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Pipes, Peers and Prevention:

Harm Reduction Strategies for People who Use Stimulant Drugs **Technical Guide**

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SIPP
SAFE INHALATION PIPE PROVISION

Peer income and stimulant pipe production

This technical resource on stimulant pipes highlights the many positive reasons to distribute heat-resistant stimulant harm reduction pipes. However, we want to add a cautionary note on the need to look for and respect the role of peer pipe production that can emerge among people who use stimulants.

During a community consultation in 2015 in Afghanistan, Coact worked with Bridge Hope Health Organisation in Kabul to document current drug trends by gathering community voices. The community consultation uncovered the large-scale arrival of crystal methamphetamine and its widespread adoption in Kabul, which had happened over the previous 6 months.

Coact and Bridge were able to video document one of the early pipe makers on the Kabul meth scene. The Afghan pipe makers recycle two 5ML water ampoules that are melted and blown into meth pipes. These pipes are relatively risk-free while being made from fine glass that is fragile. Given the difficulties of securing consent for a formal harm reduction pipe distribution scheme in this complex context, the peer pipe makers created the conditions for Bridge peer educators to promote the “keep your pipe personal” message. The value of protecting this small-scale drug user economy was recognised both to secure the pipe makers income and support this community pathway to accessing safer stimulant pipes.

In other settings meth pipes are blown from discarded fluorescent light bulbs creating a greater health hazard. This adds complexity because the glass being recycled will also include chemicals that could be harmful to health. However, this assumption needs to be tested and the principle of not undermining limited peer income opportunities should also be considered. This can be achieved by engaging pipe makers as community stakeholders in the design and development of pipe-based campaigns



Meth pipe blowing in Kabul.
Mat Southwell Coact 2015

Southwell, M, Harris, M, Lahov, A and Tanguay, P (2025). Pipes, Peers and Prevention: Harm Reduction Strategies for People who Use Stimulant Drugs Technical Guide, Coact, UK.

Introduction

Harm reduction has been driven by the need to respond to the risk of HIV transmission among people who inject drugs and has focussed particularly on opioid dependence and overdose. Around the world, stimulant drug use is becoming more prevalent, and the number of people who use stimulants – either in combination with opioids or with other depressant drugs – has increased. With more people using stimulants by inhalation – smoking in a pipe – there is an imperative to lower the accessibility threshold and increase the availability of harm reduction services to facilitate the engagement of this diverse population and preserve their health and better meet their social care needs. The distribution of stimulant pipes was pioneered in the mid-1990s, in New York, by Mark Kinzley, an activist and researcher.

The World Health Organization (WHO) commissioned literature reviews in 2017 which highlighted varying prevalence of HIV and hepatitis C (HCV) among people who use cocaine/crack, methamphetamines and other amphetamine-type stimulants (ATS), and new psychoactive substances (NPS) stimulants most notably synthetic cathinones. Risk factors are likely to be linked to the rapid and repeated administration patterns associated with injected stimulant use and the enhanced sexual risks associated the sexualised use of stimulant drugs¹.

This *Technical Guide* presents a solid justification and robust evidence for the distribution of stimulant pipes. It includes three case studies based on scientific research and programmatic implementation with people who use stimulants. The results clearly demonstrate that such interventions can be successfully deployed to meaningfully engage people who use stimulant drugs in health and social care.



Pipe kit developed by Exchange Supplies feedback from people who use crack as part of the Safe Inhalation Pipe Provision Study.

Issues with Smoking Stimulants by Pipe

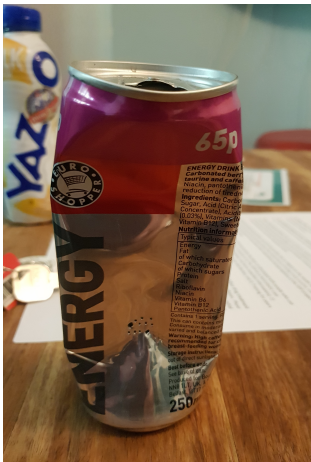
Mat Southwell, Managing and Technical Director, Coact

Smoking stimulants through a pipe is a high-dose method of drug consumption that provides an effect similar to injecting in its intensity. However, the effects from smoking are faster than with injection, as smoking is the fastest route to deliver drugs to the brain. Smoking with a pipe leads to the same type of surging, intense effect associated with injecting. Other non-injecting routes such as smoking on silver foil, smoking in cigarette, or snorting nasally tend to be associated with lower doses and slower onset.

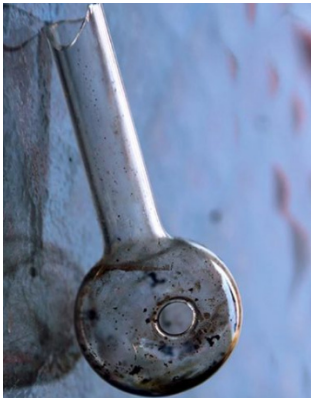
High-dose consumption is associated with greater risk of overdose that can lead to myocardial infarctions (heart attacks), heat strokes, acute anxiety responses (panic attacks), serotonin syndrome, psychotic episodes and other negative health problems as the nervous system is overwhelmed. Regular high-dose consumption is also associated with stronger cravings to use again, which increases the challenges of sustaining self-control and mediating overall consumption. High-dose consumption is also associated with a more pronounced aftereffect – deeper crash or come down – following consumption sessions: the higher one goes up, the harder and deeper one comes down. This can increase demand for people to consume more alcohol, cannabis, opioids and/or benzodiazepines to reduce the aftereffects of smoking stimulant drugs.

Challenges reported from use of street stimulant pipes

People who use stimulants often smoke their drugs in a variety of re-purposed or homemade pipes. Multiple components that are used to fabricate these “street pipes” are associated with different potential health risks. The table below presents various commonly used inhalation devices assembled by people who use stimulants that have been identified through Coact’s community-led harm reduction analysis.

Item	Description	Picture	Challenges
Tin can	Tin cans can be quickly repurposed into a crack pipe by bending and indenting the can. Holes are pierced in the middle of the tin can. The pull ring is removed, and the opening is used as the mouthpiece. An airhole can sometimes be added to the top end of the tin can so clean air can be flushed through to remove residual smoke from the substance consumed.	 A photograph of a repurposed tin can, likely a 65p can, used as a crack pipe. The can is bent and has a hole in the middle. It is sitting on a wooden surface.	Paint – containing toxins – from the outside of the tin can be vapourised and inhaled. The metal on the edge of the removed pull ring can cut lips, increasing the risk of contact with blood if shared, thus increasing the risk for transmission of blood-borne infections. People who smoke through tin cans use cigarette ash to suspend the substance (see below).

