# Community Action on Harm Reduction (CAHR)

# Impact Brief

**Key changes made in the lives of people who use drugs in China, Kenya, India, Indonesia and Malaysia**

# January 2016

## 1. Introduction

Community Action on Harm Reduction (CAHR) is an ambitious programme implemented between 2011 and 2015 with the objective of expanding coverage of HIV prevention, treatment and care, sexual and reproductive health and other services to more than 230,000 people who inject drugs (PWID), their partners and children in five countries – China, India, Indonesia, Kenya and Malaysia – and, since 2015, with the addition of Myanmar, through funding from the Social Department/Health and AIDS Division of the Ministry of Foreign Affairs of the Government of The Netherlands. Due to specific higher-risk behaviours, PWID are at increased risk of HIV irrespective of the epidemic type or local context; they often have legal and social issues related to their behaviours that increase their vulnerability to HIV.

The programme is implemented through a consortium of Alliance Linking Organisations (LOs): AIDS Care China[1], India HIV/AIDS Alliance (Alliance India)[2], Rumah Cemara[3] in Indonesia, the Kenya AIDS NGO Consortium (KANCO)[4], the Malaysian AIDS Council (MAC)[5], and Alliance Myanmar[6], in collaboration with four international policy partners: the International HIV/AIDS Alliance[7], Harm Reduction International (HRI)[8], the International Drug Policy Consortium (IDPC)[9] and the International Network of People who Use Drugs (INPUD)[10]; several other agencies also provide specialised technical assistance in various areas.

This briefing document highlights the impact on the lives of PWID and their family members of the CAHR programme as well as the continued support needed by PWID to fully realise their right to quality health services that are evidence-based and free from stigma and discrimination.

## 2. Summary of Key Findings

***A comprehensive response using evidence-based good practices***

The CAHR programme has been instrumental in advancing the right to health for PWID in all six countries. Specifically, CAHR has supported implementation of the comprehensive package of services recommended by WHO, UNODC and UNAIDS for HIV prevention, treatment and care among PWID[11]. Such support has included technical and material assistance to needle/syringe programmes (NSP), opioid substitution therapy (OST), HIV testing and counselling (HTC), prevention and treatment of sexually transmitted infections (STIs), condom programmes, targeted information, education and communication (IEC), and the prevention, diagnosis and treatment of tuberculosis (TB).

The programme has implemented such work through building close relations with key linking organisations (LO) of the Alliance in each country as well as with other key international organisations. Each Alliance LO has, in turn, supported communities of PWID and their family members to become more aware of their rights to health, social and economic wellbeing and has provided them with a range of tools to enable them to advocate for themselves as well as to access services made available through CAHR support to health systems in each implementation site of each country in which CAHR has been operational.

## *Safer injecting behaviours by PWID leading to better health*

One of the most important behaviour changes sought by the CAHR programme was a reduction in the use of needles/syringes that had already been used by other PWID as the use of contaminated injecting equipment is one of the most effective methods of transmitting HIV as well as other communicable diseases, including hepatitis C (HCV). As a result of the provision of consumables (sterile injecting equipment in particular) and IEC materials, by CAHR implementers, there was an average increase of 8.6 percentage points in the number of PWID using a clean, i.e. sterile, needle/syringe the last time they injected, rising from 81.5% to 90.1% over the duration of the programme, with support to the fledgling national efforts to introduce a NSP in Kenya of particular note. The impact of this achievement should not be underestimated. Potentially, many thousands of PWID will have been protected from the transmission of HIV by being able to regularly access sterile needles/syringes. This is one of the most fundamental steps in reducing drug injecting harm.

*Outreach work in Malaysia. © Slava Kushakov*

## *Increased access to harm reduction supplies and services*

A further key achievement of the overall programme has been the reported fall in the use of 'used' needles/syringes during the last 30 days from an average of 21.7% at the start of CAHR implementation to an average of 10.3% by 2015. Reduction in the use of preloaded syringes during the past 30 days has also been achieved across five countries, with a particularly notable drop in India from 53.6% to just 4%, and with a major drop also seen in Kenya. In this way, CAHR has supported the ability of PWID to protect themselves from HIV and thereby to be better able to lead healthier and more productive lives as active members of the broader community, as well as contributing to the social and economic well-being of their family unit.

