION
PHC           PRIMARY HEALTH CARE
STI           SEXUALLY TRANSMITTED INFECTION
VCT           VOULNTARY COUNSELING AND TESTING
Executive Summary

The HIV/AIDS Prevention Drug Harm Reduction Programme (HAPDHRP) is a strong step towards reaching out to the vulnerable and marginalised population of drug users, however, it needs to be further strengthened by developing standard protocols and guidelines for communication and other services that are being provided.

Behaviour Change Communication (BCC) is a multi-level tool for promoting positive voluntary behaviour change. This tool aims to reduce risks to people by using tailor-made messages which are communicated in a variety of ways. The underlying assumption is that given a supportive environment, voluntary decision making leads to sustainable action.

These guidelines have been prepared after a thorough literature search, an evaluation of the current HAPDHRP projects, and a three-day consultative meeting with the project staff.

Based on the learning’s of current HAPDHRP programmes and Aahung’s experience in behaviour change and out-reach programmes, this report recommends a BCC strategy that enshrines the principles of human rights and empowerment. At the same time it advocates for a strategy that is flexible enough to be operationalised in various local contexts and settings. The ultimate goal of this strategy is to empower clients to make healthier and safer decisions. The guidelines also recommend strategies to strengthen and develop a comprehensive monitoring and evaluation system that would not only make sure that targets are being achieved, but would also guide the programme and strengthen the processes taken to
achieve the targets. Behaviour change processes have been reviewed in depth and specific messages have been recommended at each level in the behaviour change continuum. These messages are applicable for both drug users as well as other populations who fall within the scope of such programmes, such as the community and local community leaders.

Programme managers will find these guidelines helpful in strengthening present strategies and in developing new strategies towards achieving their goals. Programme staff will be able to continually assess their work in accordance with programmatic principles and hence will be able to contribute more effectively to the overall improvement of their programmes. Finally, these guidelines will be useful for policy makers in defining crucial policies that support an enabling environment where the rights of the individual are respected, protected, and fulfilled.
Chapter 1: Drug users and harm reduction: the context

1. Introduction

Currently injecting drug use is not the most common method of drug-use in Pakistan; however the usage of this method is on the rise. Though the reported prevalence of drug users varies in different areas and as reported in small and large scale studies, the projected figures are disturbingly high and may be as large as four to five million nation wide. The most common drugs used include cannabis (hashish and charas), followed by heroine and alcohol. Other drugs include psychotropic preparations like Valium and Diazepam. Heroine is most popular in urban centres and more so in Balochistan and Punjab. The mean age of drug users as reported is 31-33 years and although female users do exist, users are predominately found to be male.

The term ‘harm reduction’ refers to various strategies and approaches for reducing the physical and social harms associated with risk-taking behaviour. It may be impossible to prevent harmful behaviour in all the cases, but it may be possible to reduce the harm done. Amongst these risk-taking groups, IV Drug Users (IDUs) are at increased risk of acquiring and transmitting HIV/AIDS. However, it must be mentioned that a common fallacy amongst programmes working with such vulnerable groups is to consider them as “diseases waiting to happen”. Such an approach not only increases the stigmatization of clients, but is also discriminatory with regards to their basic rights to respect and human dignity. Such an attitude may also be a barrier in ‘enabling’ clients to make safer and healthier
decisions in a consistent and sustainable manner.

It must also be mentioned that each community and area may have its own drug sub-culture. Therefore an understanding of the socio-cultural, religious, and historical contexts is essential in order to develop strategies that will be most effective for that specific group and that fall within the framework of human rights, dignity, and empowerment. An in-depth understanding of the context is crucial, therefore, to determine both barriers to change as well mobilizing factors.

1.1 Factors that increase risk of drug users to HIV/AIDS

A substantial body of research indicates that injecting drug use has provided a kick start to the HIV epidemic in South Asia. The particular risk factors in drug users and in particular IDUs are summarized below:

1.1.1 Sharing of equipments: The most common pathway for HIV transmission among IDUs is the sharing of equipment used in injecting drugs. This would include needles, syringes and water to prepare injections. Equipment may be shared due to scarcity or lack of access to safe injecting equipments and legal sanctions against possessing injecting equipments. The high prices of syringes and the effort required to buy them (moving from the ‘shelter’ of shooting spots to the pharmacy and purchasing syringes) may also be a contributory factor.

1.1.2 Stigma and discrimination: Judgmental attitudes of communities and/or staff are a major barrier towards positive behaviour change.
Labelling drug users as ‘bad people’ or personifying them as ‘animals’ leads to stigmatization and the subsequent discrimination. Such discrimination results in low self-esteem and confidence and poor decision making skills, which prohibit access to information and health services and impede any positive behaviour change. For example, to avoid the stigma attached to being HIV positive, the drug users would avoid testing and/or revealing HIV serostatus to partners and family members which leads to spread in healthy individuals.

1.1.3 Unsafe sexual practices: Research has shown that persons who are injecting drug users are more likely to also work as sex workers or/and practice unsafe sexual behaviours. The risk of contracting HIV and other sexually transmitted infections, including Hepatitis B and C is hence multiplied. Sexual practices that further enhance the risk include a high number of clients or partners that a person has and, the frequency with which the person engages in anal sexual intercourse, without using a condom and/or lubrication.

1.1.4 Poverty: IV drug users invariably end up losing any employment and are forced to petty crimes and even prostitution to earn money to support their drug use. Thus they are perpetually exposed to all kinds of risks and especially to unsafe behaviours.

1.1.5 Social-Political pressure: Since drug use is considered an illegal

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2 During focus group discussions with DUs, respondents reported that many discriminatory words were used by the community to label them. These included ‘bad people’, ‘animals’, ‘charsee’ and ‘mawaalee’. They regarded these terms as very derogatory and ‘hurtful’.
activity, drug users find themselves in direct conflict with law enforcing agencies and many drug users end up in lock-ups. Here they are even more vulnerable to risky behaviours, such as sharing of equipment and, unsafe sexual practices, especially unprotected anal and oral sex with multiple partners. The fear of being physically violated and the prolonged period of separation from families further increase their risk of contracting HIV. In jails, their access to health services is also prohibited or decreased considerably.

1.1.6 Malnutrition: As a result of poverty, low economic conditions and bad hygiene, the immune system becomes further depressed and the progression of HIV to AIDS occurs more quickly.

1.2  Factors acting as barriers to change

1.2.1 Drug addiction and the fear of withdrawal: One of the biggest barriers to change mentioned in interviews is the fear of withdrawal symptoms. Even though drug users seem to be knowledgeable regarding causes and modes of transmission of HIV, there seems to be little self-risk perception. The immediate feeling of intoxication overrides the desire to act safely. This also brings the focus to the importance of skill building and awareness raising beyond simply giving knowledge.

1.2.2 Availability of injectable drugs: Coupled with the idea that drug users feel injectable drugs are ‘easier to use,’ the relative ease of acquiring injectable drugs proves to be a barrier towards harm-reduction efforts. Even if ‘powder’ was unavailable or too expensive, psychotropic drugs are readily available at most pharmacies.
1.2.3 Staff attitude: The staff at conventional rehabilitation centres are reported as notorious for ‘beating’ users and treating them with disrespect. This is a major cause of anxiety for drug users wanting to visit rehabilitation centres and ultimately a barrier to behaviour change.

1.2.4 Lack of motivation: This is especially relevant to users who have been ‘abandoned’ by their families. They believe that “once a drug user is, always a drug user,” referring to the communities discriminatory attitudes. Generally all marginalized populations feel that mainstream society disregards their existence and does not want any social mingling with them, thus further reinforcing their marginalization. Mainstream society, on the other hand, have their own limitations and reasons for excluding drug-users from their societal networks and support systems.

1.2.5 Police attitudes: Police officers attitudes have been described by users as inhuman and cruel. However, it is worth considering that most drug-users behaviours are considered unlawful by the state. This would include drug use and commercial sex work. Hence the police are ‘protecting' the law, especially in spaces defined as public domain.

