

Young People, HIV/AIDS, Drug and Substance USE in Asia

A Workshop Report

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18 - 22 March 2002
Kathmandu, Nepal

UNICEF Regional Office for South Asia (ROSA)
Kathmandu

UNICEF East & Pacific Regional Office (EAPRO)
Bangkok

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Introduction

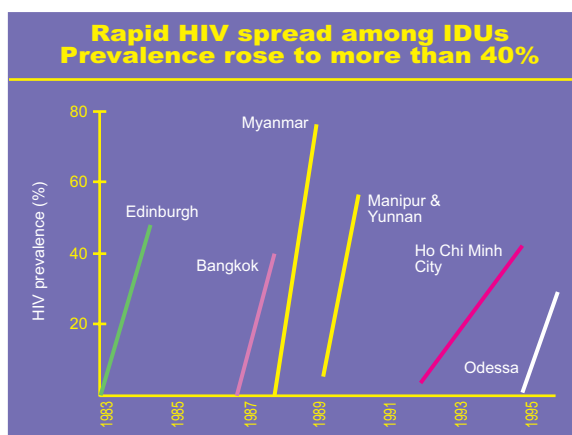
The inter-regional workshop 'Young people, HIV/AIDS, Drug and Substance Use in Asia' organized jointly by the UNICEF East Asia and the Pacific Regional Office (EAPRO) and the Regional Office for South Asia (ROSA), in collaboration with UNDCP Regional office for South Asia, took place in Kathmandu, Nepal, from 18 – 22 March 2002. It brought together a total of fifty-eight participants from the various government ministries, the NGO sector as well as UNICEF staff from eleven countries in South and South East Asia.

The workshop was inaugurated by the Honourable Devendra Raj Kendal, the State Minister for Home Affairs, Nepal, who drew attention to the increasing problem of HIV/AIDS infection among drug users in the country and confirmed his Majesty's governments commitment to focus more attention to these issues. Mr. Ashok Nigam, the Officer-in-Charge of UNICEF ROSA highlighted the urgent need for the implementation of large scale harm reduction programmes to address the twin epidemics of HIV/AIDS and drug use. Close collaboration and partnership between the government, the NGOs and the international agencies he added, would facilitate the implementation of these programmes and could contribute to upscaling on-going projects to increase coverage to reach the large numbers of vulnerable young people.

Background and rationale

Drug use and HIV/AIDS of increasing concern in Asia

The production and trafficking of drugs and more recently of amphetamine type substances continue to be a major problem in South and South East Asia. Afghanistan and Myanmar are the world's largest producers and suppliers of opium and heroin. Many countries in the region are criss-crossed by trafficking and transiting routes linking drug production zones to lucrative consumer markets. This has also led to a significant increase in drug use in most countries in South and South East Asia. Though the drug use scene varies widely among the countries and within the countries, of major concerns are the increasing abuse of amphetamines and the shift from smoking and sniffing to injecting drugs in all the countries.¹



Source: Taken from presentation by Tim Brown - UNAIDS Collaborating Center at the East West Center

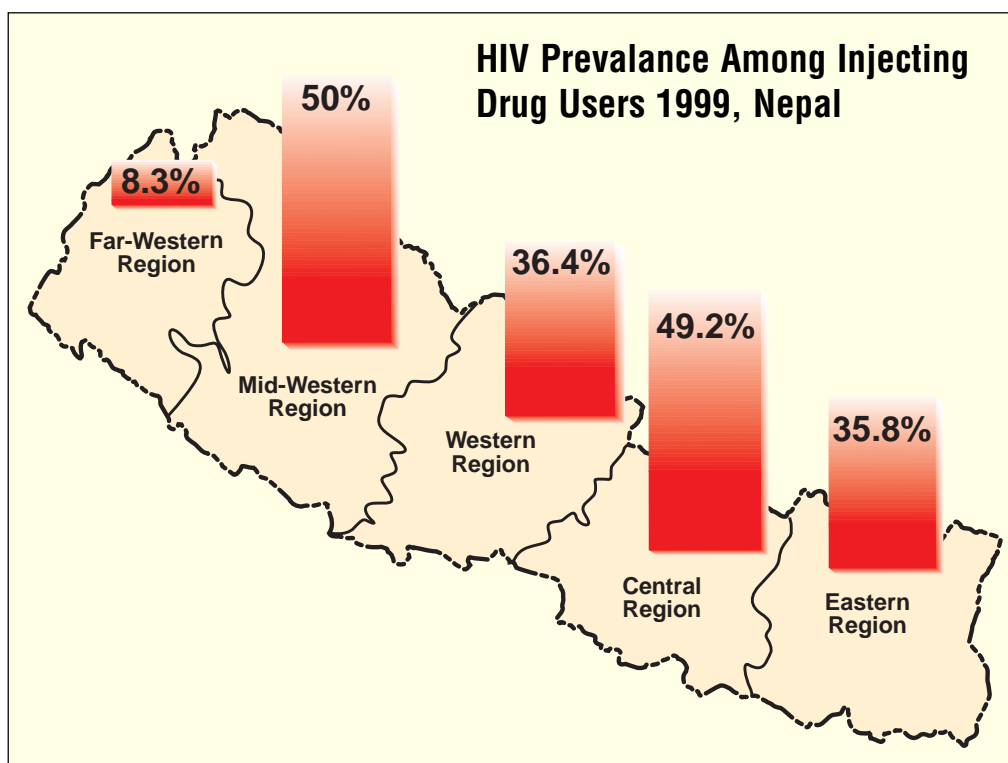
¹ Unless otherwise specified, main source of data on drug trade and use: 'Revisiting the 'Hidden epidemic' A situation assessment of drug Use in Asia in the context of HIV/AIDS'; The Center for Harm Reduction, Burnet Institute, January 2002.

Much of the injecting drug use is carried out through sharing unsterilized needles and syringes. Professional injectors and shooting galleries operate in Bangladesh, Pakistan, India, Nepal, Vietnam, Myanmar and Malaysia. Data show that transmission through injection of any sort is a very efficient way of spreading HIV. With the exception of Cambodia, Laos and Southern India – the HIV/AIDS epidemic in all the other countries of Asia was ignited by injecting drug users resulting in two epidemics interacting with each other - one of HIV/AIDS and a second of drug use.²

Countries often report very rapid rise of HIV among injectors once the first case of HIV is reported among them. It is estimated that more than 40 per cent of injecting drug users in Myanmar, Nepal, Thailand, China's Yunan Province and Manipur in India have acquired HIV infection.

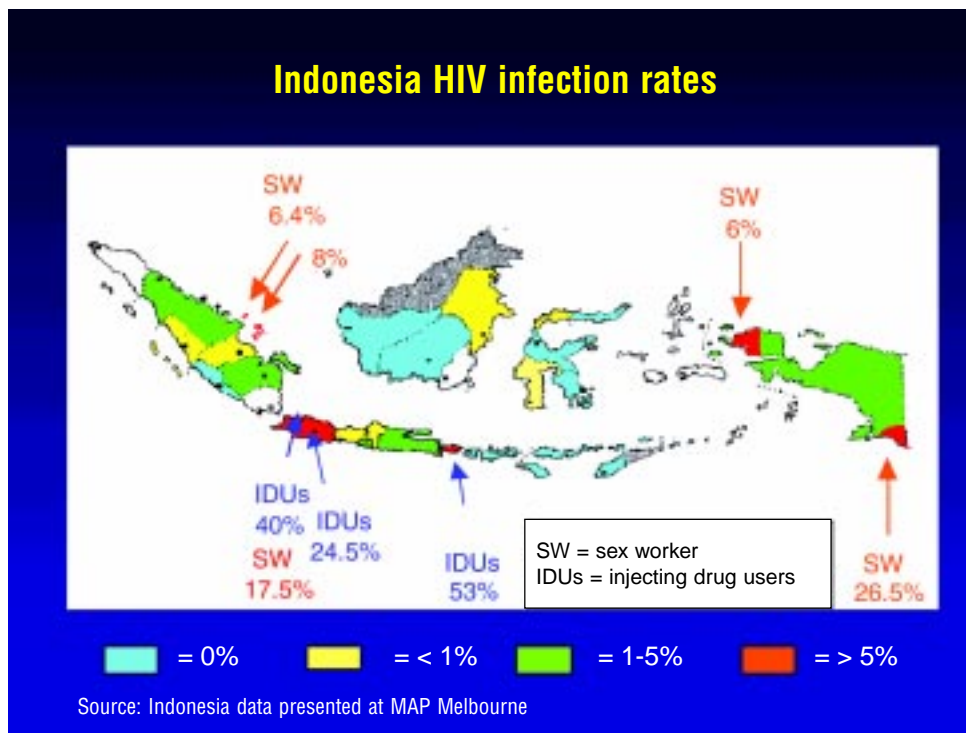
In Nepal, HIV prevalence shot up among injecting drug users from 2.2% in 1995 to nearly 50% by 1998.³ HIV prevalence among injecting drug users in Indonesia reached 15 percent in 1999/2000 and within the following year, 40% of injectors in treatment centres in Jakarta were found to be HIV positive. In 2001, seven Chinese provinces showed 70 per cent HIV prevalence among injecting drug users in a number of areas.⁴

The HIV infection risk among drug users does not only arise from injecting. Many types of psychoactive substances, whether injected or not, including alcohol, are risky to the extent that they affect the individual's ability to make decisions about safe sexual behaviour. Methamphetamine use appears to have skyrocketed particularly in countries in South East Asia while in India, Nepal Pakistan and Bangladesh the use of buprenorphine



Source: 'Breaking the silence around HIV/AIDS' Nepal. UNAIDS. 2000

² Annex 2: Overview of drug use and HIV/AIDS prevalence in selected countries in South and S.E Asia
³ National Centre for AIDS and STD Control, MOH, Kathmandu. 2000
⁴ HIV/AIDS in Asia and the Pacific Region. WHO 2001



has become widespread. Studies have associated crack-cocaine use with elevated levels of high-risk sexual behaviours, for example in the United States, where crack-cocaine users account for increasing proportion of AIDS cases.