Across the CAHR implementation sites, there has been an increase in the availability of, and access to, harm reduction supplies and services by PWID and access to sexual and reproductive health and rights (SRHR) services for female PWID, and especially for female spouse of PWID in some countries, such as some programme implementation sites in India. This has further strengthened the holistic approach to HIV prevention for the family of PWID and for the broader community.

## *Increase in number of PWID protected from HIV & other communicable diseases*

HIV transmission and prevention knowledge has remained relatively high in the CAHR programme overall among PWID at around 95%. Importantly, there has been a rise from an average of 71% to 78% in the number of PWID accessing HIV voluntary counselling and testing (VCT). HIV positivity as self-reported by PWID fell overall to 27%

from 20%, with notable reductions in HIV prevalence seen at CAHR implementation sites in India (falling to 6% from 21%) and in Kenya (falling to 21% from 29%). Registration with antiretroviral therapy (ART) increased over the whole programme by an average of 31 percentage points, with a high of 83% of PWID living with HIV (LHIV) in China being registered for ART and a low of 31% in Malaysia (but up from 7%). However, registration for ART does not mean that those PWID are actually receiving ART and such ART access has not been reported by the CAHR programme to-date. Consequently, there has been an increase in the number of PWID protecting themselves from HIV and other communicable diseases through improved safe injecting behaviours.

***Consistent condom use has been a challenge across all sites***

Consistent condom use by PWID has, however, been challenging with decreasing use seen across the board, falling by an overall average of 5.9 percentage points to to 42.4% overall. The focus of the project on the promotion of NSP and access to VCT may have resulted in less than adequate attention being given to the prevention of HIV and other STIs through unsafe sexual practices in many of the CAHR programme sites.

***Incarceration & compulsory drug treatment remain a major issue***

The percentage of PWID arrested in the past 12 months has decreased, with the exception of the CAHR implementation sites in China. The greatest reduction in arrests has been seen in the CAHR implementation sites in India, down 17 percentage points to 34% at end-of-project; a similar pattern is seen in Malaysia with arrests down 14 percentage points.

*Outreach work among fishermen in Malaysia.*
*© Slava Kushakov*

The reasons for such reductions may be due to improved understanding by local law enforcement personnel of harm reduction through their exposure to the CAHR project and its staff, as well as the potential improvement in the knowledge of PWID as to their rights following training initiatives of the project. PWID forced to enter a compulsory drug treatment centre in the previous 12 months has also declined, with a marked decrease in India of nearly 65 percentage points to 8% of PWID experiencing such rights violations.

***Holistic approach to PWID, their family & their community is reducing stigma & discrimination***

Support to the family and community of PWID has increased, resulting in a more holistic approach to the health of PWID with China, India and Kenya reporting increased community support in particular. This appears to be helping to improve

retention in, and adherence to, health interventions by PWID, such as TB.

***Economic well-being is a primary need of most PWID***

Services in most demand by PWID across all CAHR implementation sites appears to be focused on economic well-being, specifically income generating activities and support to develop skills to gain, and retain, paid employment; this is especially the case in China, Indonesia and Kenya.


**Map 1 Countries where the CAHR project has been implemented through the Alliance, 2011-2015** (http://www.cahrproject.org/where-we-work/, accessed 8 February 2016)

## 3. Methodology

An analysis was undertaken of key data obtained through baseline[12] and end-of-project studies[13] from the implementing organisations, and their research partners, as well as ongoing programme data from 2015.

The studies involved both quantitative and qualitative data collection and analysis gathered through interviews from the target group using structured/semi-structured questionnaires. Baseline and end of project studies have not yet been conducted in Myanmar and, consequently, data from Myanmar has not been analysed.

## 4. Key findings on changes in the life of PWID

### 4.1 Drug use and risky injecting behaviour

Drug use becomes particularly high-risk for the transmission of HIV and other communicable diseases, such as hepatitis C, when drugs are injected frequently and injecting equipment is shared with other PWID. Although the number of PWID injecting up to three times per day has increased overall among users of CAHR services in the five countries, the most important factor is the use of safe injecting practices every time drugs are injected.

'Risky injecting practices' are primarily those in which 'used' needles and/or syringes are reused by a different person, thereby increasing the opportunity for HIV, and other communicable diseases, to be transmitted from one person to another. As shown in Figure 1, there was an average increase of 8.6 percentage points in the number of PWID using a clean, i.e. sterile, needle/syringe the last time that they injected, rising from 81.5% at baseline to 90.1% at end-of-project. As the fundamental basis of HIV prevention among PWID, this accomplishment should not be underestimated.