Plastic water bottle, asthma inhaler, methadone bottle, etc.	Plastic bottles, asthma inhaler casings, and methadone bottles can all be repurposed into crack pipes. This generally involves putting aluminium foil over the bottle opening or on top of the inhaler and piercing it with a pin or needle.	 Photo: Nigel Brunson injecting Advice	The top of the bottle or inhaler casing becomes hot when a flame is drawn into the pipe. This can release carcinogenic or toxic fumes. Moreover, contact with heated tips can dry and crack lips, potentially producing blood or wounds that increase the risk for transmission of blood-borne infections. Pipes made from plastic bottles, asthma casings, and methadone bottles all use cigarette ash to suspend the substance (see below).
Plastic straws, plastic ballpoint pen casings, plastic syringe barrels, etc.	Pipes to smoke crack or crystal meth can include plastic tubes made from pen casings, plastic straws or syringes barrels. These are generally secured in place with blue tack or chewing gum.		The tip of the plastic tube can increase the risk for transmission of blood-borne infections if shared. The plastic tube can be heated by the hot smoke, releasing carcinogenic or toxic fumes.
Cigarette ash	When heated, a rock of crack passes from a solid state to a liquid before evaporating into smoke, then back to a solid state as it cools. When placed on aluminium foil with holes, the liquid pours into the pipe if cigarette suspension agent wasn't used.		When inhaling, cigarette ash can be drawn directly into the lungs causing injuries, like "black lung" injuries suffered by miners. It can also cause bronchial infections known as green phlegm lung.
Stainless steel scrubber pads	Stainless steel scrubber pads can be used by people who smoke crack as a suspension agent. Pieces of stainless steel are cut up and stuffed into the pipe. The crack is held in its liquid state in the mashed-up metal filaments.		Flecks of stainless steel become brittle and can break off. When inhaling, those flecks can be aspirated, burning the mouth and becoming lodged in the lungs.

Commercial glass pipes	Various pipes suitable for smoking stimulant drugs can be legally purchased from corner shops in some settings or from online sources. These are normally cheap and made from fragile glass. Such pipes are not normally made of heat-resistant glass.		Commercial glass pipes risk breaking, and the resulting sharp edges can cut lips. Glass that is not heat resistant also warms to high temperatures that can cause blisters or wounds. Both types of injuries increase the risk for transmission of blood-borne infections from contact when shared.
Repurposed glass pipes	Glass ornaments - such as artificial roses in glass casings - can also be repurposed as street pipes. These are made of fragile glass that is not heat resistant.		These glass casings are broken to remove the content before adding stainless steel scrubber. The broken casings can cause cuts and the heated glass can cause blisters or wounds. Both types of injuries increase the risk for transmission of blood-borne infections if shared.
Light bulbs	Pieces of light bulbs can be repurposed into crack pipes. Glass from long florescent light bulbs can be used as pipes to smoke methamphetamine.		Meth pipes made from light bulbs can be fragile and can break, increasing the risk of cuts that can facilitate transmission of blood-borne infections. Fluorescent bulbs also contain traces of mercury which is a highly toxic heavy metal.
Aluminium foil	Aluminium foil can be used to smoke heroin, brown heroin, crack, or methamphetamine in crystal or tablet forms. This technique provides a lower dose layered effect.		Depending on its thickness, aluminium foil can melt if too thin or retain heat if too thick. The common conception that all aluminium foil is coated with oil is inaccurate, although foil can release aluminium oxide fumes that can irritate the respiratory tract and contribute to long-term lung damage. The black coating removed in this process is soot from the lighter flame.

The Role of Stimulant Pipes as an Engagement Tool

WHO recognises the role of stimulant pipes as an engagement tool. The provision of a heat-resistant stimulant pipes and / or safer pipe kits provides an effective channel to initiate a discussion with people who use stimulants. It creates an opportunity for peer education, harm reduction support, and service engagement.

The UK's Safer Inhalation Pipe Provision (SIPP) study showed that the distribution of pipes has facilitated outreach with people who use crack-cocaine and increased visits to fixed site drug services driven by the offer of a free pipe / safer smoking kit. This engagement often resulted in people disclosing significant unmet needs associated with their physical and mental health and led to increased service uptake.



People who use stimulant drugs are also at increased risk of contracting HIV, STIs and to a lesser extent HCV due to the role of stimulants in the sexualised use of drugs.²³⁴ Chemsex among gay, bisexual and men who have sex with men (GBMSM) and stimulant use among sex workers highlight the challenges of reaching the diverse hidden populations who use stimulant drugs.

The Role of Stimulant Pipes as a Prevention Tool

International evidence indicates that stimulant pipe supply through harm reduction and drug treatment services can reduce injecting, acute injuries, respiratory harms, viral infections, and increase health seeking behaviours for drug treatment services where health, harm reduction, social, and psychological interventions can be delivered⁵⁶⁷⁸⁹. Over time, with insufficient rehydration, a person who uses stimulants can become dehydrated. Using stimulant drugs causes the body to heat up, triggering perspiration to cool the body down. The resulting dehydration can lead to cracked lips, which can be further dried and blistered by hot smoke and heated pipe.¹⁰¹¹¹²¹³ Shorter pipes are likely to deliver hotter smoke to the lips and mouth, accelerating dry and cracking lips. This can be further compounded by the effects of sunburn or exposure for those without fixed housing. Cracked and bloodied lips create the conditions for blood contact. Homemade pipes can have sharp edges, and store-bought glass pipes are often fragile and susceptible to breaking. Both can cause cuts to the lips and mouth, creating a transmission pathway for HCV.¹⁴¹⁵¹⁶

Sharing stimulant pipes is a common practice exacerbated by the social nature of stimulant use, and the criminalisation of harm reduction commodities.¹⁷¹⁸ Research has shown that HCV can be found on pipes used to smoke stimulants¹⁹ and transmitted through pipe sharing practices, particularly among people who have cuts or burns on their hands and/or mouths.²⁰²¹ People who use stimulants can share cold sores, common colds, and flu viruses. Understandably, concerns have been raised about the potential for shared stimulant pipes to spread respiratory infections like

COVID-19 and tuberculosis. HCV has been found on returned stimulant pipes, demonstrating that it can be passed through a pipe and the virus can survive outside the body for over 24 hours.

