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Regional Workshop on HIV and Drug Use

**HIV Prevention, Care and Treatment for
People Who Inject Drugs: A review of
evidence-based findings and best practices**

June 13-15, Nairobi, Kenya

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Rich Needle
Gillian Anderson
Shimon Prohow
Gaston Djomand

Acronyms List

AIDSTAR	AIDS Support and Technical Assistance Resources
ART	Antiretroviral therapy
CAHR	Community Action on Harm Reduction
CBO	Community based organization
CDC	United States Centers for Disease Control and Prevention
COP	Country operational plans
CSO	Civil society organization
FBO	Faith-based organization
FSW	Female sex worker
HBV	Hepatitis B virus
HVC	Hepatitis C virus
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HTC	HIV testing and counseling
IDU	Injecting drug user
IEC	Information, education and communication
KANCO	Kenya AIDS NGOs Consortium
KNASP III	Kenya National AIDS Strategic Plan III
MARP	Most-at-risk population
MAT	Medication-assisted treatment
M&E	Monitoring and evaluation
MOH	Ministry of Health
NASCOP	National AIDS Control Program (Kenya)
NGO	Nongovernmental organization
NSP	Needle and syringe program
OSIEA	Open Society Institute East Africa
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
RDS IBBSS	Respondent Driven Sampling Integrated Biological and Behavioral Surveillance Survey
SOP	Standard operating procedure
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization
ZACP	Zanzibar AIDS Control Program

I. Executive Summary

The majority of new HIV diagnoses in Sub-Saharan Africa are attributable to sexual transmission, but the influence of drug use and of drug injecting is becoming increasingly evident in many countries. Although data on drug use in the region are limited, injecting drug use has been reported in the majority of the 47 sub-Saharan countries and there are indications that HIV prevalence is high among people who inject drugs (PWID). Needle and syringe sharing is common, and extremely risky practices have been reported in Dar es Salaam and Zanzibar, Tanzania and in Mombasa and Nairobi, Kenya.

The response to HIV among PWID in the context of large-scale heterosexually transmitted generalized epidemics in the region has until recently been limited. While other countries are planning to introduce needle and syringe programs (NSPs), Mauritius is the only country in sub-Saharan Africa where these programs have been implemented. Medication-assisted treatment (MAT) – one component of a comprehensive HIV prevention program – has been implemented in Mauritius and Tanzania. Several other countries are considering the introduction of MAT into their HIV prevention portfolio.

The regional workshop on HIV and drug use, HIV Prevention, Care and Treatment for People Who Inject Drugs: A Review of Evidence-Based Findings and Best Practices, took place June 13-15, 2011 in Nairobi, Kenya. It was convened as one of a series of three regional meetings to bring together government officials, civil society, multilateral agency representatives and US Government (USG) field staff from select countries in sub-Saharan Africa and to share evidence-based practices, lessons learned, and the way forward for improving strategic planning for HIV prevention and care among PWID. Participating countries included Kenya, Tanzania, Nigeria, Seychelles, Mauritius, Madagascar, Mozambique, and South Africa.

The meeting focused on advocating for and supporting the introduction of an evidence-based comprehensive HIV prevention for PWID in sub-Saharan African countries. PEPFAR, WHO, UNODC, and UNAIDS support a comprehensive package of the following interventions for PWID: community based outreach; needle and syringe programs; medication-assisted treatment; HIV testing and counseling (HTC); HIV care and treatment; prevention and treatment of sexually transmitted infections (STIs); condom programs for PWID and their sex partners; targeted information, education and communication (IEC) campaigns for PWID and their sex partners; vaccination, diagnosis and treatment of viral hepatitis; and prevention, diagnosis and treatment of tuberculosis (TB). The rationale and supportive science for a comprehensive program are described in PEPFAR's Comprehensive HIV Prevention for People Who Inject Drugs Guidance. See <http://www.pepfar.gov/documents/organization/144970.pdf>.

The objectives of the workshop included:

- Provide up-to-date, evidence-based, critical information related to the prevention, care and treatment needs of PWID, including the 2010 PEPFAR guidance.
- Provide the opportunity to share country experiences regarding prevention, care, and treatment of PWID, including successes (and best practices), failures, and challenges; and to develop collaborative relationships among key stakeholders in neighboring countries.
- Provide knowledge and tools to enhance countries' abilities to set targets, implement, and monitor and evaluate programmatic efforts targeting PWID.
- Facilitate exercises to allow country teams to work together to plan future programming for PWID, including preparation for PEPFAR FY 2012 Country Operational Plans (COP). Provide workshop participants with the opportunity to identify technical assistance needs and resources, including from US-based organizations and from the field (i.e., South-South technical assistance).

This report summarizes the content of the workshop's sessions and attendee input. The report is organized by day and covers the opening remarks, daily session summaries, and concludes with a note regarding the importance of continuing efforts to enable a stronger response to the important needs of PWID. To obtain individual session presentations, contact Erin Rains who provided conference support, erains@msh.org.

II. Day One: Monday, June 13, 2011: Opening Ceremony

The first day of the workshop consisted of an introduction to the meeting, the epidemiology of injecting drug use – with a focus on sub-Saharan Africa – and an introduction to the key interventions to combat HIV amongst PWID.

Welcome

*Dr. Willis Akwhale, Head Department of Disease Prevention and Control
Ministry of Public Health and Sanitation, Kenya*

Distinguished Guests, Ladies and Gentlemen, Colleagues,

It gives me pleasure to address this consultation for two particular reasons: first, because it is the first international consultation on the specific issue of reducing harm related to injecting drug use, including prevention of HIV transmission. It is also special because it comes at a time when Kenya is creating momentum to lead to more comprehensive efforts to reduce and eliminate drug use altogether and accelerate HIV prevention efforts.

I see in this room a dedicated group of individuals who share a common goal of making HIV prevention, treatment and care for drug users a reality. Congratulations to all the organizations involved in this initiative.

The most recent estimates from the United Nations show that there are around 16 million injecting drug users worldwide. Of the 33.3 million people living with HIV globally, an estimated three million are people who inject drugs. People who inject drugs account for 30% of HIV infections outside of sub-Saharan Africa, and up to 80% of infections in Eastern Europe and Central Asia. In much of the world, the HIV epidemic among drug users is long-standing. But in some places it is newly emerging. In East Africa, HIV transmission due to drug use is rising. There are concerns that rising numbers of injecting drug users will propel a new wave of infections and undo recent gains we have made in curbing sexual transmission of HIV.

According to some of the statistics available in Kenya injecting drug users contribute up to about 4% of new infections and the latest integrated bio behavioral studies show that HIV prevalence is about 20% among PWID, which is four times more than the national average of 6.3%. There is however a big discrepancy between those injecting drug users who share needles and those that never share needles; with a prevalence of 33% and 6% respectively. Because of this reality, Kenya has developed comprehensive HIV strategies for injecting drug users and we are in the process of scaling up access to core services that are critical to stopping the spread of HIV among this group. During this meeting, my technical staff will be sharing with you the details of our programs including support from the Global Fund

under round 10 for starting pilot programs for needle and syringe programs among other components in service delivery for injecting drug users.

The 2001 UNGASS Declaration of Commitment and the 2006 Political Declaration on HIV/AIDS established time-bound targets to be met and reported on by countries worldwide. The commitments aimed to address the needs of people who inject drugs, their families and the communities in which they live through an “urgent, coordinated and sustained response.” These commitments remain unfulfilled. People who inject drugs are increasing as a percentage of global HIV infections with devastating consequences for individuals and communities.