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2 DUs reported in focus groups that conventional drug rehabilitation services bound up users with ropes or chains and locked them and also beat them occasionally. Two respondents had undergone such treatment themselves, but the majority had heard of someone being tied and beaten up by rehabilitation staff.
1.3 Factors that may enable change

1.3.1 Desire to change: In a study conducted by the Futures Group, it was shown that the majority of drug users link health with a drug free life and sickness with drug use. Almost all drug users have a desire to change mainly because of health related issues. They equate bad health with drug use and this can be used as motivation for behaviour change keeping in mind that care must be taken to avoid fear based messages.

1.3.2 Religious faith: Similar to the general population, most users will equate their drug use as ‘against their religion’ and hence a good motivation to change the habit. Religion has been used elsewhere to help users overcome their addictions (for example establishing a daily prayer routine) and can play a central role in the rehabilitation process.

1.3.3 Fear of death: With their peers dying frequently and in miserable conditions, drug users that were interviewed all mentioned that they did not want to die on the streets. This again could be a good source of motivation to initiate behaviour change.

1.3.4 Social network: Drug users develop their own social networks and even though their main social activities revolve around drug use, the networks can be manipulated to enforce group cohesion and support, with rehabilitated users acting as role models for their peers.

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3 Most of the drug users interviewed for this report were Muslim, and believed that drug use was not
Each community has its own particular values, norms and sub-cultures that need to be understood in order to provide services that are acceptable, accessible and ‘client centred’. Thus programme staff needs to be aware of the contextual factors underlying their focus population and strengthen factors enabling change, while at the same time empowering clients by providing correct information and developing appropriate skills to adopt safer behaviour that will reduce harm in a consistent and sustainable manner.

acceptable in Islam and they had been told by religious figures that it was also a ‘sin’
2. Introduction

Behaviour Change Communication (BCC) is a multi-level tool for promoting voluntary, positive behaviour change aimed at reducing risks using tailor made messages in a variety of communication channels. The process should be one that empowers the individual to make safer and healthier choices, with the underlying assumption that voluntary decision making leads to a greater probability of action taken that is sustainable, given a supportive environment.

Behaviour change is not an easy task, as can be judged by various studies and observation of the complexity of human nature and ourselli, with respect to the socio-cultural and political environment. Programmes and projects that have used various behaviour change models include those in the fields of family planning, malaria control, tobacco use and more recently HIV/AIDS. Most modern epidemics and in particular HIV/AIDS are deeply entwined in the way societies organise themselves, and are affected primarily through social, as well as, personal behaviour. Much behaviour, such as sexual practices, may not even be considered health related by traditional public health programmes and are thus, overlooked. Therefore, for any programme to be a success, planners and policy makers must be aware and sensitive to the socio-cultural-political realities and design interventions accordingly.
With regard to HIV/AIDS, before risk and vulnerability to the disease can be reduced, individuals and communities must understand the urgency of the epidemic and realise that their personal risk depends on certain behaviour, such as unsafe sexual practices, needle use, and blood transfusions. These individuals must be given facts about HIV/AIDS, taught a set of protective skills, and also be offered appropriate services and products. Perhaps most importantly, individuals must perceive their environment to be supportive of them changing and maintaining safe behaviour. Often, this would entail discussion on sex and sexuality (as HIV is primarily a sexually transmitted infection) risk, hazardous settings and behaviour. Programmes therefore, may have to challenge some cultural beliefs and practices that harm or weaken the rights-based approach for client empowerment towards healthier living and decision making. BCC is vital to this process and can set the precedence for compassionate and rights-based interventions by giving power to the individual to alter his/her behaviour for the betterment of him/herself and society i.e., empower them to make safer and healthier decisions. (See Annex 1 for the model on empowering behaviour change using communication.)

A broad range of programmes have been implemented world-wide to foster harm reduction principles and prevent HIV infection among intravenous drug users (IDUs). These include:

- The establishment of drop-in centers for drug users
- Establishment of detox/rehabilitation programmes
- The provision of condom promotion and distribution
- Outreach education using peer educators
- Sterile needle/syringe/distribution and disposal programmes
Guidelines for BCC for HR Service Provision

- **Counselling and testing** among IDUs for HIV
- Increased access to **primary health care**
- **Referral** to specialized **medical care** facilities and for **drug treatment and rehabilitation** services.
- **Reducing stigma and discrimination** for those living with HIV/AIDS

### 2.1 BCC Components

#### 2.1.1 Outreach mobile services

The strategy for use of outreach mobile services relies on outreach workers who are indigenous to the local community and familiar with its drug-use subculture. Ex-drug users are not only sensitive to the clients needs but also serve as excellent role models for users who wish to change. They are trained to access hard-to-reach, out-of-treatment IDUs and non-injecting drug users, and present them with risk-reduction information and supplies in settings that are familiar to them (e.g., streets, parks, ‘shooting galleries’ and other neighbourhood settings). Outreach workers provide, HIV/AIDS education information and the means for behaviour change, such as bleach kits for disinfecting injection equipment; condoms for safer sex, referrals for testing and counselling for HIV, HBV, HCV and other sexually transmitted infections. In addition, knowledge about drug addiction treatment, medical and social services, and syringe access programmes is also provided. It is recommended however, that registration takes place only at centres to avoid multiple registrations. The use of the mobile vehicle is to not only provide quality outreach services including information, first aid and basic medical facilities and counselling, but also to decrease anxiety and the fear of visiting the drop in centres for clients who have not
visited so far.

2.1.2 Syringe exchange

Syringe exchange and access programmes complement community-based outreach and drug addiction treatment because they provide access to sterile syringes and other services for drug users who, (1) will not, or cannot stop using drugs, (2) do not have access to, or cannot enter and remain in drug treatment programmes or (3) are in treatment programmes and continue to use drugs. The settings and range of services for syringe access vary, reaching out to drug users in their natural environments. These programmes permit the exchange of sterile syringes for potentially HIV-contaminated (HBV- or HCV-contaminated) used syringes, and serve as a bridge to drug users by providing risk-reduction information and materials, offering testing and counselling, and referrals to drug treatment, and other services. Despite the fact that prevalence of IDU may not be very high in certain areas, syringe exchange is not only an excellent harm reduction technique but is an incentive for IDUs to visit centers. Recovery of used syringes can also be used to gauge behaviour change. Considering that the reason IDUs prefer IV methods is to get a higher ‘buzz’, it is prudent to assume that IV use may increase over time. Hence, it is recommended that every centre should have the provision for this service. However, the failure to return used syringes should not be a reason to disqualify a user to availing the service.
2.1.3 Counselling

Counselling is a confidential dialogue between a client and provider aimed at enabling the client to cope with the stress, take decisions related to the problem and adopt preventive and coping behaviour. This includes an evaluation of personal situations or problems and planning for adjustments by providing information, and education and psychological support. Effective counselling is the cornerstone of any client provider interaction and more so in the case of IDUs. Although all staff dealing with such clients should have excellent communication skills and basic counselling skills, a specific trained counsellor should be present at specific times to deal with complex behaviour and personality related issues of individual clients and their families.

2.1.4 VCT

Voluntary Counselling and Testing (VCT) has been described as an entry point for HIV prevention and care. It can not only facilitate acceptance and coping of serostatus and referral for preventive and early management of opportunistic infections but also facilitates behavioural change. High public awareness of HIV, increasing numbers of persons (especially peers) sick and dying with AIDS, and knowledge of personal risk behaviour results in an increased desire to learn one’s serostatus. The need for VCT is increasingly compelling as HIV infection rates continue to rise and countries recognise the need for their population to know their serostatus as an important preventive and intervention tool. Those people who learn they are seronegative can be empowered to remain disease-free. For those HIV-infected, the development of less costly interventions to reduce
mother-to-child transmission (MCTC) of HIV and HIV-associated infections (e.g., tuberculosis preventive therapy and prophylaxis for other opportunistic infections) takes on new importance. The proper provision of pre and post test counselling cannot be over emphasised here. In addition, other medical and supportive services and in particular, provision of anti-retroviral therapy can help those diagnosed with HIV to live longer, healthier lives, and prevent transmission to others.

