Preventing HIV/AIDS among drug users

Case studies from Asia

Regional Task Force on Drug Use and HIV Vulnerability

UNAIDS
Joint United Nations Programme on HIV/AIDS
UNICEF • UNDP • UNFPA • UNDCP
ILO • UNESCO • WHO • WORLD BANK

ASIAN HARM REDUCTION NETWORK

UNITED NATIONS
Office on Drugs and Crime
Regional Centre for East Asia and the Pacific

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Foreword

In 1997 the Task Force on Drug Use and HIV Vulnerability commenced its operation in Bangkok. It immediately identified the lack of information concerning HIV/AIDS among drug users in the Asia region across three broad thematic areas: insufficient epidemiological data; limited knowledge within the region on policies related to drug use and HIV/AIDS; and, inadequate documentation and dissemination of good interventions. Subsequent to these observations, UN organisations and their partners have undertaken much work in order to fill this vacuum. The Asian Harm Reduction Network, along with other partners, has published two editions of the "Hidden Epidemic", that provides details on the status of the HIV/AIDS epidemics among drug users in the countries of the region. In October 2000, the Task Force itself published the report "Drug Use and HIV Vulnerability: Policy Research Study in Asia". These two publications have concisely addressed the issues of epidemiology and policy.

This current publication "Preventing HIV/AIDS Among Drug Users: Case Studies from Asia", addresses the third important area, the dissemination of good practices on HIV/AIDS prevention and care interventions among drug users. Emphasis is laid on addressing the practical aspects of *how to do it*. Each of the studies has been arranged in a format to promote the reader's further consideration of the issues such that they might be replicated and adapted to their own particular context and needs.

The case studies describe a variety of interventions, focusing on HIV/AIDS vulnerability and demand reduction, outreach interventions (including the provision of clean needles and syringes), condoms and counseling, institutional treatment, care and support, substitution therapy and advocacy. They also reflect a recurrent strategic theme that single isolated interventions are unlikely to be effective unless they are integrated within a comprehensive approach. While we are familiar with all the elements of a comprehensive approach and, as the case studies indicate, there is indeed practical experience on how to best proceed, the challenge remains as to how to scale up such interventions to a level commensurate with the scale of HIV/AIDS epidemics among drug users.

This publication was developed in a spirit of cooperation. UNAIDS, through the inter-country teams for South East Asia and the Pacific, South Asia and the Pakistan office, UNODC through its regional centre in Bangkok, its regional office in New Dehli and the Pakistan office, and the Regional Task Force on Drug Use and HIV Vulnerability closely collaborated in the selection of the studies, the review of manuscripts, and the provision of technical and financial assistance. All those involved, authors, reviewers, editors and responsible staff members deserve a 'thank you' for their dedication and enthusiasm making this publication possible.

Sandro Calvani

Chair, United Nations Regional Theme Group on HIV/AIDS, and

Representative, UNODC Regional Centre for East Asia and the Pacific

I. At a glance

The case studies in this volume were written in a participatory manner, in conjunction with programme staff. The style is intended to be simple and often-followed practices, such as referencing, have been omitted. The studies presented focus on five areas including: 1) community based interventions; 2) care and support; 3) outreach; 4) substitution therapy; and, 5) advocacy.

Community-based interventions

In *"Drug demand reduction and prevention of HIV transmission"* the development and implementation of a pilot project is described. The project is designed to address the risk of HIV transmission among drug users through demand reduction and community development. Its methods, strategies and principles were drawn from experiences in the field of population health promotion and prevention, community health, home care and participatory rural development and poverty alleviation disciplines. The project progressed through several sequential steps that included the harnessing of community support, formation of organisational structures with the community, training, assessment activities, development and implementation of action plans and monitoring and evaluation.

The project included drug use prevention, education and awareness raising activities. They canvassed issues such as: the provision of healthy lifestyle activities; voluntary cessation of drug use; the organisation and delivery of counseling and treatment in the community; follow-up and home care services; socio-economic rehabilitation and reintegration assistance; essential community services such as clean water, sanitary latrines, community centre; and, income and food security support assistance.

An important lesson learned from the project was that once empowered, remote, rural and under-serviced communities were capable of taking charge of and addressing their drug use problems in a lasting and effective manner. Similarly, communities were able to more effectively address their priority needs including clean water, sanitation, income and food security.

Care and support

In *"HIV/AIDS prevention and home based care"* the experience of SASO is documented. In the late 1980s there were virtually no services for drug users available in the north-eastern state of Manipur in India. In 1990, a group of male ex-drug users, all of whom were in their mid-twenties, formed a self-help group. Most of the men were members of Narcotics Anonymous. Their goal was to support each other in order to remain drug free and live a meaningful life. The group felt that a main cause for relapses amongst drug users was the lack of trust and negative attitudes among families and the wider community towards those recovering from drug use. The group decided to work towards changing community attitudes that ostracized drug users. Accordingly both sports events and community awareness meetings were organised.

At the time of writing this report, SASO provided a wide range of services to drug users with HIV/AIDS including home-based care and support services to sick and terminally ill persons. It operated a free community clinic as part of its drop-in-centre, organised detoxification support within the home environment, provided education for family members on HIV/AIDS transmission and appropriate nursing care, counseling that canvassed both HIV/AIDS and drug related areas and, provided medicine, financial support and condoms. The successful entry and retention of clients to SASOs home care programme

was through the provision of a broad spectrum of drug treatment and harm reduction interventions such as needle syringe programmes.

The importance of offering clients a wide variety of options with improved quality of services were important lessons learned. Home-based care was deemed to work well in the presence of effective linkages with community and hospital care. Community acceptance of people with HIV/AIDS and their families was also deemed crucial in the long term to ensure positive programme outcomes and sustainability.

Outreach

The SHAKTI project undertakes outreach in Dhaka, Bangladesh providing on-going targeted interventions for injecting drug users and other vulnerable populations such as sex and transport workers. Meaning 'power' in Bengalese the SHAKTI project supports a number of initiatives including a highly successful needle-syringe exchange component. Begun in May 1998 this component embraces five broad categories of activities including: outreach workers who are themselves drug users; drop-in-centre based activities in seven different areas of Dhaka; project management; expansion of needle-syringe exchange processes; and, advocacy with law enforcement personnel, the general community and through the formation of self-help groups.

The work of SHAKTI provides clear evidence that a peer-based approach is an effective way of reaching out to a large number of injecting drug users within a short period of time in a developing country. Advocacy within the community is deemed necessary concomitant with the provision of needle and syringe exchange processes in order to avoid broader community misunderstandings of the project. The importance of providing various treatment options for drug users, such as detoxification, longer term treatment and rehabilitation, and the treatment of sexually transmitted infections, have also been identified.

"Outreach to injecting drug users in Pakistan": Throughout the past years the expanded Theme Group on HIV/AIDS in Pakistan advocated strongly for issues related to injecting drug use to be placed on the agenda of government agencies. As a result, a collaborative project between UNAIDS, UNODC and the non-governmental organisation Nai Zindagi was developed. The project, situated at Lahore, aimed to minimise health problems and other related social consequences of injecting drug use. Its design was based on experiences in Pakistan and the lessons learned from projects in neighbouring countries such as Bangladesh and India.

The project provided an opportunity to learn several important lessons in terms of how best to initiate and sustain interventions to prevent HIV/AIDS transmissions among injecting drug users. Further, a better understanding of the limitations of supply and demand reduction efforts and of the need to compliment HIV/AIDS prevention efforts with specific services, such as needle and syringe exchange programmes and condom promotion, was gleaned amongst specific stakeholders within government and civil society. Concomitant with such progress is the recognition of the need for interventions to be integrated into the wider field of drug demand reduction and to include various treatments and social re-integration options.

To exemplify this view, it is useful to consider the *"work with street children in Cambodia",* the primary goal of which was to remove the children from the streets and place them into safer environments. Mith Samlanh commenced working on this project through the concerns of three travelers who arrived in Phnom Penh in 1994. The concern of the travelers was directed at the number and state of children on the streets. Accordingly, the children became the subject of constructive initiatives that included the provision of food using the travelers' own resources through to the provision of shelters, training, family re-integration and, HIV/AIDS prevention education and support within the context of the current programme.

The key lessons learned related to the strengthening of links between different projects such that they fell under one comprehensive programme. This it was found would benefit every component of the programme. Peer educators and direct observations were also found to be powerful tools when working

with children. Similarly, it was found important to recognise the chaotic lives of street children and incorporate that understanding into future planning.

Substitution therapy

Narcotics clinics in Bangkok, established in the late 1970s and early 1980s through the Bangkok Metropolitan Administration operates some fifteen outpatient health clinics, two hospitals and one mobile unit in Bangkok. At the time of writing this report, 49, 521 clients had been treated in the clinics. Most of those treated in the year 2000 were heroine users. Guidelines exist for four protocols of pharmacological treatment including: Naltrexone, long term and short term Methadone treatments.

Short-term Methadone treatments were found not to yield the expected results. The main lesson learned being that treatments of less than 45 days were conducive to the client relapsing. Unfortunately, whilst treatment personnel were aware of this for some time, it took many years for policy makers to accept the Methadone maintenance as a viable option for treatment. Further it was found that Naltrexone provided few successful outcomes.

The *Methadone Treatment Programme in Hong Kong* became fully operational in 1972. It remains a low cost intervention offering treatment to some 10,000 clients. It remains the most popular treatment facility in Hong Kong with approximately 7,000 clients attending daily within a network of twenty-one outpatient Methadone clinics. The clinics are located in areas where drug-users congregate and offer substitution treatment to opiate users in low-threshold facilities. These are open seven days each week with an open door and non-judgmental policy. Clients pay HK$1 for each attendance.

The Hong Kong Methadone Treatment Programme owes its success to the government's commitment to a rational, evidence-based approach to the treatment and rehabilitation of drug users. In addition to the programme the government supports the efforts of an extensive network of non-government organisations that provide after care and rehabilitation services. It is however apparent that the changing patterns of drug use in the community, the increase in the use of non-opiate and poly-drug use, the decline in the age of newly reported opiate users, and the increase in the number of women users necessitate some re-thinking and re-adjustment of the programme.

Advocacy

"APICT 1996 to 2000: An agenda for advocacy in Asia" describes the evolution of work in the regional entities of the UN system in South East Asia related to HIV/AIDS among drug users. In particular it provides insight into the work of the UNAIDS Inter-country Team and the UNODC Regional Centre. The Team reviewed the HIV/AIDS situation in the region in 1997 and concluded that HIV/AIDS among drug users was an issue of serious concern. There was no reason to believe that the HIV/AIDS epidemic among drug users would plateau or become self-contained. Consequently, the Team placed the prevention of HIV/AIDS among drug users amongst its priority work areas.

The Team developed an advocacy strategy to address HIV/AIDS among drug users. It focused on raising awareness amongst government agencies in countries of the region through setting HIV/AIDS issues on the agenda of agencies and strengthening their capacities to better respond to the crisis. This strategy also included assistance in policy and large-scale programme development. The various steps undertaken to pursue such a strategy were described in detail and conclusions presented. Two highlights within the conclusions included the following.

- It is possible to change governments' perceptions, attitudes and also policies with respect to HIV/AIDS among drug users.
- It is important to establish a broad network of partnerships between all relevant agencies, even those with contradictory political mandates to achieve the above goals.

Community-based interventions

People, not institutions, ultimately decide whether to adapt their sexual, economic and social behaviour to the threat of HIV infection. They are the subjects of the response to AIDS, not merely the objects of outside interventions. Therefore, responses to HIV are in the first instance local: which implies the involvement of people in the places where they live – in their homes, their neighbourhoods and their workplaces. Community members are also indispensable for mobilising local commitment and resources for effective action. In particular, people living with HIV/AIDS must play a prominent role and bring their unique experience and perspective into programmes, starting from the planning stage.

II. Drug demand reduction and the prevention of HIV transmission

A. Profile

Project title	Reducing illicit drug use in the highlands of East Asia
Project countries	Cambodia, China, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam
Related thematic area	• Drug demand reduction; • Community participation and development; • Community based treatment; • Outreach and peer education; • Care and support.
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Project status	It was carried out from October 1996 to September 2000.
Primary beneficiaries	Drug users, their families, and residents of seventeen ethnic highland communities in five countries.
Secondary beneficiaries	• National agencies with drug control, treatment and rehabilitation mandates; • Implementing agencies (government and non-governmental).
Funding	US$1.5 million, provided by UNDP and DFID.

B. Background

The problem of drug use in Asia entered a dangerous period between the late 1980s and early 1990s with the onset of HIV/AIDS. In a number of countries in the region, such as China, Indonesia, Myanmar, Thailand and Viet Nam, the HIV/AIDS epidemic was found to have begun in drug using populations

before moving to other populations. At the time of writing this report, drug users continued to constitute the largest group of new infections in China, Indonesia, Malaysia and Viet Nam.

Drug users in Asia are highly vulnerable to HIV transmission because of the legal, political, socio-economic, health service and cultural situations, in which they live. For example, poverty and underemployment in rural areas are often the cause for and result of drug use. In addition the lack of health and social services, significantly contribute to their vulnerability to HIV/AIDS. Below, a project is presented that specifically seeks to address such underlying contextual factors by mobilising community resources with a broad-based community development approach.

C. Objectives, principles and strategies

The project was implemented in seventeen rural communities with drug problems in five Mekong countries from October 1996 to June 2000. These included – Lao People's Democratic Republic, Myanmar, Thailand, Viet Nam and China. It aimed at creating a supportive environment within communities, in which services for drug users and their families could be delivered. Its immediate objective was to develop community, national and sub-regional capacities to reduce the use of drugs and related social problems in ethnic highland minority groups.

Underlying principles

- The project was based on the community's own ability and resources in planning, prioritising and addressing its needs for social development, infrastructure, food security, health, and education.
- Project assistance was designed to serve as the catalyst to empowerment and community development.
- Knowledge, skills, practice, confidence and competence building was the main focus of technical assistance of UNODC.
- The project fostered a broad based process of participation, coalition and ownership building.
- The project was adaptable to emerging and specific needs in the communities.
- Technical, methodological and managerial principles were made understandable to the participating community.

Strategies

- Create commitment and sustained action in the community.
- Adapt interventions to the needs and aspirations of the community.
- Focus on the entire community regarding community development needs, and at the same time reach out to drug users.

D. Activities

Entry into the community

The project manager, the focal point agency, often the national drug control agency, and the UNODC field office in the project countries, jointly identified project areas and participating communities. These communities were made aware of the serious implications of drug use. Consensus was generated through the participation of residents, elders and the community government representatives in order to take action that included:

- stakeholder and community consultations leading to understanding and acceptance of the project and its principles;
- general community assemblies and group discussions leading to individual and collective commitment;
- formation of community committees, and training of members and leaders on how to plan and manage project activities; and,
- needs assessments through the application of Participatory Rural Appraisal techniques, including social mapping and baseline surveys, leading to an action plan with targets, time lines and resource requirements.

Village action committees were formed through consultations and consensus. National Project Coordinators, who received training earlier at the regional level, provided training to the committee members together with locally recruited resource persons and experts.

Trainers and training resources were provided from within the region for the Village Action Committees and officials of focal point agencies in each of the countries. Existing resource materials were translated into national and local languages. They addressed topics such as drug use prevention, treatment, withdrawal management, counselling and community work. Training activities covered community based needs assessment, action planning, committee work, volunteers' recruitment, group work, decision-making and problem solving, financial management, progress monitoring and review. Training was also provided in the areas of coordination, communication, supervision, reporting and management systems, and related guidelines were provided to the project teams and workers.

Baseline surveys and needs assessments were carried out through surveys and enumerations, and the results maintained confidentially by the Village Action Committee. Information was collected in the following areas.

- Drug use prevalence, and socio-economic and demographic characteristics of drug users.
- Household income, food security and tangible assets.
- Health problems and diseases.
- Infrastructure such as roadways, schools, health clinic, community centre, clean water, sanitation, electricity, sports and recreation.
- Human capital and assets such as teachers and high school graduates.
- Natural resources such as arable land, water for irrigation and forest.

Action plan development

The Village Action Committees, village, governments and community members in general community assemblies discussed the results and their implications. Specific action groups such as the women's, drug user and youth groups were also consulted. Each of them underwent exercises in participatory rural appraisal, village map making and land use planning. Based on a set of prioritised needs with respect to drug use, assistance to drug users and socio-economic improvements, action plans were developed, revised and finalized. The action plans were forwarded to the regional project management for endorsement and financial approval. During action plan development, the project coordinator played the role of catalyst and moderator.

Implementation of interventions

Management, monitoring, reporting and documentation

During the implementation of activities, the Village Action Committee held weekly meetings to review progress and discuss the implementation processes for the forthcoming week. Support was provided to

the Committees during routine visits to the project sites by the project coordinator and the district and provincial officials. In the village, officials from related government agencies also provided support, training and input. During the process, project implementation and management methods were continuously adapted to emerging needs.

The village action committees maintained detailed accounts of project activities and progress. Based on their reports and site visits, the national project coordinator filed monthly narrative progress reports together with photos and video footage to the district, provincial and national officials, and to UNODC.

The villagers carried out all the project activities themselves, including planning, implementation, management, supervision, reporting and documentation. The project maintained the community's active involvement throughout the project processes. This resulted in strong community ownership of both the project and its processes. From time to time meetings were held with the entire community. Project progress, news and views were routinely shared through prominently placed large roadside bulletin boards in the village and various information sharing events were organised. Exchange visits to the project were made by officials and neighbouring villagers. National TV stations, newspapers and magazines also covered the project.

Improvements in the community

Villages carried out a number of projects addressing their essential community development needs such as clean water, sanitary latrines, agricultural development, hydro-electricity, building and repair of roadways, community centres, school rehabilitation, community trust and revolving loan fund, occupational training and skills generation, day care centres and support to women's groups. The project offered income and food security assistance to needy households and facilitated increased availability of agricultural extension services and inputs to the village by coordinating with the line agencies in the area. Clean water systems in the community reduced both water borne diseases and the time to collect water. Preventative health education and activities such as malaria prevention education with mosquito net soaking in permetherine, education on sexually transmitted infections, making available condoms and basic health services resulted in an improved health status.

Prevention and awareness

Drug use awareness and prevention campaigns were locally planned and executed. A range of locally relevant and community wide information and education campaigns concerning the effects of drug use and the various laws and regulations prohibiting drug use (focused on users to encourage detoxification) were undertaken. Community radio and loudspeakers were used. Anti-drug messages were promoted through creating traditional songs and mini-dramas. Posters and booklets were distributed. Roadside information boards were used, and door-to-door campaigns were carried out. Schools, teachers and students were involved in drug education, essay and poem writing. Churches, monasteries and traditional leaders were also involved. Also, prevention was promoted through making available and supporting a range of healthy lifestyle and leisure time activities to the young people such as traditional music, songs and dancing; stage shows, karaoke bar; sporting activities and library services.

Detoxification and treatment campaigns in the community

Young people at risk, drug users and their families were contacted and through information, education and counselling, a supportive and trusting relationship was created. As a result, drug users came forward seeking help and were encouraged to participate in detoxification camps. Spouses and immediate family members were required to actively participate in the process. Those drug users, who could not undergo treatment, were encouraged to reduce their drug consumption over time and were supported in the process.

Buildings were constructed in seventeen pilot villages for detoxification, which were later used as community centres. Detoxification was organised in the community in small groups of up to twenty users at a time. Users, their spouses, families, friends, villagers and medical officials joined together and carried out detoxification. Camp duration varied from seven to twenty-eight days. Herbal and western medications were used. No major complications were recorded.

Follow up, rehabilitation and reintegration

Caseworkers, recruited from the families of drug users and ex-users, continued to provide care to recovering drug users through home visits, health checks and family counselling for a few months in decreasing frequency. Up to ten drug users were assigned to one caseworker. The same level of care services was maintained for those who could not give up drug use fully and who were suffering from drug use induced complications, acute and chronic illnesses. Recovering users regularly met in groups to discuss progress and share experiences. Recovered users, from earlier treatment groups, provided support and acted as mentors to the newly recovering users. Spouses and caregivers met separately to learn from each other.

During the follow up, the caseworker developed in conjunction with the recovering user and his family, a plan for income generation. Loans from the community trust fund, which was created through the project, was utilised. The recovered users also received training in agricultural techniques and assistance from the respective government agencies. Self-confidence, regained health, productivity, increased household income, improved living conditions and acceptance back into the community contributed to relapse prevention.

The special needs of injecting drug users

The project was not specifically designed for injecting drug users, but the pilot communities in Myanmar and Yunnan province in China addressed the needs of heroin users (70 per cent of all known drug users, N = 222), including those found to be injecting. Urgent prevention and care services were required, however establishing contact was difficult due to the stigmatisation and discriminatory conduct resulting in rejection from their community. As a consequence, injecting drug users were found to isolate themselves and hide from their communities. The project took more than one year to establish sufficiently stable relationships, conducive to their participation in the programme.

All drug users, including injecting drug users, received information, education, counselling, detoxification treatment and follow up services in the community as described above. In addition, they were informed about the dangers of needle and syringe sharing as a route of HIV transmission. They were advised in the best methods for cleaning needles and syringes. Sexual transmission was also addressed, and condoms were supplied free of charge. The project also provided, free of charge, medical care, including treatment of abscesses and nutritional supplements. For injecting drug users who were suffering from symptoms associated with AIDS, such as chronic diarrhoea, cold or skin sores, the project arranged for locally available medical treatment, and paid for the medications and supported home care through their spouses and family members.

E. Results and evaluation

Performance indicators

Monitoring and evaluation was carried out through data collection and record keeping throughout the entire project implementation. The following indicators were used to measure success.

- Training needs identified and met.
- Priority community needs identified and an action plan developed through a participatory rural appraisal process.
- On-going photo and video documentation by the community.
- Records of progress monitoring and review activities, and committee meetings.
- Before, during and after surveys of the project along a set of selected variables and indicators, including:
    - drug use incidence and prevalence rate;
    - healthy lifestyle activities;

- number of drug dealers;
- relapse rate at 18 months from the detoxification;
- incidence of petty crimes such as thefts in the community;
- household income and food security of the ex-user families;
- clean drinking water and sanitation systems for the community; and,
- records of information sharing and networking.

- Record of visitors to the project and the visitors' comments.

Main outcomes and coverage

Based on these indicators, the project achieved the following results.

- The project covered a total of 824 drug users, 3,760 households and more than 21,000 villagers in five countries in East Asia.
- Residents in the project communities were aware of the impact of drug use and started to take action against it along with addressing common needs for socio-economic improvements.
- In all project communities a reduction was found in the number of new drug users, in the amount of drugs consumed of those who could not undergo detoxification, and in the incidence of drug trafficking and petty crimes.
- The project was characterised by low relapse rates among those who were supported by project activities such as community based detoxification and treatment and rehabilitation.
- The general infrastructure in the project communities improved considerably. The project made available clean water, sanitary latrines, community centres, sporting and cultural events, video and karaoke shows, day care centres, loans, income and employment opportunities and other non-tangible improvements.
- In all project communities, household income and food security increased especially in the households of recovered drug users, who received micro-credit assistance.

The project was not able to reduce the high mortality rate among injecting drug users who were suspected of dying from AIDS. Nor was it possible to carry out blood tests for HIV infections among injecting drug users and their partners. There was limited provision of medical services for the treatment of complicated medical conditions related to injections. Additionally, for those drug users who continued to inject, the project was unable to provide clean needles and syringes.

External evaluation

An external evaluation of the project was undertaken in December 1999. An excerpt of the highlights of the evaluation findings follows.

