By Janna Ataiants and Dasha Ocheret

A guide to developing and implementing overdose prevention programs

2012

EURASIAN HARM REDUCTION NETWORK
HARM REDUCTION KNOWLEDGE HUB

Eurasian Harm Reduction Network

The mission of Eurasian Harm Reduction Network (EHRN) is to promote humane, evidence-based harm reduction approaches to drug use, with the aim of improving health and protecting human rights at the individual, community, and societal level.

Founded in 1997, the Eurasian Harm Reduction Network (EHRN) unites over 340 members from 29 countries of Eastern and Central Europe and Central Asia (ECECA). Our members include harm reduction organisations, communities of people using drugs and/or living with HIV, drug treatment services, HIV-service organisations, governmental institutions, researchers and experts. EHRN is governed by its members through a Steering Committee; with a Secretariat based in Vilnius (Lithuania).

EHRN relies on ECECA best practices in the sphere of harm reduction, drug policy reform, HIV/AIDS, tuberculosis, Hepatitis C and overdose prevention. EHRN works toward its mission through documentation and advocacy; technical assistance and training; information and networking. The primary goal is to advocate for non-discriminatory, harm reduction-oriented drug policies, and improve the quality and range of harm reduction services in the region.

Postal address:	Svitrigailos St. 11B, Vilnius 03228, Lithuania
Telephone:	+370 5 269 1600
Fax:	+370 5 269 1601
E-mail:	info@harm-reduction.org
Website:	www.harm-reduction.org

Authors
Janna Ataiants, Dasha Ocheret

Translator
Katya Smirnova

Editing
Matt Curtis

Design and layout
Design: Donaldas Andziulis, «Ex Arte»
Layout: Birute Vilutiene, «Ex Arte»
«Ex Arte», Lithuania

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Contents

Introduction

This Guide was developed in response to the growing need among service providers working with drug users in Central and Eastern Europe and Central Asia to introduce overdose prevention work into their services. What any organization working with drug users knows from experience, and what has been confirmed by numerous scientific studies in USA, Western Europe and Australia, is that overdose is a major cause of death among their clients.[1]

It is nearly impossible to obtain reliable official data on the numbers of overdoses – fatal or non-fatal – for the region. Foreign studies found that at least two-thirds of injecting opiate users had experienced an overdose in their lifetime, with approximately 4 out of 100 overdose cases having a lethal outcome.[2] At the same time, official statistics in the region registers disproportionally low figures of fatal overdoses[3], which brings governments' attention away from the problem. Funding is not being allocated to overdose prevention, medical services are insufficiently equipped with naloxone (a highly effective antidote to opioid overdose), and naloxone is only poorly available – if at all – in local pharmacies.

While the governments hesitate to lead targeted responses to lower overdose mortality in their countries, non-governmental organizations and medical facilities initiated their own pilot responses to the issue. In total, about 90 projects now work in six countries of the region (Georgia, Kazakhstan, Kyrgyzstan, Russia, Tajikistan and Ukraine) to provide access to naloxone and improve first-aid overdose prevention skills.

In this Guide, we have summarized best regional practices to offer a useful tool to non-governmental organizations working with people who use drugs and willing to expand their services and introduce overdose prevention. Here you will find a set of concise recommendations on overdose programming based on lessons learned from colleagues in the region. You will also find sources of additional information on various issues of overdose prevention, as well as annexes with an overview of first pilot results that can guide you in planning, implementation and monitoring of your project.

But before we get into some suggestions for starting and operating overdose prevention projects, there is one thing we would like to stress: Just Do It. It's helpful to do surveys and focus groups to determine how big a prob-

[1] For the review of research on overdose as the leading cause of death among injecting drug users in different countries see Coffin P, Sherman S, & Curtis M, 2010.

[2] Coffin P: 'Overdose: a major cause of preventable death in Central and Eastern Europe and Central Asia', 2008.

[3] For example, in Ukraine, with its estimate number of IDUs ranging from 230 500 to 361 000 people (Reference Group to the United Nations on HIV and Injecting Drug Use, 2008), only 203 deaths from poisoning due to psychoactive substance use were registered in 2008 (according to the Ukrainian Monitoring Centre on Drug Use).

lem overdose is in your community. But 100% of harm reduction groups already see people in need of overdose services. Naloxone is an incredibly valuable, life-saving tool. But if you don't have it today, it's a missed opportunity not to still teach someone about rescue breathing and other first aid skills. Money for projects is important, but there are millions of positive steps that can be taken before you get funding. So just do it. You have the power to reduce the toll of overdose deaths in your community, and now is the time to use it.

I. Strategic issues

A quality overdose prevention program requires a solid foundation. First of all, you should assess the urgency of the issue in your city or district, analyses the legal framework of naloxone provision, and garner support from potential project partners.

Conduct situation assessment

It should be your first step: evaluate the urgency of the overdose problem in your target group in your city or local area. Consider conducting a mini-assessment to answer three core questions:

- What are the drugs most commonly used (the 'drug scene') and what causes overdoses?
- What is the official and not official statistics on fatal and non-fatal overdoses in your city/area?
- Is medical attention for overdoses timely and adequate?

