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# BARCELONA'S SAFER INJECTION FACILITY - EVA: A HARM REDUCTION PROGRAM LACKING OFFICIAL SUPPORT

**MANEL ANORO, ENRIQUE ILUNDAIN, OSCAR SANTISTEBAN**

*EVA – Espacio de Venopunción higiénica Asistida – is the first safe injection facility (SIF) in Barcelona, Spain. Started on September 12, 2001, it began as a “poor relative” of DAVE –Dispositivo Asistencial de Venopunción – in Madrid. EVA suffers from the general underfunding of its parent program, the Can Tunis outreach program, and it has no formal or material support from municipal authorities. This SIF can accommodate five drug injectors at one time and also operates as a mobile room for shelter, contact, and health education, addressing mainly those drug users who are at highest risk of overdose, HIV infection, violence, and death. The project offers consistent services provided by an array of health care and welfare professionals, and it is ready to intervene in overdose and/or crisis situations. To date, it has an excellent record in providing a safe environment for both its staff of health care professionals and its clients. Below the Can Tunis area in general, the outreach program, and EVA are described. The advantages, disadvantages, and what has been learned from working in this quarter of Barcelona with the injection drug using community is discussed. In closing, questions and proposals for future efforts are addressed.*

## **INTRODUCTION: ABOUT THE CAN TUNIS QUARTER OF BARCELONA**

The quarter of Can Tunis lies in Barcelona, among the cemetery of Montjuïc, a sprawling industrial harbor area, a coastal speedway, and the industrial area of Zona Franca. It is a “no-man’s land,” inhabited by homeless people living in freight containers and shanty dwellings and by gypsies living in a rundown public housing complex on the margins of the industrial harbor area. It was originally built for the

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rehousing of Gitano (Romani gypsy families then living in slums), but was abandoned over the years, especially to drug dealers. Beginning in the 1980s, the area turned into one of the worst redoubts of marginality in Barcelona and Catalonia. Can Tunis is a failed experiment in social integration. In fact, until recently it was named in city maps as the “experimental housing project of Can Tunis.”

Indeed, by the time this issue of the Journal of Drug Issues is published, the Can Tunis quarter may be demolished, and the outreach program and the SIF may be closed. If this happens, clients will be scattered throughout the larger metropolitan area, losing needed social and health care services with no viable alternatives.

### **THE CAN TUNIS OUTREACH PROGRAM**

#### *TARGET POPULATION*

From July 2001 to December 2002, 1,677 different clients were registered (Associació Benestar i Desenvolupament [ABD], 2002 and 2003). Of them, 82.4% were men, 17.3% were women, and 0.3% were transsexuals. Their average age is 32, although there is usually a shift to younger clients during the spring and summer; there is constant initiation of youths to injecting drug use in the area.

Sixty-seven percent of users are Spanish citizens; 14.5% are citizens from the rest of the European Community; 9% are from non-EC European countries; 8% are migrants from Northern Africa (Maghreb countries); and the remaining 1.7% of clients come from Africa and Latin America. An estimated 55% to 60% are homeless or dwelling in unstable living situations. Sixty to 70% of the clients have little or no access to social and health care services.

The following is a description of the typical drug users who inhabit the Can Tunis area and are clients of the program (for a further description see Ilundain, 2002).

#### *HOMELESS PEOPLE*

There are about 100 homeless dwellers in the Can Tunis area at any given time. Their hustling occupations vary according to the following categories:

- *chuteros*: street vendors of needles and syringes, most of which are obtained from the needle exchange program (NEP) that EVA operates
- *punteros*: street vendors of drugs in small doses and of injection equipment – commissioned by dealers or on their own
- *machacas*: persons who work in the houses of dealers – they usually take part in preparing the “bags” in which drugs are sold; they also sell drugs out of drug houses, and clean and

maintain the premises – always in exchange for drugs and a precarious place to rest

- “cotton bandits” and beggars, much like those portrayed by Philippe Bourgois (1999) in San Francisco
- street prostitutes, working in the Can Tunis quarter.

The health and welfare of these people are vulnerable because their lifestyles and circumstances rarely allow access to services, or their work involves many risks and demands. Helping them requires flexible services that can adapt to the constraints of their lives, and providing any kind of case management is a complicated task.

There are also large numbers of homeless people who dwell in other areas of Barcelona, mainly downtown (Raval) and in the Gràcia district. There is a constant but shifting presence of “travelers,” squatters, and “punkies” from other European countries, Italians being the most visible.

#### *DAILY VISITORS*

The greater number of clients coming to EVA and the SIF are people who come from other areas of Barcelona (e.g., residents from Zona Franca, Casc Antic, Sants, etc.), and from other cities in the larger metropolitan area in the state of Catalonia. Many of them are also regular clients of methadone programs, and many of them have stable jobs, families, and social networks. Few are involved in criminal activities.

Most daily visitors are attracted to Can Tunis by the opportunity to buy small and inexpensive doses. Nevertheless, this simple “budgetary” explanation is not sufficient to explain why some people come from long distances. There is the commonly accepted idea about the “hook of Can Tunis,” i.e., the notion that buying and using drugs, meeting peers, and hustling is easier here than anywhere else in Barcelona. There is a feeling of illicit freedom associated with the area.

Visitors to Can Tunis typically arrive by bus line #38, which has become infamous because of the constant presence of homeless drug using passengers. Three years ago the bus also became fare-free when the news media reported that many drug users were being hit by cars and killed while walking on the speedway because they could not afford a ticket.