The mobilization of an “intensified, much more urgent and comprehensive response” to HIV for people who inject drugs requires strong global leadership, concrete national policies and adequate funds to implement and scale up evidence-based services. The targets and commitments set in the 2006 Political Declaration must be met to address the needs of, and to fulfill the human rights of people who inject drugs living with, and at risk for HIV acquisition.

Universal Access and barriers to access among drug users

PEPFAR’s First Annual Report (2003) stated that, “Emergency Plan funds will not support needle or syringe exchange.” However, in July 2010, PEPFAR reissued guidance for HIV prevention for injecting drug users. The new guidance actively encourages a “comprehensive HIV prevention package” for PWID including needle and syringe programs and other harm reduction strategies previously disallowed under PEPFAR. According to the revised guidance, “needle exchange and syringe programs do not increase the numbers of persons who begin to inject drugs or increase the frequency of drug use” and “studies have shown that NSPs result in marked decreases in drug-related risk behavior.”

This updated PEPFAR guidance recommends giving priority to interventions reaching people who inject drugs in all countries that report injecting drug use and it provides practical guidance on a comprehensive package of interventions for prevention of HIV related to injecting drug use. A comprehensive package therefore means providing a full range of treatment options and relevant services. These include opioid substitution treatment, needle and syringe programs, peer education and outreach, voluntary HIV testing and counseling, prevention of sexually transmitted infections, primary health care and anti retroviral therapy.

However, the current coverage of these services is appallingly low. It is shocking that according to UNAIDS the global average is fewer than 2 clean needles per month per injecting drug user, that under 13% of drug users are in opioid substitution treatment and that only 4% of injecting drug users living with HIV are on HIV treatment.

Ladies and gentlemen, it is clear that today we have the means needed to make a real difference tackling HIV related to injecting drug use. We have high-level commitment to address the epidemic; we have the science, meaning that we know what works and we have the resources to scale up interventions. It's time to take action but to do so we must consider some of the obstacles we must tackle to get there. I wish to highlight a few examples.

One of the main barriers for access to prevention, treatment and care services by people who inject drugs continues to be the stigma and discrimination associated both with HIV and injecting drug use. The prejudice encountered by people living with HIV is well documented. But people who use drugs also report stigma and discrimination, and being an HIV-positive drug user brings with it a “double-stigma” that makes it all the more difficult to access relevant services.

We also know that in several countries drug users and positive people's networks are still not allowed to organize themselves and that drug users and their networks are excluded from decisions that affect them. This needs to change. The stigma and discrimination associated with drug use and HIV need to go, communities and governments need to embrace the reality of what works in curbing the epidemic.

But the one, overarching bottleneck noted across most sub-Saharan countries is how current legislation and policies hamper implementation of comprehensive programs for prevention of HIV among injecting drug users. There is an urgent need to harmonize drug policies with HIV policies. Criminalization of drug users hampers access to treatment and prevention services.

Let us use this consultation as a platform from which to call on all those who are involved in the response to HIV to move toward concerted action on the following agenda:

- To review and revise laws that criminalize drug use
- To tackle the stigma associated with drug use and HIV
- To ensure comprehensive coverage of PWID with prevention, treatment and care interventions
- To involve networks of drug users and community based organizations in delivery of prevention, treatment, care and support services
- To maximize financial and technical resources for prevention, treatment and care programs for injecting drug users
- And finally to promote and facilitate organizations of people who use drugs.

If we can take these concrete steps, we can make universal access a reality and stop the emerging threat of HIV and injecting drug use. It's now my pleasure to officially open this meeting and wish you the best in your deliberations.

Changes in USG policy to allow for strengthened HIV prevention and treatment for PWID: Setting the stage

Dr. Richard Needle, Senior Public Health Advisor, Office of the US Global AIDS Coordinator

In the summer of 2010, PEPFAR issued new guidance to enable US-funded programs to effectively react to HIV prevention among PWID and to demonstrate leadership in the fight against HIV. Addressing the HIV epidemic among vulnerable populations in sub-Saharan Africa requires political leadership and commitment together with multi-sectoral coordination supporting implementation of comprehensive prevention, treatment and care programs; a strong public health rights-based approach; reliance on evidence based findings to inform policy and program. Strategies must be implemented to address HIV among PWID and inclusion of drug addiction treatment in HIV treatment for HIV positive PWID.

PEPFAR plans to increase access, expand coverage and reduce the burden of HIV on PWID in PEPFAR-supported countries. There is therefore a need for responsive programming. PEPFAR is taking initiative to strengthen civil society efforts to fight HIV. An implementation science research agenda is critical to improve the uptake of services, by translating research findings into routine best practice.

There are approximately 16 million IDUs worldwide, with an estimated 3 million living with HIV. The emerging twin epidemics of injecting drug use and HIV infection among PWID has posed challenges in sub-Saharan Africa because there is a high and expanding HIV burden among PWID and barriers persist limiting the scope and quality of core interventions for PWID.

PEPFAR supports a comprehensive package of interventions for prevention and treatment for PWID with three core prevention interventions specific to HIV prevention among IDUs, including community-based outreach, needle and syringe programs (NSP), and medication-assisted treatment (MAT). The challenge for PEPFAR supported countries is to move from the guidance document to strategy and process, through planning to implementation based on experiences.

From the PEPFAR perspective it is hoped that this meeting will:

- Stimulate increased FY12 COP requests for PWID programs, monitoring and evaluation, and surveillance
- Facilitate the adoption of a standardized indicator package

- Contribute to the cumulative evidence-base
- Strengthen civil society
- Foster country-to-country networking and sharing of experiences and best practices

Session Summary: Current epidemiology of drug use and HIV among PWID

Speakers: Dr. Rey Chad Abdool, UNODC Senior Regional HIV and AIDS Advisor; Dr. Farhat Khalid, Strategic Information Coordinator, Zanzibar AIDS Control Program, MoH; Scott Geibel, Population Council HIV and AIDS Program; Dr. Amita Pathack, National AIDS Coordinator, National AIDS Secretariat, Mauritius; David Makapela, UNODC Regional HIV and AIDS Advisor, Southern Africa.

Overviews of epidemiological data from Tanzania, Zanzibar, Kenya, Mauritius, and the southern Africa region were presented during this session. UNODC presented an overall regional overview:

- Drivers of the HIV epidemic vary across countries with concentrated PWID epidemics in Mauritius and Zanzibar to more mixed and generalized epidemics in Kenya, mainland Tanzania and southern Africa.
- In the absence of PWID-specific prevention programs and with high rates of needle sharing present, it is probable that there will be a continuing high prevalence of HIV and co-infection of hepatitis B virus (HBV) and hepatitis C virus.
- PWID programming varies by country, from Kenya which is in the planning stages of comprehensive PWID programs that will include needle and syringe programs and medically assisted therapy; to Dar es Salaam which is piloting MAT; to established programming in Mauritius where MAT and NSP pilots are moving to scale in the coming months.
- Heroin is the most widely injected drug across the countries, except in Mauritius, where 80% of PWID currently inject buprenorphine.

See Table 1 for epidemiology, programs and policies presented during the workshop. Note that not all countries represented at the meeting are in listed in the table.

