

A YOUNG PEER TRAINER'S GUIDE

TO PROVIDE SEXUAL HEALTH AND
DRUG-RELATED HARM REDUCTION
EDUCATION



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This guide is the result of a series of workshops conducted in 2009 and 2010 by young people in Romania, India, Mexico and Canada. During these workshops we identified gaps in the information young people have regarding sexual health and drug use. We also identified the best ways to talk about drug use and sexual health among young peers.

This guide provides information, practical activities, and resources to facilitate youth-led peer trainings. The guide includes: basic information about HIV/AIDS and drug use; provides strategies for reducing sexual and drug-related harms; and addresses stigma and discrimination related to sexual behaviour and drug use.

We hope this guide provides you with the necessary tools to explore the concepts of harm reduction as they relate to issues of HIV, sexual health and drug use. Because we are constantly looking for ways to improve our work, please send any and all feedback to info@youthrise.org and/or info@espolea.org.

What is this guide?

Youth Resource. Information. Support. Education for reducing drug-related harm (Youth R.I.S.E.) is an international youth-led organization, and is uniquely positioned to address the issues faced by young people who use drugs. It is the aim of Youth R.I.S.E. to empower young people who are affected by drug use and policy to effectively and proactively work at systemic policy change to ensure that young people are included in harm reduction strategies and within the drug policy debate.

Espolea is a youth-led NGO founded in Mexico City in 2005. Espolea works with young people to defend human rights, sexual and reproductive rights and gender equality; reduce HIV/AIDS among young people; and fight stigma and discrimination against young people.

Who are we?

Before you start

Before you start, you should know that this guide offers information and practical activities for young trainers who wish to help other young people in their community explore the relationship between drug use and sexual health. In your hands you have a training guide aimed to empower young people to play an active role in the education of other young people in similar situations, in order to prevent unintended or unwanted consequences of sexual activity and/or drug use.

Peer communication is direct and honest, effectively providing information to help young people prevent harms and diseases associated with drug use and unsafe sex. The trainer who uses this guide should be a young person who facilitates a small group of 15 to 25 young people, in a space accessible to and considered safe by participants. The training should be a forum for young people to speak their minds and voice their concerns, and should also be based in the following principles:

- _ Every person has an inalienable right to make informed choices about drug use and sexual activity through access to accurate education and information and supplies that support safety, such as healthy and safe contraception;
- _ Individuals and the relationships they choose must be respected, ergo sexual health and the use of drugs must be addressed through a harm reduction framework; and
- _ The promotion of sexual health and minimising of drug-related harm improves an individual's quality of life and helps the individual achieve health.

In the following pages you will find information and activities in different sections to help you pick and choose what works best for you. Whenever possible, we also offer references for further information. We encourage you to incorporate your own resources and knowledge to add to what we have provided. This training guide outlines a two-day workshop. If this format doesn't work for you, change it as you see fit to meet your needs. Each session in this guide may contain up to four colour coded sections: **Get Ready, Peer Facilitator Tools, Remember That..., For Further Reading.**

Get Ready is an introduction to each session and allows you to individually explore the information you currently possess and how you may want to build on it to facilitate the session. One of the main roles of a peer facilitator is to aid in the transfer of knowledge among people who share similar circumstances, experiences or backgrounds, such as age, life experiences, or common activities. In the guide, these people are defined as 'peer groups'. The facilitator is responsible for listening to the concerns of the participants, facilitating discussions and providing participants with accurate information about sexual health, drug use and harm reduction practices.

Peer facilitators must ensure that participants feel safe and comfortable by creating a structure for the training and guidelines for the way participants respond to each other in the space. You, as the facilitator, are in a unique position to inspire and encourage your peers to adopt safer sex and/or safer drug use practices because you share common strengths, language and experiences. There are many issues to consider before beginning this training. For example, why is this training important, whom does it serve, and, how can it benefit the greater community? Peer facilitators need to have in-depth understandings of the content in the guide, as well as the ability to facilitate meaningful and engaging discussions.

What will you find?

Inside: **Get Ready**

Inside: Peer Facilitator Tools

Peer Facilitator Tools provide you with sample activities and group discussion topics. These tools provide you with prompts, advice and guidance during the training. Keep in mind, the guide provides basic information on the subjects presented. However, you are encouraged to conduct further research and reading, as well as to “think outside the guide” to develop a training programme that meets a group’s specific needs. The guide provides effective facilitation tools that will come in handy for developing group guidelines and activity formats!

- _ Where are you going to have your training? How might this affect participants’ experiences? Consider issues of safety, time of day and accessibility of the space.
- _ Who are the participants in the training? How were they recruited? How many participants are attending? Ensure that the group isn’t too large. We suggest a group of 15 to 25 people.
- _ Consider the age range, geographical location, lived experiences of the participants. Ask yourself – how does this change the facilitation and content of the training?
- _ What do you hope the participants will get out of the training? Ensure you have clear learning objectives and share these with the participants at the beginning of the training.
- _ Will participants receive any resources after the training, such as condensed information? If so, have materials prepared in advance.
- _ Prepare all training materials (e.g., such as large white flip-chart papers or a chalkboard, food for participants, resource folders, etc.) in advance. It is up to you and your budget to decide what is needed and what works for the group.
- _ Plan sufficient time for the sessions you want to deliver. You will find time suggestions for each activity provided in this guide.

Remember That... provides definitions of terms or concepts or highlights issues you may want to bring up and discuss within your training group.

Inside: **Remember That...**

For further reading is a bibliographical compendium, including some references to reading materials, as well as links to videos, that we recommend both for training facilitators and participants. You should use this section at your own convenience.

Inside: **For Further Reading**





Session 1

Getting Started



Participants have arrived and the workshop is about to begin! Have everyone sit in a circle or a formation that allows all participants and facilitators to see each other. Ensure that facilitators are mixed with the group, as this is a discussion, not a lecture. Before you begin the first ice-breaker activity, ask all participants to put on a nametag. Go around the circle and have all participants introduce themselves. In addition, ask them to say what they hope to get out of the training or why they think this training might be useful.

Remember to set the agenda for the subjects and activities your workshop will pursue. Participants should have a clear outline of the sessions that will be covered in the training, a timeline for the training days, and a list of learning objectives they are expected to achieve by the end of the two days. Let participants know where the washrooms are and where they may securely store their belongings if needed.

Once you've completed introductions and before you begin the actual training, it is important that you and the participants set guidelines for the space. Be clear about the roles of the participants and facilitators. This is a key element in ensuring that participants feel comfortable and safe. Let participants know this is space where they can speak freely about issues related to sex and drug use without fear of repercussion or judgment.

Brainstorm with the participants what they need to feel safe and comfortable during the training. Write their suggestions on flipchart paper and post on a wall in the room. Some possible ideas are:

Be on time - mobile phones set to silent mode - respect everyone's opinions - agree to disagree - confidentiality (anything personal stays in the room), etc.

Set guidelines for the training

Notes

By the end of this session, participants will be able to identify at least three other people with similar interests or experiences in the room.

Learning Objective

Expected time of activity: 15 minutes

Prepare a series of 10 to 15 questions for the group to respond to. Some ideas are: the first letter of your first name, your gender, whether you like cats or dogs better, the type of music that you like, if you have tried drugs before or not, if you have driven a car while drunk or not, if you have had unprotected sex or not, what kind of drug do you prefer, etc. The questions should allow people to get to know interests, similarities and differences around the room. Include some basic questions about drug use and sexual experiences without making people feel uncomfortable.

Beforehand

Begin by asking participants to stand in a circle in the middle of the room. Explain to the group that you will pose a question and people need to quickly and informally identify other individuals who have the same answer to the question and form small groups. Continue to ask questions so that group members move around the room and learn what similarities and differences they have with one another. This should take no longer than 15 minutes. If you are running out of time, consider cutting out some of the questions you prepared.

Activity





Session 2

Factors influencing health



Much of this session is focused on providing introductory information and facilitating brainstorming exercises. It provides participants with an understanding of the concept of health, social factors influencing health and drug use and sexual risk behaviour. The brainstorming exercises allow participants to develop their own understanding of the issues and how information presented during the training might be useful to them. To get the ball rolling, we suggest an activity to start discussion. After the group has come to some of its own conclusions, you will have an opportunity to round up this knowledge with some more accurate definitions and information, if needed.

Participants will learn that **“health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”** (WHO, 1946). When you are healthy, it means that you can stay active, productive and happy.

There are ways to reduce the impact many drugs and sexual activities may have on our health. The first step is learning about various drugs and sexual activities, the pros and the cons, and ways to reduce potential harm. Once an individual has done this, he or she can freely and consciously decide what behaviours to engage in. This is the baseline of harm reduction and now we can go a bit deeper into that.

Ready, set, go!

What will participants learn

Notes

Learning objective: By the end of this session, participants will be able to define drugs and sex and describe at least ten reasons why people use drugs and/or have sex.

Learning Objective

Expected time of activity: 50 minutes

Prepare flip charts or paper in advance. You will need markers for each participant and enough pieces of coloured paper size half an A4 sheet or similar for each participant to have several pieces. It is recommended that you have at least 3 different sets of coloured paper (e.g., set of yellow, set of pink, set of green). Make sure you have tape you can use on the walls (e.g., painter's tape that won't strip the paint on the walls).

