

Manual for

# REDUCING

drug related harm in Asia

**The Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research  
and Asian Harm Reduction Network**



**Revised and  
Updated**

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Macfarlane Burnet Centre for Medical Research and  
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The Centre  
For Harm  
Reduction



Burnet Institute



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The Manual for Reducing Drug-Related Harm in Asia

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#### Contact details

The Centre for Harm Reduction  
The Macfarlane Burnet Institute for Medical Research and Public Health Ltd  
Commercial Road, Melbourne, Victoria, 3004, Australia  
PO Box 2284, Melbourne, Vic, 3001, Australia  
Tel: +61 3 9282 2169  
Fax: +61 3 9482 3123  
E-mail: crofts@burnet.edu.au  
Website: www.chr.asn.au/

Asian Harm Reduction Network  
P.O. Box 235 Phrasingh Post Office  
Chiangmai, Thailand, 50200  
Tel: +66 53 801 494  
Fax: +66 53 801 495  
E-mail: arhn@loxinfo.co.th  
Website: www.ahrn.net/

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**Editor:** Nick Crofts

Lead writer: Genevieve Costigan

Other writers: Nick Crofts, Gary Reid

Cartoonist: Julie Smith

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# Introduction to the First Edition

**O**F ALL the epidemics of HIV (the ‘AIDS virus’) among the different groups in the community whose behaviours put them at risk, none is more rapid or devastating than epidemics among people who inject drugs. But at the same time, nowhere in the field of AIDS prevention are there such dazzling success stories than with prevention of HIV among injecting drug users.

We know how to prevent spread of HIV among injecting drug users: where this has been done, not only does it give breathing space to tackle the problems of use of illicit drugs, it also prevents extensions of these epidemics to sexual partners and to children of drug users. Compared with achieving behaviour change to stop HIV infection with other groups, stopping HIV among injecting drug users is relatively easy.

Why then are there raging epidemics of HIV among injecting drug users, their sexual partners and their children in many parts of world, especially over the last decade in Asia? Action has not been taken to stop these epidemics because of ignorance – about the importance of prevention, and about how to go about it; because of fear – the fear that acting to prevent HIV among drug users will somehow encourage drug use; and because of prejudice – that people who inject drugs are somehow less than human, and that their human rights have vanished because they use drugs.

This Manual grew out of the combined efforts of many people battling in Asia to stop HIV. It contains the accumulated experience of over decade of attempts to change policy and implement programs to stop this devastating scourge, collected over several years from many countries in Asia. We sincerely hope this Manual will provide a valuable resource for those arguing to get programs to stop HIV and other harms among drug users, their sexual partners and children in Asia; for those beginning programs; and for those already in the fight.

There are two enemies: one is HIV, the other is the ignorance, fear and prejudice which support and fuel HIV epidemics. We hope this Manual will help in some small way those battling to overcome both these threats. We welcome feedback from anyone using this Manual on ways to make it more useful, and we will continue to try to upgrade it, finding funding to produce country-specific versions in particular.

HIV will be defeated, but to achieve this we must defeat ignorance, fear and prejudice. We wish you all the greatest success in your most important work to achieve these goals.

Dr Nick Crofts  
Director  
The Centre for Harm Reduction

# Introduction to the Second Edition

*Manual for  
reducing drug  
related harm  
in Asia*

SINCE THE publication of the first edition of *The Manual for Reducing Drug Related Harm in Asia* (in 1999), and partly as a result of its publication and of that of two editions (1997, 2002) of *The Hidden Epidemic*, a regional situation analysis of drug use and HIV vulnerability in Asia, there has been heightened awareness and recognition of the HIV epidemics among IDUs in most Asian countries. An increasing level of awareness has been partly matched by an increasing level of funding for programs and for program development. It is no longer the case that these epidemics are seen as unimportant; there have been trials of most harm reduction strategies in Asia, including outreach, peer education, needle and syringe programs, and substitution therapies.

However, programs are still too few and too small. Few harm reduction programs in Asia are government supported or integrated into mainstream service delivery, be it primary health care or drug treatment. There is little if any evidence that a decade's work has actually had any significant impact on the rate of growth of the multiple HIV epidemics centred around IDU transmission. There is now the challenge of scaling-up programs which have been demonstrated to be safe and effective to a point at which they will have a significant impact – this is being attempted in Dhaka, Bangladesh; Manipur State, India; and Nepal. It is to be hoped these scaling-up efforts will show the way forward.

But further advocacy is required. IDUs are still subject across the region to neglect, incarceration and discrimination; HIV epidemics among IDUs are still relatively downplayed in most countries, with more socially palatable epidemics the focus of attention.

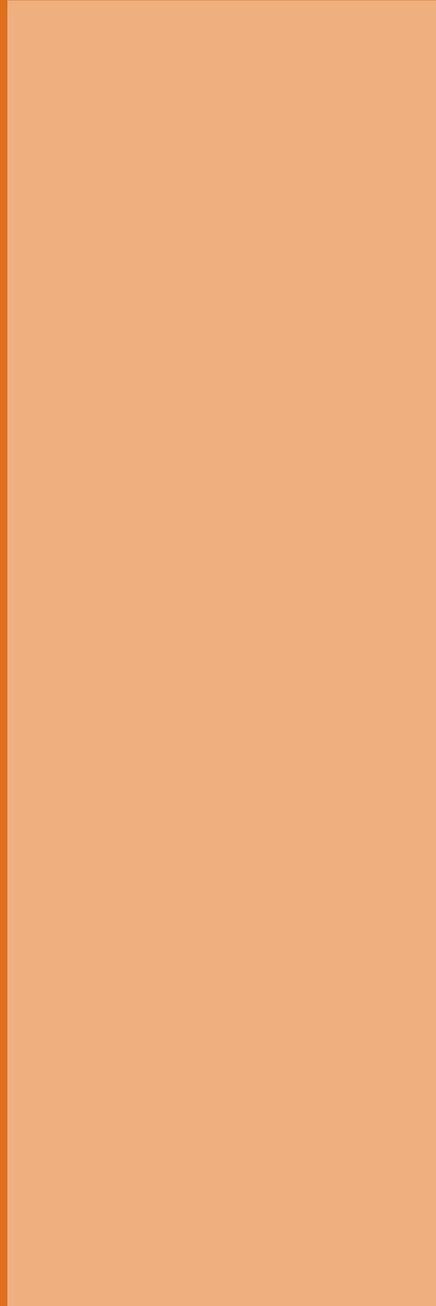
It is very clear that this epidemic can and must be stopped; we know exactly how to do this. We hope this updated, revised and expanded second edition of the *Manual for Reducing Drug Related Harm in Asia* will prove as useful a tool for advocacy and for guiding program design and implementation as was the first. And again, we wish all those engaged in the fight against HIV, discrimination and other human rights abuses the best in their continuing struggle.

Nick Crofts  
Director  
The Centre for Harm Reduction

# **Section 1**

## **Background and Rationale**

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# Section 1

## *Chapter One*

# Drug Use and HIV Vulnerability

History of the drug trade in Asia

Emerging trends: drug use

Explosive epidemics

HIV among IDUs in Asia and the West

**Drugs in Asia**  
**-The Ever-Changing Scene**

**T**he consumption and injecting of illicit drugs is increasing around the world, involving at least 15 million people in over 130 countries. Patterns of production, consumption and administration have changed rapidly since the early 1990s, and continue to change rapidly. Countries where the biggest changes are occurring, involving the biggest populations, are in the developing world, especially in South and South-East Asia and in Latin America. Many western countries experienced epidemics of heroin injecting beginning in the late 1960s, and these have continued. Many Asian countries began to experience such epidemics in the late 1980s, and this trend is continuing across Asia into the new millennium.

Changes from the *smoking of opium* to the *injecting of heroin* have come about with changing distribution routes, changes in the purity of available drugs and the introduction of injecting as a route of administration. The injecting of drugs is now a problem in over 130 countries worldwide, with an estimated 15 million people regularly injecting drugs globally; over 110 of these countries have reported **HIV infection** among these **injecting drug users (IDUs)**.

**These three epidemics** – of opiate use, of heroin injecting, and of HIV infection among heroin injectors – **can develop extremely quickly, and often unexpectedly**. However, the epidemics have developed differently and to varying extents in different countries. It is worth examining these developments in several parts of the world to discover what makes them different and to discover whether there is anything that can be done to prevent such epidemics.

**This Manual is primarily about the prevention of HIV infection among injecting drug users in Asia.** It will also cover questions of the prevention of drug use and of drug injecting, as these are fundamental to the spread of HIV among drug injectors. However, it must be borne in mind that prevention and control of drug use are *long-term* issues, whereas HIV can spread

**Globalization of the HIV/AIDS pandemic in IDUs**

	1992	1991	1996	1998	1999
Number of countries					
IDU	80	118	121	128	134
HIV+	52	78	81	103	114

Source: WHO, UNAIDS

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with extraordinary rapidity. **The first imperative is to prevent the spread of HIV**, because it is so devastating in its effects, and once it has begun to spread it is *much* harder to control. In this Manual, we will examine the evidence that these epidemics are predictable and that they are preventable. To understand better why HIV spreads among drug users, and what can be done to prevent this spread and protect the community, we will review the experience of several countries – in western countries, in Latin America, in Asia, and in the region of Central and Eastern Europe and the former Soviet Union. By doing this we will be able to see common principles underlying both the spread of HIV among IDUs, and the implementation of effective responses to prevent the spread.

## The History of the Drug Trade in Asia

Opium has been produced throughout south and central south-east Asia for centuries. The extracted opium from the opium poppies was fundamentally administered by smoking (as a *recreational* drug) and also ingested by mouth (for medicinal purposes). China was a major producer of opium and, until 1949, the world's largest consumer. In 1949, China had an estimated 20 million people (about 5 per cent of the population at the time) who were addicted to opium. Currently, the two major areas producing opium for the illegal market are:

- the Golden Triangle region of Thailand, Myanmar and Laos in south-east Asia. (At the end of 2002, Myanmar is the second largest source of illicit opium in the world, with Laos in third place), and
- the Golden Crescent region of Pakistan, Afghanistan, Iran and Turkey in western Asia. (In 2000, Afghanistan was the world's largest opium producer but civil conflict, military attacks on the country and the overthrow of the Taliban regime, resulted in their share of global

production falling to 12 per cent by the end of 2001. However, since the fall of the Taliban, Afghanistan is once again the world's largest opium producer).

Until the 1960s, much of the opium produced in the Golden Triangle was for local consumption, where it was smoked especially by the older people in the region. During the US war in Vietnam, several things changed. Firstly, trade in opium to the outside world was stimulated to raise revenue to carry on the wars in Cambodia, Laos and Vietnam. Secondly, supply routes to the US were opened up, partly through the involvement in drug use by the US Army in Vietnam. Some of these supply routes went through Australia, though the largest went through the Philippines. In the US itself there was a ready market among disadvantaged black and Hispanic ghetto dwellers in the big cities in the north-east and mid-west, whose economic and social positions had been growing steadily worse through the 1960s.

This trade to the US, which rapidly grew to become a billion-dollar market, consisted mostly of opium exported from Burma and Thailand, especially through Bangkok. The opium was refined into heroin for the US

market in the Philippines and in the Mediterranean, particularly by the Mafia in the south of France, Italy and Corsica.

Throughout the 1970s, US-led efforts to prevent the trafficking of opium had several effects: heroin refining factories in the Philippines and the Mediterranean were closed down, and trafficking through Malaysia and Singapore became much more difficult. Thailand managed to restrict the trade through Bangkok, and the Myanmar government had minor successes in

preventing trafficking from the south of Myanmar. However, the demand for the drug, and therefore the market, did not go away; in fact, the opposite happened – it continued to grow.

There were two immediate effects of this restriction of traffic through the south coast of south-east Asia and the closure of the heroin factories in other countries. Firstly, new trafficking routes opened up: through the north of Myanmar, across the Indian border through the north-east Indian states



Golden Triangle and supply routes

## Emerging trends: drug use

of Manipur and Mizoram, and across the north of India through Pakistan and Afghanistan to Europe. This route was aided by increasing involvement of Afghanistan *mujabadeen* in the drug trade to finance their purchases of arms through the south of China to Hong Kong and Macao, and onwards to the US, Europe and Australia. This was aided by China's 'Open Door' Policy in 1982, freeing up traffic across the borders.

Secondly, the refinement of opium into heroin moved back to the actual production countries, especially to Myanmar. There are several advantages in trafficking heroin as opposed to opium: it takes up less than a tenth of the volume, it has less smell (making it more difficult for sniffer dogs to detect), and it is more profitable. Additionally, it is ready for the market, so there are fewer middle men involved, which means more profit and less chance of detection.

Throughout most of the 20th century, national and international interventions to control illicit drugs have been progressively strengthened. Penalties for cultivating, producing, transporting, distributing, selling or administering psychoactive substances have been increasingly severe (except for alcohol and tobacco). In the latter part of the century, patterns of illicit drug use emerged that are now becoming *globalised* and *standardised*. Simple strategies to deal with the drug problem have become largely ineffective due to the complexity of global drug production, distribution networks, diversified marketing and new and emerging markets that are both dynamic and thriving. The changes in production and distribution patterns have exposed new populations to opiates, both for their consumption and for their trade. This has resulted in an increase in opiate use in many populations in Asia who had not used opiates before.

The shift to production and distribution of high-grade heroin made injecting a reality. Combined with increasing costs due to law enforcement crackdowns, and as a response to what was seen as a western fashion, injecting drug use followed hard on the heels of these opiate epidemics. A generation or two ago, heroin injection was rare on the Asian mainland.

In recent years the production, distribution and use of amphetamine type substances (ATS) have flourished. Based on global ATS seizures most ATS production occurs in the Asia, and worldwide over 50 per cent of ATS use is found in Asia. It is the drug of choice or fast becoming so in Thailand, South Korea, the Philippines, Taiwan, Japan, Cambodia, Laos, China and Indonesia.

Currently, countries where injecting is not found in Asia are the exception rather than the rule.

Chapter  
One  
*Drug use and  
HIV  
vulnerability*

Smoking or inhaling of drugs does not carry a direct risk of HIV transmission.

When the drug becomes scarcer as a result of drug control efforts, it becomes uneconomical for the drug user to smoke or inhale the drug, as much of it is lost in smoke. This is a major reason why drug users turn to injecting, and this route of administration ensures that *all* of the drug is used. In most settings in the developing world, for many reasons, injecting involves frequent reuse of the same equipment by different people without adequate cleaning in between. This is the perfect situation for the rapid transmission of blood-borne viruses such as HIV (the AIDS virus) and the hepatitis B and hepatitis C viruses. It also causes many other illnesses among the drug injectors, including septicaemia and heart disease, and occasionally outbreaks of malaria.

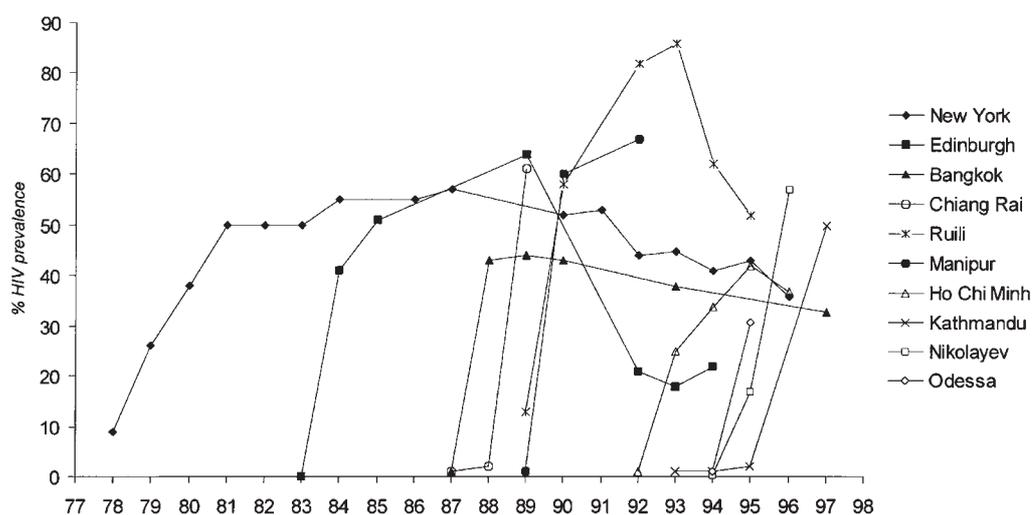
Changing patterns in the production, trafficking and use of heroin, especially from the Golden Triangle region of Myanmar, North East India, China, Thailand and Laos, has led to a series of HIV epidemics among drug injectors across Asia. HIV infection

among IDUs has been reported in Bangladesh, Brunei Darussalam, Cambodia, China (including Hong Kong and Macau), India, Indonesia, Iran, Japan, Lao PDR, Malaysia, Mongolia, Myanmar, Nepal, Pakistan, the Philippines, Republic of South Korea, Singapore, Taiwan, Thailand and Vietnam.

One of the consistent features of this epidemic has been the close relationship between the spread of HIV infection among IDUs and drug trafficking routes. Drug trafficking routes have become less stable over time as intense efforts by law enforcement to control drug supplies have resulted in the movement of these routes to new areas where there are – temporarily – lower risks. This instability of drug trafficking routes has, unfortunately, had the unintended negative consequence of exposing additional larger populations to the threat of HIV infection among and from drug injecting users.

Populations of drug users develop rapidly along trafficking routes, creating new drug markets and HIV threat in host countries.

Figure 1: HIV prevalence among IDUs in selected locations, 1987–1996



## Explosive epidemics

The diffusion of HIV among IDUs has been most pronounced in drug producing and transport countries in south-east Asia. Epidemics of HIV that can only be called explosive have been documented among IDUs in China, Thailand, Myanmar, Malaysia, Indonesia, Iran, Vietnam and north-east India. The prevalence of HIV infection among injecting drug users has often reached 60-90 per cent within six months to a year from the appearance of the first case. In many countries, explosive epidemics among IDUs then form epicentres for wider diffusion of the HIV epidemic to other parts of the community. In some places up to 60 per cent of IDUs have been infected with HIV within the first two years of injecting.

Several communities in Asia have had HIV among IDUs for some time and are now in the grip of multiple ongoing epidemics:

- of drug use and its consequences
- of HIV infection among IDUs
- of HIV transmitted from IDUs to their sexual partners and their children
- of subsequent AIDS
- of tuberculosis.

While the scenario of these epidemics is totally predictable, and much scientific evidence is available to support the belief that they are preventable, implementing action to prevent such epidemics has often been fraught with legal, 'moral', religious and political obstacles.

## HIV among IDUs in Asia and the West

To understand better why HIV spreads among drug users, and what can be done to prevent this spread and protect this community, we will review the experiences of several countries in western countries – in Latin America, in Asia, and in the region of Central and Eastern Europe and the former Soviet Union. By doing this we will be able to seek common principles underlying both the spread of HIV among IDUs, and the implementation of effective responses to prevent this spread.

### The United Kingdom

When testing for HIV began in England in 1985, over 90 per cent of all those found to be infected were homosexual men. Only a very small proportion of IDUs were HIV infected, and this has been maintained. Currently a substantial proportion of HIV infections in England (70 per cent) are acquired through heterosexual contacts, of whom most are from, or have lived in or visited, high HIV prevalence countries.

In Scotland, however, just north of England and with no effective border between them, the picture was very different. When testing first began in Scotland, over 80 per cent of those found to be infected were IDUs. Since then this proportion has been reduced for two reasons: firstly, because the spread has slowed among IDUs, and secondly because HIV has spread more widely in other groups, especially heterosexuals and children. As in the US, much of this spread to other groups has come from the IDUs.

Why did the epidemic take such different forms in two countries which are so close, geographically and culturally? In fact, if we were to look more closely into the situation, the differences are just as profound within the countries as between them. For instance, Edinburgh had a massive epidemic of HIV

among drug users beginning in the early 1980s (exceeding 40 per cent within two years of the first reported case), while in Glasgow, another Scottish city only 70 miles away, the HIV prevalence was around 1 per cent. The low rate was due to implementing early, wide-scale interventions, including a needle syringe program (NSP), encouragement to use bleach if sterile equipment was not available, and the development of an HIV awareness campaign targeting IDUs.

By 1990 there were approximately 250 NSPs operating in England and Wales and by the end of the 1990s there were over 2,000 outlets (pharmacies and other outlets) throughout the United Kingdom distributing an estimated 27 million syringes annually. Drug treatment services experienced a major expansion from the mid-1980s and methadone as a substitution therapy became widely available. In 1999, the HIV prevalence among IDUs in England was 1 per cent and there are no HIV infections among IDUs under 25 years of age.

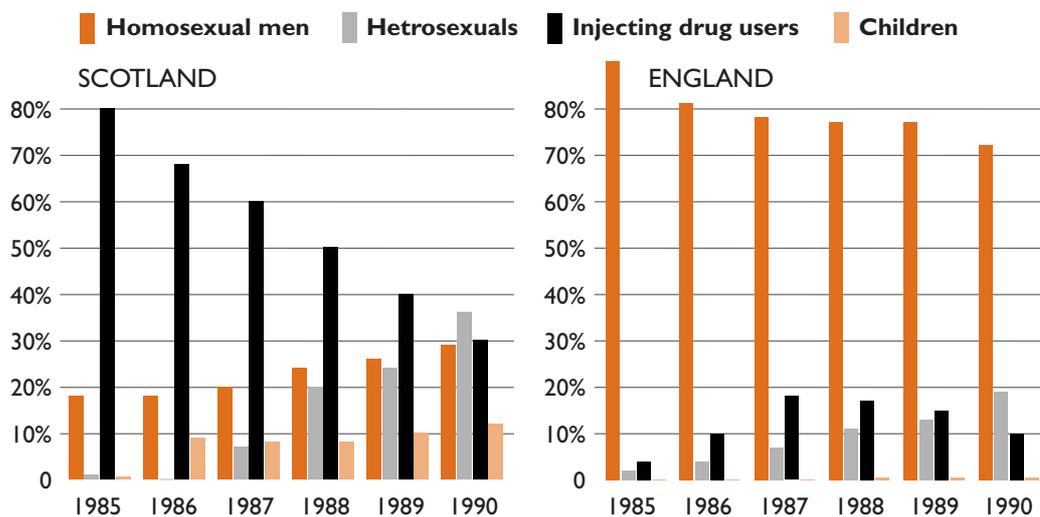
Even where there is much drug use and much injecting of drugs, and HIV is around, it is not inevitable that an epidemic of HIV infection will occur among IDUs. This is the first major point:

HIV epidemics among IDUs can be prevented.

The second major point is that although IDUs may form only small proportions of the population, they can be extremely important in the development of the HIV epidemic in a particular community, this being more so if substantial proportions of IDUs are sex workers and vice versa. This is so, firstly, because HIV can spread so rapidly through IDUs, and secondly because having done so they can then spread HIV to their sexual partners, their children and the rest of the community.

Injecting drug users provide an important focus for spread of HIV to the rest of the community.

Figure 2: Testing for HIV in England and Scotland



USA

In the mid-1960s, America started to experience an epidemic of heroin use. On the supply side, this was because of the opening up of trafficking routes from the Golden Triangle region of south-east Asia due to the US involvement in the Vietnam War. On the demand side, it was due to the disintegration of the inner areas of the big cities of the north-east and the mid-west of the US: New York, Baltimore, Jersey City, Chicago, Philadelphia and so on, especially among the black and Hispanic minorities. For example, during the 1970s, in some of the black areas of Chicago or the Bronx in New York, adult unemployment reached 80 per cent or more, and poverty, crime and drug use became the predominant feature of these societies.

At this point it should be noted that, for a variety of circumstances, through the 1970s, a phenomenon known as ‘shooting galleries’ grew up in the US. They are named after the slang term for injecting, ‘shooting’. They are places where an injector buys and prepares the drug, and then injects using the syringe and needle that are kept there. He or she then leaves this syringe and needle behind for the next person to use. In this way, the one syringe and needle might be used by 20-50 different people. Around 1977, when HIV arrived in the US, thousands of these shooting galleries existed. In this setting HIV spread rapidly, and still does. We will look into the reasons for these shooting galleries later, but what needs to be emphasised here is that the worst situation for the spread of HIV among IDUs is when equipment is shared among many people. The other setting in which this occurs in the US, and globally, is in prisons. There is less drug use in prison than on the outside because drugs are more difficult to obtain in

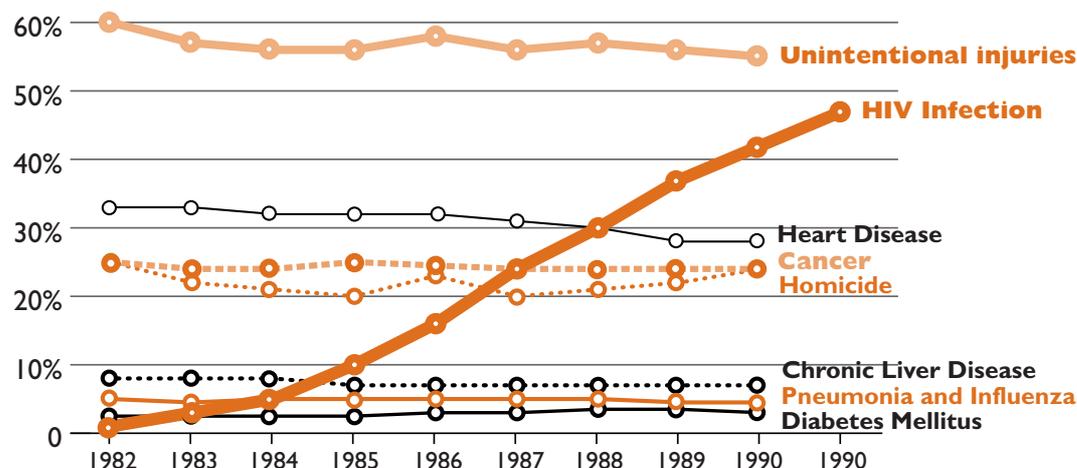
prison. However, drug use occurs in every prison in the world, and because of the scarcity of equipment every injection is very likely to be unsafe and the same syringe and needle may be shared by 50-100 people.

HIV spreads most rapidly among injecting drug users when equipment is shared between many people.

Figure 3 shows the major causes of death in the United States among men aged 25-44 years, the most productive years of life and the major reproductive years. While most other causes of death have been slowly coming down (with the exception of homicide), over a single decade in the 1980s HIV infection has gone from not being a cause of death to being the second leading cause. Throughout the 1990s, HIV was the leading cause of death of young men.

Much of the HIV infection in the US has been among homosexual men. However, since the start of the epidemic more than one-third of all AIDS cases (36%) in the country have been directly or indirectly linked to drug injecting, and this trend has not changed. In New York City in 1993, 50 per cent of new HIV/AIDS cases were among drug users, with only 33 per cent among homosexual men. Over half of all women infected with HIV in the US are either drug users or the sexual partners of drug users. Most of the children who are born infected with HIV have one or other parent who is a drug user. In 2000, the prevalence of HIV among IDUs in New York City has dropped to around 30 per cent and this is largely a result of the introduction and impact of NSPs. The epidemics of drug use and of HIV

Figure 3: Leading causes of mortality among males aged 25-44 in the United States



are strongly associated with race: in 1998 the drug injecting associated HIV infection rate was 10 times higher among African Americans than among whites. This is because of the much greater poverty among African Americans than among whites. The US has failed to cope with these epidemics. Similarly in Western Europe, while in 1984 IDUs made up only 7 per cent of AIDS cases, by 1992 they made up 39 per cent, a higher proportion than among homosexual men, who made up 35 per cent. In 2001, IDUs made up 32 per cent of AIDS cases, a larger proportion than among homosexual/bisexual men, which stood at 19 per cent. Heterosexually acquired cases among males and females form the largest group at 36 per cent.

It is not drug use which causes HIV infection, it is not even drug injecting, it is the sharing of contaminated injecting equipment that transmits HIV infection.

### Australia

HIV infection appeared among IDUs in Australia as early as 1984, but did not spread greatly. Australia had an epidemic of heroin injecting beginning in the early 1970s, and continuing today. A second epidemic, of amphetamine use, began in the early 1980s and also continues. Although there is much drug injecting in Australia, and HIV has been present in these populations for over a decade, the rates of HIV infection among injecting drug users remain very low, less than 2 per cent.

The major reason why HIV has not spread among IDUs in Australia is because policy makers there took heed of what they saw happening in the US and realised that if they acted quickly they could prevent the HIV epidemic among IDUs from taking off. From the outset the response was based on public health, with harm reduction accepted at the most senior level. Starting in 1984, Australia introduced harm reduction policies and programs, especially community education, peer education, needle and syringe distribution and disposal programs, and substantially boosted drug treatment programs, especially methadone maintenance.

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## Brazil

Brazil does not produce much cocaine. The coca tree, from which cocaine is derived, grows best at higher altitudes and the central countries for production are therefore those in the Andes mountain ranges: Colombia, Bolivia and Peru. Historically, the cocaine has passed from these countries northwards through Central America to the United States, where from the late 1970s a huge epidemic of cocaine use has existed. Much of this cocaine came through Panama, onwards to Florida and the east coast.

Through the 1980s, the US government spent billions of dollars trying to stop this trafficking. There were two fronts to this drug war: stopping production in South America, and preventing trafficking through Central America. The first battle has so far failed; the second battle has been successful, but at the cost of the US invasion of Panama.

The effect of these efforts has been to decrease the flow of cocaine through Central America, but not to stop either the supply of, or the demand for, the drug in the US or Europe. As with the export of heroin from the Golden Triangle, traffickers have simply found different ways of getting the drug out of Central America, mainly through Brazilian ports and on to Europe and the east coast of the US. As a result, since the beginning of the 1990s, enormous amounts of pure cocaine, particularly from Colombia, began leaving Brazil, especially from the port cities of Santos and Rio de Janeiro. Even though the drug can be inhaled or smoked, and it is pure and cheap, the people in these cities are so poor that they cannot afford to buy much and cannot afford to waste any. In the early 1990s there was a huge epidemic of cocaine injecting in the large cities in Brazil, and along with this an explosive epidemic of HIV infection. In Brazil, IDUs have played a central role in the HIV/AIDS epidemic,

especially in Sao Paulo State and on the south coast. In Santos, HIV prevalence among IDUs reached 50-60 per cent in the early 1990s and in Rio it reached approximately 25 per cent. While HIV first spread among drug users, it moved into the heterosexual populations, through prostitutes who were drug injectors and through their clients. The main lesson here is that:

Epidemics of drug use and drug injecting can occur extremely quickly, where there is an at-risk population and where supply routes change so that the drug becomes available.

In 2000, 21 per cent of AIDS cases were found among IDUs. Nationwide the HIV prevalence among IDUs fell from 63 per cent in 1992 to 42 per cent in 1999, although it has been suggested this may be related to the transition from cocaine injecting to crack cocaine smoking. Brazil was the first country in Latin America to introduce a range of risk reduction activities targeting IDUs, and in 1995 in the City of Salvador the first NSP was opened. In 2001, 41 NSPs operated throughout Brazil.

## Thailand

The first cases of AIDS were reported in Thailand in 1984, in people who were either foreign born or had contact with foreigners, particularly in America. Through 1987 there did not appear to be very much spread of HIV, but in late 1987 and early 1988 there was suddenly an extremely rapid spread of the virus through IDUs. This spread was so rapid that almost half of all the thousands of drug injectors in Bangkok were infected within 18 months. This again illustrates the speed with which HIV can spread through a population of IDUs given the wrong conditions.

Thailand did not heed the warning signs. Throughout the mid-1980s, many in the Thai health services said that AIDS was not a threat to Thailand. They were disastrously wrong. Since the beginning of the epidemic nearly 300,000 people have died of AIDS and it has been estimated at the end of 2001 an estimated 670,000 adults and children were living with HIV/AIDS. In 2001, an estimated 55,000 people died of AIDS alone. Many in the public security services have said that stamping out drug use was more important than preventing an HIV epidemic. While HIV prevalence in recent years among army conscripts, pregnant women and sex workers has declined sharply, this has not been observed among IDUs. In 1995, the national HIV prevalence among IDUs was 32 per cent, increasing to 51 per cent in 1999 and 54 per cent in 2000. It has been estimated that 5-10 per cent of drug users become HIV infected each year.

Preventing an epidemic of HIV among drug injectors may not have prevented an AIDS epidemic in Thailand totally, but as the risky behaviour among this group has not been addressed it does consequently stand out as a major cause of continued HIV transmission in the country. Since the late 1990s there has been a dramatic increase in methamphetamine use and there are now an estimated two to three million drug users in the country. While most methamphetamine is smoked or ingested it may still facilitate increased sexual risk taking and thus the potential for HIV to occur.

## India

In the late 1980s, the opening up of supply routes through northern Myanmar and across the Indian border into the north-east states of Manipur, Mizoram and Nagaland merely followed a centuries-old smuggling and trading route. However, it was also responding to new markets in the Middle East and Europe, with rapid expansion of the number of drug users from Pakistan to Turkey and beyond.

With this influx of drugs and money, the young men of north-east India rapidly developed very heavy heroin habits, in a situation where accessing sterile injecting equipment was difficult. Therefore much sharing of injecting equipment (often homemade) and a resultant explosion of HIV occurred throughout the north-east: from virtually none in mid-1989 to over half infected by the start of 1990. In India it is common to hear politicians blame this phenomenon on Myanmar, ignoring the fact that there are many Indians involved in the trafficking. This is the first example of the next major lesson:

Every country blames its neighbours for its AIDS epidemic.

### Prevalence of HIV Infection among IDUs in various cities, India, 2000 (%)

City	HIV Prevalence
Imphal (Manipur)	58%
New Delhi	45%
Chennai	27%
Mumbai	24%
Kolkata	2%

Source: Dorabjee and Samson 2000; Dorabjee 2000

While there may be some truth in this from an epidemiological point of view, it is too often used as an excuse for not doing anything to stop the epidemic within one's own borders. Heroin use has been spreading rapidly in the major metropolitan cities of India since the early 1980s. By the 1990s an epidemic of injecting pharmaceuticals, in particular buprenorphine, often used as an alternative among heroin users, was found in all major metropolitan cities and has not abated. The sharing of injecting equipment among India's drug injecting community is widespread and consequently in some cities and regions the prevalence of HIV is high among these people.

### Malaysia

In north-east Malaysia there is much cross-border traffic - in drugs and sex – into south Thailand to purchase and use drugs and to use prostitutes. In Malaysia, as is commonly found throughout Asia, drug use is on the rise. In the mid-1990s there were an estimated 20,000-50,000 IDUs and by the end of the 1990s this figure increased to an estimated 200,000 IDUs. In Kota Bharu (the capital of Kelantan State in the north-east on the border with Thailand) the proportion of drug injectors entering the drug rehabilitation centres who were infected with HIV in 1991 was 9 per cent; by 1992 this had reached 30 per cent. More importantly, most of these drug injectors had not been out of Malaysia; despite the official belief that HIV was present only among those who went to Thailand; the virus was spreading within Malaysia itself. The drug injecting population of Malaysia is extremely mobile and the opportunities for HIV infection to spread to other parts of the country have been considerable; currently no state in Malaysia is free from IDUs or HIV infection. Malaysia is a country with a HIV epidemic

that primarily affects IDUs. As of the end of 2001, 76 per cent of all reported HIV infections were to be found among IDUs.

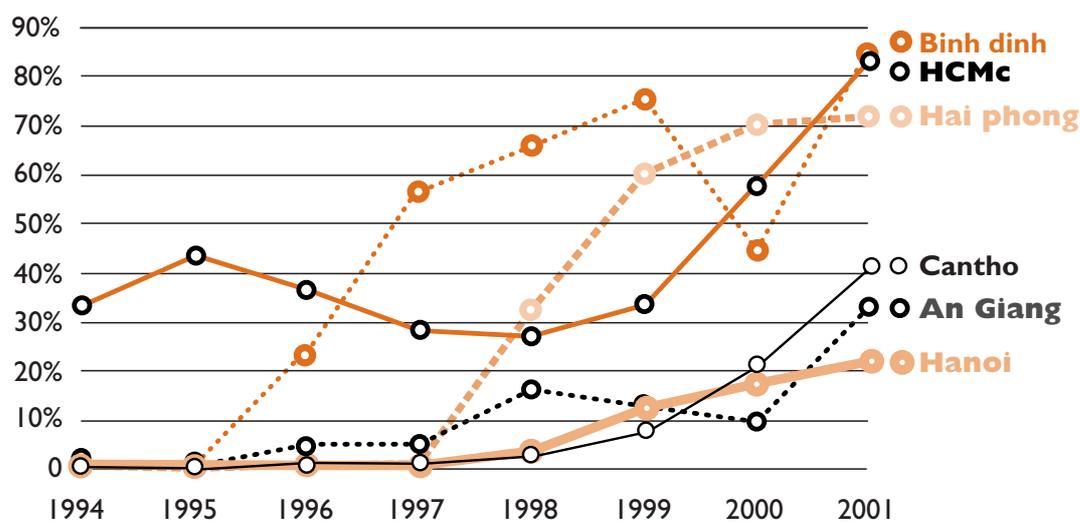
The only response to the problem of HIV among IDUs has been to increase incarceration in drug rehabilitation centres, the recidivism rate for which is over 70 per cent. There is widespread sharing of injecting equipment, which is not only a result of drug using etiquette but also because getting injecting equipment is not always that easy. Drug users can be fearful of being identified by law enforcement authorities and do not wish to be seen buying needles and syringes from pharmacies or being in possession of such equipment, which legally is an offence. Research in Malaysia, as elsewhere, has illustrated the role of sharing of injecting equipment: those with the most sharing partners are the most likely to be infected. Again, this emphasises the fact that in relation to drug use it is not the use of drugs, nor even the injecting of drugs, which causes HIV infection; it is the sharing of equipment, especially with many other people.

### Vietnam

Vietnam's epidemic of injecting heroin use goes back to the American War in Vietnam, when there was a huge influx of cheap opium for use by the US Army. The Americans generally smoked opium, rather than injecting heroin, but some injected and it is likely they taught the Vietnamese to inject. The Vietnamese for a long time made do with injecting 'blackwater' opium, the residue left over from smoking opium, and as a result they were ready when heroin started replacing opium in the 1970s-1980s. HIV did not arrive among drug injectors in Ho Chi Minh City (HCMC) until mid-1992, but when it did, it spread very rapidly, rising from 1 per cent in mid-1992 to 42 per cent

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related harm  
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Trend of HIV Infection among IDUs in selected Provinces, Vietnam, 1994-2001



Source: Nguyen Tran Hien 2001

in 1995, and continues to remain at high levels. A major reason for this initial high prevalence was the way heroin was injected. It was common practice in HCMC, and the rest of the country, for drug injectors not to inject themselves but to be injected by the dealer or by a professional injector. At the time it was estimated that in HCMC alone there were up to 3,000 professional injectors. The emergence of this injecting trait is due in part to it being a cultural habit, and in part because of the scarcity of injecting equipment. This led to the development of a phenomenon, similar to the shooting galleries in the US, where many people are injected with the same equipment, without any or adequate cleaning between injections, although it is now believed that shooting galleries are rare.

Most explosive outbreaks of HIV occur in situations where many people share or reuse the same injecting equipment. The predominant mode of HIV transmission in Vietnam is drug injecting and in 2000, HIV infections among IDUs accounted for 65 per

cent of the total reported HIV cases; high prevalence rates among IDUs have been evident since the mid-1990s. A recent phenomenon is the high prevalence of drug injecting among sex workers in various cities of Vietnam: the implication is for a rapid spread of HIV infection from this group of IDUs to the wider community.

It is common practice in many Asian countries to purchase medicines and inject them at home, and so, culturally, many people are used to needles and syringes. Additionally there is often a shared belief in the greater efficacy of injected rather than swallowed medicines. Such practices and shared beliefs can further facilitate the spread of HIV/AIDS in Asia.

## China

Since the late 1980s, China has experienced the phenomenon of epidemics of opium and heroin use, injecting of heroin and HIV infection. This occurred largely as a result of changes in trafficking routes and the opening of the Chinese border, particularly with Myanmar. By the mid-to-late 1980s the Yunnan Province, which borders with Myanmar, became a principal trafficking route for drugs entering China and a focal point for serious drug problems and an explosive HIV epidemic. As a result of the porous border separating China and Myanmar it is all too easy to go across the border to buy and use drugs; in most places there is effectively no border. Drug use has become widespread in China: 2,033 out of 2,143 counties have currently reported drug using problems. In 1990, China had 70,000 registered drug users increasing to 860,000 by 2000. However this number of drug users is not reflective of the true situation, as it is a severely punishable offence. It is estimated there may be up to 6 to 7 million drug users, of which half are IDUs.

In recent years the connection between heroin use, trafficking routes and the spread of HIV/AIDS in China has been shown. By using advanced molecular epidemiology, linking HIV subtypes to specific trafficking routes, it has been shown that HIV has

spread along the various trafficking routes and has entered provinces previously untouched by HIV infection. By 2001, a total of 27 of the 31 provinces had identified HIV among their drug injecting population and, of these, seven provinces have serious HIV epidemics among IDUs. The spread of HIV infection among IDUs first occurred in Yunnan in the late 1980s and was mainly concentrated among ethnic minorities. While reported HIV infections in China continue to be concentrated among IDUs (70 per cent of all reported infections), the spread of HIV infection has moved into the majority Han population and is increasingly transmitted sexually. While most drug users are male the number of females using drug is increasing and in the provinces of Yunnan and Guangxi they make up 16 to 25 per cent of all drug users in treatment - the majority are also involved in sex work to support their heroin addiction.

Despite efforts to curb the growth of drug use and injecting, and to prevent continued spread of HIV among injecting drug users, provincial HIV epidemics among IDUs have been spreading progressively. With a rapid implementation of risk reduction activities targeting IDUs these epidemics could have been prevented.

China continues to be a major transit country for heroin and methamphetamines, produced in the Golden Triangle, particularly Myanmar. Heroin and opium

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### Provinces and sites with highest infection rates among IDUs in 2000

Provinces	Sites and Rates			
Xinjiang	Yining 84%	Urumqi 39%		
Yunnan	Ruili >80%	Wenshan 75%	Kaiyuan 58%	Yingjiang 70%
Guangdong	Sentinel site: 21%			
Guangxi	Baise 30-40%	Pingxiang 12%	Liuzhou 12%	
Jiangxi	Sentinel site: 17%			

Source: China Annual STI and HIV/AIDS Sentinel Surveillance Report 2000 Annual Report, Guangxi Epidemic Prevention Station as cited in UNAIDS 2002

are still the drugs of choice but there are increasing amounts of amphetamine type substances being produced, trafficked and used in the country. This suggests that methamphetamine may become, over time, the drug of choice because of its cheapness, accessibility and availability.

## Nepal

Nepal is not a major producer of narcotics or on any major trafficking route, and most heroin used in the country has its origins elsewhere. The most commonly used drug is buprenorphine (commonly called *Tidigesic*), which is mainly injected. Drug injecting has become increasingly popular and, although sharing of injecting equipment occurs, surveys among IDUs in 1991 through to 1994 found HIV prevalence among IDUs was very low (it remained below 2 per cent) and was not spreading to any degree, perhaps as a result of small and isolated networks. In 1991, an outreach needle exchange and primary health care program for IDUs was established in Kathmandu, which continues to operate, but with limited resources only an estimated 10 per cent of an estimated 15,000 IDUs in the Kathmandu Valley are contacted. In 1997, 50 per cent of IDUs tested in Kathmandu were HIV positive. The latest research in 2002 shows 68 per cent of IDUs in Kathmandu Valley tested HIV positive and nationwide the HIV prevalence among IDUs is around 45 per cent.

Nepal has learnt the lesson that it is not enough simply to have small, NGO-run harm reduction programs which cannot provide national responses on the same scale as the epidemic. These programs must be taken up by governments and integrated into normal primary health care delivery if they are to be effective.

Non-government organisations generally take the lead in instigating harm reduction programs but these programs are few in number and small scale and unlikely to reach most drug users.

## Indonesia

In Indonesia the subject of illicit drug use and in particular injecting drug use was previously an extremely sensitive issue. Poor documentation and data suggested assessments were often very restricted and too problematic for government authorities to openly discuss. However, this is generally not the case any more, with major assessments taking place and public debate on drug use issues increasing. While Indonesia is not a major producer of drugs (except for marijuana), heroin is being smuggled into the country, mainly from Myanmar, and there is a major increase in production and use of methamphetamines. Since the late 1990s, the country has been faced with an unstable political environment, accompanied with economic and social upheaval. At the same time drug use also increased substantially, with drug assessors estimating there are up to 1.3 to 2 million drug users and suggestions that up to half are IDUs (in the late 1990s it was estimated to be 30,000-40,000 IDUs).

Surveys undertaken show a high prevalence of risky behaviours among drug users. Sharing of injecting equipment is widespread and often takes place between two to 11 other users, most of whom do not clean their needles properly before reuse. Before 2000, HIV infections due to drug injecting made up less than 1 per cent of total cases: in 2001 this figure had increased to 19 per cent of all cases. HIV infections in specific environments is alarming, with the main prison in Bali showing that among the incarcerated IDUs 56 per cent were HIV

infected and almost all of these having a history of sharing injecting equipment outside the prison. Recent studies show that 35-40 per cent of all IDUs in treatment in Jakarta are HIV infected.

## Central and Eastern Europe and the Newly Independent States (NIS) of the former Soviet Union

The governmental structures of the former Soviet Union, Eastern and Central Europe collapsed in the late 1980s and early 1990s following years of economic crisis and social unrest. Alcoholism and drug use increased and the opening of the various borders resulted in the mass movement of narcotics throughout the region. As a consequence there was an increasing availability and accessibility of imported substances such as opium and heroin from Afghanistan. The drug industry flourished, and with many people affected by poverty and unemployment the selling of drugs became a growing source of income. With many people increasingly vulnerable and seeking an escape from hardship and the growing social uncertainties, consumption of illicit substances increased markedly.

Until 1995 there was little sign of a major HIV threat in the region but a rapid diffusion of drug injecting had reached epidemic proportions and this new phenomenon resulted in an explosive HIV/AIDS situation. By the end of 2000 it was estimated there were 4 million IDUs in the region and in Russia alone there could be as many 2.5 million IDUs. By the end of 1999 the estimated number of HIV infections in the region reached 420,000 and a year later it had risen to 700,000. In the NSI (Ukraine, Belarus, Moldova, the Russian Federation, the Baltic states and Central Asia) the large majority of the HIV cases are linked to drug injecting.

In recent years efforts have been made to stem the tide of the HIV epidemic through a variety of risk reduction activities, with many tailored to the specific political, legal and social context in which they operate. Services such as outreach and peer education for IDUs, disinfecting material, NSPs and so on have been introduced, mainly by the non-government sector. Only by capacity building and a major scaling up of activities can a decrease in HIV infection among IDUs become a reality.

## Central Asia - Kazakhstan

The collapse of the Soviet Union had a severe economic impact upon Central Asia. The transition to a free market economy created substantial economic and social instability, resulting in a dramatic rise in unemployment and poverty accompanied by an increasingly fragile health infrastructure and decreasing government spending on the social sector. Poverty has fuelled a massive expansion of the drug trade in this region and Kazakhstan has been hit particularly hard by the twin epidemic of drug use and HIV/AIDS. Several major drug trafficking routes transporting raw opium and heroin from Afghanistan, ultimately for Russia and Europe, pass through various countries of Central Asia, of which Kazakhstan is included. Over time the narcotics trade became deeply embedded into the economy and access to more potent drugs is now easier and cheaper. The effects of the increased drug trade in Kazakhstan have been an increase in drug addiction, and by 1999 there were 37,000 drug users officially registered. However, unofficially it is estimated there were 200,000-300,000 drug users, with many believed to be IDUs. Currently Kazakhstan is believed to have the highest number of IDUs in Central Asia.

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It was not until the mid-1990s that the number of HIV/AIDS infections increased dramatically, and between 1995 and 2000 there was a 38-fold increase in HIV infections being detected. As of January 2001, there were just under 1,400 HIV-infected individuals but unofficially the estimated number of HIV cases was 10,000. Currently 85 per cent of all HIV infections are attributed to drug injecting. There is widespread sharing of injecting equipment and it has been documented that blood is introduced into the drug preparation prior to injecting. Many drug users are reported not to be aware of HIV/AIDS prevention methods. A recent study among sex workers (SWs) in the city of Almaty estimated there were 10,000 SWs, of which 30 per cent used illicit drugs and many injected. The risk behaviours of low condom use and the sharing of needles suggest they and their clients are likely to facilitate the spread of HIV to the general population in the future. Kazakhstan also has the problem of having a relatively high rate of incarceration, and two-thirds of the 80,000-90,000 prisoners are drug users. Drugs are smuggled into the prisons and injecting does occur, consequently exacerbating the spread of HIV/AIDS. The response to the rising rate of HIV infections among IDUs has been slow but in recent years harm reduction programs have been implemented, including NSPs, outreach and the dissemination of information on ways to prevent the transmission of HIV infection to others. However, it is estimated that approximately only 5 per cent of all drug users utilise harm reduction programs in Kazakhstan and all known prevention initiatives related to drug use and HIV are dependent upon the support of the international donor community.

## Conclusion

Countries in all regions of the world have experienced rapid increases in drug use, drug injecting and subsequent HIV epidemics, which began among IDUs and moved to their sexual partners and onwards to the general community. Those countries which have most successfully stemmed the tide of this last epidemic are countries which: have acted early in the course of the epidemic (e.g. before HIV prevalence has reached 5-10 per cent among IDUs); developed programs based on the principles of harm reduction; and integrated and generalised these programs on a national scale, so the response is as large as the threat.

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**For further information refer to WHO resources : Policy and Programming Guide for HIV Prevention Among Injecting Drug Users & Evidence for Action Papers. Refer to following website: [www.who.int/hiv](http://www.who.int/hiv) (publications expected online from May 2003)**

## References

- Academy for Educational Development. 2000. *A comprehensive approach: preventing blood-borne infections among injecting drug users*. Academy for Educational Development. United States.
- Ball A. 2000. *Drug use and HIV/AIDS*. Summary papers given in Track D of the XIIITH International AIDS Conference, Durban. South Africa, 9-14 July.
- Bastos FI, Strathdee SA, Derrico M and Pina F. 1999. Drug use and the spread of HIV/AIDS in South America and the Caribbean. *Drugs: Education, Prevention & Policy* 6(1): 29-50.
- Burrows D, Holmes D and Schwalbe N. 2002. Drug use injects HIV/AIDS into Former Soviet Union. *AIDS Link*. Issue 2. March.
- Burrows D, Panda S and Crofts N. 2001. *HIV/AIDS prevention among injecting drug users in Kathmandu Valley*. Report for The Centre for Harm Reduction. Melbourne, Australia.
- Burrows D, Rhodes T, Trautman F, Bilj M, Stimson G *et al.* 1998. Responding to HIV infection associated with drug injecting in Eastern Europe. *Drug and Alcohol Review*. 17: 453-463.
- Dallabetta G and Gavrilin S. 2001. *Assessment of the HIV situation in selected sites in Kyrgyzstan, Uzbekistan and Kazakhstan*. Report prepared for the USAID/Regional Mission for Central Asia.
- Dorabjee J and Samson L. 2000. A multicentre rapid assessment of injecting drug use in India. *International Journal of Drug Policy*. 11: pp 99-112.
- Dorabjee J. 2002. *Building the capacity of NGOs and other institutions to work with injecting drug users in India*. Report submitted to Family Health International, New Delhi, India.
- EuroHIV. 2001. *HIV surveillance in Europe*. End of the year report. No 66. For more detail [www.eurohiv.org] See tables 6 & 7.
- Ghys PD, Bazant W, Monteiro MG, Calvani S and Lazzari S. 2001. The epidemics of injecting drug use and HIV in Asia. *AIDS*. 15 (suppl 5): S91-S99.
- Green C. 2000a. AIDS: A nightmare ingredient in the Indonesia development broth. *Development Bulletin*, 52: 52-53.
- Grund JP. 2001. A candle lit from both sides: the epidemic of HIV infection in Central and Eastern Europe. In McElrath K (ed), *HIV and AIDS: a world view*. Westport, Ct. Greenwood Press. United States.
- Hien NT. 2000. *HIV prevalence trends and risk behaviours among injecting drug users (IDUs) in Vietnam*. Global Research Network Meeting on HIV Prevention in Drug-Using Populations, Third Annual Meeting Report. July 5-7 Durban, South Africa.
- Higgs, P. 2001. HIV and drug use in Vietnam, (briefing paper for Pathfinder International delegation). The Centre for Harm Reduction. Macfarlane Burnet Institute for Medical Research & Public Health, Hanoi, April.
- International Crisis Group (ICG). 2001. *Central Asia: drugs and conflict*. ICG Asia Report No 25. Osh/Brussels.
- Irwanto I. 2001a. *Drug use epidemic in Indonesia: some warning signs*. Paper presented at the 25th Anniversary meeting of the community epidemiology work group. June 12-15, Rockville. Maryland. USA.
- Karki BB. 1999. *RAR survey among drug users in Nepal*. Paper prepared for the 'The Harm Reduction Planning Workshop' 7 - 11 June 1999. Kathmandu. Nepal.

- MAP (Monitoring the AIDS Pandemic). 2001. *The status and trends of HIV/AIDS/STI epidemics in Asia and the Pacific*. MAP. Provisional Report October 4.
- Ministry of Health. 2001. *Statistical case of HIV/AIDS in Indonesia*. Directorate General of CDC and EH, Ministry of Health, Republic of Indonesia [http://www1.rad.net.id/aids/data.htm].
- NCAIDS, Department of Behavioural Intervention. 2001. *IDU rapid assessment and response, WHO Drug Injecting Project PHASE II*. Final Report. June 21. NCAIDS. Beijing, China.
- Open Society Institute (OSI). 2001. *Drugs, AIDS and harm reduction: how to slow the HIV epidemic in Eastern Europe and the Former Soviet Union*. OSI, International Harm Reduction Development. New York. United States.
- Parsons J, Hickmen M, Turnbull P, McSweeney T, Stimson G et al. 2002. Over a decade of syringe exchange: results from 1997 UK survey. *Addiction*. 97: 845-850.
- Peak A. 2000. *Fact finding mission to Kazakhstan*. Report submitted to Soros Foundation, Open Society Institute, International Harm Reduction Department.
- Peak A. 2001. *Drug use and HIV/AIDS in Thailand in the year 2000*. Family Health International Asia Regional Office.
- Peak MJ, Rana S and Rai LB. 2001. *HIV and injecting drug use in selected sites of the terai, Nepal*. Kathmandu. Family Health International. Kathmandu. Nepal.
- Reid G. 2001. The challenges and activities of responding to the drug using situation in Bali, Indonesia. *National AIDS Bulletin*. Vol 14 (5): 28-30.
- Reid G. and AHRN. 1998. *The hidden epidemic: a situation assessment of drug use in South East Asia and East Asia in the context of HIV vulnerability*. Asian Harm Reduction Network. Thailand.
- Reid G and Costigan G. 2002. *Revisiting the hidden epidemic: a situation assessment of drug use in Asia in the context of HIV/AIDS*. Burnet Institute – Centre for Harm Reduction. Melbourne. Australia.
- Rhodes T, Ball A, Stimson G, Kobayshcha Y, Fitch C et al. 1999. HIV infection associated with drug injecting in the Newly Independent States, Eastern Europe: the social and economic context of epidemics. *Addiction*. 94(9): 1323-1336.
- Shrestha L. 2001. *Briefing note: HIV/AIDS in Central Asia*. World Bank
- UNAIDS & World Health Organisation. 2002. *Epidemiological Fact Sheet on HIV/AIDS and sexually transmitted diseases, Thailand*. Update.
- UNAIDS. 2001. *Update on the HIV/AIDS epidemic in China*. Report on the situation as of early August 2001. Beijing. China.
- UNAIDS and UNDCP. 2000. *Drug use and HIV vulnerability: policy research study in Asia*. Regional Centre for East Asia and the Pacific. Bangkok. Thailand.
- UNAIDS. 2002. *HIV/AIDS: China's titanic peril. 2001 update of the AIDS situation and needs assessment report*. The UN Theme Group on HIV/AIDS in China.
- UNDCP. 2000. *China country profile*. Regional Centre for East Asia and the Pacific. Bangkok. Thailand.
- Vu Doan Trang. 2001. Harm reduction for injecting drug users in Vietnam: a situation assessment. *Report for Macfarlane Burnet Centre. Victorian Public Health Training Scheme*. March. Melbourne. Australia. [http://www.chr.asn.au/projects.html]

- Wodak A and Lurie P. 1996. A tale of two countries: attempts to control HIV among injecting drug users in Australia and the United States. *Journal of Drug Issues*. 27(1): 117-134.
- World Bank. 2000. Thailand's *Response to AIDS, building on success, confronting the future*. Report commissioned by The World Bank. Bangkok. Thailand.
- World Health Organization and Ministry of Health, Malaysia, 2001. *STI/HIV consensus report on STI, HIV and AIDS epidemiology, Malaysia*. Regional Office for the Western Pacific. Manila. Philippines.
- Wu Z. 2000. *Country situation and responses – China*. Presentation to Regional Task Force on Drug Use and HIV Vulnerability. Beijing. November.

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# Section One

## *Chapter Two*

# Rationale for Harm Reduction

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## Introduction

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*Manual for  
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**I**N RECENT YEARS there has been ample research evidence to indicate that drug use can spread very rapidly, given the wrong social, economic and political conditions. Traditionally, in Asia, the consumption of opium was by smoking but prohibitive laws against opium consumption and production inadvertently promoted the consumption of heroin, initially by smoking and later by injection. It was this transition towards injecting drug use (IDU) that resulted in the prevailing epidemic of HIV among injecting drug users (IDUs) in a number of developed and developing countries; the Asian region being among the worst affected. The transmission of HIV among IDUs has proven both extremely rapid and a focus for spread among other sections of the community, particularly those who are sexually active and to their children.

Reducing the supply of drugs is fraught with difficulties. Effective measures do not often produce quick results and many successful actions have a diminished effectiveness when they have simply led to new distribution routes, new dealers and traffickers, and new groups of people at risk of drug use. Any effectiveness they might have is over the medium to long term.

Reducing the demand on drugs through education, social and economic development of the community, and rehabilitation and treatment of drug users, also works only in the long term. Many programs for education about drugs probably do not even work in the long term, as they are often based on assumptions and prejudices rather than on honest education, and often the reasons people – especially young people – use drugs are not reasons education about drugs can effectively address.

As HIV transmission among IDUs can be extremely rapid, approaches to intervene and obstruct the spread of HIV infection has needed to be explored by many countries. What has emerged, both within the developed and developing world, is the approach of ‘Harm Reduction’.

## Harm Reduction: A Practical Approach

A clear example of a harm reduction strategy in many countries is the compulsory wearing of seat belts in cars. By themselves seat belts do not prevent motor car accidents from occurring, but when these accidents do occur the wearing of seat belts significantly decreases the mortality and injury rates among the occupants. Making seat belts compulsory is not condoning bad driving, speeding or drunkenness, but it is admitting the reality that these things do occur, and it is attempting to cope with the effects of these socially undesirable activities. Making seat belts compulsory is not an excuse for inaction on all other aspects of accident prevention, such as driver education, road building and law enforcement: it is complementary to these other efforts which will take longer to have effect. It is a similar philosophy which underlies harm reduction approaches to illicit drug use – they do not condone drug use, and are entirely compatible with education, treatment and law enforcement approaches to decrease drug use.

Deng Xiao Ping:  
“it does not matter if a cat is black or white as long as it catches mice”.

### Defining Harm Reduction

Harm reduction can be viewed as the prevention of adverse consequences of illicit drug use without necessarily reducing their consumption.

The harm reduction perspective can encompass various aspects of psychoactive drug use, from restricting the advertising of cigarettes to promoting hepatitis vaccination programs for IDUs. It was during the mid 1980s that harm reduction was catapulted into the official drug policy of the United Kingdom, Australia, Switzerland and elsewhere, with the recognition of the link between injecting drugs and HIV infection. Since the growth of harm reduction activities, a single generally accepted definition has yet to emerge. However, there are a number of common elements that assist us in both defining the term and concept of harm reduction. These are as follows:

#### 1. Short term goals

- there is an emphasis for short term pragmatic goals over long term idealistic goals. Efforts to prevent rapid HIV transmission are implemented as quickly as possible. The rapid, potentially explosive spread of HIV infection must be prevented *first*, or the longer term goals of abstinence and vocational rehabilitation will be invalid.

#### 2. A scale of means to achieve specific goals

- an encouragement for the drug user to stop using illicit drugs
- an encouragement for the drug users to stop *injecting* illicit drugs

- ensuring that the drug user does not *share* any of their injecting equipment, especially needles and syringes, with any other person
- lastly, if sharing does occur the injecting equipment must be disinfected between each use

### 3. Involvement of drug users

- drug users are not to be considered as passive recipients of services but must be viewed as playing a vitally important role in the prevention of HIV/AIDS. It has been shown consistently that drug user organisations contribute greatly to the strategy development of harm reduction.

Harm reduction involves alternative methods, and it must be remembered that different programs are to be considered as complementary rather than in conflict.

A broad range of programs has been implemented to foster harm reduction principles and to prevent HIV infection among IDUs. These include:

- the provision of **information programs** to inform IDUs of the risks
- the establishment of **drug treatment substitution programs**
- **outreach education using peer educators**
- **sterile needle/syringe /distribution and disposal programs**
- over the counter sales of injecting equipment
- **counselling and testing for HIV among IDUs**
- increasing access to **primary health care**
- **removing the barriers** to safer injecting, including laws and police practices
- targeting special groups and circumstances

These programs all aim to change behaviour and thereby reduce the risks of HIV infection among IDUs.

A number of countries implemented a combination of these identified measures early in the epidemic such as Australia, New Zealand, the United Kingdom, the Netherlands and Denmark. The early, vigorous implementation of these combined approaches has resulted in a lower HIV infection among IDUs than in most other countries. The success of these measures will now be briefly reviewed.

### Education about safe injecting

Education of drug users about safe injecting and HIV prevention is a critical factor in harm reduction programs. When HIV enters a group of IDUs, before the introduction and implementation of any HIV/AIDS education awareness, the rapid spread and speed of the epidemic has proven to have a devastating impact. The strength and impact of drug education initiatives include graphic representations of harm reduction messages targeting drug users. Much of this education material is provided in a “user friendly” style and language, with the content being both *credible* and *comprehensive* and the information designed to suit both new recruits and those with a long history of drug injecting. It has been shown that a little education can go a long way in reducing the harms associated with drug injecting, including HIV infection.

It needs to be emphasised that HIV infection can be transmitted not only by needles and syringes but also by the sharing of spoons, bottle tops, cotton wool and any materials used to draw up and prepare the injection, all of which become contaminated and transmit infection.

## Needle and Syringe Programs (NSPs)

The availability of, and encouragement to use, sterile injecting equipment is a second crucial factor in harm reduction programs. A decline in risk behaviour among IDUs has occurred in many countries as a result of the HIV epidemic. Since the early 1980s, NSPs have emerged as particularly important in preventing HIV infection among IDUs. Conclusions from a wide variety of sources have clearly indicated that NSPs are effective, and cost effective, in the prevention of HIV. In the US, a country that has great difficulty in accepting NSPs (only providing tenuous funding and generally only permitting their operations on a small scale), six major government reviews have found that

NSPs reduce HIV transmission without serious unwanted side effects.

Exhaustive reviews of evidence have also concluded that

NSPs do not increase drug use or recruit new IDUs.

Other studies around the globe have also confirmed that in cities with NSPs, there has been, on average, a decrease in the prevalence of HIV among IDUs, compared to cities without NSPs where the prevalence of HIV has continued to increase. The effectiveness of these programs, which include the dissemination of information about the risks of HIV/AIDS, the reduction of the risks of sharing of injecting equipment by providing sterile needles and syringes, and assisting in the disposal of used injecting equipment, have reduced the transmission of HIV and other blood borne infections by and among drug injectors.

The costs to the community in human life, and the financial implications in not reducing the incidence of HIV infection among IDUs clearly indicate that NSPs have much validity. Conservative assumptions indicate that the USA could have prevented an estimated 4,400 to 10,000 HIV infections among IDUs, at a cost to the health care system of \$US240 million to \$US540 million if NSPs had been adopted in 1987 and expanded until 1995.

A recent report from Australia has found that between 1990 and 2000 nearly \$150 million (Australian) had been invested in NSPs. This level of investment and return from NSPs over 10 years has resulted in:

- an estimated 25,000 cases of HIV being avoided
- an estimated 21,000 cases of hepatitis C being avoided
- an estimated saving of over 5,000 lives by 2010
- an investment of \$150 million has resulted in an estimated return of somewhere between \$2.4 and 7.7 billion.

The establishment and expansion of NSPs have now occurred in various regions of the world and in over 40 countries including: Western Europe, North America, Australia, New Zealand and in the developing world they are found in China, Nepal, India, Philippines, Thailand, Pakistan, Bangladesh, Vietnam, Russia, Kazakhstan, Brazil, Argentina and Colombia.

## Drug Treatment and Substitution Programs

It is very important that any drug treatment offered is both effective and attractive to drug users. Research has shown that drug treatment is most effective when it is available to the drug user at the time when he or she seeks it voluntarily. A comprehensive approach to HIV prevention among IDUs requires a flexible, accessible and caring drug treatment system. In many countries, drug addictions are left under the care of the penal system or to rehabilitation centres which are effectively prisons. These systems aim for long term abstinence but often prove ineffective; relapse rates are consistently very high. Detoxification succeeds in removing people from the drug scene in the short term, but the impact of detoxification programs on long term drug use is very small.

In most countries, the most common drug injected is heroin and the most effective treatment developed so far for heroin addiction is *drug substitution programs*. The most acknowledged and extensively researched substitution program is *methadone maintenance*. There is now overwhelming evidence that methadone maintenance is

- safe
- effectively improves health outcomes
- reduces deaths
- reduces crime
- enhances social functioning

There is clear indication that those receiving methadone maintenance therapy are at lower risk of HIV transmission as they inject less frequently and therefore decrease their sharing of injecting equipment. Methadone maintenance does not ‘cure’ the addiction. However, it removes IDUs from the various adverse and criminal circumstances of their

world and moves them into the world of a socially acceptable clinic, where they can receive counselling and other medical and social services.

The fundamental aim of substitution programs is to retain the drug user in the program – the longer the drug user stays in the program, the more successful the program is at reducing adverse health and social consequences of drug use and achieving long term benefit. Methadone maintenance has proven to be the most effective treatment in attracting and retaining heroin dependent patients, far more than any other non-pharmaceutical treatments. Currently there are dozens of countries that dispense oral methadone, including Nepal, Vietnam, and Thailand, indicating their willingness to adopt and maintain this effective harm reduction approach. Alternative drug substitution programs, such as buprenorphine, are currently being investigated and trialled, to broaden the applicability of such approaches beyond those who can benefit from methadone.

Methadone maintenance therapy within a harm reduction framework aims to reduce the individual and social harm associated with illicit opiate use.

## Peer Education Programs

Research has shown that education and behaviour change around safe injecting and HIV prevention among IDUs is most effective and sustainable when it is delivered by peers – drug users themselves – in a supportive environment. Peer education of IDUs allows contact with those who are not being seen at treatment or law enforcement agencies. It delivers health education from a source more credible to the IDUs than are most agencies, especially agencies identified with governments. The range of tasks undertaken

by peer educators includes the provision of injecting equipment and supplies of bleach, the collection of used injecting equipment, disseminating information about the disinfection principles of bleach and issues related to primary health care and counselling. This wide range of services clearly demonstrates that peer support and peer education fits into the framework of harm reduction.

The development of organisations of IDUs to provide peer education has proven to be an effective strategy. These organisations can provide program planners and policy makers with informed advice from the IDUs on education and/or other interventions. The importance of these groups is they can advocate on behalf of IDUs about both human rights and HIV prevention. It should be recognised that such community development is not always possible in all communities.

### Sale and purchase of injecting equipment

There are a number of countries that have not accepted NSPs but have instead accepted that sterile needles and syringes be readily available through pharmacies and other outlets. In Italy, during the early 1980s, needles and syringes could be purchased from retail outlets cheaply but IDUs were not encouraged to buy them and the result was an extensive spread of HIV infection among IDUs. It must be emphasised that simply having injecting equipment accessible at retail outlets, including pharmacies, and at a cheap price does not thwart HIV infection among IDUs unless they are encouraged to buy and use the sterile injecting equipment and are discouraged from sharing their injecting equipment.

In many countries where needles and syringes are for sale, they are seen by authorities to be cheap, and therefore there is no need for programs for distribution of sterile equipment. However, this neglects the extreme poverty of many IDUs, and their need for clean needles and syringes perhaps two or three times a day every day of the week. This cost mounts up very quickly, and drug users whose main priority is purchasing the drug will use their very scarce money on drugs rather than needles and syringes.

Ensuring that each injection is performed with sterile needles and syringes is sufficient to break the chain of transmission and to prevent the majority of HIV infections among IDUs.

### Primary Health Care

Gaining access to primary health care services is often difficult or impossible for IDUs because of their status of being involved in illegal activities and due to backgrounds that are largely poor, both socially and educationally. The often widespread discrimination and abuse of IDUs has frequently promoted their marginalisation within the community. There are many adverse health problems that IDUs can suffer from including other infections associated with drug injection, malnutrition and other ailments common to their community. Accessible primary health care services for IDUs can not only respond to their immediate multiple health problems, but can also address HIV prevention strategies and, in the long term, assist those who seek drug treatment.

## Counselling and Testing

Counsellors should provide support for IDUs making a decision about having an HIV test and in the follow up when providing the result of the test. The aim is to provide both psychological support for those whose lives have or may be affected by HIV/AIDS and to prevent HIV transmission to other people. Prevention messages achieve greater acceptance when they are presented as relevant to the IDU's needs and lifestyle. While the counsellor provides the necessary information and comprehensive risk reduction advice, any modification of lifestyle will still depend on the individual responsibility of the IDU. Confidentiality and informed consent are crucial to pre- and post-test counselling. Potential benefits of counselling for the IDU include reduction in risk behaviour, motivation to maintain or initiate safer drug related behaviour, earlier access to care and treatment/prevention for HIV related illness, emotional support and improved ability to cope with HIV related anxiety.

## Removing the barriers to safer injecting

It is important to examine the social, legal, cultural and political context with a view to removing the barriers which may exist and prevent safer injecting. These barriers include lack of access to information, primary health care and drug treatment. Legal barriers such as criminalising the act of being in possession of injecting equipment to deter IDUs from injecting, can result in sharing common injecting equipment (and therefore HIV transmission); this occurs as individuals attempt to avoid criminal charges related to

the possession of needles and syringes. This is one of the major reasons behind the development of 'shooting galleries' in US cities, which have contributed so markedly to the rapid and continuing spread of HIV in those cities. This is a clear example of how laws to control drug use, which do not work in controlling drug use, can unexpectedly promote the spread of HIV. Abolishing such laws removes a major barrier to safer use for the motivated IDU.

## Special Groups and Circumstances

Special groups may be numerically smaller than mainstream groups, but they can, and often do, contribute disproportionately to the HIV epidemic. The more disenfranchised or marginalised the IDU, the less opportunity he or she will have to modify their behaviour relating to HIV risk. Prisoners that inject drugs are often at extreme risk of HIV transmission due to the rare availability of clean injecting equipment and because of the mixing of social groups that may not otherwise meet. Ethnic minorities often feature IDUs and many are found to be involved in production or trafficking of drugs and have poor access to health care and employment. Women IDUs, and particularly those involved in sex work, are often at increased risk of HIV transmission largely due to their subordinate status within society. Among all of these marginalised groups, it is important to implement various special programs to prevent or reduce the risks of HIV transmission.

## Conclusion

Harm reduction provides an alternative approach and framework to deal with the problems IDUs face. Harm reduction has been adopted by an increasing number of countries as it has proven to be pragmatic, humane and an effective holistic public health measure in controlling the epidemic of HIV infection among IDUs.

## References

- Caplehorn J and Ross M. 1995. Methadone maintenance and the likelihood of risky needle sharing. *The International Journal of Addiction*. 30(6):685-598.
- Commonwealth Department of Health and Ageing. 2002. Return on investment in needle and syringe programs in Australia. Canberra. Commonwealth of Australia [http://www.health.gov.au/pubhlth/publicat/hac.htm]
- Crofts N and Herkt D. 1995. A history of peer-based drug user groups in Australia. *The Journal of Drug Issues* 25(3):599-616.
- Des Jarlais DC. 1995. Harm Reduction: A Framework for Incorporating Science into Drug Policy. *American Journal Of Public Health*. 85: 10-12 [http://www.lindesmith.org/library/tlcdjarl.html]
- Des Jarlais DC and Friedman SR. 1993. AIDS, Injecting drug use and harm reduction. In Heather N, Wodak A, Nadelmann E and O'Hare P (ed) 1993. *Psychoactive Drugs and Harm Reduction: From Faith to Science*. London. Whurr Publishers.
- Drucker E. 1995. Harm Reduction: A Public Health Strategy. *Current Issues in Public Health* 1: 64-70. [http://www.lindesmith.org/library/tlcdruck.html]
- Friedman S, De Jong W and Wodak A. 1993. Community Development as a response to HIV among drug injectors. *AIDS* (Suppl 1):S263-S269.
- Keene J. 1994. High risk groups and prison policies. *The International Journal of Drug Policy* 5(3):142-146.
- Lenton S, Single E. The definition of harm reduction. *Drug Alcohol Rev* 1998;17:213-220
- Lurie P and Drucker E. 1997. An opportunity lost: HIV infections associated with lack of a national needle-exchange program in the USA. *Lancet* Vol 349, March 1: 604-608.

Chapter Two  
Rationale for Harm Reduction

### Section One, Chapter Two: Rationale for Harm Reduction

For further information refer to WHO resources: Policy and Programming Guide for HIV Prevention Among Injecting Drug Users, Evidence for Action Papers, Intervention Guides (NSP) & Training Guides (Outreach). Refer to the following website: [www.who.int/hiv](http://www.who.int/hiv) (publications expected online from May 2003)

The Centre for Harm Reduction

- Lurie P and Reingold A. 1993. *The public health impact of needle exchange programs in the United States and abroad*. Berkley, CA: School of Public Health.
- Mulleady G. 1992. *Counselling drug users about HIV and AIDS*. Oxford. Blackwell Scientific Publications.
- Nadelmann E, Cohen P, Drucker E, Locher U, Stimson G. *et al.* 1994. *The harm Reduction Approach to Drug Control: International Progress*.  
[<http://www.paranoia.com/drugs/war.on.drugs/debate/harm-reduction.html>]
- Nadelmann E. 1998. Commonsense Drug Policy. *Foreign Affairs* 77(1) January-February.  
[<http://www.lindsmith.org/library/foreigna.html>]
- Normand J, Vlahov D and Moses L. 1995. *Preventing HIV transmission: the role of sterile needles and bleach*. Washington D.C. National Academy Press.
- Paone D, Des Jarlais DC, Gangloff R, Milliken J and Friedman SR. 1995. Syringe Exchange: HIV prevention, key findings, and future directions. *The International Journal of the Addictions* 30 (12):1647-1683.
- Power R, Jones S, Kearns G, Ward J and Perena J. 1995. Drug user networks, coping strategies and HIV prevention in the community. *Journal of Drug Issues* 25(3):565-581.
- Riley D. 1993. *The Policy and Practice of Harm Reduction*. Unpublished paper. Canadian Centre on Substance Abuse, Policy and Research Unit and University of Toronto, Department of Behavioural Science.
- Stimson G. 1993. The global diffusion of injecting drug use: implications for human immunodeficiency virus infection. *Bulletin on Narcotics*. XLV (1):3-17.
- Trautman F. 1995. Peer support as a method of risk reduction in injecting drug-user communities: experiences in Dutch projects and the European Peer Support Project. *Journal of Drug Issues*. 25(3):617-628.
- UNAIDS. 1997. *UNAIDS policy on HIV testing and counselling*. Geneva. UNAIDS.
- Wodak A. 1996. *Prevention works: effectiveness of prevention of HIV spread among injecting drug users*. Paper presented July 6, 1996 Vancouver, Canada. Unpublished.
- Wodak A. 1995. Needle exchange and bleach distribution programs: The Australian Experience. *The International Journal of Drug Policy* 6(1):46-56.
- Wodak A. 1997. Needle Exchange: just do it! (Guest Editorial) *AIDS Target Information* 11(5).
- Wodak A, Crofts N and Fisher R. HIV infection among drug users in Asia: an evolving public health crisis. *AIDS Care* 5: 313-320.
- Wodak A and Des Jarlais DC. 1993. Strategies for the prevention of HIV infection among and from injecting drug users. *Bulletin on Narcotics*. 45(1):47-60.
- Wodak A and Lurie P. 1996. A tale of two countries: attempts to control HIV infection among injecting drug users in Australia and the United States. *Journal of Drug Issues*. 27(1):117-134.
- World Health Organization. 1990. *Guidelines for Counselling about HIV Infection and Disease*. Geneva. World Health Organization.



## **Section One:**

### *Chapter Three*

# **Balancing and integrating the approaches of Supply Reduction, Demand Reduction and Harm Reduction**

## **Supply reduction**

### **Cultivation**

### **Processing**

### **Transport**

### **Distribution**

### **Finance**

## **Demand reduction**

### **Education about drugs**

### **Treatment for drug abuse**

### **Community development**

## **Harm reduction**

## **Integration of the three approaches**

## Supply Reduction

Throughout the world, international and national approaches to the control of drug use traditionally have focused on law enforcement to reduce supply; targeting both the production and trafficking of drugs. Many attempts to prevent the supply of illicit drugs are linked to several steps involved in the production and distribution of these drugs to their consumers. These steps include cultivation, processing, transport and distribution. The various strategies which have been implemented require assessment as to: *how effective they are* and *what the consequences have been*. It is also worth examining the economic aspects of the drug trade and the structural barriers to interdiction and prevention methods.

### Cultivation

Cultivation of the crops from which many illicit drugs are derived often takes place in settings where intervention is difficult, for many various and familiar reasons. The areas of cultivation are often in regions that are relatively inaccessible, such as the mountainous areas of Myanmar, Thailand and Laos for the opium poppy, or of Bolivia and Colombia for the coca tree. Some of these areas are often either uncontrolled by central governments, or are at least politically unstable. For example: the Wa people of north east Myanmar are in areas controlled by separatist movements or other guerrilla groups, and who depend on the production and sale of the drugs to raise money for their armies. Many of the communities who cultivate illicit crops are poor and of an ethnic minority within their own country.

The countries where cultivation of these crops takes place are often beset by structural problems which make it difficult or impossible to raise the issue of curbing illicit crop cultivation to a high level on the political agenda. These countries are beset by political instability, often have extremely high foreign debt against a background of poor economic growth, and the result is poor infrastructure development. Some countries are occupied with fighting rebellions or secessionist movements and spend high proportions of their scarce resources on supporting large armed forces. A number of governments lack the time, resources, skills or consistent commitments to take up the struggle against the cultivation of illicit crops, even when they acknowledge the problem as a priority. In some instances there is involvement of the central government or its regulatory arms in the trade, either through control of the trade or through bribery and corruption. The political will to curb this cultivation is not always present, or if it seems to be, it may not be strong enough to ensure that programs are carried through in the face of resistance from corrupt authorities.

Crop substitution is another strategy to decrease cultivation. Strategies to develop sustainable cropping systems can be complex and multifaceted. They often require the existence of good markets, the provision of education and other social services, a better road system and sometimes the securing of land use rights. There are current collaborations between authorities in Yunnan and Wa authorities in Myanmar to replace opium crops with tobacco and the Vietnamese have embarked on an ambitious campaign of crop replacement, without much overall effect as yet. Crop substitution programs which are designed to persuade poor rural communities to grow legal crops often cannot compete with the profits from harvesting illicit crops.

**Potential opium production in the South-West and South-East Asia, 1994–2002**

Metric tons

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Afghanistan	1,970	2,330	3,416	2,335	2,228	2,804	2,693	4,565	3,276	185	3,400
Myanmar	1,660	1,791	1,583	1,664	1,760	1,676	1,303	895	1,087	1,097	828
Laos	127	169	120	128	140	147	124	124	167	134	112
Thailand	14	17	3	2	5	4	8	8	6	6	N/A

Source: UNDCP Global Illicit Drug Trends 2002

N/A - not available

Attempts have been and continue to be made to eradicate illicit drugs in some countries. The military government in Myanmar has over the years attempted to destroy some areas of poppy cultivation, but these attempts are generally too limited in duration and scope to have had a significant impact. However, opium cultivation levels have been depressed in recent years largely because of unfavourable weather conditions during opium growing seasons, as well as increased eradication efforts. Between 1996 and 2000, potential opium production has been steadily declining, from 1,760 tons to 1,087 tons. A recent study conducted in 2001 estimated that opium production had been reduced to 828 tons. However, in 2000-2001 the ban on opium cultivation in Afghanistan resulted in Myanmar becoming the largest source of opium and heroin in the world. It is important to add that while opium production in Myanmar has declined substantially the country is currently the primary source of amphetamine type substances in Asia producing an estimated 800 million tablets per year.

**Processing**

The chemicals required for the processing of opium into heroin are reasonably common and are used in a variety of other industrial processes. While attempts can be made to interdict supply of these chemicals, this is difficult when their transport is occurring in the midst of much other trade, especially industrial trade. For example, since the mid-1980s when China and Vietnam adopted economic ‘open door’ policies there has been a marked increase in industrial trade with their neighbouring countries and a perceived increase in the surge of trafficking in and use of illicit drugs. In several Asian countries, precursor chemicals are not subject to international levels of control due to inadequate legislative provision and limited administrative infrastructure and resources. In the 1960s, the close of chemical production factories in the Philippines and the Mediterranean resulted in a shift of the production processes closer to the source of the raw materials. The use of technology has increased as has the sophistication of the producers of refined drugs. This has allowed a skillful mobilisation of factories, which have become highly transportable when detected and threatened with closure by law enforcement.

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## Transport

In several settings worldwide it has been estimated, despite the effort put into interrupting supply routes for drugs, such efforts are at best only 5-10 per cent effective. This means, of all the drugs being shipped into and out of any country on earth, even with the best interdiction efforts, 90 per cent get through to the consumers of the drugs. This is a situation which is worsening for drug control agencies internationally, as free trade agreements abolish many of the existing barriers to trade and as the volume of international trade and travel continues to expand dramatically. Much of this trade is becoming depersonalised, and it is much harder to detect the existence of shipments of drugs, especially heroin which is small in volume and does not smell much in containers from ships or planes.

In 1996, the potential yield of opium in the Yunnan Province of China was estimated to be 16 metric tonnes. In the same year Myanmar had a potential yield of opium estimated to be 2,560 metric tonnes while Thailand's potential yield of opium was estimated at 30 tonnes.

A particular tactic, which is common to drug traffickers, is using transshipment ports which have not before been seen to be involved in drug trafficking routes. In the early 1980s, when the supply of drugs from Thailand through Malaysia and Singapore to Europe was becoming increasingly difficult, the Thai traffickers began to make use of Thailand's connections with Nigeria, in west Africa. There were many students from Nigeria in south-east Asia, and much travel between the regions, as well as much travel between Nigeria and Europe. By shipping the drugs first to Nigeria and then on to Europe, the traffickers opened up a new and unexpected route. Customs authorities in the end ports in Europe were not concerned about drugs coming in from Nigeria, which is not a producing country, and were less vigilant than they would have been with people coming from Asia. Rampant corruption within the Nigerian Government virtually assures Nigerian trafficking organisations a favoured place in the heroin trade. One result of this change in trafficking routes is that Nigeria now has developed a heroin dependent population, and opium is beginning to be produced in Nigeria to meet the local need.