#### *WEEKEND AND SPORADIC VISITORS*

On weekends, there is an increased number of visitors from other neighborhoods and towns in addition to the customary clients to the quarter. Some weekend and sporadic visitors come to the quarter because of the following:

- tourists: they have time to spare, and want to use it meeting new people like themselves
- budgetary: they just want to buy and use cheap drugs
- business: they want to buy cheap drugs to resell them in other towns
- binging: those who come in rows from other towns hell-bent on getting “blown away”
- preoffice: weekend dance drug users who “chase” brown heroin to help them sleep in order to get ready to go back to work, school, or university on Mondays.

Sporadic visitors include the following:

- detoxified people who are relapsing
- people just getting out of prison
- people undergoing some kind of personal crises (e.g., being left by a spouse or lover, or having lost a loved person, etc.)
- people who are mentally ill.

Considering such traits, sporadic visitors face a higher risk for overdoses, assaults, and accidents. Also, because of personal conflicts, sporadic visitors are more likely to exhibit suicidal or parasuicidal characteristics.

### PROGRAM'S OPERATIONS

The ordinary operation of the program consists of the staff of health professionals offering several different types of social and health services to drug users who show up in the zone. The Can Tunis program is supported by a public services contract between the Municipal Drug Plan of Barcelona and ABD (*Associació Benestar i Desenvolupament* [Association for Welfare and Development]). A team of 14 professionals and six volunteers maintains a mobile operation consisting of a very large bus, a smaller truck, and a shuttle van. The program operates six hours a day, from 9:00 a.m. to 3:00 p.m. every day of the year. The program has informal agreements with the district's national police not to interfere with harm reduction activities or arrest persons entering or leaving the facility. The agreement is honored most of the time, but not by the local police. They have been known to harass and intimidate the clients at random, which discourages clients from coming to the program for help. Formal agreements are in place with the nearest primary health care center in the Zona Franca quarter to assist clients who have a national health insurance card; however, few of EVA's clients have this insurance coverage.

## EVA

The principal client contact area is the needle exchange program (NEP). Clients are registered and entered into the database, which is regularly updated. Each client is given a code number so they do not need to disclose personal information every time they attend the NEP; staff members consult the NEP's master list if there is doubt as to a client's identity. From the NEP, clients can be referred to other areas of the program for services, such as the following:

### *SOCIAL TEAM (THREE SOCIAL WORKERS, AN EDUCATOR, VOLUNTEERS)*

- Psychosocial assessment and follow-up
- Documentation procedures
- Information, referrals and accompanying clients to other healthcare and welfare facilities
- Occupational activities, such as sweeps of the area to pick up debris, discarded injection materials, and/or providing specific educational workshops
- Dispensing food
- Dispensing clothes.

### *SANITARY TEAM (A PHYSICIAN, THREE NURSES, A NURSING AUXILIARY)*

#### Assistance:

- Basic health care, of wounds, common diseases, and problems related to both drug use and/or homelessness
- Elementary medical tests: blood, urine, and pregnancy
- Emergency assistance in crises, overdoses and accidents
- Assessing the need for referrals to other health care facilities (hospitals, PHC, medical specialties).

#### Prevention:

- Health education – group workshops, individualized messages, and tips
- Special educational services such as training in first aid for drug users, crisis intervention, response to overdoses, basic CPR, and use of naloxone
- Vaccinations (HBV, tetanus, influenza, pneumococcus)
- Hygienic medically assisted injection room (EVA), which provides a safe space and sterile equipment for injecting preobtained drugs, along with risk prevention education.

**TABLE 1**  
**AVERAGE PERCENTAGES FOR INFIRMARY ACTIVITIES, 2001-2002**

<b>Activities</b>	<b>%</b>
Cures: initial/follow-up	35.0
Physician/nurse consulting	14.7
Podiatry problems	14.2
Phlebitis/allergic reactions to drugs	7.8
Health education, individual interventions	6.4
Opiate overdoses	4.7
Odontology problems	4.5
Tests and vaccinations	3.0
Abscess drainage	2.6
Deparasitations	2.4
Trauma/aggression/suicide attempt	2.3
Demands for detoxification	1.9
Acute reactions to cocaine	0.5
 <b>Other data</b>	
Mean number of daily activities:	11
Use of medicines:	41% of cases

From both the social and sanitary teams, not only in situ solutions for problems, but also health care and welfare services are sought. The NEP team and volunteers participate in different ways with the social and sanitary teams. The NEP team identifies and refers clients after the basic contacts; the volunteers help in the allotment of food and clothes, or in providing occupational activities.

Infirmary clients are 80% male and 20% female. Their average age is 31 year old. Sixty-five percent live in the street or in precarious living circumstances, and 71% do not have proper documents that enable them to access health care facilities – a figure that shows many of the failings of the Spanish neo-liberal economy that have developed over time.

Health-related problems among the clients correspond with those of ordinary drug users throughout Spain: 31% are HIV+, 22% have hepatitis B, and 70% are HCV+. A third of the infirmary clients have been incorrectly vaccinated for tetanus, and half have been incorrectly vaccinated for hepatitis B. At least 15% have noninfectious chronic conditions, mostly mental disorders.

Among primary care services, approximately 50% of the clients have health problems related to hustling for drugs; approximately 40% of these problems are related to unhygienic injection practices that increase during the summertime, when people tend to abandon methadone treatment and start reusing illegal drugs (e.g., for overdoses see Figure 1).

According to the program's overdose records (January 2001 to March 2003), the staff has assisted 377 cases, 52% of which involved respiratory arrest. Nevertheless, no overdose deaths have occurred in the larger community or in the safer injection facility during office hours. Twelve and one-half percent of the cases involved acute reactions to cocaine, which are characterized by anxiety, distress, panic, arrhythmias, convulsions, and neurological symptoms. This problem appears to be increasing.