Beforehand

Instruct participants to brainstorm responses to a series of questions (see table below). They should provide concrete ideas or words for each question and should write their answers down on coloured paper, using a new sheet of paper for each response. Instruct participants to write in big bold letters so everyone can read their responses. People may use as many sheets of paper as needed and provide as many answers as required for each question.

Activity

Begin by asking one question and give the group up to 5 minutes to respond. Continue like this for each round of questions and answers. While people write, walk around the room and pick up their answers. Stick each answer up on the wall under categories. Put up pieces of paper with the questions written on them to act as column headers (see illustration to the left). Make sure that you split the answers up by categories in different columns and by subtopics so that you can analyse responses from the group and discuss the brainstorm activity together.

Questions for the group: drugs

“A drug is any substance that affects the mind, body or both”

Andrew Weil & Winifred Rosen, From Chocolate to Morphine

What is a drug?

Allow participants to throw out definitions.

If they are stuck, ask something like, “If I opened the dictionary and looked up the word ‘drug,’ what do you think I would find?”.

What drugs do you know?

Allow participants to list all the different types of drugs they know including all illicit and licit drugs; different slang names shall be considered. Encourage participants to list substances that aren’t often seen as drugs like caffeine, chocolate or alcohol.

What are some reasons people use drugs?

Responses may include reasons such as: to fall asleep, to stay awake, to have fun, because of peer pressure, out of curiosity, to be social, to hide hunger or pain, because of religion or customs, etc.

On a different large piece of paper or another side of the same wall, where everyone can see, ask participants the questions below. Keep the same sheets of coloured paper for question 1 in the drugs section and question 1 in the sex section. Do the same with the other two. Make sure to also split into different columns. Ask the following questions:

What is sex?

Make sure you differentiate between gender, sexual activities, and other uses of the word. Important: sex is the biological component of sexuality that allows differentiating men and women.

What are some sexual activities?

Activities may include role playing, foreplay, coitus, vaginal sex, anal sex, oral sex, fetishism, and people may engage in activities that are in monogamous or open relationships.

Why do young people have sex?

Generate a discussion for participants to analyze the similarities and differences of the experiences of others and bring into the discussion issues of peer pressure and cultural backgrounds.

Questions for the group: sex

In this guide, *sex is understood as a sexual intercourse*, in turn defined by a series of actions, simple or complex, that two or more people carry out to obtain arousal, sexual desire, pleasure, and/or procreation. Some examples are anal, oral or vaginal sex.

Observe and discuss

Now instruct the group to observe their posted responses for a minute or two and facilitate discussion by reading aloud responses that seem most interesting, even if some of them make you uncomfortable or you don't personally like them. You can ask the group "What do you think of all these responses?" and create discussion around the issues presented during the brainstorm. If you don't understand someone's response, you can say, "Tell me more about that," to try to get clarification.

In addition, this session provides a smooth transition to the next topic; harm reduction. Note that the questions "what is sex?" and "what is a drug?" are on one same colour paper on different parts of the wall or flip chart paper. Ask the group what relationships they see, if any, between both questions. Similarly, ask participants if they see any relations between the other answers in section 1 and 2 of this exercise. Use this discussion as a transition to the next section, which includes more concrete information on sexual health and drug-related harm reduction.

Format for brainstorming activity

Headers for the columns to write on paper

What is a drug?	What drugs do you know?	What are some reasons people use drugs?	What is sex?	What are some sexual activities?	Why do young people have sex?
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Examples of brainstorm responses

A substance that makes you high	Cocaine	To forget	Having an orgasm	Missionary position	Because it feels good
Something that affects your mind	Alcohol	For fun	Physical pleasure	Anal sex	To not feel left out, like the last virgin

Notes

We will provide a more detailed and in-depth bibliography later in this document.

Here are some informative introductory books about drugs:

Weil, A. and Rosen, W. (2004) "From Chocolate to Morphine: Everything You Need to Know About Mind-Altering Drugs". Houghton Mifflin Books.

Aggleton, Peter; Ball, Andrew and Mane, Purmina (2006) "Sex Drugs and Young People. International Perspectives". Routledge, Taylor and Francis Group. New York.

Escohotado, Antonio (1998) "General History of Drugs". Espasa.

Grof, Stanislav (1975) "Realms of the Human Unconscious". The Viking Press, New York.

Ott, Jonathan (1993) "Pharmactheon". (Spanish edition) La Liebre de Marzo.





Session 3

Drug-related harm reduction

“Harm reduction is against harm, neutral on the use of drugs, *per se*, and for any positive change (that’s any positive change) as defined by the person making that change.”

Dave Purchase, Pragmatic Strategies for Managing High-Risk Behaviours

In this session you will revisit harm reduction as a non-judgmental public health approach that seeks to reduce the risks and harms related to the use of drugs. Participants will learn that harm reduction is an approach that is particularly important to young people because it takes into account our realities and seeks to meet us where we are in our lives. This approach recognizes that while drug use and/or sexual activity aren't currently happening in the lives of all young people, drug use and/or sexual activity are the reality for many young people throughout the world.

Harm reduction in relation to drug use means reducing the harmful consequences of drug use without necessarily reducing drug consumption. The major harmful consequences of drug use include blood borne viruses such as HIV, Hepatitis B and C, overdose, various other medical and psychological conditions, and involvement in illegal, violent or damaging activities.

When we talk about harm reduction services or programmes, we're referring to those programs that engage the individual where he or she is and go beyond suggesting abstinence as the only form treatment. The harm reduction model challenges the traditional model of drug treatment that has as its main goal abstinence. The traditional model requires the individual to stop using drugs, even if he or she is unwilling or unable to do so. The harm reduction model holds the health and well being of people who use drugs as its primary concern, whether or not the person is willing or able to abstain from the use of drugs.

Harm reduction policies, strategies and activities aim to reduce the negative consequences of drug use and other behaviours that may pose risks.

A different approach

Examples of potential harm

- _ The social and economic costs of widespread drug use within a community (e.g., stigma and social exclusion, alienation from the family, loss of employment, lack of financial resources due to the cost of drugs).
- _ The economic costs of treating people living with HIV/AIDS.
- _ The legal costs associated with the justice system and the imprisoning of drug users.
- _ The criminalisation of drug use resulting in fear of persecution, human rights abuses, social marginalisation and denial of basic health care and other social services to people who use drugs.

The aim of harm reduction

The aim of harm reduction programmes is to allow people to make their own behaviour change goals – harm reduction programmes never impose behaviour change goals on individuals. Harm reduction principles emphasise that the people engaged in drug use or other behaviour that may put them at risk are the primary agents of change. Harm reduction efforts emphasise the dignity and human rights of all members of a society, including drug users. Harm reduction programmes aim to protect all members of the community from crime by engaging with the affected community and developing strategies together, and protecting all members of the community from sexual or vertical transmission of HIV by focusing on people who use drugs, their sexual partners, and, in the case of pregnancy, the foetus.

The philosophy of harm reduction

The philosophy of harm reduction is to encourage drug users to choose their own behaviour change goals and progress towards reduced harm and improved health at their own pace. Importantly, harm reduction does not stigmatise those who practice high-risk behaviour, recognising that such behaviours result from complex social, environmental, economic, cultural and personal factors.

Principle one: short-term pragmatic goals

Harm reduction emphasises short-term pragmatic goals, recognising that long-term idealistic goals are difficult to achieve. The efforts to prevent rapid HIV transmission need to begin as quickly as possible. The explosive spread of HIV infection among people who inject drugs and their sexual partners must be prevented first or the longer-term goals of abstinence and vocational rehabilitation are meaningless. Prevention activities are best begun before the prevalence of HIV among people who inject drugs is greater than five percent in order to prevent a rapid rise in HIV.

Principle two: hierarchy of risks

It is good to establish a hierarchy of risks for avoiding HIV infection from drug use:

1. Stop or never start using drugs.
2. If you use drugs, avoid injecting them.
3. If you inject, do not share injection supplies (e.g., needles, cookers/spoons or filters) with others to avoid blood borne viruses such as HIV and hepatitis C. Use new injecting equipment every time!
4. If you need to re-use any equipment, use your own injecting equipment every time to avoid viral infections such as HIV and hepatitis C.
5. If you need to re-use any equipment, including someone else's equipment (needle or equipment sharing), clean needles by bleaching syringes. Remember there is some risk of HIV transmission after needle cleaning and there is no known way to kill the Hep C virus thus far, but cleaning in an approved manner will reduce the likelihood of transmission.

Notes

By the end of this activity, participants will be able to articulate the concept that “information alone does not change behaviour”.

Expected time of activity: 15 minutes

Have the group sit in a circle.

Have all participants stand in front of their chairs. Introduce the exercise by saying: “To start this exercise, you all need to stand in front of your chairs. I’m going to read some statements. If your answer to one of them is ‘no’, you have to sit in your chair. As long as you reply ‘yes’ to the statements, you remain standing. Once you have sat down, you remain seated, even if your answer to subsequent statements is ‘yes’. For example, if the first statement is ‘I get regular medical check-ups’ and you do not have regular medical check-ups, you have to sit down and remain seated.”

