WHAT WORKS

IN HIV PREVENTION for substance users

until it's over
AIDS ACTION

What Works in HIV Prevention for Substance Users is a product of AIDS Action.

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AIDS Action is the national voice on AIDS. We are committed to advocating for people affected by HIV/AIDS "Until It's Over" – until no more people become infected with HIV, until people living with HIV have the care and support they need, and until a cure is found.

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chapter 1

INTRODUCTION

Preventing HIV infection among substance users is critical to reducing the rate of new HIV infections in the United States. Any relationship between substance use and HIV infection goes far beyond the substance users themselves. Others at risk for exposure to HIV include men and women who have unprotected sex with an injecting drug user, as well as children born to mothers who have contracted HIV. These mothers have most commonly been exposed to the virus either through their own substance use or through unprotected heterosexual sex with a substance user.

The Centers for Disease Control and Prevention (CDC) estimates that since the AIDS epidemic began, injection drug use has directly accounted for nearly one third (31 percent) of AIDS cases in the United States. In spite of promising new strategies to reach this vulnerable population, substance use still accounted for one quarter of AIDS cases in the United States through June 2000. Moreover, injection drug use was responsible for as many as half of all new HIV infections within the same time period.

Substances that affect behavior and subsequently increase the risk of HIV infection can be legal or illegal. HIV prevention strategies must account for those who inject or consume illegal drugs as well as those who may alter their moods or behaviors legally. Risky substance consumption may include, but is not limited to, injecting drugs, non-injecting illegal drugs, unsupervised use of prescription drugs, steroid intake, or alcohol abuse. HIV transmission is possible when an individual is a routine, occasional, or even a one-time substance user.

In addition to the risk of HIV infection, substance users also face an increased risk of infection of other blood-borne diseases. Hepatitis B (HBV) and Hepatitis C (HCV) are two infectious diseases that pose serious health threats to current and former substance users. Individuals infected with HCV are at an increased risk for HIV infection. HIV prevention efforts among substance users should be extended to individuals infected with other blood-borne infections including HCV and HBV as an effective method to prevent further infections with HIV.

Community-based organizations (CBOs) are uniquely positioned to help prevent HIV infections among substance users. These organizations have been at the forefront of HIV and AIDS awareness efforts and have had a tremendous amount of experience collaborating with researchers to design effective intervention strategies. Furthermore, evaluations of these programs have shown that substance users can and will change their behaviors to reduce their risk of HIV infection. Thus, the promising programs detailed in this guide provide an opportunity to extend successful HIV prevention strategies to CBOs seeking to develop programs to target substance users at risk for HIV infection.

This guide showcases a number of strategies and techniques that have reduced the transmission of HIV among substance users. This guide is by no means a comprehensive catalog, but rather seeks to illustrate approaches that are making a difference. The document begins with a statistical snapshot of HIV and AIDS within the substance user community. Following this discussion is a brief outline of strategies and models from the research literature that may be useful in designing effective risk reduction programs. The discussion of HIV prevention research is followed by descriptions of CBOs actively engaged in the fight against HIV infection among substance users. Finally, resources and references are found at the end of the document to aid in further research.

chapter 2

HIV AND SUBSTANCE USE

As mentioned earlier, substance use may refer to illegal drugs, prescription medicines, and alcohol. Programs developed to prevent HIV transmission among substance users must address the complicated effects of some of the following substances:

- Heroin
- Cocaine
- Crystal Methamphetamine
- Ritalin as a stimulus in adults
- Talwin
- Anabolic steroids and other hormones
- "Club Drugs" like ecstasy, ketamine, gamma-hydroxybutyrate (GHB), and nitrates
- Marijuana
- Alcohol

Behavioral effects of the drug, equipment used to take drugs, and behavior driven by the need for the drug all have the potential to put a substance user at increased risk for HIV infection. Additionally, research literature shows that the use of non-injecting drugs such as alcohol, cocaine, and other club drugs leads to a heightened risk of potential HIV infection. This risk is primarily due to impaired judgment and an increase in related risk behaviors.

Behavioral effects of the Drug and HIV Risk

While under the influence of a drug, individuals may feel less inhibited and may be more likely to engage in risky behavior. This tendency has significant implications for HIV prevention strategies. A Massachusetts Department of Education Study found that students who used alcohol or drugs before their last sexual encounter were less likely to use a condom. Of the 4,159 students surveyed, only 47 percent of those using drugs or alcohol reported using a condom, compared to 60 percent among students who did not use drugs or alcohol (Massachusetts Dept. of Education, 1995). Risky sexual behaviors include unprotected anal, vaginal, or oral sex; sex with multiple partners; and a lack of treatment of other sexually transmitted diseases.

Other high-risk drug and sexual behaviors intersect in a number of ways leading to increased risk of HIV infection. Sex partners of injecting drug users often begin to inject drugs themselves (Quellet et. al, 1998). Dependency on any particular substance can lead to an increased need to obtain the substance at higher doses. Ultimately, this can lead to unhealthy behavioral risks such as the exchange of sex for drugs or money for drugs. Additionally, substance dependency can lead to individuals engaging in commercial sex or hustling to accumulate income for their habits (AED, 1997).

Equipment used to take Drugs and HIV Risk

Using needles to inject drugs is one of the most effective methods of HIV transmission. The blood-borne pathogen passes between individuals through the blood remaining in the needle following each injection. As injection drug use must occur via a vein or artery, users must determine if the needle is located within a vein. To determine this, a user pulls back on the syringe plunger to see if blood enters the syringe. This process, know as "Registering" contaminates the entire syringe with blood; the needle, hub, barrel, and plunger (Koester, 1998). HIV can survive in residual blood in used syringes, even if the syringe is rinsed with water. One study has shown that HIV in used syringes remains viable and infectious at room temperature for more than four weeks (Abdala, 1999).