2.1.5 STI management and prevention and condom promotion

Promotion of safer sex among IDUs, including the promotion of condom use, should be an integral part of any community-based or outreach harm reduction programme for IDUs. A strong link exists between sexually transmitted infections (STIs) or diseases, and the sexual transmission of HIV infection. Data from a large number of biological and epidemiological studies conducted in four continents provides compelling evidence that STIs are a co-factor for HIV transmission. An untreated STI can increase both the acquisition and transmission of HIV by up to tenfold. This suggests that STI control has the potential to play an important role in the reduction of sexually acquired HIV transmission. Some of these male injectors may also be at risk from sexual contact with other men, creating a bisexual population ‘bridge’ to women’s infection. Additionally, with many women infected through their own or their sexual partners’ drug use, heterosexual transmission of the virus from women to men is now occurring more frequently than originally believed possible. Thus, the need exists to reinforce primary prevention (promote risk reduction behaviour, including use of condoms), improve STI health seeking behaviour and strengthen quality STI services.
2.1.6 IEC material

Information, Education and Communication (IEC) material is an important component of BCC strategies and deals with providing knowledge that enables clients to minimize risk. However, it may not lead to behaviour change by itself. Material can be in the form of pamphlets, booklets, posters, video, and slides. Even with an illiterate population, the use of pictograms and posters can be compelling tools along with the use of video and films. IEC material may also be a very effective way to create awareness amongst the communities especially if supplemented with a reinforcing media campaign on television or the radio.

2.1.7 Other social services

Social services (hair cutting, bathing, laundry facilities and refreshments) serve a multiple of functions within a harm reduction programme. They serve as incentives for drug users (DUs) to visit facilities, and also promote self-esteem and confidence in users. Adoption of better hygienic and grooming practices can also be used to assess behaviour change and gauge clients acceptability of services. Social services also help develop rapport and trust building between programme staff and clients.

2.1.8 Community awareness

A major barrier to behaviour change and in order to sustain it is the community’s negative attitude towards drug users, which stigmatises them and marginalises them even further. The same attitude makes it very difficult for users to be re-integrated into society and has been mentioned
as a major cause of relapse. The community needs to be educated to the needs of drug users. Community members can be invited to participate in centre activities and perhaps in planning, implementation and evaluation as well, depending on the level of support and local ownership. Such activities not only raise awareness but help reduce stigmatisation and increase the self esteem of Dus. Perhaps the most important members of communities by the client perspective, are the families. Families usually have to put up with their wards for a very long time, most eventually giving up and severing all ties with them. Family members however, need to be contacted and encouraged to participate in the recovery of drug users, and learn how to play a supportive role.

Interventions must take into account sex, race/ethnicity, sexual orientation, and/or risky behaviour, and the social context in which the individual behaviour occurs, the ultimate goal of which should be to empower people better able to make safer and healthier decisions.
CHAPTER 3: Assessment of HAPDHRP – Best practices

3. Introduction

The HAPDHRP is a strong step towards reaching out to the vulnerable and marginalised population of drug users. It needs to be further strengthened by developing standard quality protocols and guidelines for communication, and other services being provided.

3.1 HAPDHRP Goals and Objectives of BCC

Harm reduction can be viewed as the prevention of adverse consequences of illicit drug use. The main purpose of harm reduction is the prevention of rapid HIV transmission. The specific goal of HAPDHRP is:

“To reduce the health, social and economic ill effects of drug abuse on Pakistani individuals, families, communities and society. This will include minimising the further spread of blood borne diseases, in particular HIV and Hepatitis C, amongst IDUs.”

The specific expected outputs of the project include:

- Increases access, especially for the most marginalized users, to better quality, affordable, seamless drug treatment services
- Strengthened capacity amongst NGOs to plan, manage, evaluate drug demand and harm reduction initiatives
• Strengthened systems and capacities for the procurement and management of NGOs (which can be used by NACP and/or ANF)

• Generation of additional knowledge on ‘good practice’ in Pakistan context, and on appropriate approaches for scaling up to a national programme.

• To encourage drug users to stop injecting illicit drugs

### 3.2 Sites visited

In order to develop a BCC strategy specific to the needs of the HAPDHRP, Aahung visited the various project sites in the country. The objectives of this visit were, (1) to identify current practices with regards to BCC (with special emphasis on best practices), (2) to identify gaps and barriers in effective communication, and (3) to assess specific capacity building requirements of partner NGOs with regard to effective BCC within the programme scope. All seven projects were visited (Annex 2) and in-depth interviews, focus groups, and observational checklists were used to collect data.

The interaction between client and various programme staff was assessed at three levels:

1. In the field before the first visit to the centers
2. At the facility during various stages in the client pathway (Annex 3)
3. Through the various levels of the behaviour change continuum

The following sections describe the findings of the visits and offers recommendations for the development of a comprehensive BCC strategy based on best practices identified and published literature.
3.3 Vision and approach

Most of the staff interviewed were former drug users and as a result, were acutely sensitive to the needs of the clients. On the whole they seemed highly motivated and dedicated to what they were doing. They appeared to have strong faith in themselves as well as the drug users. Although the success rate (as judged by the number of Dus undergoing successful rehabilitation and being drug free for at least six months) was estimated to be “1 in 10,” they felt this was satisfactory considering the limitations of facilities and funds.

Even though all the organisations had the same goals and targets to achieve, their vision and rationale for their work differed based on their cultural settings and organisational values. On being asked the rationale for their work one organisation was of the opinion that they wanted to prolong the life of drug users so that they could have more opportunities to change their behaviour. Another organization asserted that given that drug users were human beings, they had the right to be loved and respected, and since the community did not impart these emotions towards them, they would do all they could to make drug users feel loved and respected. A third organisation believed that drug abuse was ‘bad’ and that they themselves were providing ‘free’ opportunity and support for these people to change their counsellor and hence, were ‘helping’ these people. All five organisations wanted their clients to be able to re-adjust into society and lead respectful and productive lives.

Despite the difference in vision and ideologies, the outcomes appear
similar with regards to successful rehabilitation and harm reduction. Therefore, any BCC strategy should have the flexibility to cater to these subtle cultural differences as long as the basic values of respect, human dignity and voluntary decision making are not violated and the emphasis is on empowering clients to take control over their lives. Empowering clients is not only in accordance with the concept of human rights and a rights-based approach but it also increases the chance of successful and sustainable behaviour change. Hence, project objectives and indicators to measure success should be based on this goal i.e., Empowerment of clients to make healthier, safer decisions.

3.4 Effects of current BCC strategies

Based on the service package recommended by the HAPDHRP, all the centers were providing several services geared to behaviour change and harm reduction. The description below is based on the analysis of the observations and interviews with staff and categorised as practices that need to be continued, improved upon and avoided.

3.4.1 Best practices

- **Individual and emotionally appealing services:** The services provided were to quite an extent individualised, i.e., based on individual needs and one-on-one attention. They also had a strong element of emotional appeal.

- **Non threatening environment:** The environment of the centers was respectful, non-judgmental, and relatively comfortable and non-threatening. This was mainly achieved through the use of
positive role models from the community, i.e., ex-drug users serving mostly as peer outreach workers and volunteers, most of whom had undergone successful rehabilitation in the same centers.

- **The use of role models:** Role models are a particularly effective way to motivate individuals to change by increasing confidence in their ability to change, by persuading them of the positive benefits of change, and by showing them how to change. Thus, the use of role models not only contributes to creating the sort of emotional commitment that can lead to change but provides concrete examples of that can be replicated. Current selection of former users as peer out-reach educators must be continued.

- **Mobile out-reach services:** HAPDHRP’s mobile outreach services improve access of services while at the same time motivate users to use stationary facilities, and helps to reduce the fear and anxiety related to doing so. Mobile services by providing essential facilities including registration, counselling, first aid, and referrals were greatly appreciated by the clients. At certain locations, even in the absence of a vehicle, outreach workers were providing first aid and referral services. The vehicles, wherever present, were regarded by clients as high quality and non-threatening. The use of these mobile clinics not only provides quality outreach services including information and counselling but also helps decrease anxiety and fear of visiting the drop in centers for new clients. It is also a good vehicle to create awareness among the local community.