Explain two additional rules: “Sometimes someone has to sit down right away, after the first or second statement. If the order of statements had been different, they might have still been standing. They ask if they can stand up again. But participants may not stand up once they have had to sit down. This might not seem fair, but that is how this exercise works. Also, sometimes someone says, for example, ‘Oh, sure, I get regular medical check-ups. Let’s see, I think my last one was in 1992!’. We have to decide together how frequent regular is in this exercise, but it must be reasonable: regular is not once every ten years!”

Learning Objective

Beforehand

Activity

Ask the participants to stand up. Then read out the statements from the list below quickly, in a clear, audible voice:

- I drink regularly at parties**
- I don't smoke cigarettes.**
- I don't smoke weed (cannabis)**
- I stick to legal drugs**
- I never use any drug to excess**
- I get regular medical check-ups**

When everyone is seated, ask the participants what these statements have in common. If no one says it, point out that they are all health and drug-use related behaviours. Explain that while we all might know what is basically in the best interest of our health, we do not always use this information as well as we could. For example, even though we know we shouldn't drink too much, we sometimes drink more than we planned: that second or third shot of tequila might just be calling us too loudly from the bar!

Purchase, D. (2002) “Pragmatic Strategies for Managing High-Risk Behaviours”. The Guilford Press

Harm Reduction Coalition “How to Get Off Right”, manual.

For more information on how to effectively clean injecting equipment, check out this video on YouTube: http://www.youtube.com/watch?v=xWUfpHlk_kg





Session 4

Sexual health and HIV

Notes



In this session you will explore, alongside participants, what the implications of sex may be and, ultimately, how to protect oneself when having sex. There are many good things about sex, such as intimacy and pleasure. Sex, however, also comes with risks, such as the possibility of HIV, other sexually transmitted infections (STIs) and unplanned pregnancies.

Knowing that how you are expressing your sexuality is also reducing these risks can decrease your worries and increase your sexual pleasure. You have the right to information to help you make informed decisions and understand your sexual health and to health services to help you monitor and take care of your sexual and reproductive health.

Some people have sex when they have been drinking alcohol or using drugs. Being drunk or high can affect people's decisions about sex and safer sex. If someone wants to have sex and may get drunk or high, they can plan ahead by bringing condoms and lube or putting them close to where they usually have sex. This way they won't forget them in the heat of the moment. Sexual partners must be able to freely consent to sexual activity. It is not okay to have sex with someone who is so drunk or high that they are staggering, incoherent or have passed out.

The above paragraphs were taken entirely from the International Planned Parenthood Federation (IPPF) guide: "Happy, Healthy and Hot: A Young Person's Guide to Their Rights". The full guide can be found at: <http://espolea.org/?p=195>

Sexually transmitted infections (STIs) are infections that are passed during person-to-person sexual contact, such as intercourse, oral and anal sex. If treated early, many can be cured with the use of antibiotics. It's important to get tested regularly as some STIs, such as syphilis and chlamydia, may have no symptoms. Here are some of the most common sexual transmitted infections and their symptoms.

STIs

Name of infection

Symptoms in females

Symptoms in males

Chlamydia

* Symptoms usually appear 1-3 weeks after infection, but then go away, even if left untreated. Many people never have any symptoms.

80% of females have no symptoms.

Symptoms include:

- _ Pain and itching of the vulva or vagina
- _ Vaginal discharge
- _ Pain with urination
- _ Bleeding between periods
- _ Bleeding after sex
- _ Abdominal pain

50% of infected males have no symptoms.

Symptoms include:

- _ A discharge from the head of the penis or the anus
- _ Pain or itching at the head of the penis
- _ A burning sensation or pain when urinating

Human Papillomavirus (HPV) / Genital Warts

_ There are many different types of HPV. Most are harmless - especially the ones which cause the external warts you can see. There are a few types, classified as high risk, which can cause changes in the cells of the cervix (opening to the uterus) or the cells of the anus and could lead to cancer. For this reason, it is recommended that all women should have a pap smear test every year. Some health officials are currently considering recommending yearly anal pap smears for sexually active gay and bisexual men.

_ Not everyone who has the wart virus will have visible warts. Warts may appear as wart-like growths or may be flat and only slightly raised from the skin. They may be single or multiple, small or large. They tend to be flesh-colored or whitish in appearance. Warts usually do not cause itching or burning.

_ There is an HPV vaccine (Gardasil*) that is very effective at preventing cervical cancer and warts. It is recommended for females age 12-26 and is given as a series of three shots. Some doctors are recommending the vaccine for males, as well.

Gonorrhoea

Although most women are asymptomatic (without symptoms), for those who do have symptoms, they usually appear within 10 days after being exposed.

Symptoms include:

- _ Vaginal or anal discharge with a yellow or greenish colour, depending on what type of sex you have had (vaginal or anal)
- _ Lower abdominal pain, especially during or after sex
- _ Unusual bleeding with cramping
- _ Pain or a burning when urinating

Most men develop symptoms of gonorrhea within two to five days after being exposed, with a possible range of one to thirty days.

Symptoms include:

- _ Clear, yellow or white discharge from the penis or anus, depending on what type of sex you have had (penile or anal)
- _ Pain or itching of the head of the penis;
- _ Swelling of the penis or testicles
- _ Pain or burning upon urination
- _ Frequent urination
- _ Anal or rectal itching
- _ White anal discharge
- _ Pain during bowel movements

Name of infection

Symptoms in females

Symptoms in males

Syphilis

* Syphilis infection occurs in four stages, if left untreated

Primary Syphilis

Symptoms usually show up 2-12 weeks after being exposed. The first sign is often a skin sore called a chancre (shank-er). You may have more than one, or you may have chancres and not notice them because they are inside your anus or vagina. Chancres can also appear on your scrotum, penis, vaginal lips, anus or in your mouth. They are usually not painful. The sores will go away after several weeks without treatment, but you would still be infected.

Secondary Syphilis

Most people who have secondary syphilis notice a skin rash covering their body 4 to 12 weeks after infection. The identifying feature of this rash is that it shows up on the palms of the hands and soles of the feet. Often it is not itchy. Other common symptoms of secondary syphilis are swollen glands in various areas of the body, fever, fatigue, patchy hair loss, weight loss, and headache. Since these symptoms are so similar to those of many other health problems, syphilis has sometimes been called "the great imitator."

_ Additional symptoms during secondary syphilis that are particularly important are syphilis warts and white patches. These warts and patches are highly infectious and can occur in moist areas of the body like the mouth, side of the tongue, anus, etc.

_ Secondary syphilis symptoms usually last from 1 to 3 months, but sometimes they last longer, and once in awhile the symptoms come and go over a year or two. But even after the symptoms of secondary syphilis clear up, if left untreated, the infection continues in your body.

Latent Syphilis

Latent syphilis causes no symptoms. The infection can be detected only by a blood test. If not treated, latent syphilis continues for life. Many people with latent syphilis never have serious problems, but some progress to the final stage, called tertiary syphilis.

Tertiary (late) Syphilis

About one-third of untreated people with syphilis experience serious damage to various organs and body systems. Tertiary syphilis can appear any time from a year to 50 years after becoming infected; most cases occur within 20 years. The brain, heart, liver, and bones are the most commonly involved organs. Tertiary syphilis can cause paralysis, mental problems, blindness, deafness, heart failure, and death.

Hepatitis B

The severity and type of symptoms vary greatly. Many people do not have symptoms at all. If you do have symptoms, they could include fatigue, flu-like symptoms, nausea, loss of appetite, stomach pain, yellowing of the skin or eyes (jaundice), dark urine, light colored stool and/or fever. Symptoms usually appear 6 weeks to 6 months after exposure, if at all.

_ There is a hepatitis B vaccine that is very effective at preventing hepatitis B acquisition.

It is recommended for anyone who is sexually active.

Info from <http://www.sfcityclinic.org/stdbasics/>

Notes

STI testing often can be done at your local health centre or hospital and may include a health care provider (e.g., doctor or nurse) taking samples of:

- _ Blood: Hepatitis, herpes, HIV and Syphilis
- _ Urine: Chlamydia and Gonorrhoea
- _ Cells or swabs: Chlamydia, Gonorrhoea, Herpes, Human Papillomavirus
- _ Fluid, secretion or discharge, when there is active sore or secretion or wart: Gonorrhoea, Herpes, Human Papillomavirus, Syphilis

It is possible to have more than one STI at a time so it is essential that you ask to get tested for everything, including HIV.

Approximately half of the world population is under the age of 25 years, representing over three billion people. Young people are increasingly more vulnerable to HIV because of a lack of knowledge about the virus, lack of access to harm reduction services and sex education, and limited experience with safer injection and safer sex practices.

According to the UNAIDS, young people represent more than 40% of all new HIV infections worldwide.

UNAIDS conference underscores young people's leadership in HIV prevention. Available online (2010). http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2010/20100827_FS_mexico_youth.asp.

How to get tested for STIs

How to prevent HIV transmission

Notes

The Human Immunodeficiency Virus, known as HIV, is a virus that attacks the immune system, leaving HIV positive people vulnerable to infections and cancers. When someone acquires HIV, they are said to be “HIV positive”. This, however, does not necessarily mean that they have AIDS. A person who is HIV positive may be healthy and able to live an otherwise healthy, fulfilling and enjoyable life. People who are HIV positive may not even know they are HIV positive without having a blood test. While the virus cannot currently be cured, AntiRetroviral Therapy (ART) is used to treat the infection. ART consists of the use of at least three antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV diseases. The use of ART, plus good nutrition and a healthy lifestyle, can help those living with HIV remain well and productive for many, many years.