> *"The project was very successful in developing and implementing community-based, participatory programme models that were integrated with socio-economic improvements in highland communities across all five countries that participated in pilot activities. The project was also successful in realising its unique design features, including a community mobilisation process, integration of socio-economic improvements and a process orientation. The integration of socio-economic improvements was found to be especially effective in gaining community support and participation, and it is strongly recommended that demand reduction projects in highland areas continue to use this strategy."*

Replication

In the final year of the project (1999-2000), neighbouring villages in Kachin and Shan States, Myanmar and in Thailand started replicating the project activities with technical guidance from the pilot villages and

mostly with local resources. At the same time, the government of Australia financed a similar project in Northern Shan State. The European Union financed a rural development project in Son La and Lai Cau provinces of Viet Nam. It adopted the project model for rural drug treatment and demand reduction. The provincial drug control agency in Yunnan, China adopted that component of the main project model that dealt with post-detoxification care services and rehabilitation for all of its rural drug demand reduction work. This suggests that the project model is readily portable to various rural farming communities with a homogenous ethnic background. Whether the model could be used in urban and heterogeneous communities remains to be tested.

Sustainability

Project sustainability without external financial assistance over the longer run is yet to be proven. Post-pilot unofficial reports on the project confirm sustainability of some of the core activities namely, relapse prevention, prevention of new cases of drug use, prevention of drug dealing and maintenance of common services such as micro-credit, water, sanitary latrine and healthy lifestyle activities under community management. Experiences from piloting indicate that core project activities are sustainable with strong and sustained community commitment. However, it is unlikely that the community will sustain the commitment to drug demand reduction without external inputs for socio-economic and livelihood improvements.

F. Lessons learned

Overall lessons

An important lesson learned during this project was the need to address drug problems in rural highland communities within their socio-economic context. Preventive interventions have a greater likelihood of success, if at the same time basic community needs such as clean water, sanitary latrines, income and employment opportunities are met. The project also showed the necessity for community involvement in all project related processes. Communities are capable of addressing drug use related problems as well as problems related to the infrastructure in a lasting manner.

A further lesson was that resources for socio-economic improvements and drug demand reduction can be mobilised, if partnerships are established between the various levels of government, non-governmental organisations and the communities. Partnerships are not only necessary for resource mobilisation, but also particularly important for addressing issues of vulnerability arising from drug use and HIV/AIDS. In this regard it was felt that the project could mobilise important stakeholders such as parents, elders and religious leaders.

Through addressing contextual factors and mobilising broad-based support, the project created an environment, which allowed the delivery of specific interventions such as prevention and treatment options. As a result, drug users were acknowledged as fellow family members, neighbours and community residents, who were chronically ill and in desperate need of treatment and care. Drug users came out of isolation and voluntarily signed up for treatment and care.

G. Recommendations

- The details of the project methodology be documented in the form of a simple and easy to use resource book.
- Countries should be assisted in establishing and promoting policies and build capacity for demand reduction and socio-economic development specifically in highland communities.
- New projects should be initiated that move beyond pilot testing to the broader objective of integrating demand reduction in rural development and poverty alleviation programmes for highland communities.
- Those organisations working in the field of socio-economic development should form a network for the exchange of experience and mutual learning.

Care and support

Care and support, involving community participation, must be provided to drug users living with HIV/AIDS and to their families, including access to affordable clinical and home-based care, effective HIV prevention interventions, essential legal and social services, psychosocial support and counselling services. Attention should be paid to drug users' medical care needs, including on-site primary medical care services and organised referrals to medical care institutions.

III. HIV/AIDS prevention and home based care in Manipur, India

A. Profile

Name	SASO-AIDS prevention, intervention and home-based care project
Country	India
Related thematic area	Treatment and advocacy
Contact person	Birendrajit Singh, Secretary SASO
Contact information	Social Awareness Service Organization (SASO), RIMS Road, Khwai Lalumbung Makhong, Imphal, Manipur, Phone: +91-385-310011, 411408, E-mail: sasoimph@dte.vsnl.net.in, Fax: +91-385-411409
Project status	On-going, and is at the end of year two in a five-year project cycle, which began in 1999.
Beneficiaries	• People living with HIV/AIDS; • Drug users, particularly injecting drug users, spouses and children of those who are infected.
Partners	• Oxfam • Manipur AIDS Control Society • Directorate of Health Services (Manipur)
Funding	Total funding for five-year period 1999-2004: US$44,724

B. Background

The project is implemented in Imphal, the capital city of Manipur, one of India's smallest states in the North East. Manipur is a state with weak infrastructure and governance. Development has suffered severely over the past decades partly due to on-going conflicts in the presence of various armed pressure groups.

Health infrastructure is generally poor in Manipur and highly concentrated in the area of and around Imphal. For a large majority of the population access to health services is restricted due to physical, economic and psychosocial reasons. Throughout the last decade the situation improved marginally and today there are two AIDS hospices in Manipur (as of 1999) – one in Imphal and the other in Churachandpur, Manipur's second largest city. In Imphal the hospice has 15 beds. Without a blood bank and no stock of medicines, it provides only nursing care and presently cannot deal with even minor surgical procedures.

Drug use and HIV/AIDS

According to a rapid situation assessment of drug use conducted jointly by UNESCO and UNODC in 2000, approximately 12,000 to 15,000 injecting drug users live in Imphal. Of these 95 per cent were injectors and 93 per cent male. While levels of knowledge on HIV transmission and prevention are high, risk behaviour levels also continue to be high. According to the assessment nearly 30 per cent of injecting drug users frequently shared needles and syringes, and condom use levels in commercial sexual encounters were lower than 50 per cent.

HIV/AIDS was first detected in the state in 1989 and has since resulted in a public health catastrophe. By the end of 2001 there were 13,836 confirmed cases of people infected with HIV/AIDS of which 1,369 had AIDS. However, it is widely assumed that this is an underestimate of the magnitude of the epidemic. Data quality is poor and voluntary testing remains the exception rather than the norm.

In the initial phases the epidemic was almost exclusively related to injecting drug use. However in 2002 it was determined that approximately three quarters of people with HIV/AIDS had become infected in the course of sharing drug-injecting equipment. Sexual and perinatal transmission accounted for the remainder, with the wives and children of infected drug users overwhelmingly affected. Sentinel surveillance figures indicated a 60 per cent sero-prevalence rate among injecting drug users in the year 2002. A large majority (68 per cent) of those infected are from Imphal. Approximately 3.0 per cent of antenatal clinic attendees also tested positive for HIV further pointing to the increasing sexual transmission levels of HIV within the population and, indicating a generalised HIV/AIDS epidemic.

Health care

One state hospital conducts an out patient clinic for those with problems associated with HIV/AIDS in the general out patient department. However, patients access the service only on a bi-weekly basis when the concerned specialists are available. Waiting periods are sometimes hours, that is it-self draining for the patient. According to SASO care workers approximately 70 per cent of those who are taken to hospital with HIV/AIDS related illness are sent away due to lack of beds or unavailability of doctors. It was also reported that only six hospital beds are allocated to the medical team treating HIV/AIDS related illnesses.

As in other parts of the country, availability of medication is poor and there is no access to anti-retroviral drugs through the existing health care system. In terms of medication for opportunistic infections, the existing health care system provides access to medication for tuberculosis through the Direct Observed Treatment (DOT) programme since the end of 1999. Other medication for infections such as herpes, is seldom made available through the health care system. Hence, after a decade since the first case of HIV was detected in Manipur, there remains very little infrastructure or resource allocation within the existing health care system to deal with the care needs of those infected with HIV.

Negative attitudes towards those at risk, or who suffer from HIV/AIDS, have caused further restrictions to be placed on access to medical services. In the early and mid-1990s hospitals refused to admit people with HIV/AIDS and, nurses and doctors refused to treat people suspected with HIV/AIDS. Those seeking access to treatment stopped presenting at hospitals for fear of the consequences, including the fear of their HIV status being publicly revealed. The utility of voluntary testing was diminished significantly in the absence of medical staff observing patient confidentiality protocols. As people began to realise the extent of stigma and discrimination associated with being sero-positive, voluntary testing was no longer viewed as a viable option.

Community attitudes to HIV/AIDS have improved marginally over the past decade, however they are relatively negative in comparison with other parts of India where the HIV/AIDS epidemic has made its presence felt strongly. Negative attitudes result in the continuing marginalization of people with HIV/AIDS and their families. The fact that a majority are injecting drug users worsens the situation. There are instances of drug users and people with HIV/AIDS being targeted by various organisations, and maltreated.

About SASO

SASO was founded in 1990 by a group of ex-drug users as a self-help group. They are young men in their early to mid-twenties. Most were members of Narcotics Anonymous (NA). The primary objective was to support each other to stay away from drugs and live a meaningful life. It was felt by the group that one of the main causes for relapse among drug users was a lack of trust and negative attitudes among families and the wider community towards recovering drug users. They decided to work towards changing community attitudes that marginalized drug users through the organisation of sporting events and community awareness meetings.

When the first HIV-positive drug users began to develop opportunistic infections, SASO members witnessed first-hand accounts of their treatment by the medical community. Watching friends and acquaintances with HIV/AIDS unable to secure the provision of medical services and help evoked a sense of deep empathy among SASO members. Through NA meetings they heard of who was ill and needed help. They visited them in their homes and provided any support possible. This included nursing care, emotional and financial support. They contributed from their own pockets, where required, used their own vehicles, gave injections and dressed wounds and abscesses as best they could.

In 1993 SASO members jointly decided to formalize this initiative in the form of a home based care programme. The main objective behind the initiative at that time was to provide humanitarian aid to drug users affected by HIV/AIDS. Those people infected were unable to access any medical support from medics in the community or hospitals. SASO staff often arranged for sympathetic physicians to visit clients or took clients to them. They helped with transport arrangements and in accessing medication. Where no nurses and doctors came forward to administer injections and intra-venous drips, SASO care workers did so. They were aided by their experience of injecting themselves or their friends during their drug using pasts. Although untrained, they picked up skills from watching the few doctors who visited clients and quickly learned about basic medication related to opportunistic infections.

When SASO's home-based care programme began in 1993, the prevailing circumstances were extremely unfavourable. The setting in which the programme was implemented was at the very least daunting, with an extreme paucity of resources, little access to basic medical support, rampant stigma and discrimination and an extremely volatile political, law and order situation. The project commenced without any funding and was implemented by untrained volunteers.

C. Objectives

When the project began it had only one main objective being to provide humanitarian assistance to those suffering from HIV/AIDS. As the epidemic progressed SASO staff realised that unless they could involve family members and the community closely in providing care, the project would be unsustainable. Thus, the undertaking of advocacy through information and training programmes within the community and among family members became another key objective in 1995. As the epidemic continued, more spouses and children of infected individuals contracted the disease. The need for providing services for this group became clear to SASO staff, both in terms of prevention and care. Hence, key objectives shifted from simply the provision of care to those infected to the inclusion of preventative measures among those at risk. Further, the focus shifted from drug use issues towards safe sex education and condom promotion. Finally, the project evolved from providing services to engaging in advocacy and today the project has three key objectives.

- To provide quality home based care for people with HIV/AIDS.
- To prevent HIV transmission to spouses and children of those infected, and providing care and support to them when affected/infected.
- To actively engage in advocacy to remove misconceptions associated with HIV/AIDS in the family, medical profession and the wider community.

D. Major activities

Home visits: A team constituting a social worker, care worker and doctor visited clients in their homes. Clients are identified as falling into one of three categories: asymptomatic, sick and terminally ill. Approximately eight visits per month are made to those who are deemed to be terminal. Two to three visits per month are made to those who are deemed to be sick and one visit per month is made to those having no symptoms.

Doctor's visit: SASO operates a free community clinic as part of its drop-in-centre. Many home care clients visit this facility for their health-care needs. However, when a client is unable to travel and requires medical attention, the doctor from the clinic visits them in the home with the social worker and care worker.

Free Clinic: The establishment of a free community clinic open five days each week providing free medical services has created support in the community for the care programme. The clinic treats opportunistic infections successfully in a primary health care setting.

Home Detoxification: A significant number of care clients continue to use drugs. Attempts to access detoxification and rehabilitation facilities were denied to clients due to their HIV-positive status. Hence, for those clients wishing to stop using drugs it was essential to provide detoxification services within their homes. Detoxification medication is prescribed and made available free of charge by a doctor. It is entrusted to the parents or main caregiver, who supervises its dispensation. Between August 1999 and March 2001, SASO provided home detoxification services to 285 clients. Of these 8 per cent were reported to be drug-free at follow up.

Education of family members: To prevent the marginalization of care clients and ensure their care and support within the family, care workers provide education to family members on prevention of HIV transmission, bio-safety and nursing care.

Counselling is provided for both HIV/AIDS and drug use clients. Counsellors regularly provide pre- and post-test counselling whilst also attending to the information and emotional support needs of care clients.

Referral: The project provides referral to drug treatment services, hospital services and voluntary testing. Often clients and their families call project staff if the condition of the client creates cause for concern. In such cases clients are taken to hospital by the care workers or visited by the project doctor in their homes.

Medicine provision: The project aims to provide a certain amount of medication to clients with no charge. Tuberculosis medication is also made available without charge. However, the project does not provide access to anti-retroviral drugs. Twenty-one clients from the home-based care programme are using anti-retroviral drugs procured privately.

Financial support: A small amount of financial assistance is made available towards the cost of medication that is otherwise unavailable through the project. This has the effect of increasing levels of 'hope' among people who have very limited or no resources to procure medication.

Telephone help line: This was established first in 1994 to enable people concerned about HIV/AIDS to obtain information on the disease and available services without compromising their confidentiality. The service continues today with three to four calls received daily. A counsellor provides information on a range of issues, including voluntary testing and safe sex.

Condom provision and promotion: As part of home care support, safe sex education and condom demonstration is a part of the counselling and education services provided. Condoms are provided free of cost in the project.

Treatment of other sexually transmitted infections is made available free of charge as part of the project.

Self-help groups: There are three self help groups formed under the home-based care programme. The first is a widows group, which meets once every month and is now registered independently. The second self help group is made up of spouses of care clients and female care clients. They have one meeting every month. The third group is comprised of male care clients who meet twice each month. The groups were established with financial support from the Home Based Care project and their expenses continue to be borne by SASO.

Logistical support: The project workers often accompany clients to the hospital, arrange transport, meet with doctors, and spend the night in hospital if required. Very often clients feel more empowered to access treatment and medical help in future visits as a result of this support in the first few visits.

Networking and liaison: The project collaborates with the Ministry of Social Justice and Empowerment and the Ministry of Family Welfare regularly to access as much support for clients as is available. For example, project staff negotiated grants and loans for care clients to assist them financially. The Ministry of Family Welfare makes condoms available to the project. The project has also established linkages to the private sector for the benefit of clients. Discounts, for example, are negotiated regularly with laboratories offering diagnostic health services for clients who are otherwise unable to pay the full rate.

Advocacy: SASO staff were continuously involved in advocacy to bring to the fore the issue of care and support for those suffering from HIV/AIDS. It has used state, national and international fora and conferences to point out the lack of services in this area. One of the direct outcomes of this advocacy has been increasing pressure on the State Government to rectify the situation. SASO has also engaged in direct advocacy with the medical profession. Staff members of the organisation actively established personal relationships with doctors and nurses, which made them more willing to treat patients with HIV/AIDS. Once a patient became familiar with the doctor they were able to access him or her independently of SASO. The organisation also facilitated training and exposure opportunities for young and inexperienced doctors, which lead to an increase in the pool of medical personnel to support care work.

E. Evaluation

Indicators

The main measures that were used to determine the progress of the project include number of enrolled clients, referrals made and referrals received from other agencies. Also, the frequency of specific activities such as counselling, follow-up visits, home detoxification, trained caregivers, and calls on the help line were used as indicators for monitoring and evaluation.

Main outcomes

Due to the absence of baseline data it is not possible to provide comparative information for project outcomes. However, the available information indicates that 184 clients obtained care in their homes since August 1999, including women and children. It is estimated that 300 clients benefited from SASO's Care programme in previous years. In the period between August 1999 and July 2000, 58 cases of tuberculosis, 43 cases of persistent fever, 13 cases of persist diarrhoea along with other opportunistic infections were treated at home. In the free clinic, which is also regularly accessed by home care clients, 80 cases of tuberculosis, 53 cases of skin infections, 25 cases of persistent diarrhoea, and 15 cases of other sexually transmitted infections were treated. See Table 1 for a summary of project results in the year 2000.

Table 1: Summary of main project outputs in 2000

Number of:	
• Visits made to free clinic	765
• HIV/AIDS related counselling sessions	444
• Persons provided with financial and medicine support	104
• Education sessions on nursing care and HIV/AIDS	380
• Referrals received	107
• Referrals made	89
• Clients receiving drug related counselling	98

Three self-help groups were established through the project, one of which is now a separate registered body. Four training sessions were held on positive living, nursing and palliative care, HIV/AIDS and drug treatment for home care clients. Approximately 50 clients were trained in workshops with a duration ranging from one to three days. Two training courses were also provided to immediate caregivers, usually family members of those with HIV/AIDS.

Feedback from staff members

Staff members of the project expressed the view that the project responded well to the immediate needs of clients. In particular its value in terms of the provision of nursing care and referrals, in spite of a resource poor environment and difficult operating conditions, was noted. It has filled a gap in services provision for the care and support of those with HIV/AIDS and their families, which other agencies were not able to bridge.

The provision of a free clinic, together with home visits by medical practitioners, significantly reduced the need for both hospitalisation and referrals. It similarly contributed to a more cost effective care service. Moreover, the home-based nature of service provision increased access to care and prevention services within a cultural context that sees people avoiding hospitals.

According to service users, the project has been critical to the improvement of the quality of lives through the provision of vital services that would otherwise be inaccessible. They reported that, apart from providing health services, the project provided critical psychosocial support and assistance to clients in countering stigma and discrimination. SASO staff often mediated in community and family situations to protect client rights. They also undertook on-going advocacy activities with law enforcement and medical agencies with a view to protecting client interests.

Staff members working on the project are generally considered to be enthusiastic and committed to their jobs. They have a genuine and humane approach to their clients, and adhere to norms established to maintain confidentiality. This has helped to develop and maintain very good working relationships between the client and their families and project staff. Levels of client satisfaction with the project and its staff are generally high.

Issues to be addressed in future

The need to strengthen and restructure interaction between clients' families, particularly the main caregiver and the project staff was identified as an issue in need of urgent attention. Currently this interaction is hampered by cultural constraints imposed on the ability of largely male project staff to deliver and reinforce safe sex and other prevention messages to women caregivers. More female staff should be engaged in this process. Further, it would be desirable for project staff to maintain a checklist ensuring the delivery to a client and family of all prevention, bio-safety, care and nursing information.

The project should be more responsive to the needs of female care clients. Staff and clients repeatedly expressed the need for a female doctor. As the proportion of female clients is increasing with the maturing of the epidemic, the project must be sufficiently flexible and responsive to accommodate their needs. The lack of resources and basic equipment impeded a coordinated response from project staff. For example one motorbike is allocated to the project. When visiting a client's home, the team is unable to arrive together. This particularly impacts negatively on follow up activities.

The project should engage the wider community to address issues of marginalisation and discrimination. Currently such activities are planned however not yet undertaken as foreshadowed at the commencement of the project.

Coverage

The home-based care programme is limited to the Imphal Municipal Area. Visits are made to clients' homes within this region, which has a total population of approximately 300,000. According to the epidemiological surveys at March 2001, 5,552 people were living with HIV/AIDS in this area, but of this group the project offered services to only 3 per cent. The number of 5,552 does not include the spouses or sexual partners of those living with HIV/AIDS. Hence, it is not unreasonable to conclude that only a small proportion of those requiring care and prevention services are being assisted through this project.

Replication

Currently one key factor contributes to SASO's home care programme's success. This is linked to the deep sense of empathy that programme staff share with HIV/AIDS positive people. Further SASO's organisational structure facilitates a participatory approach, promoting a sense of equal project ownership amongst all staff members, and which has a positive impact on motivation. Seven out of ten cases, referred to hospital for admission by programme staff, are rejected. Accordingly programme staff display extraordinary dedication by ensuring those clients refused admission at hospital receive medical attention. Staff members regularly contribute from their pockets to help clients with medicine and diagnostic costs. This is indicative of the benefits of engaging people affected with HIV/AIDS in designing and delivering programmes.

Sustainability

Based on current information, it is clear that the programme is sustainable at least in the short and mid-term. However in the longer term the programme will need to strengthen its operation, particularly in the areas of community sensitisation and advocacy.

Contributing factors to the sustainability of the programme include the following.

- The programme is community based. It arose from within a community of ex-drug users and worked for drug users who were infected with HIV. Thus, the programme has not evolved in a top down fashion but has emerged from the needs and wants of the community. It should be noted that care was being provided by SASO even when there was no external funding available. The funding arose in response to the achievements of the programme in the years prior to 1995.
- The home-based care programme is a priority for SASO. Even with funding interruptions, as occurred in 1997, the programme was not shut down. It operated on a minimum level and financial support extended to clients was more limited. The crucial factor that should be emphasised is that the programme is viewed as a priority because of its community basis. The importance of the involvement of the community of ex-drug users and those affected by the disease should not be underestimated. Without the implementers being stakeholders in the programme, it is unlikely that funding of the programme would have commenced, nor continued.

- Another factor conducive to the sustainability of the programme is its cost effectiveness. With an annual budget of under $9,000, the programme currently offers a care package to 184 clients. Whilst there is no doubt that more resources are urgently required, much is being achieved at the current level of funding.

The long term sustainability of the programme will require the negation of unfavourable attitudes that currently exist within the community toward people with HIV/AIDS and their families. In the absence of a supportive community environment a model of community care cannot be successfully implemented.

F. Lessons learned

Home-based care only works well in the presence of effective linkages to community and hospital care. It is imperative that referrals be made to hospitals for nursing care and the treatment of severe opportunistic infections. Community acceptance of people with HIV/AIDS and their families is crucial in the long term to ensure positive programme outcomes.

The delivery of home care programmes must maximise family involvement. When family resources are utilized sub-optimally care workers end up shouldering the care burden to a disproportionate extent. In the long term it creates unrealistic expectations both on the clients and their families. The programme must be flexible in its design and implementation to be sufficiently responsive to the changing client profiles as epidemics mature and progress.

According to project staff the main lessons learned have been both positive and negative. Positive lessons learned include the following.

- The project filled a gap in the provision of care and support services for those living with HIV/AIDS. It began without any funding or training. One of the most important lessons learned is that it is possible to provide services even in resource poor settings.
- Services can be provided in a very cost effective manner, with average annual spending per client receiving services varying between US$50 and US$75.
- The existence of the project has led to a process, that has countered stigma and discrimination in the medical and wider community. Hence, another important lesson learned is that service provision itself can become a platform for advocacy and change.
- A significant factor that promotes entry and retention into SASO's home-care programme is the provision of a large spectrum of drug use treatment, such as detoxification in community camps, referrals to detoxification and rehabilitation facilities, and harm reduction services such as substitution therapy and needle syringe exchange programmes. A significant lesson learned is that the existence of a continuum of services offering a wide variety of options to clients increases the quality of services provided and retains clients.

Negative lessons that staff learned include the following.

- While family attitudes to those suffering from HIV/AIDS have improved substantially, those of the wider community remain negative and unsupportive. The programme will need to be refocused in a manner that sensitises the community to issues related to HIV/AIDS. Unless, this is achieved, care in the community will not be sustainable.
- There is a high level of dependency on programme staff not simply from care clients but also their families. There is conjecture as to the benefits of such dependency. One reason for the development of dependency is the emotional and empathetic attitude of project staff towards those suffering. This may be linked to the fact that many of those with HIV/AIDS were friends and colleagues of SASO staff from their drug using days. There is a lack of objectivity in dealing with clients. Project staff overburden themselves with the support function, often allowing for complacency within the family to develop. Dependency also arises due to the marginalisation of

people with HIV/AIDS by the community. People feel completely helpless and incapable of negotiating even the simplest of their needs. This has reinforced the belief of the programme staff that community education and sensitisation needs to be addressed as a priority.