### Seizure of heroin and raw and prepared opium (kilograms) in 1995–2000

	1995		1996		1997		1998		1999		2000	
	Heroin	Opium										
Iran	2,075	126,554	804	149,557	1986	162,413	2894	154,453	6,030	204,485	6,189	179,053
China	2,375	1,110	4,347	1,745	5,477	1,880	7,358	1,215	5,364	1,193	6,281	2,428
Myanmar	72	1,060	504	1,300	1,401	7,883	403	5,705	273	1,759	158	1,773
Thailand	517	927	597	381	323	1,150	507	1,631	405	421	385	1,591

Source: UNDCP Global Illicit Drug Trends 2002

**Seizure of amphetamine type substance in kilograms (excluding ecstasy) in 1995–2001**

Metric tons

Year	1995	1996	1997	1998	1999	2000	2001
China	1,303	1,599	1,334	1,608	1,659	20,900	4,890
Myanmar	N/A	531	455	1,441	2,599	2,408	2,877
Thailand	561	812	2,183	3,013	4,518	7,422	8,338

Source: UNDCP Global Illicit Drug Trends 2002, UNDCP Bangkok 2002

N/A - not available

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**Distribution**

The import price of drugs like heroin reaching western countries for their markets is only five per cent of what the drug costs the consumer, because of middlemen and accumulating profit. One of the major reasons for the profits generated at every step of the trafficking route is the need for money to fuel corruption and to protect the supply route. The drug industry requires a wide range of specialised personnel including chemists, chemical engineers, pilots, communication specialists, money launders, accountants, lawyers, security guards and ‘hit men’. Because of this enormous profit margin, removal of any one link in the chain of trafficking leads to immediate replacement by another. This happens at any stage in the chain: for example, the current efforts of the Burmese government to close down the production of opium by one Shan producer is merely leading to a jockeying for position on the part of other major opium producers in Myanmar. Similarly, the death of one cartel boss in Bolivia simply left the field open for other major producers of cocaine to take control of the trade. Further down the trail, the removal of Colonel Noriega in the invasion of Panama resulted in a change in supply routes but no decrease in the amount of drugs entering the US

**Finance**

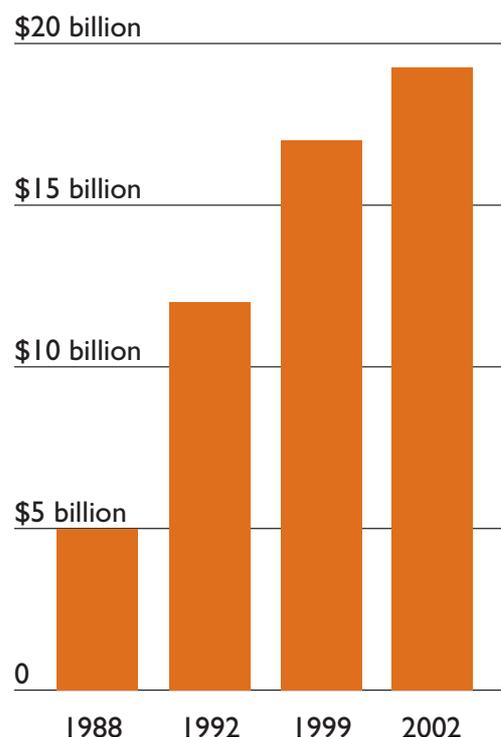
According to the United Nations International Drug Control Program, the illicit drug trade generates as much as US\$400 billion in trade annually – all of it part of the ‘black economy’. It is one of the largest sectors of international trade, and is completely outside of government control. In terms of global industries, as part of the black economy, it is second in magnitude only to the arms trade, and just ahead of the prostitution industry. The three are often inextricably linked, with money from drugs and prostitution financing arms deals.

The enormous profits available to major drug traffickers are usually enough to corrupt any authorities who stand in their way, thereby protecting the supply routes. According to United Nations sources, in 2000 a kilogram of heroin in Pakistan cost an average of US\$2,720, and after transport to the United States was then sold for an average of US\$129,380. Similarly the UN reported that in the late 1990s a kilogram of coca base in Colombia cost an average of US\$950; it then retailed for US\$25,000 in the United States. It is little wonder that corruption associated with the illicit drug trade is universal.

The drug trade needs corruption in order to flourish and the powerful instrument for corrupting any society is money. The current enormous profit margins derived from the drug trade are without historical precedent.

The Centre  
for Harm  
Reduction

**Expenditures on the US War on Drugs, 1988-2002**



Against these resources, the US federal budget committed US\$19.2 billion to its war on drugs in 2002, rising from 5 billion in 1988. State and local governments will spend at least another US\$20 billion. The vast majority of this expenditure goes into attempts to prevent drugs entering the country and in detecting, arresting and incarcerating individuals involved in drug trafficking and dealing. In 1980, approximately 50,000 people were imprisoned in the US for violating a drug law. By 2000 the figure was nearly 500,000 and the overall inmate population has quadrupled to nearly 2 million and continues to rise. The expenditure involved in the war on drugs has had little impact on diminishing the problems associated with drug use in the US.

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### India: Manipur and Madras

The epidemics of drug use, drug injecting and HIV infection in the north-eastern states of India, Manipur in particular, left the authorities with only one available response: to imprison drug injectors, as there were no treatment facilities available. In fact, many of the drug injectors in Manipur prisons were referred there by their parents, who had despaired of their sons' drug habits and had no alternatives for treatment. However, recidivism to drug use after release from prison in Manipur is virtually 100 per cent. As a result of police crackdowns, many drug injectors moved to Madras and Bombay, carrying their habits with them.

Meanwhile, in Madras, another situation was emerging. Drug users in Madras had had a fairly cheap and readily available supply of opium, with most of it coming from Sri Lanka where the Tamil separatists trafficked in the drug with their ethnic brethren on the mainland to support their armed struggle. To the end of the 1980s the predominant method of administration of opiates in Madras was smoking. With the assassination of Rajiv Gandhi in 1991, the border with Sri Lanka was closed, and the smuggling of opium became more difficult. As a result, heroin became the predominant drug, along with pharmaceuticals such as injectable Tidigesic (Buprenorphine): the price went up, purity became less, and the addict population of Madras turned from smoking their drugs to injecting them. This occurred at the same time as the refugees from Manipur arrived in Madras which now has an explosive outbreak of HIV among its thousands of IDUs.

## Conclusions

The lessons of the changing routes of supply in South America from Central America to Brazil, and in Asia from the south coast of south-east Asia to north-east India and south China, are universal.

Without a decrease in demand and with drug trafficking remaining profitable, the closing of one supply route merely leads to the opening up of others.

Drug smuggling and trafficking has become very profitable, offering new economic advantages to many people. Drug trafficking on any scale produces large-scale profits for those involved and this has two effects:

- a need to protect the trade from the attentions of narcotics authorities
- sufficient profit to do so, by bribing and corrupting these authorities

Large-scale trafficking cannot exist without large-scale corruption.

Increased profits means an increased ability to bribe. To protect the drug traders' investment, there is an incentive for the drug trafficker to increase the volume of the drug traded. Therefore, we must consider that:

- on the one hand, efforts to stem the flow of drugs will fail if there are not also measures taken to tackle corruption in society
- on the other, corruption is often a worse social evil and more destructive to a society than the drug use is itself.

It needs to be acknowledged there are millions of people throughout the world who much prefer the experience of drugs over the experience of their daily lives and the result is that their demand will stimulate the growth of further supplies.

- Closing one supply route merely leads to the opening up of others
- Removing one supplier leads to the appearance of others
- Large-scale trafficking cannot exist without large scale corruption
- Public health prevents drug use, rehabilitates drug users and prevents HIV infection
- Supply restriction only works when demand restrictions is working

Public Security efforts are best directed against major criminals, traffickers and corrupt officials, and not against minor criminals such as drug users themselves.

A snake is not killed by cutting off the tail, but by cutting off the head.

Public Health efforts are best directed towards the drug users themselves, to rehabilitate them and to prevent them from becoming infected with HIV and other diseases, and towards the general community for health education. The consequences of attempting to cut off the supply of drugs is demonstrated in the case of India:

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*Balancing and integrating the approaches of Supply Reduction, Demand Reduction and Harm Reduction*

## Demand Reduction

It is only when the demand for drugs is low, detection is easy and substitutes are not readily available, that restricting the supply of drugs will help reduce drug problems. This suggests that reducing the supply of drugs will only become a successful strategy, for the decrease of the harm associated with drug use, when effective demand reduction strategies have been implemented. In 1987, the International Conference on Drug Abuse and Illicit Trafficking in Vienna (attended by 138 nations with representatives of Government and Non Government delegates under a United Nations mandate) called for a balanced approach in dealing with the demand and supply of illicit drugs. Demand reduction, it was announced, would be given the same importance in policy and priority in resource allocation, as supply reduction.

Many strategies have been tried for reducing the demand for drugs in various countries. They are generally built on an imperfect understanding of why people use different drugs, in different circumstances and at different times. Drug use is a very complex phenomenon, and we must be pragmatic in our choice of strategies. These strategies have included education of young people and others about the dangers of drug use, the provision of alternatives to drug use to prevent young people beginning to use drugs, and treatment for drug users to decrease their consumption of drugs. Education also includes direct education of drug users, most importantly in the ways to prevent HIV infection.

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## Education about drugs

Educational programs about drug use and its dangers are generally targeted at three levels: the general community, youth (through school based programs), and drug users themselves.

Mass education campaigns can be effective in providing a background understanding among the general community about drugs and their effects, about the threat of HIV epidemics and about the need for harm reduction approaches. However, experience has shown that they have only a minimal effect in decreasing the amount of drug use. If they consist solely of messages aimed at making drug users appear as the enemies of society, then their net effect is often simply to drive the drug users underground. This makes their activities more hidden but does not decrease the numbers of people either beginning or continuing to use drugs.

Mass media campaigns, often based on a slogan and a few facts, can have a limited impact due to their inability to tackle complex problems.

Many educational campaigns are ineffective because they are unrealistic, and do not recognise the reality of the situation in which potential and actual drug users live. For instance, if social structures such as the family or the village are weak and if there is high unemployment, then the drug user's major social ties may be with his peer group, all of whom may be drug users themselves. In this situation, information about the dangers of drug use will appear to the drug user as an attack on his major social bonds, and will simply have the effect of discrediting the authority from which the messages come. Drug users put themselves outside of society by their drug use, by

engaging in an activity which in most countries is illegal. Education campaigns which stress the evil they do to themselves and their society merely have the result of putting them further outside society, when the intention is to bring them back into society once again as useful members by helping them to stop using drugs.

A more fruitful approach for mass education is one of education about drug addiction as an illness, requiring supportive care. With a supportive community, which does not condone drug use but has sympathy for its victims, the chances of successful treatment are greatly enhanced. This approach makes a clear distinction between the dealers and traffickers of drugs, whose only motive is profit, and the drug users themselves (including those drug users who traffic in small amounts of drug to raise the money to pay for their own drug needs).

**School based education**, similarly, does not have a good record around the world. Education about the dangers of drug use by itself is not effective in preventing initiation into drug use. In fact, the opposite has been the case with some education campaigns, which have led to an increase in experimentation with drugs among the target populations. This is particularly the case where drug education has been conducted by outside specialists, including police, who have come into the classroom especially to give lectures on drugs. The effect of this type of approach is to sensationalise drug use, and to make experimentation more attractive.

Good school based education should be integrated into the whole curriculum, provided by the children's normal teachers who can provide role models for the children to emulate. Proper education about drugs should now include education about HIV and other diseases associated with injecting drug use. Information about drug use (including alcohol and smoking), including

its effects on the body and the mind, social relationships and the community, and exposure to healthy behaviour which is incompatible with drug abuse should be available from pre-school through tertiary and post-graduate education. Such education about drug use and its effects should be seen as one part of a comprehensive approach to demand reduction. But it should be realistic, integrated into life education in the school and in the home, and should not be relied upon by itself to achieve anything more than long term and background impact.

However, it must be recognised that the roots of drug use for most people are not associated solely, or often even at all, with mere ignorance. The reasons why people begin and continue drug use are complex and multiple, and often to do with social and economic development. Problematic drug use is associated with economic and social poverty in most societies, though of course there are exceptions. In these cases, education by itself is not the answer. For one thing many people do not have access to education and for another, the alternatives to drug use, such as meaningful employment or strong social structures may not exist or may be weak.

A young person who is alienated from mainstream social structures, including family and meaningful employment, is not likely to be touched by information about the future long term effect of drugs on his health. This will especially be the case if it is through his drug use with his peer group that he presently gains social meaning in his life. Like most young people, he is concerned with what is happening now or over the next few weeks, not with what will happen in ten years' time.

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## Treatment for drug dependence

Treatment for problematic drug use, particularly addiction, requires more than simple detoxification. Injecting of heroin especially is a very difficult condition to satisfactorily treat. The heroin addict, in most cultures, remains addicted to his opiates for between ten and twenty years, *with or without treatment interventions*. The first principle to understand is that not all drug users are alike in their drug needs or habits, and that many drug users go through different stages of their drug use at different times of their lives. Many people around the world smoke opium or heroin, or inject heroin, without necessarily being addicted to it. For most people who use these drugs, there is a period of time when they are using the drugs without being addicted: it is only with regular use over a period of time that addiction appears. This period may vary from a few weeks to many years. Therefore, treatment approaches should also vary. We need to know much more about who the drug users are, how they use their drugs, what their social circumstances are, and what alternatives can be realistically offered in their social setting.

A comprehensive understanding of the drug users must be made in order for the treatment approach to be beneficial and valid.

It is important to have methods for early identification of drug users, through unobtrusive monitoring in community settings. The more that drug addiction can be portrayed as an illness, and drug addicts see treatment services as confidential and caring, the more likely they are to seek treatment of their own accord. Not all people who use psychoactive drugs require detoxification. In some instances,

detoxification may be counter to the goals of eventual abstinence. Where it is appropriate, detoxification at all times should be carried out under medical supervision. Detoxification, for perhaps the majority of people, does not need to be carried out in an institution; much can be done in the community and in the home, where it is vastly less expensive. Various forms of longer term treatment, such as therapeutic communities, have been extensively used in different parts of the world. But the experience with such treatment approaches is that they are expensive, slow, protracted and may need constant repetition. They do not provide a quick or efficient answer to the problems of drug addiction.

It is the common experience of all treatment approaches that they have long term success with only a small proportion of patients on any one occasion: recidivism rates are very high. It is to be expected that treatment for any one addict might be required two, three or multiple times. For those who chronically relapse, who return for treatment several or many times, it is worth considering a drug substitution program. In many countries, including some countries in Asia, the most common drug substitution program is methadone maintenance. This is different from the use of methadone for detoxification; it involves maintaining the person's addiction but with a legal drug provided in a socially sanctioned environment. As well as decreasing the person's use of illegal drugs and stopping injecting (and therefore the risk of HIV transmission), this has the effect of bringing the person back into formal contact with the socially legitimate world.

## Treatment for drug problems

- REDUCE RISK OF HIV INFECTION WITH METHADONE MAINTENANCE TREATMENT
- LONGER DURATION AND HIGHER DOSE – LOWER HIV
- METHADONE LOWERS RISK THROUGH REDUCED INJECTING NOT REDUCED SHARING
- CLOSE LINK BETWEEN METHADONE DOSE AND FREQUENCY OF INJECTING
- A PRIORITY FOR HIV INFECTED IDUS IN THE EARLY PHASE OF AN HIV EPIDEMIC

Many studies have shown that bringing patients into methadone maintenance programs raises possibilities for involving them in other treatment programs, which over the longer term are effective at helping them stop drug use entirely. Methadone maintenance will be covered more extensively in Section Two, Chapter Six: Drug Use and Substitution, but here it will simply be stated that drug substitution, as part of an integrated treatment program, is the approach which shows the most promise, at the present, for long term treatment of heroin addiction.

A most important point in all rehabilitation approaches is that rehabilitation does not finish with the end of treatment. If a drug user spends time in a rehabilitation centre, and is off his drugs when he is discharged, but he is discharged back into exactly the same environment in which he first began using drugs, the likelihood is that he will begin using drugs again. Without programs to ensure the transition from the drug-free environment of the rehabilitation centre back to the outside

world, such programs will fail. These transition programs may include support through the family and community, employment and support at the workplace, or continued attendance at an outpatient rehabilitation centre for counselling, support and ongoing treatment.

## Community development

Many of the root causes of drug use are in the social setting that young people, particularly, find themselves. The strongest defence against drug use is strong integration into meaningful social structures. These include the family, the school system, the community and the workplace. If the antecedent causes of drug use are examined in any society, it will always be found to be disproportionately common among those who are alienated, feel powerless and have less economic opportunity in their lives. None of these situations can be overcome rapidly, and it has to be recognised that strategies to overcome them may in the short term make things worse. For instance, in an economically underdeveloped community where there is much poverty, this poverty may be associated with drug abuse. A first effect of development strategies aimed at raising the economic level of this community might be to make more money available to people in the community. At this point, some of this increased income might be spent on drug use, and the actual consumption of drugs might increase as a result of economic development. Economic development creates social pressures which must be accounted for – economic development without social development can lead to many untoward effects.

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## Conclusion

Efforts to reduce the demand for drugs are slow, long term and incremental in their effects. Many are expensive, ineffective and very inefficient because they are unrealistic in their aims, not properly targeted, and stem from a philosophical position rather than a recognition of the world as it actually is. Prevention and treatment of drug abuse are worthy goals, and comprehensive strategies for both are necessary parts of programs to prevent the spread of HIV among IDUs. But by themselves, they are not enough.

## Harm reduction

Medicine's Hippocratic oath – “first do no harm” – should be adopted as a first principle of drug control policy.

Since the mid 1980s and the arrival of HIV/AIDS among IDUs throughout the world, harm reduction strategies have become prominent. The strategies of supply and demand reduction are primarily focused on mid to long term goals which do not address the rapid transmission of HIV infection; HIV prevalence among IDUs in many parts of Asia have climbed from zero to 50 per cent in just a few months.

Harm reduction policies are increasingly being adopted, or adapted, according to the needs of different countries or communities. The relatively new approach of harm reduction is consistent with present scientific knowledge and, within its framework, it has incorporated the current scientific findings.

Harm reduction emphasises the need to base drug policy on research rather than on stereotypes of both legal and illegal drug users.

Harm reduction accepts the reality that illicit drugs will not be eradicated in the foreseeable future: therefore the accessibility of illicit drugs and the social conditions creating demand for them will result in their continued use. Drug policies must be pragmatic and must not be based on a utopian belief that there will always be safe drug use among drug users. It is important that the drug user be integrated into the community, not marginalised, so that their health can be monitored and protected and therefore reduce the risk of HIV transmission. While a wide variety of interventions are required, to protect the drug user from individual and social harm, it is not always necessary to reduce drug use to reduce the harms. The basic components, measures and rationale of harm reduction have been described in detail in Section One: Chapter Two.

## Integration of the Three Approaches

Attempts to restrict illicit drug supplies have been costly, produced substantial unintended negative consequences, and rarely have produced significant and sustained reductions in drug-related problems. Only when demand for drugs is low, detection is difficult to evade and substitutes are not readily available, can restricting supply help reduce drug problems. This suggests that reducing the supply of drugs will only become a

successful strategy for the decrease of the harm associated with drug use when effective demand reduction strategies have been implemented.

HIV prevention strategies among IDUs are developed and implemented in the context of both efforts to decrease drug use, including law enforcement, education and drug treatment on the one hand and, meeting other needs of IDUs, such as primary health and human rights on the other. Effective drug education both in and out of school can, with the appropriate approach, decrease experimentation with drugs. But, at the same time, it can ensure that those who do experiment have the knowledge necessary to prevent many of the harms associated with the drug, especially HIV exposure.

Law enforcement can continue to effectively target major suppliers of drugs while participating in a public health approach to the users of the drugs. For an individual, drugs may be causing personal and health problems, and the individual therefore requires a personal health approach. For a society, imprisoning drug users, simply for the use of the drug, in no way diminishes demand for the drug. It potentially causes major harm to the individual, who is exposed to more harm in prisons (including a higher risk of HIV infection) while usually not receiving treatment for his or her drug or other personal problems. Recognising these factors can provide police forces with very important roles in the prevention of HIV transmission. In some countries, police actively participate in harm reduction, by referring drug users for treatment rather than arresting them, and even providing them with clean needles and syringes.

Independent of each other, the three different approaches of supply, demand and harm reduction cannot be regarded as singularly effective. However, **together** they can complement each other – resulting in a favourable environment in which it is possible to contain the problem of illicit drug misuse and address the public health catastrophe of HIV/AIDS among IDUs.

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**Section One, Chapter Three:  
Balancing and integrating the  
approaches of Supply Reduction,  
Demand Reduction and Harm  
Reduction**

**For further information refer to  
WHO resources: Policy and  
Programming Guide for HIV  
Prevention Among Injecting Drug  
Users & Evidence for Action  
Papers. Refer to following website:  
[www.who.int/hiv](http://www.who.int/hiv) (publications  
expected online from May 2003)**

The Centre  
for Harm  
Reduction

## References

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- Manual for reducing drug related harm in Asia*
- Bureau for International Narcotics and Law Enforcement Affairs, US Department of State, Washington D.C. *International Narcotics Control Strategy Report, Asia* 1996.  
[\[http://www.state.gov/www/global/narcotics\\_law/1996\\_narc\\_report/index.html\]](http://www.state.gov/www/global/narcotics_law/1996_narc_report/index.html)
- Chi'en J. 1997. The Three Reduction Approach: A Balanced Strategy for Reducing Illicit Drugs, Supply, Demand and Harms. *Spotlight, The Hong Kong Council of Social Services*. Vol 27, August 1997.
- De Haes WFM. 1987. Looking for effective drug education programs: Fifteen years exploration of the effects of different drug education programs. In Coomber R (ed). 1994. *Drugs and Drug Use in Society*. Dartford: Greenwich University Press.
- Des Jarlais DC. 1995. Harm Reduction: A Framework for incorporating Science into Drug Policy. *American Journal Of Public Health*. 85:10-12.  
[\[http://www.lindesmith.org/library/tlcdjarl.html\]](http://www.lindesmith.org/library/tlcdjarl.html)
- Drucker E. 1995. Harm Reduction: A Public Health Strategy. *Current Issues in Public Health*. 1: 64-70.  
[\[http://www.lindesmith.org/library/tlcdruck.html\]](http://www.lindesmith.org/library/tlcdruck.html)
- Ennet TS, Tobler SN, Ringwalt LC and Flewelling R. 1994. How effective is drug abuse resistance education? A meta-analysis of project DARE outcome evaluations. *American Journal of Public Health*. 84(9):1394-1401. Heather N, Wodak A, Nadelmann E and O'Hare P (ed).1993. *Psychoactive Drugs and Harm Reduction: From Faith to Science*. London:Whurr Publishers.
- Kumar MS, Mudaliar S and Daniels D. 1997. *Research Monograph on Drug Abuse and HIV/AIDS*. Chennai (Madras): Sahai Trust, Chennai, India.
- Liang AD. 1992. The Golden Triangle: Burma, Laos and Thailand. In Mc Donald BS and Zagaris B (ed). 1992. *International Handbook on Drug Control*. Westport, Connecticut: Greenwood Press.
- Mc Coy WA. 1991. *The Politics for Heroin: CIA complicity in the global drug trade*. New York: Lawrence Hill Books.
- Nadelmann E. 1998. Commonsense Drug Policy. *Foreign Affairs*. 77(1) January-February.  
[\[http://www.lindesmith.org/library/foreigna.html\]](http://www.lindesmith.org/library/foreigna.html)
- Nadelmann E. 1989. Drug Prohibition in the United States: Costs, Consequences, and Alternatives. *Science*. September 1989:939-947.  
[\[http://www.lindesmith.org/library/science/science.html\]](http://www.lindesmith.org/library/science/science.html)
- Nadelmann E and Mc Neely J. 1996. Doing Methadone Right. *Public Interest*. 123:83-93.  
[\[http://www.lindesmith.org/library/tlcn-jm.html\]](http://www.lindesmith.org/library/tlcn-jm.html)
- Narcotics Control Strategy Report. 2001. Myanmar Released by the Bureau for International Narcotics and Law Enforcement Affairs, US Department of State Washington, D.C.
- Rana S. 1996. *Harm Reduction in Asia*. Paper presented at the 7th International Conference on the Reduction of Drug Related Harm, Hobart, Australia, March 6th, 1996.
- Regional Drug Control Profile for Southeast Asia and the Pacific. UNDCP Regional Centre for East Asia and Pacific. Bangkok. Thailand.
- Rosenbaum M. 1996. *Policy Statement; Kids, Drugs and Drug Education: A Harm Reduction Approach*. San Francisco: National Council on Crime and Delinquency.

- Segar A. 1996. *Drugs and Development in Southeast Asia: A Background and Discussion Paper*. Unpublished paper. Project Drugs and Development in Asia, GTZ, Germany.
- Shadow Conventions 2000: Fact Sheet Compiled by Drug Policy Alliance. 2000. [<http://www.lindesmith.org/events/archive/conferences/shadow/factsheet/index.cfm>]
- Singh M and Peak A. 1997. *Increasing trends towards the reduction of drug related harm throughout Asia*. Paper presented at the 8th International Conference in the Reduction of Drug Related harm, Paris, France, March 23-27. 1997.
- Smith ML, Thongtham CN, Sadeque N, Bravo AM, Rumrill R. *et al.* 1992. *Why People Grow Drugs*. London: Panos Publication Ltd.
- Stimson G. 1985. Can a War on Drugs Succeed? In Coomber R. (ed). 1994. *Drugs and Drug Use in Society*. Dartford: Greenwich University Press.
- Regional Drug Control Profile for Southeast Asia and the Pacific. UNDCP Regional Centre for East Asia and Pacific. Bangkok. Thailand.
- United Nations International Drug Control Programme. 1997. *World Drug Report*. New York: Oxford University Press.
- United Nations International Drug Control Programme. 1997. *Drug Control Briefs*. United Nations Drug Control Program Regional Centre for East Asia, July 1997.
- United Nations Drug Control Programme. 1995. *Ky Son Alternative Socio-Economic Development Project, Vietnam*. Hanoi: United Nations Drug Control Programme.
- United Nations Office for Drug Control and Crime Prevention. 2000. *Global Illicit Drug Trends*. New York, UNDCP.
- Wodak A and Des Jarlais DC. 1993. Strategies for the prevention of HIV infection among and from injecting drug users. *Bulletin on Narcotics XLV* (1): 47-60.
- Wodak A and Owens R. 1996. *Drug Prohibition: A Call For Change*. Sydney: University of New South Wales.
- Wodak A, Seivewright N, Wells B, Reuter P, Des Jarlais DC. *et al.* 1994. Comments on Ball and van de Wijngaart's Article AA Dutch Addict's View of Methadone Maintenance: An American and Dutch Appraisal. *Addiction*. 89:803-814.

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# Briefing papers

- 1. Injecting drug use and AIDS: An explosive combination**
- 2. Mapping drug use in Asia in the context of HIV/AIDS**
- 3. A Review of amphetamine type substances**
- 4. Care and support of injecting drug users with HIV and AIDS**

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*Briefing  
Papers*

The first paper provides a summary of the global situation of HIV among injecting drug users (IDUs), the rationale for harm reduction approaches, and evidence about the effectiveness of these approaches. The second paper focuses on Asia and describes the illicit drug problem, its links to adverse health consequences (particularly the enormity of the HIV/AIDS problem), current inappropriate responses, and the lack of effective programs for HIV prevention among Asian IDUs. The third paper is devoted specifically to amphetamine type substances as they are of great concern in Asia due to substantial and increasing production and widespread use. The last paper deals with care and support of IDUs with HIV/AIDS, and HIV/AIDS-related stigma and discrimination.

These papers are intended to be used as Briefing Papers for distribution to key people as part of advocacy for the development of harm reduction approaches towards prevention of HIV among IDUs. They also provide an overview of the drug use and HIV/AIDS situation in Asia – for politicians and other policy makers, for key bureaucrats in public health and public security, for police, for journalists, for public health practitioners, and so on. They may be photocopied for distribution as self-contained documents.

## BRIEFING PAPER ONE

# Injecting drug use and AIDS: An explosive combination

*Briefing  
Paper  
One*

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**HIV infection can spread very rapidly among injecting drug users, then to their sex partners and children; but is easily controlled by appropriate interventions.**

The injection of illicit drugs has been reported in over 130 countries, and in 114 of these HIV is epidemic among injecting drug users (IDUs). HIV can spread rapidly through IDU populations, and as IDUs often engage in other risk behaviours for HIV, such as sex work or paid blood donation, they are a vector for further sexual and vertical transmission (parent to child). It is vital to include effective measures to prevent HIV transmission among IDUs in any comprehensive HIV/AIDS strategy. IDUs are a hidden and stigmatised group because their behaviour is illegal, thus specialised approaches are required. HIV prevention strategies based on the principles of harm reduction are the only effective approaches and this has been demonstrated worldwide.

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**BACKGROUND**

The phenomenon of illicit drug injecting is widespread, involving perhaps 15 million people in over 130 countries. Directly or indirectly, injecting drug use affects everyone in a community in which it occurs.

Worldwide, the commonest injected drugs are heroin, amphetamines and cocaine, though many other drugs are also injected, including tranquillisers and other pharmaceuticals. Which drugs are injected in a particular location depends on availability and cost (often reliant on geographic proximity to production areas or trafficking routes), personality traits and peer group norms, among other factors.

The drug being injected influences to some degree the behaviours associated with injecting, but, whatever the drug, if the equipment used to prepare and inject the drug is shared between users without adequate sterilisation, potential for HIV transmission exists. Shared needles and syringes are a particular risk, as they can

transmit large quantities of blood. Reasons for sharing injecting equipment are many, but include scarcity or cost of needles and syringes, cultural practices, and legal or policing barriers to availability or use. Nevertheless, simply increasing the availability and accessibility of sterile injecting equipment in order to reduce sharing, though this is fundamentally important in reducing the risks of HIV transmission among IDUs, may not be sufficient to control HIV spread. Injecting drug use is embedded in a socio-cultural context of which illegality is a defining feature. Because IDUs participate in illegal activities, such as property crime to raise the money to purchase drugs, they are generally stigmatised, discriminated against or excluded from access to health services, and subject to human rights violations.

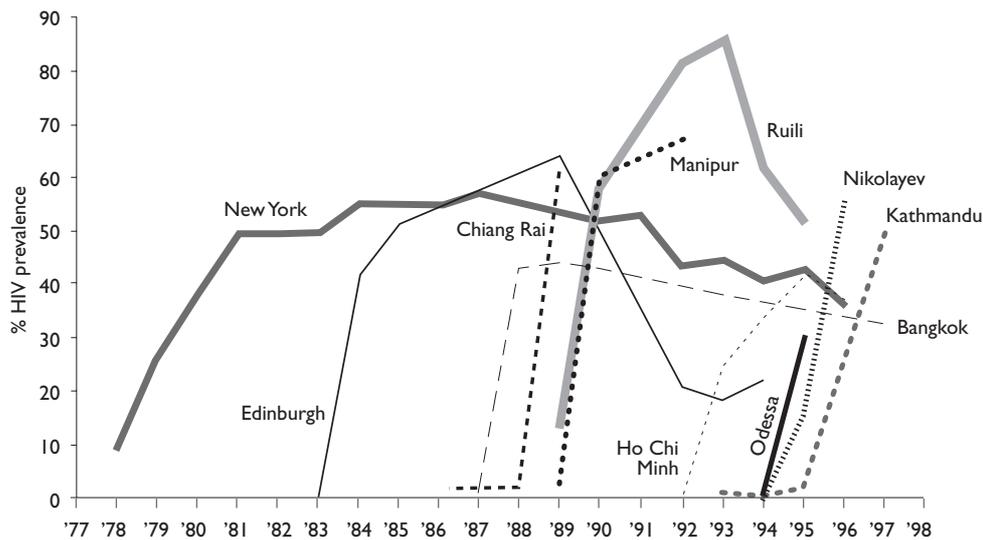
AT A GLANCE

**Injecting drug use and HIV infection:**

- Illicit drugs are injected in many parts of the world
- HIV spreads among groups of IDUs mainly because of the reuse or sharing of needles and syringes which have become contaminated with infected blood
- It is not drug use or injecting drugs per se which spreads HIV, but unsterile practices – in particular the sharing of needles and syringes
- Reasons for sharing include poverty, lack of availability of or access to needles and syringes, cultural factors and ignorance

- Given the wrong conditions, spread of HIV among IDUs can be explosive, with up to 90% of all IDUs in a community infected in the space of a few months. This has happened in places as separated geographically and culturally as New York, Milan, Edinburgh, Bangkok, Santos, Odessa, Ho Chi Minh City, Yunnan Province in China, and Manipur State in India
- Aspects of enforcement of prohibition of illicit drugs promote conditions for transmission of HIV among IDUs
- HIV usually spreads from IDUs to their sexual partners and children
- If IDUs are clients of sex workers or are sex workers themselves, HIV spreads more rapidly to the rest of the community.

**Figure 1. Rapid increases in HIV prevalence among IDUs, 1978–1998**



(Ref: Rhodes T et al 1999)

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## THE CHALLENGE



### The scale of HIV spread among IDUs, their sexual partners and their children depends on:

- The drugs injected and frequency of injecting
- The social organisation of drug injecting, especially the existence of ‘shooting galleries’ or professional injectors ( persons skilled to inject others)
- IDUs’ awareness of HIV, hepatitis viruses and other infections which can be associated with unsterile injecting
- The availability of sterile injecting equipment or of the means to sterilise equipment
- The availability and accessibility of drug treatment programs
- The availability and accessibility of welfare and primary health programs for IDUs.

Currently all prevention of HIV transmission among IDUs occurs in a context of attempting to reduce the use of illicit drugs by reducing their supply or decreasing the demand for them. Strategies to achieve these objectives often conflict, and a balance must be achieved in the relative emphasis placed on demand reduction, supply reduction and HIV prevention so as to minimise the harms associated with injecting drug use. Because of the potential rapidity of the spread of HIV among IDUs, it is vital that effective preventive responses be implemented early in an epidemic in ways that allows these responses to coexist with demand and supply reduction initiatives.



### Eliminating sharing of needles and syringes

The basic challenge in reducing the spread of HIV among IDUs is to decrease or eliminate the sharing of injecting equipment, and with it the risk of HIV transmission. IDUs share and/or reuse injecting equipment for many reasons, and these must be determined for each locality. Where sharing involves frequent use of the same needle and syringe by multiple IDUs, HIV can spread explosively (see Figure 1). This phenomenon has been documented in environments where there are ‘shooting galleries’ and professional injectors, and in numerous prisons around the world.

A common perception standing in the way of increasing availability of sterile injecting equipment is the fear that these programs will increase drug use and the number of drug users; many studies have demonstrated that this is not the case.

*Briefing  
Paper  
One*



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## **Integrating and balancing harm reduction with drug control and AIDS programs**

Most societies have programs in place to decrease demand for and supply of illicit drugs, in the context of which HIV prevention efforts must be implemented. Strategies to decrease the demand for drugs include education, drug treatment and rehabilitation, and a community development approach where drug users are integrated into meaningful social structures. In general, even the most effective drug use prevention strategies decrease uptake of drug use by small proportions, over relatively long periods, and often do not reach those most at risk of drug use; some well-meaning programs have even been shown to lead to increased drug use. Treatment options for drug use are frequently limited in scope, availability and effectiveness, and are inappropriate or unavailable for the majority of IDUs most of the time.

Similarly, attempts to reduce supply of drugs for which there is a persistent demand are typically of limited effectiveness and often of very poor cost-effectiveness. Worse still, they often divert scarce resources away from drug treatment and HIV prevention programs. Moreover, harsh application of supply control strategies, such as restriction of availability of syringes or imprisonment of drug users, often creates favourable conditions for spread of HIV.

Reaching the optimum balance between efforts to decrease drug use and to prevent HIV transmission among IDUs can be difficult. Recognition that HIV can spread faster than strategies can reduce the at-risk population, however, means the implementation of HIV prevention programs must take priority. The challenge, therefore, is twofold: firstly, to ensure that HIV prevention is adequately considered in national drug strategies (demand and supply control); secondly, that injecting drug use is adequately considered in national AIDS programs.



## **Introducing harm reduction before HIV enters**

Preventing spread of HIV among IDUs is much easier when prevalence is low or zero than when the virus has become established; however, the measures needed are often politically unpalatable, and ironically it is often the case that appropriate measures are not considered until after HIV has begun to spread and the required response has grown larger and more costly. Stimulating political action before HIV prevalence among IDUs has risen significantly, and while there is little perception of this as a public health problem, is difficult but crucially important.

The common scenario of concern being raised only after HIV has begun to spread widely among IDUs means that responses must be framed in a context of providing care for many people with HIV infection and disease, thereby diminishing the availability of resources for prevention and the community's capacity for response. Very little work has

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been conducted on developing and evaluating HIV prevention measures in areas where prevalence of HIV among IDUs is already high. This is partly due to the perception that the problem is intractable and therefore resources expended on it will be wasted. That this is not the case has been demonstrated in some locations in the West (Edinburgh, New York City), but there is an urgent need for further demonstration projects working in high prevalence areas.

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### **HIV prevention in high prevalence populations**

HIV prevention programs are working successfully among IDUs in many parts of the world, but in most countries they remain small efforts meeting the needs of very few IDUs compared with the numbers needing help. In developing-world situations, programs are often operating in isolated and sometimes hostile environments, making their task doubly difficult. As well as the need to see such programs expanded to national levels, supported by national AIDS and drug policies, it is important to strengthen their ability to operate through peer support and networking. Through sharing of expertise and experience, networking can foster development of HIV prevention programs in regions where a response is lacking or in its infancy.

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### **Care for HIV-infected IDUs**

As the number of IDUs with HIV infection and AIDS is continually growing, and as many of these people are social outcasts even prior to their HIV infection, providing for their medical and social needs is a major challenge. IDUs are disadvantaged in terms of access to primary healthcare because of their drug use and its associations, such as poverty or ethnicity. Drug treatment is available to a tiny percentage of the world's IDUs, and effective with only a percentage of those. Specific care for HIV-infected IDUs, tailored to their particular needs and provided in a non-judgmental, caring and accessible environment, is virtually non-existent globally. Creating a healthy environment for IDUs, especially those infected with HIV, involves confronting issues of human rights and discrimination, often within medical or other agencies charged with providing the care. Educating service providers is a major priority in this process, but legal reform is also vitally important.

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## A BALANCED APPROACH FOR A DUAL EPIDEMIC

The most effective response to the spread of HIV among IDUs is harm reduction - the primary aim of which is to reduce the harm associated with the injecting of drugs, especially the transmission of HIV and other blood borne viruses, without necessarily diminishing the amount of drug use. This approach is entirely compatible with sensible demand and supply reduction approaches, and sees drug use primarily as a public health issue rather than a law and order issue. The harm reduction philosophy acknowledges the humanity and worth of IDUs, and advocates partnerships with IDUs and their communities to protect their common health.

Conflict between efforts to decrease drug use in a community and prevent HIV among drug users is avoidable. Law enforcement can continue to effectively target major suppliers of drugs while participating in a public health approach to the users of the drugs.

“Prevention of HIV infection among injecting drug users is a higher public health priority than is prevention of drug use.”

– Scottish Home Office

For an individual, drugs may be causing personal and health problems, and the individual therefore requires a personal health approach. For a society, imprisoning drug users simply for using drugs in no way diminishes demand for drugs, and potentially causes major harm to the individual, who is exposed to more harm in prisons (including higher risk of HIV infection) while usually not receiving treatment for his or her drug or other personal problems. Recognising these factors can provide police forces with very important roles in prevention of HIV transmission. In some countries, (e.g. Australia, United Kingdom, Netherlands, Switzerland, Germany and in some parts of India) police actively participate in harm reduction by referring drug users to treatment rather than arresting them.

Epidemics of HIV among IDUs have been prevented, even where there is no decrease in drug use or injecting. Countries which have been most successful in this are countries which have adopted the public health approach known as harm reduction.

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**EFFECTIVE RESPONSES**

**Promoting use of sterile equipment**

Most HIV transmissions among IDUs result from sharing injecting equipment contaminated with infected blood. Therefore, ensuring that each injection is prepared and performed with sterile injecting equipment is sufficient to break the chain of transmission and prevent the majority of HIV infections among IDUs.

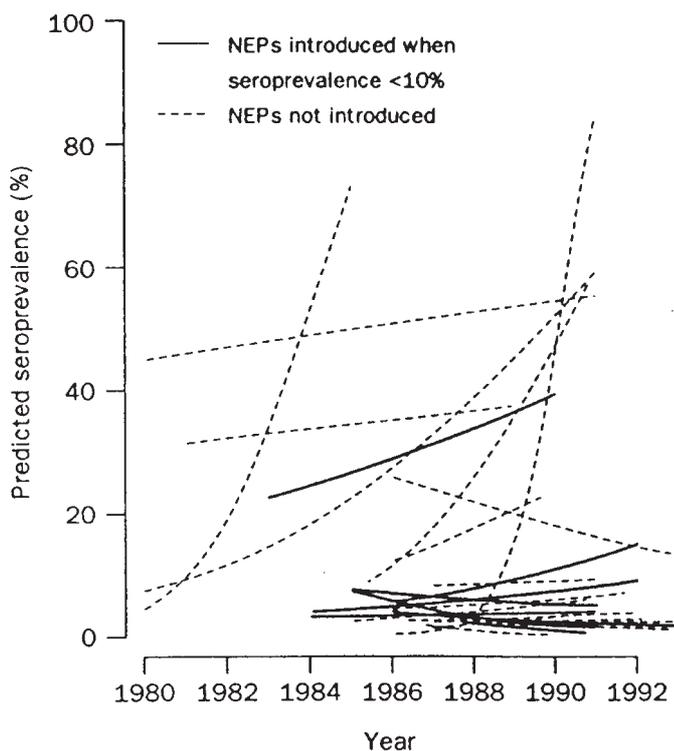
Strategies to increase the use of sterile equipment vary, depending on local context and the reasons for sharing. Effective and sustainable strategies must be built on a sound understanding of the pressures on IDUs to share equipment. Scarcity of or lack of access to injecting equipment, and legal or policing sanctions against the possession of

needles and syringes or other injecting paraphernalia, are the two commonest reasons for reuse and/or sharing of needles and syringes. Others include ignorance of the risks of HIV infection and how to prevent them, cultural factors promoting sharing, and inter-personal factors as in sexual relationships.

Two successful models for increasing needle and syringe availability are the sale of needles and syringes at minimum prices through pharmacies or other outlets, and needle and syringe programs (NSPs). NSPs operate on the basis of providing sterile needles and syringes, and include in their aims the distribution of educational material and the removal from circulation of contaminated needles and syringes. A vital principle for community acceptance of these programs is ensuring that needles and syringes are

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**Figure 2. Trends in prevalence of HIV among IDUs in cities with and without needle exchange programs.**



(Ref: Hurley S et al 1997)



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appropriately disposed of after use, and do not pose threats to the non-IDU community. The inadequate disposal of used needles is often a major reason for rejection of NSPs by communities.

NSPs and pharmacy sales do not by themselves prevent HIV transmission among IDUs, but are a key and integral part of any comprehensive and effective response to the problem. Figure 2 shows one aspect of the success of NSPs as part of programs to prevent HIV transmission.

The use of bleach or other chemicals to decontaminate and sterilise used injecting equipment before it is reused is often promoted as a method of preventing HIV transmission where programs to increase needle and syringe availability are politically unacceptable (for instance, in prison). Unfortunately, no chemical method of decontamination is totally effective, especially in field conditions. Therefore the use of decontamination as a strategy for HIV prevention among IDUs should always be seen as a second-best option.



## Education and information

A basic necessity in preventing the spread of HIV among IDUs is information about what HIV is and does, how it is transmitted, how transmission can be prevented, and how IDUs can practically change their behaviour to stop HIV transmission. Education and information must focus on risk behaviours associated with injecting drugs but also include sexual and vertical (parent-to-child) transmission. This information must be culturally relevant to IDUs, realistic and practical. Many IDUs distrust official sources of information and consequently the most effective form of education is that performed by 'peers' – that is, current or ex-IDUs who are in contact with other IDUs whom they can inform.



## Peer education and organisation

Many studies have shown that education and behaviour change around safer injecting and HIV prevention among IDUs is most effective and sustainable when it is delivered by peers in a supportive environment, especially with the understanding and cooperation of police. Peer education

### Does needle syringe programs (NSPs) increase the use of injected drugs?

Six major reviews of the impact of NSPs around the world were unanimous in two major findings:

- (i) NSPs are instrumental in slowing or stopping the spread of HIV among IDUs; and
- (ii) NSPs have not been shown to increase participation in drug use, or to encourage people who would not otherwise use drugs to begin doing so.

Many reviews of NSPs have found them to be a highly effective and cost-effective approach to HIV prevention, and an additional means of bringing into drug treatment drug users who would not be reached otherwise.

facilitates contact with IDUs in the community, delivering health education from a source more credible to the IDUs than are most agencies, especially agencies IDUs identify with governments.

Developing organisations of IDUs to provide peer education has been an effective strategy in those countries where it has been possible. Drug user organisations also provide program planners and policy makers with informed advice from drug users for educational or other interventions, and can advocate on behalf of IDUs in relation to both human rights and HIV prevention issues.

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### Primary health care

Because of their engagement in illegal activities, and because many have disadvantaged backgrounds, IDUs' access to primary health care is often limited or non-existent. Protection from HIV infection must be seen as one part of a holistic approach to health care among IDUs, who suffer many health problems, including other infections associated with drug injecting and malnutrition, as well as the health problems common to their community. Safer injecting, and therefore HIV prevention, is not a meaningful concept to IDUs who cannot gain access to basic health care, and who may have much more pressing health and social problems; thus HIV prevention approaches must be responsive to these other needs.

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### Drug treatment and substitution programs

Treatment for drug dependence has been shown to be highly effective (and cost-effective) as an HIV prevention strategy. Research has demonstrated that drug treatment is most effective when it is available to the drug user at the time when he or she needs it. Therefore as part of a comprehensive approach to HIV prevention among IDUs a flexible, accessible and caring drug treatment system is vital.

In many places, treatment for drug addiction or other problems is left to the penal system, or to rehabilitation centres that are effectively prisons. These systems are not effective in promoting and/or achieving long-term abstinence: rates of relapse on discharge are typically 90 per cent and above.

Detoxification programs are beneficial to many people in the short term, but have poor long-term success rates. The most effective programs for heroin dependence so far developed are drug substitution programs, the best known and most well researched being methadone maintenance. Substitution programs do not 'cure' the addiction, but they allow IDUs to escape the criminal world of illegal drugs into a more socially acceptable environment, and have been demonstrated to decrease HIV transmission among IDUs – generally by decreasing the frequency of injecting and needle-sharing.

The key goal of substitution programs is retention of the drug users in the program – the longer the retention, the more successful is the program at reducing adverse health and social consequences of drug use, and in achieving long-term benefit. A range of drug substitution programs is currently being investigated and trialled, to broaden the applicability of such approaches beyond those who can benefit from methadone and/or to offer an alternative in countries where methadone is not acceptable.



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## Removing the barriers to safer injecting

Behaviours that put IDUs at risk of HIV infection are not random: they result from defined social, legal and political contexts. To enhance the ability of IDUs to behave in ways which reduce or prevent HIV transmission, it is most important to examine the social, cultural and political context with a view to removing any barriers to safer injecting. These barriers may include lack of access to information, primary health care or drug treatment; there may also be legal barriers which do little to control drug use and simultaneously increase HIV transmission risk. An example is the so-called ‘paraphernalia laws’, under which possession of injecting equipment is criminalised. Rather than deterring IDUs from injecting, such laws discourage the carriage of new injecting equipment and promote sharing and reuse (and therefore HIV transmission). Abolishing such laws does not increase participation in drug use, but does remove a barrier to safer use for the motivated IDU.



## Special groups and circumstances

There are many special situations of higher risk for HIV transmission among IDUs that should be considered separately because of their epidemiological importance in promoting epidemics. Though the groups might be numerically small relative to mainstream groups, they can and often do contribute disproportionately to HIV epidemics and therefore should be central to HIV prevention efforts. Special situations include:

**Prisons:** drug use and injecting occurs in most prisons in the world, less frequently than among IDUs outside prison but usually with greater HIV risk because of the extreme scarcity of needles and syringes. Many IDUs are imprisoned at some time, and prisons bring together IDUs from a wide range of socio-geographic backgrounds, allowing transmission of blood-borne viruses between social and geographic groups that may not otherwise overlap. Programs to decrease risk in prison can include peer education and provision of bleach for disinfecting equipment.

**Ethnic minorities:** injecting drug use is often observed among ethnic minorities, who become involved in production or trafficking of drugs in many parts of the world largely because of their subordinate status. These groups often have low participation in many aspects of the general community, including health care and employment. Special programs targeting IDUs in these communities are necessary to reduce HIV risk, and must be built on accepted community development guidelines.

**Women:** women IDUs in Asia are increasing in number and can be at high risk of HIV infection because of their subordinate status in many communities, which may require them to provide sex on demand or always use a needle and syringe after their male partner. HIV infection risk is further increased when women are also involved in sex work. Again, special programs are required which address all the relevant issues, not only needle sharing.

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**REFERENCES**

Adelekan, Moruf and Stimson, Gerry. Problems and prospects of implementing harm reduction for HIV and injecting drug use in high risk sub-Saharan African countries. *Journal of Drug Issues* 1997;27(1):97-116.

Comment ► *The only major review of the current situation regarding drug injecting and HIV in Africa; demonstrates that this largely ignored situation could potentially become very important, very rapidly.*

Caplehorn, John and Ross, Michael. Methadone maintenance and the likelihood of risky needle sharing. *International Journal of Addiction* 1995;30(6):685-598.

Comment ► *A review of the current literature evaluating the effectiveness of methadone maintenance therapy in HIV prevention among IDUs, finding a consensus that it is a very effective strategy.*

Crofts N, Reid G and Deany P. 1998. Injecting drug use and HIV infection in Asia. *AIDS*. 12 (suppl B): 569–578

Crofts N, Costigan G, Narayanan P, Gray J, Dorayee J, et al. 1998 *AIDS*. 12 (suppl B): 5109–5115

Friedman, Sam, De Jong, Wouter, Wodak, Alex. Community development as a response to HIV among drug injectors. *AIDS* 1993(Suppl 1):S263-S269

Hurley S, Jolley D and Kaldor J. 1997. Effectiveness of needle-exchange programmes for prevention of HIV infection. *Lancet*. 349: 1797–1800

Lurie, Peter, and Reingold, Arthur. The public health impact of needle exchange programs in the United States and abroad. Berkeley, CA: School of Public Health, 1993.

Comment ► *A most comprehensive review of the effectiveness and safety of needle and syringe exchange as a strategy for limiting HIV transmission among IDUs.*

Normand, Jacques, Vlahov, David and Moses, Lincoln. Preventing HIV transmission: the role of sterile needles and bleach. Washington, D.C.: National Academy Press, 1995.

Comment ► *A comprehensive and authoritative perspective on preventing HIV transmission among IDUs, very much from an American perspective.*

Rhodes T, Stimson G, Crofts N, Ball A, Dehne K and Khodakevich L. 1999. Drug injecting, rapid HIV spread, and the ‘risk environment’: implications for assessment and response. *AIDS*. 13 (suppl A): S259-S269

Stimson, Gerry. The global diffusion of injecting drug use: implications for human immunodeficiency virus infection. *Bulletin on Narcotics* 1993;XLV(1):3-17.

Comment ► *A comprehensive background to the HIV epidemic among injecting drug users globally.*

**Briefing  
Paper  
One**

Trautmann, Franz. Peer support as a method of risk reduction in injecting drug-user communities: experiences in Dutch projects and the “European Peer Support Project”. *Journal of Drug Issues* 1995;25(3):617-628.

Comment ► *An excellent review of the methods, strengths and weaknesses of peer support among IDUs as a means of HIV prevention, specifically looking at European experience.*

Wodak, Alex and Des Jarlais, Don. Strategies for the prevention of HIV infection among and from injecting drug users. *Bulletin on Narcotics* 1993;45(1):47-60.

Comment ► *A comprehensive perspective on HIV prevention strategies among IDUs, with some evaluation of their relative efficacy and appropriateness.*

Wodak, Alex and Lurie, Peter. A tale of two countries: attempts to control HIV among injecting drug users in Australia and the United States. *Journal of Drug Issues* 1996;27(1):117-134.

Comment ► *A clear exposition of why the HIV epidemic among IDUs has evolved so differently in two apparently similar countries – fundamental case studies demonstrating the impact of drug policy on the spread of HIV.*

Power, Robert, Jones, Steve, Kearns, Gerry, Ward, Jenni, and Perera, Jan. Drug user networks, coping strategies and HIV prevention in the community. *Journal of Drug Issues* 1995;25(3):565-581.

Comment ► *An essential review of the role of peers and communities in protecting themselves against HIV, a perspective which has not often enough been applied to injecting drug users.*

**BRIEFING PAPER TWO**

# Mapping drug use in Asia in the context of HIV/AIDS

Briefing  
Paper  
Two

**INTRODUCTION**

**Since the late 1980s and continuing into the new millennium, injecting drug use has become one of the major accelerants of the HIV epidemic in the Asian region. Although evidence of burgeoning or mature epidemics of HIV among injecting drug users (IDUs) is found throughout much of Asia, an appropriate response commensurate with the scale of the problem is greatly lacking.**

Drug production is flourishing, and increasing numbers of new populations are consuming, and injecting, drugs. The high prevalence of HIV infection among IDUs is largely a result of the widespread sharing of contaminated injecting equipment. A more recent phenomenon is the increasing crossover between drug injectors and sex work and consequently the implications for the further spread of HIV infection among and from IDUs to the wider community. The following regional overview shows not only the enormity of the illicit drug problem and its links to adverse health consequences, particularly HIV/AIDS, but also inappropriate responses and the lack of effective programs for HIV prevention among IDUs.



## Regional availability and sources of illicit drugs

Up until 2000, Afghanistan had firmly established itself as the world's largest opium producer, accounting for 72% of the world's illicit opium supply. By 2000 the Taliban authorities imposed a complete ban on opium cultivation, resulting in the reduction of opium cultivation by 91%. With civil conflict, military attacks on Afghanistan by the United States and the eventual overthrow of the Taliban regime, Afghanistan's share in global production fell to 12% by the end of 2001. In 2002, as a result of ongoing socio-economic hardships, Afghan farmers once again resumed opium cultivation and opium production reached levels not seen since the mid 1990s. In 2002, Afghanistan is once again the world's largest opium producer.

The opium industry of South-East Asia's Golden Triangle – with Myanmar as its epicentre – continues unabated. In 2001, as a result of upheavals in Afghanistan, Myanmar became the largest source of illicit opium in the world, but in 2002 the country once again became the second largest opium producer (with Laos in third place). The most dramatic change in Myanmar has been drug diversification; the country has become the primary source of ATS in Asia, producing an estimated 800 million methamphetamine tablets per year. Interceptions of methamphetamine tablets being trafficked from Myanmar across the Thailand border, but also through to China, Laos, Cambodia, India and Vietnam, have greatly increased in frequency. In 1999 an estimated 300 million methamphetamine tablets were imported into Thailand but this had doubled by 2000. Based on global ATS seizures it has been shown that most ATS production occurs in the



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Asian region. Prices for a methamphetamine tablet fluctuate: while it may cost US\$0.8 to produce a tablet can be sold for US\$1 in Bangkok and up to US\$20 in Tokyo.

Both heroin and methamphetamines require precursor chemicals – acetic anhydride for heroin and ephedrine for methamphetamine – for their production and these are principally sourced from China and India. Caffeine is also a major ingredient for methamphetamine production, most of which is trafficked from Thailand into Myanmar. Many countries in the region are criss-crossed by trafficking and transiting routes linking drug production zones to lucrative consumer markets. For example, Iran is a major bridge for opium and heroin en route to the Persian Gulf, Turkey, Russia and Europe.

China has recently become a major producer of methamphetamines for domestic use and has an established record of supplying to international markets – primarily Japan, South Korea, the Philippines and Taiwan. Production of methamphetamines in China appears to have accelerated, with 1,608 kilograms of the drug seized in 1999, increasing to 20,000 kilograms by 2000. The production of cannabis occurs in many countries of the Asian region; one is the Philippines, which is a major source of cannabis supplied to Japan, Malaysia, Taiwan, the United States and Europe. Research has shown consistently that populations of drug users develop rapidly along trafficking routes, creating new drug markets and HIV threats in host countries.

- In 2002, Afghan farmers again resumed opium cultivation and opium production reached levels not seen since the mid 1990s. In 2002, Afghanistan was once again the world's largest opium producer
- Myanmar is the primary source of amphetamine type substances (ATS) in Asia ... most ATS [global] production occurs in the Asian region
- ... populations of drug users develop rapidly along trafficking routes, creating new drug markets and HIV threats in host countries.



## Drugs of choice

Use of heroin and opium occurs throughout Asia. Opium use as a general rule appears to be on the decline in much of the region, particularly among those geographically distant from the sites of opium cultivation. Heroin use and addiction on the other hand remains an ongoing problem and an expanding heroin using population can be found in China, Vietnam and Myanmar. Methamphetamine use has skyrocketed in recent years and is the drug of choice, or is fast becoming so, in Thailand, South Korea, the Philippines, Taiwan, Japan, Cambodia, Laos, China and Indonesia. It is believed that worldwide over 50% of ATS use is to be found in Asia. In Thailand for example the use of ATS is growing at a rate of 50% per year.

- Heroin use and addiction remains an ongoing problem ... methamphetamine use has skyrocketed ... worldwide over 50% of ATS use is found in Asia.

The use of ecstasy is gaining in popularity throughout the region, as a part of the burgeoning dance party scene found in many

urban centres. Illicit ingestion of pharmaceuticals is popular, and in India, Bangladesh, Pakistan and Nepal the use of buprenorphine (a synthetic opioid) have become widespread. Cough mixtures containing codeine are commonly used, and a plethora of other analgesics and tranquillisers are trafficked and consumed throughout the region. The use of solvents and glue is common (particularly among street children) in India, Laos, Cambodia, Indonesia, Mongolia, Vietnam, the Philippines and Thailand. Cannabis and hashish consumption is commonly found throughout the region, especially among the countries that grow it. Cannabis is often the second drug of choice among many drug users admitted into treatment for either heroin or ATS addiction.

### Drug taking practices and risk factors

Favoured administration routes for drugs vary from place to place, over periods of time and in different cultural and social settings. Heroin is commonly (particularly in the initial stage) smoked in cigarettes or inhaled by 'chasing the dragon' (heating the drug on foil and inhaling the vapour). As a result of economic factors (the need to minimise the wastage of expensive drugs that can result from smoking), the desire for a stronger effect or because of peer pressures, the popularity of injecting is increasing and recognised by drug users in all of Asia. Injecting is most often associated with heroin, but there are reports of amphetamine injecting in South Korea and Japan, and in small numbers in Thailand, Laos, Indonesia, the Philippines and China. In India, Pakistan and Bangladesh drug users frequently inject buprenorphine, often with a cocktail of pharmaceuticals. Countries where drug injectors have become more apparent in recent years are Cambodia, Laos and

Mongolia, although estimated numbers of injectors are still relatively small. In countries where opium is consumed (Afghanistan, Iran, Pakistan, Myanmar, Laos, China, India, South Korea and Thailand) it is mostly smoked or orally ingested (either in food or in tea) and is still used in some communities for medicinal purposes.

Among IDUs in the region, sharing of equipment is common and, as shown in various surveys undertaken, the rate of sharing is frequently 50% and above.

- As a result of economic factors, the desire for a stronger effect or because of peer pressures, the popularity of injecting is increasing in Asia.
- ... the rate of sharing [injecting equipment] is frequently 50% and above ....

The sharing and reusing of injecting equipment is largely driven by issues associated with scarcity, accessibility, relative costs of equipment, peer and cultural customs and the social environment. It has also been shown that in most cases the methods of cleaning injecting equipment are often inadequate to prevent the transmission of blood-borne viruses (BBVs). Many IDUs use cold water to clean needles and syringes; few use boiling water or bleach. Professional injectors (people skilled in injecting others, often for a fee) and 'shooting galleries' are found in Pakistan, India, Bangladesh, Nepal, Vietnam, Myanmar and Malaysia, and inevitably promote the spread of BBVs. In Myanmar for example the practice of professional injecting is firmly established, mainly found in tea shops or shooting galleries, and the risk of HIV is great as sterilisation of the various injecting equipment tools is rarely considered.



## Prevalence of drug use

Estimates of the number of drug users and IDUs have generally increased over the years and in some countries the rise is substantial. In Indonesia drug use was previously an extremely sensitive issue and the figures were downplayed. In the late 1990s it was estimated there were 30,000-40,000 IDUs. Currently local researchers believe there could be 2 million drug users, of whom half are drug injectors. In 1990 China had 70,000 registered drug users and by 2001 the Chinese Government reported a figure of 900,000, an increase of over 200,000 in two years. However, unofficial estimates put the figure closer to six to seven million, with approximately half being IDUs. Estimates for India remain elusive; figures of one to five million opium users and one million heroin users, which date from the early 1990s, are still quoted by government officials and UN sources. Unofficially the use of heroin is believed to be much greater. Drug injecting is increasingly popular, and in five major Indian urban centres there are now at least 100,000 IDUs.

► Estimates of the number of drug users and IDUs have increased ... in some countries the rise is substantial.

In Myanmar an estimated 300,000-500,000 people use illicit drugs and up to half are injecting. In Malaysia there are as many as 200,000 IDUs and in Iran there could be as many as 3.3 million drug users, with an estimated 200,000-300,000 IDUs. Japan has an estimated 600,000 addicted users and 2.18 million casual users of methamphetamine. Two to three million drug users (nearly 5% of the population) are believed to exist in Thailand, and with a massive increase in the use of ATS there are currently estimated to be 300,000 ATS-

dependent persons. The estimated number of IDUs remains elusive and figures of 100,000-250,000, quoted from the mid-1990s, are still officially in use. In the Philippines, another country where methamphetamines are popular, the number of drug users is estimated at one million but could be substantially higher; at least 10,000 people are injecting. In Laos opium use remains widespread – prevalence could exceed 2%, making it second only to Iran. In some parts of the country 5% of the population above 15 years old are opiate users. The number of IDUs is considered low, but with a survey showing that among ATS users 12% injected, the potential for an exponential rise is likely. Finally, in Pakistan it has been estimated there are four to nearly five million drug users and that half are heroin users; there are currently only around 180,000 IDUs but there is enormous potential for IDU numbers to increase substantially in coming years..



## Prevalence of HIV/AIDS

Confirmed cases of HIV infection and of AIDS have increased in frequency throughout the region and several countries have serious HIV epidemics among IDUs. The countries with high prevalence of HIV infections among IDUs are Myanmar, Vietnam, China, Thailand, Malaysia, Indonesia, Nepal, India and Iran. In the late 1990s China had sporadic pockets of HIV infection (predominantly among IDUs), but is currently facing a massive explosion of HIV. Up until the mid-1990s the estimated number of HIV infections was 10,000. By 2001 the Chinese Ministry of Health put the figure at 600,000 HIV infections while UNAIDS believes it to be 800,000-1.5 million. HIV infection appears to have spread along several trafficking routes; the main transmission pathway is injecting and

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IDUs now account for 70% of cumulative cases.

► ... several countries have serious HIV epidemics among IDUs ... Myanmar, Vietnam, China, Thailand, Malaysia, Indonesia, Nepal, India and Iran.

In Malaysia IDUs are the main group affected by HIV infection (76% of all reported cases), a situation that has changed little since the beginning of the HIV epidemic in that country. In Indonesia fewer than 1% of confirmed HIV infections were due to IDU prior to 2000, but by the end of 2001 this had increased to 19% nationally, with up to 50% in some parts of the country. In Iran 75% of HIV infections can be traced to injecting drugs. HIV infections among Vietnamese IDUs accounted for 65% of the total reported cases. Dramatic increases in HIV prevalence among IDUs – reaching levels of up to 84% – have been detected in the north of the country where evidence of HIV was very limited just four to five years ago. In Thailand the HIV infection rate among IDUs remains high and the outlook is poor. National sentinel surveillance showed that among IDUs the prevalence of HIV infection was on the rise, increasing from 32% in 1995 to 54% in 2000. It has been estimated 5%-10% of drug users become HIV infected each year.

The Philippines, Laos, Cambodia, Hong Kong, Macau, Pakistan, Cambodia, Afghanistan and Bangladesh all face potential HIV epidemics among IDUs. Hong Kong maintains a low HIV infection rate among IDUs but this may be changing as IDUs seeking cheap drugs continue to cross the border into mainland China, where many are known to inject and where 70% of HIV infections are found among IDUs. The prevalence of HIV infection among IDUs in Bangladesh is currently low but there is

widespread sharing of injecting equipment (55%-75%) and the use of professional injectors, often with poor hygiene standards, is common practice.

## Profile of drug users

The majority of drug users in the region are men but female drug users are found in all countries; taboos against women using drugs and being recognised as drug users impact upon gender representation in available data. Nevertheless, the data imply that increasing numbers of Asian women are using drugs and many are involved in sex work. In China, in the Provinces of Yunnan and Guangxi, 16-25% of drug users in treatment are female and in Guangxi, for example, 80% of them were involved in sex work to fund their heroin addiction. Female IDUs are also increasingly involved in sex work in Vietnam, Nepal, the Philippines, India, Bangladesh, Indonesia, Sri Lanka, Hong Kong and Pakistan. Recent surveys have found the prevalence of injecting drug use among females involved sex work ranging from 10%-50%. There is scant information about this group of drug users but the crossover between IDUs and sex work is established and will add further to the spread of HIV infection to other sections of the community.

► increasing numbers of Asian women are using drugs and many are involved in sex work ... the crossover between IDUs and sex work will further spread HIV infection to other sections of the community.

Throughout Asia the age of initiation into drug use is declining; drug users' rates of unemployment and levels of involvement in unskilled work are high; users tend to be poorly educated, and sexually active but



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infrequent users of condoms; high percentages of users have experienced incarceration; and many users are in poor health, worsening with length of drug use.



## Government responses to illicit drug problems

The standard drug control policy of the countries assessed is to impose harsh penalties on people convicted of trafficking, production and importing and exporting drugs. The death penalty, mostly for trafficking, may be applied in China, Singapore, India, Indonesia, Iran, Malaysia, Brunei Darussalam, Myanmar, the Philippines, Sri Lanka, Thailand and Vietnam. The penalties imposed upon drug users are variable and depend on the type and amount of drug in possession.

It is common in Asia for drug users who come into contact with the legal system to be coerced into treatment, but in some countries incarceration is the sole outcome. It is abundantly clear that there are insufficient treatment and rehabilitation centres in most countries to cater for their drug users and as a consequence the risks for the health of those addicted to drugs tend to be severe. On the positive side, while drug use remains illegal, most countries do regard drug users as victims; China is a case in point – terminology there has recently shifted from ‘illegal persons’ to ‘illegal patients’.

There are few treatment centres in the region that offer psychological and behavioural rehabilitation, counselling or after care services for extended periods of time following discharge. Even when drug users do receive treatment, recidivism rates, according to government sources, commonly

range from 70%-90%. The reality is in drug rehabilitation centre style programs it is almost universally 90%.

- ... there are insufficient treatment and rehabilitation centres to cater for drug users and as a consequence the risks for the health of those addicted to drugs tend to be severe.
- ... when drug users do receive treatment, recidivism rates, according to government sources, commonly range from 70%-90%. The reality is in drug rehabilitation centre style programs it is almost universally 90%.

As a result some countries are becoming frustrated by this outcome and – for those with chronic relapsing conditions – a new punitive approach closely linked with ‘social order’ policies is emerging to keep drug users detained for longer periods of time in the hope that this approach will prove more effective.

In Singapore a person who relapses into drug use three or more times is imprisoned for five to seven years, and the sentence is increased to 13 years following another relapse. In Vietnam the average duration of treatment has been increased from six months to twelve months. Chinese drug users who relapse following rehabilitation are sent to a ‘re-education through labour’ camp for two to three years. These punitive interventions are often directed by a public security agenda which often overshadows the public health priority of improving or maintaining the health of drug users.



## Government response to drug use and HIV

Most countries in Asia have been slow to implement HIV/AIDS prevention and control measures for IDUs or are yet to implement appropriate responses. Injecting drug use in the context of HIV/AIDS is universally recognised as a major public health problem but is seldom accorded the priority it deserves. Most governments in Asia are still more concerned with the legal implications of drug use rather than the public health implications of HIV/AIDS. HIV/AIDS and drug use prevention activities in this region have generally focused on information for the wider population and rarely specifically for IDUs. The available information is often lacking in detail and not explicit or far reaching enough to impact on drug users.

- ▶ Most governments in Asia are still more concerned with the legal implications of drug use rather than the public health implications of HIV/AIDS.

Some countries with high HIV prevalence among IDUs have implemented HIV prevention approaches but they are often so limited and reach so few drug users that their ability to effectively impact upon the epidemics among IDUs is low. Overwhelmingly these approaches and activities are implemented by the non-government sector but are sanctioned by government authorities. Needle and syringe programs (NSPs), while few in number and small in scale, are operating in Vietnam, China, Nepal, India, Iran, Bangladesh, Pakistan, Thailand and the Philippines. Methadone maintenance programs (MMP), similarly few and small, are currently found in China, Thailand, Hong Kong, Iran, Nepal and Indonesia. Only Hong Kong has

completely embraced MMP, with 21 clinics in operation. Substitution therapy using buprenorphine is in use in some Indian cities.



## National AIDS Policy

Most countries in Asia are some years away from creating or implementing specific policies that address the issue of HIV/AIDS among IDUs. Some governments appear to have taken the view that because an epidemic of HIV has yet to occur among their IDUs, policies and programs focusing on drug use and HIV are not necessary. Even in countries where the high prevalence of HIV infection among IDUs (such as Thailand, China, Vietnam, Nepal, Iran, Malaysia and Indonesia) is acknowledged, risk reduction and prevention activities are held back, largely due to the constraints of narcotics legislation and the public security agenda. Operational links between drug control policy and HIV prevention and intervention policies are more often than not poor.

- ▶ Operational links between drug control policy and HIV prevention and intervention policies are ... poor.

India has officially approved a harm reduction philosophy. However, there is reluctance among many professionals in the area of HIV prevention to fully support harm reduction principles, and there remains a poor understanding of these concepts on the part of senior-level drug and health policy makers. In Laos harm reduction is a component of the National AIDS Plan (although no programs have yet been implemented). China announced a five-year action plan for HIV/AIDS prevention and control (2001-2005) which includes needle and syringe social marketing and promotion of the use of clean injecting equipment.

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## BRIEFING PAPER THREE

# A Review of Amphetamine Type Substances

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**In recent years Asia has experienced a massive increase in production of amphetamine type substances (ATS) and, based on seizures, much of the world production of ATS now takes place in this region.**

Production of ATS is primarily found in the border areas of Myanmar/Thailand and Myanmar/China. It has been estimated that over 50% of worldwide use of ATS is to be found in Asia, in particular Thailand, Japan, the Philippines, the Republic of Korea and Taiwan. An increasing number of youth are experimenting and becoming chronic users of ATS. Currently the injecting of ATS is not as widespread as that associated with heroin but many users of ATS are involved in unsafe sexual activity with multiple partners and are consequently at risk of HIV/AIDS. With increased production and widespread use of ATS, and associated sexual risk behaviours, ATS has become an illicit drug of great concern in the Asian region.

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### WHAT ARE AMPHETAMINE TYPE SUBSTANCES?

ATS are chemically similar to adrenalin, a hormone produced by the adrenal gland, which stimulates the sympathetic nervous system (partly responsible for controlling bodily functions that are not consciously controlled) and the central nervous system (brain and spinal cord). They are potent stimulants, similar in structure and producing similar effects to the naturally occurring neuro-transmitters adrenaline, dopamine and noradrenaline.

'Amphetamines' is a generic term that refers to a range of amphetamine-based substances that includes amphetamine and methamphetamine but does not include such substances as ecstasy, classified instead as an 'amphetamine analogue' (similar and chemically related but only in a general way).

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### BACKGROUND

Amphetamines were first synthesised in Germany in 1887. In 1919, methamphetamine, a derivative of amphetamine, was developed in Japan. It was not until the 1930s that amphetamines were first used for therapeutic reasons, mainly to treat asthma and nasal congestion but also used to treat schizophrenia, morphine addiction, tobacco addiction and low blood pressure. During World War II methamphetamine was widely used by military personnel in the United Kingdom, Germany, Japan and the United States to increase personal endurance and performance. In the 1960s amphetamines were commonly used for weight control and to combat depression. New uses have been found for amphetamines in recent years, such as for treatment of attention deficit hyperactivity disorder in children and narcolepsy (uncontrollable sleeping episodes).

Synthetic drugs are a product of the pharmaceutical industry that has flourished throughout the late 20th century. A consequence of this growth, and of increasing attacks on production of heroin and cocaine,

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has been an increase in the number of people using synthetic substances illicitly. The growing use of ATS is linked to their increasing availability, low cost and ability to be manufactured easily in large quantities from readily available chemical ingredients.

In the late 1990s the World Health Organisation estimated there were 35 million regular users of ATS in the world, making it the most common illicit drug after cannabis. It has been reported that methamphetamines are the most commonly used intravenous drug in the United States. Methamphetamine first appeared in the US, in the mid-1980s, and in its purified form is a transparent rock-like crystal resembling crushed ice. It is commonly referred to as 'ice' but also has the names 'shabu', 'batu', 'glass', 'yaba', 'crystal' and 'crystal meth'. In recent years seizures of ATS in Myanmar, Thailand, the Philippines, Indonesia and China have soared, suggesting that illicit manufacture in East and South-East Asia has been increasing. Vast profits are made from the manufacturing and trafficking of ATS and many of the criminal groups are often the same as those involved in the heroin trade.



### How are ATS produced?

ATS are chemically synthesised by the pharmaceutical industry and by illicit laboratories. A crucial component (a 'precursor chemical') in the production of amphetamines is ephedrine, derived from plants of the genus Ephedra (a traditional Chinese herb, first used 5,000 years ago) or made synthetically. Ephedrine is the most common precursor chemical used in the production of amphetamines, and much of what is produced still comes from China. Methamphetamines can be produced in several ways using combinations of 32 different chemicals, one-third of which are classed as extremely hazardous.



### How are ATS administered?

ATS are oil based but are converted to powder for easier handling and manufacture. The powders can be taken intranasally ('snorted'), swallowed, smoked or (after being dissolved in water) injected. Vapours produced by heating crystallised methamphetamine can be inhaled.



### Effects of ATS

ATS alleviate fatigue and produce feelings of mental alertness, wellbeing and improved self-confidence while under the influence of the drug. The effects often depend on the route of administration, how much is used and the particular chemicals in the substance. Smoking or injecting generally results in an intense 'rush' that lasts a few minutes, and then produces a euphoric high which can last from 8 to 12 hours. Users of ATS can become tolerant to the induced euphoria, resulting in the desire to use higher dosages. It is not uncommon for users to 'graduate' from smoking or snorting to intravenous use when the desired effects are no longer achieved through ingestion or inhalation. Drug users can also move from smoking to injecting ATS as a result of economic savings. It has been suggested that smoking requires twice the amount of ATS powder as injection to receive the same effect. Experienced users claim euphoric and stimulant properties of methamphetamines are greater than amphetamines.

#### Short term effects

Highly enhanced self-confidence; feelings of wellbeing and increased potency; insomnia; reduced appetite; irritability; talkativeness; panic attacks; palpitations; anxiety; increased respirations; increased activity; increase sexual desire.



**Long term effects**

Depression; paranoia; tendency towards violence; irregular heartbeat; tremors; loss of coordination; vagueness; distracted and poor concentration; psychosis, often indistinguishable from paranoid schizophrenia; hallucinations; mood swings; decreased immunity; poor memory; sexual dysfunction; premature births; feelings of suicide.

**Other health consequences**

Injecting ATS usually carries an increased risk of the transmission of blood-borne viruses such as HIV/AIDS and hepatitis B and C through the sharing of needles and injecting equipment. Many users are also involved in unsafe sexual activity with multiple partners and are at risk of HIV/AIDS. Fatalities have been documented among ATS users as a result of poly-drug use and accidents while under the influence.



**Treatment and management**

Drug treatment services are generally aimed at opiate users and are ill equipped to deal with ATS users. Simultaneously, ATS users are often reluctant to seek treatment even though they face a variety of physical, psychological, inter-personal and social problems. Instead of attending specialist services, many attempt to stop using ATS by replacing them with benzodiazepines, cannabis and alcohol – often to re-establish a normal sleep pattern. Physical health problems may be tolerated but it is the unwanted psychological and behavioural problems that prove the most disturbing for most ATS users. Breakdown of relationships with peers and family members, typically as a result of paranoid or aggressive behaviour, may be the ultimate trigger for an ATS user seeking formal help.

There are different types of interventions and approaches to treatment, but there is no consensus as to what constitutes effective treatment. Pharmacological interventions such as anti-depressants and the substitute therapy drug dexamphetamine are being trialled in different parts of the world. There are also various non-pharmacological interventions and these include: 28-day in-patient programs; therapeutic communities; 12-step programs; peer interventions; behavioural strategies; cognitive behavioural interventions; and non-traditional methods. In many ways the approach used is to rebuild and enhance the personality of those recovering from ATS use by promoting relapse prevention techniques, regular urine testing, family involvement, and links with support groups. There is little evidence that any of these approaches is at all effective for the majority of ATS users (other than substitution therapy, but in this case it is only used for very heavy injectors of ATS).

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**BIBLIOGRAPHY**

- Anglin M.D, Burke C, Perrochet B, Stamper E and Dawud-Noursi S. 2000. History of the methamphetamine problem. *Journal of Psychoactive Drugs*. 32(2): 137-141.
- Asian Harm Reduction Newsletter. 2000. *ATS: the emerging drug of choice?* Special edition on ATS. Asian Harm Reduction Network. 19 - 20, January - April.
- Australian Bureau of Criminal Intelligence. 2001. Amphetamine Type Substances. In Australian Bureau of Criminal Intelligence. *Australian Illicit Drug Report 1999-2000*. Canberra. Australian Bureau of Criminal Intelligence.
- Brands B, Sproule B and Marshman J. 1998. *Drugs and Drug Abuse: a reference text. {section 3, amphetamines}* (3rd edition) Toronto. Addiction Research Foundation
- Donoghue M.C. 1997. *Amphetamine-type Stimulants: a report from the WHO meeting on amphetamines, MDMA and other psychostimulants*. Geneva, 12-15 November 1996. World Health Organization.
- Doweiko H.E. 1999. *Concepts of Chemical Dependency*. Pacific Groove. Brooks/Cole Publishing Company.
- Fleming P.M. 1998. Prescribing amphetamine to amphetamine users as a harm reduction measure. *International Journal of Drug Policy*. 9: 339-344.
- Greenblatt J.C. and Gfroerer J.C. 1998. Methamphetamine abuse in the United States. In *Analysis of substance abuse and treatment need issues*. Rockville, MD, US Department of Health and Human Services  
[<http://www.health.org/txneeds/httoc.htm>]
- Kamieniecki G, Vincent N, Allsop S and Lintzeris N. 1998. Models of intervention and care for psychostimulant users. Monograph Series No. 32. National Centre for Education and Training on Addiction. Commonwealth Department of Health and Family Services.  
[<http://www.health.gov.au:80/pubhlth/publicat/document/mono32.pdf>]
- Klee H. 1997. *Amphetamine misuse: international perspective on current trends*. Harwood Publishers
- Matsumoto T, Kamijo A, Miyakawa T, Endo M, Yabana T et al. 2002. Methamphetamine in Japan: consequences of methamphetamine abuse as a function of route of administration. *Addiction*. 97: 809-817.
- McKetin R and Mattick R.P. 1997. Attention and memory in illicit amphetamine users. *Drug and Alcohol Dependence*. 48:235-242.
- Remberg B. 1997. Stimulant Abuse: from amphetamine to ecstasy. In *World Drug Report*. United Nations Drug Control Programme. Oxford University Press
- Sattah M, Supawitkul S, Dondero T, Kilmarx P, Young N et al. 2002. Prevalence of and risk factors for methamphetamine use in northern Thai youth: results of an audio-computer-assisted self-interviewing survey with urine testing. *Addiction*. 97: 801-808.
- United Nations Drug Control Program (UNDCP). 2002. Regional Drug Control Profile for Southeast Asia and the Pacific. UNDCP, Bangkok, Thailand.
- UNODCCP. 2001. *Global Illicit Drug Trends 2000*. Report commissioned by the United Nations Office for Drug Control and Crime Prevention. New York.
- Vincent N, Shoobridge J, Ask A, Allsop S and Ali R. 1998. Physical and mental health problems in amphetamine users from metropolitan Adelaide, Australia. *Drug and Alcohol Review*. 17: 187-195.

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## BRIEFING PAPER FOUR

# Care and Support of Injecting Drug Users with HIV and AIDS

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### The link between prevention and care

Harm reduction workers are often in the front line in term of access to marginalised injecting drug users (IDUs) with HIV/AIDS. They can therefore have a significant role in the advocacy for and care and support of this group. It is neither easy, nor particularly useful, to draw a clear line between prevention and care when working in harm reduction and HIV/AIDS. Providing counselling, treatment, care and support to IDUs with HIV/AIDS can make a significant prevention intervention. People with HIV who are informed, supported and provided with the skills to avoid passing HIV on to others are an important resource for HIV/AIDS prevention. IDUs with HIV/AIDS can play an important role in providing peer education and support to their fellow community members, and have been particularly successful in maintaining contact with hard-to-reach groups.

Harm reduction workers are often called upon to advocate on behalf of IDUs with HIV/AIDS, assisting them to access health, welfare and drug treatment services, and to re-establish contact with their families.

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### Stigma and discrimination

HIV-positive IDUs face a triple stigma. As IDUs, they are often marginalised from communities and face difficulties in securing work and gaining access to housing and welfare services. As people with HIV, they face the stigma and discrimination that all people with HIV encounter. As clients of support services, they may also face

discrimination from HIV/AIDS clinical and community service providers. Many service providers stereotype IDUs as difficult clients - prone to anger and erratic behaviour, unreliable when it comes to appointments and adherence to treatment protocols, and more likely to disrupt the smooth running of their services. They may also be perceived as somehow more 'deserving' of HIV than other clients. This discrimination by HIV/AIDS service providers may be overt or covert. Sometimes it is expressed in the rules or policies that the services put in place - rules effectively preventing IDUs with HIV from accessing the service. There are, however, many HIV/AIDS clinical and support services that have in place policies to ensure that IDUs with HIV/AIDS have access to services. These services have often emerged from organisations that are firmly connected to injecting drug user communities. They are often services that have been able to offer IDUs a say in how the services are designed and delivered.

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### HIV Testing issues

HIV testing should always be accompanied by pre-test counselling, and occur only after voluntary informed consent. However, many IDUs are tested for HIV without their consent and without counselling, often when they are admitted to compulsory drug treatment facilities. Often they do not receive their HIV test results. In these cases, HIV testing appears to be primarily used for surveillance. Services and government agencies need to clearly differentiate between HIV testing for surveillance and clinical HIV testing. Surveillance is conducted to provide information on the extent of the epidemic and its changing patterns. HIV testing of



individuals for surveillance activities needs to be separated from HIV testing as part of an ongoing counselling care and support program. If testing is to be more than an exercise in counting, policies need to be developed to make counselling, support and ongoing care available.

The aim of voluntary HIV counselling and testing is:

- to provide the individual with information about their HIV status;
- to provide information and the skills to reduce HIV transmission in the future;
- to provide the support for informing sexual and drug use partners about their risk; and
- to provide a bridge to ongoing care and support.

This is both an individual and public health initiative. Before embarking on voluntary counselling and testing for IDUs, agencies need to think about:

- how they will ensure confidentiality;
- who will conduct pre- and post-test counselling, and how they will do this;
- what training they will need to be able to do this sensitively;
- what information and ongoing counselling they will need to provide;
- whether they will discharge HIV-positive people from compulsory drug treatment; and
- how they will ensure that people receive support and care in the community.

Some drug rehabilitation services have been reluctant to pass HIV positive results on to people in their care, arguing that the diagnosis will interrupt the person's rehabilitation and lead to anger and violence. To avoid this outcome, staff should be trained to deliver HIV test results with

appropriate counselling, and agencies should endeavour to provide support for HIV-positive individuals and facilitate their access to ongoing care and treatment.



## Continuum of care

HIV/AIDS treatment, care and support is not just the job of hospitals and health services. People with HIV and their families can only maximise their health and wellbeing if they are supported by a continuum of health, welfare and community support services. Hospitalising or institutionalising IDUs with HIV/AIDS for extensive periods is neither cost-effective nor humane. People with HIV can continue to make a contribution to society and, with support and ongoing care, can live productively for many years. Agencies interested in providing care and support for IDUs need to examine the full range of needs that people with HIV and their families encounter. These include housing and safety, nutrition, emotional support, support for continued drug avoidance and/or drug substitution, access to work and income, involvement in ventures to promote independence and purpose, physical care, clinical monitoring, and spiritual support. Non-government organisations set up by IDUs to provide information, support, advocacy and clean injecting equipment have played a key role in HIV/AIDS prevention and care in many countries. Peer support groups and HIV positive support groups facilitated by current and past IDUs have been particularly successful in reaching into injecting drug user communities and mobilising the resources of these communities.



## Monitoring and HIV treatment issues

Even in resource-poor environments there are useful strategies that can be employed to monitor and maximise the health of IDUs with HIV/AIDS. IDUs with HIV/AIDS should have the same access to treatment and care as other people with HIV in the community. As the immune system becomes damaged by HIV, people become susceptible to opportunistic infections that can threaten their health and life. These include tuberculosis, Pneumocystis pneumonia, meningitis, candidiasis and many others. The damage to the immune system can be monitored using blood tests (CD4 tests), if available, or by observing physical markers like rapid weight loss and other symptoms. Many opportunistic infections can be avoided by using simple antibiotics. General health can be maximised by providing access to good nutrition, rest and psychological support. Many opportunistic infections can be prevented with cheap antibiotics, and those that do occur can be treated if drugs are available.

IDUs with HIV/AIDS experience a range of other illnesses and conditions that also need to be taken into account. Many will be co-infected with hepatitis B and/or C, have liver damage from multiple drug use, and have injection abscesses and health impacts from injection and other complications. Health service providers will need to take all of these conditions into account when providing treatment and ongoing monitoring.