HIV

AIDS stands for Acquired Immune Deficiency Syndrome, which has historically been the medical term for the final stage of HIV, when the body no longer can fight off infections, cancers, and HIV-related illnesses. The virus weakens the immune system, allowing for opportunistic infections. Treatment may become increasingly ineffective and the person may die. An HIV-positive person can acquire AIDS at different stages in one’s life, depending on access to health care services, including ART, response to treatment, and other health factors.

AIDS

HIV is transmitted through the exchange of blood, semen (including precum), vaginal fluid, or breast milk of someone who is infected with HIV to someone who is not infected with HIV. It is transmitted through the following activities:

_ Unprotected sex (primarily vaginal sex and anal sex; oral sex is very low risk)

How is HIV transmitted?

- _ Sharing injection equipment, mainly needles and syringes
- _ Mother-to-child transmission during the birth process, delivery and/or breastfeeding
- _ Any blood-to blood exposure (e.g., blood-play, cutting, exposed wounds, etc.)

While the majority of people living with HIV acquired it during sexual intercourse, the main modes of transmission depend on the region of the world in which a person lives or is travelling. For instance, in parts of Asia and Eastern Europe, the predominant mode of transmission is through the sharing of needles and syringes for the injection of drugs.

HIV cannot be transmitted through casual contact.

HIV cannot be transmitted through saliva, tears, urine or any other body fluid except blood, semen, vaginal fluids and breast milk. It is impossible to contract HIV by:

- _ Kissing, hugging or shaking hands
- _ Insect or animal bites
- _ Sharing eating utensils or drinking glasses
- _ Sitting on a toilet seat
- _ Living with an HIV positive person
- _ Swimming in the same pool as someone living with HIV
- _ Touching or coming into contact with someone's tears or sweat

A number of studies of families living with an HIV positive family member have documented that there is no risk of HIV transmission via everyday contact.

If you are sexually active and have unprotected anal or vaginal intercourse (without a condom) and/or share injection equipment, HIV may be transmitted from one partner

to the other if one of you has HIV. The only way to be sure about your HIV status and your partners' is to get an HIV test.

- _ Always discuss HIV status with potential sexual partners and negotiate safer sex; use a condom for vaginal and anal sex.
- _ Avoid sharing injecting equipment, body piercing equipment or knives used to cut the skin.
- _ Ensure only new or properly sterilised equipment is used for medical procedures.
- _ Refer HIV pregnant women to Prevention of Mother to Child Transmission (PMTCT) programmes.
- _ Follow WHO guidelines for nursing mothers who are breastfeeding and HIV positive (check more at the end of this section).

- _ Abstinence: This is the only 100% effective way to prevent HIV and other STIs, however if you are sexually active there are many ways to practice safer sex.
- _ Use a “male” condom during vaginal or anal intercourse: Condoms are 95-99% effective and are often made up of either latex or polyurethane. They are easily accessible at most health centres and/or pharmacies.
- _ Use a “female” condom: Female condoms are another effective way to reduce the risk of contracting any STIs and HIV. However, they are often expensive and not always easily available
- _ Use a dental dam: Dental dams are used during oral sex. Although the risk of contracting HIV from oral sex is very low, other STIs may be transmitted easily through oral sex. Dental dams protect from transmitting or contracting any STIs during oral stimulation.

Basic HIV prevention strategies

Barrier methods that prevent the spread of STIs and HIV

Notes

By the end of the session, participants will be able to demonstrate how to use a male and a female condom.

Expected time of activity: 30 minutes

Have at least one male and female condom; however, the more you have on hand, the better. Condoms may be acquired for free at several clinics and/or community centres. This exercise requires a demonstration. It's important that participants see you put on both a male and female condom properly. When and if possible, every participant should have one male and one female condom and will be able to practice using them with a banana, cucumber or dildo. Make sure you practice this exercise several times before you demonstrate it. Follow instructions below:

Before you put on the condom

- 1) Always check the expiry date on the condom wrapper!
- 2) Rub your fingers over the wrapper to ensure air is in the package and the condom hasn't dried up.
- 3) Never open the condom wrapper with your teeth! This could rip or tear the condom.
- 4) Never use two condoms. This could lead to tearing of the condom, making it ineffective in preventing STIs or HIV.

Objectives

Beforehand

Activity

How to use the male condom

Putting on the condom

- 1) The penis must be erect before placing the condom over the head of the penis.
- 2) Make sure that the tip of the condom is facing upwards and gently roll it down with your hand to the end of the base of the penis.
- 3) Gently pinch the tip of the condom with one hand to leave enough room for semen to collect at the tip of the condom upon ejaculation. If you do not pinch the tip when putting the condom on, an air pocket will remain and, upon ejaculation, the force could cause the condom to burst.

Taking the condom off

- 1) Roll the condom off the penis making sure that the semen has collected at the tip of the condom.
- 2) Dispose in garbage. Make sure the garbage is out of reach of children and pets.
- 3) Use a new condom for the next sex act. Condoms are not reusable!

How to use the female condom

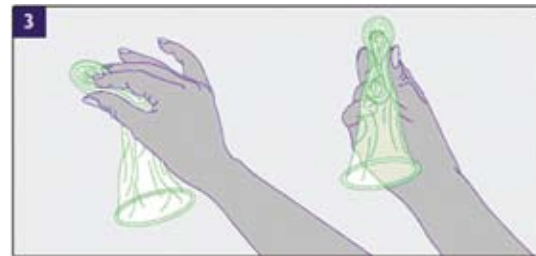
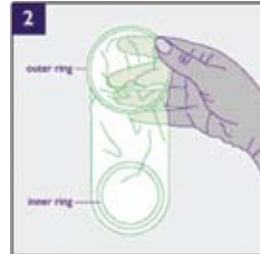
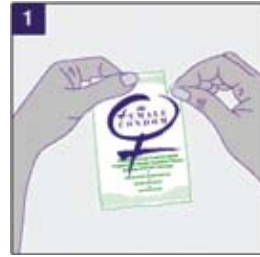
The female condom is a sleeve-like device made of polyurethane. It has a small closed end, and a larger open end. Each end contains a flexible ring. Use this simple step-by-step guide to using female condoms to assure that you are using them properly during vaginal and/or anal sex.

- 1) Check the expiry date on the wrapper.
- 2) Ensure that the condom hasn't been opened.
- 3) Do not open the condom wrapper with your teeth as this might tear the condom.

Open the female condom package carefully; tear at the notch on the top right of the package. Do not use scissors or a knife to open.

The outer ring covers the area around the opening of the vagina. The inner ring is used for insertion and to help hold the sheath in place during intercourse.

While holding the female condom at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow.



Notes

Two popular World Health Organisation guides on how to prevent mother-to-child transmission of HIV are accessible online at the following web addresses:

<http://www.who.int/hiv/pub/mtct/PMTCTfactsheet/en/index.html>

http://whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf

A video on how to put on a male condom may be found here:

http://www.everything-condoms.com/male_condoms/how_to_put_a_condom_on_video.htm

Images illustrating proper use of a condom are available here:

<http://www.everything-condoms.com>



Session 5

Drug use, harm reduction and HIV



As we discussed in Session 2, there are various reasons why people use drugs. In addition, many people around the world share needles and other injection equipment due to some of these factors:

- _ The difficulty of obtaining new equipment due to cost and/or accessibility
- _ Fear of legal repercussions as possession of needles and syringes is illegal in many countries
- _ Reluctance to buy needles and syringes from pharmacies or other shops for fear of identification and discrimination
- _ Lack of information about the risks of sharing equipment
- _ Peer pressure
- _ Incarceration in jails or prisons where new injecting equipment is generally unavailable*

*The Centre for Harm Reduction. Available online.

Notes

This session provides participants with practical HIV prevention strategies for people who use drugs. Start this session by providing an overview of the issue – if possible, find out how many people use drugs in your country and how many of these are young people. While it is true that many countries do not have disaggregated data, we believe it is worth trying to provide information on your local context. Explain to the group that they will tackle two main subjects: a) drug-related harm reduction practices and b) strategies for effective HIV prevention for people who inject drugs. Remember to allow participants to ask questions and be sure to use diagrams/illustrations when necessary.

According to the United Nations Office on Drugs and Crime (UNODC) World Report 2010, there are 18 to 38 million people who are ‘problematic drug users’ between the ages of 15 and 64. Between 172 and 250 million people in this age range used drugs at least once in the last year. The report describes evidence of increased drug use in developing countries, and growing use of amphetamine-type stimulants (ATS) and prescription drugs around the world.

In certain parts of the world, such as Eastern Europe and South East Asia, the sharing of injection equipment among people who inject drugs is one of the fastest growing routes of HIV transmission. Young people who inject drugs face increased stigma and discrimination and are often denied essential life-saving HIV prevention and treatment services. Barriers to access for young people who inject drugs include, but are not limited to: lack of youth-friendly harm reduction services, limited disaggregated data on young people and drug use, age restrictions and issues of confidentiality with existing drug services.