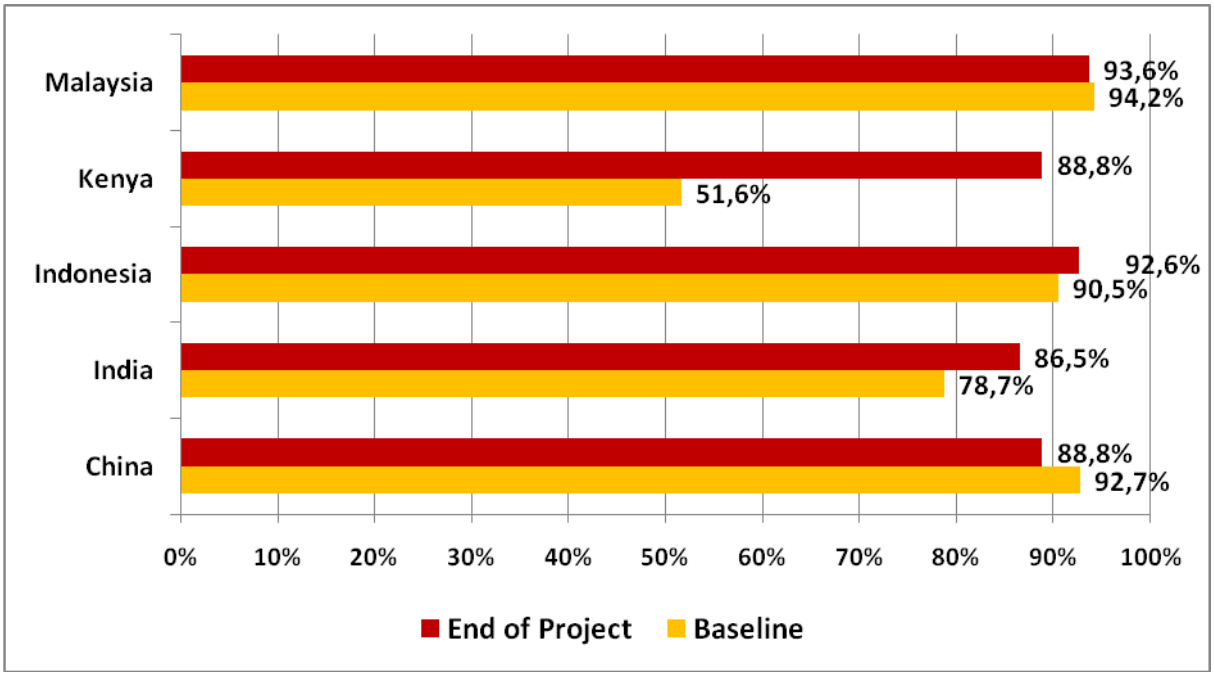


**Figure 1 Percentage of respondents by country who injected with a clean needle the last time**

The most significant achievement of the CAHR project is its support to the fledgling needle/syringe programme (NSP) in Kenya, with an increase of 37.2 percentage points (from 51.6% to 88.8%) in PWID using sterile needles/syringes. This also indicates in a practical way the high level of knowledge among PWID of the dangers associated with sharing injecting equipment.

Sterile needle/syringe use during the last 30 days, as seen in Figure 2, shows that reported use of a 'used' needle/syringe during the last 30 days has dropped by more than half overall from 21.7% to an average of 10.3%. Most significant of all has been the progress made in Kenya, with a massive reduction of 89.3 percentage points in 'used' needle/syringe use in the past 30 days. Major progress has also been seen in the CAHR implementation sites in India with a reduction of 17.2 percentage points since baseline. This reduction in the use of potentially contaminated injecting equipment will

protect such PWID from HIV and other communicable diseases and thereby reduce the healthcare costs incurred whenever a person requires antiretroviral (ARV) drugs to treat HIV, for example. Consequently, such HIV protective measures as NSP is saving the health system in each country a considerable amount of money as well as contributing to individual, family and community well-being and potential for socio-economic development. However, further efforts are needed at CAHR sites in Indonesia in which earlier education efforts with new PWID are needed before such injecting risk behaviours take on a natural course.