You can obtain official statistics on overdoses in the following governmental services:

- Municipal healthcare department;
- Ambulance and first-aid service;
- Intensive care units in hospitals;
- Toxicological units in hospitals and poison-control centers;
- Drug treatment facility;
- Forensic examination bureau;
- AIDS Centre;
- Law enforcement statistic services.

NOTE:

If you are not able to obtain overdose statistics online or through personal visits to institutions, try sending out official data requests. Legal regulations in many countries require governmental structures to respond to official inquiries by citizens over a certain period of time (usually one month).

You can collect data on overdose causes and the quality of medical aid, as well as alternative data on the number of overdoses in your area through a survey among *outreach workers, volunteers and clients. Ask them, in particular:*

- What types of drugs are currently used in your area, how often, how are they administered, what is the dose?
- How would you describe the current dynamics of the situation with overdoses: more cases, less cases, for what reason?
- How many people known to you died from overdose in a certain period of time?
- How often are ambulances sent for overdose, how often they arrive, what kind of medical help they offer?
- What do drug users know about naloxone? Can it be purchased in pharmacies? Will it be in demand?

This mini-survey will help you generate valuable information to be used towards meeting the following objectives:

- Getting hold of information that will assist you in rationalizing the urgency of your project in a grant proposal;
- Focusing your program on actual needs of the target group;
- Obtaining baseline data for further evaluation of project impact on the situation with overdoses at the stage of monitoring and evaluation.

ADDITIONAL INFORMATION:

EHRN's document 'Incidence and circumstances of injecting drug overdoses' (2009) can serve as an example of situation assessment.[4] The document is published in NP 'ESVERO' educational material 'The model of overdose prevention and case management' (A. Carpets and co-authors, 2011, p.48-56).[5]

[4] Detailed information about this and other sources mentioned in the 'Additional Information' boxes you can find in the 'Bibliography' chapter below.

[5] Карпец, А., Белецкий, Л., Утяшева, Л., Нечаева Л., Царев, С. (2011). *Модель профилактики и оказания комплексной помощи при передозировках психоактивными веществами, на основе опыта реализации проекта «Обеспечение устойчивости профилактики передозировок опиатами в Российской Федерации» в 2008–2011 гг.* Москва: Некомерческое партнерство «ЭСВЕРО». Доступно на: http://esvero.ru/files/model_profilaktiky_web.pdf

Analyze legal framework for the provision of naloxone

If your needs assessment showed that opiate overdose is an urgent issue for your target group, you should explore ways of providing your clients with access to naloxone – a highly effective antidote to acute opioid poisonings. For that, you will need to conduct another mini-research: to identify the legal status of naloxone in your country, its availability in pharmacies and legal possibilities for your organization to provide naloxone.

Most often, naloxone has the status of ***a prescribed drug***. Access to naloxone is often limited: it's either in temporary stock at pharmacies, or not available at all due to lack of demand, or is available only in big pharmacies or in capital cities.

You should also study *the legal framework for the provision of naloxone in your country, its possibilities and limitations*. In many countries of the former Soviet Union, an NGO with no medical or pharmaceutical license and without a special status of research organization cannot purchase, store or distribute naloxone. You will have to establish connections with organizations and specialists having such a license or status.

Practice shows that regardless of the legal status of naloxone in a given country, NGOs have been able to organize legal ways to distribute naloxone in their communities. In places where prescriptions or other special conditions are required, this is often accomplished through agreements between harm reduction projects and medical institutions or pharmacies that can provide staff to write prescriptions or otherwise support the project (for details see the section on 'Planning'). When in doubt, try checking with an existing overdose project in your country about how they do it, or consult a lawyer or experts with international organizations working in your country.

ADDITIONAL INFORMATION:

View 'The legal status of naloxone in the Russian Federation' by the Canadian HIV/AIDS Legal Network, produced on request from the Russian Harm Reduction Network (in Russian).

Garner support from potential project partners

Before you start detailed project planning, define the potential partner organizations. These could include governmental facilities where you obtained official statistics on overdoses, pharmacies or naloxone distributors, and medical agencies, other harm reduction groups, or likeminded organizations that can help you carry out the project.

At the preparation stage, organize meetings with potential partners, tell them about the project, exchange contact information, secure their support. This type of cooperation has an added value: it will improve the overall significance of the project.

NOTE:

Fatal overdoses is an issue that usually triggers a much more compassionate response from decision makers compared to other harm reduction initiatives, therefore the project is likely to receive support from new allies, such as drug control service or municipal healthcare department.

Use findings of pilot overdose prevention projects to establish cooperation with specific structures:

Medical personnel	• If naloxone is a prescription drug in your country, involve a narcologist or other medical doctor who is allowed to prescribe it to project clients. It may be useful to sign an agreement with an institution rather than individual doctors in order to increase the number of people who can write prescriptions and the times at which prescriptions can be made.
Ambulance and first-aid services	• Conduct training on overdoses for ambulance paramedics to raise their motivation to promptly respond to emergency calls and promote tolerant attitude towards drug users. • From experience of the 'Tomsk-AntiSPID' foundation (Russia), you should inform ambulance staff about the project – before it starts and after it ends, as this information will be very useful for doctors.
Law enforcement bodies	• If you are planning to distribute naloxone directly to drug users, try getting support from the local law enforcement bodies. • From experience of NGO 'Aiperon' (Tajikistan), it's helpful to conduct trainings or round tables for representatives of law enforcement to explain the purpose of the project, that naloxone is not a narcotic drug, and that project participants posses naloxone legally.