Even if injecting substance users use a sterile syringe for injection, indirect sharing of equipment can lead to HIV infection. In 1994, Koester and Hoffer found that the following sharing practices could all spread HIV:

- Squirting drug solutions from a previously contaminated syringe into another container (cooker or spoon) and drawing the solution into a clean syringe;
- Using a plunger from a contaminated syringe to mix drugs with water;
- Drawing up water for dissolving a drug by using a contaminated syringe or inadequately disinfected syringe; and
- "Kicking out a taste" by putting a part of a drug/water solution from a previously contaminated syringe into another user's syringe so that another or several other users can access some of the drug.

Behavior motivated by a need for a substance: Implications for HIV risk

Individuals who engage in risky behavior in order to maintain their dependency on a drug are at increased risk for HIV infection. Outreach workers in contact with this especially vulnerable population may find that sex is traded for substances of all types. Safe sex may not be a viable option due to the fear of violence or loss of limited economic opportunity. Additionally, other groups of users have coexisting challenges including mental illness, physical illness, homelessness, and incarceration. Up to 30 percent of homeless adults may be substance users (NIDA, 1990). Another study of homeless adults found that two-thirds are at risk of HIV infection from various sources, including unprotected sex with multiple partners, injecting drug use, sex with an injecting drug user, and exchange of sex for money or drugs (St. Lawrence and Brasfield, 1995).

Impaired judgment affected by substance users: Heightened risk taking

Research has also linked non-injecting drug use to an increased risk of HIV infection. Mind altering substances including alcohol may promote a decrease in safe behaviors including negotiation of sex (including safer sex), the decision to use a condom, and even proper use of condoms. Frequent substance use can impair an individual's decision making process and lead to heightened risk.

National Statistics on Substance Use

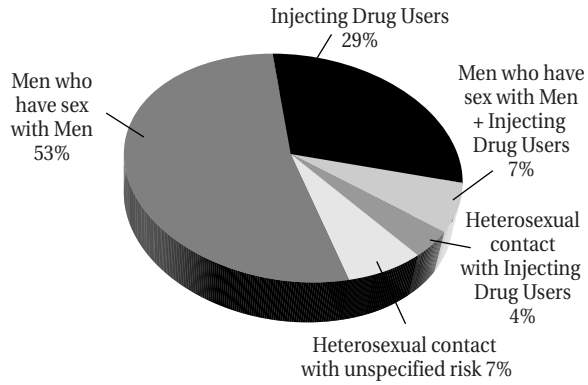
The extent to which substances are used within the U.S. population provides strong evidence to support targeted HIV prevention efforts for substance users. The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) data suggest that substance use is prevalent among many age groups, especially young people. SAMHSA identifies illicit drug use through the National Household Survey on Drug Abuse (NHSDA). This study examines substance use in the civilian, non-institutionalized population of the United States. According to NHSDA figures, approximately 14.8 million Americans currently use illicit drugs, or an estimated 6.7 percent of the U.S. population (SAMHSA, 1999). Marijuana was the most common substance used – 75 percent of the 14.8 million substance users reported smoking marijuana. According to the study, an estimated 1.5 million Americans were current cocaine users, 413,000 individuals reported using crack cocaine, and 200,000 Americans were current heroin users.

According to SAMHSA's data, 149,000 Americans became new heroin users in 1999. Although this aggregate figure is not drastically different from the two previous years, when the data is analyzed some significant changes emerge. Heroin initiation for individuals aged 12-17 doubled from the 1980's to the 1990's. Among the estimated 471,000 persons who used heroin for the first time between 1996 and 1998, a quarter (125,000) of these individuals were under age 18 and another 47 percent (222,000) were between the ages of 18-25 (SAMSHA, 2000).

The highest rate of illicit drug use for all age groups was found among persons aged 18-20, 20 percent of whom reported drug use. As in previous years, in 1999 men reported more substance use than women. Across racial and ethnic groups, other differences emerged. Native-Americans and African-Americans reported the highest prevalence of substance use, 10 percent and 7.7 percent respectively. Approximately 6.6 percent of White, non-

Latino individuals reported substance use as compared to 6.8 percent of Latinos and 3.2 percent of Asian Pacific Islanders.

In addition to race and ethnicity, geographic location can also influence HIV risk among substance users. Because geography in the United States affects the type of drugs available, location dictates how a substance is administered into the body. Heroin use on the East coast is generally in the high quality powdered form. With this higher quality there is higher purity and an increased preference for users to snort the drug. In contrast, on the West Coast, Texas and the Midwest, heroin is less pure and use of the drug often occurs through intravenous injection (CEWG, 1998).



[Source: CDC, 2000, 12:1, Table 5]

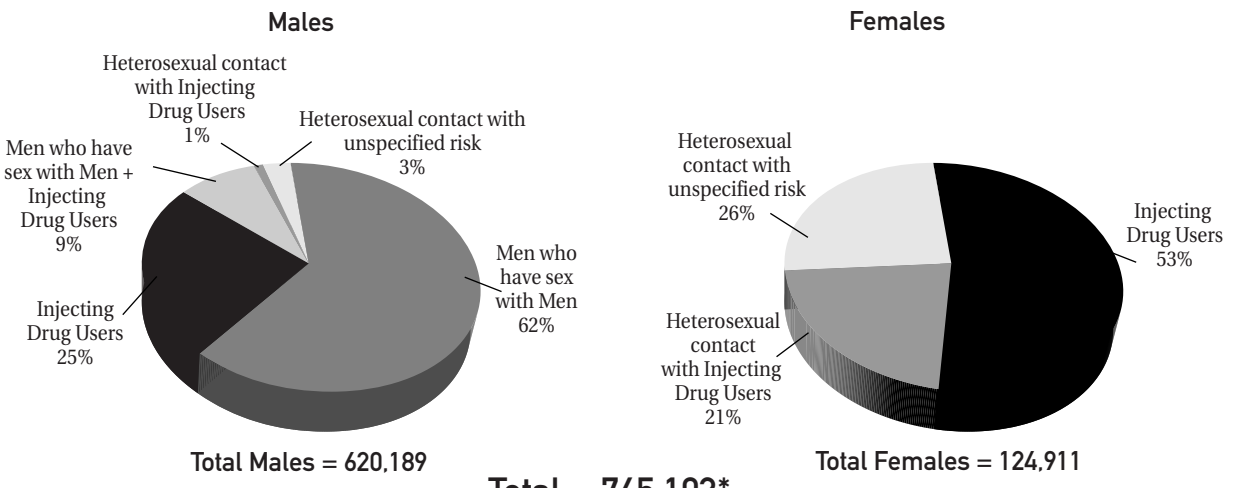
HIV Infection

Surveillance data gathered by the CDC provides a broad range of information about the relationship between substance use and HIV infection. [All of the information in the discussion below is derived from CDC surveillance data unless otherwise noted.] As of June 2000, there were 753,907 cumulative AIDS cases in the U.S. Of these cases, over one-third (40 percent) involved injection drug use or a related exposure. Among new AIDS cases in 1999, of the 46,400 new cases reported, almost 14,000 (30 percent) were related to injection drug use.