- Nearly eight years after SASO began to deliver home-care services, documentation and reporting remain extremely weak. Staff and management are now beginning to appreciate that in the absence of meaningful documentation and reporting the development of project strategies is seriously compromised. It also hampers evaluation activities and impacts on effective programme design and implementation.
- Home-based care works well subject to the willingness of primary and tertiary health services responding to referrals. A loss of credibility to the service provider referring clients to hospitals and other health facilities arises, when those referred are refused access. For example, in circumstances where a shortage of beds or doctors exist.

G. Recommendations

- Home-based care is an effective model of care provision in the Manipur context and must be scaled up to provide services to a larger group of people. The present project is highly cost effective but can be improved by more realistic resource allocations, both human and financial.
- Project staff must be provided with training in the areas of documentation and programme management. The skills of programme staff should be matched more closely to their job descriptions. It is recommended that a female doctor be made available to fulfil the health needs of female clients.
- Networking and liaising activities should be strengthened with other non-governmental organisations and health facilities to facilitate referrals.
- Care workers are placed in emotionally and physically vulnerable situations in the course of their jobs. Therefore it is recommended that care workers themselves have access to regular counselling and health check ups.

Outreach

Treatment is not chosen by all drug users at risk for HIV infection, nor may it be regarded as an attractive option early in their injecting career. Recovery from drug use can be a long term process and frequently requires multiple episodes of treatment. Relapses can occur during or after successful treatment episodes. Various *outreach activities* have been designed to access, motivate and support drug users who are not in treatment to change their behaviour. Findings from research indicate that outreach activities increase drug treatment referrals, and may reduce risk behaviour and HIV incidence. Several reviews of the effectiveness of *syringe and needle exchange programmes* have shown reductions in HIV transmission and no evidence of increase in injecting drug use. Such programmes have shown to serve as points of contact between drug users and service providers, including drug use treatment programmes. The benefits of such programmes increase considerably, when a broad range of options are made available including drug treatment.

IV. Outreach in Dhaka, Bangladesh

A. Profile

Title	**S**topping **H**IV/**A**IDS through **K**nowledge and **T**raining **I**nitiatives (SHAKTI)
Project country	Bangladesh
Related thematic area	Targeted interventions for injecting drug users, sex workers, transport workers
Contact persons	Shamim Rabbani
Contact information	Dhaka Multi-Project Field Office, Technical Co-ordinator, Injecting drug user Intervention, HIV Program, CARE-Bangladesh House number 49/1, Babar Road, Block-B, Mohammadpur Housing estate, Dhaka-1207, Tel: 880-2-8123364/Fax: 880-2-811 4183, E-mail: carebang@bangla.net
Project status	On-going
Beneficiaries	Injecting drug users
Partners and stakeholders	• Government agencies, non-governmental and community-based organisations; • Donors, including DFID, UNDP, UNODC, UNAIDS; • Families and friends of injecting drug users; • Local communities, including drug dealers, youth clubs, medicine shop keeper.
Funding	Since 1993: CARE-Bangladesh Since1995: UK Department for International Development

B. Background

The first cases of AIDS or HIV infection in Bangladesh were detected during the late 1980s and early 1990s. By the end of 2001, the estimated number of adults and children with HIV/AIDS was 13,000. High-risk behaviour such as sex work, men having sex with men and injecting drug use is frequently evidenced whilst high rates of sexually transmitted infections point to widespread unsafe sexual practices.

These characteristics raise concern that the spread of HIV might occur in a manner similar to that documented in several neighbouring countries.

Estimates of the number of drug users in Bangladesh range from 100,000 to 1.7 million. In the early 1990s it was estimated that there were 100,000 heroin users in the country, although today its accuracy remains in doubt given Buprenorphine has become the favoured drug. From studies in three major sites where drug injecting has been reported, estimates suggest that there are approximately 20,000 to 25,000 injecting drug users across the sites. In the capital Dhaka, data suggest that there are over 7,500 injectors and at least 11,000 heroin users. In northern Bangladesh there are an estimated 12,000 to 15,000 injectors, most of whom live in the cities of Rajshahi and Chapai Nawabganj.

Current trends indicate that injecting appears to be gaining popularity. Data from 1996 indicate that injecting of sedatives and Buprenorphine was widespread. Today, the drug of choice is Buprenorphine, which is frequently mixed in a cocktail of substances, including Diazepam, Promethazine Hydrochloride and Chlorpheniramine. When heroin is injected, it is usually dissolved in lemon juice before injecting.

C. Objectives

The main objectives of the work of SHAKTI are to: provide a broad spectrum of health services to injecting drug users in order to reduce the risk of transmission of HIV and other blood borne diseases; treat ailments related to drug use; and, establish an environment conducive to behaviour change. SHAKTI works in partnership with other organisations to implement HIV intervention programmes for injecting drug users, and disseminates the lessons learned to national stakeholders.

D. Activities

“SHAKTI” carries out four broad categories of activities, which include the following.

- Drop-in-centre based activities in seven different areas of Dhaka.
- Service provision through outreach workers.
- Field office based activities in Dhaka.
- Expansion of needle and syringe exchange programmes to other parts of Bangladesh.

These activities are discussed in greater detail below.

Drop-in-centre

The drop-in-centres are the focal points for a team of outreach workers. Local communities provided space for the drop-in-centres free of charge in one area for two years, and in another area the local youth club agreed to share space with the project at a low rate. Drug users come to these centres to ‘hang out’, play indoor games, receive treatment for sexually transmitted infections, dress abscesses and treat other ailments.

Staff members of the drop-in-centre conduct educational sessions for drug users on drug use, HIV/AIDS and blood borne infections. With one exception, all staff members of drop-in-centres in Dhaka are from a drug use background. Needle and syringes are not exchanged at the drop-in-centres and, in line with the policy of CARE, smoking is not allowed.

A male doctor comes once a week to each of the centres for a limited period of time. Drug users can seek advice and treatment for sexually transmitted infections and other common illnesses free of charge. As of March 1999, Marie Stopes Clinic Society, Bangladesh, is bearing part of the cost of the management of sexually transmitted infections in partnership with CARE-Bangladesh. The dresser, who was trained by the project and who is also a current drug user, dresses minor wounds, drains abscesses

and dispenses simple medicines for fever, pain and healing of abscesses. Those cases not manageable at the drop-in-centres are referred to clinics.

Outreach workers

Outreach activities are conducted at different spots around each of the drop-in-centres in Dhaka through 23 outreach workers who are current injectors. Before launching the needle syringe exchange, the outreach workers prepared a master list of injectors staying in different outreach locations of Dhaka. Through extensive fieldwork and creating a trusting relationship with the drug using community, this confidential list is regularly updated through snowballing. As the project progressed, more and more injecting drug users volunteered to be included in the list. However, the number of injecting drug users each outreach worker subsequently met for exchanging needles and syringes after initiation of the project was always less compared to that in the master list. The reasons for this include switching to smoking drugs, deaths and migration.

Each location has several spots at which outreach workers operate on alternate days. Initially outreach workers looked for drug users, but after some time, they were met at pre-fixed places for exchanging syringe and needles. One-for-one exchange has been practised with rare exceptions. Drug users receive two syringes and needles at each contact consistent with the service provided to them on alternate days. The corners of the packs of syringes and needles are torn before distribution to avoid their resale. Condoms are distributed on demand and free of charge to drug users and the latter are referred to the drop-in-centres for treatment of sexually transmitted infections or other health conditions.

Outreach workers return to their respective drop-in-centres each afternoon with used syringes and needles and to complete their paper work. Returned syringes and needles are counted by the drop-in-centre staff and disposed of at regular intervals with the help of an incinerator in a research organisation in Dhaka.

Field office

A field office has been established in Dhaka to organise and coordinate all activities under the project. It is staffed with a technical co-ordinator, project officers, field trainers (supervisors) and an administrative assistant for the needle-syringe exchange project. The tasks of the office include management of the project, supervision of outreach workers and troubleshooting, the organisation of community-based detoxification camps, training and the organisation of various advocacy events.

Supervision and troubleshooting

Field trainers regularly accompany outreach workers to ensure the correct delivery of: needles, syringes and condoms; and, education messages and materials on HIV/AIDS and drug use. Outreach workers receive on-the-job training.

Regular meetings are held at the field office involving the technical co-ordinator, project officers, field trainers and outreach workers. Administrative and technical problems are discussed and may include reinforcement training when necessary. The technical officer encourages the entire team to interact with different visitors and experts visiting the project conducive to the generation and exchange of new ideas and views.

In the event of critical situations arising in the field, such as harassment of outreach workers by the police or hoodlums, field trainers notify the project officers who immediately proceed to the scene to assist.

Training

Training of peer educators, medicine shopkeepers/pharmacies and drug dealers who assist drug users in injecting is a major field-office based activity. Since the commencement of the project 350 peer educators, 75 medicine shopkeepers and 50 drug dealers from Dhaka have been educated on the modes

of transmission of HIV and harm related to drug use. Medicine shopkeepers in the training are educated about the benefits of needle and syringe exchange in the prevention of the spread of different blood borne infections. They are encouraged not to buy syringes and needles from drug users. Drug dealers are trained on safer injecting practices. Refresher courses are also organised. Following completion of the training the peer educators work as volunteers in the field and disseminate the new information acquired to other injecting drug users.

Community-based detoxification camp

The field office also organises community-based detoxification camps. The camps were not a part of the original project design and arose as a need of the drug users participating in needle and syringe exchange. At times, the local community offered spaces free of charge in brick-houses for holding the camps. Otherwise spaces are rented at subsidised rates from the community for the duration of the camp.

Outreach workers, drug users who had previously joined a camp or neighbours who become familiar with the activities from drop-in-centres, inform drug users and encourage their involvement. The participants of the camp pay 150 Taka (US$1 = 50 Taka) to join. The monies are then provided to the self-help group of drug users. There is no charge for board, lodgings, or medication in the camps. Drug users stay for fourteen days, the initial three days of which are supported by medicines for withdrawal symptoms. A doctor from a government hospital, who is provided with a small remuneration, comes to the camps and offers medical check-ups for drug users. The field trainers are usually available for night-duty in the camps.

Advocacy and sensitisation

The technical co-ordinator takes a special interest in designing and developing cultural programmes with the help of local cultural groups. Such events have been used as advocacy and sensitisation tools. Folk songs and street dramas have been composed; video films, flip charts, information-folders on drug and HIV/AIDS have also been used. These tools are intended to raise awareness on drug use and HIV among drug users, their family members, key persons in the community, police, university students and other community members.

Needle and syringe exchange in other parts of Bangladesh

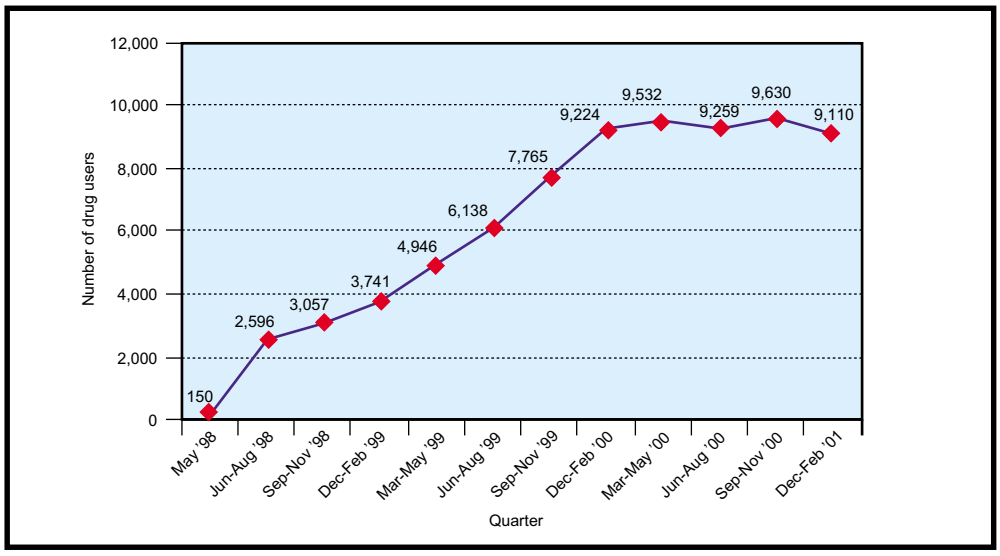
In 1999, CARE-Bangladesh initiated needle and syringe exchange programmes in Rajshahi and Chapai Nawabganj both in the Northwest of the country. Shooting galleries in these areas are small thatched huts inhabited by dealers who also help drug users inject. The same syringes are used for a number of clients. The feasibility of expanding needle and syringe exchange to nearby areas was also explored because information indicated the presence of injecting drug use in these places. While activities followed the same work pattern as in Dhaka, development of partnership with the local organisations was given priority in these areas. Altogether, services were provided to 600 injecting drug users.

E. Outcome

Injecting drug users covered

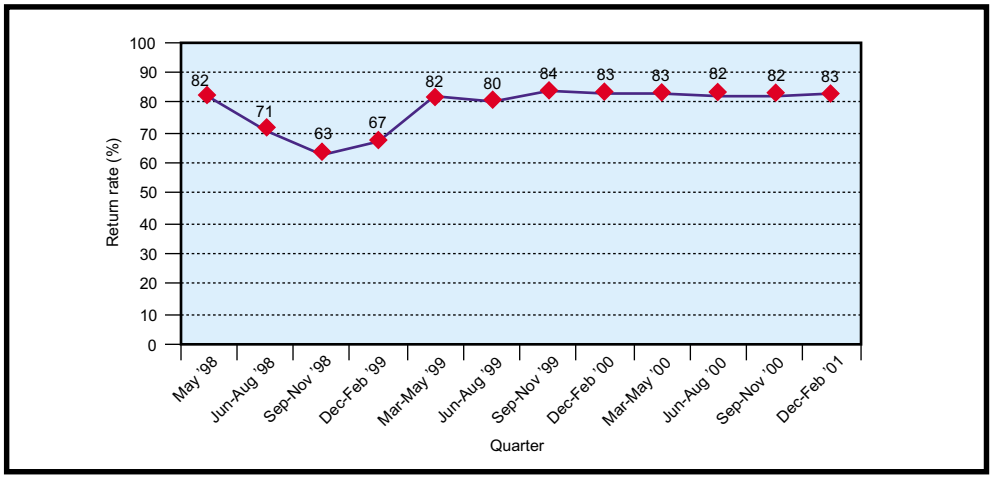
The intervention among injecting drug users in Dhaka started in May 1998 with 150 drug users and gradually increased (see Figure 1). This was achieved through snowballing and trust built by the project staff with the drug users on the streets. A plateau in the number of clients covered was reached by the end of the second year of the project and the total number of drug users contacted per three months after reaching the plateau was about 9,000. Cross checking with the master list, which is regularly updated, revealed that the *enlisted* number of drug users in Dhaka city had also reached an all time high of 4,000 per month during the second year of the project and, henceforth, experienced little change.

Figure 1: Cumulative Number of drug users reached per quarter, 1998-2001



One-for-one exchange of syringes was emphasised since beginning the project. The return rate was high (around 80 per cent per quarter, see Figure 2) in all years except at the time of the devastating floods in Bangladesh in the third quarter of 1998.

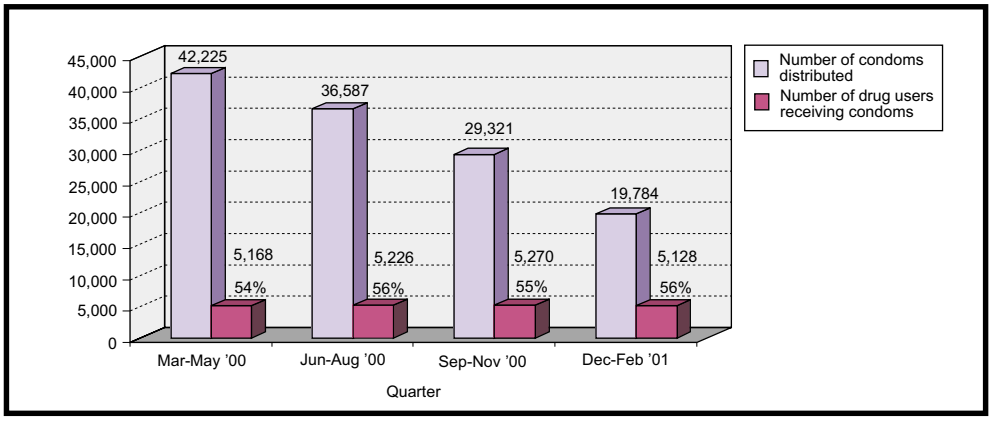
Figure 2: Average Syringe and needle return rate per quarter



Condoms distributed

The baseline information indicated that many drug users had sexually transmitted infections. A high proportion of this group also reported visiting sex workers. Therefore, outreach workers distributed condoms free of charge from the beginning of the project. The number of condoms received by drug users declined over the years and levelled off at approximately 55 per cent of all drug users contacted by outreach workers (see Figure 3). Data was not available for the period before March 2000.

Figure 3: Cumulative Condom distribution per quarter



Drop-in-centre attendance

Since the second year of the project the number of drug users frequenting drop-in-centres remained static within the range of 3,500 to 4,000 per month. There was some reduction in the number of drug users needing treatment of abscesses, which was due to their participation in the needle and syringe exchange programmes. However there was no significant decrease noted in the proportion of those receiving treatment for sexually transmitted infections.

Harassment of drug users

Harassment of drug users by police and local "mastans" (physical torture, extortion of money, sexual assault) were recorded at the time of baseline studies and were found to increase high-risk injection practices. Immediately after harassment, drug users went underground and distanced themselves from drop-in-centres and outreach workers, thereby decreasing their access to services. Consequently, abscesses and sexually transmitted infections could not be treated and the needle and syringe exchange was interrupted. Repeated advocacy with police and local hoodlums reduced the overall incidence of harassment during the project period.

F. Evaluation

Indicators determining the progress of the project

In 1998, a team of evaluators examined various components of the project and recommended that:

- the number of drop-in-centres be increased to cover a larger population of drug users;
- sufficient funds be made available to ensure adequate supply of clean needles, cotton swabs and condoms;
- treatment of sexually transmitted infections be improved;
- partnerships be developed with other organisations providing treatment and rehabilitation;
- six-monthly surveillance of HIV infection among the participants of the needle and syringe exchange project be established;
- long term information, education and communication strategy with materials specifically tailored to the needs of drug users be developed; and,
- voluntary counselling and testing facilities for HIV infection be established.

CARE implemented several of the above recommendations in subsequent years, which increased the coverage of drug users assisted by the project in Dhaka.

Project staff conducted semi-annual behaviour surveys starting in April 2000 in which self-reported behaviour of drug users was recorded. The results of the surveys indicated that the rate of sharing syringes and needles decreased and the knowledge on HIV/AIDS increased significantly. However, results also indicated that it was necessary to reduce the extent of harassment of drug users and improve the quality of service at drop-in-centres.

Regularity of contact

A drug user can contact an outreach worker of the needle and syringe exchange project for a maximum of 13 days a month because outreach workers operate in each spot on alternate days. According to the monitoring sheets of April 2001, only 58 per cent of all drug users contacted outreach workers between 10 and 13 days; 22 per cent contacted outreach workers between seven and nine days, and the rest between six and less than three days.

Mobility of drug users was one of the reasons for non-regular contact with the programme. While drug users could avail themselves of the services of needle and syringe exchange in new project areas, it was necessary to record this factor in detail so that the exact degree of coverage could be established. It is worth noting that around the three drop-in-centres, the coverage for the 10 to 13 day periods ranged from 72 to 99 per cent. Lower coverage and greater mobility were found in areas of the city, such as slums, from which people were forcibly evicted.

Replication

The potential of replication of the needle and syringe exchange project was demonstrated by CARE-Bangladesh through the introduction of similar activities in the Northwest of the country. However, the lessons learned from this replication are critically important and include the following.

- Replication should be based on a thorough situation assessment.
- Outreach interventions should be implemented by current drug users.
- When replicating project activities, partner organisations must adhere to confidentiality, must have positive attitudes towards injecting drug users, and respect the choice made by injecting drug users in accessing a variety of treatment options.
- Replication requires flexibility, preparedness to address advocacy issues and the needs of injecting drug users in specific situations.

Sustainability

There are, in the view of the project staff, three ways to attain sustainability.

- Through acceptance by the governmental, non-governmental and community-based organisations.
- Through the formation of self-help groups of current and ex-injecting drug users who would carry on the task of promoting safer drug use in the future.
- Financial sustainability.

To increase sustainability, CARE shared its experience with the needle and syringe exchange project with the Government of Bangladesh, various non-governmental organisations and funding agencies at different fora. The Government of Bangladesh recently amended the law on the control of narcotic substances, which allows a variety of treatment options for drug users. However, there is a need for greater dissemination of this information so that all partners share the workload.

CARE facilitated the formation of a self-help group of current injectors called “PROCHESTA” (meaning *effort* in Bengali) in Dhaka, which is trying to build a trust fund for harm reduction work among drug users in general and injecting drug users in particular. The partner organisation of CARE in Rajshahi formed by ex-users is also moving towards the goal of building their own fund for their work.

G. Lessons learned

An important lesson learned is that peer outreach is an effective approach to providing services to a large number of injecting drug users within a short time period in a setting such as Bangladesh. It is possible to involve current drug users as outreach workers provided they develop a set of “ground rules” for themselves along with other project staff. Expansion of needle and syringe exchange activities in new areas and in partnership with other organisations should be based on peer outreach.

In order to avoid misinterpretation of the project by the community, it is necessary to both work with the community and conduct needle and syringe exchange for injecting drug users. Once the confidence of the community is gained, the community can contribute in a significant way to the programme.

Further, drug users should be provided with various options, including detoxification, treatment and rehabilitation, and the treatment of sexually transmitted infections. This does not only meet the needs of drug users, but also increases acceptance with the community and government.

As HIV/AIDS intervention projects for drug users need to address issues related to law enforcement, it is important to establish good relations with police stations and other law enforcement actors near outreach sites. Advocacy with police that is limited to crisis situations is insufficient.

Development of partnerships to expand harm reduction activities for injecting drug users should be based on sound ethical principles such as those of confidentiality, and a positive attitude towards the rights and choices of injecting drug users to access different treatment options. Partnerships should also be built in order to cater for different treatment needs, such as substitution and in-door based detoxification.

V. Outreach to injecting drug users in Pakistan

A. Profile

Title	Reducing the risk of injecting related harm in Lahore
Project country	Pakistan
Related thematic area	Drug demand and HIV/AIDS prevention
Contact persons	Syed Tariq Zafar (recovery@isb.compol.com) Nadeem Rehman (nrehman@un.org.pk) Furrukh Mahmood (fmahmood@un.org.pk)
Contact information	Nai Zindagi, Head Office, #37-38, 1st Floor, Beverley Centre, Blue Area, Islamabad, Ph: 9251-2874120-21 Fax: 92-51-2275895
Project status	Completed (June 2000 – 31 October 2001)
Beneficiaries	Street drug users, their families
Partners and stakeholders	Theme Group on HIV/AIDS, UNAIDS, UNODC, government agencies
Funding	US$63,000 for 18 months

B. Drug use and HIV/AIDS

The situation

The results of a national assessment study on drug use in Pakistan, conducted in 2000, approximated the number of heroin users (including injecting drug users) at 500,000. The overall prevalence of drug use for the total population of the country was 0.3 per cent which appears consistent with several other countries. Further, approximately 15 per cent (60,000) heroin users were using drugs by injection. Injecting drug use was reported from all the major cities of Pakistan.