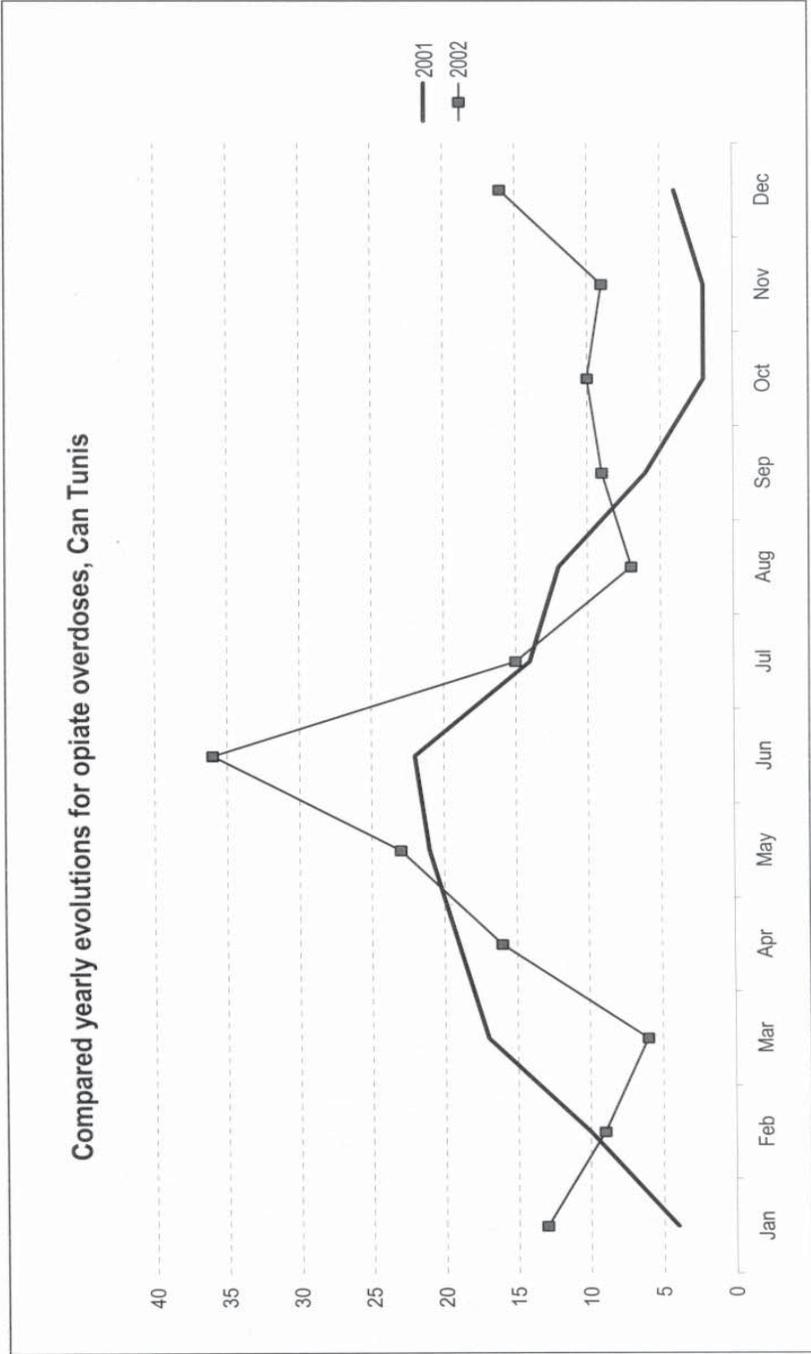
Eighty percent of overdose interventions have been carried out by nurses, and the remainder with the participation of the physician and/or nonmedically trained staff. Only 9% of overdose cases have required the staff to call for an ambulance. Abstinence, which reduces a person's drug tolerance level, is the only statistically significant risk factor for severe overdoses – those that present respiratory arrest – in this study of Can Tunis (Anoro et al., unpublished). Each day a person remains abstinent before getting high again increases his chances of severe overdose by 1.3%. In addition, mixing substances, including alcohol, is related statistically to overdoses without respiratory arrest.

The availability of naloxone, which staff and clients can use, has significantly helped to reduce mortality rates due to overdose. Staff members administer between 0.4 to 0.8 mg. of naloxone intravenously in overdose cases. Clients prefer rather to administer 0.4 mg intramuscular or intravenous doses to prevent withdrawal but do not hesitate to use a higher dose in severe cases. In all cases, even when naloxone is the key therapeutic weapon, respiratory support must be the first step and must be continued until the person appears to be out of danger.

Concerning risk reduction, the NEP is the pillar of the program of services. Normally a team of three staff members operate the NEP and are devoted to distributing injection equipment and harm reduction materials and to recovering used equipment. The NEP attracts approximately 200 clients and distributes over 2,000 needle and syringe kits daily – although these figures increase during the summer when Barcelona is inundated with tourists and travelers. Although it takes time and effort to educate clients, the NEP is now recovering approximately 90% of the needles and syringes distributed.

Other paraphernalia provided by the program include alcohol swabs and sterile water; aluminum foil for chasers and freebase smokers; rubber hoses (tourniquets) to raise veins; citric acid to prepare brown heroin for injection; and steel bowls for

**FIGURE 1**  
**COMPARED YEARLY EVOLUTIONS FOR OPIATE OVERDOSES, CAN TUNIS (DAILY, (9:00 A.M. TO 3:00 P.M.))**



## EVA

preparing powder solutions properly. Also, increasing the delivery of condoms is the most urgent risk reduction effort currently being pursued, as there has been a marked increase in the level of street prostitution in the surroundings of the coastal speedway over the last 15 months.