II. Planning

After you conducted a situation assessment in your city, studied the legal framework for prescribing naloxone and found project partners, it's time to plan you project in detail. You need to choose a model of naloxone provision, train staff, make a checklist of first-aid supplies, develoip training outlines, prepare informational materials, define technical support needs, sharpen advocacy strategies and make a budget.

Choose a model for procurement, storage and distribution of naloxone

As noted above, there is no one 'right' way to carry out an overdose project, but you should think carefully about the model(s) you want to introduce. Some examples from existing projects include models:

- Based on harm reduction NGOs and linked to syringe exchange and other community-based services;
- Based on pharmacies and medical services as a means of complimenting services delivered by harm reduction groups;
- Based on emergency services, in order to increase the availability of naloxone in ambulances and train emergency personnel to deliver overdose education.

ADDITIONAL INFORMATION:

For detailed description of these kinds of models with examples of projects in the region, see Annex 1.

You will need to select the model of naloxone provision depending on your country's legislation. Remember, however, that evidence and practice demonstrate that ***distribution of overdose education and naloxone directly to people who use opioids through low-threshold programs is the most effective method of preventing fatal overdoses.***

Below you will find information on how harm reduction organizations in Russia, Ukraine and Georgia, having chosen the low-threshold model of naloxone provision, organized procurement, storage and distribution procedures in their countries.

Procurement:

In situations where naloxone is not widely available in pharmacies, or has a limited availability, you should purchase the medication either directly from a producing company or through a distributor. If you are not able to purchase large quantities of naloxone without medical or pharmaceutical licenses, sign an agreement with a pharmacy or a trusted medical organization (such as AIDS Centre or drug treatment facility) that will arrange procurement of naloxone for your project.

Storage:

If you are able to store naloxone at your office, there is one simple rule to follow: keep naloxone out of light and at regular room temperature. Doing so will prolong its shelf life. Usually, this means that simply storing naloxone in its original packaging in a regular storage closet is fine.

Rules about storage of naloxone at non-medical organizations vary from country to country. In some places in EECA, for example, small quantities of naloxone (e.g. up to 500 ampules) may be stored in office premises for a period of one month. You should consult with local medical professionals, a lawyer, or other experts to determine the rules in your country.

In EECA, larger quantities of naloxone are often stored in warehouses of a facility that orders its supplies (e.g. pharmacy warehouse, drug storage in AIDS Centre or drug treatment center). If naloxone is purchased by one organization, stored at another, and then distributed by a harm reduction group, it is usually necessary to sign an agreement between the harm reduction project, procuring organization and storage facility.

Distribution:

You can distribute naloxone after group or individual training in the office, at a mobile needle exchange, at a hired training facility or the homes of people who use drugs. Naloxone can be given out in exchange for a prescription provided by the doctor partnering with your project. If naloxone is distributed during outreach work, you should be aware laws that may restrict how much of the medication may be carried by an individual. Laws regarding medication administration usually allow possession of small quantities for personal use. These laws and regulations, however, most often don't stipulate the exact amounts, but it is likely that having one package of naloxone ampoules will not be a problem, especially if pharmacies don't sell it per ampoule. In Ukraine, for example, outreach workers can legally carry around naloxone, which is documented in a cooperation agreement with ambulance service.

NOTE:

Even though naloxone distribution through pharmacies is not the most effective way to prevent overdoses among the most vulnerable drug users, the project can refer clients to pharmacies (if naloxone is available there) in situations where there's not enough free naloxone on site. For example, 'Humanitarian Action' charity foundation (St. Petersburg, Russia) gives out naloxone prescriptions to those project clients who state that they are able to buy it themselves.

Sometimes drug users are reluctant to carry naloxone, fearing that if searched by police, its possession will provoke detention and subsequent drug tests. Clearly explain to your clients what the law is, that they should not be detained for possessing naloxone, and that if they are then they should report the incident to the project for follow-up. Overdose projects also have a responsibility to try to minimize the potential for clients to be harassed or arrested for participating, for example by educating police, advocating for local police orders to not interfere with the project, and including a card in each naloxone kit that briefly explains the project and gives contact information for the providing organization.

NOTE:

Timor Islamova Foundation (Naberezhnye Chelny, Russia) gives its clients small leather covers to hang around the neck. These covers can hold two naloxone ampoules, and they don't draw unnecessary attention and keep the medication from breaking.

Prepare for staff training and individual consultationsй

Quality training for staff and clients is key to the success of an overdose prevention project. While we provide a short explanation of how to organize trainings here, for much more information please see the Open Society Foundations' manual on Overdose Prevention and Response and EHRN's overdose training module (links to both are included in the "Useful Literature" section at the end of this guide).

At the training preparation stage, take the following steps:

- Invite expert trainers for preliminary staff training. Define what types of additional technical support in conducting training and consultations you will need, and include them in the technical support plan and budget (for details see section 'Add technical support components' of this chapter).

> NOTE:
>
> Experts from the following organizations can help you with your training: Eurasian Harm Reduction Network, Open Society Foundations, AIDS Foundation East-West, Médecins du Monde – France, national harm reduction associations, as well as Harm Reduction Coalition and Chicago Recovery Alliance.

