Biregional Strategy for Harm Reduction 2005 - 2009

HIV and Injecting Drug Use

WORLD HEALTH ORGANIZATION
South-East Asia Region Western Pacific Region

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ACKNOWLEDGEMENTS

This document was prepared for the South-East Asia and Western Pacific Regional Offices by staff and consultants working for the relevant units in each Region. We would particularly like to acknowledge the work of Ruth Birgin who worked as a short-term consultant on the document. The contributions of the Technical Advisory group (See Appendix 4) have been invaluable.

Development and publication has been supported by the Australian Agency for International Development (AusAID) through its support of the World Health Organization for an expanded response to HIV/AIDS among injecting drug users.

WHO Library Cataloguing in Publication Data

Biregional strategy for harm reduction, 2005 -2009 : HIV and injecting drug

1. Harm reduction. 2. Acquired immunodeficiency syndrome -- prevention and control. 3. HIV infections -- prevention and control. 4. Substances abuse, intravenous -- complications.

ISBN 92 9061 195 2 (NLM Classification: WF 270)

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TABLE OF CONTENTS

ACRONYMS USED IN THIS DOCUMENT

AHRN	Asian Harm Reduction Network
AIDS	Acquired Immune Deficiency Syndrome
ARHP	Asia Regional HIV/AIDS Project
ART	Anti Retroviral Therapy
ARV	Anti Retroviral Medication
ATS	Amphetamine Type Stimulants
Aus AID	Australian Agency for International Development
BSS	Behavioural Sentinel Surveillance
CDC	Centre for Disease Control and Prevention
CDC (US)	Centers for Disease Control and Prevention, United States
China/UK	The China/United Kingdom Project - DFID funded
CHR	Centre for Harm Reduction, Melbourne, Australia
CO	Country Office (refers to World Health Organization offices)
CSW	Commercial Sex Workers
DFID	UK Department for International Development
DTC	Drug Treatment Centres
ECHO	Eastern Connecticut Health Outreach project
EMR	Eastern Mediterranean Region (of the World Health Organization)
EPP	Essential Prevention Package
FHI	Family Health International
GAP	Global AIDS Program, CDC (US)
GFATM	The Global Fund for AIDS, Tuberculosis and Malaria
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HSS	HIV Sentinel Surveillance
IDU	Injecting Drug Use
ICG	Intercountry Contact Group on harm reduction
IEC	Information, Education and Communication
IHRA	International Harm Reduction Association
INGO	International Nongovernmental Organization
M&E	Monitoring and Evaluation
MMT	Methadone Maintenance Therapy
MOU	Memorandum Of Understanding
NGO	Nongovernmental Organization
NSP	Needle and Syringe Programme
OI	Opportunistic Infections
PLHA	People Living with HIV/AIDS
RAR	Rapid Assessment and Response
STI	Sexually Transmitted Infections
SEAR	South-East Asia Region (of the World Health Organization)
TOT	Training of Trainers
TWG	Technical Working Group
UN	United Nations

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNAIDS-SEAPICT	UNAIDS South East Asia & Pacific Intercountry Team
UNGASS	United Nations General Assembly Special Session
UNODC	United Nations Office on Drugs and Crime
UNTG	United Nations Theme Group
UNRTF-DHV HIV	United Nations Regional Taskforce on Drugs and Vulnerability
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WPR	Western Pacific Region (of the World Health Organization)

1. INTRODUCTION

An estimated 7.4 million people (range: 5.0–10.5 million) in Asia are living with HIV. These include more than 50% of people who inject drugs in parts of Thailand, Nepal, Indonesia, Myanmar, and the state of Manipur in India. Further, localized HIV epidemics are occurring among those who inject drugs in various provinces in China and Viet Nam[1]. These high prevalence rates have critical implications for the generalization of HIV/AIDS epidemics. Drug users are a heterogeneous population hidden across the socioeconomic spectrum and their numbers are unknown in most countries. Several countries have reported significant numbers of injecting drug users engaging in commercial sex work and report increasing HIV prevalence among sex workers after appearing among drug users (Fig. 1[i]). Epidemiological data shows that sexual transmission is occurring from HIV-positive people who inject drugs to their sexual partners and subsequently to their children.[2,3,4,5,6]

Injecting drug use is rising worldwide. Of an estimated 13.2 million people now injecting drugs, 78% are in developing and transitional countries, with as many as half in the South-East Asia and Western Pacific Regions[7,8.] HIV can spread explosively amid circumstances that create risk situations or facilitate unsafe behaviour among those who inject drugs (Fig. 2). This has been the case in many regions including the United States of America, Europe, South-East Asia and the Western Pacific where blood-to-blood transmission through injecting drug use has had a swift and dramatic impact on HIV infection rates.

Asia contributes significantly to the global supply of illicit opiates. New and constantly changing trade routes develop which, in turn, expose new populations in Asia to injecting drug use and the risk of HIV infection.[9] Amphetamine type stimulants (ATS) have displaced or come close to displacing heroin as the most widely used drug in numerous countries in Asia, i.e. Thailand, the Lao People's Democratic Republic, Cambodia, Indonesia, the Philippines, China, Taiwan, Japan and South Korea. Reports indicate that the use of injectable forms of ATS (ice) is on the rise in Asian countries[10]. Newer drugs, particularly amphetamine type stimulants, are becoming increasingly popular and there are reports of these being injected. In the South-East Asian and the Western Pacific Regions significant HIV epidemics among people who inject drugs have been reported in China, Indonesia, Malaysia, Myanmar, Nepal, Thailand, India and Viet Nam, while the Philippines, Laos, Hong Kong (China), Macao (China), Cambodia and Bangladesh all face potential epidemics among and from injecting drug users.[11]

[i] Figures 1, 2 and 3 appear in Appendix 1.

Three key United Nations documents provide the framework for the effective response to HIV spread through injecting drug use in the target regions, namely:

- The *UNGASS on HIV & AIDS Declaration of Commitment;*
- The UN Position Paper *Preventing the Transmission of HIV Among Drug Abusers* (which includes reference to UN System Policy, UN Health Promotion Policy and the Ottawa Charter*);* and
- The World Health Organization Global Health Sector Strategy for HIV AIDS 2003 – 2007.

The Warsaw Declaration 2002, *A Framework for Effective Action on HIV/AIDS and Injecting Drug Use* [12] has also become an important planning reference.

Collectively, these papers identify the need for commitment to comprehensive prevention programmes, based on harm reduction methodologies, in mounting an effective response to the spread of HIV through injecting drug use. Policy makers are encouraged to adopt an evidence-based approach, implementing proven intervention strategies that lower HIV prevalence among people who inject drugs. Specifically, these strategies embrace advocacy and policy adjustment, HIV prevention information and education, access to the means of prevention (condoms and lubricant, needles and syringes, cleaning materials), voluntary and confidential HIV counselling and testing (VCT), the availability of and referral to a range of drug dependence treatment options including drug substitution therapy, treatment care and support services, as well as antiretroviral therapy (ART) for drug users living with HIV/AIDS.

Acknowledging increasing drug use and the rapidly increasing prevalence of HIV/AIDS among people who inject drugs in the region, ASEAN developed a three-year workplan selecting Indonesia, Malaysia, Myanmar and Viet Nam as lead countries. The workplan details harm reduction activities to be undertaken in order to achieve positive outcomes:

- governments address the issue through national policies reflecting a health/harm reduction approach;
- enabling environments are created for implementing harm reduction interventions;
- drug users have access to drug dependence treatment, HIV prevention and care services;
- collaborative regional action; and
- surveillance of HIV/AIDS among drug users.[13]

It is intended that this Biregional Strategy will be used by a varied group of relevant agencies including:

- national and provincial programme planners in health ministries, other ministries contributing to a multisectoral approach to HIV/AIDS and injecting drug use;
- the World Health Organization, including WPRO, SEARO, Country Offices and the Intercountry Contact Group;
- UN agencies and programmes;
- regional bodies, networks and programmes;
- international development agencies; and
- funding agencies.

2. DEFINITION OF HARM REDUCTION

For the purposes of this document the definition of harm reduction recommended by the International Harm Reduction Association (IHRA) is used:

> *Harm reduction is a comprehensive package of policies and programmes which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individuals, drug users, their families and their communities.*[14]

Harm reduction is based on implementing evidence-based public health interventions to prevent or reduce the negative health consequences associated with the sharing of contaminated injecting equipment and to improve the health and social status of those at greatest risk of acquiring HIV/AIDS.[15] Harm reduction is a complimentary response to illicit drug use, and can work together with supply and demand reduction strategies.

Harm reduction does not conflict with abstinence as a strategy for reducing drug related harm, but gives priority to the more urgent and practical goal of reducing harm for users who cannot be expected to stop using at the present time. The approach acknowledges that no method to eliminate drug use has been demonstrated, and that HIV/AIDS presents a more serious global threat than drug use itself. [16]

Harm reduction approaches are both effective and cost-effective in reducing the spread of HIV among and from people who inject drugs.[17, 18, 19, 20] An evaluation carried out in 99 cities showed a reduction in HIV transmission risk by 19% in cities with harm reduction programmes, compared to an 8% increase in cities lacking them.[21] Harm reduction interventions have also been shown to be safe, and do not lead to increases in the number of drug users or the frequency of drug use.

