

## Part 2: Report of the UNDP Sponsored Panel Session:



### **7. Background to the UNDP-Sponsored Session: *Drug-related HIV Risk, Livelihoods and Communities in Asia***

The UNDP-sponsored session, *Drug-related HIV Risk, Livelihoods and Communities in Asia*, was attended by over 200 conference delegates and featured presentations from 13 panellists from India, Iran, Bangladesh, Indonesia, Myanmar, Thailand and Australia. Along with presentations, the session featured a street play by SAHARA Community Theatre Group and a UNAIDS-Sponsored exhibition by photographer Anita Khemka, poignantly detailing the lives of HIV positive people.

The session highlighted the need for sustained and informed dialogue between all sectors government and civil society in order to development more humane and pragmatic solutions to the twin problems of HIV/AIDS and drug related harm. A key theme was the responsibility of governments and the roles played by policies and legislation, in any country, in influencing both the course of the epidemic and the experience of people living with HIV and AIDS.

Of equal importance, the session indicated the need to build more effective strategic alliances between governments, donor agencies, community based programs, drug users and other key stakeholders in order to develop interventions with the broad-based support needed to tackle the complex problem of illicit drug use and HIV.

Presentations also pointed to the need to continue building our knowledge on ‘what works’ with relation to reducing drug related harm so that we have a much more substantial body of evidence-based approaches on which to model new responses.

Context of the Session: the 12<sup>th</sup> International Conference on the Reduction of Drug Related Harm (12<sup>th</sup> ICRDRH)

The 12<sup>th</sup> International Conference on the Reduction of Drug Related Harm (12<sup>th</sup> ICRDRH) entitled *Community Development for Harm Reduction*, took place in New Delhi India from April 1<sup>st</sup> to 5<sup>th</sup> 2001. Over 850 delegates from 54 countries attended the conference, representing health workers, governments, the media, NGOs, drug treatment

agencies, women's groups and people living with HIV and AIDS. This was also the first time this significant international meeting had been held in Asia.

The local and international Organising Committees of the 12th ICRDRH, led by the International Harm Reduction Association (IHRA) and Delhi based NGO, SHARAN worked hard to facilitate a global conference that was also locally relevant for the vast and diverse Asian region. The result was an impressive forum for a wide range of ideas, voices, discussion, debate, and commitment to change.

Focusing on drug policy, recent research findings and programmatic responses from around the globe, presentations throughout the conference clearly demonstrated that drug use particularly injecting drug use (IDU) has become a major accelerant of HIV worldwide, especially among marginalised communities in developing regions across Asia.

Building on the conference theme *Community Development for Harm Reduction* key themes for the 12<sup>th</sup> ICRDRH included:

- HIV Prevention and Injecting Drug use in the Region
- Strategic Advocacy and Partnerships
- Learning from Harm Reduction Experiences
- Health Enhancing Drug Policy
- Community Development
- Changing the Risk Environment
- Working with law Enforcement
- Harm Reduction for Legal Drugs
- Redefining Harm Reduction Treatment.

The conference opened with voices of Indian people currently using drugs and at risk of HIV, highlighting the importance of inclusion of current and ex-drug users as important stakeholders in the challenge to reduce drug related harm. Another theme constant throughout the conference was the need to make health care, welfare, family support, employment and drug treatment services more accessible to drug users and to increase coverage of these services to meet the rapidly expanding global spread of HIV through drug injecting and needle sharing.

The pressing need for greater political commitment, for a multi-sectoral response from local communities and international agencies, and for immediate action was the clear message running throughout the conference. Representatives from governments, the UN system, civil society and the pharmaceutical industry all spoke at the conference on the need turn rhetoric and research into large-scale and rapid responses aimed at stemming the rising tide of HIV epidemics caused by unrealistic drug policies and programs.

These themes were expanded throughout the conference in which some of the worlds' leading researchers program managers and activists discussed latest findings and issues relating to the reduction of drug related harm. In addition to the plenary and major session other activities of the conference included skills sharing and problem solving

workshops to help the transfer of skills and practical solutions to common problems. Narrative and personal experience sessions to enable participants to give accounts of their experiences in a narrative or storytelling format.

The UNDP sponsored session was a specially organised evening session to provide a forum specifically focussing on the linkages between drug use, HIV/AIDS and development issues in Asia.

#### Presentations from the Panel

#### ***8. Key points from Welcome Address:***

#### **Sonam Yangchen Rana, Programme Co-ordinator UNDP HIV & Development Project for South and Southwest Asia**

Though we know it is true that neither HIV/AIDS nor drug use is limited to any one section of society, we also know that the vulnerability of people is strongly linked to the socio-economic conditions which determine the amount of control they have over their lives. People who are marginalised, treated as outcasts, denied basic rights and struggling to survive are particularly vulnerable, including vulnerable to drug related harm and to HIV/AIDSs.

There is a particularly strong link between this vulnerability and the lack of sustainable income opportunities. When people cannot find regular work, cannot provide basic needs for their families, or are forced by lack of alternatives into the types of work known as 3D – dirty, demeaning and dangerous - the risk of HIV infection can be perceived by them as a low priority when compared with more immediate threats to individual or family survival, if indeed, they know of the risk at all.

For those who leave their homes in search of work or improving their circumstances, there are many factors which can lead them, especially young people, to behave in ways that they might not do at home, including sexual relations and drug taking behaviour which can make them susceptible to exposure to HIV.

Some of these factors include:

- being away from family, home community and socio-cultural norms, which influence behaviour and provide a sense of belonging;
- separation from the husband or wife, maybe for long periods of time;
- discrimination, isolation and loneliness;
- poor living and working conditions and lack of health facilities;
- uncertainty about their employment or even their legal status.

Displacement and uprootedness have been noted to place migrants at higher risk of drug use, and figures from treatment centres reflect this, with high numbers of migrants among people being treated.

Increasing the importance placed by society on the safety and welfare of people, including poor people and migrants, will, in turn, enable them to pay more attention to

the risks involved in their behavioural choices. Field experience and research over the last ten years has shown that people, including drug users, do act to reduce the spread of HIV when they have the knowledge, motivation and means to do so, and a supportive environment.

To create this environment it is essential to involve communities in the responses. The purpose of this session is to share experiences from around Asia of working with communities, and some of the lessons learned from research and field experience about the links between drug related harm and socio-economic factors.

-----

### **9. Opening Remarks:**

**Anand Bordia, Community Wide Drug Demand Reduction in India, UNDCP, New Delhi**

This session on “*Drug related HIV risk, livelihood and communities in Asia*” is directly relevant to the theme of the 12<sup>th</sup> International Conference- “Community Development for Harm Reduction”. UNDP has brought together practitioners with field experiences illustrating the nature of the problem and community responses, and researchers whose data and analysis throw light on these linkages.

Three issues are central when discussing community involvement in responses to HIV and drug use. Firstly, community participation is crucial to reducing drug related HIV risk. For the success of a range of social, health, education and environment programmes it is necessary that community understands them, owns them and becomes a major implementation partner.

Secondly, collective community responses tend to be conservative. This is especially pronounced in developing Asian countries. Without analysing the causes for the underlying conservatism, it is necessary to emphasise that, both in the field of drug abuse and HIV/AIDS, prolonged “denial” inhibits the understanding and delays implementation of drug demand reduction and HIV/AIDS prevention activities.

Thirdly, South and Southeast Asian countries have pockets of tribal societies. These communities witness high levels of addiction when undergoing rapid changes during the so-called ‘development’ and ‘growth’ compressed in a short span of time. At the same time, these societies have strong social and cultural ties and a value system based on family structure. Thus the harm reduction programmes should draw upon their strong, vibrant and active community based organisations.

The whole nature of drug use harm and strategies to reduce such harm have drastically changed in the post-HIV era. We have had drug use and abuse for many decades, and in some countries for perhaps many centuries, but the whole scenario has drastically changed post HIV.

So we can say that drug use harm pre-HIV and that drug use harm post-HIV are two drastically different situations. Drug use harm responses have to alter drastically in the post-HIV era so that massive and very damaging harm causing HIV infection is reduced. These responses will need to integrate HIV/AIDS and drug abuse into other social sectors, health and education related activities and use participatory approaches.

-----

### **10. The Reduction of Drug Related Harm Field Experience in Mizoram, India:**

**Dr. J.C. Chhuanliana, Community Health Action Network, CHAN.**

The practice of injecting drug use was initially introduced to Mizoram by a small number of ethnic Mizos living in (Burma) Myanmar and neighbouring state of Manipur in the late seventies and early eighties, and also by students who have gone to big cities in different parts of the country. In the beginning, only high income groups were affected but young people from middle and lower income groups also took to the habit partly due to glamorisation of drug culture, peer group pressure, and for many with uncertain future as an escape from reality. The practice of injecting drug use used to be more or less confined to the city of Aizawl in the beginning but has been rapidly spreading to sub towns and small villages and at present, every corner of the state appears to be affected. The problem is also equally affecting all social and economic strata of Mizo society despite the efforts of GOs and NGOs to curb the problem.

The state government's crack down on heroin trade in the late eighties inflated the street price of heroin beyond the reach of most drug users and the supply was scarce. In their search to find substitution for heroin, addicts at Aizawl experimented with intravenous injection of Proxyvon. The effect, when injected intravenously is quite different from that of oral administration but the pleasurable effect does not last long (15-30 mins). For about 90-95 percent of IDUs in Aizawl, the main drug of abuse is Proxyvon, a combination of dextropropoxyphene and paracetamol (or similar combinations of other brand names).