There is much evidence that the HIV infection among drug users is not self-contained. An increasing cross over is being observed in some countries as in India, Thailand, Bangladesh, between injecting drug use and commercial sex workers which contributes to the spread of the virus to the clients. This together with the sexual networks among the drug users, the sharing of injecting equipment increases the risk of HIV infection not only among the drug users but also facilitates the transmission of the virus to their partners, wives, and to their children.

Studies from parts of India, China, Myanmar suggests that more women are being infected through sex with drug users than in any other way.

In high drug use related HIV prevalent areas such as in Manipur, India, transmission of HIV virus from injecting drug users to their spouses increased from 6 per cent in 1991 to 45 per cent in 1995 and an increase in prevalence among pregnant women from 1.3 in 1994 to 2.7 percent in 1999.

Young people at the center of both the HIV/AIDS and the drug use epidemics

Though up to date information on the actual size and magnitude of the drug use problem is still limited, available data imply that increasing number of Asian women are using drugs and that the age of initiation into drug use is declining throughout the region.

In India, recent data from a rapid situation assessment study on drug use shows that the age of onset of drug use in various cities ranged from 15 to 18 years. Half of Nepal's 50,000 drug users, including non-injecting drug users, are in the age group of 16 – 25.⁵ Infection patterns, as in other

⁵ National Centre for AIDS and STD Control, MOH, Kathmandu. 2000

regions, already show the disturbing trend of increased infections in young people below the age of 25. This has serious implications for some countries in the Asian region in which approximately 54 % of its population is below the age of 25.

The major factors which increase the vulnerability of young people to both drug use and to HIV infection are closely linked to rising poverty and decreasing vocational training and employment options accompanied by changes in values and breakdown of communication within families. Young girls, in particular, are vulnerable due to gender norms and low social status which makes them unable to refuse unwanted or unsafe sex. The instability and mobility brought about by conflict situations as in Pakistan and Afghanistan contribute to this increased vulnerability for both boys and girls.

Young people are made even more vulnerable by their limited access to information and condoms. Many young injecting drug users are unaware of the HIV infection risks linked to unprotected sex or to sharing needles. Very few services address their special drug use and sexual health needs including protection from HIV infection. This vulnerability of young people is made much greater by criminalisation of drug use, social attitudes of discrimination and stigma leading to rejection of drug users and of people living with HIV/AIDS.

The positive news is that apart from a few countries in the region, the HIV/AIDS prevalence levels are still low. The majority of young people in all these countries are still uninfected. But from what is known about the explosive nature of the HIV/AIDS epidemic among drug users the potential for a major epidemic cannot be

underestimated. Unless action is taken now to stem the HIV/AIDS epidemic among young drug users and to reduce drug use in general, a whole generation may be lost.

Need for an urgent, comprehensive response

Recognition and acceptance of the existence of the drug use problem and of HIV/AIDS epidemic by governments, NGOs and by donor agencies has increased over the last four to five years. Despite this, most governments in the region have been slow to provide resources and to implement comprehensive harm reduction programmes. Australia has demonstrated and so have small scale NGO projects in this region that prevention of HIV transmission among drug users is possible through harm reduction programmes⁶.

Government implementation of harm reduction policies and strategies in many countries is being held back mainly by narcotics legislation. In India, there is official sanction but confusion in the understanding of the concept of harm reduction among drug and health policy makers hampers its large scale implementation. In Vietnam the concept of harm reduction is well understood, but insufficient funds and an ambivalence in attitude stand in the way of large scale implementation.

It is the NGO sector in all these countries that has taken the lead in the prevention of HIV/AIDS among drug users. NGOs have implemented harm reduction and community outreach initiatives in several countries including India, Bangladesh, Thailand, Indonesia, Nepal, Myanmar. Though these programmes have been effective within their target population they are unfortunately too few and too limited in scale to reach the majority of those in need and to have a major impact on the epidemics.

⁶ Annex 3: *What has shown to work in other countries'*

Several UN documents provide the framework for UN agency support and action in the formulation of strategic approaches to preventing transmission of HIV among drug users. The UN position paper endorsed by UNAIDS, WHO and UNDCP clearly states that the drug use problem cannot be solved simply by criminal justice initiatives. It outlines the human rights principles and the strategic approaches for a comprehensive package of interventions.⁷

In June 2001, all governments in the region signed the UNGASS declaration of commitment on HIV/AIDS to ensure that by 2005 at least 90% and by 2010 at least 95% of young men and women aged 15-24 have access to prevention tools and services for reduction in vulnerability to HIV infection.

Political will and leadership, supportive policies and resources will be needed to meet this commitment. The purpose of this workshop was to advocate for a greater commitment for the prevention of HIV/AIDS among drug users by:

- promoting a better understanding of the links between vulnerability to HIV/AIDS/STD infection and drug use and of the comprehensive strategies essential to prevent HIV/AIDS among drug users;
 - and by providing a platform for exchange of experiences, lessons learnt and for networking among the countries in the region as well as for the participants to recommend specific follow-up action for their countries.
- sharing information on the status of drug use and HIV/AIDS epidemics,

By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics, cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counseling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections⁸

⁷ 'Preventing transmission of HIV among drug users' A position paper of the UN System. WHO/UNDCP/UNAIDS Initiative. 8th session of ACC Subcommittee on drug Control, Vienna, 28-29 Sept. 2000

⁸ Declaration of Commitment on HIV/AIDS. United Nations General assembly special session on HIV/AIDS. June 25-27 2001. United Nations

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The Proceedings of the Workshop

The four day workshop agenda⁹ provided for plenary presentations on the status and issues related to the twin epidemics of drug use and HIV/AIDS in the Asian countries as well as on the critical components of a comprehensive strategy for prevention of HIV infection among drug users and care for those affected.

Field visits to projects in Kathmandu addressing the issue of drug use and HIV/AIDS prevention; the exhibition and presentation of NGO projects from around the region at a *market stall*, provided the participants with opportunities for sharing of experiences and lessons learnt in the implementation of life-skills-based education and harm reduction programmes in the region. All these formed the basis for discussions during the working group sessions on constraints, identification of needs and gaps as well as for the recommendations made by the participants for the country specific strategic framework and follow-up actions.

2.1 Plenary sessions: the status of the epidemic and the comprehensive strategies for prevention of HIV/AIDS among drug users

This section briefly summarizes the presentations¹⁰ and discussions during the plenary session of the

key elements of a comprehensive strategic approach to HIV/AIDS prevention among drug users.

A review of the ***dynamics of the Asian epidemics and the status, issues and challenges of the drug use related HIV/AIDS epidemic in South and South East Asia*** was presented by Robert Bennoun and Doris D'Cruz-Grote, UNICEF Regional Advisers, HIV/AIDS.

Asia is characterized by multiple inter-linked epidemics in men who have sex with men, sex workers and clients, injecting drug users, and through these to the wives, girlfriends and children. Prevalence rates are still low in most countries of the region but even low prevalence rates translate to large numbers of people living with HIV/AIDS because of the huge size of Asian populations.

Of concern is the increasing drug use and substance use and the transition to injecting drug use accompanied by needle sharing. HIV transmission through injecting drug users has been found to drive the heterosexual transmission of the virus to the general population. Since all countries of the region have large sexually active populations, there is a serious potential for further and extensive HIV spread through unsafe sexual

⁹ Annex 2: workshop agenda

¹⁰ All presentations are in the CD ROM attached to this report

behaviour. Poverty, mobility, gender norms, limited access to services and information – all increase vulnerability to risk taking behaviour, to HIV infection. New epidemics continue to emerge around the region as shown by the recent dramatic increase in HIV prevalence in Indonesia.