3. RATIONALE FOR A BIREGIONAL HARM REDUCTION STRATEGY

Regional, political and jurisdictional boundaries, including those established by the WHO and the UN, are in a sense unrelated to the spread of HIV. Moreover, a biregional strategy that combines efforts of the two WHO regions will facilitate an Asia-wide response, providing crucial linkage among countries. Such links generate evidence for advocacy, support advocacy efforts, build and mobilize partnerships and resources, educate communities regarding harm reduction, and ultimately reduce the incidence and prevalence of HIV. The experience gained in some countries can benefit others through biregionally shared learning networks and collaboration between countries. International organizations and implementers in this process will assist in developing enabling policy environments for harm reduction.

WHO is well placed to support and contribute to advocacy efforts and the establishment of collaborative partnerships across the regions. This effort will help create enabling policy environments and the scale up of effective approaches to HIV/AIDS among people who inject drugs. In recognizing the need for an accelerated response in this area and the importance of health sector collaboration as its basis, the World Health Organization convenes the *Biregional Partners Meetings on Harm Reduction among Injecting Drug Users* (Appendix 2).

Asia is the centre of world heroin production. The wide and increasing availability of drugs and the rising trend of injecting drugs are fuelling HIV transmission here[22, 23]. Asia is also characterized by large mobile populations, shared social and economic interests, and transnational routes along which both drugs and HIV travel.

4. GUIDING PRINCIPLES

The following guiding principles are at the foundation of any effective approach to HIV prevention among and from people who inject drugs. While they flow from and build upon the UNGASS Declaration of Commitment[24], the Warsaw Declaration[25], the UNAIDS Global Strategy Framework on HIV/AIDS, and the WHO Global Health Sector Strategy on HIV/AIDS[26] it is important to note that they are experientially based, reflecting what has been shown to work.

- The most effective approach to preventing the transmission of HIV among drug users is one based on harm reduction.
- A multisectoral response is most effective, particularly where that involves all ministries that contribute to the overall social response to illicit drug use. The harmonization of drug policies and strategies with HIV/AIDS policies is essential.

- Responses to illicit drug use, particularly injecting drug use, and drug dependence must take account of the health and social consequences of HIV spread among this population and how such spread may be reduced.
- Community representatives are to be involved in planning, implementing and monitoring harm reduction initiatives. Peer education, as a cornerstone of effective approaches to HIV/AIDS among drug users, needs to be recognized and strongly supported.
- Effective HIV prevention is based on respect for the individual's capacity to make choices appropriate for them and, once given information, access the means of prevention and a supportive environment.
- The Biregional Strategy must accommodate the varying epidemiological, sociological and cultural environments that exist in Asia.
- Respect for the fundamental human right of all individuals to achieve the highest level of health attainable, consideration of the gender inequities that contribute to the epidemic and, non-discriminatory service delivery are essential to HIV/AIDS prevention and care.

5. EXPERIENCE SO FAR AND CHALLENGES AHEAD

Injecting drug use is a growing global problem and it is expanding in the Western Pacific and South-East Asia Regions. To address this mutual challenge, the two Regions will collaborate in a biregional response to control the HIV/AIDS epidemic among and from injecting drug user populations. Some countries in the Regions are already developing responses in this area and have gained valuable experience from which lessons have been learnt.

5.1 Experience in the Regions

Seven countries from the South-East Asia and Western Pacific Regions—India, Indonesia, Malaysia, Nepal, Thailand, Vietnam and China—are among those with a HIV prevalence of 20% or more among injecting drug users. In Malaysia, China and Vietnam, needle and syringe sharing accounts for the majority of HIV transmissions.

China

HIV/AIDS data indicates that HIV transmission among injecting populations is continuing to increase. Over half of the 25 injecting drug user sites detected HIV infection and HIV prevalence rates ranging from 1%-80% in the provinces of Yunnan, Xinjiang, Guangxi, and Sichuan.

In 2004, people who inject drugs constituted 43.9% of known HIV infections, followed by former plasma donors at 24.1%.

In 2003, the Government stepped up efforts to fight AIDS by revising policies, approving greater spending, showing a renewed willingness to accept overseas assistance and generally adopting a greater openness about the HIV/AIDS situation. A shift from describing illicit drug users as "illegal persons" to "illegal patients" suggests an understanding that illicit drug use is partly a health issue. The appropriateness of a harm reduction approach is recognized in the National HIV/AIDS Strategy, and China has accelerated its response in this area, with rapid implementation of methadone maintenance therapy (MMT) programmes, and some small-scale needle and syringe programmes (NSP) and outreach projects.

Indonesia

After very little change in the HIV/AIDS situation for many years, in the late 1990s an explosive HIV epidemic emerged among injecting populations. Injecting drug use now accounts for approximately 80% of new HIV infections.

The Indonesian National HIV/AIDS Strategy 2003–07 states, as part of the HIV/AIDS prevention policy that: "Harm reduction activities should be employed to reduce HIV infections among injecting drug users". In 2004, an MOU was signed between National Police and Social Welfare Ministries (on behalf of the National Narcotics Bureau and the National AIDS Commission) to facilitate multisectoral coordination to address HIV/AIDS and drug use. There is a limited funding allocation for NSP, substitution therapies, ART and VCT, although planning and implementation of these is yet to be finalized.

Donor support brought a considerable response to this rapid change in circumstances. However, activities are still small scale, reaching only an estimated 10%-15% of the target population in some areas. These include various pilot NSP and outreach programmes, pilot methadone maintenance programmes in two provinces, and methadone programmes to be trailed in two prisons.

Myanmar

HIV prevalence among people who inject drugs in the capital, Yangon, had reached 73% by 1989, and since then, HIV infection rates among injecting drug users tested in Yangon and Mandalay have ranged from over 50% to 85%.

In 2002 a national workshop achieved consensus on an operational plan for scaling up effective interventions for reducing HIV infection among

people who inject drugs. Current activities are focused in Kachin, North Shan and East Shan States, areas thought to cover 85% of the drug dependent population. The ministries of Health and Home Affairs have worked alongside UN agencies, INGOs and NGOs to commence small-scale pilot programmes with a focus on NSP, outreach, methadone substitution therapy and advocacy. A concerted effort will be required to ensure people who inject drugs have equal access to upcoming ART services. Drug substitution therapy provision will also need to expand rapidly.

Nepal

During the early 1990s, HIV prevalence remained under 1% among injecting drug users. However, by 1998, 50% of people injecting drugs surveyed in Kathmandu tested HIV-positive, another example of the explosive nature of HIV transmission among people who inject drugs. In early 1999, the National Centre for AIDS and STD Control of the Ministry of Health in Nepal conducted an HIV prevalence survey among injecting drug user populations in 19 cities throughout the country which showed a national overall HIV prevalence of 40%, with Kathmandu registering 50% of people who inject drugs as HIV-positive.

Kathmandu was the site of one of the first NSP in Asia, however, it was small scale and thus failed to have an impact on the course of the epidemic. In 2002, efforts were made to introduce harm reduction interventions 'to scale' across the country. Nineteen programmes were initiated and operative over an 18-month period, reaching an estimated 8000 injecting drug users. This should have been a showcase example for the region. However, due to wavering or withdrawal of political support, many of the programmes were closed in 2003.

The Philippines

The Philippines has been characterized as one of the countries to have a "low and slow" epidemic; adult HIV prevalence is estimated at <0.1% and largely attributed to sexual transmission.[27] Rather than take the steps that would prevent an epidemic, the response has similarly been "low and slow" notably with respect to the potential for transmission among drug users. Sentinel surveillance was established in 1992, however Cebu City was the only site that identified and collected data among drug users. There is now no monitoring of HIV among drug users elsewhere. There is however, considerable anecdotal evidence of widespread injecting drug use. For example, the emergence of injecting drug use was highlighted in another of the sentinel surveillance sites, where it is estimated there are some 400 injecting drug users.[28] Where studies have been done among drug users, needle and syringe sharing is common, including through shooting galleries servicing extended geographical areas.[29] There has been

very little action from the government, including the response to drug use and need for treatment services.[30] There are very few harm reduction interventions, no national consensus on the extent of drug use, and no national strategy to prevent the development of an IDU driven HIV epidemic.

Viet Nam

Significant levels of HIV infection among drug users were recorded in Viet Nam as early as 1993. HIV prevalence has rapidly increased among people who inject drugs (from 9.6% in 1996 to 29.35% in 2002). [21] Injecting drug use related transmission represents 60%–89% of all known cases.

The recently adopted Strategy for HIV Prevention and Control in Vietnam (2005-2010) explicitly adopts harm reduction as the basis of the response to HIV/AIDS among drug users. It has committed to the inclusion of people who inject drugs in HIV prevention and care services, including ART[ii]. Currently there are some small-scale harm reduction initiatives, and some links have been established between law enforcement and health sectors.

These few regional examples provide some valuable lessons for harm reduction implementation and highlight the need for a timely response and adequate coverage within a supportive policy environment. Asian countries have been slow to respond to the challenge of HIV prevention among people who inject drugs. The response has been small scale, sporadic and accompanied by a punitive response to illicit drug use rather than a comprehensive one, including a health-oriented component targeting those who do use drugs.