Relatively little research on the consequences of drug use was undertaken in the country. There are no official statistics or reliable reports available on drug-related deaths or drug-related HIV/AIDS cases. Given the large number of drug users, especially heroin users, in the country a significant shift to intravenous injection bears the potential of an epidemic of blood borne diseases such as HIV/AIDS.

Within this context, in 1999 UNODC and UNAIDS in Pakistan jointly supported a study entitled *"Baseline Study of the Relationship between Injecting Drug Use, HIV and Hepatitis C among Male Intravenous Drug Users in Lahore".* The results from this study indicated a high prevalence of hepatitis C (89 per cent of the 200 injecting drug users sampled) at the time of the study. Although no cases of HIV/AIDS were detected in the sample, the high prevalence of hepatitis C, combined with high rates of self-reported needle sharing (64 per cent) indicates that there is a well-established chain of transmission for hepatitis C and other blood borne infections such as HIV in this population. The Lahore study also suggests transmission links to the general population through sexual contact, as just over half of the study sample reported having engaged in sexual activity in the last year. In addition, nearly half (48.5 per cent) of the study respondents reported ever having sex with commercial sex workers. Condom use was reported to be minimal and irregular.

The response

In Pakistan three ministries are involved in the response to drug use and HIV. The Anti-Narcotic Force, including its Drug Demand Reduction Wing, located in the Ministry of Interior, focuses on drug demand and harm reduction. The Ministry of Health provides technical support related to HIV/AIDS. The Ministry of Social Welfare is responsible for rehabilitation programmes, follow up, and after care.

There is an acknowledgment and concern in the Ministry of Health that injecting drug users are at a high risk of acquiring HIV and other blood born infections, largely as a result of the widespread sharing of injecting equipment. The Ministry is also aware of the HIV risk that injecting drug use presents in terms of its bridging effect to the general population through sexual transmission. Attention to HIV/AIDS prevention among injecting drug users is a major component of the country's National HIV/AIDS Strategic Framework. The government realises that there is still a window of opportunity to prevent expansion of the epidemic in the country. Therefore, the Ministry of Health is expanding behavioural change interventions, along with primary health care and services for the treatment of sexually transmitted infections to drug users. These include needle and syringe programmes with the support of the World Bank and the Department for International Development (United Kingdom). No drug substitution therapy is yet planned.

It is widely acknowledged that the government cannot address the HIV/AIDS epidemic alone and that non-governmental organisations have special access to groups at higher risk of HIV infection. Currently there are least 72 organisations involved in HIV/AIDS related activities. Approximately five organisations, working in the area of drug demand reduction in Lahore, Karachi, Peshawer, Quetta and Rawalpindi, are directly providing services to injecting drug users on the street. The Nai Zindagi pilot project in Lahore is one of the pioneer projects in Pakistan.

C. Objectives

The United Nations expanded Theme Group on HIV/AIDS advocated strongly over the years that issues related to injecting drug use be placed on the agenda of government agencies. Beyond approximately three years ago, this was not the case. UNODC, working closely with UNAIDS, took a lead role in advocating for comprehensive HIV/AIDS prevention strategies among drug users. Both organisations actively established a dialogue with the national drug control agency, and established cooperation between the National AIDS Control Programme of the Ministry of Health and the drug control sector. This was achieved by inviting both agencies to the Theme Group meetings, encouraging the drug control agency's participation in regional and international meetings and conferences on AIDS and harm reduction, and involving both sectors in assessment work, particularly the rapid assessment carried out by UNODC.

After a collaborative project development phase between UNAIDS, UNODC and the non-governmental organisation Nai Zindagi, UNODC and UNAIDS jointly launched a pilot project in Lahore in June 2000 to minimise the adverse health and social consequences associated with injecting drug use. The project

methodology was based on experiences in Pakistan, and lessons learned in neighbouring countries such as Bangladesh and India. Prior to project development, personnel of UNODC and UNAIDS consulted with project implementers in these countries and drew on the expertise of the UNAIDS South East Asia Pacific Inter-country Team in Bangkok and the South Asia Inter-country Team in Delhi.

The overall objective of the pilot outreach project was to reduce injecting drug use, and drug related harm and minimise the risk of transmission of HIV and other blood-borne diseases among drug users and related vulnerable groups.

The specific objectives sought to:

- reduce drug-related harm, including reduction in the transmission of blood-borne and sexually transmitted infections;
- reduce unsafe injecting and sexual behaviour in the target population;
- enhance the understanding of the injecting drug use situation in specific areas of Lahore, and its implications for the spread of blood-borne infections such as HIV and hepatitis C;
- monitor the impact of street based interventions to reduce the transmission of HIV and other blood-borne and sexually transmitted infections by following up 500 injecting drug users for a period of 12 months; and,
- establish a referral system for medical and drug treatment and rehabilitation services.

D. The implementing agency

The implementing agency of the pilot project was a non-governmental organisation called *Nai Zindagi*, which translated means *New Life*. Established in 1990 by a group of former drug users, the organisation provides a range of services to marginalised drug users in Pakistan to prevent the transmission of HIV, reduce drug related harm and risks, and provide opportunities for socio-economic rehabilitation to reduce the demand for drugs.

Programmes are integrated to establish a continuum of care, leading to a comprehensive process of reintegration. Ex-drug users who have lived on the streets and been trained by Nai Zindagi in outreach work usually provide services. A recent programme called Reach Out was implemented with international donor assistance in two phases: the first phase from January 1997 to June 1999 and the second phase from February 2001 to March 2002. Some of the elements of these two programmes are described in the sections below.

The work of Nai Zindagi

Street outreach services from drop-in-centres

The street outreach partners provided the services from drop-in-centres established in the areas where drug users gather, by trained outreach workers. These services included counselling, motivational therapy, on-site basic medical care, social services to the clients, contacting their families, medical referrals and day care services. Harm reduction services aimed at preventing the transmission of blood-borne diseases like HIV/AIDS and hepatitis C. If necessary, clients with a substance use problem were referred to appropriate services in the project, such as detoxification and rehabilitation.

Detoxification and rehabilitation services

Non-governmental organisations assisting in detoxification provided detoxification of clients under medical supervision, which included counselling and motivational therapy, provision of social services and referral for rehabilitation to Nai Zindagi. Usually, detoxification services were carried out in rural environments far away from town.

After detoxification, Nai Zindagi provided a six to eight week residential rehabilitation programme to clients. The rehabilitation services were aimed at providing an environment where they were able to learn life skills by attending group sessions on drug use and its consequences, self-esteem, coping skills, and relapse prevention skills, by involving them in various services within the treatment centre. The ultimate aim of the rehabilitation programme is to facilitate social re-integration after leaving the programme. Activities in the rehabilitation programme included: counselling and motivational therapy; assessment of support systems and family structures; family therapy and counselling; behaviour modification; assessment of vocational skills; and, planning and implementation of after-care programmes.

Vocational skills training services

In order to provide clients with opportunities and choices to gain financial independence and to generate income to support programme costs, market-oriented enterprises were established: "Elements" is a carpentry vocational skills training unit whereas "Project Jeep" is an automobile rebuilding workshop. These enterprises (see Figure 4) provided vocational skills training, including management of production, marketing and overall management of business enterprises. Activities in the programme included assessment of skills and vocational experiences, skills training, job placement, after-care and follow-up related to workplace issues.

Figure 4: Vocational skills training at Nai Zindagi

Construction work	Carpentry	Jeeps	Leather shop

Evaluation cell

The increasing complexity of the activities of Nai Zindagi necessitated the establishment of a monitoring and evaluation unit. Accordingly, a Project Coordination and Evaluation Cell was established. It reviews project progress, documents meetings, ensures quality of services by visiting project sites from time to time, takes necessary action, and helps in the resolution of conflict among partners and staff. The Evaluation Cell assists in training, encourages participatory management and collects data from all partners.

Why Nai Zindagi was chosen as the implementer of the Lahore pilot project?

The above description of activities of Nai Zindagi indicates that the organisation has accumulated a wealth of experience and expertise in the field of drug use. This expertise includes outreach to drug users and injecting drug users, treatment and rehabilitation, and data collection and analysis. Working with Nai Zindagi also enabled the project's expansion to other geographic areas, and the integration of pilot project activities into other drug demand reduction activities.

E. Major activities

Trained street outreach workers provided the following services from drop-in-centres established in the areas where drug users gather.

- Registration of clients on the street into the project.
- Provision of basic outreach services to registered clients including, counselling, motivational therapy, on-site basic medical care, social services, contacting their families, medical referrals and day care services.
- Harm reduction services aimed at preventing the transmission of blood borne diseases like HIV/AIDS and hepatitis C including, needle and syringe exchange and condom promotion and distribution.
- Clients registered in the programme undertook project orientation, and if assessed with a substance abuse problem, were referred to an appropriate project service.

Outreach work is characterised by a warm, non-judgmental relationship and many clients are known by name. Primary health care at the drop-in-centres, although primarily established to cater for the needs of drug users, also serve the needs of non-drug users. In a low resource environment, this approach draws upon both the goodwill and support of the community, especially in terms of acknowledging the mandate of the drop-in-centre. At several locations religious leaders provide drug education in the format of hierarchy of goals, including harm reduction messages and referral to the drop-in-centres.

An important component of the project monitored risk behaviour data from injecting drug users to assess the effect of the interventions. Variables for assessment included knowledge on HIV/AIDS and hepatitis C, use of clean injecting instruments and condoms.

F. Main results

During the 18 months of implementation of the pilot project, 1,339 injecting drug users were registered, 25,684 syringes were distributed under the needle and syringe exchange programme, and 1,500 to 2,000 condoms were distributed. There were 57 clients referred for advance medical treatment, and 646 clients referred to drug treatment facilities. Of 646 drug users discharged from the Nai Zindagi drug treatment facility following detoxification, 35 per cent returned to the streets, of which 8 per cent remained drug free by the end of October 2001. This was a direct reduction of the street drug-using scene by 65 per cent having not returned, and of which 8 per cent were drug free. This translates to a 73 per cent immediate reduction following 10 to 12 days of detoxification. Table 2 provides a comparison of the results of the baseline study (October 2000) with the follow-up study (January 2002) among injecting drug users in Lahore.

Table 2: Comparison between baseline and follow-up

Category	Percentage of respondents	
	Base line study	Follow-up study
Cleaning syringe “always” before re-use	19	61
Syringe sharing	90	26
Abscess at drug injecting sites	65	22
Suffered from sexually transmitted infections	44	21
Knowledge about means of contracting HIV	44	87
Knowledge about health related problems caused by syringe re-use:		
HIV/AIDS	12	97
Hepatitis	5	38
Condom use	24	39

The Lahore outreach programme showed that needle and syringe programmes provide an excellent entry point for services to drug users.

Sustainability and replication

The project was clearly designed as a pilot and demonstration project, assessing the effectiveness of specific interventions to reduce drug use related harm. It was the culmination of joint advocacy efforts of the UN system, particularly of UNODC and UNAIDS, and non-governmental partners that moved the government and civil society organisations to address HIV/AIDS among drug users, and to prevent a major epidemic in this and related sub-populations such as sex workers. It was the view and the hope of the project planners and all stakeholders involved that a successful pilot project would lead to sustainable prevention activities on a larger scale.

These views have proven correct. The programme is being replicated in some other parts of the country. For example, in Karachi two different street-based harm reduction programmes were established with the financial support of UNAIDS and executed by UNODC as a replication of the Lahore project. The training of staff in designing and implementing the programmes for both projects was carried out on the basis of the lessons learned in Lahore.

G. Lessons learned

The important lesson learned from the process that led to the project, arose from the manner interventions to prevent HIV transmissions among injecting drug users were initiated, and the progress made. The UN Theme Group, the civil society sector and relevant government agencies effectively collaborated to overcome many political and cultural obstacles. The political and societal climate related to HIV/AIDS in the country changed significantly, and all interventions cumulatively created an enabling environment, conducive to addressing HIV/AIDS generally and issues of injecting drug users specifically.

There is equally an overall understanding among all stakeholders from government and civil society, that given the limitations of supply and demand of reduction efforts, HIV/AIDS prevention needs to be complemented with specific services such as needle and syringe programmes, and condom promotion. It is also clear that the government sector alone cannot cater to these needs at this stage. Partnership with private sector and non-governmental organisations proved to be of critical importance.

Another important lesson, reiterated by the implementing agency, Nai Zindagi, related to the necessity for interventions, such as needle and syringe programmes and condom promotion, to be integrated into the wider field of drug demand reduction and to include various treatment options as well as social re-integration. Specific interventions to reduce drug-related harm should be coupled with comprehensive treatment programmes and have the ultimate goal of re-integrating drug users into mainstream society. Involvement of former drug users is essential for the success of outreach programmes.

H. Recommendations

- There is a continuing need for street-based interventions for street drug users, including the provision of needles and syringes, and condoms. Programming efforts should, therefore move quickly to large-scale interventions with sufficient coverage of the sub-population of injecting drug users. Every effort should be undertaken to ensure that those drug users, currently not injecting drugs, do not proceed to injecting.
- Programmes should have a comprehensive approach to improve the physical health and social conditions of drug users, their chances of employment and to decrease crime.
- Partnerships with other relevant organisations in programming and implementation should be encouraged to maximize cost effectiveness and to ensure maximum coverage.

VI. Work with street children in Cambodia

A. Profile

Painting of a child, from the Mith Samlanh website

Name	Mith Samlanh/Friends
Country	Cambodia
Related Thematic Area	Street children at increased risk of HIV infection due to poverty, drug use and sexual exploitation.
Contact Persons	Sebastien Marot, Programme Coordinator, friends@forum.org.kh Lyn Mayson, Technical Advisor, HIV/AIDS and Substance Use, lyn.friends@forum.org.kh
Contact Information	House #215, Street 13, Phnom Penh, Cambodia Mailing address: P.O. Box 588, Phnom Penh, Kingdom of Cambodia Website: http://www.streetfriends.org, Ph/fax: +855-23-426-728 E-mail: friends@forum.org.kh, website: http://www.streetfriends.org
Project Status	On-going
Primary beneficiaries	Street children, their families and their community.
Secondary beneficiaries	People with AIDS and their children; local communities
Funding	Total budget in 2001: US$223,532; approximately 50 per cent for salaries
Staffing	108 staff

B. Background

Social and cultural context

Cambodia has a population of around 11.5 million, of which approximately 15 per cent are urbanised, and 1 million live in the capital Phnom Penh. Over 40 per cent are under the age of 15 years, and almost 40 per cent live below the poverty line. Cambodia ranks at 121 on the Human Development Index, making it the second lowest ranking country in South East Asia.

Cambodia has had a troubled history over many years, in particular the genocide perpetrated throughout the 1970s. Estimates of the numbers of lives lost vary considerably however it is possible that up to 3.5 million people died, due to disease, starvation, war, torture, murder or mistreatment. A relatively large proportion of males were killed or 'lost' resulting in a change in the male to female population ratio. Another direct outcome of this period was the decimation of the country's human resources, knowledge and skills base. It destroyed social infrastructure and negatively affected social institutions. The country remained in a state of civil war until the late 1990s and this, along with continued political fragility, undoubtedly frustrated its re-building.

At the time of writing this report, the government's investment in health and education remained low with less than 2 per cent of the GDP invested in these sectors. The average per capita income per annum was only US$249. Development remains dependent on international aid. A number of non-governmental organisations, international and national, active in the country play varying roles and contribute to varying degrees of development.

Since agreement was reached with the Khmer Rouge in the late 1990s following the end of civil war, the country's capacity to address the many other problems improved. Development however is uneven with urban areas seen as attractive both to individuals as well as to families.

As an outcome of civil war and unrest, there is an increasing population of children living on the streets or in the squatter areas in and around Phnom Penh. Mith Samlanh, a street children programme, estimates that there are some 1,200 "street-living children", between 10,000 to 20,000 "street-working children" and "between 500 and several thousand street-living families" in Phnom Penh.

HIV/AIDS in Cambodia

Cambodia has the highest HIV infection rate in South East Asia and the Prime Minister of Cambodia has been reported as saying that HIV has the potential to affect the country in the same way, as did the Khmer Rouge. The sentinel surveillance survey of 2000 found that the national prevalence among adults aged 15 to 49 years was 2.8 per cent and approximately 169,000 adults are living with HIV/AIDS in Cambodia. While the incidence appears to be declining the numbers of people with AIDS and of AIDS related deaths is increasing.

Drug use in Cambodia

There is currently no systematic information available on drug use, but rather snapshot and anecdotal reports. A Rapid Assessment Study conducted in 1995 found that drug use was not a major problem in Cambodia, but that there was clear evidence of an increase in illicit drug use and of widespread drug trafficking. There was low awareness in the community about drug matters and about the potential of transmission of HIV through the sharing of injecting equipment (whether for medical or non-medical purposes) and about the relationship between drug intoxication and unsafe sexual behaviours.

A 1998 study found that 25.6 per cent of street children interviewed (N = 250) had used a psychotropic substance and of these 47.5 per cent used inhalants. Local non-governmental organisations also reported drug use in Battambang and Poipet. Another study conducted in late 1999, involving 2,000 young people, identified the use of amphetamine-type stimulants as well as some black-water opium injecting.

Despite the limited information that was drawn from studies of only one group, it is evident that the trends identified in 1995 have been sustained. Amongst street children, drug use has continued to increase, from 37.3 per cent in 1999, to 46.6 per cent in 2000. The recent June 2001 snapshot results followed the trend and provided more disturbing information. Whilst 51.9 per cent of all children interviewed reported drug use, there has also been a rapid increase in amphetamine-type stimulant use and an increase in injecting. Those reporting injecting drug use rose from 0.6 per cent to 4.3 per cent within one year.

Mith Samlanh

Mith Samlanh began through the concerns of three travellers who arrived separately in Phnom Penh in 1994. They were appalled by the number and state of children on the streets. From feeding the children out of their own resources to the current programme, which is still coordinated by one of the three travellers, has been a seven-year journey of supporting children living on the street and providing them with alternatives. This includes providing them with shelter, training, family reintegration, HIV/AIDS prevention education and support, and drug education. All of this has been undertaken within a programme, the primary goal of which is to remove the children from the street and into a safer environment for the future.

C. Objectives

Mith Samlanh is a street children programme with the following overall objectives.

- Meeting the street children's immediate needs in accordance with the Convention on the Rights of the Child, including the right to life (providing nutritional meals, shelter, a safe environment and medical care); the right to development (providing education and reintegrating them into public schools); and, the right to protection (fighting all forms of abuse of children, including physical, sexual, family, and emotional abuse).
- Reintegrating the children into their families, society, public school system, and their culture.
- Building the capacity of the staff to work with children.

Within these objectives the programme has developed a holistic approach to service delivery that combine projects on reproductive health, HIV/AIDS prevention and care, drug use prevention and treatment. The needs of the children defined the programme development, including the addition of projects addressing reproductive health, HIV/AIDS and drug use.

The HIV/AIDS project

The main objectives of the current HIV/AIDS project are: (a) allowing street children and their families to protect themselves from HIV/AIDS and sexually transmitted infections; and (b) supporting children affected by HIV and AIDS in remaining off the streets. These main objectives were refined in the new project proposal in the following terms.

- To enable street children to protect themselves from being infected by the virus.
- To improve the care of HIV infected street children.
- To reduce the number of children living on the streets because of HIV/AIDS.
- To improve the capacity of staff to care and provide support to at risk children or those living with or affected by HIV/AIDS.

Drug use project

The overall objective of the drug use project is to provide comprehensive services and alternatives to protect street children from substance use and its consequences.

The specific objectives include the following.

- Reducing substance use and its harmful consequences among street children.
- Providing street children with access to alternatives to substance use.

- Developing and supporting the rehabilitation process of children using or having used substances towards social reintegration.
- Developing capacity of staff to provide appropriate responses and support to the street children using substances.
- Liaison and cooperation with government agencies and various non-governmental organisations for policy and capacity development.

D. Major activities

The Mith Samlanh programme has approximately 1,600 client contacts per day. Services are delivered through a number of fixed sites and through outreach teams, which work on the streets.

The main centre

The main centre's activities include the following.

- A *medical facility* with a doctor and nurse, staff and clients (about 100 staff and up to 500 children) of the centre are treated. HIV testing and counselling is carried out, basic HIV/AIDS care is provided.
- *Sewing classes,* levels 1 to 3.
- *Production centre – sewing:* Graduates from the sewing classes who are yet to move out of the programme and are now contributing to their own support. They produce clothing for use by other children or for sale. One way they sell is through a stall at the front gate of the centre.
- *Beauticians and ladies hairdressing class:* Learn to cut, treat and dye hair, and manicure. Clients are the children in the centre. Graduates can go out and work in the neighbourhood. Local women can come to the centre but usually prefer services in their homes.
- *Haircutting:* Cut hair of the children in the centre and other street children.
- *Cooking, level 1:* Learn basic cooking and cook for the children in the centre's school (up to 250 children).
- *Cooking, level 2:* The prepared food is sold through a street stall set up at the front gate of the centre.
- *Cooking, level 3:* These students also work in the restaurant on the ground floor of the main centre building. Proceeds are going to the centre and the staff of the restaurant.
- *Tiling and ceramics:* A relatively small class as few children chose it.
- *Electronics:* A relatively small class, working on TV, radios.
- *Motorcycle repairs:* A popular programme that had at least 30 children working in small groups repairing and maintaining the bikes used at the centre.
- *Electrical and small appliance repairs:* A small class because it is difficult to get regular work after completing this course.
- *School:* Several classrooms, a library plus a large covered open area where students can play and eat. There are 250 children in the school in 7 levels: following which students are moved to the public education system.
- *Club Friends:* Open house style drop-in-centre where the children can do as they please. Also used by visiting artists, groups who want to do things with or for the children, for example, run video or photography classes, put on plays, teach dance. Club Friends began as an outreach activity in the slum areas however it proved so popular that it was felt necessary to open it at the centre itself.

Other fixed sites

Boarding House

A standard shop front house near the main city market accommodates street-working boys who work both at night (dusting cars, minding cars, begging, sex work, petty theft) and during the daytime. They can return there in the morning, bath, wash their clothes and have a safe place to sleep. By their own decision they pay 800 Riel a day to use the premises. There is a clinic where medical treatment is available, receive counselling and other services. There are plans to open a 'condom café' on the ground level shortly (work had begun at the time of writing this report) as a drop-in-centre targeting residents. It will have Khmer style food and provide information and access to services on HIV/AIDS and drug use.

Camp Sabay Sabay

This is a combined centre in a rural area for detoxification and teaching about farming. Groups of children go down on a seven day basis for detoxification, to take a break from the city, and explore whether they want to learn farming.

Transitional Home

The Transitional Home's goal is to re-unite street children with their families. It has a capacity of 157 residents, of which 30 were girls at the time of writing this report.

Preah Sihanouk Hospital Day Care Centre

Located in the AIDS ward at the hospital and staffed by a trainer and a social worker, educational groups for people in the ward and their families are conducted. A user-friendly place, children are brought in by patients, which often leads to more work for Mith Samlanh. It can be difficult when patients die in the ward, as is often the case, as they usually come only when they fall very sick. Knowing who they and the children are and how to contact relatives can be a challenge.

Basac Slum Community Centre

A drop-in-centre for children in the Basac slum, close to the main centre of town. The centre has a small clinic. There is a group in the centre, working on the Mith Samlanh newsletter, children playing different games, using the library, talking with a counsellor and the ubiquitous karaoke was very popular.