Table 1. HIV Epidemiology and PWID programs

	Kenya		Tanzania		Mauritius	Mozambique	South Africa
	Coast	Nairobi	Zanzibar	Mainland			
National HIV prevalence	6.3%		0.60%	5.7%	~1%	0.2%	10.9%
HIV prevalence among PWID	31%	19%	16%	42%	75%	Not known	Not known
PWID size estimation	Not known	3,000-10,000	-	-	~20,000	-	-
Risk behavior	40-50% are needle-sharing, taking drugs from a common reservoir, using ready-made solution without boiling, and not exchanging a used for a new syringe in the past month	61.4% of HIV+ lent a needle to person in past month HIV prevalence among persons who share needles (31%) and those who never shared (5%)	54% are needle sharing 9% flash blood practice (males) Multiple partners in past month (33%) Sold sex (16.5%)	31% needle sharing 16.6% flash blood practice (females) Multiple partners in past month (51%) Sold sex (33%; 85% female)	80% of PWID inject buprenorphine, 19.4 % heroin 30.5% FSWs inject 58% never use condoms with paid partners 77% always clean needle/ syringe in past 3 months	Group injection consumption is high Renting of needles Scarce needle supplies	30% don't see importance of clean needles 47% lack access to services
Needle and syringe programs	-	-	-	-	Yes	-	-
Medically Assisted Therapy	-	-	Planned to begin Fall 2011	Yes, 189 people enrolled	Yes, 2,000 people enrolled	-	-
Other programs or policies	Provincial Commissioner has begun open community forums for discourse, instructed police to refer to services instead of arrest	NASCOP is developing comprehensive HIV prevention for PWID/PWUD, including provision of NSPs and MAT	ZACP has begun training its HTC counselors to deliver PWID specific pre- and post- test HIV counseling	MoH is reviewing initial data from MAT rollout and considering adding additional MAT sites to reach better coverage	MoH has included harm reduction HIV prevention language in its 2006 HIV national plan	-	-

Session Summary: Sexual HIV transmission among PWID and programmatic considerations for women who use drugs

Speakers: Dr. Timothy Mah, Senior HIV Prevention Advisor, USAID Office of HIV/AIDS; Marina Rifkin, Public Health Prevention Specialist, CDC South Africa; Rebecca Tolson, Deputy Director of the International Harm Reduction Development Program, Open Society Foundations.

Practical moderation also provided by Mercy Muthui, Technical Advisor, HIV Prevention, CDC Kenya.

As epidemics mature, changes in the percentage of new infections attributable to drug using practices and sexual transmission are likely to occur. This has been demonstrated in countries such as the United States, Russia, Ukraine, India and China. This typically is a shift in transmission from drug use to sexual transmission. Modeling and cohort studies have shown that among PWID, sexual transmission is rapidly becoming a key source of new infections in Russia and the United States.^{1, 2, 3} The impact of different patterns of sexual mixing between groups with different levels of sexual activity and between injecting drug users, non-injecting drug users and persons who do not use drugs, has important programmatic implications.

High risk injection practices often co-occur with high-risk sexual practices. One example was provided during a presentation from a two-phase rapid assessment (I-RARE) in Durban, Cape Town and Pretoria South Africa conducted in 2005 and 2007.⁴ See Slide 1, on the following page, for I-RARE participants categorized by risk behavior.

A convenient sample of sex workers and men who have sex with men showed that among long-term heroin injectors, drug use and sex were often two separate activities. Others reported foregoing sex due to a loss of sexual arousal, mentioning the use of stimulant-type drugs such as crystal meth-amphetamine and ecstasy to increase sexual desire. More often than not, when drug use and sex are mixed, the ordering is drug use first, and then sexual contact as noted in Slide 2.

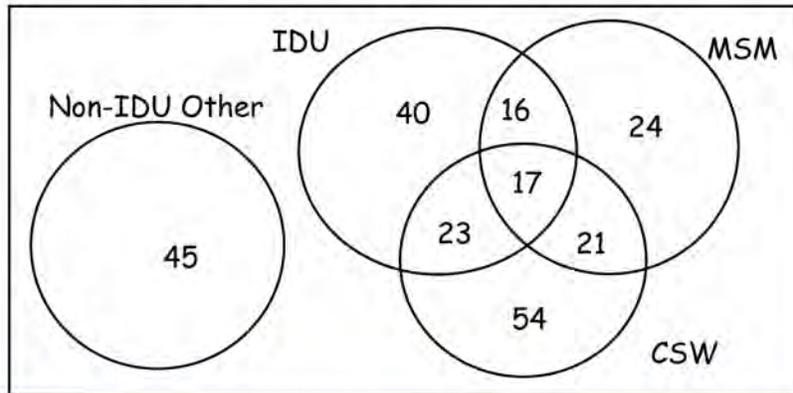
1 Grassly, N. C et al. (2003). Modelling emerging HIV epidemics: the role of injecting drug use and sexual transmission in the Russian Federation, China and India. *International Journal of Drug Policy* 14, 25-43.

2 Strathdee, S. A. et al. (2001). Sex differences in risk factors for HIV seroconversion among injection drug users—a 10-year perspective. *Archives of Internal Medicine* 161, 1281-1288.

3 Kral, A. H. et al. (2001). Sexual transmission of HIV-1 among injection drug users in San Francisco, USA: risk-factor analysis. *Lancet* 357, 1397-1401.

4 Parry et al. (2008). Rapid assessment of drug-related HIV risk among men who have sex with men in three South African cities. *Drug and Alcohol Dependence* 95, 45-53.

Breakdown of Drug Using Interviewees by “type” – SA I-RARE Project



Total: 131 KII & 109 FGI = 240

Slide 1. I-RARE participants categorized by risk behavior.

Risk Behavior by 3 Main Subgroups

	CSW	MSM	IDU
Drugs & sex order	Most use drugs before sex work, but some used drugs with clients during or after sex	Most use drugs 1 st (with drug use sometimes following sex as well), but others do it the other way around	Mostly drugs 1 st . Often cycle of drugs, sex, drugs etc. Others start with sex as sex drive can wane on IV drugs
Drugs & sexual risk	Many less cautious about using condoms when drugged, but others said they always practiced safe sex. Some said they would do things like group sex & anal sex to get money for next 'hit' while intoxicated	Drugs prolonging sex sessions. Less cautious about using condoms when on drugs. When on drugs also more likely to have sex with strangers, to participate in orgies or have sex with multiple partners, or having anal sex or less worried about HIV/AIDS	More likely to have sex without a condom when using alcohol/drugs

Slide 2. Context of drug use among I-RARE respondents

The co-occurrence of both risk practices and even timed use of substances (concurrent, pre, post) in relation to unprotected sex is of particular importance and should be considered when developing prevention programs that adequately address the intersection of high risk behavior.

Second on the Needle

“I was always home and he would go buy it himself until he got busted. Even now I rarely inject myself. Whoever is near me injects me. Right now it’s my boyfriend.”

—Female injecting drug user from Ukraine

Too often the discussion of injecting drug use is centered on male PWID and programmatic responses. Female PWID face unique risks for HIV acquisition and transmission. Studies show that women often inject last in a group and are more likely to need help injecting; two circumstances that can increase their exposure to HIV. Women are also much more likely than men to have sex partners who also use drugs, compounding their risk exposure to HIV,

HCV and HBV. In addition to heightened risk for women, female PWID are often commonly neglected for quality care and prevention services. Pregnant women with a history of drug use are significantly less likely to receive prenatal care, including timely HIV tests and, when necessary, ARVs for PMTCT. Women face stigma and discrimination for multiple reasons: gender, drug use, and HIV status. Parenting rights are commonly withheld, with coerced abortion and adoptions. High rates of sexual exchange for money or drugs are found among female PWID, and more often than not female PWID experience high rates of physical and sexual violence. Some studies have shown women to have a greater propensity to engage in flashblood, a practice in which a person who has recently injected heroin uses her syringe to withdraw blood from her vein and directly inject her blood into another person, as a weak proxy for injecting heroin. Often described as an act of altruistic behavior, people risk their own health thinking that small trace of heroin in their blood will prevent another from getting sick with withdrawal.