- Train all outreach workers and doctors you plan to involve in trainings and individual counseling. If possible, train also volunteers and all staff that are in contact with the target group.

> NOTE:
>
> When holding training for trainers, stress the difference between naltrexone and naloxone ('Narcan'). Naltrexone is a drug used primarily in alcohol and opioid dependence management, whereas naloxone is used to treat acute opiate poisonings and prevent overdoses.

- Develop a training agenda or use an existing one.
- Make a checklist of necessary equipment and training materials:
  - manikin,
  - multimedia projector,
  - flipchart and markers,
  - notebooks and pens,
  - handout materials (brochures or instruction sheets),
  - naloxone ampoules or first-aid kits.

NOTE:

- You will need a manikin to develop and strengthen the skills of the closed-chest cardiac massage. If your organization cannot purchase one, loan it at the local Red Cross representative office or in a medical college.
- It's handy to have two manikins: a stationary one (weighs about 20 kilos) for office trainings and a moveable one (about 4 kilos) for on-site trainings.
- The 'Tomsk Anti-AIDS' foundation (Russia) uses a more expensive, but also a better alternative to a manikin: a heart-lung and brain resuscitation training device (the 'Maxim' series), which is a great tool for strengthening CPR skills.

- Define your target audiences. These can include:
  - active drug users,
  - drug users in remission,
  - close ones of drug users (parents, spouses, partners, relatives or friends living together with drug users),
  - staff and clients of rehabilitation centres,
  - medical workers,
  - law enforcement officers,
  - officials and decision makers.

NOTE:

- The 'Tomsk Anti-AIDS' foundation (Russia) holds trainings for active drug users, staff and clients of rehabilitation centres, medical staff from the regional TB hospital and the municipal hospital (departments of infectious control, surgery and therapeutics).
- The 'Renaissance' project (Kazakhstan) conducts trainings for drug using spouses.
- The Timor Islamova foundation (Naberezhnye Chelny, Russia) conducts educational sessions for drug users in drug treatment in-patient units, in the streets, as well as at homes and 'cooking labs'.
- A drug treatment clinic in Simferopol (Ukraine) provides training to nursing staff of the clinic and clients of the substitution program.

- Select location, define training regularity and duration.
  - You can plan both in-office and on-site trainings.
  - Staff trainings should be held at least once a year; trainings for the target group – at least once a month.
  - No more than 10-15 participants per group.
  - Hold short-lasting trainings for active drug users and longer ones for other audiences.

NOTE:

'Humanitarian Action' charity foundation (St. Petersburg, Russia) organizes three types of trainings for different audiences:

- 15-30-minute trainings for active drug users, where all participants receive a brochure with training information;
- 2-3-hour trainings for volunteers, people in rehabilitation or remission;
- 4-6-hour trainings for healthcare workers with a special session on drug addiction.

If you don't have a possibility to hold a group training, consider conducting individual consultations – another proven educational tool to provide this type of information.

You can train drug users and give out naloxone in several possible locations (see Chart at page 14).

Don't forget to distribute information sheets and several naloxone ampoules among all training participants!

ADDITIONAL INFORMATION:

Overdose training agenda is available at the website of the Eurasian Harm Reduction Network (http://www.harm-reduction.org/hub/knowledge-hub/ehrn-training-modules/), as well as in the guide by M. Curtis and L. Guterman: 'Overdose prevention and response' (2009, p.87-93).

Sites where drug users can be reached

Develop informational materials

You will need at least a short information sheet describing causes and signs of an overdose, as well as first-aid actions. It would also be good to have a detailed brochure on overdoses and hand it out during trainings for healthcare workers.

You can adapt existing materials to your project's needs or use already developed materials.

Define what types of technical support you will need to develop materials, and include them in the technical support plan and budget (for details see section 'Add technical support components' of this chapter).

ADDITIONAL INFORMATION:

Some examples of informational materials that can be used in your overdose prevention projects: 'Opiate overdose' and 'Stimulant overdose' (AIDS Foundation East-West; reprinted by NP 'ESVERO' in 2011); 'Overdose prevention and response' (M. Curtis, L. Guterman, 2009).

Determine how many first-aid kits are needed

First of all, you should decide what to include in the first-aid kits that you will distribute among project clients. At a later stage, this will be a separate item in your budget.

Suggested minimum contents of an overdose first-aid kit:

- At least 2 ampoules of naloxone;
- At least one syringe for each ampule of naloxone. Ideally, syringes should be at least 1ml (2ml is better) and have fixed (**not** detachable) needles. Needles **must** be for intramuscular injection, which are longer than needles commonly used for injecting heroin or other drugs;
- Alcohol swabs;
- Information on basic overdose prevention and first aid techniques, including how to diagnose an overdose, do rescue breathing, and use naloxone;
- A card or other printed material that briefly explains the project and includes contact information for your organization, in case the client in stopped by police.

NOTE:

'Humanitarian Action' (St. Petersburg) gives out at least 3 ampoules of naloxone per person. There is a chance that a client breaks or loses one, or has it confiscated by police. Besides, another overdose may occur in a short time after naloxone is administered, so the second ampoule may be needed.