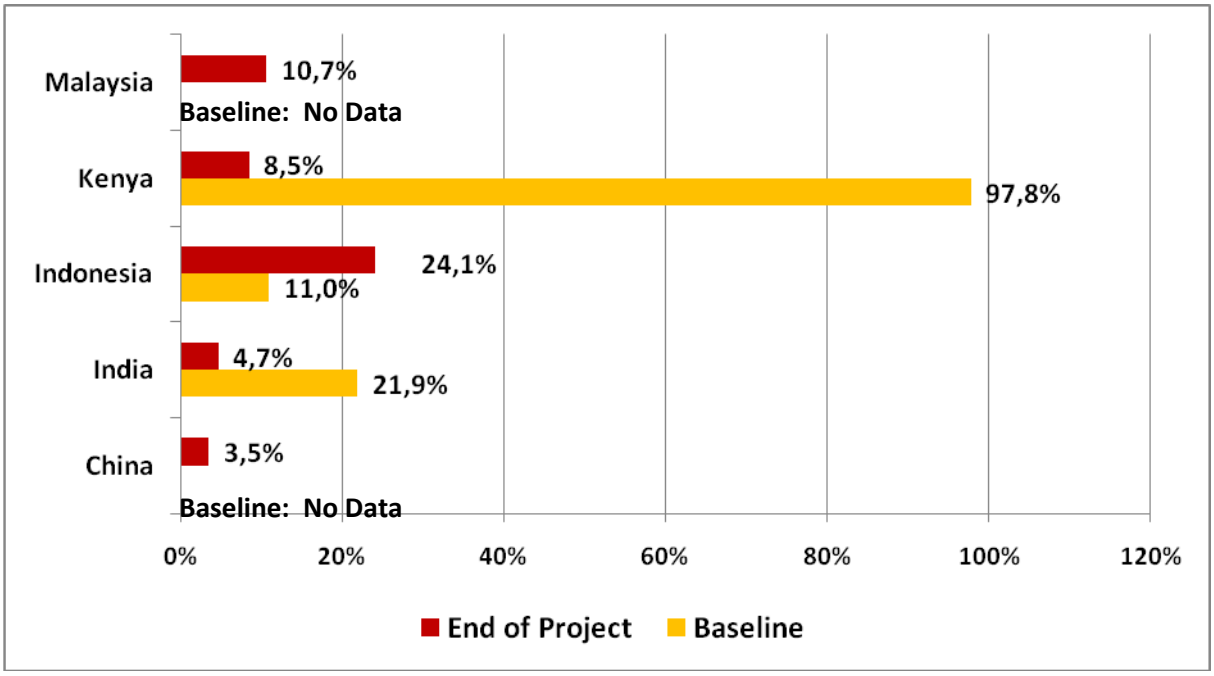


**Figure 2 Percentage of respondents by country who injected with a 'used' needle/syringe in the last 30 days**

Progress was also made in reducing the use of preloaded syringes during the past 30 days. Although the overall rate at all CAHR implementation sites improved by an average of only 15 percentage points, the rate dropped from 53.6% to just 4% in India and a major drop in Kenya was also seen, falling from 25.3% to 6%. Further efforts to reduce such risky injecting behaviours are needed in Indonesia and China in particular, with future CAHR implementation in Myanmar being part of the approach to cross-border injecting behaviours with PWID in China.

### 4.2 Substances preferred in different countries

Across all five CAHR implementation countries, heroin is by far the most frequently used, and injected, illegal drug. Only in India is heroin second in preference to pharmaceuticals and sedatives, including benzodiazepines. Over the period of CAHR project implementation, there has been no significant change in the use of heroin at between 95%-100% of all survey respondents at baseline and end-of-project in China, Indonesia and Kenya. In Malaysia, there has been a reduction in heroin use from 98.1% to 87.9% and in India, heroin use has dropped considerably from 38.8% to 10%.

### 4.3 Police and law

The percentage of PWID arrested in the past 12 months has decreased, with the exception of the CAHR implementation sites in China, although not substantially so with the average reduction in

arrests at only 1 percentage point (from an average of 42% at baseline). The greatest reduction in arrests has been seen in the CAHR implementation sites in India, down from 51% to 34%; a similar pattern is seen in Malaysia with arrests down to 14%. More limited reductions in arrests have been seen in Kenya (down to 7%) and Indonesia (down to 3%), respectively. The reasons for such reductions may be due to improved understanding by local law enforcement personnel of harm reduction through their exposure to the CAHR project and its staff, as well as the potential improvement in the knowledge of PWID as to their rights and their increased capacity to negotiate with authorities following training and awareness initiatives of the project.