To reduce pipe sharing, behavior change communications have focused on key messages like “Keep Your Pipe Personal” to promote people who smoke stimulants to carry and use their own pipe. Mouthpieces or mouthguards are also effective at creating a barrier to infection if a pipe is shared.

The Role of Stimulant Pipes as a Switch or Route Transition Intervention Tool

Injecting stimulant drugs has been associated with a rapid, repeated pattern of use. Between 2014 and 2015, a series of HIV outbreaks affected people who inject stimulants; linked to cocaine in Glasgow, Scotland and mephedrone in Bucharest, Romania and Dublin, Ireland. These highlighted the challenges comparable to the intensity and frequency of injecting that come with heavy stimulant use. For some, the HCV transmission risks associated with injecting paraphernalia makes injecting stimulants too bloody. Given that smoking stimulants in a pipe leads to an effect similar to injecting, it is unsurprising that people who had previously injected cocaine and crack reported to the SIPP study that they had switched to smoking crack as a harm reduction strategy.

Route transition interventions (also known as switch interventions) have been developed to reinforce and encourage others to follow these spontaneous trends and abandon injecting stimulants in favour of smoking through a pipe.

The Role of Stimulant Pipes in HCV Test and Treat

Stimulant drugs are often used in group or social and sexual settings. Consumption in these settings generates additional risks, especially when stimulant drugs are taken in a group setting over an extended period as part of sexualised drug use.

This combination of risk factors implies that people who use stimulants can benefit from testing and diagnostic interventions to detect HIV, HCV and sexually transmitted infections (STIs). As the case study from Kyrgyzstan illustrates below, stimulant pipe distribution can be used in combination with community mobilisation and online outreach to mobilize diverse populations vulnerable to and affected by blood-borne infections and STIs. Stimulant pipes and safer smoking kits can be used to incentivise engagement in testing and research studies to better understand the complex array of intersecting risk factors that impact various sub-populations.

The Criminalisation of Drug Use Paraphernalia

Most drug control regulations prohibit the sale and sometimes the possession of drug-related paraphernalia. Law enforcement often use drug paraphernalia to identify people who use drugs and to legitimise further searches, seizures and sanctions. Used drug paraphernalia also contains drug residue, which in some jurisdictions can be sufficient grounds for prosecution for drug possession. These factors disincentivise people who use stimulants from carrying their own pipes, which makes sharing pipes more likely.

Stimulant pipes can be exempted from drug control regulations on the same public health basis as needles and syringes and other safe injecting equipment and harm reduction commodities. Alternatively, high-ranking law enforcement officers and relevant agencies can issue letters of comfort to provide exemptions to allow distribution under harm reduction projects, as the Indonesia case study highlights. Such letters of comfort confirm that the police do not see a public interest in prosecuting those distributing stimulant pipes when implemented in the context of harm reduction interventions.

Decriminalisation of drugs (and paraphernalia) creates better conditions for distributing harm reduction commodities and managing drug use as a public health issue.

United Nations Technical Guide and Training Toolkit

In 2018, the United Nations Office on Drugs and Crime (UNODC) invited a group of people who use stimulants who were also harm reduction and community mobilisation experts to draft the *UNODC UNAIDS WHO Technical Guide on HIV Prevention, Treatment, Care and Support with People who Use Stimulant Drugs*. This document was informed by three literature reviews that were commissioned by WHO. The reviews considered the three primary stimulant drugs – smoked cocaine, methamphetamines and ATS, and NPS, most notably cathinones – implicated in HIV transmission among people who use stimulants. A fourth literature review was conducted into interventions for people who use stimulant drugs.

The resulting *Technical Guide* recommended eight core interventions for people who use stimulants. This included the use of harm reduction commodities – a plentiful supply of sterile needles and syringes for people who inject stimulants and an endorsement of distributing stimulant pipes.

This encouraged the Global Fund to Fight AIDS, Tuberculosis, and Malaria to confirm funding for responses targeting people who use stimulants in Round 7. In practice, the competition between different key population priorities for HIV funding and the existing underfunding of harm reduction for people who inject drugs resulted in few if any funding requests for projects targeting people who use stimulants. However, the increase in technical know-how and civil society advocacy has encouraged more countries to seek funding for HIV and HCV prevention, testing and treatment with people who use stimulants from alternative sources.

UNODC has developed a training toolkit in partnership with civil society organisations working on drugs and HIV to promote the *Technical Guide*. The training toolkit has three different versions highlighting the responses to smoked cocaine, methamphetamines, and NPS stimulants. The UNODC in-country training course has provided a space for catalytic, high-level policy and practice conversations about the needs of people who use stimulants. It is now being made available on a train-the-trainers basis to support onward dissemination at a country level.

Conclusion

Given prohibitions on stimulant pipe supply and the historic focus on distributing harm reduction commodities for people who inject drugs, there is a dearth of evidence on associated interventions in humanitarian aid settings. However, reports from Ireland and Canada, where crack pipe provision is legal, demonstrate strong intervention engagement and acceptability among highly marginalised and at-risk populations.²²²³²⁴ Two studies have specifically engaged peers to distribute crack pipes in the US and Brazil.²⁵ Stimulant pipe distribution has been demonstrated to reduce pipe sharing and use of harmful pipes/smoking methods.²⁶²⁷²⁸ The distribution of stimulant pipes has also led to an increase in service engagement and acceptance of harm reduction messages,²⁹³⁰ a process often facilitated by peer-to-peer interactions.³¹³² Furthermore, HCV rates were reduced over a period in which pipes were distributed as part of a study in Canada, although these results are only observational.³³

The UK SIPP study provides new compelling evidence for the value of crack pipe distribution. Our two case studies from Kyrgyzstan and Indonesia highlight how the distribution of stimulant pipes is being deployed as an engagement tool to draw people who use methamphetamines and cathinones into HIV, HCV and STI testing and the wider drug treatment and health system.