Conventional harm reduction programs are generally designed around male clientele with virtually no specially trained staff and facilities to accommodate female drug users. As became evident in country presentations on their harm reduction programs (during later workshop sessions), enrollment numbers from Mauritius and Tanzania showed very few female injectors were being reached by their country’s NSP and MAT programs. This gender imbalance must be addressed.

During this session, some best practices were offered to help countries move forward in meeting the unique hardships that female PWID face:

- Integrate sexual and reproductive health services into PWID-specific programs
- Design programs and entry points that are low-threshold (easily accessible)

- Include gender-specific information, provide counseling and support as well as case management to improve follow-up
- Pregnant and parenting opiate users should be prioritized for making substitution treatment accessible
- Safe spaces that promote motherhood and family preservation projects (e.g., adding daycare to drug treatment services, provision of diapers or pediatric care, access to washing machines) should be considered as options for attracting female PWID to services
- Female-oriented PWID sites should also provide a full range of in-house medical and opioid treatment options, including NSP, condoms and MAT
- Additional gender-responsive services suggested included providing legal aid and assistance with regaining lost passports, housing or child custody, and empowerment projects

Session Summary: Monitoring and evaluation of programs for PWID

Speakers: Annette Verster, Technical Officer at WHO HIV Department; Dr. Patrick Muriithi, National AIDS Control Council.

Achieving universal access to HIV prevention and treatment for all those who need it, as declared at the G8 Summit in 2005, requires target setting and monitoring. Such goal setting requires a consensus on terminology, priority interventions, coverage levels to achieve defined timelines, and decision-making on how to measure progress within and between countries. First published in 2009, technical experts have participated in various review forums to develop a WHO, UNODC, UNAIDS Technical Guide to set targets for universal access to HIV prevention, treatment and care for injecting drug users. Since its publication, this technical guide has been endorsed by high-level political bodies including the Economic and Social Council, UN Commission on Narcotic Drugs, the UN high level meeting on HIV/AIDS 2011, and the UNAIDS Program Coordinating Board.

Currently, the indicators and targets are under revision in an effort to further fine tune them. Revised indicators have been piloted in multiple settings with varying epidemiologic profiles, with an expected revision to the Technical Guide to be published late 2011 to 2012. Examples of issues when defining targets include: How to define the population – drug user or injection drug user? Current drug use or life-time ever drug use? The measuring process is challenging largely because countries are at different stages of establishing a comprehensive response. Additionally countries need to formalize such a system so that it is ongoing and not sporadic or for one-time use. Recognizing that many countries do

not implement the entire package of PWID HIV services, the technical guide recommends at least four of the interventions be monitored as a minimum requirement: needle and syringe programs, medically assisted therapy, HIV testing and counseling, and HIV care and treatment.

Such indicators measure availability, coverage, quality, and impact, with suggested indicators listed in the Technical Guide. See Slide 3 for sample indicators for measuring NSPs. Countries may want to consider the following next steps if planned use of the target setting guide:

- Assess the situation in their country (know your epidemic)
- Define priority interventions on the basis of the recommended package of nine key interventions
- Set targets for each intervention against timelines
- Monitor progress of the defined indicators and use data to improve program quality, coverage, accessibility and impact

Suggested indicators for NSP	
• Availability	No. of NSP sites per 1000 IDUs
• Coverage	% of IDUs regularly reached by NSP No. of syringes distributed per IDU per year
• Target	60% of IDUs regularly reached 200 syringes/IDU/year is high
• Quality	Adhering to WHO guidelines, UNAIDS best practice recommendations, provision of IEC and condoms
• Impact	Increase in % of IDUs reporting use of sterile equipment the last time they injected
• Data sources	UN Reference Group, locally derived programme data, surveys of IDUs, pharmacy surveys

1 | Target Setting - Nairobi, June 2011

World Health Organization

Slide 3. WHO-suggested indicators for NSPs

Dr. Patrick Muriithi from Kenya’s National AIDS Control Council described Kenya’s national HIV/AIDS Monitoring and Evaluation (M&E) framework, which outlines 55 national indicators to track progress over the lifetime of KNASP III and includes two indicators to track progress of programs for people who inject drugs:

1. Annual number of new HIV infections among PWID
2. Percentage of injecting drug users who reported using sterile injecting equipment the last time of injection

Dr. Muriithi listed data sources that will help to measure these indicators are integrated bio-behavioral surveillance surveys (performed every two to three years among most-at-risk populations) and routine service delivery data (facility and community based). Kenya is working to resolve challenges such as a lack of predictable schedule of surveillance studies among PWID and the general absence of clearly defined standard services for PWID.

Session Summary: Outreach

Speakers: Karina Rapposelli, Behavioral Scientist, Centers for Disease Control and Prevention (CDC); Tinga Kalafa, Outreach Field Supervisor, Kenya Network for IDUs Trust (KNIT); Dr. Amita Pathack, National AIDS Coordinator, National AIDS Secretariat, Mauritius.

When working with hidden populations, access to services is largely dependent on the outreach that facilitates the delivery of such services. Outreach is a systematic approach to delivering services to people who inject drugs in their natural environments. In general, two components comprise outreach: (1) making contact, and (2) type of encounter (which generally includes screening, assessment of need, engagement, service delivery and follow-up). Outreach workers must be trusted and viewed as sources of information and services by the target community. Outreach is typically delivered by peers, but doesn't have to be. In Medley et al. (2008) peer outreach is significantly associated with increased levels of HIV knowledge (OR 1.82), reduced STI prevalence (OR .70), increased condom use (OR 1.61), and increased condom use with both casual (OR 1.65) and regular partners (OR 1.58).⁵ Some best practices in outreach include formalization of peer educators, selection of peers who represent different groups within the target community, inclusion of quality standards (hiring, training, retention mechanisms, supervision, program implementation, M&E).

Looking at specific country examples, PWID-targeted outreach services in Kenya vary by location and are generally more sophisticated along the coastal region where heroin consumption is believed to be greater. PWID outreach services along Kenya's coast include HTC drop-in center, HTC and STI referral, case-management, peer support groups, drug rehabilitation referral and other wrap-around service referrals.



Slide 4. Mobile van offering needle and syringe services in Mauritius

In Mauritius, PWID-targeted outreach services began in 1989 and have a high degree of political buy-in and support. This was formalized with a comprehensive outreach program, which was endorsed in the National Strategic Framework for HIV and AIDS, 2001-2005. Due in large part to vocal advocacy from civil society, NGOs and the Ministry of Health (MoH) have a strong working relationship delivering information, education and communication (IEC) and peer awareness and education, HIV, STI and Hepatitis B and C testing,

5 Medley A. et al (2009). Effectiveness of peer education interventions for HIV prevention in developing countries: a systematic review and meta-analysis. *AIDS Education and Prevention*, 21(3) 181-206.

condom promotion and distribution, modeled safe injection practices (NSPs began in 2006), and other service referrals (such as MAT). A peer driven intervention (PDI) model was developed as an alternative to traditional peer outreach, to have enhanced involvement of peer leaders within the community. This model was bolstered also by the successful inclusion of peers during RDS IBBSS's performed in 2009-2010. Slide 4 depicts Mauritius government-operated mobile van offering needle and syringe services.

Session Summary: HIV testing and counseling among PWID

Speakers: Charlene A. Brown, MD, MPH, Senior Technical Advisor, HIV Testing and Counseling, USAID; Gillian Anderson, MPH Public Health Analyst, CDC; Irene Benech, MD HIV Prevention Chief, CDC Tanzania.