One of the most important efforts of the overall program is the promotion of appropriate relationships among clients and staff. The staff works in the daily delivery of services and in weekly team meetings to revise the program's regulations and strategies, in an effort to normalize client-staff relationships as much as possible. The staff seeks to relate to its clients as normal adults and peers. At the same time, staff members are concerned with their own self-protective measures, especially conflict management with clients. They face conflicts every day and often rely on common sense to resolve them. Because a measure of confidence has been achieved in working with clients and because clients support the program, staff members involve clients in resolving conflicts. So far this effort has been quite successful: clients are usually able to remind other clients of the basic rules that govern good relationships.

### **EVA – ESPACIO DE VENOPUNCIÓN HIGIÉNICA ASISTIDA: OUR MEDICALLY ASSISTED INJECTION ROOM**

#### *BACKGROUND AND HISTORY*

There was no serious attempt to implement an SIF in Barcelona prior to EVA in Can Tunis. At the beginning of 2000, and in light of Madrid's SIF called DAVE (Díaz, 2001), the time was right to open one in Barcelona. However, just prior to opening the first facility, stories then appearing in the media alarmed the public and provoked a protest in the Sants district. This prompted Barcelona's mayor to withdraw his support, and efforts were temporarily shelved.

First, the EVA facility differs from Madrid's DAVE in several important ways. The staff works only part-time and – importantly – they lack the political, official, and community support that DAVE enjoys. The Madrid injection facility operates 24 hours a day, every day of the year, and has a staff of approximately 50 people. The staff works in five shifts with teams comprised of about nine people. DAVE has a hostel and kitchen facility that was added a year ago, which offers clients breakfast, lunch, and dinner, and there is a mobile methadone program that clients can use in the area. DAVE's budget is, thus, about nine times larger than ours (Díaz, 2001). Nevertheless, EVA is similar to DAVE in that it is located in an isolated area of Barcelona, a location where drug users exist quite apart from mainstream society and where people are “free” to use drugs because nobody cares, including the police.

By the middle of 2001, approximately 40% of EVA's health care activities were directly related to dealing with injection problems, with little or no opportunity to address primary health care issues (ABD, 2002, 2003; Anoro, Ilundain, Prieto, Rodriguez, & Rosell, 2002). These figures, together with the observed large numbers of drug users coming to the area, led to the implementation of an SIF as the most direct and immediate way achieve some tangible harm reduction results "on the front line."

Prior to 2000, Barcelona's municipality had not initiated any new prevention projects for some time. There had been no innovative efforts or new ideas for years as municipal leaders chose to do nothing.

Second, the "community" of Can Tunis to which drug users were increasingly drawn, was rather unique. On the one hand, the drug dealers of the quarter, all of them Gitano, reluctantly tolerated concerns about protecting drug users' health. On the other hand, most drug users are *Payos* (non-Gitano) like ourselves, and the program staff exists somewhere in between these groups. While EVA tries not to interfere with the dealers' business interests, doing so engenders criticism and conflicts with other local residents; e.g., the program is generally associated with the discarded needles in the area. The result is that intercultural and intergroup dialogue is always difficult, and widespread misunderstanding adds to the blight of the overall area. Residents from the rest of the district oppose both drug users and Gitano drug dealers.

It would be much easier if this program enjoyed visible support from municipal officials. Barring that, the staff must expend considerable effort to maintain a dialogue with residents and cultivate whatever support is possible on a day-to-day basis.

Third, there is no consistent budget on which to depend from one funding period to another. The NGO (nongovernmental organization) *Associació Benestar i Desenvolupament* runs the general social and health care program in Can Tunis, and all funding comes from public, municipal drug plan budgets. The general budget is inadequate to sustain the usual activities of the overall Can Tunis program. Consequently, maintaining EVA is difficult; the agency stretches the limited resources of the NGO and exists on residual funds. The Municipality of Barcelona does not contribute any specific funding or any facility for EVA's efforts: the organization is funded primarily through private donations. Despite this, municipal officials encourage the EVA staff to "keep up the good work" and to continue the project. They express concern for these efforts but maintain that they cannot offer support, neither with funding nor with community dialogue and representation to local residents. For example, to date, no news about the facility has ever been released to the media by municipal authorities. The authors are not aware of any other social and health program that must operate under these conditions. Thus, EVA faces a

deplorable organizational situation: they enjoy no direct fiscal support, have no institutional support, no community base, and no prior comparable intervention references.

Despite these problems, the team perseveres and has designed and implemented a unique project. In order to accomplish this, the organization has to do more than minimize costs – it operates without any regular funding, and it is dependent on volunteer staff from other NGO programs. EVA's work is done quietly, not raising suspicions because, if the public knew of the SIF's fragility, it would probably be shut down immediately. The EVA program actually started up in a tent that was set up daily in September 2001. The tent had a rubber floor and accommodated three drug users injecting at any given time. Each user was provided a folding chair, a little table for setting up his or her equipment, and sterile needles and other injection paraphernalia. Only a single member of the health care team was present at any given time for monitoring and providing assistance, providing injection material, settling disputes and maintaining order, providing health education, and keeping the tent reasonably clean. The tent was erected and taken down every afternoon, usually with the help of clients.

Bad weather affected the operation of the room and made it difficult to keep it clean. In addition, erecting and taking down the tent each day proved to be time consuming. The tent, once new, soon wore out, and cleaning it became increasingly more difficult. Most importantly, there was no access to electricity or running water, and water had to be trucked in.