To determine the amount of naloxone your project will need, consider the following factors:

- Local drug scene (the project will need large quantities of naloxone if the drug in demand is injecting heroine – or some new drug that often causes overdoses: in this case you might get more clients willing to get training and naloxone);
- Client coverage (at the start, your overdose prevention project may attract similar amounts of clients your organization usually gets, but as soon as the target group sees the effect of naloxone, you may see the raise in both recurrent demand for the medication and the number of new clients);
- The number of ampoules per person at a time (often it's two 1ml ampoules).

NOTE:

- 'Humanitarian Action' (St. Petersburg) gives out at least 3 ampoules of naloxone per person. There is a chance that a client breaks or loses one, or has it confiscated by police. Besides, another overdose may occur in a short time after naloxone is administered, so the second ampoule may be needed.
- 'Tomsk-AntiAIDS' charity (Russia) hands out 2-3 ampoules to drug users, 2 ampoules – to relatives and friends after trainings and 20 ampoules – for storage in apartments frequented by drug users.

From experience of overdose prevention pilot projects in Russian cities with a population of about half a million people, you may need up to 400 ampoules a month if heroin use is dominant at the drug scene.

NOTE:

Remember to supply outreach workers with naloxone to be used in case they witness an overdose. Even if in your area naloxone can only be prescribed by a doctor, outreach workers are allowed to carry 2-3 ampoules. They cannot be charged or prosecuted for possession of naloxone for personal use, as naloxone is not a controlled drug (it's not included in the lists of narcotic, psychotropic or potent drugs).

Add technical support components

Since overdose prevention programs are new to your organization, make special provisions for technical support in the structure of your project. The scale of technical support needs and proportion of the budget you will allocate to this project component will vary depending on the experience and capacity of your organization, but some things that other organizations have found helpful include:

- Expert support in overdose-related situation assessment;
- Expert site-visits to provide counseling at the launch of the program; support in talking with decision makers and conducting round tables or workshops with potential partner organizations;
- Support in conducting trainings for future trainers from among outreach workers;
- Development of training agenda on overdose prevention for the target group, healthcare workers, law enforcement officers;
- Expert support to improve availability of naloxone, including its registration, import and availability in pharmacies, as well as its inclusion into the list of essential medicines;
- Legal assistance related to the status of naloxone and development of legal schemes of naloxone provision through outreach workers;
- Consultations to adjust the project at the implementation stage (for example, changing project design following shifts at the drug scene);
- Support in project monitoring and evaluation;
- Expert assistance to document project results and successes;
- Support in the development of an advocacy strategy.

NOTE:

- You can get technical support from such organizations as Eurasian Harm Reduction Network, Open Society Foundations, Population Services International, AIDS Foundation East-West, UNODC (advocacy issues) and national harm reduction associations, such as NP 'ESVERO' (Russia).

Develop the project's advocacy strategy

Since you may be new to overdose prevention activities, your advocacy activities will probably be centered around local-level initiatives that may include:

- Round tables for healthcare departments, law enforcement bodies and other external partners to inform them about project objectives at the start-up stage, and present results and successes after the project;
- Documenting project successes and distributing related information;
- Recording absence of naloxone in first-aid kits of medical facilities providing services to drug users (drug treatment facilities, TB clinics, infectious hospitals, AIDS Centre's in-patient wards);
- Training medical and non-medical staff from governmental healthcare services on issues of first aid to respond to drug overdoses – as part of work aimed at expanding overdose prevention initiatives and encouraging tolerant attitudes of health workers towards drug users;
- Round tables or meetings with drug treatment specialists to raise their motivation to prescribe naloxone to patients of drug treatment clinics;
- Campaigns on prescribing naloxone through cooperation with project-friendly narcologists and pharmacies;
- Facilitating inclusion of overdose prevention issues in advanced training programs for healthcare staff, as well as in municipal drug use and HIV/AIDS prevention programs.

NOTE:

In the first year of their overdose prevention projects:

- NGO 'Novy Put' ('New Way' – Tbilisi, Georgia) and Altay Public Organization 'Vybor' ('Choice' – Biysk, Russia) obtained permission to purchase naloxone from the budget of the Global Fund grant, even though these purchases had not been planned in the initial proposal;
- Timor Islamova Foundation (Naberezhnye Chelny, Russia) and drug treatment clinic of Chapayevsk (Russia) were able to prove urgency and significance of the project in the course of round tables with local departments of the Federal Drug Control Service;
- 'Xenon' Association (Zugdidi, Georgia) received high appraisal of their naloxone distribution activities during a work meeting with representatives from ambulance services who reported decreased levels of overdose emergency calls and overdose-related mortality;
- Drug treatment clinic in Simferopol (Ukraine) secured the inclusion of 'Harm Reduction' section (with overdose prevention components) in the study curriculum for mid-level healthcare workers;
- In Bishkek (Kyrgyzstan), the proportion of referrals from the pilot overdose prevention project to governmental drug treatment facilities increased from 2% to 13%.

Make a budget

While most costs associated with overdose prevention projects are quite small and there are often many things that can be done with your existing resources, there are costs for which you will need to budget. If the overdose project is well integrated with your other services, it is unlikely, for example, that you would need new staff resources. On the other hand, purchasing naloxone (and to a lesser extent other basic supplies) can be a significant cost, especially for small organizations.