While these statistics suggest the impact of substance use in general, it is important to examine the different patterns of exposure by gender, race/ethnicity, and age to design effective prevention programs. Incarcerated populations whose risk factors include substance use should also be considered.

Differences between Men and Women

After sexual contact with other men, injecting drug use is the second most common exposure category for men with AIDS. Through December 2000,



[Source: CDC, 2000, 12:1, Table 5]

*includes three persons whose sex is unknown

injecting drug use accounted for one quarter of the total AIDS cases among men. Additionally, 10 percent of AIDS cases among males were the result of exposure to multiple risk factors (e.g., men having sex with men and injecting drugs, or heterosexual contact with an injection drug user).

Among women, the AIDS epidemic has unfolded differently. The vast majority of AIDS cases are the result of injection drug use (53 percent) or heterosexual contact with an HIV positive individual. Heterosexual contact with an injection drug user has resulted in a significant number of infections among women (21 percent).

Ethnic/Racial differences

Substance use is a risk factor for a disproportionate number of AIDS cases among people of color. From July 1999 through June 2000, individual injection drug use and related exposures were responsible for 42 percent of all AIDS cases among African-Americans and 42 percent of all AIDS cases among Latinos. Approximately 20 percent of AIDS cases among white, non-Latinos were related to injection drug use (CDC, 2000).

AIDS cases among men of different racial and ethnic groups can be attributed to a myriad of risk factors. While injection drug use and related factors account for approximately two thirds of all AIDS cases among women of all racial and ethnic groups, the relationship between substance use and AIDS incidence is less uniform among men. For African-American and Latino men with AIDS, the proportion of identified risk factors associated with injection drug use and men who have sex with men are similar. This is not the case for white, non-Latino men: a disproportionate number of AIDS cases continue to be among men who have sex with men.

Teens and Young Adults

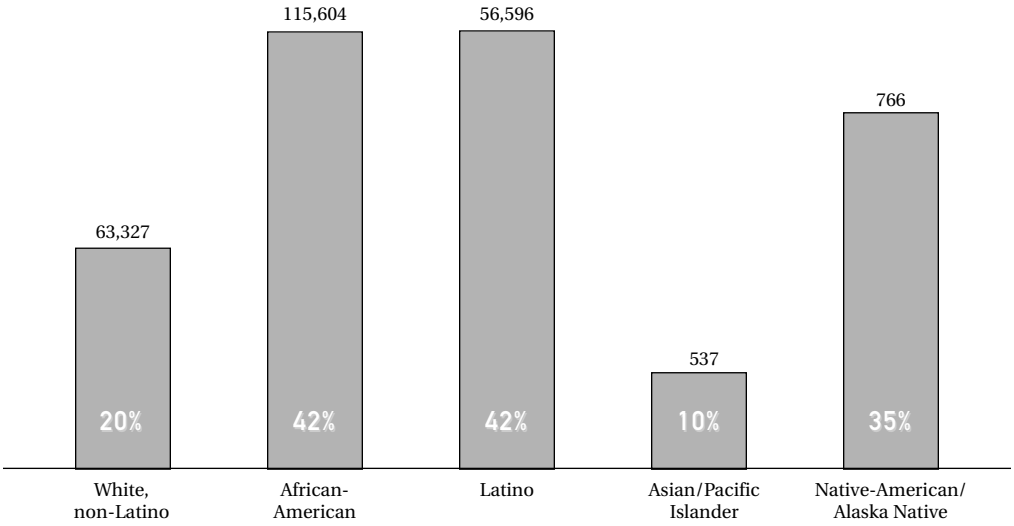
For young people between the ages of 13 and 24, the exposure categories for HIV/AIDS vary. In young men, AIDS continues to be most prevalent among men who have sex with men, while unprotected heterosexual contact is the highest risk factor for HIV infection among young women.

Of the 690 AIDS cases among young women in 1999, 124 were reported to be related to substance use. Among substance using young men, 152 of 1999's 949 AIDS cases were related to substance use.