This *Technical Guide* helps gather the technical learning and practice experience that confirms distribution of stimulant pipes as an effective harm reduction strategy. This can support engagement of diverse groups of people who use stimulants in HIV, HCV, and STI testing and treatment, and act as an entry point into wider health and social care services. Stimulant pipes are best delivered as part of a low-threshold response drawing on the privileged access fostered by community mobilisation.

Recommendations

- Stimulant pipes are a proven intervention to support the engagement of people who use stimulant drugs. Heat resistant pyrex pipe kits should be provided as an engagement and harm reduction tool by drug services and drug user organisations.
- Stimulant pipes come in different forms for different stimulant drugs. The type of pipe must align with different drugs and different contexts. This highlights the need for a participative development approach that consults people who use stimulants about the different types of available harm reduction pipes. This will allow people who use stimulant drugs to make an informed choice about which pipes best fit with their drug use patterns.
- Stimulant pipes can be distributed in kits with lighters with harm reduction messages, lip salve, mouthpieces, sugar free chewing gum to support oral health, and IEC materials. Cases are useful both to hold the equipment but also to hold pieces of stimulant drug to support dose regulation.
- Stimulant pipes and online outreach provide synergize to better reach gay, bisexual and men who have sex with men who are involved in chemsex. This can support access to harm

reduction advice and materials, condoms and lubricants, PEP and PREP, and access to testing and treatment.

- Key developments and innovations have been led by drug user organisations. Drug user activists have unique access to the non-service using population and pipe distribution should be used as part of community outreach and peer education. Investments in capacity building are therefore essential to effective peer-led interventions.
- Further research and testing should be done in low- and middle-income countries with people who use stimulant drugs, ideally as part of research studies to further build the evidence on stimulant pipe provision.
- The SIPP study uncovered the significant unmet mental health needs among people who use stimulants. This is an area for further consideration.

The eight recommended HIV interventions for people who use stimulant drugs

1. Condoms, lubricants and safer sex programmes
2. Needle and syringe programmes (NSP) and other commodities
3. HIV testing services (HTS)
4. Antiretroviral therapy (ART)
5. Evidence-based psychosocial interventions and drug dependence treatments
6. Prevention, diagnosis and treatment of sexually transmitted infections (STIs), hepatitis and tuberculosis (TB)
7. Targeted information, education and communication (IEC) for people who use stimulant drugs and their sexual partners
8. Prevention and management of overdose and acute intoxication

Case Studies

Case Study 1: Safe inhalation pipe provision (SIPP): A collaborative research project pilot to improve health outcomes and service provision for people who use crack in England.

Magdalena Harris, with and on behalf of, the SIPP Team*

“Until this study into the pipes, there’s been nothing really for crack users ... now, we’ve had so many new sign-ups ... never accessed treatment, or any services like that. [There are] positive outcomes. Like, one guy ... long-term heroin and crack user ... he’s stopped IV use and he’s stopped heroin use, now all he does is smoke crack on the pipes. So it’s been really, really good ... for the new sign-ups it’s unbelievable, I think we’ve touched about 300 new sign-ups of people that we’d never get to engage in services before” (Service provider)

Background

In England, cocaine is the second most used drug on the unregulated market, after cannabis. Cocaine can be used in powder (hydrochloride) or solid (base) form. Base cocaine, known as crack, is typically smoked, but can be injected with the addition of an acidifier. Injection of crack and heroin in combination (a ‘snowball’) is common in England, and people can alternate between crack smoking and injection. 180,000 people use crack in England, with most also using opioids. An estimated 50,000 people use crack but not opioids, and therefore are less likely to be in touch with drug treatment or harm reduction services.

Crack use is associated with social marginalisation, housing, food and income insecurity. People who use crack can be reluctant to seek help for health, social and drug use problems due to criminalisation and social stigma. English drug treatment and harm reduction services focus on reducing risks associated with opioid dependency and drug injection. There are very few supports available for people who use crack, particularly those who smoke crack. No pharmacotherapy options are currently available for people with a stimulant dependency in the UK, and provision of smoking or inhalation equipment for the purpose of stimulant use is illegal.

The UK Misuse of Drugs Act 1971 requires that any equipment for the purpose of drug preparation is listed under Section 9A in order to be legally provided. A variety of equipment for injecting is included, and in 2014 – after extensive advocacy and evidence hearings – foil for heroin smoking was included as an amendment to the act.

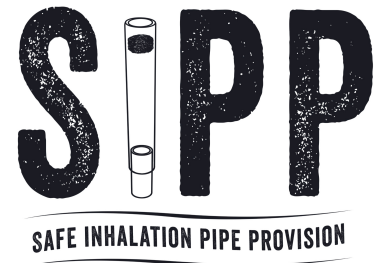
Crack pipes used in England, therefore, are often homemade or repurposed from other materials. Glass and metal pipes are available to purchase from shops and online in England where they can be sold as ‘ornaments’ or for the consumption of legal substances. They are generally not as durable and/or heat resistant as glass Pyrex pipes, and require cash outlay.

During the Covid pandemic members of the research team became concerned about mortality risks facing people who smoked crack. With policing support, we wrote a request for a national ‘letter of comfort’ or memorandum of understanding allowing for the provision of safer stimulant

smoking equipment to reduce risk of covid transmission (through pipe sharing) and mortality, among a population who already had poor respiratory health. This was rejected at the Government level – but led to the development of the SIPP project, which we report on below

The Project & intervention

The SIPP (Safer Inhalation Pipe Provision) study team developed, piloted and evaluated a crack equipment and harm reduction training intervention in England. The aim of the study is to reduce health harms and increase service engagement among people who use crack, providing evidence of impact to inform legislative review.



The study was funded by the National Institute for Health and Care Research (NIHR) and led by a team at the London School of Hygiene and Tropical Medicine (LSTM) with academic, community and peer partners. The Principal Investigator (MH) has lived experience of crack use and people who use crack were actively involved throughout, from project design through to delivery and findings dissemination. Appropriate ethics committee approval and local police permissions (as the intervention was illegal) were obtained prior to study start.

The intervention consisted of a 'SIPP Kit', online provider training, and harm reduction information. The SIPP kit included a straight stem Pyrex glass pipe, steel gauzes, rubber mouthpieces and a wooden push stick in a plastic case. A basic crack equipment information and harm reduction leaflet was provided alongside or in the case. The team developed an e-learning module for drug service providers, including information on crack administration practices, health risks and harm reduction, equipment distribution and client engagement.