Average frequency of injection by an individual is 6-10 times per day depending on availability and affordability of the drug. This need for several injections per day make it difficult for IDUs to use clean and sterile instruments every time, and sharing of instruments is very common. They are at very high risk of contracting HIV infection and IDUs constitute 86.6 % in 91, 66% in 95, 44% in 97 and 47% in 2000 of all HIV positive cases in Mizoram. Other common drug related harms are- widespread damage to venous system, soft tissue infection, systemic infection, abscess neurological damages and paralysis, major venous rupture and fatal haemorrhages etc. with high morbidity and mortality.

*Economically backward, low per capita income, rising problem of unemployment, no infrastructure for development, almost non-existent recreational facilities for young people, very uncertain future. This is one picture of Mizoram after years of the*

insurgency problem hindering development works in the state. On the other hand it has a very high literacy percentage, free society and strong community structure. The youths are exposed to modern day technology, making them see what other people in other countries are having. A very wide contrast between their dream world and reality, and uncertainty of the future make them vulnerable to be drawn into drug use and its related harm. The only resource at hand to address to the problem is the strength of the community which needs to be sensitised and mobilised so as to develop its capacity to cope with the problem and respond accordingly.

### Activities of CHAN

(i) A special clinic cum day care centre for treating drug related complications is run by CHAN where facilities for medical care, needle and syringe exchange, free condoms, counselling and voluntary HIV testing are provided.

(ii) Clients are also followed into their homes by counsellors and after-care workers where family members are counselled and educated in basic health care for IDUs. Home-based detoxification is also provided where there is strong family support and co-operation.

(iii) Systematic house to house visits are also done to sensitise and educate the community about drug abuse and HIV/AIDS, sometime targeting community leaders to mobilise community response. Rumours spread fast and whatever information people first acquired, whether right or wrong is very difficult to dislodge and change. This is complicated by the invisible epidemic of HIV/AIDS and accompanying myths and stigma. The most important thing to mobilise community efforts for effective responses to the HIV/AIDS and drugs problem is providing the right information about them. Our experience shows that the most effective way to achieve this is by being with the people and clarifying every misconception they have through person to person interaction. It is also noted that for this kind of work people with practical experience in providing care to affected groups are better accepted and trusted. When people have acquired right information they usually respond to the problem affecting their community in a more meaningful way.

(iv) Church groups and other organisations are also given training and as a result several support groups have been formed in different localities.

(v) School children are also educated about the harmful effects of drug use with the help of slide and video shows. These groups are considered very vulnerable as a 1997 study of IDUs in Aizawl indicate that about 70 percent of them were introduced to drug use in the age group of 13-17 years.

Integrated efforts to address the needs of a particular community with the activities mentioned above could lead to interesting development of community capacity to cope with the problem and to respond effectively, such as in this example.

A person known to be HIV positive died, and the family of the deceased also did not deny the fact. The body was wrapped in a polythene sheet and was immediately buried, and all the clothes and bedding of the person were burnt. They also treated dead bodies of IDUs in the same way irrespective of their HIV status. After house to house visits, and a strong church based support group was born in the locality, the community leaders sat together and decided not to discriminate against any person just because they are IDUs. They agreed to treat all dead bodies in the same way.

Community leaders who have been trained and support group members are instrumental in influencing their own community decisions. In other localities also, when communities are sensitised by their own members to identify their concerns and address their needs, interesting developments happened.

Our experience has shown us that care is the key to providing entry points into the drug-user community as well as into the general community for the development of effective preventive measures.

-----

## **11. An outline on livelihoods, community and HIV risk**

Dr. Mohammad Shamsuddin, Lifesaving and Life-giving Society (LALS) Kathmandu, Nepal

Asia is being engulfed by an epidemic of HIV infection. In many Asian countries, including Nepal, HIV infection among injecting drug users is alarmingly increasing and it is further victimising their sexual partners and people in general with indications of an uncontrolled situation.

In the Nepalese context drug addiction is not a new phenomenon. However, it is usually looked down upon as a deviant behaviour. Injecting drug use, in particular, is regarded in even more negative terms. Injecting Drug Users (IDUs) are widely discriminated against and stigmatised by the society in number of ways. They are even treated as an unsociable element of society and restricted in getting employment even when they are able and can perform as good work as other people. Most of the IDUs in Nepal are male (90%) having sole responsibility to look after the family for financial requirements. On the one hand they are using illicit drugs and on the other hand they are jobless. This situation has left many IDUs under risk of HIV transmission as well as contributing to affecting their family life and relationships in the long run. It is seen that once the family life is destroyed it has a direct impact on the society/community, which ultimately affects the environment of developmental opportunities.

Also due to unco-operative and non-supportive attitudes of the community people towards injecting drug users it is difficult for IDUs to practise safer behaviour. The family always stands against what injecting drug users want to do for their protection and safety, through lack of understanding.

First of all, to avoid this situation, it is necessary to sensitise the communities and then the families of the IDUs. Community mobilisation in this particular regard is important to

promote increased involvement and participation of different people within the community to make decisions that will impact on themselves and their involvement. This can again prepare ground for other community people to join hands and move ahead collectively and with unity. It is also a key element of expanding the response to HIV/AIDS where greater emphasis is placed on understanding the societal and individual factors influencing the epidemic, and the development of an enhanced response through the mobilisation of human, material and financial resources. Expanding the response calls for social change as a more effective way of reducing risk and vulnerability to HIV.



To intensify HIV/AIDS preventive efforts among IDUs, advocacy with local-based clubs, committees and local government, such as municipal ward offices and local police stations, can prepare a suitable and supportive environment for effective delivery of this type of program. This also helps in generating their long term support and co-operation with additional possibility for sustainability. Since HIV and drugs has a direct effect on the family, there some mechanism should be developed so that the family can more easily handle HIV positive people or drug addicts. In this context, family counselling is very essential to maintain good relationships among them. Through family counselling the IDUs start getting accepted by their families and spouse in a more open manner and this can help them change their behaviour either by switching off drugs totally or by starting to practise safer behaviour to avoid HIV/AIDS and other diseases.

Each community is believed to be rich within itself in regard to local resources. The already existing resources within the community can be utilised to design and develop programmes suitable to IDUs and HIV. The community resources like skills, knowledge and information when used for their communities can provide a relevant and effective response. In this connection, if we organise a small group discussion or interaction among local women, it will create a positive environment to openly discuss issues related to HIV/AIDS and drug abuse even in restricted circumstances. Once the women are sensitised it is easier to receive support from other people as well.

As far as socio-economic conditions are concerned, there is a direct influence on the development of the children of the users. Because of financial constraints the fathers are unable to pay for education of the children. So the learning opportunity and capability of the children cannot be that much be developed and national productivity in terms of qualified human resources declines.

Due to increasing unemployment amongst injecting drug users and ex-users cases of thefts and robberies have been part of their daily life. It further creates an insecure

neighbourhood, for them and the surrounding inhabitants. The IDUs most of the time are living on the street, they are less concerned with health and hygienic life style which makes them more vulnerable for common and infectious diseases such as abscesses, fever, diarrhoea and burns etc. They don't get any medical treatment from the governmental run hospitals and there is a high discrimination rate in private clinics.

Even after users are successful in stopping their drug abuse after detoxification and treatment in a rehabilitation centre, most of them don't have chances to start working. If they are able to find a job, most of the time they are widely discriminated against because of their background. This has led many ex-users to relapse in their drug abuse habits.

Rapid spread of HIV among injecting drug users in Nepal is alarming and it has become one of the contributing factors in spreading HIV to the general population. As seen in some parts of the country women who are not drug users and have only one sexual partner are getting infected with HIV/AIDS through the sexual mode of transmission. They are dispelled from their jobs due to being infected with HIV. There is no security or medical treatment for those who are infected with HIV. Only a few organisations are raising their voices for that.

As per a recent study carried out by UNAIDS in Nepal around 34,000 people are living with HIV/AIDS and it is on the rise. The report further estimates that among the adolescent population (15-19 years) the prevalence rate is 0.29 percent. The adult population infected with HIV/AIDS is estimated to be around 33,000 out of which 10,000 are women. This is an alarming indication as well as a threat to developmental work. Therefore, the involvement of the private sector in the mainstream of HIV/AIDS prevention and control programmes could be meaningful. Similarly, as per our experience, collaboration of this type of programme with local government, such as municipal corporations and other developmental organisations may bring about the situation of positive change with significant outcomes.

To respond to the issues on livelihoods, community and HIV risk, LALS has a programme to attain the harm reduction or health maintenance philosophy and the strategy for service delivery to the clients is primarily "street based outreach". LALS has established working policies as guide lines while working with its clients. The key words are *confidential, non-judgmental, non-coercive and anonymous*.

LALS key programme intervention strategies are:

- Enhancing collaboration between agencies and departments;
- Enhancing programme effectiveness and sustainability through peer education;
- Promoting availability of new injecting equipment to IDUs through medical shops without discrimination;
- Creating an enabling environment for the operation of harm reduction programmes through networking with ward representatives and local police personnel.

- Establishing mechanism for referral of sexually transmitted diseases (STDs) and other ailments for treatment through mobilising ward clinics.