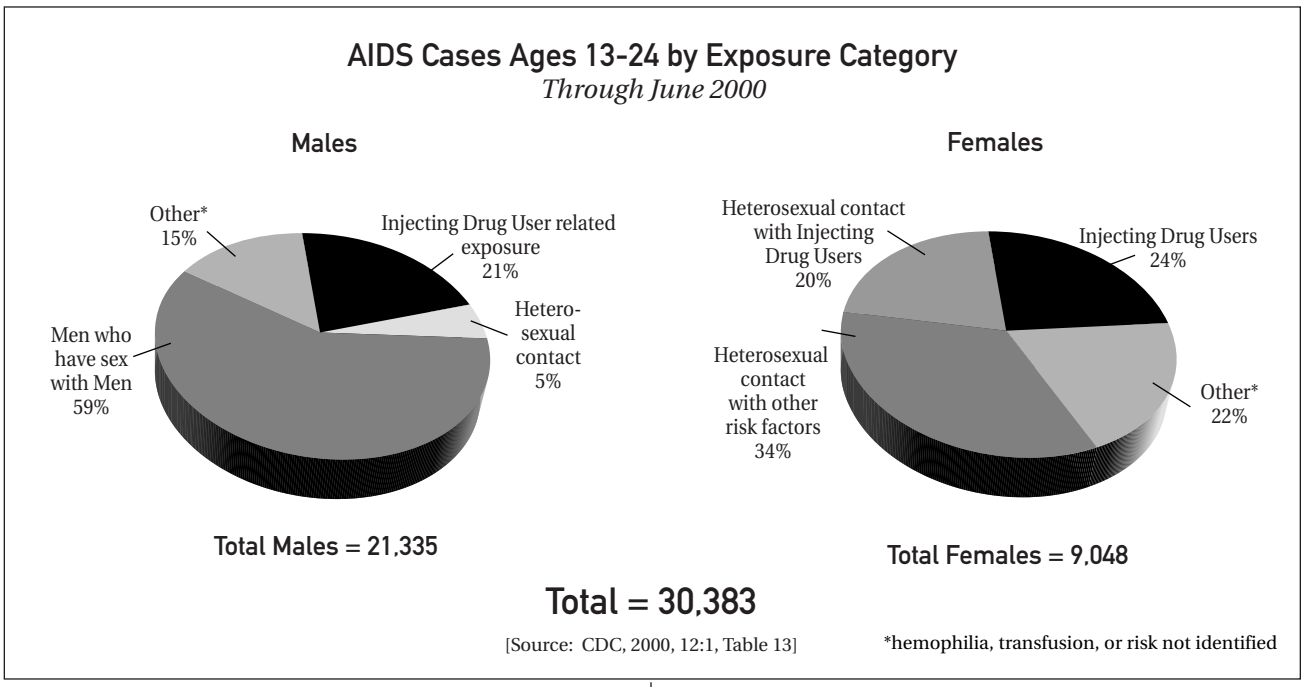
Racial and ethnic differences are most pronounced among young women. The highest AIDS incidence related to substance use was found in white, non-Latino women (46 percent) and Native-American/Alaska Native women (52 percent). The

Within Race/Ethnicity, the Cumulative Number of AIDS Cases Related to Injection Drug Use

Through June 2000



[CDC, 2000 12:1, Table 9 & 11]



proportion of African-American and Latino women with substance use related HIV infections were lower, 34 percent and 39 percent respectively.

Incarcerated Populations

AIDS cases found among incarcerated populations may also be the result of substance use. Illegal drugs in prisons, including injection drugs, may be available even though clean needles may not be. An estimated 25 percent of prisoners have used needles to inject drugs and nearly half of those individuals have shared needles. This is problematic since neither clean needles nor condoms are easily accessible within correctional facilities.

Other Blood-borne Pathogens

The transmission of other blood-borne pathogens including Hepatitis B (HBV) and Hepatitis C (HCV) through unsafe sexual practices and substance use is yet another issue affecting HIV prevention efforts for substance users. The CDC estimates that 1.25 million Americans are infected with HBV and an additional 2.7 million Americans are infected with HCV. These pathogens are chronic illnesses and individuals unaware of their infections may experience no symptoms for 20-30 years following infection. Studies have consistently shown that injecting drug use is the single most important risk factor for HCV infection (Alter et. al, 1999). Other blood-borne pathogens are important to diagnose because infection with one of these illnesses is an indicator for increased risk of HIV infection (Crofts et. al, 2000).

chapter 3

PREVENTION EFFORTS TARGETING SUBSTANCE USERS

For the past fifteen years the National Institute of Drug Abuse has researched the dual epidemics of drug abuse and HIV infection. These studies on the development, implementation, and evaluation of HIV prevention programs have helped define the characteristics of effective prevention models. Three models particularly suited for community-based organizations (CBOs); Community Outreach, Access to Sterile Syringes, and Drug Treatment are briefly described below.

Community Outreach

Identifying and developing relationships with substance using populations in order to educate them on the relationship between substance use and HIV infection is a proven method of HIV prevention. This model focuses on changing behaviors and reducing the risk of acquiring or transmitting HIV. Community outreach has long been a strength of CBO programs and can be expanded to educate drug users about the role substance use plays in HIV transmission.

Access to Sterile Syringes

Access to sterile injection equipment is a cost-effective strategy for the prevention of HIV infection among substance users. This prevention model requires that CBOs work with public policy makers and the criminal justice system to set priorities for HIV prevention programs while simultaneously accommodating law enforcement and legislative concerns. Programs often distribute sterile needles for use in intravenous or subcutaneous injection of drugs, usually in exchange for used needles. Bleach kits used to clean needles may also be distributed. This exchange also traditionally involves the dissemination of educational information about substance use and HIV infection. Often these programs provide referrals and linkages to substance use treatment centers and methadone clinics.

A major stumbling block to syringe exchange programs (SEPs) is the fact that most states have legal restriction on the sale and distribution of sterile syringes. Thus, injecting drug users have limited access to sterile syringes (Gostin et. al, 1997). Forty-seven states have drug paraphernalia laws and eight states have syringe prescription laws that limit the sale of clean syringes to substance users by pharmacists and prescription of sterile syringes by physicians. Additionally, twenty-three states have pharmaceutical regulations on the sale and possession of sterile syringes. Regulations may require purchasers to show identification, state the purpose of the purchase, or sign a register. These regulations reduce a substance user's willingness or ability to purchase sterile equipment. Additionally, a substance user's attitude may also limit access. Fear of arrest, lack of money, and reluctance to self-identify as an injecting drug user by visiting a sterile syringe exchange program may increase the risk of using contaminated needles.

Drug Treatment

Drug treatment programs may be administered in an inpatient, outpatient, or community-based setting. Although these programs are effective, they can be costly and cumbersome for a CBO to implement or conduct alone. Critical partnerships forged between CBOs and treatment facilities can ensure that a continuum of services is available to substance users, from initial outreach to comprehensive substance use treatment. CBOs often play an important role in referring substance users to local drug treatment facilities when appropriate.