5.2 Challenges

Who is at risk?

All those who inject drugs and may at some time share needles and syringes and other paraphernalia are at risk of HIV and other blood-borne infections. There were an estimated 13.2 million people who inject drugs around the world at the end of 2003, with 10.3 million of them living in developing countries.[31] In the Regions, injecting drug use has been reported among consumers of a number of different drug types: opioids, amphetamine type stimulants, cocaine and other psychoactive substances.

Although there is a lack of research into the numbers of people injecting drugs in many countries, which must be addressed to, best plan and manage an effective response, we know that drug use and injecting drug use are increasing. The stereotype of the addicted drug user does not

[ii] The Ministry of Health plans to provide 70% of all PLHA with ART by 2010.

describe the majority of those who need to be reached with HIV prevention and education. Dependent use is not an immediate outcome of first use for heroin users, and there is typically a period of one to two years before dependent using is reported.[32] Many drug users do not become dependent and drug use for many is a functional aspect of their lives, often having immediate benefits and mostly experienced as pleasurable, with only a minority experiencing significant problems.[33] For example, many heroin users are able to control or moderate their drug use for sustained periods. Research cited by the Australian National Council on Drugs found that the proportion of heroin users who become dependent is estimated to be about 23% of those who ever use heroin.[34] This means that HIV education and prevention efforts related to drug use need to reach a much larger audience than the number of drug dependent users suggests. And this group will not be accessible through drug dependence treatment services. Thus HIV prevention must reach beyond prisons, detoxification, treatment and rehabilitation centres. As important as it can be, MMT will still only be applicable to a minority proportion of the at-risk target population. Building capacity among service providers to increase such knowledge regarding dependency and behaviour change will facilitate greater efficiency in targeting interventions.

Coverage

Work on the resource needs for effective HIV/AIDS prevention and treatment[35] has proved useful in the development and reporting of service coverage[36]. This work is also useful in establishing service levels, however some countries do not report HIV/AIDS among injecting populations either because it is thought that injecting drug use is not practised, or because data is not collected. For these countries, the experience of Indonesia and Cambodia provide good evidence of the speed with which circumstances can rapidly change and emphasize the importance of developing suitable mechanisms for monitoring and reporting on HIV and drug use. Section 7 discusses goals and indicators for HIV prevention among people who use drugs in the Regions.

Rethinking drug dependence treatment

Drug dependence treatment is, in many cases, within a social affairs, justice and public security portfolio. But the involvement of the health sector in the provision of evidence-based drug dependence treatment has become a key issue. Drug dependence treatment has generally been under-resourced and has often had the effect of taking those caught for using illicit drugs out of their communities, without providing any credible treatment or therapy. Where treatment programmes are available they may not yet have adapted to the rapid rise in the use of amphetamine type stimulants in the region. In most countries, a range of evidence-based, voluntary drug dependence treatments is not widely available.

There are reports of growing private sector entry into this area, yet few countries have standards or service accreditation mechanisms in place. Effective, transparent systems are required for monitoring and evaluating services and programmes.

Where treatments are provided by the State, these are usually based on simple efforts to achieve abstinence, however, relapse rates in excess of 90% are associated with these programmes.[37] Countries should ensure provision of an array of quality-controlled, evidence-based drug dependency treatments, including maintenance[iii] substitution therapy. This will have positive outcomes both in terms of HIV prevention and general health and lifestyle improvements among clients.

Community Development

Experience has shown that a key to success is the involvement of vulnerable communities as partners in the development and delivery of the response. Following the recommendation of the Third Biregional Partners Meeting, community representatives will be involved in the development and delivery of the biregional harm reduction programme.

The development of community capacity to participate should also be an outcome of the programme. In some countries, where, for example, it is mandatory to report drug users to the authorities, implementation of certain regulations will need to be tempered by the more urgent public health imperative of HIV/AIDS prevention. An enabling and supportive environment is required to have meaningful target community involvement. Capacity development for community participation and the involvement of people who inject drugs can also include, for example, support and/or training for proposal writing, public speaking, management and programme coordination, report writing and similar activities. It can also involve sponsoring participation in national and international forums and conferences.

Intersectoral Partnerships

Partnerships at all levels, particularly between those ministries and departments that directly or indirectly target drug users, including Health, Public Security, Social Security, Justice and Drug Control, are critical. Health and law enforcement sectors should work in partnership to develop

[iii] "Maintenance therapy" means, in this case, a period negotiated by the client and doctor that can, in some cases, extend for years. The emphasis is on maintaining clients in treatment until they are willing and able to abstain, thereby reducing much HIV transmission risk, and offering lifestyle stability which can then support harm reduction interventions, ART and adherence to medications, counselling and other service provisions as available and appropriate. Substitution therapy is not appropriate for all opioid users.

and support legislation, policy and practices that facilitates effective HIV prevention.

Harm reduction programmes cannot function without effective partnerships at the site level, and sustainability will be compromised without vital cooperation at provincial and national levels. Capacity building for police and health workers must highlight the importance of the role they can play and the public health imperative. At the site level, this will enhance police and health cooperation, facilitate access for NSP and substitution therapy clients, and allow people who inject drugs to be contacted through outreach work. Police and health sector representatives should establish joint "steering committees" designed to resolve any programme issues as they arise. Appropriate guidelines for police should be developed with regard to NSP and drug treatment clinics, non-fatal drug overdoses, and drug user organizations.

At provincial and national levels, the collaboration of relevant sectors is required to redress policy obstacles to the implementation of harm reduction initiatives, such as condom and injecting paraphernalia restriction laws. Adjustments may be necessary at local, state, national and regional levels to ensure law enforcement, health and corrections authorities have the necessary capacity to play central roles in controlling HIV transmission among and from people who inject drugs. Training is necessary for health workers, police and corrections staff at all levels including in training institutions and in service. The development of a range of resources is required, from research summaries for high-level administrators and curricula for training institutes, to pamphlets for workers in the field.

Stigma and Discrimination

Responsible programme planning authorities should be aware of the challenge inherent in addressing a stigmatized and stereotyped population. Despite the common perception, this is a heterogeneous population and the goal should be development of comprehensive programmes that reach all those at risk. This is a group with little or no incentive to expose itself or to become readily accessible. Even those who are dependent and desire treatment will be reluctant to seek it if the cost is social disenfranchisement, shame for the family and possibly a long period of confinement. Relevant health sector planners and service providers need to understand such facts in order to facilitate the development and effective delivery of a broader array of drug treatment and HIV prevention options.

Injecting drug user populations are generally well hidden in the community, largely for fear of stigmatization, discrimination and incarceration. To gain access to this "hidden population" and to achieve high target group coverage with relevant services and credible information, peer education has been demonstrated to be a powerful mechanism.

Closed settings

The response to illicit drug use across the regions continues to be dominated by punitive action resulting in drug users being jailed[iv] or placed in compulsory treatment and rehabilitation centres, despite clear evidence that these mandatory institutional, or closed, settings are not only ineffective in assisting drug dependent people to cease drug use, but can also significantly exacerbate HIV transmission among and from this population (fig 3)[v]. Drug use and sexual activity continue, and there are documented cases of HIV infection within such settings.[38] While inmates are generally able to access drugs they can inject, restrictive policy means that injecting equipment is less available, and sharing is the norm. One study reported that 50% of inmates were drug injectors, that almost half injected while in prison and that 94% shared injecting equipment.[39] These circumstances, common to closed settings throughout Asia, have been known to lead to HIV outbreaks within such institutions. [40] Detainees will return home with the attendant risk of transmission to partners, families and communities.[41]

If people are placed in such closed settings then it is important that HIV/AIDS education is provided for staff and inmates. However it is evident that awareness of risks alone will not significantly impact on HIV/AIDS prevalence in prisons. Some prisons are now finding that successful control of the epidemic in correctional facilities can be achieved through implementation of additional harm reduction interventions including the provision of prevention commodities such as bleach for sterilization of injecting equipment, NSP and condoms, and provision of substitution therapy, and VCT with ART. The implementation of these interventions reflects the pragmatic acknowledgement that, even in the highly controlled environments of closed settings, supply and demand reduction approaches will not completely eliminate drug use, and that the associated risks for inmates and society should be actively reduced. A recent study concluded that "extensive evaluation of demand and harm reduction strategies in community settings has suggested similar benefits are likely in correctional environments"[42]. These interventions have been implemented successfully for over 10 years in some countries[43], proving effective in reducing the risk of HIV transmission in prisons.

HIV prevention education and access to the means of prevention (condoms, needles and syringes, substitution therapy, bleach, peer education, IEC) are required in these settings. In addition, a review and reform of policy that may otherwise obstruct harm reduction programmes in closed settings is necessary. Legislative change or amendment is required to move away from a punitive approach as the major response to drug use, towards addressing the issue in socio-medical terms.

[iv] Including prisons, detention or remand centres and police lockups.
[v] see Appendix 1

Approaches adopted by national AIDS programmes should apply equally to inmates and to the community. Countries in these two regions have an excellent opportunity for including drug users in closed settings early in the scaling up of MMT[vi], ART and VCT.