If anti-retroviral therapies are available in the community, IDUs with HIV should not be discriminated against when they attempt to access them. Anti-retroviral therapies are only effective if they are taken consistently. Interruptions in anti-retroviral treatment

may lead to viral resistance, i.e. HIV mutates and the treatment is no longer effective. Some services use this as a reason not to offer treatment to IDUs with HIV, arguing that they are often unreliable when it comes to maintaining treatment regimes. It is possible for agencies to work with IDUs to determine strategies to maximise treatment compliance (avoiding interruptions or missed doses). These include simple dose regimens, supervised treatment (as in methadone programs), use of community volunteers to assist in treatment compliance, use of sponsors or 'buddies' (as in Alcoholics Anonymous and Narcotics Anonymous programs), better access to local clinics, and more realistic clinic opening times.



## Support for families and communities

Ultimately, much of the care and support for IDUs with HIV is done within families and communities. Harm reduction workers have an important role to play in assisting families and communities to provide this care. In order to do this, families and communities have to be assisted in overcoming their fear of HIV infection, their judgement of IDUs as unworthy of care, and the feeling of helplessness they can often experience in the face of a growing AIDS epidemic.

There are many examples of families and communities working together to provide this care. There have been several key lessons learned from designing these programs.

These include:

- obtaining the support of influential community members (religious, local government, civil society);
- involving the person with HIV/AIDS and their family in the design of the service and the policies and procedures it adopts;

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- networking between the community services and hospitals, clinics and key health workers; and
- paying attention to the basic physical and welfare needs of people with HIV and families.



## Grief and loss

If harm reduction programs are working effectively in communities at risk they will encounter many people with HIV/AIDS and their families. This will expose them to the range of feelings that people experience as they face a terminal illness or the death of a relative and friend. In communities with rapidly expanding HIV epidemics, this grief and loss can sweep across entire communities. People working in all aspects of HIV/AIDS need to be able to access training and support to deal with individual, family and community grief. Failure to address grief and loss issues can severely jeopardise HIV prevention initiatives as individual and community reactions to grief make it difficult to maintain the safe behaviour that prevention programs attempt to inspire.



## WEBPAGES:

WHO Fact Sheets on HIV/AIDS for nurses and midwives  
[http://www3.who.int/whosis/factsheets\\_hiv\\_nurses/index.html](http://www3.who.int/whosis/factsheets_hiv_nurses/index.html)

Improving Access to Care in developing countries: lessons from practice, research, resources and partnerships [http://www.unaids.org/publications/documents/care/acc\\_access/JC809-Access-to-Care-E.pdf](http://www.unaids.org/publications/documents/care/acc_access/JC809-Access-to-Care-E.pdf)

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## REFERENCES:

Brandsmaa R. 1999. *Stimulating access and compliance to anti-HIV combination therapy for drug users*. Paper presented at the International Conference on the Reduction of Drug-Related Harm Geneva

Buhringer G, Greenwood J, Gsellhofer B, Kunzel J and Torrens M. 1998. *Drug use and HIV infection: the care of drug users and the treatment system*. WHO (Europe) Working Group Report. Munich EUR/ICP/LVNG 02 07 10

Burrows D. 2000. *Treatment, care and support of injecting drug users living with HIV/AIDS: implications for Ukraine MSF-H Ukraine*. Kiev. May. 2000 (available in English, Russian, Ukrainian and Bahasa Indonesia)

Lert F and Marne M-J. 1992. Hospital care for drug users with AIDS or HIV infection in France. *AIDS Care* 4 (3)

Marte C and Gatell JM. 1999. *HIV/AIDS policy issues related to care, treatment and support of IDU communities*. Dialogue on AIDS Series: Policy dilemmas facing governments: Paper 2. UNAIDS/ Health Canada. Montebello.

McAmmond D and Skirrow J. 1997. *Care, treatment and support for injecting drug users living with HIV/AIDS*. A consultation report. Health Canada. Toronto

McCallum, L. 2000. *Caring for people with HIV/AIDS at home*, Medecins Sans Frontiers, Ukraine/ Netherlands (in Russian and English).

# **Section 2**

## **Program Design, Implementation and Maintenance**



## **Section 2**

### *Chapter One*

# **Rapid Situation Assessments**



**What are rapid situation assessments?**

**Finding and analysing existing information**

**Conducting interviews**

**Questions to ask**

**The outcomes of a rapid situation assessment**

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## Introduction

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**W**ITHOUT research the most well intentioned program will fail. For a program or project to be successful it needs to be established within the context of solid research. For example, it may be determined to introduce needle and syringe program into a particular district but for legal and cultural reasons the intervention, at this stage, would not work. If the necessary research had been done before the project began other more appropriate or acceptable action could have been planned. Or, on a simpler level, a project which is aimed at an often hidden population, such as injecting drug users (IDUs), needs to undertake research to find out the basics of where the IDUs are, how to contact them and what sort of assistance they may need and/or want.

If you are going to set up a program aimed at IDUs it is essential to examine the nature of drug policies and the factors influencing drug use and related HIV transmission in that particular country or community. You also need to know what resources exist to respond to drug use and HIV in the community. The programs which are eventually developed must be culturally, socially, and politically appropriate to the specific environment. This chapter will discuss Rapid Situation Assessments (RSA) and concentrate specifically on RSA to do with drug use and HIV/AIDS.

This chapter will examine:

- 1 What are Rapid Situation Assessments?
- 2 Finding and analysing existing information
- 3 Conducting interviews
- 4 Questions to ask
- 5 The outcomes of a Rapid Situation Assessment.

## I. What are Rapid Situation Assessments?

Rapid Situation Assessments encompass both the assessment of the problem and an assessment of the resources available, or that might be needed, to address the problem.

Assessing the problem means discovering the type, depth and scope of the problem.

Assessing the resources available to deal with the problem means appraising what resources are available (funds, people, buildings, knowledge) and what resources are needed.<sup>1</sup>

Rapid Situation Assessments (RSA) use research tools adapted from anthropology, sociology, epidemiology and evaluation research methods. RSA differ from other social science investigations in:

- **Speed:** RSA are usually conducted rapidly (a few days to a few months) as time is of the essence when tackling unfolding social and health problems, especially when dealing with HIV and its ability to spread quickly through a community.
- **Cost:** RSA are often conducted by one or two people who work quickly to gather the necessary information hence avoiding long term salaries, establishing offices and so on.
- **Use of existing data:** RSA use information which already exists as much as possible.
- **Use of a variety of sources:** RSA use a variety of sources and methods to gather the information. This means the RSA does not rely on just one source or survey. For example, an RSA may use government statistics of recent drug arrests, enrolments in rehabilitation centres, interviews with drug users etc.
- **Detective work:** many societies deny the drug use in their communities. RSA investigate beyond government rhetoric and gather information from a wide array of sources and double check it with key informants, their own observations and official statistics.

- **Consultation:** RSA recognise the need to consult with a wide range of people, including drug users.<sup>2</sup>

The aim of RSA is to uncover what is really happening in a community in order to design and implement programs which will be successful in reducing the harms of injecting drug use and the spread of HIV/AIDS.

Rapid Situation Assessments involve collecting information from a variety of sources. RSA make use of data such as government statistics and less formal information from interviews with people connected to or from the target group. Some information may be readily accessible, for example the number of drug arrests. Other sensitive information is not as easy to get – such as why people start injecting drugs.

A person conducting an RSA might find themselves, in one day, wading through official law enforcement figures on recent drug arrests, interviewing a local community leader and having an informal chat with a local drug user. The techniques involved in collecting these different types of information are numerous and a good RSA usually involves a mix of the following techniques:

- Finding, examining and analysing existing information
- Conducting interviews with a wide range of people (key informants)
- Focus group discussions
- Round table discussions
- Observation.

## 2. Finding and analysing existing information<sup>3</sup>

- Where do you find the information?
- How do you select the information?
- How do you manage the information?
- How do you interpret statistics?
- Monitoring the mass media.

Given that speed and cost are often of great consideration when conducting an RSA, locating and examining information which already exists can be of valuable assistance.

Examining existing information should be the first step in an RSA. This information will give background information and ensure that the researcher does not waste his/her time in amassing information which already exists. Collecting existing information will also help in identifying gaps in knowledge.

The researcher should approach the existing data with critical eyes and continually ask himself/herself how accurate the information is.

### Where do you find the existing information?

The information which already exists may include:

- Official estimates of drug use and the number of drug users and injectors
- Official estimates of sex workers and the number of people arrested for sex work
- Number and type of arrests for drug-related offences
- Drugs seized, including analysis of drugs for purity and dilutants
- Prescription tracking
- Drug use surveys
- Number of HIV infections among drug users
- Number and type of hospital admissions for drug related conditions
- Number of people on methadone and other drug substitution programs (and on waiting lists)<sup>4</sup>

- Annual number of drug users first, second and third entry to a detoxification centre
- Annual number of condoms distributed by family planning programs
- Newspaper articles on drug use, policy, HIV/AIDS etc.
- Records of parliamentary debates dealing with drug use and/or HIV/AIDS
- Annual reports from government and non-government agencies dealing with drug use and HIV/AIDS
- Minutes of public meetings dealing with drugs use and HIV/AIDS.

This information will be available from a variety of sources including:

**Drug treatment programs:** can provide information about the numbers and characteristics of drug users who seek treatment and the drugs that are being used. They may also provide contact with drug users for in-depth interviews.

**Health care facilities:** including hospital emergency rooms, mental health services, STD clinics, dermatology clinics and primary health care sites. They may have information on the complications arising from drug use, where drug users live etc. Families of drug users also often approach doctors at general or psychiatric hospitals about their family member's drug use.

**STD clinics and/or the HIV surveillance system:** should be able to provide you with information on HIV, hepatitis and STDs.

**National AIDS organisation:** if one exists they should have useful statistics and information about any programs in place.

**Pharmacists and shopkeepers:** if they sell needles and syringes they will probably have had contact with drug users, have information on how many needles and syringes they are selling etc.

**Police, prisons and other law enforcement:** can provide information on drug related arrests, drugs seized etc.

**Social service agencies:** may have contact with drug users and their families.

**NGOs:** may work in slum areas and/or run facilities for youths and drug users or, through providing maternal and child health care, have come into contact with drug users.

**Traditional healers and religious workers:** may be dealing with drug users through traditional medicine, counselling etc. and are often consulted by families and friends of drug users.

**Journalists:** may provide information from their research and/or give you access to newspaper files.

**Social scientists and medical researchers:** in universities or independent institutions, may have information from studies conducted with drug users or can provide information on particular patterns and behaviours.<sup>5</sup>

## How do you select the existing information?

When beginning an RSA, researchers need to establish guidelines about the sort of information they are seeking otherwise much time can be wasted wading through masses of statistics and reports which may be irrelevant. It can be useful to keep in mind:

- **Relevance:** clearly identify the questions, topics and issues the RSA is investigating.
- **Constraints:** only collect information which will be used.
- **Time:** it is usually better to concentrate on the most recent and up-to-date information. For a longer term view concentrate on summaries or commentaries.
- **Audience:** think about who put the information together and what their motives may have been (e.g. a government report may concentrate on the positive, rather than negative, consequences of policy change).
- **Coverage:** who is described in the information? Are there people or locations left out of the data? Is the information representative?



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- **Adequacy:** existing information is usually produced to meet the needs and agendas of other people. Researchers may have to work with imperfect materials rather than spending time trying to locate sources which answer all their questions.<sup>6</sup>

## How do you manage the information?

If you manage the information you collect, and keep it in order, it will be easier to write up the RSA. Here are some hints:

- **Tag and date materials:** including details of whom and where the information came from.
- **Summarise the key points:** summaries will allow you to quickly identify why the information is important, what topics it covers and links to other materials.
- **Distribute information:** to other members of the RSA team
- **File:** start a filing system at the beginning of the RSA to avoid being overwhelmed by the information and so you can quickly locate it.

When you have gathered the information which you think may be relevant:

- **Determine the aim of the document:** look at the contents page, index, abstract and summary. This will help you work out why the document was written and how it was structured.
- **Identify how and when the information was collected:** note down the method used for collecting the information and the time period the information covers. If the document is from a meeting note down who was at the meeting.

- **Note the main findings:** these will give you an overview of the context in which the RSA is taking place and will help to identify local behaviours and the experience gained from previous research.
- **Consider the conclusion:** are any criticisms or recommendations in the document justified? Does it raise questions for further research? Does it outline any likely interventions or potential developments that the researcher was not aware of?
- **Record any useful references or sources:** these may have useful information and/or contacts, or may be required in the later stages of the RSA.

Remember that the information may be biased. Media, political documents, government and non-government reports will have been written from a particular perspective and will often cite only the information which supports their argument. Keep in mind also that the research may have been inadequate or badly done.

## How do you interpret statistics?

Statistics can seem daunting and difficult to interpret but they can be important. They are routinely used by:

- government bodies
- health professionals
- economists
- journalists
- NGOs.

Statistics may be presented in various forms including; raw data, tables, graphs and as general descriptions. However they are presented, the basic principles in interpreting them are the same:

- **Read the title:** this should explain what is being described.
- **Consult any notes:** researchers should look at *how* the data were collected and *who* collected them.
- **Read any headings or keys:** this will outline the type of information contained in each cell, row or column.
- **Identify the units or labels:** the data presented may refer to whole numbers, percentages, averages or the number of cases per 100,000 population.
- **Consider the conclusions:** are they justifiable?
- **Consider whether there is sufficient information to interpret the data:** note any problems in interpreting the data.
- **Can include hidden distortions:** keep in mind the context in which the statistics were gathered. For example, drug users interviewed trying to get into a treatment program may answer questions in a particular way to improve their chances of getting into the program.
- **Are often used to support a particular argument or conclusion:** don't accept statistics at face value, they need to be examined thoroughly.<sup>7</sup>

### Monitoring the Mass Media

Newspapers and magazines sometimes publish articles about drug use and drug users that may be current and accurate. Studying the mass media is an especially good way to assess how the community at large sees the issue of drug use. It can be worthwhile to contact journalists who have displayed an interest in the subject matter (e.g. have written sympathetically about the issues in the past). These journalists can play an important role in explaining to the general public the rationale behind a program aimed at reducing harm to drug users.

Although statistics can often appear persuasive and official it is important to remember that they:

- **Only describe the reported cases:** this is not the same as the actual cases. For example, not all treatment agencies will comply in reporting data to a central organisation and/or people in some areas are difficult to contact.
- **Under-reporting of culturally sensitive or shameful behaviours:** statistics are often collected by structured interviews or questionnaires so may miss certain behaviours or respondents may not trust the interviewers.
- **Use specific definitions:** before something can be counted and measured it must be defined. For example, drug users may interpret certain terms differently to the researchers.



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in Asia

For example, this extract from a Malaysian journalist's article published in *The Sunday Star*:

## Harm Reduction **News**

### Drug Users Need Options

KUALA LUMPUR, MALAYSIA

The first step for people giving up cigarettes, alcohol or drugs is simply making the decision to stop.

“Unless you make the decision to give up drugs, treatment has little chance of working” said Dave Burrows, a policy officer on injecting drug use for the Australian Federation of AIDS Organisations. Burrows has stated “drug users who are forced to enter treatments are essentially being kept in detention and are not being treated.” This may explain why rehabilitation centres in Malaysia, which are nearly all coercive, have a very high failure rate. In 1994, 70 per cent of ex-inmates from rehabilitation centres relapsed within a year.

Alternative programs do exist. The voluntary based therapeutic community (TC) program used by the organi-

sation Rumah Pengasih in Kuala Lumpur have success rates of 80 per cent. TC programs include both a medically based detoxification as well as support and understanding from Pengasih's staff, of whom a number are ex-addicts.

**“Methadone is popular as it allows people to continue a ‘normal life’ and ... eliminates needle sharing...”**

Another highly effective treatment is methadone, a cheap synthetic treatment, that is taken as a substitute for heroin. Methadone is popular as it allows people to continue a “normal life” and it also eliminates needle sharing – a big plus point today with the rise of HIV/AIDS among drug users.

“Most people stop taking methadone after 26 months, although some may relapse and need another treatment” said Dr Alex Wodak, director of the Alcohol and Drug Service, Sydney, Australia.

Methadone is no longer reserved to developed countries. Thailand, Hong Kong and even Nepal, one of the poorest countries in Asia, have methadone programs.

Other common programs are outreach and needle exchange, which are even done in Thailand, India and Nepal. Outreach workers help the drug users by offering medical help, information (such as HIV/AIDS), counselling, support and can also do needle exchange.

The typical message on HIV prevention for the outreach worker is: if you can't stop using drugs, then stop injecting; if you can't do that, then don't share needles, and if that's not possible, sterilise your needle with bleach.”<sup>8</sup>

### 3. Conducting Interviews

- Who should be interviewed?
- How do you organise an interview?
- How do you prepare for an interview?
- What are the various types of interviews?
- What can a researcher do to improve interviews?
- What is observation?

Interviews are a key part of Rapid Situation Assessments. Interviews will give the RSA team:

- people’s experiences and knowledge about the area of study
- information about local meanings and understanding of risk behaviours and health consequences
- information from people who are not usually consulted by government officials and policy makers<sup>9</sup>

An RSA should involve interviews with a wide range of people in order to uncover information about what is really happening in relation to drugs and HIV/AIDS rather than just hearing the official line.

#### Who should be interviewed?

Some of the people you contact when you are searching for existing information you may also interview later on, or these people may put you in contact with people to interview. For example, a drug treatment worker may be able to put you in touch with current and ex drug users. But, yet again, time restraints mean you can’t interview everyone: you will need to work out who are the *best* people to interview.

A key informant interview is a direct, face-to-face meeting which is used to gather information from individuals rather than from groups. These interviews are carried out with a broad cross-section of people who have some knowledge of, or contact with, the issues of drug use and HIV.

A key informant is:

- someone who is knowledgeable about the topic
- someone who is currently involved in the activity of interest or has recently been involved (e.g. a drug user or an ex-user, drug treatment worker and so on)
- someone who is important to either getting the RSA done or the program going.

The list of potential key informants is similar to the list for sources of existing information (see page 80 of this chapter). But, importantly, key informants must also include drug users. Drug users will have current information about the drugs in use, drug taking behaviours and attitudes.

#### How do you organise an interview?<sup>10</sup>

Researchers should organise their interviews as soon as possible as people are busy and/or difficult to contact. Once a key informant is contacted you should:

- **explain:** why you want to talk to them: try to make them interested by discussing the importance of the RSA in a broad public health sense or for the individual’s benefit
- **correct:** any misconceptions they may have about the RSA
- **assure:** informants that the information they provide will be confidential
- **negotiate:** the time and date for the interview and mention how long it will take
- **collect:** contact details of the informant and give them your contact details in case a problem occurs and the interview has to be rescheduled.

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in Asia

## How do you prepare for an interview?

It is best to conduct your interview in a quiet and private place. This will make it easier for both the interviewer and the key informant. When you are dealing with traditionally taboo subjects, such as drug use and sexuality, privacy is particularly important. A drug user is more likely to talk frankly if away from authority figures or family members. Likewise, an official or politician may tell you quite a different story if they know their comments will be taken as “off the record” and/or confidential.

It is also useful to use a tape-recorder during interviews as well as taking notes. You must ask the key informants’ permission to tape the interview.

Interviews will be more successful if the researcher is well prepared: he/she is familiar

with the existing information, has prepared lists of questions and has organised the time and place for the interview. Generally it can be helpful to:

- **Identify appropriate topics and questions:** think about what information the key informant may have and focus on their areas of knowledge (i.e. a drug user is unlikely to know how many people have been arrested for possession of drugs in the last six months but may be able to tell you what methods they use to avoid arrest).
- **Decide on the level of detail:** depending on which method of interviewing you are using (e.g. structured or unstructured questions – see below) you can write a list of topics you want to cover and refer to these in the interview or you may devise a structured questionnaire.

## HARM REDUCTION NEWS



### CONFIDENTIALITY: A GOLDEN RULE

NEW DELHI, INDIA

I HAD met LL the previous day and he had given me a few details about the target community and his activities in working with injecting drug users.

During my previous contacts with LL I had learned that he is connected with the SHARAN outreach NGO and that he works in the slum area Nizamuddin West.

This slum area is notable for a high prevalence of injecting drug users as well as pushers, and other activities.

At the beginning of the

interview I commented to him that everything he told me would be confidential, and that his name, and any name he mentioned would

“  
**You’re not going to let the police see this, are you?**  
”

not appear in any written form in any reports or other written material.

I also told him that his responses were entirely voluntary and that he should

feel free not to answer any questions that he didn’t want to answer.

Somewhat later in the interview, when he was describing something about drug injecting, he, perhaps playfully, asked “you’re not going to let the police see this, are you?”

I answered that I would do all I could to protect these notes and certainly keep them from the police and that it is our duty, as information collectors, to protect these confidential, personal statements from any unauthorised people.<sup>11</sup>

- **Draft the questions:** for a more informal interview it is still beneficial to have a list of specific questions to refer to – it is easy to get sidetracked in an interview (while the tangent may be relevant, you want to make sure that you also cover nominated areas). For a structured interview the questions will need to be worked out well ahead of time. It is worthwhile to have your questions checked by a key informant who may identify gaps or suggest areas where you may have to change the language to guard against cultural insensitivity.
- **Order the questions:** it is easier for both the interviewer and the key informant if there is a logical order to the questions. For example, you may ask questions about the type of drugs available to start with, then move onto the way people take drugs and then to the specifics of sharing and the key informant’s personal experience. Any particularly sensitive questions are often better off being asked later in the interview when rapport has built up.

## What are the various types of interviews?

In an RSA you may conduct a variety of interviews. These may include:

- 1 One-to-one key informant interviews
- 2 Focus group discussions
- 3 Round table discussions

### 1 One-to-one key informant interviews:

These interviews will generally involve the researcher and one key informant. A translator may also need to be present and sometimes another member of the RSA team may sit in to take the notes or just to observe. These interviews should allow sufficient time to cover the area of interest but also to give the interviewer and key informant the chance to relax and build up some trust.

### 2 Focus group discussions:

A focus group is an in-depth discussion where a small number of people gather, with a researcher, to discuss a particular issue or issues. In the case of a Rapid Situation Assessment related to injecting drug use, the topics will relate to HIV and drug use and its impact on the community. Participants in each focus group have something in common: they could be all ex-drug users, drug treatment workers or local church leaders. It is important to have this commonality because focus group discussions are an attempt to understand the perspectives of a *certain* group of people. Focus group discussions try to reach beyond superficial responses and focus on the participants’ feelings and firmly-held views on any given subject.

In a focus group discussion the researcher will need to act as a facilitator, that is encouraging members of the group to talk about relevant issues. The researcher guides the discussion to ensure that the discussion stays on the topic, covers the areas the researcher is interested in and allows, as much as possible, everybody an opportunity to talk.

Focus groups are good for:

- producing a lot of information quickly
- identifying and exploring beliefs, attitudes and behaviours

A focus group may require:

- a location that is neutral, comfortable, accessible and free of interruption
- a list of questions or topic areas
- a tape recorder with extra tapes, batteries and labels
- a blackboard, whiteboard or paper and pens
- a key informant to help recruit participants

### 3 Round table discussions

Round table discussions bring together people from different perspectives to discuss the issues. Such a discussion may include a health worker, drug user, church leader, government representative and so on. The idea is to have a broad range of attitudes and interests and yet be able to explore areas of agreement and areas of disagreement.

The round table discussion will need to be structured with the researcher having a list of questions and topics which he/she can bring the participants back to if the discussion gets off track. As with one-to-one interviews and focus groups, it is worthwhile taping the proceedings and taking notes. The researcher needs to be experienced in dealing with group dynamics where prominent individuals or sub-groups can dominate the discussion.

### What can a researcher do to improve interviews?<sup>12</sup>

- arrive early at the place where you are going to conduct the interview: try to ensure that it is quiet and private
- translators should be briefed on what is going to happen
- make sure tape recorders are working and have extra tapes and batteries available
- introduce anyone present to the informant and assure them of confidentiality
- use clear and simple language and allow informants time to answer the questions
- sensitive questions can be put by asking what other people do, e.g. if a man wanted to buy some heroin what would he do?
- reflecting people's answers back in their own words is a good way of clarifying issues
- be a good listener and ask how and why

- if the interview looks like going on longer than expected check with the informant that this is okay
- always collect demographic information, e.g. age, position, ethnicity, type of drug use
- summarise the key issues and opinions when the interview is finished, ask the informant if there is anything that they would like to say
- carry health promotion leaflets and other relevant information to give to the informant

### What is Observation?<sup>13</sup>

Along with gathering and analysing existing information and conducting various interviews, an RSA team will also be observing what is going on. Observation allows the researcher to experience, first-hand, the meanings, relationships and contexts of human behaviour and to describe these. This may take the form of:

- casual or unstructured observation
- formal or structured observation

Unstructured observations may occur at any time, especially at the beginning of an RSA when the researcher is collecting background data on the local area; observing the types of drug taking behaviour and local conditions. While it may be possible to take some notes on your observations, often it is necessary to write up observations later. This should be done as soon as possible after the observation.

Structured observations use pre-selected categories to work out what needs to be observed.<sup>14</sup> These usually occur after initial research, that is after examining the existing information and making contact with the key informants. Collecting further information may require the observation of specific behaviours or activities, in certain places and at certain times. To help

Harm Reduction **News** **Working Hard for Community Support**

CHURACHANDPUR, INDIA

When we started everything was not easy. We had to do the base work. We had a lot of focus group discussions with different key people in the community. For example: church leaders (almost 10 per cent are Christians), bureaucrats, police and village authorities. We were preparing them psychologically and asking their views. Out of those meetings, we realised we could start our project aimed at reducing harm among drug users. Many issues arose, such as distributing condoms and bleach. Some thought we were encouraging drug use and free sex but through the

focus group discussions they became more aware and tolerant. In our office we had informal ongoing community meetings. They divided into different areas, meetings

**“...to reduce harm among drug users takes time but we must be patient because it is worthwhile.”**

were with families and friends of IDUs. We asked them questions such as: do you see HIV as a problem in the town and what do you think you can do about it? People responded that they thought HIV was not an immediate problem but drug users were. They would see

their own family or neighbour's son taking drugs and thought that was more of a problem than HIV.

So we had to convince them about the benefits of reducing harm among drug users. We told them about the project, about health issues, materials being distributed, drop-in centres and facilities such as counselling. They asked questions about condoning free sex and drug use so we had to take the trouble to explain. It's not easy but we have to take the time: they'll listen even if initially they are hostile. Explaining how a program works to reduce harm among drug users takes time but we must be patient because it is worthwhile.”<sup>15</sup>

researchers it is useful to use observational guides and record sheets.

**An observational guide:** is useful for stating what should and should not be observed. The guide may include broad reminders of what to observe, specific instructions on how to do this or precise tasks.

**A record sheet:** records the presence of a behaviour or the number of times it occurs.

**Field notes:** are the researcher's written account of what they have observed. Brief notes may be made during the research, if the informants don't mind, and written up in more detail soon after.

**Tape recordings, videos and photographs:** can provide useful records of observations, as long as this is agreed to by the informants.

Sometimes a researcher may want to make ongoing observations of a particular event or site. For example: monitoring the types, behaviours and interactions of people who visit a known drug dealing point during a 24 hour period.

The researcher could note if people return more than once, which direction they came from, if they came on foot or by private vehicle or taxi, the police presence on the site and if any outreach work was conducted.

## HARM REDUCTION NEWS



### THE HIDDEN WORLD OF 'SHOOTING GALLERIES'

HANOI, VIETNAM

ONCE it was clear that we were not connected to the government or the police, the peer educators were willing to take us to some shooting galleries. We caught a taxi to a southern district of Hanoi, about 10 minutes from the centre of the city. The area was extremely poor. We were taken through muddy paths which were lined with tiny shacks on either side made of bamboo, old tyres and plastic bags. We came to a shack with low wooden benches, a table, a bed in the background and mattresses rolled and secured in the ceiling. The shack was called a café: its produce included one bottle of fanta, one of sprite, a few bowls of fruit and a glass cabinet with one empty beer bottle. Hanging from the bamboo were plastic bags; one filled with various packets of pills, another with disposable needles and syringes. The woman who ran the café looked to be in her mid 40s and sat behind the table. She wore the usual polyester short shirt and loose pants. There were several small children running about and four men and four women.

The main person we spoke to was Phuong, a 28 year old woman with a small child. Her hands, feet and arms were covered in scars

(healed injection sites). She pulled back her long black hair to show us several infected puncture marks on her neck. All the veins in her arms had collapsed. She had recently had a fix, her eyes were pinned. She told us she

“  
**Phuong has been using opium for seven years: at first smoking and then she moved onto injecting.**”  
”

could only afford one hit a day now, but when she had money she would have three a day. The price depended on the dose but she generally paid about 700 dong (approximately 50 cents US). Her husband had died five days ago: he was 36 years old. She told us he had decided to stop using and had been clean for three days. On the fourth day he had a hit, overdosed and died. Phuong has been using opium for seven years: at first smoking and then she moved onto injecting. She said she wouldn't go back to smoking. She has been tested for HIV and the results were negative. She said she now only uses a new needle and syringe and does not share.

The peer outreach workers come here every day and collect the used needle and syringes which they take

back to the Health Centre for disposal. As the incinerator had broken they now poured petrol on the syringes and burnt them.

On the table was a large white bowl full of a murky black liquid: this was the opium. The owner of the café covered the bowl with a thatched fan when she saw me looking at it. The owner was also a user.

Later, we walked further through the settlement to another house. An old woman ran the place and said she was glad we had come: “I heard you were here and I wanted to know why you weren't interviewing me” she said. The peer educators had been visiting her for over a year and now she provides disposable needles and syringes to her customers. She was very proud of this fact. A young man came and sat with us and one of the peer educators collected three used syringes from him and gave him three new ones. In this house people did not inject on the premises. The old woman would take clean syringes, measure the opium into a phial and draw the drug up. The user would take this away and inject somewhere else.

The peer workers were very committed to their work and had established an easy trust with the users.<sup>16</sup>

4. Questions to ask

Although observation can produce rich and varied information, and paint a more detailed picture than just statistics and questionnaires, it can be affected by:

- **selective attention:** the interests, experience and expectations of the researcher can all affect what is being observed
- **selective interpretation:** jumping to conclusions
- **selective memory:** the longer a researcher waits until writing up notes, the less likely these are to be accurate and perceptive
- **‘observer’ effects:** being watched may mean people change their normal pattern of behaviour

- **What are the types of questions asked in interviews?**
- **The questions**

**What are the types of questions asked in interviews?**

In an RSA researchers will usually use different interviewing methods at different interviews, or in the same interview, to gain the information.

The types of questions used are called:

- Semi-structured questions
- Structured questions

**Semi-structured questions**

Semi-structured questions are generally used in more informal interviews where the topics covered are not constrained by a detailed interview guide. While the interview will still deal with key topics, the more unstructured approach allows the researcher and the informant to discuss issues which are not on an interview guide.

The aim of this type of interview is to encourage informants to offer freely their opinions, information and experience. This requires the interviewer to have good communication skills: to listen carefully, to be open to new and interesting information and to be able to guide the informant away from irrelevant matters.

**Structured questions**

Structured questions are used when a researcher wants to have more control over the topics discussed and the format of the interview.<sup>17</sup> In this more formal sort of interview the researcher may use a detailed question guide outlining the areas to cover and even the order in which to ask them. The questions may also have to be asked exactly as they are written with no improvisation.

Structured interviews usually occur mid way through an RSA, after the existing information has been analysed and background research conducted. This helps researchers to identify areas and topics which need further investigation.

Structured questions:

- when they are the common format across each interview it can be easier to code, analyse and compare the information
- the interview guide allows the researcher to decide how long to spend on each question or topic; this can help in running interviews to time or in prioritising the questions if time is running out
- can help inexperienced researchers run their interviews
- do not allow the informant to discuss other areas not covered by the structured questions

## The Questions

The following section contains a series of questions which you may use in interviews conducted in a Rapid Situation Assessment. These questions are just a guide to the sort of issues you may wish to explore. The questions have been divided into:

Core and Supplementary questions (which include structured and semi-structured questions) for:

- 1 Drug users
- 2 Health professionals, government and law enforcement officials
- 3 HIV/AIDS related NGO staff and management
- 4 Drug treatment staff and management

## Core Questions

The interviewer may ask these questions of many of their informants. The answers will provide a variety of perspectives on the problem and you will be able to compare and contrast the responses. These questions are semi-structured, giving the interviewer a framework to work from but he/she can probe for more details at any stage. These questions are just a guide and you may add or delete questions as you see fit.

- How many people do you think use injectable and opioid drugs in this city? (this refers to both smokeable and injectable opioids and the full range of prescription drugs which may be injected)
- In what areas of the city are drugs used?
- How many people do you think are currently injecting? Are there some areas where drug injecting is more common than others? Where are those areas?
- Are different drugs used in different areas? If so, which drugs tend to be used in which areas?
- How are these drugs brought into the city or are they manufactured here?
- How are they distributed/sold?
- How are they used?
- Is possession of needles and syringes illegal?
- Where can you obtain needles and syringes?
- Do you think it would be feasible to establish a needle and syringe program in this community?
- Do you believe drug injecting is more common in this city today than it was five years ago? Two years ago? Why do you think this change has occurred?
- Have you noticed any changes in drug using in this city in the last few years? Why do think these changes have occurred?

- Do you believe that injecting drug use is an important issue in your city? Why/Why not?
- What kinds of detoxification facilities and drug treatment services do you know of in this city? Please describe their activities.
- Can a drug user get into drug treatment in this city whenever he or she wants to? What are the obstacles to getting into treatment?
- Can a drug user get detoxified in this city whenever he or she wants to? What are the barriers to getting detoxified?
- Is methadone classified as an illegal drug?
- Do you think a methadone treatment or maintenance program is feasible in this community?
- How many people in this city do you think are HIV positive? Of these, how many HIV infections do you think are directly or partly related to factors surrounding drug injection?
- Do you believe HIV infection among injecting drug users is an important issue in your city? Why/why not?
- Are there any programs/projects in this city to: prevent the spread of HIV among IDUs and from drug users to other people in the community? To provide health assistance to current and ex-drug users who are HIV positive? If so, please describe their activities. What are the barriers to these programs/projects' effectiveness?
- What types of interventions are needed in this city to address these issues?
- What policies or strategies are needed, and what policy changes are needed, to address HIV spreading among IDUs?

### Supplementary or Follow-On Questions

As noted above, not everyone you interview will be able to answer all of the core questions or give the same amount of detail. You will need supplementary questions for specific groups. For example: you may question a local doctor in a drug using area who treats IDUs about the sorts of illnesses/wounds he/she has seen with these patients, but you would not question a law enforcement officer about such detailed medical information. The supplementary/follow-on questions will be different for each group.

#### I Supplementary questions for drug users:



Drug users can be interviewed by using a structured questionnaire and/or a semi-structured questionnaire. The

advantage of doing both is that you will be able to get a better and more accurate picture of drug use. For example, information about how many drugs a drug user takes in a week can be obtained through a structured questionnaire, but the more detailed information such as *how they use* the drug is best obtained through a less formal interview.

Structured questions may include:

- Age
- Sex
- Area where you live
- Ethnicity
- When did you start taking drugs? What drug was that?
- If injecting, when did you start injecting? What drug was that? What drug(s) do you inject now?
- What is the drug you most prefer to use?
- What other drugs do you use?

- How do you use those drugs – by smoking, by injection, by swallowing pills? Partly or all of the time?
- How much of each drug do you use in a day/in a week?
- How much do you spend on drugs in a week?
- Do you usually use these drugs by yourself or with others?
- When you have injected a drug in the past week, how many times did you inject in a setting where other people were also injecting?
- What was the usual number of people who were injecting at the same time?
- Was it usual in these places for each drug user to have his/her own needle and syringe or did people share needles and syringes?
- How many people usually share one needle and syringe in these places?
- In what places do you usually inject by yourself or with other people?
- What is the largest number of people you have ever injected with?
- Have you ever met or seen a “professional” injector who injects drug users for a fee?
- If yes to the above, have you ever been injected by a professional injector? How many times?
- How many people do you know who use drugs?
- Do any of your friends or relatives also inject? If so, how many?
- Do your friends who use drugs live close to each other? In what area(s) of the city do your friends live?
- Have you ever tried to stop using drugs? If so, how many times? When was the most recent time you tried to stop using drugs?

- Have you ever tried to get help to stop using drugs? If yes, were you able to find any help? If yes, what kind of help did you get? What is your opinion of this help – was it useful for you? How long did you stop using drugs?
- Do you have a girlfriend/boyfriend?
- Do you have other sexual partners?
- Do you use condoms?
- Do you have sex after you have been using drugs?

Semi-structured/less formal questions may include:

- Please describe, in as much detail as you can, how you use drugs (for all types of drug use, but with specific emphasis on injecting). So, let’s start with the drug. Say you have just bought it – what do you do next?
- If you inject, can you please tell me about the first time you injected. Where were you? Who were you with? What drug was it? Please describe each step of the process when you first injected.
- What can you tell me about AIDS?
- What is your opinion of people who have HIV or AIDS?
- Do you believe AIDS is a problem you should worry about? Why/Why not?

## 2 Supplementary questions for health professionals and government health and law enforcement officials:



- Do you have an HIV/AIDS strategy or policy related to injecting drug use? If so, may I have a copy?
- Have you produced any educational materials about HIV/AIDS and injecting drug use? If so, may I have a copy?

- Are you aware of any educational materials about HIV/AIDS and injecting drug use produced in this city or this state? If so, can you tell me where I might find them?
- What are the characteristics of programs, organisations, policies and strategies that address drug use in this city or state?
- Of these, what are the characteristics of programs and organisations specifically addressing injecting drug use and HIV infection?
- How adequate and how appropriate do you believe the following are in your city:
  - legal responses to drug use (e.g. law enforcement)
  - prevention of drug use or drug problems
  - prevention of HIV transmission among drug users
  - care and support of drug users with HIV
- What are the laws relating to drug use and HIV in this city/state (e.g. needle and syringe distribution and possession, drug possession, possession of injecting equipment)?
- How are these policies and laws interpreted and to what extent are they enforced?
- What is the level of political support at the national, provincial/regional, district and local levels for effective HIV prevention among IDUs?
- Does the level of political support vary in different parts of the country?
- What are the factors in the levels of support?
- Are there formal policies and/or laws which enhance implementation of an HIV prevention program for IDUs? If so what are they?
- Who do you think of people who use drugs?
- What do you think of people who use drugs and are infected with HIV?

### 3 Supplementary questions for HIV/AIDS related NGO staff/management:



These questions are designed for HIV-related NGOs working directly with drug users or ex-drug users. In

cities where there are no such organisations, three to four NGOs should be selected who are likely to see drug users, at least, occasionally.

- Do any of your programs address injecting drug use? If so, please describe them to me:
- How long have you been operating?
- Number of staff and roles?
- Funding: from where and (if possible) how much?
- What are your activities/objectives/target groups?
- Co-operation with other organisations
- How adequate and how appropriate do you believe the following are in your city:
  - legal responses to drug use (e.g. law enforcement)
  - prevention of drug use or drug problems
  - prevention of HIV transmission among drug users
  - treatment of drug problems
  - care and support of drug users with HIV
- What do you think of people who use drugs?
- What do you think of people who use drugs and are infected with HIV?

#### 4 Supplementary questions for drug treatment staff/management:



- What is the current estimated number of IDUs in the country?
- What is the geographical distribution of IDUs in the country? Are there more IDUs in particular regions, states or provinces?
- Is there geographical variation in the level of HIV infections among IDUs in the country? If so, which states/provinces/regions have the most infections among IDUs and why is that?
- Do you have an HIV/AIDS strategy or policy related to injecting drug use?
- Do any of your programs address HIV/AIDS? If so, please describe them to me.
- How long has your program been operating?
- Funding: from where and (if possible) how much?
- What are your activities/objectives/target groups?
- Do you have cooperation with other organisations? Who are they? How does it work?
- How adequate and how appropriate do you believe the following are in your city:
  - legal responses to drug use (e.g. law enforcement)
  - prevention of drug use or drug problems
  - treatment of drug problems
  - care and support of drug users with HIV
- What do you think of people who use drugs?
- What do you think of people who use drugs and are infected with HIV?

#### 5 The Outcomes of a Rapid Situation Assessment

A Rapid Situation Assessment should provide:

- a detailed snapshot of the drug use and HIV risks in a particular environment
- a description of the locations, activities and members of IDU groups that you can target for interventions
- maps of city locations where risk taking behaviour is occurring and estimates of the population involved
- a list of NGOs and other organisations working in the areas of interest
- descriptions of the social and organisational networks available to address HIV and drug use
- a network of key informants for future research which will help to identify how local organisations and communities make decisions and what structures and processes they use
- how the IDU community makes decisions
- identification of the key issues, problems, and gaps in information and service provision, which the program will hope to address

## HARM REDUCTION NEWS



### A RAPID SITUATION ASSESSMENT IN CAMBODIA

PHNOM PENH, CAMBODIA

A RAPID Situation Assessment (RSA) was undertaken to determine drug use and concomitant HIV risk behaviours in Cambodia. Multiple research techniques and activities were used in order to identify not only what happens to those using illicit drugs but why it happens.

“  
**Multiple research techniques ... were used...**  
”

An absence of any systematic information about drug use in Cambodia made it necessary to consider and locate numerous sources of information to build up a picture of the drug using situation. Key informants from government departments (i.e. the Ministry of Health), non-government organisations (national and international), private and government health care workers, sex workers, street children, border police, fishermen and pharmacy owners were interviewed in various regions of the country. Visits to ten provinces took place, each

lasting between two to five days.

Before visiting Cambodia, and following preliminary interviews with a small number of informants, a series of broad questions were identified:

- Is there a drug problem in Cambodia?
- Are drugs such as heroin and opium available?
- Which segment of Cambodian society is involved in drug taking and drug trafficking?
- Are health services involved with drug users?
- Are there potential resources in the community to deal with drugs?

The interviews were open ended, followed a topic guide and were conducted with the assistance of a trained Khmer researcher. The information was systematically recorded

“  
**Unobtrusive observations were also used ...**  
”

by the researchers either during, or immediately after, the interview. Unobtrusive observations were also used to enlarge and to cross check the

information obtained from key informants. These observations took place at various locations such as provincial

“  
**national newspapers ... revealed frequent stories about drug trafficking...**  
”

hospitals, village market places or in cafes in Phnom Penh where drug trading and drug use were said to occur.

Focus group discussions were also used as they are an effective way of checking and consolidating information (e.g. street children attending an NGO facility were interviewed).

In the absence of documentation in Cambodia on drug issues, articles from two English language national newspapers were systematically perused during the study period and revealed frequent stories about drug trafficking and money laundering. Most of the information on the historical background of drug use in Cambodia was found outside of the country from research centres focusing on Asia.<sup>18</sup>

## Harm Reduction News

### Drug Use Assessment in Myanmar

YANGON, MYANMAR

#### Methodology

The Rapid Situation Assessment was used in assessing the extent and nature of drug abuse in Myanmar. It is an eclectic approach to data collection which uses multiple sources to get multiple indicators, as no one method of data gathering is sufficient to expose the real drug abuse situation in a community. The RSA used both qualitative and quantitative analysis to assess the data and the information gathered.

Originally the assessment was to be carried out just in high risk areas but more sites were added which extended

**“...no one method of data gathering is sufficient to expose the real drug abuse situation in a community.”**

the study to 36 townships in all states and divisions. These included mining areas, border towns, poppy cultivation areas and high risk urban areas. The reasons for selecting these sites were:

- available statistics from drug treatment centres
- available media news of drug routes and arrests for trafficking
- drug abuse is more common in urban than rural areas
- drug traffickers usually prefer to use border towns and mining (jade and ruby) areas where money is more available

Nine sites in low risk areas with few reports of drug abuse were also included. The geographical area selected covered about 11 per cent of the total townships of the country and included all major jails.

#### Study team

The study team consisted of three psychiatrists from the Drug Treatment Centres, one epidemiologist, one social scientist, two statisticians (one a computer specialist), 23 trained research coordinators who are doctors and 124 local interviewers.

#### Study period

The study period was divided into three phases:

- 1 the preparatory phase – for designing, planning and identifying the geographical areas to be surveyed, for selecting research coordinators and training them for research work
- 2 monitoring and making field visits to research areas and collecting data and information
- 3 compiling and analysing the information collected and the preparation of the report

#### Study method

To estimate the exact size of the drug problem was a difficult task. Although confidentiality was explained before an interview was conducted, the drug user, or his relatives, were sometimes reluctant to reveal the addiction as it is a hidden problem especially in a country like Myanmar where drug

abuse has a very bad image and the penalties are severe. As no single method was sufficient to expose the real situation, multiple methods were used. These included:

- key informant interviews
- group discussions
- informal conversations
- participant observation
- small group discussions
- interviews with those dealing with drug users
- interviews with drug users

The number of participants interviewed was: 286 key informants, 672 drug users, 90 informal conversations and 32 small group discussions.

#### Constraints

Exposing the drug abuse situation is not without difficulty as the problem tends to be hidden. In addition, the addicts are stigmatised by socio-cultural prohibition. The legal context of Myanmar, which implies punishment for drug abusers, made it more difficult to organise drug users' participation and discuss their drug using habits, despite the reassurance of confidentiality. The lengthy monsoon season meant the field visits had to be carried out a month later than scheduled, as the muddy roads in the hilly areas made villages inaccessible. Including more areas to be studied created difficulties in both administration and implementation. Nevertheless, the team managed to overcome the difficulties and developed a large body of research material for future use.<sup>19</sup>

Summary

Rapid Situation Assessments

Rapid Situation Assessments are an assessment of the problem and the resources available to address the problem. The research tools used have been adapted from anthropology, sociology, epidemiology and evaluation research methods.

Rapid Situation Assessments are:

- conducted rapidly
- inexpensive
- prepared to use existing data
- not reliant upon one source of information
- investigative of the various sources available
- consultative with a wide range of people

Finding and analysing existing information

Some existing information can include:

- drug surveys
- number and type of arrests for drug related offences

Some information sources are:

- drug treatment programs
- health care facilities
- National AIDS organisations
- prisons and other law enforcement agencies

All information collected needs to be relevant, representative and sufficiently useful to the RSA. Ignore information that will not be used.

The RSA team should, after collecting the information, address a number of key issues that include determining the aim of the document and examining their conclusions. Note that information collected can be biased or prove inadequate.

Interviews and Observations

RSA interviews with key informants provide insights about local meanings and understanding about risk behaviours and health consequences. Key informants are important for information as they are:

- knowledgeable about the topic
- currently or have recently been involved in the activity of interest
- important to either getting the RSA done or the program going

An interview should be conducted privately and will prove more successful if the researcher is well prepared: this results from a good understanding of the topic and a well-crafted question line. Some good interview techniques to note are a quiet environment, being a good listener, using clear and simple language and summarising key issues and opinions at the conclusion of the interview.

The types of interviews are:

- one to one key informant interviews
- focus group discussions
- round table discussions

Observations assist the researcher to experience the meanings, relationships and contexts of human behaviour and to describe these. Observations are conducted either casually or formally. Research tools such as an observational guide of what to observe and/or field notes, can be useful.

Observations can be valuable but the validity can be affected as a result of selective attention, selective interpretation and selective memory. Additionally, behavioural changes can occur when a person is observed.

Chapter One  
*Rapid situation assessments*

The Centre for Harm Reduction

## Summary

*Manual for  
reducing drug  
related harm  
in Asia*

### Questions Styles

The two different interviewing question methods are:

- Semi-structured questions
- more informal, with few limited constraints
- informants are free to offer opinions, information and experience

### Structured questions

- question line more formal, orderly, detailed and with no improvisation
- likely to occur after completing analysis of existing information and background research

Core and supplementary questions maybe designed for the following groups:

- drug users
- health professional, government and law enforcement officials
- HIV/AIDS related NGO staff and management
- drug treatment staff and management

Core questions are generally semi-structured and provide various perspectives on a problem. This is in contrast to supplementary questions that have been created for specific groups (i.e., drug users), allowing key informants a wider scope of questions to answer. The questions can be structured and/or semi-structured.

### Outcomes of a RSA

An RSA should:

- provide insight into drug use and HIV risks in a particular environment
- describe locations, activities and members of IDU groups for targeted intervention
- discover information gaps which a program can hope to address

#### Section Two, Chapter One: Rapid Situation Assessment

For further information refer to **WHO resources: Technical Guides to Rapid Assessment and Response & Evidence for Action Papers. Refer to following websites:**  
[www.who.int/hiv](http://www.who.int/hiv) (publications expected online from May 2003) & [www.RARarchives.org](http://www.RARarchives.org)

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*Manual for reducing drug related harm in Asia*  
**SECTION 2 • CHAPTER 1 • OVERHEAD 1**

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SECTION 2 • CHAPTER 1 • OVERHEAD 3

**CENTRE FOR HARM REDUCTION**  
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**SECTION 2 • CHAPTER 1 • OVERHEAD 4**

CENTRE FOR HARM REDUCTION  
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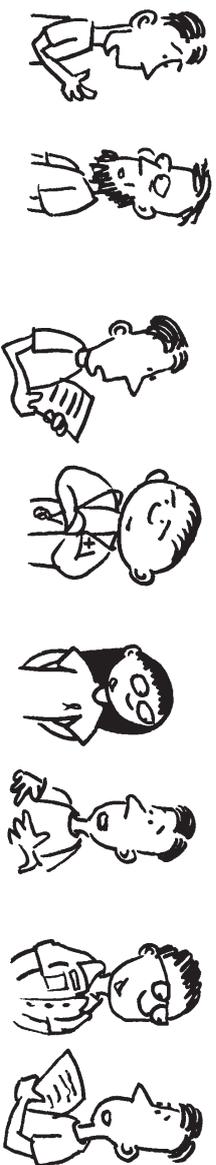
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## Section Two

### *Chapter Two*

## **Establishing and Sustaining a Program**

**Planning the intervention**

**Drawing up the project plan**

**Implementing the plan**

**Monitoring and evaluation**

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## Introduction

Three stages are basically involved in establishing a program:

- Rapid Situation Assessment (see Chapter One)
- Selecting the appropriate mix of HIV intervention activities
- Implementing, managing, monitoring and evaluating the intervention activities

In other words, the process includes:

- Identifying the problems
- Attempting to find solutions to the problems
- Establishing a project/program
- Evaluating and monitoring the project/program
- Reassessing and redesigning the project/program if necessary

This chapter is divided into four sections:

- 1 **Planning the intervention:** who do you target? Are there local organisations you can work with? What are the aims and objectives of the program? What activities/strategies are viable?
- 2 **Drawing up the project plan:** what is a project plan? How do you get funding? What is a budget?
- 3 **Implementing the plan:** how do you manage the program/project? What about staff? What are performance targets?
- 4 **Monitoring and Evaluation:** identifying the indicators which can be used to monitor the progress, collecting and analysing data, modifying existing interventions and developing new interventions.

## I. Planning the intervention

Who do you target?

Are there local organisations you can work with?

What are the aims and objectives of the program?

What activities are viable?

### Who do you target?

If the Rapid Situation Assessment (RSA) has shown a need for intervention in a community, in this case in regard to drug injecting or potential drug injecting and the risk of HIV transmission, it will be necessary to devise some programs to deal with these issues.

There are two linked stages:

- 1 the identification of target groups, problems and locations; and
- 2 the selection of appropriate interventions based on the above, the available local resources and the range of current activities

The RSA should provide information which will help to identify:

- target groups
- target problems
- sites for intervention activities

The target groups may include:

- non-injecting and/or injecting drug users
- urban middle class or slum dwellers
- rural farmers
- fishermen
- truck drivers
- students
- drug users in or out of treatment
- prisoners
- occasional or recreational injectors or frequent and compulsive injectors
- sexual partners of drug users
- sex workers who use drugs

The target problems may include:

- low levels of knowledge of HIV/AIDS among injectors

- lack of drug treatment facilities and options
- behavioural norms that sustain needle and syringe sharing
- stigmatisation of drug injectors
- low level of knowledge among project workers
- legislation that prohibits the sale of needles and syringes to injectors and other legal constraints that impede activities

The sites for activities may include:

- towns
- city areas
- prisons
- villages
- refugee camps
- brothels<sup>1</sup>

### Are there local organisations you can work with?

An important part of the RSA will have been to identify and assess the activities of other organisations, especially NGOs. There may be opportunities to complement the project you are establishing with other projects already in existence. This can provide support and also avoids duplication of services.

The project may be located within an existing program or institution such as a public health department, a university or an NGO. The advantage of locating the program within an existing organisation is



you may be able to use their resources, for example: buildings, photocopier, telephone system, meeting rooms. The disadvantage is that the host organisation may try to influence your program's activities. For example, it may be difficult to distribute needles and syringes or a disinfectant such as a bleach within an abstinence-based drug program.

Even if your program is established independently of existing organisations or programs it is important to keep in mind how you can work with these organisations.

- You must be willing to network with other drug-related or HIV/AIDS NGOs throughout the period of implementing your program
- One of the primary aims of networking should be to build up services for IDUs in the long term
- Organisations working with drug users should also try to do some advocacy with existing HIV/AIDS organisations and law enforcement agencies<sup>2</sup>

A Rapid Situation Assessment in Kathmandu, Nepal revealed that while there was a need for IDUs to have access to clean injecting equipment and HIV risk reduction information, some IDUs also expressed the need to go into drug detoxification/ rehabilitation. The organisational strength of Lifesaving & Lifegiving Society (LALS) was felt to be in doing outreach to those IDUs who had little or no access to HIV risk reduction information. Furthermore, the RSA had also revealed that there were numerous drug detoxification/ rehabilitation facilities. So, LALS took on outreach work but networking and referral to drug treatment facilities also became a priority area of work. Thus, LALS was able to support and complement the ongoing work of other NGOs while at the same time providing a much needed service to IDUs which had not existed before.

## What are the aims and objectives of the program?

When planning a program it is essential to have a overriding sense of *what* your program is trying to achieve and *how* you plan to achieve it. These aims and objectives help in designing the program and serve as reminder and reference when you are actually running the program.

**Aims:** are general statements which outline what you want to achieve through the program. For example; the aim of a program among IDUs may be to reduce the spread of HIV in this population.

**Objectives:** are more specific and outline the changes required to bring about your aim. For example; the objective of a program among IDUs may be to reduce needle and syringe sharing in order to reduce the risk of HIV transmission.

**Activities:** are the aims and objectives translated into action, that is, how the objectives may be achieved. For example; the activities of a program among IDUs which aims to reduce the spread of HIV by the objective of reducing the sharing of needles and syringes may include a needle and syringe program and/or the distribution of disinfectant to clean needles and syringes.

**Strategies:** A set of activities undertaken to meet a specific objective constitute a strategy.<sup>3</sup> The strategy describes the overall approach to achieving the aims and objectives. For example: the strategy to reduce HIV transmission among IDUs might be to promote the cleaning of needles and syringes with an appropriate disinfectant.

## What activities/strategies are viable?

The RSA will probably have identified possible intervention activities for the particular community it investigated. The

next stage will be to identify which activities will be the most appropriate and to devise an HIV prevention strategy.

The strategy will generally consist of activities to reduce the risks associated with injecting drug use. These activities may include:

- mass media education
- local information campaigns
- providing advice (to IDUs, the community, police, government etc.)
- information and counselling about risky behaviours and protective strategies
- improving the supply and return of needles and syringes
- providing information about syringe cleaning and providing supplies of suitable decontaminants such as bleach
- designing an information pamphlet with drug users about cleaning needles and syringes
- installing an incinerator for the disposal of used needles and syringes
- establishing a drug substitution program, e.g. methadone
- developing outreach services to hard to reach populations
- providing health care in such a way as to attract target groups (e.g. delivering primary health care to IDUs in the neighbourhood where they use drugs)
- introducing peer education within local drug-using communities
- promoting condoms<sup>4</sup>

The choice of a particular strategy may be influenced by the prevailing moral attitudes of the government and the community to drug use and sexual behaviour. If the government and/or the community resists certain strategies it is important to explore why this is so:

- the reasons may be soundly based on the community's knowledge of their own culture and history
- or the objectives of the program may be based on false perceptions of low risk or denial of the threat of the spread of HIV

## 2. Drawing up the Project Plan

**What is a project plan?**

**How do you get funding?**

**What is a budget?**

### What is a project plan?

Before you start your project you will need to draw up a project development plan. The plan often takes the form of a project proposal and identifies what is needed to get the project up and running and the stages for the development of the project.

Start with an outline of what needs to be done: more details can be added in later.

#### EXAMPLE OF PART OF A PROJECT DEVELOPMENT PLAN:

The RSA identified the need for HIV education leaflets to be distributed among drug injectors.

- 1 Decide on the aim and contents of the leaflet.
- 2 Organise professional staff and outreach workers to assemble and review existing printed material designed for drug injectors (if any exists).
- 3 Find a local artist and writer to design the leaflet.
- 4 Pre-test a selection of leaflets in focus groups of drug users to see which leaflet is most effective.
- 5 Select and/or redesign, based on the focus group results.
- 6 Do a final pre-test of the leaflet in another focus group.
- 7 Print the leaflets.
- 8 Distribute the leaflets through outreach workers.

Often, the planned intervention among injecting drug users will consist of more than one activity. While part of the plan may include designing and distributing leaflets to IDUs about HIV transmission, other components may include providing primary health care to IDUs, teaching IDUs how to clean their needles and syringes and providing them with the means to do so and so on. Each component will need to be planned.

A project plan usually includes:

- the order of activities
- the timetable of activities
- job descriptions and individual staff responsibilities for the various project activities
- identification of the supplies needed and how they will be distributed
- guidelines on collecting information for monitoring and evaluation
- guidelines for reporting the project <sup>5</sup>

The project plan needs to show what has to be done for the project to begin. For example, if the activity involves distributing needles and syringes or bleach these supplies have to be available before distribution can begin, or if the project is going to employ outreach workers the project timetable will have to outline how and when the workers will be recruited and when they will be trained.

Several activities in a project may be running at the same time. It can be helpful to draw up a flow chart to show at which particular stages of the project an activity takes place. The flow chart can also anticipate changes during the life of the project and help to assess the need for different resources at different stages.<sup>6</sup> For example, the training of outreach workers may take place at the beginning of the project so time will need to be set aside at the beginning of the project, later on in the project this time may be used for other activities.

## How do you get funding?

An important part of planning a project is to consider where you will get the money to get the project up and running. Depending on the project you may need money for:

- premises
- office equipment
- staff salaries
- supplies
- operating expenses
- communications (telephone, fax, e-mail etc.)
- travel
- training materials

Some questions you may consider concerning funding are:

- How will funds be found for the project?
- Will funds be sought from local, national or international funders?
- Will money be sought from the government or private trusts and foundations?
- What obligations will you have to the funders?

Wherever the funds are sought, it will probably be necessary to write a proposal to the potential funder.

### EXAMPLE OF A PROPOSAL OUTLINE TO SEEK FUNDING FOR A PROJECT:

- 1 Explain the credibility of your organisation
- 2 Explain the need for the intervention (you can draw on the RSA for this information).
- 3 Give clear, specific and attainable objectives for the intervention.
- 4 Justify the approach you have chosen
- 5 Include the methods for evaluating the project (see later in this chapter)
- 6 Prepare a realistic budget (see below)
- 7 Use simple language in the proposal, avoid jargon, be brief and pay attention to the presentation of the document.<sup>7</sup>

### 3. Implementing the Project Plan

Chapter Two  
Establishing and sustaining a program

#### What is a budget?

The budget is a plan which identifies where you can get the money for your project and how you will use it once you have received the money. A budget helps to show what support you may need from outside of the organisation. It also makes sure that money is put aside for the various needs of the project.

You will need to work through the project plan (as above) to list all the items that will need to be included in the budget. The categories in the budget should include, at least:

- **Project staff:** salaries
- **Non-staff costs:** supplies (e.g. needles and syringes, bleach, condoms etc.), equipment, training costs
- **Project support costs:** communications (telephone, fax, e-mail, postage) production and printing of materials (leaflets, posters), report preparations, car/motorbike (if necessary), public transport costs
- **Project overhead costs:** non-project staff support, office accommodation, utilities, audits, insurance, bank charges, office supplies

How do you manage the program/project?

What about staff?

What are performance targets?

#### How do you manage the program/project?

Most programs will have a coordinator or supervisor who oversees and directs the program. A program may also have a management team or committee to oversee the running of the program. The management team may have representatives from the community and experts who can advise on the project development. If you establish a management committee you will need to consider:

- Who will be on the committee?
  - How will they be chosen?
  - What are their terms of reference (i.e. is it an advisory team or does it have management powers)?
  - How often will the committee meet?
- Other management decisions include:
- Who will be managing the staff involved in the project?
  - Who will make the decisions about the project?
  - Who will report to whom during the project?
  - Who will be responsible for reporting to others (e.g. funders, government, the community)?
  - What form will the reporting take (see the section on monitoring and evaluation further on in this chapter)?

The coordinator, and the management team, will need to provide leadership for the project. They need to keep in mind the aims and objectives of the project. They also need to pay attention to the staff and provide support and feedback to staff who are often

working in stressful situations. For more information on staff stress and burnout see **Chapter Eight: Counselling and Testing.**

## What about staff?

Projects working with drug users often have problems recruiting and maintaining staff. Working with an often hidden and stigmatised population requires workers to be *non-judgmental, non-coercive and able to maintain confidentiality*. It is not always easy to find people who are willing to work with drug users who are often under the constant threat of harassment and arrest by law enforcement. Many NGOs have tried to overcome this problem by recruiting staff from the IDU communities:

- current users have been recruited as peer educators and outreach workers and have proved invaluable in bridging the gap between users and NGOs
- ex-users are able to work with users because of the trust and credibility that exists between the two as they are, or have been, part of the same community. An important issue surrounding the hiring ex-users is the danger of relapse and the associated loss of credibility with IDU communities. Strategies exist to overcome this problem but NGOs hiring ex-users have to be aware of this real threat.

Once you have found your staff you should set up training sessions. These sessions will provide basic training on:

- HIV/AIDS and how the virus is transmitted
- Risks associated with drug use and injecting
- Risks associated with unprotected sex
- Information on safer drug use and sexual activity
- What the aims and objectives of the project are
- What the workers will be expected to do

The training session should also look at attitudes to drug use and drug users. This will include examining stereotypes, prejudice and discrimination. Current or former drug users can be extremely effective as staff trainers in explaining and moving beyond commonly held views of drug users. They can also describe the problems that drug users face.

In training sessions it is also important to focus on, and make clear, the expectations and responsibilities of the staff. This may include the importance of:

- Maintaining confidentiality with drug users
- Treating drug users with respect
- Understanding the local laws
- Understanding any health risks and taking necessary precautions
- Recognising unacceptable risks and knowing how to get out of difficult situations

For more information about working with drug users and outreach see **Chapter Four: Education.**



## What are performance targets?

Performance targets show the degrees of change you hope to achieve in a given period of time. Performance targets should:

- Provide an overall goal and sense of purpose
- Be explicit and able to be monitored
- Be achievable over a specified time
- Be challenging<sup>a</sup>

Some of the targets will indicate the success of *implementing* activities: depending on what sort of program you are involved with these may include the

- number of staff trained
- number of bleach bottle/packets distributed
- number of people passing through the drug treatment system
- number of HIV/AIDS leaflets distributed to drug users

Other targets will indicate the successful *impact* of the activities: depending on what sort of program you are involved with these may include the

- proportion of IDUs cleaning their needles and syringes with bleach
- proportion of IDUs using a new needle and syringe for each injection
- proportion of IDUs using condoms
- proportion of IDUs sharing needles and syringes

Depending on the program the performance targets may be written up as:

- By (date) x % in the target population will be able to cite at least two acceptable ways of protecting themselves from HIV infection
- By (date) x % of pharmacies will be supplying injecting equipment to IDUs on request

- By (date) the number of IDUs receiving treatment at treatment sites will be xxx
- By (date) x % of IDUs will be enrolled in a drug substitution program

Performance targets help a program to analyse how the project is progressing and, if it is not, what changes need to be made. A program will need to keep detailed records to show their funders how the project is progressing. This information is also useful for the project workers and planners: to see how the project is progressing and whether changes are necessary. This is an essential part of a program and will be discussed in more detail in the next section.

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## 4. Monitoring and Evaluation

Evaluation is a crucial part of a program. It provides information about how the program is progressing and highlights what is working well and what is not. Evaluation should not be an after thought: it needs to be taken into account from the designing stage of a program. Funds need to be made available for evaluation – as part of the budget.

Once a program is planned and has begun, it is important to see if the program's activities are being carried out as planned. This process, called *monitoring*, is a continuous collection of relevant information about the implementation of the program. It is the way to ensure:

- a coordinated and organised schedule of supervision of work and workers
- it results in producing the information that funding agencies will want in regular program reports

*Evaluation* is the process of collecting and analysing the information, at regular intervals, to look at the effectiveness and the impact of the program. This may occur on:

- an annual basis to assist the development of an annual work plan
- or at the end of the period for which the program was planned or funded

The purpose of the evaluation is to:

- assess the extent to which the intervention is meeting its aims and objectives
- establish whether interventions need to be modified to make them more effective

The principles of evaluation are to:

- build evaluation into the program from the beginning
- use local resources
- use existing information where possible
- keep the evaluation simple
- give feedback from the results quickly to help develop interventions<sup>9</sup>

There are three main stages of monitoring and evaluating a program:

- Identifying the indicators which can be used to monitor the progress
- Collecting and analysing data
- Modifying existing interventions and developing new interventions

### Identifying the indicators which can be used to monitor the progress

The first task when planning for monitoring and evaluation as part of your program is to select which indicators will best show if your program is meeting its aims and objectives. Indicators are the measures which will show you if the intended changes are happening.

The performance targets, discussed earlier, are helpful for evaluation purposes in that they will have outlined specific levels of achievement.

Two main types of evaluation should be carried out:

#### Implementation Evaluation

This involves assessing the extent to which the intervention activities have been developed as planned. The questions that need to be asked are:



- Has the project been established successfully?
- Is the project reaching or attracting the target population?
- Is the project delivering the service as intended?

### Impact Evaluation

This involves assessing the extent to which the intervention has had the desired impact on the target population. The questions that need to be asked are:

- Has the desired change in the target group occurred as a result of the intervention?
- Is the intervention an effective use of resources?

Implementation and impact indicators are the measures which will show if the intended activities have been implemented as planned and if they are having the desired impact. Indicators give a structure to monitoring and evaluation.

Implementation indicators which show if the activities have been developed as planned may include:

- For the establishment of the program
  - The number of staff recruited and employed
  - The number of training sessions organised for the staff
- For reaching the target population
  - The number or proportion of the target population contacted
- For delivery of service
  - The number of items of service delivered (e.g. the number of AIDS information leaflets delivered, the number of needles and syringes distributed and collected)

Impact indicators which show if the activities have had the desired effect may include:

- Desired change as a result of the intervention
  - Levels of HIV/AIDS awareness among

the target population (e.g. knowledge of safer injecting practices)

- The proportion of drug users who inject
- The proportion of drug injectors who share injecting equipment
- The proportion of drug users who regularly clean their needles and syringes with bleach

## Collecting and analysing information

### Why should you collect information?

Information needs to be collected:

- to assist program managers monitor and review the progress of a program
- to provide content for project reports
- to inform the community involved and affected by the program
- to show the funders how the program is progressing
- to use in advocacy to show government/police etc. the benefits of the program
- to use in articles and other publications

Some information is collected daily or weekly, for example workers at an outreach clinic will mark down attendances at the clinic, what services were provided, what medication and other supplies were distributed and so on.

Other information is collected periodically, such as:

- at the start of the program (base line data)
- and again at times of annual review
- or at the end of a program evaluation

The periodic collection of information allows for comparison of the information over the life of the program. For example: a program that sets out to reduce the spread of HIV among IDUs, may measure the sero-prevalence of HIV among IDUs who enter the program over a number of years. This

would involve a measure of sero-prevalence at the beginning of the project among potential clients and every year afterwards among its clients

**Who should collect the information?**

**Program staff** usually collect the information for the regular monitoring of the program. It is important that program managers recognise that this requires time and sometimes specific training. Training of staff must be planned early on so that funds for training are allowed for in the budget.

**Program clients** can also participate by keeping personal records (medication, needle exchange etc.).

**External evaluation** is sometimes a requirement of a funding arrangement. While it can appear threatening, external evaluation can be an objective way of assessing progress and receiving input from people outside the program who are experienced and familiar with programs aimed at reducing harm among drug users.

**Participatory evaluation** allows community members, including clients, to participate in the evaluation along with program staff and/or an external evaluator. The major advantage of this approach is that the evaluation gains from the insights of the target group and what is learnt through the process is retained in the community and not taken away by people outside of the program.

**Choosing impact and implementation indicators**

- If the objective of the intervention is to improve access to treatment for drug problems, an impact indicator could be: the number of IDUs seeking treatment at treatment sites, the number of IDUs accepted into treatment and the number of IDUs who complete the treatment successfully.
- If the objective of the intervention is to increase the availability of injecting equipment from pharmacists for IDUs, with the aim of decreasing the sharing of needles and syringes, the implementation indicators could include: the number of pharmacies supplying injecting equipment and the number of needles and syringes sold. An impact indicator could be the proportion of IDUs who share injecting equipment.
- If the objective of the intervention is to distribute leaflets to IDUs through outreach workers, with the aim of increasing HIV/AIDS awareness, the implementation indicators could include: the number of outreach workers involved, the number of contacts made with members of the target group, the average length of time spent with clients and the number of leaflets distributed. Such information can be gathered by asking the outreach workers to keep a diary to record this type of information. An impact indicator could be: the proportion of the target population who can cite at least two acceptable ways of protecting themselves from HIV infection<sup>10</sup>

**What information needs to be collected?**

Only information that is useful should be collected. Information that is not used in any way wastes time and resources and leads to staff fatigue. Staff that spend valuable time in the collection of information can be encouraged by seeing value placed on their work through an analysis and application of the results.

The information to be collected, depending on the program, may concern:

- the use of new injecting equipment
- number of clients in a methadone program and their responses to the program
- the adopting of cleaning practices
- the general health of the clients
- condom usage
- the training of IDU peer outreach workers

The information may be found in:

- registers
- work schedules
- field diaries
- account books
- a standard computer spreadsheet program
- the minutes of meetings
- reports of consultations
- events in the life of a program
- accounts, invoices and receipts

**Sero-prevalence information:**

In programs that specifically set out to reduce the transmission of HIV among IDUs, through a number interventions, an *HIV sero-prevalence study* may be established. Such a study measures:

- the prevalence of HIV among IDUs before the program started
- and the prevalence of HIV among IDUs periodically thereafter, usually on an annual basis

The prevalence of *HIV* measures the total numbers of all HIV cases among the population being studied (such as IDUs

enrolled in a program) at a particular point in time. This can then be repeated at regular intervals, such as the same month every year.

In a very large program, involving a state or large district, HIV prevalence may be measured in a number of regions among selected groups of people (referred to as sentinel groups) who are at high risk of HIV transmission. In such a situation the program would be said to be carrying out *HIV sentinel surveillance*. Thus trends in HIV infection are monitored over time, by group and by place. For more information on HIV testing see **Chapter Eight: Counselling and Testing**.

**When should the information be collected?**

Although the information will be collected throughout the life of the project (monitoring) and periodically (evaluation), it must be *planned for early*, when the program is at the planning stage. This allows for allocation of time and also resources in the budget.

**Baseline surveys** are usually carried out at the beginning of the program. This allows for comparison and a measure of progress toward achieving the program's objectives when the survey is repeated later (usually at the end of a funding cycle).

Monitoring implies that the information is collected on a regular basis. Some information will be collected on a daily basis (e.g. IDUs attendance at the needle syringe program) and for others monthly (e.g. records of the regular monthly staff planning meeting).

**How is the information analysed?**

The way that information is analysed will depend on what sort of information it is. If the information is about numbers, rates and ratios (i.e. Quantitative data) it may be analysed mathematically and statistically. For example: this sort of information could be about the number of IDUs visiting a

## Harm Reduction News

### Behavioural monitoring survey among injecting drug users in Cebu City, Philippines

CEBU CITY, PHILIPPINES

The Regular Behavioural Monitoring Survey (BMS) is being conducted by all the agencies involved in the AIDS Surveillance and Education project sponsored by the Program for Appropriate Technology in Health (PATH). The survey covers high risk groups: freelance and registered sex workers, men who have sex with men, sex workers' clients and injecting drug users.

This survey attempts to track behaviour changes, particularly on the correct

and consistent use of condoms, the reduction of the number of sexual partners, the seeking of treatment from professional health practitioners for STDs and not sharing and cleaning/bleaching of injecting equipment.

Conducting the BMS involves:

- Drafting of the survey (PATH)
- Revision (NGO)
- Reformatting (PATH/NGO)
- Pre-testing (NGO)
- Revision (PATH)
- Final printing (PATH)
- Training of interviewers (PATH)

- Data collection (NGO)
- Analysis (PATH)
- Reporting and feedback

The University of Southern Philippines Foundation Inc., who handles the project in Cebu, looks after the access and collection of data from the injecting drug users. Systematic fielding out and completion of the questionnaire follows. All collected data are then submitted to PATH for collation and analysis. The results are reported to the university to assist in project implementation.<sup>11</sup>

program every week, the amount of needles and syringes distributed in a week and the number of IDUs outreach workers have contacted in a week. Analysing this sort of information mostly requires time and a calculator.

Information gathering methods that use and analyse words, providing impressions and context (i.e. Qualitative information), collect information through recorded observation, interviews and group discussions and cannot be analysed statistically as can numerical data. But this information can be:

- categorised
- summarised
- used anecdotally

#### Who should analyse the information?

Where possible, the information should be analysed by the person who collected it. The person collecting the information will then appreciate the significance and relevance and is unlikely to waste time collecting information that is irrelevant and won't be used. This, of course, will be dependant on the work load of the person and whether such a person has the skills for analysing the information. Often, in a large program, a specialist or the program manager will be responsible for analysing the information.

## Modifying existing interventions and developing new interventions

### How can reports be generated by monitoring?

Reports are a feature of all programs. The demand for reports, both formal (written) and informal (verbal) come from a number of sources including:

- donor agencies
- governments
- the community where the program functions
- clients and beneficiaries
- the program staff themselves

The nature of the reports needed, and their formats, will vary and may differ considerably.

### How can feedback be stimulated by monitoring ?

Programs are not just accountable to their donors but to their target group and the wider community. Feedback to those intimately involved in the program, such as IDUs, creates an opportunity for greater involvement of IDUs and a greater sense of participation in the program.

Monitoring and review processes allow for feedback about the progress of a program. This progress can be presented at a variety of meetings, such as community, project management and staff meetings.

### What are the benefits of conducting an evaluation?

The benefits of conducting an evaluation may be:

- creating a regional approach by sharing information with other programs
- providing an opportunity to be culturally appropriate rather than always adopting strategies from other countries' programs

- establishing self-help groups by bringing together various groups during the evaluation
- providing social research on the local situation
- providing the opportunity for publication
- providing an opportunity to network using the information and the results from the evaluation with in your own country and internationally

### How can an evaluation result in program changes?

The findings of an evaluation may show, for example, that an intervention has not been established as planned and/or that it is not having the desired impact upon the target group. The evaluation information will help a program coordinator and staff to reassess the program and make changes to make the activities more appropriate.

An evaluation of the progress of a program offers the chance to look back and to look forward. The lessons learnt from a program are brought to light by an evaluation. These lessons, together with an understanding of the actual progress made toward achieving the program's objectives, help to plan the program for the future.

As a result, objectives, targets and strategies are often amended in the light of an evaluation. An evaluation allows for change and justifies it, to the community, the clients and to the funders.

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## Summary

### Planning the Intervention

The Rapid Situation Assessment should provide information to assist with the identification of target groups, target problems and the sites for intervention activities. Target groups may include urban middle class or slum dwellers, students and sexual partners of drug users. Target problems may include stigmatisation of drug injectors, inadequate knowledge of HIV/AIDS among injectors and the lack of drug treatment facilities. Intervention activities may occur in towns, city areas, prisons, refugee camps and brothels.

Identifying and assessing the roles of local organisations that you can work with, particularly NGOs, is important for gaining support and avoiding duplication of services. Locating the program within an existing organisation can result in the availability of resources (i.e. office space). However, a host organisation could influence a program's activities and, for example, create difficulties with the distribution of needles and syringes. An independent program should have a good working relationship with other drug related or HIV/AIDS organisations in to order build up services for IDUs in the long term and to encourage harm reduction advocacy.

It is essential to know *what* the program is trying to achieve and *how* this can be achieved. This is why establishing aims ( what you want to be achieve) and objectives ( outlining changes to bring about your aim) are crucial. Aims and objectives can then act as a reference during the implementation of the program. Activities are then implemented in order for the objectives to be achieved. Lastly, strategies establish a set of activities to be undertaken to meet a specific objective.

Some strategies believed to be the most appropriate to reduce the risks associated with IDU may include:

- improving the supply and return of needles and syringes
- providing information about cleaning techniques for injecting equipment
- establishing a drug substitution program, e.g., methadone
- introducing peer education within local drug-using communities

### Drawing up the Project Plan

A project plan identifies what is needed to get the project functioning and the stages for the development of the project. As interventions will often consist of more than one activity, each component will need to be planned. Project plans can include:

- the order and timetable of activities
- job descriptions and individual staff responsibilities for the various activities
- identification of the supplies needed and how they will be distributed

With the implementation of several activities at the same time the introduction of a flow chart can display changes during the life of the project. This may help to assess the need for different resources at different stages.

A project may require money for various costs (i.e. the premises, office equipment, staff salaries, travel and communications). Wherever the funds are sought (i.e. local, national, international, government, private trusts and foundations) a written proposal to a potential funder will probably be necessary.

A budget plan identifies where money can be sought for the project and how it will be used when it is received. Various categories in the budget will need to include

salaries for the staff, costs of supplies (i.e. needles and syringes), costs to support the project (i.e. telephone and postage) and project overhead costs (i.e. office accommodation).

## Implementing the Project Plan

A program can be directed by a coordinator or supervisor and may also include a management team to oversee and advise on the project. The team to advise can include community representatives and experts. It will need to be decided who is on the team, how they are chosen and how often they meet.

Staff recruited to the project are required to be non-judgemental, non-coercive and able to maintain confidentiality. As it may be difficult to recruit appropriate staff many NGOs seek out those from the IDU communities. Staff need to attend basic training sessions examining some areas such as HIV/AIDS and virus transmission, risks associated with drug use, injecting and unprotected sex, an overview of the project and the tasks that are involved. Consideration of issues related to stereotypes, prejudice and discrimination of drug use and drug users is required. Throughout the training session expectations and responsibility of the staff must be made clear.

Performance targets show the degrees of change you hope to achieve in a given point of time. A target indicating the success of *implementing* an activity could be, for example, the number of bleach bottle/packets distributed. An example to indicate the successful *impact* of an activity could be the proportion of IDUs cleaning their injecting equipment.

## Monitoring and Evaluation

Monitoring is a continuous collection of relevant information about the implementation of the program.

Evaluation is the process of collecting and analysing the information, at regular intervals, to look at the effectiveness and the impact of the program. This can occur on an annual basis or at the end of a period for which the program was planned and funded.

Implementation evaluation involves assessing the extent to which the intervention activities have been developed as planned. Impact evaluation involves assessing the extent to which the intervention has had the desired impact on the target population. Indicators measure if the intended changes are occurring and give a structure to monitoring and evaluation.

## Collecting and analysing information

Some reasons why information is collected can include:

- providing content for project reports
- assisting program managers to monitor and review the progress of a program
- informing the community involved and affected by the program

Those who should be collecting information can include:

- program staff, program clients, external evaluators and community members

Information to be collected can include:

- the use of new injecting equipment
- the general health of the clients
- the training of IDU peer outreach workers
- HIV sero-prevalence among IDUs

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Information should be collected during the following:

- throughout the life of the project (monitoring)
- periodically (evaluation) and when the program is at the planning stage

Information is analysed in the following manner:

- Quantitative data ( numbers, rates and ratios) are analysed statistically
- Qualitative data ( interviews, impressions) are categorised and summarised

Analyses of the information should be done by the following:

- the person who collected the information, a specialist or the program manager

**Modifying existing interventions and developing new interventions**

Reports are generated by monitoring for the following sources:

- donor agencies, governments, clients and beneficiaries and program staff

Feedback stimulated by monitoring:

- creates an opportunity for greater involvement of IDUs
- allows a greater sense of participation in the program

Benefits of conducting an evaluation can include:

- creating a regional approach by sharing information with other programs
- the opportunity to be culturally appropriate and not adopting strategies from elsewhere
- providing social research on the local situation and the opportunity for publication

Evaluations resulting in program changes can occur when:

- the findings may show an intervention has not been established as planned leading to a program reassessment and the need for more appropriate activities
- the ability to look back and forward can encourage greater understanding of the progress in achieving the program's objectives

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**For further information refer to WHO resources: Monitoring and Evaluation (NAP M& E Guide) & Policy and Programming Guide for HIV Prevention Among Injecting Drug Users. Refer to the following website: [www.who.int/hiv](http://www.who.int/hiv) (publications expected online from May 2003)**

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**▼▲ Planning the Intervention**

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**Target groups can include:**

1. Middle class or slum dwellers
2. Students
3. Sexual partners of IDUs

**Target problems can include:**

1. Stigmatisation
2. Low level knowledge of HIV/AIDS among IDUs
3. Lack of drug treatment facilities

**Sites for intervention activities can include:**

1. City areas
2. Prisons
3. Refugee camps
4. Brothels

A program within an existing organisation has benefits but there also can be disadvantages particularly in relation to fulfilling all program activities.

It is essential to know what the program is trying to achieve and how this can be achieved.

This process involves the establishment of the following:

1. Aims
2. Objectives
3. Activities
4. Strategies

**CENTRE FOR HARM REDUCTION**  
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**▼▲ Drawing up the Project Plan**

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**A project plan identifies what is needed to get the project functioning and the stages for the development for the project. The plan can include:**

- the order and timetable of activities
- the identification of the supplies needed and how they will be distributed

**A project may require money for costs involving office equipment, staff salaries and communications.**

**Whether the funds are sought nationally, internationally, from government or a foundation, a written proposal to a funder is likely.**

**Budget plans identify where money can be sought and how it will be used when it is broken down into categories.**

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**▼▲ Implementing the Project Plan**

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Program direction can come from a coordinator, a supervisor and/or a management team (i.e. community representatives and/or experts) to oversee the function of the project.

**Staff recruited to the project are required to be non-judgemental, non-coercive and able to maintain confidentiality.**

**Many NGOs have indicated that seeking staff from the IDU communities can prove invaluable.**

Basic training sessions for staff need to examine areas including:

- ▶ HIV/AIDS and virus transmission and risks associated with drug use
- ▶ injecting and unprotected sex
- ▶ an overview of the project and the tasks that are involved

**Performance targets show the degrees of change that are aimed for in a given period of time.**

**Successful changes can be indicated by the implementation and the impact of an activity.**

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▼▲ **Monitoring and Evaluation**

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**Monitoring**

- ▶ a continuous collection of relevant information about the implementation of the program.

**Evaluation**

- ▶ a process of collecting and analysing the information, at regular intervals, to look at the effectiveness of the program.

***Implementation evaluation*** involves assessing the extent to which the intervention activities have been developed as planned.

***Impact evaluation*** involves assessing the extent to which the intervention has had the desired impact upon the target population.

Indicators show if intended changes are occurring and give a structure to monitoring and evaluation.

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**CENTRE FOR HARM REDUCTION**  
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**▼▲ Collecting and analysing the information**

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**The reasons for collecting information include:**

- ▶ providing content for project reports
- ▶ program managers can monitor and review the progress of a program
- ▶ to inform the community involved and affected by the program

**Those collecting the information can include:**

1. Program staff and clients
2. External evaluators
3. Community members

**Information to be collected can include:**

- ▶ the use of new injecting equipment
- ▶ the general health of the clients
- ▶ the training of IDU peer outreach workers
- ▶ HIV sero-prevalence among IDUs

**Information should be collected during the following:**

- ▶ throughout the life of the project (monitoring)
- ▶ periodically (evaluation) and the program planning stage

**Information is analysed in two ways:**

- ▶ quantitative data – statistically and mathematically
- ▶ qualitative data – categorised and summarised

**Information analyses should be done by the following:**

1. Information collector
2. Specialist
3. Program manager

**CENTRE FOR HARM REDUCTION**  
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**▼▲ Modifying existing interventions and developing new interventions**

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**Reports are produced by monitoring for certain sources including:**

1. Donor agencies
2. Governments
3. Clients and beneficiaries
4. Program staff

**Feedback stimulated by monitoring can include:**

- the opportunity for greater involvement and sense of participation in the program for IDUs can occur

**Benefits of conducting an evaluation can include:**

- creating a regional approach through the sharing of information
- adopting strategies that are culturally appropriate
- opportunity for local social research and potential publication

**Program changes following evaluations can include:**

- discovering interventions not established as planned resulting in program reassessment and the need for more appropriate activities
- ability to look back and forward encourages better understanding of the progress in achieving the program's objectives

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**SECTION 2 • CHAPTER 2 • OVERHEAD 6**

## **Section Two**

### *Chapter Three*

## **Working Together**

**The community**

**Religious groups**

**Police and law enforcement**

**Prisons**

**Governments**



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## Introduction

Successful harm reduction programs rely heavily on the support and involvement of different sectors of the community, ranging from government leaders through to injecting drug users.