*Income generating units run by LALS*

---

## **12. Injecting Drug Use Prevention Education in Kachin State, Myanmar:**

**Ms. I.V. Domingo, World Concern, Myanmar**

The Injecting Drug Use Prevention Education Project was approved by UNDCP in January 1998, and subsequently endorsed by the Central Committee for Drug Abuse Control (CCDAC) in October of the same year. There were two components of the project: the Participatory Learning Approach (PLA), and the Stepping Stones (SS). The PLA was employed with drug using clients in three urban sites while the Stepping Stones was used with whole communities in rural villages. The project, in its final implementation, aimed to:

- **Reduce drug use (i.e., drug demand reduction)**
- **Reduce drug-related harm**
- **Reduce HIV transmission**

### *Evolution of project methodology*

The project was initially conceived as having mass media-based approaches as its core method of implementation. However, this was changed to a participatory approach which had a more limited reach compared to mass media-based programmes, but was expected to enhance individual learning, leading to attitude and behaviour changes.

The staff worked intensively with small groups of individuals using the Participatory Learning and Action (PLA) methodology. Six (6) core PLA tools were used with the clients to enable personal analysis of their life situations and assist them in developing solutions to their problems. These tools assisted the clients in better understanding the effects and outcomes of drug use, and in developing personal strategies to reduce or eliminate drug use and to minimise drug-related harm to themselves, their families, and their communities. Each meeting with 'clients' took from 1.5- 3 hours and was done over

a period of several weeks. The activity culminated in action planning that detailed positive changes in behaviour that the clients intended to undertake.



A mid-term project review by external consultants recommended that an equal emphasis should also be placed on drug use prevention and on developing an enabling environment. A new participatory component to work with rural communities, referred to as Stepping Stones was initiated in November 1999. The methodology was adapted from the training package of the same name developed by ACTIONAID in Africa. The original package was modified to reflect the emphasis of injecting drug use as a major route to HIV spread in addition to sexual transmission - a prevalent problem in Kachin State.

Stepping Stones was designed to bring together the whole community to address relevant issues. The villagers were split into four peer groups (old men, old women, young men, and young women) for discussions about issues that confront them-- as a group and as a community. Working separately with peer groups encouraged participants to talk openly about issues they would not otherwise feel comfortable doing in groups of mixed gender and age. Over a period of 3-4 weeks, the peer groups engaged in sessions consisting of 12 units dealing with communication, co-operation, participatory problem solving and similar topics especially within the context of HIV/AIDS and IDU prevention.

### **PLA Component**

**While the 173 IDUs reached by the project seems to be a small figure, this group is notoriously difficult to reach, and even more difficult to engage actively in program participation. It is also important to acknowledge that people who currently smoke, sniff or otherwise eat raw opium, including those who use amphetamines and “yama”, are highly likely to be potential injectors in the future.**

The project has likewise achieved considerable success in engaging women as participants (25%). Many of these women were sex workers (and at the same time drug users), and who were even more difficult to engage.

The rate of completion of the entire course of the PLA process indicates that they have found the whole exercise relevant and useful, and therefore had high levels of motivation to participate and complete the whole process.

- Some participants reported that they have stopped or reduced their drug use.
- Some participants began to make changes that will reduce HIV transmission. This has a direct impact on reducing further HIV transmission among IDUs to their injecting and sexual partners.
- Some women reported having given up sex work, thereby further reducing the chance of being infected or otherwise infecting others.
- Some participants gone back to their own families and communities.
- Some have begun to continue pursuing studies, or have begun to actively engage in work again. This most often includes family related work such as farming or gardening. It sometimes includes mining for jade or gold.
- Some clients have not only stopped using drugs themselves, but they have also encouraged others to join the PLA sessions or helped others to stop.

### Immediate impacts on communities

There appeared to have been significant impact on making improvements to the “enabling environment”. The project helped to bring this about in the sense that many people in the community now understand the existence and value of PLA work, and are thus more likely to be supportive through helping drug users to find out about the project, participate in the PLA exercises, and talk with others about what they learn. The enabling environment is also improved as a result of people understanding the usefulness of working with drug users in a non-judgmental way.

- Gatekeepers' changes. In Hopin, some communities initially believed it was not possible to assist drug users. After 6 months of project implementation however, they have seen that some change is possible and they then became more supportive to the project.
- The community also understood the usefulness of working with drug users in a non-judgmental way. One project staff noted, for example, that:

*“Most of the drug users are intelligent people. They don’t want to be told to do this, to not do that... They do not want a didactic way of doing it. If we approached the community first, a didactic response would result. This would be very different from the approach which starts with promoting self-reflection among drug users.”*

### Limitations and Challenges

Although it appears that the PLA method has been successful in facilitating a desire for change by the clients who attended the sessions, it was unlikely that they can give up, or perhaps even reduce, their drug use simply through the process of self-reflection and raising of awareness. Experience throughout the world indicates that complete detoxification and cessation of drug use is almost impossible, even in supportive environments with access to helpful medications.

However, some of the clients attended the PLA groups with friends who were also drug users, or were introduced to the staff by their ex- drug using friends and this might help create a supportive enabling environment. Others were brought to the groups by their parents, and this would also tend to indicate that family support is possible.

The training in PLA did not prepare the staff to be able to give practical advice or other assistance about management of drug use and its related problems. Once the drug users decide to stop or reduce their drug use, they are often not able to receive ongoing support for this.

### Stepping Stones

Stepping Stones proved to be an effective method of providing accurate information about drug use and HIV to the programme participants. This was consistent with many alternative approaches to provision of information, with no particular programming approach being markedly different to others. However, there did appear to be a very important difference in the way the participants had received the information. Many of them reported that “others” had been to their villages to teach them about drugs and HIV, but it was with this project that they had “really understood” the information for the first time. Evidence that there was a deep understanding of relevant issues was provided in response to one of the evaluators’ question of “What is HIV?”. In the village where this was asked, the participants staged an impromptu role play about HIV; this indicated more than just a simple knowledge-based understanding, as they demonstrated how HIV is directly relevant to their own lives, their own village.

### Impact on attitude change

Stepping Stones led to important changes in people’s attitudes toward people who used drugs and people living with HIV. This might have also been brought about by their viewing and discussing of two video documentaries about PLWHAs from Laos and Vietnam that were translated and dubbed by the project into the local language.

Positive, affirming attitudes can make it easier for communities to recognise existing problems and find solutions to them. The evaluators deliberately asked different questions in each village about these attitudes, as they attempted to ensure that they did not just receive packaged responses designed to impress. In all cases, the participants responded with positive attitudes toward drug users and people with HIV.

### *Other impacts*

- Generation of “deep understanding” which goes beyond just learning a set of information
- Skills building in relevant areas which include: reflection, sharing (of ideas, perceptions, understandings), discussion and other means of communication
- Ability to mutually challenge each other in a constructive way
- Ability to identify problems and start to find solutions

- Understanding of how drugs and HIV are related to other concerns
- Community recognition of the limitations of “usual” approaches to solving the problems of drug use and HIV

### Limitations and Challenges

In contexts where it is difficult for people who inject drugs (or people living with HIV) to participate in group or community discussions, the impact of those discussions is limited; there was a noticeable absence of voices of drug users or HIV+ people in the evaluation discussions. Some of the participants might have already been infected but not know their HIV antibody status, as opportunities for voluntary testing are extremely limited. Open discussion about drug use is difficult because of the illegal nature of drug use and the stigma attached to it.

Another limitation is that SS emphasised the identification and discussion of problems. Although problem identification is the first stage to solving them, most of them are cannot be solved once identified. This was not so much a problem of the project itself, as it is a problem arising from the broader context. Some of those problems include: rural poverty, mobility, lack or absence of support for people to reduce or eliminate drug use, and support for people with HIV.

*Acknowledgement: The section on “Evaluation Finding” borrowed liberally from the project terminal evaluation report written by Bruce Parnell and Dr. B. Langkham.*

### **13. A Drug Dependence Treatment Centre’s Response to the HIV Epidemic in Northern Thailand:**

#### **Dr Jaroon Jittiwutikarn**

The HIV epidemic in Thailand has reportedly been “under control” in recent years after effective prevention programmes were vigorously implemented by the government and communities. However, HIV prevalence and incidence among drug users in Thailand are still very high.

This presentation describes the response of the Northern Drug Dependence Centre (NDTC) to this challenging HIV epidemic among drug users in northern Thailand. The NDTC is one of the six drug dependence treatment centres of the Thailand Ministry of Public Health. Located in Chiang Mai Province, it provides:

- 21-day drug dependence treatment to drug users in the 17 northern provinces of Thailand
- 3,000 in-patient admissions and about 6,000 out-patient services per year
- Collaboration with other governmental organisations (GO) and non-governmental organisations (NGO) in:
  - Treatment and referral services

- Prevention services
- Inclusion of HIV prevention in drug addiction counselling
- Community outreach activities

The program has observed alarmingly high HIV prevalence among in-patient drug users through unlinked anonymous HIV screening:

- 1996        17.9% (IDU: 29.7%; Non-IDU: 8.1%)
- 1997        18.0% (IDU: 42.2%; Non-IDU: 6.4%)

Basic knowledge on HIV was provided to the staff who became quite concerned about the high HIV prevalence among the patients at NDTC. Universal precautions have been strictly reinforced to prevent any transmission of HIV at NDTC as well as to assure safety for both the staff and the patients. Selected staff were provided basic courses on management of HIV-infected patients, referral services and other supportive services in the area. Unlinked HIV-screening system was initiated to monitor the trend of HIV at NDTC without any personal identifiers (before the HIV counselling courses were provided to the staff in 1998)

The project featured collaboration with GOs and NGOs including: Office of the Communicable Disease Control Region-10, provincial and district hospitals and health centres, national and local law enforcement agencies, and the Office of Narcotic Control Board (ONCB) on raising the issues of the importance of HIV prevention and control among drug users. Other important stakeholders included hilltribe and Thai NGOs on drug abuse and HIV prevention by reaching out to the communities and setting up training and workshops, the Royal Project and the Office of Water Management in contacting and providing transportation to hilltribe drug users who would like to come to NDTC for treatment.