- **Social services:** Social services like haircuts, shower facilities, tea and snacks were significant in promoting access to centers, and
establishing trust and rapport with staff. The clients considered these to be good incentives to visit centers, and were well appreciated and accepted. It was interesting to note that at drop in centers all such activities were run and managed by the clients themselves. For example, clients had duties assigned for making tea and ensuring the cleanliness of the place. This enabled them to feel important and boost their self-esteem as well as develop ownership. According to one staff, “they have forgotten how to do all these things and need to re-learn”. Such activities therefore, help clients undertake daily chores with responsibility, a skill that can further help them in their rehabilitation efforts.

3.4.2 Good practices that need improvement

- **Syringe exchange**: Syringe exchange is one of the most effective harm reduction strategies for IDUs and must be offered by all programmes. In centers that offered syringe exchange clients were utilising the service and showed significant behaviour change with regard to safe needle practices. Two centers did not offer needle exchange programmes because they believed the prevalence of IDU was low in their areas. Syringe exchange and access programmes complement community based outreach and drug addiction treatment because they provide access to sterile syringes and other services for drug users. Usually, these drug users are the ones who, (1) will not or cannot stop using drugs, (2) will not access, enter nor remain in drug treatment programmes, and (3) who are in treatment programmes and continue to use drugs. Despite the fact that prevalence of IDU may not be very high in certain areas, needle exchange is not
only an effective harm reduction technique, but is an added incentive for IDUs to visit centers. Recovery of used syringes can also be used to gauge behaviour change. Barriers to promote syringe exchange reported by the project staff included accusations from the community that the project was promoting drug use and the high prevalence of irregular IV drug use. Many Dus use IV methods to tide them over periods when the supplies of their regular form of heroine is not available and fear of opposition from drug sellers. Considering that the reason for Dus to start IV drugs is to get a higher doze due to constantly increasing tolerance, it is prudent to assume that IV use may increase over time if unchecked. Hence, it is recommended that every center should have the provision for this service.

- **Counselling services**: Counselling is a confidential dialogue between a client and provider aimed at enabling the client to cope with stress, to find solutions to their problems, and to help the client adopt preventive and coping behaviours. This includes an initial evaluation by the counsellor of personal situations or problems conducted, and then planning for adjustments by providing information, education, and psychological support. Effective counselling is the cornerstone of any client provider interaction and more so in the case of IDUs. Many centers did not have a specific counsellor; instead ‘everyone’ was deemed a counsellor. The team witnessed doctors, educators, and even old clients counselling each other. At one road site in Lahore the team saw local shopkeepers counselling drug users who had gathered to visit the mobile clinic. It is important for each staff member to have good counselling skills, as necessary for their standard functions; furthermore, a qualified counsellor should be
present to deal with complex psychological and behaviour related issues to cater to each client’s specific needs, as well as handle group sessions on a systemic basis.

- **Condom distribution and promotion**: Condom distribution is also considered to be an essential and necessary component of all harm reduction programmes for IDUs because of the high occurrence of risky sexual practices, a high prevalence of Hepatitis B and C, and the risk of HIV/AIDS. All centers were distributing and educating individuals about condoms. In most sites however, staff felt that they could not talk about condoms in public because of cultural constraints and hence, did not do so in the field sites. As it is most workers were sceptical about whether their clients were using condoms. Since HIV/AIDS, and Hepatitis B and C are so often related to sexual activity, staff has to develop increased comfort levels in talking about such issues involving sexuality and sexual behaviours of clients. While the number of condoms distributed is noted, the actual use of condoms is not gauged and should be incorporated in the Monitoring and Evaluation (M&E) system.

- **Voluntary Counselling and Testing**: Voluntary Counselling and Testing (VCT) is as an entry point for HIV prevention and care. It can not only facilitate acceptance and coping of serostatus, and referral for preventive and early management of opportunistic infections but can also facilitate behavioural change. High public awareness of HIV, increasing numbers of persons (especially peers) sick and dying with AIDS, and knowledge of personal risk behaviours result in an increased desire to learn one’s serostatus. The need for VCT is increasingly
compelling as HIV infection rates continue to rise, and countries recognise the need for their populations to know their serostatus as an important prevention and intervention tool. Those people who learn they are seronegative can be empowered to remain disease-free. For those HIV-infected, the development of less costly interventions to reduce mother-to-child transmission (MCTC) of HIV and HIV-associated infections (e.g., tuberculosis preventive therapy and prophylaxis for other opportunistic infections) takes on new importance. In addition, other medical and supportive services can help those living with HIV to live longer, healthier lives and prevent transmission to others. All centers visited claimed to provide VCT services. However, the Aahung team felt that the concept of VCT as an informed choice and voluntary decision to test and hence, a process in the empowerment of clients was not really comprehended by the staff and was instead perceived as a mode of ‘case finding’. This is an area where concepts need to be clarified.

- **IEC**: Effective Information, Education, and Communication (IEC) material is a tool that not only delivers knowledge and facts but also provides information that will contribute to changing attitudes and behaviour. Thus, IEC strategies that only support the first part of the adoption process, do not necessarily lead to behaviour change. In any case, effective IEC material, i.e., leaflets, pamphlets, posters, video or any forms of street-based cultural oriented folk media such as dramas, folk songs, and counsel, is a powerful tool when used appropriately. The team came across no IEC material developed for IDUs. Workers thought that since most of the clients were illiterate, they did not need any IEC materials and only made use of flip charts and markers in
the sessions (they called the sessions ‘lectures’ pointing towards a non-participatory methodology with a one-way flow of information). However, in one center, material (pamphlets on AIDS, STIs and Hepatitis) was being used for group discussions in which the material was read by a client who could read and write to the group and also hold discussions on the same. Effective IEC material has to be developed for IDUs (preferably pictograms) and also for peer outreach workers.

Harm reduction refers to various strategies and approaches to reduce the physical and social harm associated with risk-taking behaviour. It is perhaps a realistic acceptance of the practicalities and difficulties of behaviour change as well as an acceptance of individual rights and empowerment to change. Since many of the clients will not enter detoxification and rehabilitation services, and many others will relapse, it is imperative that special emphasis be paid to risk-reduction strategies. It is not only important to provide information about safer sex and injection practices, but also to put an equal effort into addressing these risky behaviours that will help staff to motivate drug users to quit drugs altogether. The distinct components of harm reduction (syringe exchange, condom distribution, VCT, counselling, etc.) therefore, need to be further strengthened. Although the highest attainable goal would be to stop all drug use, voluntary adoption of any risk reduction behaviour should be encouraged and viewed as a positive step.

3.4.3 Practices to avoid

- **Fear-based messages:** During interviews, some fear based messages were identified. Fear reduces confidence and motivation
to take ‘difficult’ steps towards safer behaviour. Such messages should be avoided as they victimise the client and have proven to be rarely effective for sustainable behaviour change.

- **Client dependency**: There was also fear felt by the staff with regard to creating a dependency among Dus on staff members that makes it all the more important to empower clients to make their own decisions. Staff should be aware of signs of dependency. These signs could include the inability of clients to take a decision of their own free will, client insistence that a particular staff member see them each time they visit the center or even demanding too much personalised attention. Clients should be made aware that the staff is there to support them but that any change in their lives will be brought about by their own free will and motivation.

### 3.4.4 Practices that need to be integrated into programmes

- **De-stigmatization of drug users and community involvement**: One of the major problems of rehabilitating drug users is the stigmatisation and discrimination they face in society. This is not only detrimental for the morale of clients but is also cited as a major reason for relapse after successful rehabilitation. The programme so far seems to have made a breakthrough with regards to community awareness and de-stigmatisation obvious by the involvement of local community leaders, drug enforcement agencies and other community members who are at best involved with center activities, and at worst tolerant of their endeavours. One center made it a point to invite influential members of the
surrounding community to their programmes at the drop in center. These included government officials, nazims and other community leaders who were invited to the weekly parties that were arranged for clients. Such activities not only raise community awareness but also help reduce stigmatisation and increase the self-esteem of Dus. Similarly, family counselling was deemed essential but cited as the most difficult to bring about by all groups. As one worker put it, “Cure the family...not only the drug user”.