Outreach teams

In addition to the education and training projects listed above, most of which are concerned with training and reintegration of the street children, Mith Samlanh has outreach teams that work three times a day in the city. The teams consist of four to five members from different outreach projects of Mith Samlanh, including on HIV/AIDS, drug use, reproductive health and the centre outreach project, designed to identify and assist the street children to access the services of the major projects. The team may include a doctor as well as a social worker, drug and HIV/AIDS educator. They work on the streets, in the grounds of temples and in the squatter areas, wherever necessary.

Drug users in Phnom Penh report commencing drug use for three reasons: peer pressure, boredom and life pressures, all of which are highly relevant for street children. The street children may also be sexually active and are certainly at risk of being drawn into the sex industry, particularly the females either through coercion or opportunistically as a means of survival. In all venues and under all circumstances, the children are constantly exposed to material, which encourages condom use and HIV/AIDS prevention. There is also a significant amount of promotional material about drug use, primarily addressing the health issues related to alcohol drinking, cigarette smoking and glue sniffing.

E. Main outcomes

Apart from meeting objectives set out for the projects they conduct, the most significant outcome has been that Mith Samlanh has put the issues of street children, drug use and HIV on the agenda of the government and non-governmental organisations in the country.

Drug education is based on harm reduction principles and is appropriate for the local setting. It was designed for delivery on the street, in the community, within school and a training setting. The main drug of use at the time of this report was glue sniffing and Mith Samlanh provides information and education accordingly. It assists the children reduce their use of the glue product and minimise the health impact. Information and education on other drug using practices are also provided.

Because holistic approaches are integral to the Mith Samlanh programme, HIV/AIDS and drug use prevention and education activities reach some 1,600 street children daily on the street, in their communities, within the training and school environments. Children in the programme have been trained and now work as peer educators. They often come from Club Friends and later 'work' there and in the outreach teams. This approach fits well with the overall objectives of Mith Samlanh.

F. Evaluation

Indicators

The HIV/AIDS project produced monthly reports during the first six months of its operation. They reported on a number of indicators, including the number of children participating in HIV/AIDS prevention activities, number of diagnosed and treated sexually transmitted infections, and number of counselling sessions. The drug use project also reported monthly. No external evaluation of the programme has been undertaken.

Coverage

Depending on the definition and according to the figures accepted by UNICEF in Cambodia, there are between 600 and 1,000 street children who have completely cut ties with their families and have made the streets their home. There are 10,000 street children who have kept ties with their family and returned home either regularly or irregularly. However Mith Samlanh uses a somewhat wider definition to define its target population, including street living families. Overall they believe that there are between 12,000 and 25,000 street children in Phnom Penh. While the impact of the Mith Samlanh programme is impressive with some 1,600 client contacts a day, it is clear that the number of street children in Phnom Penh is growing as more people, including children alone or with families, are drawn into the city. A broader based national response is required.

Replication

No particular impediments to replication of work of this nature with street children were identified. The programme could readily be replicated given the funding and planning capacity. Moreover, it is clear that programmes such as this provide ideal mechanisms for the delivery of HIV/AIDS and drug use related prevention and education to particularly vulnerable populations. This project demonstrates clearly that integration can benefit the overall programme as well.

However, the problem of donors seeking to fund projects of short duration, that can be taken over by government or in-country agencies or that can become self-sustaining, remains of concern and has been raised accordingly with funding agencies, particularly large government and foundation donors. The problems of poverty and social distress are far from being solved in Cambodia. Accordingly, it is foreshadowed that there will be a chronic street children problem into the future. Concomitant with such a phenomenon is the need to provide on-going programmes that train and support the children; that find ways for more effective reintegration and better access to benefits provided through development work

being undertaken; and that address the children's vulnerability to drug misuse, sexual exploitation and HIV infection. These needs will not diminish until such time as Cambodia has progressed in its development.

Sustainability

At the time of writing this report Mith Samlanh had two significant funding proposals under consideration, to support HIV/AIDS work and drug use prevention and harm reduction. The proposals included staff training and development components.

The programme reached a point in its development where a plan to address the issue of consolidated core funding covering a significant period was required. Mith Samlanh conducted its work with support from a pool of funding agencies, including AusAID, Save the Children Australia, UNICEF, UNAIDS, UNFPA/EC, World Food Program, FHI-Impact/USAID, ILO/IPEC, DOH-International/EC, CCFD, the British Embassy in Cambodia, the Australian Embassy in Cambodia and private donors. It is evident that the pressure of constantly having to piece together funding to support the overall programme and the need to report to a large number of agencies, at different times and in different formats requires additional infrastructure, increased administration costs and is a significant drain on management's capacity to deliver programmes.

A further issue for Mith Samlanh as a whole is its management structure and the continuing role of those who started the original programme. One of the three travellers continues to play a critical role in the organisation, and the question of the organisation's strength without that continued input remained an issue. It was readily acknowledged and there are already plans in place to transfer senior management responsibility.

G. Lessons learned

- Be child centred! A major strength of the Mith Samlanh programme is that in all respects it was designed and is delivered with the children in mind.
- Different projects should be combined to provide a holistic programme, to the benefit of every component. Mith Samlanh undertakes a range of activities but these are not regarded as separate components. They are combined in such a way as to deliver a comprehensive education, training, outreach and support programme that successfully integrates HIV/AIDS and harm reduction based drug use programmes.
- Harm reduction involves a set of principles that can be applied to a variety of circumstances and drugs used. In Phnom Penh, among street children, the predominant drug practice is inhaling glue. Mith Samlanh developed simple messages and educational tools that are used with the children to reduce the negative impacts of this behaviour as well as providing more familiar harm reduction messages.
- Direct observations and work through peers are powerful tools when working with children. Mith Samlanh recruits street children into their education and outreach teams after having trained them. An advantage of street children having access to Club Friends, which is on the main site, is that they see the benefits and the manner of their provision.
- The chaotic nature of street children's lives must be incorporated into programme planning. For many of the target population it is unrealistic to expect that they will enter the programme and continue through without any problems. Accordingly, the programme is responsive to the children's needs and the fact that they may enter, leave and seek to re-enter the programme.
- There is limited coordination and planning of services between public and non-government services, or forward planning, and this can be a particular problem for agencies like Mith Samlanh. This can be further exacerbated by inequities between 'competing' Ministries that are looking for comparative

advantage and the acknowledged problems related to non-governmental organisations working in a truly consultative and collaborative way.

- Cooperation between service delivery agencies is also difficult at the 'bottom end' and attempts by Mith Samlanh to work collaboratively with other agencies have not always been successful. In particular this has created problems with their efforts to define their area of capacity.

H. Recommendations

- HIV/AIDS and drug use related activities should be integrated into existing programmes wherever possible so as to provide a holistic approach. This will enhance all elements of the programme whilst accessing a wider population group through existing, credible channels.
- An internal review of the extent of harm reduction activity delivered would be beneficial. The work being undertaken by Mith Samlanh is well grounded in harm reduction principles however the extent to which they currently provide services focussed on injecting drug users may require review given the growing number of their target group reportedly injecting.
- Harm reduction based materials around the issues of HIV/AIDS and drug use, in the local language should be developed and disseminated.
- Agencies need to be aware of the extent to which their local environment will support the adoption of harm reduction approaches. This is a task that requires skilled management to keep moving along the harm reduction continuum without alienating partners. When a new harm reduction based activity is implemented, consultation and education with other agencies should be undertaken to improve the likelihood of success. Outreach teams at Mith Samlanh have found themselves criticised by external actors for encouraging drug use.
- Research into the nature and extent of drug use to provide guidance on the development of health promotion interventions should be undertaken as a priority.
- National planning on HIV/AIDS should specifically include injecting drug use related transmission as a priority and, once the current situation is better understood, explore avenues conducive to beneficial outcomes. Whilst anecdotal evidence has thus far supported the findings of Mith Samlanh, that injecting is not a major mode of drug use, it should be noted however that evidence suggests that both drug use and injecting are increasing.

Substitution therapy

Drug use treatment is one approach that may have an impact on preventing HIV infection. Many large-magnitude studies have shown that patients participating in drug substitution treatment such as Methadone maintenance, decrease their drug consumption significantly. Several longitudinal studies examining changes in HIV risk behaviour for patients currently in treatment have found that longer retention in treatment, as well as completion of treatment, are correlated with reduction in HIV risk behaviour or an increase in protective behaviour.

VII. Narcotics clinics in Bangkok

A. Profile

Title	Bangkok Metropolitan Administration Methadone Programme
Project country	Thailand
Thematic area	Substitution therapy
Contact persons	Dr. Krit Hiranras, Director General, Department of Health; Dr. Boonrawd Prasithiphol, Director, Drug Abuse Prevention and Treatment Division, Department of Health, Bangkok Metropolitan Administration; Praewpim Pratontep, Social Worker, Drug Abuse Prevention and Treatment Division, Department of Health, Bangkok Metropolitan Administration
Contact information	Division of Drug Abuse Prevention and Treatment, Ratchathevi District Office 7th Floor, 10 Phayathai Road, Ratchathevi Bangkok 10400, Thailand Telephone: +66-2-245 7790 Fax: +66-2-248 5747
Project status	On-going
Primary beneficiaries	Drug users, particularly opiate users, injecting drug users, and drug users with HIV/AIDS
Secondary beneficiaries	The families of drug users and their communities

B. Background

Drug use and HIV/AIDS in Thailand

The first case of HIV/AIDS in Thailand was detected in September 1984. Substantial spread was not noted until 1987-88, when infection among injecting drug users in Bangkok increased significantly. Within a single year reported cases increased from nil to more than 40 per cent of the known drug user population. Due to the urgent need to control the epidemic, policy makers and professionals reconsidered the use of Methadone, because it was believed that such treatment could deter the spread of HIV among drug users by reducing the risk behaviour related to the injection of drugs. However, longer-term treatment would have to be considered. Methadone maintenance was tried in previous years but was not generally considered acceptable since the goal of treatment was abstinence. Clinical trials of Methadone maintenance were launched in the late 1980s.

During this period the Bangkok Metropolitan Administration (BMA) launched its own controlled trial of methadone maintenance. The results of the study provided evidence that Methadone maintenance

programmes were superior to 45-day programmes in terms of the retention of clients and follow up for health education and HIV prevention messages. Methadone maintenance was successful in reducing heroin intake, which, in turn, lowered the frequency of injection. This translated into lowered risk of HIV infection from shared needles.

Official recognition of methadone maintenance programmes occurred in 2000 following years of unofficial pilot programme practices through BMA clinics. Whilst alternative methods have been tried in detoxification and in the treatment of heroin addicts, currently long term and short term methadone treatment remains the standard procedure for opiate addiction.

Drug treatment in Thailand

There are two treatment modalities for drug use in Thailand: compulsory and voluntary. Compulsory treatment is provided by the correctional system for convicted drug offenders in a few designated prisons. It also provides supervised probation for them and a treatment programme for adolescents. A law, passed in 1991, provides for compulsory treatment under the parole system although it has not been completely enforced due to lack of resources. Methadone treatment is not a part of the compulsory programme. The voluntary programme stresses that there is legal exemption from the crime of using a controlled substance (Methadone) while under treatment. The Ministry of Public Health issued regulations that define the management and treatment services for the voluntary system.

The Bangkok Metropolitan Administration narcotic clinics were established in the late 1970s and early 1980s as part of the voluntary programme. Initially some controversy persisted regarding the short term provision of methadone treatment. Relapse rates were high after 45 days and there were studies done on the effectiveness of 90-day programmes.

C. Objectives

Given the history as briefly outlined above, the objectives of the programme changed over time. In the beginning, the BMA narcotic clinics and their methadone programmes were established to reduce the increasing drug problem in Thailand. Heroin addiction was a rapidly expanding threat, because very pure forms of inexpensive heroin were readily available. In the 1970s, heroin users made up more than 80 per cent of the substance dependent population, more than half of them resided in Bangkok and the central regions of Thailand. Their age mostly ranged from 20 to 35 years, less than 7 per cent were students, 30 per cent were unemployed and more than 70 per cent administered heroin intravenously. More than 90 per cent of heroin and opium users were male. This profile of drug users remained relatively stable over 3 decades.

By 1976 it had become clear that the substance use problem was increasing. Accordingly, the government established the Narcotics Control Board and the 1979 Narcotics Law. Bangkok urgently needed more treatment centres and, since Methadone had already been used with some success both in Thailand and other countries, Methadone detoxification became the favoured treatment. With financial and technical assistance from the Narcotics Affairs Section of the U.S. Government, an outpatient narcotic clinic with Methadone treatment was established as a pilot project in 1976 at the Bangkok Lumpini Health Centre. In 1978, the first three BMA narcotic clinics were created. The remainder were established within the following five years. There was no Methadone maintenance provided at that time, but rather 45-day detoxification, medical care for withdrawal symptoms and counselling. Chronic users were observed to re-enter the programme frequently. At that time the objective was to attempt to alleviate the opiate addiction problem by providing more services on a voluntary, outpatient basis.

The further objective of referral to rehabilitation centres and reintegration of clients into the community met with less success. A very small percentage of patients were able to achieve the abstinence necessary for this step. Those that were able to remain in rehabilitation were generally followed up for one year. Research showed however that many returned to their drug use habit in succeeding years.

In 1987 new objectives were added to the drug treatment sector. Through the 1980s, drug dependence treatment units increased nation-wide from 45 to 138 and the total number of cases in treatment increased from 30,000 to 60,000 cases per year. The majority of these were heroin users of which many were injecting. According to a sero-prevalence survey of the BMA narcotic clinics from 1988 to 1991 the HIV sero-positive prevalence in injecting drug users increased from 15.6 per cent in March 1988 to 44.6 per cent in April of 1989.

In light of these statistics, the BMA launched a controlled trial of Methadone maintenance for injecting drug users to study the implications for prevention of HIV transmission. The results were sufficiently optimistic such that the clinics commenced, on a pilot bases, the implementation of Methadone maintenance programmes. In 1989 a BMA working group put together a handbook for pre- and post-test HIV counselling using guidelines of the US National Institute for Drug Abuse. Accordingly, prevention, diagnosis of HIV infection, and health care for people with HIV/AIDS became part of the programme. Methadone maintenance, on-going counselling and medical input supported the objective of slowing the spread of HIV among injecting drug users and their sexual partners.

D. Funding

In 1978, the US Government provided funding for the establishment of 15 narcotic clinics over a five-year period. The BMA was able to create 17 narcotic clinics by using the facilities in two hospitals. Since then the US Government has provided funds and training workshops for various initiatives. In 1987 the Canadian Government through the Addiction Research Foundation, provided training in counselling methods and evaluation techniques both in Bangkok and Toronto. In 1989 the Australian Government provided approximately six million Baht for prevention and education. A Life Education Centre was created following an Australian model. Most recently, in 1999, the European Union provided funding in the amount of approximately six million Baht for two mobile units – one for prevention and education and the other for treatment services.

As for human resources, the narcotic clinics have on average 1 doctor, 4 nurses (one or two of which are technical nurses), three social workers, one psychologist, one clerk, one or two cleaners, and perhaps a driver. A clinical researcher was added to the staff of most clinics with the onset of HIV/AIDS vaccine trials.

E. Operations of narcotic clinics

The BMA Narcotic Clinics generally operate from 8:30 a.m. until 4:30 p.m., 7 days a week. During the period of 1997 to 1999 six clinics began to operate at the extended times of 4 p.m. to 8 p.m. Most Methadone patients must come to the clinic every day to receive their dose.

When a patient first comes to the clinic s/he is taken through the **pre-admission** stage, where the patient's history and drug use behaviour is documented. A social worker or psychologist prepares the patient for treatment through information sharing. If possible, the family is included since it is preferred if they are supportive throughout the process. It has been found that family participation in the treatment and recovery is invaluable. They can assist with relief of symptoms and supervision and, as such, influence effective outcomes. Medical check ups are undertaken, including chest x-rays every six months and urinalyses routinely, during the treatment period to check for traces of narcotic use.

At pre-admission the doctor will assign the patient to one of the following medical protocols.

- **Protocol 1** – Short term detoxification using a major tranquilliser such as Chlorpromazine for mental and emotional withdrawal symptoms or a low dosage of Methadone with Clonidine. The patient criteria for this model are:
  - new patient;
  - long term Methadone free cases;
  - patients with urine opiates of less than 5 micrograms; and,
  - patients who want short term treatment.

- **Protocol 2** – Detoxification using methadone over a period of 45 days. Supporting drugs such as minor tranquillisers and Clonidine can also be given during this time. Rehabilitative counselling is undertaken. The patient criteria are:
  - patients who participated in Protocol 1 with no more than five visits;
  - new cases; and,
  - patients with a history of long periods of abstinence either during treatment or between drug abusing episodes.
- **Protocol 3** – Use of Naltrexone, an opiate antagonist, which blocks the euphoric feelings associated with heroin use. If heroin is taken during this period a greater dosage is required to induce the state of feeling 'high' and there is a risk of overdose. Also, the patient must have stopped using both heroin and methadone for at least 10 days before starting naltrexone treatment or severe withdrawal symptoms will occur. Naltrexone treatment should be given for at least six months. Rehabilitative counselling is also provided with this protocol. The patient criteria are:
  - history of immediate relapse after detoxification;
  - patients with high motivation; and,
  - patients who are detoxified and have been abstinent from both heroin and Methadone for more than 10 days.
- **Protocol 4** – This is a long term programme where Methadone is used as a substitute for heroin. The starting doses are the same as for the 45-day programme but are raised slowly (by 5-10 mg) until withdrawal symptoms are covered. The dose is then maintained until the patient asks for further regulation up or down. The course of treatment is at least one year and drug and AIDS counselling are provided. After one year the patient can be withdrawn from Methadone over three to six months. According to assessment of history and difficulties, some clients may need to be given Methadone for a much longer term. No side effects have been found even with dosages as high as 140 mg a day but care must be taken if the patient is not abstinent from heroin. Recruitment into this programme is sometimes difficult because many patients do not want long term treatment. The patient criteria are:
  - HIV infected patients (patients do not have to be HIV positive but many in this protocol are);
  - patients who have been in Methadone detoxification at least five times and have never stopped using illicit drugs; and,
  - patient must be over 20 years old.

In all of these protocols other medications, such as anti-depressants or pain relievers for symptoms of withdrawal, are used at the doctor's discretion.

After the patient is assigned to one of these protocols, weight is taken (and again every two months) and blood pressure and pupil dilation are measured. These latter two should be done every day and the patient should be questioned regarding the last dose of heroin. Since most patients merely reduce their drug taking frequency rather than practice complete abstinence, it is important to assess both the quantity and frequency of heroin intake. Dosage of methadone can be adjusted accordingly.

Counselling is provided to patients either on a weekly or monthly basis depending on length of treatment.

During the **detoxification** stage the patient receives one of the four medical protocols according to the doctor's diagnosis. In addition, the patient receives counselling, medical care for withdrawal symptoms and other illnesses, information about prevention and treatment of HIV and other health issues around drug use. Pre-test counselling and blood tests are undertaken. HIV positive clients receive appropriate medical care.

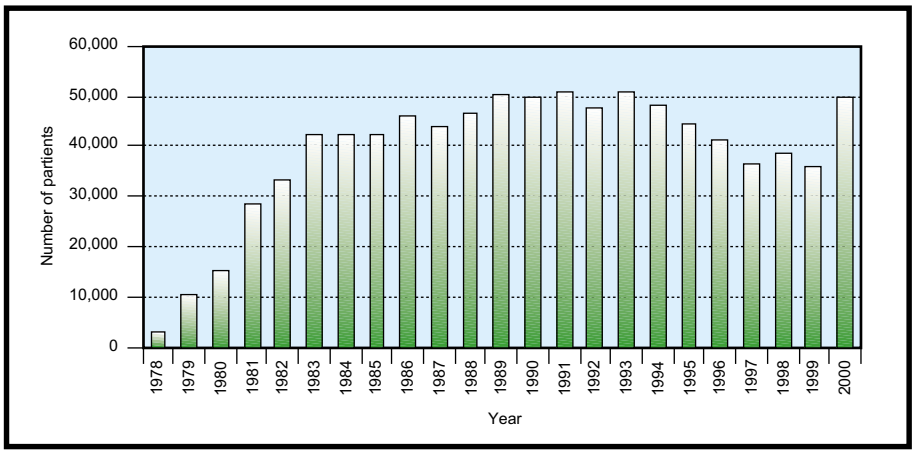
Following detoxification the client may either be referred to a rehabilitation centre, provided s/he has achieved abstinence from both opiates and Methadone, or encouragement to attend an after-care programme. During the **after-care** period followed up is undertaken with home visits to the client or letters/telephone contact is used to make consultation appointments.

F. Indicators

Measuring progress in treatment of drug dependence is difficult. Many countries around the world with a variety of treatment programmes have vocalised this problem. People are often mobile, outcomes are unclear and relapse rates can be high. Human lives are messy and unpredictable. Nevertheless measurements have been established to determine the progress of this project.

According to BMA clinic statistics 3,180 patients were treated in 1978. In the year 2000 there were 49,521 patients treated. This is clear evidence that over time more drug users are seeking treatment (see Figure 5). Probably the most definitive indicators of progress are the recent figures regarding the sero-status of injecting drug users. There is very strong evidence that the BMA Methadone Programme, Methadone maintenance plus education and health care plus counselling, is helping to reduce the prevalence of HIV transmission among injecting drug users. In comparing the national sero prevalence figures with those of the BMA, it has become clear that in recent years the prevalence of HIV infections in the BMA clinics was substantially lower than national data.

Figure 5: Number of patients treated in BMA clinics



At this time indicators of the status of the HIV Vaccine Programme included successful enrolment of participants and a trend of success in retention of participants. It was anticipated that the first Trial Evaluation results would be available in 2002.

G. Other activities

This programme involved the implementation and development of many activities. Some of the more significant activities are listed below.

- Training and evaluation programme sponsored by the Addiction Research Foundation of Canada in 1987.
- Study of naltrexone treatment.
- Study of Methadone maintenance with implications for prevention of HIV transmission.
- Training of social workers and psychologists in counselling techniques and the creation of a handbook for pre- and post HIV test counselling.
- Creation and development of the Life Education Programme with the help of Australia in 1989.

- Implementation of sero prevalence studies.
- The acquisition of two mobile units for outreach work with the help of the European Union in 1999.
- Most recently, the Phase 111 Trial of the AIDS (VAX B/E) Vaccine.

Since the onset of the worldwide HIV/AIDS epidemic, scientists have been trying to create a vaccine that would prevent HIV infection. This trial was set up to determine the effectiveness of AIDS/VAX vaccine. This vaccine consists of highly purified glycoproteins produced in hamster ovary cells. The data derived from phases I and II of the trials, conducted in both Thailand and USA, showed that the vaccine was safe and immunogenic (the immune system responds to it).

Four agencies collaborated to establish Phase III of the vaccine trial in Bangkok, using the BMA Narcotic Clinics. The collaborating agencies include BMA; Faculty of Tropical Medicine, Mahidol University; the HIV/AIDS Collaboration, U.S. Centre for Disease Control; and VaxGen Inc. The study began in 1999 with an objective to determine whether immunization with AIDS (VAX B/E) vaccine effectively protects intravenous drug users from HIV-1 infection. Mathematical models show that vaccine that is at least 30 per cent effective will help in prevention efforts.

Volunteers for this study were recruited from the injecting drug using clients of the BMA clinics. Since 2,500 volunteers were needed and there were insufficient eligible volunteers from the Bangkok population, additional volunteers were recruited from outside the city. It was necessary that volunteers met the following criteria.

- No serious illnesses.
- HIV negative status.
- Not pregnant.
- Had injected drugs within the last year.
- Permanent residents of Thailand.
- Willingness to participate in the trial for three years.