Basic information on HIV transmission and prevention was included in counselling sessions on drug dependence treatment, reaching out to hilltribe drug users and providing drug dependence treatment, counselling on drug use and HIV prevention in their own languages by their native speakers. Billboards and posters with regards to HIV transmission and prevention have been posted at NDTC including the wards and out-patient areas. Distribution of condoms to the patients after their discharge from NDTC as well as HIV prevention strategies to the patients and their partners also occurred. Finally, voluntary confidential HIV pre- and post-test counselling has been provided since February 1999 as a part of a collaborative research project on HIV infection among drug users in northern Thailand.

Research was also in collaboration with Research Institute for Health Sciences, Chiang Mai University, and the Johns Hopkins University, U.S.A. Key research topics included: HIV epidemiology among drug users, behavioural risk factors, sexual and drug use practices, knowledge on HIV transmission and prevention, HIV subtypes among HIV-infected drug users, Hepatitis and STD among drug users, social network of drug users and the impact of HIV testing and counselling on behavioural change among drug users.

Other services have included pre- and post-test counselling. All outpatients and inpatients have been provided basic knowledge on HIV prevention since 1999. Nurses from Chiang Mai Juvenile Detention Centre and other agencies have been invited to HIV prevention counselling training sessions at NDTC. Information on treatment, referral and social services have been provided to everyone who might have been infected or affected by the HIV epidemic. Appropriate referral services have been provided to HIV+ patients and their families as requested. Finally, confidentiality of HIV statuses of the patients have been strictly enforced

In all, 30,000 people have been provided information on drug use prevention, treatment, rehabilitation, relapse prevention and HIV prevention annually by the NDTC staff. 8,000 visitors come to NDTC annually from local schools, communities, government agencies, NGO and international agencies. Frequent radio programs have also been provided by NDTC on drug use and HIV prevention in northern Thailand along with Community outreach visits to schools and villages including hilltribe communities.

### Discussion

A comprehensive approach to drug dependence treatment and HIV prevention is urgently needed in northern Thailand where both drug use and HIV prevalence are high. Capacity building for staff on basic HIV knowledge and HIV prevention counselling is essential in HIV prevention programs. Unwavering support, guidance and participation from the government and communities are crucial in planning, implementing and improving HIV prevention programs for drug users. National and international collaboration in conducting research projects to improve the knowledge of transmission and prevention strategies will be important in developing effective and sustainable HIV prevention and control programmes.

### *Acknowledgements*

- *Napa Rungiwaroj, Areerat Chatwuthanon, Supanee Intarat, Saran Keeratiphongsathorn, Bungorn Supreeda, Therawat Wongton, Myat Htoo Razak, Chawalit Natpratana, Vinai Suriyanon*
- *Communicable Disease Control Region 10, Thailand, Northern Drug Dependence Treatment Center, Ministry of Public Health, Thailand, Research Institute for Health Sciences, Chiang Mai University, Thailand, Johns Hopkins University, Research staff from Opiate User Research (OUR) Project and U.S. National Institute on Drug Abuse (NIDA) and National Institutes of Health (NIH).*

---

### **14. Voice of an ex-IDU:**

**Deepak Kumar, Manipur Network of People Living with HIV/AIDS**

I am an ex-injecting drug user, living with HIV since 1996. The Manipur network of PLWAH started out with five members who were ex-IDUs and had contracted HIV through needle and syringe sharing. If the Harm Minimisation programme like NSEP had come much earlier, I would not be an HIV positive person today.

The immediate concern is the need for a more effective participation by the community. It is through the involvement of the community that HIV transmission rate among IDUs has come down from 75% to 54% in Manipur, since 1993. There are a lot of attitudinal changes taking place among the community vis-à-vis HIV and IDUs and there is a need to capitalise on these changes. Attitudinal change alone cannot bring down HIV transmission; scaling up of harm-reduction areas from urban to rural areas is urgently required.

A holistic package, or programme, which includes NSEP, condom promotion, care and support for PLWHA, accompanied by sensitisation, advocacy and economic support for the target audience is the need of the hour. Above all, the most important need is for regular follow up and re-planning of needs based programmes.

## **15. SAHARA Community Theatre Group**

*The panel session was enlivened by a street play performed by SAHARA Community Theatre Group. SAHARA House is a Delhi based community care and support home involved in drug abuse prevention and AIDS awareness. Very simply performed but very effective in its message, the play was performed in Hindi and also used mime to illustrate some of the issues and dilemmas facing young people who come to cities seeking work and opportunity, but instead find unemployment, isolation and AIDS. The following is a brief explanation of the play given by the performers.*

“One of our objectives is to create awareness in the community on HIV/AIDS and drugs. For this we have our awareness team which consists mostly of addicts and people living with HIV/AIDS. The objective is to sensitise the community on HIV and drugs through street plays. Now we are going to perform one of such skits that we take into communities:

This play is street theatre from a master to a pupil or protégé. That is how it is going to be narrated. It will be in street theatre style because we know that AIDS is a very grim situation. We want to give awareness on this grim topic in a not so grim fashion. Secondly, we know that a lot of material and knowledge on AIDS is written and quite a lot of people in our society do not have access to the written work. Even if they do have access they cannot understand. So by this medium we are able to give them the information.



So this play is about a boy called Raju who is stepping into adulthood from adolescence and he wants to improve his chances in the world. He goes to his father and says ‘I want to go to the city to study and get a job.’ So our man Raju goes to town and he gets into the colourful city life. Things do not turn out as easy as he expected and he gets frustrated and lonely. He gets involved with a woman who introduces him to drug use, and there he somehow gets the HIV infection.

This play then shows that when he comes back home he has been diagnosed as HIV positive and the reaction from the family of fear of ostracism. Then the myths are exposed that this is not a disease spread by touch. How it is spread and the various myths are dispelled. Finally it shows how Raju copes with his situation when he realises that he has this. In brief, he says he copes with prompt and adequate medication, balanced diet, light exercise, adequate rest, yoga and tension free life, hope and faith. Last, but not the least, hope and faith of good things to happen and abstinence from further high risk behaviour.”

## **16. Indonesia’s coping with the “new” epidemic – Too much to handle?**

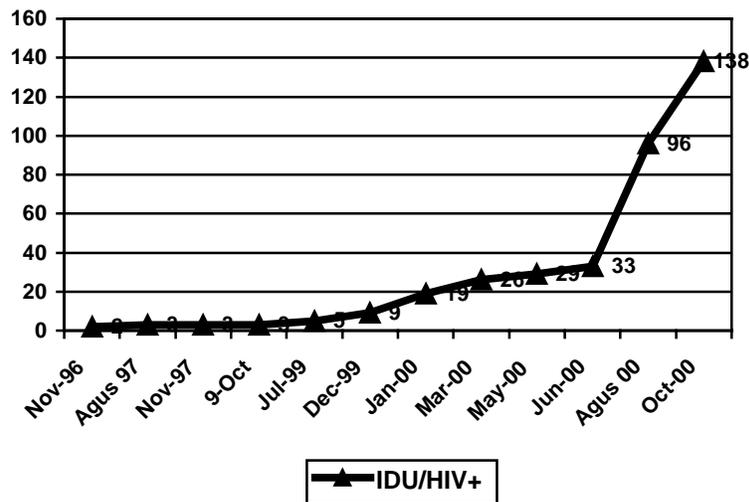
**by Dr Irwanto, Centre for Societal Development Studies, Atma Jaya Catholic University, Indonesia**

Since the first AIDS case reported in 1987, cumulated number of cases had increased to 1,880 cases (1391 males and 489 females; 1273 HIV, 489 AIDS, and 189 unknown) in 31st March 2001. After a long and tiring debate, a national strategy was formulated in 1995. Preventing HIV/AIDS, however, was and is still low in the national public health policy priority competing with ARI, parasitic diseases, maternal mortality, etc. While the number of reported cases continue to increase, in the closing of the millennium we observe a rapid increase in the incidence of HIV+ due to injecting drug use.

Drug use has been a hidden epidemic in Indonesia for some time. In 1987 the number of active drug users was estimated at 750,000 people. Taking the current situation into account, the police estimated that there are at least 3 million active drug users in the country and approximately 20-30% or 600,000 to 900,000 are IVDUs. A sero surveillance conducted by the Ministry of Health in the Drug Dependence Hospital in Indonesia in the year 2000 suggests that the incidence rate of HIV infection among injecting drug users may be 15-20% and over 60% of Hepatitis C, enough to start a new wave of epidemic both HIV, Hepatitis C and other blood borne diseases. More importantly, Indonesia may move from a considered low or concentrated epidemic to a generalised epidemic of HIV infection.

Drug use is reaching 1-2% of population and but there a lot of confusion on how to respond. There is not much knowledge available on IDU and HIV for the public and policy makers. The problem of HIV transmission among IDUs has only recently been recognised by policy makers and there is strong resistance from the public and policy makers towards harm reduction programs.