Despite all this evidence, governments, policy makers and programmers continue to underestimate the spread of the epidemic and have delayed the timely implementation of large scale national response. There is evidence in the region coming from Thailand and Cambodia that the HIV/AIDS epidemics can be contained through political will and a pragmatic approach to large-scale implementation of comprehensive strategies to ensure full coverage of the population in need.

Antonius Smits, Executive Director, Asian Harm Reduction Network in his presentation on **AIDS, Drugs and Substance Abuse** described the drug use scenario, outlined the framework for the way forward through a comprehensive approach for HIV prevention through harm reduction. He drew attention to the fact that drug related harms such as HIV/AIDS and related opportunistic infections of TB, the other blood borne diseases of hepatitis B and C, and crime among drug users are soaring. Injecting drug use is accounting for 40-70 per cent of all HIV infections in China, Malaysia, Indonesia, and Vietnam. Hepatitis C infection rates of 60-80 per cent among drug users are not uncommon. The related human and economic consequences, the increased national health expenditures of this drug-related harm are reversing development trends of entire regions at risk.

Antonius Smits stressed the urgent need for a broader view of drug prevention; for a shift from traditional drug policies based on demand reduction and on law enforcement to supportive

policies, away from the disease treatment approach model to harm reduction approaches. He justified the need for a revision of the punishment paradigm and advocated for a broader approach to reduction of drug use and related harm based on addressing the determinants of drug use. He strongly recommended a proactive leadership role for the UN agencies to work closely with governments for the development of evidenced-based policies and approaches for the integration of harm reduction to combat the HIV epidemic among drug users.¹¹

Key elements of a comprehensive strategic approach to HIV/AIDS prevention among drug users

Tobi Saidel, Senior Technical Officer, Family Health International/Asia Regional Office in her presentation on **Behaviour Sentinel Surveillance, drug use and HIV/AIDS** explained how behavioral and sentinel surveillance data could be used to: identify groups at risk and behaviors in need of change; track the potential for spread between high and low prevalence areas through mobility; explore interaction among groups with risk behaviors such as injecting drug users, sex workers, as well as provide evidence for success of interventions and for advocacy.

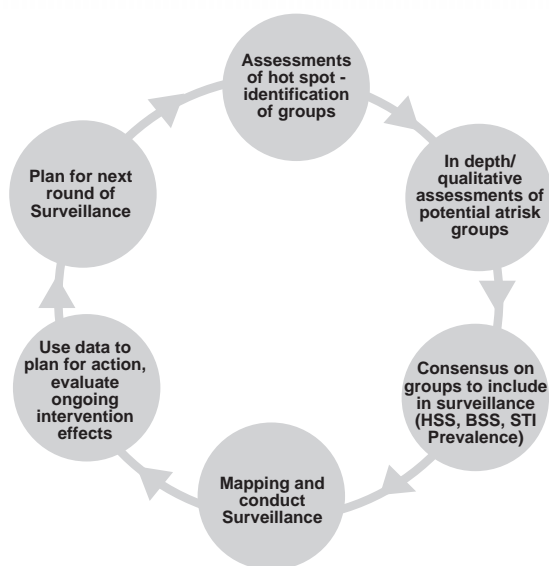
Behaviour Sentinel Surveillance (BSS) has special significance as an advocacy tool to demonstrate to policy makers: the scenarios which can take place in countries if high risk behaviour among certain groups such as sex workers, drug users is not changed; the cost implications for different types of interventions; and the impact interventions can have on the spread of HIV. For example in the case of injecting drug users, BSS can help to show how risk behaviors among injecting drug users contribute to the further spread of the HIV

¹¹ Annex: 'What has shown to work in other countries'; Scaling Harm Reduction for Drug Use in Asia – AHRN Recommendations

Box 1: Methodological Features of Behavioral Surveillance

1. Commonly included populations
 - Sex workers (male and female)
 - MSM (many categories)
 - Injecting Drug Users
 - Migrant/Mobile population
 - Other bridge populations (e.g. police Businessmen)
 - Youth
2. Standardized set of indicators for the global comparison
3. Instruments/ indicators for global comparison
4. Emphasis on methodological rigor while maintaining feasibility

Box 2: Surveillance Cycle



infection to sexual partners.

Education for harm reduction

The presentation on ***Life skills-based education for HIV prevention among injecting drug users*** by Gregory Carl, UNICEF EAPRO outlined the essential elements of behaviour development and change model and the critical role played by the life skills based approach. It has been shown that information alone has not contributed to change

in behaviour. Through the life skills-based approach, the information is combined with helping young people make informed decisions, set goals and give them other competencies that may help them to lead a healthy and productive life.

The life skills-based education can be used for a variety of problem situations – for prevention of HIV infection and drug abuse, dealing with unhealthy relationships. It has proven effective in different setting : in schools as part of the school curriculum, in outreach work, in communities.

During the discussions which followed, participants gave examples of how life skills based approach and harm reduction initiatives have enabled commercial sex workers, who are also drug users to practice safe sex by helping them to ‘time’ substance use more appropriately. Using substances after a commercial transaction rather than before gave the sex workers a greater opportunity to be in control during the sex act, especially for negotiation of condom use, etc.

Ms Cheng Wing Sie, presented the communication initiative, implemented by UNICEF in Nepal, using the life skills based approach. This initiative comprised of a TV soap opera ‘*Catmandu*’ and the radio program ‘*Chatting with my best friend*’. Both of these aim to provide young people with information and skills to cope with difficult situations and to make informed choices. The programmes are supplemented by reading materials, which were designed with the help of

Box 3: Life Skills & Harm Reduction

- Personal risk perception & motivation to act
- Health seeking behavior and access to services & supplies
- Life Skills - critical thinking, decision making, etc.
- Technical Skills - condom use and other HR methods
- Self-esteem & a supportive environment

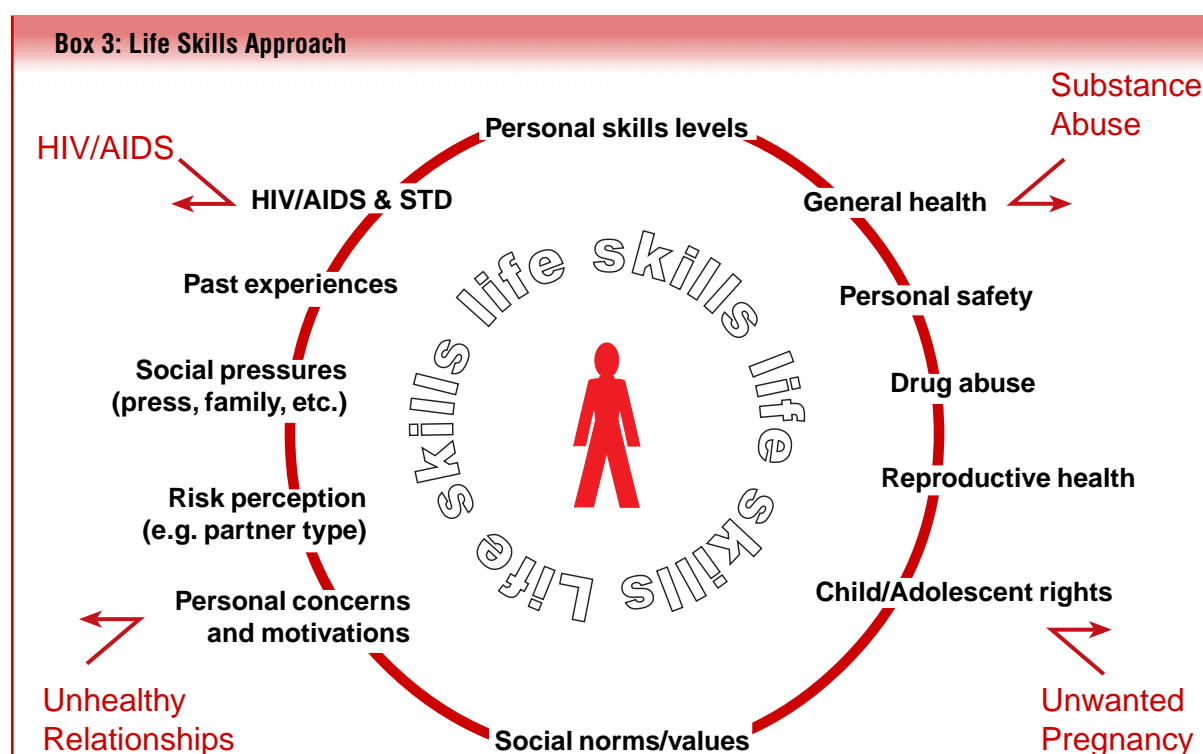
teenagers. Responses to the programs, up to 300 letters a week, have shown their acceptance and usefulness in helping young people to deal with difficult situations in their lives.

The premise of the presentation on ***Incorporating Drug Education and Harm Reduction: School and Community Strategies*** by Michael Rosati, Health and Human Development Programs, South East Asia Initiative, was that risk and protective factors are to be found in both the individual and in the environment. Therefore, protection from harm through drug use and HIV infection will require the reduction of risk factors, the enhancement of protective factors in young people and the development of a supportive environment for the development and sustainment of positive behaviors.