Despite these limitations, the tent was well received by clients and was used for four months. Clients said they were grateful for a shelter from the weather. The hygiene that was offered, though limited, was far better than no hygiene at all, allowing clients to inject in a safe and quiet environment. Clients largely kept their complaints about inconveniences (such as not being able to shoot up with friends) and other concerns (such as claiming someone owed them a cigarette, money, etc.) to themselves. The clients realized that the staff was not in a position to allow drug users to settle their personal scores in the little tent.

It is important to note that the tent proved to be an acid test for project the health staff. Even when the staff was accustomed to a very direct and friendly relationship with most clients, the work did not interfere in their drug habits or related lifeways. The objective was to help clients live their lives more safely. Most other staff members had no personal information about, or specific interest in, the details of illicit drug use and/or dealing, nor did they take part in clients' quarrels, fights, and interpersonal problems. Their use of the tent, however, placed the staff in a difficult position. In order to maintain the peace and keep the tent relatively clean, new rules and expectations were developed to minimize conflicts among clients. Because

there were no physical barriers (doors or walls) to shield the staff from clients' interactions, they too often had to restrain disruptive clients. Doing so proved problematic, however, as this was at odds with the nonjudgmental attitude the staff had associated with harm reduction outreach programs. Having to set and enforce rules of conduct and place demands on clients was the most difficult issue confronted in running the tent operation. Ultimately, it proved to be a major factor that inspired, for better or for worse, the shift to the new EVA, which is describe below.

### **THE RENEWAL OF EVA**

Early in 2002, the it became necessary to move out of the tent because it was scarcely functional, and the work required to maintain it was causing staff burnout. Obtaining a building was not an option, however, given local political conditions. Even if a proper building could be found, the staff would not have been able to guarantee its security during off hours in the Can Tunis quarter.

As an alternative, project organizers obtained a large new bus for the program, a vehicle that enabled the inauguration of a new EVA. All social and health care activities were relocated on the bus, and the SIF was moved from the tent into an old van. The van had previously been used for street distribution of methadone in Barcelona and was handed down to the Can Tunis program in November of 2000. The provision of the van enabled EVA to move the SIF at no cost (other than gas and maintenance), and Can Tunis residents who were already familiar with the vehicle accepted it without question. The van facility requires daily maintenance, such as loading it with water and supplies. It is also in poor repair and minimally passes its annual inspection. Despite these drawbacks, the van has more room than the tent, is easier to keep clean and maintain (no setting up and taking down everyday), and provides a more stable environment.

### **THE NEW EVA'S DAILY OPERATION**

The van-based injection room is integrated with the NEP and the SIF, and together there are several points of entry: the front door for the driver, one where the NEP staff receives clients, and two rear doors for accessing EVA, the SIF.

The van is driven to the Can Tunis quarter every morning to a general parking area and operates for four hours a day. These limited hours of operation are necessary because the organization has only one driver for both vehicles (the bus and the van). EVA consists of a single room in the van containing five small tables and chairs, allowing five users to inject at one time; there are also containers present to hold discarded needles and syringes. One health professional stays in the SIF at all times. The EVA is equipped with the following resources:

## EVA

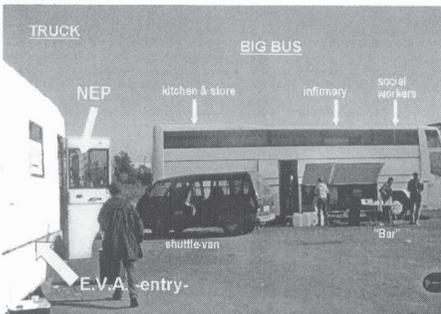
- Injection materials
- Sterile syringes and needles
- Distilled water for injection
- Alcohol swabs
- Citric acid (for cooking brown heroin)
- Nonsterile paper, rubber strips, filters, and scissors
- Emergency items to treat overdoses to heroin or cocaine, or epileptic fits
- Materials for cleansing the room and furniture.

Drug users access EVA through the entrance doors, provide their code numbers to the registry clerk, and then receive the injection materials they need to prepare a clean shot. They must bring their own drugs to EVA, and drug dealing on or around the SIF is prohibited. Time limits on the use of EVA are determined by the presence of other users waiting to access the room; in general clients are limited to about an hour. Once users finish injecting, the staff clean the table with a bleach solution and dispose of the injection materials. Rules for operation and good fellowship are posted: e.g., no smoking of tobacco or “chasing the dragon”; no drug dealing on the premises; no quarreling among clients; no violence or threats of violence; and no disturbing other clients. To prevent accidental needle sticks and exposure to clients’ blood, clients are not permitted to walk around the room (van) while preparing their shot or injecting. Clients who break these rules are reprimanded by restricting their access to the facility, or by banning them completely in extreme cases. As described above, these rules have evolved over time, based on practical experience. Many of them were developed in consultation and negotiation with the drug users themselves.