Drug treatment combines medical, psychological, and behavioral support to encourage the cessation of substance use. Because substance use treatment seeks to reduce or eliminate the number of injections by substance users, it lowers the risk of HIV or Hepatitis infection that results from unsafe injection practices. Furthermore, because substance use impairs rational decision making, drug treatment can reduce the risk of HIV infection that occurs through unprotected sex and other at-risk activities. Even when drug treatment is not completely successful in eliminating the use of a particular substance, HIV prevention messages and interventions can reduce the risk of HIV infection for current users and their sexual partners.

HIV Testing, Counseling, and Partner Notification

Since substance users and their sexual partners are at high risk for HIV infection, voluntary HIV testing and counseling should be an integral aspect of any CBO-sponsored program. Access to early HIV testing greatly improves an individual's access to life-prolonging medications and the health care necessary to combat the debilitating effects of living with HIV and AIDS. A pre- and post-test counseling service for substance users increases HIV awareness among this population. Additionally, CBOs should encourage voluntary partner notification for individuals who are infected with HIV. By encouraging individuals living with HIV and AIDS to notify their sexual partners of their serostatus, substance users who are living with HIV and their sexual partners can take the necessary precautions to protect other non-infected individuals from risk of HIV infection.

Characteristics of Effective Programs

Important aspects of effective HIV prevention programs can be found in the research literature. The general outline that follows may be useful as both a starting point and evaluation tool for CBOs tailoring HIV prevention programs to the needs of substance users.

Characteristics of Effective Programs

- Start HIV prevention interventions as early as possible.
- Recognize that there are multiple goals in prevention. (Remember that in addition to drug abstinence, risk reduction itself is an appropriate, realistic outcome of HIV interventions with drug abusers.)
- Recognize that people at risk are at different stages of readiness to participate in programs to change their behaviors.
- Consider using different techniques to both attract and retain people in the program. Techniques include:
  - (a) Motivational techniques and/or
  - (b) Contingency management and/or
  - (c) Cognitive strategies and/or
  - (d) Peer-driven interventions
- Target multiple risk behaviors simultaneously, including drug use, needle risk, and sexual practices.
- Use multiple strategies for behavior change including:
  - (a) INFORMATION on risk reduction
  - (b) SUPPLIES for risk reduction, including syringes, bleach, and related injection hygiene materials, and condoms (male and female)
  - (c) TESTING for HIV antibody with pre- and post-test supportive and behavioral counseling
- Conduct programs in multiple settings to reach as many at-risk people as possible, including:
  - (a) Streets and other places where drug abusers congregate
  - (b) Health-related settings, such as clinics, pharmacies, drug treatment centers
  - (c) New outlets established to attract drug users, such as mobile vans, storefront offices, and needle/syringe exchanges
- Rely on peers of your target population to serve as outreach workers, role models, and educators, or advocates.
- Plan and conduct interventions at multiple levels to alter community behavioral norms and risk behaviors. (This is important because of the need to create opportunities for at-risk individuals to make and sustain behavior change in a supportive environment.)
  - (a) Policy level
  - (b) Legal level
  - (c) Institutional level
  - (d) Community level
  - (e) Network level
- Create opportunities for increased exposure to programs through booster sessions. (This is important because it reinforces skills and knowledge learned in the initial intervention, which extends the effectiveness of the program.)

Source: Sloboda, 1998.

chapter 4

SUCCESSFUL HIV PREVENTION PROGRAMS FOR SUBSTANCE USERS

The programs described below have helped thousands of people reduce their risk for HIV infection and lead healthier lives. The HIV prevention models and the CBO programs that are presented provide examples for other organizations hoping to expand or enhance their HIV prevention strategies. This is by no means a comprehensive list of programs, but rather highlights innovative approaches that may be useful. Contact information is provided for each CBO program.

PREVENTION MODEL - COMMUNITY OUTREACH

Community outreach programs may focus on specific populations identified by a high incidence of substance use, or may focus more broadly on individuals experiencing a number of interrelated hardships such as poverty, physical violence, lack of access to health care, homelessness, or mental illness. Many outreach projects have found that substance use mitigates harsh living conditions. As such, many of the HIV prevention services address multiple issues affecting the target population in addition to HIV and AIDS education.

HIV education delivered through a community outreach model is often provided at drop-in centers or in mobile vans. Educational materials may include the following information:

- HIV testing and counseling;
- Referrals to available health services in the local area;
- Sterile syringe access;
- Referrals to drug treatment;
- Referrals to housing; and
- Local support groups.

Community outreach has the potential to reach a wide audience of substance users. Community-based organizations are directly engaged with and accountable to the individuals they serve. These groups have proven successful in adapting community-based research strategies to provide HIV prevention services to their target population.

CBO PROGRAM - THE COMMUNITY PROMISE PROGRAM

Focus:	Substance users in five U.S. cities
Strategy:	Peer education delivered by a community-based organization

The Community Promise program was a research study that examined the ability of peer education messages and role modeling to prevent HIV infections. Specifically, the study sought to evaluate the degree to which community level interventions increased condom use and decreased HIV infections through injection equipment among substance users (CDC, 1999). Funding was provided by the Centers for Disease Control and Prevention (CDC), and the intervention took place in five cities over the course of three years. Participating cities included Dallas, Denver, Long Beach, New York, and Seattle.

The Community Promise program is based on three theoretical principles:

- According to the transtheoretical model of behavior change, developed by Prochaska and DiClemente, behavioral change occurs in stages.
- The theory of reasoned action outlines the way behavior is influenced by individual attitudes, beliefs, and expectations.

- The social cognitive theory emphasizes the importance of observing others when seeking to change behavior.

In the Community Promise program, volunteers are trained as peer advocates. Training exercises focus on drawing attention to and reinforcing HIV prevention strategies. Once trained, peer advocates distribute condoms, bleach kits, and role model stories in their communities. Role model stories describe members of the target population as they moved from early to late stages of behavior change. Peer advocates seek to draw attention to these role model stories to encourage individuals to reduce their HIV risk behaviors.