However, CAHR implementation sites in China have seen an increase from 14% to 50% at end-of-project with such arrest levels now similar to those of many other countries. The operational environment in China is very sensitive to changes at the local level that may be misunderstood by central government authorities and, as a result, a more cautious approach is taken. The role of the CAHR project in supporting access to, and retention in, methadone maintenance therapy (MMT) may, over time, help to alleviate detention of PWID through providing a treatment alternative to local law enforcement.

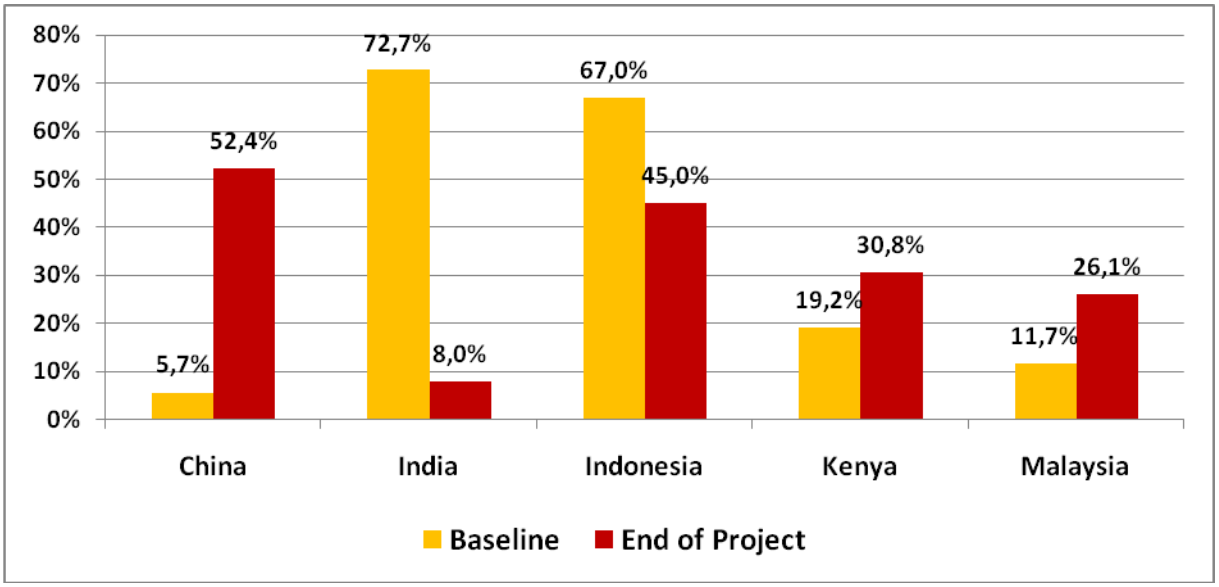


**Figure 3 Percentage of respondents by country who experienced compulsory drug treatment in the past 12 months**

The situation for PWID forced to enter a compulsory drug treatment centre in the previous 12 months has seen some significant improvements, as shown in Figure 3. CAHR implementation sites in India have seen a marked decrease of nearly 65 percentage points in such forced drug treatment, down from 72.7% to 8% at end-of-project. Efforts in China, however, are ongoing to try to stop the increase in such approaches as the rate has risen to 52.4% of PWID respondents from a relatively low number of 5.7% at baseline. Reasons for such variations in progress may inherently be a result of alternative options being made available to local law enforcement personnel, as well as central government edicts for the incarceration of PWID in such compulsory drug treatment centres; CAHR is helping authorities to find evidence-based alternatives for many PWID.

### 4.4 Sexual behaviour

Supporting PWID in reducing the sexual transmission of HIV and other diseases has been challenging. Overall, condom use the last time a PWID had sexual intercourse with any type of partner has fallen by 5.9 percentage points over the course of CAHR project implementation, from an average over the five countries of 48.3% to 42.4% at end-of-project. Condom use by PWID with commercial sex workers in India has shown a marked increase, rising from 52% to 90% at end-of-project, and in Kenya a more modest increase has been seen, rising from 73% to 83%. However, PWID condom use with commercial sex partners has declined the most, down 15 percentage points over the five countries, with casual partners it has fallen by an average of 1.1 percentage points, and is down 1.6 percentage points with permanent partners/spouse.