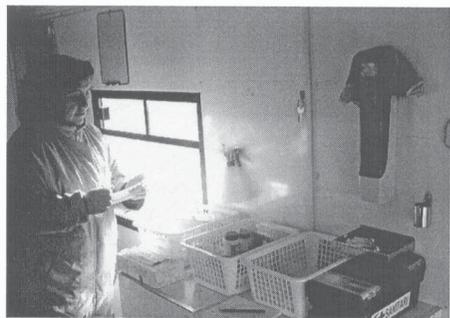
The staff will assist users in some special circumstances: they will, for example, help them find or raise a vein if they cannot do so by themselves. Clients frequently ask staff to “fix” them once they have prepared their own syringe, and, certain circumstances, this occurs. However, most often clients are taught how to do things on their own. This limited staff assistance should not be confused with encouraging clients to continue their drug use; a client’s unsuccessful attempt to find a vein while suffering withdrawal is a high-risk situation that must be taken seriously, and project staff also try to remind clients of the existence of alternatives to injection, such as chasing the dragon or other safer routes of administration. Clients are also encouraged to enroll in detoxification and substitution programs. The constant aim of EVA staff is harm reduction – to help active drug users take better care of themselves. They are not present to facilitate drug use in general, or drug injection in particular. It is hoped that the program staff can provide clients with a sobering assessment of the real problems and risks they face in relation to their drug use.



Two pictures of the truck that contains the EVA – safer injection room.



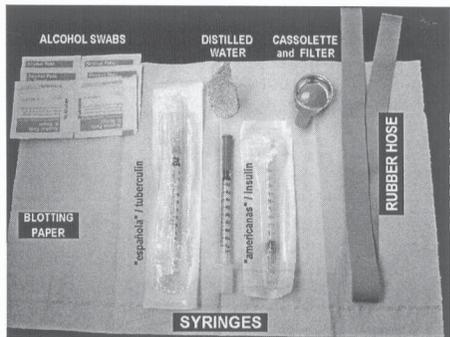
Panoramic appearance of our service.



Rosa Rodriguez, RN, arranging EVA for the daily shift.



Users of EVA, in an ordinary operation day.



The injection equipment provided to EVA's clients.

Clients often need to be reminded of their condition – for example, weight loss, abscesses, or jaundice – through messages expressed out of concern for their health and well being.

**ANALYSIS OF EVA'S ACTIVITIES AND OUTCOMES**

The following offers a candid analysis of the positive and negative characteristics of the SIF, many of which are specific to this drug scene, the local policies and politics of the Can Tunis area, and the operation of the overall program. Since many of the program's limitations or achievements are unique to its own particular situation, the authors do not try to generalize about (or make them valid for) other programs, places and social circumstances.

*ADVANTAGES*

EVA provides a fundamental space of shelter for the drug users in the Can Tunis area who choose to use it. The SIF is a place of relief from a high-risk environment – physically, mentally, emotionally, and socially. As a “stress-free, risk reduction, hygienic room” (as described in Stöver, 2002), the SIF helps minimize drug-related damage and somewhat enhances drugs users' sense of competence in self-care. In coming to the room, drug users are making an effort to take care of themselves; they are seeking help.

For the staff, this SIF is a place to connect with this high-risk population. Sustaining contact and liaison with drug injectors at high risk in one of the most alienating areas in the larger metropolitan area and creating pathways for the “normalization” of people's drug use are the program's most important goals. The SIF also gives us an opportunity to stress basic hygiene and health education to a population with problems related to precarious social situations. Thus, EVA is not meant to be merely “bait” to attract drug users; it provides drug users the opportunity to protect their health and to see that risk reduction is a real option. The SIF is clearly accessible and in the heart of the drug scene, where it is most needed. EVA cannot be improved upon in this respect.

EVA's mobility (since it exists inside of a van) also allows us to move as the drug scene moves. Its mobility enhances the safety of both clients and professionals. The only way to improve it would be to stay open longer hours, especially during evenings and nights.

EVA facilitates prevention of diseases and injuries and provides for immediate care in cases of acute medical and drug-related problems, especially overdoses. Our clients are under constant supervision by a health professional acting under strict protocols for CPR (basic and advanced) and naloxone use. EVA has, in fact, served as a mechanism for recruiting and training users in basic CPR, and some are allowed to take naloxone with them out into the community. This “take-away” program that relies on active drug users to administer naloxone and CPR in the community is estimated to have reduced overdose mortality by one third in the Can Tunis quarter between the years 2000 and 2001.

In terms of contributing to the improvement of public spaces and order – a main concern in many communities in Western Europe, especially Germany (Stöver, 2002) – EVA has, if anything, reduced uncontrolled congregations of drug users and visible conflicts in the Can Tunis area. In fact, most of EVA's clients are the "use-and-go" type: people who previously spent considerable time looking for a safe injection opportunity can now access EVA rather quickly, inject without fear of a disturbance or of being assaulted, and then move on. This reduces drug users congregating, trying to help one another.

EVA, as part of the social and health care program for Can Tunis, is a means of direct access to drug treatment centers, to general welfare and health services, and to other outreach programs. Also, EVA's clients, over time, get accustomed to injecting in a safer, more quiet and hygienic environment. Helping people calm down, take fewer risks, and get into a daily habit of taking better care of themselves is great progress for such an alienated population. Even when results come slowly, providing some access to care and some tools for self-care pays health dividends that become apparent rather readily, as it has among staff. Some clients make remarkable improvements in their physical and mental health.

#### *DISADVANTAGES*

##### *MATERIAL SCARCITIES*

When EVA's van is not running, the continuity of its harm reduction program is interrupted, undermining the improvement in health behaviors that clients are working towards. Both the bus and the van lack adequate means for facilitating personal hygiene (taking showers, washing up, etc.), and for keeping the vehicles clean. The lack of electricity and electric lights, air conditioning, and refrigeration for medicines and vaccines further weakens these health care efforts and the operation of the SIF. The lack of adequate water connections and the difficulty of disposing of the program's contaminated water and garbage make it difficult to maintain hygiene for the overall program. The actual injection room is inadequate in terms of space, availability, and resources, and these tight quarters do not contribute to everyone's safety. Finally, the van does not provide a very stable platform for injecting, and it is far from comfortable and/or sufficiently quiet and orderly.