6. THE BIREGIONAL STRATEGY

6.1 Goal and Objectives

Goal: To reduce HIV incidence resulting from the sharing of needles and syringes in drug use in the South-East Asia and Western Pacific Regions.[vii]

Objectives:

- ☑ to ensure access to the essential prevention package for people who inject drugs;
- ☑ to ensure access to treatment, care and support services for people who inject drugs; and
- ☑ to create an enabling environment for harm reduction interventions.

6.2 Objective 1. Access to the Essential Prevention Package

Many regions have successfully prevented HIV epidemics through injecting drug use [44, 47, 48] and there is good evidence for what works in preventing the spread of HIV through injecting drug use [49, 50, 51, 52, 53] . There have also been studies into why seroprevalence has remained low and stable[54, 55]. One study looked at five cities and identified common prevention activities, summarized in Table 1, below. This suggests that success is the result of starting work relatively early, including the provision of sterile injecting equipment, community outreach, and expanded drug dependence treatment. These findings have been supported by more recent work in India[56].

Table 1. Prevention activities of cities in which HIV prevalence has remained low and stable

Cities	Began early	Provided Sterile Equipment	Community Outreach	Greatly expanded drug treatment	Extensive HIV testing	Bleach Distribution	Self-reported behaviour change among IDU
Glasgow	✔	✔	✔				✔
Lund	✔	✔	✔		✔		✔
Sydney	✔	✔	✔	✔		✔	✔
Tacoma	✔	✔	✔			✔	✔
Toronto	✔	✔	✔			✔	✔

[vi] Indonesia is planning to trial MMT in two prisons.
[vii] including secondary, sexual transmission among and from drug users.

Along with access to information and education, these key interventions together constitute the essential prevention package (EPP) for effective prevention of HIV for people who inject drugs.

Implementing this package at the necessary level can slow, stop and reverse the spread of HIV among those who inject drugs and their sexual partners. One intervention alone (such as needle and syringe programmes, or outreach) will not have the desired outcome; the combination of interventions is required to make an impact on the epidemic [12, 13].

People who inject drugs are difficult to identify and reach, and peer-based education and outreach have been shown to be most effective for providing HIV prevention information and education [13]. Due to their familiarity with drug cultures and communities, peer outreach workers are also uniquely able to identify additional risks of HIV transmission (through, for example, different modes of drug preparation) and to develop and deliver credible prevention information materials. These interventions, which have been shown to be effective in several developing countries, are detailed in Table 2. A suitably enabling political, legal, social and medical environment (see sub-section 6.4) is optimal.

Table 2. Essential Prevention Package

Information and Education
• Ensuring individuals are capable of acting to protect themselves and others is a key task. The first requirement is information and the opportunity to learn how to prevent HIV transmission. • Targeted information in appropriate style and language will be most successful in reaching particular communities. • Education is best achieved using peers-as-educators. • Given the alarming trend to increased injecting throughout Asia, non-judgemental interventions to reduce initiation into injecting[58, 59, 60, 61] [viii] should be explored.
The means of prevention: needle and syringe access and condom
• To protect themselves and others, people require access to the *means of prevention*: needles and syringes, condoms, lubricant. • NSP have been proven effective in reducing the sharing of needles and syringes among people who inject drugs and in preventing HIV transmission. It has been shown that NSP do not increase drug use or numbers of drug users62, 63.

[viii] Some programmes trailed elsewhere acknowledge that first-time injectors generally start with more experienced associates, and so work with injecting drug users to discourage introduction of injecting to novices

- Sectoral planning should aim to ensure access to the means of prevention at those times and locations as is required to reduce sharing of contaminated equipment to a minimum.
- NSP programme development should therefore be multisectoral and include the public and private sectors: strategies should be employed to involve the private sector (e.g. pharmacies) in ensuring affordable and available access to the means of prevention; a variety of appropriate delivery models (e.g. including fixed and mobile outlets, outreach, vending machines) should be explored.
- Safe disposal is an essential component of NSP programmes, ideally utilizing existing hospital waste or other incinerator facilities as an end point.

An expanded range of drug dependence treatment

- Drug dependence treatment is an effective way of reducing both the demand for illicit drugs and the risks associated with drug use.
- A range of drug dependence treatment options is encouraged in order to attract more drug dependent people into treatment[64, 65].
- Drug substitution maintenance programmes have been demonstrated to reduce or eliminate injecting. Clients of these programmes significantly decrease their illicit drug consumption, are less involved in crime, and gain greater stability in their lives.
- All drug treatment services should have HIV prevention and education integrated into their treatment programmes and should ensure access to the means of prevention.
- Extended programmes, including e.g. vocational training, social reintegration support will improve outcomes.
- Drug dependence treatment services also offer opportunities to provide integrated HIV treatment and care.

Outreach

- The most effective way to access hidden populations who inject drugs is by taking interventions to those in need through outreach.
- Outreach has been shown to be effective in reaching a larger proportion of the injecting community over a short period, particularly where people with experience of illicit drug use are employed as outreach workers.
- Outreach workers and other harm reduction intervention staff may also have an important role to play in supporting equitable access, and adherence, to ART.[ix]

The issue is no longer whether or not to implement this package but how to implement it on a scale necessary to prevent or stop the spread of HIV within this community. In countries, provinces or areas with established epidemics among drug users, the immediate implementation of the essential package is critical. For those yet to experience such epidemics, the opportunity exists to prevent the establishment of significant HIV epidemics among drug users from the outset.

6.3 Objective 2. Access to treatment, care and support services

For some countries HIV infection is already well established among drug using communities and these communities are most affected by the epidemic. HIV/AIDS treatment and care services must be planned with this in mind and identifying entry points and ensuring equitable access will be critical to this effort.

Comprehensive HIV/AIDS treatment, care and support for people who inject drugs

While the health sector is responsible for the provision of prevention, treatment and care services for People living with HIV/AIDS (PLHA), outcomes will improve if additional, ongoing support is provided, including psychosocial, counselling, financial, legal and employment, as well as assistance with housing and living in an enabling environment and the care and support of orphans. All PLHA should be seen as partners in their own care and incorporating harm reduction principles into the continuum will facilitate non-judgemental service delivery while helping drug user clients minimize harm. Treatment staff may require training to understand the issues affecting injecting drug user PLHA, their drug use and drug treatment concerns. Specific considerations with regard to drug users as clients include supportive strategies for clients who have difficulty adhering to treatment regimens, and the need to appropriately address pain relief for people who inject drugs within and outside health care settings. Support for families and friends is also needed, including training and education programmes on home-based care for PLHA[66, 67], and on dealing with drug use or drug treatments[x].

Complications likely to be encountered when planning for services to reach drug users is the stigma associated with drug use and the discrimination drug users experience. Fear of prejudice, harassment and arrest and of health

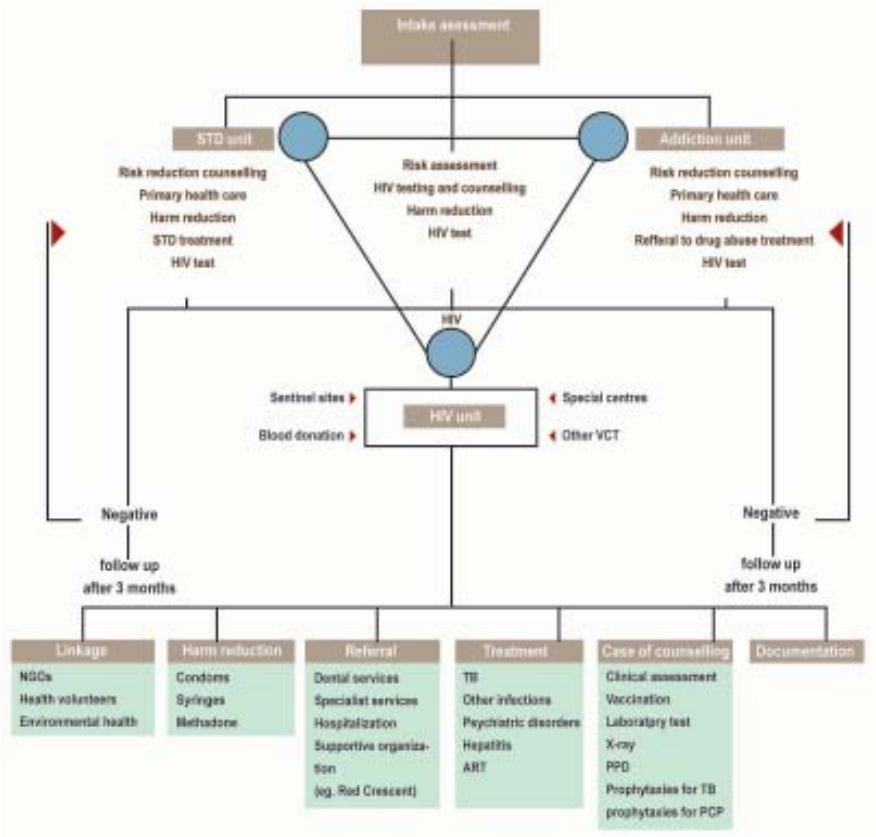
[ix] Outreach and NSP also provide an important "gateway" for people who are frequently otherwise not in contact with health services. NSP and outreach staff can provide harm reduction information and materials as well as client-driven referral to treatment and support services as available.