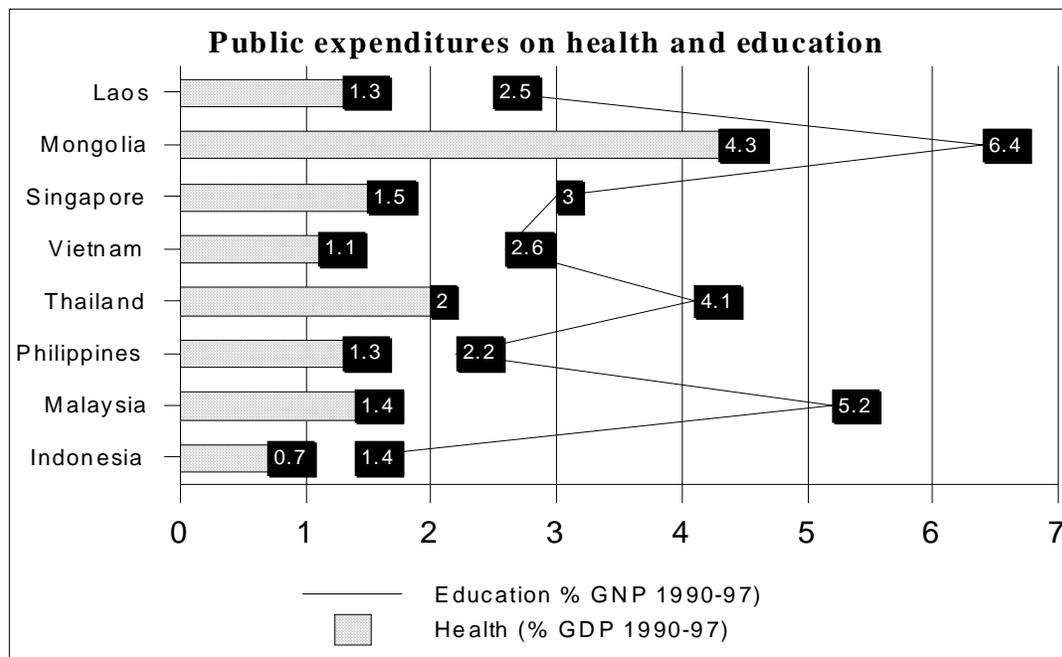
**Cummulative number of reported IDU related HIV+ (1996-2000)**



**Is Indonesia able to cope with the problem?**

On the strengths side there is serious concern from the community and local leaders followed by higher degree of participation. Strong religious institutions, once convinced, become a very effective medium for community mobilisation. Indonesia also has a number of research institutions having the capacity to provide technical assistance and a considerable number of NGOs keenly working on HIV/AIDS prevention and care and support provision

On the other hand, weaknesses include an overall lack of HIV/AIDS prevention and early intervention programmes, dependence on donors, lack of social integration programmes for youth (parenting, reproductive health, career development, life-skill education, drug education etc), poverty – especially in the urban areas, poor legal culture with available legal provisions but poor enforcement, lack of policy and programme co-ordination and low human capital investment (the total human capital investment during 1996-1997/8 was 6.15% of GDP in comparison to 20.70% investment in physical capital.)



But there are also significant opportunities such as: the low prevalence of HIV/AIDS, increased autonomy at regional level with some regions able to mobilise local resources (including political support); increased community participation borne out of frustration over poor legal enforcement and government limitations to respond to the problem; untapped private sector potentials. IDU is now a global issue with international pressures hopefully leading to better responses. But we need to begin by contributing to IDUs knowledge and skills and systematic data need to be collected

Threats include: the growing population of injecting drug users; the unstable political environment – power politics without a sense of crisis and wide spread corruption; international migration of undocumented workers, 2-3 million workers, mostly women, and trafficking; unprepared social development workers especially when dealing with stigmatised problems like HIV/AIDS and Drug Use; social isolation and mob justice which does not help the general public to learn to develop and implement constructive responses.

In concluding, there are many immediate necessary actions to consider . The most pressing needs include:

- Collecting more epidemiological data at least every other year for 5 years;
- Acknowledging the problem and developing necessary policy instruments – including to review and improve the law and its enforcement, and discussion of possible areas for decriminalisation;
- Strengthening existing community participation; some projects do demonstrate that the community is able to solve some of it's own problems;
- Improving the quality of basic education;

- Piloting and testing harm reduction programmes and training of care and support professionals.

### **17. Comparison Study on Socio-economic Factors in Iranian Injecting Drug Users (IDUs):**

**Dr. Emran M. Razzaghi, Deputy for Prevention, Iranian Welfare Organisation**

Injecting drug use is rising in Iran. The negative consequences of this change will not only affect the IDUs themselves, but will also be a danger to the health of the society as a whole. Overall, drug demand reduction is a young strategy in Iran but harm reduction programs are about to start in the near future.

The information presented here is based on Rapid Situation Analysis (RSA) of Drug Use in Iran held in 1998. The RSA covered all parts of the country and looked at three different groups of drug users (i.e. street drug users, imprisoned drug users, and drug users seeking treatment). 1,472 drug users were reached in that study, thus the RSA is highly believed to show the profile of drug use in Iran.

IDUs in Iran seem not to be as young as reported in other countries. The mean age for starting drug use reported by IDUs was 19.6 years. Also, there is a seven year lag between initiation of drug use and becoming IDU.

According to the study some of the factors that leads to drug use are- history of drug use in family, family conflict, pleasure seeking, peer pressure, failure in exams, availability of drugs, failure in love affair, lack of family control, emotional lack, unemployment and relief from somatic pains. The most significant factor is the history of drug use in family, 49.5% in case of IDUs and 44.35% in case of non- IDUs.

The data does not show that IDUs are receiving financial support from their families. Accordingly, two assumptions may be developed:

- i. Families might halt financial support of their IDU members; and
- ii. Families might not be able to bear the high expenses of IDU.

Regarding income, IDUs earn money through illegal activities four times more than non-IDUs. Unemployment is twice seen in IDUs, compared to non-users. Drug users spend all their earning on drugs and are vulnerable to any further financial pressure, and are thus at high-risk for crime. They have no resources available for basic minimum needs (BMN), and thus are at high-risk through not fulfilling these needs.

Although there has been no specific AIDS awareness programme for IDUs in Iran, 53.7% of IDUs are aware about HIV/AIDS. However this awareness has not resulted in behaviour change; 52.8% of IDUs who report being aware still report sharing needles.

### **18. HIV and Drug Use: A New Development Crisis:**

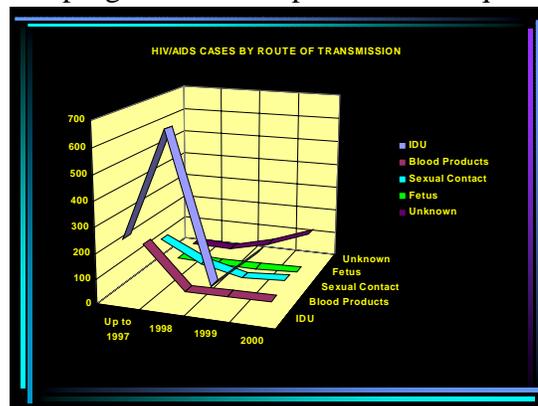
**Mr Paul Deany, The Centre for Harm Reduction, Burnet Institute**

Illicit drug use, especially injecting is changing the face of AIDS and of development. But few countries have around the world have displayed the pragmatism, foresight and vision to deal with this problem in a timely or effective way. Governments and communities alike are struggling to respond adequately, especially because of the social, legal and political sanctions surrounding illicit drug use. But at the same time, some of the most outstanding successes in HIV prevention are occurring through programs specifically targeting injecting drug users.

### **Injecting drug use and HIV infection**

It is now estimated that more than ten percent of HIV infections worldwide, in three and half million people, are due to injecting drug use. Of all the different ways that the virus can be passed on, directly injecting a substance contaminated with HIV into the blood stream is the by far the most efficient way - much more so, in fact, than through sexual means. Together, therefore, drug injecting and HIV form an explosive combination.

The most rapid increases in HIV among IDUs have been in developing countries such as Nepal, India, Thailand, Myanmar, Iran and China, where drug injecting is a major cause of HIV infection. The countries experiencing these epidemics are inexperienced in developing policy and programmatic responses to adequately deal with injecting drug



use. Where responses are developed, they mainly target the long-term goals of eradication of drug supply and drug use, rather than the more pressing problem of HIV transmission.

Redressing these imbalances is a major challenge for the development community. The relationship between IDU and HIV transmission is also different in each location. Changes to policies and programs must therefore be developed separately through a process of ongoing analysis, consultation and trailing of responses.

### **HIV, Drug Use and Development**

It is becoming increasingly evident that development problems foster drug problems. Communities in remote areas, which are marginalised and have little control over their economic and social development, are natural habitats for the cultivation, trafficking and consumption of narcotic drugs. New patterns of drug use appear to be influenced by the

interplay of macro social, economic and political factors. It seems to be no coincidence that rapid diffusions in drug use and drug injecting have occurred since 1990, paralleled by major social dislocation and change. Shifts to private economic production have occurred in the context of dramatic declines in gross domestic product and have led to dramatic unemployment, increased income differential and poverty, and the rapid expansion of criminal economies.

In the face of these complexities, there is a small number of programs developing and implementing effective HIV prevention responses among IDUs, and much willingness on the part of many policy and programme designers to consider the various strategies that could be tried. The most successful and sustainable of these strategies are those known as harm reduction programs.

- In India, SHARAN is implementing wide-ranging and comprehensive community-based HIV prevention measures among IDUs in the slum populations in Delhi. These measures include rapid situation assessments, HIV counselling, vocational rehabilitation, a drop-in centre, primary health care and needle-exchange
- In Asia and the Pacific, the Centre for Harm Reduction and the Asian Harm Reduction Network have teamed together to produce the Asia-specific 'Manual for Reducing Drug Related Harm', a practical guide pooling together global experience in harm reduction.
- Globally, national and regional 'harm reduction networks' have emerged as important mechanisms for building expertise, legitimising harm reduction and strengthening supports for HIV prevention programmes targeting injecting drug users.