Over the three-year period, interviews were conducted with 15,205 individuals to evaluate the success of the project. Injection drug users, their partners, sex workers, men who have sex with men, and high risk youth were among those interviewed. The population interviewed was evenly divided among men and women (46 - 54 percent), but the racial/ethnic composition was less uniform. Of the 15,205 individuals interviewed, 54 percent were African-American, 22 percent were white, non-Latino, and 19 percent were Latino. According to survey results, those participating in the project demonstrated significantly higher rates of consistent condom use compared to those not reached by the peer education messages.

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CBO PROGRAM - BIENESTAR

Focus:	Community members, especially injection drug users and recent immigrants
Strategy:	Culturally sensitive outreach, education and risk assessment

Bienestar was founded in 1989 to provide a wide range of services and promote the health and well being of the Latino community in Los Angeles. Although the agency provides a variety of programming, particular emphasis is placed on HIV and sexually transmitted disease (STD) prevention. Most notably, Bienestar has designed educational programs that are specifically tailored to meet the needs of the target population.

Programs at Bienestar have expanded from HIV education and information and condom distribution to include a wide range of services that complement and enhance these outreach efforts. Agency experience has shown that the most effective prevention strategies first assess each individual's risk and then respond accordingly with tailored harm reduction strategies and referrals where appropriate. Public Outreach Prevention Services (POPS) teams provide these expanded, individualized services as part of the Bienestar community outreach program.

The POPS teams are trained peer educators who work primarily with adult injection drug users and crack and cocaine users. Outreach teams attempt to engage individuals by distributing leaflets and condoms and offering to administer an HIV risk assessment. Outreach workers then discuss the results of the risk assessment and provide suggestions about immediate behavior changes that can reduce the individual's risk profile. POPS team members leave information regarding the availability of walk-in HIV testing and counseling with each individual.

In addition to direct outreach, POPS team members are also vocal members of the community at large. The team participates in educational forums such as health fairs. POPS is also involved in other community outreach programs including the prevention of domestic and gang violence.

Bienestar POPS teams tend to work with adults, but significant efforts also focus on young men and women at risk for HIV infection. Other programs target inner city Latino youth and operate throughout Los Angeles County. Peer education and case management strategies encourage young people to recognize how much knowledge they already have about HIV/AIDS, and to use that knowledge to assess their own risk behavior. Hip-hop groups and young girls' groups facilitate Bienestar's outreach to young people. Outreach workers interact with Latino youth on an individual basis through the development of behavior change contracts. All of Bienestar's programs seek to persuade young people to change their behavior, but Bienestar emphasizes the importance of including the young people as essential partners in the process rather than simply targets for HIV prevention messages. Towards that end, participating youth may work with POPS team members to develop a behavior change contract to reduce their individual risk of HIV exposure.

Bienestar staff members evaluate their programs through the collection of community outreach statistics. In one sample month, Bienestar reached 134 participants through "Safe Sex Workshops." Workshops were held at churches and day labor sites. Of the 134 participants, 105 completed a safer sex negotiation contract. The contract asked individuals to identify one way they would reduce their risk for HIV infection. Also, 98 individuals attended drop in sessions and Bienestar has successfully followed up with 49 participants.

FOR FURTHER INFORMATION:

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CBO PROGRAM -PROJECT NEON

Focus:	Men who have sex with men and also use crystal methamphetamine
Strategies:	Peer education and targeted media education efforts combined with needle exchange and substance use counseling and treatment programs

Research continues to show that use of crystal methamphetamine among gay men is one of the most powerful predictors of HIV risk behaviors. A 1992 San Francisco study of seronegative gay and bisexual men found that while 33 percent of the total sample reported using crystal over the course of a year, nearly half (48 percent) of the 22 men who became infected with HIV during the study period were using crystal methamphetamine (Stone et al., 1995). Crystal methamphetamine is especially popular with young gay and bisexual men, and when compared with non-users, crystal users reported more unsafe receptive anal intercourse, more condom breakage, and more unprotected sex with seropositive partners. These findings are generally supported by other reports that gay men who use crystal methamphetamine may have an especially difficult time maintaining safe sexual practices (Gorman, Morgan, and Lambert 1995; Paul, Stall, and Davis, 1993).

Project NEON (Needle and sex Education Outreach Network) is a community level intervention targeting men who have sex with men and inject drugs. Based in Seattle, the project relies on collaboration between public health officials, Stonewall Recovery Services, and community members. Project NEON's staff reflects this partnership. Health educators from the public health department, certified chemical dependency counselors from the Stonewall Recovery Services, and peer educators all work together to reduce risk behavior among men who have sex with men and use crystal methamphetamine. According to NEON, almost half of the men who have sex with men and inject crystal methamphetamine in Seattle-King County are HIV positive. These individuals represent the highest rate of HIV infection in Washington State.

Project NEON seeks to raise awareness about the connection between substance use and HIV transmission. It provides comprehensive, factual information about how crystal methamphetamine affects the body and mind, in addition to risk reduction information. The program also provides one-on-one counseling, peer education programs, needle exchange, advocacy, and support groups.

The intervention is based on the stages of change theory of behavior, which provides the foundation for some of Project NEON's support groups. NEON programs offer a continuum of services structured to address the needs of participants at all stages of drug use, from experimentation to addiction to recovery. Support groups exist for men who are concerned about their substance use, but are not ready to quit. Other groups support men who are ready to make a change and quit using crystal methamphetamine. Additionally, Stonewall Recovery distributes a quarterly magazine to raise awareness among men who have sex with men and use crystal methamphetamine. The magazine, *AmphetaZINE*, features stories from members of the community, articles on health, and harm reduction and creative writing.

Evaluations of Project NEON are heavily based on focus groups, peer evaluations, and individual interviews. Project NEON staff members estimate the number of individuals reached by the program and use pre- and post- evaluations to measure behavior change among participants. The Project reports that peer educators make over 2,500 outreach contacts annually. The needle exchange program exchanges over 57,000 syringes per year. Of the 100-120 clients involved with Project NEON programs and Stonewall Recovery Services, 30 - 40 percent stop using crystal methamphetamine within six months.