The SIPP kits were supplied for six months through 3 drug treatment services, 1 sex worker service, and two peer networks at three geographical sites, with 4 drug treatment services and 1 peer network in three comparable geographical sites as controls (ie, receiving no intervention). Service sites provided people with a short survey when they got a SIPP kit. This asked if this was the first time they had been to any drug service ever and what they were there for.

The intervention was evaluated using a survey delivered at all the sites before and after the 6 month SIPP intervention duration. Peer networks received training to recruit and deliver the survey, with the aim of reaching people not in touch with drug treatment services. The survey included questions on participant demographics, crack smoking practices, other drug use, crack-related respiratory symptoms and health conditions and service engagement.

Qualitative interviews and observations took place throughout the study at all sites, exploring local contexts, crack use practices, SIPP kit acceptability, and the intervention process with both people who used crack, peer network members and service providers.

Select Findings & Implications

1. Service engagement

a. SIPP kits increased contact with services

During the 6-month intervention period service sites returned over 3000 monitoring surveys. From these, 205 people reported it was the first time **ever** that they had been to **any** drug service, and for 177 (86%) the reason for attendance was a SIPP kit. Interviews with providers illustrated that this was the tip of the iceberg, with one service reporting over 200 new people coming in for pipes within the first two months of the intervention. Many may have attended a service at some point in their lives, therefore not be counted in monitoring data.

b. SIPP kits + provider training increased engagement with services

The SIPP e-learning provider training was widely taken up and helped to increase provider knowledge and confidence in general crack-related issues, including crack smoking practice and harm reduction advice. This enabled conversations about crack use to take place with clients when giving out a SIPP kit, providing relationship building opportunities.

c. Trusted engagement enables support provision

Relationship building opportunities enabled providers to notice other areas of unmet need and/or clients to express concerns and receive support. Supports provided to people coming in for SIPP kits included: sexual health and blood borne virus testing; treatment appointments and referrals; assistance and finance for eyesight checks and new glasses; as well as housing, criminal justice/probation and other social service assistance.

2. Peer expertise and collaboration

a. Peer networks reached more marginalised people

The privileged access of peers to networks of people who use crack was demonstrated through survey data. Compared to the services, peers recruited people who were more likely to: a) smoke crack daily; b) be street homeless or in unstable accommodation; c) identify as a marginalised (non-white) ethnicity; and d) not be in touch with drug services or receive opioid agonist therapy.



b. SIPP will not resolve barriers to service access

Interviews and observations with people recruited through peers illustrated: a) the value of key community members in providing emotional and practical support to their peers (eg. by helping with benefit forms); b) a desire for increased harm reduction knowledge and support around crack use and b) fear of identification as someone who uses crack (due to the potential for child removal, job loss, loss of family and/or social standing) is an intractable barrier to service access for crack related supports.

c. Peer to peer distribution is crucial alongside service provision

Peers distributed SIPP kits widely, including to people that would never attend services. They were also instrumental in providing harm reduction advice, when feasible. If legislative change enables SIPP provision through services, it is crucial that peer networks are also capacitated, supported and financed to deliver equipment and harm reduction information within their communities, as this will ensure reach to people experiencing high unmet need.

3. SIPP Kit acceptability

a. SIPP kits were welcome but not ideal

Participant feedback on the SIPP kit was uniform: a) the pipe was too long and too wide; b) the gauze was too dense; c) the case was too large and fiddly. However, despite these concerns, they were still experienced as welcome and uptake was high across all intervention sites.

b. Early modifications to the kit demonstrated researcher responsiveness

On receiving this feedback Exchange Supplies (study partner who enabled this research through free equipment provision) provided a shorter stem pipe as an additional option early in the intervention period. This was well received by the sites, with one provider saying clients now felt that their input was heard, made a difference and that the research team were responsive to community need and would provide value rather than being purely extractive.

c. Peer feedback and co-design is crucial for equipment acceptability

Provision of the shorter pipe was welcome, but did not resolve concerns regarding pipe width, gauze density and case composition. The team worked with Exchange Supplies and peer partners to troubleshoot these issues, resulting in the development of an improved kit with mid length narrow straight-shooter pipe, reduced density gauze with ease of unravelling for adaptability; and a compact case with pipe holder which was both discreet and robust.

4. Crack smoking risks and respiratory health

a. Repurposed pipes risk respiratory harm

The baseline (pre-intervention) survey and interviews illustrated both how common the use of homemade and repurposed pipes were, and the risks associated with them. Common were accounts of: fume inhalation from plastic inhalers; burns to mouth and throat from use of small metal pipes; inhalation of metal fragments from degraded stainless steel scrubber; inhalation of ash and paint fumes from metal cans; cuts to hands and mouth from broken glass pipes, and cuts to fingers while preparing 'wire wool' filters. Scraping crack residue or 'recycle' out of pipes with sharp implements can cause fragments of the pipe to break off and/or be inhaled, such as glass particles, and common were accounts of smoking plastic scrapings from inhalers incorporated with the crack recycle.

b. High prevalence of respiratory harm and unmet need

Our survey samples were approximately 730 at baseline and follow-up, with a total of over 1000 unique individuals. Eligibility criteria was to have used crack in the past month. 99% of the sample smoked crack, and over 60% reported not injecting. Over half reported respiratory health

symptoms (such as difficulty breathing) in the past 6 months, and over one third reported ever being hospitalised for a respiratory condition, with pneumonia the most common.

c. Pipe scarcity and respiratory harm increase blood-borne virus risk

Some participants spoke of transitioning to injecting due to the impact of smoking on their respiratory health and associated quality of life. Others, of sharing pipes due to inability to source a pipe or the materials to easily make one. Although the evidence on the risk of hepatitis C transmission through pipe sharing is mixed, the increased risk of blood borne virus transmission through injection is clear.