A range of comprehensive school and community strategies already exist, which have been found to be effective in both educating individuals and in

creating safe and healthy environments. The classroom, however, is not the only setting to approach young people. Recreational opportunities, community service, cultural activities, mentoring and tutoring are equally important and effective avenues to reach and mobilize young people. The development of community partnerships and the cooperation with schools, governments, students, parents and community members in the design and implementation of logical and measurable strategic plans are critical to ensuring the desired outcomes.

The challenge is to implement these strategies as a long-term process, to be adapted over time, rather than a ready-made set of tools. The inclusion of sexual health education in curriculum requires advocacy with the Ministries of Education and time to get the support of parents – both of which are essential for their effective implementation.



Box 4: Comprehensive Strategies: School-Based

- Policy and Procedures
- Curriculum
- School Environment and Climate
- Student Health and Intervention Services
- Student Involvement
- Family Involvement
- Positive (Alternative) Activities

Box 5: Comprehensive Strategies: Community-Based

- Policy
- Enforcement
- Community and Professional Education
- Communications
- Collaboration
- Alternatives
- Early Intervention

Access to youth friendly health services, Voluntary Counseling and Testing as well as to condoms for prevention of HIV/AIDS among drug users

Scott McGill, WHO, HQ in his presentation on the ***role of voluntary counseling and testing in HIV/AIDS prevention with specific reference to prevention among drug users*** reinforced the importance of Voluntary Counseling and Testing (VCT) as a vital entry point for HIV/AIDS prevention and for the ethical delivery of care. The concept of VCT is based on counseling a person willing to get tested, so he or she can make an informed decision, at the same time ensuring confidentiality to the individual. It also provides an opportunity to educate people on transmission and prevention of infection, for protection from drug use and to help them cope with the consequences of an HIV infection by giving emotional support and referring them to relevant services.

But VCT services specific for young people in general and young drug users in particular, continue to face a number of challenges. They are either not available or difficult to access. When available, the services are not used out of fear of stigmatization. Exploratory research has shown though that the acceptance of VCT is high among young people when the service is youth friendly. This can be done by introducing VCT in youth reproductive health centers; with counselors trained on youth issues; by a reduction in costs of testing services; and by making these services more accessible through schools and youth groups.

One of the major constraints to the implementation of VCT services is its high cost compared to other prevention interventions. WHO is currently exploring the feasibility of lowering the cost through social marketing to enable expansion of VCT services in South East Asia.

Luisa Engracia, UNFPA Country Support Team for South and West Asia, reinforced the importance of ***youth friendly health services*** in the provision of information on HIV/AIDS, for protection from unwanted pregnancies and from sexually transmitted infections. Unfortunately, most health services are designed to cater entirely to the needs of adults. The challenge is, as in the case of VCT, to transform existing health services to make them youth friendly through training staff on youth issues, ensuring privacy and confidentiality, and by ensuring accessibility. Even more effective would be the setting up of health services specifically designed for young people with their participation. Though not much research has been done on the effectiveness of youth friendly health services, monitoring results have shown a wide acceptance. A major challenge is to increase access to out-of-school youth and other hard-to reach groups such as young drug users.

Steve Honeyman, Country Director, Population Services International, Nepal presented the **social marketing** approach for the promotion of condoms for family planning, for reproductive health and to prevent the spread of HIV/AIDS. He presented in detail the approach used by PSI in Myanmar to make condoms available to a wide population at a low price and at the same time educated people on the correct use of the condom and the need to change risk behaviours through a life skills-based approach and through soap operas.

Supportive policy and legislation on harm reduction

Dr. Khomdon Singh, Project Director, Manipur State AIDS Society, India in his presentation traced the events which led to the development and implementation of **the Manipur State Policy on Harm Reduction**. He outlined the main features of the State AIDS Policy on harm reduction; and showed how the policy was translated into action.

In Manipur, the HIV/AIDS prevalence rate increased dramatically by 50% from 1989 to 1990. The governments immediate response was to implement the 'Police Model' comprising of mass arrests of drug addicts, shooting of drug users and mandatory disclosure of HIV positive status. These punitive actions resulted in the drug users going underground; increased the sharing of injecting equipment; and the further spread of the epidemic.

This was followed by the implementation of the 'Abstinence Model' from 1991 to 1996. The main message was '*Say no to drugs, yes to life*'. The main features of the model were drug de-addiction centers with counseling services, peer education; advocacy campaigns and school-based HIV/AIDS education. But this approach did not offer the drug users information and services for safe sex, safe

injecting practices or other options to drug use with the result that relapse rates were as high as 95%, the age of initiation remained the same and HIV prevalence rates were not reduced.

In 1996 available data showed that though the HIV epidemic was still concentrated in the injecting drug user population, there was an increasing threat of it spreading to the general population. This situation led to the development and implementation of the Manipur State AIDS Policy. Harm reduction, needle/syringe exchange, drug substitution therapy and social marketing of condoms are the major components of the policy. Implemented together with the Rapid Intervention and Care (RIAC) program, the policy created a supportive environment for the injecting drug users to access services. The HIV prevalence rate reduced significantly from 78.9% in 1997 to 55% in 1999.

2.2 Summary of presentations and discussions at the market stalls and the field visits

The Market Stalls

One of the innovative features of the workshop was the '*market stall*' for the presentation of projects by NGOs from the different countries. The objectives of the market stall were:

- To provide a platform for sharing of lessons learnt and experiences in the implementation of community-based outreach interventions for prevention of HIV among drug users
- To discuss issues, constraints and opportunities for operationalizing interventions and these to be used as a basis for developing recommendations for country-specific strategies during the working group sessions.

Twelve NGOs working in HIV/AIDS prevention,

Box 6: Market stall presentation on project on life-skills based education

Representatives from the Ministries of Education from Laos and Indonesia did a combined presentation on Life-skills based Education. Both countries have incorporated LSBE into the health education curriculum for primary and secondary level pupils.

Lessons learned:

- ongoing coordination and a close inter-agency collaboration are needed for integrating LSBE into the curriculum.
- ONE single LSBE curriculum should be followed by schools at all level.
- Consistent campaigns through the electronic and print media as well as support and training for teachers is necessary.
- The evaluations suggested that the students became more creative, confident and the class room environment became more dynamic with increasing involvement of both teachers and students to discuss sex and sexuality issues in innovative ways.

Challenges:

- Generally teachers lack ability to improvise and be creative in teaching LSBE.
- The large number of students (40) in each classroom makes implementation of LSBE difficult.
- Difficult to maintain a long-term institutional commitment and inter-ministerial collaboration

Box 7: CARE Bangladesh market stall presentation on project on Harm Reduction

CARE Bangladesh presented the SHAKTI (Stopping HIV/AIDS through Knowledge and training Initiatives) which was implemented in July 1995 with DFID funding for five years. This harm reduction project reaches 3500 daily. The two major components are:

- Drop-in Centers in various areas of Dhaka city providing a safe space for IDUs to meet and access referral services for drug treatment, treatment for abscess, STD and other ailments.
- Outreach Services with about thirty-five trained peer outreach workers (current IDUs) who train and educate other IDUs about safer practices; distribute new syringe-needles in exchange for the old ones as well as disseminate HIV/AIDS information along with the condoms.

Lessons Learned:

- Peer based approach found to be effective for needle-syringe exchange program in the marginalized community.
- User friendly monitoring tools and research techniques with active participation from the targeted community are very important to monitor and evaluate changes in behaviors of IDUs and outcomes of the intervention programs.
- Participation and involvement of marginalized community helped to promote information on contextual vulnerability factors to overcome constraints in accessing information and services to maintain good health and safe practices.

Constraints:

- Interference by the local goons in carrying out programs among IDUs and their sex partners.
- Frequent police harassment of peer educators as well as outreach workers doing needle-syringe exchange.
- Displacement of participants (IDUs) due to flood, cleaning of streets or eviction of slum areas.

care and support among injecting drug users presented their projects during the market stall session. The presentations, in some cases done together with government counterparts, comprised of background information on the projects. The stalls displayed training modules and support materials related to the projects such as videos,

posters. A number of government representatives took the opportunity to present the national AIDS Control Strategies of their countries. Discussions during the facilitated group visits of the participants to the stalls focussed mainly on issues related to implementation, monitoring and evaluation.

The Field visits

To set the framework for the field visits, Dr. Shyam Sundar Mishra, the Acting Director of the National Center for AIDS and STD Control, Ministry of Health, Nepal, made a presentation on the current status of the HIV/AIDS epidemic in Nepal. Female sex workers and injecting drug users are the two most vulnerable groups in Nepal. He said that the government recognises the fact that if an effective national response is not implemented immediately, then HIV/AIDS will become the No.1 killer disease as well as the No.1 public health problem within the coming decade. He outlined the different programmatic approaches implemented within the national framework.