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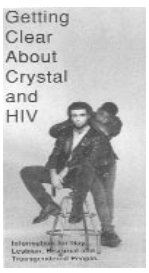

PREVENTION MODEL - DRUG TREATMENT

Research has demonstrated that drug treatment programs can prevent HIV infection among substance users by minimizing injection drug use. The seminal study on drug treatment as mechanism for HIV prevention was published in 1988, and its results were confirmed by later research. Ball (1988) surveyed 633 male substance users in drug treatment programs in three eastern cities. Although substance use was not completely eliminated, results indicated that 71 percent of the individuals surveyed had not injected drugs during the previous month and 60 percent had not injected drugs after one year. Recently, a Metzger review (1998) included over 17 studies with 11,000 subjects and echoed Ball's findings. Reduction in substance use not only reduced sharing needles and equipment, but individuals also reported a decrease in other risky behaviors.

Drug treatment is an important method of preventing HIV infection among substance users. Many community-based organizations, however, do not have the budget or resources to directly provide drug treatment programs. Therefore, it is the partnerships between CBOs and drug treatment programs that offer the most promising strategies for reducing the incidence of HIV infections among substance users.

The symbiotic relationship between drug treatment programs and CBOs is important for a number of reasons. Community-based outreach programs often are aware of substance use and risk behaviors prevalent in a community and can be a knowledgeable resource for drug treatment programs. In addition, these organizations refer individuals to area drug treatment programs and can encourage consistent participation by offering support groups, childcare, and transportation. Finally, direct service and outreach programs often play a role for individuals during recovery by acting as a strong social influence and minimizing situations that threaten continued sobriety.

Because society views many substance users as throwaways and substance use behaviors are often criminalized in the U.S., treatment to reduce substance use is critical to the success of the HIV prevention battle. By providing comprehensive treat-

ment programs, including methadone clinic access, substance use treatment programs can directly minimize HIV risk behaviors.

CBO PROGRAM - EXPONENTS, INC., THE ARRIVE TRAINING PROGRAM

Focus:	Substance users in all phases of transition, from addiction to recovery, from incarceration to parole/release, from HIV negative to HIV positive, and from welfare to work
Strategies:	Comprehensive, professional, and peer-delivered services

The ARRIVE program was founded in 1988 by Howard Josepher to prevent HIV infection among substance users in New York City while simultaneously improving their quality of life. This is achieved by appreciating the connection between addiction and HIV transmission. As of June 2000, 38 of the 44 full time staff members providing client services at ARRIVE were graduates of the program.

ARRIVE recruits active substance users, people in recovery, people living with HIV and AIDS, and individuals recently released from prisons or jails as prospective clients. The program seeks to eliminate barriers to drug treatment and other social services. ARRIVE's philosophy challenges the convention that substance users will only benefit from rehabilitative services once they have stopped using substances altogether. Instead, the program works with individuals where they are and promotes recovery readiness along with building more general skills, as well as stress management. The ARRIVE program helped pioneer harm reduction as a humane and effective substance use treatment model.

This peer-facilitated program uses a 24 class training curriculum. Classes address harm reduction techniques and stress reduction activities while challenging cultural norms. Some sessions discuss negotiation of safer sex, while others focus on sexuality or family issues. All classes are preceded and followed by stress reduction activities. The open and safe environment is essential for individuals to identify the roots of their addictions and self-destructive attitudes that can lead to relapse.

Above and beyond classes and peer support groups, ARRIVE participants receive needs assessments and HIV counseling. Referrals to appropriate job training programs, medical care, mental health services, and detoxification programs are also provided where appropriate. These referrals are especially effective because of the formal linkages ARRIVE has forged with area drug treatment, primary care and AIDS service facilities, and CBOs throughout New York. Over 250 of these linkages exist and written "affiliation agreements" ensure that their programs are accessible to all ARRIVE clients who need them.

ARRIVE has been the subject of several evaluations. Client retention has been estimated at between 80 - 90 percent. According to study findings, condom use and HIV testing occurred more frequently among ARRIVE graduates, and these individuals also reported fewer sexual contacts with high-risk individuals. Graduates of the programs were also less likely to be involved in criminal activities and reported higher levels of employment.

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PREVENTION MODEL - STERILE SYRINGE ACCESS

Sterile syringe access programs and needle exchange programs (NEPs) have demonstrated a high level of effectiveness in preventing HIV transmission among substance users and their partners. The National Institutes of Health (NIH) reported that these programs were able to reduce risk behaviors among injection drug users by 80 percent and reduce HIV infection among the same population by 30 percent (1997). Sterile syringe access has been

incorporated into community-based prevention strategies in a number of ways. At times, CBOs began a NEP and expanded services to incorporate other HIV prevention and drug treatment services. Other community-based organizations began HIV prevention or treatment programs that incorporated NEPs later in their organizational development in order to more effectively minimize HIV risk among substance users. Other CBOs have advocated for the decriminalization of drug paraphernalia laws and the removal of penalties against physicians and pharmacists who provide sterile syringes to injecting drug users.

Syringe exchange programs are politically sensitive and no longer receive financial support from the federal government. For some, sterile syringe access programs are controversial because the distribution of clean needles may appear to condone drug use. Many studies suggest, however, that Syringe Exchange Programs neither encourage increased drug use among current users, nor do they lead to initiation of drug use among non-users (Vlahov and Junge, 1998). In some cases, sterile syringe access programs facilitate ties between substance users, social service organizations, and drug treatment programs. Other programs have had success in decreasing substance use when sterile syringe access programs are linked to methadone treatment clinics and facilities.

In practice, some states are moving to decriminalize the purchase of hypodermic needles to make sterile equipment more available. According to the National Conference of State Legislatures, 17 states allowed syringe exchange programs to operate as of September 2000 (NCSL, 2000). In May of last year, New York became the 43rd state to allow adults to purchase hypodermic needles without a prescription (Kaiser Family Foundation, 2000).