Facts about young people, drug use and HIV

- _ There are an estimated 13.2 million people who inject drugs in more than 155 countries, many of them young people.
- _ The World Health Organisation conducted a study with over 6,000 young people who inject drugs. Between 72% and 96% of participants reported that they began injecting before they were 25 years old.
- _ A UNAIDS study revealed that in countries like Russia and Ukraine, some people begin injecting when they are as young as 12 years old and account for more than 20% of people who inject drugs in these countries.
- _ In Eastern Europe and South East Asia, where the growing number of young people who are injecting drugs largely drives the HIV epidemic, young people aged 15-24 make up one third of new HIV infections.
- _ Approximately 51% of street children in St. Petersburg, Russia have experience with injecting and more than 30% of people who inject drugs in Albania report initial injection between the ages of 15 and 19. (UNICEF. 2006)
- _ In Manipur, India, the proportion of young drug injectors (median age 25) infected with HIV increased from virtually zero in 1989 to 56 percent within six months, and to between 60 and 75 percent by 2003. (UNODC.2004)

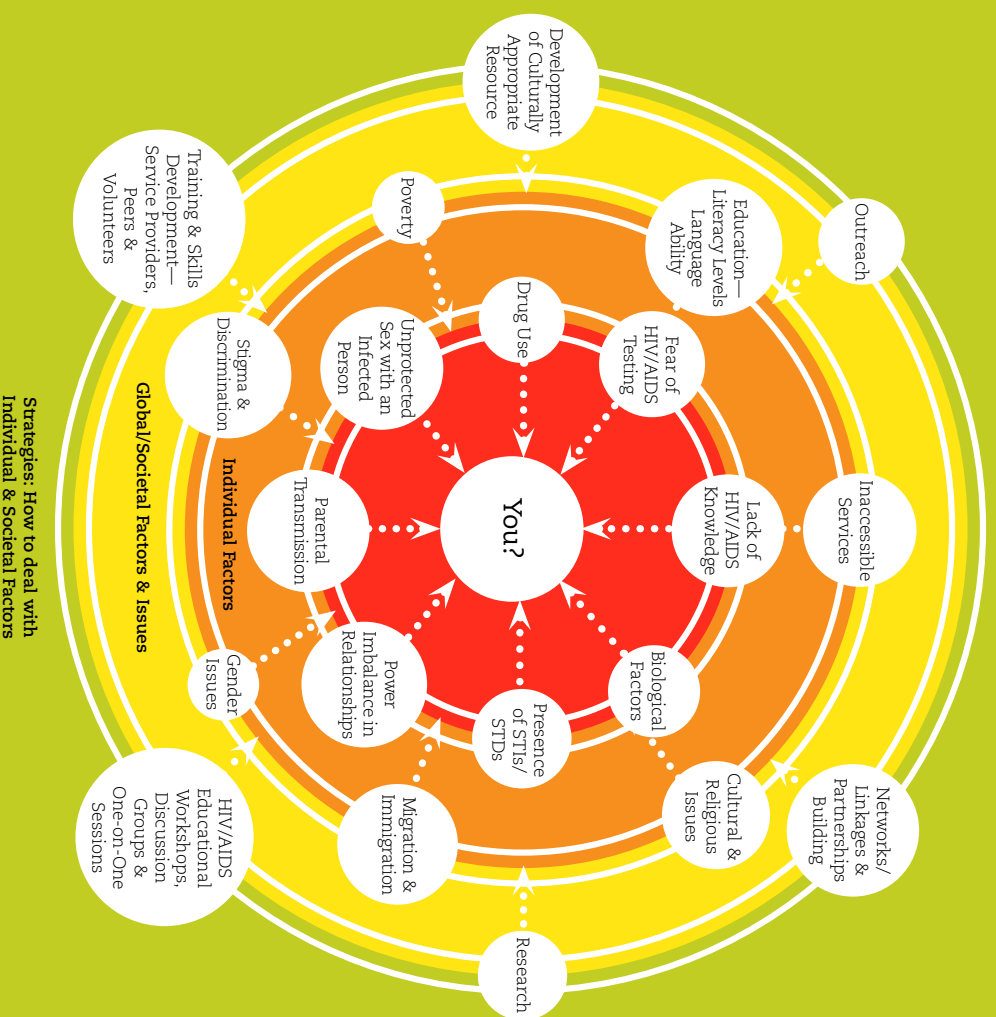
As we said before, and as you know, there are young people who use drugs all around the world. Many of these people do not inject, but use drugs through other routes, such as smoking, inhaling, swallowing (liquid or pills), etc. What does it mean to reduce drug-related harm for these individuals? What are the responses that harm reduction and other comprehensive programmes provide for non-injecting drug users? What concerns exist for STIs and blood borne infections and non-injection drug use, such as ATS, alcohol, marihuana, cocaine, and etcetera.

For the most part, young people do not have access to information regarding drugs and drug use that is friendly and objective. Furthermore, young people tend not to lack tools to communicate, advocate and propose new strategies to deal with drugs and/or drug policies overall. It is important that we, as young people, understand drugs, drug use and drug policies so we can come up with harm reduction strategies that work for us.

Next, we provide you with a diagram that outlines the HIV/AIDS Education Prevention Risk Reduction Model. The Model illustrates numerous factors that impact an individual's vulnerability to HIV and categorizes them as individual factors or global/societal factors. It also outlines strategies for how to deal with individual and global/societal factors. This diagram may be helpful for facilitating group discussion about HIV prevention.

Harm reduction strategies for people who use drugs, but do not inject

HIV AIDS EDUCATION PREVENTION RISK REDUCTION MODEL (HIEP)



**Strategies: How to deal with
Individual & Societal Factors**

This helpful diagram, produced by Wangari Tharao from Women's Health in Women's Hands, is useful for visualizing the different factors which impact an individual's vulnerability to HIV. All of these factors may be experienced by youth.

By the end of the session, participants should be able to articulate at least three strategies to reduce drug-related harm associated with non-injection use of drugs.

Objectives

Expected time of activity: 30 minutes

Sit the group in a circle and give everyone a marker and three pieces of paper, each in a different colour (e.g., each person gets a pink, green and yellow piece of paper).

Beforehand

Ask the group to construct a flow chart of the different stages of a party night, using the coloured papers. On each paper they should list a different drug, for example: alcohol, marihuana and ecstasy. Ask them to list on each paper risks related to that drug and HIV and to identify what can they do to minimise risks. As a large group, review each of the papers and encourage discussion about the risks participants associate with each drug, as well as the strategies to address the risks. Ask the group to draw conclusions about how to engage in safer “partying”. Correct any major flaws in information along the way.

Activities

For a video presentation on how successfully clean your injecting equipment, check out this video on YouTube:
<http://www.youtube.com/watch?v=rTdgvg86to4>

HIV Prevention Strategies for people who inject drugs

It is important to remember that if someone injects, there are ways to reduce the risks of contracting HIV, hepatitis C and other blood borne infections, experiencing overdose, and damaging veins.

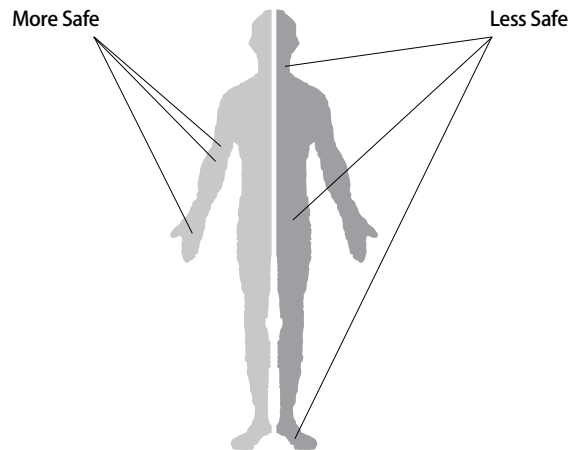
Irreversible damage to the veins may occur where there is:

- _ Repeated use of the same area of the body for injection
- _ Poor injection technique
- _ Injection with blunt (reused) needles
- _ Injection with needles that are too large for the vein you are using
- _ Injection of irritant substances

In the course of conversations about injecting techniques, discuss how service providers should provide information to their clients about the importance of:

- _ Washing hands and cleaning the injection site with soap and water, or an alcohol swab.
- _ Preparing drugs for personal use in one's own space, and using equipment that has not been used by anyone else.
- _ Choosing the smallest possible bore and length needle for the injection site.
- _ Selecting a suitable vein, introducing the needle carefully by sliding it under the skin, at a shallow angle with the bevel up.
- _ Injecting with the blood flow, i.e. towards the heart.
- _ Injecting slowly to reduce the likelihood of drugs leaking into the tissues surrounding the vein and damaging the vein.

Safer injecting practices



- _ Injecting the hit in two halves with a short break (a few seconds) between to reduce the risk of overdose.
- _ Pulling back the plunger to identify that the needle is in a vein – a small amount of dark red venous blood should trickle into the syringe. If a tourniquet is used it should be loosened once blood has been drawn into the syringe.
- _ Not jacking back blood (pulling out and back in) and flushing after a shot as this can significantly increase damage to the vein.
- _ Removing the needle slowly and carefully.
- _ Applying pressure to the site with a blood-proof pad, gauze, cotton wool or tissue (bruising is caused by bleeding into the surrounding tissue. Immediate firm pressure will limit the amount of bruising caused).
- _ Safely disposing of used injecting equipment, including whatever has been used to stop bleeding.