NOTE:

- Budget a maximum estimated amount of naloxone, as you would not want to run out of it in case there is a sudden inflow of clients or the situation changes at the drug scene. Naloxone can be stored for three years, so it will not expire.
- Take into account all possible distribution channels: to participants of awareness sessions and individual consultations; through outreach workers and at needle exchange points; through narcologists and doctors-infectionists.

The following is an example of a possible budget structure for an overdose prevention project. Remember that few projects will require all of these expenses, and that you should adapt your budget planning to match with your own needs and available resources.

BUDGET SECTION	ITEM DETALISATION
Staff salaries (part-time)	Coordinator (outreach-manager) Outreach workers Consultant-neurologist Lawyer Accountant
First-aid supplies	Naloxone Syringes Sterile wipes for rescue breathing Alcohol swabs Zipper bags (plastic or other)
Trainings	Trainers' fees (for staff trainings) Manikin Rental fees for training facility and multimedia projector for on-site trainings Coffee-break expenses Flipchart, markers, notebooks, pens
Technical support	Tickets, accommodation, travelling allowance for experts Experts' fees
Advocacy activities	Rental fees for facility to conduct round tables Coffee-break expenses Stationery
Monitoring and evaluation	Experts' fees Print and copy costs of interview forms, questionnaires, focus-group and in-depth interview protocols
Informational materials	Obtaining/printing/copying informational materials
Administrative costs	Costs related to broker's contracts on procurement and storage of naloxone

III. Monitoring and evaluation

It's important to monitor and evaluate overdose prevention programs for at least two reasons: to adjust the provision of services and streamline advocacy activities. ***Basic program monitoring*** requires keeping track of at least four indicators:

- dominating drugs and practices of use;
- number of distributed naloxone ampoules and number of people who received naloxon;
- number of people trained in first-aid skills to manage overdoses;
- number of naloxone-administration events in response to overdoses.

Document cases of naloxone administration

An important tool of monitoring overdose prevention programs is to record cases of naloxone administration and related circumstances. These real-life cases will not only provide you with statistics on the saved lives, but also deliver quality information about shifts at the drug scene, first-aid skills of drug users and character of response from medical services.

NOTE:

- A good time to put down stories of your clients about people they saved would be when they come back to request new ampoules. Ask them to describe in writing how they used the previous stock.
- Discuss these stories with outreach workers during weekly meetings with an outreach manager.

Monitor impact indicators

If you are just about to start an overdose prevention program, for advocacy purposes it should be enough to monitor one impact indicator: ***number of naloxone-administration events in response to overdoses***. This target alone will have a significant value when you promote the program among donors, decision makers and healthcare community.

Facts and figures collected in the process of project monitoring will be much more convincing if you had conducted a detailed situation assessment before the project (see the first section of the 'Strategic Issues' chapter) and continue tracking the same targets in the course of project implementation. [6]

ADDITIONAL INFORMATION:

- See Annex 2 for a list of indicators of existing pilot programs with examples from different countries.
- See Annex 3 for a list of indicators for in-depth monitoring of overdose prevention responses.
- Check out outcomes of an overdose prevention pilot in Kyrgyzstan in a publication by Zh. Bakirova: 'Reducing opioid overdose mortality among active drug users' (2010).
- S. Tsarev's research study 'Cost effectiveness of opiate-related overdose deaths: case study of a pilot project in the town of Chapayevsk, Samara region of Russia' (2011) which was published in NP 'ESVERO' educational material: 'The model of overdose prevention and case management' (A. Carpets and co-authors, 2011, p. 30-32)[6]

[6] Карпец, А., Белецкий, Л., Утяшева, Л., Нечаева Л., Царев, С. (2011). Модель профилактики и оказания комплексной помощи при передозировках психоактивными веществами, на основе опыта реализации проекта «Обеспечение устойчивости профилактики передозировок опиатами в Российской Федерации» в 2008–2011 гг. Москва: Некомерческое партнерство «ЭСВЕРО». Доступно на: http://esvero.ru/files/model_profilaktiky_web.pdf

Conclusion

Introducing overdose prevention services in the structure of your organization requires careful preparation, establishment of partnerships with other organization and consolidated effort of your project team. But your work will make an invaluable impact in the end.

Overdose prevention activities will be in demand among clients of your organization. Drug users are always interested to learn about first-aid techniques and naloxone administration to respond to an overdose.

Overdose prevention will be the most appreciated task for outreach workers, who will feel their importance and gladly be 'saviours' of other people.

Moreover, these initiatives will give you unique opportunities to engage in a dialogue with local authorities and strengthen position of your organization. Your efforts to save people's lives will be met with understanding and sympathy from officials; they will reduce the number of overdose emergency calls to ambulance services, and improve statistics on overdose deaths for law enforcement agencies. Like no other aspect of harm reduction strategies, the goal of overdose prevention is one of the heaviest arguments in favor of continuing and expanding harm reduction activities in general.

Most importantly, soon after you start preventing overdoses and gathering feedback from clients, you will see with your own eyes how effective and important your work actually is. Below you will find a real-life story sent by a project client from Tomsk (Russia). Please read it, and expect to get many more success stories of your own.