Without broad community support and involvement, even the best designed and funded programs will struggle to succeed. Ongoing community consultations are also critical to the success of the HIV prevention programs targeting IDUs.

In this chapter we will examine the key groups to work with:

- 1 the community
- 2 religious groups
- 3 police and law enforcement
- 4 prisons
- 5 governments

## I. Working with the Community

What does community mean?  
 What should the community know?  
 Why are injecting drug users a key resource?  
 How can you mobilise community responses to HIV among IDUs?  
 What are some of the main components of working with the community?  
 Who should you consult?  
 How do you organise community consultations?

Community ownership, and participation in programs, have long been recognised as essential ingredients in developing effective responses to HIV/AIDS. This is especially true for programs targeting injecting drug users.

The most effective responses to HIV among IDUs have come from communities (large and small) where HIV and drug injecting are seen as *everyone's* problem, not just a problem for health workers, injecting drug users or those living with HIV/AIDS.

### What does community mean?

A community can be defined as a group of people who have something in common and will act together in their common interest. This common interest may be the neighbourhood or city people live in, it may also be an area of shared interest, such as a local community of drug users or the global community of people working with HIV/AIDS.

Modern communications technology and the AIDS pandemic have each challenged and widened the concept of community. But in the end, it is how people identify themselves as community members that really defines the concept of community.

For example, the way you identify with your community's drug problems may be very different if you live in a city of ten million people than if you live in a town or

village of 30,000 people. It all depends on your viewpoint.

When one considers the diversity and complexity of IDUs and HIV it is not surprising that there are wide-ranging public perceptions. These views and community attitudes can have an enormous bearing on policies and responses towards these problems.

### What should the community know?

Why does HIV and drug use challenge a community's ability to respond effectively to a problem that may result in deaths and widespread suffering? The answer is often distance and denial. People find it is easier to say "AIDS won't happen to me, it will only affect drug users and other high risk groups. I don't need to worry".

Much of the denial fuelling the HIV/AIDS epidemic stems from an attitude that this disease only affects high risk groups; such as sex workers, male homosexuals or IDUs. Both governments and individuals have wrongly thought that they don't need to worry about HIV/AIDS: that it only affects so-called high risk groups. It is, in fact, high risk behaviour, rather than high risk groups, that is of concern.

However, this misconception has even led to people saying that HIV among IDUs is a good thing because the HIV will wipe out all the drug users, thus cancelling out both the HIV and drug users at the same time.

But the spread of HIV/AIDS around the world in less than two decades shows that this disease never stays within the one group or region. In several Asian countries, IDUs have been demonstrated to be a key vector for the spread of HIV into the wider community. Injecting drug users are mobile, widespread and sexually active.<sup>1</sup> IDUs are therefore an important group to target for HIV prevention and a key resource in developing effective programs.

## Why are injecting drug users a key resource?

As a growing number of programs are demonstrating, IDUs are one group that can be successfully targeted to prevent HIV/AIDS. Injecting drug users can also be one of the greatest assets a community or agency has when developing effective responses to HIV and drug injecting. They are the ones with the most experience and expertise.

Some people spend a great deal of energy turning drug users into demons, and blaming them for everything that is wrong with the world. Much can be gained by turning drug users back into human beings: by simply talking to them and, more importantly, by listening to them.

"You must take into account the culture, the social belief, the background and the history of that particular community. If the problem is drug abuse you have to take into account the history of drug abuse in the country.

Whatever the intervention, if it is to be successful, it needs to build and empower the community. Empowering comes from building self-esteem, giving back ego to marginalised communities: it is not ego-breaking, it is ego-building. It is giving back responsibilities and trust to the marginalised communities that is essential.

You cannot be judgemental or moralistic, although many times what you are faced with is actually against your principles and beliefs.

You need to respond quickly. You need to know what the community is trying to tell you and you need to respond to it. You must listen to the community. You don't decide for yourself what is best for them, you listen to them and you respond to what they are telling you. If you don't do that then you're not going to have a successful program

because you'd be doing everything you think is right and it might benefit you in your reports and with your government but it won't be of any benefit to your clients." 2

### Injecting drug users

- know what they need
- know what the barriers are
- know how to achieve what needs to be done (e.g. what sort of information and the form it should take to successfully reach IDUs)

Although often marginalised and outcast by the community, IDUs interact regularly with different members of the community; other IDUs, police, health and welfare groups, their own friends and family.

Program workers involved in responses to HIV and IDU are also important members in their own community.

### Community concern

Many parents, police, politicians and other community members see drug use in their community as someone else's problem. This attitude can make it extremely difficult to respond to the drug use and its associated risks and harms. Consequently, responses have been delayed until preventable HIV infections have become fatal AIDS cases. By this time, what began as problems affecting only a small population of drug users may have expanded to a national problem affecting all sectors of the community.

A community can be triggered into action by an urgent or perceived problem. But, with HIV/AIDS and IDUs, community concern and action often do not occur until people have been personally touched by knowing a drug user or person living with HIV/AIDS. This can mean that community mobilisation does not occur until HIV and possibly AIDS has taken hold; usually years after HIV has begun spreading in the community.

**Community mobilisation**

A community that is mobilised, that is aware and ready to take action, has most or all of the following characteristics:

- members are aware, in a detailed and realistic way, of their individual and collective vulnerability to HIV/AIDS

- members are motivated to do something about this vulnerability
- members have practical knowledge of the different options they can take to reduce their vulnerability
- members take action within their capability, applying their own strengths and investing their own resources including; money, labour, materials or whatever else they can contribute
- members participate in decision-making about what actions to take, evaluate the results and take responsibility for both success and failure
- the community seeks outside assistance and cooperation when needed<sup>3</sup>

In short, a mobilised community is one that takes responsibility for its own problems.



**HARM REDUCTION NEWS**



**HARM REDUCTION WORKS IN SOUTH CHINA**

RUILI COUNTY, CHINA

Handeng village is located in Long Dao Xiang in a remote part of Ruili, Yunnan province, China. There are 77 households in the village consisting of 304 residents. Since the 1980s, 46 drug users have been identified as HIV positive. During the 1990s, increased drug use created other problems such as poverty, drug trafficking and violence. Handeng became known, notoriously, as the 'problem village'. In 1991, Handeng was chosen as a pilot site for the imple-

mentation of a community oriented drug demand reduction project. With outside government assistance, a village leaders' group, parents' group, women's group, publicity group and a youth group were formed to carry out activities within the community. The various groups met once a month for activities ranging from youth forums to discuss their specific problems and needs to the implementation of procedures to organise detoxification and rehabilitation of drug users.

Public awareness cam-

paigns and educational activities relevant to different groups were implemented by the community. Assistance and help were given to drug users and families of HIV positive people. HIV positive drug users were supplied with condoms on a regular basis. After a few years there was improved knowledge and significant attitudinal changes to contraception and issues of drug use and the risk of HIV/AIDS. Since 1991, there have been no new cases of HIV/AIDS related to drug use.<sup>4</sup>

## Harm Reduction News

### The community Gets Involved

CEBU CITY, PHILIPPINES

**B**EFORE any of the AIDS Surveillance and Education Projects (ASEPs) in Cebu City, Philippines started, the City Health officer called up representatives of different sectors of the community to discuss how a health issue with possibly grave societal repercussions could be resolved.

These groups included: city government, police, church, academics, women's groups, media and rehabilitation centre members. They all

agreed on a multi-sectoral approach. So, when the AIDS concern was presented, all those representatives reiterated the need for collaborative work.

However, they did stress

**“...all those representatives reiterated the need for collaborative work.”**

that as the issue was delicate and sensitive it should have a low profile until such a time as there were tangible results

and improvement in the prevention and control of HIV/AIDS among drug users. These people are current members of the Cebu City Technical Advisory Council for AIDS Prevention and Control and they meet regularly, every second Tuesday of the month.

They also assist in the implementation of all ASEP projects. They also call on support and services from other sectors including education, social welfare and the business and financial sectors.<sup>5</sup>

### How can you mobilise community responses to HIV among IDUs?

- Organise community forums and consultations
- Pilot different non-government and community-based responses, which have the approval of government
- Seek funds to support local programs
- Identify prominent community figures (entertainers, politicians, journalists, etc.) to support efforts to prevent HIV among IDUs
- Involve affected people (IDUs, ex-users, their families, health workers) in responses, responsible media coverage, ongoing planning and debate

### What are some of the main components of working with the community?

Illicit drugs often provoke strong community responses because of the passionate views, prejudices and ideas so many people have about this topic. You may not get such a strong community response to a sudden increase in coffee or nicotine usage among teenagers. But if the increase is in the use of heroin or some other illegal substance, passionate responses and viewpoints are likely to both unite and divide communities.

If you wish to develop responses to drug use and HIV that reflect the concerns and needs of the community it is essential to get out into the community and talk to people.

## HARM REDUCTION NEWS



### THE COMMUNITY TAKES OWNERSHIP

CHURACHANDPUR, INDIA

The Society for HIV/AIDS and Lifeline Operation in Manipur, (SHALOM), India, is a program which works closely with community members, district health authorities and non government and government agencies. This is possible partly because SHALOM is based in a small district and township where community concern

“  
**The authorities and community in Manipur embraced their experiment with harm reduction with relative ease ...**  
”

about HIV among IDUs has been translated into community ownership and action, and SHALOM is one of Asia's first Government approved harm reduction programs.

With a population of 180,000. the township of Churachandpur had 3,000 intravenous drug users. It also had a pool of highly motivated community leaders who had given much time

and effort to the problem of drug addiction.

SHALOM was formed in 1995, after widespread community consultations and funding from AusAID. During the first year of the project, SHALOM staff continued to hold extensive consultations with Church leaders, different tribal groups in Manipur, drug users and their families, prisoners and youth. These formal and informal consultations took place both before and during the implementation of controversial harm reduction measures, such as needle exchange.

The authorities and community in Manipur embraced their experiment with harm reduction with relative ease, largely due to the extensive consultations carried out to discover what was acceptable to the community.

No opposition to the needle and syringe exchange has been reported and the Churachandpur Superintendent of Police issued orders that SHALOM clients and staff should not be detained for possession of needles and syringes, normally a jailable offence. This was a direct outcome of good relations and

lengthy talks with the police.

“We have chosen to live with the lesser evil of drug abuse in order to curb the AIDS menace, and so far I have not had occasion to regret my decision to allow the syringe and needle exchange program,” Superintendent Khaute said.

SHALOM could not have succeeded without the support and “blessing” of police, government and community members. And this couldn't have been achieved without extensive consultations.

“  
**...this couldn't have been achieved without extensive consultations.**  
”

Civil unrest, poverty and other problems at the time of writing mean that SHALOM and the people of Manipur still have a long road ahead before HIV/AIDS is under control. But the community, police and government have taken on HIV and drug use as their own problem and one that they must respond to themselves.

#### Who should you consult?

- injecting and other drug users
- ex-users
- their families
- school and University teachers/Students
- youth in general
- authorities
- police
- government officials
- anyone who sees themselves as part of the community

These groups will probably have been contacted during the Rapid Situation Assessment (see **Chapter One: Rapid Situation Assessments**). During the establishment of a program, and during the life of the program, contact should be maintained with these groups to inform them of the progress of the program and to attempt to keep them onside.

### How do you organise community consultations?

There are many simple ways you can organise community consultations: they can be formal or informal meetings. The main point is to get out and talk to people and find out what people think, feel and need.

- Use existing community networks, gatherings and forums (church meetings, community groups, ethnic associations, etc.) to find out people's views on drug use and HIV risk in the community
- Ask school principals if you can talk to the students about HIV/AIDS
- Post a wooden box at a school, or outside your program, where young people can write and leave questions about drugs and HIV/AIDS
- Convince a local radio station to run a segment where people can ring in and ask an expert about their concerns
- Organise more formal consultations with IDUs, ex-users, community members or other affected groups (assure confidentiality and perhaps also organise a meal)
- Get out onto the streets and talk to people in shops, cafes or wherever they gather
- Talk to community members at all stages of program design and implementation

## 2. Religious Groups

**What are the positive roles religious groups can play?**

**What are the negative attitudes religion can promote?**

**How can you work effectively with religious groups and beliefs?**

Responses to drugs and HIV/AIDS are closely linked to the morals, attitudes and religious beliefs of a society or community. Religious leaders can play an important part in shaping attitudes and responses to HIV and drug use. This is especially true in communities where religion plays a central part in people's lives.

On a practical level, church and religious groups often provide the "front-line" of care and counselling for IDUs and people living with HIV/AIDS. Religious groups can also have a strong influence on the ways drug use and drug users are viewed by society. This can have good and bad outcomes for the person with a drug dependence or HIV/AIDS problem.

### What are the positive roles religious groups can play?

- care and counselling for people affected by HIV/AIDS and illicit drugs
- providing hope and comfort
- meeting people's practical needs (clothing, accommodation, food)
- community leadership and mobilisation
- reduction in stigma and marginalisation for people affected by HIV/AIDS and illicit drugs
- acceptance, rather than judgement, of people and their problems

### What are the negative attitudes religion can promote?

Religious groups and beliefs can also lead to negative attitudes about drug use and HIV/AIDS, and judgemental attitudes including:

- HIV/AIDS is divine retribution for people's sins because it only happens to homosexuals, drug users and sex workers
- drug users are bad people
- a moral and god-fearing society won't be affected by HIV/AIDS or drugs
- prayer alone can save people from HIV/AIDS

HIV/AIDS is a disease not a punishment. It does not ask if people are Hindu or Christian, heterosexual or homosexual, good or bad. Religious, moral or cultural beliefs do not provide some sort of special protection for communities from HIV/AIDS. While religious beliefs and writings can be used to condemn and judge people affected by HIV/AIDS and drugs, they can also be interpreted and used as powerful tools against these problems.

### How can you work effectively with religious groups and beliefs?

- educate religious leaders about HIV/AIDS and drug use and tell them they have a role to play and suggest how they might play that role
- organise a meeting of religious and other community leaders
- find out if churches, temples, mosques and other religious institutions have groups or activities targeting youth, HIV/AIDS or drug use
- coordinate with church-based aid and welfare organisations
- examine how religious texts (the Bible, Koran, etc.) talk about compassion, forgiveness and non-judgemental approaches
- find ways to meet people's spiritual needs

## 3. Police and Law Enforcement

What do you need to find out?

How do you get the police to support your program?

What else can you do?

Police and law enforcement officials are central players in any response to illicit drugs. Law enforcement is an important part of reducing the supply of illicit drugs. Despite decades of international efforts to reduce drug supply and consumption through harsher penalties, specialised anti-narcotics forces, and other stringent measures, the availability of illicit drugs in most countries continues to grow.

But police and law enforcement forces can also be important allies in responses to HIV infection and other harms affecting drug injectors. When developing responses to this problem, the police must be consulted and hopefully involved. This should be pursued whether or not the local police are sympathetic to the health risks posed by needle and syringe sharing, unsafe injecting and overdose.

### What do you need to find out?

To understand police activities and their presence in relation to drug users you may want to find out:

- how many police stations are there?
- how do they operate?
- what are the relevant laws and penalties?
- how do they interpret/enforce paraphernalia laws, e.g. finding a person with a needle and syringe on them?
- what are drug users' rights?
- do they enforce the law or express community prejudice?
- how many police are there in the area?
- how active are they?
- do they use or sell drugs?
- do the police harass IDUs?
- what is their attitude to drug users?

Chapter  
Three  
*Working  
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The Centre  
for Harm  
Reduction

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in Asia

The support of senior police/narcotics enforcement personnel has been essential in the establishment of needle and syringe programs in Asia, for example in Nepal, India and Vietnam. However, despite the support of senior officials, HIV prevention programs among IDUs can still suffer harassment from local street-level police.

### How do you get the police to support your program?

- involve senior police in early consultations: to gain their permission and ongoing support
- educate junior level police about what the program is aiming to achieve
- use co-operative and supportive police to be peer educators among other police
- use educational opportunities, e.g., include HIV/AIDS education in police training courses, offer to run the course
- obtain formal agreement from the police to suspend police activities relating to IDUs for the period when a harm reduction trial program is operating
- visit police stations and police officers and find out their concerns
- organise a meeting of police and other community leaders
- invite police members to be on the board or advisory group of HIV prevention programs targeting IDUs
- obtain police permission, or an amnesty in writing, for programs attempting to make clean needles and syringes available

## Harm Reduction News



### Getting the Police On Side

KUALA LUMPUR, MALAYSIA

At the beginning, because we are a registered organisation, there wasn't much of a problem with the police. What was a problem, was that the police who handled that particular area of town did not know that we existed. They would carry on doing their jobs, which was to catch drug users and put them into rehabilitation centres, or harass them. Also there were times when we were harassed by the police as well. So, it was very important that we worked with the police. It's also important to have a person (in the pro-

gram) who has diplomatic skills and because Karen had these skills she went to the police, spoke to them and presented our case: why it

**“We were amazed at how some of the police responded very positively.”**

was important. We were amazed at how some of the police responded very positively. I think many times the impression we got of the police was “those in the field who catch drug users,” but as we went higher up in the hierarchy, we found people

who were totally supportive, committed in their work and who you can tap into.

In Malaysia, there are just so many drug users and so few rehabilitation centres, we have 28, but they are already overflowing and there is such a high relapse rate amongst drug users. Some of the drug users have been in rehab three times. So, the police are seeing the same people over and over again and the police understand the problem. They know the circle, they catch the guy, send him to rehab and then he comes out and goes back to drugs.”<sup>6</sup>

4. Prisons

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together*

What else can you do?

- educate the police about the rights of drug users
- educate drug users about their rights
- establish a good relationship with the Superintendent of Police (if possible)
- discuss with the police the idea of identity cards for the clients of your program
- arrange a meeting between program workers and the police to educate them about harm reduction
- consult and include police in decision making processes
- try to personalise the issues for the police, e.g., if you pat people down you may get stuck by a needle or imagine if the drug user was your brother
- you may need to separate those people in your program who do the liaison work with the police from those people involved in the outreach work: if IDUs see outreach workers with the police they may think the workers are linked to the police

Why are the risks so great in prisons?  
What can communities do?  
How do you reach the prisoners?

People who use illicit drugs are at great risk of being sent to prison for drug offences. Being in prison poses major health risks for the dependent drug user because of:

- the unavailability of health services
- the high prevalence of unsafe drug practice by inmates
- the unavailability of sterile needles and syringes, condoms and other barriers to harm

Taking drugs in prison can mean:

- changes in the type of drug used: from a less to a more potent kind
- increases in the risks associated with the drug use
- no effective reduction of drug use

Why are the risks so great in prisons?

People who are put in prison are not sealed off from the risks of HIV and AIDS. Most people who are in prison will be released back into the community. Whatever is contracted in prison can and will be passed on to the outside world once the prisoner is released.

Prisons put people at great risk of HIV/AIDS because of:

- overcrowding: contributes to the climate of violence and tension and the spread of HIV and TB
- continued drug use: many people in prison are there because of drug offences, the atmosphere and availability of drugs doesn't help in giving up drugs



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Reduction

- unsafe injecting practices: injecting equipment is usually scarce in prisons, so prisoners share their needles and syringes (or their home-made equipment such as a ball point pen) without cleaning between use, due to lack of sterilising equipment
- unprotected sex and rape: sex between men in prison is common but condoms are not
- tattooing, skin piercing and blood brotherhood rites: equipment is usually unsterile and shared between prisoners
- risk of overdose for people leaving prison if their drug tolerance has lessened

In Thailand, a country that has endured one of the fastest spreads of the epidemic in Asia, the first wave of HIV infections occurred in 1988 among injecting drug users. From a negligible percentage at the beginning of the year, the prevalence rate among injectors rose to over 40 per cent by September, fuelled in part by transmission of the virus as IDUs moved in and out of prison.<sup>7</sup>

### What can communities do?

Communities often deny that injecting drug use is going on in their prisons. In some countries people have put their drug using children in prison in the hope that they will stop taking drugs. But drugs and needle and syringes will find their way through the thickest and most secure of prison walls.<sup>8</sup> It is not easy to establish a harm reduction program in a prison: you need to get the authorities on side.

### Possible harm reduction strategies in prisons may include:

- providing needles and syringes to prisoners: this usually meets with resistance in most communities. However, it may be possible if it is presented as a pilot program to assess its impact on the spread of HIV in the prison
- providing cleaning equipment to prisoners: give prisoners the means to clean their injecting equipment (such as bleach or another disinfectant see **Chapter Five: Injecting Safely** for more information) and information about how to do it
- providing condoms to prisoners: denial about sex going on in prison will not stop sex from occurring nor the spread of STDs including HIV/AIDS
- setting up health care for prisoners in prison: health checks for prisoners, tests for TB etc. will provide an opportunity to give prisoners information about HIV/AIDS

### How do you reach the prisoners?

Although it may be difficult to establish a program in a prison there are ways to begin:

- identify and use the groups who already visit prisons and camps: prison support groups and networks, health workers, teachers etc.
- encourage prisoners to educate other prisoners: prisoners who are well-accepted and liked by the other prisoners
- talk to prison officers about the risks of HIV/AIDS
- target families and partners of people in prison
- HIV messages can be embedded in other health messages
- look at ways of reducing the incidence of IDUs being locked up in the first place

## HARM REDUCTION NEWS



### JAIL SENTENCE IS NOT THE SOLUTION

CHURACHANDPUR, INDIA

The jail is located up behind the town on a hill, in a dirty white walled up building. But is not particularly imposing, just barren and cold, even in the warm sun. There is a wide expanse of mostly empty dirt between the barracks, with no trees, no plants but also no asphalt or concrete. Down against a far wall someone has planted a kitchen garden.

We are met by a young man who Grace introduces to me. She says he is very intelligent and he accompanies us for the rest of the visit. He is a wealth of information and keen to talk. He has been in jail ten times, freely admits that he can't break the habit outside of jail, and has been

in jail now for four months and doesn't know when he'll get out. He tells me his parents put him in jail, similar to many of the parents of the young men here. They get sick of their sons doing drugs so they get the police to put

“  
**They get sick of their sons doing drugs so they get the police to put them in jail.**  
”

them in jail. This man tells me he won't get out until his parents say so.

I ask the young man what the men (other prisoners) do all day. He says:

“Nothing, we get up, have breakfast about 7.30 am, we

sleep all day, we have dinner and we sleep.” We go into one of the barrack-like buildings. There is no furniture only rows of men laying on mats, lined against the walls. Immediately I am struck by the mixture of the sweet smell of diarrhoea and ganja. That explains how they can sleep all day.

Almost all of the 30 men in this room are IDU, almost all have AIDS and almost all will also have TB. There are very few men here for criminal offences apart from using drugs. The place is very quiet, the men are too sick and stoned to do much else but lie on their mats.”<sup>9</sup>

*For further information on prisons see Chapter Nine: Specific Groups.*

#### Questions to think about:

What messages can you give to prisoners?

How are you going to get those messages to them?

Are there any substitution programs operating in your community?

How are prisoners with HIV treated in prison?

Is counselling attached to testing?

How can you make the sterilising of injecting equipment more effective in prison?

What treatment is available to offer to IDUs as an alternative to prison?

## 5. Governments

Which sections of government do you focus on?

What sort of government responses have there been?

How do you strike a balanced approach to drug policy and HIV?

Where do you begin with governments ?

How do you convince governments to support your program?

Drug policies make a statement about a society's fears and concerns that goes beyond the drug use issue. Governments and policy makers respond to these fears, often without concrete evidence and research, to decide what they consider the best response to illicit drug use.

Illicit drug use is a very difficult issue for governments. For example, is heroin usage primarily a legal issue, a public health issue, or both? The way heroin, and other drug use, is treated by government will have a large bearing on the health and welfare of users.

Which sections of government do you focus on?

How drug use is viewed may depend on which section of government you speak to:

- the Health Department may see HIV and drug overdose as the fundamental problem posed by injecting drug use
- the Police may be more concerned with the crime associated with illicit drugs
- the Home Ministry or border patrol may be primarily concerned with suppressing the supply of drugs
- the Chief Minister may be concerned with the drug problem's overall impact on the community, concluding that a "War on Drugs" may be the most politically and socially acceptable solution to a problem that affects so many sectors of society

The fact that injecting drug use can fall between so many different areas of government shows the difficulty governments and agencies around the world have in dealing effectively with the public health, social and legal implications of illicit drug use.

What sort of government responses have there been?

- Prohibition
- Supply reduction (increased border scrutiny, intensified law enforcement, a "War on Drugs")
- Demand reduction (treatment, education and other means for reducing the demand for illicit drugs)
- Harm reduction (making safe drug use a priority over the eradication of drug use, by targeting harms like HIV, Hepatitis C, overdoses, abscesses, and other health problems)
- Drug Law Reform

For more detailed information on these responses see **Section One: Background and Rationale**.

How do you strike a balanced approach to drug policy and HIV?

Whatever approach governments and other policy making agencies take towards illicit drug use, it is important that they carefully consider the full implications of their policy decisions. Declaring stringent bans on drug use and prison for all offenders may sound like strong leadership, but if such measures are taken in isolation from other public health concerns, more harm may occur from HIV than from the drug use itself.

## Harm Reduction News

### Harm Reduction Seen as Constructive Option

HONG KONG, CHINA

In Hong Kong, the Department of Health has screened nearly 20,000 body fluid samples (blood, urine and saliva) and by end of September 1996 only 14 cases of HIV had been identified: four of whom had developed full blown AIDS. This relatively low infection rate, as compared with neighbouring countries, can be attributed to the following prevention and harm reduction measures:

- Since 1985, the implementation of mid-term prevention strategies by the Department of Health: even before the first HIV case among IDU was discovered
- The availability of multi-modality treatment system including: 21 Methadone Clinics, compulsory residential and numerous voluntary placement programs which makes treatment and intervention avail-

able to any drug user without delay

- The public education given by the CEPAIDS and the outreaching service organised by its Working Group on Drugs and AIDS with the support of SARDA, Pui Hong Self-Help Association and other agencies
- The experimental harm reduction clinic (including needle exchange) operated by the Medicine Sans Frontiers in the Vietnamese Boat People Camps

**“...risk behaviour associated with drug taking if unchecked, often result in fatality or irreversible disability...”**

The three reductions of supply, demand and harm have been in practice in Hong Kong for about two decades but have been formally proposed as a policy approach only recently. Standing alone,

none of the three approaches is singularly effective but together they complement each other and make it possible to contain the problems of drug abuse. For ideological reasons some treatment experts, who aim at the total abstinence from all substances of abuse, claim that harm reduction represents a defeatist attitude largely through lack of understanding of its close relationship with demand reduction.

Whole person recovery with voluntary abstinence is by nature the long term goal for rehabilitation, which can hardly be accomplished overnight. Meanwhile the harmful effects and risk behaviour associated with drug taking if unchecked, often result in fatality or irreversible disability nullifying the rehabilitation process. However, they can be minimised or changed much more expeditiously according to our experience in Hong Kong and elsewhere.<sup>10</sup>

Uncoordinated policies may lead to a clash between the goals of different agencies involved in combating drug abuse. Drug use is both a health and a legal problem. Accordingly, governments must strike a balance between the need to curb illicit drug use and the reality that drug use cannot be

stopped overnight (if at all), so it must be made safe. If not, more and more people will become infected by HIV while governments grapple with ways to deal with the problems of illicit drug use.

### Local government, government and non-government agencies working together

Local government can be especially important in dealing with drug use and HIV risk: needle sharing and other unsafe drug taking practices often occur in the streets, lanes, shooting galleries and other settings in the local community.

Non-government and community based organisations have often been at the forefront of responses to HIV among drug injectors. Non-government organisations can position themselves between the government and the community and provide a means of communication and access. They can also allow a government to support a program but still keep its distance.

The threat of HIV/AIDS among IDUs is seeing some governments and policy makers in Asia treat drug use as a public health problem rather than just a legal one.



### Where do you begin with governments ?

- identify allies and enemies
- identify the key office holders, e.g. narcotics, police, health
- identify levels of government, e.g. federal, state, local
- promote your program as part of the health policy
- at first, informal approaches often work better than formal approaches
- use any personal contacts you have within the government
- approach public servants who may not be as reluctant to deal with sensitive issues as politicians, and can be a way into government
- direct support can take a long time: indirect support can happen quite quickly

### How do you convince governments to support your program?

- invite politicians to inaugurate programs
- educate politicians and involve them on program committees
- use video films as advocacy tools
- provide opportunities for politicians to be acknowledged, e.g. press coverage to enhance their public profile
- give politicians credit as instigators of the program, when acceptable
- make contacts with the media to promote your work and make it easier for the politicians to support you
- keep government officials up-to-date with the results of your program, pilot program results often have greater effect than talking
- organise study tours for senior leaders of government, have experts do the training
- avoid conflict: persuade – don't bully

Summary

- make sure you understand *how* government works, e.g. levels of power, bureaucracy
- use the examples of successful harm reduction programs in other countries to show that they can work

You can learn a great deal by asking other NGOs how they got support and cooperation from various sectors of the community. The questions may include:

- How did you establish relationships with various groups: police, government, community and religious groups?
- How successful were your approaches?
- What problems did you encounter (with setting up a NSP, substitution, etc.)?
- How did you overcome these problems?
- Have these groups' attitudes changed since you began the program?
- How and why have they changed?
- What are the most important areas to focus on when establishing relationships with these groups?
- How can you encourage community involvement and ownership of the program and activities?



Working with the Community

Community ownership and participation are essential in developing successful responses to HIV/AIDS and targeting programs for IDUs. Effective responses to HIV among IDUs arise when the issue is recognised as everyone's problem. Unfortunately, community concern often only arises when the problem becomes national and affects all sectors of the community.

Various approaches where the community takes responsibility for its problems may include:

- community forums and consultations
- trialling non-government and community based responses (government approved)
- seeking funds to support local programs

The attitude that the wider community can remain immune from the HIV/AIDS epidemic has proven to be false. Many Asian countries have experienced IDUs as a key vector for the spread of HIV; these have been successfully targeted to prevent further HIV/AIDS. Although often marginalised by the community, it is *vital* that agencies and programs incorporate the experiences and expertise of IDUs in order to develop effective responses to HIV and drug injecting.

Addressing community concerns and their needs require consultation with various groups ranging from current IDUs and youth in general to police authorities and government officials. There are various ways to implement community consultation by formal or informal meetings but what is *crucial* is getting out and talking to people to find out what they think, feel and need.

Chapter Three  
*Working together*

The Centre for Harm Reduction

Summary

*Manual for  
reducing drug  
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## Religious Groups

Consultation with religious groups is important as their leaders are often influential in shaping attitudes and responses among the community towards HIV and drug use. Religious groups can play a positive role (i.e. care and counselling for those affected by HIV/AIDS and illicit drugs) or a negative role (i.e. moralising judgments about the “badness” of such actions and their implications).

To work effectively with religious groups and beliefs strategies may include:

- educating religious leaders about HIV/AIDS and drug use
- coordinating with religious-based aid and welfare organisations
- meetings with religious and other community leaders

## Police and Law Enforcement

Police and law enforcement officials are central players in any response to illicit drugs. Major international efforts have attempted to reduce supply and consumption of illicit drugs but their availability continues to rise. Through ongoing consultation, police and law enforcement forces can become important allies responding to both HIV and harm reduction issues. In Asia, gaining the support of senior police officials is essential for harm reduction programs but local street level police support is also important in order the programs may function freely. Various approaches have, and can be, implemented to gain their support.

## Prisons

Prison poses major health risks for drug dependent drug users due to:

- the unavailability of health services
- the high prevalence of unsafe drug injecting practices by inmates
- unavailability of clean needles and syringes, condoms and other barriers to harm

As drugs, needles and syringes are certain to be smuggled into prisons, strategies will be required to establish harm reduction programs. Successful programs depend on approval by authorities.

Possible strategies include pilot needle and programs that may evolve into permanent comprehensive programs, to the provision of condoms for inmates acknowledging that sex within prisons exists.

Establishing programs within prisons requires various tasks such as:

- identifying and gaining access to prison support groups and networks, health workers, teachers, etc.
- using prison peer educators who have good rapport with other prisoners
- communication with prison officers about risks of HIV/AIDS
- incorporating HIV messages with other health messages

## Governments and Policy

Illicit drug use is a very difficult issue for governments to deal with. While injecting drugs and HIV is clearly a public health issue, police authorities often associate and link illicit drugs with crime. Additionally, border control authorities are focused on suppressing the supply of drugs while the 'War on Drugs' is often promoted as the ultimate politically and socially acceptable solution. This situation has raised many difficulties for international governments and agencies in the effort to effectively tackle the problem of illicit drug use.

Government responses have included:

- **prohibition** (very often ineffective as demand and consumption of illicit drugs increase)
- **supply reduction** (a very costly exercise while illicit drug sales generate huge profits and demand for drugs remains great; the results are major difficulties in substantially reducing supply over a lengthy period of time)
- **demand reduction** (various strategies including youth education to discourage IDU, drug substitution programs and promoting incentives and alternatives to drug use in community)
- **harm reduction** (pragmatic approach to decrease the adverse consequences of drug use without necessarily (though still desirable) requiring a reduction in drug consumption)

Governments must strike a balance between the need to curb illicit drug use and the reality that drug use must be made safe. The major threat of HIV/AIDS among IDUs has seen some government and policy makers in Asia view the problem not only as a legal one but as a public health concern. Within this context various successful strategies have been and can be implemented to convince governments of the merit of harm reduction programs.

Chapter  
Three  
*Working  
together*

### Section Two, Chapter Three: Working Together

For further information refer to **WHO resources: Advocacy Guide & Evidence for Action Papers. Refer to the following website: [www.who.int/hiv](http://www.who.int/hiv) (publications expected online from May 2003)**

The Centre  
for Harm  
Reduction

CENTRE FOR HARM REDUCTION  
.....

▼▲ **Community**

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**Effective responses to HIV among IDUs arise when the issue is recognised as everyone's problem not as someone else's problem**

Community Responsibility & Approaches

- Community forums & consultations
- Trial non-government & community based responses
- Seek funds for activities

The wider community does not remain immune from the HIV/AIDS epidemic

*Manual for reducing drug related harm in Asia*  
SECTION 2 • CHAPTER 3 • OVERHEAD 1

CENTRE FOR HARM REDUCTION  
.....

▼▲ **Community Consultation Groups**

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- Current IDUs
  
- Youth in general
  
- Police Authorities
  
- Government Officials

*Manual for reducing drug related harm in Asia*  
SECTION 2 • CHAPTER 3 • OVERHEAD 2

CENTRE FOR HARM REDUCTION  
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▼▲ **Religious Groups**

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**Religious leaders can often have influence in shaping attitudes and responses among the community towards HIV and drug use**

Effective measures with religious groups

- ▶ Education on HIV/AIDS
- ▶ Coordination with religious-based aid and welfare groups
- ▶ Meet religious and community leaders

*Manual for reducing drug related harm in Asia*  
SECTION 2 • CHAPTER 3 • OVERHEAD 3

CENTRE FOR HARM REDUCTION  
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▼▲ **Police/Law Enforcement**

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**Police are important allies, ranging from the senior to local street level in enabling harm reduction programs to function freely.**



*Manual for reducing drug related harm in Asia*  
SECTION 2 • CHAPTER 3 • OVERHEAD 4

**CENTRE FOR HARM REDUCTION**  
.....

**▼▲ Prisons**

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**Major Health Risks**

- Poor or no health services
- Unsafe drug practices
- No needles, syringes or condoms

**Programs within Prisons**

- Prison support groups/networks, health workers etc
- Prison peer educators
- Information for prison officers about HIV/AIDS
- HIV message included with other health messages

*Manual for reducing drug related harm in Asia*  
**SECTION 2 • CHAPTER 3 • OVERHEAD 5**

CENTRE FOR HARM REDUCTION  
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▼▲ **Governments and Policy**

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**Governments and agencies have great difficulties in tackling illicit drug use.**

**Conflicts of approach arise, for example law enforcement versus public health issues.**

**Police often link illicit drugs with crime.**

Government Responses

- Prohibition
- Supply reduction
- Demand Reduction
- Harm Reduction

**Increasingly illicit drug use is viewed as both a legal and a public health problem allowing the benefit of harm reduction to be shown**

*Manual for reducing drug related harm in Asia*

SECTION 2 • CHAPTER 3 • OVERHEAD 6

## **Section Two**

### *Chapter Four*

## **Education**

**Educating drug users**

**Types of education**

**Educating police and policy makers**

**Educating youth**



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## Introduction

Education is a powerful tool in the fight against HIV/AIDS. People cannot even begin to change behaviours which put them at risk if:

- they don't know *which behaviours* are putting them at risk
- or, if they do know what is risky, they don't know *the ways to minimise the risk* (e.g. using condoms, not sharing needles and syringes, cleaning equipment with disinfectant).

This chapter examines the ways that education can be used in programs aimed at reducing the harm to drug users in Asia and will look specifically at:

- 1 Educating drug users
- 2 Types of education
- 3 Educating police and policy makers
- 4 Educating youth

## I. Educating Drug Users

What is the role of education for drug users?

What is effective in an HIV prevention program among IDUs?

What are some of the principles of work with drug users?

What options are available?

### What is the role of education for drug users?

Three elements are needed for successful HIV prevention programs among any group or population:

- information/education
- health and social services
- a supportive societal environment<sup>1</sup>

The education of drug users generally means attempting to persuade drug injectors to change their behaviour or to practise safer injecting behaviour. The behaviour change(s) sought by these interventions aim to prevent the transmission of HIV which can occur through sharing needles and syringes, and other injecting equipment, or through sexual transmission.

The behaviour changes sought generally range from:

- stopping injecting to using a full new set of injection equipment for every injection to
- cleaning needles and syringes before re-using them
- and being monogamous and/or using condoms for penetrative sex

Apart from this type of approach, there are other education methods where drug users work with other drug users to determine their education needs and to meet those needs: researching, interpreting and weighing up scientific and other data to make decisions.

### What is effective in an HIV prevention program among IDUs?

- having a non-judgmental perspective and accepting that there are many different types of people who inject drugs
- providing information/education about HIV transmission and how to prevent transmission, based on an understanding of risk behaviours
- enhancing injectors' ability to care for themselves
- targeting everyday injecting behaviour
- providing a variety of means to prevent transmission (e.g. needles and syringes, bleach) or links information messages with the means of prevention and other health and social services
- is carried out in a supportive peer environment<sup>2</sup>

### What are some of the principles of working with drug users?

- emphasis on short-term pragmatic goals (e.g. preventing HIV transmission in a specific circumstance) over long-term idealistic goals (e.g. stopping drug use)
- establishment of a scale of behaviours to assist people in achieving specific goals
- use of multiple strategies to achieve goals
- involvement of people with experience of drug injection in the planning, design, production and implementation of all programs through recruitment of current (or ex) drug users to paid and voluntary employment, and advisory, project and steering committees

### What options are available?

- Stop using drugs: if you do not use injectable drugs you cannot catch infectious diseases through sharing injecting equipment
- If you can't stop using drugs, use them in any way except injecting: if you do not inject drugs, you cannot catch infectious diseases through sharing injection equipment

- If you inject, do not share needles, cookers/spoons or filters with other drug users, use new injecting equipment every time: if you use new injection equipment every time, you cannot catch viral infections such as HIV
- If you need to re-use any equipment, use your own injecting equipment every time: if you re-use your own injection equipment every time, you cannot catch viral infections such as HIV (unless someone else has used your equipment without your knowledge)
- If you need to re-use any equipment and you believe you need to use someone else's equipment (needle or equipment sharing), clean needles and syringes by an approved method: cleaning reduces the risk, but there is some risk of HIV transmission after needle cleaning, and there is certainly a risk of hepatitis C transmission

Programs which aim to reduce harm to drug users attempt to assist drug users to move from the more risky activities to the less risky activities.

#### What sort of education can be useful?

Injecting drug users are marginalised in most societies, and drug injecting or the use of injectable drugs is illegal in almost all of the countries where they are practised. IDUs are often referred to as a *hidden population* and are difficult to reach. There is good reason for this: most IDUs' experiences of the authorities have involved discrimination and often imprisonment. This means it is not easy to reach IDUs with health education messages and specifically with HIV prevention education.

A range of sources of education is useful as they can reinforce each other's messages. A large number of **settings** and **sources** for HIV prevention education aimed at injecting drug users can be found.

These include:

- Mass media campaigns by governments
- Targeted campaigns by governments
- Educational/information materials from treatment agencies
- Educational/information materials developed and produced by drug users themselves (often through IDU groups)
- Pre and post HIV antibody test counselling
- Group education at IDU group offices and treatment centres
- One-to-one education sessions by drugs counsellors, GPs, needle and syringe program workers, and other health care workers
- One-to-one education by drug users trained by needle and syringe program workers, drugs treatment centres and IDU groups
- Peer education with drug users by drug users with no connection to formal organisations
- One-to-one and group education by researchers

#### What sort of behaviour change needs to happen for programs to be successful?

Three levels of behaviour change need to be tackled for effective HIV prevention among injecting drug users.

1. **Information and education:** on the individual level each drug user needs information and education about:
  - HIV and AIDS
  - HIV transmission through sharing injecting equipment
  - HIV transmission through unprotected sex
  - The ways to prevent transmission

Most effective education programs are linked to ways of providing the *means* to prevent infection: this will normally include condoms and some form of assistance in acquiring new injecting equipment and/or cleaning injecting equipment.

**2. Communication and negotiation skills:**

On a wider level communication between one drug user and another (or others) needs to be developed. The focus is on negotiating skills, both for negotiating safer sex and safer injecting. For example, if one drug user wants to use new equipment to remain free of infection but his/her friend does not have new equipment, the user needs to be able to deal with the situation. One strategy might be to provide training in cleaning needles and syringes and to encourage users to have appropriate materials (e.g. bleach) at hand.

**3. Social and community network:**

The social network or community (e.g. groups of friends or acquaintances) with whom drug users buy, consume and, perhaps, sell drugs needs to be approached. Drug injecting social networks are largely based on the shared knowledge and practices of injecting drugs, rather than on any wider sense of being part of the same community.<sup>3</sup> At this level, the focus is on changing or maintaining social norms of behaviour. For example, if most drug users in a given social network share their needles and syringes, it will be much harder for an individual user to maintain safer behaviour. In this situation, an intervention may attempt to change the “norm” of needle sharing so that it becomes normal for members of this social network to use new injecting equipment every time they inject.

**Types of Education**

Education efforts among drug users can be classified as:

- one-to-one education
- face-to-face group education
- targeted education
- mass media campaigns

**What is one-to-one education?**

One to one education can take place in a range of settings. In outreach work, this type of education usually involves:

- Making contact with a drug user
- Creating rapport (establishing trust)
- Engaging the drug user in conversation
- Providing HIV prevention education

One to one education will not work if the outreach worker is the one doing all the talking. An outreach worker should begin by finding out the drug user’s perspective rather than imposing his/her own.

- Find out what their concerns and needs are (e.g. some medical assistance for injecting related wounds or TB)
- Earn and gain their acceptance and trust (put yourself in their shoes: why should they trust you?)
- Be reliable – do what you say you will do
- Offer to help them move towards safer injecting or offer to help them maintain safer injecting practices. This may include:
  - distributing needles and syringes and other injecting equipment
  - distributing bleach or other disinfectants
  - conducting cleaning demonstrations
  - conducting safer injecting demonstrations



## HARM REDUCTION NEWS



### HOLISTIC AND HUMANE

KUALA LUMPUR, MALAYSIA

We didn't have an office in Chowkit, so we would park the car there and go to the streets and give the IDUs bleach and teach them how to clean their needles. Twice with water, twice with bleach, twice with water again. But then we realised this wasn't going to work: he has maggots crawling out of his legs, he is going to die, HIV is so invisible, how could he pay any notice to HIV, he needs something more concrete in front of his eyes.

So what we did, during our outreach, was incorporate iodine and gauze so that we could do medical treat-

ment on the street. We also brought biscuits etc. to give to people on the streets. What is important is to keep going back and keep up a

“  
...he has maggots  
crawling out of his  
legs, he is going to die  
... how could he pay  
any notice to HIV...  
”

constant rapport with people. One of the major things we had was every Monday, Wednesday and Friday we'd go out and whatever happens you go that day because

people are expecting you.

Eventually, we set up a base in a small office...people then had a place to rest that was safe. Then you could talk about HIV and AIDS and tell them what it is, how it affects their lives and how important it is to take it into consideration.

So really what we did was go down to the street and see what people needed. From that time onwards it has just been a process of finding out their needs and responding to them immediately. All this is done in a non-judgmental manner – that is the main thing.”<sup>4</sup>

- assistance to gain access to detoxification and drug treatment programs
- assistance with housing, employment, medical treatment etc.

#### Outreach

In most countries, outreach is provided by non-government organisations and involves teams of ex-drug users, current users and/or non-users. Outreach education may change between workers: depending on the drug use status of the outreach worker. For example, a drug user employed as an outreach worker may be primarily working with his/her friends and their interaction will be very different to the situation of an ex-user who may see his/her primary role as ensuring that the drug user enters drug treatment.

There are benefits and disadvantages to

employing each type of outreach worker but the disadvantages seem to be lessened by employing mixed groups and providing appropriate training and supervision. Providing education to drug users, without necessarily trying to persuade them to go into treatment, can be an effective way to build up trust with drug users. However, in Asian countries, HIV prevention education may have to be linked to drug treatment, at least initially, for two reasons:

- this approach may be the only politically viable way of working with drug users
- drug treatment services are an established infrastructure which can begin this type of education work quickly and cheaply: a separate outreach program may take many months to establish and require a bigger budget to begin the work.

## Harm Reduction News

### One Big Family

CALCUTTA, INDIA

In Calcutta, the Indian Council of Medical Research has established a needle exchange and outreach education centre staffed by current injecting drug users. The outreach workers are based at a drop-in centre in the inner suburb/ward of Mehidibagan, and provide outreach to six other wards. Outreach takes place for about two hours each morning and evening, five days a week, with the rest

of the time spent at the drop-in centre. They provide education about how HIV, hepatitis B and C are spread and how abscesses can occur, together with preven-

**“We love the user because we think we are one big family.”**

tion information. Needles, syringes, condoms, bleach containers and cotton soaked in antiseptic are provided, and any minor

abscesses, cuts, wounds or infections are treated at the drop-in centre. Referrals are provided to detoxification centres, hospitals, sexually transmitted disease clinics and tuberculosis clinics.

In a group interview, the outreach workers said they were better able to understand drug users because of their own drug use: “If users have a trouble, we know it. Users are happy to talk to us. We love the user because we think we are one big family.”

#### Other settings

One-to-one education also occurs within institutional settings such as drug treatment centres, prisons, hospitals, etc. In these settings, one to one education is often carried out as part of a wider range of counselling activities. People working in these settings need to balance the need for education, which will assist a drug user to remain as healthy as possible, with the need to respect the operating philosophy of the institution.

For example: a psychiatrist in Calcutta was concerned about demonstrations of how to clean needles and syringes at his drug treatment centre. He thought the sight of these objects would act as “triggers” on the cravings of the recovering drug user. Where these problems occur, targeted education resources can be useful.

One-to-one education also occurs as part of pre and post test counselling for HIV or hepatitis antibody tests (see **Chapter Eight:**

**Counselling and Testing**). Education, in these situations, can be extremely effective in making the issues of HIV or hepatitis a reality for clients and in impressing upon them the need for safe behaviours.

## HARM REDUCTION NEWS



### STREET OUTREACH HAS MESSAGE OF MERIT

KUALA LUMPUR, MALAYSIA

Penghasi Bakti Kasih (PBK) was established in 1995 to provide education and support to drug users in the Chow Kit area of Kuala Lumpur, Malaysia. The project was established by Persatuan Pengasih Malaysia, a therapeutic community which provides long-term residential rehabilitation for drug users, based on the principles of Islam and Narcotics Anonymous. Street outreach has formed only a small part of PBK's activities.

For the last two years outreach has been provided to about 650 current drug users and people at risk on the streets and in the shopping malls. The main reason for this low number is that street

outreach is restricted to 1-2 hours per week, usually on a Saturday or a Wednesday night. Young people at risk of HIV, drug users and sex workers are the main targets of street outreach. The main purpose of the outreach is to encourage drug users to visit PBK's drop-in centre and consider stopping drug use. The secondary purpose is to provide education on

“  
If they have wounds,  
we can often do  
nursing on the spot.”

HIV/AIDS transmission and prevention.

One staff member said “When we do street outreach

to shooting galleries, we have to look at the situation. We have information cards we can give. If they're still high, they can't be talked to, we just say you're always welcome, though we ask them to eventually get detoxified. If we can talk to them, we tell them how to clean needles, use condoms with your wife, if you want to have a (HIV) test we can help you with counselling. If they have wounds, we can often do nursing on the spot. We sometimes go out and leave bottles of bleach and instructions for cleaning. We have a lot of trouble with this, because carrying kits and helping others clean can trigger problems for volunteers. Volunteers are well trained but it's hard.”

#### What is group education?

Group education can also be provided in a range of settings. Group education relies on the notion that drug users form social networks which can have a positive effect on their capacity to maintain safer behaviours.<sup>5</sup> Targeting social networks of IDUs has become increasingly popular in recent years, especially when it is coupled with peer education.<sup>6</sup>

Peer education means people within a subculture or community, such as drug users, devise education strategies for their peers which they believe will be appropriate and then deliver these messages. The aim is to

provide support and information and encourage safer behaviours.

Peer education/support programs may be:

- set up and run by the target group, e.g. a drug user group or
- based within a professional organisation, e.g. a health service or drug aid organisation.<sup>7</sup>

In reality most peer projects lie somewhere between the two: a peer support group supported by an organisation or an organisation relying on the expertise of drug users.

## Harm Reduction News

### Peer Educators Embrace Empathy

HO CHI MINH CITY, VIETNAM

Firstly, we all go to the ward's authority and ask for the list of people regarded as having social evils. Then we go to the people's houses. Through the conversations we know or sometimes they tell us that they are HIV positive. It depends on the people's attitude and behaviour whether or not we tell them we are HIV positive.

Usually everything goes really well. We get to understand each other quickly. This is an advantage of us having once been drug addicts. I think peer education is the quickest and most

**"...peer education is the quickest and most effective way of communication and education."**

effective way of communication and education. We just console, encourage and advise people with all our heart, we really have no power to control or suppress them. If they want to quit drugs we help them with the formalities."

*Mr. T. is a member of the 'Friends Helping Friends' community support group in Ho Chi Minh City, Vietnam.*

Peer education has been used throughout the communities and networks affected by HIV and AIDS in many countries as an effective way to promote behaviour change for:

- HIV prevention, particularly for young people
- for programs about sex
- covert or illegal issues such as drug use
- for socially marginalised behaviours.<sup>8</sup>

In a formal peer education workshop, drug users learn some basic information about HIV including transmission and prevention. In some cases, participants of these groups are also given training in *how* to pass this information on to other people.

#### Drug user groups

Drug user groups use a different form of group education. Injecting drug user groups often speak of peer education not as "teaching" by a "good user" to change the behaviour of another drug user. Rather, they talk of drug users *sharing* information on how to inject as safely as possible, given their

current circumstances. In this approach, drug users create a safe using language and invent safer ways to inject. This leads to a supportive peer environment in their friendship networks, and allows the development of materials for "friendly, supportive" education rather than lecturing.



## HARM REDUCTION NEWS



### ‘SHOOTERS’ DISPLAY CARE FOR OTHERS

CEBU CITY, PHILIPPINES

In Barangay Kamagayan (Cebu, Philippines) the injecting drug users have organised themselves into an organisation called *Shooters* which stands for the Sterile Hypodermic Organised Outreach Team Educating and Reaching Out to Save Lives. *Shooters* is composed of 10 IDUs, one of whom is the owner of a shooting gallery.

*Shooters* was organised as a response to the community's health problems. The majority of the people in Kamagayan blamed the IDUs for an outbreak of malaria and hepatitis A and B in 1992. They believed it was because

of their unsafe injecting, and sexual practices among their partners who also worked as freelance sex workers.

Ligaya, a community health outreach worker (CHOW), who was once an IDU herself, initiated a

“  
...the members of  
**Shooters** gave the  
knowledge to new and  
uninformed IDUs.”  
”

meeting with 10 IDUs. The approach for such a meeting was to discuss relevant issues. During the meeting they discussed the possibility of having an epidemic of

STDs and HIV/AIDS and other blood borne diseases if they continued their unsafe practices. After a series of meetings where they were educated about safe injecting and sexual practices, the members of *Shooters* gave the knowledge to new and uninformed IDUs.

For the two years of its existence, *Shooters* has only had six active members who frequently meet in shooting galleries. They continue to educate IDUs about safe injecting practices. Some of the members of *Shooters* have been incarcerated, some have been rehabilitated and some have changed their lifestyles.<sup>9</sup>

Using the drug user group approach, effective peer education:

- supports the sharing of information within networks of users, thus respecting the knowledge, experience and skills drug users already have
- places less emphasis on *what* is the correct way to inject and more emphasis on *why* using sterile water (or any other strategy) may make injecting safer
- acknowledges that drug users are an extraordinarily diverse group requiring education in a range of formats and styles
- is based on an understanding of the cultural and situational aspects of injecting for each social or friendship network

- provides information in a way that enables users to pass the information on
- shares power between drug users, rather than a formal program which places peer educators in a position of authority and knowledge over other users
- is based on trust and respect<sup>10</sup>

#### Other types of group education

Apart from peer education, there is a range of other types of group education, with the information often provided by an authoritative figure such as a doctor, epidemiologist, drug treatment worker or NGO worker. These sessions tend to follow a similar pattern to the formal peer education sessions described above. But the control over the information, and the education drug users

## Harm Reduction News

### Self-esteem Boost for Ex-users

CHURACHANDPUR, INDIA

We had two drop-in centres and the outreach workers had to go in pairs firstly, because being an ex-user they'd see their old friends and all the familiar peddlers, so they'd be very tempted. Secondly, it was for

security reasons. For example, one might be tempted to take the drugs but because a friend is there they resist.

Getting ex-users involved

**“Getting ex-users involved in programs really helps...”**

in programs really helps: they are street wise, they know the ins and outs of the drug scene. They can really make an impact on someone thinking about giving up. They, too, feel that they have a job, are being accepted back into society and this helps their self-confidence.<sup>11</sup>

receive, rests with the person leading the workshop. Unless this person has a clear idea of the educational needs of the participants, this type of group education may be ineffective.

Group education also takes place in institutional settings, such as in drug treatment centres and jails, where HIV education is often raised as a topic for group discussion. But the institution's policies may not allow full and frank discussion of the various ways that HIV can be transmitted and steps that can be taken to reduce the risk of transmission.

In drug treatment agencies, participants are usually encouraged to believe that they will remain drug-free after they leave the program therefore removing the need to learn specific details about HIV prevention (such as needle and syringe cleaning techniques) while in treatment. Some treatment centres believe that the high rate of relapse after treatment (estimated to average 95 per cent worldwide) means that drug users in recovery need explicit information about safe injecting so that they know how to protect themselves and others if they return to injecting.

#### What is targeted education?

Targeted campaigns/programs which aim to reach a wider audience can:

- raise awareness about HIV/AIDS among IDUs
- provide information/education in a way that appeals to IDUs, in language and visual materials they understand and trust
- personalise HIV prevention for sub-populations of drug users

These programs can involve posters, videos, newsletters, keyrings, drug packaging, advertising on syringes and toilet doors, booklets, events, etc. or, can use more traditional channels of communication such as street theatre and musical groups.

When designing materials for targeted campaigns, consideration must be given to:

- cultural acceptability
- literacy levels (e.g. may need to use pictures rather than words)
- preferred way of receiving information
- available resources (e.g. printing materials, publishing)

The important features of targeted campaigns for IDUs are that:

## HARM REDUCTION NEWS



### REHABILITATION CENTRE PROVIDES HOPE

NEW DELHI, INDIA

Sahara House is a rehabilitation centre in New Delhi, India. It operates from a three storey house with about 12 rooms, housing about 100-150 clients per year. Sahara House takes in a wide range of people: people with low-level psychiatric problems, alcohol users, brown sugar smokers and heroin injectors. Some people have both psychiatric and drug use problems.

Residents are asked for a six-month commitment, and are usually requested to spend three months in a halfway house, as a transi-

tional phase, before returning to independent living. The schedule is similar to other rehabilitation programs, except that there are only two absolute rules:

“  
**Residents are asked  
for a six-month  
commitment...**

”  
everyone is woken at 5am and everyone must play football. Apart from that, there are devotions twice a day, and ‘input’ twice a day, which can be about anything residents would like to know,

including group dynamics, psychotherapy, group counselling or a talk from an ex-resident now working and living independently. HIV/AIDS prevention education is provided in these group sessions.

Residents are also informed about the other programs operating in Delhi so that, if they leave or if they are found using drugs on the premises and are asked to leave, they know about places where they can acquire needles and syringes, information, advice and substitution drugs.

- current drug users are involved in all aspects of the campaign
- campaigns use media, language and images closely associated with drug users
- they are explicit in their messages (to prevent misunderstanding and confusion): this is the main reason they cannot usually be part of a mass media campaign

Targeted campaigns, and outreach, in some countries are managed and operated by current and/or ex-drug users. As drug users learn more about HIV/AIDS, they begin to develop safer ways to use drugs. These messages about safer injecting are then spread through their drug using social networks.

Another popular form of targeted communication is a drug users’ newsletter or magazine. These have been produced by drug users in countries around the world. To date, the only Asian users’ newsletter has been *Beyond Appearances*, which was started in May 1997 by a group of users and ex-users in Delhi. In this publication, articles are provided on drug users’ rights under the Indian Constitution, safer injecting, HIV awareness, the role of drug user groups and experiences of harassment and drug treatment. *Beyond Appearances* was originally only printed in English but now is distributed to IDUs on the streets: the Hindi version is handwritten, xeroxed and then distributed. A support group of the same name has been established with 100 members who meet twice a month.

## Harm Reduction News

### Messages Target Injecting Drug Users

NEW DELHI, INDIA

SHARAN drop-in centre in Nizamuddin in New Delhi, India has several small posters on its walls providing specific instructions about safer injection. Messages include:

- Always use your own needle and syringe
- Rotate injecting sites regularly
- Clean injecting site with alcohol swab

- Ensure there are no bubbles in syringe
- Dispose of syringe in safe place

**“...the posters are carefully targeted...”**

These posters were designed in English on a computer, then printed on a colour printer. Hand-written Hindi versions accompany the English posters. These

posters could be very problematic (in terms of negative media coverage, political interference, etc.) if they were put up on every electricity pole in Delhi. Because the posters are carefully targeted – they are only on display in SHARAN offices and the drop-in centre – they are able to provide specific, explicit information to assist in reducing harm from drug use.

### HIV PREVENTION FOCUSED ON DRUG USERS

YANGON, MYANMAR

The Myanmar National AIDS program and the UNDCP estimate that the HIV prevalence rate among drug users in Kachin state is 93 per cent, and in the northern Shan state 82 per cent. A program to educate drug users in detoxification centres, and to train the centres’ health workers in HIV prevention, was devised to address this major problem. A training kit *Smarter than AIDS* was created which included an information manual written in the local language, a board to display plastic covered colour pic-

tures drawn by Myanmar artists and two wooden penis models to demonstrate correct condom use.

The medical staff from six detoxification centre were

**“...a campaign began ... using mobile teams who reached IDUs in tea shops and shooting galleries.”**

trained: the new skills enabled them to organise educational sessions for the IDUs. They deliver training sessions for approximately

2,500 IDUs each year. During the second phase of the project, peer education activities were initiated for the drug users who could then find other IDUs in the shooting galleries and provide information about HIV prevention. In early 1997, a campaign began to promote risk reducing behaviour among the IDUs by using mobile teams who reached IDUs in tea shops and shooting galleries. Educators from Christian organisations are specially trained to use the kit, demonstrate condom use and show IDUs how to prepare bleach to clean needles and syringes.<sup>12</sup>

## Harm Reduction News



### Realistic Strategies for HIV Prevention

YUNNAN PROVINCE, CHINA

Information from the Yunnan Centre for AIDS Research in China shows that of all the HIV positive persons monitored in Yunnan, about 70 per cent, are injecting drug users. It was decided that an education training course should be implemented for a group of drug users under treatment in a compulsory detoxification centre. There were thirty young trainees, both male and female, with a history of sex work among the women and most having experienced widespread sharing of injecting equipment. The training program focused on basic knowledge about AIDS/STDs and prevention, drug use and AIDS and demonstrations of various techniques (i.e. how to use condoms correctly and how to sterilise needles and syringes). The trainees under-

stood that the demonstration of the sterilisation of the needles and syringes was not meant as encouragement for continuing intravenous drug use but as a realistic consideration for when they were discharged from the detoxification centre.

Distrust and suspicion

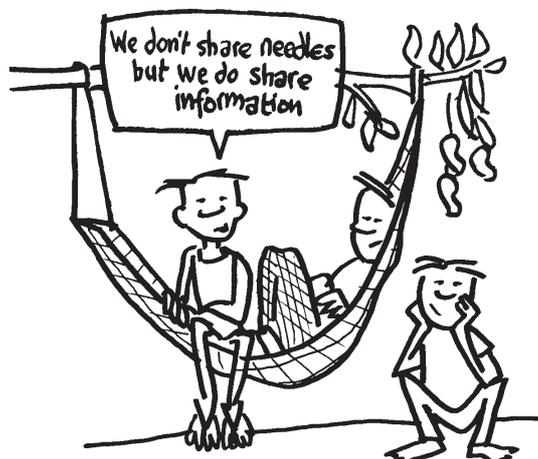
**“We did not know China had such people as you who would reach out to give us real help.”**

are common problems encountered when implementing training among drug users. To resolve this problem, it was important to make the training more interesting and lively. Games, role playing, group discussions and illustrative charts are powerful means of enhancing the trainees’ sense of involvement. In addition

to good trainers’ guiding skills, it was important to be flexible with the training method and make adjustments to the program as required. While the three day training did not provide sufficient time to fulfil all the practical needs of the trainees, what did emerge was newly developed skills of self protection and knowledge about STDs and AIDS prevention. Some trainees commented: “We did not know China had such people as you who would reach out to give us real help”. At the end of the session the trainees admitted that abstinence would not be easy, indicating that they may engage in sex work and drug use activities in the future. What has been learnt is that this training program may be a realistic strategy for HIV prevention among drug users.<sup>13</sup>

#### What is mass media education?

Mass media advertising campaigns are rarely useful in preventing HIV transmission among injecting drug users because, mostly, the campaigns do not provide explicit advice. However, the mass media can be useful in other ways. As the mass media is the main source of general information on HIV/AIDS for many drug users, it is important that appropriate messages be conveyed in these media. Mass media approval (or, more often, disapproval) of education programs can have



a very important impact on the program's effectiveness.

Various strategies can be used in dealing with the media when establishing education programs about HIV among IDUs:

- ask senior journalists and editors in a city or state to attend a meeting where the problems of rapid HIV transmission among drug users and the proposed education interventions are described and discussed
- select one or more journalists who seem 'friendly' to the idea of helping to reduce harm to drug users and work with them to provide news stories supporting programs
- ignore all media on the basis that they cannot be trusted to be supportive and to maintain a low profile for your program

## Educating the police and policy makers

### How do you successfully educate the police and policy makers?

It is important to remember that programs among drug users do not occur in isolation: they need the assistance of other individuals and organisations. The context in which programs are carried out includes:

- the laws, customs and traditions of a society (or subgroups within the society)
- the rules and philosophy of dominant religions
- the political climate and beliefs of those who hold key posts such as the Prime Minister and Minister for Health

Several different cultures (for example, ethnic groups), political beliefs (conservative and progressive), customs and so on can exist in a single city or local area at the same time. All of these need to be taken into account by people setting up or operating programs.

It is important to gain as much community support as possible to ensure a successful program. Education by liaison and consultation to help build this support can be done both formally and informally:

- a formal occasion might be a half-yearly or yearly report to the local council on the program's activities
- an informal consultation might be a private talk with key individuals to find out whether they would support a new initiative

In these consultations, it is useful to have some scientific papers or other reports that can assist in showing community leaders and policy makers that a program is needed and that it can work. These documents may come from the Rapid Situation Assessment (see **Chapter One: Rapid Situation Assessment**).

### What are some useful strategies for consultation?

#### Building coalitions

Find other individuals and organisations who are trying to carry out HIV prevention, and work with them for the changes that are needed. A project may have the support of a local charity group who have access to important people in the area. This can lead to meetings and discussions at a senior level.

#### Identifying common issues

When working with others, identify:

- the most important issues common to all of the groups in the coalition: this can assist groups to concentrate on those issues where they can work together
- the issues which are the most pressing and important to drug users and/or which will lessen the HIV risk among IDUs: seek assistance from other coalition members to achieve these goals.

In many situations, 10 or 20 different groups or individuals may be able to influence a decision. It is important to find out *who* has the power to assist or obstruct a program, and try to win their support.

### Why is it important to liaise with the police?

Police are probably the most important group to work with to ensure success for programs aimed at reducing harm to drug users. In some Asian countries, other law enforcement groups such as the military or para-military forces may also be important. The police will already know of the problem with drug users: they will probably have put many IDUs into prison and/or detoxification camps and seen that it does not work well. A program can position itself as finding and providing a ‘solution’ to the police’s problem.

Throughout the world, stories are told of the obstacles that police (often individuals rather than in a concerted action) have placed in the way of needle and syringe programs and other programs. It is vital to keep up liaison with the police and to ensure that they understand the role of the program and the reasons for its introduction.

Much care is needed in balancing a program’s relationship with the police to its relationship with drug users. Even a hint of collusion or collaboration with the police, circulating among clients, can cause a program enormous credibility problems. At the same time, the police may ask for details about drug use in the area (as part of their intelligence-gathering exercise). It is up to program managers to judge how close the relationship can and should be with the local police. For more information on working with police see **Chapter Three: Working Together**.

## Educating Youth

### What do countries concentrate on when an HIV epidemic begins?

At the beginning of an HIV epidemic among drug users, most countries concentrate on attempting to prevent people from **starting** to use illicit drugs or, if they have started, persuading them to **stop**. This may be done through:

- mass media campaigns warning of the dangers of drug use (including HIV/AIDS)
- youth and school activities to prevent drug use
- programs to sign young people to a contract in which they vow never to use illicit drugs

### Why don’t these programs work?

Unfortunately, these programs, have not by themselves prevented a single HIV epidemic among drug users anywhere in the world. The reasons for this failure are:

- at the beginning of an epidemic, HIV tends to affect injecting drug users who have usually been injecting for several years and who are not at school or in youth settings and who therefore ignore or do not receive the messages
- IDUs have been told by virtually everyone (family, police, courts, doctors, nurses) for many years that they must give up using drugs. But they continue to take drugs in the face of significant health dangers, arrest, prison, etc. A mass media campaign is not sufficient to change their behaviour (and may be counter-productive if IDUs believe HIV is just another tool used by governments to demand they stop using drugs)
- there are very good reasons to inject drugs, especially for regular users, including economic reasons: these cannot be dealt with simply by talking about the dangers of AIDS or other risks from drug use

## HARM REDUCTION NEWS



### HARSH PENALTIES FOR CARRYING SYRINGES

YANGON, MYANMAR

The time was not right, in 1997, to establish a needle and syringe exchange program in Myanmar. Success depends heavily on an agreement with the police that they will not arrest drug users carrying syringes (currently a person, particularly a young person, found in possession of a syringe and/or needle is liable to be arrested and charged), those visiting shooting galleries and those

reached by mobile health educating teams. The law against the non-medical possession of syringes needs to

“  
**The law against the non-medical possession of syringes needs to be changed...**

”  
be changed to allow personal possession of syringes and to regularise their availability.

Police and law enforcement systems need to be discouraged from confiscating syringes, warned of the danger to themselves when handling them and persuaded that they are not essential in the prosecution of offenders. Only when these issues are resolved can more effective HIV prevention and risk education programs for injecting drug users be implemented at the grassroots level by more non-government organisations (NGOs).<sup>14</sup>

### POLICE HARASSMENT FADES

KATHMANDU, NEPAL

Initially, we didn't have trouble with the police. There was a place, a temple where a lot of drug users were hanging out and we'd be meeting early in the morning. It was right next to the Army barracks and the army people would come and pay homage and people were curious to see what we were doing there and whether it was legal.

Another area where it became an issue was in Thamel, a tourist area where there were a lot of police around, and in Durbar Square where the police headquarters for Kathmandu are.

One time I was with Aaron (the co-founder of LALS) and the police had come to pick him up: they'd noticed something was happening and wanted to take him to the police station. I happened to be there too so I

“  
**We never had to bail anyone out of prison.**

”  
asked: 'Is there a problem?' I explained what we were doing and it was okay. I never got picked up by the police but Aaron did, probably because he was a foreigner. Aaron had spoken to the

Chief of Narcotics and they knew what he was doing. Because I spoke Nepali it was easier for me.

At some stage the Chief of Narcotics communicated with the police, so after a while we weren't personally harassed. Every now and then, when the CHOWS (Community Health Outreach Workers) were out, the police would approach them but it would be okay because the organisation was registered as an NGO. 'If you have any questions, call the office' was usually what we said. We never had to bail anyone out of prison.<sup>15</sup>

- drug users do not believe governments and people in authority, they rely on their friends and other drug users for accurate information. If they see that their friends have HIV and are not sick, they think HIV is not a problem and that the government is trying to trick them.

Drug prevention programs are largely symbolic in nature. They allow parents, policy makers, politicians and others to say they are doing something about drugs without addressing the root causes of drug use, which are often boredom, alienation, unemployment, poverty, rapid social and economic changes and so on.

In a comprehensive study of US school drug education programs in 1988, in which 350 different programs were reviewed, only three reported reductions in alcohol, tobacco or drug use. One of the most popular programs, DARE, in which 20,000 police officers delivered drug education to 25 million school students, has shown no long term effects.

While drugs prevention education programs have their place in a holistic approach to managing drug use and HIV prevention, emphasis needs to be placed on those programs which will:

- assist young people to protect themselves from HIV infection
- involve credible outreach and targeted communications

## Summary

### Educating Drug Users

**A principal educational approach for drug users is to encourage a change in their behaviour, to practise safer injecting behaviour.**

Various behavioural changes range from:

- no longer injecting
- using a new set of injecting equipment for every injection
- cleaning needles and syringes before re-using them
- ‘faithful to one partner’ and/or using condoms for penetrative sex

Effective HIV prevention programs among IDUs include:

- a non-judgmental perspective
- information/education about HIV transmission
- encourage responsibility and self care
- provide the means to prevent transmission
- encourage a supportive peer environment

### Principles of Educating Hidden Populations

- Short-term pragmatic goals over long term idealistic goals
- Scale of behaviours assist in achieving specific goals
- Multiple strategies to achieve goals
- Involve those with experience of drug injecting (current or ex-drug users) throughout all stages of the program

Programs aimed at reducing harm attempt to assist drug users to move from more risky activities to less risky activities

Dissemination of health education messages for IDUs, with specific focus on HIV prevention, can be achieved through various settings and sources. Targeted campaigns by governments, provision of education/information materials from treatment agencies and the use of peer educators are just some of the ways to educate this often *hidden population*.

## Types of Education

### One to one

- Trust
- Conversations
- Preventive education

### Group Education

- Peer education
- Workshops
- Transfer of knowledge
- Sharing of information
- Authoritative figures e.g. doctor
- Institutional settings e.g. jail

### Targeted education

- Clear and simple information/education
- Posters, booklets, newsletters etc
- Issues of cultural acceptability, literacy levels, etc
- Explicit information
- Involvement of current drug users throughout *all* stages of the program

### Mass Media

- Non explicitness = confusion = ineffectiveness
- Mass media can help spread effective information
- Can assist in the implementation of various strategies
- Can create supportive public environment

## Educating policy makers and police

### Policy makers

- Local community support essential
- Liaisons and consultation, both formal and informal
- Strategies for building coalitions
- Identification of common issues
- Locating those with major influence and establishing support networks

### Police

- Good rapport *essential*
- Maintain balanced credibility
- Depth of relationship with police must be done with discernment

## Educating the youth

- Simply “say ‘NO’ to drugs” = failure
- Drug prevention programs largely symbolic
- Widespread aversion to examine the root of drug taking problem
- Holistic education drug programs have validity
- Emphasis must be on
  1. Protection against HIV infection
  2. Credible outreach with targeted communication

## Basic Education Principles for Programs

- broad categorisation of drugs including alcohol, nicotine and illicit drugs
- total abstinence from all drugs for most people is unrealistic
- major determinant of the difference between use and abuse is *context*

### Section Two, Chapter Four: Education

For further information refer to WHO resources: Policy and Programming Guide for HIV Prevention Among Injecting Drug Users, Training Guides (Outreach), Advocacy Guide & Evidence for Action Papers. Refer to the following website: [www.who.int/hiv](http://www.who.int/hiv) (publications expected online from May 2003)

CENTRE FOR HARM REDUCTION  
.....

▼▲ **Drug users need to be encouraged to change behaviour or practise safe injecting**

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**Behavioural changes**

- Quit injecting
  
- Use clean injecting equipment for each injection
  
- Clean injecting equipment before re-use
  
- Being faithful to one partner and/ or use condoms

*Manual for reducing drug related harm in Asia*  
SECTION 2 • CHAPTER 4 • OVERHEAD 1

CENTRE FOR HARM REDUCTION  
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▼▲ **Effective HIV programs for IDUs**

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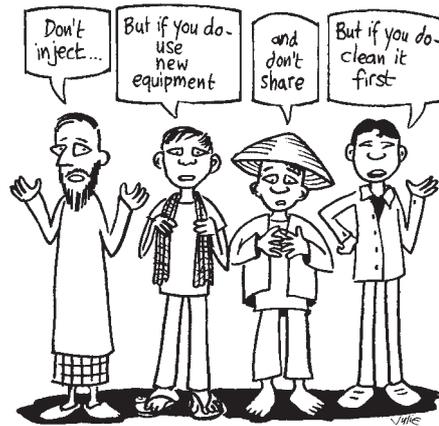
- Perspective aimed at reducing harm
  
- Information/Education
  
- Encourage responsibility and self care
  
- Means to prevent transmission
  
- Supportive peer environment

*Manual for reducing drug related harm in Asia*  
SECTION 2 • CHAPTER 4 • OVERHEAD 2

CENTRE FOR HARM REDUCTION

▼▲ Principles of programs reducing harm among drug users

- Short term pragmatic goals
- Scale of behaviours
- Multiple Strategies
- Current or ex-drug users involved at all stages of program

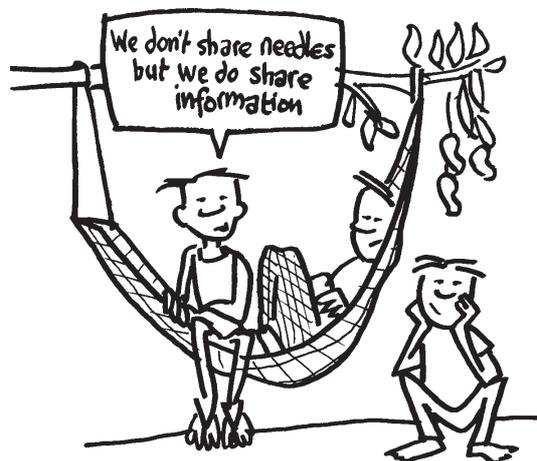


*Manual for reducing drug related harm in Asia*  
SECTION 2 • CHAPTER 4 • OVERHEAD 3

CENTRE FOR HARM REDUCTION

▼▲ Types of Education

- One to one
- Group education
- Targeted education
- Mass media



*Manual for reducing drug related harm in Asia*  
SECTION 2 • CHAPTER 4 • OVERHEAD 4

**CENTRE FOR HARM REDUCTION**  
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**▼▲ Educating Policy Makers & Police**

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- Local community support essential
- Liaisons/consultation both formal and informal
- Strategic coalitions
- Common issues identified
- Establish network with the influential
- Good rapport and balanced credibility with police
- Relationship with police is discerning

*Manual for reducing drug related harm in Asia*  
**SECTION 2 • CHAPTER 4 • OVERHEAD 5**

**CENTRE FOR HARM REDUCTION**  
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**▼▲ Educating Youth**

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- ▶ Accept youth realities
- ▶ Symbolism of drug prevention programs
- ▶ Aversion to the root of drug taking
- ▶ Holistic drug education have validity
- ▶ Emphasis on HIV protection & credible outreach with targeted communication

**Basic Education Principles for Programs**

- ▶ Broad categorisation of drugs
- ▶ Total abstinence is unrealistic
- ▶ Difference between use & abuse is context

*Manual for reducing drug related harm in Asia*

**SECTION 2 • CHAPTER 4 • OVERHEAD 6**

## **Section Two**

### *Chapter Five*

## **Injecting Safely**

**Sharing of injecting equipment**

**Increasing IDUs awareness of HIV**

**The supply of sterile equipment**

**The disinfection of used equipment**

**The disposal of unsterile equipment**

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## Introduction

The objectives for establishing programs dealing specifically with injecting drug use are:

- to reduce the spread of HIV among IDUs
- to reduce the spread of HIV among non-IDUs
- to reduce the spread of HIV through sexual transmission
- to reduce the spread of blood borne viruses
- to reduce other harms connected with drug use (overdoses, abscesses etc.)

This chapter explores issues related to injecting drug use including discussion of:

- 1 Sharing of injecting equipment
- 2 Increasing IDUs' awareness of HIV
- 3 The supply of sterile equipment
- 4 Safer injecting
- 5 The disinfection of used equipment
- 6 The disposal of unsterile equipment

## I. Sharing of Injecting Equipment

What are blood borne viruses?

Why does sharing happen?

What are other reasons for sharing?

What are the ways that sharing occurs?

How can the sharing of equipment be prevented?

### What are blood borne viruses?

The sharing of drug injecting equipment provides many opportunities for blood to be passed from one person to another. If a person is infected with HIV and/or hepatitis B and C, he/she can transmit these viruses to anyone they share injecting equipment with. Small amounts of blood, which are not necessarily visible, can remain in needles and syringes after they have been used. This is also true of spoons, filters, water, glasses, skin, tourniquets, surfaces and other equipment used for injecting. If the equipment is re-used, this blood will be directly injected into the next person. If the blood is infected with HIV then HIV can be passed on to that person.

### Why does sharing happen?

There is no simple reason why people share their injecting equipment. It may happen because there is a lack of injecting equipment available or because it is a cultural or socially popular practice. Other reasons may include:

- a lack of awareness of the risks involved in sharing equipment
- intoxication during the injecting procedure
- because the person is suffering from withdrawal symptoms
- or it may be that sharing is seen as an extension of a sexual relationship or friendship

### The lack of clean injecting equipment

In many countries needles and syringes cannot be bought from shops or pharmacies. In other countries, you may be able to buy them, but the cost is prohibitive or users may be denied access to them. Even where needles and syringes are available many drug users are reluctant to carry them for fear they will be identified as a drug user and face possible arrest and discrimination. These situations make it more likely that people will share injecting equipment.

### The lack of knowledge about the risks of HIV transmission

One reason people continue to share injecting equipment is that they are unaware of the risks surrounding such behaviour. Misconceptions persist, and while some people may be aware of the risk of sexual transmission, they may not know about the risks associated with sharing injecting equipment. This lack of knowledge may include or lead to:

- unintentional indirect sharing of pots, spoons, water
- poor understanding of general health principles
- unsafe injecting behaviour learnt in their initiation to drug use
- inability to inject oneself leading to reliance on other people to administer injections
- misconceptions about the nature of viruses and how they are transmitted

### What are the other reasons for sharing?

- sharing drugs is commonplace and injecting equipment may be the only accurate way to divide up the drugs
- equipment may be deliberately re-used to extract drug residue (for some people this may be their only way of obtaining drugs)

- only part of the message has been absorbed (i.e. people may carefully avoid sharing needles but continue to share syringes)
- lack of perceived risk (i.e. none of my friends have HIV)
- being put in prison when drug dependent

Situation and circumstantial contexts play important roles in the sharing process. Perhaps the most important route into sharing is through initiation. Unlike other routes of administration of illegal drugs (smoking, inhaling or snorting), injecting of drugs not only requires specific technology and equipment but also requires a level of expertise. Often an individual's first experience of injecting will also be their first experience of sharing. In our study findings, most injecting drug users reported that their first successful injection experience was assisted by another person, most commonly a partner or close friend. This is partly because the latter will have the expertise but also because he/she will have the necessary equipment. Such circumstances result in the likelihood of sharing being high.<sup>1</sup>

### What are the ways that sharing occurs?

Sharing may occur directly or indirectly. The most obvious example of direct sharing is where people share the same syringe without sterilising it between use. Indirect sharing is less obvious and may include:

- sharing water, cooker or filter
- using a used syringe plunger to stir drug solution
- recycling used filters to extract any left over drug residue
- using unclean rinse water to mix with the drug
- using a dirty syringe to draw up water or measure shared drugs
- returning a portion of the drug solution to the cooker from the used syringe
- sharing unknowingly (needle and syringe etc. have been lent to someone else without the IDU's knowledge)
- backloading: where the drug solution is transferred from one previously blood contaminated syringe to another. In this case, the plunger is removed from the syringe into which the drug will be transferred. The drug mixture is then squirted into the back of the syringe
- frontloading: where the drug solution is transferred from one previously blood contaminated syringe to another by removing the needle on the syringe receiving the solution, and then squirting the drug solution into the syringe's barrel. This is not possible for needles and syringes where the needle cannot be removed.<sup>2</sup>

Apart from the personal reasons people share injecting equipment, other more general factors can lead to a widening of the sharing circle, allowing blood borne viruses to spread to other regions and countries. These include:

- **mobility** among IDUs (within one region/country or may extend into other countries) which may be due to:
  - the type of work done (truck drivers, fishermen etc.)
  - the need to travel to find work
  - in an attempt to evade the police
  - tourism (including drug and sex tourism)
  - civil war or unrest.
- The extent of drug injecting and sharing of equipment in **prisons**
- The use of **shooting galleries**, where injecting equipment is shared among many people
- The illegality of drugs in the region means IDUs live with the anxiety that they may be caught by police and locked up: they therefore tend to spend as little time as possible injecting drugs in any

## 2. Increasing IDUs' Awareness of HIV and other Harms

communal setting, including prisons and shooting galleries

- The change from smoking to injecting drugs: brought about by a change in the kind of drugs available and the rise and fall in street prices of various drugs
- The widespread practices among some IDUs such as 'blood brother' rituals, that are used to symbolise the intimacy of drug sharing
- The tendency to continue to share injecting equipment with sexual partners, regardless of wider sharing practices
- Shifts in where the drugs are cultivated, trafficked and then sold

### How can the sharing of equipment be prevented?

Before implementing programs to encourage IDUs not to share their injecting equipment, it is important that workers understand both *why* sharing occurs in a particular community and *what* realistic strategies will work in this environment.

These **strategies** may include:

- raising the level of awareness among IDUs of the risks associated with sharing
- increasing the availability of sterile injecting equipment
- decreasing the availability of used injecting equipment
- working together with government departments (i.e. police)
- working together with IDUs to change peer norms
- encouraging and facilitating other ways of taking the drugs
- providing IDUs with both the information and the means to change risky behaviour
- promoting abstinence
- education (see **Chapter Four: Education**)
- drug substitution (see **Chapter Six: Drug Use and Substitution**)

How do you make IDUs aware of the risks?

What are the other health risks?

### How do you make IDUs aware of the risks?

Drug users need to be made aware of the risks of sharing injecting equipment in terms of contracting and/or passing on blood borne viruses. It is likely that most IDUs will already be aware of other harms associated with injecting such as abscesses, scarring, circulatory problems and so on. The most important strategy is education: to give IDUs the information so that they know the risks and can take measures to minimise the harm associated with drug use and injecting. At the same time IDUs need to be given information about safer sexual practices (see **Chapter Seven: HIV/AIDS Preventing Sexual Transmission and between Mother and Child**).

Program developers need to keep in mind that:

- the content must be credible and the presentation acceptable
- behaviour change requires attitudinal change plus the means for behaviour change
- they must adopt realistic and achievable goals
- the aim is to change peer norms
- provide accurate information on: all injection equipment as a source of transmission, strategies for cleaning, need for change in sexual behaviour (use of condoms etc.), where to find help for drug problems
- use peers as educators
- recognise the diversity of IDUs
- target sub-populations specifically: young people, women, sex workers, indigenous groups etc.

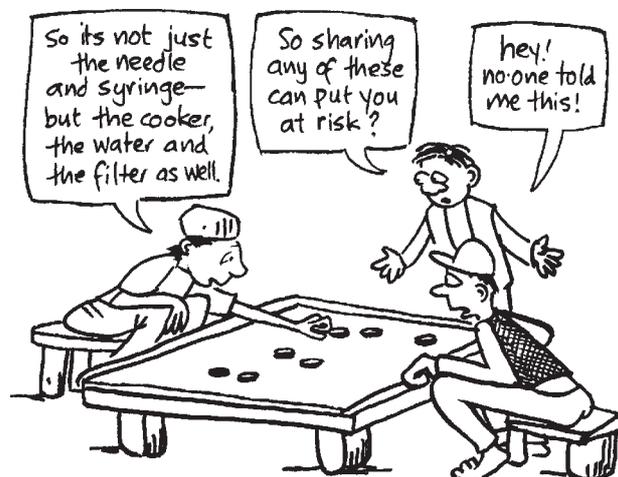
Programs will fail to increase IDUs' awareness of HIV and other harms if they are established without the knowledge of, and consultation with, drug users. Programs need to be aware of the conditions and practices of drug users in any particular community:

- the drugs used
- the routes of administration
- the availability of sterile equipment
- the prevalence of HIV
- sharing practices.<sup>3</sup>

The drug users in a community will be the ones with the most accurate information about the drug scene. By talking to several drug users, program workers will have a much better idea of the drug using situation and how they may be able to help.