Sites for intravenous drug injection

Neck

INJECTING IN THE NECK IS EXTREMELY DANGEROUS, as there are many arteries, veins and nerves close together. Hitting an artery can result in strokes, while hitting nerves is very painful and can cause paralysis. Part of the risk arises from the fact that for people injecting themselves, injection in the neck requires the use of a mirror. This difficulty may lead injectors to ask others to attempt neck injection for them, thereby increasing the chances of both viral transmission and local injury, and removing all personal control over the process. It may also leave the injector open to at least a manslaughter charge if the person dies — even if the person who died requested the injection.

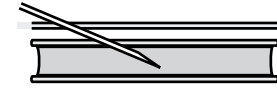
The common complications of neck injecting may be similar to the usual vein problems, such as cellulites and abscess formation, but have even more devastating effects. An abscess or cellulites in the neck can cause dangerous pressure on nerves or obstruct the airway. What else can go wrong? Accidental injection into an artery means the drug, and any other matter contained in the solution, will go directly to the brain, potentially causing a range of brain problems, including strokes, weakening of the blood vessel wall and nerve damage, including vocal chord paralysis.

Pubis or groin

INJECTING IN THE PUBIS IS EXTREMELY DANGEROUS. Before starting to inject in the pubis area, the injector must first make sure that he/she has no other alternative, and still wants to continue injecting. The facilitator should present all the risks involved with this route of administration (swelling, infection, paralysis, overdose) and explain the difference in the colour of the blood drawn in the syringe before injecting – red for vein (safe), pink for artery (unsafe). Since the pubic region is one of the more sensitive areas of the body, it needs a lot of blood, hence there are many arteries close to the surface in the pubis area, as well as nerves. This makes it one of the “worst” places to use for IV injection. And it really hurts!

Arteries

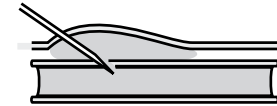
INJECTING INTO AN ARTERY IS EXTREMELY DANGEROUS. Injecting into an artery is by mistake – you would certainly never want to do it on purpose! All drug injectors should be warned that they should never inject into a blood vessel in which they can feel a pulse. Arteries carry fresh blood from the heart around body. If an artery is hit there is



Correct Needle Insertion



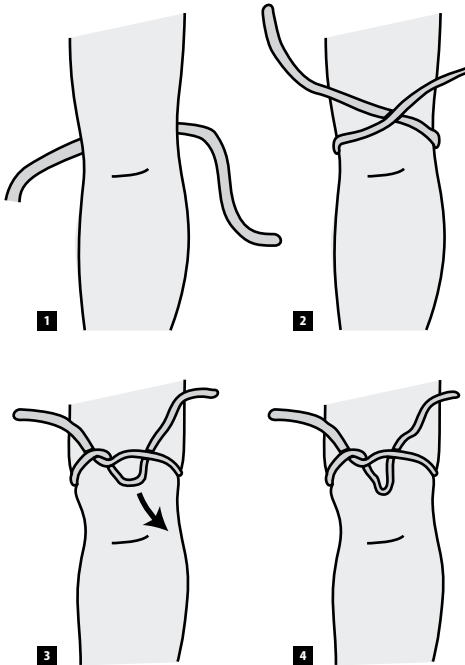
Incorrect Needle Insertion



a risk of stopping the blood reaching the extremities, like toes, feet, legs and fingers. If these areas are deprived of blood they can die and drop off due to gangrene.

Blood clots may also travel to the brain and possibly cause strokes. This usually does not happen at the time of injection, but some time later. Veins, arteries and nerves run alongside one another in a tangled mess. Wherever there's a vein there's a possibility of injecting into an artery.

For those who hit an artery by mistake or otherwise, they should immediately withdraw the needle and not complete the injection. They should put strong pressure on the site for at least 15 minutes and raise the affected limb if possible and use ice around the area to limit swelling. Bleeding may persist. If it does, the person should seek immediate medical care. Gentle massage over the next few days may help to remove toxins from the area, but if any pain is experienced, it will only cause more damage.



Arms

Injecting in the arms is the least dangerous location. The loss of usable arm veins will leave the injector with stark choices: either to stop injecting and switch to another route of administration, or to move to another site on the body with greater risks. It is for this reason that injectors should be encouraged to do everything they can to preserve the veins in their arm for as long as possible. It is important that workers seeing clients who are having difficulty accessing veins in their arms discuss with them the plans they have for the time when it becomes impossible. Reinforcing any taboos the client has about moving to more dangerous sites may help prevent or delay transitions to more dangerous routes of injection. If he or she does not have any taboos, you should try to talk to him/her in a more direct and objective way to avoid a lack of trust or

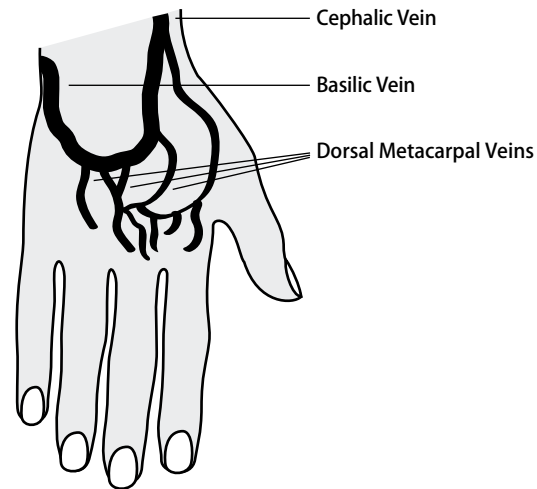
rejection. Provide strategies for maintaining vein health (see Safer Injecting Practices listed previously in this document).

Hands

The veins on the backs of the hands can be highly visible, although they tend to be small and fragile. As it can be difficult to hide the evidence of injecting here, many injectors avoid these sites. Furthermore, if complications such as infection or cellulites occur, they are likely to be much more disabling in the hand than in the arm and lead to severe problems, especially if rings are on the fingers. Fingers should be avoided, as the veins are very small. If clients insist on injecting in their fingers, they should understand the vital importance of removing rings prior to injecting. If a finger starts to swell with a ring in place, it can quickly obstruct the blood flow leading to loss of the finger. The artery that supplies blood to the finger lies just below the vein – if the artery is damaged the finger can die. The superficial veins of the hand tend to ‘wobble’ when people try to get a needle in them, and this can result in more frequent missed hits and vein damage.

Legs

The superficial leg veins are unlikely to be viable long-term prospects for injecting. The blood flow in these veins is slow, and if people inject too quickly there is often leakage into surrounding tissue. This can cause infection and further vein damage or it can cause the person to lose their dose. The legs contain many valves, which increases the likelihood of problems, as injecting at or around a valve causes more turbulence, and therefore clotting of the blood. This can damage the valve and further slow blood flow. The superficial veins of the leg tend to wobble’ when people



try to get a needle in them, and this can result in more frequent missed hits' and vein damage.

As the flow of blood in the leg veins is upwards (i.e. towards the heart) it can be difficult to self inject in the correct direction in the legs, i.e. with the needle pointing up towards the top of the leg. Because these veins are furthest from the heart, and due to gravity, blood flow through the leg veins is slow. If drugs are injected too fast, the veins will be unable to cope with the extra fluid. When this happens, fluid can escape from the vein, around the needle, causing a miss.' Injecting slowly can reduce this. Healing of injection site damage and resistance to infection are less reliable because the blood flow is slow. Abscesses and other infections are therefore more possible for those injecting into their legs.

Varicose veins form, usually in the leg veins, because of damaged valves. The varicose vein has tight, thin walls and is often raised, stretching the skin. They should not be injected into, as they can bleed profusely because the damaged valves mean that blood can run back down the vein and out of the wound.

Feet

Although some injectors use the veins in the feet, there are several factors that make them an unsuitable choice for anything other than occasional use:

- _ Venous blood flow in the feet is slow.
- _ If local infection occurs, this can lead to loss of mobility.
- _ Injury to the feet may be slower to heal than in other areas, especially in individuals with already damaged circulation.
- _ Fungal infections of the feet are common for most people. If there is a need to wear

shoes his may encourage or compound problems of infection.

_ As with the legs, injections in the feet should be done as slowly as possible to prevent overloading the vein.

_ The superficial veins of the feet tend to wobble‘ when people try to get a needle in them, and this can result in more frequent missed hits‘ and vein damage.

Notes

By the end of this session, participants should be able to articulate at least three injection-related risks and present strategies to reduce these risks.

Objectives

Expected time of activity: 20 minutes each

Choose from either of the following activities. You may also do them both in the order provided depending on the amount of time you have available. If you do Activity 1, prepare images of the body, which may be photocopies from images provided in this guide or by downloading directly from the Internet.