In Summary

“So, it would be shavings of blue plastic mixed in with it, which wasn't very nice ... I did think about the long-term effects of inhaling so much plastic, but it was a thought that briefly came, and then went when I needed another hit again ... I had very severe like coughing problems, wheezing, coughed up a lot of phlegm”

The quote above is from a SIPP study participant reflecting on the risks of using plastic asthma inhalers to collect crack residue from and smoke on. He makes a clear connection between these pipes and his poor respiratory health. Others spoke of transitioning to injecting due to extended periods of coughing up blood. These issues are of serious concern in a policy landscape whereby services are primarily orientated toward opioid use and safer equipment provision is prohibited. We have highlighted select findings from this project, which is the first to provide and comprehensively evaluate a crack equipment and training intervention in the UK. Greater detail on these and other findings will be available in peer-review publication – with the study protocol available³⁴ for additional background and methods information.

In short, we found that the SIPP intervention both helped provide people who use crack with safer equipment but also enabled providers to develop confidence in their ability to engage with people who used crack and provide informed harm reduction advice. For some this led to increased engagement with services and provision of help for unmet health needs. For others, peer networks were instrumental in providing both equipment and information. SIPP is not a pipe only intervention – workforce skill development was crucial to success, and it is not a purely service based intervention – peer expertise and partnership working ensured the intervention reached those most in need and that the final equipment offer reflected their preferences.

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Case Study 2: Web-Based, Tailored Harm Reduction for People Who Use Stimulants in Kyrgyzstan³⁵

Alexei Lahov, Coact Consultant and EuroNpud Executive Director

In response to the rising use of synthetic stimulants - particularly mephedrone and alpha-PVP - among key populations in Kyrgyzstan, the "Web Harm Reduction" pilot project was launched and implemented from 2022 to 2024 with financial support from the Elton John AIDS Foundation (EJAF). This initiative aimed to reduce the risks of HIV, viral hepatitis, and sexually transmitted infections (STIs) associated with stimulant use. The project was rolled out in Bishkek, Osh, and selected districts of Chuy oblast, introducing a new digital outreach model to connect with populations traditionally underserved by public health systems.



The Web Harm Reduction model integrated online outreach with personalised harm reduction services. Outreach workers - trained peers with lived experience of substance use - were central to the intervention. Using platforms such as Telegram (including bots, groups, and direct messages), dating apps, and online forums (including those operating in the hidden or encrypted web), outreach workers identified and engaged potential clients. These digital contacts were used to deliver harm reduction messages, promote HIV self-testing, and offer access to practical tools and psychosocial support. A key innovation was the use of discreet Telegram bots for ordering and delivering harm reduction kits. These kits often served as a first point of contact for individuals hesitant to engage with offline services.

Each harm reduction kit was carefully assembled to reflect the specific risks associated with stimulant smoking. They included heat-resistant glass stems to reduce injuries and discourage sharing, lubricants and condoms for sexual health, lip balms and healing ointments to prevent burns and sores from pipe use, vitamin C for metabolic support, and chewing gum to mitigate stimulant-related anxiety and jaw tension. Each kit also contained an HIV self-test kit, allowing for anonymous and voluntary testing. The integration of these items created a comprehensive entry point into health services for people who might otherwise remain invisible.

Outreach workers did more than deliver supplies - they established trust, provided risk-reduction education, and connected clients to health care and social support systems. For clients who tested positive for HIV, outreach workers coordinated confirmatory testing, facilitated registration with AIDS centres, and supported initiation and adherence to antiretroviral therapy (ART). In many cases, this support extended to accompaniment to services and ongoing follow-up, helping bridge structural and social barriers to care.

Despite the digital orientation of the intervention, the project uncovered significant hesitancy around fully remote service delivery. While the anonymity of the online format was appreciated, many clients expressed a strong preference for in-person interactions when receiving HIV tests or discussing sensitive health concerns. These preferences were driven by both security concerns - such as confidence in correct test administration - and emotional needs, such as receiving encouragement or reassurance during testing. As a result, the project organically evolved into a hybrid model, blending online outreach with face-to-face service provision where necessary.

Between December 2022 and May 2024, the project reached 2,526 unique clients. Most participants were young men between 18 and 29 years old. Ninety-four percent reported using stimulants by smoking, ingestion, or nasal insufflation, with only 6% identifying as people who inject drugs. However, qualitative feedback from outreach workers indicated growing trends of transitioning to injection among stimulant users - especially in response to changing drug market dynamics. This shift underscored the urgency of continued outreach and the potential need to integrate syringe distribution within stimulant harm reduction responses.

Of the total clients reached, 38% (n≈950) reported engaging in high-risk sexual behaviour within the 30 days preceding project intake, including multiple partners and low rates of condom use. Furthermore, among those who reported pipe sharing - a key risk factor for hepatitis C virus (HCV) transmission - data revealed that only 24% had previously received harm reduction materials. This reinforces the HEPCIII finding that distribution of safer smoking equipment can play a critical role in reducing viral transmission and engaging clients who would otherwise be unreachable.

Notably, 84 clients were re-engaged after 6 months and showed significant improvements in protective behaviour, including more consistent condom use and reduced sharing practices. While this represents a small fraction of overall reach, it highlights the value of continued contact and long-term support in behaviour change and health outcomes.

Focus groups and key informant interviews revealed overwhelmingly positive feedback about the intervention. Clients praised the non-judgmental tone, relevance of the information, and convenience of the digital model. Outreach workers emphasized the project's success in reaching populations previously excluded from prevention efforts, including sex workers, men who have sex with men (MSM), transgender people, and migrants. However, several implementation challenges persisted. These included low digital literacy among older clients, fear of surveillance, and difficulties in maintaining confidentiality on shared devices.

The project also invested in capacity building for local outreach teams. Web outreach workers were trained not only in digital communication but also in psychosocial support, motivational



interviewing, and the clinical aspects of HIV/STI transmission and prevention. Training curricula were developed collaboratively with national partners and incorporated feedback from both clients and peer staff. As the project matured, collaboration with government stakeholders - including the Republican Center for Psychiatry and Narcology and the Ministry of Internal Affairs - helped build buy-in for web outreach as a viable component of the national HIV response.



Alexei Lahov training Kyrgyzstan partners.

Importantly, the project contributed to the expanding body of evidence for web-based harm reduction in Eastern Europe and Central Asia (EECA). The Kyrgyzstan case illustrates that digital harm reduction, when grounded in community participation and supported by hybrid models, can successfully engage high-risk populations and promote testing, prevention, and care. It demonstrates that people who use stimulants can be reached through the very technologies they already use - and that tailored, peer-led services can make these interactions meaningful.