workers failing to guard confidentiality often result in limited access to a full range of services for people who inject drugs.[68] Another issue is that drug users may experience periods out of their communities through incarceration or compulsory drug treatment. These challenges can be overcome and several countries have demonstrated that a continuum of care is optimum in providing care and support for those affected.[69] A continuum of care will include treatment of all co-morbidities and an adequate referral and collaborative care network from hospital to the community, and home.[70]

The longer-term goal may be the integration of HIV prevention, treatment and care services into general public health service delivery models. However it is likely that this will not immediately or always be possible, including where injecting drug users, particularly those who are drug dependent or continue to use, are patients. Programme planning should be flexible, adopting delivery models that reflect local realities and encourage maximum service utilization. This may mean linking a number of specialized services and access points. In areas of high prevalence and continuing risk or where particularly vulnerable populations are established, integrated services can be most effective. This has been successfully demonstrated in very different settings, e.g. The Kirketon Road Centre in Sydney Australia[71] and the Triangular Clinic in Kermanshah, Iran[72]. The Triangular Clinic (Fig. 1, page 24) is adaptable, it has been adopted in community as well as closed settings: it is now being used in at least six prisons in five provinces and in drug rehabilitation centres.

[x] Specific medical information concerning drug interactions, toxicity management and ART in patients with chronic liver disease is provided in the WHO publication; "Comprehensive Care and Treatment of the HIV-Infected User" whilst a WHO SEARO publication has addressed general issues of HIV care are covered in "Scaling-Up Antiretroviral Therapy in Resource-Poor Settings" WHO SEARO Feb 2004

Fig. 1. The Kermanshah Triangular Clinic



These approaches should be considered as part of a continuum of care for countries in this region where injecting drug use is responsible for significant HIV infection.

A particular challenge in HIV treatment and care in this context is successful access to anti-retroviral therapy (ART), the focal point of the joint UNAIDS/WHO 3 by 5 Initiative[xi]. The 3 by 5 Initiative is a beginning (see Appendix 1, Table 1), which will make a substantive contribution to improving conditions for PLHA in the Regions. It is a step towards the goal of universal access to ART and HIV/AIDS care for all those who need it. Historically, disregarding the rights of the most vulnerable has allowed HIV to flourish and in accordance with International Human Rights Policy, WHO supports the availability of ART to all PLHA, regardless of mode of transmission and the legal status of past or current behaviour[xii]. Part of this action will be to develop treatment access models and conduct action research to rapidly adapt these models.

[xi] To treat 3 million people in the developing world with antiretroviral drugs by the end of 2005. See also Appendix 1, Table 1 for a regional breakdown.

At present, in countries across the two Regions, people who inject drugs represent a minority of those receiving ART even though they are often a substantial percentage of those infected. This discrepancy is medically and ethically unacceptable and developing treatment and care services that can reach this client group is a major challenge. Work on ART service provision for people who inject drugs is being undertaken by the World Health Organization and it should lead to wider availability.

The capacity of people who inject drugs to adhere and benefit from ART has been raised: evidence demonstrates that HIV positive people who inject drugs can benefit as much as others from ART provided health care systems are adapted to meet their needs.[73, 74] The key to effective ART and treatment of any co-morbidities is careful assessment and education of the person leading to the development of an individualized treatment plan to maximize adherence. Social services, education, adherence support, drug substitution and other substance use treatment are vital elements of an effective HIV care programme. If injecting drug users are able to keep medical appointments and adhere to a drug schedule, they are likely to have as successful a response to ART as other PLHA. In a non-judgmental care environment, any relapse or on-going substance use can be addressed as a problem requiring additional attention, and can be managed as are other co-morbidities[75].

It has been suggested that drug users should be abstinent or at least entering drug dependence treatment in order to access ART. This presents serious obstacles for those who suffer from a chronic, relapsing medical condition and ill-founded efforts at dependence treatment can lead to relapses in drug use, associated with non-adherence or failure in ART. Notwithstanding this, one approach to improving access to ART for PLHA who inject drugs can be to link it with the expansion of evidence- based drug dependence treatments, particularly opioid agonist pharmaco-therapies. These provide regular patient–clinician contact and have demonstrated capacity to assist patients to achieve a more stable lifestyle. ART should be adapted to meet the needs of the patient (regardless of background) and, where required, patients should be offered assistance with adherence.

Examples of ART provision for people who inject drugs demonstrate that such programmes are attainable and sustainable in developing and transitional countries. [30, 76, 77, 78] These include examples of practical steps to increase service availability and accessibility for people who inject drugs. Studies undertaken in 2004[79] for the World Health Organization revealed

[xii] WHO HIV/AIDS Treatment and Care Protocols for Countries of the Commonwealth of Independent States, 2004, states: "Access to HIV treatment should not be artificially restricted due to political or social constraints. Specifically, there should be no categorical exclusion of people who inject drugs from any level of care. All patients who meet eligibility criteria, and want treatment should receive it, including people who inject drugs.

the lack of access to both general health services and HIV treatments in Asia and elsewhere.

Table 3. Check-list towards providing ART for injecting drug users

- Provide low cost ARV therapy and professional training to ART providers
- Develop links between ART providers and organizations working with people who inject drugs
- Integrate curriculum dealing with HIV/AIDS and drug use issues into training for health and social care workers
- Identify and redress policy and practice barriers to ART access for people who inject drugs
- Enact universal anti-discrimination policy and practice ensuring access to ART regardless of how HIV was contracted
- Scale up peer-based outreach as a first step in accessing, and potentially providing ART to, people who inject drugs
- Scale up substitution treatments and link with peer education and ART providers. Drug use can be stabilized by a variety of treatment options and at the same time primary health care needs can be met
- Provide pre-ARV treatment for OI, HCV and psychosocial support
- Support local organizations in grant application writing

Expansion of Voluntary Counselling and Testing

In developing countries, fewer than one in 10 HIV-positive people know their serostatus[80], and in SEAR and WPR, voluntary testing coverage has been estimated at less than 0.1%.[8] While testing for HIV is the first step towards treatment, it has not been generally advocated unless access to treatment services can be provided. The 3 by 5 Initiative target and other initiatives have improved the value and attractiveness of HIV testing for those who might previously have had little incentive to learn their serostatus[81].

The World Health Organization supports Voluntary Counselling and Testing (VCT)[xiii] and targeted community education campaigns can encourage those at risk to seek testing. VCT includes pre-test and post-test counselling for both HIV negative and HIV positive persons. An efficient referral system to HIV/AIDS and harm reduction services is crucial: those tested HIV positive should be offered follow-up counselling and referral to treatment providers, HIV/AIDS care and support, NSP,

[xiii] VCT is a voluntary and confidential process by which a client chooses to be tested for HIV.

outreach and peer education programmes, and support groups. For HIV negative people, information and referrals to prevention services should be provided, as well as where to find appropriate information and referrals to drug treatment options.

The uptake of VCT by people who inject drugs is often constrained by their valid concerns over stigmatization and resultant discrimination. In order to provide non-judgemental services thereby improving treatment uptake, procedures, policies and training on VCT and drug use issues will be required. Referral networks linking other services targeting people who inject drugs (particularly those services which are peer-based) to VCT and other elements of a continuum of care will improve treatment access and outcomes.

6.4 Objective 3. A Supportive and Enabling Environment

It is the responsibility of government to ensure the provision of an effective and efficient response to HIV/AIDS among people who inject drugs. Health ministries have a key role to play, in drafting public health policy, and as service providers. Public health policies and services should be evidence-based, cost-effective and comprehensive.

Multisectoral Partnership

A partnership approach between those sectors involved in addressing both HIV/AIDS and drug use will be most effective and the health-sector should be proactive in its support of a multisectoral response and in development of this partnership.

Particular efforts will also be needed to build intersectoral collaboration, between the Ministries and Departments that directly or indirectly address issues related to illicit drug use including Health, Public Security, Social Security, Justice, and Drug Control. The nongovernmental and private sectors, civil society, international and regional agencies are a part of this collaboration and can play key roles.

To develop and deliver effective responses to the challenge of HIV/AIDS among people who inject drugs, affected communities should be empowered through support from relevant authorities, and through information, education, and participation in decision-making.

Advocacy efforts should target key points in the decision-making process, to gain the necessary high-level political and bureaucratic support. Advocacy for harm reduction should include the following: translation, adaptation and dissemination of WHO advocacy materials[xiv] into national lan-

[xiv] Including The WHO Advocacy Guide for Effective HIV Prevention Among Injecting Drug Users, WHO Policy Briefs on needle and syringe availability, substation treatment, outreach and prison settings.

guages; advocacy meetings and training workshops (national and provincial); the establishment of national, provincial and district advocacy groups; the development of advocacy materials for influential audiences, and advocacy campaigns.