Common to these and other harm reduction activities is an approach fundamentally different from that of demand and supply reduction, in that reduction in the use of drugs is not a primary goal, but these differing approaches should be and can be complementary (Crofts, 1999). But the introduction of harm reduction is always controversial as it is seen to condone continued illicit drug use. This presents complex challenges to the international development community and governments alike, as they struggle to balance failing attempts to eradicate drug use with ongoing reality of HIV epidemics among injecting drug users.

### **Policy responses**

The lack of a supportive policy environment is perhaps the greatest obstacle and thus the greatest challenge for controlling HIV among injecting drug users. Despite the fact that drug use is driving the HIV/AIDS epidemic in many countries, the relationship between HIV and drug use is a particularly neglected area of national AIDS and drug policies. Drugs and HIV/AIDS policies often develop at different times through different processes, so it is no surprise that they have often evolved with different goals and approaches. Drug policies do not focus on public health issues such as HIV/AIDS.

Instead, governments and development agencies are placing priority on finding long-term solutions to the drug abuse problem, rather than addressing the more immediate harms

caused by drug abuse, most notably HIV. It seems, the international community cannot reach consensus on how to deal with the problem of illicit drugs, arguing about the merits of demand reduction, supply reduction and harm reduction approaches, while the HIV epidemic among drug injectors continues unabated.

In the absence of effective national policies and programmes to prevent HIV among IDU, community-based programs are often the only modality left to implement responses. But these programs are inhibited by the fact that government policies may prevent interventions that have been proven to prevent HIV elsewhere, such as needle exchange programs and drug substitution. This situation is changing, but usually only after HIV epidemics among IDUs have taken off. The challenge therefore is to examine and pilot ways that governments, local programmes and policy makers can be engaged to develop policies that will support the early implementation of effective responses among IDUs.

To do this, governments and development agencies need to be armed with more comprehensive understanding on the nature and extent of HIV epidemics among IDUs, and be exposed to strategies for consideration and examples of programmatic and policy responses.

## **Conclusion**

The drug problem is a complex problem that touches on many issues other than just drugs, dealers and users. When HIV and injecting drug use is added to this mix, the complexities involved are multiplied. We need to understand the connections among these issues, to see the total picture and not just single pieces of the jigsaw.

Rather than stigmatising drug users, and focusing mainly on supply reduction, we need to change the social and economic environments that help create demands for drug use. We need to review and change our development paradigm to one that restores respect for human dignity and equality of human rights regardless of race, religion, gender, and economic, social, or health status (Duongsa 1998).

The ultimate way to prevent harm from drug use is to completely stop the demand for using drugs. But, just as it unrealistic to expect to control HIV/AIDS by asking people to stop having sex, we must also be realistic about the likelihood of the global eradication of drug use in the near future.

Governments and communities therefore need to be provided with options for dealing with the drug problem, space where they can consider these options and practical ways they can be supported in the process of debate and policy reform.

Most of all we need to strengthen political and donor support, mobilise diminishing resources and turn awareness into action. If not, the spread of HIV through injecting drug use will continue to be a glaring and devastating omission in global efforts to eradicate AIDS.

*This paper summarises a much larger report prepared for UNDP HIV Development Programme New York involving consultations during 1999-2000 across nine countries in Asia and Central and Eastern Europe. This report can be viewed on <http://www.undp.org/hiv/publications/deany.htm>*

## **19. Concluding Observations:**

**Ms. Neelam Kapur, Deputy Director, National AIDS Control Organisation (NACO), Ministry of Health, India**

Community mobilisation and empowerment are critical and fundamental to HIV/AIDS prevention and care. But how does community mobilisation happen? On one side we see it in terms of social activism or individual action, but there is also an important role for partnership between NGOs, who have some of the best ways of really working with marginalised groups such as injecting drug users, and government programmes.

In the National AIDS Control Programme in India we have tried to create those spaces through government action for facilitating greater NGO action. It has been a big challenge for all concerned to create the relationship of trust which has been achieved.

Building a multisectorial response has presented a similar challenge. A multisectorial response is not restricted to STD treatment, counselling or condom promotion. So we work with the Ministry of Education for school education, the Ministry of Youth for youth leadership, the Ministry of Social Justice and Empowerment on drug related issues and the Department of Women and Child Development on issues of trafficking and women's empowerment. Thus we are able to provide linkages and create social safety nets that will ultimately involve communities in prevention, in awareness, in empowering and also in care. Every NGO which has a development agenda has a place in the AIDS program.

In every intervention project that the Government of India funds, there is a component of flexible funding which is used for creating an enabling environment. In India we are dealing with a multiplicity of epidemics, so we do not prescribe at any government level what this enabling environment is going to be or what are the activities, but try to look at a process by which these activities can be defined and articulated. And this has perhaps been the hallmark of the success of our program for NGOs, where in one year we have 550 NGOs working with us and with some of the most difficult and most marginalised communities.

In concluding, communities have three important roles:

One is in terms of prevention and awareness. The second is in creating an environment that is enabling because in countries where people are struggling with so many development issues it is not enough just to give them information.

The third, which I think is perhaps the most important, is in terms of care and support. In countries like India the provision of free drugs through the National Programme is still a dream for many of us. And that is a challenge. We are looking at alternative models of care and NGOs and community organisations have developed and evolved this kind of model. Community care centres have been set up which provide outreach, which provide services and which actually empower individuals to live with the epidemic on various levels, emotional, psychological and otherwise.

These are the three areas that we need to look at in any kind of programme on HIV/AIDS prevention and control which will be effective. The coming together of these three goals, or agendas, will provide the opportunity to create the greatest effect.

-----

## **20. People Plus, a Photo Exhibition: Anita Khemka**

The UNDP session featured an outstanding photo exhibition by Delhi-based photographer, Anita Khemka. The exhibition was produced with the support of members of MNP+ and UNAIDS. Featuring compelling black and white images of people in their everyday homes and communities, the photos illustrated the poignant reality of people living with HIV/AIDS. This exhibition gave us glimpses into the lives of people who are HIV positive, including many drug users, in Manipur and Maharashtra.

This exhibition is very special because of the participatory way in which it was put together over 7 months, and the involvement of the communities whose members appeared in the photographs. A representative of the community photographed in Manipur participated in the UNDP panel session, linking the exhibition with the discussion of the human story of drug use and HIV/AIDS.



## **Appendices**

### **Drug Related HIV Risk, Livelihoods and Communities in Asia**

**3<sup>rd</sup> April, 7 – 10pm, Banquet Hall, Ashok Hotel, New Delhi**

### **AGENDA**

7.00 *Welcome* : Ms. Sonam Yangchen Rana, Regional Programme Co-ordinator, UNDP HIV and Development Project, South and South West Asia, New Delhi, India.

*Opening Remarks by Moderator:* Mr. Anand Bordia, National Project Manager, Community-wide Drug Demand Reduction in India, UNDCP, New Delhi, India.

7.10 – 8.00 *Panel Presentations: Community Based responses:*

1. Dr. Syed Kamal Uddin Ahmed, Behaviour Change Support Intervention Specialist, National AIDS/STD Programme, Directorate of Health Services, Bangladesh
2. Dr. J.C. Chhuanliana, Programme Co-ordinator, Community Health Action Network, Mizoram, India
3. Dr. Mohammad Shamsuddin, Director, Life Saving and Life Giving Society, LALS, Nepal.
4. Ms. I.V. Domingo, World Concern, Myanmar
5. Dr. Jaroon Jittiwutikarn, Director, Northern Drug Dependence Treatment Center, Ministry of Public Health, Thailand

8.00 – 8.20 *Open Discussion with Introductory Remarks by*

-Mr. Deepak Singh, Secretary, MNP+, Manipur  
-Ms. Nemlian Ching, Co-ordinator – SAHARA Women and Children's Home, New Delhi.

8.20 *Play* by SAHARA Community Theatre Group  
*Distribution of packed suppers*

8.30 – 9.00 *Panel Presentations: Research and Application:*

1. Dr. Irwanto, Senior Researcher, Centre for Societal Development Studies, Atmajaya University, Indonesia
2. Dr. Emran M. Razzaghi, M.D., Assistant Professor of Psychiatry, Tehran University of Medical Sciences, Iran
3. Mr. Paul Deany, Senior Project Officer, The Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research, Australia.

9.00 – 9.15 *Open Discussion*

9.15 Concluding Observations: *Ms. Neelam Kapoor, Deputy Director, National AIDS Control Organization, NACO, New Delhi, India*

9.20 *Final Conclusions and Wrap up:* Mr. Anand Bordia - Moderator

9.25 *Vote of Thanks*: Ms. Beverly Brar, Programme Advisor, UNDP HIV and Development Project, South and South West Asia, New Delhi, India.