This was followed by visits to NGO projects in Kathmandu. The field visits provided the participants with the opportunity to have discussions with the project staff, observe field staff doing outreach work and learn about the practical issues and constraints related to the implementation of HIV/AIDS prevention and care interventions for drug users and for the reduction of drug use in general. The visits also provided opportunities for many participants to discuss issues and problems with young drug users, including those living with HIV/AIDS.

The participants appreciated the possibility offered by both the market stall presentations and the field visits for sharing of experiences and lessons learned. The information gained during the field visits and market stalls formed the basis for the working group sessions: for the identification of needs and gaps, to assess situations in their own countries and to develop recommendations for country-specific strategies to combat HIV/AIDS epidemic among young drug users.

NGO Projects visited

Aashara Sudar Kendra:

An NGO which runs a residential camp for treatment and rehabilitation of drug users using the 'cold-turkey' approach without any medical or drug therapy; the police play a vital role in assisting security inside the camp and as a major networking, referral and monitoring body. One of the most important features of the kendra's program is its attempt to maximize parental involvement in the rehabilitation and treatment process of a drug-user.

Freedom Center:

A rehabilitation centre with a live-in detoxification program for heroin users accompanied by auricular acupuncture and counselling. The clients live as a community and are given small responsibilities, including cooking and cleaning. The center makes every effort to help the client to rebuild the family relationships, and once the client has enough self-confidence to stand on his own and fit into his family, he moves home again.

LALS (Life-giving and life-saving Society)

Conducts harm reduction through community outreach for injecting drug users with a major focus on HIV/AIDS prevention through behavior change interventions in targeted sites of Kathmandu and Lalitpur Districts. Service delivery (IEC materials, needle exchange, bleach, condoms, drug treatment referrals) is through street based outreach and drop-in centers.

Youth Vision:

Runs an in-patient drug abuse recovery center with medical (including detoxification), psychological, social and spiritual support to Nepali youth. Services are also offered to HIV, TB and Hepatitis B/C patients. Other activities include the formation of community HIV/AIDS and Drug Support Groups: Education program and a Buprenorphine Substitution Therapy with an Intensive Out-patient/Day-Care managed Psycho-dynamic Support Group Program.

2.3 Working Group sessions: Summary of discussions and outputs

The four working group sessions, which were an integral part of the workshop, were process orientated. The discussions and outcomes of each one of them contributed to the formulation and development of the final recommendations. Working group sessions were convened after the technical presentations as well as after the market stalls and the field visits to discuss the information gained, and to share the experiences and lessons learned. For the first two sessions the groups comprised of participants from different countries so as to facilitate the exchange and sharing among the countries in the two regions. The participants took forward the outputs of these discussions to the two concluding working group sessions, when they assembled in country teams to develop their

country specific strategic framework and next steps. Guidelines were developed for the different sessions outlining the objectives, expected outcomes and the process.

Working group session 1: Identification of data needs and gaps:

The purpose of this session was to identify issues, gaps and needs related to data in general, data collection and use, data for advocacy and strategic planning. The presentation on *Behaviour Sentinel Surveillance, drug use and HIV/AIDS* by Tobi Saidel, provided the framework for the discussions during this working group session.

The main gaps and needs which were identified by the participants are summarised in the table below:

Gaps	Needs
<p><i>Data in general:</i></p> <ul style="list-style-type: none"> Data on the magnitude of the HIV epidemic is insufficient Lack of desegregated behavioural data by sex and age and by location - rural and urban populations Insufficient STD prevalence data, especially in low HIV prevalence countries 	<ul style="list-style-type: none"> Need data on determinants of risk taking behaviour, in particular among groups at high risk There is a need for more specific data on young people and their risk taking sexual and drug use behaviour and on STIs among young people Desegregated data by age and sex
<p><i>Data collection and use</i></p> <ul style="list-style-type: none"> There is limited understanding who the data is for and limited resources and skills for proper data collection The target groups are not involved in data collection Inhibiting factors such as, fear of stigmatization and discrimination by high-risk groups, consent approvals and laws limit the data collection 	<ul style="list-style-type: none"> Capacity building for participatory data collection, analysis and for proper use of data Strong collaboration between UN agencies, governments and other stakeholders for data collection and the use of data for effective programming. This should be facilitated by UNAIDS

<p><i>Advocacy</i></p> <ul style="list-style-type: none"> • Insufficient evidence on the impact of strategies eg life-skills education in schools and harm reduction programs on the prevention of HIV/AIDS and Drug use • Lack of national data that could be used as an advocacy tool for policy-makers • Data on cost-effectiveness of programmes 	<ul style="list-style-type: none"> • Documentation of best practices regarding effective policies/measures for prevention HIV/AIDS and drug use • Mapping of the areas affected by HIV/AIDS, especially in relation to drug users • Modeling of possible socio-economic impact of HIV/AIDS at family level, community level and national level; as well as costs for interventions • Develop strategies to translate data for advocacy with policy makers and to educate communities on the impact of HIV/AIDS
<p><i>Strategic planning</i></p>	
<ul style="list-style-type: none"> • No linkages of data between different population groups; general population as well as high-risk groups • Financial resources for data collection 	<ul style="list-style-type: none"> • Periodic update of data for monitoring / evaluation and strategic planning

Working group session 2: Strategic approaches and feasibility of adaptation of approaches/interventions

This working group session, which brought together the participants after the visits to the market stalls, was mainly to exchange information on programming issues based on the presentations at the market stalls and to discuss the feasibility of adaptation of the interventions at country and regional level.

The market stall presentations on life-skills based education motivated participants from other countries to explore opportunities to adapt such strategies. It was pointed out during the working group session that Vietnam, based on the experience made in Laos, has initiated school based life-skills education. Participants from Pakistan will share the information on life skills-based education approach used in Laos and Vietnam with the Ministries of Home, Education and Labor in their country. These ministries have

expressed interested in incorporating life-skills based education into the curriculum.

The sessions discussed in detail the components of the Harm Reduction strategy based on the presentation by CARE Bangladesh of the SHAKTI project. This project illustrated the effectiveness of the peer-based approach to promote needle-exchange, as a component of the harm-reduction strategy in the reduction of risk behaviour to HIV infections among drug users and to increase coverage. The Nepali participants felt that based on the experience of the SHAKTI project in Bangladesh, the needle exchange programme (NEP) in Nepal must be up-scaled to increase coverage. Nepal was one of the first countries to introduce the needle exchange programme (NEP) in the early 1990s when the HIV prevalence was less than 1 percent among injecting drug users. But

the NEP only reached 10 per cent of the injecting drug users in the country. The HIV prevalence reached 50% within four years among injecting drug users in 1999.

In general, it was felt that many of the innovative ways of working with hard-to-reach populations, which were presented during the market stalls and field visits, could be adapted throughout the region. In particular the innovative features of a couple of the interventions, such as coordination among partners and the consortium approach, the setting up of the *Narcotic Anonymous* were worth considering for adaptation. It was noted that the monitoring and evaluation components were weak and needed to be improved in all the interventions.

Working group sessions 3 & 4: Formulation of country specific follow-up action steps and recommendations for prevention of HIV among injecting drug users

These working groups sessions brought together participants from the same countries. The sessions were designed to review and, as an option, use the SWOT analysis to assess the major strategies discussed and presented during the workshop, as well as to analyze issues, constraints, gaps, needs and opportunities in their own countries. Based on the SWOT analysis, the country teams developed specific country level recommendations. Some of

the main areas of action recommended were: advocacy and sensitization targeting policy makers; networking among the key partners; capacity-building for voluntary counselling and testing and for Behavioural Sentinel Surveillance; for a review and analysis of policies and for strengthening of the life skill-based approach.

Box 8: Result of the SWOT analysis conducted by the Bangladesh country team

Strengths:

1. Harm reduction is part of the National AIDS Policy
2. The President of the country is the chief patron of National AIDS committee
3. 13 ministries are involved in AIDS prevention activities
4. National strategic plan and behavioural change strategies exists & is being implemented
5. National workplan on AIDS prevention being implemented through government and NGO and other development partners

Weaknesses:

1. Lack of coordination in implementation
2. Role and accountability of relevant ministries are not clearly specified
3. Capacity and infrastructure for VCT inadequate
4. Capacity on care and support inadequate

Opportunities

1. Funds are available
2. Strong commitment of the government
3. Large-scale NGOs and civil society network involved in the implementation of program

Main areas of action recommended

1. Advocacy and sensitization
2. Capacity building

3

Recommendations and Conclusions

3.1 Participants' Recommendations and Conclusions

Based on the four days of technical presentations, market stalls, field visits, discussions during the working group sessions and sharing of experiences the participants formulated during the last working group session the following final recommendations¹² :

- Advocate with government and other partners to introduce harm reduction strategies and life skills based education into national plans of action and existing programmes
- Sensitize, advocate and involve regional bodies, such as SAARC and ASEAN to address cross-boarder issues relating to HIV/AIDS and drug use, including migration and drug trafficking
- Strengthen networking and sharing of information among programmers within the region on young people, HIV and drugs
- Identify networks and mobilize CBOs and NGOs for programmes on harm reduction and social marketing of condoms
- Involve peer groups (ex- and current drug users) in planning, implementation and evaluation of programmes
- Build capacity in data collection, especially on determinants of behavior including sexual networking, analysis and use for evidence-based programming

- Improve youth friendly services including the expansion of VCT, training of health care staff, social marketing of condoms
- Improve care and support for people effected and affected by HIV/AIDS.