Surveillance and Research

On-going surveillance and research among people who inject drugs is vital in providing sound evidence on the impact of HIV/AIDS interventions on the HIV/AIDS epidemic. Data remains insufficient in some areas to accurately monitor and report HIV prevalence and incidence among drug users. Indeed, many jurisdictions cannot report on the number of drug users or what proportion are injecting. Accurate data allows planners to confidently estimate HIV prevalence and incidence, both nationally and within vulnerable communities. This supports programme development and also provides evidence of effectiveness.

The development of what have been termed "second generation surveillance systems"[xv] should provide biological and behavioural surveillance of populations at high risk behaviour such as the injecting drug using population, bridging groups, and in the general population, depending on epidemic state. This system includes repeat cross-sectional surveys of behaviour and HIV sentinel surveillance in those target populations[82]. Ensuring that this does occur, however, may be dependent on advocacy efforts to convince policy-makers of the need and benefit of monitoring the situation in this vulnerable population.

Sentinel surveillance of people who inject drugs has more often been conducted through treatment centres and, in some countries, through the prison system. There is evidence, however, that such surveys are not representative of the larger injecting drug user population[xvi] and this information presents only part of the picture needed for developing an effective response to HIV. Some countries have successfully used peer-based and outreach programmes to carry out voluntary anonymous biological surveillance to strengthen their surveillance efforts. In some cases this has proved difficult because of constraints in accessing sentinel populations or because drug use is reportedly at very low levels. Where this is the case, surrogate approaches should be considered. For example, conducting specific surveys, studies or assessment on drug use and modalities of drug use may complement the behavioural surveillance to alert authorities to behavioural changes that increase the risk of HIV transmission in their jurisdiction.

[xv] Which are supported by the World Health Organization

[xvi] e.g. in Iran, where mandatory testing of marriage applicants, job applicants and driving licence applicants found 2.4% tested positive for opiates; 25% of those interviewed in a rapid assessment reported admission to a drug treatment facility and between 16% and 37% had been incarcerated (ref. 58).

A qualitative research programme providing valuable information on the social and sub-cultural milieu within which drug use and sex occur develops our understanding of how risk situations emerge and what changes are occurring within affected and vulnerable communities, particularly if it contributes to the monitoring of trends. Qualitative research is also useful in directing the development of targeted information, education and prevention programmes Efforts must be made to assist and ensure the sample is as representative as possible of injecting drug user communities. The most reliable results are obtained when peers are actively involved in mapping, sampling and recruitment.[83, 84, 85] Linkages with existing harm reduction services such as NSP and outreach programmes assist this.

Accountability, Monitoring and Evaluation

National strategic plans for harm reduction must develop systems ensuring accountability within government, among nongovernmental service providers as well as systems supporting monitoring and evaluation. These mechanisms ensure:

- ☑ Interventions contained in national strategic plans are working effectively.
- ☑ Allocated financial and human resources are being used for the purposes intended.
- ☑ The community is kept informed of the successes of national strategic plans and of future actions.

Where financial support is provided performance agreements and indicators consistent with the UNAIDS "Three Ones" (see Section 8) should be included, contributing to monitoring and evaluation efforts as well as ensuring accountability. The participation of private sector contributors in monitoring and evaluation efforts is a further means of enhancing the quality of outcomes.

7. TARGETS AND INDICATORS

The goal of this strategy is to reduce HIV incidence resulting from the sharing of needles and syringes in drug use and secondary sexual transmission. To gauge the extent of success, or otherwise, data on HIV prevalence among injecting drug users in 2009 can be compared with the baseline year, 2004.

Appendix 3 provides some background and the rationale for the development of targets and indicators for this strategy, which draws on the work UNAIDS, the Three Ones: Key Principles, the UNGASS Declaration of Commitment on AIDS and the Millennium Development Goals.[86] Success in reaching these targets will largely depend on the degree

of commitment from Member States to introduce effective approaches to HIV prevention among people who inject drugs. The emphasis should be on scaling up to need so as to ensure that the majority of people who inject drugs have ready access to harm reduction interventions. Each country should identify national and provincial targets for coverage with minimum package services. The regional coverage estimates for 2003 (Appendix 3, Table 5b) highlight the urgent need for increased effort to build an appropriate response to HIV/AIDS among and from people who inject drugs.

Table 4.
Objectives, targets and indicators for the biregional strategy

Targets	Indicator
Objective 1. To ensure access to the essential prevention package	
• By 2008, EPP service levels are achieved (based on baseline HIV prevalence as discussed below).	• Number of countries that effectively report on number of injecting drug users and number eligible for ART. • Number of countries which achieve essential prevention package target (target for access to EPP will be dependent on their epidemic states, and use of sterilized equipment, as in table 5)
Objective 2. To ensure access to treatment, care and support services for people who inject drugs	
• Special provisions made to ensure that people who inject drugs have equal access to ART. • By 2007 all eligible HIV infected injecting drug users received adequate ARV therapy.	• Number of countries reporting strengthened health care systems and other necessary measures to expand HIV/AIDS treatment for people who inject drugs. • Number of reported patients with adequate ART who report IDU as mode of infection
Objective 3. To create an enabling environment for harm reduction interventions	
• By 2006, develop and/or strengthen national strategies, policies and programmes, to promote and protect the health of people who inject drugs. • Intensify interregional cooperation and coordination to develop strategies and responses in support of expanded country efforts.	• Number of countries with national HIV strategy that includes a prevention strategy adopting a harm reduction approach.

The work of Schwartlander B. et al[87] in 2001 discusses both essential prevention and care needs and the costs of these. This work has been adapted and used to report on service coverage in low and middle income countries[88]. It can also provide an indication of EPP service delivery levels, in different epidemic situations[89] in order to reduce HIV transmission among injecting drug users[xvii]. These levels are detailed in Table 5 below and should be used to guide programme development. Thus for example, in provinces or districts where HIV prevalence is > 5% among drug users (a concentrated epidemic through injecting drug use, as defined by UNAIDS/WHO), planning should aim to deliver the EPP to 80% of the target population must be achieved.

Table 5. Service levels for the Essential Prevention Package for varying HIV prevalence levels among injecting drug user populations[90]

HIV Prevalence Among Injecting Drug Users	V. Low (<0.5%)	Low (0.5-1%)	Med. (1-5%)	High (>5%)
Essential Prevention Package Coverage Target (%)	30%	30%	50%	80%
Target % of Injections Using Sterilized or New injecting equipment	70%	70%	80%	90%

8. IMPLEMENTING THE BIREGIONAL STRATEGY

Implementing the strategy will require effort to gain political support, capacity building across several areas, and the development of suitable monitoring arrangements to report and to refine activity. Despite the fact that the harm reduction approach has been proven essential to an effective response to HIV prevention among people who inject drugs, and documented examples of harm reduction initiatives show that the harm reduction approach can be effective in South-East Asia and Western Pacific Regions[91], only an estimated 1.5% of people who inject drugs in the regions have access to any harm reduction programmes or drug related treatment[92]. Such a limited response cannot be expected to have any significant impact on the epidemic. The reasons behind the delay in development of the response are complex but include the hesitation, in many countries, to account properly for the threat of HIV/AIDS among and from people who inject drugs. Complicating this is the tendency to focus on drug use as a social or moral evil, ignoring its significance as a public health issue.

[xvii] Note that to measure this it will be necessary to estimate the total number of injecting drug users. While such estimates may be difficult to derive, improving surveillance and service statistics will allow future refinement. In the meantime, current estimates of coverage are required to serve as a baseline against which to evaluate coverage.

There is a continuing need for advocacy at the highest levels of government as well as at provincial and local levels to support a multisectoral response.

The urgent challenge is to develop a programme based on proven interventions. The next is to develop this programme to a scale that will slow, reduce and reverse the spread of HIV. Such a programme must ensure sufficient coverage of the minimum prevention package (section 6) across the target group in order to have an impact on the epidemic. Table 5, Section 7 provides targets for this. A mechanism that ensures universal, equitable access to ART for people who inject drugs is also needed. Effort at national and regional levels should concentrate on these goals.

8.1 Political Support

Goal: Gain high-level political support both biregionally and nationally for a strategic response based on the harm reduction approach.

This will involve providing high-level advocacy for integrating HIV prevention and care for injecting drug users into national policy. Activities will include:

- support regionally for the Intercountry contact Group (ICG) and nationally by collaborating with UNAIDS and other cosponsors in establishing UNTG sub-committees;
- advocacy and technical support targeting appropriate sectors to facilitate development of national harm reduction policy and strategic plans;
- establishment of, and technical support for, regional, national, state/province and local advocacy coordination groups;
- extensive advocacy training workshops addressing concerns of segmented target audiences; and
- legal review and reform.