Potential volunteers were educated about the trial. Before having their blood tested for HIV they received pre-test counselling in order to understand the advantages and disadvantages of knowing their HIV status. They were also given post-test counselling in order to reduce risk behaviour and to learn how to protect their health. Non-HIV infected volunteers went on to take a comprehension test about the programme. Following a physical examination and, providing they had passed all of the screening segments, they signed an informed consent and became enrolled in the study. The first vaccination was given on 24 March 1999. The last volunteer was enrolled in August of 2000. Volunteers remain in the study for three years and the target retention rate is 80-90 per cent. They are closely followed up. Clinic staff were trained in various areas including counselling, education and operational procedures such that the study and results were carefully monitored for adverse reactions as well as HIV status. The confidential data and results are held in both Thailand and US.

Volunteers are issued health care cards and receive free medical care through the BMA hospitals. If they become HIV positive during the course of the study they are taken off the vaccine (or placebo as the case may be) and given appropriate medical care. Volunteers are also provided with antiretroviral drugs. During the course of the programme the follow up rate was 95 per cent. Final results were not due to be available before 2002. It was agreed that should the vaccine be found to be effective, all placebo volunteers remaining HIV negative would be vaccinated.

H. Main outcomes

The BMA Methadone Programme served many clients and enjoyed some success along the way. Since its inception, over 20 years ago, the Programme has provided access to treatment for drug use to thousands of clients in the Bangkok area. It became the venue for a number of studies on Methadone and alternative treatments as well as the prevalence of HIV in the intravenous drug population. Governments and donors demonstrated their commitment to the basic programme through the provision of funding for projects, studies and training. With the mobile units and the prevention mandate, increasing numbers of the population are being educated about prevention strategies, health issues and HIV.

I. Evaluation

Outcome evaluation

Whilst the programme is monitored (sero prevalence studies, record of client demographics) to some extent and specific studies are undertaken, no overall evaluation was completed. Evaluation is problematic, as the BMA system appears to provide no specific requirements for outcomes. The system simply continues with activities and projects.

Coverage

The BMA Methadone Programme serves a portion of the heroin users in Bangkok. There are approximately 65 drug treatment centres in the city (although some are only operational intermittently). The BMA has 17 narcotic clinics as well as the rehabilitation centres. In a 1999 statistical report published by Chulalonghorn University and the Ministry of Public Health it was noted that BMA clinics treated 16,746 patients whilst 43 treatment centres in Bangkok treated 20,834 patients. Obviously the BMA is serving a large share of the treatment population. However, its share of the coverage of the drug using population with treatment in Bangkok is unknown. Research has shown that the time interval between first drug use and seeking of treatment is at least five years although often up to 10 years. Accordingly, it is reasonable to conclude that a fairly large at-risk population exists which has not been reached. It is noted that only a small percentage of the clients treated achieve abstinence for a significant length of time. The most important achievement however is that the majority of clients achieve reduced drug use, which translates into less injections and less risk of HIV transmission.

Replication

The Methadone programme is a fairly simple programme to replicate, however, certain resources are required. An operational health care system must be in place together with a supportive administrative body. Prevention, treatment and law enforcement must be developed and coordinated. The creation of the BMA narcotic clinics was greatly facilitated by the fact that, in most instances, they could be housed in established health centres. Both human and physical resources were readily available. Skilled medical and counselling staff is a necessity and systems of research, monitoring and evaluation must be set in place. Lack of infrastructure, resources, facilities, or funds will create problems. Further, community or national policies must be supportive of treatment for drug use problems and, specifically treatment of opiate injection use with Methadone.

Sustainability

It is anticipated that the basic programme will continue with funding from government and other outside sources. The resources required have not varied significantly throughout the years except in instances when testing of new medications or upgrading of medical equipment was required. The programme was expected to expand leading to the creation of more rehabilitation centres.

J. Lessons learned

A lesson that was learned very early in the Methadone programme was that the 45-day protocol as a single standard of treatment did not yield the expected results in many cases. Since Methadone has a high dependence liability, establishing a course of treatment with clients followed by removal within 45 days invited relapse in many cases. Treatment personnel knew of this as an issue having worked in this field over a long period of time. Nevertheless it has taken many years for policy makers to declare methadone maintenance a viable form of treatment. Even today the client must fail the 45-day protocol five times before s/he is considered eligible for methadone maintenance. Complete abstinence was once thought of as the only proper goal however the realities of heroin addiction have proven that small steps towards recovery are more achievable.

Another issue is the lack of rehabilitation centres in Bangkok. Whilst the benefits of outpatient detoxification are real, many drug users need the added support of in-patient rehabilitation in order to stabilize. There is a very large drug using and recovering population in Bangkok. The shortage of rehabilitation centres contributes to higher relapse rates, as many people do not receive sufficient post-detoxification follow up and aftercare. Related to this is the further issue of where the BMA might send women for rehabilitative care both immediately and in the future.

The Controlled Trial of Methadone Maintenance in injecting drug users helped those involved to understand that methadone maintenance was a useful tool in preventing HIV infection and in retaining clients for longer periods. Clients received more consistent counselling and health education. Accordingly, it can be concluded that methadone maintenance contributed to lowered HIV sero prevalence rates in BMA clinics.

It became clear that the rapid spread of HIV infection translated into the need for high quality, consistent counselling. Informative booklets and training in counselling techniques contributed to further development of the skills of the counsellors and psychologists.

Naltrexone use has met with very little success. Personal motivation however makes a large difference. Artificial blocking agents are of limited value given the large percentage of the treatment population that is unable to attain complete abstinence.

Over the years it has become clearer that prevention is inextricably linked to treatment. Dissemination of information in the community and education of youth are absolutely imperative to assisting the recovery in countries that have a large drug abusing population.

K. Recommendations

- Policy makers and administrators should review the Ministry of Health regulations regarding treatment services for the future. More flexibility needs to be built into the 7-day, 45-day, 180-day and 1 year rule. Human recovery cannot be regimented in this way as the high relapse rate shows, and the face of the drug scene is changing. With more drug users mixing and matching their drugs of choice, treatment management and protocols will have to become more tailored to individual needs.
- Services need to be continually expanded in order to reach a larger percentage of the population. Change and growth of the programme should aim to be consistent with new external approaches to achieving objectives. Accordingly, it is important to be observant of instances where a reluctance to progress is evident. Mobile units, for example, whilst complimentary to this approach should only be considered as starting points. This is particularly so given their services have remained relatively unchanged for more than 20 years. In-patient rehabilitation centres need to be established in such a way that they coordinate with outpatient treatment. There must be enough space for referrals and the system must equitably cater to all clients.

- Management of treatment must become more proactive and prepare for the future. It is with the benefit of hindsight that the inadequacies of countries' preparedness to deal with various drug epidemics becomes clear. Each new epidemic may overwhelm a system and may exacerbate already inadequate response cycles.
- Prevention and treatment sectors must develop greater liaison with law enforcement authorities. There should be a body within the overall organisation that looks after this. The resolution of nationwide drug problems deteriorates if these two sectors become embroiled in adversarial engagement. Indeed, internal conflict often allows such problems to escalate.
- Attention needs to be given to the specific problems of women and drug use. There needs to be rehabilitation centres and programmes that target women's issues. This area has been granted limited attention in the BMA programme.
- Better-trained and skilled people need to be encouraged to enter the field of addiction treatment. Currently this area of work it is not perceived as enjoying any prestige associated with it and the stigma of working with drug users is widespread. Education and promotion would help affect changes to attitudes.
- Monitoring, assessment and evaluation data need to be better organised and more easily accessible.
- The viability of a needle exchange programme should be studied. Messages about cleaning needles and the provision of the materials to do so, have met with mixed results.

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VIII. Hong Kong: Methadone treatment programme

A. Profile

Hong Kong: The skyline

Methadone clinic in Hong Kong

Name	Methadone Treatment Programme
Country	China – Hong Kong Special Administrative Region
Related thematic area	Treatment intervention
Contact persons	Dr. Cindy Lai, Assistant Director of Health, Special Health Services, Department of Health, Government of Hong Kong Special Administrative Region Ms. Mimi Lee, Principal Assistant Secretary for Security (Narcotics)
	Dr. SS Lee, Special Health Services, Department of Health, Government of Hong Kong Special Administrative Region
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Project status	On-going
Key primary partners stakeholders	The Government of Hong Kong Special Administrative Region Department of Health, Narcotics Division, Narcotic addicts in Hong Kong
Secondary partners stakeholders	Society for the Aid and Rehabilitation of Drug Abusers (SARDA), Hong Kong Council of Social Services, Auxiliary Medical Services (AMS), ex-addict volunteers, Red Ribbon Centre for HIV/AIDS prevention
Funding	*Total* yearly expenditure: HK$ 42 million, expenditure per client attendance was about 17 HK$ in 1999

B. Background

Hong Kong became a Special Administrative Region of the People's Republic of China in 1997 following a century of British colonial rule. Official figures derived from a voluntary reporting system that began in 1972 indicate that in 1999 there were 16,307 drug users known to the authorities. However, in the absence of any other estimation of the overall drug use situation the data must be seen primarily as indicative of drug use trends in Hong Kong. The Methadone Treatment Programme, which is the subject of this report, is the cornerstone of Hong Kong's multi-modality response to drugs. It consists of a range of clinical and residential facilities many of which are implemented by non-government organisations including religious bodies. The Methadone clinics attract the largest number of voluntary clients. Data from 1998, for example, indicates that 65.7 per cent of all drug treatment registrations in Hong Kong were to the Methadone Treatment Programme.

Hong Kong has been successful in containing the HIV epidemic. Surveillance of HIV has been on-going since 1984 and cumulative figures suggest that the number of HIV infected individuals in December 2000 was only 1,542. Of these 500 people had progressed to AIDS and only 32 cases of infection could be directly attributable to injection drug use. This presents a significant contrast to trends in neighbouring countries.

At the beginning of the new millennium the Hong Kong authorities were acutely aware of rapid social and economic changes in both Hong Kong and across the border on the Chinese mainland. New drug taking patterns continue to emerge in many neighbouring countries in East and South Asia, and drug injecting has manifest as a key risk factor for HIV/AIDS in the Chinese mainland. This report examines Hong Kong's Methadone Treatment Programme and considers its appropriateness for the future.

Drug use in Hong Kong

Hong Kong began formulating its anti-narcotics policy over 40 years ago. In 1959 the government published a White Paper '*The Problem of Narcotic Drugs in Hong Kong'.* The paper referred to drugs as 'one of Hong Kong's greatest social and economic problems'. In a 1974 White Paper the government announced that it was determined to 'stop illicit drug trafficking of drugs through Hong Kong and to eradicate drug use from the community'.

A multi-sectoral Action Committee Against Narcotics (ACAN) was formed in 1965 and re-constituted in 1993. Its functions are to advise the government on all aspects of drug control and policy. ACAN has had a major impact on the development of drug policy in Hong Kong. Upon its suggestion the Narcotics Division in the Government Secretariat was established, the police dealing with narcotics was re-organised and internal corruption addressed. Further, the post of Commissioner of Narcotics was created, as was the Central Registry of Drug Abuse (CRDA). ACAN was charged with insuring collaboration between those working in law enforcement, treatment and rehabilitation, preventive education and publicity. ACAN continues to focus on all aspects of drug control, prevention, treatment and rehabilitation though not specifically on the prevention of HIV/AIDS among drug users.

Drug use trends

The most authoritative source of information about current drug use and drug use trends in Hong Kong is the Central Registry of Drug Abuse, which was established in the Narcotics Division of the Government Secretariat in 1972. The major objectives of the CRDA are to identify trends in the nature of addiction in Hong Kong and to analyse the characteristics of the drug using population. Approximately 34 different agencies report regularly to the CRDA comprising law enforcement, treatment agencies, hospitals, clinics and many of the welfare organisations in Hong Kong. Each reporting agency completes a record sheet on a voluntary basis whenever contact is made with known or suspected drug users. The Narcotics Division provides guidelines and training for reporting agencies.

For the purpose of reporting, drug use is defined as 'the taking of drugs which harms or threatens the physical, mental or social well-being of an individual, in doses above or for periods beyond those normally regarded as therapeutic'. Thus, the use of all scheduled drugs, not merely that of narcotic drugs, including psychedelics is reported. The analysis from reporting agencies distinguishes between new or previously reported individuals. All records are confidential and accessible only to those involved in the operation of the CRDA. Hong Kong holds 24 years of CRDA data, with reports updated half yearly. Since its inception the Registry had received more than 731,700 reports encompassing 98,320 drug users.

The total number of drug users known to the Registry at any one time has not varied significantly between 1980 and 1999. These range from 13,171 reported cases in 1980 to 16,307 in 1999. The number of reported drug users peaked in 1994 (20,328). The majority of drug users that reported to the Registry used heroin (85.5 per cent in 1999) and of this group 54 per cent were injectors.

A number of underlying trends should be noted. The most important of these are: an increase in young users; a decline in the age of newly reported opiate users (fewer of whom are injectors); an increase in the number of women drug users; and, an increase in the number of new users who are using non-opiate drugs as well as a combination of drugs. Some of the significant features are listed below.

- The number of young users (under 21) is rising steadily. The most recent statistics show a rise of 42 per cent between the second half of 1999 and the first half of 2000. About half of those were aged between 16-18 years.
- The mean age of *newly reported* drug users is declining. The mean age of those reported in 1980 was 36.3 while in 1999 it was 24.8.
- Under half of drug users under 21 used heroin (49 per cent).
- Although the majority of drug users are men, the numbers of newly reported women has more than doubled in the last decade (from 238 women in 1980 to 692 in 1999).
- Although heroin remains the predominant drug of use among all reported individuals, there are significant increases in the number of MDMA (ecstasy), ketamine and methylamphetamine (ice) users.
- The most significant increases in non-opiate use were noted among those under the age of 21, though psychotropic drug use was not only confined to young users.
- The use of cannabis was considerably higher among those under 21. In 2000, 22.6 per cent of those under 21 used cannabis compared to just 4.1 per cent of those over 21.
- 32 per cent of newly reported cases under 21 in the first half of 2000 reported using more than one drug.
- When comparing 1991 with 1999 there was a decline in the number of heroin injectors and an increase in the use of heroin by fume inhalation.

The Registry does not purport to represent an accurate account of the drug use situation in Hong Kong but is indicative of drug use trends. Informal accounts from outreach workers would suggest that psychotropic drug use is more extensive among young people then indicated by the CRDA data.

The legal framework

The Dangerous Drugs Ordinance (CAP. 134) has been operative since 1969. Section 8 deals with the possession of drugs in Hong Kong and prescribes the maximum sentences for *'Possession of dangerous drug otherwise than for trafficking, and consumption of dangerous drug'.* According to law *'no person shall have in his possession or smoke, inhale, injest or inject a dangerous drug'* and *'any person who contravenes (*the above*) shall be guilty of an offence and shall be liable to* either' *(on conviction upon indictment) to a fine of HK$1,000,000 and subject to 54A to imprisonment for seven years or on summary conviction to a fine of HK$100,000 and subject to 54A to imprisonment for three years'.* In addition there are additional guidelines on sentencing and on penalties in the guidelines issued to judges.

The Dangerous Drugs Ordinance Cap 134 Part Y section 36 prohibits the possession of drug use paraphernalia *'no person shall have in possession any pipe, equipment or apparatus fit and intended for the smoking, inhalation or injection of a dangerous drug'*. Furthermore, traces of blood or of an illegal drug may be used as evidence in the court of law that an offence of possession has been committed.

Under the Drug Addiction Treatment Centre Ordinance (Ch 244 of the Laws of Hong Kong) which was gazetted in 1997 the establishment of compulsory Addiction Treatment Centres (DATC) was formalised. The courts were empowered to sentence an addict found guilty of an offence to detention in such a centre, which is operated by the Correctional Service Department. The Ordinance allows for an order of detention in a centre for a period of between two and 12 months.

Interventions

Hong Kong adopts a wide variety of approaches in the treatment and rehabilitation of drug users, each catering to the different needs of drug users. These range from a compulsory placement scheme operated by the Correctional Services Department, consisting of two compulsory addiction treatment centres, to the Methadone Treatment Programme which offers voluntary 'substitution' long term therapy to those who are not able or willing to attend other forms of treatment. In addition Hong Kong has numerous voluntary residential drug-free treatment programmes where clients undergo detoxification followed by rehabilitation and after care. All are administered by non-government organisations some of which are religious organisations. Most receive major financial support from the Hong Kong Government. The Society for the Aid and Rehabilitation of Drug Abusers (SARDA) is the largest of the voluntary organisations and was established in 1961. It currently has an annual budget for its voluntary treatment and rehabilitation facilities in 1998/99 of almost HK$30 million. SARDA expends approximately HK$9 million annually on supporting 21 social workers and counsellors to work in Hong Kong's Methadone clinics. In addition the Department of Health's Hospital Authority in Hong Kong has established six substance use clinics, which cater predominantly to non-opiate drug users.

A general practitioner, Dr. L K Ding, established the first two Methadone clinics in Kowloon and Hong Kong Island. By 1972 the programme had expanded and was taken over by the Department of Health. There are now 21 Methadone clinics strategically located in different Hong Kong neighbourhoods.

HIV/AIDS in Hong Kong

HIV/AIDS policy

Hong Kong initiated its HIV/AIDS prevention policy in 1984 with the establishment of an *Expert Committee on AIDS* in the Medical and Health Department. In the subsequent two years AIDS counselling including an AIDS hotline were established, voluntary HIV testing was made available, voluntary medical surveillance and reporting was instigated and the safety of blood products were ensured.

In the following years Hong Kong's HIV/AIDS strategy followed closely the World Health Organisation guidelines. Efforts were at first focused on enhancing public knowledge on the risks of HIV by expanding education and public information, and expanding the AIDS counselling services of the Department of Health. In 1990 Hong Kong's Governor established an Advisory Council on AIDS (ACA). The Council was charged with the task of advising the government on AIDS prevention and care strategies. At the same time HIV surveillance was strengthened by the introduction of unlinked anonymous testing among selected population groups.

The Advisory Council on AIDS advises the government on AIDS policies. It meets every three months to deliberate issues, make recommendations and publish guidelines. The recommendations of the ACA inform Hong Kong's policy formulation. Additionally, the ACA commissioned an external evaluation of Hong Kong's programme (1998). As a result the following major recommendations were made.

- Shifting the response from publicity and education to prevention and focusing efforts where they will have the greatest impact, such as vulnerable groups that may include travellers from China, sex

workers and their clients, men who have sex with men, youth, STD clinic attendees and injecting drug users.

- Strengthening of partnerships especially through a participatory community planning process as well as improving joint evaluations of on-going initiatives with community and other stakeholders.
- Ensuring quality care for those infected with the virus and maintaining Hong Kong's commitment to providing good treatment and support to those living with HIV/AIDS.

The ACA accepted these recommendations and in its August 1999 to July 2000 report provided an account of the community planning process, which was initiated in order to strengthen the co-ordinated response to HIV/AIDS. The structure and role of the ACA itself was revised and a number of technical sub-committees established. Several task forces to recommend strategies for the prevention of HIV among vulnerable groups was established including a Task Force on Drug Users. A draft strategy for preventing HIV among drug users in Hong Kong has been accepted.

Epidemiology

At the end of December 2000 a total of 1,542 HIV infections (of whom 265 were women) and 500 AIDS cases (57 women) had been reported in Hong Kong. The majority (57 per cent) of infection was due to heterosexual transmission while 19 per cent were due to homosexual transmission. The information on the epidemiology of HIV/AIDS is monitored through a number of surveillance mechanisms. Surveillance began in mid 1980s as a voluntary case reporting system. However, by mid 1990s a programme of sero-surveillance studies was established in communities with/without risk taking behaviours. At present HIV/AIDS epidemiology is co-ordinated by the Department of Health's AIDS Unit through four different reporting mechanisms.

Below are the various sources of HIV information used in Hong Kong.

- Voluntary HIV/AIDS reporting – this is a case-based surveillance system, which consists of voluntary reporting by both doctors and through laboratories. This voluntary reporting system has been on-going since 1984.
- HIV sero-prevalence studies in three population sub-groups. Clients in Social Hygiene clinics (for the treatment of sexually transmitted infections) and drug users attending treatment programmes are offered voluntary HIV tests. All blood donors were tested for HIV.
- Unlinked Anonymous Screening began in 1990 and is targeted at drug users attending Methadone clinics, street drug users, correctional institution inmates, tuberculosis clients, pregnant women and male government recruits.
- Behavioural surveillance began in 1994 and consists of surveys that focus on nine behavioural markers selected to monitor sexual and drug taking behaviour.

Current trends indicate an increase in infections among women, the majority of which are the result of sexual transmission.

HIV/AIDS and drug users

At the end of 2000, 32 (including two women) injecting drug users were infected with HIV and a further nine progressed to AIDS. These figures represent 2.1 per cent of the total known infections in Hong Kong. Although the absolute number of HIV infected drug users remains small a persistent rising trend of infections is reason for concern.

For drug users the most critical risk behaviours are injecting drug use and needle sharing. Data from the CRDA register suggests that there has been a change in drug use behaviour with a significant reduction in injecting among newly reported users. Data from the first half of 2000 suggests that among newly reported drug users, injecting is the most popular method of using heroin (54.8 per cent), fume inhalation was favoured by 36.5 per cent of newly reported drug users and smoking was the preferred method for

15.1 per cent. These preferences are similar to those of drug users and who were previously reported with longer histories of drug use.

Additional information on risk taking among drug users can be derived from a number of studies that were conducted in Methadone clinics, in the treatment and rehabilitation facility of Shek Kwu Chau (SKC) and from Street Addict Surveys. All studies of drug users in Hong Kong suggest that there is still a high level of injecting drug use. However, studies in Methadone clinics and in residential rehabilitation centres suggest that for these clients the level of needle sharing is generally low.

However, studies of *Street Drug Users* conducted by SARDA/PHSHA indicate that needle sharing remains a prominent feature of their drug use behaviour. It is interesting to note that there was an overall decline in the percentage of addicts who inject and a decrease in the number who admit to sharing needles and syringes. Almost a third of Street Drug Users are still sharing injecting paraphernalia. It is also interesting to note that data from the December 2000 survey indicates that 16 per cent of the 500 drug users interviewed crossed the border to the Chinese mainland for the purpose of buying and using drugs. As needles and syringes are much more difficult to obtain in Mainland China the likelihood of sharing injection equipment is considerably greater than in Hong Kong.

HIV/AIDS prevention among drug users

Although remaining small, there were recent increases in the numbers of drug users who became infected with HIV. The need for stringent efforts to prevent the spread of the disease is recognised by the authorities. The Hong Kong Advisory Council on AIDS through its sub-committee on drugs considered how best to improve prevention focused on drug takers. It made the following recommendations.

- An open policy of *harm reduction* should be advocated in parallel with supply and demand reduction policies.
- There should be a liberalisation of the criminal liability for possessing needles and syringes so as to encourage safe drug use.
- Needle and syringe exchange schemes should be considered.
- Voluntary testing for HIV to be encouraged.

In Hong Kong's three-year Plan on the Treatment and Rehabilitation Services, which was prepared by the Narcotics Division Bureau, for the years 2000-2002 there are additional provisions for clinics to enhance HIV prevention. The plan calls for efforts to increase the awareness of drug workers on the harmful effect of multiple-drug use, the increase in social support to clients and their families, and the development of group activities. Additionally the plan noted that the increase in female drug use necessitated more gender sensitive approaches. However, the plan makes no mention of some of the Advisory Council on AIDS major concerns such as the need to have an explicitly open policy on harm reduction, increasing voluntary HIV testing and a needle and syringe exchange scheme.