Beforehand

Activity1: As an exercise for participants, display each of the areas of the body where people may inject as pictures or cut outs. Have enough sets of illustrations for each participant. Ask each of the participants to place the pictures in order of risk, from least risk to greatest risk. This exercise can be done on the floor or up on a wall, depending on the space you are using for your training. Once all participants have placed the diagrams on a hard surface, verify their answers for accuracy with the information provided in this guide.

Activity 1 or Activity 2

Activity2: Ask participants to formulate questions that will help assess the possible risks a peer may experience. The questions should be related to behaviour, emotional state, resources and other methods of change. Two volunteers will play the roles of educator/counsellor and client. The educator/counsellor will be given the questions to ask the client.

At the end of the role-play ask the group the following questions:

What was the risk of infection of the client? / What resources does he currently have to help him change his behaviour? / What resources does he lack that would help him change his behaviour? / Which questions were hardest to for the client to answer?

Notes

- _ “Better Vein Care Injection”, Any Positive Change, The Chicago Recovery Alliance:
<http://www.anypositivechange.org/res.html>
- _ Pates, Richard; McBride, Andrew and Arnold, Karin (Eds.) (2005) “Injecting Illicit Drugs”. Blackwell Publishing, Oxford, UK

Here are some links with information about safer injection practices:

- _ <http://www.harmreduction.org/article.php?id=212>
- _ http://www.harmreductionworks.org.uk/safer_injecting.html
- _ <http://www.saferinjecting.net/index.html>



Session 6

The relationship between sex
and drugs

Remember that... Drug legislation is different around the world and legal penalties may vary from paying a fee to imprisonment or, in some countries, death. When discussing with your peers the implications of drug use with sexual activities, you must also take into account the implications of the criminalization of drugs.

Drugs can change the way in which people engage in sexual behaviour, sometimes altering and impairing one's judgment and understanding of their surroundings, blurring sexual boundaries and, in some cases, leading to memory loss. Many studies show that injection drug users and young people who have consumed alcohol during sex have inconsistent condom usage. Drug use can also further complicate issues of sexual assault. Drugs such as cocaine, crack, heroin, and ATS have also been associated with increased sexual health risks. Studies show that ATS, cocaine and crack use are linked with inconsistent safer sex practices.

A World Health Organisation study of injection drug use in cities such as Rome and Rio de Janeiro revealed that the percentage of IDU who never use condoms ranges from 50% to 82%. While abstinence may be the most effective way of reducing both drug-related and sex-related risks, for many young people abstinence is not a realistic option. As with drug use, harm reduction programs must recognise that young people engage in sexual activities and may use drugs while doing so.

The intersection between harm reduction, sexual health and drug use is important because it acknowledges the issues that young people face and provides realistic approaches to dealing with such issues. Harm reduction programmes are supportive and enable young people to make decisions that fit their needs and experiences. Harm reduction tools may be used to mitigate sexual risks and can play a significant role in HIV and STI prevention. Young people need access to information and comprehensive education about drug use and the effects of drugs on their perception and risk, allowing them to learn ways to keep themselves protected while engaging in sexual activities and drug use.

Notes

By the end of this session, participants should be able to articulate the relationship between sexual activity and drug use and be able to describe at least three harm reduction strategies for sex workers.

Expected time of activity: 20 minutes

This session is intended to provide more information on drug use, safer sex and sex work. It is an extension of the last couple of sessions. We do not provide activities for this session, as we think it is best if you simply present to the group and facilitate discussion. We seek to employ the principles of harm reduction when examining the linkages between drug use and sexual health. You will explore the following issues alongside the participants of the training: How does drug use affect sexual health? How would harm reduction strategies be useful when dealing with sexual health issues? How do these issues particularly affect young people?

After reviewing the information provided below with the group, get into a discussion of the topic by tackling stigma and discrimination affecting young people, in particular young drug users and sex workers. Visit the next session materials for activities about stigma.

Objectives

Notes

Harm reduction for sex and sex work

The use of harm reduction principles can help to safeguard sex workers' lives in the same way that drug users have benefited from harm reduction strategies related to drug use. Many sex workers are exposed to serious harms: drug use, infections, violence, discrimination, debt, criminalisation, and exploitation (non-voluntary sex work, such as child prostitution, trafficking for sex work, and exploitation of migrants).

Successful and promising harm reduction strategies are available: education, empowerment, prevention, care, occupational health and safety, decriminalisation of sex workers, and human rights-based approaches. Successful interventions include peer education, training in condom-negotiating skills, safety tips for street-based sex workers, male and female condom provision, linkage from HIV prevention to care, occupational health and safety guidelines for brothels, self-help organisations, and community-based child protection networks. Straightforward and achievable steps are available to improve the day-to-day lives of sex workers while they continue to work. Conceptualising and debating harm reduction strategies for sex workers can hasten this process.

- _ Listen to a potential client's voice and observe body language. Listen to your instincts: if it doesn't feel right, there's a good chance it isn't.
- _ Make sure the client is alone. Getting into a car with more than one person increases your risks. Check behind the back seat to make sure that no one is hiding.
- _ Always check car door handles before you get in to make sure they work from the inside. Make sure you know how to unlock the door before entering the car. Avoid vans.

Size up the situation

- _ Get the money first.
- _ Check the address. If a client says he's taking you to one place, but pulls up at another, this may not be all he's lying about. Unless he's a regular, avoid bridges and tunnels.
- _ USE A BUDDY SYSTEM: Have a friend or co-worker write down the license plate number of the car before you drive off in it. Do the same when someone else goes off with a client.
- _ If no one you know is around, ACT AS IF! Call to the nearest passerby something in the vein of "See you at such and such, at such and such time". Anything to let the client know that you will be missed and have been witnessed leaving with him/her. Talking into your cell phone, even if it's not operating, can lend to the impression that you are 'connected'. If working from a regular spot, make sure someone sees you both go in, so they can make sure you both come out.
- _ Share information with your co-workers. If you have had a bad experience with a client pass their details on to co-workers. Describe the car, how he or she looks, his or her rap, anything that will help others avoid going off with him or her.
- _ Consider reporting the incident to the police. Some police are sympathetic and will do all they can to help get this person off the streets and prevent them from harming someone else. Remember: an assault is an assault, whether you live in the White House or you don't even have a house.

Health

- _ Try to use a latex/polyurethane condom for each sexual act, to prevent STIs and HIV. For oral sex try a non-lubricated or flavoured condom.
- _ For vaginal/anal sex, use a lubricated condom and as much lube as possible (remember, don't use oil or sugar-based lubes with latex condoms), to reduce "trauma and abrasions",

which means harm to your vagina or anus. It's especially important to protect yourself from secondary/re-infection with HIV if you are immune compromised from HIV or hepatitis C. Obviously, condoms also prevent pregnancy!

_ If you are really high or really sick, you may find yourself agreeing to do things you normally wouldn't when you negotiate terms with a client. Try to get straight before your date.

_ Wear shoes you can run in.

_ Avoid wearing necklaces, scarves, key chains, anything around the neck, as it can be used to strangle or drag you.

_ Maintain hygiene. If at all possible, try to wash between dates. If water is not available, non-alcohol towelettes are good.

_ Get yourself checked as often as possible (at least every six months). If you need help accessing HIV/STI care or gynaecological care, contact your local community centre or needle/syringe program. More and more programs are working with sex workers!

_ Get the money first and, again, listen to you heart and instincts.

Dress for success

Take charge





Session 7

Stigma affecting young people

Remember that... “Stigma is a dynamic process of devaluation that ‘significantly discredits’ an individual in the eyes of others” *Goffman, 1963*

It's important when facilitating the training that you address issues of stigma and discrimination as they create barriers that prevent some young people from accessing harm reduction services and HIV treatment. Young drug users and sex workers face a great deal of stigma as result of their age and use of substances and/or engagement in sex work. This session is divided into two sections: stigma and barriers affecting young people's access to harm reduction services.

Stigma is based on assumptions and perceptions associated with arbitrary qualities such as someone's culture, colour of skin, occupation, sexual behaviour, gender, drug use, HIV status or other characteristics. HIV stigma plays on the fears and misinformation about the virus, perpetuating stereotypes that further marginalise already marginalised behaviours such as same gender sex, sex work and drug use. Some believe people living with HIV/AIDS deserve the infection because they 'chose' to engage in such behaviours or did something 'wrong' (UNAIDS, 2007).

This type of thinking ostracises young people from accessing HIV prevention services and treatment. For instance, in a study conducted by United Nations Population Fund (UNFPA) in China among 2,500 young people, 60% stated that they believe people living with HIV should be isolated to a certain degree from the rest of society (UNICEF China, 2006).

Stigma

Notes

By the end of this session, participants will be able to define stigma, describe how young people experience stigma, and how stigma affects young people's access to harm reduction services and HIV treatment. In addition, participants will be able to describe three barriers affecting young people's access to harm reduction services.

Expected time of activity: 20 minutes.

Write the following questions on a big piece of paper or on a board and ask the training participants to answer during a large group discussion:

- _ What is "stigma"?
- _ How do young people experience stigma? Have you ever been stigmatised?

Ask participants to share their thoughts for 5 to 10 minutes. After the discussion has taken its course and people around the room have had an opportunity to learn what others think, pose the following two questions on a big piece of paper or on a board. Make sure that nobody from the group has seen these questions during the first part of the activity:

- _ How might young people experience stigma when they are a drug user, sex worker and/or HIV positive?
- _ How are people living with HIV, drug users or sex workers described by some people?