Action for World Health Organization Regional and Country Offices

- Advocate for the adoption of a harm reduction approach regionally and in Member States
- Support intersectoral advocacy efforts
- Translate and adapt advocacy tools and guidelines to assist these efforts
- Collaborate at country level and regionally, with UNAIDS and other multi-laterals in advocacy efforts, through support for and involvement in the UNTG

- Work to establish UNTG sub-committees addressing HIV prevention and care with injecting drug users in priority countries and to ensure HIV prevention and care with injecting drug users is included in the agenda in other countries

- Ensure leadership and coordination is provided regionally through active involvement in the UN joint response, represented by the UN Regional Taskforce on drugs and HIV vulnerability (UNRTF); and by collaborating with regional implementing agencies and donors

- Regionally build a sustainable collaborative relationship across the organization, as well as with other regional bodies (including through the continuation of the WHO biregional partners meeting and the ICG)

8.2 Resource mobilization

If left unchecked the economic impact of HIV/AIDS can be devastating. Harm reduction approaches have demonstrated cost-effectiveness, therefore priority investment in harm reduction programmes is a logical response. Most countries in the Regions either lack or have not allocated resources for adequate HIV/AIDS related prevention and care activities, and harm reduction programmes have yet to be introduced to scale. For countries already experiencing concentrated epidemics among people who inject drugs, it is important to note that maximum cost benefit can be achieved when interventions target people who inject drugs (and other vulnerable populations) before the epidemic becomes generalized.

Resources to establish and expand harm reduction activities to meet targets will, in many cases, require the support of international agencies and donors. However, the longer term should see governments of member states accepting increasing responsibility for programmes.

A concerted effort from all countries is needed to maximize funding for HIV/AIDS prevention through government budget allocations. Several national governments including Indonesia, Viet Nam, Myanmar and China are recognizing the need to develop a detailed funding plan as a key element of national harm reduction strategy. An effective funding plan will be supported by:

- effective systems and processes for estimating costs of these interventions;

- effective, transparent systems for funding allocations and accountability; and
- effective, transparent systems for monitoring and evaluating services and programmes

Action for World Health Organization Regional and Country Offices

- Encourage the inclusion of harm reduction in considerations for Global Fund and other resource applications, particularly for those countries where drug use is a major factor in HIV transmission

- Develop regional and country funding strategies to implement harm reduction approaches

8.3 Increasing Capacity

In order to improve access to prevention, care and support services it is necessary to develop ways to extend the reach of existing services, strengthen them by making them more "user friendly", expanding the range of services available and ensuring that a supportive environment is maintained. Activities will include:

- situation assessments, including Rapid Assessment and Response (RAR);
- preparation of health services, law enforcement, and the community through targeted advocacy activities;
- strengthen procurement and distribution system for supplies (sterile injecting equipment, substitution therapy drugs, etc);
- piloting and evaluating the programme; and
- programme expansion.

Workforce development and training is a key element for United Nations agencies, implementers, health workers, law enforcement, justice, and corrective services. The development and adaptation of tools, guidelines and training curricula on options for preventing HIV among people who inject drugs is needed for health, law enforcement, justice, and corrective services, and should include ways to reorganize and strengthen the existing health service delivery system and address the stigma and discrimination associated with drug use.

The list of those to be trained is long and the training materials are only now being developed in some sectors. The WHO is developing a harm reduction toolkit that already includes:

- *Advocacy Guide for Effective HIV Prevention Among Injecting Drug Users*
- *Training Guide for HIV Prevention Outreach to Injecting Drug Users*

- *Policy and Programme Development Guide for HIV Prevention and Care Among Injecting Drug Users*
- *Technical Guide to Rapid Assessment and Response*
- *Second Generation Surveillance for HIV: Compilation of Basic Material (UNAIDS/WHO Working Group on Global HIV/AIDS and STI Surveillance)*

These have been made available to implementing agencies and the health sector, and have been translated into Mandarin, Myanmar/Burmese, Vietnamese and Indonesian. The AusAID funded ARHP has also produced regionally available harm reduction training materials, translated and adapted for different countries (Myanmar, Viet Nam and China). These include a police curriculum, training materials and videos for police, the health sector and for outreach workers. The Burnet Centre for Harm (CHR), FHI and others have also produced relevant materials.

Nevertheless, there is a need for the expansion and broader application of training resources, to engage the public sector and to develop, standardize and accredit resources and national trainers to meet workforce needs as effective approaches are scaled-up to meet targets. Pre-existing training institutions and agencies should be involved in the provision of such harm reduction training (e.g. WHO/UNAIDS collaborating centres; medical and health training faculties; national centres for education, research; police academies etc.). A collaborative effort will be required to identify and utilize existing public/private health sector training facilities and services to help develop country workforces. In order to meet economies of scale, the development of regional level training centres or "knowledge hubs" may be a useful approach for providing or facilitating provision of standardized and accredited harm reduction modules for different occupational trainee groups.

Action for World Health Organization Regional and Country Offices

- Develop, translate and adapt tools and guidelines for health-sector contribution to harm reduction based service delivery to drug users in the community and in closed settings
- Support strategic planning and collaborative efforts
- Provide technical support to pilot harm reduction projects
- Develop and contribute to capacity building for effective service delivery
- Ensure people who inject drugs have equitable access to ART, and other care and support services

8.4 Measurement

Improved surveillance, monitoring and evaluation

Improving and refining surveillance, monitoring and evaluation is necessary for providing information for advocacy, policy decisions, programme planning and the development of performance indicators. It may be necessary to:

- develop surveillance systems that will provide information on the extent of drug use and injecting drug use and on behaviour change within this population;
- monitor and report on the impact of HIV on injecting drug user populations;
- assess the magnitude and contribution to HIV epidemics of injecting drug use related cases; and
- monitor, evaluate and report on the impact of national programmes and their collaborative efforts.

Action for World Health Organization Regional and Country Offices

- Support RAR in areas where is it thought injecting drug use is an issue of concern
- Include injecting drug use issues in BSS and HSS surveillance
- Support the development of qualitative research programmes that include issues related to HIV/AIDS and injecting drug use
- Support national and provincial size estimation
- WHO will strengthen its collaboration with UNODC on research and surveillance across the Asia-Pacific region. WHO should support the research UNODC undertakes regarding drug use patterns, incarceration, size estimates etc. with connections to health issues and HIV

9. CONCLUSION

Without implementation of full HIV/AIDS prevention interventions by 2005, projections suggest that an additional 20 million HIV infections will occur in the two regions by 2010[108], together with severe associated social and economic problems.

The goal of the biregional harm reduction strategy is to reduce HIV incidence resulting from the sharing of needles and syringes in drug use. The strategy proposed is cost-effective and evidence-based with the full endorsement and support of the UN system.

The guiding principles were devised on the basis of effective collaboration between countries in the regions to integrate within the health system the harm reduction approach to HIV/AIDS among people who inject drugs.

The strategy proposes steps for the implementation of harm reduction activities, ranging from Rapid Assessment Response (RAR) activity and the development of harm reduction policies and strategic plans, to the preparation of health services and communities for phased implementation of harm reduction programmes.

The World Health Organization Regional Offices for South-East Asia and Western Pacific, together with the WHO Country Offices, are committed to supporting implementation of this Biregional Strategy for harm reduction as an important contribution to controlling the HIV/AIDS epidemic across the Regions.

APPENDIX 1. Figures and Tables

Figure 1.

HIV prevalence among people who inject drugs followed by increased prevalence among CSW

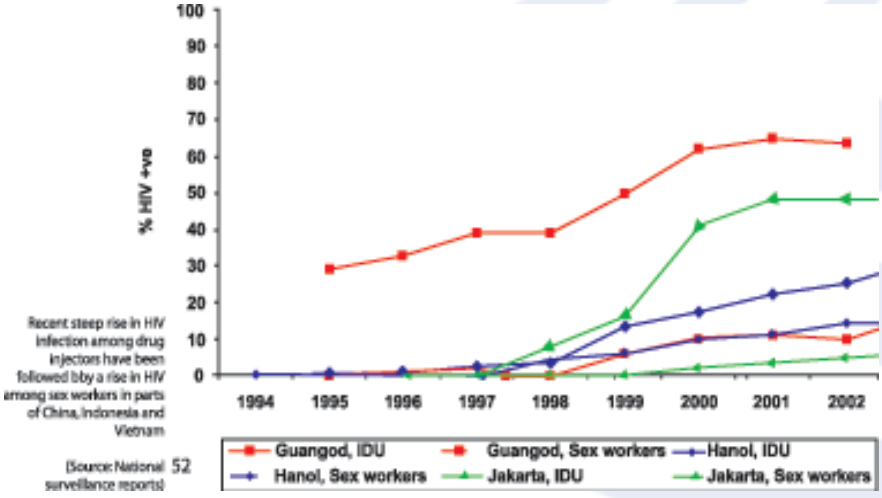
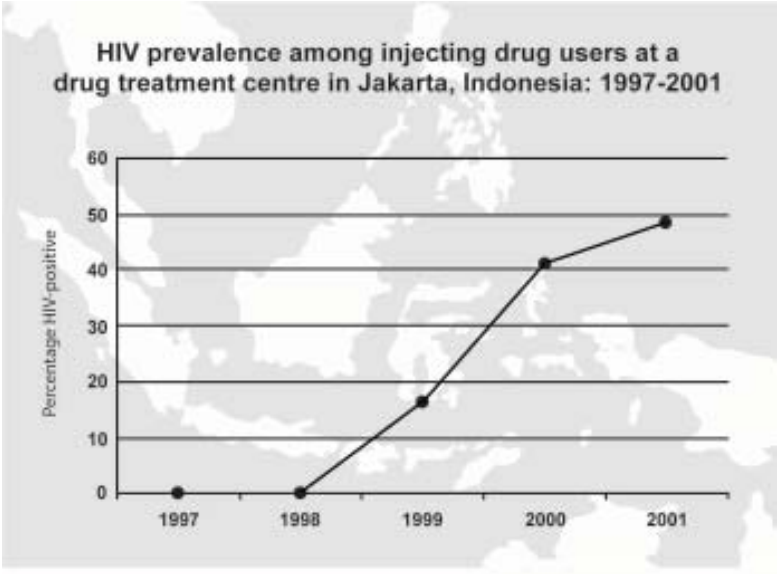