Kyrgyzstan's experience with web-based, tailored harm reduction for people who use stimulants underscores the potential of digital platforms to reach populations otherwise disconnected from health systems. The success of the project hinged on its ability to combine low-threshold entry points, peer leadership, culturally adapted messaging, and pragmatic service delivery. When community-based and community-led organizations and initiatives offer people who use stimulants both virtual and physical pathways to care, it lays important groundwork for the expansion and institutionalisation of stimulant-specific harm reduction programming in the region.

Case Study 3: Distributing safe smoking equipment to people who use methamphetamine in Indonesia

Pascal Tanguay, Coact Development Director

Country cultural context

Comprising over 17,500 islands, Indonesia is the world's largest archipelagic state and the 14th largest country by area, spread over close to 2 million square kilometres which are divided into 34 provinces. Counting over 280 million people in 2020, Indonesia is the world's 4th most-populous country and, with 83% of the population being Muslim, it is the most populous Muslim-majority country. This large population includes numerous ethnic, cultural and linguistic groups, speaking 724 distinct languages and dialects. Java, the world's most populous island, is home to more than half of the country's population, while Kalimantan and Papua are the least densely populated regions.



Indonesia's public health system, overseen by the Ministry of Health, is structured around a primary health care concept with community health centres (locally known as *puskesmas*) as the primary point of contact, supported by hospitals and other community-based facilities³⁶. The national health system aims to provide universal health coverage through the *Jaminan Kesehatan Nasional* (national health insurance) program which covers 95.8% of the population³⁷ at a monthly cost between ~USD 2 to 9.5 per participant.³⁸ Per capita expenditure on health was estimated at USD 160.64 in 2021 by the World Bank³⁹, ranking 127th globally⁴⁰.

Indonesia's first HIV case was reported in 1987, and has since evolved into a concentrated epidemic, mainly affecting key populations like men who have sex with men (MSM), female sex workers (FSW), transgender women (TGW) and people who inject drugs (PWID). The estimated HIV prevalence in the general population (adults aged 15-49) is estimated at 0.5%, but prevalence is significantly higher among key populations: 28.8% among PWID, 25.8% among MSM, 24.8% among TGW and 5.3% among FSW⁴¹. Prevalence of hepatitis C virus (HCV) among PWID is estimated at 89.2%⁴². In 2018 just over 50% of people living with HIV were aware of their status and fewer than 20% of them were receiving antiretroviral treatment (ART), but no data is presently available on ART coverage among PWID⁴³.

A national survey conducted by the National Narcotic Board (NNB)⁴⁴ in 2019 estimated that just under 3.5 million people are currently using drugs, with over 27,000 who inject drugs⁴⁵. Harm

reduction was introduced in 2003 with support from NNB and the National AIDS Commission to prevent HIV transmission among PWID. Existing harm reduction services are mostly government-run and heavily reliant on funds from international donors⁴⁶. Sterile injecting equipment is available in 194 facilities across 19 provinces and 72 districts/cities, and 92 facilities provide methadone, although only 53% of PWID are covered by HIV prevention services⁴⁷.

The synthetic drug trade in Indonesia is thriving, with methamphetamine – locally called *shabu* – being the most widely used and seized drug after cannabis⁴⁸, effectively displacing the heroin market⁴⁹. Between 2015 and 2017, methamphetamine users were the most common patients admitted to rehabilitation facilities in Indonesia⁵⁰. Based on data from the national rehabilitation centre in Lido Bogor, methamphetamine users are predominantly male (94.2%) and most (54.3%) consume more than 0.2g per session by smoking and inhaling. However, reports also indicate a shift to injecting, especially among individuals who also use or have a history of using heroin⁵¹. Data from a quantitative study revealed an HIV and hepatitis C prevalence of 10% and 14% respectively among methamphetamine users, although prevalence was much higher for those with previous injection experience (35% and 62% respectively)⁵².

Karisma's response to the needs of people who use methamphetamines

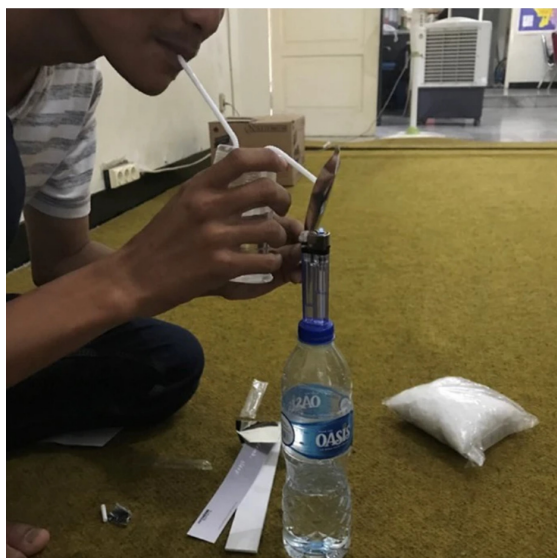
Karitas Sani Madani Foundation (Karisma) was established in Jakarta in 2001 by people whose lives have been affected by drug use to provide support to people who use drugs and who are vulnerable to HIV. Karisma provides HIV and drug counselling through a community-based recovery center, peer support and targeted outreach, and supplies people who inject drugs with safe injecting equipment. In 2016, Karisma received a EUR ~200,000 grant from Mainline Foundation to initiate a 5-year harm reduction outreach pilot project targeting people who use methamphetamines – the first of its kind in the country⁵³. The project was operated by 11 paid staff and 17 voluntary peer outreach workers.

A local step-by-step tool was developed to guide outreach among people who use methamphetamines⁵⁴. Through repeated needs assessments, a total of 25 districts in and around Jakarta were targeted for implementation by the end of the project. In 2017, following recommendations from project beneficiaries, Karisma⁵⁵ started distributing safer smoking kits. Karisma's safer smoking kits included a branded lighter, aluminium foil, straws, and informative leaflets (Figure 1). Printed messages on the foil and the lighter – “eat, drink, and sleep” – reminded beneficiaries of the importance of self-care. In 2019, Karisma added glass stems – locally called *cangklong* – to the safer smoking kits. While distributing the kits, outreach workers and peer educators also provided harm reduction information.

This brief report describes the methamphetamine harm reduction project, the impact of safer smoking kit distribution, and draws out implications for the future of harm reduction for methamphetamine users.