Assessments undertaken at the various CAHR implementation sites across the five countries suggests that the focus of the project on the promotion of NSP and access to HIV testing and counselling has resulted in less than adequate attention being given to the prevention of HIV and other STIs through unsafe sexual practices. Consequently, the promotion of sexual and reproductive health needs to be one of the main focuses of ongoing harm reduction support and could include, for example, the creation of issue-specific IEC materials, conducting regular knowledge drives, and providing job-aids to the outreach staff on SRHR issues.


*Rapid assessment in new sites in Kenya. © Maryna Braga*

### 4.5 Knowledge on HIV and safe injecting

The levels of knowledge as to how HIV is transmitted, and how to prevent it, has remained relatively high among PWID across all five countries during implementation of the CAHR project, at around 95%. In most cases, correct responses to HIV knowledge questions have increased but only marginally. This has occurred even though many PWID are new to the CAHR project in each country, thereby demonstrating the ability of the CAHR implementing partners to maintain a high level of HIV awareness among PWID participants. There remains a significant gap between high levels of HIV knowledge by PWID in general and practical HIV prevention activities, especially concerning the sexual transmission of HIV. Safe injecting practices have improved in all CAHR implementation sites overall with Kenya showing outstanding improvement as part of the CAHR support to the NSP.

### 4.6 HIV testing

On average, there has been an increase of 7 percentage points in the number of PWID accessing HIV voluntary counselling and testing (VCT) over the five countries implementing the CAHR project, rising from an average of 71% to 78% by end-of-project and with a median increase of 6 percentage points (rising from a median of 83% to a median of 89%). Using the average of PWID access to VCT and the end-of-project survey sample size of 1,597 PWID, this equates to 1,248 PWID who accessed VCT over

the duration of CAHR implementation in the five countries. However, further efforts to promote VCT access by PWID are crucial in supporting the realisation of the global goal of '90-90-90' by 2020.

HIV positivity as self-reported by PWID fell by an average of 7 percentage points (to 27%), and a median of 5 percentage points (to 21%), over all CAHR implementation sites. However, this hides some major differences with HIV-positivity dropping by 15 percentage points in India (to 6%) and 8 percentage points in Kenya (to 21%) but rising by 1 percentage points in Malaysia (to 23%). No change was found at CAHR implementation sites in Indonesia (at 65%) and, although no baseline data was available for China, the end-of-project rate for CAHR implementation sites was 20%. Using the end-of-project CAHR reports, and assuming that 29% of PWID who accessed VCT were diagnosed with HIV during the implementation of the CAHR project in the five countries, this equates to 290 PWID living with HIV (PWID-LHIV).

Registration for ART increased by an average of 31 percentage points over the course of the CAHR project in the five countries, from 29% to 54%. Each country saw an increase in the number of PWID registering for ART in their respective CAHR implementation sites: 83% in China (although no baseline is available); 54% in Kenya (up from 6% at baseline); 34% in India (up from 27% at baseline); 84% in Indonesia (up from 74%); and 31% in Malaysia (up from 7%). However, it is important to note that registering for ART does not mean that such PWID-LHIV are actually receiving ART itself. No data is yet available from CAHR project sites as to the number of PWID-LHIV who actually received ART, nor the percentage of those who were retained on ART at 6 and 12 months. Consequently, no data is available as to the number of PWID whose viral load was suppressed as a result of taking ART.

To estimate the HIV test, treat and retain (TTR) cascade for CAHR implementation sites in four of the five countries (excluding China, for which no complete baseline data is available), average baseline and end-of-project data have been used as shown in Table 1.

| **HIV TTR Cascade Step** | **Baseline (2011)** | | **End of Project (2015)** | |
|---|---|---|---|---|
| Number of PWID | 100% | 765 | 100% | 1,284 |
| PWID accessing VCT | 68% | 522 PWID | 78% | 1,001 PWID |
| PWID self reported as HIV-positive | 34% | 177 PWID | 29% | 290 PWID |
| PWID registered for ART | 29% | 50 PWID | 54% | 157 PWID |

**Table 1 Comparison of PWID HIV test and treatment registration data at baseline and end-of-project for CAHR sites in India, Indonesia, Kenya and Malaysia combined**

Whilst the full PWID HIV test, treat and retain cascade cannot be drawn based on the available data, it is possible to provide an indicative PWID HIV test and treatment registration cascade, as shown in Figure 4.