The workshop concluded that there is a very strong link between injecting drug use and HIV/AIDS. The policies and programmes need to go beyond health interventions and should incorporate comprehensive strategies as well as embrace a multi-sectoral response. The presentations and the discussions highlighted the urgent need for targeted interventions, to upscale effective programmes and to increase coverage. In countries with low HIV prevalence among drug users the focus should be on primary prevention programmes to prevent further spread of HIV. In countries with high HIV prevalence among injecting drug users, there is an immediate need for advocacy for the implementation and expansion of harm reduction strategies. There was consensus that good practices existed in the region and these should be documented and lessons learned shared and/or adopted within the regions.

Drawing on these conclusions, the participants

¹² Annex 5: country specific recommendations

committed themselves as a first step to continue the networking initiated at the workshop, to conduct a similar workshop at country level as well as to organize study tours. The commitment to take the agenda forward has already led to the setting up of an informal network on the use of the life skills based education approach across regions.

Although the participants were motivated to implement actions at country-level, they recognized the barriers for implementation such as the non-supportive government policies, limited budget and lack of institutional capacity, coordination and information. UNICEF was being looked at as a potential partner. Financial and technical support was requested from UNICEF for capacity building in programme development, implementation and monitoring for prevention of HIV/AIDS among young users and for prevention of drug use in general in their countries.

3.2 UNICEF: role and commitments

Based on the recommendations made by the participants, UNICEF committed itself to explore avenues for responding to the twin epidemics of

HIV/AIDS and drug use among young people. As agreed upon, UNICEF can play a pivotal role in advocacy for drawing attention to the need for immediate action in the area of HIV prevention among drug users.

UNICEF EAPRO and ROSA see the following activities as options for their initial support within the coming 12 months¹³:

- Country level situation analysis
- A regional situation assessment/mapping report on young people, HIV/AIDS and drug use
- Support country level advocacy workshops
- Organisation of study tours to effective projects to countries in either South Asia or in South East Asia
- Technical support for strengthening in life-skills based education approach for prevention of HIV among drug users and for reduction in drug use
- Advocacy for and organization of a young people's track at the 2003 International Congress on Harm Reduction and where feasible support country-level participation at the Congress.

¹³ Annex 6: Detail UNICEF EAPRO and UNICEF ROSA recommendations and action

Annexes

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Annex 2: An overview of drug use prevalence and HIV/AIDS prevalence in selected countries of Asia¹⁴

Country	Estimated number of drug users	Estimated number of IDUs	Estimated number of HIV infection among IDUs
Bangladesh	100,000 - 1.7 million	20,000 - 25,000	2.5% of IDUs at detoxification centres are HIV+
China	860,000 registered drug users, unofficial estimate 6-7 million	3.5 million	HIV prevalence rates range from 1% to 80% according to the region
India	Over 5 million	in 5 cities over 100,000	overall rate 4.16% in certain areas higher, e.g. Manipur 80%, 44.8% Delhi, 31% Chennai
Myanmar	300,000 - 500,000	150,000 - 250,000	Average 63%, some states as high as 90%
Nepal	40,000 - 50,000 (official figures)	20,000	0.5% of total 15-49 population HIV+, but in Kathmandu 50% of IDUs tested HIV positive
Pakistan	4 - 4.8 million	180,000 (conservative)	4%
Sri Lanka	240,000 - 300,000	Of 30,000 (lowest figure), 2% inject	HIV has not been found among IDUs, but as a group they are not tested
Thailand	2 - 3 million, or possibly nearly 5% of the population	currently unknown	rates of 50%
Viet Nam	185,000 - 200,000	In 1997, 69,000 (probably conservative)	HIV infections among IDUs accounted for 65% of total reported HIV cases

¹⁴ Source: 'Revisiting the 'Hidden epidemic' A situation assessment of drug Use in Asia in the context of HIV/AIDS'; The Center for Harm Reduction, Burnet Institute, January 2002.

Annex 3: The Agenda

Monday, 18 March

08.30 – 09.00	Registration of participants
09.00 – 10.15	Official Opening: Welcome address Ashok Nigam, Officer In-charge, UNICEF ROSA Opening address Honorable Devendra Raj Kendal Minster of State for Home Affairs, Nepal Presentation: 'The HIV/AIDS epidemic and drug use in South and East Asia: the challenges ahead' Doris D'Cruz-Grote, Robert Bennoun, UNICEF Regional Advisers, HIV/AIDS
10.15 - 10.45	Coffee break
10.45 – 11.45	Objectives of the workshop, review of agenda Introduction of participants and resource persons
11.45 – 12. 30	Plenary session: Chairperson: Ian Macleod, UNICEF, Nepal AIDS, Drugs and Substance Abuse Antonius Smits, Executive Director, Asian Harm Reduction Network Discussion
12.30 – 13.30	Lunch
13.30 – 14.30	Plenary session: Chairperson: Ian Macleod, UNICEF, Nepal Behaviour Sentinel Surveillance, drug use and HIV/AIDS Tobi Saidel, Senior Technical Officer, Evaluation, Research & Epidemiological Unit, Family Health International/Asia Regional Office. Discussion
14.30 – 15.30	Working Group session: Facilitators: Michael Rosati Health & Human Development Programme, South East Initiative, Luke Samson, SHARAN, India Use of data, identification of gaps and needs based on available data in certain population groups
15.30 – 16.00	Tea break
16.00 –17.30	Plenary Session: Chairperson: Mr. Harka Man Shrestha, Chief, Heath and Ed. Section, Curriculum Development Center, Nepal Lifeskills-based education for HIV prevention among injecting drug users. Gregory Carl, UNICEF EAPRO Presentation of 'Chatting with my Best Friend' a life-skills-based communication initiative. Cheng Wing Sie, UNICEF, Nepal Country Office
18.30 - 20.00	Reception. Yak & Yeti, Garden

Tuesday, 19 March

9.00 – 9.15	Review of day one
Plenary sessions:	Chairperson: Supodjane Chutidamrong, Office of Narcotic Control Board, Thailand
9.15 – 10.00	Condom promotion and correct use of condoms Steve Honeyman, Country Director, Population Services International, Nepal Discussion
10.00 – 10.45	The role of Voluntary Counseling and Testing in HIV/AIDS prevention with specific reference to prevention among drug users Scott McGill, Technical Officer, Voluntary Counseling and Testing, HIV/AIDS Prevention Department, WHO
10.45 – 11.15	Tea break
Plenary sessions:	Chairperson: Shamim Matin Chowdhury, Treatment Center for Drug Addiction, Dhaka, Bangladesh
11.15 – 12.00	Access to Youth Friendly Health Services Luisa Engracia, UNFPA Country Technical Services Team for South and West Asia Discussion
12.00 – 13.00	Incorporating Drug education and Harm Reduction Michael Rosati, Director, Health and Human Development Programmes, S.E Asia Initiative Discussion
13.00 - 14.00	Lunch
Plenary session:	Chairperson: Ashita Mittal, UNDCP ROSA
14.00 – 14.45	Supportive policy and legislation for harm reduction Presentation of Manipur State Policy on Harm Reduction followed by Discussion Dr. Khondom Singh, Project Director, Manipur State AIDS Society, Manipur, India
14. 45 – 17.30	Market stalls: Facilitators: Luke Samson, Michael Rosati Facilitated small group visits to market stalls of comprehensive, community-based interventions for injecting drug users from South and South East Asia Followed by group work on identification on discussion of ' <i>what works</i> ', of needs, constraints for implementation of comprehensive community-based interventions

Wednesday, 20 March

- 09.00 - 09.30** Review of previous day and briefing for field visits
- 9.30 – 13.00** **Field visits**
Group 1: LALS - Harm Reduction with young injecting drug users
Group 2: Freedom Center: Treatment & Rehabilitation
Group 3: Aasara Sudhar Kendra: Treatment & Rehabilitation
Group 4: Youth Vision: Treatment and Rehabilitation
- 13.00 -14.00** **Lunch**
- 14.00 – 15.00** **Working group Session:** Facilitators: Michael Rosati, Luke Samson
Country Teams to incorporate findings from field visits to working group sessions from the previous day
- 15.00 – 15.30** **Tea break**
- 15.30 – 17.00** **Plenary Session: Chairperson:** Myo Zin Nyunt, UNICEF, Myanmar
Presentations of working group sessions of needs, gaps for comprehensive community-based interventions