Because of the hidden nature of PWID, multiple approaches and delivery settings for HTC should be considered depending on assessment of the community being reached. Types of HTC can include provider initiated testing and counseling at PWID clinical service points (e.g. at NSP or MAT sites), home-based, mobile outreach, drop-in center, voluntary counseling and testing (VCT) stand alone sites and others. HIV testing and counseling should be accompanied by a package of HIV-related prevention, treatment, care and support services, although not all services need necessarily be available in the same location in which the HIV test is performed, but every effort should be made to co-locate services and strengthen linkages to referrals made (e.g. referral documentation, peer escorts, case manager to monitor referrals, etc.).

Rapid HIV testing with same-day results and non-venous puncture specimen collection is recommended for all most at-risk populations. VCT should include a standard intake risk assessment and PWID-specific pre and post-test counseling.

The Centers for Disease Control and Prevention in collaboration with WHO have developed and piloted a one-week most-at-risk population (MARP) HIV testing and counseling training curriculum for healthcare providers and lay counselors to become proficient in targeted HIV testing and counseling to PWID populations. Developed in 2008, the training has been piloted in two epidemiologically diverse locations (Antigua and Zanzibar) with an expected third pilot in South East Asia. Once revisions are finalized, the curriculum will be made available with technical assistance support.

The next panelist discussed current HTC services being provided in mainland and Zanzibar Tanzania. Zanzibar provides static and mobile HTC outreach services in conjunction with STI and TB screening and peer escort referrals for wraparound services and for those needing HIV care and treatment. As seen in slide 5, gender imbalances remain with HIV testing. In Dar es Salaam, HIV testing and counseling for PWID is provided through caravans

with three private rooms and includes Hepatitis C screening. Services are provided six days a week during times convenient for the surrounding community.

HTC Services for PWID - Znz
Cumulative data for MARPS accessing HTC
from Jan 2009 – March 2011

	Received HTC Services	HIV-Infected	Enrolled into Care & Treatment
PWID	698	87	64
Male	662	80	59
Female	36	7	5
PWUD (excl PWID)	2662	52	40
Male	1984	32	28
Female	678	20	12
SW	224	19	8
Male	28	4	2
Female	196	15	6
MSM	77	10	6
Total	3661	168	118

Slide 5. HTC coverage in Zanzibar among MARPs

III. Day Two: Tuesday, June 14, 2011

The second day of the workshop focused on the implementation of PWID interventions in sub-Saharan Africa and the unique challenges that working in the African environment poses.

Session Summary: Perspectives from the community

Speakers: Suleiman Mauly, Outreach Community Officer, ICAP Tanzania; Calleb Angira, Project Director, NOSET Maisha House, Kenya; Filipe Charles, National Coordinator, Global Health Communication, Mozambique. Practicum moderators: Dr. Rey Chad Abdool, UNODC Senior Regional HIV and AIDS Advisor, Karina Rapposelli, Behavioral Scientist, Center for Global Health/Division of Global HIV/AIDS, US CDC.

Three representatives from NGOs shared their personal experiences about their work on the ground, noting common difficulties they face and in-roads they've made.

Suleiman Mauly works with ICAP Tanzania to educate and sensitize pharmacies for needle/syringe provision, and works among a cadre of about 100 peer outreach workers at 40 outreach sites in Zanzibar to deliver risk reduction messages, demonstrations about condom use and clean needle and equipment and offer peer-escorted referrals. He's also been instrumental in working with healthcare workers to help educate them about working with PWID populations.

Calleb Angira, the Project Director of NOSET Maisha House in Kenya, is a trained psychologist on drug dependency. He shared his experiences of trying to retain people in services once they are reached. A challenge he emphasized was finding interventions that provide sustainable alternatives to drug use that empower people to take control of their own lives. He noted the extreme poverty that some clients live in and that providing basic human necessities such as food and shelter was important; but cautioned about the longer term need for rehabilitating people as productive and healthy members of society.

Filipe Charles, National Coordinator of the NGO Global Health Communication in Mozambique, discussed the struggles to get support for the inclusion of MARPs in his country's National HIV strategic plan and described a PWID punitive legal and political environment that undermines harm reduction approaches (e.g., systematic consumer arrests as opposed to drug traffickers, arrests when drug using equipment is found on an individual, the involvement of police and custom agents in drug networks, etc.). In Mozambique, high-risk behaviors include common group consumption, sharing of needles and drug solution, and scarcity of needles, causing a black market of 'renting' needles. Filipe noted a lack of behavioral and biologic data study data or population surveillance data and the heavy reliance on anecdotal information. Currently, an IBBSS is planned for Mozambique.

During the practicum, many voiced the issue that law enforcement poses a threat to HIV services as police often view PWID as social deviants and the need for law enforcement to control consumption of drugs. The high prevalence of HIV and injecting drug use in prisons highlights the need for alternative strategies. Kenya's recent crisis on its coast and its transition from a punitive system to one where PWID "will not be arrested [if they] come forward for treatment" shows that government can move quickly to switch policies when there is commitment and urgency. Other examples from the practicum highlighted best practices such as training law enforcement, positive publicity surrounding PWID programs and the simultaneous shifting of laws and attitudes.

Session Summary: Needle and syringe programs (NSPs)

Speakers: Don Des Jarlais, PhD, Director of Research, Beth Israel Medical Center; Myriam Tomol, MD, Director Health Services, MoH, Mauritius; Helbar Mutua, Program Manager, MARPs and Vulnerable Groups, National HIV/STI Control Program, MoH Kenya.

Dr. Don Des Jarlais, a leading researcher of needle and syringe programs, opened this session by presenting multiple research findings related to NSPs and the impact on HIV incidence. Studies showed definitively that geographic areas with NSPs are associated with lower levels of HCV and HIV among sample populations. Some specific subgroups showed positive changes in HIV or HCV over time. Effects were strongest among young and new injectors. Dr. Des Jarlais described some best NSP practices, such as early initiation of syringe programs; large scale NSPs with no limit on exchanges; encouragement of secondary exchange; and no strict one-for-one exchange limitations. He noted that programs need to be user friendly, treat participants with respect, offer convenient hours and locations known to the community, and provide multiple services including STI screening/treatment, condom distribution, and safe injecting equipment. NSP should involve injectors as experts in the PWID community to assist with operations and distribution; and ensure initial and continued cooperation and non-interference with local law enforcement.

The session continued with a description of the courageous work in Mauritius. In large part because of strong advocacy by civil society, policy makers created the HIV/AIDS Act of 2006, which first authorized NSPs in Mauritius. The NSP program was first initiated by two NGOs at two street-based sites. Six months later, the MoH supported the NGOs by funding all equipment/supplies and compensation to the field workers. As the NGOs had limited capacity to add more NSPs and expand, strong demand helped move the MoH to launch its own mobile van program offering NSP services. See Table 2, below, for services provided by Mauritius NGOs. Mobile services began in 2008 and included: two caravans with two health care assistants and one nurse officer per van to conduct HIV, hepatitis, and STI testing. Each van would visits 5-6 sites daily between 9 a.m. and 6 p.m. Each site is visited twice weekly on a "same day, same time" basis for consistency. Monitoring the patient/client-level data is

made possible by the issuance of registration card that has a unique code with no personal identifiers. A concerted effort was made to negotiate with police not to arrest anyone who has a NSP registration card because the person has drug paraphernalia on his person.

Table 2. NSPs operated by NGOs in Mauritius

NGOs	Number of NSP sites	Service days by week
CUT	9	Varies from 2-6 days
I GOOMANY	3	1 day shift/week 4 night shifts/week
AIDACTION	1	3/week
MODA	1	1/week

Although other parts of sub-Saharan Africa have made less progress with initiating NSPs, some steps have been taken. For example, NSP planning is underway in Kenya, with a three-phase implementation plan:

1. Setting up structures – conducting needs assessment, community engagement, and service planning
2. Scale-up – mainstreaming NSPs into public health sector facilities
3. Integration and surveillance – institutionalization of regular surveillance and Quality Assurance/Quality Improvement activities.