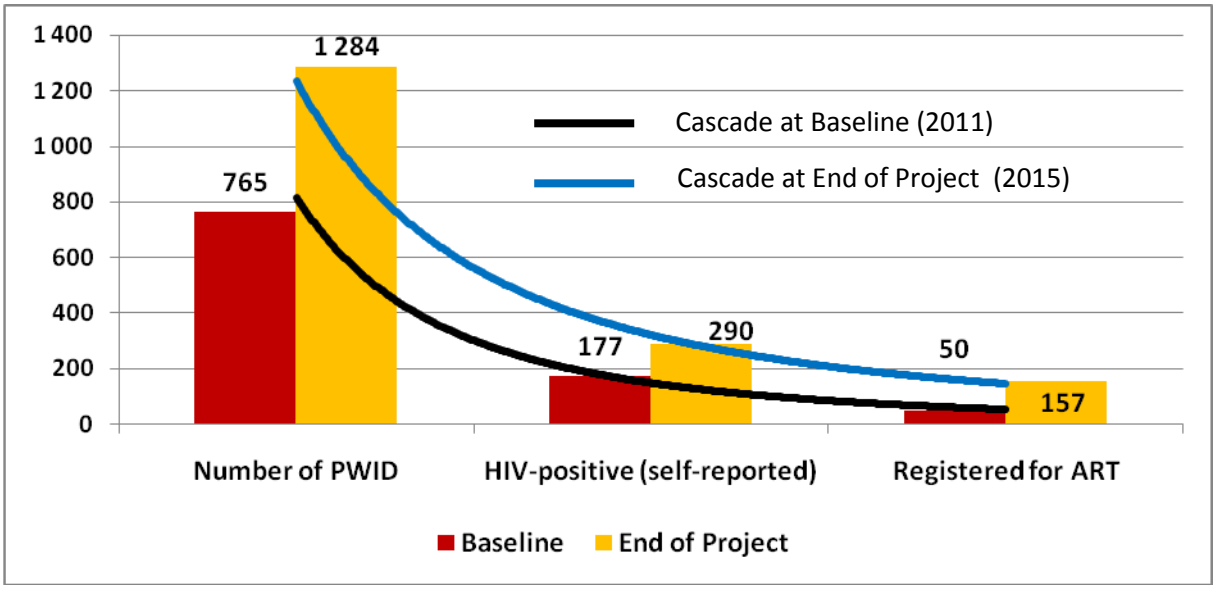


**Figure 4 Comparison of the PWID HIV test and treatment registration cascade at baseline and end-of-project for CAHR sites in India, Indonesia, Kenya and Malaysia combined**

### 4.7 Access to services

As a result of CAHR implementation in the five countries, there has been an increase in the availability of, and access to, harm reduction supplies and services by PWID. In addition, support to the family and community of PWID has increased, especially in India, resulting in a more holistic approach to the health of PWID being implemented at the local level. Access to SRHR services for female PWID, and especially for female spouse of PWID, has increased in some countries. However, the data suggests strongly that more needs to be undertaken in this regard as consistent condom use remains problematic at best. However, in terms of broader health needs, including access to VCT, TB and viral hepatitis testing, counselling and treatment, there has been little overall change in the views of PWID between baseline and end-of-project, with an increase in dissatisfaction of only 1.5% of all PWID on average.

*Outreach work in Malaysia. © Slava Kushakov*

Services in most demand by PWID across all CAHR implementation sites appears to be focused on economic well-being, specifically income generating activities and support to develop skills to gain, and retain, paid employment; this is especially the case in China, Indonesia and Kenya.

### 4.8 Well-being and quality of life

Well-being and quality of life for PWID benefiting from CAHR implementation has improved overall. PWID in China, India and Kenya report increased community support. In Indonesia, there has been a slight reduction in community support in the perception of PWID whilst in Malaysia, this reduction in

community support has been far more substantial, with three-quarters of PWID respondents at the end-of-project having negative views about community support as compared with about one-quarter of PWID at baseline. There has also been a large increase in the number of PWID respondents feeling that extremely negative attitudes and actions taken by the police and law enforcement agencies in Malaysia is reducing their well-being and quality of life, rising from under 10% at baseline to over half of all PWID at end-of-project. CAHR implementation sites in the other four countries have not experienced this negative view of law enforcement as seen in Malaysia.

Similarly negative feelings about family involvement with them are reported by PWID in Malaysia over the period of CAHR project implementation, with 1.5% of PWID at baseline and 47.1% of PWID at the end-of-project feeling that their family does not want to have any relations with them. All other countries - with the exception of India - report a similar trend, although not to the extent of Malaysia. The situation of family acceptance of PWID has improved somewhat in India, however, most likely as a result of specific attention paid by the CAHR project at its implementation sites in supporting the reintegration of PWID into their family unit.