> «It's a shame I missed the first training: I need a consultation from a neurologist on naloxone. I saved three people already! One man gave himself a 'morning after' shot – and went all blue, even his ears. Stopped breathing. We slapped him on his face, tried rescue breathing and heart massage. It didn't work, so we put him face down in the snow and called an ambulance, and one of us went to get naloxone from an outreach worker at his home, as we didn't have any with us. We injected him one ampoule in the shoulder, his colour returned, and in three minutes he started talking. Ambulance never came. Then there was another friend who I helped: injected naloxone into his upper arm and watched him come back to his senses, but very slowly. So I injected another 1 ml, and he woke up immediately. Didn't even get the shakes. And another girl I saved with naloxone. So we see effect from it, and it's great! If notfor naloxone, they would all be dead.»

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Annexes

ANNEX 1.

Naloxone distribution models in six countries

1. HARM REDUCTION PROGRAMMES			
Place of distribution	**Country**	**Distribution scheme**	**Special requirements**
Fixed-site NEPs[7], outreach, medical facilities, rehabilitation centres, homes of drug users, harm reduction bus	Russia (Naberezhnye Chelny, Tomsk, St. Petersburg)	Purchased through medical facilities having medical/pharmaceutical license, or through pharmacies. Stored partly in medical facilities (AIDS Centre, infectious hospital, drug treatment centre), partly at the fixed-site NEP. Given out at NEP, through street and mobile outreach, in medical facilities, at homes of drug users.	Given out to IDUs or their relatives after special training or drug consultation in exchange for a prescription.
Fixed-site NEP	Russia (Elista)	Purchased and stored in AIDS Centre. Given out at NEP based in AIDS Centre.	Given out to IDUs or their relatives in exchange for a prescription.
Fixed-site NEPs	Ukraine (some of projects)	Purchased by projects at pharmaceutical companies or medicine distributors. Stored at NGO office facilities. Given out at fixed-site NEPs.	Given out after special training or drug consultation in exchange for a prescription.
Fixed-site NEPs and prison-based NEP	Kyrgyzstan	Purchased by the Republican Drug Treatment Centre, stored for most part in a pharmacies, distributed to NEPs at their request and then stored in their lockboxes. In the penal system it's distributed to the medical service that sends it along to NEP.	In fixed-site NEPs given out together with an original prescription, in the penal system – without a prescription.

[7] Needle exchange programs

Fixed-site NEPs, outreach, mini-groups of drug users	Georgia	Purchased by projects in pharmacies, stored in NGO facilities. Distributed among IDUs through fixed-site NEPs, outreach and mini-groups of drug users.	Given out after mini-training without a prescription.
2. SPECIALISED MEDICAL SERVICES AND PHARMACIES			
Place of distribution	**Country**	**Distribution scheme**	**Special requirements**
Drug treatment facility	Russia (Chapayevsk)	Purchased, stored and given out by drug treatment facility.	Given out to IDUs (mostly IDUs with low rehabilitation potential) or their relatives after training or drug consultation without a prescription.
	Ukraine (Simferopol)	A naloxone kit is given out (if the facility can purchase it), or just a prescription.	Given out or sold in pharmacy on prescription following individual drug counselling.
AIDS Centre	Kazakhstan ('Renaissance' project and Social bureau 'Doverie')	Purchased though the Global Health Research Centre in Central Asia and sent to the AIDS Centre, where it is stored and distributed. Clients get prescriptions (vouchers) to obtain naloxone at the AIDS Centre after training in the 'Renaissance' project or Social bureau 'Doverie', both having their offices based on the premises of the AIDS Centre.	A naloxone kit is given out in exchange for a voucher after a guidance session at the AIDS Centre. The 'Renaissance' project vouchers are valid only for project clients; Social bureau 'Doverie' vouchers are valid for all IDUs.
Intensive care units of district hospitals	Tajikistan (NGO 'Aiperon')	Purchased by the Global Fund upon agreement with Tajikistan's government on procurement of medicines and equipment as part of the harm reduction programme. Then distributed to the NGO free of charge. Stored in intensive care units, following a tripartite agreement between the NGO, GF and hospitals. Prescription is given out by social workers after mini-training at the fixed-site NEP.	Given out upon referral from NGO 'Aiperon'.
Pharmacies	Ukraine (some of the projects)	Purchased and stored in pharmacy.	Given out free of charge on prescription.
3. PROVIDING NALOXONE TO EMERGENCY SERVICES			
Place of distribution	**Country**	**Distribution scheme**	**Special requirements**
Ambulance service station, intensive care unit of the regional hospital	Tajikistan (NGO 'Volonter' ('Volunteer')	Purchased by the Central pharmacy upon agreement with NGO, stored at ambulance service station and intensive care unit of the regional hospital. Administered by doctors.	Not given out to IDUs.
Ambulance service station	Ukraine (some of the projects)	Purchased by NGO, distributed to ambulance service and stored there. Administered by doctors.	Not given out to IDUs.

ANNEX 2.