Thursday, 21 March

- 09.00 – 09.15** Review of day 3
- 09.15 – 10.45** **Working group session:** Facilitators: Michael Rosati, Luke Samson
Country team working group sessions: recommendations for taking forward the agenda on prevention of HIV infection among drug users
- 11.15 – 12.30** Presentations of the reports of the working group sessions
- 12.30 – 14.00** **Lunch**
- 14.00 – 15.00** **Closing session: UNICEF**
Final recommendations on next steps and strategic framework, Evaluation, close of workshop

Annex 4: AHRN Recommendations for Scaling up Harm Reduction for injecting drug Users in Asia

- Research in the Developing World on Structural determinants of Drug Use
- High level leadership.
- Adequate Surveillance on Twin Epidemics Drug Use and HIV/AIDS
- Implementation of UNGASS Commitments for DUs
- Policy and financial support for the establishment of country wide comprehensive programs for IDUs including needle and syringe availability programs and treatment including drug substitution programs
- Solidarity and support from Western countries
- Timely interventions (start early in the epidemic before prevalence reaches 5%)
- Minimum program reach of 80% of the target population for all programs, within 4 years
- High Level Advocacy Missions to countries affected
- Social Marketing of Harm Reduction Strategies and Commodities
- Inter sectoral collaboration: integration of harm reduction for DUs into health and other sector programs, particularly education, police, military, public security.
- Behavioral Surveillance on Drug Use and HIV/AIDS
- Development of country specific training/advocacy materials
- Research/Studies on:
 - Legal and Environmental impediments
 - Program Documentation
 - Current interventions on DU (1st, 2nd, 3rd Prevention)
 - Social Research on DU and Impact
 - DU policy environment
- Review of existing educational programs for health/police professionals for incorporation of harm reduction elements

Annex 4: What has shown to work in other countries in HIV prevention among drug users¹⁵

Experience in East Asia clearly shows both the value of addressing HIV among drug users, particularly injecting drug users as early as possible and the need, no matter which direction the epidemic takes, to address the issues contributing to increasing drug use among young people. Effective approaches to HIV/AIDS and injecting drug use should be based on the principles of the Ottawa charter of Health Promotion (WHO 1986) which states that five activities:

- Promoting health through public policy
- Creating a supportive environment
- Reorienting health services
- Strengthening community action
- Developing personal skills

UN agencies and WHO recommend that these public health measures be carried out in a framework of harm reduction policies - strategies and activities that aim to limit or reduce the nature and extent of adverse consequences of drug use including:

- Health: including HIV and other communicable disease transmission
- Social: including social effects of (usually) young IDUs dying of AIDS
- Economic: including costs of treating people with HIV/AIDS
- Legal: including detection, arrest and imprisonment of IDUs

Harm reduction activities have been extensively evaluated and are the only proven effective means of preventing HIV epidemics among IDUs or controlling and reducing large IDU-related HIV epidemics.

¹⁵ Taken from: Dave Burrows. 'Effective approaches to HIV/AIDS and injecting drug use'

Harm reduction is one of the three complementary approaches to addressing drug issues, the others being supply reduction and demand reduction. Supply reduction includes seizing drugs through customs operations and assisting drug producers to stop growing, for example, opium poppies and substitute them with legal crops. It also includes arresting drug traffickers and breaking up supply routes for illicit drugs. Demand reduction is a complex of measures, usually provided by social, education and medical services, to promote a healthy lifestyle free from drugs, and to assist drug users to stop using and achieve medical and social rehabilitation.

Harm reduction work is based on several principles¹⁶ and on the realistic acknowledgement that there are no known interventions for completely eliminating drug use or drug related problems in any city, community or country. Three main components can be identified, which include needle and syringe programs (NSPs), outreach and drug treatment. Harm reduction in the community setting is a fourth component to ensure that the program is accepted within the community and the local authorities.

1. Needle and Syringe exchange programs

Needle and Syringe exchange programs have been studied in many different countries and in great detail due to the controversy surrounding their introduction. The US government found that there was no increase in the number of drug injectors or any increase of drug use following the introduction of NSPs. No reports have contradicted these findings.

An evaluation of Australian NSPs found that these programs saved an estimated 3000 lives in a single year. The number of times a syringe is used was reduced by more than half after IDUs started attending NSPs in three different cities. In a worldwide survey it was found that cities with NSPs the HIV zero prevalence was reduced by 5.8% per year, whilst without NSPs the HIV zero prevalence increased by 5.9%. A reduction of 70% in HIV incidence was found when comparing NSP participants against non-participants in New York. And in Dhaka, Bangladesh, where NSPs reached around 80% of the IDUs, the HIV prevalence remained below 5% despite rapid rises in other South Asian cities.

To implement successful NSPs it is important to obtain high levels of coverage in order to reach as many IDUs as possible. This includes selecting a site, which is accessible to a large number of drug users; if necessary have mobile NSP units that can access different locations.

In some cases NSPs also broaden their services to include educational material and condoms for IDUs, in order to prevent the transmission of HIV.

2. Outreach

Outreach work is usually needed to identify networks of IDUs; introduce them to the program's services; build up trust between program staff and IDUs; sometimes distribute sterile injecting equipment and educational materials; and carry out research on the needs of IDUs. The active involvement of IDUs themselves plays a crucial role in the success of outreach programs, especially in the form of peer educators and/or peer support. The work of the New Delhi based NGO SHARAN (attached in Annex 3) provides for a good example in that domain.

In peer education, active IDUs are trained to educate other IDUs about HIV risks, safer injecting and safe sex practices. An European survey found that educational materials were better accepted when distributed by another IDU, rather than from a counsellor or other professional.

In peer support, this process is broadened so that IDUs are involved in all aspects of defining what issues need to be addressed, what types of educational materials should be employed, as well as carrying out education and other processes.

There is a strong need to reach IDUs at high risk of acquiring HIV like female IDUs (especially those who are sex workers) and street youth, in order to cater to their specific needs.

¹⁶ The principles of harm reduction are listed in Annex 6

3. Drug treatment

Drug treatment programs have been found to be effective in assisting drug users to reduce or stop injecting, especially when substitution drug treatments are used. Methadone programs are the most widely used type of substitution drug treatments, but there are a number of others. They have been found to be very effective HIV prevention measures. US studies have found that participants in a methadone program are half as likely to be infected with HIV as non-participant drug users.

Harm reduction programs in the community setting

To establish and run a successful harm reduction program, it is important to gain and maintain support from local authorities and communities. In almost every country there are serious difficulties between the operation of harm reduction programs and law enforcement activities directed towards preventing drug selling and buying. Hostile police activities can have devastating effects on a program's work. In Australia the client contacts fell by 40% at an NSP within a month after a sustained police operation targeting drug users in the local area around the program.

But harm reduction programs can also have an important impact on police behaviour towards IDUs. For example, an advocacy project by the SHAKTI NSP in Dhaka, Bangladesh targeted local police with orientation and advocacy materials. Prior to the project, 84% of the NSP clients had been arrested by the police, which fell to 12% after the project.

Specific harm reduction programs for young people are under-researched but the World Health Organisation has found that activities outlined above are as effective for young IDUs as they are for older users. Effectiveness of programs for young people appears to be enhanced by employment of peer staff and youth friendliness of education materials, premises and staff: this includes use of youth culture symbols in educational materials and as posters on the premises; involvement of young IDUs in designing and producing educational materials and in planning and implementing programs; and staff training to understand the needs and culture of young IDUs.

Annex 5: Country specific recommendations as presented by the country teams

Nepal

- Needed most: *Advocacy*
- Form a task force that comprises of representatives of the government, from INGOS, UN agencies, local NGOS and CBOs at a national level which should:
- Develop advocacy materials for specific stakeholders – consistent information
- Lobby for implementation of already existing inter-country agreements on cross – boarder issues (drug traders), i.e. this could be done on a wider scale through SAARC as well as regional UN offices with relation to HIV prevention
- Review existing policy and recommend changes to incorporate the elements of capacity building, increasing sensitivity towards programs like harm reduction and care & support of IDUs
- Develop key strategies to take with the advocacy agenda issues of funding and resource mobilisation

Pakistan

- Revitalise National AIDS Committee to demonstrate leadership in articulating comprehensive strategic framework
- Expand surveillance mechanisms for all high-risk groups
- Introduce and incorporate life skills and livelihood skills in national plan of action
- Enhance capacity and expand VCT services as well as comprehensive service package to ensure adequate coverage of high-risk groups
- Identify networks and mobilise community based organisations & NGOs for mass communication and social marketing

China – Laos – Myanmar

- Establish and strengthen sub-group on HIV and harm reduction under the UN Theme Group
- Advocacy at different levels
- Capacity building of all partners (UNICEF/government/NGOs)
- Sensitise governments, policy makers through regional forums (ASEAN)
- Networking and sharing experience material in region / cross region