Several additional issues were raised during the practicum session on NSP. Dr. Des Jarlais raised the importance of knowing the local situation including injecting patterns, size estimates, demographic characteristics, prime stakeholders, and the types of drugs being injected. He also emphasized the importance of identifying potential barriers to NSP programs and program effectiveness such as political opposition, stigma, lack of information, operation challenges, funding issues and the need to maintain both comprehensive, compassionate treatment and rigorously well-run operations.

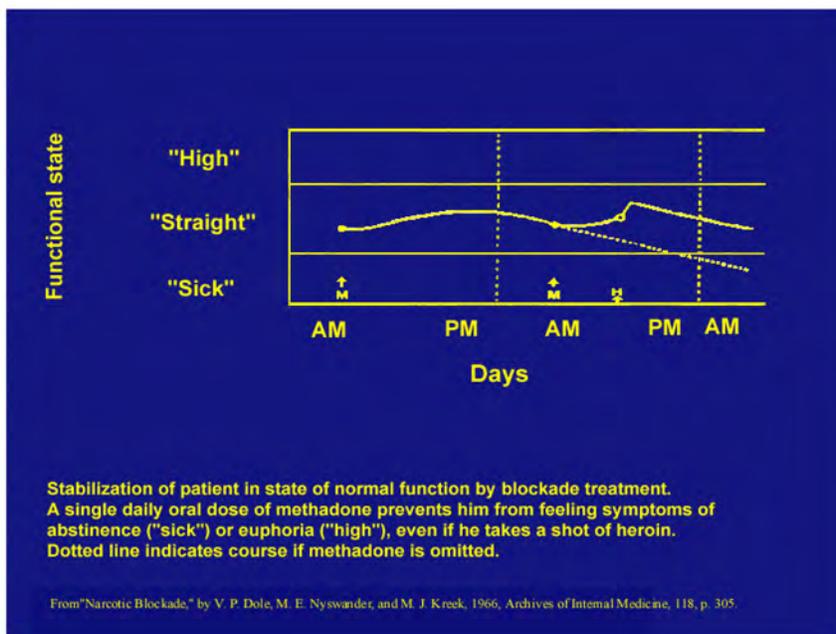
Session Summary: Medication-Assisted Treatment as an HIV prevention tool

Speakers: Dr. Doug Bruce, Assistant Professor of Medicine and Epidemiology, Yale University; Dr. Jessie Mwanbo, Senior Psychiatrist at Muhimbili Hospital and Researcher at Muhimbili University, Tanzania; Dr. Myriam Timol, Director, Health Services MoH Mauritius; Pacifica Onyancha, Provincial Director, Medical Services Kenya.

Strong evidence from a number of randomized controlled trials show that medication- assisted treatment with methadone or buprenorphine is effective in reducing heroin use and increases retention of heroin dependent patients in drug abuse treatment. It also reduces drug-related HIV risk behavior, including frequency of injecting and sharing equipment. As seen in Slide 6, below, patients stabilize in a state of normal functioning when assisted by methadone treatment.

“Methadone is a medicine, not a substitute for heroin.”

—Dr. Doug Druce, Assistant Professor of Medicine and Epidemiology, Yale University



Slide 6. Type of functional state with and without methadone for a heroin user

Best practices for MAT include provision of low threshold, rapid access, appropriately dosed medications; culturally appropriate counseling for heroin addiction, ranging from simple (narcotics anonymous) to more complex (cognitive behavioral therapy); and treatment of medical issues associated with addiction (e.g., HIV, hepatitis B and C, TB, depression, etc.). In this case, rapid access should be defined as streamlined admissions processes with rapid access to treatment, ideally dosing on the day of presentation, access to treatment seven days per week, adequate medical staff to ensure capacity to admit patients and dose efficiently, and never delaying MAT program initiation for alternative treatment options.

Despite the science to support MAT as an effective intervention to prevent HIV, little progress has been made on the ground so far in sub-Saharan Africa. The first MAT program on mainland Africa began in Dar es Salaam, Tanzania at the Muhimbili National Hospital in February 2011. Careful and thoughtful pre-launch planning included: various high level meetings with stakeholders both at the national and local levels, developing national guidance documents and standard operating procedures (SOPs) for the MAT clinic, physical renovation and readying of clinic (including safe storage of methadone), procurement and development of supply chain system, and training of staff, outreach workers, NGOs, municipal health officers, and community police. Currently, about 200 people are enrolled in treatment. According to intake records, an overwhelming number of patients were reactive for HCV (89.6%), fewer were positive for HBV (2%); and very few elected to share their HIV status. It is unclear how many are accepting an HIV test at the MAT clinic. Challenges include enrolling women – only 12 women were enrolled out of 189 clients by June 10, 2011. Preparations are being made to open a second MAT clinic in Mwananyamala Municipal Hospital and rollout MAT services to Zanzibar in October 2011.

Mauritius' methadone program, which strives for strategic geographical coverage, has two types of MAT programs: residential (two-week duration) and day care clinics. As of May 2011, 4,141, people have been initiated into the program, nearly 40% of the estimated PWID population of 10,000 people. Program retention rate is above 95%. During the induction phase, clients receive a medical assessment including urine testing; are provided with a low dose of methadone and monitored (including twice daily dosing checks) for the next four to five days. Other services provided include: counseling, HIV/STI testing and counseling, dental care, nutrition counseling, fitness, case management, individual and group therapy, and occupational therapy – including gardening and cleaning. Some key procedures to minimize diversion include directly observed treatment (DOT)



Slide 7. First methadone clinic in Dar es Salaam, Tanzania

and future plans for automated dispensing machines. Mauritius is currently evaluating its MAT program for best practices and ways to improve. Likely areas for modification include possible restructuring of the residential program to be outpatient and implementing

harm reduction drop-in centers with extended dispensing hours. In addition, Mauritius is exploring detoxification, introduction of buprenorphine, and methadone programs in prisons (currently only prisoners already inducted into treatment programs prior to arrest are supplied methadone in prison).

Kenya is preparing for comprehensive PWID HIV prevention, including rollout of NSPs and MAT. Key preparation milestones range from healthcare provider training of trainers, development of a national treatment protocol for substance abuse disorders, inclusion of methadone in Kenya's Essential Drug List, and creation of SOPs for establishing, maintaining and management of treatment sites. Next steps are the rollouts in two cities, sensitization of community police, continued stakeholder engagement, and training on treatment of substance abuse for 720 healthcare workers.

During the practicum on MAT, several additional issues were raised regarding increasing the quality and effectiveness of MAT programming. Great emphasis was put on creating a welcoming, accommodating environment for PWID seeking treatment which would improve access and retention to services. Service coverage should be as encompassing and open as possible. Staff should be understanding and sensitive to the unique needs of PWID and other most-at-risk populations. Meeting attendees also asked about the implications of asking participants to pay for MAT vs. receiving free MAT, contrasting the dual objectives of supportive financing versus more inclusive programming. Finally, each PWID's care should be tailored to his or her specific needs.

Session Summary: Access to antiretroviral treatment

Speakers: Dr. Doug Bruce, Assistant Professor of Medicine and Epidemiology, Yale University; Daniel Wolfe, Director, International Harm Reduction Development Program, Open Society Foundations.