In order to achieve this the committee recommended that HIV/AIDS education and harm reduction programmes be regularly conducted in every drug treatment centre, Methadone clinic and continued in the aftercare phase of recovery. Furthermore, education targeted at users of 'party drugs' should be increased. The committee also urged media publicity on the association between HIV and drug use be continued and shown frequently. Finally, the committee recognised the need for peer counsellors and for improved training for paraprofessionals to contribute to prevention efforts.

Currently, the Special Preventive Programme of the Department of Health closely monitors the trend of HIV in Hong Kong. The key responsibility for the preparation of publicity and education materials was given to the Red Ribbon Centre which is an AIDS Education and Research facility operated by the Department of Health and since 1998 a UNAIDS collaborating centre. The Red Ribbon Centre undertakes extensive prevention activities by targeting the general population and especially vulnerable groups. It prepares mass media information campaigns, including regular TV information broadcasts.

It has a website where people are given guidelines on how to assess their own risk behaviours. The Centre stages information exhibitions in shopping arcades and other community venues to educate on HIV/AIDS.

The Red Ribbon Centre opened officially in 1997 but has been in operation targeting Methadone clinic clients for HIV preventive activities since the mid-1980s. It distributes posters and leaflets at the clinics and offers training to clinic staff. In addition the Centre has assisted the clinics in the conduct of surveys of clients and in improving the staff's interviewing skills. A project to distribute free condoms in clinics, was first begun in 1994 in six Methadone clinics and was later extended to all clinics. Approximately 5,000 condoms are distributed each month.

C. Objectives

Hong Kong's response to drug use is both comprehensive and multi-sectoral but the Methadone Programme represents its major and sometimes most controversial response. It was established as a response to Hong Kong's rising drug use problem and the emerging widespread concerns in the public over high level criminal connections with the drug trade and police corruption. The major objectives of the programme were re-stated by the Programme Review (December 2000).

- Provide a readily accessible, legal, medically safe and effective alternative to continued drug use.
- Help clients to lead a normal and economically productive life.
- Help in the reduction of crime and antisocial behaviour related to illicit opiate drug use.
- Assist in the prevention of blood-borne diseases such as hepatitis, tetanus and HIV infection by reducing injecting drug use and needle sharing through surveillance, health education and counselling.
- Assist drug dependent persons to achieve a drug free state by providing a detoxification programme.
- Provide a 'safety net' by accommodating rising demands.
- Continue to operate an open door policy.

D. Main Activities of the Methadone Treatment Programme

The Methadone Treatment Programme in Hong Kong consists of 21 outpatient clinics, four on Hong Kong Island, ten in Kowloon and seven in the New Territories. The clinics adopt an open-door policy and accepts anyone regardless of age, sex, nationality or religion (including visitors to Hong Kong). Clinics open seven days each week including holidays (special arrangements are made during typhoons) and remain open for long hours to cater for the needs of clients who are working. Clients are required to pay HK$1 per clinic attendance. The clinics have no waiting lists and the attending medical officer sees new clients as soon as possible after they present at the clinic. The majority of clinics share facilities with general outpatient clinics. Clinic facilities generally include a dispensing counter, an area for the administrative staff and one or two rooms that serve the medical officer and the social workers. All clinics display HIV/AIDS prevention material and makes condoms freely available.

Medical assessment

The client's medical and social history is recorded, followed by a physical examination on admission. A checklist on drug use and sexual behaviour is completed. A urine test is routinely undertaken after the initial visit. New and readmitted clients undergo urine tests every two weeks in the first two months to determine the client's tolerance to Methadone. The initial dose of Methadone does not usually exceed 30 mg. At the initial interview the physician attempts to assess the patient's tolerance to opiate based on the frequency and estimated quantity of drugs used daily. After admission, doses of Methadone may be increased by 10 mg daily. The optimum dose does not usually exceed 60 mg daily.

Clients under the age of 21 or those with less than two years addiction history are first encouraged to attend residential drug free treatment. However, if the clients consider such treatment as inappropriate they are admitted to the maintenance programme. Those under the age of 18 are generally requested to provide evidence of parental consent.

All new and readmitted clients are provided with counselling by the medical officer on HIV/AIDS prevention. The dangers of contracting the virus through unprotected sexual activities and through the sharing of needle and syringes are explained, and the use of condoms is promoted.

Support services

Counselling is provided by social workers seconded to the clinics by the Society for the Aid and Rehabilitation of Drug Abusers (SARDA), a major non-governmental organisation that is primarily funded by the government. SARDA has been operating residential and aftercare services for drug users since 1961. It provides the clinics with 21 full time social workers serving a client population of over 6,000 attendees daily. Intensive counselling is offered to clients below the age of 21, but because of limited resources counselling to older clients and re-admitted clients is only provided on request. One social worker is assigned to each clinic. Although social workers provide their clients with information on how to prevent HIV/AIDS, the peer education programme remains at an embryonic stage. Clinics have little or no facilities for group activities or discussions. The clinics do not engage in any community-based activities and outreach services remain non-existent.

Clinic treatment

The clinics offer clients two treatment options that are outlined below.

- *Detoxification Programme:* In general new clients aged below 21 years or those with a short history of addiction will be encouraged to consider residential treatment. However where clients consider residential treatment too disruptive to their work or schooling, they may be detoxified on an outpatient basis. When a patient chooses this option the clinic will offer counselling and a full explanation of the detoxification programme. A detoxification regime will initially be implemented for three to five months. Clients undergoing detoxification are regularly monitored and counselled. If detoxification fails clients are encouraged to re-enrol in a drug free residential programme or recommence outpatient detoxification. Clients who successfully complete their treatment are followed up for 18 months. Urine is tested every three months to verify that no illegal opiates are being used. Uptake for the detoxification programme is rather low.
- *Maintenance Programme:* Clients are required to attend clinics once a day to take a dose of Methadone under the supervision of the clinic staff. For a newly admitted patient the dosage of Methadone is increased from the beginning dose of 30 mg to reach their optimal dose. The average daily Methadone dose is 60 mg. After registration each patient is issued with a patient identification card, which is required before Methadone is dispensed. Methadone must be consumed on the premises and in full view of the clinic staff. Changing clinics requires the approval of the medical officer. Urine tests are conducted once every four weeks.

Box 1: Example: A Methadone clinic

This clinic opened in 1974 and is situated in General Outpatient Clinic. It has a separate entrance from the rest of the service so that Methadone clients do not mix with the rest of the patients. It remains open from 7.00 a.m. to 10.00 p.m. daily. Approximately 1,000 clients are registered at this clinic of which about 850 attend each day making this one of the largest clinics in Hong Kong. Staffing consists of one full time doctor who is also in charge of eight other smaller clinics. The doctor works intensively in two of the eight clinics and supervises the remaining seven evening clinics. The doctor assesses each new client following a protocol, which includes questions on social, medical, sexual and drug taking history, patterns and behaviours. In addition clients undergo a physical examination. The doctor formulates a treatment plan for the client and provides all clients with basic HIV preventive information. Two social workers are employed part-time (nine clinical sessions). The social worker targets young/new clients particularly those under 21. Each has a caseload of some 70 clients monthly. In addition there are 13 Auxiliary Medical Service staff that carry out the day-to-day dispensing work.

Patient profile: The majority of clients are over 25 and the ratio of males to females is 8:1. Approximately 50-60 per cent of clients are in employment. 95 per cent of all this clinic's clients are on the Methadone maintenance programme and only 5 per cent on the opiate detoxification programme. The average Methadone dose prescribed at this clinic is 60 mg and the optimal dose is 70 mg. At least 70 per cent of maintenance clients are known to be using heroin as well as their prescribed Methadone (most continue to inject). Detoxification clients are offered counselling for the duration of their programme and are followed up for 18 months after completion of detoxification.

HIV/AIDS prevention: The clinic provides leaflets and displays posters informing clients about the risks of HIV infection and providing information about safe drug use and safe sex. A video providing relevant information is being continuously shown in the clinic. Free condoms are available at the clinic

Clients pay HK$1 each time they attend the clinic.
Many clients have contacts in Mainland China across the border.
The clinic described above is one of the largest Methadone clinics in Hong Kong.

As of October 2000 the Methadone Treatment Programme had 9,434 clients of whom approximately 69 per cent attended daily.

E. Main Outcomes

As indicated above the primary objective of Hong Kong's Methadone Treatment Programmes is to provide a readily accessible, medically safe, effective and legal alternative to illegal drug use. The Methadone programme seeks to help drug users resume a normal, productive and crime free life in the community. Increasingly the Methadone treatment clinics have undertaken public health functions such as HIV surveillance, health education and counselling. There is no doubt that the Programme has succeeded in many of its objectives.

Box 2: Low threshold, easily accessible treatment, legal alternatives to illicit drugs

The Methadone programme is the largest treatment programme in Hong Kong attracting the vast majority of drug users known to the CRDA. Active registration in the programme as of October 2000 was 9,434 clients (of a total of 12,904 known heroin users – at the end of 1999). Of these about 69 per cent attended Methadone treatment clinics daily. The number of clients who also use illicit drugs has been reduced (71 per cent had used heroin in the four weeks prior to the Methadone review).

A large proportion of known drug users in Hong Kong attend the clinics. It is the single most popular drug treatment model used by 65 per cent of drug users in treatment. Furthermore, the clinics, which are strategically located in Hong Kong, offer a first point of contact with a helping agency for many of Hong Kong's drug users and act as an important channel for referral to other treatment agencies for those who seek to become drug free. In addition, the Methadone clinics provide an important 'safety net' for drug users at times when heroin becomes scarce or unavailable, and preventing drug users from switching to the injection use of psychoactive drugs and other dangerous substances.

Measured against its stated objectives it is clear that the Methadone Treatment Programme has succeeded in its major objectives.

Box 3: Lead a normal, economically productive life, reduce criminal involvement

The Methadone treatment review Indicated that about 49 per cent of clinic clients were unemployed when they joined the Methadone programme but that their employment record improved slightly while in treatment (44 per cent were now unemployed). There was also an decrease in crime committed by Methadone clients. Of those joining the programme about 80 per cent had some criminal involvement. While attending the programme about 50 per cent claimed that clients committed less crime when they joined the Methadone programme.

The majority of clients expressed general satisfaction with the clinic services although there were some who complained about the dosages, which range between 30 and 60 mgs daily (higher doses are rarely prescribed), and the clinic environments (clinics do not have sufficient room for counselling and group activities).

Box 4: Reducing high risk behaviour

The Methadone treatment review found that of those who were still using heroin less than 5 per cent had shared syringes with others. Most clients in the programme (91 per cent) knew that AIDS might be contracted through the shared use of needles and syringes. The incidence of HIV infection among clinic clients remains low. Unlinked anonymous screening found 0.27 per cent prevalence rate in the year 2000. However, this rate, although low, represents an increase when compared to previous years.

F. Evaluation

Indicators for evaluating the MTP are implied rather than explicitly stated. It is noted however, that the numbers of drug users in Hong Kong have remained stable and that few people appear to be injecting and sharing injection equipment. Indicators specific to the programme itself may include the percentage of drug users who attend the clinics, and the percentage that attend regularly. Both of these were discussed earlier in this report. Both were noted as being numerically high – the MTP is the most popular treatment model in Hong Kong.

The low rates of HIV among clinic clients, the evidence that clinic clients are well informed about HIV as well as the declining numbers of clients who share needle and syringes are additional (non-explicit) indicators that suggest that it is possible to carry out effective HIV/AIDS education in the clinics.

Outcome evaluation

Since it was first established the Hong Kong Methadone Treatment Programme has been evaluated several times. Numerous research projects have been undertaken to determine the effectiveness of MTP functions and whether it adequately meets the needs of its clients. Prominent among these periodic

evaluations are the reports of Professor Robert Newman (in 1994 and 1998) who was instrumental in setting up the Methadone clinics and who subsequently re-visited the Hong Kong programme to determine its progress. The most recent evaluation, already alluded to throughout this report, is the Review of the Methadone Treatment Programme, which was completed in December 2000. The comments below summarise the views and opinions expressed in those reports as well as the verbal or informal comments made in respect to the programme by key informants in Hong Kong.

The Methadone Treatment Programme in Hong Kong has been in operation for over a quarter of a century. It remains accessible, friendly and inexpensive. There is little doubt that its establishment was a timely and highly successful response to the drug use situation in the 1970s and beyond. The Programme continues to remain the major treatment response to drug problems in Hong Kong and is credited with an outstanding record of maintaining low rates of new HIV infections among drug users. It is interesting to note that soon after its inception a major prison in Hong Kong was closed for lack of inmates. The programme has had a continued impact on reducing drug-related crime. Overall, the programme has been judged to be successful in meeting most of its objectives and the December 2000 Review of the programme recommended its continuation.

Several key questions remain however and these relate to whether the Methadone Treatment Programme as currently constituted is likely to serve Hong Kong well in the future? Is the programme sufficiently responsive to the changing drug scene in Hong Kong and elsewhere in Asia and will it continue to be effective in preventing the spread of HIV in their vulnerable client group? The Review attempted to address these issues.

(1) Will the Methadone Treatment Programme continue to contribute to the successful prevention of harmful drug use and HIV? Although it is not possible to demonstrate a direct causal relationship between the low rate of HIV among drug users and the availability of Methadone there is no doubt that Hong Kong was well prepared to deal with and contain the HIV epidemic among drug users. Hong Kong has a variety of voluntary treatment facilities of which Methadone maintenance treatment is the most significant approach. The Methadone clinics are important venues for HIV prevention among drug users. They are used as sentinel sites to monitor the epidemic, offer voluntary HIV testing and provide education on HIV. Assisted by the Red Ribbon Centre, the clinics distribute leaflets and posters about the harmful effects of drug use and particularly on the dangers of injection and of sharing needles and syringes. Condoms are also available in all clinics, as is information on safe sex.

However, recent changes in drug use patterns in Hong Kong and the increases in the HIV infections among Methadone clients indicate that Hong Kong should not remain complacent and that HIV prevention among this highly vulnerable group must continue to be conducted rigorously. Of major concern is the lack of sufficient communication and collaboration between the Hong Kong Advisory Council on AIDS and its AIDS prevention and Care Committee and the Action Committee against Narcotics. On the operational level there is also little formal co-operation between the Narcotics Division, the Methadone Treatment Programme and the Health Department in planning preventive HIV/AIDS education and information at the clinics.

(2) Does the fact that the concept of 'harm reduction' which is not explicitly stated in the Methadone Treatment Programme objectives, an impediment to successful HIV prevention policy? HIV prevention among drug users would be much strengthened if this concept was clarified and adopted officially as an objective for the Methadone programme. Aspects of harm reduction are implicit in the Methadone clinic approach. But the lack of explicit endorsement is an impediment to continued effective prevention of HIV. For example, it is sometimes unclear whether detoxification rather than long term maintenance are really the most desirable goals for the programme. Social workers from SARDA are inclined to recommend drug free rehabilitation as a favoured approach. In fact the numbers of clients who opt for the detoxification programme remains small. The introduction of needle and syringe exchange schemes was not given serious consideration on the ground that needle and syringes are easily obtained in Hong Kong. The harm reduction objective, which is to provide an opportunity for HIV prevention, has also been overlooked. In addition it is notable that little effort is made to try to counter the widespread continued

use by clients of drug injection by manipulating (increasing) the conservative dosages of Methadone prescribed to many clients.

(3) Are changes in drug use patterns in Hong Kong adequately addressed in the Methadone clinics? The answer is probably that they are not and hence should the clinics transform themselves into being more generic drug treatment clinics? There is evidence of changes in the clinic client profiles and these probably reflect changes in drug use patterns in Hong Kong. Many Methadone treatment clients are long term opiate users and the clinic is less popular with younger drug users. Below is a summary of information on the client profile of those attending the clinics.

Box 5: Client Profiles

- Just 13.5 per cent of clients have used drugs for less than five years. The rest have addiction careers spanning from 5-30 years (mean length of addiction career is 18 years).
- Almost a third (29 per cent) of clients have been registered in the programme for between 10-19 years and a further 19 per cent for 20 years or more. Making for a substantial group (48 per cent) of 'old' clients.
- The client group is characterised by a large number of previous admission to the programme. Thus, the mean number of previous admission was seven, with one quarter having between five and nine previous admissions.
- Only 14 per cent were newly registered clients with no previous admission.

These data confirm that the Methadone Treatment Programme is successful in attracting heroin users, and caters largely to those who have long addiction histories.

So far non-opiate drug users are offered help in six small Substance Use Clinics with an average of 500 patients a year (some of whom have predominately alcohol problems). It is true that Methadone clinics do not generally have a role beyond providing treatment to heroin users. However, as drug use patterns in the community are changing, the Methadone clinics 'the cornerstone' of Hong Kong's drug treatment policy need to consider using their accumulated knowledge and expertise in the drug field to ensure that all drug users are assisted. It is crucial that no one engaged in high-risk behaviours, whether they are injecting heroin or misusing other substances and engaging in unprotected sexual activity, should be excluded from preventive efforts.

Coverage

The Methadone programme adequately covers the population of opiate users in Hong Kong. Clinics are distributed throughout the territory conducive to ease of access for clients. However, the clinics are not designed to address non-opiate drug use and this may become a problem in the future.

Replication

The Hong Kong Methadone Treatment Programme is easily replicated once government support is gained. The programme succeeded in preserving a simple and cheap mode of operation. The safety of the delivery and distribution of the Methadone itself are well regulated. Guidelines for the dispensing of Methadone are clear, clients consume the drug on the premises, and opportunities for 'double scripting' are minimised through the use of identification procedures. The cost to clients has been kept to a minimum (just HK$1) per dose of Methadone making it widely affordable. The programme is noted to be not only the most popular in Hong Kong but also the cheapest.

Sustainability

The Methadone Treatment Programme is the government's official response to injecting opiate use. The Hong Kong Government funds the programme, and although it relies heavily on volunteer auxiliary medical workers, and on the services of social workers seconded by SARDA (which is supported by the government), the government remains fully committed to the continuation and improvement of the programme. Suggestions about improving the physical conditions in the clinics were made by the Methadone Review and are likely to be accepted by the government.

G. Lessons learned

The main lesson learned from the Hong Kong experience is that the Methadone Treatment Programme owes its success to the government commitment to a rational, evidence-based approach to the treatment and rehabilitation of drug users. The government recognised the usefulness of Methadone substitution programmes in the early 1970s and once introduced, the programme was sustained. The Narcotics Division Security Bureau continues to state its objective as 'providing effective and timely response to new trends and situations' and 'promoting a greater awareness of the harmful effects of drugs'. The government of Hong Kong also supports additional ancillary services for drug users, through significant subvention of the non-governmental sector.

After more than a quarter of a century of existence, it is evident that low cost Methadone clinics can be effective. Hong Kong's clinics are unadorned facilities with minimum staff, many of who are volunteers receiving no more than a stipend to assist them to cover their expenses. Clinics are located in population centres where there are many known drug users, remain open for long hours and provide non-judgmental, easy access service to drug users. Although a significant proportion of clinic clients also use street drugs from time to time, in addition to their Methadone prescription, they remain in contact with treatment services and thus are exposed to prevention messages. This approach has enabled the programme to make a significant contribution to drug and HIV prevention and control.

It is highly probable that Hong Kong's early adoption of Methadone is an important factor in its low HIV infection rates among drug users. Opiate substitution treatment is cheap, easy to access and the clinics provide on-going education about safe injecting practises for those who continue to inject. Indeed the rate of injection and of sharing needles and syringes among clinic patients is low. Additionally, the Methadone clinics provide the opportunity for tracking HIV infection rates among drug users. However, it is of concern to note that ACAN in its 2000-report made no mention of HIV prevention and that the Narcotics Division 2000-2002 plan also failed to address issues of HIV prevention.

H. Recommendations

It is recommended that:

- in light of changing political, social and economic conditions in Hong Kong that official and strategic communication be established between the Narcotics control and prevention authorities and the HIV/AIDS prevention and control authorities;
- rehabilitation and after care services, many of which work closely with the Methadone clinics adopt and explicitly promote the principles of harm reduction;

  (Note: To-date all the after-care non-medical services for drug users in Hong Kong are abstinence based. Harm reduction messages would ensure the most effective HIV prevention for drug users.)
- the MTP should build monitoring and evaluation mechanisms into their programme to include clear indicators by which the programme can be evaluated;
- attention should be paid to the high number of clients who regularly use additional drugs;

(Note: Clinics need to review the dosages of Methadone prescribed to clients. Higher dosages for certain clients should be considered.)

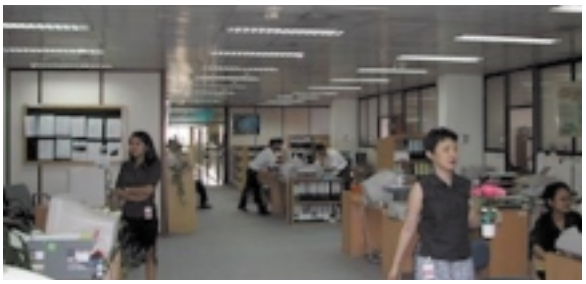
- clinics offer counselling to all those who may need it and not restrict social work interventions to new clients under 21; and,
- the MTP be more pro-active in reaching out to drug users in the community and undertaking assessments of their needs.

  (Note: There is growing evidence of 'street users' engaging in risky behaviours and using multiple substances beyond opiates. The clinics could use their vast experience in working with drug users to expand their scope of activities.)

Advocacy

Deciding on the implementation of intervention strategies to prevent HIV in injecting drug users is one of the most urgent questions facing policy makers. Studies have demonstrated that HIV transmission among injecting drug users can be prevented and that the epidemic already has been slowed and even reversed in some cases. HIV prevention activities, which have shown impact on HIV prevalence and risk behaviour, include AIDS education, access to condoms and clean injecting equipment, counselling and substance use treatment

IX. SEAPICT 1996 to 2000: An agenda for advocacy in Asia



The UNAIDS South East Asia-Pacific Inter-country Team as well as the offices of the UN Office on Drugs and Crime (UNODC) Regional Centre for East Asia and the Pacific and many other partners are located in the building of the Economic and Social Commission for Asia and the Pacific in Bangkok.

A. Introduction

When the World Bank funded South East Asia HIV/AIDS project began its operation in June 1995 in Bangkok, HIV/AIDS among drug users was identified as a priority area. The Joint United Nations Programme on HIV/AIDS began its operation in January 1996. The South East Asia-Pacific Inter-country Team in Bangkok was established in July 1996 continuing the work of the World Bank project. This paper briefly summarises the background and rationale methodological approach of the Inter-country Team's activities for the prevention of HIV transmission among drug users, covering the period from 1996 to end of 2000, and provides some conclusions and lessons learned.

B. HIV/AIDS and drug use in Asia

Production, trafficking and consumption of narcotics, exist in many countries of the region for more than a hundred years, and various attempts have been made to solve these problems. The production of narcotics and traditional opium smoking can be reduced significantly in a number of areas however trafficking and consumption of heroin remain an issue of serious concern with an increasing trend toward injecting drug use. In addition to the use of narcotics, endemic levels of inhalant use exist, mostly associated with street children living in impoverished and harsh conditions. Many countries of the region have also experienced a rapid and significant spread of amphetamine-type stimulant (ATS) use, particularly methamphetamine. Most countries in South East Asia are affected to some extent.