Sri Lanka

- Advocacy for implementation of National Policy for 'Drug Control & HIV'

India

- Migrant workers from Nepal acquire HIV in India through feeling freer than in their own communities; awareness programs can help and are one of the targeted intervention in India – tip for Nepal
- Involvement of peer group in all interventions, especially for IDUs, truckers, CSW; so reliable data on who is infected and who uses drugs can be collected
- Capacity building in various groups like teachers, health care sector

Bangladesh

- Needs assessment & strategic planning on harm reduction – review, revamp
- Advocacy and sensitisation on harm reduction with policy makers / service providers & community stakeholders
- Explore possibilities to integrate HIV/AIDS & substance abuse issues into existing youth, reproductive health, education programming with life skills based education
- Capacity building on counseling and VCT related to harm reduction & HIV/AIDS
- Strengthen inter-country coordination mechanisms
- **Regional:** Cooperation and joint strategies to deal with cross border issues related to AIDS/drugs/trafficking & migrant workers

Thailand

- Should be an official resolution from the workshop
- Have national workshop on youth, drugs and HIV/AIDS
- Regional forum on youth, drugs and HIV – not enough youth in workshop
- National Youth Forum

Indonesia/Vietnam**Recommendations for UNICEF**

- Improve networking, exchanges and establish links with other countries, other regions
- Identify a focal point for Harm Reduction among drug users who should work in close collaboration with other agencies
- Serve as a focal point for life skills-based education
- Should UNICEF take lead in Harm Reduction? UNICEF should collaborate with other UN agencies, advocate with government and with donor agencies

Recommendations for the government

- Close collaboration and coordination between the drug/narcotics control ministries/departments and the national AIDS Control bodies for prevention of HIV/AIDS among injecting drug users
- Adopt a new approach which should be combination of the 'medical', legal and rights approach
- Facilitate exchange visits to countries for policy makers to learn from effective programmes
- Coordinate donors efforts so as to avoid 'separate islands' of donors working in isolation on projects

Annex 6: UNICEF proposed follow-up action plans and recommendations

EAPRO follow-up meeting, Kathmandu, 22 March 2002

Next Steps for Preparation and Participation in Harm Reduction/Young People/ Substance Abuse/ HIV-AIDS issues, leading to the 2003 Harm Reduction Conference, Chiang Mai , Thailand

The EAPRO group concluded that the upcoming Global Conference will provide an opportunity to address harm reduction in a meaningful way, yet using minimal resources. The following are suggestions for possible next steps, followed by agreed-upon actions for EAPRO and Country Offices represented at the meeting:

- Some countries will prepare and conduct National Workshops (eg. Thailand) as a preparatory step for the Global Conference next year.
- All countries will work on improving the availability of data, or enhancing the use of existing data on substance abuse/ HIV-AIDS/ young people issues
- All UNICEF Country Offices need to review intersectoral collaboration and convergence, and define methods of working together on HIV/AIDS issues. Countries with active, successful methods (such as Myanmar, with the CHAT will share experience and Terms of Reference of working groups to help guide the process in other countries)
- All UNICEF Country Offices need to seek high level senior management support for the harm reduction/ young people/ substance abuse/ HIV-AIDS outcomes of the Kathmandu Workshop.
- All countries require a standardized terminology to use when the raising and addressing the issues of harm reduction/ young people/ substance abuse/HIV-AIDS. These may differ from country to country, but should be agreed upon at least within the organization, and well defined.
- All UNICEF- Country Offices need to prepare a very brief situation report (maximum 2-3 pages) to describe the current state of affairs. This report should be shared by the CO Rep. with the Regional Director of EAPRO.
- At-risk countries (at least) and any other interested countries should be invited to participate in the mapping exercise, to chart, review, assess, and analyse on-going and past activities in the areas of harm reduction/young people/ substance abuse/ HIV-AIDS. UNICEF-EAPRO would consider hiring a regional consultant to coordinate the exercise, and to provide technical assistance within some countries(upon the request of Reps) to carry out the mapping exercise.
- With the detailed situation assessments, Country Offices could review country program activities to determine gaps and possible entry points / opportunities for programming and advocacy.
- With the detailed situation assessment, UNICEF Reps could raise the issues at UN Theme Group meetings to determine potential interest and commitment from other UN Agencies, and to develop a new framework (or to adapt/revise an existing framework) for working on issues of harm reduction/ substance abuse/ HIV-AIDS to include a focus on youth people.
- Once UN Agency commitment and interest is determined, a process of working with the broader HIV-AIDS prevention and treatment agency community will be initiated to further define roles and responsibilities.
- Ultimately, in each country, UNICEF's role in both programming and advocacy will be defined, and at regional level, UNICEF-EAPRO's role in coordination, fund-raising, advocacy and communication with Global level will be activated.

ACTIONS

EAPRO:

- Share AUSAID and UNDCP project documents with all EAPRO country offices.
- Finalize KTM Workshop report and send (at least an executive summary) within one/two weeks to Country Offices.
- Investigate possibilities for organizing/ coordinating a regional situation assessment /mapping exercise.
- Provide information to Reps at the upcoming May RTM meeting, reviewing the outcomes of the KTM Workshop, giving an overview of the situation in the region based on available data as well as country offices briefs, informing RTM members about the Global Conference in 2003, and suggesting possible next steps.
- Consider sponsoring a regional event (workshop or seminar), prior to the April 2003 Global Conference, to bring together partners from the region, to prepare inputs to the 2003 meeting, and to highlight and address specific issues of concern, including cross-border issues.

COUNTRY OFFICES:

- Brief upon return from KTM Workshop, to HIV/AIDS working groups or task force, and to senior managers (Rep, SPO and Section Chiefs)
- Prepare a 2-3 page briefing note on the current situation of harm reduction/young people/substance abuse/HIV/AIDS programming and advocacy, and send through Rep, to EAPRO Regional Director by mid April so that results can be compiled and shared with Reps at May RMT
- After discussion with CO office staff and partners, request assistance to conduct a broader mapping exercise in each country.
- Share results of the mapping exercise with internal UNICEF HIV/AIDS working groups at country office level, and with UN Theme Groups at national level.
- Consider preparing and holding a national workshop, in preparation for the April 2003 Global Conference.

UNICEF ROSA Follow-up meeting, 22 March, 2002

Recommendations for follow-up action steps for advocacy and strategy development for HIV/AIDS prevention among young drug users and for reduction in drug based on meeting with country office participants from Bangladesh, Nepal and Pakistan:

1. Sensitisation and internal advocacy with senior management:
Action: ROSA to send report of workshop to country Reps and SPOs with recommended follow-up steps and further follow-up during regional Advisers' visit
2. Advocacy at country level through ROSA technical and financial support:
 - Conduct in each country a mapping/ situation assessment of status of drug use HIV/AIDS prevalence among injecting drug users among young people and analyse on-going activities on harm reduction and share the report widely.
 - Based on findings of above, country offices can determine together with the other members of the UN Theme Group their 'niche' in HIV/AIDS prevention among drug users and develop country strategy based on coordination and partnership and for a collective UN advocacy voice
 - organise a similar workshop at country level with the major stakeholders for sharing of findings of mapping/assessment, sharing of lessons learned and for development of strategy and action plan with roles and responsibilities clearly defined
 - advocacy focus should be on a shift from punitive measures to creating supportive environment and for inclusion of government departments other than only health
 - organise participation at the 2003 Harm Reduction Conference organised by the Asian Harm Reduction Network, Chiang Mai, Thailand
3. Country office to work closely with the UNAIDS established data base centres in each country on improving the availability of desegregated by age and sex; use of data, development of specific indicators on substance abuse/HIV/AIDS/ young people issues for advocacy and planning for evidenced based strategies. Action: ROSA to coordinate with UNAIDS
4. Country offices to explore possibilities of collaborating with juvenile justice programmes in particular for integration of services for harm reduction
5. Strengthen lifeskills-based education approach in the country offices and its partners and use this approach as a vehicle for mainstreaming in education and child protection sections

Role of Regional office

1. Finalize regional workshop report and send it soonest to country offices and review report implications for country work with Reps and SPOs
2. Organise technical support to country offices in life skills based approach for HIV/AIDS prevention among young people and to include protection from drug use
3. Prepare a regional advocacy report to be widely shared among UN agencies, donors based on a regional situation assessment /mapping exercise which can be a compilation of country level mapping.
4. Conduct discussions on inclusion of issues related to drug use related HIV/AIDS epidemic with the World Bank during their appraisal/ project formulation missions to countries in the region so that funding can be allocated to prevention among drug users
5. Support countries in catalysing donors, fund raising, advocacy and strategy development.
6. Together with EAPRO, plan the role and participation of UNICEF at the 2003 Harm Reduction Conference

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*“If our children don’t die of AIDS,
they die of drug overdose. What is
the way out? We are exhausted.
Both my younger sons are injecting
drugs. I have lost the older one to
AIDS.....”*

*Mother of four teenage children,
Manipur, India.*