CBO PROGRAM - LOWER EAST SIDE HARM REDUCTION PROGRAM (LESHRP)

Focus:	Injection drug users in the lower east side of New York City
Strategy:	Recruit individuals into treatment programs by distributing sterile needles

The Lower East Side Harm Reduction Program (LESHRP) began in the early 1990s as a component of the larger ACT UP organization in New York. The program recognized that injection drug use led to the majority of AIDS cases among residents of the Lower East Side of New York City. LESHRP sought to reduce needle sharing and HIV transmission among injection drug users in this area of the city by providing sterile needles. The majority of the program's clients are men (70 percent). White, non-Latinos account for 59 percent of participants, and approximately half of the individuals that participate in the LESHRP are homeless or unstably housed.

LESHRP distributes needles both for intravenous injection of drugs and hormones. At the initial visit, ten needles are given to the individual. Staff members collect personal information on the participant but all records are kept confidential. One clean needle is exchanged for each used needle at subsequent visits. At each visit, LESHRP staffs encourage the individual to participate in available harm reduction and treatment services.

Anecdotal evidence suggests that the LESHRP is making a difference. The program staff has noticed a visible improvement in the health of the community. Drug- related health complications such as abscesses, septicemia, and pericarditious are less common than in past years. Evaluations have found that LESHRP participants' HIV seroprevalence was much lower than a comparison population taken from a local family planning clinic and community center.

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CBO PROGRAM - FROM OUR STREETS WITH DIGNITY (FROST'D)

Focus:	Female sex workers
Strategy:	Street outreach, testing and referrals, and case management services

From Our Streets with Dignity (FROST'D) was founded in 1986 by Dr. Joyce Wallace to evaluate HIV prevalence among New York City sex workers. The program operates in Manhattan, Brooklyn, and the Bronx. Since 1989, a mobile outreach van has provided services to sex workers five days and six nights a week. The Care van runs a needle exchange program that exchanges sterile needles and links individuals with drug treatment programs. Individuals also have access to HIV, STD, and pregnancy tests, counseling, and referral services. Basic necessities, including food and clothing, are made available as part of outreach efforts.

In addition to the Care van, a motor home acts as a drop-in center for women at-risk. Case managers help women access benefits and social services. For example, most of the women do not have health insurance that will pay for drug treatment programs. While Medicaid does cover drug treatment in New York, in order to qualify an applicant must have a birth certificate, a social security card, and a mailing address. FROST'D helps women locate and complete this paperwork so they can access Medicaid and voluntarily enroll in drug treatment programs.

The success of FROST'D's programs prompted the Manhattan Criminal Courts to offer a treatment readiness program. The program is an alternative sentence for people arraigned on misdemeanor prostitution or drug charges and serves over 2,500 individuals a year. This collaborative effort includes education on substance use and its relationship to HIV infection in addition to facilitating access to long-term treatment programs. The treatment readiness program reports a 92 percent completion rate.

Women are receptive to the FROST'D program because outreach workers provide information without being judgmental. The program encourages women to take advantage of services that get them off the street. Outreach workers also appreciate the myriad issues women may face: substance use, homelessness, history of current and childhood abuse, and mental health issues.

The program is evaluated by conducting interviews with women during outreach activities. Women are asked about their substance use history, sexual behaviors, and condom use. HIV infection rates appear to be declining among the target population, from 37 percent of sex workers surveyed in 1990 to 7 percent in 1999. Consistent condom use also appears to be improving. In 1989, 44 percent of women reported using a condom consistently. This percent increased significantly to 82 percent by 1996.

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chapter 5

TAILORING HIV PREVENTION PROGRAMS TO FIT YOUR NEEDS

This guide presents model prevention programs and examples of how they have been implemented by specific community-based organizations. One of the central tenets of prevention research is that one size does not fit all. Yet there are elements of each model presented here that can be applied to diverse populations with similar impact. CBOs can adapt these models to meet the individual needs of the client populations they serve. It is important to maintain the core elements of each prevention model while customizing the delivery of the HIV prevention message.

The HIV prevention strategies discussed in this guide are established, effective programs. Moreover, they incorporate a number of CDC recommendations for improving HIV outreach and education among substance users. The CBO programs not only address the risks for HIV infection associated with individual substance use, but also provide information about the sexual transmission of HIV as well as information about Hepatitis B and Hepatitis C.

Drug treatment programs also play a critical role in the HIV prevention strategies outlined as part of this guide. The valuable partnerships forged between community-based organizations and more traditional drug treatment facilities cannot be underestimated. Ultimately, substance use treatment efforts greatly enhance HIV prevention efforts because they directly reduce risk behaviors. Sterile syringe access programs are important in reducing the risk of HIV transmission among individuals not ready to discontinue substance use. These programs should seek to bring substance users into programs that encourage behavior change to ensure that a unique opportunity for communication about HIV infection is not lost.

Community-based organizations bring an expert knowledge of the communities they serve to HIV prevention work. CBOs can take the models presented here and shape them according to the culture of their communities, the available resources, and the strength and expertise of their staff. In addition, CBOs can ensure the effectiveness of their prevention efforts by seeking input from groups or individuals they plan to serve and conducting rigorous evaluations.

The challenge of meeting the constant demand for new, innovative, and successful HIV prevention strategies can only be addressed through the development of additional HIV prevention models for diverse communities. Prevention works. Each CBO should determine how and in what form HIV prevention can reach the people it serves.

RESOURCES

The Body: An AIDS and HIV Information Resource - www.thebody.com

CAPS Model programs - www.caps.ucsf.edu

CAPS Toolbox - www.caps.ucsf.edu/toolbox/SCIENCEindex.html

CDC's Replicating Effective Programs (REP) – www.cdc.gov/hiv/projects/rep/default.htm

CDC Research to Classroom: Programs that Work (PTW) – www.cdc.gov/hiv/conferences/hiv99/abstracts/283.pdf

The C-RSP Project: Characteristics of Reputationally Strong Programs – www.cdc.gov/hiv/projects/rep/crsppproj.htm

HIV Insite – Gateway to AIDS Information - http://hivinsite.ucsf.edu

North American Syringe Exchange Network - www.nasen.org

Sterile Syringe Access and Exchange Resources - www.projectsero.org

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