## 5. Key achievements of the CAHR programme, 2012-2015

- NSP distribution is reaching many people who would otherwise have to resort to the sharing of injecting equipment. The role of peer outreach workers as facilitators of NSP is commendable as it provides increased confidence to PWID that they will be safe going to such places to get commodities.
- Awareness raising with police, judiciary, and the broader community has resulted in the gradual improvement in status of PWID which, in turn, has increased access by PWID to health and related services.
- The 'Support. Don't Punish' campaign supported by IDPC through CAHR funding has far exceeded initial) expectations in terms of the number of countries involved in the 'Day of Action' advocacy efforts to change drug control policy on June 26 each year; the initial target was 5 countries but in 2013 it reached 20 countries, rising to 48 countries in 2014[14].
- HRI has produced a range of top quality materials on a range of issues related to advocacy and awareness. Of particular note is the 2012 publication entitled, 'The Global State of Harm Reduction 2012: Towards an Integrated Response'[15]. HRI has published a wide range of other information and advocacy materials and is a strong partner in the global advocacy campaign for equal rights for PWUD, including PWID.
- Crucial work has taken place in Malaysia and Indonesia related to HIV services for **prisoners**, especially those inmates who are in the process of being released back into the community.

- **In China**, AIDS Care China (ACC) is becoming a model of excellence in the provision of innovative harm reduction interventions within the Chinese context in close partnership with their government counterparts. Retention of PWID in MMT is increasing due to the innovation brought to local government authorities by ACC. The development of community-based drug treatment approaches by ACC is starting to provide government authorities with an effective alternative to sending PWID to compulsory detention centres. Considerable work is already ongoing in the border areas of Myanmar and China in support of PWID living and working on both sides of the border.

- **CAHR in India** has been particularly successful implementing crucial social and economic support services for PWID and for spouses and/or other key caregivers of PWID. The active involvement of spouse/other caregivers to support PWID makes the interventions distinctive and a potential programme of excellence to which other countries in the region, and beyond, could learn.

*Methadone clinic in China© Slava Kushakov*

- PWID with no more than two years of experience of using **CAHR supported services in Indonesia** are more prominent than PWID with a longer period of service use; as a result, it appears likely that the CAHR programme has attracted PWID with higher health risk behaviours than was the case when the programme began. Improved access to health services, a feeling of considerably more community support to them, and a reduction in negative attitudes by law enforcement agencies towards them are just some of the indicators that suggest that PWID now enjoy a higher service quality and improved wellbeing than when CAHR implementation began in the country and has expanded care to individuals who would otherwise have been difficult to reach by any other means; CAHR was the first point of contact for 45% of PWID to other services. Furthermore, harm reduction services within prisons has been advocated for in Indonesia through the CAHR programme with the specific assistance of the AIDS Foundation East-West (AFEW). Technical assistance from AFEW has also assisted in the implementation of a care programme in Bancey prison in which the quality of services has improved, including referral of prisoners being released to halfway houses.

- **In Kenya**, after a very difficult start, NSP distribution was restarted through the careful work of the CAHR partner, KANCO, and its local partners, especially along the coast; this shows courage and an astute awareness of timing and risk management on behalf of the KANCO managers directing the CAHR programme. Also, female injectors have played a significant role in the development and implementation of harm reduction services in Kenya. CAHR has also supported the development of the Kenyan Network of People who Use Drugs (KeNPUD) that is becoming a truly representative network of PWID for all areas of the country following effective work and support from INPUD.

- Self-reported sharing of needles/syringes by PWID at CAHR implementation sites in **Malaysia** is very small and the availability of sterile needles/syringes is now high. 22.8% of respondents at the end of the CAHR project claimed to have substituted the injecting of heroin with the taking of

methadone orally as a result of CAHR support whereas no PWID reported such drug substitution activities at baseline. Some centres, such as DIC Kuantan and CAKNA in Terengganu, have established small businesses, including car washing and farming, for income generation opportunities for PWID. Important efforts are also underway to increase access to harm reduction services by prisoners upon release as well as the piloting of NSP inside one prison; lessons from this pilot will be useful for many other countries in the region and beyond. The 'throughcare' programme for transitional client management at one prison near to Kuala Lumpur that began towards the end of the project is of particular note.

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