##### *TIMETABLE LIMITATIONS*

Both staff and clients continuously face enormous health risks in Can Tunis. During its six hours of daily operation, the medical, outreach, and counseling program cannot provide adequate intervention; EVA's timetable – four hours a day, Monday through Friday – is even shorter. These concerns prompted staff to initiate a take-

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away naloxone program and basic CPR training for drug users (the overdose mortality rate before this action was taken was one incident every three days). The prevention and health care coverage of the overall program is, thus, too limited to meet the needs of the users in the community.

### *LACK OF SOCIAL AND OFFICIAL SUPPORT*

(1) In combination, these difficulties have several practical consequences. They threaten the continued existence of the program, since its services are only offered sporadically and may be terminated at any time.

(2) Without such social and political support, the program is basically a clandestine operation, only minimally supervised by authorities and generally unacknowledged. Consequently, the quality and efficacy of client assistance is solely a product of the good will and skills of the staff of professionals and volunteers. These clients do not have access to the level of health care enjoyed by other citizens of Barcelona.

(3) There are no means for clients to register a complaint about program services (should they find them lacking), and any quarrel or grievance must be resolved at the interpersonal level between clients and program staff. This leaves the staff, regardless of how well meaning they are, in positions of omnipotence and unaccountability.

(4) Finally, the absence of renewable funding negatively impacts the quality of the services rendered, though many clients express gratitude for the help receive.

### *SPECIFIC SIF OPERATION PROBLEMS AND RISKS*

EVA's restricted physical space undermines confidentiality and the resolution of conflicts and sensitive problems. Drug effects – especially those related to cocaine injection – distort normal adult relationships and coping skills. EVA team members also lack regular psychological supervision and backup counseling services to deal with burnout and to help them cope with their own frustrations, psychological problems, and stress.

## **FURTHER PROPOSALS AND LESSONS LEARNED FROM TRIAL AND ERROR**

The accumulated evidence of some 18 months has revealed the advantages and disadvantages of the overall EVA program. While acknowledging that the program has not been formally evaluated, there may be some value in sharing experiences with others who might be considering the implementation of a similar effort.

First, official and institutional local/regional support is crucial for facilities of this nature. Any safer injection facility needs continual support to guarantee its viability, quality of service (e.g., assuring the civil rights of clients, sustaining professional

orientations), and job stability (employee precariousness has direct repercussions on the daily operations of the program).

Second, all public health interventions, before they are implemented, should be preceded by adequate needs assessments and thoroughly considered project designs. The Can Tunis program developed over time without a needs assessment, and the elaboration of all of the program's projects has always occurred without adequate planning for sustainability. The basis upon which the program began lacked empirical justification, and many of its policies were based on untested assumptions. For example, the program's morning timetable was due to the original, smaller outreach team's fear of staying in the area during the most dangerous hours – evening and night. Many of these fears have dissipated, but the morning schedule remains. However, morning hours are critical for at-risk drug users because of withdrawal symptoms, and, thus, there is justification morning services not originally foresee. There are also critical needs to be met during the rest of the day, even when there is less availability of ambulances and police surveillance in the area to guarantee the safety of the staff and intervention. Problems such as these reveal the lack of rigor of the program's policies and infrastructural supports, even though in the eyes of many the program appears to be well organized.

Such programs would also benefit from continuous needs assessments. Rapid assessment procedures (e.g., Stimson, Fitch, & Rhodes, 1998) and similar methodological practices would be helpful to guide and renew the program. Today, it is commonly accepted that empirical insights made by field workers can be extremely helpful and important for program planning and evaluation. It is also necessary to take into account the knowledge and experience of drug users and ex-users themselves and for clients to play active roles in the design and operation of the interventions. The literature (e.g., Fry, 1999) clearly indicates the need to consider drug users' needs and expectations in relation to the implementation of an SIF.

Third, a program such as EVA must have a reasonable budget for various phases of its implementation and development. Only public administrations and NGOs should ever assume nonprofit investments of this nature; in practice, only public funds can support nonprofit welfare and health care facilities such as an SIF. EVA is the product of the staff's labor and sacrifice, and this has never been acknowledged by any municipal authority.

Fourthly, rejection by the larger community limits the development of any drug service, especially an SIF. This makes it imperative that the program staff works harder to garner community support and overcome reluctance among neighbors, by-standers, official authorities, the mass media, and the public. Doing so, in turn, translates into more economic and institutional support, greater willingness among

authorities to mediate among professionals and the community, and greater basis upon which disagreements can be mediated and problems solved. Without garnering community support, vicious circles develop – a community opposing a poorly operated program results in a program that operates poorly because of community opposition. This is a difficult cycle to break, and only those in positions of authority who are prepared to exercise leadership and make valiant decisions can reverse such downward cycles. Hiding a program's problems for fear of criticism by others, as experienced in Barcelona, condemns a program and the drugs policies upon which it is based to a precariousness existence and to the lack of a serious public health mission. Only programs that are transparent in their operations and policies, and open to social dialogue, can dissolve community fears; the leadership of officials, combined with a dedicated staff, is crucial for all of this to happen. A good example of this is the official recognition that the needle exchange program enjoys and the community support it receives as a valuable public health service.

Fifth, illicit drug use generates problems in many areas. It impacts places like Can Tunis and its marginal population and poses extreme burdens to society, including health care crises and emergencies, abandoned families, and increased crime. Therefore, it is essential that programs such as EVA become part of locally coordinated and diversified social and health care networks that also address nutrition, hygiene, child care, mental health, housing, documentation, employment, education, job training, and police services – preferably under the supervision of public authorities. The problem in Barcelona (and elsewhere in Spain) is that public administrations ignore these issues and defer to private charities and NGOs, further fragmenting intervention strategies. Unfortunately, most professionals in the larger health and welfare network in Barcelona are not associated or coordinated with one another, much less with programs such as EVA.