Drug users in Asia are highly vulnerable to HIV transmission because of the legal, political, socio-economic, health service and cultural situations in which they live. These situations, however, vary considerably from country to country, and from community to community within the same country. In the 1990s, and in some countries to date, national drug laws prescribe severe punishments for drug-related offences such as injecting drug use, the possession of drugs and drug use paraphernalia, including needles and syringes. The level of penalties and the stringency with which they are applied locally impacts upon the feasibility of HIV preventive interventions for drug users, including providing them with information and

where needed, the means to protect themselves against HIV infection. In some areas it remains difficult to buy needles and syringes, even if readily available, the accessibility of syringes and needles within the actual situation in which drugs are used tend to be low. Often, the police use the possession of needles and syringes as evidence for drug offences. The consequences of these policies are often incarceration of drug users in overcrowded prisons with constrained health services. In prison settings HIV/AIDS risks are increased while the imprisonment itself further stigmatises drug users and complicates re-socialisation.

C. The advocacy strategy of SEAPICT

The analysis of information on HIV/AIDS related to drug use in the region indicated that the epidemic started in a number of countries in drug using populations. In a number of countries, drug users themselves were the main group with HIV infection. Taking the available evidence together, SEAPICT Team concluded in 1997 that HIV/AIDS among drug using populations was an issue of serious concern. There was no reason to believe that the HIV/AIDS epidemic among drug users would plateau or be self-contained. On the contrary, the Team concluded that, based on the available evidence, HIV would continue to spread among drug using populations, and from the drug using community to the general population through sexual transmission. Consequently, the Team decided to address the prevention of HIV/AIDS among drug users as one of its priority areas.

In-house expertise and partnerships

The Team began with consultations with the co-sponsor organisations of UNAIDS on how best to address the issue of HIV/AIDS among drug users. During these consultations it became evident that it would be necessary that one staff member of the Team devote time to issues regarding drug use and HIV/AIDS. Furthermore, it would be necessary to identify partners who could contribute expertise and financial assistance to develop and implement a comprehensive response to HIV/AIDS among drug users.

Potential partners were all those organisations, who had worked in the past on drug or HIV/AIDS issues in the region. These organisations included the Regional Centre for East-Asia [1] (Bangkok) and the Regional Office for South Asia (New Delhi) of the then United Nations International Drug Control Programme (UNDCP) (Note: renamed UNODC) [2], the Regional Office for South East Asia (New Delhi) and the Western Pacific Regional Office (Manila) of the World Health Organisation, the Social Development Division of the Economic and Social Commission for Asia and the Pacific (ESCAP) (Bangkok) and the UNICEF Regional Office for South East Asia (Bangkok). All of these potential partners agreed to contribute to policy and programme development and implementation.

Significant contributions were also made by a number of organisations outside the United Nations system. These included, amongst others, the Asia Harm Reduction Network (AHRN), Melbourne [3], the MacFarlane Burnett Centre, Melbourne, Australia, and the Bangkok office of Family Health International.

Establishing a multi-disciplinary task force

After consultations with co-sponsors and key partners, the SEAPICT Team decided to establish a Regional United Nations Task Force on Drug Use and HIV Vulnerability with a view to accelerating the development and implementation of effective interventions for the prevention of the HIV transmission among drug users. The Task Force on Drug Use and HIV Vulnerability was designed as a forum for identifying priorities and proposing strategies, guidelines and options for collaborative policy and programme action on drug use, harm reduction and HIV vulnerability in the Asia-Pacific region. The work of the Task Force also seeks to accelerate efforts to develop and implement policies and programmes for the prevention of drug use and reduction of HIV vulnerability through practical and multi-country activities.

The purpose of the Task Force was to advise the South East Asia-Pacific Inter-country Team on all matters pertaining to drug use and HIV vulnerability including each of the following tasks.

- Assist in the development of regional, sub-regional and inter-country policies, programmes and projects.
- Assist in developing appropriate work programme activities on drug use and HIV vulnerability.
- Periodically review the implementation of on-going work programme activities.
- Bring new developments related to drug use and HIV vulnerability to the attention of the Team.

The Team appointed the members of the Task Force for a period of 12 months on the basis of their individual expertise relevant to various aspects of drug use and HIV vulnerability and not as representatives of their organisations.

Creating awareness and setting the agenda

During its first meeting, the Task Force identified the paucity of systematic information related to drug use and HIV/AIDS as the main constraint for the development of effective policies, programmes and interventions. However, the members of the Task Force were aware that various organisations had collected information and that the available information had not been collated in a systematic manner. The Task Force, therefore, recommended that the Team commission a rapid desk review and analysis of HIV/AIDS among drug users, using already existing data. In response to that recommendation, the Team commissioned the Asian Harm Reduction Network (AHRN) in August 1997 to carry out a situation assessment into drug use and HIV vulnerability in South East and East Asia. AHRN was requested to prepare a comprehensive report for the Team by November 1997. The Task Force was requested to review the report in December 1997.

The report, which was developed in collaboration with the MacFarlane Burnett Centre, Melbourne, Australia, confirmed that HIV infection among drug users in the region was a major problem. Few, if any, countries had responded effectively. Large gaps were identified in terms of monitoring, documenting, and responding to the problem, suggestive of the low priority status given by governments.

The report indicated that drug use patterns in the region were dynamic. New drugs appeared and new populations were identified as becoming involved in drug use. As a consequence, more people were becoming vulnerable to HIV transmission.

The report quoted the following factors as contributing to the HIV/AIDS epidemic.

- The move from smoking opium to injecting heroin.
- New trafficking routes.
- The involvement of mobile populations such as seafarers and truck drivers.
- Internal migration associated with economic development.
- Civil disruption and continuing armed struggle leading to refugees.

The report called for an urgent and tangible response to the crisis of HIV/AIDS among drug users. That response should be linked to the following activities.

- On-going assessment and documentation of the situation, followed by rapid action.
- Support for existing programmes and the development of new programmes.
- Providing information for countries in the region to develop policies based on evidence.
- Assisting countries in assigning high priority to HIV/AIDS among drug users.

After review of the report, the Task Force strongly recommended its wide dissemination in the region, and the Team requested AHRN provide copies to all governments of the region, the chairpersons of the

United Nations Theme Groups on HIV/AIDS, UNAIDS co-sponsors and country programme advisors, relevant United Nations bodies and entities, and non-governmental organisations. After reviewing the dissemination process of the report, the Task Force recommended that the SEAPICT Team support AHRN in enhancing its capacity for information dissemination through establishing a clearinghouse for information pertaining to drug use and HIV/AIDS in the region.

Despite the compelling evidence provided by the situation assessment, no immediate action for the prevention of HIV/AIDS among drug users followed in countries of the region. Although governments began to acknowledge the problem of HIV/AIDS among drug users, providing information alone was not sufficient for developing new policies and programmes. Other factors interfered with developing an effective response. By the middle of 1998, the Task Force identified these factors as reflecting a lack of technical capacity to develop and implement an appropriate response. Further, it was felt that factors which might otherwise be inherent in traditional drug policies could not then be specified, as the impact of drug policies on HIV/AIDS preventions had not yet been examined systematically.

The Task Force, therefore, recommended that SEAPICT:

- organise capacity building workshops for officials of drug control and public health agencies;
- commission a study to identify potential policy barriers for effective prevention of HIV transmission among drug users;
- develop guiding principles for policy and programme development for the prevention of HIV transmission among drug users; and,
- organise a meeting for senior officials of both drug control and public agencies to review and adopt these principles.

Furthermore, the Task Force recommended that the Team undertake every effort to increase the technical capacity of those working with drug use and HIV/AIDS and to use every opportunity for advocacy with a view to developing more appropriate policies and programmes for the prevention of HIV/AIDS among drug users in the region.

The Task Force therefore recommended that:

- UNAIDS consider creating regular posts at both headquarters and the regional level for dealing with the twin issues of drug use and HIV vulnerability; and,
- the SEAPICT Team solicit funding for participation of drug control and public health officials at international conferences addressing HIV/AIDS among drug users.

In response to the recommendations of the Task Force, the Team ascertained initial funding for the implementation of the recommendations. Financial resources available from the World Bank were used to support AHRN in establishing the clearinghouse and to support the participation of drug control officials at international conferences and to commission a policy research study on drug use and HIV vulnerability. Several institutions, including the Government of Australia, ESCAP, UNODC, UNICEF and WHO, supported the organisation of regional capacity building workshops. The Team initiated steps toward the creation of a fix-term post for a regional advisor on drug use and HIV vulnerability, based in the SEAPICT office in Bangkok. The Task Force is now convened by the Regional Office of UNODC in close collaboration with SEAPICT.

The clearinghouse at AHRN

The rationale of the clearinghouse was to increase access to information about on-going activities and research findings in the region for the rapid development and implementation of policies and programmes for the prevention of the transmission of HIV among drug users. By using various channels of information dissemination, the clearinghouse assisted in strengthening the capacity of all those involved in programme planning and implementation at all levels. It could also enhance information sharing, training

and networking with individuals and organisations in and outside the region. The goal was to establish a repository of advocacy tools and to catalyse and foster the exchange of experience and expertise.

Information was to be made available through web pages, regular newsletters, special documentation, reports and publications. Emphasis was to be given to material developed in the Asia-Pacific region. Key material would be translated into the main local languages. The clearinghouse should also provide information on upcoming events, conferences, meetings, workshops and training courses and scholarship programmes in the field of prevention of HIV/AIDS among drug users. It would collect best practice examples and respond to queries of persons and institutions working with drug users.

Concrete work to create the clearinghouse began by the end of 1998. The clearinghouse was established at the secretariat of the Asian Harm Reduction Network in Chiangmai, Thailand by mid-1999 and it became fully operational in November 1999. Collaborating partners of the clearinghouse include the UNAIDS South East Asian Information Support Service, Bangkok; Chiangmai University, Thailand; the Centre for Harm Reduction, Melbourne, Australia; Foundation du Present, Geneva, Switzerland, the International Harm Reduction Association, Rome and Amsterdam; Forum, New Delhi; NAZANET, Jakarta. Other partners collaborating with AHRN in this activity include the Australian Government; the Royal Dutch Government; the Government of Thailand; UNAIDS, UNODC, UNDP, WHO; the Macfarlane Burnet Centre for Medical Research; the Drug Policy Alliance; and the Lindesmith Centre.

Participation in international conference as an advocacy tool

In October 1998, the Team began consultations with the UNAIDS co-sponsors and key partners on the selection of key persons from drug control agencies to participate in international conferences on HIV/AIDS among drug users. The purpose of the participation was to increase the awareness of drug control organisations on matters pertaining to HIV/AIDS among drug users.

After a consultative process, the Team was able to select officials of the China National Narcotics Control Commission, the Thailand Office of Narcotics Control Board, and the Malaysia National Narcotics Agency, to participate in the 10th International Conference on the Reduction of Drug Related Harm, Geneva, Switzerland, in March 1999. Following the Conference, there was broad agreement amongst the participants that rapid action needed to be implemented for the prevention of HIV/AIDS in their respective countries however, there was considerable controversy as how best to intervene. Of particular concern were the appropriateness of methods such as substitution treatment, needle and syringe programmes, and safe injecting rooms. The participants were of the view that their institutions would first need to explore the legal ramifications of specific interventions.

Similarly, a number of officials from drug control agencies in China, Bangladesh, India, Indonesia, Malaysia, Pakistan, Thailand and Viet Nam participated in the 5th International Congress on AIDS in Asia and the Pacific, Kuala Lumpur, in October 1999. At the Congress the participants had the opportunity to discuss issues of HIV/AIDS among drug users with colleagues from other countries in the region and with officials from public health agencies as well as non-governmental organisations.

Regional advisor on drug use and HIV vulnerability

The Team explored the possibility of establishing a regular post for drug use in Bangkok in the second half of 1998. A post was created and filled by January 2000.

Inter-country technical workshops

As recommended by the Task Force, SEAPICT organised jointly with the Regional Centre for East Asia and the Pacific and the Regional Office for South Asia of UNODC, ESCAP and the Substance Abuse Department of WHO two technical workshops for senior personnel of drug control and public health agencies dealing with HIV/AIDS in countries of South East Asia (Cambodia, China, Indonesia, Malaysia, Myanmar, Thailand and Viet Nam) and South Asia (Bangladesh, India, the Maldives, Nepal and

Sri Lanka). The workshops were convened in May 1999 in Bangkok and in June 1999 in New Delhi, respectively. In addition, AHRN organised a similar workshop for officials from China and Viet Nam in Nanning, Guangxi, China, in June 1999 and a national drug policy workshop in Thailand in October 1999.

The purpose of the workshops was to update knowledge and skills on reducing the risk for transmission of HIV among injecting drug users and to facilitate the establishment of working relations between drug control and public health agencies of countries in the region. The participants of the workshops concluded that urgent action was needed to prevent the rapid spread of HIV among drug users and from drug users to the general population however, to launch such activities, it was considered necessary to re-examine national drug policies.

Developing policies

Policy research report

In the second half of 1998 the SEAPICT Team began working on a policy research study, which was carried out from March to May 1999 in seven countries (China, India, Malaysia, Myanmar, Nepal, Thailand and Viet Nam) and published in October 2000.

The main purpose of the study was to establish a basis for effective assistance to governments in the development and implementation of policies and programmes for the prevention of the transmission of HIV among drug users. The study was designed as an exploration of national and regional factors, which facilitate or hinder efforts to reduce HIV/AIDS vulnerability among drug users.

The main findings of the study included the following.

- High-risk behaviour is commonplace among drug users in all the study-countries and there is a trend of multiple drug use.
- In general, drug policies in the study-countries are not supportive of effective HIV prevention among drug users and complicate interventions. With the exception of law enforcement, drug problems are not generally accorded high funding priority.
- There is inadequate dialogue between drug control and HIV/AIDS control agencies in the seven study-countries. Consequently there are few programmes in the region, which directly address problems presented by the interface between drug use and HIV/AIDS. Measures to prevent the spread of HIV/AIDS among drug users and their sexual partners are often localised, short term, under-funded, and insufficient in scope.
- Adherence to traditional values is strong in many of the study-countries making debate on HIV/AIDS prevention and sexual behaviour sensitive.
- Drug treatment almost invariably focuses on detoxification treatment. Drug users have no choice of treatment, which is mostly compulsory, residential and long term. Most treatments include a strong penal element. Drug treatment personnel are often non-specialists in the drug field, and derived from the public security or non-governmental sectors. The need for training was observed in all the study-countries.
- In many of the study-countries minor modifications to the drug control legislation are necessary in order to implement more effective HIV/AIDS prevention among drug users. In all study-countries there were many opportunities for the development of interventions to enhance the efficacy of HIV/AIDS prevention. This assertion is based on the following observations.
    - The need for adequate responses to the HIV/AIDS epidemic is acknowledged and understood in all study-countries.
    - The legal impediments enshrined in drug control legislation were generally not serious and may require minor modification to regulations.

- UNAIDS Theme Groups in some of the study-countries are in a position to coordinate and facilitate consensus building and collaboration between stakeholders.

The Task Force reviewed the draft report in April 2000 and recommended its wide dissemination. The report was finalised and widely circulated in the region. The main results of the study were presented at various regional and international conferences and meetings.

Regional advocacy workshop

While the main purpose of the Inter-country Technical Workshops was to upgrade knowledge and skills related to HIV/AIDS among drug users, the purpose of the Regional Advocacy Workshop on the Prevention of Drug Use and HIV/AIDS in Asia and the Pacific in October 2000 was to assist in policy formulation. The Task Force, SEAPICT and the UNODC Regional Centre for East Asia and the Pacific jointly organised the workshop in collaboration with ESCAP and the Office of the Narcotics Control Board, Thailand. Senior drug control officials, HIV/AIDS and drug treatment professionals from China, Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Thailand and Viet Nam participated.

The Workshop aimed at facilitating policy dialogue at the highest level among various agencies from the countries of the region. Issues focussed on the prevention of HIV and other adverse consequences of drug use and drug injecting, and enhancing interaction and exchange of experiences among drug control, public health and drug treatment agencies.

The participants of the Workshop reviewed and adopted a note prepared by the secretariat, which contained the principles and strategic approach of the position paper of the United Nations system entitled “Preventing the transmission of HIV among drug abusers”, adopted at the meeting of the Subcommittee on Drug Control of the United Nations Administrative Committee for Coordination Vienna, 28-29 September 2000. The significance of the adoption of the principles lies in the fact that previously controversial approaches, such as needle and syringe programmes and needle cleaning and substitution treatment, should be implemented as part of a comprehensive package. Through the adoption of the position paper, the United Nations system sent a strong signal to governments that methods for the prevention of HIV/AIDS among drug users do not contradict the spirit of these conventions. The governments represented at the Workshop fully endorsed that position.

Both the governments represented at the Workshop and the United Nations system made it very clear through the adoption of the principles that discrimination against those living with HIV/AIDS and drug users should not be tolerated. To make interventions effective discriminatory behaviour needs to be overcome. The principles make clear that punitive approaches may drive people underground who are in need of prevention and care services. It is considered therefore that a concerted effort to respond consistent with the principles could dramatically change prevention and treatment policies of many countries in the region.

D. Conclusions

When the South East Asia-Pacific Inter-country Team began to address the issue of HIV/AIDS among drug users, HIV/AIDS was absent from the agenda of most drug control agencies of the countries in the region. Public health and HIV/AIDS agencies faced significant barriers to implement interventions for drug users given most drug use issues were in the purview of drug control agencies. Communication between drug control agencies and public health agencies was virtually non-existent. There were only a few non-governmental and community-based organisations addressing the issue of HIV/AIDS among drug users with small-scale interventions, often on the brink of illegality. Bodies and entities of the United Nations sent mixed and often contradictory messages to governments on how to proceed with interventions for the prevention of HIV/AIDS among drug users.

Specific information on HIV/AIDS among drug users was scant and not readily available. Little information was existent on the extent of the epidemic among drug users as well as on policies related to

HIV/AIDS among drug users. Both drug control and public health agencies had limited technical capacities with which to develop and implement policies, programmes and interventions for the prevention of HIV transmission among drug users.

This picture has slowly changed over the past three years. In some countries such as Myanmar and Nepal, HIV/AIDS among drug users has become an important area in drug control agencies. Co-ordination mechanisms between public health and drug control agencies have been established through their participation in expanded UN Theme Groups. Otherwise, work is underway to establish national task forces, which will provide opportunities for dialogue between the drug control and public health sectors.

Regional partnerships are also slowly developing. HIV/AIDS is included in the ACCORD Plan of Action adopted by ASEAN the International Congress "*In pursuit of a drug free ASEAN 2015: sharing the vision, leading the change*". ASEAN established a Task Force on AIDS and endorsed a Work Programme on HIV/AIDS in November 2001, which identifies drug users as a priority for intervention. The know-how on the development and implementation of appropriate interventions has increased significantly in relevant government agencies. Various manuals and training modules on programme development and implementation are now readily available. Information dissemination mechanisms are working effectively. UNODC is meanwhile a co-sponsor of UNAIDS. The United Nations has come up with a system-wide position paper, clarifying what should and could be done in the framework of existing conventions and international legal agreements for the prevention of HIV/AIDS among drug users.

Although the basic framework for interventions in the region was developed and agreed upon, large-scale interventions with a high degree of coverage are still lacking in most of the countries. In 1997 the reasons for this were several including, policy and legal barriers, lack of information and technical skills among policy makers and national programme developers. Although today these reasons have diminished it nevertheless remains the case that countries of the region have little experience in developing and implementing concrete interventions. Therefore, there is generally a preference to start on small-scale pilot bases and extend coverage in a stepwise approach. Countries continue to require technical assistance, particularly in training of field-level workers and concrete programme development. Assistance is required in the planning of concrete interventions. Countries also lack financial resources to develop and implement large-scale programmes. It is also useful to note the importance of continuing to strengthen the non-governmental sector's interest and capacity to address HIV/AIDS among drug users.

E. Lessons learned

An important lesson learned from the activities relates to the importance of establishing a broad network of partnerships between all relevant agencies, even those with contradictory political mandates. Creating such a network of partnerships is not an easy task as many agencies and persons seek to pursue agenda, which may not necessarily be conducive to achieving a common overall goal.

For both governments and the United Nations system, it is important that technical capacities are enhanced. Effective advocacy cannot be undertaken, if human resources are insufficient. In many drug control agencies there was no responsible staff available to deal with HIV/AIDS issues, and in many public health agencies, no staff dealt specifically with matters pertaining to drug use. It was also important to strengthen the capacity of the SEAPICT Team itself. Most significantly, this was realised by employing a full-time regional advisor on drug use and HIV vulnerability and through the establishment and maintenance of a multi-disciplinary task force.

The advocacy agenda followed the paradigm of creating awareness, setting the agenda, enhancing technical capacities and developing policies. The development and implementation of large-scale interventions was added as the last step in this paradigm. In order to create awareness, information on the extent of the epidemic needed to be readily available. The Team quickly learned that such information was not sufficient for effective advocacy. Information on policies and how policies are developed is equally important. In the advocacy process it was also important to obtain the right information in the right format for the right people, meaning that effective dissemination mechanisms

needed to be established. Too often information is incorrectly targetted. In this regard the Asian Harm Reduction Network played a crucial role by enhancing its dissemination capacities in a sensitive way.

The advocacy efforts of the team received a significant boost with the arrival of a full time technical advisor for drug use. Success of advocacy found its roots in strategic networking with key organisations and players. It may best be judged on whether the region is prepared to embrace harm reduction for drug users including the commitment by governments in terms of how they prioritise their budgets in order to scale up interventions.

Is the agenda for advocacy of the SEAPICT Team applicable for other institutions at the national, regional and global levels? The experience indicates that in a number of countries institutions have begun advocacy work using a similar paradigm focusing particularly on communication between public health and public security agencies. Examples include Myanmar, Nepal and Pakistan. Moreover, international non-governmental organisations such as the International Harm Reduction Association increasingly have begun a dialogue with drug control agencies, for example in a recent visit in Myanmar and in discussions with the Thailand Office of the Narcotics Control Board on the preparation of the 14th International Conference on Drug Related Harm, to be held in Thailand in April 2003.

F. Notes

1 Today called Regional Centre for East Asia and the Pacific

2 UNDCP became co-sponsor of UNAIDS in April 1999. However at the time of publishing this report it had formerly charged its name to the United Nations Office on Drugs and Crime (UNODC). All references to the organisation throughout this volume are noted as UNODC.

3 AHRN was established in March 1996 in Hobart, Australia, and moved in 1998 to Chiangmai, Thailand.

Glossary

ACA	Advisory Council on AIDS-Hong Kong
ACAN	Action Committee Against Narcotics-Hong Kong
AHRN	Asian Harm Reduction Network
AMS	Auxiliary Medical Services-Hong Kong
BMA	Bangkok Metropolitan Administration
CARE	CARE International
CRDA	Call Registry of Drug Abuse-Hong Kong
DATC	Drug Addiction Treatment Centre
DFID	United Kingdom's Department for International Development
DOH	DOH-International
DOT	Direct Observed Treatment
EC	European Commission
ESCAP	Economic and Social Commission of Asia and the Pacific
FHI	Family Health International
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HK$	Hong Kong dollar
ILO-IPEC	International Labour Organisation-International Programme on the Elimination of Child Labour
MTP	Methadone Treatment Programme
NA	Narcotics Anonymous
SASO-AIDS	Social Awareness Service Organisation
SARDA	Society for the Aid and Rehabilitation of Drug Abusers-Hong Kong
SEAPICT	UNAIDS South East Asia and Pacific Inter-country Team
SKC	Shek Kwu Chau Rehabilitation Facility and Clinic
STD	Sexually Transmitted Disease
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Economic, Social and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNODC	United Nations Office on Drugs and Crime (formerly the United Nations International Drug Control Programme)
US	United States
USAID	United States International Aid Program
US$	United States dollar
WHO	World Health Organisation

Joint United Nations Programme on HIV/AIDS

UNAIDS

UNICEF • UNDP • UNFPA • UNDCP
ILO • UNESCO • WHO • WORLD BANK

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