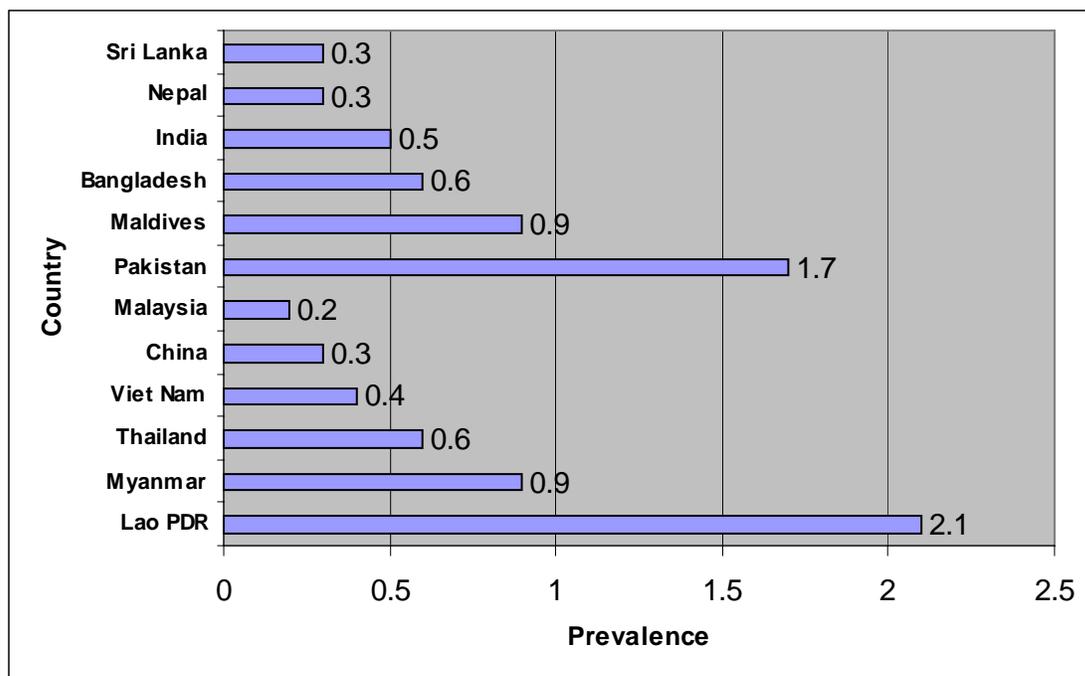
9.30 – 10.00 Viewing of UNAIDS sponsored Photo Exhibition, “*People Plus*”, by Anita Khemka.

---

## Appendix II: Drug use in Asia

For more than a century, Asia has experienced drug use problems in the form of large-scale epidemics with devastating effects on its countries. Such epidemics have caused social disintegration, civil unrest and serious public health problems, exacerbated poverty and problems related to poverty, caused enormous direct and indirect economic costs and impeded social and economic development. The drug trade, a multi-billion dollar operation, causes and abets the financing of wars. It continues to be a financial resource for purchasing arms for guerrilla armies. Governments have undertaken strenuous measures to reduce drug use problems, however, despite all efforts drug use is not under control to date.

Asia is home of the infamous opium production areas called “The Golden Triangle”, an area covering Thailand, Myanmar and the Lao People’s Democratic Republic, and the “Golden Crescent” between Afghanistan and Pakistan. Significant opium production is found in Afghanistan, Lao People’s Democratic Republic, Myanmar and Pakistan, often in areas, which are not under government control. From the production areas opiates are being shipped to various consumer markets in Asia, Australia, Europe and the Americas. The main areas of consumption are, however, still close to production areas and along trafficking routes.

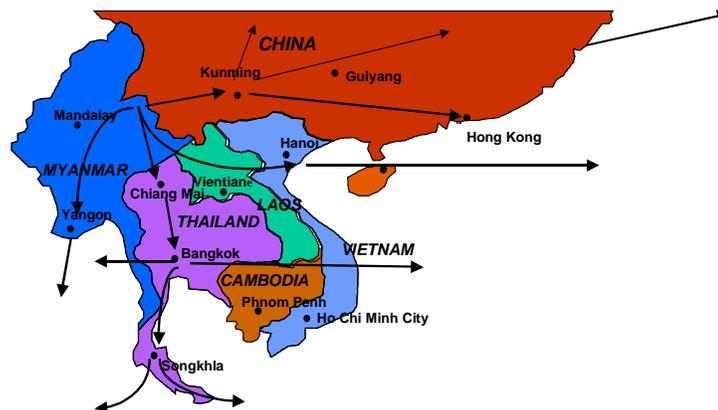


## Figure 1. Prevalence of opiate use, selected countries

To date, the production of opiates has been reduced significantly in a number of areas. Trafficking and consumption, however, remain an issue of serious concern. Over the past years, an increasing trend from opium to heroin use has been observed in many countries. Codeine, other narcotics and psychotropic substances are also being used at a significant level, including Tidigesic, Buprenorphine, Phensedyl, Nitrozepam and Temgistic. These substances are either produced in clandestine laboratories and distributed to the drug user markets, or produced legally by large pharmaceutical industries and diverted from there to illegal markets. Smoking or “chasing the dragon” continues to be the main route of narcotics administration, however, injection has become a predominant and widespread method for drug use. The trends toward injection seem to be related to the availability and purity of heroin and the availability of prevention and treatment services for drug users.

## Figure 2. Trafficking routes in South East Asia<sup>1</sup>

Many countries of the region are experiencing currently an epidemic abuse of amphetamine-type stimulant (ATS), particularly of methamphetamine. Virtually all



(Picture Source: UNAIDS Best Practice Collection 2001, *The Asian Harm Reduction Network, Supporting Responses to HIV and Injecting Drug Use in Asia*, Deany et al, May 2001)

countries in South East Asia are now affected to some extent. Data indicate that ATS use is generally higher among young adult males, although there is a continuing problem among special occupational groups such as truck drivers, fishermen and construction workers. Commercial sex workers have also been identified as a high-risk group related to ATS. As these groups have a high degree of mobility, they are hard to reach by traditional prevention and treatment services.

<sup>1</sup> Courtesy of the UNDCP Regional Centre for East Asia and the Pacific

In addition to the use of narcotics and psychotropic substances, endemic levels of inhalant use exist in many Asian countries. Such usage is particularly associated with street children living in impoverished, harsh, conditions. Many countries have identified inhalant use as a significant drug issue in many of their cities. Cannabis use in its various preparations continues to be widespread in most countries of the region.

#### Drug use and HIV in Asia: a snapshot

- Illicit and licit drugs are injected in many parts of the world, especially in regions where poverty, homelessness, migration, gender inequity and other social-economic problems are common.
- The re-use of contaminated needles and syringes by different people is common in many of these settings where injecting drug use takes place.
- The reasons for sharing are various and include poverty, cultural factors, lack of availability or access to needles and syringes, the illegality of carrying injecting equipment and lack information about HIV and IDU.
- Drug injectors are a major vector for spreading HIV to their sexual partners and children.
- The Asian region shares borders with major areas of drug production (the 'Golden Triangle' and the 'Golden Crescent'). Some of the countries (notably India, Nepal and Pakistan) are also drug producers. Producer countries have in recent decades become consuming countries.
- In all countries in the region there was an established acceptable use of opium smoking and cannabis (especially in rural communities) and these were not considered major problems. However, the recent phenomenon of heroin and of pharmaceutical abuse are perceived as problems.
- The region has large pharmaceutical industries coupled with lax controls over sales and distribution. This has led to large-scale pharmaceutical drug abuse (e.g. buprenorphine and benzodiazepines and codeine-based cough mixtures). There is evidence in the region of increasing poly-drug use and of the emergence of drug use problems in urban areas.
- An increase of drug use among 'street children' has been reported.
- The most significant recent shift in drug use patterns in the region is the move from smoking or 'chasing' to injecting drug use.

- Many factors encourage injecting behaviours and these include: widespread availability of pure heroin, or conversely, when little heroin is available or if it is too expensive or of low purity, than injection may be favoured for a better 'high'.
- Drug users in the region are a heterogeneous group – no clear profile emerges. However, the majority are male and from socio-economically weaker sections of the population.

### Appendix III: Framework for understanding & responding to the development challenges posed by HIV and drug use

Issue	Challenges	Possible Actions
<p><b>Policy and program development</b></p>	<ul style="list-style-type: none"> <li>• There are few programs specifically focused on HIV prevention, care and treatment of drug users</li> <li>• Programs targeting injecting drug users are not integrated with HIV prevention activities and health and welfare programs</li> <li>• Governments have been slow to address health consequences of IDU, especially HIV</li> <li>• Government policies on drug use are likely to encourage HIV spread</li> <li>• Government lack of commitment for programs to reduce HIV among IDU</li> <li>• Governments have not been sensitised to the policy options for responding to HIV and IDU</li> </ul>	<ul style="list-style-type: none"> <li>• Developing comprehensive pilot projects on HIV prevention among IDUs, linking harm reduction approaches to development principles</li> <li>• Mainstreaming HIV and injecting drug use into key programming areas, such as poverty reduction, gender equity and good governance through studies, workshops, training and technical support</li> <li>• National and community level consultations to enable participants to identify the types of programs and governance needed to act on the challenge of the HIV epidemic among IDUs</li> <li>• Developing national HIV and drug policies promoting early interventions among IDUs</li> <li>• Involving relevant UN programs in developing a clear consensus statement and regional action-plan on the prevention of HIV and IDU in Asia and in Central and Eastern Europe</li> <li>• Supporting donor conferences, gatherings of community leaders and other colloquia at the national and regional level to discuss ways to give higher public priority to early HIV prevention among IDUs</li> </ul>
<p><b>Strengthening the capacity of communities to respond</b></p>	<ul style="list-style-type: none"> <li>• Poor understanding and acceptance of the need to prevent HIV among IDUs</li> <li>• Skills, experience and capacity for developing HIV prevention programs for IDUs are lacking</li> <li>• There is not enough coverage of programs</li> </ul>	<ul style="list-style-type: none"> <li>• Developing ways for communities to explore, understand and respond to the development implications of injecting drug use and HIV epidemics</li> <li>• Capacity development through workshops, study tours and pilot programs which explore innovative ways of increasing program effectiveness and sustainability among IDUs</li> </ul>