Methodology

In preparation of this report, a comprehensive desk review of project reports and relevant literature was undertaken in March 2025. To complement the literature review, two rounds of key informant interviews were held with two representatives at Karisma who were directly involved in the methamphetamine harm reduction project. Additional data was collected through correspondence with Mainline and other key stakeholders. Representatives from Karisma and Mainline reviewed the draft and provided comments and suggestions on the draft before finalization and publication.



Homemade water pipes are made from small glass or plastic bottles which are punctured to attach a straw. People who use methamphetamines generally prefer these homemade water pipes to glass stems given that the water filters and softens the smoke. Unlike older users, younger users tend to avoid smoking off foil, preferring glass stems. Possession of drug paraphernalia like glass stems provides law enforcement with opportunities for searches, harassment and arrests.

Implementation of harm reduction for methamphetamine users

The methamphetamine harm reduction pilot project implemented by Karisma was designed to reach people who use methamphetamines, provide them with information and skills to reduce the risks and harms associated with their drug use and refer them to health services to improve their overall quality of life. The project was successfully implemented and reached close to 5,500 people who use methamphetamines through targeted outreach. A large proportion of the clients were frequently contacted (up to 16 times per month) by outreach workers by the end of the project. Clients reached were provided with a range of commodities – including a leaflet (IEC) with harm reduction advice and guidance, condoms, lubricants, sterile needles and syringes, alcohol swabs, lighters, foil, and glass stems. Table 1 provides a summary of commodities distributed as part of the safer smoking kit.

Table 1: Commodities distributed to people who use methamphetamine, by year

YEAR	Clients reached	Stems	Foil	Lighters	IEC	Condoms	Lubricants	Needles and syringes	Alcohol swab
2016	194	-	-	-	-	-	-	-	-
2017	873	-	223	211	238	350	42	1	27
2018	1,645	-	-	-	-	-	-	-	-
2019	959	139	297	854	1,116	1,688	299	128	43
2020	1,774	1,132	154	169	832	3,329	482	67	33
TOTAL	5,445	1,271	674	1,234	2,186	6,016	823	196	103

* Data for 2018 was not available

The success of the project relied on extensive capacity building, differentiated service delivery strategies, strategic partnerships, and meaningful participation and involvement of people who use methamphetamines. In terms of capacity building, significant investments were made to sensitize, raise awareness and provide technical skills to people who use methamphetamines, peer educators, civil society partners, community leaders, health service providers and law enforcement representatives. Efforts were made to improve attitudes and skills related to drug-related risks associated with methamphetamines (including overdose), harm reduction, peer-led outreach, HIV and HCV testing and treatment, mental health, behaviour change communications and community education, sexual and reproductive health, legal environment and rights, stigma and discrimination, as well as basic and professional skills such as public speaking and report writing.

A differentiated service delivery strategy was elaborated to better engage with clients and gain their trust. Specifically, consultations with female clients were initiated to better understand their needs and a team of female peer educators was assembled to conduct outreach with female clients. The female outreach team mapped and targeted specific venues where they could better engage female clients – massage parlours, saunas, spa, karaoke and dorms. At least 607 of the 5,445 clients reached by the project were women, representing 11% of the total clients and almost double the proportion of women who attended the national rehabilitation centre in Lido Bogor in 2016-2017. The differentiated outreach strategy included the establishment of formal and informal partnerships, particularly with civil society organizations that had established trust with other key population groups who also use methamphetamines. For example, Karisma worked in partnership with *Yayasan Kusuma Buana* and *Organisasi Perubahan Sosial Indonesia* – the Indonesian national association of sex workers – to facilitate access to female sex workers who use methamphetamines. Collaboration with *Yayasan Inter Medika* was also developed to engage with MSM who use methamphetamines. Out of the clients reached by the project in 2020, 453 clients reached identified as MSM (20%), 89 clients identified as FSW (4%), and 22 clients identified as

TGW (1%). Karisma was also able to establish formal partnerships with several *psukesmas*, and memoranda of understanding were signed to formalize the partnerships.

People who use methamphetamines were mobilized early in the project to participate in planning and implementation. From the very start, the value of a peer-led outreach approach was recognized and people who use methamphetamines were invited to play formal roles. Moreover, the challenge of transitioning the harm reduction approach from meeting the needs of opiate users to those of methamphetamine users required regular engagement of the targeted beneficiaries. Throughout the project life cycle, focus-group discussions were held regularly to engage clients and solicit their inputs to guide implementation of activities. Clients were invited to participate in weekly internal coordination meetings to provide inputs and suggestions which greatly reinforced project planning and service delivery. An informal network of people who use methamphetamines was established during the project and its members remain active and connected to pursue opportunities to provide harm reduction services and advocate for their community.

While the project was a success, challenges related to staff turnover and the repressive political environment undermined the results. Turnover of peer educators was accelerated during the COVID-19 pandemic. Police interference and the fear of arrest among peer educators and clients alike also undermined outreach. The war on drugs declared in early 2010s was sustained throughout the project with punctual escalations that led to recurrent raids and drug busts.

Conclusion

Although no formal quantitative or qualitative evaluation of the methamphetamine harm reduction project was conducted, stem distribution was assessed by the project team to be feasible, appreciated and effective. Project workers reported that clients appreciated the project and its interventions, that the safer smoking kit contributed to risk reduction, and that stem distribution reduced sharing of smoking equipment, all of which were particularly impactful during the COVID-19 pandemic. Project workers also noted that stem distribution contributed to keeping methamphetamine users out of reach of law enforcement since many local shops that sell stems have been known turn customers they suspect use *shabu* in to the police. Project workers also noted that the value of stems and safer smoking kits were greatly enhanced by targeted outreach, differentiated service delivery strategies, effective partnerships and sustained meaningful involvement of people who use methamphetamines.

In the end, the project made important contributions to the overall sustainability of harm reduction for people who use methamphetamines. The advocacy work that was undertaken led to the inclusion of people who use methamphetamines in the Ministry of Health's *National Action Plan on HIV/AIDS*, although funding for harm reduction interventions has decreased in Indonesia and none has been formally allocated from domestic sources or the Global Fund to carry on the efforts initiated by Karisma. However, the integration of people who use methamphetamines in national action plans has generated local interest from health officials to replicate the project.

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