- **Vocational training/opportunities**: Another important variable in sustainable rehabilitation is the presence of opportunities for vocational training and/or income generation. Many drug users relapse because they find that no one is willing to give them work. Boredom and disillusionment soon leads them back to drug abuse. One organisation mentioned that their connections with another organisation that could provide vocational opportunities for their clients was a strength. Indeed, the absence of such networks was mentioned as a weakness by others. Networking with factories and other organisations that can offer vocational training and/or jobs should be explored as a strategy that augments the overall goals of the programme. Current practice of recruiting former drug users as volunteers should be encouraged where practical.
3.5 Consolidation of project processes

In order to consolidate the achievements of the HAPDHRP, the following recommendations are suggested for the immediate future (short to mid term period).

Capacity building of staff for enhancing their skills to empower clients, while remaining professionally detached and stress free is recommended in the following areas:

1. Counselling and communication skills: This would focus on one-to-one personal communication with clients aimed at enabling the client to cope with stress, to take decision related to problems, and to adopt preventive and coping behaviours without creating dependency on staff. Learning would focus on listening skills, being assertive, body language, non-judgmental attitudes and counselling skills.

   Staff should receive training and refreshers in communication skills and counselling

2. Stress management: Dealing with DUs on a daily basis was reported by staff as a major source of stress. This can lead to staff burnout. Hence, training staff on stress relieving techniques would be beneficial and would also help them to be tolerant and patient with a particularly difficult group of clients.

   Stress releasing exercise need to be incorporated. Staff should be encouraged to take their due holidays and vacations as a policy to
make sure that burn-out is minimized.

3. Comfort with sexuality and talking about related issues: Since HIV/AIDS and Hepatitis B and C is mainly related to sexual practices, it is imperative that staff feel comfortable to talk about sexuality and sexual practices with clients. This will not only help create a comfortable and non-judgmental environment necessary to elicit a detailed sexual history but will also facilitate discussion of safer sex and proper condom usage and gauge any change in sexual behaviour. As any monitoring and evaluation of sexual behaviour would be done through the reporting by clients themselves, comfort in talking about such issues should lead to better reporting.

*Staff need to undergo self awareness workshops in which sexuality and self development are explored to create comfort in staff to deal with such issues with their clients and hence increase the quality and scope of services*

4. Human rights and a rights-based approach: A rights-based approach looks at the individual rights of a client (i.e., right to information, access to quality services, respect and human dignity) as a basis for all interventions. Therefore, a conceptual understanding is necessary to create an enabling environment that empowers clients.

*Staff training in the concepts of rights and operationalizing of these concepts, for example the rights-based approach, is recommended.*

5. Gender mainstreaming: Although, the number of female Dus is reported to be lower than males, anecdotal evidence suggests that at some places, they make up a considerable part of the DU
population. The centers visited had no provision for female clients. Staff should be aware of gender considerations and have the skills to gender mainstream all their activities.

Some suggestions may be the provision of limited additional services for women, or delegated workers dealing with women only. The setting up of an outreach team for women may also be considered in areas where there are many female drug users (for example in Rehri Goth, Karachi)
4. Introduction

A strong monitoring and evaluation (M&E) component for behaviour change would lead to strengthening of the overall M&E system and is imperative for the effective implementation of any programme. The objectives of this monitoring system should be:

1. To judge outcomes of the programme with regards to overall targets,
2. To assess for positive behaviour change and empowerment of individual clients,
3. To improve services and make needs-specific changes if and when needed, and
4. To encourage staff motivation.
5. To assist in planning and improvement of services

Data collected can help managers and other programme staff in many ways:

- Determine effectiveness of programmes
- Identify priorities and help set goals
- Promote more efficient use of resources
- Ensure quality of programmes
- Facilitate scaling up and coverage of responses
- Provide arguments for advocacy
- Ensure accountability of different stakeholders
- Promote a coherent and integrated response
- Respond to donor requirements
M&E programmes specific to IDU populations are difficult to implement because access to this population is limited and special techniques that are sensitive to the dynamics of this group of people are required. Data collected for M&E purposes is usually limited as it is restricted to only those clients that are registered and regularly visit the centers. Furthermore, because men are more likely than women to be IV drug users, women are often not included when collecting data.

Another major barrier identified was the difficulty in following up with the clients. Even though the current client registration form being used contains sections for a three and six-month evaluation, all project staff reported the difficulty of a follow-up and loss of clients over that time period.

Finally, since the data collected is based on self-reporting, there is a valid fear that it may not be completely honest and accurate. It was also found that although there was some provision to collect data pertaining to risky behaviours or the incidence and prevalence of HIV in drug-using populations, the system was not deemed as in-effective, mainly due to ‘difficulty in follow-up”. However, it is imperative to monitor and evaluate behavioural trends and the spread of HIV in both IDU and non-IDU populations, as well as to assess the impact of HIV interventions and policies on high-risk behaviours. This is obviously done through national level surveillance systems. The nature and extent of the monitoring and evaluation system will greatly depend on country-level HIV patterns, infrastructure, and resources available. The HAPDHRP project is a valuable source of community based data on drug use, drug users and HIV.
4.1 Indicators

Indicators should be sensitive, specific to the socio-cultural realities, and ideally be derived from current data collection, although some data may be collected by special periodic surveys. Annex 4 consists of a list of indicators developed by programme staff and augmented by standard indicators from literature that may be used to collect relevant data to monitor service utilisation and behaviour change. The following is a brief summary of various categories of indicators that can be collected.

4.1.1 Behavioural level indicators

Depending on available baseline data on risky behaviour for HIV, behavioural surveillance, and other studies, critical risk reducing practices will be identified and translated into measurable targets for intervention. Specific focus should be paid to drug use, injecting practices, non-
injecting drug use, and sexual risk behaviours. The behavioural indicators could include changes in the types of drugs used, routes of administration (e.g., smoked, inhaled, injected), distribution of drugs for injecting, preparation of drugs for injecting (e.g., heated, not-heated), syringe sharing and lending, syringe disposal, and a range of sexual practices (e.g. regular condom use, trading sex for money, trading sex for drugs). These data may be derived from behavioural surveillance surveys or routinely collected data of regular clients.

4.1.2 HIV prevalence and incidence

VCT services can provide information about sero-prevalence in IDUs, even though it must not be used as a case-finding strategy. HIV prevalence and incidence information from surveillance systems or special studies could be used in evaluating interventions. Incidence and prevalence data from the NACP records can be a baseline for comparing the incidence and prevalence of HIV among IDUs to the general population and exploring trends.

4.1.3 Process level indicators

For each intervention in the comprehensive BCC strategies, indicators obtain data on the provision (availability, accessibility, and coverage), quality, and use of services. Coverage is critical to understanding the effectiveness of interventions in preventing HIV infection in drug-using populations. Baseline data will be needed to determine the percentage changes expected and to develop specific measurable objectives. Best practices data from literature indicate that starting early, or as early as
possible, is necessary to gain access to the highest risk IDUs and to reach maximum numbers possible. Specific indicators include the number of outreach contacts, condoms distributed, syringes provided and/or exchanged, numbers counselled and tested, and numbers enrolled in substance abuse treatment programmes. Field team assessments will help determine the need for new interventions, changes in the current delivery strategy related to the time, places and people reached and, linkages to other services to increase the likelihood of collaborative and coordinated HIV prevention efforts.

4.1.4 Policy level indicators

Specific and measurable policy indicators have been reported in the UNAIDS National AIDS Programme Guide to Monitoring and Evaluation and, The Global Research Network Indicator Database on HIV Prevention Among Injecting Drug Users.

The following indicators to measure policy level change have been suggested:

a. Changes in the legal system, including political factors and barriers to community-based outreach, syringe access programmes, voluntary counselling and testing programmes, availability of substance abuse treatment and other approaches to HIV prevention among IDUs.

b. Actions taken to address societal biases, including stereotypes and beliefs about drug users and,

c. Overcoming stigma associated with drug abuse and HIV/AIDS.
4.1.5  Quality indicators

Quality of services is an important factor in enhancing acceptance and accessibility of services and should be an important aspect to monitor. Adherence to standard protocols (with regards to treatment, facilitation of clients and client satisfaction) could be a basis measuring quality of services. Exit interviews with random clients could be a valuable source of judging client satisfaction.
CHAPTER 5:  Behaviour Change and Key Messages

5. The Behaviour Change Continuum

Approaches to complex behaviour change focus primarily on the five main influences on behaviour:

1. Subjective Norms: The perceptions a person has of the expectations of significant others regarding their behaviour and the motivation to comply with these expectations.