Sixth, providing services such as safer injection facilities should be of the highest importance, given their demonstrated efficacy and the opportunity for intervention. In addition, public attention should be directed to their cost effectiveness, their role in reducing societal conflict and harm, and their contribution to the “normalization” of enormous social problems. The promotion of public understanding about SIFs is the responsibility of harm reduction professionals and clients, as well as public authorities who design policies and have an interest in promoting the common good.

Seventh, the need for outreach to drug users has been apparent since the 1970s and 1980s, for reducing the spread of HIV and HCV. Low-threshold facilities that provide maximum access for a diverse group of drug users are the most important feature of successful harm reduction programs. For success to be possible, an SIF must be placed in close proximity to the locales where drug users live and visit regularly, and drug users must perceive using an SIF as a natural option. On one

hand, extended and stable drug scenes could benefit from the availability of comprehensive, well-funded harm reduction centers that offer complete, well-trained, and diversified services and assistance administered by professionals in collaboration with street-savvy health educators. On the other hand, small and/or shifting drug scenes can best benefit from mobile outreach programs (and SIFs) that are relatively inexpensive to operate and have highly efficient “back-pack” services. However, their staff must have high levels of back-up assistance and be managed by sensitive supervisors who understand the stress and trauma of working in high-risk scenes. Thus, the latter are probably best sponsored by smaller organizations, public or private.

Eighth, cumulative experience has taught that particular concern should be given to the rules and norms that govern a service like EVA. The program’s rules of operation and norms for fostering good fellowship among clients and professionals have evolved over time. While staff members have become more seasoned and flexible, they have grown more committed to enforcing certain basic rules of operation. It would not be wise for us to suggest concrete protocols for other facilities, since circumstances vary so much from one city and drug scene to another. Even so, some guidelines may be outlined here:

- Program rules must be the product of continuous consensus and negotiation among staff and clients as much as possible. Too often, staff members have found themselves prone to rigidity for the sake of their own comfort, and this can damage clients’ acceptance and use of the facility.
- Rules for staff must be firm enough to prevent harm (needle sticks or exposure to conflicts and exploitation by clients), together with enough flexibility to encourage staff to deal with diverse clients with different problems. Professional and personal differences must be regulated by high levels of staff consensus and negotiation when at work, while leaving plenty of room for individual staff members to deal with the twin problems of burnout and job calcification.
- All rules must be constantly open to review, and all staff complaints taken seriously. Staff must be encouraged to be open to advice from workmates and clients and should not fear recrimination because they offer criticisms or make suggestions for improvement.
- All client penalties or restrictions in their access to services must be upon by the whole team and, subsequently, supported

en bloc by everyone on staff. If not, decision making will be ill fated.

Ninth, workers of an SIF or an NEP usually face burnout. There can be pressure coming from “difficult” clients as a result of few positive outcomes and from low rewards on the job in terms of pay, fringe benefits, and working conditions. These are common features in outreach teams. Also, outreach staff burn out because of the ill treatment they receive from supervisors and employers, and even their own workmates (e.g., “mobbing”), etc. Working with marginal populations usually involves low pay (compared to jobs in more conventional social service sectors), irregular work schedules, substantial unpaid overtime, understaffing, and high on-the-job risks, etc. Lots of NGOs with modest means keep projects going by calling upon their workers’ good will, commitment, and enthusiasm to serve others. This frequently is a form of “velvet exploitation.” Nevertheless, team members should receive decent salaries and be provided adequate working conditions: enthusiasm to serve others should not be taken for granted or, even worse, preyed upon by projects, as every outreach worker knows so well.

Also important are strategies to mitigate the weariness of working with marginal populations. Personal/team research projects, opportunities to attend conferences and workshops, providing and receiving in-service training, and meeting other professional teams are potential ways for sustaining the morale of teams and avoiding burnout.

Tenth, new ideas and proposals for improving services and interactions with clients should be explored constantly. The program began as a mere needle exchange program, but grew in time into a health care and welfare facility, a program for health education, and an SIF. In providing harm reduction services, it is important not to specialize in one type of client (e.g., injection drug users), problem (e.g., homelessness), or context (e.g., outskirts of town). Doing so risks stereotyping drug users and drug use. There is a risk of forgetting or not “seeing” users where they are; for example, the users most at risk of overdose in Can Tunis are those who do not attract staff attention because they keep to themselves and ask for less than the more dysfunctional, homeless drug users.

#### **EPILOGUE: THE END OF CAN TUNIS**

The Can Tunis area is on the verge of demolition, with its grounds added to the industrial and merchant harbors of Barcelona. The displacement of Can Tunis residents and the homeless drug users in the area will probably be coercive. As an example, the highest local authority in charge of the “renewal” of the quarter and ejection of its inhabitants made the following comment to the press (March, 2002):

“Once Can Tunis disappears, junkies will also disappear.” This unrealistic attitude undermines the future of drug-related harm reduction interventions in Barcelona.

As professionals who are stigmatized simply because they work with drug injectors, staff members are committed to resisting such attitudes, promoting new interventions, and continuing to bring to light the problems of drug users and the abuse or neglect by authorities because they are drug users. This paper is part of that attempt – to direct attention to the destruction of the publicly “invisible” element of this quarter and its dwellers on the outskirts of one of the most beautiful and prosperous cities in the world.

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