Dr. Doug Bruce, Assistant Professor of Medicine and Epidemiology at Yale School of Medicine, and Daniel Wolfe, Director of International Harm Reduction Development Program spoke passionately about the ongoing reality that HIV positive PWID remain marginalized from HIV care and treatment. Practices of actively excluding or withholding antiretroviral treatment from PWID may still be occurring and are largely due to the false belief that active drug use will prevent ART adherence. Dr. Bruce drew an important parallel: HIV patients with other medical illnesses are not denied treatment and in some settings (e.g. HIV/TB), having another medical illness with HIV makes ARV treatment a priority. Physicians often try to predict adherence, despite evidence that they are poor predictors of ARV adherence. Evidence dispels the myth that heroin abusers will have poor ART adherence. A cohort of 1191 ARV naïve patients in British Columbia followed from ARV initiation showed resistance was found in 25% of the cohort during the first 30 months;

there was no statistical difference in resistance between PWID and non-PWID patients starting ARV.

Delivery models of HIV care include:

- Separate services
- Co-located services (e.g., an HIV care provider delivering services at a NSP)
- Integrated services, which means having staff cross-trained to do multiple tasks (e.g., physicians trained to do HIV care, methadone, and TB care).

The key is limiting the barriers to medication access and adherence. Some examples include staff sensitization training, negotiations with police to adopt service-friendly attitudes, directly observed therapy, peer adherence support, peer outreach workers, family assistance, provision of pre-filled pill boxes, and redefining clinical services to include services that PWID most want.

Session Summary: Improving linkage and retention into care and other services

Speakers: Dr. Carol Langley, Senior Technical Advisor, Care and Support, Office of the US Global AIDS Coordinator; Dr. Syangu Mwankemwa, Project Manager, MAT, Tanzania Drug Control Commission Social; Taib Basheeib, Reach Out Trust, Mombasa, Kenya.

Apart from the risk of HIV infection, PWID have a complex and unique range of needs which can include mental illness, overdose risks and social needs. Suitable interventions should include focused linkage and retention into health services, psycho social care, legal support and other important services. Rarely if ever are the entire nine interventions of comprehensive HIV prevention and care offered in a single location – which creates a system based on referrals. Because of the various limitations precluding patients from seeking care from multiple delivery points, a strong coordinated referral system which includes back referrals needs to be put into place where services are not co-located. One successful example mentioned during the meeting is the system established in Tanzania, where outreach workers provide peer-to-peer escort to services and then continued follow-up to help with client retention in care.

Session Summary: Panel dialogue

Speakers: Dr. Amita Pathack, National AIDS Coordinator, National AIDS Secretariat, Prime Minister's Office, Mauritius; Dr. Rey Chad Abdool, UNODC Senior Regional HIV and AIDS Advisor; Simon Angira, Outreach worker, NOSET Maisha House, Kenya; Beverly Cummings, Behavioral Scientist, CDC, Mozambique.

Several questions centered on the issue of how to advocate for initiation and then expansion of PWID programs while avoiding the pitfalls of legal or negative media attention. In the case of Mauritius, PWID programmers realized that all decisions needed to be based on strong evidence and that programs needed to start small and scale-up over time. Initial restrictions were relaxed once program effectiveness was demonstrated, with Mauritian health officials highlighting program successes to the government to advocate for a stronger civil society response. As in many other countries, this necessitated a conversation about law enforcement and the need for cooperation with police. A panelist explained that in general, law enforcement views its job as enforcing laws to protect life and property, that they view public health not as part of their job responsibilities. Training of law enforcement needs to explain the connection and role that police have with improving the greater health of the community.

The panel was asked how to answer questions like why limited funds should be directed towards giving needles to drug users who want to harm themselves. In this case, the panel advocated for strong community education to teach neighbors that the needles are there not to encourage heroin use but to prevent the spread of HIV. The Kenyan delegation on the panel said that education often needed to start with the drug users themselves first, who then spread the message about the benefits of needle and syringe programs to their families and then to leaders of the community and beyond. The Mauritius delegation added that change in behavior and reduction in heroin use could only follow the immediate problem of a lack of clean needles.

Once communities understand the necessity for clean needles, they often become concerned with the economics of providing needles and services to PWID in resource-poor settings. To this point, the presenter from Mauritius suggested explaining to decision-makers how the risk of HIV and the costs of treating patients make distributing clean needles and MAT an economically advantageous decision. The speaker from Kenya added that it helps to put a human face on PWID rather than treat them solely as an economic liability. One outreach worker who had formerly opposed MAT in favor of

“Telling an active heroin addict to say no to drugs is like telling a manic depressive to ‘have a nice day.’”

abstinence said that he had come to recognize that “telling an active heroin addict to say no to drugs is like telling a manic depressive to ‘have a nice day.’”

It remains critical to create a more nuanced understanding of drug users. Programmers should put a human face on drug users and insist that they are always treated as human beings. It is important for programmers to maintain a good rapport with both leaders and the media and educate them and the police on the positive benefits of services for PWID. The eventual goal is policy change but intermediate steps include information dissemination, a better atmosphere for drug users and improved access to services.

In order to increase support for MAT and NSP, programmers need to advocate relentlessly on behalf harm reduction programs, highlighting their low costs, positive impacts and beneficial externalities. Leaders and law enforcement personnel especially should be given training on the means and effects of programs. As in the case of Kenya, once police were trained with the message that PWID should not be arrested but should be helped, a huge change in the relationship between the government and PWID occurred. This led to broader political support and even engagement with members of the parliament.

IV. Day Three: Wednesday, June 15, 2011

Session Summary: Enabling environment: support for program initiation and scale human rights approach to HIV prevention

Speakers: Daniel Wolfe, Director International Harm Reduction Development Program, Open Society Foundations; Dr. Sobbie Mulindi, Deputy Director, NACC Kenya.

Daniel Wolfe opened the session by describing Open Society Institute East Africa's (OSIEA) support for programs working with PWID. These programs have done great work in assisting vulnerable communities. OSIEA maintains a human rights focus on the most vulnerable and protects them by addressing the social structures which create the risks for PWID. There is a need for law enforcement, human rights and health policy to emphasize disease control and access to information and care, rather than control of the person. In public health terms, it is ineffective to have roundups, surveillance and locked wards, mob justice, incarceration, and schemes where police don't direct people to treatment. The fear caused from such activities will lead to hurried injecting; hiding of needles; and mistrust and reluctance of PWID to access HIV prevention or drug treatment.

Wolfe emphasized several steps to building an enabling environment. Programs should provide training for police. Law enforcement should be encouraged to create an incentive program with positive results when police direct PWID towards service through referrals and institute negative incentives to prevent police from abusing PWID and other marginalized populations. Health providers should receive training on working with PWID. Legal aid should be provided to PWID to increase access to justice. Finally, countries need legal and regulatory reform to protect high risk populations from discrimination, such as decriminalization of addiction, revision of drug sentencing guidelines, and encouraging law enforcement to divert PWID to harm reduction services at the point of arrest. This has the potential to improve safety and public order as well as protect law enforcement occupational safety.

Dr. Mulindi then described Kenya's efforts to build a more supportive environment. This approach included raising national awareness of HIV/AIDS to decision makers and addressing the issue of vulnerability, stigma, and discrimination; increasing professional training opportunities on the subject of MARPs (e.g. for police, judges and legislators); strengthening health systems; and adapting existing toolkits to better apply evidence-based practices. These policies are geared to promote universal access and decriminalize drug users and men who have sex with men.

Kenya's immediate and long term needs include a comprehensive package of interventions with targeted HIV prevention, treatment, care, and support, which has respect for

human rights and international law. The PLHIV and other groups need to be involved in these initiatives. Further, funding for MARPs from the Government of Kenya and other development partners must be ensured together with an effective monitoring and quality control strategy. Information sharing can take place through regular workshops and new evidence must be used for programming.