2. Attitudes: The positive or negative evaluations of the possible consequences of performing certain behaviours.

3. Self-efficacy for the behaviour or change of behaviour: The situation-specific confidence a person has that they are able to change their behaviour and maintain this behaviour change. A common argument is that people cannot be expected to engage in a behaviour, or even to form intentions to engage in a behaviour unless they believe that they have the necessary skills and abilities to perform the behaviour.

4. Peer support: The availability of support from peers and particularly the extent to which peers also demonstrate or model the relevant behaviour.

5. Knowledge from information/education: The extent to which a person has the knowledge of the causes and consequences of their current behaviour and possible alternative behaviour.

The most frequently used model of behaviour change literature and the
one used for this strategy is the 'Transtheoretical model' (Prochaska, DiClemente & Norcross, 1992). The model includes six stages which are as follows:

1. Pre-contemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance
6. Termination
Figure 2: The trantheoretical model of behaviour change

**SOCIAL FEATURES**
- nature of personal relationships;
- expectations of class, position, age, gender;
- access to knowledge, information

**CULTURAL FEATURES**
- The behaviours and attitudes considered acceptable in given contexts – eg. Relating to sex, gender, drugs, leisure, and participation.

**ETHICAL AND SPIRITUAL FEATURES**
Influence of personal and shared values and discussions about moral systems from which those are derived – can include rituals, religion and rights of passage.

**LEGAL FEATURES**
Laws determining what people can do and activities to encourage observance of those laws.

**POLITICAL FEATURES**
Systems of governance in which change will have to take place – can, for example; limit access to information and involvement in social action.

**RESOURCE FEATURES**
- Affect what is required to make things happen – covers human, financial and material resources; community knowledge and skills; and items for exchange.
5.1 Messages during each stage of change

Broadly, individuals are thought to traverse stages of change ranging from “not interested in change” to “sustained change” (Prochaska & Velicer, 1997). The process is however, not necessarily a linear one and individuals may relapse to an earlier stage, and complete the whole cycle several times before long term maintenance of behaviour. In the different stages of the above model, individuals have different but overlapping requirements, and messages should be tailored and delivered according to the stage the person is in (i.e., his awareness, level of comfort, skills and readiness to change). The following sections describe characteristics of individuals at each stage of the behaviour change continuum, and how best the programme can support them to positive change. Suggested key messages appear in boxes with each section.

5.1.1 Pre-contemplation

This is the stage in which people are not intending to change or take action in the foreseeable future. This is the case for many of the initial contacts made by peer outreach workers. People may be at this stage because they are uninformed or misinformed about the consequences of their behaviour and the possible benefits of changing their behaviour. The programme has to increase awareness regarding the need to change and personalise information on risks and benefits. This is also the time to develop rapport and build trust so that users may visit the services and register themselves.
Knowledge (risk perception)
Sharing syringes can cause HIV/AIDS, Hepatitis B&C
Messages related to STIs causes and prevention (refer to 5.2)
Example: Unsafe sex can lead to many diseases (HIV/AIDS, Hepatitis B&C, other STIs)

Messages related to HIV/AIDS (causes and prevention)
Messages related to safe syringe use (refer to 5.29)

Motivation to visit centers
You can live longer healthier lives if you choose to:
Come and relax (sakoon) at the drop-in center
Coming to the center is like performing ‘zakat’ of the body (jism ki zakat)
The money you use on drugs can be spent on yourself, and for your parents and family members
Use services at the center for free
Take advantage of this facility if you want to improve your life
Lets save ourselves for ‘free’
Be conscious of the consequences of your behaviour

Attitudes
You have the right to be respected and respect yourselves
I was a drug user also… If I can do it, so can you
You had forgotten all the normal activities of life…. You can remember if you want.
Life is important
Everything depends on your choice
5.1.2 Contemplation
This is the stage at which people are intending to change within the foreseeable future. They are more aware of the pros and cons of changing but are also acutely aware of the possible negative consequences of changing like discomfort, withdrawal symptoms, loss of current social network and not being taken seriously by family and friends. This balance between the costs and benefits of change can keep people trapped at this stage for long periods of time, and therefore, it is important to support them and motivate them to advance to the next stage. Many of the people referred to the center by outreach staff or those visiting/referred from other cities will be at this stage. It is important at this stage to motivate clients and encourage them to make specific plans.

Knowledge (availability of services)

| You can take as many condoms as you want |
| You can visit the doctor for any condition you may have |
| You can take new syringes for free, but you have to give back the old ones (syringes are also available without exchange) |
| You can get a free haircut, wash your clothes or have a bath |
| Reinforce knowledge about harm reduction (safer sex, safer injecting/safer blood practices) |
| Knowledge about anti-septic dressing (ASD) |

Attitudes

| You are important |
| You have a purpose (when God made you he did not waste time in making you) |
| You have to recognize yourself |
There is a ‘nasha’ in respect, good food, love, friends, clothes…. Not just heroine
You have courage to even come here

**Motivation: Self esteem and confidence**

You can take care of yourself
When mind and heart are together you can achieve all your positive goals
You can start a new life if you want
If you can do this you can do more
You don’t have to stop drug use until you want to
You can live longer and healthier if you decide to
It’s difficult to change, but not impossible

**5.1.3 Preparation**

This is the stage at which people are intending to take action in the immediate future. They are warmed up to change and can clearly see the benefits for themselves, and for others. They are very aware of the costs and benefits of change and are likely to have taken some significant action recently (e.g. actively sought information on detoxification services, or availability and procedure to take free condoms). Most of the regular clients should be at this stage within a month and in some cases up to six months of first registering or even earlier, depending on the individual. They need to be assisted in developing concrete actions whether it be applying for detox and rehabilitation, or adopting safer behaviours (condoms, safe syringes, testing for HIV).
**Knowledge**

Reinforce earlier messages on services and safer behaviours. Have clients share ‘success’ stories.

You have many options to choose from... it's your choice.

**Family and community awareness**

Your son/brother (family) needs you in their efforts to quit drugs.

Your involvement will make a big difference in his/her success.

It is a habit, not an illness or curse.

Do not punish them more, they have already suffered a lot.

Hate the drugs not the drug user.

**5.1.4 Action**

This is the stage at which people have made specific, overt recent modifications to their behaviour. These people will have higher confidence levels, and are good role models for other unaware clients and those at earlier stages of the change continuum. At this stage it is important to assist with feedback, problem solving, social support and reinforcement. It is important that family members be encouraged to take part in their ward’s progress at this stage. Many of these clients will be in detox/rehabilitation, or in between.

You can go out and tell people with pride that you quit drugs.

You are not out of the family... they just need time to accept you again.
You should be proud of yourself
You deserve to respect yourself
If you are patient and don’t give up... you will be accepted back in society

5.1.5 Maintenance

This is the stage at which people are working to prevent a relapse to the previous behaviour. Compared with other stages, they are also less tempted to relapse and demonstrate more confidence (self-efficacy) so that they can continue their changes. It is important to assist with coping strategies, reminders, finding alternatives, and avoiding slips and relapses.

Try to keep busy
You can contact us to keep busy any time.
If you work with honesty, you can do it.
Do not care of other peoples’ negative remarks
Be thankful for what you have now
We are here to listen to you whenever you want

5.1.6 Termination

This is the stage at which people have zero temptation and 100 percent self-efficacy to maintain their behaviour. These people are valuable resources for out-reach and other services because they have gone through the whole process, are aware of the needs and specificity at each
stage and have high self-esteem and confidence levels.

5.2 **Key messages regarding various BCC components**

5.2.1 **Prevention of sexually transmitted infections**

The best way to prevent STIs is to avoid sexual contact with others. If you decide to be sexually active, there are things that you can do to reduce your risk of developing an STI.