These questions should provide a program worker with information about the injecting and sharing practices among drug users in that particular community:

- do you inject?
- how frequently do you inject?
- what drugs do you usually inject?
- would you be able/willing to consider safer methods of taking the drugs, such as smoking or sniffing?
- are there other drugs you occasionally inject?
- what type of injecting equipment do you use?
- how often do you re-use your injecting equipment?
- do you know how sharing equipment can transmit HIV?
- in what situations do you think sharing may occur?
- do you think you are at risk of HIV?
- do you want to change your injecting/drug use in any way?
- do you ever borrow someone else's needle/syringe – under what circumstances?
- do you ever lend your needle/syringe to anyone else – under what circumstances?
- do you share needles/syringes with your sexual partner?
- does your partner ever share needles/syringes with anyone else?
- what needle/syringe cleaning method do you use? Under what circumstances (i.e. for cleaning your own needle/syringe or other people's)?
- where do you inject?
- how long does it take to find a vein?
- do you alternate injection sites?
- do you clean injection sites? What with?
- do you have any physical problems as a result of injecting?
- what do you mix your drugs with?<sup>4</sup>



## What are the other health risks?

Apart from blood borne viruses, injecting drug users are at risk of other medical complications arising from their drug use. These may include:

- drug overdose – through mixing drugs or fluctuating purity of the drugs
- abscesses – due to irritant drugs or poor injecting technique
- septicaemia – caused by bacteria in the bloodstream
- bacterial endocarditis – inflammation and damage to the lining of the heart caused by an infective organism
- embolism – a substance such as air, or impurities in illicit drugs, carried by the bloodstream until it causes obstruction by blocking a blood vessel
- thrombosis – narrowing of the veins, causing blood clots
- gangrene – due to damaged circulation and poor care of wounds
- poor healing of wounds – due to inadequate general health and poor circulation
- circulatory problems
- scarring<sup>5</sup>

Often it may be one of these physical ailments that brings an IDU into contact with health workers. Dealing with primary health care issues, such as lancing an abscess or dressing a wound, can be a start for establishing a relationship of trust with an IDU which can lead into opportunities for giving information on safer using techniques and treatment.

## 3. The supply and use of sterile equipment

- What are Needle and Syringe programs?
- Why does outreach work?
- How do you find your clients?
- What are other ways IDUs can get new equipment and/or medical help?
- What are shooting galleries?

### What are Needle and Syringe Programs?

Often IDUs will share their injecting equipment because of the difficulty in obtaining new equipment. This may be because it is illegal to possess needles and syringes. But, even in regions where needles/syringes are legal, and can be bought in pharmacies or other retail outlets, IDUs may be reluctant to visit such places for fear of being identified as a drug user.

Needle and Syringe Programs (NSP) have been operating successfully for years in many countries around the world. In Asia, a needle and syringe program was first established in 1991 in Kathmandu, Nepal and now also operate in Asian countries including Bangladesh, Pakistan, China, Indonesia, Vietnam, Thailand and India.

In many countries and regions establishing NSP is extremely difficult because of legal restrictions. Fears are widespread that allowing needle and syringe distribution will promote and increase drug use. Some law enforcement agencies can see the benefits in NSPs but they cannot support them in law. However, in practice, the law is applied unevenly and to varying degrees, which can result in unofficial tolerance at a local level. The small scale and low visibility of many programs can make a certain amount of tolerance possible.

## Harm Reduction News



### Hilltribe Villages Accept Injecting Safely Programs

CHIANG MAI, THAILAND

The Akha hilltribe villagers of the Mae Chan district, in the Chiang Rai province of Thailand, live about 30 kilometres south of the Burmese border on the lower tip of the Golden Triangle. There are approximately 36,000 Akha people. They have a long history of using opium for social, ritual and medicinal purposes. Many of those now dependent on opium became so through the use of opium as a herbal remedy for coughs, diarrhoea, fevers and to mask the symptoms of hunger.

Until the late 1980s, opium was readily available and the majority of the using population smoked or ate opium on a daily basis. Up to 60 per cent of adult males, and a smaller percentage of adult females, in these villages are habitual users of opium/ heroin. As opium became less available (due to opium crop eradication in the south and the establishment of laboratories producing heroin in the north) the type of heroin available was more suitable for injecting than smoking. The villagers initially smoked heroin but found it inefficient and expensive. Injecting, on the other hand, is quick, effec-

tive, satisfying and highly portable. This ease of use makes it attractive in the face of police harassment: injecting takes little time, can be done anywhere and needles and syringes are easily disposed of and hidden.

The needle and syringe exchanges were established in three villages: all within

**“...villagers initially smoked heroin but found it inefficient and expensive. Injecting ... is quick, effective, satisfying and highly portable.”**

two kilometres walking distance from each other. The villages have an average of 47 households with five to six people per house. The villages were selected on the basis of evident drug use and a clear indication that injecting drug use was not only prevalent but increasing. There is scarcely a household in these three villages without at least one member habitually using opium or heroin.

Injecting drugs was fairly new behaviour and one that the villagers felt unsure about. They were afraid of the needles and syringes and unhappy that this new

behaviour had entered their villages. These communities have watched their social and economic life disintegrate as a result of ever increasing drug use: young women have entered the sex industry, women have become beggars on the streets of the city and habitual users are increasingly unable to take part in farming and other productive activities, thus impoverishing their families.

Drug use is, in many ways, an important part of the daily activity of these men: they like to sit around in groups of three or four and spend the day talking and sleeping. When smoking opium they shared the pipe and often their opium. This has changed little with the switch to injecting heroin. Needles and syringes were shared, occasionally rinsed with water but mostly not. There had been no suggestion that sharing needles and syringes could be harmful and therefore no need to go to the expense and effort of always having your own supply.

A series of meetings was held in each of the villages, involving all the villagers and including; the users, the village committee, male elders

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## Harm Reduction News

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and local representatives of the Thai government. Various strategies for preventing the spread of HIV were discussed. Alternatives such as boiling needles and syringes for re-use were considered and rejected on the basis of incompatibility with lifestyle (i.e. these villages have no electricity or gas and boiling water over a slow-burning charcoal pit in between injections was not deemed feasible). In addition plastic syringes would melt after three such treatments.

The villagers also rejected the suggestion that they each buy their own supply of needles and syringes from the pharmacy in the nearby lowland town: the trip to the town could cost them the equivalent of one day's heroin (for lighter users).

Over six weeks, after much discussion, the villagers in each village agreed that needle and syringe exchange would be useful. The death of a 16 year old IDU from a needle-related tetanus poisoning in one village brought home the risks associated with dirty needles.

The needle and syringe exchanges commenced in November 1992 with a supply of 5,000 1cc needle and syringe fits: an amount considered adequate for one year's supply. A register was drawn up recording users' names, the number of times

they injected on a daily basis, the amount of heroin they used per day and it also gave details of the sharing networks among IDUs. The village committee in each village undertook the responsibility for distributing clean needles and syringes and disposing of old ones.

Each user was educated individually about safer using techniques, following the 2x2x2 method used in Australia – cleaning the needle and syringe twice with

**“The death of a 16 year old IDU from a needle-related tetanus poisoning in one village brought home the risks associated with dirty needles.”**

cold water, twice with bleach and twice again with cold water. The uncertainty of continued needle and syringe supply meant they had to be conservative with the amounts of needles and syringes they distributed. It was limited to a maximum of three needles and syringes per user per week.

The operation of the needle and syringe exchanges in these first three villages worked in a fairly systematic way for one and a half years until the supply of needles and syringes abruptly ran out. However, by this time the IDUs had developed a

strong sense of responsibility in their using behaviour. They had become accustomed to individual use of injecting equipment, and in the majority of cases, were no longer sharing needles and syringes.

The NSP now operate on a two-tiered level: direct exchanges and on an on-request basis. The direct exchanges operate in six villages, along similar lines to the original exchanges but are now administered by paid health care workers. Records are kept of the number of needles and syringes distributed and the number returned each week. Users who have not attended the exchange are followed up to see what problems they may be encountering and assistance is provided where feasible. Seventy five IDUs are provided with up to three needles and syringes per week in these district exchanges. Of the needles distributed more than 90 per cent are returned each week.

The exchange programs in the villages have generally worked well and continue to have the support of the villagers until such a time as adequate treatment programs are implemented. Both the villagers and the village committee have always regarded the exchanges as a short-term measure until such treatment programs are put in place.<sup>6</sup>

## HARM REDUCTION NEWS



### ACTION TO REDUCE SHARING OF NEEDLES

HO CHI MINH CITY, VIETNAM

The reports from Ho Chi Minh City's AIDS Committee estimate that 80 per cent of people with HIV in the city are IDUs. They mainly use opium and the sharing of needles is the major cause of HIV transmission.

The Needle Exchange project in Ho Chi Minh city began in 1995 and is supported by WHO and implemented by the National AIDS Committee of Vietnam. The program focuses on the downtown area of the city known as District 1. The program workers educate IDUs about AIDS prevention and make clean needles and syringes available for free in exchange for used ones. Six former users (men and

women) are engaged in the education and exchange under the supervision of a medical doctor. Their familiarity with IDUs and drugs makes their involvement cru-

“  
...workers educate IDUs about AIDS prevention and make clean needles and syringes available for free...  
”

cial to the project's implementation.

Every morning, from 7.00 to 9.00, the volunteer workers, in blue project uniforms with full packs of needles and syringes take positions in areas where drugs are commonly found, such as by the

river, and wait to be approached. Most of their clients are poor cyclo drivers who have been injecting opium for some years and who now come to get a clean needle in exchange for their used one. As they know each other well, chatting and exchange of information between the volunteers and the IDUs is easy. About 40 – 60 needles and syringes are exchanged each day and mostly by the same users.

When new drug users show up the volunteers interview them on their drug using habits and talk to them about drug use. When the current project ends the Committee will conduct an evaluation so that the project can be thoroughly reviewed before planning further.<sup>7</sup>

#### Distribution:

Needle and Syringe Programs (NSP) are usually involved in three areas:

- syringe distribution
- syringe disposal
- the provision of advice and information

Needles and syringes may be distributed in various ways: through shops and pharmacies, vending machines, health centres and by outreach workers.

NSP distribute new needles and syringes to their clients. At the same time they may also distribute other injecting equipment: the aim being to minimise the sharing of

other equipment which can also be an indirect route of HIV transmission.

- the equipment may include clean water, swabs, spoons and cooking pots
- the beneficial side-effects of using clean equipment, apart from preventing the transmission of HIV, are a reduction in abscesses, bruising, collapsed veins and other related harms
- this can provide the motivation for adopting safer using practices even before HIV emerges at a significant level in an IDU community

## Why does outreach work?

IDUs are more likely to respond to approaches from outreach workers who are working within the community, than to walk through the doors of an established drug service centre. Some of the reasons for staying away from health services include:

- the fear of being identified as a drug user and the resulting stigmatisation and discrimination
- because they do not expect a non-judgemental response from anybody

Most drug users have received ill-treatment from police, doctors, nurses, pharmacies and other health agencies. Therefore, it is not surprising that IDUs will initially treat outreach workers with some suspicion. The outreach worker has to build up a level of trust and credibility with the drug user and the wider community.

Outreach is often the most suitable way to make initial contact with IDUs and to gradually convince them that the help being offered is genuine. Involving ex or current users in outreach work can aid in establishing trust.



## How do you find your clients?

One of the most difficult tasks in establishing an NSP is getting people to use the service. As mentioned above there is a great deal of suspicion to overcome. Once the local situation has been assessed (see **Chapter One: Rapid Situation Assessment**) and a program has found out what the drug users need and what the program can do to satisfy that need, program workers will need to establish contact with drug users. It may begin by a relationship with one drug user who introduces the outreach worker to another drug user and so on. Although it may appear at first that the NSP is only in touch with one network, eventually if the outreach worker keeps asking each new person to introduce them to another, they will start to cross social networks and discover unknown groups who have had no contact with the NSP.

## What are other ways IDUs can get new equipment and/or medical help?

### Pharmacies/retail

In some countries, distributing needles and syringes through retail outlets has been the preferred option. In 14 provinces in Vietnam equipment is distributed in this way.

### Health and welfare centres

IDUs are often reluctant to visit health and welfare centres due to the discrimination and stigmatisation they have suffered in a health care setting. Programs throughout Asia have tried to encourage people at risk of HIV to visit health care centres. Outreach workers are often able to administer primary health care to IDUs and assist people to visit health care organisations.

## Harm Reduction News

### Needle Exchange – A Success Story in Nepal

KATHMANDU, NEPAL

The Lifesaving and Lifegiving Society (LALS) was established by two volunteers, Aaron Peak and Sujata Rana, in 1991 in Kathmandu. LALS now has 24 fulltime workers including eight community health outreach workers (CHOWS). The outreach teams include ex-drug users, nurses and social workers and they work with approximately 860 IDUs. They visit 65 different areas in Kathmandu to perform needle/syringe exchange, distribute condoms, give primary health care and counselling to IDUs and their families/sexual partners. LALS also educates the community about HIV/AIDS and prevention methods. Syringes are exchanged on a one to one basis with no limit on the number of exchanges at any particular contact.

From August, 1991 to February 1997, 1,73,798 exchanges had occurred. LALS disposes of syringes by burning them on their terraces: they average 165 per day.

HIV has been in Nepal since 1991 and studies suggest that HIV is not spreading among the IDUs associated with LALS. Mr Jimmy Dorabjee of the SHARAN

agency in New Delhi visited LALS and accompanied the outreach workers on their rounds.

“...CHOWS distributed packets of condoms to people who requested them. I was struck by the casualness that prevailed, and though we stood right outside some

**“Syringes are exchanged on a one to one basis with no limit on the number of exchanges at any particular contact.”**

shops, no-one seemed disturbed at the actions happening outside. They'd probably seen this all before, it was not new. I had been curious to witness reactions on the needle exchanges, wondering at the actual interactions that took place during exchanges...I was initially sceptical about the claims of LALS about needle exchanges working in conservative societies like Nepal but the two hours I spent with the CHOWS has shown me how successful they have been.

“A flight of steep stairs, onto the first floor of a Tibetan restaurant (where clients filled in question-

naires and Jimmy spoke to one IDU). The man complained of the lack of facilities and services that drug users in Nepal suffer, the need to be accepted and treated as individuals, the problems of unemployment bringing down the motivation to stay clean. In the meantime, two of the IDUs had drawn blood and the CHOWS deposited it into glass tubes, to be taken for tests for Hepatitis, VDR and HIV. When I asked why they wanted it done they replied ‘for safety’. The owner of the cafe was apparently informed when we entered about our activities, and didn't seem to mind.

“Half an hour later we were on the street again, the CHOWS making contact with IDUs at their homes to exchange syringes/needles. It's strictly one for one exchange, probably preempting the resale of material. En route I asked what would happen if I went into a chemist and asked for a syringe. ‘Just go in and see the response’. A little nervously I went in, came out a few minutes later with a syringe, costing Nepali Rs.9/. ‘It was easy, no problem’ I told them.”<sup>8</sup>

## HARM REDUCTION NEWS



### INJECTING EQUIPMENT MADE ACCESSIBLE

TAIPEI, TAIWAN

For many years, the Taiwan government has imposed harsh penalties on drug users and the concept of a needle exchange program has never been viewed as acceptable. In Taiwan, as required by law, drug users are regarded as criminals but in recent years they have also been viewed as patients that should be sent to hospital for detoxification. While the injecting of

“  
... the Department of Health has placed ‘no controls on needles and syringes: they can be purchased without a prescription’...  
”

heroin is rising, the Department of Health has placed no controls on needles and syringes: they can be purchased without a pre-

scription for \$7.12 Taiwan (approximately US\$0.25 – the average weekly wage in Taiwan is US \$300). Pharmacies that stock needles and syringes are found throughout the country. Government authorities prefer this approach arguing that HIV infection among injecting drug users is currently low and therefore the need for a needle and syringe exchange program cannot be supported.<sup>9</sup>

### What are shooting galleries?

A ‘shooting gallery’ is the name given to an area where IDUs can inject their drugs. The shooting gallery may be a room in an abandoned building, a shack or hut or someone’s house. The reasons IDUs use shooting galleries may be because:

- they don’t want to carry needles and syringes for fear of being arrested as a drug user
- they don’t have their own equipment
- the shooting gallery owner is also their dealer so they score and use at the same place

One of the problems with shooting galleries is the sharing of equipment. In many shooting galleries the same needle and syringe are used over and over until the needle is too blunt to be used any more. Mostly, the needle and syringe is not cleaned between clients, or if it is cleaned it will be just rinsed quickly with water. The opportunity for spreading blood borne viruses is enormous.

Dealers are a good group to involve in intervention programs as they have regular contact with users (through selling them the drugs) and because dealers often provide an extra service as the injector.

## Harm Reduction News

### Support for Drug Users with HIV

HO CHI MINH CITY, VIETNAM

A Home Health Care Group (HHC) and a 'Friend's House' (FH) for injecting drug users was established in Ho Chi Minh City by Save the Children/UK. They hired a Vietnamese team leader who was responsible for both activities. The team leader acted as a facilitator for a staff of volunteers who received a monthly allowance which was determined by the amount of time and effort they put into the program. The first six weeks of the program were spent on training and information about various aspects of health care. This was followed by service delivery to

30 HIV infected IDUs. They had to establish priority for certain IDUs as 10 of their clients developed illnesses associated with HIV. Before the services began the pro-

**"...most hospitals would not admit them because of their drug using history."**

ject assessed the IDUs: looking at medical, social and psychological needs. The IDUs who required most care were those without family support and those who had suffered the most discrimination. This service provided enormous comfort to the sick IDUs as most hospitals would not admit them

because of their drug using history.

Apart from these services they also established the 'Friend's Home' for IDUs with HIV who had no family support. The 'Friend's Home' is a residential house where the IDU receives medical support, counselling on HIV and drug use and help with practical strategies about how to reintegrate into their family. The IDU's family also receive these services to help them better understand the situation and to ensure the reintegration is sustainable. The aim of the project is to become self-sufficient through income generating projects and to gain government recognition.<sup>10</sup>

## HARM REDUCTION NEWS



### SERVICE DELIVERY INSIDE SHOOTING GALLERIES

CEBU CITY, PHILIPPINES

There are eight shooting galleries in Barangay Kamagayan, Cebu in the Philippines. Each gallery is open 24 hours and caters to about 100 to 150 IDUs daily. The operation of the gallery has become a family business where each member of the family has to do his/her share in delivering efficient services to IDUs. One person may be in charge of cleaning used syringes with bleach and water, another may be

the middle man in buying the drugs and another may be responsible for peddling the drugs.

“  
...shooting galleries ...  
(create) a sense of  
community and  
friendship.  
”

Aside from the services provided, IDUs prefer to inject at such shooting galleries because of the bonding

and ambience of the galleries which creates a sense of community and friendship. This gives the IDUs the comfort of being with people who lead a similar lifestyle. For those who cannot afford to buy the drugs they can pitch in with other people to buy them. Other people prefer to inject in shooting galleries for fear that they might get caught in possession of regulated drugs, punishable by law under the city's ordinance.<sup>11</sup>

#### Distribution and the police

Outreach workers may face certain problems by working, technically, outside the law. Outreach workers may be arrested for possession of injecting equipment. It is important to work not only with the police commissioners but also the local police whom the outreach workers and IDUs are more likely to run into. Some programs register outreach workers with police agencies in order to avoid arrest.

It is important to ensure that IDUs contact with outreach workers does not lead to their identification by the police. Some programs provide their clients and outreach workers with identification cards which they can show the police if questioned or harassed. For more information about working with the police see **Chapter Three: Working Together**.

## Harm Reduction News

### Shooting Galleries – Trade and Profit

HO CHI MINH CITY, VIETNAM

The shooting gallery in Bach Dang, Vietnam is very popular and visited by 50 to 70 IDUs every day. In this shooting gallery there is one dealer, two injectors and several watchers. Recently, there have been police campaigns to eradicate drug use and arrest the IDUs in this area.

For this reason the majority of the IDUs will inject in their neck, groin or behind the knee as it takes less time. The syringes used by the injectors are only rinsed with cold water periodically and never sterilised.

There are many stalls located close to the shooting gallery where Mr Ha is allowed to conduct outreach services. Save the Children Fund (SCF/U.K.) at one time conducted a pilot needle

exchange program in this shooting gallery. But it was discontinued because the dealers would not let them exchange syringes at the site as the dealers also sold syringes to the IDUs and the competition was not good for their profits.

**“...the dealers would not let them exchange syringes at the site as the dealers also sold syringes to the IDUs...”**

Another shooting gallery is located in a private house and another in an abandoned army barracks field. The number of clients varies from 100 to 150 every day. Those clients who have more money choose to go to the private house where the drugs are more expensive but of a higher quality and the

location is safer. The house provides two injectors and four watchers. Those people who don't have as much money will go to the abandoned army barracks which has one injector and the IDUs have to buy their drugs from a different source.

The outreach worker found it easier to gain access to the IDUs at the barracks because he initially established a good relationship with the injector. However, due to the high turn-over in injectors the process had to be constantly repeated. The needle exchange at the house did not work as well as the dealer would not let the IDUs use a SCF syringe at the house. If an IDU wanted the injector to use a clean syringe he would have to buy it from the dealer.<sup>12</sup>

Churachandpur, the 17th Aug., 1995

To

- 1 SDPO/Churachandpur
- 2 C.C.Churachandpur Police Station

As part of harm minimisation program with regard to the spread of HIV/AIDS, the Society for HIV/AIDS and Lifeline operations in Manipur (SHALOM), Rengkai Road Churachandpur will be advocating issue of syringes and needles to its clients.

Keeping in view the need to control the spread of AIDS in the district the police is expected to extend maximum co-operation to SHALOM in its endeavour. Police, therefore may allow SHALOM clients undergoing SNEP to carry syringes and needles without harassment. The police may also see to it that the SHALOM staff/volunteers who are supervising the program are not harassed. The SHALOM will be issuing identity cards/badges to the clients and volunteers. Any confusion about the genuineness of the identity cards/badges and the volunteers/clients may be cleared by contacting the Co-Directors, SHALOM, Churachandpur.

*Letter from the Superintendent of Police, Churachandpur to local police instructing them not to hinder the work of the SHALOM project.<sup>13</sup>*

	<b>DRUG DEMAND REDUCTION PROJECT</b>	
	Supported by the European Union	
<b>CLIENT IDENTIFICATION CARD NO :</b> _____		
Name :.....		
Address :.....		
Admission Date :.....		
<b>SHARAN - Society For Serving The Urban Poor</b>		
<small>G-46, Green Park (Main), New Delhi-110 016 Tel. : 6858086 Fax : 91-11-6858501</small>		

<b>DROP-IN CENTRE</b> CS 91/777, KHASARA No. 556, Nizamuddin Basti 8:00 a.m-8.00p.m.	For <b>SHARAN,</b> Society For Serving The Urban Poor  (Authorised Signatory with Seal)
Signature of Holder _____	
<b><u>THIS CARD IS NOT TRANSFERABLE</u></b>	

## 4. Safer Injecting

### Why use safer injecting practices?

Safer injecting can prevent the transmission of HIV/AIDS and other blood-borne viruses such as hepatitis B and C. It can also prevent bruises, poisoning of blood and abscesses.

When injecting it is important to do so safely and carefully. The best way is to always inject with a new needle and syringe, sterile water, a clean tourniquet, a clean spoon, a clean filter, a clean injecting space and clean hands – and make sure the part of the body where you are to inject is clean.

#### Preparation

- Try to choose a safe, clean and private location to inject where you cannot be disturbed.
- Injecting equipment needs to be free of dust or dirt. After selecting your location to inject, place your injecting equipment on a piece of plastic or newspaper that covers the ground or surface.
- Wash your hands before injecting and ensure that the part of the body you are injecting into is also clean. Washing your hands is important as it can remove viruses, bacteria and dirt when you are injecting. Make sure you have everything within reach: new sterile injecting equipment; sterile water if to be mixed with a drug (or cooled-down boiled water); clean spoon; clean filter; clean tourniquet (if used); and clean sterile swabs (if available).

#### Mixing the drugs

- If you use a spoon to mix your drugs, clean the spoon first.
- Use new injecting equipment to draw up sterile water. If sterile water is not available use cooled-down boiled water.
- No matter how well your injecting equipment has been cleaned, never let your equipment be used by others, and

your needle and syringe should not be in contact with a drug mix that is used by other drug users. It is best that each drug user has their own injecting equipment.

- Add the sterile water (if possible) to the drug and mix. You can use the blunt end (the plunger) of your clean syringe for mixing.
- Draw up the drug solution through a filter in order to avoid impurities. The best filters are a cotton bud or cotton wool. If possible, do not use a cigarette filter as they may contain tiny glass fibres which can damage veins.
- Remove air bubbles by pointing the needle skywards and gently flicking the syringe on the side near the needle. Push the plunger up slowly until the air bubbles escape through the eye of the needle.

#### Injecting

- Clean the injecting site with soap and water, and a sterile swab (or use a clean piece of material that is moist). Rub the area in one direction, not backwards and forwards, to avoid putting dirt and bacteria back onto the injecting site.
- If you use a tourniquet, place it around just above the injection site. Do not leave it on too long - never for more than one minute. If you have trouble finding a vein, release the tourniquet and try again.
- If you are finding it difficult to find a vein try to run warm water over the injecting site as this may help to raise the vein, or you can open and close your hand in a pumping action. It can also help to gently pat the area where you are trying to inject.
- Slowly insert the needle into your arm at a 15-35 degree angle with the hole of the needle (bevel) facing upwards. The wider the angle of insertion the greater the chance the needle will go straight through the vein. If there is no visible

blood in the syringe, then your needle is not in the vein and you will need to remove the tourniquet and the needle from your arm. When the needle is removed apply pressure (using a cotton ball, tissues or toilet paper) to stop the bleeding. Take a deep breath and start again.

- When you are sure the needle is in the vein (a small amount of blood enters into the barrel of the syringe), loosen the tourniquet and gently push down on the plunger. If you feel any pain or resistance you may have missed the vein and you will need to start again.
- If you have been successful with injecting, remove the needle and keep your arm straight, in order to avoid bruising. Apply pressure to the injection site for a couple of minutes (using a cotton ball, tissues or toilet paper).
- Regularly change your injection sites to prevent bruising, abscesses and damage to the vein. If you do not regularly change your injecting sites vein damage may be irreversible.

#### **Cleaning up**

- Even if do not intend to reuse your injecting equipment, you should rinse the needle and syringe with cold water, several times, straight after injecting - the more the better. This will remove most of the blood and prevent the needle from blocking with dried blood in case you are forced to use the needle and syringe again.
- You should dispose of your rinsing water immediately so that no one else can use it, to prevent them becoming contaminated with your blood.
- Carefully recap your needle and ensure safe disposal into a puncture-proof container like a hard plastic container or glass jar, or return the injecting equipment to an outreach worker.

- It is best not to reuse any of the following equipment when injecting: needle and syringe, the cloth to clean the area, filters, swabs, and any opened sterile water ampoules.
- Store all of your injecting equipment in a clean safe place so that no one else can have access to it or use it.

The only really safe way to protect yourself and others from viruses like HIV and Hepatitis B and C is never to share any injecting equipment

## **5. The Disinfection of Used Equipment**

**How can IDUs protect themselves and others?**

**What are effective ways to disinfect injecting equipment?**

**What are some of the other methods?**

### **How can IDUs protect themselves and others?**

The best scenario is to always use sterile equipment for every injection. Anything short of this carries some risk of infection. But in many regions sterile equipment is unavailable most, if not all, of the time. In this case it is important to inform, educate and if possible provide the means for drug users to disinfect their injecting equipment.

However, the success of any cleaning message depends greatly on the local circumstances:

- whether the law will permit a needle and syringe program and therefore make the message of 'use a new needle and syringe for every injection' possible
- whether there are adequate funds to maintain the supply of needles and syringes

## HARM REDUCTION NEWS



### SAFER INJECTING – NOT WITHOUT PROBLEMS

HANOI, VIETNAM

In Lao Cai, Vietnam, a project was established to design an appropriate leaflet for drug users. The aim of the pamphlet was to explain the difference between cleaning drug injecting equipment and sterilising it. The project coordinator spoke to injecting drug users, who were about 17 years of age and new to injecting, to find out what they knew about cleaning and sterilising and what they thought was a realistic message. As the drug users lived with their parents they felt it was impossible to keep their own injecting equipment. They were afraid their parents would find out and that the police would search them and find the equipment. So they

went in groups to the community injector. They also believed that having your own equipment went against the group ethos of sharing everything. Once explained, they

“  
...having your own  
equipment went  
against the group  
ethos of sharing  
everything.”  
”

understood the difference between cleaning and sterilising but felt they would not be able to carry out sterilisation of equipment.

The provincial authorities objected to the mention of alcohol (70 per cent proof) in

the leaflet as a means of sterilising injecting equipment, as it was not in line with Ministry of Health regulations. Taking all the local conditions into account, the final version of the leaflet described a best to less effective practice for cleaning and sterilising. It seemed obvious that the best the drug users could manage was to clean rather than sterilise their equipment. Buying new needles and syringes, sterile cotton for filters, sterile water and alcohol for cleaning was considered unacceptable. The young drug users said they could not afford to buy this equipment and that any money they had would be pooled to buy drugs. Peer pressure and economic reasons prevented them from practising safer injecting.<sup>14</sup>

- whether a particular cleaning agent is available in the country or region
  - whether a particular cleaning agent is acceptable to IDUs
  - whether the cleaning message is realistic for IDUs (i.e. does it take too long? can it be done on the streets?)
  - be quick (drug users will not use a method that demands too much time)
  - be easy to use (using the method should require only minor changes in behaviour)
  - be safe for injectors (if accidentally injected and for others who may be accidentally exposed, such as children)
  - be cheap
  - become a part of a routine
- Any cleaning method must:
- use an effective flushing agent (such as bleach)
  - be available and accessible

## What are effective ways to disinfect injecting equipment?

Two effective approaches for disinfecting injecting equipment are:

- the use of **heat** (continuous boiling for 20 minutes)
- the use of **chemicals** such as bleach

The boiling method is particularly suitable for glass syringes but can only be used once or twice for disposable plastic syringes. Even then some disposable syringes will perish the first time they are boiled. In terms of disinfection with chemicals, the longer the equipment soaks in the cleaning agent the better: the more time the cleaning agent is in contact with blood the more likely it is that viruses will be destroyed.

However, the reality is that drug users are rarely in a situation where they are able to boil or soak their equipment for long periods of time. These cleaning messages have been developed with those constraints in mind.

Until 1993 the cleaning message for needles and syringes was the 2 x 2 x 2 technique. The message suggested that when re-using or sharing a needle and syringe, users should always rinse the needle/syringe twice in water, twice in bleach and twice again in water. But research showed that this method was not 100 per cent effective in preventing the transmission of HIV or hepatitis C. The message was then expanded to maximise the amount of time the cleaning agent (i.e. bleach) is in the syringe and therefore in contact with the virus as well as increasing the number of times of cleaning with water.

## How to clean needles and syringes with bleach

Cleaning needles and syringes involves three stages:

1. Water x 3 (rinsing with water 3 times)
2. Bleach x 2 (rinsing with bleach 2 times)
3. Water x 6 (rinsing with water 6 times)

### Stage 1 – Water x 3 (rinsing with water 3 times)

- Draw up fresh clean cold tap water from *first* container into the needle and syringe. Do not use hot water or water too cold as this may cause blood to congeal inside the needle and syringe
- Squirt the water out
- Repeat this process *2 more times*
- If required keep rinsing until you cannot see any traces of blood

### Stage 2 – Bleach x 2 (rinsing with bleach 2 times)

- Draw up bleach from the *second* container into the needle and syringe and shake it at for least 30 seconds
- If you do not have a watch, count slowly so that the bleach has enough time in contact with any virus present. For example count “one thousand, two thousand... “up to thirty thousand”.
- The counting is extremely important as the bleach must be in contact with the virus for at least 30 seconds for the virus to be destroyed
- Squirt the bleach out of the needle and syringe.
- Repeat the bleach process *at least 1 more time*.

## Harm Reduction News

### Disposal Controls in Place

CHIANG MAI, THAILAND

In the early days of operating the needle exchange program in the hills of Thailand, before we had paid employees, members of the village committee and the drug users undertook to jointly dispose of the needles and syringes. Every week, one member of the village committee and one of the users would collect the bottles which the old needles and syringes were stored in and burn them on the communal rubbish dump. The plastic would melt and the needles were dug into the ground and covered over with the ashes from the other rubbish. This system seemed to work well with no cases of needle stick injury, nor were there any problems with the villagers.

As the needle exchange program expanded and the

volume of needles and syringes increased, a new method was adopted. The employment of primary health care (PHC) workers, the establishment of primary health care centres and a strong link with the local hospital meant the users and the village committee were no longer involved with the disposal of injecting equipment.

**“...disposal reinforces to the health workers and the users the seriousness of HIV transmission.”**

The program operates as a direct needle exchange and not through the method of distribution. Needles and syringes are returned to the primary health care centre and documented in a book by the PHC workers. Needles and syringes are collected weekly from each primary

health care centre and taken by the project staff to the local hospital and disposed of in their incinerator.

This is not a burden for the hospital, is easy for the staff, and removes any possibility of needle stick injuries in the village. The practice of disposal reinforces to the health workers and the users the seriousness of HIV transmission.

As we only exchange old equipment for new equipment (with a 90 per cent plus return rate) we were able to control disposal. Before the introduction of our program, needles and syringes were discarded around houses and the users were unconscious of the need to dispose of their equipment carefully. The introduction of the program has resulted in no litter from injecting equipment being found in the villages.”<sup>16</sup>

### Disposal Controls in Place

CEBU CITY, PHILIPPINES

In the early stages of the project in Cebu (in the Philippines) used syringes were scattered all over the place: many littered the streets, pathways, canals, in the wooden walls of shanties and in the ceilings of shooting galleries. When the rain came, used syringes, empty injecting drug bottles and other paraphernalia clogged the canals and drains: they were also seen floating in canals and pathways.

Alarmed by the possibility of spreading disease because of this unsanitary disposal of used syringes by the IDUs, the Community Outreach Workers (CHOWS) of the program came up with the idea of constructing a drop box for used syringes in the shooting galleries. Locks are provided and the keys are kept safe so that no used syringe can be retrieved. Out of the eight shooting galleries in the area, only three accepted the drop boxes as the rest were apprehensive

that in case of raids the drop box would be seen as prima facie evidence of drug peddling.

CHOWS regularly collect the used syringes from the drop boxes, and the plastic containers preferred by other shooting galleries. They also pick up syringes scattered along the pathways to ensure that children and adults will not get pricked by the needles. The collected syringes are then brought to the City Health office for incineration.<sup>17</sup>

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**Stage 3 – Water x 6****(rinsing with water 6 times)**

- Draw up fresh clean tap water from the *third* container into the needle and syringe
- Do not use water from the first glass as it may be contaminated with blood
- Flush the water out of the needle and syringe
- Repeat this process at least *5 more times*, until all of the bleach is removed.

**Remember the formula – 3 x 2 x 6**

It is important the needle and syringe be rinsed with cold clean water as many times as possible immediately after injecting to help remove traces of blood.

The bleach method should only take about five minutes. Be careful not to squirt the water from the syringe back into the rinsing water and avoid re-dipping syringes into water that may already have been used. Flushing several times with water will remove the bleach. Any tiny amounts of bleach that may remain and be injected are *not* harmful.

**What are some of the other methods?**

Other cleaning agents used to clean needles and syringes include household dishwashing detergent, iodine and alcohol. While it is good to rinse syringes with any of these solutions, it is even better to soak them.

**Cleaning with dish-washing detergent**

1. Take the syringe apart.
2. Soak it in a detergent solution (one tablespoon of detergent in one cup of water) for at least two minutes. Make sure the whole syringe is covered by the solution.
3. Rinse thoroughly by flushing with fresh clean cold water several times.

**Cleaning with alcohol**

Medical alcohol (ethanol, isopropanol or n-propanol) is the best alcohol to use. If household alcohol is all that is available it should be as pure as possible (at least 70 per cent and preferably a clear spirit).

1. Pull up cold clean water through the needle until the syringe is completely full and squirt down a drain or toilet. Do this several times to remove any visible blood.
2. Pull up the alcohol through the needle and allow it to settle for two minutes. Shake the syringe well before squirting the alcohol out. Repeat this process another time.
3. Pull up cold clean water through the needle until the syringe is full and then squirt the water down a drain or toilet. Do this several times.

Alternatively and even better, the syringe can be rinsed in clean cold water and then soaked in a bowl of alcohol for one hour.

## Summary

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### Boiling the injecting equipment

1. Rinse the needle and syringe in clean cold water by pulling the water up through the needle and squirting it out down a drain or toilet. Do this several times.
2. If possible detach the needle from the barrel and pull out the plunger. Place all the parts in boiling water for at least 20 minutes. Start the counting from once the water comes back to the boil after you have put the equipment in the water.
3. Allow all the parts to cool down before you put them back together.
4. Rinse the syringe in cold clean water again before using.

The spoon or cooker can also be boiled along with the syringe. The important principle for boiling is to make sure that there is sufficient heat for sufficient time.<sup>15</sup>

## 6. The Disposal of Unsterile Equipment

### What are the aims of disposal?

- to retrieve used equipment
- to ensure that clean equipment is being used
- to avoid re-sale of clean equipment
- to ensure appropriate disposal of used equipment



Needles and syringes may be disposed of by returning them to the place where they were bought: the pharmacy may be persuaded to keep a safe disposal container or they may be disposed of through burning or other methods.

In some communities used needles and syringes can be disposed of at the local hospital, burnt in an incinerator or sometimes buried in a deep hole where no-one will be able to find them.

Some NSP and hospitals may provide plastic disposal containers which can be returned when full. If these are not available used needles and syringes can be placed in puncture proof glass or plastic jar or bottle with a secure lid. If possible they should be yellow in colour and marked 'Danger' 'Contaminated Sharps' with the Biohazard symbol in black.

## Summary

The promotion of the return of, and/or safe disposal of, used needle and syringes is an important component of Needle and Syringe Programs (NSP). Safe disposal information should be incorporated in all exchange transactions wherever possible. NSP workers need to pay particular attention to encouraging safe disposal practices by users: used syringes lying around upsets both the general community and the police and is the surest way to close down a NSP program. Safe disposal can be one issue to discuss with the local police and politicians to persuade them of the benefits of NSP.

Disposal is a complex and difficult issue for many communities. In many countries garbage is recycled and people commonly comb through rubbish piles and dumps for recyclable material or even sometimes for food. Children also often play at rubbish tips. Although the chance of contracting HIV through a needle stick injury is fairly remote, hepatitis B and C can survive for a longer time and may be transmitted.



### Sharing of Injecting Equipment

The transfer of blood borne viruses (HIV, Hepatitis B and C) can occur through sharing injecting equipment including:

- needles and syringes
- spoons, filters, water, glasses, tourniquets, surfaces, etc.

Any uncleaned injecting equipment that is re-used can lead to visible/invisible blood particles being injected directly into the next person.

Some reasons for sharing

- lack of injecting equipment
- popular cultural or social practice
- lack of awareness of risks from sharing equipment
- extension of sexual relationship or friendship
- lack of perceived risks (e.g. none of my friends have HIV)
- lack of smokeable opioid (e.g. market dries up)

Some reasons for lack of clean injecting equipment

- inability to purchase from shops or pharmacies
- prohibitive costs of purchasing injecting equipment
- reluctance to carry injecting equipment for fear of arrest and discrimination

Lack of knowledge about risks of HIV transmission

- unintentional indirect sharing of pots, spoons, water
- poor understanding of general health principles
- unsafe injecting behaviour learnt in their initiation to drug use

Some general factors enhancing the spread of blood borne viruses to other regions and countries

- mobility (i.e. truck drivers, fishing men, etc.)
- sharing of injecting equipment inside prisons
- shooting galleries
- transition from smoking to injecting drugs

Some realistic strategies to prevent sharing of injecting equipment

- raise level of awareness among IDUs of risks associated with sharing
- increase availability of sterile injecting equipment
- decrease availability of used injecting equipment
- provide information/education and the means to change risky behaviour
- united efforts with IDUs to change peer norms

## Increasing IDUs' Awareness of HIV and other Harms

Program approaches to make IDUs aware of the risks

- education/information provided must be credible and presented in acceptable manner
- change in attitude and the means for behaviour change must be promoted
- use peers as educators
- aim to change peer norms

Successful programs on IDUs awareness of HIV and other harms can only happen with the knowledge and consultation of those within the drug user community. This community possess very accurate information about injecting and sharing practices.

Other health risks that IDUs can experience are:

- drug overdose
- septicemia
- poor healing of wounds
- abscesses
- thrombosis
- circulatory problems

## The Supply and Use of Sterile Equipment

Needle and Syringe Programs (NSPs) are usually involved in the distribution of new needles and syringes or other injecting equipment to their clients: the aim is to minimise the sharing of equipment which can result in the indirect transmission of HIV transmission. Countries in Asia such as Nepal, India, Vietnam and Thailand have implemented NSPs. Implementation of NSPs can be *very* difficult due to legal restrictions but small scale and low visibility of programs has allowed a degree of tolerance within certain communities.

IDUs tend to respond more favourably to outreach workers than institutionalised health workers. Enrolling ex or current users in outreach work helps develop trust and extend the reach of the NSP to wider networks of drug users.

A shooting gallery is the name given to an area where IDUs inject their drugs together. A major problem in shooting galleries is that it is common to share injecting equipment.

## The Disinfection of Used Equipment

Disinfection of used equipment can occur when sterile equipment is unavailable. The use of *heat* to boil equipment is effective but in many regions of the world this approach is not practical. The use of a chemical such as bleach is both *effective* and *practical*. The bleach method can be done in 5 minutes but effectiveness depends upon the correct technique being used. Other methods include cleaning with dish-washing detergent, alcohol or iodine.

## The Disposal of Unsterile Equipment

The disposal of and the retrieval of unsterile injecting equipment aims to:

- ensure that clean equipment is being used
- to avoid re-sale of clean equipment
- to ensure appropriate disposal of used equipment
- prevent needlestick injuries to others

Some sites for disposal and retrieval:

- the place where injecting equipment was bought (i.e. pharmacy)
- local hospital, burnt in an incinerator, buried in deep hole
- NSPs or hospitals may be able to provide disposable containers that are returned when full

Information on the safe return of or disposal of used needles and syringes should be included in all exchange transactions. Although disposal can be difficult and a complex issue for many countries, to avoid health hazards it must be dealt with. Effective disposal eases community fears and encourages support for NSPs.

### Section Two, Chapter Five: Injecting Safely

**For further information refer to WHO resources: Training Guide (Outreach), Intervention Guide (NSP) and Evidence for Action Papers. Refer to the following website: [www.who.int/hiv](http://www.who.int/hiv) (publications expected online from May 2003)**

CENTRE FOR HARM REDUCTION  
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**▼▲ HIV, Hepatitis B & C can come from sharing injecting equipment such as needles, syringes, spoons, filters, water, glasses, tourniquets**

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**Reasons for sharing**

- Lack of injecting equipment
- Cultural and social practice
- Unaware of risks
- Extension of sexual relationship or friendship
- Lack of perceived risks
- Lack of smokeable opioid

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CENTRE FOR HARM REDUCTION  
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**▼▲ Lack of clean injecting equipment**

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- Unable to purchase
- Costs
- Reluctance to carry injecting equipment

**Poor knowledge of HIV transmission**

- Unintentional indirect sharing
- Poor understanding of health principles
- Unsafe initiation to drug use

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**SECTION 2 • CHAPTER 5 • OVERHEAD 2**

CENTRE FOR HARM REDUCTION  
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**▼▲ Regional spread of blood borne viruses**

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- Mobility
- Prisons and sharing
- Shooting galleries/professional injectors
- Transitions from smoking to injecting drugs

**▼▲ Strategies to Prevent Sharing**

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- Raise level of awareness among IDUs
- Sterile equipment freely available
- Used equipment unavailable
- Information/education on risks
- Change peer norms

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SECTION 2 • CHAPTER 5 • OVERHEAD 3

CENTRE FOR HARM REDUCTION  
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**▼▲ Approaches on risk awareness**

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- Education/information is credible and acceptable
- Promote attitude and behaviour change
- Peer educators
- Change peer norms

**Needle and Syringe programs aim to minimise the sharing of equipment thus reducing the risk of HIV transmission.**

**Outreach workers help IDUs to use NSP and lessen the problems associated with shooting galleries.**

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SECTION 2 • CHAPTER 5 • OVERHEAD 4

CENTRE FOR HARM REDUCTION  
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▼▲ **Disinfection of used equipment**

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- Boil equipment
- Rinse with water after use
- Bleach
- Dish washing detergent, alcohol, iodine

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SECTION 2 • CHAPTER 5 • OVERHEAD 5

CENTRE FOR HARM REDUCTION  
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▼▲ **Disposing, Retrieval Aims and Sites for Unsterile Equipment**

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- Ensures clean equipment used
- Avoids re-sale of equipment
- Ensures appropriate disposal
- Handed back to place of purchase
- Burn in incinerator
- Provision of disposable containers

**Disposal can be complex and difficult but to avoid health hazards it needs to be addressed**

*Manual for reducing drug related harm in Asia*  
SECTION 2 • CHAPTER 5 • OVERHEAD 6

## Section Two

### *Chapter Six*

## Drug Use and Substitution



Drug use

Drug substitution

Methadone

Buprenorphine

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## Introduction

Drug substitution is one of the options for reducing harm to drug users. For many drug users going “cold turkey” that is, abruptly stopping drug use, is too painful and fearful to contemplate. Their motivations may be good but the physical pain of withdrawing is too much: before they know it they are out looking for drugs again. Even if the drug user feels highly motivated to give up using drugs, the influence of his/her peers in their social scene can easily lead them to using drugs again. Drug substitution programs aim to stabilise drug users, to give them an opportunity to re-establish their lives. Drug substitution, and other programs aimed at HIV prevention, also offer the opportunity of attending to the primary health needs of drug users and giving them information on ways to protect their health, and the health of others, if they continue to take drugs.

This chapter will look at:

- 1 Drug use
- 2 Drug substitution
- 3 Methadone
- 4 Buprenorphine

I. Drug Use

- What types of drugs do people use?
- Why do people use drugs?
- What are the levels of drug use?
- What are the reasons people change or stop their drug use?
- Why do people relapse?

“Given the complexity of drug use, the extreme difficulty experienced by many dependent drug users in changing and staying changed, the difficulties experienced by clinicians and others in seeking to assist them, and the limited understanding of the bio-psycho-social interaction which shapes drug use, harm reduction would seem a pragmatic and socially responsible policy option.”<sup>1</sup>

Dr Adrian Reynolds

Societies throughout the world have always used substances that suppress pain and sorrow and also provide a pleasurable sensation. In many cultures drugs are used in traditional religious rituals. Drugs are also used to ease the pain of illness, such as opium either in its original form or as morphine (or synthetic versions) in hospitals throughout the world. Archaeological evidence indicates that cannabis cultivation dates back to at least 6000 BC.<sup>2</sup>

Many drugs have the capacity to create a strong habit in the user, making further use difficult to avoid. The power of drugs and their potential for dependency is obvious in the legal, and often socially sanctioned, drugs such as alcohol and tobacco.

Each group of drugs produces its own variety of effects and dependency. But the compulsion (need) to use the drugs is an important common factor shared by dependent drug users be it for opiates, depressants, stimulants or nicotine.<sup>3</sup>

What types of drugs do people use?

(For more information on the pharmacology of drugs see Appendix 2 – Drugs and their Actions)

**Opiates (Opioids)**

Opium is the coagulated juice from the unripe capsule of the poppy plant: it contains morphine and other psychoactive substances which can be extracted in pure form, such as codeine. Morphine can quite easily be converted to heroin by a simple chemical process. There are also many entirely synthetic opiates such as methadone and pethidine. All these substances share the capacity to:

- relieve pain
- produce a pleasant, detached, dreamy euphoria
- to induce physical dependence leading to distressing withdrawal symptoms when the drug is stopped

**Depressants**

Depressants include alcohol, barbiturates and synthetic sedatives and sleeping tablets. These substances cause a degree of drowsiness and sedation or pleasant relaxation. They can also have serious withdrawal symptoms.

**Stimulants**

Stimulants include cocaine which is the psychoactive ingredient of the coca leaf. It produces a sense of exhilaration and decreases fatigue and hunger. There are also synthetic stimulants such as amphetamines. These substances have a high dependence potential.

Chapter Six  
*Drug use and substitution*

## Hallucinogens

Hallucinogens include LSD (lysergic acid diethylamide) and can come from both synthetic and plant derived substances. These drugs have the capacity to induce highly complex psychological effects including 'out of body' experiences, hallucinations and other types of perceptual distortions.

Hallucinogens do not induce physical dependence.

## Other drugs

There are many other drugs people use which do not fit into the above categories satisfactorily. They include cannabis, inhalants (glue, paint thinners etc.) and other drugs such as kava (used in the Pacific islands and New Guinea) and betel nut (used widely in Asia and the Pacific).<sup>4</sup>

## Why do people use drugs?

People may use drugs at particular times in their lives: young and experimenting or old and for pain relief. They may also use drugs in different ways at different times. Many theories exist about why people use drugs but there is no simple answer. Drug use and drug problems appear to be influenced by a range of factors, so that no single theory seems adequate. Some of the reasons people may use drugs include:

- **Tradition:** as part of symbolic or religious ceremonies
- **Self-medication:** to relieve feelings of fear, anxiety and depression
- **Pain relief:** to relieve physical symptoms of pain
- **Enjoyment:** for the pleasurable effects, for fun
- **Lifestyle:** to belong to a peer group
- **Forget:** to alleviate misery, poverty and disadvantage

## What are the levels of drug use?

### Level 1. Experimental

Single or short term use: motivated by curiosity or a desire to experience new feelings or moods.

### Level 2. Social/Recreational

Well-controlled use in social setting: experienced users know what drug suits them and in what circumstances. If they like the effects and the group, they will use despite its illegality.

### Level 3. Circumstantial

Specific purpose: situations where particular tasks have to be performed or freedom from pain is sought, where temporary relief is needed. For example; study, stress, bereavement.

### Level 4. Intensive

Major doses daily: similar to previous category but borders on dependence.

### Level 5. Compulsive

Persistent, frequent high dose: producing psychological and physiological dependence such that the user cannot discontinue without experiencing significant mental and/or physical distress.<sup>5</sup>



## HARM REDUCTION NEWS



### MS R.

CHURACHANDPUR, INDIA

**M**s R was born in 1976 into a poor family with five children in the north eastern Indian state of Manipur. By the age of 10 she had started drinking alcohol and taking pills. “When I was in eighth class my friends told me that by injecting heroin you get the kick immediately. That was tempting as I had to wait for half an hour for the kick while taking pills. One day I happened to accompany a friend who was injecting. Being a friend, I could not stay away while she was injecting. So, I accepted the offer made by the pedlar to me, and he injected me with an old syringe that he kept at home for his customers. I vomited instantly and complained that it was not nice. I decided not to inject again at all but my friend kept on saying that I

should do it again and again to taste the high. After a week or so I began to realise that I was already addicted. I had to provide for myself so I started cheating people. Every time people invited us for a drink we drugged them with certain pills and emptied their pockets when they fell unconscious. After a year of injecting my body became weaker and weaker.”

Ms R. continued to inject various drugs and developed severe abscesses. “I got operated on three places simultaneously by SHALOM staff. I thought that I would surely die this time. It was a miracle I recovered but I was bedridden for about seven months. During my illness the SHALOM staff visited me regularly and counselled me. They educated me about HIV/AIDS and encouraged me to stop using drugs com-

pletely. I went for a confidential blood test and learned my HIV status. Though deep in my mind I had always suspected myself to be positive, when I first learned that I was HIV positive I could not believe it and at one point I even thought of committing suicide. During those days there was a spiritual counselling session going on at SHALOM for a week and I joined it. It was there I came to realise that I had something worthwhile to live for. I am now committed to helping people like me to lead a positive lifestyle. I can lead a cheerful life even if I am HIV positive and anybody else can.”

Ms R. now works as an outreach worker for SHALOM and has appeared on local television as a spokeswoman for people who are infected with HIV.

“  
By the age of 10 she had started drinking alcohol and taking pills.  
”

“  
After a year of injecting my body became weaker and weaker.  
”

“  
... I came to realise that I had something worthwhile to live for.  
”

### What are the reasons people change or stop their drug use?

There are various models which seek to explain the factors influencing behaviour change. Some reasons behaviour change may be successful include:

- believing that one is susceptible (vulnerable) to a serious health problem (perceived threat)
- having the knowledge and understanding of healthier choices
- having the motivation to implement healthier choices
- believing that doing something will reduce the perceived threat
- having the skills to make the behaviour change
- having the means to make the behaviour change (e.g. clean needles and syringes, substitution programs, condoms)
- having the confidence in one’s ability to implement behaviours which will protect one’s health

Chapter Six  
*Drug use and substitution*

The Centre for Harm Reduction

- having a supportive social, economic, policy and legal environment for adopting healthier choices (e.g. needle and syringe programs, drug use viewed as a health rather than criminal issue)
- having the basic human needs provided (e.g. food, shelter, income, employment, education, freedom from violence)<sup>6</sup>

### Why do people relapse?

Many people who are dependent on drugs may stop using them, for long or short periods, but eventually start using them again. Some people do manage to stop their drug use but are considered vulnerable to relapse. An alcoholic is generally considered an alcoholic for life whether they are drinking or not. Recovery from drug use is a delicate balancing act. Most initial attempts at stopping drug use are unsuccessful and drug dependent people may relapse many times, particularly in the early stages of treatment.<sup>7</sup> Even if the motivation to stop using drugs is strong a person may be unable to resist the temptation. The reasons for relapse are varied and may include:

- stopping drug use was not the person's own decision (e.g. being forced into treatment and rehabilitation)
- the level of dose of the substitution drug is too low
- recovering health and feeling that no great harm will come from taking drugs
- emotional stress
- the power of group dynamics – friends persuading the person to take drugs

It can be dispiriting for both the drug user and treatment worker when relapse occurs. It is important to keep in mind that behaviour change takes time. The risk of relapse is another good reason for making sure that people in treatment know about safer using practices (see **Chapter Five: Injecting Safely**).

When a drug user comes into contact with an HIV prevention program or a treatment program, it is a good opportunity to explain the risks of sharing injecting equipment and having unprotected sex. By giving people information about safer drug using practices a program worker is not condoning drug use. The worker/counsellor is instead *protecting* the health of the individual, his/her friends and partners and the health of the wider community.

## 2. Drug Substitution

### What is drug substitution?

Drug substitution means replacing the drugs a drug user is taking with another drug or a similar drug. It may also mean using the same drug but taking it in a different way, for example, sublingual buprenorphine to replace injecting of the drug. Often, the initial common responses to the idea of a drug substitution program are: why on earth would you do that? Isn't that just encouraging and condoning drug use? But the goal of drug substitution is to reduce the health, social and economic harms to individuals and to the community, not to 'push' drugs.

Drug substitution programs have a long history. During the first two decades of this century many morphine maintenance clinics existed in the United States before being closed down under the pressure of law enforcement authorities. Until the last twenty years or so in Asia, government outlets allowed addicts to register and obtain legal access to opium. In the U.K. doctors are still able to prescribe whatever drugs they decide are appropriate: this includes heroin, cocaine, amphetamines and other drugs. Switzerland has been running a heroin substitution and maintenance trial program since 1994.<sup>8</sup> Many Western, and some Asian countries, run methadone (and increasingly buprenorphine) substitution and maintenance programs with good results.

The aims of drug substitution are:

- to lessen the risks of contracting or transmitting HIV/AIDS
- to switch users from 'black market' drugs of indeterminate quality, purity and potency to legal drugs of known purity and potency
- to minimise the risks of overdoses and other medical complications
- to switch from an injected to a non-injected substance

- to reduce hazardous drug use, e.g. sharing injecting equipment, polydrug use, injecting crushed/filtered tablets
- to reduce the motivation and need for addicts to commit crimes to support their drug habits and to keep them out of the dangerous environment of prisons
- to maintain contact with drug users
- to provide counselling, referral and treatment
- to help drug users stabilise their lives and re-integrate with the general community

A variety of drugs can be used for drug substitution, these include:

- Methadone
- Buprenorphine
- Tincture of opium
- LAAM (levo-alpha-acetylmethadol)
- Morphine
- Codeine
- Naltrexone

### 3. Methadone

**What is methadone?**

**How is methadone used for detoxification?**

**What is methadone maintenance treatment?**

**What makes a methadone maintenance program successful?**

**How long should a methadone program last?**

**What is the methadone dose?**

“Although ideally patients should be able to achieve a drug free state, it is accepted that this will not be possible for a significant number of drug abusers, given the chronic relapsing nature of narcotic addiction. However, the {methadone} program does provide to every single drug abuser a readily accessible, medically safe and effective alternative to continued illicit self-administration of heroin.”

*Action Committee Against Narcotics  
– Hong Kong<sup>9</sup>*

#### What is methadone?

Methadone was developed in Germany in 1945 as a painkiller and was first trialled in New York in the mid 1960s to treat heroin addicts who had not responded well to abstinence-based treatments. The positive outcomes of this trial have been replicated throughout the world.<sup>10</sup>

Methadone belongs to a group of drugs called opiates which include heroin, codeine and morphine. These drugs are narcotic analgesics: that is they are all strong painkillers. Opiates also induce a sense of wellbeing and euphoria. People who are addicted to heroin, or other opiates, are physically, and often psychologically, dependent on the drug. If the concentration of opiates falls below a certain level in a dependent user’s body he/she will experience withdrawal symptoms. Methadone is a long-acting synthetic drug which alleviates the withdrawal symptoms.

Methadone is not a cure for opiate addiction: while on methadone a client is still physically dependent on opiates. But, methadone offers people a chance to stabilise their lives and lessen the risks associated with illegal drug use such as sharing injecting equipment and contracting and passing on blood borne viruses.

Methadone is widely established in Australia and Europe as a treatment for opiate dependency. Methadone is used both to detoxify people who are dependent on opiates and as an ongoing treatment.

#### How is methadone used for detoxification?

Programs firmly focused on abstinence generally use short-term methadone treatment, which aims at rapid detoxification. The short-term treatment will have a fixed time frame for the client to take the methadone. For example, in Thailand methadone treatment generally consists of a 45 day detoxification regime.

However, the research shows that this approach is associated with poor treatment outcomes with the majority of clients returning to opiate use.<sup>11</sup>

Comparative studies between short term (detoxification) methadone programs and the longer term methadone maintenance programs show that:

- the more effective programs use higher doses of methadone (above 50-60 mg daily)
- have a treatment goal of long-term maintenance as opposed to detoxification to abstinence
- have better support services (including counselling, social and medical services)
- have better staff-client relationships<sup>12</sup>

Programs which offer both methadone maintenance and detoxification (at the clients’ choosing) have better rates of success. In Hong

Harm Reduction **News** 

**Methadone Substitution in Northern Thailand**

MAE CHAN, THAILAND

During the early 1990s, the Akha hilltribe villages in far north Thailand experienced a dramatic increase in injecting drug use. In the past the Akha people smoked opium for ritual purposes and for use as a pain killer. Continuing political problems in Myanmar, and opium crop eradication in Thailand, have led to significant changes in the nature of opium crop production in the mountainous Shan State. While there is less opium in

**“While there is less opium in the villages the availability of injectable heroin has increased.”**

the villages the availability of injectable heroin has increased.

In response to this increase, and the associated harms of injecting and blood borne viruses, needle and syringe exchange programs were established in nine villages (for more information on this part of the project see Chapter Five: Injecting Safely).

Eighteen months after the needle and syringe program was established (1995), the project started a methadone detoxification program in six of the nine villages, following the 45 day schedule of the Thai government. Later, two of the villages extended the

detox period from 45 to 98 days. The majority of drug users in each village were admitted to the program. Methadone was distributed at the village twice a day by the project staff. The maximum starting dose was 40 mg of methadone and came down by 5 mg. Once the dose fell under 25 mg a day compliance rates were dramatically reduced (in terms of people turning up to the clinic and abstaining from other drug use). Relapse rates were high: of the 194 clients in the detox program only six of them were abstinent after two months.

In 1996, permission was given to the project to introduce methadone maintenance. The program operates in nine villages with 77 per cent of the drug using population participating. Methadone is distributed once a day at a set time from the primary health care centres which the project built and established. The workers also carry out limited follow up for people who don't turn up for their dose.

The results of the methadone maintenance program are encouraging: data from one village show that of 69 habitual users at the beginning of the program the majority have remained in treatment or achieved abstinence. Overall, the use of heroin in the village has declined. With more than 60 former habitual drug users no

longer using, the community as a whole has benefited: stealing has all but disappeared, malnutrition rates among the children have decreased, attention to personal hygiene has improved as has employment levels, and the sale of illicit drugs in the village has been banned.

**“... the majority have remained in treatment or achieved abstinence.”**

Methadone is given out at the community level. This means:

- 1 clients are able to remain in treatment because the services are provided within walking distance of their homes
- 2 peer support has been organised and is ongoing and encourages people to stay in treatment
- 3 the dispensing of methadone has been 'demedicalized' by recruiting, training and employing young villagers as primary health care workers to dispense the methadone (and in one village tincture of opium).

The successful experience of methadone maintenance in a remote part of northern Thailand shows that an intervention which has been used almost exclusively in urban centres in developed countries can be implemented in a variety of settings.<sup>13</sup>

Kong, for example, there is no waiting list for people wishing to start on a methadone program: there is also no time limit for how long they are on the program. But, if and when patients feel ready and able to go off the program they are offered a detoxification program. The detoxification program consists of slowly reducing the client's dose of methadone over a period of time until they no longer take any methadone (see p. 219 of this chapter for more detail on dose reduction).

## What is Methadone Maintenance Treatment?

Research has shown that longer term treatment, that is Methadone Maintenance Treatment (MMT), is effective in the prevention of HIV infection. MMT is associated with lower rates of HIV prevalence and reductions in HIV risk related to injection and sharing behaviours for individuals during treatment.<sup>14</sup>

A methadone maintenance treatment program aims to minimise the harms experienced by people who are dependent on opiates and to normalise their lifestyles and behaviours.<sup>15</sup>

The objectives of a methadone maintenance program are:

- to reduce injecting drug use
- to reduce the risk of premature death
- to reduce illegal drug use
- to improve IDUs' health
- to reduce involvement in crime
- to improve psychological and social functioning

Methadone maintenance programs have been found to be successful in improving the physical, mental and social wellbeing of clients. However, it is unrealistic to expect that a program will be able to eliminate all clients' drug taking and associated behaviours. Setting such high goals leads to a sense of

failure for both the clients and the workers. Methadone is not a miracle cure and for the best results it needs ongoing counselling, information and support for the clients.

## What makes a methadone maintenance treatment program successful?

- the dose of methadone must be sufficient to keep clients from going into withdrawal (60 mg or more a day). Research in western countries has shown that if the dose of methadone is adequate clients are less likely to use other drugs and as a result the risk of HIV transmission is reduced<sup>16</sup>
- the policies of the program, and the attitudes and skill of the staff, play an important part in keeping a client in treatment. If clients are treated well and with respect they are much more likely to stay in the program and build a relationship of trust with the staff
- the program should provide more than just the daily dose of methadone, staff should be trained about HIV/AIDS, counselling techniques, primary health care etc.

### Positive features of Methadone Maintenance Treatments:

- methadone can be taken orally
- methadone lasts long enough in the body (from 24 to 36 hours) so that it only needs to be taken once a day
- is more attractive to many clients than other options (i.e. cold turkey, short term detoxification, imprisonment)
- scientific research shows that MMT is more effective than abstinence based treatments at keeping clients in treatment, that is it has lower relapse rates, has reduced injecting drug use and its associated harms
- is cheaper than detoxification followed by outpatient counselling, therapeutic communities or imprisonment

**Potential side-effects of Methadone treatment**

- nausea
- vomiting: 10 – 15 per cent of people respond this way to methadone but this usually settles down over several days to a week
- constipation: as with all opioids, diet and exercise can help
- sweating: this may occur as a side-effect of the methadone or because the dose is inadequate
- amenorrhoea: lack of menstrual periods, alternatively methadone can make periods more regular
- libido: may reduce sexual desire
- lethargy: may lessen on a lower dose <sup>17</sup>



Clients need to have the potential side-effects explained to them and weighed up against the benefits of being on a program before they begin treatment. (See **Section Three: Drugs and their Actions** for more information on the pharmacology of methadone.)

**How long should a methadone maintenance program last?**

Most methadone maintenance programs have no set time limit. The programs are more likely to encourage clients **not** to leave the program for at least the first six months. A program which has adequate resources (that is, it can continue to supply the methadone and other services to clients) should continue to provide access to MMT for opiate dependent people for as long as they continue to benefit from it. In this it is similar to the way drugs are provided indefinitely for people with a range of other health problems such as heart disease, hypertension, diabetes etc.<sup>18</sup>

This does not mean that programs accept that their clients will always be dependent on opiates. A MMT offers clients an opportunity to stabilise their lives: to improve family relationships, to find and maintain a job, to feel physically and psychologically healthier. This change in lifestyle can give clients the confidence and motivation to attempt a drug free life.

**What is the methadone dose?**

**Starting off:** doses of methadone vary from client to client due to differences in metabolism, body weight and tolerance to opiates. It takes a while to determine the correct dose of methadone for each client. At the start of treatment a client needs to be seen daily and assessed to see how he/she is coping with the dose. If the client displays significant signs and symptoms of opiate withdrawal the dose will have to be

Manual for  
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## HARM REDUCTION NEWS



### METHADONE TRIAL IN VIETNAM

HANOI, VIETNAM

Vietnam is trialling a methadone maintenance program in Hanoi as part of the effort to combat the HIV epidemic. The program is being run through the National Institute of Mental Health. It is located in a spacious one-room facility at the Institute and is staffed part-time by three doctors and full-time by a nurse; all come from the psychiatric department of the Institute. The idea of a substitution program is new to Vietnam so they are proceeding cautiously and providing regular information to officials from various government ministries to keep them informed of the program's progress.

It is a ten month trial of just 70 people, all of whom must have support from their families and live within commuting distance of the project

site. This is to ensure compliance with the treatment.

At the beginning of the study the client has to report to the methadone maintenance centre every day for ten days. Up until the third month the client reports six days a week with a take-home dose of methadone on Sundays. The take-home dose

“  
The idea of a  
substitution program  
is new to Vietnam ...  
”

is only allowed if the urine analysis tests and compliance are satisfactory. The take-home dose is always given to a reliable family member: this is one of the reasons the program insists the client must have a supportive family. After three months, if all is going well, the patient only has to

come to the project site three times a week and this may be reduced to once a week. By the seventh month of the program the client's dose of methadone is slowly reduced (as this is only a 10 month treatment).

If, at any time, a client has a positive urine analysis he/she are required to start the procedure again and pay a fine of 500,000 dong (\$40 US – the average annual wage in Vietnam is \$240 US). The management believe this will deter clients from using other drugs. The methadone maintenance treatment program is only in its infancy and has problems of staff shortages so the follow-up at the completion of the program is minimal. During the program, staff attempt to provide some counselling on drug use and HIV to their clients.<sup>20</sup>

increased. Many programs start with a dose of 20 mg of methadone and will increase the dose 5-10 mg per day according to the client's tolerance.

**Maintenance:** generally clients will stay in treatment and limit (or stop) their illicit drug use if their dose of methadone is moderate to high (60 – 100 mg).<sup>19</sup> It is important that the dose is increased carefully and slowly until the client is experiencing only the mildest of withdrawal symptoms and is not sedated by the dose.

**Reduction:** reducing the dose of methadone with the aim of coming off the

drug should be at the request of the client. Ideally, by this time the client's life will have stabilised: he/she will have some work, have made social contacts outside the drug scene and have not used other drugs for many months. The rate of reductions in dose varies: some people reduce their dose very slowly, others more quickly.

It is important to closely monitor a client who is withdrawing from a methadone maintenance program. If the client is showing obvious physical or psychological distress it may be best to stop the dose reductions for several weeks until the client

is feeling more comfortable and confident about the reductions. If, in the face of distress, the reduction continues as planned invariably clients relapse into using illicit drugs.

DOSE REDUCTION:  
METHADONE DOSE RECOMMENDED  
RATE OF REDUCTION

**High** greater than 80 mg  
5 – 10 mg per week/fortnight

**Medium** 40 mg to 80 mg  
2.5 – 5mg per week/fortnight

**Low** below 40 mg  
1 – 2.5 mg per week/fortnight <sup>21</sup>

**Use of other drugs :** it is common for clients to continue to use other drugs when they first begin on a methadone program. This may occur particularly when their dose has not yet stabilised. While clients may continue with some opioid use, they may also use non-opioid drugs such as alcohol and benzodiazepines. The major concern here is that the use of multiple drugs can lead to overdose. Workers in methadone maintenance treatment programs need to be aware of the potential use of other drugs by their clients and aim to establish a relationship with their clients where they can openly discuss the drug use and the problems the client is having in stopping other drug use.

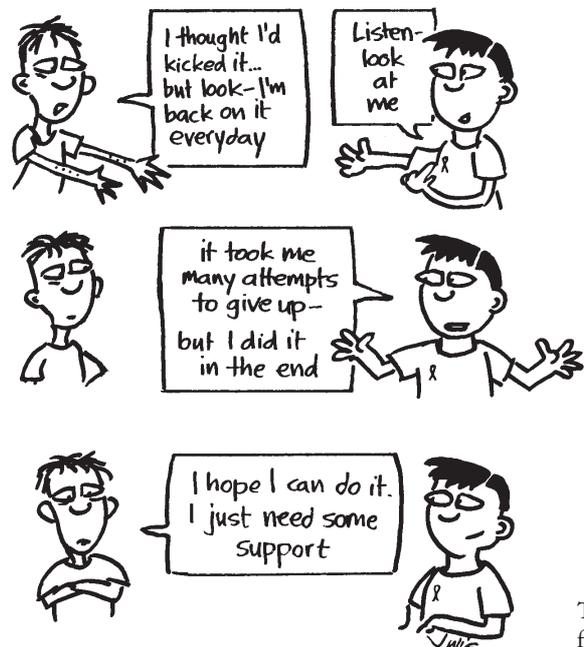
Often, continued other drug use may be because the dose of methadone is too low for the client. If a client continues to use other opioids while in a MMT, the methadone dose should ordinarily be carefully increased providing there is no significant risk of overdose.<sup>22</sup>

**Intoxication:** there are a number of options available if a client turns up at the clinic for his/her dose and it is obvious that he/she has taken enough opioids or other

drugs which combined with the methadone may lead to an overdose. The most important thing to remember is that you don't want to do any harm to the client.

- You may have to withhold a part of, or the entire dose, for that day
- You may ask the client to return 2 – 6 hours later when you will review him/her again before dosing is considered
- If you are extremely concerned about the client's wellbeing you may ask him/her to stay at the clinic under medical supervision or be admitted to hospital until his/her condition is stable.<sup>23</sup>

**Missed doses:** it is important for clients to receive their dose regularly to make sure they have steady levels of methadone in their bloodstreams: to keep them balanced and to avoid the onset of withdrawal symptoms. If a client has missed a dose/s it may be necessary to adjust the dose as his/her opioid tolerance may have reduced unless they have had other opioids in the meantime. It may be a good opportunity to spend some time with the client to discuss why they have missed a dose/s and to examine how they are doing on the program.



## Harm Reduction News

### Methadone in Hong Kong

HONG KONG, CHINA

Methadone has been used as a substitute drug in Hong Kong since 1972. It was initially established as a three year trial as a treatment for heroin addiction. More than a year before the study finished the government had decided to set up a massive methadone

**“Within five years the number of addicts arrested ... had dropped by 70 per cent.”**

treatment program through a network of clinics throughout Hong Kong. Within two years the ambitious goal of offering every heroin addict immediate access to treatment was met through a network of 20 clinics. Emphasis was still being placed on prevention, education and local and international law enforcement. Voluntary drug free residential treatments were still encouraged and available. By 1976, almost 10,000 patients were receiving methadone daily. Within five years the number of addicts arrested for drug or

other offences had dropped by 70 per cent.<sup>24</sup>

Twenty-one methadone clinics now operate in Hong Kong which are open either between 6-10 pm or 7am – 10 pm seven days a week. The Department of Health runs all methadone maintenance and detoxification treatments. All new methadone patients start on 30 mg or less and the dose can be increased by 5 mg per day. The maximum level of increase within a week is 25 mg. The clinics have found that patients who take a higher dose of methadone are comparatively more stable than those patients on less and they tend to use heroin less often.<sup>25</sup> Clients take the methadone orally in a syrup: they have to take their dose in front of the dispensing staff and are not allowed to take their dose away from the clinic. The price of methadone has stayed the same for 20 years – \$1 (Hong Kong).

Since 1993, social workers from the Society for the Aid and Rehabilitation of Drug Abusers (SARDA) have provided counselling services for the patients at all the clinics.

SARDA also refer clients to relevant agencies for residential treatment and health social services. Their prime target group is people under 21 years of age who are presenting for methadone treatment for the first time. Since the 1960s, SARDA has also

**“...it can help heroin addicts regain a normal life ...”**

provided voluntary inpatient treatment centres for both male and female drug users. For people who have gone through a methadone detoxification program, social workers at SARDA will provide follow up services and assess the client's progress.<sup>26</sup>

The advantage of methadone as a substitute for heroin is that it can help heroin addicts regain a normal life and achieve social stability. This has been officially recognised in Hong Kong. By June 1997, the estimated number of HIV infections among injecting drug users was 16.<sup>27</sup>

## 4. Buprenorphine

### What is buprenorphine?

Why does buprenorphine work as a substitution drug?

“About 85 per cent of our clients work but very few have jobs on a monthly basis: it is daily labour. So they have to work – they can’t afford to spend time in the detox or rehab centres getting treatment while the wife and children starve – most are married. So they have to go on living, they have to continue feeding their families but over a period of time that capacity stops. Now they take this medication and they find they can go back to work and do things.”<sup>28</sup>

Jimmy Dorabjee, SHARAN, India.

### What is buprenorphine?

Buprenorphine is a synthetic drug which is used as a pain killer. It is easily and widely available in some countries in Asia as an across the pharmacy counter drug. As the price of heroin has increased in certain communities, drug users have begun using buprenorphine as an alternative.

Buprenorphine is increasingly being studied and used as a substitution drug in programs for people who are dependent on opiates. The interest in buprenorphine in Asia has increased in recent years because:

- of its acceptability and availability compared to methadone (e.g. in India methadone is not manufactured and therefore it would be very expensive to import the drug whereas buprenorphine is available in pharmacies)
- it is increasingly being used by drug users
- it is a relatively safe drug

### Why does buprenorphine work as a substitution drug?

Research into buprenorphine shows that the use of the drug in substitution programs:

- reduces the use of other opioids
- keeps clients in treatment
- is safe and death from buprenorphine use alone has not been reported
- causes few side-effects
- is liked by the clients
- is a good substitute drug for people with low to moderate opiate dependency
- has only mild withdrawal symptoms<sup>29</sup>

Buprenorphine has two characteristics which make it uniquely suitable as an opioid substitution treatment medication:

- 1 It is unlikely that people will overdose on it
- 2 It is a long-acting drug

The benefit of buprenorphine as a long-acting drug means that it does not have to be taken daily. This can make it more acceptable to clients as they don’t have to visit the clinic every day which gives them more flexibility in regard to work, other commitments and the sense of being in control of their lives.

Buprenorphine (and other) substitution programs measure their success by:

- how many clients remain in treatment
- follow up with clients
- the numbers of people who go back to using opiates or other drugs when they have completed a substitution program
- the client’s physical wellbeing
- the incidence of HIV, Hepatitis B and C, Tuberculosis
- the client’s quality of life

Chapter  
Six

*Drug use  
and  
substitution*

The Centre  
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## HARM REDUCTION NEWS



### BUPRENORPHINE SUBSTITUTION PROGRAM

NEW DELHI, INDIA

SHARAN, the Society for Serving the Urban Poor, is an urban development non-government organisation in New Delhi, India.

In the early 1990s, SHARAN identified a growing problem of injecting drug use in the city among urban slum dwellers. Many of the IDUs had serious health problems associated with their injecting; such as incorrect injecting practices with the consequent development of ulcers, abscesses, cellulitis and thrombophlebitis. SHARAN found that there was frequent needle and syringe sharing with little cleaning occurring between uses, increasing the risk of the spread of hepatitis and HIV.

As the price of heroin increased the users began switching from inhaling heroin to injecting Buprenorphine. Through a series of focus group discussions with IDUs, SHARAN sought to discover why the injecting of Buprenorphine had become such an attractive alternative to heroin use. They found that most of the IDUs began injecting Buprenorphine in the belief that they would be able to stop using heroin and because Buprenorphine was cheaper. The focus groups also revealed that most heroin inhalers are potential injectors: all that is required is

heroin availability to drop for them to take up injecting.

SHARAN clearly saw the need for some intervention with the IDUs and established a trial program of sublingual Buprenorphine. The trial established that Buprenorphine was acceptable to heroin addicts, has few side effects, blocks the effects of subsequently administered doses of morphine, binds tightly to the opioid receptors, appears to induce only a low level of physical dependence and significantly diminishes the self-administration of heroin.

SHARAN had already made contact with many IDUs through their detoxification camps. The substitution program began on a pilot basis in early 1993 with 30 IDUs and quickly expanded to 300. Initially the doses of Buprenorphine were administered through a street delivery system. SHARAN discovered, that for some clients, the dose of Buprenorphine was too low and they were going into withdrawal. They increased the doses and found that this also had the added benefit of blocking the effect of any other narcotics taken by the IDUs.

As their clients increased, SHARAN established a drop-in centre where their clients could receive their dose. The drop-in centre also doubles as a bi-weekly health clinic.

Clients are given Buprenorphine for one year for free: after this time they are offered prescriptions which are reviewed monthly. During this time any client who wants to detox can do so in SHARAN's detoxification camps or be referred to other services. Short term rehabilitation is also offered and clients can embark on a structured dose reduction program. From February 1995 to January 1997, 315 of the 1320 Buprenorphine clients attended the clinic regularly. Thirty four per cent (447) of the clients were IDUs and of these 33 per cent (148) had given up injecting. Thirty-five per cent (158) had stopped sharing equipment and/or reduced the frequency of injections. Initially, there was some client resistance to taking their Buprenorphine orally but over time it was accepted. Through a system of peer education and peer research, SHARAN has continued to interview and evaluate clients' attitudes to the program: most clients reported that their quality of life, economically, socially and health-wise, had improved. As a result of this experience, SHARAN believes that oral Buprenorphine is a feasible, low-cost and effective tool which diminishes the risk of HIV among high risk opiate injectors.<sup>30</sup>

“  
Many of the IDUs had serious health problems associated with their injecting...  
”

“  
...most heroin inhalers are potential injectors...  
”

“  
...33 per cent had given up injecting. Thirty-five per cent had stopped sharing...  
”

Summary

Drug Use

**Principal drugs used are as follows:**

**Opiates (Opioids):** opium is derived from the opium poppy and contains morphine and other psychoactive substances. Morphine can be converted into heroin. Various synthetic opiates exist such as methadone and pethidine. While opiates relieve pain and produce a feeling of euphoria they can also induce a high level of dependency.

**Depressants:** are alcohol, barbiturates, synthetic sedatives and sleeping tablets. They can cause drowsiness, sedation or pleasant feelings of relaxation.

Withdrawal symptoms can be serious.

**Stimulants:** include cocaine that is derived from the coca leaf and synthetic stimulants such as amphetamines. A sense of exhilaration often arises. Potential for psychological dependency is high.

**Hallucinogens:** can be synthetic (e.g. lysergic acid diethylamide, LSD) or plant derived substances (e.g. certain mushrooms). While they can induce highly complex psychological effects they do not induce physical dependency.

The levels of drug use vary and range from the single or short term use (i.e. experimental) to the final stage of compulsion, when greater drug use is not only persistent but psychological and physiological dependency means withdrawal from the drug causes mental and/or physical distress.

**Some reasons to change or stop drug use:**

- susceptible to serious health problems
- knowledge and understanding of healthier choices
- motivation, skills and the means to change behaviour

- self-confidence to implement a changed behaviour
- supportive social, economic, policy and legal environment for healthier choices

Recovery from drug use is a delicate balancing act and drug dependent people may relapse many times. Temptation to re-use drugs can be great and relapse can occur for various reasons: decision to stop using drugs made by others (e.g. rehabilitation centre), substitution drug is inadequate, emotional stress and peer pressure to take drugs. It must be emphasised that behavioural changes take time.

Drug Substitution

Drug substitution means replacing the drugs a drug user is taking with either the same drug or a similar drug. The drug substitution goal is to reduce the health, social and economic harms to individuals and to the community, not to 'push' drugs.

**Some aims of drug substitution:**

- lessen the risk of contracting or transmitting HIV/AIDS
- to switch users to legal drugs of known purity and potency
- to minimise the risks of overdose and other medical complications
- to provide counselling, referral and treatment
- to help drug users stabilise their lives and re-integrate with the general community
- by removing them from the criminal scene

Summary

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**Methadone**

Methadone belongs to a group of drugs called opiates that include heroin, codeine and morphine. People addicted to heroin or other opiates are physically, and/or psychologically, dependent on the drug. Withdrawal symptoms occur when the concentration of opiates falls below a certain level in a dependent user’s body. Methadone is a long acting synthetic drug which alleviates withdrawal symptoms such as aches, pains and cravings etc.

Short term methadone treatment (i.e. 45 day detoxification program as in Thailand) aims at rapid detoxification and is firmly focused on abstinence. The success of this approach is limited as research has shown clients often returning to opiate use. Programs offering both long term methadone maintenance and detoxification (at the client’s choosing) have better rates of success.

**Methadone Maintenance Treatment (MMT)** is a long term treatment that successfully improves the physical, mental and social well being of clients and has proven effective in the prevention of HIV infection. MMT programs are successful if:

- the dose of methadone is sufficient to overcome withdrawal symptoms
- positive attitude and treatment by the staff towards the clients results in a trusting relationship which encourages the client to remain in treatment
- besides providing methadone dosage, staff are trained about HIV/AIDS, counselling techniques, primary health care, etc.

Some positive features of MMT are:

1. Methadone can be taken orally
2. Methadone remains in the body for 24-36 hours and therefore only needs to be taken once a day
3. Scientific research indicates that MMT is effective in keeping clients in treatment, has lower relapse rates and has reduced injecting drug use and associated harms

*Before beginning on methadone all clients need to be told about the potential side effects and how they weigh up against the benefits. These side effects include, nausea, vomiting (temporary), constipation, sweating, lethargy, decreased libido and for women, loss of periods.*

MMT programs encourage clients to stay in the program for at least six months. Access to the MMT should be provided for as long as the client can benefit from the program. A MMT program allows a client to feel physically and psychologically healthier and assists them in gaining the confidence and motivation to have a drug free life.

**Methadone dose:**

**Starting off:** dosage varies from client to client and daily assessment is required during the commencement of treatment. The first dose is often 20mg and will have increases of 5-10 mg per day according to the client’s tolerance.

**Maintenance:** maintaining client treatment and the limiting or stopping of illicit drug use can be achieved if the methadone dose is 60-100mg. Any withdrawal symptoms must remain mild and sedation of the client must be avoided.

**Reduction:** reducing the dose should arise at the request of the client. Physical and psychological distress arising from methadone reduction must be closely monitored. Ignoring distress signals can result in the client invariably relapsing into using illicit drugs.

*It is important that workers in MMT programs are aware of the potential use of other drugs by their clients. The use of multiple drugs with methadone can lead to an overdose. Other drug use can be linked to an inadequate methadone dose, resulting in the need to carefully increase the dose. Intoxication of the client arriving at the clinic for a methadone dose can create a dilemma for the staff. In order to avoid doing any harm to the client, alternative options must always exist for such circumstances. Lastly, the problem of missed doses should be avoided so as maintain a methadone balance and to avert withdrawal symptoms; such situations often necessitate an adjustment of the dose. Discussions as to why a dose was missed and how the client is doing on the program should be encouraged.*

## Buprenorphine

Buprenorphine is a synthetic drug that is used as a pain killer. Interest in buprenorphine as a substitute drug in Asia has increased due to its acceptability and availability compared to methadone, its increased use by drug users and its relative safety. Research into buprenorphine has shown a number of benefits: it can reduce the use of other opiates, it causes few side effects and its long acting drug effect does not warrant a daily dosage resulting in greater flexibility and control for the drug user.