Outcomes of overdose prevention pilot projects[8]

IMPACT ON DRUG USERS AND THEIR FAMILIES	
Indicator	**Example**
Reducing frequency of overdoses and overdose mortality	**Georgia, Zugdidi:** At a work meeting with NGO 'Xenon', representatives from the ambulance service reported a sharp decrease in overdose emergency calls and overdose deaths. This decrease, they stated, was the result of naloxone distribution by the 'Xenon' project.
	Russia, Chapayevsk: As a result of project implementation, the number of official cases of overdose deaths in 2009 reduced twice compared to 2008 (from 37 to 18), while in 2010 only one fatal heroin overdose was registered.
	Russia, Naberezhnye Chelny: Through project activities, according to data from the drug treatment facility, the number of fatal overdoses reduced from 33 cases in 2007 to 4 cases in 2008. The number of overdose emergency calls reduced from 251 in 2008 to 113 within 9 months of 2009.
	Tajikistan, Khorog: Over the five years of NGO 'Volonter' project implementation (from 2006 to 2010), official overdose cases in Gorno-Badakhshan Autonomous Region were reduced 40-fold (from 245 in 2006 to 6 in 2010); officially recorded overdose fatalities reduced 13.5-fold: from 27 in 2006 to 2 in 2010.
	Tajikistan, Khatlon region: In one year of project implementation by NGO 'Aiperon' (2009-2010), a total number of overdoses in three discricts of the region reduced 4-fold, while the amount of fatal overdoses dropped 7-fold. Only in the first two months of 2011 four lives were saved.
Strengthening overdose-related first-aid skills	**Kyrgyzstan, Bishkek:** A survey among pilot project clients in Kyrgyzstan (2009) demonstrated an increase in the proportion of those who administered naloxone to manage an overdose (from 1% at baseline survey to 19% at repeated survey), as well as a decrease in the percentage of people who administered intravenous saline solutions (from 30% to 5% respectively).
Increasing demand for naloxone	**Russia, Chapayevsk and Tomsk:** In the course of the project, increase in the recurrent demand for naloxone was registered.
	Tajikistan, Khatlon region: Over three years of project activities, naloxone became a popular medicine among IDUs and co-dependent people (relatives, family members, etc.).
IMPACT ON COMMUNITY IN GENERAL	
Indicator	**Example**
Cost effectiveness	**Russia, Chapayevsk:** An annual economic impact of the given average of prevented fatal opiate overdoses in Chapayevsk is 9.8 times higher than costs of related prevention activities, which proves the project's cost-effectiveness and funding rationale.

[8] Original of this Annex was published in the report by J. Ataiants, A. Latypov and D. Ocheret 'Overdose: situation overview and response in 12 countries of Eastern Europe and Central Asia', 2011.

IMPACT ON HEALTHCARE WORKERS	
Indicator	**Example**
Introducing overdose prevention components into training curricula for healthcare staff	**Russia, Tomsk:** Training activities on overdose prevention for medical personnel in the city were approved by the Regional Healthcare Department and endorsed as part of the municipal training curriculum. **Ukraine, Simferopol:** The 'Harm Reduction' training section with its overdose prevention component was introduced into the study curriculum for mid-level healthcare workers.
Improved readiness of narcologists to prescribe naloxone	**Russia, NP 'ESVERO':** Due limited availability of naloxone at the final stages of Russian projects in 2010, trusted narcologists, at their own initiative, started prescribing naloxone to their patients who had suffered from an overdose.
More tolerant attitude to IDUs among healthcare workers	**Russia, Chapayevsk and Elista:** A more tolerant attitude towards IDUs from the part of ambulance staff was reported as one of naloxone training effects.
IMPACT ON HARM REDUCTION PROGRAMMES	
Indicator	**Example**
Scaling up positive image and trust towards harm reduction programmes, increasing the number of HR project clients	**Russia, NP 'ESVERO':** Both IDUs and regional authorities / medical facilities respond with higher levels of trust to harm reduction projects; there's an inflow of new clients to the projects. In Tomsk, the project received positive appraisals from medical personnel and the media. In Chapayevsk, the Federal Drug Control Service recognised the project's urgency and effectiveness. In Elista, project data were presented by the Minister of Health of the Kalmyk Republic at the meeting of the Committee against Drugs.

ANNEX 3.

Quantity and quality indicators of overdose prevention program effectiveness

QUANTITY INDICATORS	QUALITY INDICATORS
Number of naloxone administration events to manage an overdose *(surveys of outreach workers, volunteers, recurrent clients)*	Improved overdose-response first-aid skills among drug users and their relatives *(questionnaire among participants of trainings and consultations: pre and post evaluation, surveys of recurrent clients, records of success stories and saved lives)*
Increased coverage of new and recurrent project clients *(client registry book)*	Increased tolerance of ambulance service workers towards drug users *(surveys of project clients and ambulance staff, surveys of recurrent clients, records of success stories and saved lives)*
Increased demand for naloxone among drug users and their relatives *(naloxone distribution registry)*	Introducing overdose prevention into advanced training programs for healthcare workers
Reduced levels of overdose mortality in the city/area *(local statistics on overdose mortality and acute drug poisonings, surveys of outreach workers and volunteers)*	Improved readiness of narcologists to prescribe naloxone *(surveys of clients and narcologists at the initial and final stages of the project)*
Referring overdose project clients to medical services: drug treatment facilities, rehabilitation centres, TB and infectious hospitals, AIDS Centres *(outreach worker reports, database of medical services)*	
Cost effectiveness *(evaluation of project costs compared to averted harm from premature overdose mortality)*	