Kenya hopes to capitalize on momentum from a recent symposium in Mombasa on MARPs and PWID to advocate for new HIV initiatives in the region. The appointment of a new Kenyan chief justice may provide an opportunity for greater sensitivity for PWID and the services they need.

Session Summary: Building the evidence base for sustainable programs: implementation science

Presenters: Dr. Richard Needle, Senior Public Health Advisor, Office of the US Global AIDS Coordinator; Daniel Wolfe, Director International Harm Reduction Development Program, Open Society Foundation; Dr. Nicholas Muraguri, Director, National AIDS Control Program (NAS COP), Kenya.

PEPFAR's perspective is that it must focus on methods to improve the uptake, implementation, and translation of research findings into routine and common practices. Programs must make impact in terms of reducing prevalence in order for PEPFAR to ask decision makers to invest in reducing HIV incidence among stigmatized populations. Implementation Science generates information about choice and the appropriate intervention that will result in the greatest benefits and deliver the most efficient methods.

The major components are monitoring and evaluation (inputs/outputs), operations research, and impact evaluation. In monitoring and evaluation, the key questions touch on fidelity, program components, reach and targeting, and process indicators and intermediate effects. Operations research focuses on increasing the efficiency of implementation and operational aspects of a particular program using scientifically valid methods. Impact evaluation looks at what would have happened had the program not taken place and examines the impact of the intervention on beneficiaries.

Daniel Wolfe highlighted several high priority questions for implementation science in East Africa based on previous presentations and published literature. These questions centered on the theme of moving away from "if" questions and towards "how" questions. For the purposes of PWID programming, research topics include the link between drug supply and injecting vs. smoking heroin; the effectiveness of the "Break the Cycle" intervention to discourage initiation of new injectors; the effectiveness or lack thereof of auto-disposable and other syringes procured for NSP, with particular attention to the needs of PWID; the

utility of Naloxone interventions to reverse opiate overdoses; the effectiveness of working with women to prevent flashblood practices and to create other useful interventions; and the effectiveness of providing legal services to PWID.

Dr. Muraguri added that implementation science is about making science work on the ground. HIV should not be a public health issue in years to come and ways need to be found to work in resource constrained environment. Behind the injections there is a person who is injecting, and we need to ask ourselves who our target population is. The realization that the risk profile is not the same will help increase the level of coverage to stop the spread of HIV. Speed and coverage matters and it is important to know which program models work by studying what will increase uptake. Therefore, entry points for intervention must be maximized to optimize impact.

Session Summary: Community Action on Harm Reduction

Speaker: Peter Kamau, Kenya AIDS NGOs Consortium

Peter Kamau presented the Kenya AIDS NGOs Consortium (KANCO), a national membership network of NGOs, community based organizations (CBOs), faith-based organizations (FBOs), private sector actors, and research and learning institutions involved in or interested in HIV/AIDS and TB activities in Kenya. KANCO uses community systems strengthening to improve policy for HIV/AIDS and TB.

The Community Action on Harm Reduction (CAHR) program is designed to increase access to health and HIV services by people who inject drugs. The program will promote human rights of PWID and is involved in capacity building and knowledge sharing to expand and grow harm reduction expertise. CAHR plans to implement activities including intensive technical support, expansion of service delivery, advocacy for the scale-up of effective HIV and drug use services, knowledge sharing, stakeholder collaboration, and monitoring and research. CAHR will focus its resources and work along the Kenyan coast and the city of Nairobi.

Session Summary: Drug and substance use in Coastal Province, Kenya

Speaker: Ernest Munyi, Provincial Commissioner Coast Province

In late 2010 a public health crisis was occurring in the Coastal Province of Kenya. Following a police crackdown on drug distribution with several high profile arrests, heroin supply in the region plummeted. Subsequently, many people began experiencing severe heroin withdrawal and without monitored detoxification, hundreds of people became fatally sick.

Kenya's President sent a delegation headed by Dr. Njenga to work with Provincial Commissioner Ernest Munyi, and together they devised a new three pronged strategy:

1. Change the relationship between law enforcement and drug users (e.g. relationship building, law enforcement sensitization training).

2. Kenyan police would focus their efforts on drug distributors and dealers, not individual users. Police would actively refer drug users to treatment and support services instead of arrests.



Government response to a health crisis in Mombasa

- Drug abuse treated as a health issue and related to the spread of HIV
- 20 dens closed, 19 drug suppliers arrested and 674 drug users referred from dens to treatment
- 14 health facilities provide treatment and HTC
- Psychosocial support and entrepreneurship training for drug users treated
- Community fora created and law enforcement officers sensitized on new approach to deal with drug users
- Lesson: Do not wait for laws to be changed to take action

3. Government funded medical care to drug

Slide 8. Government response to a health crisis in Mombasa

users. Clinics were established to monitor withdrawal and detoxification. WHO and UNAIDS provided assistance for procuring large quantities of codeine.

As a result of these initiatives, 20 dens have been closed and 19 drugs suppliers have been arrested and arraigned in court. A total of 14 health facilities have been opened to attend to drug users who police found in the drug dens and subsequently were referred to care. Six hundred seventy-seven (677) drug users are now seeking medical attention at the established centers.

Plans are also in place for entrepreneurship training and capital support for recovering addicts as well as the formation of psycho-social support groups where peers can share with one another and become a support system for each other.

Training forums have been conducted for training security personnel and the law enforcement officers being sensitized on the new approach in the fight against drugs.

Session Summary: Cost-effectiveness of Medication-Assisted Therapy (MAT) in reducing HIV transmission among PWID

Speaker: Vimalanand S. Prabhu, Health Economics and Finance Team, DGHA, CGH, CDC, Atlanta, USA

A mathematical model was developed to estimate the cost-effectiveness of MAT in a hypothetical cohort of 1,000 PWID in Tanzania. The model examined the cost of MAT per person per year, rate of expected HIV sero-conversions with and without MAT, annual infections averted, and cost per infection averted. The annual cost of MAT per person is lower than the annual cost of ART and the cost effectiveness of MAT is comparable to other interventions such as HIV counseling and testing (see Table 3, below). Cost effectiveness studies are particularly important and help make the case to policy makers for supporting interventions that show cost-savings.

Table 3. Cost savings of MAT

	Cost per person (US\$)	Sero conversion rate (# per person per year)	Infections averted per 1,000 on MAT	Incremental cost (US\$)	ICER (Cost per infection averted)
Without MAT	\$0	22.0%	-	-	-
With MAT	\$112	3.5%	185	\$112,000	\$605

V. Conclusion

The Nairobi workshop was an important step forward, highlighting the region's progress made in PWID programming and validating the urgent need for a stronger response as availability to opioid substances in sub-Saharan Africa increases. Additionally, the meeting was an important declaration of PEPFAR's commitment to advance its response to targeted and evidenced-based HIV prevention and its will to harness the support of and collaborate with other funding streams and multi-lateral agencies doing important work with PWID. The Office of the U.S. Global AIDS Coordinator's recent release of its updated PWID guidance strengthens PEPFAR's support for an evidence-based package of services and bolsters future country program planning to include needle and syringe programs and medically assisted therapy. Although injecting drug use has not achieved the same levels in sub-Saharan Africa that it has in other parts of the world, the need for PWID programs is critically necessary to maintain hard-won gains in the general population's HIV prevention and treatment.

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WHO UNAIDS UNODC Policy Brief: Reduction of HIV Transmission through Outreach

Integrating Gender Into Programs with Most-at-risk Populations

AIDSTAR-One Case Study Series - The International HIV/AIDS Alliance in Ukraine: Promising Approaches to Combination HIV Prevention Programming in Concentrated Epidemics