Figure 2:

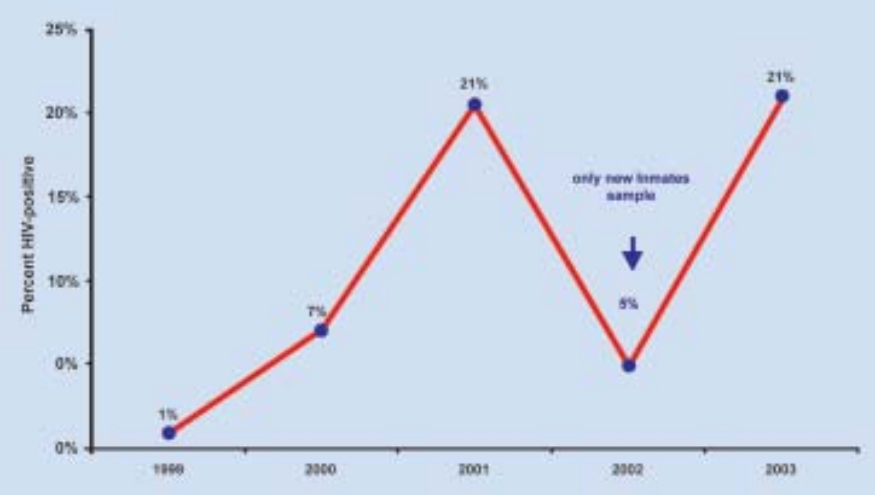
Explosive rise in HIV Prevalence among injecting drug users at the Drug Dependence Hospital, Jakarta 1997-2001



Source – RSKO[94]

Figure 3.

Percent of prisoners testing HIV positive at a West Java jail. 1999-2001 and 2003 are a random sample of all inmates, 2002 is new inmates only. The difference between new arrivals and all inmates suggests HIV is being transmitted within Indonesia's jails.



Indonesian national surveillance data; MAP report[95]

Table 1. Antiretroviral Therapy Needs and WHO 3 by 5 Targets[96]

Country	Total number of people needing ART	Number of people on ART in 2003	Proposed WHO 3x5 target by 2005
China	100 000	7000	30 000 – 50 000
India	687 000	13 000	343 500
Indonesia	19 500	1100	8650
Myanmar	63 000	1000	10 000
Nepal	9000	100	4500
Thailand	100 500	13 000	50 250
Vietnam	22 000	1100	12 000 – 15 000

APPENDIX 2. Biregional Partners Meetings

The first meeting, which had a focus on China, Myanmar, Indonesia and Viet Nam was held in Hanoi, Viet Nam, in October 2002.

The main recommendations of this meeting were:

- A call for urgent action specifically to prevent and reduce HIV epidemics among injecting drug users through harm reduction approaches.
- Broad application of the *Tools and Guidelines* developed by World Health Organization. These include:
  - *Advocacy Guide for Effective HIV Prevention Among Injecting Drug Users;*
  - *Training Guide for HIV Prevention Outreach to Injecting Drug Users;*
  - *Policy and Programme Development Guide for HIV Prevention and Care Among Injecting Drug Users;*
  - *Technical Guide to Rapid Assessment and Response; and*
  - *Second Generation Surveillance for HIV: Compilation of Basic Material (UNAIDS/World Health Organization Working Group on Global HIV/AIDS and STI Surveillance.*
- The establishment of a Regional Contact Group working with and through existing mechanisms wherever possible to:
  - further assist in the adaptation and implementation of the tools and guidelines;
  - formalize and organize national networks and relationships; and
  - provide advocacy at regional and international conferences, forums and meetings including with UN Theme Groups in each country.
- Address cross-border issues
- The development of capacity-building with intercountry training as a priority for advocacy purposes
- The establishment of regional resource centres to provide training to local and regional consultants

The second meeting with expanded participation including Cambodia, Malaysia and Thailand, was held in Yangon in August 2003. This meeting established the Intercountry Contact Group (ICG), supported the convening of a technical working group to assist development of a regional strategy and adopted the revised framework for the biregional strategy.

The third biregional partners meeting was held in Melbourne in April 2004. The meeting recommended several action points to the concerned parties, as follows.

Action points by WHO

In collaboration with UNAIDS cosponsors and other partners, WHO will:

- Assist countries to enhance effective intersectoral cooperation between health, correction and public security agencies for a comprehensive national workplan with regard to HIV prevention, care and drug dependence treatment for populations in closed settings. Partners for this include the UN Regional Taskforce on Drugs and HIV Vulnerability and the UNODC Regional Centre for East Asia and the Pacific.
- Advocate for enhanced national strategic plans for HIV prevention, care and support to address populations in closed settings equally to that which exists in the non-incarcerated community.
- Advocate and provide support for the greater involvement of people who inject drugs and with HIV/AIDS in designing and implementing prevention, care and treatment programmes at all levels. In this regard, representatives of people who inject drugs and with HIV/AIDS will be invited to join the WHO Technical Working Group on harm reduction.
- Build capacity in countries for the management of drug dependence treatment and antiretroviral therapy that address the specific needs of drug dependent people. In this regard, by April 2005, WHO in collaboration with UNODC and other partners will develop and adapt a toolkit addressing treatment needs for those who require drug dependence treatment and/or HIV prevention education and treatment in closed settings.
- Gather experiences from different countries concerning HIV/AIDS treatment and care for injecting drug users as possible models of good practice for countries to scale up services.

Action points by Member States

Recognizing progress already made, Member States should:

- Further strengthen effective intersectoral cooperation between health, correction and public security agencies, NGO and civil society with regard to HIV prevention, care and drug dependence for populations, including those in closed settings.

- Ensure national strategic plans for HIV prevention, care, support and treatment address populations in closed settings equally to what exists in the non-incarcerated community.

- Increase the involvement of people who inject drugs and with HIV/AIDS in designing and implementing prevention, care and treatment programmes.
- Advocate and develop supportive policies and implementation strategies for the management of drug dependence treatment and antiretroviral therapy that address the specific needs of drug dependent people.[xviii]

[xviii] Note that the goal of the statement is to be inclusive rather than exclusive, thus "HIV prevention, care …" is used as an inclusive term to simplify the statement, rather than having to repeatedly write HIV/AIDS education, prevention, treatment and care and drug dependence. Similarly, "people who inject drugs and with HIV/AIDS", refers to the involvement of people with HIV, people who use drugs, and/or both.

APPENDIX 3. Background to Targets and Indicators

UNAIDS Three Ones Key Principles

The "Three Ones", agreed to at the United Nations in April 2004, calls for a common Monitoring and Evaluation framework and recommends that these be linked to the UNGASS Declaration.

One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.
One National AIDS Coordinating Authority, with a broad based multi-sector mandate.
One agreed country level Monitoring and Evaluation System.

The UNGASS Declaration of Commitment on AIDS

The "Three Ones" Key Principles recommend that indicators should be linked to the UNGASS Declaration of Commitment on AIDS, and incorporate the following principles to forge stronger national monitoring and evaluation frameworks:

- Commitment to be made at global level to align their need for M&E to ensure accountability for funds and programme development based on results.
- Each national HIV/AIDS Action framework should be accompanied by a core system for monitoring progress towards controlling the epidemic.
- Stakeholders should agree on how systems can be improved to provide high quality data for analysing country performance.
- National governments, AIDS authorities and the associated development and AIDS action partnerships must invest in building essential human capacity to meet national M&E needs.[97]

The UNGASS indicator[98] related to injecting drug users (Table 5a) measures the extent to which HIV/AIDS prevention services are provided to people who inject drugs.

Table 5a. UNGASS Indicator for Measuring Harm Reduction Outcomes

Purpose	To assess progress in the implementation of programmes and services for the prevention of HIV transmission associated with injecting drug use
Applicability	Countries where injecting drug use is a significant mode of HIV transmission
Frequency	Biennial
Measurement Tools	Prevalence estimation methods for the number of regular injecting drug users for the denominator; Service statistics from outreach projects and programmes, and treatment facilities, for the numerator.
Method of Measurement	From existing data and information, the proportion of regular injecting drug users in service is calculated
Numerator:	Number of regular injecting drug users, who were, in the past month, reached with (outreach) prevention services plus the number of injecting drug users in drug dependence treatment, either longer-term drug-free* or substitution therapy.
Denominator:	Estimated total number of injecting drug users, disaggregated by sex if feasible.

Source: UNAIDS 2000

Table 5b. Current regional minimum package coverage estimates

Region	South-East Asia	Western Pacific
Actual Essential Prevention Package Coverage 2003 (%)	5.4%	2.9%

Schwartlander B. et al. and the POLICY Project 2004 report

APPENDIX 4. The Technical Advisory Group

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