Societies throughout the world have used drug substances for many reasons; from the suppression of pain and sorrow to desire to experience the pleasurable sensations. While each group of drugs produces its variety of effects and dependency the important common factor shared by dependent drug users is the compulsion to use the drugs, be it opiates, depressants, stimulants or nicotine.

Chapter  
Six  
*Drug use  
and  
substitution*

### Section Two: Chapter Six: Drug Use and Substitution

For further information refer to WHO resources: Evidence for Action Papers. Refer to the following website: [www.who.int/hiv](http://www.who.int/hiv) (publications expected online from May 2003)

The Centre  
for Harm  
Reduction

CENTRE FOR HARM REDUCTION

▼▲ **Principal Drugs in Use**

- Opiates (Opioids): include opium, morphine, heroin, methadone, pethidine, buprenorphine
- Depressants: include alcohol, barbiturates, benzodiazepines, synthetic sedatives and sleeping tablets
- Stimulants: include cocaine and amphetamine
- Hallucinogens: include chemical synthetics (LSD) and plant derived substances (mushrooms)



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CENTRE FOR HARM REDUCTION

▼▲ **Reasons to change or stop drug use**

- Belief in vulnerability to serious health problem
- Knowledge/understanding of healthier choices
- Motivation/Skills/Means and self-confidence to change behaviour
- Environment of social, economic, policy and legal support for healthier choices

**Temptations to re-use drugs are great and drug dependent people may relapse many times for various reasons (e.g. emotional stress, peer pressure). It must be emphasised that behavioural changes take time.**



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CENTRE FOR HARM REDUCTION

▼▲ **Drug substitution replaces the drugs a drug user is taking with either the same drug or a similar drug. Emphasis is on comprehensively reducing harm.**

Positive aspects of drug substitution include:

- Contracting/Transmitting HIV/AIDS lessened
- Legal drugs have known purity and potency
- Reduces risk of overdose or side effects
- Counselling, Referral & Treatment
- Stability and Re-Integration

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SECTION 2 • CHAPTER 6 • OVERHEAD 3

CENTRE FOR HARM REDUCTION

▼▲ **Methadone maintenance**

Methadone is a long acting synthetic drug that alleviates withdrawal symptoms for those physically dependent on heroin or other opiates.

**Methadone Maintenance Treatment (MMT) Approaches**

- Withdrawal symptoms tolerated with sufficient dose
- Clients remain in treatment with good, trusting, empathetic staff
- Comprehensive training of staff on HIV/AIDS, counselling , etc



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CENTRE FOR HARM REDUCTION  
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▼▲ **Positive Features of MMT**

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- Taken orally
- Long acting, 24-36 hours
- Retains clients
- Lowers relapse rates
- Reduces injecting drug use and associated harms
- MMT enables clients to feel physically and psychologically healthier and can promote confidence and motivation towards a drug free life

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CENTRE FOR HARM REDUCTION  
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▼▲ **Stages of Methadone Dose**

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- 1 Starting Dose
- 2 Maintenance Dose
- 3 Reduction Dose

**Potential use of other drugs and adverse consequences experienced by clients on methadone is a reality. Options do exist for staff confronted with such problems.**

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CENTRE FOR HARM REDUCTION  
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▼▲ **Buprenorphine substitution**

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**Positive Features of Buprenorphine**

- ▶ Increased acceptability and availability in Asia compared to methadone
- ▶ Increased use by drug users in Asia
- ▶ Relative safety
- ▶ Reduces use of other opiates
- ▶ Fewer side effects
- ▶ Long acting drug

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## Section Two

### *Chapter Seven*

## **HIV/AIDS: Preventing Transmission**

### **- Through Sex**

### **- Between Parent and Child**

#### **Sexual transmission**

#### **Reducing sexual transmission**

#### **Women's position in society**

#### **Transmission of HIV to babies**

#### **Preventing parent to child transmission of HIV, within a child survival approach**



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## Introduction

Injecting drug users (IDUs) are at risk of HIV infection from sharing injecting equipment and from unprotected sex. Many IDUs are unaware, or not fully aware, that they are at risk from both behaviours. Other IDUs may be aware of the risk but continue to practise risky behaviours. Current evidence suggests that interventions aimed at promoting safer sexual behaviour among IDUs have met with limited success, particularly among IDUs with regular partners, who may themselves inject drugs.

The risk of sexual transmission is closely related to the frequency of equipment sharing, the frequency of risk-associated sexual activity and also to the extent of the epidemic in a given area.

This chapter examines:

- 1 Sexual transmission
- 2 Reducing sexual transmission
- 3 Women's position in society
- 4 Transmission of HIV to babies
- 5 Preventing parent to child transmission of HIV, within a child survival approach

## I. Sexual Transmission

How is HIV transmitted through sex?

What are the most common signs of STIs?

What are the relative risks of HIV infection?

Who is particularly at risk?

Why is it important to give IDUs information about sexual transmission?

### How is HIV transmitted through sex?

The majority of cases of HIV infection worldwide (approximately 75 per cent) are the result of unprotected sexual intercourse. Any sexual activity that allows an infected person's semen and sperm, vaginal fluids or blood (including menstrual blood) to enter another person's bloodstream can spread HIV and other sexually transmissible diseases (STIs). The way these body fluids enter the bloodstream can be through:

- the lining of the vagina or the rectum
- the opening of the tip of the penis
- a break in the skin's surface such as a cut, scratch, bleeding gums, open sore or ulcer

Every act of unprotected sexual intercourse with an HIV infected partner, that is without using a condom, puts the uninfected partner at risk of contracting HIV. The extent of the risk may be determined by:

- whether there are any other STIs present
- the sex and age of the uninfected partner
- the type of sexual act undertaken
- the stage of illness of the infected partner
- the virulence of the HIV strain involved

### Sexually transmitted infections (STIs)

Sexually transmissible diseases (STIs) range from mild and easily treatable irritations to serious diseases which can cause infertility and even lead to death. Common STIs are herpes, genital warts, chlamydia, gonorrhoea, syphilis, hepatitis etc. Many STIs have no tell tale signs or symptoms.

### What are the most common signs of STIs?

- unusual discharge from the penis or vagina
- burning, stinging or irritation when urinating
- sores, blisters, ulcers, warts, lumps or rashes in the genital and/or anal area
- itchiness or irritation in the genital and/or anal area
- pain during intercourse or a low abdominal pain (in women)
- a non-itchy rash on the palms of the hands or soles of the feet
- persistent or recurring diarrhoea

The presence of other STIs, especially diseases which manifest as open sores, increase the risk of acquiring and transmitting HIV in both men and women. They also indicate sexual activity with one or more partners. If a person has active herpes, syphilis, chancroid and so on, an open wound allows HIV to penetrate tissue and enter the bloodstream much more easily. An STI causes inflammation which means T-cells (which fight infection) are sent to the area to check on the infection. If the person is infected with HIV then some of these cells will be carrying the virus and this can increase the amount of HIV present in the reproductive tract. This magnifies the risk of transmitting the virus. If the other person also has an STI the risk is even greater again.

Chapter

Seven

*HIV/AIDS*

The Centre

Reduction

Women are generally more vulnerable to STIs, and consequently HIV, for several reasons including their biology. In women a larger surface is potentially exposed to infection: the vagina and the cervix. There is also a higher concentration of HIV in semen than in vaginal and cervical fluids.

Often women do not experience any symptoms of STIs and so don't seek out treatment. For women who do have symptoms, the stigma of attending an STI clinic may be so great that she will not seek treatment. These untreated STIs leave women more vulnerable to HIV infection. Women may not recognise a low grade infection as an STI as they do not perceive themselves as at risk : they may not realise their partner is involved in sexual behaviour outside of the relationship that is putting them both at risk. (For more information about specific STIs see **Appendix 3: Sexually Transmitted Infections**).

### Sex and age

Young girls are particularly vulnerable to infection as an immature cervix and low vaginal mucus production provides less of a barrier to HIV. However, older women, who have been through menopause, are also more vulnerable due to the thinning and drying of vaginal mucosa (hence a weaker barrier).

### Type of sexual act

Sexual transmission of HIV most commonly occurs through unprotected vaginal or anal intercourse between a man and a woman, or through anal intercourse between men, when one of the partners has HIV. During unprotected intercourse semen is deposited in the vagina or rectum and the penis comes into contact with vaginal or anal mucus. Some studies suggest that the receptive partner in intercourse (the person who is penetrated) is more at risk than the insertive partner. This is true for both vaginal and anal sex (this includes heterosexuals and homosexuals having anal sex).

Oral sex is not considered a high risk activity. It becomes more risky when there are cuts, sores or bleeding in the mouth or genitals. These inflammations mean that bodily fluids, including blood, can be transmitted into the other person's bloodstream. Sexual practices that may cause bleeding are risky. Inserting fingers or a fist into the rectum or vagina may cause damage and cut or bruise the tissue. Rough penetrative sex may also cause this sort of damage.



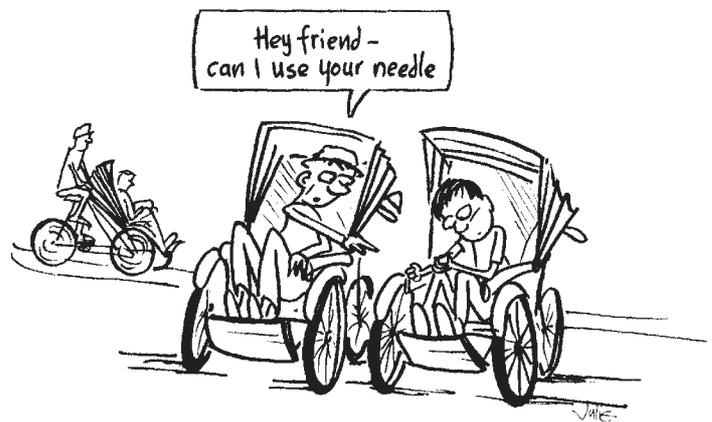
RISK

What are the relative risks of HIV infection?

RELATIVE RISK	ACTIVITY
VERY HIGH	<ul style="list-style-type: none"> <li>– transfusion of infected blood or blood products</li> <li>– sharing of contaminated needles and syringes</li> <li>– anal intercourse without a condom</li> <li>– vaginal or anal intercourse without a condom in the presence of another STI</li> </ul>
HIGH	<ul style="list-style-type: none"> <li>– some exposure of broken skin to infected blood</li> <li>– vaginal intercourse without a condom</li> <li>– breast feeding (by infected mothers)</li> </ul>
MODERATE	<ul style="list-style-type: none"> <li>– needle stick injury</li> <li>– slight exposure of broken skin to infected blood</li> </ul>
VERY LOW	<ul style="list-style-type: none"> <li>– sexual intercourse with proper use of condoms</li> <li>– oral sex (in the absence of ulcers or broken skin)</li> </ul>
NEGLIGIBLE	<ul style="list-style-type: none"> <li>– deep kissing</li> <li>– lip kissing</li> <li>– exposure of intact skin to infected blood</li> </ul>
NONE	<ul style="list-style-type: none"> <li>– any form of sexual activity between two uninfected faithful life-long partners</li> <li>– touching or hugging a person with AIDS</li> <li>– celibacy<sup>1</sup></li> </ul>



RISK



RISK

**The stage of illness:**

People who are infected with HIV are more likely to transmit the virus in the very early stages, usually before they have any idea that they are infected. This is because the viral load (or the amount of HIV in the blood) is very high just after infection. It can take up to three months after a person is infected before a test will show whether or not they are infected with HIV. This is because it takes time for the body to produce HIV antibodies. This is called the window period. The most commonly used tests to diagnose HIV look for the presence of antibodies rather than for the presence of the virus. (For more on testing see **Chapter Eight: Counselling and Testing**).

People are also more likely to transmit the virus when they have advanced HIV-related illnesses because the level of the virus in their blood is higher than at other times. The more times that an uninfected partner has sexual intercourse with an infected partner the greater the chance that they will become infected with HIV.

**The virulence of the HIV strain and viral load**

Part of the success of HIV in defeating the immune system and drug treatments is its ability to mutate into drug resistant or more virulent strains.<sup>2</sup> There is significant variation in HIV around the world, with some strains affecting particular groups and some strains seeming to be more or less infectious.

The viral load refers to the amount of the virus a person has in their body at any one time. Originally it was believed there was a latency period with HIV infection: a time between when a person was infected with HIV and developed symptoms. Research has since shown that the virus is actually multiplying in the body continuously and

the immune system is under constant pressure to try to slow or stop this replication. This leads to the eventual destruction of the immune system, HIV related illnesses and eventually AIDS.<sup>3</sup>

**Who is particularly at risk?**

- IDUs and their partners
- Sex workers and their clients
- Men who have sex with men
- STI clients
- Migrant workers
- Long distance truck drivers
- Military personnel
- Women of child-bearing age

**Why is it important to give IDUs information about sexual transmission?**

It is crucial to include information about how HIV is transmitted sexually when disseminating information on safer using practices to IDUs. IDUs are at risk of contracting and passing on HIV through sharing needles and syringes *and* through unprotected sex. Studies have shown that while there has been some success in changing IDUs injecting practices, changing IDUs' sexual behaviours has been more difficult to achieve.

IDUs face the same risk of contracting and passing on HIV through sex as other members of the community. Most IDUs are male and in general their partners do not inject drugs. They may be engaged in heterosexual and/or homosexual acts, be married, be parents, pay for sex, work as sex workers, have STDs and poor access to health services. In other words, IDUs are a diverse group and in terms of sexual transmission

## Harm Reduction News



### Jamuna

TAMIL NADU, INDIA

Jamuna is 19 and seven months pregnant with her first child. She is also HIV positive. Three years ago she was married to Nagu, a quarry labourer who works in the neighbouring state of Andhra Pradesh. Nagu's work often took him away from home for weeks at a time. He would visit home occasionally and give his earnings to his parents and wife.

After Jamuna became pregnant her in-laws sent her to stay with her parents, as is the custom, in a small town near the border between the states of Tamil Nadu and Andhra Pradesh. Two months ago Jamuna went to the local

hospital, complaining of fever and diarrhoea.

"After examining me the doctor said I would have to have a blood test to find out if I had HIV infection. After the first test showed I was positive, he sent my blood to another hospital and they confirmed the result. The doctor told me it might be best for my husband to have his blood tested too, so my father went to Andhra and spoke to my in-laws about it. They think I've been punished with this disease because I must have been unfaithful to my husband.

"But Nagu himself told me that he and his friends sleep with women at the quarry. He said that at the

end of the working day it was normal to buy some toddy (liquor) and have sex, to relax the body. My father tried his best to get Nagu to see a doctor, but he refused. I haven't seen Nagu since.

My parents got me admitted into hospital because I feel sick all the time. We've heard that my in-laws have decided to find another match for Nagu. At first I thought I would somehow try to stop them from getting him married again, but I just don't have the energy.

"If I can keep enough strength to go through with my pregnancy, all I'll have will be my child. I pray that at least my child will be free of this disease.<sup>4</sup>

they face the same risks and problems as other members of the community. But IDUs have the greatly increased risk of contracting and transmitting HIV and hepatitis C if they share drug injecting equipment.

A person may contract HIV by sharing a needle and syringe with somebody who is infected with HIV. This person can then pass the virus on to his/her partner through having unprotected sexual intercourse.

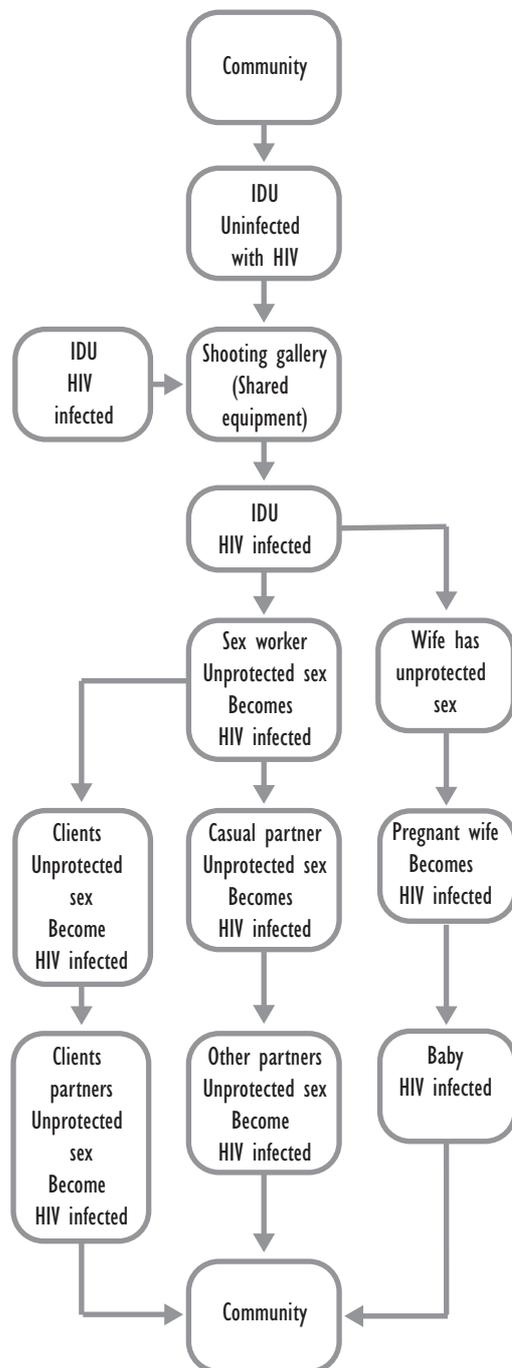
A person may have been infected with HIV by having unprotected sexual intercourse with somebody who has the virus. This person then shares a needle and syringe with somebody else and they can pass the virus on this way.

The extent of sexual networks involving IDUs is likely to increase as the epidemic increases. For example, in the early stages of a local epidemic HIV infection is likely to remain within a limited core group of IDUs. People who only occasionally inject drugs or have sex with IDUs are less likely to acquire HIV than those people who do so regularly. However, as the epidemic becomes established, more and more people are included: a person who is HIV positive and shares needles and syringes in the core group may move outside that group and share with someone else. The virus then spreads into a new group and will be transmitted both through sharing equipment and unprotected sex.

**Transmission of HIV**

- 1 Injecting drug users (mostly male) > other IDU > partners
- 2 Sex workers > clients of sex workers > partners
- 3 Partners of IDUs /clients of sex workers > children born to infected mothers

**Social network interaction of IDU and HIV transmission**



**2. Reducing Sexual Transmission**

What are the main strategies for reducing sexual transmission of HIV?

What questions should you ask the community about sexual behaviour?

What are the main strategies for reducing sexual transmission of HIV?

The main prevention strategies advocated to stop the sexual transmission of HIV are:

- to reduce the number of sexual partners
- to use condoms
- to say no to sex
- to be faithful to one partner
- to have non-penetrative sex
- to treat STIs

However, these strategies can be problematic. The strategy of reducing the number of partners is irrelevant or impossible for many women: firstly because many women only have one partner anyway, and secondly for women who are forced to sell or exchange sexual intercourse for economic reasons. The strategy of using condoms can be difficult for women: if she demands the use of a condom suspicions may arise about her fidelity and whether she has any diseases, while for sex workers clients may just go elsewhere. Women also do not often have a choice or determination over their own sexuality or their partner's faithfulness being unable to insist on either. Additionally for a growing number of girls and women, sexual assault is a reality, whereby these strategies are again irrelevant. <sup>5</sup>

## HARM REDUCTION NEWS



### INTEGRATING AIDS EDUCATION

HONG KONG, CHINA

The Hong Kong AIDS Foundation became actively involved in promoting AIDS awareness among women. The Foundation brought the message of basic concepts of HIV/AIDS, and measures for prevention, to the doorstep of each household through funfairs, seminars and workshops. However, eventually it was discovered that the women felt constrained by the traditional idea that a wife cannot refuse sex with her husband because he may go to other women. Their concern is underscored by the reality that many men have second wives and children across in

mainland China: a situation which causes many social problems.

As in most Asian countries, the women knew little about sex and did not talk about it: this reality prohibits

“  
(The Foundation)  
started integrating  
HIV/AIDS with other  
issues of interest to  
women ...  
”

many women from attending programs specifically about sex or HIV/AIDS. The Foundation changed its approach and instead of workshops and seminars

focused on AIDS specifically, it started integrating HIV/AIDS with other issues of interest to women such as health, communication in the family, parent-child and marital relationships, assertiveness skills and social services.

The Foundation believes that learning about AIDS in the context of other issues has allowed women to learn skills needed to better protect themselves. The Foundation is also providing peer education training for women in various organisations. Peer educators in these organisations share their knowledge with their members while being sensitive to their group's values and needs.<sup>6</sup>

#### Strategies for women

**Social and economic realities of women's lives:** develop strategies which give women opportunities to earn an income apart from sex work, not as rehabilitation programs for sex workers but to increase young women's range of options.

**Extend HIV infection education to all women:** public education to be directed at *all* women, not just sex workers. Education also needs to target girls who are particularly at risk.

**Alternative technologies:** development of affordable technologies for preventing HIV infection which women can control, such as refinement of the female condom.

#### Strategies for men

Encourage and increase condom use by making condoms readily available and destigmatise them. Inform men of the risks they are taking and what activities are putting them at risk. Encourage men to seek treatment for STIs and discuss safer sex techniques and HIV/AIDS at clinics.

- Only limited changes in the sexual behaviour of IDUs is evident around the world
- Becomes increasingly important as prevalence rises
- Difficulty of IDUs defining themselves as at risk sexually
- Safer sex behaviour in sex work

## Harm Reduction News

### Faithful Wives Can be At Risk

NEW DELHI, INDIA

Shenbagam is a mother of two. She and her family live in a crowded tenement in one of Palani's (in India) numerous slums. Her husband, Muthu, works as an auto-rickshaw driver.

After suffering frequently from genital irritation and discharge, she learnt that what she had was called an STD. She also learnt about HIV and AIDS, and knows that she is extremely vulnerable to infection because of her husband's sexual behaviour.

Shenbagam feels that she must have got the STD from her husband, who spends a lot of money on sex with dif-

ferent women every month. She also knows that he makes extra money booking clients for sex workers, but is unable to argue with him about these matters.

**“...she is extremely vulnerable to infection because of her husband's sexual behaviour.”**

Fearing that Muthu would suspect her of having an affair with someone else, Shenbagam did not dare tell him she was suffering from an STD. However, she decided to get treatment, without his knowledge, at the Society's clinic, where the nurse also gave her condoms.

When Shenbagam first showed Muthu a condom and told him how it could protect them both from AIDS, he beat her up. Shenbagam told someone from the Society about the problem. This person then arranged a slide show on AIDS for the men in the neighbourhood and persuaded Muthu to attend it.

The slide show was followed by a discussion, which made Muthu examine his own sexual behaviour. He now discusses AIDS with his friends, and has begun to use condoms whenever he visits sex workers. “It took a while to convince him,” says Shenbagam, “but things have changed for the better.”<sup>7</sup>

### What questions should you ask the community about sexual behaviour?

One of the difficulties facing people working in HIV prevention is the need to deal with issues which are often uncomfortable or rarely discussed publicly. Both drug use and sexuality are surrounded by taboos and secrecy. Sexual practices and drug using practices also vary from region to region and country to country.

In order to discuss sexuality and drug use, without causing offence, it is necessary to understand the sexual practices and mores of the particular culture. Information about safer sexual practices needs to be

appropriately designed and targeted with input from the targeted groups. These background questions are a starting point to uncover the nature of sexuality and how it is best discussed.

- What sort of language do people use to discuss sex?
- In what circumstances do people discuss sex?
- When do young men and women start having sex? How much choice do they have in the matter and how does it differ for men and women?
- What are the socially acceptable and unacceptable forms of sex?
- What is the difference between public perception and actual practice?

### 3. Women's Position in Society

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- Who initiates sex?
- Can women say no to unwanted or unprotected sex?
- How common is forced sex – rape, incest?
- Can women get their partners to use condoms? Can women obtain condoms? What are the barriers to women obtaining them?
- What sort of contraception is used? (e.g. oral contraceptives, injectable contraceptives, intra-uterine devices (IUD), condoms, female and male sterilisation)
- What are the traditional methods of family planning? How prevalent are these?
- How common are sexual activities which increase risk for transmission of HIV?(These include: anal sex, dry sex, beating/traumatic sex, sex during menstruation)
- How common are sexual activities which decrease risk? (These include non-penetrative sex and oral sex)
- How important is sex work for money?
- Is it organised? (e.g. brothel-based, street work, night-club-based, escort services, hotel-based?)
- Who runs sex work businesses?
- What are the types of sex work: female to male, male to male, male to female, transsexual?
- Is sex work legal? Are workers registered?
- Have sex workers formed organisations?
- Are health checks, HIV testing or treatment for STIs compulsory?
- What is the level of knowledge about the transmission and prevention of HIV and other STIs?
- Do people perceive themselves as at risk?
- Which individuals or groups of people are commonly perceived by others to be at risk? <sup>8</sup>

"The chances are that as a woman you are going to get AIDS because your man has had sex with someone with HIV and brings it home to you. How can you protect yourself? By insisting that the man uses a condom? He has the power. He says he's not doing it. So what next? For far too many of us it boils down to either no sex and therefore no support system for yourself and your children, or the risk of contracting AIDS." <sup>9</sup>

The subordination and powerlessness of many women around the world is sharply highlighted by, and fuels the spread of, the HIV/AIDS pandemic. The association between the oppression and inferior status of women and the spread of the disease is not co-incidental. Cultural, legal and economic factors limit the control that women have over their lives, their sexual lives and their ability to protect themselves from HIV and other STIs.<sup>10</sup>



The Centre for Harm Reduction

Manual for  
reducing drug  
related harm  
in Asia

## HARM REDUCTION NEWS



### A WASTED LIFE

NEW DELHI, INDIA

At puberty, Lakshmi was taken by her father to stay with an older man in a nearby community. She stayed with this man for six weeks and her father received Rs 1,500. Soon after this, the girl was brought to an area of the city which was known for prostitution. Lakshmi was sold to a brothel owner for Rs 2,000. She was being forced into prostitution but she resisted for a month: in protest she did not eat at all. After realising that there was no way out she conceded and began to work as a prostitute. She was forced to take eight to nine

clients per day by her brothel owner. It was at this point her health problems, including STDs, began. After six years

“  
**She was being forced into prostitution but she resisted ...**  
”

at this brothel she was removed from the premises by a pimp to another district to continue her work. The majority of her clients at the new brothel were truck drivers and mill workers. She continued to work for another two and a half years but was eventually forced to stop

because of health problems.

Throughout her time as a prostitute, Lakshmi had regularly attended a mobile health clinic for her STDs. Initially she was treated for STDs but the failure to respond to treatments suggested she was HIV positive. She showed severe weight loss, fever, loss of appetite, swollen glands and joint pains which did not respond to any medicines. An HIV test was performed and she was confirmed HIV positive. After a while she became very sick and was kept in the courtyard of the brothel. Lakshmi was supported by the brothel owner until she died.<sup>11</sup>

Women often have little access to education, health, training, independent incomes, property and legal rights. In many cases women rely on their partners/husbands for their economic and social status. Women's economic dependence on their partners, in order to avoid poverty for themselves and their children, makes it difficult for women to negotiate safer sexual practices. For women to bring up the subject of safer sex, such as using a condom, may lead to the risk of being rejected, beaten up or thrown out of their homes.<sup>12</sup> Some women have never discussed sexuality and sexual practices with their partners and do not have the language or experience to even know where to begin. Discussions about safer sex and condom use also bring up the issues of infidelity and/or injecting drug use.

### What are the issues and dilemmas relating to women's position in society?

- **Sexual double standards:** it is generally expected that women will be faithful to their husbands but the same standard does not necessarily hold true for men. For many women there is a feeling of helplessness in trying to control their husband's infidelity and if they ask their husband to use a condom she may in turn be accused of infidelity.
- **Importance of fertility:** in many societies the bearing of children is a woman's designated role and her only means to gain any social status. Her conflict then is between trying to protect herself from infection and the imperative to have children.

#### 4. Transmission of HIV to babies

- **Poverty, prostitution, sex tourism, migration:** for many women sex work is the only alternative to destitution. Women working in sex work may be attempting to provide an income not only for themselves but for their children and extended family. It can be difficult to insist on safer sexual practices (such as condom use) when the client can go elsewhere where he does not have to use a condom. Sex workers also travel across borders. In an unfamiliar community, often confronted with unfamiliar languages, sex workers have more difficulty in negotiating with clients and managers where they work. If they are in the country illegally, they may also face the risk of prison or deportation which makes them even more powerless.<sup>13</sup> The sex tourism industry is extremely lucrative and in the wake of fear about HIV/AIDS has often led to younger and younger women working as prostitutes who are offered to clients as young and uninfected.
- **Stigma and discrimination:** Women, and in particular female sex workers, have long been characterised as ‘vectors of disease’, a description which ignores the role of the client. Where women’s status is already low, HIV infection becomes an added stigma. The discrimination which women have experienced when it is discovered that they are HIV positive, can mean that women who know or suspect they might be infected avoid finding out, hide their status if they do get tested and delay seeking professional treatment and help.<sup>14</sup>

What is the risk of mother-to-child transmission of HIV?

What influences the risk of mother-to-child transmission of HIV?

The AIDS epidemic is having a profound impact on the lives and survival of children in developing countries. HIV can be transmitted from parents to babies, and many children are becoming orphaned when their parents die. People who inject drugs, and their partners, may worry about the risk to their children of HIV infection. Men who inject drugs need information about the risk of infecting their partner through sex and/or unsafe injecting practices, and the subsequent risk of infecting their child. Women who inject need information about the risk of HIV to their baby if they are infected with HIV and become pregnant.

The number of children infected with HIV is increasing rapidly in countries where HIV has spread widely in adults. Most women who become infected with HIV are in the reproductive age group. UNAIDS has estimated that by the end of 2001, 3 million children were living with HIV, and that 800,000 children became infected in 2001 alone, with 580,000 deaths.<sup>15</sup> To date sub-Saharan Africa has been most severely affected, but children are increasingly becoming affected in the Asia-Pacific region. HIV is currently spreading rapidly in India, China, and many parts of south-east Asia and the Pacific.<sup>16</sup> In many countries the gains made in child survival have been lost because of AIDS.

Issues of fertility, pregnancy, childbirth and breastfeeding are likely to be extremely sensitive for women who inject drugs, or have a partner who injects drugs, especially if they sell sex in order to obtain drugs. It is important for their counsellor or health care adviser to understand this when discussing these issues.

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## What is the risk of mother to child transmission of HIV?

HIV can be transmitted from an HIV-infected woman to her child:

- during pregnancy
- at delivery
- while breastfeeding.

Not all babies born to HIV-infected women become infected with HIV. When the baby is growing in the womb the blood of the mother and baby come close – but they do not usually mix. Studies show that the risk of transmission from an infected mother to her child is between 15 per cent and 48 per cent.<sup>17</sup>

If 100 HIV-infected women each have a baby, about 35 of the babies will become infected with HIV. On average the virus will have passed to seven of the babies during the pregnancy, to 15 at the time of delivery, and to 13 of the babies afterwards through breastfeeding.<sup>18</sup>

## What influences the risk of mother-to-child transmission of HIV?

There are two main risk factors:

- The virus is more likely to pass to the baby if the woman becomes infected with HIV during pregnancy or breastfeeding. This is because the amount of the virus in the blood is particularly high in the weeks after a person becomes infected.
- The virus is more likely to pass to the baby if the woman has an HIV-related illness (for example, a chronic cough, loss of weight, repeated diarrhoea). This is because the amount of virus in the blood increases during the later stages of HIV infection, when the immune system is damaged.

Other factors that increase risk include:

- any infection during pregnancy, especially a sexually transmitted infection or infection of the placenta
- poor nutrition during pregnancy, especially micronutrient deficiencies
- premature delivery
- interventions during labour, such as breaking the bag of waters around the baby
- non-exclusive breastfeeding
- mastitis and cracked nipples
- longer duration of breastfeeding.

Several studies have shown that drugs that attack HIV (antiretroviral drugs) taken by women during the final weeks of pregnancy and during delivery lower the viral load and significantly reduce transmission of HIV to the baby. In Thailand, provision of zidovudine for the last four weeks of pregnancy and during labour was found to reduce risk of transmission by half, if babies were not breastfed.<sup>19</sup> A study in Uganda showed that a single dose of a different antiretroviral drug, nevirapine, given at the time of delivery to the mother and to the newborn, reduced the risk of HIV infection by half.<sup>20</sup> This inexpensive intervention is able to reduce the risk of transmission even when babies are breastfed.



An expert panel convened by WHO in October 2000 concluded that nevirapine should be approved for widespread use.

Caesarean section before the onset of labour can reduce the risk of transmission of HIV from mother to child by half.<sup>21</sup> In developing country settings it is important to consider the safety of caesarean section, the cost, whether women can access surgery, and whether they will be able to do so for future pregnancies, since there will be an increased risk of rupture of the uterus with subsequent deliveries.

Avoidance or modification of breastfeeding can lower the risk to the baby. The additional risk of transmission to the baby from a mother already infected during pregnancy is about 12-16%.<sup>22</sup> The risk is greatest in the early weeks, but remains throughout the duration of breastfeeding. The risk of transmission to the baby if the woman becomes infected during the breastfeeding period is higher. But breastfeeding plays a vital role in protecting children's health and has important nutritional and immunological advantages. Babies who are not breastfed have a high risk of death from malnutrition, diarrhoea and respiratory infections.<sup>23</sup> Breastfeeding also has important child-spacing and environmental advantages. The health benefits of breastfeeding are of most importance in the first six months of life. The balance of risk for the baby will vary for different HIV-infected mothers in different settings.

There is evidence that exclusive breastfeeding, when the baby receives nothing but breastmilk, may be safer than mixed feeding, and may even protect against transmission of HIV at the time of delivery.<sup>24</sup> It is common for feeds of water or other fluids to be given before the milk 'comes in', and for cereals to be introduced in the first weeks of life. Babies do not need to receive any food or fluids other than breastmilk for the first six months of life.

## 5. Preventing parent to child transmission of HIV, within a child survival approach

How can we prevent babies becoming infected with HIV?

- Primary prevention
- Population-based secondary prevention
- Secondary prevention for women known to be HIV positive

Providing follow up care and support for mother and baby

What questions are useful to inform prevention and care strategies?

### How can we prevent babies becoming infected with HIV?

#### Primary prevention

The most effective way to prevent babies becoming infected with HIV is to prevent transmission between men and women. Community education to raise awareness that babies can be infected with HIV can contribute to primary prevention by appealing to men's sense of responsibility for their families.

It is especially important to prevent women becoming infected with HIV during their pregnancy or while breastfeeding because they are more likely to transmit the virus to their babies:

- If a woman is injecting drugs and wants to become pregnant she (and her partner if appropriate) should be counselled about the dangers to the baby of drug use during pregnancy, and the risk of spread of HIV to the baby if the woman becomes infected during or after the pregnancy. She needs to be supported to stop injecting drugs before she becomes pregnant, and access to contraception until she is ready to become pregnant. The woman and her partner should be counselled about the need to practise safe sex during pregnancy.

- If a woman who injects drugs is already pregnant she needs advice about the danger of transmission of HIV to herself and to the baby, and support to stop injecting drugs.
- Men have a right to be informed that unprotected sex or sharing injecting drug use equipment with others carries a high risk of HIV infection to their baby.
- During pregnancy and childbirth women are especially likely to receive a blood transfusion and/or injections. Midwives and doctors need to be trained to reduce the need for transfusions, ensure blood for transfusion is screened, and implement strict transfusion criteria and safe injection practice.
- ‘Discordant couples’, where the man is HIV positive and the woman is HIV negative, may ask for advice because they want very much to have a baby. In this situation the couple can be advised to have unprotected sex only once each month at the time the woman is most fertile. Although there is a risk of transmission of HIV to the woman, the risk is much smaller than if the couple have sex without a condom throughout the month. Women can learn how to recognise the timing of ovulation so they have sex without a condom when they are most likely to conceive. It is important to make sure that neither partner has a sexually transmitted infection.

#### Population-based secondary prevention

In countries of the Asian region most women that are infected with HIV do not know their status. Few women have access to ante-natal VCT (voluntary counselling and testing) as yet, and those who do may prefer not to be tested for HIV, or may not be in a position to decide. There are prevention strategies that do not depend on testing during pregnancy that also assist the health of women and men in general. It is important to promote these

interventions in the community, especially if they are vulnerable to infection with HIV.

To do this workers in the field can:

- prevent unwanted pregnancies through increasing access to information and contraception
- strengthen men’s and women’s reproductive health services
- counsel women with chronic illness to postpone pregnancy until they have been well for six months
- promote quality antenatal care with treatment of STIs and other infections and nutrition advice
- include men in antenatal care
- train midwives, doctors and traditional birth attendants to reduce unnecessary obstetric interventions
- promote exclusive breastfeeding for all
- train health care workers in breastfeeding skills to minimise breast problems.

Many of these activities may be components of existing reproductive health or maternal and child health programs.<sup>25</sup>

#### Secondary prevention for women known to be HIV positive

##### Before conception

When a woman of child-bearing age discovers she is infected with HIV she should be counselled on issues relating to her fertility. This means she will be able to think about the implications of becoming pregnant or postponing or avoiding pregnancy. Counselling should also inform her about the risk factors which increase the likelihood that a child will become infected with HIV. A woman should be given clear information and supported in her choices. She may need advice about and access to contraception. She should be asked whether she would like to be counselled with her partner. If she already has children she may worry about their health and want them to be tested for HIV.

**After conception**

A pregnant woman may discover that she is infected with HIV after undergoing antenatal VCT for HIV, or she may have known her status already. Either way she will need sympathetic and confidential counselling about the risk to the baby and the things that she can do to lessen the risk. This will depend on what services are available but might include:

- counselling about HIV and infant feeding choices (see below)
- counselling about maintaining good health during pregnancy through good nutrition and rest
- identifying and treating STIs and other infections
- identifying and treating preventable causes of premature births
- delivering a short course of antiretroviral prophylaxis, if available
- elective caesarean section, if appropriate
- referral to a support group
- arranging follow up care and support
- discussing contraception after the birth.

In Thailand routine offering of voluntary counselling and testing during pregnancy, with provision of zidovudine and infant formula to those who test positive, has been implemented throughout the country. But few countries in the region share the features that have enabled Thailand to expand this intervention so successfully. Thailand is a middle-income country with good health care service infrastructure, high rates of attendance at antenatal clinics, political support for the program, international support, a cohesive community, artificial feeding not stigmatised, and care available for people with HIV. Thailand has also succeeded with impressive primary prevention efforts.

These interventions require:

- community aware of possibilities for prevention of parent-to-child transmission of HIV
- accessible and affordable high quality antenatal care
- community acceptance of people infected with HIV
- trained counsellors

**Counselling on HIV and infant feeding**

Current recommendations of the inter-agency task force on infant feeding and HIV-infected mothers: <sup>26</sup>

- When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended.
- Otherwise, exclusive breastfeeding is recommended during the first months of life.
- To minimise HIV transmission risk, breastfeeding should be discontinued as soon as feasible, taking into account local circumstances, the individual woman's situation and the risks of replacement feeding (including infections other than HIV, and malnutrition).
- When HIV-infected mothers choose not to breastfeed from birth or stop breastfeeding two years of the child's life to ensure adequate replacement feeding. Programs should strive to improve conditions that will make replacement feeding safer for HIV-infected mothers and families.
- HIV-infected mothers who breastfeed should be provided with specific guidance and support when they cease breastfeeding to avoid harmful nutritional and psychological consequences and to maintain breast health.

Summary

*Manual for  
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- quality testing facilities
- anti-retroviral drugs available
- support for replacement infant feeding available
- resources for follow-up care and support.

These hospital-based programs to prevent mother-to-child transmission of HIV (often called PMTCT programs) are currently being planned or piloted in many countries in the region. To avoid potential harms, community organisations can play an important role in preparing for their introduction by raising awareness in the community, working to reduce stigma, training counsellors and establishing support groups. It is helpful for groups that work with people who inject drugs to form links with other relevant groups, such as those that promote and support breastfeeding, and women’s support groups

For most poor women in the Asian region exclusive breastfeeding is likely to be their safest option, unless resources are available to supply them with an adequate replacement for breastfeeding for at least six months. Breast milk is crucial to the health and wellbeing of most infants. Without breastmilk infants are more vulnerable to diarrhoea and respiratory and other infectious diseases, all of which can be life threatening. When an infant is already infected with HIV at birth, breastfeeding may protect them from infections that could hasten the onset of HIV-related diseases. The woman needs to receive information from a trained counsellor to assist her to weigh the risks, and to be supported in the decision she makes.

If an HIV positive woman chooses not to breastfeed she will need support to provide an adequate replacement:<sup>27</sup>

- Where few women are infected with HIV it may be possible for women who cannot afford infant formula to receive subsidised or free formula for six to 12 months. Care must be taken to ensure that breastfeeding in general is not

undermined by the availability of free or subsidised infant formula. Ideally, if women are provided with commercial infant formula this will be in a generic form rather than with a brand-name label.

- It is possible to make home-made formulas from animal milks, such as cow, buffalo or goat milk. Unmodified animal milk has too great a proportion of protein and can damage the baby’s kidneys and irritate the gut. It is necessary to dilute the milk with water, add sugar for energy, and a micro-nutrient supplement.
- HIV is killed easily by heat - the virus dies above 56° Centigrade. Theoretically a woman could express her breastmilk, boil the milk and feed the milk by cup to her baby. However, it is unlikely that women will be able to express and heat their milk for a long period of time without the stimulation of being able to put the baby to the breast. However this is the least expensive and most nutritionally appropriate option and women may want to try it.
- It is possible that a female relative could breastfeed a baby who has an infected mother. In many cultures even post-menopausal grandmothers have relactated in order to feed a baby. Such traditional solutions can be encouraged. It is important to be sure that the wetnurse is not infected with HIV and they should be counselled about the possibility that if the baby is infected with HIV there is a small risk that it may be transmitted to the wetnurse.
- Whatever replacement is used it is important that the mother or carer is taught how to use a cup to feed the baby. A cup is simple to clean thoroughly and does not need to be sterilised. Even a newborn baby can cup feed, and cup feeding ensures that the mother or caregiver holds the baby during feeding.

If a woman chooses to breastfeed she needs advice about the importance of giving the baby nothing by mouth other than breastmilk, and help in anticipating what difficulties she might face in exclusive breastfeeding:

- There are two factors that may complicate exclusive breastfeeding: the first relates to ‘pre-lacteal feeds’, or substances given in the first week of life, such as herbal mixtures, which may have a spiritual or symbolic meaning, or sugar water, often related to ‘cleansing’ and the belief that the baby needs some fluids before the milk ‘comes in’. The second relates to the early introduction of rice feeds or animal milk in the early weeks of life because the mother fears that the baby is not getting enough breastmilk. Mothers need to be given information that addresses both these factors. They need to know that colostrum protects babies, and that no additional water or milk is necessary. They need to be reassured that softening of the breasts after a few weeks is normal and does not mean that they are making less milk. They need to know that the way to increase the milk supply is to allow the baby to breastfeed frequently.
- A woman who chooses to breastfeed should consider stopping breastfeeding earlier than usual. For example she might decide to stop breastfeeding between five and six months when the baby is less vulnerable, since the risk of transmission of HIV continues throughout the duration of breastfeeding. It is important that the woman should not give both breastmilk and a replacement for long – so the period of transition should be short (perhaps one week). It is best to advise against an abrupt transition within a day or two because the mother’s breasts will become engorged, the baby will be distressed and the likelihood of reverting to breastfeeding is very high, with subsequent increased risk of transmission of HIV.

- An HIV positive women who chooses to breastfeed needs advice about stopping breastfeeding if she becomes ill or develops breast problems such as mastitis or a breast abscess. In those circumstances she should express and boil her milk before feeding to the baby, or give a replacement until the condition is better, and seek medical help.

It is a challenging task to counsel a mother to help her assess the risk to her baby of different feeding options in her particular circumstances. Counsellors need support and up-to-date information. The pace of change in knowledge about interventions to prevent the spread of the virus to the baby from an infected mother has been rapid. The inter-agency task force publishes frequent updates and guidelines for HIV and infant feeding, available on the UNAIDS website ([www.unaids.org](http://www.unaids.org)).

### Follow up care and support for mother and baby

Follow-up care and support can help mothers infected with HIV to live longer, happier lives, meaning they are able to care for their children, whether infected or uninfected. Families with children that have HIV need assistance to care for them because they will experience frequent illnesses.

When hospital interventions to prevent mother-to-child transmission of HIV are introduced, local NGOs and community organisations have an important role to play in providing a continuum of care and support between the hospital, the health centre and the community. It will be useful if peer groups and those who work with people who inject drugs can form links with health care providers.

Women who learn of their HIV infection as a result of antenatal screening need emotional support, perhaps through peer

support groups, access to treatment for their symptoms, and treatment and prevention for opportunistic infections when they become ill. We need to advocate for greater access to effective long-term combination anti-retroviral drugs for all those infected with HIV that meet the clinical or laboratory criteria for treatment.

### What questions are useful to inform prevention and care strategies?

Before planning strategies for prevention and care in relation to parent-to-child transmission of HIV, it is necessary to gather information about the current situation in the community. By talking to people working in existing health programs, community groups and individuals one can better understand the current situation and therefore plan more effective strategies. There are a number of questions to consider:

- Are there any practical, safe, affordable and acceptable alternatives to breastfeeding in this setting?
  - How are sick babies cared for?
  - What facilities are available for voluntary counselling and HIV testing for couples, and for women?
  - Do HIV-infected women have access to counselling and contraception?
  - Is abortion available to women with HIV?
  - What is the infant mortality rate and what are the common causes of child death?
- What are the cultural beliefs in relation to pregnancy, childbirth, the post-partum period and infant feeding?
  - How common is HIV infection among women of child-bearing age?
  - What proportion of women have access to, and attend, antenatal care?
  - Who makes decisions about pregnancy, antenatal care, delivery care and infant feeding? Is it the woman, her husband, her mother-in-law or other family members?
  - What is likely to happen if a pregnant woman tells her family of a positive HIV test result?
  - What are the common breastfeeding practices, knowledge and attitudes? What influences them? How common is exclusive breastfeeding and what are the barriers to exclusive breastfeeding?

## Summary

### Parent to child transmission of HIV

HIV transmission from mother to child can occur during pregnancy, at birth and through breastfeeding. If 100 HIV-infected women each have a baby, about 35 of the babies will become infected with HIV. On average the virus will have passed to seven of the babies during the pregnancy, to 15 at the time of delivery, and to 13 of the babies afterwards through breastfeeding.

The risks of HIV transmission increase:

- among woman who acquire HIV infection during pregnancy or while breastfeeding
- when an infected woman has HIV-related signs and symptoms
- if there is any infection during pregnancy, especially a sexually transmitted infection
- with poor nutrition during pregnancy
- if the child is born prematurely
- if the membranes are ruptured ('breaking the waters') artificially
- if the mother has mastitis or a breast abscess while breastfeeding
- if the child is not exclusively breastfed

### Preventing parent to child transmission of HIV within a child survival approach

#### Primary prevention

The most effective way to prevent babies becoming infected with HIV is to prevent transmission between men and women. Community education to raise awareness that babies can be infected with HIV can contribute to primary prevention by appealing to men's sense of responsibility for their families.

It is especially important to prevent women becoming infected with HIV during their pregnancy or while breastfeeding because they are more likely to transmit the virus to their babies.

#### Population-based secondary prevention

Strategies to promote this at a community level include:

- preventing unwanted pregnancies through increasing access to information and contraception
- strengthening men's and women's reproductive health services
- counselling women with chronic illness to postpone pregnancy until they have been well for six months
- promoting quality antenatal care with treatment of STIs and other infections and nutrition advice
- including men in antenatal care
- training midwives, doctors and traditional birth attendants to reduce unnecessary obstetric interventions
- promoting exclusive breastfeeding for all
- training health care workers in breastfeeding skills to minimise breast problems.

Chapter  
Seven  
*HIV/AIDS*

The Centre  
for Harm  
Reduction

**Secondary prevention for women known to be HIV positive**

**Before conception:** when a woman of child-bearing age discovers she is infected with HIV, she should receive counselling, information and support.

**After conception:** those who test positive following antenatal voluntary counselling and testing for HIV, or already know that they are infected, may be offered:

- screening and treatment of STIs and other infections
- identification and treatment for preventable causes of premature birth
- counselling about maintaining good health during pregnancy through good nutrition and rest
- counselling about use of condoms
- antiretroviral prophylaxis
- elective caesarean section, if appropriate
- counselling about HIV and infant feeding
- referral to a support group and follow-up care and support
- information about contraception after the birth.

In most settings in Asian countries the balance of risk for the baby of an HIV-infected mother will be in favour of exclusive breastfeeding for six months, then stopping breastfeeding if adequate weaning foods and a source of milk are available. HIV positive women need to be helped to reach their own decision about the most appropriate feeding method for their child.

Appropriate local replacement feeds need to be identified. Possible replacements for breastfeeding include:

- commercial infant formula
- home-prepared animal milk formula (perhaps combined with a cereal or legume milk such as soy or ragi (millet) milk)
- expressing and boiling the mother's breastmilk or donated breastmilk
- wetnursing.

Replacements should always be given by cup rather than bottle.

To be prepared to implement prevention strategies for mother-to-child transmission of HIV it is important to gather relevant information. This includes knowledge, attitudes and practices in relation to sexual practices, the desire to have babies, pregnancy, childbirth, the postpartum period, and infant feeding.

**Section Two, Chapter Seven:  
HIV/AIDS: Preventing Transmission  
through Sex and between Parent  
and Child**

For further information refer to **WHO resources: Intervention Guide (ARV clinical) & Evidence for Action Papers. Refer to the following website: [www.who.int/hiv](http://www.who.int/hiv) (publications expected online from May 2003)**

**CENTRE FOR HARM REDUCTION**  
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**▼▲ Risk factors for Sexual HIV Transmission**

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- Presence of any Sexually Transmittable Disease (STD)
- Sex and age of uninfected person
- Type of sexual act
- Stage of illness of infected person
- Virulence of HIV strain

**Information for IDUs must be on Safer Injecting Practices  
AND Sexual Transmission of HIV**

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**SECTION 2 • CHAPTER 7 • OVERHEAD 1**

**CENTRE FOR HARM REDUCTION**  
.....

**▼▲ Strategies to Reduce Sexual Transmission  
of HIV**

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- Assess social & economic realities
- Education for all women
- Affordable technologies for women
- Encourage condom use
- Information/education on risks for men

*Manual for reducing drug related harm in Asia*  
**SECTION 2 • CHAPTER 7 • OVERHEAD 2**

CENTRE FOR HARM REDUCTION

▼▲ **Issues/dilemmas: Women's position in society**

- Sexual double standards
- Fertility
- Poverty, prostitution, sex tourism, migration
- HIV stigma and discrimination



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SECTION 2 • CHAPTER 7 • OVERHEAD 3

CENTRE FOR HARM REDUCTION

▼▲ **Risk of HIV transmission from mother to child**

**Of 100 HIV-infected women, on average 35 of the babies will become infected with HIV**

- 7 during the pregnancy
- 15 at the time of delivery
- 13 afterwards through breastfeeding.

*Manual for reducing drug related harm in Asia*  
SECTION 2 • CHAPTER 7 • OVERHEAD 4

CENTRE FOR HARM REDUCTION  
.....

**▼▲ Influences on risk of transmission from mother to child**

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**Risk increased:**

- among woman acquiring HIV infection during pregnancy or breastfeeding
- when an infected woman has HIV related signs and symptoms
- with any infection during pregnancy, especially a sexually transmitted infection
- with poor nutrition during pregnancy
- if child is born prematurely
- if membranes are ruptured ('breaking the waters') artificially
- if mother has mastitis or breast abscess while breastfeeding
- if child is not exclusively breastfed

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SECTION 2 • CHAPTER 7 • OVERHEAD 5

CENTRE FOR HARM REDUCTION  
.....

**▼▲ Reducing parent-to-child transmission of HIV - Part A**

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**Primary prevention especially during pregnancy and breastfeeding**

**Secondary prevention**

**General measures to:**

- prevent unwanted pregnancies
- improve the health and nutrition of women during pregnancy
- strengthen men's and women's reproductive health services
- promote exclusive breastfeeding for all

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SECTION 2 • CHAPTER 7 • OVERHEAD 6

CENTRE FOR HARM REDUCTION  
.....

▼▲ **Reducing parent to child transmission of HIV – Part B**

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**Primary prevention especially during pregnancy and breastfeeding**

**Measures for women known to be infected with HIV:**

- good antenatal care including screening and treatment for STIs and other infections
- avoid invasive interventions during labour
- antiretroviral prophylaxis, if available
- elective caesarean section, if appropriate
- counselling about HIV and infant feeding
- advice about contraception
- follow-up care and support

*Manual for reducing drug related harm in Asia*  
**SECTION 2 • CHAPTER 7 • OVERHEAD 7**

CENTRE FOR HARM REDUCTION  
.....

▼▲ **Replacements for breast feeding**

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- commercial infant formula
- home-made animal milk formula
- expressing and boiling of the mother's breast milk (or donated breastmilk)
- wetnursing

**Cup feeding is safer than bottle feeding.**

**If no acceptable, feasible, affordable, sustainable and safe alternative is available HIV-infected women should be encouraged to exclusively breastfeed their baby for up to six months, and then cease breastfeeding if they can provide adequate weaning foods and replacement milk.**

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**SECTION 2 • CHAPTER 7 • OVERHEAD 8**

## Section Two

### *Chapter Eight*

# **Voluntary HIV Counselling and Testing**

#### **What is VCT?**

**The counselling process**

**The HIV testing process**

**Staff: burnout and stress**

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## Introduction

Voluntary counselling and testing (VCT) for HIV have become an integral part of HIV prevention and care programs in many countries. Knowledge of serostatus through VCT can encourage both negative and positive people alike to adopt safer practices to prevent HIV transmission. This intervention also facilitates access to care and support services for those who are HIV infected.

The fear and anxiety surrounding the idea of being tested, and the often incorrect information people have about HIV/AIDS, means that counselling is an essential part of the process.

This chapter examines:

1. What is VCT?
2. The counselling process
3. The HIV testing process
4. Staff: burnout and stress

## I. What is VCT?

HIV counselling is defined as: “*Confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress, and make personal decisions related to HIV/AIDS*”. The counselling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behaviour.

For the person being tested, the procedure has consequences that reach beyond the diagnosis. Although there are many benefits to knowing one’s HIV status, testing may have negative consequences in communities where HIV-infected people are stigmatised. No one should be coerced into being tested. The decision to undergo HIV testing is entirely voluntary.

### Confidentiality

Trust is one of the most important factors in the relationship between counsellor and client. It enhances the relationship and improves the chances that an individual will act on the information provided. Given the possibility of discrimination that an individual with HIV may face, it is important that confidentiality be assured. Confidentiality forbids any reference to or discussion about a client, except within a professional relationship, and only then with the consent of the client.

People who inject drugs already experience discrimination, stigmatisation and rejection because of their drug use. In most societies, injecting drug users (IDUs) are viewed as criminals and outcasts and are often a target for society’s anger and fear. Add to this a diagnosis of HIV/AIDS and IDUs become one of the most marginalised groups in a society. When deciding whether or not to have a test, an IDU may question what benefits, if any, he or she may gain from knowing their HIV status. Concerns may centre around:

- fear of further discrimination
- lack of treatment for HIV-related illnesses

- lack of immediate access to drug treatment and/or to clean injecting equipment and condoms to ensure safer practices.
- fears about how to tell partners and family if the result is positive
- fears about the future.

Confidentiality is crucial in this scenario. It usually takes some time to come to terms with receiving an HIV positive test result and people feel especially vulnerable. It is a time when a person’s sense of power over their life can evaporate: they at least need the power to determine who knows about their HIV infection. While widespread discrimination against people with HIV/AIDS, and people who use drugs, continues to exist there is good reason for people not to broadcast their HIV status. Part of the pre- and post-test counselling should be a discussion about confidentiality. A client should be told how their test results will be handled by the agency. For example:

- whether the health department is notified
- who else in the agency would have access to their file
- how their result is recorded and filed.

Any breach of this confidentiality will damage whatever trust has been built between the counsellor and the client.

## 2. The Counselling Process

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"Non-judgemental, non-coercive and confidential."

A motto of LALS (Lifegiving and Lifesaving Society), Kathmandu, Nepal.

**What are the main goals of counselling?**

**Who is counselling for?**

**Who should provide counselling?**

**What is pre-test counselling?**

**What is post-test counselling?**

**What are the types of counselling?**

**What is drug counselling?**

Counselling is an essential part of VCT. It should provide support for a person in making a decision about whether to be tested or not and in receiving the result. Information about the test, and what the results mean, will allow a person to make an informed decision about having the test. Counselling should also provide information about HIV/AIDS and how it is transmitted and how to avoid acquiring and/or transmitting the virus.

### What are the main goals of counselling?

The two main goals of counselling are to:

- 1 give psychosocial support to those people whose lives have been affected by HIV/AIDS
- 2 prevent HIV infection and its transmission to other people.

This is achieved by:

- providing clients with information on HIV: what it is, how it is transmitted, how it is prevented, what testing involves
- helping people to handle their emotional responses to an HIV positive result (i.e. anger, fear, denial)
- discussing what action a client needs to take according to their situation and needs but not lecturing clients

- encouraging change in behaviours to prevent transmission (i.e. safer using practices and safer sex).

### Who is counselling for?

Counselling is for:

- people being tested for HIV (both pre- and post-test counselling)
- people who are infected and their partners/families
- people who are experiencing difficulties with issues such as employment, housing and finances because of HIV
- people who are seeking help because of past or current risk behaviour. Remember confidentiality is important: a client needs to be able to trust the counsellor and make his/her own decision about who they will tell if they are infected with HIV. The client has the right to decide if other people are to be involved, such as their family members, people from HIV support groups and other medical clinicians.

### Who should provide counselling?

In reality, counselling forms a part of the workload of most people involved in an HIV prevention program. Counselling, in the most part, is not a one-time event. In the case of HIV testing, counselling should be given to a client at least twice: certainly before and after the HIV test. But counselling also happens on a day-to-day basis: in the streets, in people's homes, at clinics and so on. Situations arise where the opportunity to give some counselling occurs naturally. For example; a worker may be tending to an IDU's abscess, and together they discuss why the person has developed an abscess; this gives the worker an opportunity to discuss safer using techniques and the IDU a chance to ask questions.

## What is pre test counselling?

HIV testing should only be offered when it is accompanied by pre- and post-test counselling. The counselling provides the opportunity to give the client clear information about the test, to explain the confidential nature of the test and to obtain informed consent. It also allows time to build up rapport and trust between the counsellor and the client.

Pre-test counselling should, ideally, take place in an environment where privacy is assured, for example, a room away from the centre of activity in an agency. Counselling is a dialogue and not a lecture. The client should feel free to ask questions and discuss their fears and anxieties. Counselling provides the chance for a counsellor to explain the HIV test and the implications of receiving an HIV positive result. This sort of discussion will help the client make their decision about whether or not they want to proceed with the testing.

The pre-test counselling should focus on:

- the client's personal history and risk of current or past exposure to HIV
- the client's knowledge about HIV/AIDS and their ability to cope with crisis.

To assess a client's risk a counsellor will need to look at these issues:

- current or past high risk drug taking behaviour (i.e. sharing of needles and syringes and other injecting equipment)
- current and past sexual behaviour, sex work or sex with a sex worker
- use of condoms, practice of safer sex, frequency of unprotected vaginal and/or anal sex
- sex with multiple partners or known HIV-infected partners
- history of receiving a blood transfusion or organ transplant
- exposure to non-sterile invasive procedures, such as injections, tattooing and scarification.<sup>1</sup>

To assess a client's knowledge of HIV/AIDS and ability to cope, a counsellor will need to look at these issues:

- What does the client know about the test? Why is the test being requested? Has the client come willingly to counselling?
- What particular behaviours or symptoms are of concern to the client?
- Has the client considered how he or she would react to the results of the test (positive and negative)?
- What are the client's beliefs and knowledge about HIV transmission and its relationship to risky behaviours?
- If the test result is positive, who would provide emotional support for the client?

Once a counsellor has assessed a client's risk of being infected with HIV, their knowledge about the virus and their ability to cope, the counsellor should give detailed information about HIV/AIDS (what HIV/AIDS is, the difference between HIV and AIDS) and what a positive or negative test result means. The counsellor should also inform the client that very occasionally false positive and negative results occur and explain what the 'window period' means. The counsellor should also discuss ways to prevent acquiring the virus and/or passing it on to other people. He or she should also tell the client how long it will take before they get the test results. If the client decides to go ahead with testing it is important to arrange post-test counselling.

The WHO declared in 1987: *'If testing is to be used to identify specific infected individuals, voluntariness – free and informed consent – was an indispensable precondition, and must to be accompanied by counselling and protection of confidentiality.'*<sup>2</sup>

Informed consent means that the client understands the process and the implications of having an HIV test. Obtaining informed consent involves:

- educating the client about how the test is done and what the results will mean
- discussing the advantages and disadvantages of having the test
- listening to the client's concerns and fears
- answering the client's questions
- seeking the client's permission to proceed with the test.

A counsellor cannot presume that a client has consented to a test: the intention to go ahead with the test must be clear and verbalised. Informed consent means the client is competent to make such a decision, understands the purpose, risks, harms and benefits of both being tested and not being tested and that their decision is voluntary. If a person does not consent to testing their reasons can be explored through further counselling but above all their decision must be respected.

The reasons a client may not want to be tested include:

- lack of information about the test and HIV/AIDS
- feeling unprepared emotionally to deal with the possibility of an HIV positive result
- lack of social support from family and friends
- fear that their HIV status will not remain confidential
- fear that they will lose their job, house etc
- fear of losing their sexual partner.<sup>3</sup>

## What is post-test counselling?

Post-test counselling is primarily about providing the results of an HIV test to a client. But it involves much more than delivering test results and may require more than one session. This may apply both to a person whose result is positive and a person whose result is negative. The content of the post-test counselling will, of course, differ depending on the test result. Again, it is important that the counselling takes place in private and that, ideally, the counsellor has a reasonable amount of time to spend with the client.

### Counselling after a negative result

It is just as important to counsel a person who has received a negative HIV test result as it is to counsel a person who has received a positive test result. While it is understandable that a client will be happy, if not euphoric, with the news that the test result was negative there is crucial information a counsellor must give the client:

- the counsellor should explain that the test result may not be reliable because of the window period and that the client may wish to have another test in three to six months, with no further risk exposures in the meantime
- the counsellor must emphasise the importance of preventing further exposure to HIV. Information about safer sexual practices and safer using practices must be fully explained and discussed
- the counsellor may wish to make a further appointment with the client to discuss in more detail how to make changes and negotiate safer behaviour (perhaps see the client's partner at the next appointment).

**Counselling after a positive result**

It is important that a client and counsellor are in a private place when the test result is given. The counsellor should reassure the client that the discussion and the test results are confidential. It will take some time for the client to absorb the news and the counsellor needs to be supportive and sensitive to the client's shock and fear. The counsellor will then need to explain clearly and simply, using language the client understands, what the test result means. It is not the time to discuss how the disease will progress or to estimate the time left to live. The counsellor should encourage positive thinking (i.e. that the person may have many years without symptoms and that there are treatments for some of the opportunistic infections). Treatments with antiviral medication should only be mentioned if they are available and affordable in that region. The counsellor should arrange further appointments to see the client in order to establish a supportive relationship but also to repeat the information about HIV infection, ways to improve the client's health and information about preventing transmission of the virus.

The points which need to be emphasised constantly are:

- HIV infection is not AIDS
- a person infected with HIV needs to look after their health. The counsellor should stress the importance of avoiding exposure to other diseases which may weaken the immune system
- how HIV is transmitted and the ways to make sure they do not infect someone else: safer sex (use of condoms) and safer using (not sharing needles and other injecting equipment)

- that it is impossible to tell from the test results when a person was infected with HIV. This can be particularly important for people who assume they have contracted HIV from their current sexual partner and therefore believe their partner has been unfaithful.

A person's reaction to their positive HIV test result may differ according to a range of factors; including their personality and their social environment. Other factors affecting their ability to cope with the diagnosis may include:

- the person's state of health at the time
- how well prepared the person is for the news of their HIV infection
- how well they are supported in the community
- how readily the person can ask for and receive help from family and friends
- the person's personality and psychological condition
- the cultural and spiritual values attached to HIV/AIDS, to illness and to death in their particular community.

A client may also have concerns about the counselling and/or the counsellor. These concerns may centre around:

- discomfort in talking to a stranger
- fear of what will be discovered
- fear of facing the infection
- embarrassment at having to discuss intimate matters
- concern that confidentiality will not be respected
- difficulty in talking to a person of the opposite sex/different ethnic origin/linguistic group/age etc.

## HARM REDUCTION NEWS



### “I ALMOST COLLAPSED”

HO CHI MINH CITY, VIETNAM

In 1972, I was in the second year of the University of Law and being a good guitar player, I played in a musical band in a nightclub. Seeing the people smoke heroin and breathing the smoke every day, I was tempted to use it. I don't remember when I became addicted to heroin.

“  
...I was isolated in our house.  
”

In 1994, the HIV/AIDS issue really exploded and according to the original statistics, the highest percentage of overall cases were injecting drug users. My father forced me to go for a test. First I went to the Dermatology Hospital where I got a negative result for social diseases (STDs). My family did not believe the result and I was isolated in our house. They put my

things aside and I had my meals alone with my own bowl, chopsticks, glass etc. After that my father asked my younger brother to take me to the Preventative Health Centre for a test. I came back to get the result after three days. I was really nervous and praying on my way to the Centre with my brother. When the doctor informed me of the result I almost collapsed. I thought my life had ended. Thinking of being discriminated against by my family and having a fatal disease that I did not know much about, I intended to jump out the balcony of the hospital. The doctor pulled me back. I was standing still with mixed feelings, frightened, nervous and desperate. I was afraid of my brother's, then my parents' and other family member's reactions when they knew the result. The doctor asked me to go and see Dr Luyen in his office. Dr Luyen, who was in charge of counselling, talked to me a lot, but

at that time his words just flew from one ear to the other. I was extremely confused and could not think straight.

I did not know what to do. I told the doctor that I have done this so I have to bear the consequences. I begged the doctors to keep this secret for me. What I was really concerned about was

“  
I begged the doctors to keep this secret for me.  
”

that the doctor or hospital would reveal this to anyone in the area where I lived. I was excessively anxious. Dr Luyen promised to keep it confidential and advised me to take care of my health. He gently advised me to quit drugs if I wanted to prolong my life.”<sup>4</sup>

Mr S. now works as a peer educator with IDUs in Ho Chi Minh City, Vietnam.

### What are the types of counselling?

Counsellors need to find a balance between providing emotional support and care for the client and maintaining an objective approach to the client's problem. HIV counselling can

be especially difficult and intense because counsellors:

- are forced to face their own mortality
- have to deal regularly with loss
- offer support to people in distressing and difficult circumstances, and
- at times, have to accept behaviour he or she does not approve of or understand.

It is also wise for the counsellor to have someone to talk to; this will allow the counsellor an opportunity to express their feelings, sorrow and stress.

Counselling changes according to the needs of the client and at different stages. The type of counselling needed will be determined by:

- the client's needs, circumstances and psychological state
- the types of problems they are experiencing or facing
- the stage at which they seek counselling.

Apart from dealing with the client's needs as productively as possible, the counsellor needs to know at what points the client should be referred on for other services (e.g. medical care, financial assistance, social support agencies).

It is important that workers receive specific HIV counselling training as this gives them the opportunity to explore the broad range of reactions and problems a client may experience. It also gives them the chance to practise their counselling skills through role playing etc and to increase their knowledge of HIV/AIDS.

## What is drug counselling?

'The reality is that no counsellor can get their clients off drugs. Clients have to want to come off for themselves and by themselves. However, counsellors can assist, ease and support the process, provided they realize that control has to rest with the drug using clients.'<sup>5</sup>

Agencies may have a particular worker who focuses on dealing with clients' drug use and associated problems, but most workers, especially outreach workers, will be involved in drug counselling regularly. The conditions

and practices of drug use will be different from community to community. A counsellor will need to know:

- what sort of drugs are being used
- what ways people are taking the drugs (routes of administration)
- whether sterile injecting equipment is available
- the prevalence of HIV in the particular community
- what the sharing practices are
- what treatment and other services are available.<sup>6</sup>

Drug counsellors should be able to offer their clients lots of practical advice to reduce the risks associated with their drug use. This may include information about:

- cleaning needles and syringes
- rotating injection sites
- where not to inject
- treatment for abscesses
- information on HIV/AIDS and ways to prevent contracting or passing on the virus.

To do this successfully, counsellors must not be judgemental about the client's drug use. Most drug users have experienced judgement and discrimination from health professionals, family and the general community. The counsellor will not help by reinforcing these kinds of attitudes. Rather than imposing their attitudes and beliefs on the client, the counsellor should listen to what the client has to say: what is the most important issue to the client? What information do they want?

While the long term goal may be abstinence, both counsellors and clients need to be realistic. It is unusual for a person who decides to give up drugs to succeed the first time they try. If goals are unrealistically high, the sense of failure only increases a client's feelings of hopelessness: that it is all too difficult to achieve.

A counsellor, or outreach worker, can work with a client to make their drug using safer. Suggestions can include:

- taking the drugs another way, such as snorting, smoking or swallowing them
- taking a substitute drug, such as methadone, where available
- continuing to inject but using sterile equipment each time
- using a needle and syringe exchange program, if one exists
- not sharing their injecting equipment with anyone else
- having their own needle and syringe and cleaning it before use
- if having to share, because of lack of equipment, cleaning the needle and syringe between each person's use.

For more information on safer using see **Chapter Five: Injecting Safely**, for information about substitution drugs such as methadone and buprenorphine and issues surrounding drug use see **Chapter Six: Drug Use and Substitution** and for information about drugs and how they work see **Appendix 2: Drugs and their Actions**.



### 3. The HIV Testing Process

What is the test for HIV?

What do the results mean?

Who should have an HIV/AIDS test?

What questions should you ask?

#### What is the test for HIV?

The diagnosis of HIV has traditionally been made by detecting antibodies against HIV, not the virus itself. When a person becomes infected with HIV, their body produces antibodies to the virus. Antibodies are proteins the body makes to fight infections. These antibodies do not protect a person from HIV or AIDS. A wide range of HIV antibody tests are available today, including ELISA-based tests and many newer, simple and rapid HIV tests.

**ELISA testing:** The most commonly used HIV-antibody testing method is the ELISA test (enzyme-linked immunosorbent assay, also EIA), which is extremely sensitive in identifying HIV antibodies.

**Simple/rapid testing:** More recent advances in technology have led to the development of various rapid tests. Most come in kit form and are simpler to use than ELISA. Furthermore, their diagnostic performance is comparable with traditional ELISAs.

It is important to emphasise that although HIV antibody testing is highly sensitive and specific, all seropositive results from one test must be confirmed by an additional, different test. The western blot is still routine in developed countries but double-ELISA algorithms are more common in the developing world.

After exposure to the virus it may take some time to develop antibodies to HIV/AIDS. This is called the 'window period' and may last between a few weeks to three months. During this time a person may receive a negative result from their HIV test when in fact they are HIV positive.

Harm Reduction **News** 

**What Does Having HIV Mean?**

KATHMANDU, NEPAL

In early 1993 we had our first HIV positive case. He was a young boy. We got the result – it was the first one we’d had. It took us a while to catch up with him. When we did we asked him to come back to the office. He came with a friend. He told us in retrospect he had suspected he might be positive. He didn’t look very well, he might have had a bad hit. We were thinking should we tell him while he’s feeling like this? But we couldn’t lose the opportunity because who knew when we would see him again? So I took him upstairs, we had a big room where we did the training and so on, and I told him I needed to sit down and talk with him privately.

**“...should we tell him while he’s feeling like this?”**

But he didn’t want his friend to go because he sus-

pected bad news and because he was sick. I said this is between you and I and you may not want him here. But he did, so I ended up telling him we had got his test results and from the results it looked like he was HIV positive. He didn’t react that much because I think he was on his own trip but his friend was pretty shocked and he said: “My god, are you going to die?” It was a very gut reaction: I don’t know whether it was shock or he was disgusted or he was scared for his friend. It was hard to say: I think it was a combination.

**“My god, are you going to die?”**

So I sat him down and said “I’ll talk to you afterwards.” So he left and I talked to the guy with HIV. I said “Do you know what it means?” He said: “Does it mean I’m going to die?” and he started crying a little bit. I don’t know if it really sunk in at that stage. We just let it go

that day and I told him he could come back and we would talk a little more. I spoke to his friend later about privacy and confidentiality and how he should try to support his friend and not blurt it out to everyone. The young guy came back a few months later and he said: “Do I really have HIV? I don’t feel so bad.”

**“Do I really have HIV? I don’t feel so bad.”**

It was early days for HIV infection in Nepal – there were no TV programs or information to say what HIV/AIDS was, other than it was a disease that affected people who were bad. Whereas if you had said ‘TB’ people had an image of what TB does to people. If you say to people you do this today and tomorrow you’ll get TB they know to be scared but it wasn’t the same with HIV. People didn’t fully realise what being HIV positive meant.”<sup>7</sup>

Although tests may not be able to detect antibodies to HIV during the window period, the person can transmit the virus to other people through sharing needles and syringes (and other unsafe using practices), donating blood, and having sex.

If someone has been exposed to the virus recently and their test result is negative, it is recommended that they return for another test in three months as they may be in the window period. During the three-month period before the second test, the person should be encouraged not to engage in any high-risk behaviors.

## HARM REDUCTION NEWS



### A CONVERSATION BETWEEN A COUNSELLOR AND A CLIENT

ANYWHERE, ASIA

*Client:* I think I should have a test for AIDS.

*Counsellor:* Can you tell me why you think you need to have the test?

*Client:* I've heard that you can get AIDS from sharing needles and I've shared needles a few times – you know – when you can't get clean ones what can you do? So I've shared friends' needles after they've injected themselves.

*Counsellor:* Okay, well you're right about the risk of transmitting HIV/AIDS by sharing needles and syringes. HIV is the name of the virus that is transmitted and AIDS is what you have once you get sick. Anyway, sharing needles and syringes is risky but sharing any of the injecting equipment you use is also a risk like spoons, filters, water and tourniquets. We can do the test today if you like. But before we do, I'd just like to ask you a few questions about your drug use and about sex. I know it can be hard to talk about these things so is it okay with you if we talk about these matters?

*Client:* Yes, that's fine.

*Counsellor:* How long have you been sharing needles and syringes?

*Client:* I think it is probably about six months.

*Counsellor:* When was the last time you shared needles and syringes?

*Client:* Two nights ago.

*Counsellor:* Do you have a regular sexual partner and do you use condoms?

*Client:* I have a girlfriend but we don't use condoms.

*Counsellor:* Do you have any other girlfriends?

*Client:* Not for the past year. Tell me, do you think I have AIDS, I mean HIV?

*Counsellor:* It's impossible for me to say if you have HIV but I must tell you that sharing needles and syringes does put you at a high risk. Do you understand what HIV actually is?

*Client:* Not really, but I've started to hear people talking about it and they say it makes you sick and you die from it.

*Counsellor:* Well, HIV is a virus that enters the bloodstream and then circulates around the body attacking certain cells in the body which are part of the immune system. The immune system is a general term that describes the way the body defends itself from foreign substances that invade it to cause infections or disease. Some people can be infected with HIV for years and not look sick or feel sick. But AIDS is different and it develops sometime after you've contracted HIV. AIDS happens when the immune system has broken down and the person becomes sick. Does that make it a bit clearer?

*Client:* Yes, I understand.

*Counsellor:* To be sure that a person has HIV, that the test is accurate, there is what is called a window period – what this

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and testing*

means is that it can take some time for a person to develop a response to HIV that we will be able to see in the blood test. This can take between three weeks to six months.

*Client:* So how do you do the test?

*Counsellor:* We just take a little bit of your blood and send it to the laboratory.

*Client:* So do you think I should have the test?

*Counsellor:* Well, the decision is really up to you. But if you do know that you have HIV you can take care of your health and you will know how important it is that you are careful about not transmitting it to other people injecting drugs and to your girlfriend or anyone else you have sex with. But, even if you don't have the test you need to be careful about not sharing needles and syringes and having unprotected sex because you could have the virus and be passing it on to other people. Or you may not have it but pick it up from the people you share needles and syringes with or have sex with. It would be a good idea to start using condoms too.

*Client:* How many other people, apart from you, would know about the test result?

*Counsellor:* We believe that it is very important for the test results to remain confidential so we have codes for all our clients. Only the people working here will know the results but they are not allowed to discuss them with anyone else. It is up to you to decide if you

want to tell anyone. How do you think you would react if you have HIV?

*Client:* Well, I'm not going to be happy about it but I've never had to have a test like this so I don't really know how I'd feel.

*Counsellor:* Are there people you think you could talk to if you did have HIV, like your girlfriend or a good friend or your family?

*Client:* I would tell my girlfriend but I don't know if I could tell my parents. I'd have to think about it.

*Counsellor:* If the tests show that you do have HIV, it is a very common to feel depressed. So I want you to know that we do provide counselling here for all our clients and we are happy to talk to you about any of your concerns. We could also talk to your girlfriend if you wanted. Now, if you have the test today the results will be back in two weeks.

*Client:* Okay, I could come back – that's not a problem.

*Counsellor:* Do you have any questions?

*Client:* I can't think of any at the moment. It is not an easy decision for me, on the one hand I think it is best to know if I have HIV but on the other it really scares me.

*Counsellor:* Well, you can take some time to think about it if you like.

*Client:* No, it's okay I have made up my mind – I think I really should know one way or the other. So take the blood and let's just hope for the best.

## What do the results mean?

If an HIV test result is positive it means that the person has developed antibodies to HIV: in other words they are infected with the human immunodeficiency virus (HIV). This also means that they are able to infect other people and will remain infectious for life.

An HIV positive result does not mean the person has AIDS (Acquired Immunodeficiency Syndrome). Some people infected with HIV stay well for years while others become ill more quickly. An HIV positive person is diagnosed with AIDS when the immune system has broken down, leading to infections or cancers. (For more information on HIV and AIDS see **Appendix 1: Blood Borne Viruses**).

If an HIV test is negative it can mean that the person is not infected with HIV or that he or she is infected with HIV but is still in the window period and has not produced enough antibodies to show up on the test.

A negative test result can only show that a person was not infected with HIV up to three months ago. If that person has shared injecting equipment or had unsafe sex in the last three months they could still be infected, but the test will not yet show it.



## Who should have an HIV test?

The focus of who should be tested for HIV has largely been on groups of people thought to be at risk, especially injecting drug users, sex workers and gay men. A problem with this is that it focuses on groups rather than on specific risk behaviour.

Many people may practise risky behaviours but not identify themselves as fitting into any of the above groups. For example, a married man may occasionally have sex with other men but not consider himself gay; a woman may have unprotected sex with her partner but be unaware that he occasionally injects drugs and shares equipment; or a person may never share needles and syringes but will share all other injecting equipment.

A counsellor or worker in an HIV prevention program may ask a series of questions to assess the risk of a person who requests an HIV test. These questions can be used as a guideline, as most people feel embarrassed and awkward discussing such private aspects of their lives. Several meetings and conversations may be required before a level of trust exists whereby the person is willing to discuss these matters. The language used must be appropriate to the culture and religion of the region. If HIV testing facilities are not available or are too expensive, information should still be given about safer drug using and sex practices. (See **Chapter Five: Safer Injecting** and **Chapter Seven: HIV/AIDS: Preventing Transmission: • Through Sex • Between Parent and Child.**)

## 4. Staff: Burnout and Stress

### What questions should you ask?

Counsellors may ask their client questions such as:

- Has your partner, or anyone who has had sex or used drugs with your partner, been found to have HIV or AIDS?
- Do you engage in any sexual activities that could place you at risk?
- Do you use condoms? How and when?
- Do you have sex when you are using drugs and alcohol?
- Have any of your partners had problems with drugs or alcohol?
- Have you ever injected drugs?
- When was the last time you injected drugs?
- Have you ever injected drugs when you were under the influence of other drugs or alcohol?
- Has someone ever injected you with drugs?
- When was the last time you shared needles and syringes, cookers or other injecting equipment?
- Have you ever had a sexually transmitted infection (STI)?
- Have you ever had hepatitis or tuberculosis?
- Have you ever had surgery or a blood transfusion?<sup>8</sup>

'A youth with high risk practices (sharing injecting equipment and having unprotected sex with multiple partners) had, on two occasions, been treated for STIs. At pre-test counselling he volunteered that if he tested HIV positive he would seriously consider suicide. However, he came to see that behaviour change was essential for his own health and the health of his friends, irrespective of the result of the test. As a result he did not proceed to HIV testing, but joined the Needle and Syringe Program and has had no further STIs.'<sup>9</sup>

'If the grief lingers on unresolved it can have a profoundly negative effect on a worker's wellbeing and relationship to others.'<sup>10</sup>

### What is burnout?

What are some of the contributing issues relating to stress and burnout in this type of work?

How do you avoid burnout?

### What is burnout?

Burnout is a term used to describe the emotional and physical exhaustion which can happen to people who work in the 'caring' professions. It is a response to the chronic emotional strain which can occur when working intensely with other human beings, particularly when they have serious problems and/or illness. The HIV/AIDS prevention area is especially difficult as workers are not only dealing in areas which traditionally have been taboo (drug use and sex) but they also, at times, have to tell people they have a terminal illness. Burnout may manifest in:

- high levels of staff absenteeism
- high sickness levels
- fast staff turnover
- expressions of job dissatisfaction
- conflicts between staff
- ineffective delivery of services to the clients.<sup>11</sup>

Workers who are suffering from burnout may feel tired and drained of energy, with limited emotional resources and a sense of 'compassion fatigue'. This can lead to a lowering of self-esteem as the worker feels he or she is not working very well and is not being of much use to the clients, and this in turn can lead to depression.

Burnout can be categorised as a progressive loss of idealism, energy and purpose. This can be identified in four stages.<sup>12</sup>

## Harm Reduction News

### HIV Testing and Counselling Go Hand in Hand

CHURACHANDPUR, INDIA

Confidential HIV antibody testing is provided at SHALOM for clients who wish to know their HIV status. From January to September 1996, 155 people were tested for HIV. Using the ELISA kits, 72.4 per cent tested positive for HIV antibodies. The testing is voluntary and clients are assured that the result will be held in the strictest confidence. The samples are given to the laboratory technician with only a code number as an identifying mark. All clients seeking confidential testing are given counselling, before and after the antibody test. These two sets of counselling are usually performed by the same member of staff but in some

situations two people have been involved. One of these areas has been in jail where one of the nurses has, at times, given pre-test counselling and then asked the IDU counsellor to come and tell the client the result and give counselling at the same time.

**“...we find ourselves doing counselling in a hurry.”**

The heavy work-load of the counsellors means that they are not always available to provide on-the-spot counselling when clients present at the centre and want to have the test done. “The real problem we have is with the numbers of clients who come: we find ourselves

doing counselling in a hurry.” All the HIV counselling is done by the same IDU counsellor who also works on providing the detoxification services. This has meant a steady stream of clients, and often frustratingly short periods of time with each client. This is particularly acute when trying to explain to the clients the different factors involved with HIV testing. Given the limited time, it is not clear how much the client has been able to understand about the possible six-month window period between their last risky behaviour and knowing for sure that a possible negative result is really the absence of HIV infection.<sup>13</sup>



- **Enthusiasm:** initial period of high hopes, energy, unrealistic expectations; does not yet understand the full scope of the job but has high expectations
- **Stagnation:** continuing with the job but not finding it as stimulating; issues of money, working hours and career development become more important
- **Frustration:** beginning to question own effectiveness in doing the job and the value of the job itself, e.g. asking ‘What’s the point?’; emotional, physical and behavioural problems may start to manifest at this stage
- **Apathy:** occurring when the worker feels constantly frustrated in the job yet needs the job to survive; may begin to put in a minimum of time, resist challenges, even avoid clients and distance him or herself from co-workers.

Symptoms of burnout in individual workers may include: <sup>14</sup>

- Physical: headaches, backaches, frequent colds, exhaustion, lingering illnesses, sleeplessness, gastrointestinal disturbances
- Emotional: irritability, frustration, anger, a rigid and inflexible approach to work, increased use of drugs/alcohol/tobacco etc, over-eating or under-eating, increased conflict in marital or other relationships, depression and hopelessness.

## What are some of the contributing issues relating to stress and burnout in this type of work?

- for some outreach workers this may be the first time in a long time that they have had structured work, so it takes some time to adjust to the change in their lives
- for ex-users there is the constant confrontation with their old lifestyle and the chance of relapsing into using drugs
- if the outreach worker is HIV positive he or she may be constantly reminded of their HIV status through the work
- long working hours for not much pay
- workers may not have much job security because their job is reliant on funding
- workers have to deal with the social and political context, i.e. police harassment, arrest, antagonism from some members of the local community
- sense of loss and grief when clients die
- constantly having to counter stereotypes about drug users and drugs
- having to go into battle time and again for clients
- fighting feelings of futility and frustration
- difficulties associated with forming closer bonds with some clients than others
- attempting to maintain compassion and solidarity with co-workers
- a sense that their colleagues (e.g. those who do not work out on the streets) do not have a clear understanding of the pressures of the job
- if the job consists of referring people on for further treatment, there may be frustration of not seeing the work through
- being placed in positions of considerable personal risk
- working anti-social hours <sup>15</sup>

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The Centre for Harm Reduction

## Harm Reduction News

### It's worth the work

CHURACHANDPUR, INDIA

**T**HERE are times when you feel exhausted because you're working in a field where there is no easy answer to the problem. In Manipur, 95 per cent of the drug users are male, five per cent are female.