	<p>needed to prevent HIV among IDU</p> <ul style="list-style-type: none"> <li>• There is not enough involvement of community based organisations, which have direct experience in dealing with the drug problem, in developing responses</li> </ul>	<ul style="list-style-type: none"> <li>• National consultations as mechanisms for sharing research, experience, supports, and policies on HIV prevention among IDUs</li> <li>• HIV and development workshops, focusing on promoting sustainable, coordinated and broad-based responses at the country level to the HIV epidemic among injecting drug users</li> <li>• Involving community-based organisations and networks (including those listed in this paper) as key resources in research, planning and responses on HIV and IDU</li> </ul>
<b>Issue</b>	<b>Challenges</b>	<b>Possible Actions</b>
<b>Awareness raising and understanding</b>	<ul style="list-style-type: none"> <li>• Drug users are unable to access information about health risks associated with injecting drug use</li> <li>• Information on the nature and extent of injecting drug use problem is absent in most countries</li> <li>• Ignorance, fear and stigma surround the issue of illicit drug use</li> <li>• People consider the issue of IDU and HIV from differing and often conflicting perspectives</li> <li>• Information on how to develop effective programs is generally lacking</li> </ul>	<ul style="list-style-type: none"> <li>• Developing new ways of looking at HIV and development in the era of injecting drug use</li> <li>• Examining social, legal, cultural and political barriers to the development of HIV prevention initiatives among IDUs</li> <li>• Identifying research, policy and programmatic priorities relating to HIV and injecting drug use, through commissioned reviews, consultations and other activities</li> <li>• Conducting advocacy and awareness raising activities in the community</li> <li>• Creating and disseminating IEC materials, technical assistance manuals and other information on HIV prevention among IDUs, and adapting these materials to local languages and situations</li> <li>• In-depth evaluation and case studies of national and programmatic responses towards HIV among IDUs</li> </ul>
<b>Regional cooperation and networking</b>	<ul style="list-style-type: none"> <li>• Few mechanisms for inter-sectoral and inter-agency cooperation on HIV and injecting drug use issues</li> </ul>	<ul style="list-style-type: none"> <li>• Supporting regional networks, information sharing activities and technical support mechanism on HIV prevention among injecting drug users <ul style="list-style-type: none"> <li>• Inter-country consultations, training programs and meetings, sharing</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• Few opportunities and mechanisms for inter-country collaboration</li> <li>• Lack of coordination between sectors responsible for drug control and HIV</li> <li>• Need for greater liaison and cooperation within the UN system on issues of drug use, HIV vulnerability and development</li> </ul>	<p>lessons learned across borders on the development implications of IDU and HIV</p> <ul style="list-style-type: none"> <li>• Mobilising and supporting the response of the UN system and other players at the national level to maximise the effectiveness of their support for the national response to the HIV epidemic among injecting drug users</li> <li>• Liaison and co-ordination between other partners within and beyond the UN system</li> </ul>
<b>Gender issues</b>	<ul style="list-style-type: none"> <li>• Women drug users are especially stigmatised and vulnerable to HIV</li> <li>• Non-using women are also vulnerable to HIV as consenting sexual partners of male users, through physical and sexual abuse, prostitution, and poverty</li> <li>• Children of drug users, especially girls, are vulnerable to HIV, physical and sexual abuse, prostitution, stigma and poverty</li> <li>• Women carers of HIV+ drug users are vulnerable to poverty, exploitation, violence and stigma</li> </ul>	<ul style="list-style-type: none"> <li>• Developing gender-sensitive ways of looking at HIV and development in the context of injecting drug use</li> <li>• Identifying and generating gender-specific information on the nature and extent of HIV epidemics and injecting drug use</li> <li>• Examining gender dimensions of the social, legal, cultural and political barriers faced by drug users, their partners and carers, especially in relation to HIV vulnerability</li> <li>• Developing gender-sensitive approaches to HIV prevention among IDUs, through pilot programs, research and community consultations</li> <li>• Piloting specific programs for and with groups of women who are at risk from HIV through injecting drug use</li> <li>• Targeting women affected by HIV and IDU in their roles as partners, caregivers or children of HIV positive drug users</li> </ul>
<b>Responding to legal, ethical and human rights issues</b>	<ul style="list-style-type: none"> <li>• Current anti-drug and anti-paraphernalia laws are facilitating the spread of HIV through injecting drug use</li> <li>• There is little recognition or investigation of the</li> </ul>	<ul style="list-style-type: none"> <li>• Establishing priority programming and policy needs in relation to legal ethical and human rights issues surrounding injecting drug use and HIV, through consultations with those directly affected by the epidemic, especially injecting drug users</li> <li>• Identifying operational research priorities relating to legal, ethical and</li> </ul>

	<p>importance of legal, ethical and human rights issues in proliferating HIV transmission among IDUs</p> <ul style="list-style-type: none"> <li>• Drug users are facing widespread stigma, marginalisation and exclusion from the very processes and services that would protect them from HIV</li> <li>• Governments are not able to reach consensus on the health and human rights of injecting drug users</li> </ul>	<p>human rights issues concerning injecting drug use and HIV</p> <ul style="list-style-type: none"> <li>• Supporting people and institutions to reflect on and explore appropriate responses to the difficult legal, ethical and human rights issues posed by HIV and injecting drug use</li> <li>• Developing processes that support consensus building and decision making concerning HIV and IDU; the establishment of sound ethical and legal policies and practices; and the provision of appropriate and supportive services to those affected</li> <li>• Facilitating the creation of national and regional links between people and organisations that enhance their capacity to act as catalysts for sound ethical and legal policies on HIV and injecting drug use</li> </ul>
--	---	---

## References

- Ahmed R (1998) UNDP Co-Administrator, UN General Assembly Special Session on the World Drug Problem, New York, 9 June 1998
- Ball A (1999) Presentation for the World Health Organisation Programme on Substance Abuse at the 2<sup>nd</sup> Global Research Meeting on HIV and Injecting Drug Use, Atlanta, August 28, 1999
- Brown B (1999) Regional Partnerships to Achieve Enhanced Responses in Update Newsletter, UNDP Regional Programme HIV Development Asia and the Pacific, Vol 3, Issue 2, New Delhi June 1999
- Crofts (1999) The Manual for Reducing Drug Related Harm in Asia. The Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research and the Asian Harm Reduction Network, Chiangmai, Thailand
- Crofts N, Reid G, Deany P in collaboration with the Asian Harm reduction Network (1998): Injecting drug use and HIV infection in Asia. AIDS 1998, 12 (suppl B):S69-S78.

- Deany P (2000) How Harm Reduction Networks are Supporting Responses to HIV/AIDS and Injecting Drug Use. XIII International AIDS Conference, 11 July 2000, Durban, South Africa.
- Deany P, Narayanan P, Crofts C, Touze G, Riley D, Purchase P, Honti J, O'Hare P, Adelekan M, Lap M, Cavalieri C, & Allan Clear (1999) Global and regional research issues for programmes working to reduce drug-related harm. Presentation at the 1999 Global Research Network Meeting on HIV Prevention in Drug Using Populations, Atlanta, USA, Aug 27<sup>th</sup> 1999.
- Duongsoa (1998) Women, Gender and Drugs. UNDP Panel Discussion on Drugs and Development the Special Session of the General Assembly on Drugs
- Parnell, B., Lie, G., Hernandez, J.J. and Robins, C. (1996) Development and the HIV Epidemic: A forward looking evaluation of the approach of the UNDP HIV and development programme. United Nations Development Programme, New York, NY.
- Rhodes T, Stimson V, Crofts C, Ball A, Dehne K and Khodakevich L (1999) Drug Injecting, rapid HIV spread, and the 'risk environment': implications for response. AIDS 1999, 13 (suppl A): S1-S11
- Rhodes T, Ball A, Stimson G, Kobysheva Y, Fitch C, Pokrovsky V, Bezruchenko-Novachuk M, Burrows D, Renton A and Andrushchak L.(1999B) HIV infection associated with drug injecting in the Newly Independent States, eastern Europe: the social and economic context of epidemics, Addiction, in press 1999
- UNAIDS (1999) Joint United Nations Asia Pacific InterCountry Team. InterCountry Workshop on Prevention of Drug Use and HIV/AIDS, Bangkok, 11-14 May, 1999.
- UNDP (1999) Social Economic and Governance Dimensions of the HIV/AIDS epidemic in Eastern Europe, UNDP HIV and Development Programme
- UNDP (1999B) AIDS in South and Southwest Asia: A Development Challenge, UNDP HIV and Development Project, South and South West Asia, New Delhi
- UNDCP (1998) Drug Control Brief, HIV/AIDS and Drug Abuse, UNDCP Regional Office for East Asia, Bangkok
- UNDCP (1999B) What do you really know about? DRUGS. Brochure produced by UNDCP International Centre, Vienna, Austria

## **ACKNOWLEDGEMENTS**

The report was prepared by Paul Deany (Centre for Harm Reduction, Burnet Institute, Australia) with input from Sonam Yangchen Rana, Beverly Brar, Uffe Gartner, (UNDP South & South West Asia Project on HIV & Development) and Lee Nah Hsu (UNDP South East Asia HIV and Development Project). UNDP would like to thank the organisers of the 12<sup>th</sup> International Harm Reduction Conference for providing the forum for this discussion, all the speakers, Sahara Community Theatre Group, and UNAIDS, Manipur Network of Positive People, and Anita Kemka for sharing the photo exhibition "*People Plus*".