- Try to have a mutually monogamous sexual relationship with an uninfected partner. The risk of acquiring an STI also increases with the number of partners over a lifetime.
- Correctly and consistently use a male condom.
- Prevent and control other STIs to decrease susceptibility to HIV infection and to reduce your infectiousness if you are HIV-infected.
- **Remember** that you can have HIV and still test negative so repeat your test within 3 to 6 months of the first test.
- People may be perfectly healthy for some time and still be able to transmit HIV.

5.2.2 **All sexually active should do the following**

- Have regular checkups for STIs even in the absence of symptoms, and especially if having sex with a new partner. These tests can be done during a routine visit to the doctor’s office.
- Learn the common symptoms of STIs. Seek medical help immediately if any suspicious symptoms develop, even if they are mild.
- Avoid having sexual intercourse during menstruation. HIV-infected women are probably more infectious, and HIV-uninfected women are
probably more susceptible to becoming infected during that time.

- Avoid anal intercourse, but if practiced, use a male condom and water based lubrication.

### 5.2.3 Anyone diagnosed as having an STI should

- Be treated to reduce the risk of transmitting the infection to their partners.
- Notify all recent partners and urge them to get a checkup.
- Follow the doctor’s orders and complete the full course of medication prescribed. A follow-up test to ensure that the infection has been cured is often an important step in treatment.
- Avoid all sexual activity while being treated for an STI.

### 5.2.4 Who should be counselled and tested for HIV/AIDS?

- If you have had any sexually transmitted disease or have shared needles for injecting drugs.
- If you are a man who has had sex with men.
- If you are the sexual partner of a person who is an IV drug user.
- If you are the female sexual partner of a man who has had sex with men.
- If you received blood transfusions or blood products prior to 1986.
- If you are a woman who has engaged in high-risk behaviour (e.g. IV drug use or sex with a person who might be infected with the virus) OR you plan to become pregnant.
• If you believe you have reason to be concerned about your HIV status.

5.2.5 **Information all individuals, in all stages, need to know**

• Current information on the seriousness of the disease.
• How the causative virus (HIV) is spread.
• HIV has been shown to be spread from an infected person to an uninfected person by:
  ▪ sexual contact in which there is an exchange of infected bodily fluid, i.e. semen, vaginal secretions, and blood. Bodily fluids can be exchanged through any of the following modes: through penis/vagina, penis/rectum, mouth/rectum, mouth/genital contact.
  ▪ sharing needles used in injecting drugs
  ▪ an infected woman to her fetus or newly born baby
  ▪ transfusion or injection of infectious blood or blood fractions.
• An individual can be infected with HIV without having symptoms of HIV infection or appearing ill. Once infected, a person is presumed infected for life, but actual symptoms may not appear for many years. A single exposure to HIV may result in infection.
5.2.6 How the virus is known NOT to be spread

- There is no evidence that the virus is spread through casual social contact (shaking hands, social kissing, coughing, sneezing, mosquitoes, sharing swimming pools, bed linens, eating utensils, office equipment; being next to or served by an infected person). There is no reason to avoid an infected person in ordinary social contact.

- It is not spread by the process of donating blood (the donor has no risk of infection provided new transfusion equipment is used for each blood donor).

- It is not spread by sexual intercourse between individuals who have maintained a sexual relationship exclusively with each other, assuming that they have not been infected through contaminated blood, blood factors, IV drug use or a previous sexual partner.

5.2.7 How to prevent infection

Infection through sexual contact can be avoided by practicing abstinence or having a mutually monogamous relationship with no known risk factors in either partner. Young people, and people of all ages, can stay safe from AIDS by not having sex. Youth need to know that it is all right to say no to sex.

- In addition to the risk of HIV infection, there are other good reasons to postpone sexual intercourse, including the risk of gonorrhoea, syphilis, herpes, and unplanned pregnancies.
• People of all ages need to know it is all right to say no to all drugs.

• If already sexually active:
  
  ▪ ask your partner questions about his or her past sexual experience and drug use.
  
  ▪ Avoid sex with multiple partners. The more people one has sex with, the greater the chances of becoming infected.
  
  ▪ Use a condom throughout sexual intercourse with infected partners or partners whose HIV status is unknown. Condoms must be used properly with every encounter. They are not foolproof but can and must be used to reduce the risk of virus transmission.
  
  ▪ The chance of blood or semen entering the bloodstream is very high during anal sex, since it can cause tearing of delicate tissues, so anal sex should be avoided OR condoms and lubrication are used each time.
  
  ▪ Drugs and alcohol can impair the immune system functioning and may increase the risk of unsafe behaviours and early progression to HIV/AIDS.

5.2.8 If there is suspicion of infection

• Abstain from sexual intercourse OR use a water-based lubricated condom.

• Seek counselling and HIV antibody testing to be sure of the status of the
infection. (Be aware that weeks to months may elapse from the time of infection to the time that antibodies to the virus appear in the blood. During this time persons may be infectious even though they may have tested negative).

- Obtain counselling and testing if pregnancy is being considered.

### 5.2.9 Safe syringe and drug practices

- Avoid using intravenous drugs.
- If you do use IV drugs make sure you use a sterile syringe every time
- Never share a syringe with anyone else.
- Make sure you dispose of your syringe safely (put the cover on the needle and dispose it in a proper place, for example the local rubbish dump)
- It is best to bring back your syringes at the centre where they can dispose them safely.
- All drugs are harmful, but if you have to use drugs, reduce your risk by choosing the least harmful ones,
- The most harmful mode of using drugs is intravenous because of the danger of HIV/AIDS, Hepatitis B and C and chances of overdose
- Prefer inhaling or smoking over intravenous usage
- Try to reduce the dose of your daily drug intake
- Try to reduce the frequency of your daily drug intake
5.2.10 Referral services

Clients should be aware where to go for:

- STI diagnosis and treatment
- HIV testing
- Needle exchange
- PHC

5.3 Proposed means of dissemination

Perhaps the most practical means of dissemination is through word of mouth. This can take place during one to one communications. Messages should be clear and simple to understand, and staff should have good inter-personal skills. Sessions on the street may be less effective for IV drug users because of the noise and disturbance causing difficulty in hearing. However, street sessions are a good way to create community awareness and participation. The use of pictograms may be a good tool to offset the disturbances and noise on the streets.

Tips for good communication

- Respect
- Good listening skills
- Tolerance and patience
Guidelines for BCC for HR Service Provision

- Comfortable environment
- Non-judgmental attitudes
- Up to date relevant knowledge

- Colourful and simple posters are a good way to provide BCC messages and knowledge. Posters should be easy to comprehend and placed in places where clients will be most likely to look at them. Charts displaying the outcomes of projects (condoms distributed, clients treated etc.) may be motivational for clients. This information should be presented and explained using easy to understand flow charts and graphs.

- Most people in Pakistan obtain information through radio and many through television. The radio can be a powerful source of reinforcing the programme and particularly so for decreasing stigmatisation and marginalisation. The local station could be approached to interview staff and ex-users or even current users. This would help create community awareness and be motivational for users as well. Many local television channels like GEO are taking interest in national social issues and could be approached to cover the issues of drug users, and how the HAPDHRP is striving to help them gain confidence and respect.