Even if they want to give up they can't and many of them are already infected

and they're going to die. And when you think of the magnitude of the problem it makes you very depressed and really tired.

Many times people tell me: "Why are you doing this work? It isn't going to help, you're wasting your time.

**"I'm more mature now and I can handle more."**

These guys are hopeless, useless." At times there is a lot of criticism. But I've decided I want to work in this field. Initially it was very hard – I felt so for them.

I'd have sleepless nights, particularly watching people die. But later on I became more professional. I'm not totally detached but I'm more mature now and I can handle more."<sup>16</sup>

## Harm Reduction News

### It Takes a Lot of Skills

CHARACHANDPUR, INDIA

**W**ell, besides having to walk all day in all types of weather, you're being an educator, a counsellor, a primary health care worker, you're working with clients, community, if you have to take someone into drug treatment then you're having to be an administrator – you're working in one situation then five minutes later you're working in a totally

different situation. You're working in crisis management in a lot of cases. You have to know when your abilities are limited, when you have to call in somebody else. Obviously, if someone has an abscess that's easy enough to lance, to bandage.

**"Being acknowledged for your work is very important."**

But if someone is gasping for breath because they have tuberculosis, you have to know when it's above your head. Then you have to switch to referral mode, then administration mode if they need to go to the TB clinic, or you have to help a family bury someone because he or she has died of AIDS. Then you have to write up reports on that day. Being acknowledged for your work is very important."<sup>17</sup>

## HARM REDUCTION NEWS



### IT PAYS TO TAKE BURNOUT SERIOUSLY

KATHMANDU, NEPAL

Deebash started performing poorly during outreach. He has been one of our most innovative staff members but in the last couple of weeks he has been the least active and interested. Eventually management had to call him in to look at his work performance. Initially he denied that he was feeling

and behaving differently. But, after a couple of hours of talk and motivation, he said that he was not willing to work with IDUs and HIV positive

“  
he said he had been  
having nightmares  
every night  
”

people any longer: he said he had been having nightmares every night. After a few hours of in-depth counselling he was granted leave with pay for five days to go and spend some time with his family outside the valley. He returned last week as the good and happy Deebash of old and is his jovial self once more.”<sup>18</sup>

### How to avoid burnout?

It is important that agencies and programs establish mechanisms to help workers to avoid burnout and to manage their stress. Burnout is often the result of anger, frustration and grief which has not been expressed. Supervisors need to assist individual workers with their problems but also need support themselves. Burnout of individuals can also, at times, highlight the fact that there are problems in the organisation.

There are several strategies that managers/supervisors of programs need to be aware of for avoiding burnout among staff.<sup>19</sup>

- 1 **Supervision:** organise regular de-briefing meetings with individual workers (perhaps every two to three weeks). Talk to the worker about how they are finding the job, what problems they are having, what they are doing about those problems and what they are aiming for. Provide clear guidelines on work roles and levels of responsibility. Ensure the workers know what is expected of them. The supervisor may like to accompany



- workers occasionally in their outreach work, to give them support and advice.
- 2 **Team supervision:** bring all workers together every couple of weeks to discuss the program, to offer each other support, to air conflicts and to stimulate ideas.
  3. **Training:** maintain ongoing training for staff, to give them a chance to develop skills, provide intellectual stimulation and give them a useful break from their daily work.
  - 4 **Recruitment of new staff:** look at what the team needs not only in terms of skills but race, gender and personality type. Will this person fit into the team? Work to integrate new staff members into the team. Involve and support volunteers.
  - 5 **Evaluation and feedback:** keep workers up to date with what is going on in the agency/program and what their work is achieving, e.g. how many people the agency has reached, the quantity of needles and syringes exchanged, condoms distributed, primary health care delivered. Sharing this information can help motivate workers and provide job satisfaction.
  - 6 **Guidelines and protocols:** establish guidelines and agency protocols on:
    - occupational health and safety regulations for the agency
    - grievance procedures
    - strategies for dealing with abusive clients
    - procedures for handling crisis situations i.e. violence, overdose, death.

## Summary

Voluntary HIV counselling and testing (VCT) is the process by which an individual undergoes counselling, enabling him or her to make an informed choice about being tested for HIV, the virus that causes AIDS..

## Counselling Process

### Pre-test counselling

- always to accompany antibody testing
- a comprehensive assessment needs to be made of all the client's risks
- assess client's knowledge of HIV/AIDS and ability to cope with crisis
- comprehensive discussion about all aspects of the test, issues of emotional support, and examining coping mechanisms if the test result is positive
- detailed information on HIV/AIDS, issues of testing accuracy and the meaning of test results
- appointment for follow-up for post-test counselling

### Post-test counselling

- primarily involves giving the results of the HIV test to the client
- type of counselling will depend on the result and, as with the pre-test counselling, privacy and sufficient time will be important so as to discuss the issues with the client.

Comprehensive counselling is crucial even if the test results are negative. When the tests are positive the counsellor needs to be supportive and sensitive to the client's shock and fear. Explanations of the results need to be clear and simple and issues of disease progress and life expectancy are not appropriate for discussion at this time.

Further appointments need to be arranged, not only to establish a supportive relationship but to provide repeated wide ranging information about HIV infection. Reactions to a positive HIV test vary according to the client's personality and their social environment. A client may have various concerns about counselling and/or the counsellor and these need to be addressed.

### HIV Testing Process

The HIV test looks for antibodies to the virus, not for the virus itself. To confirm infection by the virus a window period (three weeks to three months) needs to occur before the accuracy of an HIV/AIDS test can be assessed. If the test result is positive, the person has developed antibodies to HIV and is infected with HIV and capable of infecting others. A negative HIV test can indicate the person is not infected with HIV or that they are still in the window period. AIDS develops when HIV has destroyed the immune system.

Determining which people should have an HIV test has largely focused upon those groups whose behaviors put them at risk:

- injecting drug users
- sex workers
- gay men.

However, many other people within the community may not associate or identify with these groups, continue practising risky behaviour and potentially become HIV infected. An HIV counsellor, keeping in mind cultural, religious and language sensitivities, can compile a series of questions to help identify those people at risk of HIV infection.

Injecting drug users are an extremely marginalised group in societies. The stigma of HIV/AIDS and the decision by IDUs to have a test, and the post-test implications, have highlighted the importance of confidentiality. Informed consent is also essential before an HIV test. Informed consent requires the client to be competent in decision making, have full understanding of the purpose, risks, harms and benefits of being or not being tested, and aware that their decision must be voluntary.

All clients should be provided with a comprehensive explanation about all matters relating to an HIV positive test. A client may not consent to a test because of a lack of information on HIV/AIDS, feelings of emotional vulnerability in receiving a positive result, lack of support by family and friends, and a fear of any breach of confidentiality.

Successful counselling can be achieved by combining various approaches. Information about HIV needs to be comprehensive, people must be given emotional assistance to cope with a positive HIV test, and encouragement must be given to adopt safe behaviours to prevent transmission. Counselling is very often not a one-time event and can occur formally or informally on a regular basis.

Summary

*Manual for  
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**Staff: Stress and Burnout**

Within harm reduction programs, staff stress and burnout have many manifestations ranging from high sickness levels to fast staff turnover. The progressive loss of idealism, energy and purpose can be identified through the following stages:

- 1 Enthusiasm
- 2 Stagnation
- 3 Frustration
- 4 Apathy

Harm reduction work has an array of contributing issues that can both be stressful and can contribute to burnout for those involved in the program. Outreach workers often meet many difficulties that are linked to personal issues that have the potential to conflict with their assigned tasks. Other issues that may arise include fighting feelings of futility and frustration, political and social struggles, battling to protect their clients and a sense of loss and grief when a client dies.

Mechanisms should be established to avoid burnout and manage stress. Strategies to avoid burnout include:

- regular de-briefing meetings with individual workers to discuss various issues encountered on the job
- team supervision to bring all workers together for open discussion, support and ongoing training
- issues related to recruitment of new staff (i.e. skills, race, gender, personality types)
- evaluation and regular feedback to staff about any developments in the program, which can not only motivate workers but also promote job satisfaction.

**Section Two, Chapter Eight:  
Voluntary HIV Counselling and  
Testing**

**For further information refer to WHO resources: Evidence for Action Papers. Refer to the following website: [www.who.int/hiv](http://www.who.int/hiv) (publications expected online from May 2003)**

CENTRE FOR HARM REDUCTION  
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**▼▲ HIV/AIDS test looks for antibodies to the virus not the virus itself. AIDS develops when HIV has destroyed the immune system.**

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**Different modes of testing**

- voluntary screening. e.g. blood donors
- compulsory
- sentinel surveillance
- anonymous and delinked

**Pre and post HIV/AIDS testing requires strict confidentiality and informed consent.**

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CENTRE FOR HARM REDUCTION  
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**▼▲ Informed Consent Requirements From Client**

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- Competency in Decision Making
- Understanding Purpose, Risks, Harms & Benefits of being Tested or of not being Tested
- Must be completely Voluntary



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CENTRE FOR HARM REDUCTION  
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▼▲ **Pre Test Counselling**

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- Antibody testing
- Comprehensive assessment of client
- Client's HIV/AIDS knowledge & coping mechanisms
- Comprehensive discussions on all aspects of test, coping mechanisms and meaning of results
- Provision of information on HIV/AIDS
- Privacy

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SECTION 2 • CHAPTER 8 • OVERHEAD 3

CENTRE FOR HARM REDUCTION  
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▼▲ **Post Test Counselling**

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- Providing results of HIV test
- Counselling style depending on result (positive, negative, indeterminable)
- Privacy, complete confidentiality

**Explain results in clear and simple language, particularly if test is positive. Supportive relationship needs to be nurtured.**

*Manual for reducing drug related harm in Asia*  
SECTION 2 • CHAPTER 8 • OVERHEAD 4

CENTRE FOR HARM REDUCTION  
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▼▲ **Staff Stress and Burnout follow Stages**

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- 1 Enthusiasm
- 2 Stagnation
- 3 Frustration
- 4 Apathy



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SECTION 2 • CHAPTER 8 • OVERHEAD 5

CENTRE FOR HARM REDUCTION  
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▼▲ **Difficulties encountered by Outreach Workers**

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- Personal Issues
- Feelings of Futility and Frustration
- Political and Social Struggles
- Protection of Clients
- Loss and Grief

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SECTION 2 • CHAPTER 8 • OVERHEAD 6

**CENTRE FOR HARM REDUCTION**  
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**▼▲ Strategies to Avoid Burnout**

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- ▶ Regular De-briefings
  
- ▶ Open Discussions & Ongoing Training
  
- ▶ Insightful Recruitment of New Staff
  
- ▶ Evaluations and Regular Feedbacks to Staff

*Manual for reducing drug related harm in Asia*  
**SECTION 2 • CHAPTER 8 • OVERHEAD 7**

## Section Two

### *Chapter Nine*

## Specific Groups

Refugees

Prisoners

Sex workers

Men who have sex with men

Migrants (mobile populations)

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## Introduction

Specific groups in the community have increased risks of contracting and transmitting HIV/AIDS. The reasons for the increased risk vary from group to group but they all revolve around circumstances which lead people to engage in risky sexual and/or drug taking behaviour. These groups require special targeting to ensure that their needs are recognised and met. Involving the specific group in the planning, establishment and running of the program will increase the chances that the program will be successful.

This chapter will look at:

- 1 Refugees
- 2 Prisoners
- 3 Sex workers
- 4 Men who have sex with men
- 5 Migrants (mobile populations)

I. Refugees

“The destruction of families, deterioration of social structures and unravelling of social mores, the loss of homes and income, overburdened health care resources, crowding and the sex trade within refugee camps are just some of the factors leading to increased risk-taking behaviour and susceptibility (to HIV/AIDS). Women and adolescent refugees, vulnerable to violence, rape and coercive sex, are at especially high risk.”<sup>1</sup>

Why is HIV/AIDS a problem for refugees?

What can be done in these situations?

It is estimated that there are 40 million refugees in the world today with the majority being women and children.<sup>2</sup> Refugees are generally forced from their homes due to a natural disaster such as an earthquake or flood or because of war or civil disruption. HIV/AIDS is often of little concern to refugees compared to their immediate needs for food and shelter. However, HIV/AIDS has been found to be a real problem for refugees.

Why is HIV/AIDS a problem for refugees?

**Blood transfusions:** many refugees need urgent blood transfusions due to injuries from war and/or because of their poor nutritional status. Transfusion with HIV-infected blood is a highly efficient means of transmitting the virus.

**Sexual contacts:** fleeing populations are often made up of unaccompanied children and many single women. In emergency situations people often lose their spouses and families. Social ties break down leading to a loosening of traditional values, rape occurs, prostitution becomes a way to earn money for basics such as food and condoms are often unavailable.

**Prostitution:**

- the need for food is paramount in refugee situations, sex is used in exchange for food and other essentials
- fuelled by the fact that men and women refugees often have no partners
- becomes established in and around the camps
- inevitably involves the host community
- both sex worker and client at risk of HIV if condoms are not used

“But what is of the utmost concern is the forced, large-scale migration of people: displacement caused by ethnic feuds, leaving whole villages torched, a large number of people dead, and the living without any visible means of livelihood. These displaced people are given temporary shelter in crudely constructed refugee camps, where conditions are usually degrading and appalling. Women enjoy no privacy and deprived of families and their livelihood they are often forced into prostitution to survive or to provide for their remaining siblings, relatives etc. As the choice of prostitution as a profession is not a free choice, they tend to shut off their minds and emotions from the work they are involved in and to do this, they usually need the help of alcohol, drugs or both.”<sup>3</sup>

**Injecting drug use:** if the emergency occurs in an area where injecting drug use is common it may also begin in the refugee camps or refugees who were already IDUs will continue injecting in the camps. It is highly likely that IDUs will be sharing needles and syringes – this carries a great risk for transmitting the virus where it is present.

**Mixing of populations:** some refugees may have knowledge of HIV (e.g. urban people) while others may not. One group may come from an area where HIV is prevalent, others from where it is not.

Chapter  
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Unprotected sex and the sharing of injecting equipment can lead to transmission of the virus between these groups. The refugees also come in contact with the local host community where HIV may be prevalent.

**Health care:** amid the chaos of an emergency, materials for HIV prevention, especially condoms and new injecting equipment, are unlikely to be available. Health care services, including care for STDs and HIV/AIDS, most probably will not exist.

### What can be done in these situations?

- make the blood supply safe: test all blood for transfusion for HIV
- provide supplies for 'universal medical precautions': adequate supplies will ensure health workers can follow the necessary precautions to prevent transmission of HIV. Universal medical precautions include:
  - Washing hands thoroughly with soap and water, especially after contact with wounds or body fluids.
  - Using protective gloves whenever there is contact with blood or potentially infected body fluids, and disposing of materials and sharp objects.
  - Using protective clothing when there is likely to be exposure to large amounts of blood.
  - Safely handling and disposing of needles and other sharp instruments.
  - Safely disposing of waste materials.
  - Properly cleaning and disinfecting medical instruments.

- provision of condoms: make condoms available immediately and in sufficient quantities even though other matters will seem of greater urgency
- provision of equipment to make injecting safer: provide supplies of household bleach (or other disinfectant) and teach IDUs how to clean their needles and syringes and /or establish a needle and syringe program
- provision of information on HIV/AIDS: give refugees information about the transmission of HIV and how to prevent it. The information should be given in the refugees' language and designed in a way which is culturally appropriate and relevant to the target group



## HARM REDUCTION NEWS



### REDUCING HARM IN A REFUGEE CAMP

HONG KONG, CHINA

**P**illar Point refugee camp in Hong Kong was primarily opened as a transit camp for Vietnamese people awaiting departure to a country of asylum. The camp is located in an area well known for its drug use and criminal activi-

“  
**(With) the sense of helplessness and hopelessness about the future...**  
”

ty. The camp's location, the difficult conditions within the camp, the sense of helplessness and hopelessness about the future, the pleasure from drugs and social acceptance of drugs among the male refugees has led to a great deal of heroin use in the camp. It is estimated that 90 – 95 per cent of Vietnamese men in Pillar Point are dependent on heroin. They work mainly as day labourers and nearly all of them now have criminal records which blocks their chances of resettlement.

In July 1996 Medecin Sans Frontiers began a program among drug users in Pillar Point camp. Their general aims were to reduce the

health risks of injecting drugs and to improve the overall quality of the lives of IDUs and their families. Their specific aims were to raise awareness of the health related risks (e.g. HIV/AIDS), encourage safer injecting practices and safer sex, to encourage safer disposal of used needles and syringes and to help IDUs gain access to methadone programs.

The field team was composed of one Vietnamese drug counsellor and one medical doctor: they mainly worked in the evening and on the weekends as this was the best time to reach IDUs. The workers offered individual counselling where alternatives of drug treatment and safer injecting practices would be discussed: all counselling was confidential. They also gave IDUs a needle pack service. This consisted of a free set of:

- three needles and syringes
- three sterile waters
- three sterile swabs
- one condom
- a leaflet with appropriate information about STDs, HIV/AIDS and condoms

Along with distributing the packs they would discuss methods of safer using and listen to the concerns of the IDUs. Individual needle and

syringe boxes, closed by a tamper proof seal, were distributed and, when used, collected by the doctor.

A three month survey of the program's clients found that:

- 70 per cent of IDUs had not shared needles and syringes

“  
**The camp has now become free of discarded used needles and syringes.**  
”

- 30 per cent of those who had shared had cleaned the needle and syringe before injecting
- 81 per cent always cleaned their skin with a swab before injecting
- 30 per cent were using sterile swabs
- 74 per cent used boiled or sterile water to mix up their drug

They also found that 75 per cent of their clients were concerned about disposal issues and understood the danger discarded needles and syringes could be to other people, especially to the children in the camp. The camp has now become free of discarded used needles and syringes.<sup>4</sup>

## 2. Prisoners

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“ Many of those in prison are there because of drug use or trafficking and they often find ways to continue drug use inside. Drug injecting is shared – non-sterile equipment is the factor probably accounting for the greatest number of new HIV cases in prisons worldwide.”<sup>5</sup>

### Why is HIV/AIDS a problem for prisoners?

#### What can programs do to stop the spread of HIV/AIDS in prisons?

HIV/AIDS has been found among prisoners in most countries throughout the world. HIV prevalence in many prisons in Asia is high – often higher than among the general population. Most prisoners return to the outside world and bring with them diseases contracted inside the prison. A prison’s population is constantly changing: prisoners are not permanently sealed off from the community. Prisoners are in a vulnerable position, at the mercy of the prison officials and often to the sexual, and other demands, of fellow prisoners.

### Why is HIV/AIDS a problem for prisoners?

Many factors contribute to make prisons a breeding ground for disease and infection including:

- **Overcrowding:** means prisons are usually unhygienic and makes the transmission of disease easier (e.g. Tuberculosis) and it also leads to increased tension between prisoners including sexual tension.
- **Violence:** an atmosphere of violence and fear is common in most prisons. This can produce attacks, including sexual attacks.

- **Drug use:** many prisoners are in prison because of drug related offences and the experience of prison does not encourage abstinence. Most prisoners cannot get access to sterile injecting equipment, but can get drugs, and what equipment exists is usually shared between many people. This is an extremely efficient way of passing on the virus.
- **Sex and Rape:** sex between prisoners is common and often includes anal sex. Rape also happens in prison and sometimes is part of an initiation to prison life: this can be gang rape. It is rare for prisoners to have access to condoms and lubricants to protect themselves from STDs including HIV/AIDS.
- **Tattooing, skin piercing, blood brother rituals:** these practices are also common in prison and the equipment is usually shared and unsterilised, presenting a great risk of HIV transmission.

### What can programs do to stop the spread of HIV/AIDS in prisons?

- accept the reality that injecting drug use and sex takes place in prisons
- provide bleach (or another appropriate disinfectant see **Chapter Five: Injecting Safely** for more details) and instructions for cleaning injecting equipment. It may be introduced into the prison as a means of cleaning needles used for tattooing etc. – this may be a more acceptable way of convincing officials and getting a disinfectant to the prisoners
- establish a needle and syringe program: establish a pilot program, this can be an easier way to convince prison officials and governments of the benefits of the program. Evaluate it, for example, after one year

Harm Reduction **News** 

**Prison Spreads AIDS**

YANGON, MYANMAR

In the past few years, approximately 100 political prisoners have died in Insein prison (in Myanmar) as a result of dysentery and severe torture. More recently, some political prisoners have died of AIDS. However, to date, the authorities are not paying any serious attention to the worsening health situation and the spread of the HIV virus among inmates of Insein.

Former political prisoner Moe Aye, who spent six years in Insein, said prisoners are afraid to go to the prison hospital. "Before, when we were sick, we would go there, but not anymore," he said.

The reason: only one needle is used a day for up to 200 patients. This includes drug

addicts. And the result – an uncontrolled spread of the virus. Inside the prison hospital, there's a small signboard at the entrance of the Out Patient Treatment (OPT) room which reads: 'Today – 15 needles are permitted for use.'

**"I've seen my friends die in prison – the authorities paid no attention."**

According to Moe Aye, the OPT treats almost 200 patients daily. Thus, if one needs an emergency injection, to ensure safety, the patient has to bribe the medical officer to the tune of 300 kyat for a new needle and syringe.

In addition, the 'medical workers' at prison are not

properly trained but are prisoners handpicked by the wardens to work in the hospital. "And many of them are drug addicts infected with HIV," Moe Aye said.

Consequently, all inmates, including political prisoners, fear getting injections at the prison hospital. Their concern is genuine. A number of political prisoners in Burma have died of AIDS. But those who suffer are not only Burmese. According to a former Thai prisoner, at least one Thai dies each month of HIV/AIDS – many of whom were fishermen arrested in Burmese waters.

"I've seen my (Thai) friends die in prison – the authorities paid no attention," Rashen Plengvithaya, who was in Insein prison for five years, said. <sup>6</sup>

- train current prisoners to become peer educators: to teach other prisoners about safer using and safer sex
- provide condoms and lubricant to prisoners through regular health visitors to the prison
- provide information on how HIV/AIDS is transmitted through sharing injecting equipment and through unprotected sex
- if possible try to persuade prison and government officials of the benefits of establishing a pilot drug substitution program (i.e. methadone, buprenorphine)
- try to persuade prison officials to allow outside doctors and health workers to visit the prisoners

### 3. Sex Workers

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“Sex work involves many more people than sex workers, and supports local economies and the people who work in them, wherever it takes place. This includes the owners and staff of hotels, clubs, bars, brothels and escort agencies that employ sex workers, local shops and food sellers; and taxi drivers, pimps, police, drug dealers and criminal elements who feed off the trade.”<sup>7</sup>

#### Why is HIV/AIDS a problem for sex workers?

#### What can programs do to stop the spread of HIV/AIDS among sex workers?

Sex work is a reality in every country in the world. Sex workers are at great risk of contracting and transmitting HIV and other STIs if they do not use condoms. However, many clients of sex workers do not want to use condoms and for various reasons (see below) sex workers are unable to insist. This puts both the sex worker, the client and their partners and potential children at risk of HIV/AIDS.

#### Why is HIV/AIDS a problem for sex workers?

**Numbers of clients:** unprotected sexual intercourse is a major risk factor for the transmission of HIV/AIDS. Due to the amount of clients sex workers see, if they are not practising safer sex (i.e. using condoms), they increase their chances of contracting HIV from a client and they then can pass it on to other clients, their sexual partners and eventually their children

**Inability to insist on condom use:** many women work as sex workers because of poverty: so that they can provide the basic necessities for their families. They often have little power to insist clients use condoms as the client may refuse to wear a condom and if they insist they will lose the business

**Violence:** sex workers who insist on condom use may face violence from clients and/or brothel owners/pimps

**Youth:** young women who are sold into sex work also have little power to insist on condom use and/or are marketed as ‘unsoiled goods’

**Trafficking:** the trafficking of women across borders and from remote areas means they may not speak the local language and safer sex messages in that language may not be understood by them

**Injecting drug use:** women who work as sex workers may also be injecting drugs and may contract HIV from sharing needles and syringes even if they use condoms in their work

**Insufficient condoms:** sex workers may not have access to sufficient numbers of condoms

**Lack of health care:** sex workers may not have access to health care to get treatment for STIs which increase their risk of contracting HIV/AIDS

**Work options:** sex workers may have no work options other than prostitution, they may also not have access to land ownership or use, money or credit



## HARM REDUCTION NEWS



### GETTING THE MESSAGE TO WHERE THE CUSTOMERS ARE

BANGKOK, THAILAND

The Thai TRAVEL SAFE pilot project was conducted by Convenience Advertising in collaboration with the Thai and Australian governments, NGOs, bar owners, sex workers and health officials. The broad objectives of the project were to: reinforce the need for safe behaviour in respect to sexual contact when travelling, to increase the personal relevance of the risks of HIV and other STDs for men who travel to South-East Asia for paid sex and to provide appropriate messages to Thai sex workers that would assist in the negotiation of safer sex. The project sought to reach 20-40 year old:

- Australian male tourists
- Sex workers

English speaking tourists Posters in both Thai and English were displayed in a range of bars and nightclubs in the Patpong area in Bangkok and at the popular

“  
**Sure, money is precious; but if you have to risk AIDS to get it, it ain't worth it.**  
 ”

resort Pattaya beach (a two and a half hour drive from Bangkok). The largest group running bars in the Patpong area is the King's Group: they are reputed to have 1000 sex workers working for them in the area. The company director endorsed the TRAVEL SAFE project and ensured its establishment in his venues.

In Bangkok 78 venues had 343 signs placed in designated areas: English messages in the client toilets and one Thai message in the sex workers' toilet. The sex workers also requested European size condoms (52) be supplied. The messages were designed by the Ministry for Public Health in Thailand.

An example of one of the signs:

LIFE IS VALUABLE. IT'S NOT WORTH GETTING AIDS. DON'T FORGET; ALWAYS USE A CONDOM.

- Always protect yourself and the one you love
- Sure, money is precious; but if you have to risk AIDS to get it, it ain't worth it
- AIDS... incurable, but you can protect yourself<sup>8</sup>

### What can programs do to stop the spread of HIV/AIDS among sex workers?

- accept the reality that reducing the number of clients a sex worker sees is an unrealistic strategy for most sex workers
- use peer educators to get the message across: educate sex workers who will be acceptable to other sex workers
- involve sex workers in the design of programs and IEC materials
- target owners and managers of brothels, bars etc. to support safer sex practices
- target clients of sex workers and educate them on the risks of unprotected sex
- assure a consistent and adequate supply of condoms: there is no point in encouraging sex workers and clients to use condoms if there are none available
- discuss injecting drug use and provide information on safer drug use including needle and syringe programs, cleaning techniques, substitution programs etc.
- provide links with health care facilities and encourage regular STI check-ups for sex workers with guaranteed confidentiality
- provide counselling and HIV testing for those sex workers who request it.

Chapter  
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The Centre  
 for Harm  
 Reduction

## Harm Reduction News

### Peer Education Works for Sex Workers

CALCUTTA, INDIA

Over 5,000 women work as sex workers in Sonagachi, a 'red-light' area in one of India's largest cities. Although most work from brothels, some women, as well as male sex workers, travel into the area to work. The male clients number more than half a million a year.

**“The success of the service depends on community participation.”**

An effective primary health care service, with an emphasis on sexual health, has been developed by working with people in the area, including sex workers, NGOs and local medical institutions. Based in a building loaned by a local club, the service functions as a community resource, with at least half of the clinic users identi-

fying themselves as sex workers.

Since the service started in 1992, the number of people with STDs has fallen. HIV prevalence, measured using anonymous and unlinked testing, has remained the same. Women reached by the project report that they use condoms with more than half their clients while elsewhere in Calcutta female sex workers report condom use with only about 20 per cent of their clients. The success of the service depends on community participation. This is made possible through continuing negotiations with community power groups, including leaders of local political parties and gangs, youth groups, brothel landlords and female managers, private practitioners and sex workers.

During the first 15 months of operation, more than 4,500 people visited the clinic for the first time. Over

three quarters of visits were made by women. A second clinic, run during the evening, is aimed at male clients and sex workers who travel to work in the area.

**“The peer educators are proud of what they do ...”**

Over 65 former and current sex workers act as peer educators, after taking part in a six week training program and passing an oral test. They visit sex workers in their homes and talk with them about their sexual health, demonstrate and distribute condoms and encourage them to visit the clinic. The peer educators are proud of what they do and feel they have gained confidence and dignity. The more experienced ones are involved in training new peer educators and other community members.<sup>9</sup>

4. Men who have sex with men

"I live in a society which thinks that I am abnormal. It will take a long time for the society to accept me and they will not understand me. All programs on homosexuality in the media are in English. Are the English speaking ones the only ones entitled to be homosexuals? You should provide more exposure in the mass media so that my parents will accept and understand me."<sup>10</sup>

Why is HIV/AIDS a problem for men who have sex with men?

What can programs do to stop the spread of HIV/AIDS among men who have sex with men?

Men who have sex with men (MSM) are an often hidden group in many countries. While some men are open about their sexuality and belong to a gay community, many other men are not. Many men who have sex with men do not see themselves as homosexual: they may be married and have children and occasionally have sex with other men. These men may not know of the risks they are taking in relation to their own health and that of their families in terms of HIV/AIDS and other STIs.

Why is HIV/AIDS a problem for men who have sex with men?<sup>11</sup>

Many factors contribute to make HIV/AIDS a risk for men who have sex with men (MSM) including:

**Sex:** unprotected anal intercourse (i.e. without using condoms and lubricants) is a high risk activity for transmitting HIV and other STIs.

**Health care:** lack of STI testing facilities for identifying and treating STIs and/or failure to attend clinics for fear of being identified as having sex with men.

**Denial:** in many countries the existence of same sex intercourse is denied by the authorities and society.

**Stigma:** because of this denial and/or the outrage of the community at MSM, many MSM feel ashamed of their sexuality, suffer from low self-esteem and attempt to keep their sexuality a secret from their families and the wider society.

**Tradition:** pressure from family and society to get married and have children, particularly a son, contributes to the secrecy about MSM. If MSM marry and continue to have unprotected sex with other men, they also put their wives and children at risk of HIV.

Chapter Nine  
Specific groups



The Centre for Harm Reduction

## HARM REDUCTION NEWS



### FRIENDSHIP FIGHTS AIDS

HO CHI MINH CITY, VIETNAM

**N**GUYEN Friendship is a society working in HIV/AIDS prevention for the gay community in Ho Chi Minh City. As in many South East Asian countries, AIDS has been the issue that gays first organised around, creating, in addition, a place for open discussion of gay, lesbian, bisexual and transgender issues.

The Nguyen Friendship Society runs a group to discuss these issues. In the group there is a leader, a secretary, a cashier, the press group, the musical group, outreach team and volunteers.

“Together we are part of 10,000 people who are

homosexual in Ho Chi Minh City and 80,000 – 100,000 gay people in the provinces. Every month we ourselves

“  
**We need all of us to unite in the spirit of mutual help and friendship ...**  
”

issue hand-size leaflets to send to them. In those, most of the news is translated from foreign information, magazines etc. so we don't have very much. We also have the money saving project to help poor gays in their difficult lives. This project has raised \$100 (US) or one million Vietnamese Dong. We hold

meetings, activities and studies so that we can think about AIDS clearly. Sometimes we also discuss the gay way of life and hope to normalise relations with other people and families, to avoid despising and discrimination.

However, for all our activities, we still have problems. We are a small group who are usually despised by oriental society. It is important that we haven't been supported yet by any associations or personal support. We need all of us to unite in the spirit of mutual help and friendship with the purpose: don't die of ignorance and let's have safer sexuality.”<sup>12</sup>

**Lack of information:** the mainstream media and program messages about HIV/AIDS tend to revolve around heterosexual sex. MSM often do not have information about the dangers of unprotected sex with other men and therefore may be ignorant of the risks.

**Injecting drug use:** MSM may also be injecting drugs and may contract HIV from sharing needles and syringes even if they use condoms.

**Sex work:** some MSM work as sex workers and are at great risk of contracting or transmitting HIV and other STIs if they have unprotected sex with their clients.

**Police:** many MSM have suffered police harassment and have little knowledge of their legal rights. Police have threatened to expose MSM or have extorted money from them. In some countries anal sex is illegal: this is a major hurdle to incorporating messages about anal sex into mainstream campaigns.

**Condoms:** MSM who are aware of the need to use condoms may be unable to get access to them. Some MSM are reluctant to use them because of reduced pleasure.

## 5. Migrants (mobile populations)

### What can programs do to stop the spread of HIV/AIDS among men who have sex with men?

- accept the reality that men do and will continue to have sex with other men
- establish STI clinics to deal specifically with MSM and/or educate existing clinic workers on the particular health risks for MSM
- train and educate MSM for peer education on HIV/AIDS, sexual health, legal rights etc.
- set up a specific project to focus on MSM
- set up informal discussion groups to examine issues surrounding HIV/AIDS, sexuality, drug use, marriage, family etc.
- provide adequate numbers of condoms and lubricants
- discuss injecting drug use and provide information on safer drug use including needle and syringe programs, cleaning techniques, drug substitution programs etc.
- provide pre and post HIV test counselling, make testing voluntary
- organise lawyers to come to a program and explain MSM' legal rights
- work with government, police and other authorities to sensitise them to MSM issues

"All throughout Asia political, ethnic and religious conflicts are major causes of migration. Because Asia is the region of economic boom the so-called 'push and pull' factors have also become major causes of migration. Mass poverty exists side by side with the so-called economic miracle taking place in Asia. People from poor areas migrate to escape from poverty and hunger, to find a better life elsewhere and to help the family back home."<sup>13</sup>

### Why is HIV/AIDS a problem for migrants?

#### What can programs do to stop the spread of HIV/AIDS among migrants?

There has always been a great deal of migration in Asia and varying reasons for the migration. People may migrate from areas of conflict to areas of relative peace and stability, from poor to richer countries, from rural to urban areas and so on.<sup>14</sup> Migrant workers often take up unskilled labour jobs in construction, manufacturing, fishing, domestic duties and the sex and entertainment industries. Illegal migrants find themselves outside of the law, without protection and often without a common language. They are a vulnerable group and at risk for HIV/AIDS.

### Why is HIV/AIDS a problem for migrants?

**Sex work:** women are trafficked from rural to urban areas to work as sex workers, other female migrants are unable to find work or their work is so lowly paid that they have little option but to take up sex work, others have no option but to work as a sex worker because they are supporting their family back in their villages. (See section on sex work for more details of the risks sex workers face).

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**Language:** migrants may have no common language with their new country and therefore don't understand safer sex and safer using messages.

**Health Services:** migrants often lack access to health services where they could get treatment for STDs and receive information on HIV/AIDS. They may be unwilling to visit hospitals for fear of being caught by the authorities or simply because they have no money.

**Law:** illegal migrants often do not have any legal protection and so can easily be exploited through lower wages, forced into sex work etc.

**Traditional social environment:** migrants are cut off from forms of control that would normally affect their behaviour (e.g. family and village pressure for sexual fidelity) and their anonymity and loneliness may mean they engage in behaviour they would not otherwise (i.e. sex with sex workers and injecting drug use).

**Lack of knowledge:** migrants may have little knowledge and information, or have misconceptions, about HIV/AIDS and how it is transmitted.

**Injecting drug use:** migrants may come into contact with injecting drug use in the new country or they may already have been injecting and continue the behaviour in the new environment. They may come from areas where drugs, such as opium, are traditionally smoked, to areas where heroin is injected. If they share injecting equipment they are at risk of HIV/AIDS.

**Borders:** migrants can often be found along border areas where trading towns and 'rest and recreation' facilities exist. HIV incidence is often higher in these places (e.g. Thai/Cambodian border and Thai/ Myanmar border). Men often outnumber women in border towns and therefore there is a demand for sex work outlets. Border towns on drug trafficking routes also have easy and regular access to drugs.

**Local populations:** can see migrants as a threat to local jobs and scarce resources, migrants can feel stigmatised and discriminated against, emphasising their outsider status.

## What can programs do to stop the spread of HIV/AIDS among migrants?

- programs need to investigate *who* the migrants are, *why* they have migrated and *what* their particular needs are
- information needs to be targeted to the migrant group to ensure the messages are culturally appropriate, relevant and in their own language. Involve migrants in the planning of projects. Provide information on how HIV/AIDS is transmitted through unprotected sex and the sharing of injecting equipment
- recruit migrants to work as peer educators as they are more likely to gain the trust of the community, especially given their outsider status in the general community
- migrants need access to health services: provide links to health care for primary health needs, STI check-ups and HIV/AIDS information
- provide sterile equipment to make injecting safer: provide supplies of household bleach (or other disinfectant) and teach IDUs how to clean their needles and syringes and/or establish a needle and syringe program
- provide condoms in sufficient quantity
- work with the general community for greater understanding and acceptance of the migrants
- inform migrants of their legal rights

Harm Reduction **News** **Migration Increases Women's HIV Risk**

KUALA LUMPUR, MALAYSIA

Recent years have witnessed a rapid feminisation of migration, originally within the manufacturing sector, now primarily through the demand for domestic labour, and in the sex and entertainment industry. In Malaysia there are more than 60,000 maids while in Saudi Arabia alone there are over 500,000 Indonesian maids.

**“...the unequal relationship that defines women's lives in Asia raises issues related to HIV vulnerability.”**

The experiences and realities only show that women on the move have to deal with multiple dangers and risks especially in terms of spatial mobility and behaviour, social networks, sexual behaviour and subordination. There is a link between these factors, especially sexual activity and the creation of networks, that can lead to HIV infection.

A study of Bangladeshi women in a community in Malaysia showed that the women not only enjoyed their new found freedom but threw away their social norms. The move to Malaysia led to anonymity. They are out of their social context and control. The anonymity created an independence and assisted them in developing relationships. They interacted freely with others. Some of them also had indiscriminate sexual behaviour that included casual sex.

Gender power relations and the unequal relationship that defines women's lives in Asia raises issues related to HIV vulnerability. As migrant workers, these power relationships seem to be much more evident especially when it comes to sexual relationships. Though the women found themselves to be free to enter into relationships, it was the male partner who made the decisions in terms of safer sex practices.

Observations of women who earn very low wages show that they tend to supplement their wages. This

seemed to be present, not only with maids, but women working in factories that pay very low wages. There is demand for sex work. And the very low wages leads to migrants seeking this alternative. Demand for better wages would bring about the risk of being dismissed from work. The need to survive and hold on to work permits makes the worker accept their situation.

**“...for migrant women the risks are even higher and more acute.”**

Women are indeed more vulnerable to HIV infection. But for migrant women the risks are even higher and more acute. The environment, stigmatisation, anonymity, exploitation and discrimination added with women's subordination, especially within sexual relationships, are all important to understand the connection between migration, women and HIV infection.”<sup>15</sup>

## HARM REDUCTION NEWS



### MIGRATION AND HIV – A MOBILE PROBLEM

BANGKOK, THAILAND

Where people move, so does HIV. The disease seems to follow any mobile group: workers migrating to countries, fishermen, sailors, traders, construction workers and transport workers in general. In Malaysia there are an estimated 2 – 2.5 million migrant workers, mostly illegal and mostly from Indonesia and Bangladesh. Thailand also has many migrant workers, again mostly illegal, from Myanmar, Cambodia, Laos, China, Nepal and Bangladesh. Migrant workers are also sizeable in Taiwan, South Korea and Japan.

Some indigenous people also move between countries, for example, some hill-tribe people from Myanmar and Laos have migrated to

Thailand. Away from home, mobile groups are not bound by social mores and traditions and are often isolated and lonely. “Migrant workers live in difficult circumstances – overcrowded slums with lit-

“  
**We need all of us to  
unite in the spirit  
of mutual help  
and friendship.**  
”

tle recreation facilities. So sex is a mode for entertainment,” says Dr Shakti Paul, Health coordinator from the Asian Research Centre for Migration in Thailand.

In many countries, sex workers may also originate from foreign countries, for example, half the prostitutes in Mumbai (Bombay) are

believed to be Nepali. “They are disadvantaged because they may not be able to speak the language. Laotian or Burmese sex workers in Thailand will not understand the media here, and so won’t have access to HIV education. They cannot communicate so they will have less bargaining power to use condoms,” says Dr Shakti.

Other mobile workers, such as fishermen and truck drivers, have lifestyles that include frequenting sex workers. In Thailand, 15 to 20 per cent of fishermen are estimated to be infected with HIV. High HIV prevalence has also been reported among truck drivers in India and Thailand, where prostitutes are easily found at truck stops. In Africa, the spread of HIV had a close parallel to major roads.<sup>16</sup>

## Summary

### Refugees

Refugee numbers continue to increase and one of the problems they encounter is that of HIV/AIDS. Following the turmoil that has led people to become refugees, various circumstances arise that increase their vulnerability towards HIV/AIDS. Some causative factors for the development of HIV/AIDS are blood transfusion of HIV infected blood, loosening of traditional values and/or economic instability leading to prostitution, non availability of condoms, mixing of refugee populations and all the disparities that exist within the various groups (i.e. knowledge of HIV and prevalence of HIV infection). Additionally, health care information and related health services on HIV prevention usually do not exist and drug injecting for those involved in such practices before an emergency is likely to continue.

#### Actions to be taken in refugee areas to prevent HIV transmission

- provide safe blood supply
- provide supplies for universal medical precautions
- provision of condoms
- provision of injecting equipment, related supplies and education/information
- provision of HIV/AIDS transmission and prevention education/information that is both culturally appropriate and relevant to the target group

### Prisoners

HIV prevalence in many prisons in Asia is high. Prisoners returning to the outside world will often bring with them diseases contracted inside the prison. Prisoner vulnerability can result in sexual and other demands of fellow prisoners leading to HIV infection.

#### Reasons for the HIV/AIDS problem among prisoners

- overcrowding often leads to poor hygiene, easier transmission of disease and potential for rising sexual tension
- atmosphere of violence that can include sexual attacks
- widespread drug use and the sharing of unsterile injecting equipment
- sexual activities and rape between prisoners can be common. Access to condoms and lubricants are rare
- tattooing, skin piercing and blood rituals with shared unsterile utensils

Prison authorities need to accept the reality that injecting drug use and sex occurs in prison and that various programs exist to prevent HIV/AIDS in prisons. Education/information materials on prevention of HIV from drug injecting and sexual acts, and the means to prevent transmission, are very important (i.e. pilot programs on needle and syringe to promote validity of such actions, introduction of bleach for cleaning needles and syringes, provision of condoms and lubricants and the training of peer educators).

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**Sex Workers**

HIV/AIDS is a problem for sex workers due to some of the following factors:

- unprotected sexual intercourse with various clients can increase risk of HIV transmission
- issues of poverty and diminished power enhances inability to insist on condom use
- violent repercussions for those insisting on condom use
- youth sold into sex work have little power over their circumstances
- lack of health care places sex workers at risk of STIs
- sex workers may be involved in injecting drug use and sharing injecting equipment

Some programs to prevent spread of HIV/AIDS among sex workers include:

- use of peer educators to disseminate education/information
- targeting both brothel owners and clients of sex workers to support safe sex practice
- maintaining consistent and adequate supply of condoms
- encouraging links with health services for regular STI check ups for sex workers

**Men who have Sex with Men**

In many countries men who have sex with men (MSM) are a hidden group and the risks they encounter of HIV/AIDS and other STIs are great. Contributing risk factors are numerous and range from unprotected anal intercourse and the lack of appropriate education/information, to issues of stigma and the inability to get condoms.

Successful programs to protect MSM from HIV/AIDS have adopted various approaches that include:

- accepting the continuing reality of MSM
- training and educating MSM as peer educators
- providing health clinic environments that are accessible for the needs of MSM
- providing condoms and lubricants

## Migrants (mobile populations)

All throughout Asia various factors (i.e. political, economic, religious) have contributed to large migrations of people. Migrant workers, both legal and illegal, have often found themselves in circumstances that can increase their vulnerability and risk of HIV/AIDS. The HIV/AIDS problems they may encounter are numerous. Poverty can lead to sex work, language difficulties can exclude them from messages of safe sex, health services may be inaccessible, little knowledge of HIV may exist, and drug users from areas of opium smoking may encounter those who inject their drugs and soon adopt the various risks of this new technique (i.e. sharing injecting equipment).

### Programs to stop the spread of HIV/AIDS among migrants:

- investigations on *who* are the migrants, *why* they have migrated, and *what* needs they have
- information needs to be culturally appropriate, relevant and understandable
- migrants need to be involved in planning of projects
- use of migrants as peer educators
- provision of means to implement safer injecting techniques (i.e. sterile injecting equipment, bleach)
- provisions of sufficient condoms
- promotion of greater understanding and acceptance of migrants among general community
- issues of legal rights for migrants

### Section Three, Chapter Nine: Specific Groups

For further information refer to WHO resources: Policy and Programming Guide for HIV Prevention Among Injecting Drug Users & Evidence for Action Papers. Refer to following website: [www.who.int/hiv](http://www.who.int/hiv) (publications expected online from May 2003)

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**CENTRE FOR HARM REDUCTION**  
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**▼▲ Preventing HIV transmission in refugees**

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- Safe blood supply
- Universal medical precautions
- Condoms provided
- Provision of injecting equipment, related supplies, education & information
- Education/information is culturally appropriate & relevant to target group

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**SECTION 2 • CHAPTER 9 • OVERHEAD 1**

**CENTRE FOR HARM REDUCTION**  
.....

**▼▲ HIV/AIDS among prisoners**

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- Overcrowding and potential for sexual tension
- Atmosphere of violence
- Drug use and sharing equipment
- Sexual activities
- Tattooing, skin piercing, blood rituals with shared equipment

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**SECTION 2 • CHAPTER 9 • OVERHEAD 2**

CENTRE FOR HARM REDUCTION  
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▼▲ **Sex Workers and HIV/AIDS**

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- ▶ Unprotected sex with many clients
- ▶ Limited negotiation power over condom use
- ▶ Violent insistence towards no condom use
- ▶ Young sex workers have minimal power
- ▶ Restricted health services for STI checks
- ▶ Injecting drug use and shared equipment

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SECTION 2 • CHAPTER 9 • OVERHEAD 3

CENTRE FOR HARM REDUCTION  
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▼▲ **Preventing HIV/AIDS among Sex Workers**

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- ▶ Peer educators
- ▶ Brothel owners and clients supporting safer sex practices
- ▶ Consistent/adequate condom supply
- ▶ Encourage regular STIs checks

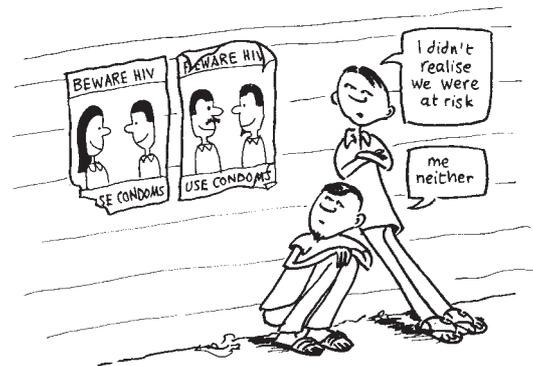


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SECTION 2 • CHAPTER 9 • OVERHEAD 4

CENTRE FOR HARM REDUCTION

▼▲ **Preventing HIV/AIDS among Men who have sex with Men (MSM)**

- Accept reality of MSM
- MSM peer educators
- Accessible health clinics for MSM
- Provide condoms and lubricants



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SECTION 2 • CHAPTER 9 • OVERHEAD 5

CENTRE FOR HARM REDUCTION

▼▲ **Preventing HIV/AIDS among Migrants**

- Comprehensive investigation about the migrants
- Information culturally appropriate, relevant and understandable
- Planning projects must involve migrants
- Peer educators
- Means for safer injecting techniques
- Provision of condoms
- Promote understanding among wider community about migrants
- Migrants' legal rights

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SECTION 2 • CHAPTER 9 • OVERHEAD 6

Endnotes

Section 2

Chapter One

- 1 Stimson, G.V., Fitch, C. & Rhodes, T. (eds) *The Guide on Rapid Assessment Methods for Drug Injecting* World Health Organisation (draft, 1997) Chapter 5, p. 1
- 2 Ibid., Chapter 5, p. 2-3
- 3 This section is based upon *The Guide on Rapid Assessment Methods for Drug Injecting* Chapter 6: Existing Information
- 4 UNDP/UNAIDS workshop, Warsaw, Poland, 1997.
- 5 *National AIDS Programme Management: A Training Course* Chapter 9: Prevention of HIV Transmission Through Injecting Drug Use, Global Programme on AIDS, WHO, 1993. p. 4 -5
- 6 Ibid., p. 4
- 7 *The Guide on Rapid Assessment Methods for Drug Injecting* Chapter 6: Existing Information op.cit., p. 5-6
- 8 Balasegaram, M. Recovery Lies in the Hands of Addicts, *The Sunday Star*, Malaysia, 11 February, 1996, p. 11
- 9 WHO Guide on RAM, op.cit., Chapter 6: Module 6.3, P.1
- 10 Much of the interviewing section is based on the WHO Ram Guide, ibid.
- 11 Abridged from Bert Palto's interview with an outreach worker from SHARAN, March, 1994. Unpublished.
- 12 WHO Guide on RAM, op.cit., Chapter 6: Module 6.3, op.cit, p.8
- 13 This section is based on WHO Guide on RAM, Chapter 6:Module 6.5, op.cit., p.1
- 14 Ibid., p.1
- 15 Interview with Ching Hangzo (Manipur, India), Chiang Mai, Thailand, May 1997.
- 16 Costigan, G. Field visit to Hanoi shooting galleries, May 1997. Unpublished.
- 17 WHO RAM Guide, Chapter 6 : Module 6.3, p. 7
- 18 Oppenheimer, E. *A Rapid Assessment of Drug Use in Cambodia and Concomitant Risk* Conducted Sept/Oct 1995
- 19 Dr Ba Thauung & Dr Khin Maung Gyee, *Rapid Assessment Study of Drug Abuse in Myanmar: A National Report*, June 1995. Unpublished.

Chapter Two

- 1 Dr Abul Abdul-Qader, *HIV Prevention for People who Inject Drugs: Planning and Conducting local HIV intervention Activities\_Guide* for local field managers, draft November 1993 P.37 Unpublished.
- 2 Aboagye-Kwarteng, T. & Moodie, R., *Community Action on HIV: Resource Manual for HIV Prevention and Care*, Chapter Three: Riding the Project Cycle. Macfarlane Burnet Centre for Medical Research, International Health Unit, Victoria, Australia, 1995.
- 3 Dallabetta, G., Laga, M. & Lamley, P., *Control of Sexually Transmitted Diseases: A Handbook of the Design and Management of Programs*. The Aids Control & Prevention (AIDSCAP) Project, Arlington, Virginia, U.S.A., Chapter Two, p. 35
- 4 *HIV Prevention for People Who Inject Drugs*, WHO Global Program on AIDS, 1995, P.13 – 14
- 5 Aboagye-Kwarteng et al, op.cit.
- 6 Abdul-Qader, op.cit., p. 72
- 7 Ibid., p.69
- 8 Ibid., p.77
- 9 *Training workshop to improve skills in prevention of HIV transmission and acquisition among injecting drug users*, workshop notes, Chiang Mai, Thailand, September 22-25, 1995, p.29
- 10 Adul-Qader, op.cit., p. 84
- 11 Lourdes D. Jereza, Harm Reduction Project, Cebu City, Philippines. (Unpublished)

Chapter Three

- 1 Stimson, G.V. *Drug Injecting and the Spread of HIV Infection in South-East Asia*, 1996. (Unpublished)
- 2 Interview with Palani Narayanan, Ikhlas Centre, Kuala Lumpur, Malaysia conducted in Chiang Mai, Thailand, May, 1997. (Unpublished)
- 3 *Community Mobilisation and AIDS: UNAIDS Technical Update*, UNAIDS: Joint United Nations Program on HIV/AIDS. April 1997, P. 2.
- 4 Shi Qing, *Changes in Handeng Village*, Director of Ruili Project, Implementation Team, March, 1996.
- 5 Information provided by the Project Director, Lourdes Jerez. Harm reduction project in Cebu City, Philippines.
- 6 Narayanan interview, op.cit.
- 7 *Prisons and AIDS*, UNAIDS Point of View, April, 1997, P.4

- 8 Ibid., P.6  
9 Deuschmann, P., Aboagye-Kwarteng, T., Gifford, S., *Living with the Epidemic: A Community Responding to AIDS in Churachandpur*, a review of SHALOM, December, 1995. P.113.  
10 Chen, J. & Stuart, P., 1996.

#### Chapter Four

- 1 Mann J, AIDS in the 1990s (Public lecture), Prince of Wales Hospital, Sydney, Australia, 1993.
- 2 Des Jarlais & Friedman 1993, Mann 1993, Burt & Stimson 1993
- 3 Rhodes, T. Risk, intervention and change: HIV prevention and drug use, *Health Education Authority/National AIDS Trust*, London, U.K., 1994.
- 4 Interview with Palani Narayanan (Iklas, Kuala Lumpur), Chiang Mai, Thailand, May 1997.
- 5 Zapka et al, Social network, support and influence: relationships with drug use and protective AIDS behaviour, *AIDS Education and Prevention* 5 (4): 1993, pp. 352-366
- 6 Rhodes., op.cit.,
- 7 Trautmann, f. & Barendregt, C. *The European Peer Support Manual* Netherlands Institute on alcohol and Drugs, Utrecht, Oct. 1994, p.3
- 8 McCalman, J. s peer education an effective strategy for providing HIV education to young people? *Thesis for Masters of Public Health*, University of Sydney, 1994, p.128
- 9 Information provided by the Harm Reduction program in Cebu, Philippines.
- 10 *Report from the Australian Intravenous League (AIVL) AGM and Peer Education conference*, Sydney, May 1995.
- 11 Interview with Ching Hangzo, (Manipur, India), Chiang Mai, Thailand, May 1997.
- 12 Prazuck, T. Myanmar: reaching out to drug users in the community, *AIDS/STD Health Promotion Exchange* (2) 1997.
- 13 Li Jiahua, Li Xialiang, Zhu Hua, *Preliminary Discussion of Harm Reduction for Drug Users in Yunnan*, 1996, unpublished.
- 14 Prazuck., op.cit.
- 15 Interview with Sujata Rana (LALS, Nepal), Chiang Mai, Thailand, May 1997.

#### Chapter Five

- 1 Navaratnam, V. & Foong, K., A study on intravenous drug use and AIDS knowledge among heroin addicts. *Research Report Series*, No. 30, 1996, Malaysia.
- 2 Mulleady, G. *Counselling Drug Users about HIV and AIDS* Blackwell Scientific Publications, Oxford, U.K., 1992 p.8
- 3 Ibid., p.33
- 4 Ibid., p. 34
- 5 Ibid., p.35
- 6 Based on Gray J. Operating Needle Exchange Programmes in the Hills of Thailand, *AIDS CARE*, Vol. 7, No.4, 1995.
- 7 *UNDCP in East Asia newsletter*, Vol. 1, No. 2, Sept., 1997. p.8
- 8 *Workshop on the Prevention of HIV Infection among Injecting Drug Users in Asia*, Kathmandu, Nepal, March 1994. (Lifesaving and Lifegiving Society, Kathmandu, Nepal, Macfarlane Burnet Centre for Medical Research, Melbourne, Australia, St. Vincent's Hospital, Sydney, Australia.) p. 33
- 9 Reid, G. *The Hidden Epidemic: A Situation Assessment of Drug Use in South East Asia in the context of HIV Vulnerability* (prepared by the Asian Harm Reduction Network for the UNAIDS/Asia Pacific Inter-Country Team, November, 1997) and information from Shik-Ku Lin Chief, department of Addiction Science, Taipei City Psychiatric Centre, Taiwan.
- 10 Peak, Aaron *Mission Report on Injecting Drug use Program for Save the Children Fund*, March – April, 1996
- 11 Information provided by the Harm Reduction Program in Cebu City, Philippines.
- 12 Peak, Aaron *Mission Report on Injecting Drug use Program for Save the Children Fund*, March – April, 1996
- 13 *Living with the Epidemic: A community responding to AIDS in Churachandpur* (Project of Emmanuel Hospital Association, India, Macfarlane Burnet Centre for Medical Research, Melbourne, Australia, AusAID)
- 14 Knuckey, S. Developing Appropriate Messages for Injecting Drug Users in Vietnam *AHRN Newsletter*, No.4, Jan/Feb 1996, p.3
- 15 Trautmann, F. & Barendregt, C. *The European Peer Support Manual*, Netherlands Institute on alcohol and Drugs, Utrecht, 1994.
- 16 Interview (1998) with Dr Jennifer Gray re: establishment of needle exchanges in three remote hill tribes in Thailand.
- 17 Information provided by the Harm Reduction program in Cebu, Philippines.

**Chapter Six**

- 1 Reynolds, A. *Training on Drug Dependence and Methadone Maintenance Treatment in Vietnam*, July 1996 (unpublished draft report), p.61
- 2 Gossop, M., Grant, M. *Preventing and Controlling Drug Abuse*, WHO, Geneva, 1990. p.19
- 3 Ibid., p.20
- 4 Ibid., pp. 2 -5
- 5 *NSW Needle and Syringe Exchange Policy and Procedures Manual*, Sydney, NSW, 1996, Section 4, p. 5
- 6 Reynolds, A. op.cit., p. 51
- 7 *HIV Prevention Among Drug Users: A Resource Book for Community Planners and Program Managers*, Academy For Educational Development (Centers for Disease Control and Prevention), US, June 1997, p.10
- 8 The Lindesmith Center, *Focus on Drug Substitution and Maintenance Approaches*, <http://www.lindesmith.org>
- 9 Cheung, Y.W., Ch'ien J.M.N. *Drug Policy and Harm Reduction in Hong Kong*, presented at the 7th International Conference on the Reduction of Drug Related Harm, Hobart, Australia, March, 1996.
- 10 Reynolds, A. op.cit., p. 19
- 11 Ibid., p.3
- 12 *WHO Drug Substitution Project: Meeting on Opioid Substitution Programs in Asia*, Kathmandu, Nepal, February 1997, (unpublished meeting report) p. 24
- 13 Ibid., p.16-18
- 14 Ibid., p.24
- 15 Ibid., p.20
- 16 Ibid., p.22
- 17 Reynolds, op.cit., p. 28
- 18 Ibid., p.23
- 19 Reynolds, A., op.cit., p. 33
- 20 Report from Aaron Peak on the Methadone Maintenance Treatment program in Vietnam, July 1997 (unpublished).
- 21 Dunlop, A, Thornton, D, Lintzeris, N. et al, *Coming Off Methadone*, Turning Point Alcohol and Drug Centre Inc, Victoria, Australia, September 1996. p. 26
- 22 Reynolds, op.cit., p. 35
- 23 Ibid., p.37
- 24 Newman, R.G, Peyser, N. Methadone Treatment: Experiment and Experience, *Journal of Psychoactive Drugs*, Vol.23 (2), Apr-Jun 1991, p.117.
- 25 A Few Notes on Methadone Programmes, *Spotlight*, The Hong Kong Council of Social Service, Vol. 25, April 1996, p. 4.

- 26 Ibid., p.4.
- 27 Reid, G. *The Hidden Epidemic: A Situation Assessment of Drug Use in South East and East Asia in the context of HIV Vulnerability* (prepared by the Asian Harm Reduction Network for the UNAIDS/Asia Pacific Inter- Country Team), November 1997. p.71.
- 28 Interview (unpublished) with Jimmy Dorabjee (SHARAN, New Delhi), Chiang Mai, May 1997.
- 29 WHO Drug Substitution Project, op.cit., p. 26
- 30 Dorabjee, J., Samson, L., Dyalchand, R., *A Community Based Intervention for Injecting Drug Users (IDUs) in the New Delhi Slums*, WHO Drug Substitution Project Meeting on Opioid Substitution Programs in Asia, Kathmandu, February, 1997.

**Chapter Seven**

- 1 Aboagye-Kwarteng, T. & Moodie R., *Community Action on HIV: Resource Manual for HIV Prevention and Care* (Macfarlane Burnet Centre for Medical Research, International Health Unit, Victoria, Australia, 1995)
- 2 Stewart,G. (Ed) *Managing HIV* (Australasian Medical Publishing Company Ltd., North Sydney, Australia, 1997) p.20
- 3 *HIV Herald* Dec/Jan 1997, Volume 7, Number 1 (AFAO Australian Federation of AIDS Organisations, Sydney, NSW, Australia)
- 4 Shreedar, J. & Colaco, A. *Broadening the Front* ACTIONAID, The British Council, UNDP, New Delhi, July 1996.
- 5 Aboagye-Kwarteng et al, p.133
- 6 Lin O.C. Hong Kong: Integrating HIV/STD issues into women's other concerns. *AIDS/STD Health Promotion Exchange*, 1995, No.3, p.9.
- 7 Shreedar et al, op.cit
- 8 Ibid., pp.54-58
- 9 *AIDS: Images of the Epidemic* (World Health Organisation, Geneva, Switzerland, 1994) p.57
- 10 Ibid., p.56
- 11 NGO, Indian Health Organisation, April 1997.
- 12 *AIDS: Images of the Epidemic*, op. cit., p.56
- 13 Ibid., p.60
- 14 Ibid., p.59
- 15 UNAIDS. Report on the Global HIV/AIDS Epidemic 2002. [www.unaids.org](http://www.unaids.org)
- 16 UNAIDS. Report on the Global HIV/AIDS Epidemic 2002. [www.unaids.org](http://www.unaids.org)
- 17 de Cock K, Fowler M, Mercier E, de Vincenzi I et al. Prevention of mother to child HIV transmission in resource-poor countries. Translating research into policy and practice. *JAMA* 2000;283:1175-1182

- 18 de Cock K, Fowler M, Mercier E, de Vincenzi I et al. Prevention of mother to child HIV transmission in resource-poor countries. Translating research into policy and practice. JAMA 2000;283:1175-1182
- 19 Shaffer N, Chuachoowong R, Mock PA, Bhadrakom C, Siriwasin W, Young NL, Chotpitayasunondh T, Chearskul S, Roongpisuthipong A, Chinayon P, Karon J, Mastro TD, Simonds RJ. Short course zidovudine for perinatal HIV-1 transmission in Bangkok, Thailand: a randomised controlled trial. Lancet 1999;353:773 -80
- 20 Guay L.A., Musoke P., Fleming T., Bagenda D., et al. Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial. Lancet 1999;354:795-802
- 21 European Mode of Delivery Collaboration. Elective caesarean-section versus vaginal delivery in prevention of vertical HIV-1 transmission: a randomised clinical trial Lancet 1999;353:1409-14
- 22 Nduati R., John G., Mbori-Ngacha D., Richardson B., Overbaugh J., Mwatha A., Ndinya-Achola J., Bwayo J., Onyango E., Hughes J., Kreiss J. Effect of breastfeeding and formula feeding on transmission of HIV-1, a randomized clinical trial. JAMA 2000; 283:1167-74
- 23 WHO Collaborative Study Team on the Role of Breastfeeding on the Prevention of Infant Mortality. Effect of breastfeeding on infant and child mortality due to infectious diseases in less developed countries: a pooled analysis. Lancet 2000; 355:451-455
- 24 Coutoudis, A., Pillay K., Kuhn L., Spooner, E., Tsai W-Y, Coovadia H.M. Method of feeding and transmission of HIV-1 from mothers to children by 15 months of age: prospective cohort study from Durban, South Africa. AIDS 2001;15:379-387
- 25 Berer M. Reducing perinatal HIV transmission in developing countries through antenatal and delivery care, and breastfeeding: supporting infant survival by supporting women's survival. WHO Bulletin 1999;77:871-76
- 26 UNFPA/UNICEF/WHO/UNAIDS Inter-Agency Task Team on Mother-to-Child Transmission of HIV. January 15 2001. [www.unaids.org/publications/documents/mtct/index.html](http://www.unaids.org/publications/documents/mtct/index.html)
- 27 WHO/UNAIDS: HIV and Infant Feeding: Guidelines for decision makers, June 1998; and WHO/UNAIDS: HIV and Infant Feeding: A guide for health-care managers and supervisor, June 1998.

### Chapter Eight

- 1 The counselling section is largely based on the Guidelines for Counselling about HIV Infection and Disease (WHO, Geneva 1990)
- 2 Mann, Tarantola & Netter AIDS in the World: A Global Report (Harvard University Press, Cambridge, Massachusetts, USA, 1992 ) p551
- 3 Canadian Counselling Guidelines for HIV Testing
- 4 My experience with; A document describing people's experiences and perceptions about the HIV/AIDS epidemic from Thailand, the Philippines and Vietnam. UNAIDS, Bangkok, Thailand, May 1997, pp82-83
- 5 Lockley, P., Counselling heroin and other drug users Free Association Books Ltd, London, U.K., 1995
- 6 Mulleady, G Counselling drug users about HIV and AIDS (Blackwell Scientific Publications, Oxford, U.K., 1992) p.33
- 7 Interview with Sujata Rana (The Lifesaving & Lifegiving Society LALS, Nepal) Chiang Mai, Thailand, May 1997.
- 8 Canadian Counselling Guidelines for HIV Testing
- 9 Living with the Epidemic: A community responding to AIDS in Churachandpur., Macfarlane Burnet Centre for Medical Research, Melbourne, Australia, December, 1995.
- 10 Majoor B., Burn Through in Harm Reduction Coalition Newsletter, Oakland, Cal., U.S.A., This section is based on Majoor, op. cit., Truatmann F., Barendregt, C., The European Peer Support Manual, Utrecht, 1994., and The NSW Needle and Syringe Exchange Policy and Procedures Manual, NSW, Australia, 1996.
- 11 Majoor, B., op.cit., p16
- 12 NSW NSEP, op.cit., Section 3., p.2
- 13 Living with the Epidemic: A community responding to AIDS in Churachandpur., Macfarlane Burnet Centre for Medical Research, Melbourne, Australia, December, 1995.
- 14 NSW NSEP, op.cit., Section 3., p.3
- 15 Majoor , B., op cit., pp. 14-16 and Mulleady, op.cit., p. 45

- 16 Interview with Ching Hangzo (Manipur, India) Chiang Mai, Thailand, May 1997.
- 17 Interview with Aaron Peak, Chiang Mai, Thailand, May 1997.
- 18 Manisha Singh (LALS, Kathmandu, Nepal)
- 19 Interview with Aaron Peak, Chiang Mai, Thailand, May 1997.
- 15 Fernandez, I. The Gender Element in Migration and HIV/AIDS, *CARAM News*, Caram Asia, Kuala Lumpur, (2), October 1997, pp.2-3 (This is an edited version of Fernandez's article).
- 16 HIV and Vulnerability, a media-aids bulletin from UNAIDS Asia-Pacific Intercountry Team, November, 1997.

### Chapter Nine

- 1 Benjamin, J. AIDS Prevention for Refugees: the Case of Rwandans in Tanzania *AIDScriptions* 3 (2) July 1996.
- 2 This section is based on *Refugees and AIDS: Point of View* UNAIDS Best Practice Collection, April 1997.
- 3 Dr Salam Irene, Imphal, Manipur, India.
- 4 Nemayechi, G & Taveaux, T. *Medecin Sans Frontieres HARP (Harm Reduction Program) for the Vietnamese drug users in Pillar Point refugee camp*, July 1996- April 1997. Evaluation Report.
- 5 *Prisons and AIDS: Point of View* UNAIDS Best Practice Collection, April 1997.
- 6 Excerpt from Aung Zaw HIV scare in Burma's Insein, *The Sunday Nation*, 19 October, 1997.
- 7 Berer, M., Ray, S. *Women and HIV/AIDS: An International Resource Book* Pandora/Harper Collins Publ., London, U.K., 1993, p. 195
- 8 Australia and Thailand unite to promote the Travel Safe message, *Installation Report for the Travel Safe Thai Pilot Program*, Convenience Advertising (Aust) Pty Ltd, March 1994.
- 9 All Part of the Service, *AIDS Action*, Asia-Pacific Edition, (26) January-March 1995, HAIN (Health Action Information Network Philippines), p.10
- 10 Quote from a Hindi-speaking boy who telephoned for counselling from the NAZ Foundation, India.
- 11 Most of the information in this section is based on information provided by Anjali Gopalan from The NAZ Foundation (India) Trust. An HIV/AIDS and Sexual Health Service for the South Asian, Turkish, Irani and Arabic communities.
- 12 This is taken from a letter sent to Utopia: South East Asian Gay and Lesbian Resources and then passed on to SEA-AIDS.
- 13 Ignacio, J.L. *Migration and HIV/AIDS*, Keynote speech at the first *Northern South-East Asian Subregional Exchange: Migrant Populations and HIV/AIDS*, Chiang Mai, Thailand, 8-12 December, 1996.
- 14 *Ibid.*, p. 5.

# **Section 3**

## **Appendices**

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# Appendices

## *Appendix One*

# **Blood Borne Viruses: Hepatitis A, B, C and HIV/AIDS**

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Chapter  
Three

*Rapid situation  
assessments*

## Hepatitis

### What is hepatitis?

Hepatitis means inflammation of the liver. **Inflammation** is the body's normal response to an injury, regardless of the cause of the injury. For example, an inflamed hand can be caused by an infection, a chemical agent, by sunburn and by many other agents (though the type of inflammation may vary with the cause).

Similarly, hepatitis can be caused by infections, chemicals and many other diseases. The hepatitis is then named after the cause of the inflammation (e.g. alcoholic hepatitis, hepatitis B etc).

When the liver is inflamed soon after the injury, this is called **acute hepatitis**. The liver may recover completely, or develop long term mild inflammation called **chronic hepatitis**. In some situations this may lead to scarring of the liver called **cirrhosis**, which can be fatal.

The liver is a large organ of the gastrointestinal system in the upper abdomen and has many functions. One of the main roles is the removal of toxic substances from the body by the liver cells, including **bile**, a yellow substance that is a normal breakdown product of red blood cells.

One effect of an inflamed liver is that the liver cells can become slightly more "leaky", and proteins that are only found in the liver can leak into the blood stream. This is not dangerous, but it does enable some simple blood tests to measure the amount of these proteins, called the **liver function tests (LFTs)**. Liver function tests then give the doctor an opportunity to assess the type and severity of the inflammation. Liver function tests do not tell the cause of the hepatitis, so that other tests are necessary to determine the cause of the inflammation.

When the liver is inflamed, bile can also leak from the liver cells. If severe enough, this can cause **jaundice**, a yellow discolouration of the skin, eyes and urine, which vary from being minor to quite dramatic, depending upon the severity of the liver damage.

### Viral Hepatitis

Viral hepatitis causes a flu-like illness with fever, nausea, loss of appetite, loss of weight and may be accompanied by jaundice. The severity of the symptoms can vary considerably, as does the time involved to recover from the illness. Hepatitis A, B and C is a viral hepatitis.

### Hepatitis A Virus Infection

This form of hepatitis, also known as **epidemic hepatitis**, was recognised long before the discovery of the hepatitis A virus, as it was distinguished from **serum hepatitis**, which was recognised to be transmitted mainly by blood borne spread. Hepatitis A virus causes a non-fatal hepatitis of varying severity. **A person will make a complete recovery from hepatitis A virus, and there will be no long-term carrier state.** Any person who has been in recent contact with someone infected with hepatitis A (that is within the previous one to two weeks) should see a doctor, as there is treatment available to prevent the further development of hepatitis, even after someone has been exposed to the hepatitis A virus.

#### Transmission & Prevention

The virus is excreted in the faeces, and can therefore be transmitted through eating or drinking contaminated food and drink, sexually transmitted (oral-faeces contact) and by close social contact among children. Hepatitis A can be prevented by washing hands before handling food.

## Hepatitis B Virus Infection

Hepatitis B virus can also cause an illness of varying severity, with two major differences from hepatitis A:

- Hepatitis B virus infection tends to be more severe, with a longer illness recovery time than hepatitis A and may even cause death.
- A small but significant number of people will develop long-term disease and may become infectious carriers of the hepatitis B virus (for life) and may develop long-term liver disease.

### Transmission

Hepatitis B is transmitted by contaminated blood products, using needles contaminated with blood, needle sharing, sexual transmission (unprotected vaginal and/or anal sex) and from an infected mother to child at the time of birth. The virus can only enter the bloodstream through broken skin or a mucous membrane.

### Prevention

Hepatitis B infection is prevented by safe sex, safe needle use practices and **vaccination**. In the developed world the blood supply is screened effectively for the presence of hepatitis B, though this remains a problem in developing countries.

**Vaccination is highly effective in preventing hepatitis A and hepatitis B infection**

## Hepatitis C Virus Infection

### History

After the discovery of the hepatitis B virus, many cases of **serum hepatitis** (hepatitis acquired from blood transfusions and contaminated needles) that were due to hepatitis B virus infection were occurring and earned the resulting name of **non-A non B hepatitis**.

It has long been recognised that many people with haemophilia who had received multiple transfusions of blood products often had abnormal liver function tests. Investigation revealed the presence of mild inflammation of the liver (**chronic hepatitis**), and infectious agents were thought to be one of the other possible causes.

In 1989, the hepatitis C virus was discovered using modern genetic engineering techniques and is one of the major achievements of molecular biology. The hepatitis C virus has never been seen or cultured

Hepatitis C is now recognised as the major cause of non-A non-B hepatitis and occurs world-wide.

### Transmission

Transmission of hepatitis C is entirely by blood to blood transmission. Sharing of any injecting drug equipment is the most common way of becoming infected. All injecting equipment – syringes, spoons, filters, water, tourniquet and swabs are high risks.

There is very little conclusive information currently available about sexual transmission, but it appears that sexual transmission is more likely to occur in the presence of acute hepatitis C infection, and that the total risk of sexual transmission of hepatitis C virus appears to be very low. The risk from household transmission also appears to be negligible.

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The risk of transmission of hepatitis C infection from mother to child is unknown, but appears to be around 10 per cent. If the mother has hepatitis C infection, around one in ten children may acquire hepatitis C. There is an increased chance of hepatitis C virus passing from the mother to child if the mother has severe hepatitis C; the opposite occurs if the hepatitis is very mild in the mother. The risks from breastfeeding are unknown, but currently research is occurring into this area.

### Diagnosis

The diagnosis of exposure to the hepatitis C virus is made by the detection of a protein in the blood that the immune system makes after exposure to the virus called the **hepatitis C antibody**. **Antibody tests** indicate whether the body has been exposed to the virus and has produced antibodies to fight it.

The hepatitis C antibody test usually does not become positive for two to three months after exposure. This antibody test identifies most people infected with the virus. However, the antibody test does not determine if a person still has the virus and for how long they have been infected.

**The presence of hepatitis C antibody DOES NOT necessarily mean that there is current disease for hepatitis C virus**

The hepatitis C antibody has “false positives” and “false negatives”. (That is some people who have antibodies to hepatitis C detected may not really have been exposed to hepatitis C infection, and also, that some people who do not have hepatitis C antibodies may have been exposed to hepatitis C virus infection).

The diagnosis of **active** hepatitis C infection is a complicated medical process and special tests at research facilities are required to detect the virus.

A person may need to be followed for two years before the final diagnosis of ongoing liver disease (chronic hepatitis) is made. Research indicates that the presence of hepatitis C antibody is not necessarily related to abnormal liver function test. The investigations for liver disease are usually made by an infectious disease physician or a gastroenterologist.

### Treatment

Currently there is no vaccine available for hepatitis C. Treatments consist of avoiding any further damage to the liver and for some people the drug interferon is used.

### Consequences of hepatitis C:

- Twenty to twenty five per cent of adults recover completely: the virus has left their system and they are no longer infectious. Hepatitis C antibodies are retained providing immunity from further infections
- Seventy five to eighty per cent retain the virus, remaining infectious for life
- Estimated that twenty five per cent of chronic carriers are at risk of developing liver cirrhosis or liver cancer
- Carriers remain free of illness until onset of liver problems
- Continued alcohol use in the presence of active hepatitis C infection appears to make any chronic hepatitis worse
- An expensive drug called Interferon is currently being trialled as treatment, with approximately half responding to the drug. Following the discontinuation of Interferon drug treatment, only half will continue to remain free of the virus.

## HIV/AIDS

### History

The spread of Human Immunodeficiency Virus (HIV) commenced in the mid to late 1970s but is believed to have existed in Africa for many years. The first cases were recognised in central Africa but their deaths were blamed upon tuberculosis and other diseases. Epidemiological studies of HIV disease began in 1981 following the first outbreaks in several US cities of a rare form of cancer, Kaposi's sarcoma and *Pneumocystis carinii* pneumonia in homosexual men. By 1982, the Centre for Disease Control and Prevention (CDC), in Atlanta, US, defined the new complexes of cancers and infectious conditions as Acquired Immune Deficiency Syndrome (AIDS): as the evolving understanding of the advance manifestations of HIV infection and diagnostic changes have occurred, the CDC's AIDS definition has had a few revisions. In 1983, the virus responsible for AIDS was identified in France: originally named HTLV-III or LAV and then renamed HIV. Tests to check for serological antibodies to HIV were developed in 1984, allowing epidemiological investigations on people with AIDS or those with symptomatic or asymptomatic forms of HIV disease.

Global experience has shown that although geography may delay the arrival of HIV, it is not protective. The HIV/AIDS epidemic has, within the last two decades, spread to over 190 countries in all continents. Five million people became newly infected with HIV in the year 2001. By the end of that year an estimated 40 million people world-wide were living with HIV; AIDS deaths in 2001 numbered 3 million. Since the beginning of the epidemic, more than 60 million people have been infected and globally it has become the world's fourth biggest killer. It is estimated that most people living with HIV/AIDS are

aged 15-24 years, most live in the developing world and most are not aware they carry the virus. At the beginning of the HIV/AIDS epidemic, in the developed world, practically all HIV infections occurred in men. This is no longer the case as women are increasingly infected by HIV.

### What is HIV ?

HIV stands for Human Immunodeficiency Virus. It is the name given to the virus that can cause AIDS.

As with all viruses, HIV depends on the cells it infects to multiply. However, unlike many other viruses, HIV can remain **permanently** in the infected person as the genetic material of HIV integrates with the genetic material of the host cell. HIV enters and integrates itself with the control centre of the CD4 cell resulting in a process that leads to the destruction of the CD4 cell.

HIV is actively infecting and destroying cells of the immune system and the obvious effect is the decline in the blood levels of CD4 and T4 cells: the immune system's principal infection fighters. During the initial stages, HIV destroys these cells without causing symptoms. As the immune system deteriorates complications begin to surface. For a brief period, HIV can survive outside of the body and this is dependant upon the fluid around the virus and the temperature (HIV is destroyed at 56° Celsius).

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## Primary HIV infection

Following first exposure to HIV, viral reproduction is very high. Generally within 3 months the body's immune system is activated, producing antibodies to HIV. This process is called **sero conversion** and some typical clinical symptoms can include fever, enlarged lymph nodes, skin rash and headaches which usually last for 10-14 days.

The latency period occurs when the HIV infected person has no symptoms for months or years: an asymptomatic stage of HIV disease of 4-5 years is common. Although asymptomatic, HIV is actively infecting and killing cells of the immune system. Before the onset of AIDS, some typical symptoms can include lack of energy, weight loss, frequent fevers and sweats and persistent skin rashes.

The rate of the HIV progression is dependent on the individual's immune system to contain the virus and the replicating ability of the viral strain in the infected individual. In time there is a decrease in the number of CD4 -T4 cells, the immunity system is damaged and vulnerability to infections occurs.

## AIDS

AIDS applies to the most advanced, serious stages of HIV infection. The majority of AIDS defining conditions are opportunistic infections, that rarely cause any harm to those with good immunity. Opportunistic infections commonly occurring with AIDS cases are Tuberculosis, *Pneumocystis carinii* pneumonia and cryptococcal meningitis. Various cancers can develop such as Kaposi's sarcoma or cancers of the immune system known as lymphomas.

In the developing world TB, in association with HIV, is one of the most important life threatening opportunistic infections. The WHO projects by the year 2000 the worldwide number of those infected with HIV and TB will reach 4 million.

It was thought that for a while that the natural history of HIV infection was different in the developed as opposed to the developing world, but this is largely discounted now. Of those with HIV infection (untreated), after ten years 25 per cent will have developed AIDS and died; 25 per cent will be living with AIDS; 25 per cent will have developed HIV disease but be short of progressing onto AIDS and 25 per cent will have no HIV/AIDS disease.

The period between exposure to HIV and signs of illness and the length of survival time for those with AIDS in the developing world, is shorter. This is largely due to the lack of antiviral drugs to treat HIV and other confounding factors such as poverty, diet, environment, lack of medical services, and prevalence of other infectious diseases

## Testing for HIV infection

Tests for HIV infection are widely available. As early HIV infection often causes no symptoms, blood is tested for the presence of antibodies (disease fighting proteins) to the virus, not for the virus itself. HIV antibodies are generally detectable within 1- 3 months (window period) following infection. HIV 'antibody positive' indicates that antibodies to the virus have been found in the blood and the person has become HIV infected. HIV testing should be accompanied by counselling, confidentiality and informed consent. (see **Chapter 8: Voluntary HIV Counselling and Testing**)

## Transmission

- The most common transmission route is by sexual contact with an infected partner. The virus found in semen, blood or vaginal fluids enters the body through the lining of the vagina, vulva, penis, rectum or mouth during unprotected sex.
- Before the screening of blood for evidence of HIV infection, and introduction of heat treating techniques to destroy HIV in blood products, HIV was transmitted through transfusions of contaminated blood or blood products. It is still a common problem for those that do not have blood donations screened before transfusion.
- HIV is commonly spread among injecting drug users by the sharing of injecting equipment (needles, syringes, tourniquets, spoons, water, filters and surfaces) with someone infected by the virus. HIV transmission from accidental needle stick injury from a patient to health worker with contaminated needles or medical instruments is rare.
- Transmission from infected mother to baby during pregnancy or birth can occur. Risk of transmission ranges from 15 per cent to 50 per cent. Studies have shown HIV can spread to babies through the breast milk of a mother infected with the virus.
- The presence of sexually transmitted diseases such as syphilis, herpes, chlamydia or gonorrhoea increase the susceptibility of someone to HIV infection during sex with an infected person. (see **Chapter 7: HIV/AIDS: Preventing Transmission: • Through sex • Between Parent and Child**)

## Prevention of HIV/AIDS

As no vaccine is available for HIV, the principal way of preventing HIV infection is to avoid behaviours that place a person at risk: e.g. sharing injecting equipment and having unprotected sex.

It is recommended that people use condoms whenever having anal, vaginal or oral sex (when either partner has herpes, ulcers or bleeding gums) with someone they are not certain is free of HIV or other sexually transmitted diseases. Condoms must be used correctly and with water based lubricant.

HIV transmission from mother to child is significantly reduced if she takes the anti-viral drug AZT (zidovudine) during pregnancy, labour and delivery and that the baby takes AZT for first six week of life.