Open up the discussion again and allow another 5 to 10 minutes for the group to discuss these two questions. If the discussion needs some prompts to get going, ask the group to list some of the names that drug users or sex workers are called. You may write these

Objectives

Activity

words on a big piece of paper or on a board and then ask participants to reflect on how they think these names make people feel. You may ask, “How would it make you feel?” to generate empathy. Discuss how young drug users and sex workers may attempt to counteract these stigmatising messages.

After brainstorming issues of stigma with the group, discuss barriers that prevent young people from accessing harm reduction services in order to address their sexual health and/or drug use behaviours. Examine the following with the participants:

- _ How does stigma affect access to health services, such as HIV prevention or harm reduction programmes?
- _ What are some of the barriers that young people face when advocating for increased harm reduction programming?

Lack of disaggregated data. Limited data on young people and drug use have created significant barriers for young people advocating for increased access to harm reduction services. Service providers and advocates lack disaggregated data about young people, leaving gaps in knowledge and, thus, in programming. There is little information about what kinds of young people are using drugs, what type of drugs they are using, how they are using them, what socio-economic factors are related to their use, and what other HIV risks they experience related to their use. United Nations Children's Fund's (UNICEF) Most At-Risk Adolescent study shows that in countries such as Ukraine and parts of Eastern Europe, the lack of disaggregated data and the legal obstacles to gathering data from minors is a barrier to programming. Globally, the lack of disaggregated data has significantly affected not only drug policies but also health and social policies. Without correct information about young people and drug use, effective best practices that truly reflect the needs of young people cannot be achieved.

Age restrictions and limitations. Many existing harm reduction programmes limit access to people under the age of 18 and often require parental consent in order for youth to access syringe/needle programmes, methadone maintenance treatment, drug treatment or rehabilitation. Young drug users are denied access to HIV prevention tools, such as access to sterile injection equipment, because either the service provider doesn't recognise that they are adults or they do not wish to disclose their drug use to their parents. These age restrictions and limitations, coupled with the decreased initial age of first injection of drugs to as young as 12 years old, mean that many young people go without treatment or access to any sort of related health services well into their twenties. Several studies have shown the early age of injection is directly correlated to increased rates of hepatitis C

Barriers to young people's access to harm reduction services

and HIV risk behaviours, leaving young drug users extremely vulnerable to blood-borne pathogens and without support to prevent or treat these conditions.

Lack of youth-friendly harm reduction services and programmes. One of the biggest challenges for young drug users is the lack of youth-friendly harm reduction services. Harm reduction programmes are often geared towards older adult clients and service providers often are limited in resources and capacity to extend their services to young people. In Youth R.I.S.E./ International Harm Reduction Association's Report on the Conventions of the Rights of the Child, a report that focuses on young people's rights and their need to access to harm reduction services, all 14 countries represented in the report identified that the lack of youth-friendly harm reduction services is one of the primary barriers for young people.

By the end of the session, participants will be able to describe stereotypes of drug users and how these stereotypes relate to young people's ability to reduce drug-related harm.

Expected time of activity: 30 minutes for each. You may choose to do both activities one after the other, depending on available time.

Activity 1: Ask participants to discuss stereotypical images of the drug user. Then examine the 'differences' between a drug user and a non-drug user. The exercise requires that participants step into the role of a stereotypical depiction of a drug user. The goal of the exercise is to encourage participants to examine stereotypes of drug users and also to bring into discussion the reasons that some people use drugs.

Key points in the discussion:

- _ A drug user can be anyone in a society
- _ Drug users are diverse (e.g., different ages, genders, cultural backgrounds, social statuses, incomes)
- _ Most drug users have friends, families, jobs, health problems, personal problems, etc., just like people who don't use drugs

Activity 2: Form groups of four role-play four attitudes that illustrate the most common intervention models for addressing drug use. Depending on time, you may ask them to simply perform these roles with one another in small groups or pick four people to perform these roles in front of the whole group.

Objectives

Activity 1 or Activity 2

The four roles are:

- _ The drug user ("I am a victim of my peers")
- _ The police officer ("drug users are offenders")
- _ The doctor ("drug addiction is an illness like any other")
- _ The addiction specialist ("addiction has many causes and can only be solved through a multi-disciplinary intervention")

At the end of the activity, participants who played the different roles will present their feelings/states of mind during the exercise and will state one strong point and one weak point about the attitude they represented. It's important that you facilitate a dialogue about the issues that come up and how they relate to larger systemic issues of stigma.

For additional resources on stigma, barriers affecting young people and HIV prevention, check out:

<http://www.worldaidscampaign.org/en/Constituencies/Youth/Resources/Fact-Sheets-for-Youth>

Youth R.I.S.E. (2009). “Report on the Conventions of the Rights of the Child”.



Session 8

Wrapping up the training
and final remarks



Kudos! You have gotten to the end of this training guide! By doing so, you and the participants of your training have been introduced to issues of drug use and drug-related harm reduction, HIV prevention and sexual health education. Furthermore, the discussions you had with the group have probably kindled several thoughts about more activities and discussions that each of you, together or individually, may facilitate in order for this information to reach more young people.

In this last session, you will close the training and provide some final remark to the group.

We believe the closing is as important, both to you and to the group, as the information you presented throughout. The closing activity provides an opportunity for you to grow as a peer facilitator by getting feedback from the group and hearing from the participants what worked well and what could be improved the next time you facilitate this training. In order to do this we suggest one last activity, which follows.

Notes

By the end of this session, participants will have described what worked about the training and what could be improved upon. They will also be able to articulate how they will use the knowledge they acquired from this training in their lives.

Expected time of activity: 20 minutes.

Prepare pieces of paper of different colours and hand out the papers and markers to everyone. There should be the same amount of colours as you have questions for the group so that each set of answers has its own colour paper.

Ask participants in the group to respond the following questions:

- _ What did you like about the training?
- _ What elements of the training could be improved?
- _ Are you leaving today with any particular questions regarding the subjects we covered?
- _ How do you think you will use the knowledge you acquired from this training after today?

While participants respond, pin or stick the pieces of paper in columns up on the wall or on a big piece of flipchart paper where everyone may see it. Allow 10 minutes or so for all answers to be submitted and posted. Read the answers aloud and find out if more than one person agrees. In general, people feel more comfortable expressing their opinions about a training when the feedback is provided anonymously.

This activity allows you to get as much feedback as possible in a quick manner. Thus, if you have any questions regarding participants' feedback, you may ask participants to help you understand the feedback given.

Objectives

Beforehand

Activity

If there are any particular questions regarding the subjects covered that you think are relevant for the larger group and won't take you much time to explain, answer them right away. If you believe the answer might take too long, ask the person who posed the question to see you after the end of the session so you can provide further information on the topic.

After you have gone through all the answers, ask the participants if there is anything else they would like to add or any personal opinions anyone would like to include. People are also welcome to talk about how they would like to pass along the knowledge they acquired through the training to their peers. If an idea that was not already posted on the wall comes up, make sure to ask the participant to write it down and stick it up. At the end, take a picture of all the answers as these will serve you in doing your final report of the training sessions or for your own archive. Last but not least, make sure to underscore the importance of them passing on the information they learned from the training to their peers. Offer your support to facilitate this process and that you are available beyond the training to help participants share information with their communities.

As a facilitator, your role was to help young people in their communities learn about the complexities of drug use and sex and resources for utilising harm reduction strategies to support the health of young people.

You have fulfilled your role and are now ready to work with another group, bringing your experience and some new ideas! Congratulations!

We believe that peer-based education about drug use and sex helps lead us to the right track to eliminate HIV and other STIs, as well as other health risks and violence associated with drug use and some sexual activities. We believe that this training is one step towards developing new generations that are informed and conscious of the impact of their decisions. We believe this work contributes towards the fight for a more just world where human rights are the basis to health policies, drug policies, and policies related to sex education, policies based on gender equality, respect of diversity and with the goal of promoting love and a better quality of life for all.



Acknowledgements



The work done to create this guide would not have been possible without the invaluable support and technical guidance of MTV's Staying Alive Foundation (SAF), Espolea and Youth R.I.S.E. In addition, this guide was created with the help of many individuals who acted as authors, peer reviewers, and training facilitators.

Special thanks to:

Amber Lacroix (Canada)
Aram Barra (Mexico)
Ashley O'Brien (Canada)
Brun González (Mexico)
Cecilia García (Mexico)
Claudia Ahumada (Chile)
Cristina Fierbinteanu (Romania)
Emalie Huriaux (US)
Ivens Reyner (Brazil)
Kalindy Bolivar (Ecuador)
Kunle Odeyemi (Nigeria)
Kyla Zanardi (Canada)
Kyle 'Pyke' (Canada)

Luciano Colonna (US)
Mary Leeder (Canada)
Mimi Melles (Kenya / US)
Murtaza Majeed (Afghanistan)
Newton Manoharmayum (India)
Oana Ana-Maria Enache (Romania)
Raluca Teodorescu (Romania)
Roshan Ningthoujam (India)
Ruben Diazconti (Mexico)
Sara Piot (UK)
Vikram Laishman (India)
Veronica Broasca (Romania)