- Theatre has been shown to be a very effective method for community mobilization, awareness and promoting dialogues and discussions. Some form of theatre like Theatre for Development, are in themselves empowering for performers and can be explored and integrated in the project scope.
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http://www.cdc.gov/nchstp/od/gap стратегий/2.8_предотвращения_навитации_HIV_transmission.htm>

- Handbook of Indicators for Monitoring National AIDS Control Programme II (http://www.naco.nic.in/nacp/indicator.pdf)
- HIV Surveys Indicators Database (http://www.cpc.unc.edu/measure/publications/unaid-00.17e/panel5.html)
• www.comminit.com
ANNEXURE 1: MODEL FOR EMPOWERING FOR BEHAVIOUR CHANGE USING COMMUNICATION

<table>
<thead>
<tr>
<th>BEHAVIOUR CHANGE</th>
<th>PRECONTEMPLATION</th>
<th>CONTEMPLATION</th>
<th>DECISION</th>
<th>ACTION</th>
<th>MAINTAINANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unaware of the problem, hasn’t thought about change.</td>
<td>Thinking about change, in the near future.</td>
<td>Making a plan to change plans, setting gradual goals.</td>
<td>Implementation of specific action plans.</td>
<td>Continuation of desirable actions, or repeating periodic recommended step(s).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EMPOWERMENT</th>
<th>SOCIAL SERVICES</th>
<th>HARM REDUCTION</th>
<th>DETOX &amp; REHAB</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>OPTIONS</th>
<th>CHOICE</th>
<th>DECISION</th>
<th>ACT</th>
<th>SUSTAIN BEHAVIOUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>MESSAGES</td>
<td>Increase awareness of need for change, personalize information on risks and benefits.</td>
<td>Motivate, encourage to make specific plans.</td>
<td>Assist in developing concrete action.</td>
<td>Assist in coping, reminders, finding alternatives, avoiding slips/relapses (as applies).</td>
</tr>
</tbody>
</table>

Guidelines for BCC for HR Service Provision
## ANNEXURE 2: HAPDHRP SITES VISITED

<table>
<thead>
<tr>
<th>Site</th>
<th>Organization</th>
<th>Facility visited</th>
<th># of Interviews held</th>
<th>M</th>
<th>S</th>
<th>Cl*</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lahore</td>
<td>Caritas Pakistan Lahore</td>
<td>Drop in center</td>
<td></td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Nai Zindagi</td>
<td>Mobile HR Unit</td>
<td></td>
<td>0</td>
<td>2</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drop in center</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Karachi</td>
<td>Marie Adelaide Drug Habilitation Programme</td>
<td>Mobile unit</td>
<td></td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drop in center</td>
<td></td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Al-Nijat Welfare Society</td>
<td>Drop in center</td>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Peshawa</td>
<td>Dost Foundation</td>
<td>Drop in center</td>
<td></td>
<td>1</td>
<td>2</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Drug Demand &amp; Harm Reduction Organization</td>
<td>Mobile service</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Quetta</td>
<td>Nai-Zindagi</td>
<td>Drop In Centre</td>
<td></td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rehabilitation center</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Field site</td>
<td></td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td>6</td>
<td>18</td>
<td>49</td>
<td>6</td>
</tr>
</tbody>
</table>

*M=Managers; S=Staff (peer outreach workers, doctor, Counsellor etc) ; Cl=clients; F=Family

80

*Focus groups held*
ANNEXURE 3: A TYPICAL DROP-IN CENTRE CLIENT PATHWAY

1. Self Referral
2. Referred by outreach worker
   - Reception desk
     - Medical checkup (doctor)
       - Registration
         - Medical facilities
         - Lecture/group session
         - Social services
           - DETOX
             - REHABILITATION
## Annexure 4: List of Indicators

### Drug use and safe syringe use

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and percentage of IDUs reporting knowledge of syringe access programme</td>
<td></td>
</tr>
<tr>
<td>Number and percentage of IDUs sharing injection equipment (syringes) in past 6 months</td>
<td></td>
</tr>
<tr>
<td>Percentage IDUs sharing injection equipment (syringes) at last injection</td>
<td></td>
</tr>
<tr>
<td>Number and percentage of IDUs sharing injection equipment (syringes) at last month</td>
<td></td>
</tr>
<tr>
<td>Number and percentage of IDUs never sharing injection equipment (syringes) in last month</td>
<td></td>
</tr>
<tr>
<td>Number and percentage of IDUs never sharing injection equipment (syringes) in past 6 months</td>
<td></td>
</tr>
<tr>
<td>Number and percentage of IDUs sharing other injection equipment (e.g., cookers, cottons, water) at last injection</td>
<td></td>
</tr>
<tr>
<td>Number and percentage of IDUs never sharing other injection equipment (e.g., cookers, cottons, water) syringes) in last month</td>
<td></td>
</tr>
<tr>
<td>Number and percentage of IDUs sharing other injection equipment (e.g., cookers, cottons, water) in past 6 months</td>
<td></td>
</tr>
<tr>
<td>Number and percentage of IDUs never sharing other injection equipment (e.g., cookers, cottons, water) in past 6 months</td>
<td></td>
</tr>
<tr>
<td>Number and percentage of IDUs shifting from IV to other forms of DU</td>
<td></td>
</tr>
<tr>
<td>Number of syringes distributed in past year</td>
<td></td>
</tr>
<tr>
<td>Estimated proportion of IDUs using needle exchange services</td>
<td></td>
</tr>
<tr>
<td>Rate of syringe exchange (syringe exchange ratio)</td>
<td></td>
</tr>
<tr>
<td>Number Syringes incinerated through SEP</td>
<td></td>
</tr>
</tbody>
</table>

### Community Based Outreach

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of community-based peer outreach visits</td>
<td></td>
</tr>
<tr>
<td>Number of IDUs that interacted with community-based peer outreach</td>
<td></td>
</tr>
<tr>
<td>Estimated proportion of IDUs reached by community based peer outreach</td>
<td></td>
</tr>
</tbody>
</table>

### Voluntary Testing and Counselling (VCT)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of people aware of testing facilities</td>
<td></td>
</tr>
<tr>
<td><strong>Number of clients requesting test</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of clients tested in VCT settings (voluntary)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number and percentage of IDUs tested for HIV</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number and percentage of IDUs tested positive for HIV</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number and percentage of IDUs tested positive for Hep B and C</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of pre-counseling sessions held</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of post test counseling sessions held</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Number of non-clients (family members) requesting HIV test</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Drug Treatment**

| **Annual number of IDUs in drug treatment** |
| **Proportion of IDUs in abstinence-based treatment** |
| **Proportion of DUs drug free after six months** |
| **Proportion of Dus drug free after one year** |
| **Number and percentage of Dus relapsed after rehabilitation after three/six months** |

**Condom promotion**

| **Number of condoms provided** |
| **Number and percentage of clients who have requested condoms** |
| **Number and percentage clients reporting condom use as preventive measure** |
| **Percentage IDUs using condoms at last sex with regular partner** |
| **Percentage IDUs using condoms at last sex with non-regular partner** |
| **Percentage IDUs using condoms the last time they bought or sold sex** |

**Medical services**

| **Number of clients coming to seek services (ASD, medication, examination) at mobile unit** |
| **Number of clients coming to seek services (ASD, medication, examination) at DIC** |
| **Number of ASDs done** |
| **Number of clients treated for STI** |
| **Number of clients availing medical services at regular basis (at least three visits in the past six months)** |
Number of clients referred for advanced medical and surgical services
Number of people other than clients availing medical services
Percentage of successful follow-up in three/six months

**Individual Behaviour change indicators** *

<table>
<thead>
<tr>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of clients participating in groups and lectures</td>
</tr>
<tr>
<td>Number of clients showing improvement in personal hygiene (bathing/shaved/hair cut)</td>
</tr>
<tr>
<td>Number of clients returning syringes regularly</td>
</tr>
<tr>
<td>Number of clients attending monthly get-togethers</td>
</tr>
<tr>
<td>Number of clients availing social services</td>
</tr>
<tr>
<td>Number of clients attending lectures</td>
</tr>
<tr>
<td>Number of clients with jobs/sources of income after three/six months</td>
</tr>
<tr>
<td>Number of clients living in the street who have moved in with families after three/six months</td>
</tr>
<tr>
<td>Decrease in criminal activity</td>
</tr>
</tbody>
</table>

*These indicators were used at an informal level to identify those clients who were mentally prepared to be referred for detox and/or rehabilitation. Staff made this distinction because clients showing such changes were more likely to sustain behaviour change and because there was a lack of treatment facilities for everyone to be sent for rehabilitation services.

Please note that for each percentage an appropriate denominator must be selected

E.g.
Percentage of clients who have requested condoms

\[
= \frac{\text{Number of clients requesting condoms in this month}}{\text{Total number of registered clients at center}}
\]

OR

\[
= \frac{\text{Total number of clients visiting center/mobile vans in this month}}{\text{Denominator}}
\]