(For injecting drug users see **Chapter 4: Education**)

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## Bibliography

- Manual for reducing drug related harm in Asia
- Aboagye-Kwarteng T and Moodie R (ed) 1995. *Community Action on HIV: A Resource Manual for HIV Prevention and Care*. Fairfield: Macfarlane Burnet Centre for Medical Research International Health Unit.
- AIDS action Asia-Pacific edition. 1996. *Tackling HIV and TB*. Issue 30 Jan-March. London: Health Action Information Network Philippines/Appropriate Health Resources & Technologies Action Group.
- Aegis: *AIDS Educational Global Information System* [ <http://www.aegis.com> ]
- Australian Gastroenterology Institute. 1991. *Hepatitis C: an information brochure for health care providers*. September 1991.
- Dixon P. 1994. *The truth about AIDS*. Eastborne: Kingsway Publication.
- Fairley CK, Leslie DE, Nicholson S, Gust ID. 1990. Epidemiology and hepatitis C in Victoria. *Medical Journal of Australia*. 153:271-273.
- Gold J, Penny R, Ross M, Morey S Stewart G et al . 1994 (3rd edition). *The AIDS Manual: Albion Street (AIDS) Centre*. Sydney: MacLennan and Petty.
- Health and Community Services. 1995. *AIDS: Your Questions Answered*. Melbourne: Victorian Government, Department of Health and Community Services.
- Kaslow RA and Francis DP (ed). 1989. *The Epidemiology of AIDS: Expression, Occurrence, and Control of HIV Type 1 Infection*. New York: Oxford University Press.
- Mackay IR. 1990. The new hepatitis virus: hepatitis C virus. *Medical Journal of Australia*. 153:247-8.
- Mann J, Tarantola DJM and Netter T (ed). 1992. *AIDS in the World: A Global Report*. Cambridge: Harvard University Press.
- Mertens TE and Low-Beer D. 1996. HIV and AIDS: where is the epidemic going? *Bulletin of the World Health Organization* 74(2): 121-129.
- Mullis KB. 1990. The unusual origin of the polymerase chain reaction. *Scientific American*. April: 36-43.
- Shilts R. 1987. *And The Band Played On: Politics, people and the AIDS epidemic*. London: Penguin Books.
- Stewart G (ed) 1997. *Managing HIV*. Sydney. Australasian Medical Publishing.
- Watson K. 1991. Hepatitis C infection in Australia. *Modern Medicine*. July:18-31.
- Victorian Government Department of Human Services. 1996. *Management, Control and Prevention of Hepatitis C: Guidelines for Medical Practitioners*. Melbourne: Victorian Government Department of Human Services.
- Victorian Government Department of Health and Community Services. 1995. *The ABC of Hepatitis*. Melbourne: AIDS/STD Unit, Victorian Government Department of Health and Community Services

# Appendices

## *Appendix Two*

# Drugs and their Actions

## Heroin – Characteristics and Effects

- First discovered by a British chemist in 1874, heroin or *diacetylmorphine* is a bonding of opium’s active ingredient, morphine (obtained from the opium poppy), with a common industrial acid, acetic anhydride. By the end of the 19th century it was being mass produced as a broad spectrum pain killer. It was previously believed to be a “safe, non addictive” substitute for morphine.
- Induces high physical addiction and lasting psychological dependence.
- Administered by injection, sniffing (snorting), or smoking.
- Depending on availability of drug and finances of user, drug is commonly injected about three times a day (every eight hours).
- Effects last from three to six hours.
- Common behaviour following administration include an intense feeling of euphoria and sleepiness soon after injection, lethargy, docile appearance and possibly a shuffling gait.
- Acute withdrawal symptoms commence within 8 to 12 hours after last dose.
- Withdrawal symptoms are generally not life threatening but they can be very distressing. Symptoms include gastrointestinal discomfort, muscle cramps, and flu- like symptoms. Withdrawal symptoms can be severe enough that when the users obtain heroin, they may inject as rapidly as possible, sometimes without concern for possible HIV, hepatitis B (HBV) and hepatitis C (HBC) risks.
- Associated health problems of long term heroin use can be collapsed veins, abscesses, tetanus, HIV/AIDS, hepatitis B (HBV), hepatitis C (HBC), heart, chest and bronchial problems and constipation. Possible overdose can occur with or without long term use.

Manual for  
reducing drug  
related harm  
in Asia

## Opium – Characteristics and Effects

- The sole source of opium is the opium poppy (*Papaver somniferum*). The psychological and healing effects of opium have been known for around 4,000 years.
- By incising the head of the opium poppy, farmers can extract its sticky brown sap from the egg shaped bulb. The raw opium sap contains 7-15 per cent morphine, which easily can be precipitated from the poppy sap after simple boiling. Raw opium has a characteristic odour which is strong and pungent.
- Opiate receptors in the brain induce high physiological addiction and lasting psychological dependence. Regular use results in increased tolerance and the need for greater quantities of the drug.
- Use of opium in Western countries has decreased substantially but it is still widely used among highland ethnic minorities in China, Laos, Cambodia, Myanmar, Thailand and Vietnam both for recreational and medical purposes.
- Can produce intense euphoria, a heightened state of wellbeing, enhanced imagination and speech. Soon after, respiration slows down, imagination diminishes and the thinking process becomes confused. Lethargy, relaxation and deep sleep usually follow.
- Administration is usually by smoking but it can also be chewed and cooked with food for digestion. Particularly in countries of origin, it can be drunk as an infusion.
- An opium pipe has a long thick stem with a bowl at one end. The opium ‘pellet’ is placed into the bowl, heated and the smoke is inhaled.

## Cocaine – Characteristics and Effects

- Sediment or the ‘dross’ left in smoking implements can contain up to 8 per cent morphine, is often used again and is known as blackwater opium. This form of opium still remains popular in particular Asian countries i.e. Vietnam, Cambodia.
- Smoking puts more of the active ingredients of opium into the blood stream faster, by the way of the lungs, so the drug begins to reach the brain in about 7 seconds.
- Long term use results in decreased mental and physical capacities with loss of appetite and body wasting.
- Withdrawal symptoms, similar to those of morphine, include agitation, irritability, anxiety, restlessness, insomnia, and abdominal and muscle pain.
- Inhabitants of South America have a history of chewing of the coca leaf for thousands of years but it has only been known to the Europeans since the 19th century. The coca leaf effects a number of neuro-transmitter systems in the brain and is active on various anatomical sites within the central nervous system.
- Cocaine is produced by chemical processing and treatment of the coca plant which transforms the leaves into coca paste. Paste is treated with hydrochloric acid to remove impurities and results in white, crystalline substance, cocaine hydrochloride.
- It is the most potent of the stimulants.
- In the form of leaf chewing or brewed tea the drug is believed to be virtually harmless but it is rarely available in this form outside of South America.
- Disagreements exist among authorities and researchers as to the addictive nature of cocaine. While some state there is a high risk of developing physical and psychological dependence, many researchers suggest that cocaine does not produce physical dependence.
- Methods of administration include snorting by intranasal inhalation (onset of effects 2-4 minutes); smoking or “freebasing” (burning the crystals and smoking the vapours; onset of effect 10-15 seconds); and injection (onset of effect 15-20 seconds).
- Effects can last from 10 to 40 minutes depending on the purity and the route of the administration.
- Typical behaviours during the effect include hyperactivity, exhilaration, increased energy, alertness, confidence and sexual activity. The user may also have unpredictable behaviour, feel invincible and be both quarrelsome and aggressive.
- A fatal condition can result from high sensitivity to the drug or massive overdose.

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- Several hours after last use, feelings of agitation and depression can occur.
- High risk of HIV transmission through multiple injections with previously used injecting equipment and through unprotected, prolonged sexual intercourse.

## Cannabis – Characteristics and Effects

- Cannabis is a psychotropic product from the plant *Cannabis sativa*. It is believed to have been used for thousands of years for medical, religious and social reasons. The stem of the plant (non potent form of cannabis) is used in the manufacture of hemp rope, string, paper, textiles and clothing.
- There are male and female plants. The strongest concentration of the psychoactive chemical, Tetrahydrocannabinol or THC, is found in the flowering shoots of the female plant.
- A widely used drug with a relatively low potential for harm when compared to heroin, alcohol and tobacco.
- Differing views by authorities on physical dependency of cannabis. Psychological dependency can be associated with frequent cannabis use.
- Three forms of cannabis exist: marijuana, hashish and hashish oil. **Marijuana** is the dried leaves and flowers of the plant and is usually the least potent of the three. **Hashish** forms as a sticky oil coating on the flowering tops of the plant which is collected and made into small blocks of dried resin. The concentration of THC is greater thus producing a stronger effect. **Hashish oil** is the extraction from the resin of the cannabis plant and is the most powerful of all the cannabis forms.
- Marijuana is usually smoked in hand rolled cigarettes or in a pipe. The concentrated form of hashish, or hashish oil, is often smoked with ordinary cigarettes or incorporated into food substances such as cakes and biscuits and ingested.

## Amphetamine – Characteristics and Effects

- Effects vary due to a number of factors in relation to the person, method of administration, cannabis form and frequency and period of use. Some effects can include euphoria, relaxation, relief from stress and pain, increased appetite, impaired motor skills, confusion, loss of concentration and decreased motivation.
- Effects normally reach their peak within 30 minutes and can last up to 3 hours.
- Withdrawal following long term use can include headaches, anxiety, depression, and sleep disturbance.
- Like other burnt inhalations cannabis contains carcinogens, tar and carbon monoxide. This can result in respiratory complications, cardiovascular effects and cancer. A single cannabis cigarette contains the same amount of tar and other noxious substances as approximately 14-16 filtered cigarettes.
- Originally synthesised in Germany in the late 19th century amphetamines were not patented until the 1930s. In the 1940s the drug came into therapeutic use for a variety of medical conditions such as epilepsy, depression and hyperkinetic children. Following World War II, amphetamines were promoted quite readily.
- Amphetamines have a stimulant action similar to the naturally occurring hormone adrenalin which stimulates the activity of the central nervous system and increases the activity of the brain.
- Amphetamines appear in a number of forms and when manufactured illegally can be found in powder, tablet, capsules or liquid.
- Administration is by ingestion, injection, inhaled through the nose and smoked when in the form of methamphetamine hydrochloride.
- Most common illicit manufacturing of amphetamine is in the form of methylamphetamine. The most common starting material for methylamphetamine is ephedrine, which is a legal substance, is readily available in tablets or capsules and is sold as a decongestant.
- Self medication with amphetamine is common among truck drivers, students, fishermen, and businessmen to stave off normal fatigue, enabling them to work for days with little sleep or food.
- Effects usually wear off after 3 to 6 hours and the user can become suddenly tired, irritable, depressed and unable to concentrate. Methylamphethatamine ‘ice’ when smoked can have an effect of between 2 to 16 hours depending on the amount taken.
- Effects from amphetamines vary and depend on dosage, mode of administration, the individual, and the circumstances in which the drug is taken.

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- Low doses can result in a sensation of euphoria, heightened alertness, increased energy and activity, reduced appetite and self confidence. Long term use can lead to malnutrition, exhaustion, depression and psychosis. Death from stimulant use is rare but is more likely to occur with intravenous injection.
- Tolerance can be pronounced where a long time user may need 20 times the initial dose to produce the same effect.
- Has a reputation for facilitating social and sexual interactions which has implications for potential HIV risks as enhanced sexuality may not be accompanied by safer sexual practices.
- Withdrawal symptoms during the initial period may be acute exhaustion, and for a regular user, it may be followed by irritability, lethargy, deep depression, anxiety attacks and episodic craving.

## Ecstasy or Methylenedioxyamph- amine (MDMA) – Characteristics and Effects

- Although first patented in Germany in 1914 as an appetite suppressant, it was never marketed. In the 1970s it was used by psychiatrists in the USA as a valuable and safe aid to counselling and therapy, until it was banned in the mid 1980s. In the 1990s it is commonly associated with dance parties and other social activities.
- Closely related to both amphetamines and hallucinogens it is often described as a psychedelic drug with stimulant properties.
- Appears as tablet (most frequently seen), capsule and powder form.
- Preferred administration is by swallowing although there are reports of experimentation by injection and inhalation.
- Taken orally the effect will commence between 30 to 60 minutes and may last for several hours.
- The immediate effects can be a 'rush' of euphoria, followed by a general sense of peacefulness and heightened sensual awareness. Inhibition can disappear, there is increased self esteem and confidence, and improved trust and communication between friends can occur. Adverse effects can include dry mouth and throat, jaw clenching, increased heart rate and blood pressure.
- Overdose can result from very high blood pressure, increased heart beat and body temperature (overheating). Deaths have been reported from fluid imbalance either by dehydration or water overloading.
- A 'high' can be followed with fatigue, anxiety and a depression which may last several days.
- Tolerance can develop with continued use and some dependence is thought to occur. Little is known about long term effects but it has been suggested that it may damage some type of brain cells.

## Hallucinogens – Characteristics and Effects

- First synthetically produced in the 1940s to remove obstructive inhibitions in psychiatric cases. Those derived from plants, such as the peyote cactus, have been used by indigenous groups of Mexico for hundreds of years for recreation and religious observations.
- Hallucinogens also known as psychedelics, act on the central nervous system to produce significant, often radical, changes to the user's state of consciousness; can distort the user's sense of reality, time and emotions.
- Lysergic acid diethylamide (LSD) is the best known of hallucinogens. It is a synthetic drug based on an ergot which has been extracted from a dry fungus that grows on rye grass. The manufacturing of LSD from precursor drugs requires a high level of technical knowledge and expertise.
- LSD is an odourless, colourless and tasteless liquid which is often absorbed into any suitable substance such as blotting paper and sugar cubes or can be incorporated into a tablet, capsule or occasionally confectionery. Its most popular form is on absorbent sheets of paper which are then divided into squares and taken orally.
- Unlike many other drugs, LSD users can have little idea of what they are embarking on and the effects can vary from person to person, from occasion to occasion and the dose.
- Effects can begin within an hour of the dose, build up between 2 – 8 hours and slowly fade after about 12 hours.
- For many LSD users the effect can be extremely enjoyable, relaxing and promote a sense of wellbeing. There are often changes in perception, of sight, sound, touch, smell, taste and space. Negative effects can include loss of emotional control, disorientation, depression, dizziness, acute panic and feelings of being invincible resulting in a person physically placing themselves in danger.
- Long term use can result in flashbacks of hallucinogenic effects, days, weeks or months after using the drug.
- There is no evidence of physical dependence and no withdrawal symptoms have been observed even after prolonged use. However, psychological dependence can occur.
- Tolerance to LSD can develop rapidly but tolerance can also disappear after 5-6 days when not used on a regular basis.
- Other hallucinogens include mescaline (natural product from the peyote cactus) nutmeg, particular mushrooms (containing the drugs psilocin and psilocybin) dimethyltryptamine (DPT), phencyclidine (PCP) and ketamine hydrochloride.

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## Nicotine /Tobacco – Characteristics and Effects

- Known to be used by Native Americans in religious and social occasions 1,000 years ago. Introduced to Europe in the 17th century where it was used for recreation and medicinal purposes. Tobacco consumption expanded with the introduction of milder forms of tobacco, automatic cigarette rolling machines, massive advertising campaigns and when governments saw its potency as a source of revenue.
- Nicotine, found in tobacco, is one of the most addictive substances known. Nicotine is a central nervous stimulant that disrupts neuro transmitter balance. Physical dependence on nicotine and more importantly, psychological dependence on cigarettes, develops quickly.
- Tobacco inhalation results in nicotine affecting the central nervous system (CNS) in about 10 seconds. With the chewing of tobacco, it takes about 3 to 5 minutes to affect the CNS.
- The effect of nicotine when tobacco is consumed in the form of smoking, chewing or as snuff is the constriction of blood vessels, raising of the heart rate, and blood pressure, decreased appetite, producing mild emphysema, partially deadens sensation of taste and smell and irritates the lungs. Prolonged use of tobacco can cause lung, heart, blood vessel damage and cancer.
- The World Health Organization estimates that smoking is responsible for 1 out of 5 deaths, or 3 million per year. Research has shown that over 50 per cent of smokers will die prematurely as a direct result of tobacco induced illnesses.
- Tolerance to the effects of nicotine develops rapidly, faster than that of heroin and cocaine.
- Withdrawal, after long term use can result in headaches, severe irritability, inability to concentrate, nervousness and sleep disturbance. Nicotine craving may last a lifetime after withdrawal.
- For the very physically dependent, nicotine patches are provided in a relatively harmless form avoiding the injurious affects of tobacco smoke such as carbon monoxide, tar, soot and other by-products.

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## Solvents, Inhalants and Volatile Substances – Characteristics and Effects

- Since ancient times people have inhaled the vapours of perfumes, ointment and burning spices as part of their religious ceremonies. Solvent misuse, as we know it, emerged during the 1950s in the USA and has since spread to most parts of the world.
- Three main types of inhalant are organic solvents, volatile nitrates and nitrous oxide.
- Some of the most common inhalants include glue, aerosol spray cans, paint thinner, petroleum products, chrome based paint, felt pens.
- Inhalation is either through the mouth or nose. Often the product can be sprayed into a plastic bag or soaked onto a rag and then inhaled or it is inhaled directly from the container.
- Inhalants are absorbed through the lungs into the blood stream, which then carries the chemicals rapidly to the brain. They slow down the activity of the brain and central nervous system.
- Intoxicating effects are often quick acting (7 to 10 seconds), intense and short lived lasting no more than 30 to 60 minutes (some inhalants only last 2 minutes).
- Effects can include excitement, dizziness, stupor, disorientated and uncoordinated, visual disturbance and slurred speech. Prolonged use, particularly leaded petroleum products, can lead to brain, liver, kidney, and especially lung damage. Death can arise from respiratory arrest and cardiac irregularities.
- Organic solvents are often readily available, inexpensive and are commonly used by young people in their first few years of secondary schooling.

## Alcohol – Characteristics and Effects

- The most commonly used psychoactive drug in the world and the oldest known. Historical references abound in literature, religion and science about alcohol, its effects and its consequences.
- The production of alcohol results from a process of fermentation, in which water and yeast act on the various sugars of various types of grains, vegetables and fruit. The psychoactive drug that is produced is ethyl alcohol.
- As a depressant drug, alcohol slows down the activity of the central nervous system and in small doses can result in people being relaxed with inhibitions being lowered. As the depressant effect takes over, it can slow reflexes, depress respiration and heart rate and disrupt reasoning and judgement.
- Heavy drinkers usually develop a tolerance to alcohol and need to drink more to experience the same effect.
- The long term effects of alcohol on the body, following heavy drinking over a long period of time, are extensive. These can include higher blood pressure, enlarged heart, cirrhosis of the liver, liver swelling and pain, skin bruising, stomach and intestinal ulcers, muscle weakness, loss of memory, loss of sensation in feet and hands and foetal damage if pregnant.
- Behavioural problems are commonly linked to alcohol. Some problems can include family violence, work absenteeism, motor accidents, legal problems and fines associated with violent assaults and financial difficulties.
- Regular drinking can result in psychological and physical dependency.
- A physically dependent person will suffer withdrawal symptoms that can include loss of appetite, irritability, confusion, inability to sleep, cramps, tremors, hallucinations and even death due to seizures.

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- Addiction to alcohol is a chronic progressive disease that is distinguished by lack of control over drinking, preoccupation with alcohol use despite adverse consequences and denial. If not controlled it can be fatal. While alcoholism can take years to develop the recovery period can take a lifetime.

## Benzodiazepines – Characteristics and Effects

- This class of synthetically based drugs was developed in the late 1940s and 1950s as an alternative to barbiturates. In the West they came into wide clinical use in the 1960s and the 1970s. The drugs were looked upon as an innovation in the treatment of anxiety disorders and sleeping problems.
- Benzodiazepines is a chemical group term which are classified as sedatives or tranquillisers. This ever increasing number of drugs include Temazepam, Diazepam, Nitrazepam, Oxazepam, Clonazepam and Flunitrazepam.
- Benzodiazepines combine with certain parts of the nerve cells in the brain to enhance inhibitory mechanisms. They induce a state of calmness, slowing down physical, mental and emotional responses. When given in large doses they will induce sleep.
- Administration is usually in tablet, capsule or liquid form. It is usually taken orally or by injection. The calming effect is evident in about 45 minutes and some degree of sedation can persist for 24 hours.
- Adverse side effects can include lethargy, confusion, mood swings, nausea, dizziness, disturbing dreams, and slurred speech. The over prescribing or individual misuse of such drugs can result in increased anxiety, irritability and hostility. Mixed with other drugs they can reduce judgement of time, space and distance and combined with alcohol can result in death.
- After a high dose continued for about 2 months or a low dose taken for a year or more, withdrawal can be extremely severe and prolonged. Feelings of craving for the drug, anxiety, sleep disturbance and possible hallucinations can occur. Withdrawal symptoms can erratically come and go in cycles separated by 2 to 10 days and may persist for several months after the drug has been stopped.

## Anabolic Steroids – Characteristics and Effects

- Performance enhancing drugs have been documented throughout human history. In the 1920s, testosterone (male hormone) was isolated and by World War 11 it was being administered to troops to overcome fatigue and injuries. Since the 1950s, testosterone has been synthetically produced and its use was soon associated with athletic performance.
- Anabolic steroids are a group of synthetic compounds which are structurally related to the natural male hormone testosterone. They produce anabolic activity (greater muscular bulk resulting in increased muscular strength) by increasing protein synthesis and androgenic activity (enhanced secondary sexual characteristics).
- Administration is by intravenous or intramuscular injection and by the oral route.
- Injectable forms are designed to be longer acting than orals and are released slowly over time. The high rate of administration via injection has raised the concern and risk of HIV, hepatitis B and hepatitis C.
- Primarily taken to increase muscle mass, they can also allow a user to train harder, promote a quicker recuperation phase and increase the healing process for some types of injuries.
- Early effects can include increased confidence, energy, enhance motivation and enthusiasm, increased aggression and sexual appetite. Larger doses can result in a loss of inhibition, lack of judgement and mood swings. Prolonged users frequently become quarrelsome and aggressive. Severe prolonged use can result in heart disease, liver damage, mental disorders and violence.
- Physical addiction is not believed to occur but some users do become psychologically dependent, believing their physical and sporting achievements will be reduced without them.
- Withdrawal symptoms can include severe depression, insomnia, lethargy, loss of appetite, headaches and craving for anabolic steroids.

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## Methadone – Characteristics and Effects

- German chemists first produced methadone in the early 20th century and it has been used clinically since the end of World War 1.
- It is a powerful synthetic opiate like heroin and morphine but without the strong sedative effect. It can substitute for heroin and is widely used by doctors in the treatment of heroin addiction.
- In its basic form it is a white crystalline powder. It is generally administered as a syrup, mixed with cordial or fruit juice and taken orally. Methadone is also available in an injectable form. Users have been known to inject the syrup often resulting in health problems.
- Effects are felt within 1 hour of a dose, with the peak effect felt at 4 to 8 hours after the dose. The effects of methadone last longer (usually up to 24 hours) than heroin and therefore administration is usually once a day.
- Doses vary for different people and from the commencement of treatment the dose is gradually increased while observing the level of tolerance and avoiding the onset of heroin withdrawal. Once treatment has stabilised, daily dosages can vary from 40mg to >100mg of methadone.
- If the dose is too low opiate withdrawal can occur resulting in symptoms such as abdominal cramps, nausea and vomiting, irritability and back and joint ache. Too high a dose can be indicated by such symptoms of drowsiness, nodding off, shallow breathing and pinpoint pupils.
- Other side effects that can occur but are unrelated to the dose can include, sweating, constipation, aching muscles and joints, decreased sex drive, fluid retention, loss of appetite and tooth decay.
- Methadone can lead to dependence but it is generally considered less serious than heroin and morphine dependence and is easier to treat. People can come off using methadone by reducing their dose gradually, by not setting a time to achieve this goal, and by consulting the counsellor /doctor involved in the methadone program about what is involved.
- Sudden withdrawal is not recommended as the discomfort encountered can result in people using heroin again regularly.

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References

Miller S N (ed). 1991. *Comprehensive Handbook of Drug and Alcohol Addiction*. New York: Marcel Dekker Publications.

Marnell T (ed). 1995. *Drug Identification Bible*. Denver: Drug Identification Bible Publications.

Stockly D. 1992. *Drug Warning: Illustrated Guide for Parents, Teachers and Employers*. London: Optima Books.

Stafford P. 1992. *Psychedelic Encyclopedia*. Berkley: Ronin Publishing.

Inaba D S and Cohen W. 1993. *Uppers, Downers, All Arounders: Physical and Mental Effects of Psychoactive Drugs*. Oregon. CNS Publishing.

Commonwealth Department of Health, Housing, Local Government and Community Services. 1993. *Handbook for Medical Practitioners and other Health Care Workers on Alcohol and other Drug Problems*. Canberra: Australian Government Publishing Service.

Gossop M and Grant M (ed). 1990. *Preventing and Controlling Drug Abuse*. Geneva: World Health Organization.

Australian Drug Foundation. 1995. *How Drugs Affect You: Alcohol* (pamphlet). North Melbourne: Australian Drug Foundation.

Australian Drug Foundation. 1995. *How Drugs Affect You: Amphetamines* (pamphlet). North Melbourne: Australian Drug Foundation.

Australian Drug Foundation. 1995. *How Drugs Affect You: Inhalants* (pamphlet). North Melbourne: Australian Drug Foundation.

Australian Drug Foundation. 1995. *How Drugs Affect You: Hallucinogens* (pamphlet). North Melbourne: Australian Drug Foundation.

Australian Drug Foundation. 1995. *How Drugs Affect You: Cannabis* (pamphlet). North Melbourne: Australian Drug Foundation.

Australian Bureau of Criminal Intelligence. 1996. *Australian Illicit Drug Report 1995-96*. Canberra: Australian Bureau of Criminal Intelligence.

Health and Community Services. 1995. *Methadone Treatment in Victoria: User Information Booklet*. Victoria: A Public Health Branch Publication.

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# Appendices

## *Appendix 3*

# Sexually transmitted infections

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## Introduction

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STIs are a serious public health problem across Asia. Unless treated early, they can lead to serious complications and sequelae, including male and female infertility, sudden life-threatening internal bleeding (e.g. ectopic pregnancy), damage to the brain and other internal organs, stillbirth, and an increased risk for HIV transmission.

In most developing countries, the World Health Organization has recommended that STIs be managed by using a ‘syndromic approach’. This means that the diagnosis and management is based on the symptoms and signs that commonly cause people with STIs to seek care from a clinic.

The most common symptoms and signs can be grouped into ‘syndromes’ for which the most common causes are already well known from previous research. Since many presenting syndromes are caused by more than one infection at a time, more than one drug is often required to manage the common causes of each syndrome. Additionally, the best drugs for treating the STIs are also known from research - this makes sure that STI germs that are resistant to some antibiotics are treated with drugs that still work well.

The most common syndromes are:

- urethral discharge
- vaginal discharge
- genital ulcers
- lower abdominal pain in women
- inguinal swelling (or bubo)
- scrotal swelling
- neonatal conjunctivitis (Ophthalmia neonatorum).

Most countries in Asia have national guidelines for managing STIs and, generally, they follow the syndromic approach and provide simple flowcharts and clinic wall charts to help health workers follow the guidelines.

Advantages of the syndromic approach include:

- It focuses on common STIs of public health importance.
- It does not depend on laboratory support.
- It allows for standardised clinical management, including drug selection, patient education to ensure adherence (compliance), counselling, contact tracing (also called partner notification or management) and demonstration and provision of male and female condoms and water-based lubricant.
- It allows for STIs to be managed at first visit in a primary health care setting.
- Multiple infections are treated at the same time.
- Different types of health workers (i.e. doctors, nurses and others) can all follow a standard and effective system - this also helps standardise training and supervision.

There are also some disadvantages of the approach, including:

- Many people will receive drugs that they did not really need (over-treatment). This adds to costs and can cause possible drug reactions.
- Low-risk women with vaginal discharge are unlikely to have an STI but since there is no simple way to diagnose whether they have one, many are over-treated.
- Contact tracing can be challenging when the diagnosis is uncertain.
- Most STIs in women and many men do not cause symptoms and thus are not addressed by the syndromic approach.

## Gonorrhoea

### Epidemiology

Caused by infection with *Neisseria gonorrhoea*, occurs worldwide, affecting both sexes and practically all ages, especially younger adult groups. Drug resistant strains are now common worldwide. Untreated patients may be infectious to others for several months. Infected with chlamydia at the same time is not uncommon.

### Symptoms and signs

The infection can be asymptomatic in both sexes. In males, a thick white or yellow discharge from the urethra occurs 2-10 days after infection. There is usually pain during urination. In people who practise anal sex, there may be a rectal discharge.

In females, the symptoms are often mild and may pass unnoticed. There may be discomfort on urination, a mild discharge, and some irritation in the vagina. Chronic infection is common and may lead to infertility.

Newborn children infected with gonorrhoea have red and swollen eyes, with a thick discharge, within 1-5 days after birth. Blindness may occur if specific treatment is not given promptly.

*Diagnosis* is by direct microscopic infection examination of a gram-stained smear taken from the discharge, or by culture.

### Which syndrome?

Remember that co-infection with chlamydia is common. In men, gonorrhoea is a common cause of urethral discharge, and a less common cause of vaginal discharge in women.

If it is not treated early, it can develop into a scrotal swelling in men or lower abdominal pain in women.

Transmission from a mother to her baby can present as neonatal conjunctivitis.

## Chlamydia (non-gonococcal urethritis)

### Epidemiology

Between 35 per cent and 50 per cent of cases of non-gonococcal urethritis are thought to be caused by *Chlamydia trachomatis*, which occurs commonly worldwide. In women it can cause mucopurulent cervicitis but infection is more commonly asymptomatic. Repeated infections of chlamydia are a very common cause of chronic pelvic inflammatory disease and infertility. Transmission is by sexual intercourse, occurring in both sexes and all ages, especially young adults.

### Symptoms and signs

Quite similar to gonorrhoea; however, many infected women may be asymptomatic. Complications of infertility in women are also common. Eye infections may occur in babies born to infected women. *Diagnosis* is usually based on failure to demonstrate the presence of gonococci in a cervical or urethral smear or culture. It may be confirmed by examination of smear material with test for chlamydial antigen.

### Which syndrome?

Remember that co-infection with gonorrhoea is common. In men, chlamydia is a common cause of urethral discharge, and a less

common cause of vaginal discharge in women.

If it is not treated early, it can develop into a scrotal swelling in men or lower abdominal pain in women.

Transmission from a mother to her baby can present as neonatal conjunctivitis.

## Syphilis

### Epidemiology

Caused by *Treponema pallidum* which is a spirochete (bacteria); occurs worldwide, primarily in young adults 20-25 years of age. More prevalent in urban areas; there has been a recent increase in incidence in some industrialised countries associated with illegal drug use and prostitution.

Transmission occurs through direct contact with early lesions (ulcers) of skin and mucous membranes or with body fluids (semen, blood, vaginal discharge) during sexual contact. Transmission may occur by blood transfusion if the donor is in the early stage of infection. Infection may be transmitted from an infected mother to the unborn child – an important cause of still birth in endemic areas.

### Symptoms and signs

A primary lesion occurs a few weeks after exposure; this is a painless ulcer at the site of original contact (penis, cervix, rectum, pharynx). The organism enters the bloodstream and a secondary stage occurs within 1-3 months, consisting of a widespread rash and enlarged lymph nodes. After a latency period of 5-20 years with few or no symptoms, the tertiary stage of syphilis

may include severe central nervous or cardiovascular system disease, causing disability and premature death. The laboratory diagnosis is usually made by serologic tests of blood or cerebrospinal fluid.

### Which syndrome?

Early syphilis usually presents as a genital ulcer. Remember that co-infection with other STIs (e.g. herpes and chancroid) is common.

## Chancroid

### Epidemiology

Caused by *Haemophilus ducreyi*, a bacterium. Most prevalent in tropical and sub-tropical regions of the world; more frequently seen in men. Chancroid lesions are highly infectious.

### Symptoms and signs

Characterised by acute, painful genital ulcers, usually single, <1cm in diameter. They usually appear 3-5 days after exposure, with painful swelling of local lymph nodes. Chancroid is more commonly asymptomatic in women. Diagnosis may be confirmed by culture of fluid from a lesion.

### Which syndrome?

Chancroid usually presents as a genital ulcer, often with an inguinal swelling (bubo). Remember that co-infection with other STIs (e.g. herpes and syphilis) is common.

## Lymphogranuloma Venereum

### Epidemiology

Caused by different variants of *Chlamydia trachomatis* from those that cause urethritis and cervicitis: occurs world wide but more common in tropical and subtropical regions. Less commonly diagnosed in women; however, this may be due to a higher rate of asymptomatic infections in women.

### Symptoms and signs

A small painless lesion on the genitalia (often not noticed) is followed by severe, painful swelling of the lymph nodes and surrounding tissues between 5-30 days after initial exposure. *Diagnosis* is made by culture of fluid from a lesion or demonstration of the organism by an antigen test.

### Which syndrome?

LGV sometimes presents as a genital ulcer but more commonly as an inguinal swelling (bubo). Remember that co-infection with other STIs (e.g. syphilis, herpes and chancroid) is common.

## Trichomonad Infections

### Epidemiology

A common, persistent infection of the female genito-urinary tract, caused by the protozoa *Trichomonas vaginalis*. Occurs worldwide, mainly diagnosed in women 16-35 years of age.

### Symptoms and signs

In women, causes inflammation of the vagina with a profuse, yellow, foul smelling discharge; however, the infection is often asymptomatic. The majority of infected men have no symptoms; in a small number, there are symptoms of urethritis. Diagnosis is made by microscopic examination of discharge and identification of the parasite.

### Which syndrome?

Trichomoniasis usually presents as a vaginal discharge. Remember that other causes of vaginal discharge are sometimes difficult to distinguish from trichomoniasis (e.g. bacterial vaginosis and candida) and that cervicitis caused by gonorrhoea or chlamydia is also a cause of vaginal discharge.

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## Genital Herpes

### Epidemiology

Usually caused by herpes simplex virus type 2 (HSV-2); occurs worldwide and type 2 antibody is found in 20 per cent-90 per cent of adults. The frequency is strongly associated with age at first intercourse and lifetime number of sexual partners. Primary infection usually occurs in adolescence or soon after sexual activity commences; recurrences are common. Vaginal delivery in pregnant women with active (especially primary) genital infection carries a high risk of severe infection to the newborn.

### Symptoms and signs

Primary and recurrent skin blisters, often painful, in the anogenital area. In women, often in the cervix, vulva, perineal skin, legs and buttocks. In men, usually on the penis; and in the anus and rectum in men and women who practise anal sex. May occur on the mouth in both sexes, depending on sexual practices. Diagnosis is usually clinical.

### Which syndrome?

Herpes usually presents as a genital ulcer. Remember that co-infection with other infections (e.g. syphilis and chancroid) is common. In many countries, herpes has not been included as part of the genital ulcer syndrome because of the costs of antiviral therapy and the fact that treatment is palliative rather than curative. Additionally, herpes is often a recurrent condition - meaning that the treatment costs will often also be ongoing. Since the cost of the most commonly used drug for herpes in developing countries (acyclovir) is declining and since herpes is also a major co-factor for HIV transmission, many countries are reviewing the situation and considering the inclusion of herpes treatment in their national guidelines.

## Anogenital Warts

### Epidemiology

These warts are found in the genital area or in and around the anus, and occur worldwide. As with other STDs they may be associated with increased risk of HIV infection (e.g., a recent study in Thailand has shown up to 16 fold increase in female-to-male transmission of HIV in the presence of anogenital warts). They are caused by the human papillomavirus.

### Which syndrome?

While warts are a common problem, they are not usually part of the syndromic approach - since the diagnosis and management is generally straightforward. They are sometimes confused with condylomata lata (wart-like lesions caused by syphilis).

### Which syndrome?

Donovanosis usually presents as a genital ulcer. Remember that co-infection with other STIs (e.g. herpes, syphilis and chancroid) is possible. In most countries, donovanosis is rare and is not routinely included as part of the genital ulcer syndrome.

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## Granuloma Inguinale (Donovanosis)

### Epidemiology

This infection is rare in industrialised countries, but endemic in many tropical and sub-tropical countries (especially southern India, Papua New Guinea, central, eastern and southern Africa, the Caribbean, South America, and central and northern Australia). Probably caused by *Donovania granulomatis*.

### Symptoms and signs

A small lesion on the skin in the genital area spreads, gradually forming a granuomatous mass which may result in extensive destruction of genital organs. Laboratory diagnosis is usually made by identification of “Donovan bodies” in Giemsa-stained smears.

## References

- Chin JE. 2000. Control of Communicable Diseases Manual (17th edition) American Public Health Association; ISBN: 0875531822.
- Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines 2002. MMWR 2002;51 (No. RR-6). Acrobat version can be downloaded from web-site: [www.cdc.gov/STD/treatment/rr5106.pdf](http://www.cdc.gov/STD/treatment/rr5106.pdf) or browsable at: [www.cdc.gov/STD/treatment/TOC2002TG.htm](http://www.cdc.gov/STD/treatment/TOC2002TG.htm) .
- Holmes KK et al. (eds). 1998, *Sexually Transmitted Diseases* (third edition). New York: McGraw Hill. ISBN: 007029688X.
- WHO Guidelines for the Management of Sexually Transmitted Infections. Geneva, 2001. [WHO/HIV\_AIDS/2001.01 and WHO/RHR/01.10]. Acrobat version can be downloaded from web-site: [www.who.int/HIV\\_AIDS/STIGlobalReport/who\\_hiv\\_aids\\_2001.01.pdf](http://www.who.int/HIV_AIDS/STIGlobalReport/who_hiv_aids_2001.01.pdf) .
- World Health Organization. 1997. *STD Case Management: The Syndromic Approach for Primary Health Care Settings*. Manila: World Health Organization, Regional Office for the Western Pacific.

### Treatment of Sexually Transmitted Infections

National guidelines should be sought from your national health department since the local situation might require different approaches in the management of specific conditions when compared with global recommendations from organizations such as World Health Organization and/or Center for Disease Control, United States. The updated references and web-sites provided can be reviewed and assessed for appropriateness.

## Glossary of Terms

- Abstinence** Going without. In relation to drug treatment the complete cessation of drug use.
- AIDS** Acquired Immunodeficiency Syndrome. It is a disease caused by the Human Immunodeficiency Virus (HIV). AIDS is the end stage of HIV infection. The body's immune system is seriously damaged and the infected person is vulnerable to common infections that can result in death.
- Burnout** A period of emotional and physical exhaustion in response to an intensity of work with other human beings, particularly those who have serious problems and/or illness.
- Chasing the dragon** A popular way to administer heroin. A portion of heroin is placed on aluminium foil. The underside of the foil is heated with a flame and as the heroin melts vapours are released and the fumes are inhaled. Inhalation is often through a little tube which is held in the mouth.
- Community** Group of people who have something in common and will act together in their common interest i.e. neighbourhood, drug users.
- Counselling** Involves providing advice, support, education, information, aid and assistance, referral and prevention strategies, for example on health related issues i.e. HIV/AIDS.
- Demand Reduction** Refers to the prevention of illicit drug use. Various prevention approaches include 1) providing education and information targeted at the general community, the youth (school based programs) and drug users in order for people to make informed decisions about healthy lifestyles 2) treatment for drug users include detoxification (where appropriate under medical supervision), methadone maintenance treatment and social rehabilitation of drug users by promoting employment prospects and re-integration into communities and 3) community development that address issues of poverty, economic opportunities and integration of people into meaningful social structures.
- Detoxification** Medically supervised programs for drug users being weaned from their physical dependence on drugs. Can be run in an institute, as an in-patient, in the community and in the home.
- Drug Substitution** Replacing the drugs a drug user is taking with a similar drug (i.e. methadone, buprenorphine). The goal is to reduce the health, social, and economic harms to the individual and the community.
- Epidemic** Any disease, infectious or chronic, occurring at a greater frequency than usually expected.
- Evaluation** Process of collecting and analysing information at regular intervals about the effectiveness and impact of the project.
- Golden Triangle** The geographical region that includes the countries of Myanmar, Thailand and Laos. This region produces 80% of the opium and heroin in Asia.
- Harm Reduction** A generally accepted definition has yet to emerge. However, a principal common element is reducing the harmful consequences of drug use without necessarily reducing the drug use. Emphasis is on short term pragmatic goals over long term idealistic goals. Various programs to foster harm reduction are, for example, needle and syringe programs, education of drug users and drug treatment and substitution programs.
- HIV** Human Immunodeficiency Virus. It is the virus that causes AIDS. HIV infects cells of the immune system, which over time become damaged. This results in the immune system no longer resisting common illnesses.

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**HIV/AIDS Test** A blood test which looks for the antibodies to the virus, not for the virus itself. A HIV/AIDS infected person will produce antibodies, which are made to fight germs, but do not protect a person from HIV or AIDS.

**HIV Positive** Antibodies to HIV have been detected by a blood test and the person has been infected with HIV. They are now able to infect other people and will remain infectious for life. It does not mean they have AIDS.

**HIV Negative** Either a person is not infected with HIV or they remain in the window period (3 weeks to 3 months) and therefore production of antibodies are not enough to be indicated by a blood test.

**Methadone** A synthetic opiate, like heroin, which is used to limit discomforts associated with heroin withdrawal.

**Methadone Maintenance Treatment (MMT)** Programs that provide outpatient services for those addicted to opiates, such as heroin, by offering methadone in combination with counselling. Methadone is provided in various dosages and its long-acting effect alleviates withdrawal symptoms. Methadone is not a cure for opiate addiction but it does offer people a chance to stabilise their lives and lessen the risks associated with illegal drug use. Maintenance means long term.

**Monitoring** Continuous process of collecting and analysing information about the implementation of the project.

**Needle and Syringe Program (NSP)** A program allowing injecting drug users access to sterile injecting equipment, providing for needle and syringe disposal and for the provision of advice and information. NSP may be a fixed site or a mobile outreach service.

**Opioids** Natural and synthetic (manufactured) opiate drugs, with the same actions on the body as opium and heroin.

**Peer Education Program** Educational strategies created and implemented by members of a particular group of people for their peers, for example, drug users. The desired outcome is to effect and sustain a change in behaviour by provision of relevant information from an acceptable source. A group of related projects or services directed towards the accomplishment of specific (usually similar or related) objectives. Projects that are long term can be viewed as a program.

**Rapid Situation Assessments** Involve both an assessment of the problem and the resources available that may be required to address the problem. The research tools are adapted from anthropological and other social sciences to examine a particular subject. These can be undertaken within a short timeframe and at low cost.

**Relapse** When a person dependant upon drugs stops using them for a period of time but eventually starts using them again. Initial attempts to stop using drugs often prove unsuccessful and relapses can be frequent.

**Sharing of Injecting Equipment** When a person uses injecting equipment which includes a needle, syringe, filter, water, glasses, tourniquet and surface and is then followed by another person re-using the same injecting equipment. This action can result in the transfer of HIV, Hepatitis B and C; needles and syringes are the most important pieces of equipment for transfer of these viruses.

**Shooting gallery** A name given to an area in which individuals gather to inject drugs, to be injected by a 'professional' injector and/or to buy drugs. It can be in an abandoned building, shack, hut or someone's house.

**Stimulants** Drugs classified as stimulants include amphetamines, cocaine, ecstasy and hallucinogens.

## Abbreviations

**Supply reduction** Various steps are implemented to prevent illicit drugs from reaching the consumer. These steps include 1) eradicating the cultivation of illicit drugs 2) crop substitution to decrease the cultivation of illicit crops 3) interdiction of precursor chemicals that are used for the processing of illicit drugs 4) interdiction of the various means of transporting drugs 5) limiting distribution in the chain of trafficking 6) control and/or legislation on money laundering and 7) the War on Drugs.

**STI** Sexually Transmitted Infections.

A variety of sexually transmitted infections can be contracted following various forms of unprotected sex with someone who is infected. HIV is one such sexually transmitted infection. Others include gonorrhoea, syphilis and chlamydia.

**Viral load** The amount of HIV in a person's blood at a particular time. This can go up and down and will depend on the person's general health and the state of their immune system.

**Withdrawal** Signs and symptoms commonly experienced when a person stops using a drug which they are dependent upon. Withdrawal symptoms can vary from being unpleasant to life threatening and can include irritability, shakiness and nausea.

HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
IDUs	Injecting Drug Users
RSA	Rapid Situation Assessment
NSPs	Needle and Syringe Programs
STIs	Sexually Transmitted Infections
SWs	Sex Workers
MSM	Men who have Sex with Men
TB	Tuberculosis
MMT	Methadone Maintenance Treatment
Mg	Milligram
WHO	World Health Organization
CHOWs	Community Health Outreach Workers
NGO	Non-Government Organisation
MBCMR	Macfarlane Burnet Centre for Medical Research
AHRN	Asian Harm Reduction Network
ELISA	Enzyme-Linked Immunosorbent Assay (test)

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*Glossary of terms*

## Internet Resources List

### **Asian Harm Reduction Network:**

A global information and support network. The four key activities are advocacy, information sharing, networking and training.  
<http://www.ahrn.net/>

### **Australian Department of Health and Ageing - Population Health:**

A 2002 report that examines the return on investment in needle and syringe programs in Australia.  
<http://www.health.gov.au/pubhlth/publicat/hac.htm>

### **Australian Drug Foundation:**

An independent non-profit organisation to prevent and reduce alcohol and other drug problems. The focus is on research, information, community development, education and advocacy.  
<http://www.adf.org.au/>

### **Australian Drug Information Network:**

Provides a central point of access to quality internet-based alcohol and drug information provided by prominent organisations in Australia and internationally. <http://www.adin.com.au/>

### **Australian National Council on Drugs:**

The principal advisory body to the Australian Government on drug-related policies and strategies.  
<http://www.ancd.org.au/>

### **Australian National Council on AIDS, Hepatitis C & Related Diseases:**

The peak advisory body on the Australian response to and the management of these diseases. <http://www.ancahrd.org/>

### **Bureau for International Narcotics & Law Enforcement Affairs:**

A unit of the US State Department, they produce an annual report on all countries of the world, examining issues of drug trafficking, supply and demand and the use of drugs.  
<http://www.state.gov/g/inl/narc/>

### **Canadian Harm Reduction Network:**

The nexus for individuals and organisations across Canada dedicated to reducing the social, health and economic harms associated with drugs and drug policies.  
<http://www.canadianharmreduction.com/>

### **Centre for Harm Reduction:**

Established at The Macfarlane Burnet Institute for Medical Research & Public Health it is the lead technical agency in the Asian region for developing responses for the reduction of drug-related harm.  
<http://www.chr.asn.au>

### **Centre for Drug Research, University of Amsterdam:**

Its goal is the determination of various aspects of the drug problem from a socio-scientific angle.  
<http://www.cedro-uva.org/>

### **Centers for Disease Control and Prevention – HIV Prevention Among Injection Drug Users:**

This web site provides access to materials and resources developed to assist HIV prevention providers working with IDUs and their sex partners.  
<http://www.cdc.gov/idu/default.htm>

### **DRCNet Online Drug Policy Library:**

A US national network working for drug policy reform from a variety of perspectives ranging from harm reduction to a more open debate on drug prohibition. <http://www.druglibrary.org/>

### **Drug Policy Alliance:**

The leading organisation working to broaden the public debate on drug policy and to promote realistic alternatives to the war on drugs based on science compassion, public health and human rights. <http://www.drugpolicy.org/>

### **Drugscope:**

The UK's leading independent centre of expertise on drugs. To inform policy development and reduce drug-related risk. Provides quality drug information, promotes effective responses to drug taking, undertakes research at local, national and international levels, advise son policy-making and encourages informed debate.  
<http://www.drugscope.org.uk/>

### **Drug Misuse Information:**

Substance Misuse Information pages are operated by UK Department of Health. Intended primarily as a resource for a wide range of professionals and managers to help in the delivery of drug prevention and treatmentservices.  
<http://www.doh.gov.uk/drugs/>

Manual for  
 reducing drug  
 related harm  
 in Asia

The Centre  
 for Harm  
 Reduction

**Drugtext:**

This foundation is for the dissemination and production of information on substance use, addiction, harm reduction, and international and national drug policy.  
<http://drugtext.org/>

**Family Health International:**

Works to improve reproductive and family health around the world through biomedical and social science research, innovative health service delivery interventions, training and information programs. Work in partnership with universities, ministries of health and non-governmental organizations, conducting ongoing projects in the US and more than 40 developing countries.  
<http://www.fhi.org>

**Francois Xavier-Bagnoud Centre:**

The first academic centre to focus exclusively on health and human rights, combines the academic strengths of research and teaching with a strong commitment to service and advocacy.  
<http://www.hsph.harvard.edu/fxbcenter/>

**Global HIV-AIDS & STD Surveillance:**

A joint effort of WHO and UNAIDS, Primary objective is to strengthen national, regional and global structures and networks for improved monitoring and surveillance of HIV/AIDS and STIs.  
<http://www.who.int/emc-hiv/>

**Harm Reduction Coalition, New York:**

Committed to reducing drug-related harm among individuals and communities by initiating and promoting local, regional, and national harm reduction education, interventions, and community organising.  
<http://www.harmreduction.org>

**Hepatitis C Council of New South Wales:**

An independent, charitable, community-base membership organisation offering assistance to people affected by the hepatitis C virus (HCV) and providing online, up to date information about hepatitis C. <http://www.hepatitisc.org.au>

**HIV Insite (University of California):**

Source for comprehensive, in-depth HIV/AIDS information and knowledge. Extensive collection of original material, including the HIV InSite Knowledge Base, a complete textbook with extensive references and related links organized by topic. [http://hivinsite.ucsf.edu/cgi-mysql/world\\_db1.pl](http://hivinsite.ucsf.edu/cgi-mysql/world_db1.pl)

**HIV/AIDS Information Centre (Journal of the American Medical Association):**

Designed as a resource for physicians and other health professionals. The site is produced and maintained by JAMA editors and staff.  
<http://www.ama-assn.org/special/hiv/>

**International Crisis Group:**

A private, multinational organisation, with staff on five continents, working through field-based analysis and high-level advocacy to prevent and contain conflict (also examines HIV/AIDS).  
<http://www.crisisweb.org/>

**International Harm Reduction Association:**

Working with local, national, regional and international organisations to assist individuals and communities in public health advocacy, collaboration and communication, best practice on various issues related to harm reduction, and education, training and research.  
<http://www.ihra.net/>

**International Narcotics Control Board:**

An independent and quasi-judicial control organ for the implementation of the United Nations drug conventions, established in 1968 by the Single Convention on Narcotic Drugs of 1961.  
<http://www.incb.org/e/index.htm>

**Mainliners:**

On-line advice and information service for people affected by drug use, HIV and hepatitis. <http://www.mliners.org/>

**National Institute on Drug Abuse:**

Researches on the health aspects of drug abuse and addiction and works towards the rapid and effective transfer of scientific data to policy makers, drug abuse practitioners, other health care practitioners and the general public.  
<http://www.drugabuse.gov/NIDAHome.html>

**Open Society Institute, International Harm Reduction Development:**

Aims to diminish the individual and social harms associated with drug use through innovative measures based on the philosophy of harm reduction. Currently supports more than 180 projects in over 20 countries in Eastern Europe and the former Soviet Union.  
<http://www.soros.org/harm-reduction>

**RARarchives:**

Site aims to provide general information and resources on rapid assessment which aim to prevent HIV and other infectious diseases among IDUs.  
<http://www.rararchives.org/>

**Trimbos Institute (Netherlands) of Mental Health and Addiction:**

Aims to promote mental health in the broadest sense of the term. The Institute is an independent national centre of expertise that, on scientific grounds, provides services in the field of mental health care, substance use and the care of addicts.  
<http://www.trimbos.nl/indexuk.html>

**UNAIDS Joint United Nations Programme on HIV/AIDS:**

The leading advocate for worldwide action against HIV/AIDS, the global mission of UNAIDS is to lead, strengthen and support an expanded response to the epidemic. <http://www.unaids.org/>

**United Nations Office for Drug Control and Crime Prevention:**

Works to educate the world about the dangers of drug abuse. Aims to strengthen international efforts against drug production, trafficking and drug related crime.  
<http://undcp.or.at/index.html>

**United Nations Drug Control Program (Regional Centre for East Asia & the Pacific):**

Responsibility for drug control in East Asia and the Pacific covering over 30 countries/areas.  
<http://www.undcp.un.or.th/>

**United Nations Development Programme, Regional Programs on HIV/AIDS in Asia/Pacific:**

Deals with various tasks associated with advocacy, sharing best practices and mobilizing resources it also addresses issues linked to HIV/AIDS.  
<http://www.hivundp.apdip.net/>

**World Health Organization, Department of Mental Health and Substance Dependence:**

Deals with all psychoactive substances, regardless of their legal status. The WHO mandate is to: prevent and reduce the negative health and social consequences of psychoactive substance use; reduce the demand for non-medical use of psychoactive substances; and assess psychoactive substances so as to advise the United Nations with regard to their regulatory control.  
[http://www.who.int/substance\\_abuse/index.html](http://www.who.int/substance_abuse/index.html)

**World Health Organization, Department of HIV/AIDS:**

As a co-sponsor of UNAIDS the WHO mandate is to head the health sector response to HIV/AIDS. This sitemap exams issues of surveillance, monitoring and evaluation, care, prevention, technical support and HIV/AIDS in emergency settings.  
<http://www.who.int/hiv>

## Useful Publications on the Internet

- AIDSCAP *Making prevention work: Global lessons learned from the AIDS Control and Prevention (AIDSCAP) Project 1991-1997*. Chapter 4: Policy development and HIV/AIDS prevention: creating a supportive environment for behaviour. 1998 Website: <http://www.fhi.org/en/aids/aidschap/aidspubs/special/lessons/chap4.html>
- Ball A and Crofts N. HIV risk reduction in injecting drug users. In: Lamptey PR and Gayle H (Eds) *HIV/AIDS Prevention and Care in Resource-Constrained Settings*. Arlington, Virginia: Family Health International 2002 <http://www.fhi.org>
- Burrows D. *Starting and Managing Needle and Syringe Programs: A guide for Central and Eastern Europe and the newly independent states of the former Soviet Union* Open Society Institute, International Harm Reduction Development (OSI/IHRD) NY 2000. From OSI/IHRD 400 West 59th St, New York NY 10019 USA. In English, Russian and Slovakian. Website:<http://www.soros.org/harm-reduction/>
- Chapman S. Advocacy in public health: roles and challenges *International Journal of Epidemiology* 2001; 30: 1226-1232. Website: <http://www.health.usyd.edu.au/tobacco/worddocs/IJE.pdf>
- Costigan G, Crofts N and Reid G. *Manual for reducing drug-related harm in Asia*. The Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research and Public Health Ltd and Asian Harm Reduction Network, Melbourne/ Chiang Mai 2003. <http://www.chr.asn.au>
- Derricot J, Preston A and Hunt N. *The Safer Injecting Briefing*. HIT Liverpool 1999. English only. Available direct from HIT Cavern Walks, Mathew Street, Liverpool L2 6RE also on the HIT Website: <http://www.drugtext.org/books/needle/>
- Johns Hopkins Centre for Communications Programs "A" frame for Advocacy. Set of nine web pages providing short descriptions of steps in advocacy for public health. No date. Accessed 7 May 2002. Index and introduction: <http://www.jhuccp.org/pr/advocacy/index.stm>
- Preston A. *Methadone Briefing* HIT Liverpool 1997. Available direct from HIT Cavern Walks, Mathew Street, Liverpool L2 6RE. Website:<http://www.drugtext.org/books/methadone/default.htm>
- Sharma RR. *An Introduction to Advocacy: Training Guide*. Support for Analysis and Research in Africa, USAID Africa Bureau Office of Sustainable Development. Washington DC 1997. Also in Spanish and French. [http://sara.aed.org/sara\\_pubs\\_list\\_sara\\_5.htm](http://sara.aed.org/sara_pubs_list_sara_5.htm)
- Stimson G, Fitch C and Rhodes T (Eds). *Rapid Assessment and Response Guide on Injecting Drug Use*. World Health Organisation/UNAIDS Geneva 1997. From WHO/UNAIDS, 20 avenue Appia, CH-1211 Geneva 27, Switzerland. Available in English and Russian. Website: [http://www.who.int/home/UNAIDS/UNDCP Drug use and HIV Vulnerability: Policies in Seven Asian Countries UNAIDS APICT. Bangkok 2001. Website: http://unaids.org/publications/documents/health/access/Drug.pdf](http://www.who.int/home/UNAIDS/UNDCP/Drug%20use%20and%20HIV%20Vulnerability%20Policies%20in%20Seven%20Asian%20Countries%20UNAIDS%20APICT%20Bangkok%202001.pdf)
- UNAIDS Drug use and HIV/AIDS UNAIDS Statement presented at the UN General Assembly Special Session on Drugs June 1998 Geneva. Also in Spanish, French and Russian Website: <http://www.unaids.org/publications/documents/specific/injecting/una99e1.pdf>
- UNAIDS/ODCCP *Drug Abuse and HIV/AIDS: Lessons Learned Case studies Booklet: Central and Eastern Europe and the Central Asian States* 2001 Website:[http://www.unaids.org/publications/documents/specific/injecting/JC673-Drug Abuse-E.pdf](http://www.unaids.org/publications/documents/specific/injecting/JC673-Drug%20Abuse-E.pdf)
- UNAIDS *Best Practice Collection* Six best practice studies on HIV/AIDS and injecting drug use in China, Bangladesh, Nepal, Belarus, Southern Cone countries (Latin America), Asia. Website: <http://www.unaids.org/bestpractice/digest/table.html#inj>
- WHO (World Health Organisation) *The Ottawa Charter on Health Promotion Geneva*. 1986 Website:<http://www.who.int/hpr/archive/docs/ottawa.html>

Internet  
Resources  
List

## International Contact List

### Afghanistan

UNDCP (for Afghanistan)  
11th Floor Saudi-Pak Tower  
P.O Box 1051  
Islamabad  
Tel: +92 51 279088  
Fax: +92 51 279085  
Email: bfrahi@org.pk  
Website: [www.undcp.org/pakistan/index.html](http://www.undcp.org/pakistan/index.html)

### Bangladesh

HIV Program  
CARE International Bangladesh  
House 66, Road 7/A  
Dhanmondi Residential area  
Dhaka-1209  
Bangladesh  
Tel: 88-02-8114195, 88-02-8114198  
Fax: 88-02-8114183  
Email: carebang@bangla.net

HIV program  
CARE Dhaka Field Office  
49/1 Babar Road  
Mohammadpur Housing State  
Block-B, Dhaka -1207  
Tel: 88-02-8123364, 88-02-8114311  
Fax: 88-02-8114183  
Email: caredfo@bangla.net,  
carebang@bangla.net

Bandu Social Welfare Society and HIV/AIDS  
and STDs Prevention Project  
106, Kakrail  
Dhaka-1000  
Tel: 88-02-9339898  
Email: bandhu@bdmail.net

HIV/AIDS STD Alliance Bangladesh  
(HASAB)  
4/1 Iqbal road, Mohammadpur  
Dhaka-1207  
Tel: 88-02-8123021, 88-02-9132644  
Fax: 88-02-8122786  
Email: hasab@bdmail.net

Concern Bangladesh  
House 61, Road 15/A  
Dhanmondi Residential Area  
Dhaka-1209

### Cambodia

UNODCP Country Office  
No4 Mao Tse-Tung Boulevard, Sangkat  
Boeung Keng Kang, Khan Chamcarmon,  
Phnom Penh  
Tel: (855-23) 726-035  
Fax: (855-23) 216-257  
Email: unodccp@bigpond.com.kh  
UNAIDS Cambodia  
PO Box 877, Phnom Penh, Cambodia  
Tel: (855) 23 721 153  
Fax: (855) 23 721 153  
Email: UNAIDSCMB@bigpond.com.kh

### China

Guangxi Centre for HIV/AIDS Prevention  
and Control  
80 Taoyuan Road, Nanning, Guangxi  
530021  
Tel: 86 771 5327110  
Fax: 86 771 5316432  
Email: gastc@public.nn.gx.cn

Yunnan Provincial Bureau of Health  
166 Wuyi Road, Kunming, 650021  
Tel: 86 871 3629527  
Fax: 86 871 3620353

Yunnan Institute for Drug Abuse  
Xi-hua-yuan, Kunming,  
650228 Yunnan Province  
Tel: 86-871-4624423  
Fax: 86-871-4624356  
Email: yidazj@public.km.yn.cn

National Center for AIDS/STD Prevention  
and Control  
Add: 27 Nanweilu, Beijing 100050, China  
Tel: 010-63174322  
Fax: 010-63179516  
Email: shenjie@aids.net.cn

Chinese AIDS Network  
Peking Union Medical College  
Add: 5 Dongdantsantiao, Beijing 100005,  
China  
Tel: 010-65296973/65296971  
Fax: 010-65288170/64812781  
Email: klzhang@95777.com

Manual for  
reducing drug  
related harm  
in Asia

Health Education and Behaviour  
Interventions Office (a focus on IDUs)  
National Center for AIDS/STD Prevention  
and Control  
Add: 27 Nanweilu, Beijing 100050, China  
Tel.: 010-63152573  
Fax: 010-63131081  
Email: wuzy@public.bta.net.cn

China-UK HIV/AIDS Prevention and Care  
Project  
27 Nanweilu Beijing 100050 China  
Ph: 8610-6313-1047/ 6313-1174  
Fax: 8610-6313-1366

**Hong Kong (Special Administrative  
Region, China)**

Red Ribbon Centre  
2/F, 200 Juntion Road East,  
Kowloon, Hong Kong  
Tel: (852) 2304 6268  
Fax: (852) 2338 0534  
Email: rrc@health.gen.gov.hk  
Website: www.rrc-hk.com

Methadone Clinic (Narcotics & Drug  
Administration)  
8/F Southorn Centre  
130 Hennessy Road, Hong Kong  
Tel: (852) 2835 1831  
Fax: (852) 2572 6072  
Website: www.harmreduction-hk.com

Phoenix Project (The Society for the Aid and  
Rehabilitation of Drug Abusers. SARDA)  
3/F, Duke of Windsor Social Service  
Building,  
15 Hennessy Road, Wanchai, Hong Kong  
Tel: (852) 2527 7726  
Fax: (852) 2865 5455  
Email: sarda@sarda.org.hk  
Website: www.sarda.org.hk

Pui Hong Self Help Association  
Flat C, 4/F, Haven Building,  
128-138, Leighton Road, Hong Kong  
Tel: (852) 2576 2356  
Fax: (852) 2882 3534  
Email: Jchien\_hk@excite.com

**Macau (Special Administrative Region,  
China)**

Department for Prevention and Treatment of  
Drug Dependence -Social Welfare Institute  
Rua Sanches de Miranda, No.5, MACAU  
(South of China)  
Tel: (853)781718  
Fax no.(853)781720  
Email: celestev@ias.gov.mo  
Website: www.ias.gov.mo

**India**

The Calcutta Samaritans  
Rev. Vijayan Pavamani  
Mahesh Nathan  
48 Ripon Street, Calcutta-16  
Tel: 033-2295920/2299731  
Fax: 033-2268097  
Email: emcal@giasl01.vsnl.net.in  
Email: <calsam@satyam.net.in>

Society for Community Intervention &  
Research (SCIR)  
Sunjoy Bhattacharya  
Mr. MM Rahaman (President)  
37, Alimuddin Street,  
Calcutta - 700 016.  
Tel: 033-2290484  
Email: scir@vsnl.net

Sahai Trust  
Fr. Desmond Daniels Chubby  
Rehab Centre: 04114-74321  
Clinic: 044-434-5668/4843836/4332285  
Office: 044-4953644 fax: 044-4958302  
Office: 15, Rosary Church Rd, Santhome  
Chennai-600004  
Rehab: Mount Carmel Mission, Kovalam  
PO Pin: 603112  
Email: sahai@eth.net

TTK Hospital  
Shanti Ranganathan  
TT Ranganathan Clinical Research Found.  
IV Main Road, Indira Nagar  
Chennai - 600 020.  
Tel: 91-44-827 5841/493 8584  
Email: ttcrf@md2.vsnl.net.in

TTK Drop in centre  
Dr. S. Srivatsan  
20, II Cross Street  
Kodambakkam, Chennai-600024  
Tel: 044-3726356

SASO - (Social Awareness Service  
Organisation)  
Khwai Lalambung - Makhong  
RMC Road, Imphal - 795 001  
MANIPUR  
Tele: 0385- 310011/411408  
Fax: 0385-411409  
Email: imphsasol@neline.com  
Email: sasoimph@sancharnet.in

North East India Harm reduction Network  
(NEIHRN)  
R.Raju  
Address/telephone: same as SASO  
Email: neihrn@yahoo.com  
Email: neihrnimph@yahoo.co.in

MUKTI Sadan  
Shoba Kapoor  
Praful Sali  
Plot No.49  
Parsee Panchayat Road, Andheri (E)  
Bombay - 400 069.  
Tel: 022-8325184 / fax: 022-837-6428

Family Health International  
Kathleen Kay  
Ground Floor (opp. Convention Centre)  
Ashok Hotel  
Chanakyapuri, New Delhi 110 021  
India  
Tel: 91-11-6873950-53  
Fax: 91-11-6873954  
Email: kkay@fhiindia.org

UNDCP-ROSA  
Renate Ehmer  
EP 16/17, Chandragupta Marg  
Chanakyapuri, New Delhi-110021  
Tel: 4104970-73  
Fax: 4104962  
Email: rehmer@undcp.ernet.in

Sharan - Society for service to urban poverty  
Luke Samson  
C-43, Neeti Bagh,  
New Delhi-110049, India  
Tel:91-11-8642311/8642322  
Email: sharanindia@vsnl.com

### Indonesia

Aksi Stop AIDS (ASA)/ Family Health  
International  
Ditjen PPM & PL Depkes RI  
Jl. Percetakan Negara 29  
Jakarta 10560  
Indonesia  
Tel: 62 21 422 3463  
Fax: 62 21 422 3455  
Email: program-asa@fhi.or.id

Yayasan Pelita Ilmu  
Jl. Tebet Timur Dalam VIII Q/6  
Jakarta 12820  
Tel: 62 21 794 6040  
Fax: 62 21 799 5847  
Email: ypilmu@link.net.id

Yayasan Hatihati  
Jl. Pulau Batam I/9  
Denpasar 80114, Bali  
Indonesia  
Tel:62 36 122 1271  
Fax: 62 36 122 1271  
Email: hatihati@indosat.net.id

Yayasan Bahtera  
Jl. Jatihandap Gg. iv / 210  
Desa Mandalajati  
Cicaheum Bandung  
Tel/Fax: 022-727-9320  
Email: ybahtera@indosat.net.id

Yakita (Yayasan Harapan Permata Hati Kita)  
Jl Ciasin no.21  
Desa Bendungan  
Ciawi, Bogor  
Tel/Fax: 0251-335-875  
Email: info@yakita.or.id  
Website: www.yakita.or.id

### Iran

United Nations Drug Control Programme  
45 Pardis Str. Mola Sadra Str. Vanak Sq.,  
199195-3471, Tehran.  
Tel: +98-21-879 5031/2  
Fax: + 98-21-877 6661  
Email: dcp.iran@undp.org

Drug Control Head Quarters (DCHQ)  
143, Baharan Sq., Vozara St., Tehran, Iran  
Tel: +98-21-877 02 35  
Fax: +98-21-877 02 35  
Website: www.dchqiran.org

State Welfare Organization  
No. 32, Ghaem Magham St. Opposite  
Mashahir St., Haft-Tir Sq., Tehran  
Tel & Fax: +98-21- 830 61 10

Ministry of Health  
South Iranshar, Opposite Iranshahr Hotel,  
No. 68, Tehran  
Tel: +98-21-882 06 78

Prisons Organization  
Shariati St., Istgah Yakhchal, 4th Floor,  
Tehran  
Tel: +98-21- 266 172  
Fax: +98-21- 267 930

**Japan**

Japanese Foundation for AIDS Prevention  
Terayama Pacific Building. 4F  
Toranomom 1-23-11,  
Minato-ku, Tokyo, 105-0001  
Tel: +81-3-3592-1181  
Fax: +81-3-3592-1182

**Laos**

UNDCP Country Office  
Route Phone Kheng, Vietiane  
Postal address P.O Box 345  
Tele: (00856-21) 413-204, 416-427  
Fax: (00856-21) 413-203  
Email: undcp Lao@undcp.org  
Website: www.undcp.org/laoPDR

UNAIDS  
P.O. Box 345  
Phon Kheng Road  
Vientiane Lao PDR  
Tel: (856-21) 213395-97  
Fax: (856-21) 241742  
Email: khamlay.manivong@undp.org

Lao-German Project 'Promotion of Drug  
Control'  
P.O.Box 9233, Vientiane, Lao PDR  
Tel/Fax: +856-21-351978  
E-mail: gtzlgdcp@laotel.com

NCCA Bureau  
Km 3, Thadeua Road  
Vientiane Municipality, Vientiane  
Tel / Fax: (856-21) 315500  
Email: ncca@laotel.com

**Malaysia**

Malaysian AIDS Council  
12, Jalan 13/48A, The Boulevard Shop  
Office  
off Jalan Sentul, 51000 Kuala Lumpur  
Tel: 603 4045 1033  
Fax:603 4042 6133  
Homepage:http://www.mac.org.my

Persatuan Pengasih Malaysia  
Rumah pengasih  
3201-A jalan Syers off Langgak Tunku  
50480 Kuala Lumpur  
Tel: 03-6201 3179/0287  
Fax: 03-6201 3013  
Email: khidmat@pengasih.net

Ikhlas Drop-In-Centre  
Pink Triangle Foundation  
7C-1, 1st Floor  
Jalan Ipoh Kecil  
off Jalan Raja laut  
50350 Kuala Lumpur  
Email: betan@pd.jaring.my

Malaysian Care  
Lot389, 8.8km Jalan Hulu Kelang  
68000 Ampang, Selangor  
Tel; 03-7785 4627  
Fax:03-7981 2954Email:  
MCAREDRPS@PO.JARING.MY

Youth With a Mission (YWAM)  
7B jalan Kenari 10  
Bandar Puchong Jaya  
47100 Puchong  
Selangor  
Tel: 03 8070 0301  
Fax:03 8076 4116  
Email:ywamkl@pd.jaring.my

**Mongolia**

National Aids Foundation:  
Executive Director. Kh. Enkhjargal  
Central Post Office,  
Ulaanbaatar-13, box-117  
Tel: 976-11-318016  
Fax: 976-11-321659  
Email: monaids@magic.net  
Website: www.naf .org.mn

**Myanmar**

UNDCP,  
PO Box 650, 11A Malikha Road, Ward 7,  
Mayangone Township, Yangon  
Tel: (951) 666 903, 660 538, 660 398  
Fax (951) 651 334  
Email: undcp.mm@undp.org

CCDAC, Corner of Set-hmu and Saya San  
Roads, Bahan Township, Yangon  
Tel: (951) 549 642  
Fax : (951)549 284

MANA, Room 101-102, Bldg 3, Myaing  
Hay-wun Estate near Junction 8, 8th Mile,  
Kyaik-waing pagoda Road, Mayangone  
Township, Yangon  
Tel: (951) 667 270  
Fax: (951) 660 266  
Email: manacentral@mptmail.net.mm

CARE International in Myanmar, 98A Kaba  
Aye Pagoda Road, Bahan Township, Yangon  
Tel: (951) 544 289, 544 805, 549 152  
Fax: (951) 549 338  
Email: caremya@mptmail.net.mm

Medecins du Monde, 10 (A) Thar Tha Na  
Yeik Street, Mahasi, off Kaba Aye Pagoda  
Road, Bahan Township, Yangon  
Tel: (951) 548 294  
Fax: (951) 544 557  
Email: mdmmya@mptmail.net.mm

**Nepal**

Centre for Harm Reduction  
Nepal Country Office  
CHA 2/173, Ward#2, Gairidhara,  
Kathmandu  
GPO Box. 19688  
Tel: +977 1 410701  
Fax: +977 1 410601  
Email: chr@mos.com.np

Government: National Centre for AIDS and  
STD Control (NCASC)  
Dr. Shyam Sundar Mishra- Director  
Address: Teku Hospital, Kathmandu Nepal  
Tel: 977-1-261653 or 258219  
Fax: 977-1-261406  
Email: ncasc@nto.net.np

Family Health International- Nepal (FHI)  
Addrss:Gha-2-789, Tangal  
G.P.O: 8803, Kathmandu  
Tel: 977-1-427540  
Fax: 977-1-414063  
Email: fhinepal@fhi.org.np  
Website: http://www.nepalinitiative.org.np

Lifesaving and Lifegiving Society (LALS)  
Address: P.O. Box 7151, Kathmandu  
Tel: 977-1-413576  
Fax: 977-1-413976  
Email: lals@info.com.np

International Nepal Fellowship (INF) Naulo  
Ghumti Program  
Address: P.O. Box: 28, Pokhara, Kaski  
district, Nepal  
Tel: 977-61-24515 / 061-23350  
Fax: 977-61-30940  
Email: naulo\_ghumti@inf.org.np

**Pakistan**

Nai Zindagi  
# 37-38, Beverly Center, Blue Area,  
Islamabad  
Tel: +92 51 2874120  
Fax: +92 51 2874121  
Email: recovery@isb.compol.com

Pakistan Society  
C-15, Block 12, Federal B Area, Karachi  
75950  
Tel: +92 21 6344644  
Fax: +92 21 6343810  
Email: pakistansociety@hotmail.com

Al Rehman  
155 A Bank Road, Rawalpindi  
Tel: +92 51 5515272  
Fax: +92 51 5515274  
Email: gallian25@hotmail.com

UNDCP (also for Afghanistan)  
11th Floor Saudi-Pak Tower  
P.O Box 1051  
Islamabad  
Tele: +92 51 279088  
Fax: +92 51 279085  
Email: bfrahi@org.pk  
Website:  
www.undcp.org/pakistan/index.html

Manual for  
reducing drug  
related harm  
in Asia

**Philippines**

Metsa Foundation  
Anita Morales - Project Coordinator  
Km. 20 Los Amigos  
Tugbok Street, Davao City  
Tel.: (0 82) 2930219  
Email: metsa@eudoramail.com

Higala Association  
Onesimo Tabaco - Executive Director  
Purok 14 Sta. Cruz  
Bugac, Ma-a Road, Davao City  
Telefax: (0 82) 2441753  
Email: higala\_association@hotmail.com

Kaugmaon Center for Children's Concerns  
Faustina Carreon - Executive Director  
59 Vinzon Street corner Cervantes Street  
Barrio Obrero, Davao City  
Tele/fax.: (0 82) 2216669  
Email: kaugmaon@mozcom.com

Shed Foundation  
Domingo Non - Executive Director  
Mindanao State University Campus  
Fatima, General Santos City  
Tel.: (0 83) 3807149  
Tele/fax: (0 83) 5538979  
Email: shed@gsc.weblink

Philippine HIV/AIDS NGO Support  
Program (PHANSUP)  
Mezzanine, Brickville Condominium  
28 N. Domingo Street  
New Manila, Quezon City 1112  
Tel.: (6 32) 7266921 to -22  
Fax: (6 32) 4154381  
Email: phansup@info.com.ph

Remedios AIDS Foundation (Cebu Youth  
Zone)  
1066 Remedios cor. Singalong Sts.  
Malate, Manila 1004  
Tel. Nos.: (6 32) 5240924/ (6 32) 5244831  
Fax: (6 32) 5223431  
Email: reme1066@skynet.net  
Website: <http://www.remedios.com.ph>  
<http://www.youthzone.com.ph>

**South Korea**

Korea Drinking Culture and Alcohol  
Research Foundation (Alcohol)  
13-8, Noryangjin-Dong, Dongjal-Gu, Seoul,  
Korea 156-050  
Tel: 822 817 6812(501)  
Fax: 822 817 6844  
Email: hanbaragi@kodcar.or.kr  
[www.kodcar.or.kr](http://www.kodcar.or.kr)

Korea Anti-Drug Campaign Center (Drug)  
238, Dangsang-Dong 6 Ga, Youngdeungpo-  
Gu, Seoul, Korea 150-809  
Tel: 822 677 2245  
Fax: 822 677 2247  
[www.drugfree.or.kr](http://www.drugfree.or.kr)

Korean Alliance to Defeat AIDS (HIV/AIDS)  
307, sEMI BUILDING, 57, Youngdeungpo-  
8Ga, Youngdeungpo-Gu, Seoul Korea, 150-  
038  
Tel: 822 675 4111-4  
Fax: 822 675 2114  
Email: kada@aids.or.kr  
[www.aids.or.kr](http://www.aids.or.kr)

Korean Anti-AIDS Federation, Inc.  
(HIV/AIDS)  
201, BOSUK BILAT, 2-15 Dongsung-Dong,  
Jongro-Gu, Seoul, Korea  
Tel: 822 747 4071  
[www.aidskorea.org.kr](http://www.aidskorea.org.kr)

**Singapore**

Action for AIDS  
c/o DCS Clinic #02-16  
31 Kelantan Lane  
Singapore, 200031  
Tele: 2509495  
Fax: 2994335  
Email: afa@pacific.net.sg

Central Narcotics Bureau  
393 New Bridge Road, Singapore, 088763  
Tel: 1800 3256666  
Fax: 6227 3978  
Website: <http://www.cnb.gov.sg>

**Sri Lanka**

UNDP  
202 & 204, Bauddhaloka Mawatha, Colombo 7, Sri Lanka or P.O. Box 1505, Colombo 7  
Tel: 580691-7.  
Fax: 00 94 01 581116/501396  
Email: registry.lk@undp.org  
Website: <http://www.undp.lk/>

National STD/AIDS Control Programme,  
P.O. Box 567, Colombo 10  
Tel: 695183, 667163, 667029, 696433  
Fax: 075 336873

National Dangerous Drugs Control Board,  
383, Kotte Road, Rajagiriya,  
Tel: 868794, 868795, 868796  
Fax: 868792

Police Narcotics Bureau  
3rd Floor, New Secretariat, Colombo 1.  
Tel: 324626, 447943, 447946, 332985  
Fax: 440584, 332985

**Taiwan**

Dept. Humanities and Social Science  
National Defense Medical Center  
Szu-Hsien Tony Lee, Ph.D.  
No 161 Sec. 6 Min-Chuan E. Road, Taipei,  
Taiwan 00114  
Tel: 02- 87923100~18588  
Email: tonylee@ndmctsgh.edu.tw

Department of Addiction Science  
Taipei City Psychiatric Center  
309 Sung-Te Road, Taipei  
Tel: 886-2-2728-5791  
Fax: 886-2-2726-7246  
Email: sklin@mail.tpc.gov.tw  
Website: [www.tpc.gov.tw](http://www.tpc.gov.tw)

**Thailand**

UNDCP  
Regional Centre for East Asia and the Pacific  
United Nations Building, 14th Floor,  
Rajadamnern Nok Ave, Bangkok 10200  
Tel: (0066-2) 288-2091  
Fax: (0066-2) 281-2129  
Email: rcdcp@undcp.un.or.th  
Website: [www.undcp.un.or.th](http://www.undcp.un.or.th)

Drug Dependence Research Centre,  
Institute of Health Research, Chulalong  
University. Institue Building II,  
Chula Soi 62,  
Phyathai Road, Bangkok  
Tel: (662) 218 8200  
Fax: (662) 255 2177  
Email: pusaneya@chula.ac.th

Family Health International  
Asian Regional Office  
Arwan Building, 8th Floor  
1339 Pracharaj 1 Road  
Bangkok 10800  
Tel: (662) 587 4750  
Fax: (662) 587 4758  
Email: ane@fhibkk.org  
Website: <http://www.fhi.org/en/cntr/asia/asiaro/asiaaro.html>

AIDS Network Development Foundation  
(AIDSNet)  
48/1 Anantasiri Tennis Court) Moo 3,  
Chang Puek  
Chiang Mai -Lampang Road  
Chiang Mai, 50300  
Tel: 6653 222417

Northern Drug Research Centre  
Chiang Mai University  
110 Intavaros Road, Chiang Mai 50202  
Tel: 053 942505 ext 107

**Vietnam**

GTZ HIV/AIDS/STI Control,  
Room 402, 4th floor,  
4 Tran Hung Dao Street,  
HANOI.  
Tel: (84-4) 933 1379/80/81  
Email: AIDSGTZ@netnam.vn  
Website: <http://www.gtz.de/vietnam/>

UNDCP  
25-29 phan boi chau  
Tel: 84 4 9421495  
Email: buddenberg@un.org.an  
Website:  
<http://www.undcp.org/vietnam/index.html>

World Health Organisation  
63 Tran Hung Dao  
Tel: (84-4) 843-3734,  
Fax: (84-4) 843-3740  
E-mail: brudonp@vtn.wpro.who.int  
Website: [www.un.org](http://www.un.org)

Manual for  
reducing drug  
related harm  
in Asia

Ministry of Health - AIDS Division  
 Dr. Trinh Quan Huan  
 Director of Preventive Medicine  
 Chairman, AIDS Division  
 Ministry of Health  
 138 Giang Vo, Hanoi  
 Tel. No.: (84 4) 846 2364  
 Fax No.: (84 4) 840 507  
 Email: tqhuan@yahoo.com

Family Health International  
 Thomas Kane, Country representative  
 Suit 201 , 30 Nguyen Du, Hanoi  
 Tel: 84 4 9431 828

Medecins du Monde France (MDMF):  
 Dr. Nguyen Quang Ngoc (Hanoi)  
 Toserc Building, room 504  
 269 Kim Ma Street, Hanoi  
 Tel. 8464688 Fax 8464689  
 Email: dow-mdm-vn@fpt.vn

MDMF: HCMC  
 Dr. Nguyen Dinh Tuan  
 11/5A Dang Van Ngu, Ward 10  
 Phu Nhuan District  
 Ho Chi Minh City  
 Tel: 08- 844 22 63  
 Fax: 08- 844 80 04  
 Email: mdmvinh@hcm.vnn.vn

**General International**

International Harm Reduction Development  
 Open Society Institute  
 400 West 59th Street  
 New York, NY, 10019 United States  
 Tel: 212 548 0677  
 Fax: 212 428 4617  
 Email: IHRD@sorosny.org  
 Website: www.soros.org/harm-reduction

United Nations Office for Drug Control and  
 Crime Prevention.  
 Vienna International Centre  
 PO Box 500, A-1400 Vienna, Austria  
 Tel: +43 1 26060 0  
 Fax: +43 1 26060 5866  
 Email: odccp@odccp.org  
 Website: www.odccp.org/odccp/index.html

World Health Organization  
 Avenue Appia 20  
 1211 Geneva 27, Switzerland  
 Tele: +41 22 791 2111  
 Fax: +41 22 791 3111  
 Email: info@who.int  
 Website: www.who.int/en

UNAIDS - Joint United Nations  
 Programme on HIV/AIDS  
 20, Avenue Appia  
 CH- 1211, Geneva 27, Switzerland  
 Tel: +4122 791 3666  
 Fax: +4122 791 4187  
 Email: unaids@unaids.org  
 Website: www.unaids.org/index.html

The International HIV/AIDS Alliance  
 Queensbury House  
 104-106 Queens Road  
 Brighton, BN1 3XF, United Kingdom  
 Tel: +44 1273 718 900  
 Fax: +44 1273 718 901  
 Email: mail@aidsalliance.org  
 Website: www.aidsalliance.org

Trimbos Institute - Netherlands Institute of  
 Mental Health and Addiction, Unit  
 International Affairs. P.O Box 725  
 3500 AS Utrecht, The Netherlands  
 Tele: +31 (0) 30 297 1100  
 Fax: +31 (0) 30 297 1111  
 Email: ftrautmann@trimbos.nl  
 Website: www.trimbos

Imperial College of Science, Technology and  
 Medicine.  
 Centre for Research on Drugs and Health  
 Behaviour, Imperial College  
 Exhibition Road, London SW7 2AZ  
 Tel: +44 (0)20 7589 5111  
 E-mail: info@ic.ac.uk  
 Website: http://www.ic.ac.uk

Johns Hopkins University,  
 Bloomberg School Public Health  
 Department of Epidemiology,  
 615 N Wolfe Street,  
 Baltimore, MD 21205, USA  
 Email: sstrathd@jhsph.edu  
 Website: www.jhu.edu

*International  
 Contact List*

The Centre  
 for Harm  
 Reduction

## WHO List of Appropriate Publications

*Manual for  
reducing drug  
related harm  
in Asia*

### Recommended Publications

The following publications are accessible through the following WHO website ([www.who.int/hiv](http://www.who.int/hiv)) These are expected online from May 2003. It is recommended to check the web address for any new publications.

Burnet Institute. 2003. Policy and Programming Guide for HIV Prevention Among Injecting Drug Users. Geneva, World Health Organization.

Burrows D. 2003. Advocacy Guide for Effective HIV Prevention among Injecting Drug Users Geneva, World Health Organization.

Burrows D. 2003. Training Guide for HIV Prevention Outreach to Injecting Drug Users. Geneva. World Health Organization.

World Health Organization. 2003. Technical Guide to Rapid Assessment and Response. Geneva. World Health Organization. (Various RAR guides are available refer to: [www.RARarchives.org](http://www.RARarchives.org)).

### Evidence for Action Papers produced by WHO for Policy Makers on HIV/AIDS Prevention among Injecting Drug Users

Topics of papers include the following:

- Nature and extent of HIV/AIDS among IDUs
- Methods for assessing and monitoring HIV risk among IDUs, its health/social/economic impact and effectiveness of interventions
- Effectiveness of HIV information, education and communication interventions for IDUs
- Effectiveness of community-based HIV interventions for IDUs
- Effectiveness of sterile needle and syringe programming (including other injecting paraphernalia)
- Effectiveness of drug dependence treatment in prevention of HIV among IDUs
- Effectiveness of interventions for preventing sexual transmission of HIV among IDUs
- Effectiveness of STI and HIV/AIDS treatment in HIV prevention among IDUs
- Effectiveness of structural and environmental interventions for HIV prevention among IDUs
- Effectiveness of interventions for young and new injectors
- Effectiveness of interventions for marginalized and particularly vulnerable IDUs

**Other useful publications:**

- Burrows D. 2000. *Starting and managing needle and syringe programs: a guide for Central and East Europe and the Newly Independent States of the former Soviet Union*. New York. International Harm Reduction Development. [[www.soros.org/harm-reduction/frame\\_publications.htm](http://www.soros.org/harm-reduction/frame_publications.htm)]
- UNAIDS. 2000. *National AIDS Programmes: A Guide to Monitoring and Evaluation*. Geneva. UNAIDS (refer to: [www.unaids.org](http://www.unaids.org))
- UNAIDS/World Bank. 2002. *National AIDS Councils: Monitoring and Evaluations Operations Manual*. Geneva. UNAIDS (refer to: [www.unaids.org](http://www.unaids.org))
- UNAIDS/WHO. 2000. *Guidelines for Second Generation HIV Surveillance*. Geneva. UNAIDS/WHO (refer to: [www.unaids.org](http://www.unaids.org))

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*WHO List of  
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