

POLICY

Drug Users Must Be Included in Scaling Up the Global Response to HIV/AIDS; Harm Reduction Advocate Challenges UN Delegates

Newsire, May 31, 2006



Plenary sessions at the UN General Assembly Special Session on HIV/AIDS in New York occurred on 31 May and 2 June.

New York; U.S. Newsire --Drug users and other marginalized groups are being left behind in the global fight against HIV/AIDS, charged Allan Clear, executive director of the U.S.-based Harm Reduction Coalition. "The triumph of ideology over public health dictates the nature - and failures - of how governments deal with HIV epidemics in marginalized groups. Despite the overwhelming evidence of the effectiveness of syringe exchange, the U.S. Federal government refuses to fund syringe exchange programmes, both domestically and internationally," said Clear today to delegates of the United Nations General Assembly high level meeting on AIDS (UNGASS). Clear delivered his remarks at the UNGASS Civil Society Hearing. "Injection drug use is global and drives the HIV epidemic in Central

and Eastern Europe, Central and South East Asia and South America," continued Clear.

"It is a travesty that only 35,000 HIV-positive drug injectors in developing and transitional countries receive antiretroviral treatment. 30,000 of these injectors are living in Brazil. It is a travesty that some countries such as Russia vehemently refuse drug users access to methadone or buprenorphine treatment, despite inclusion of these medications on WHO's Model List of Essential Medicines. And it will be a travesty if member countries retreat from the 2001 Declaration of Commitment by ratifying a document that never references drug use, sterile injection equipment or harm reduction." The United States UNGASS delegation has led the drive to water down political commitments to meaningful targets

for scaling up HIV prevention, care and antiretroviral therapy; replace references to "evidence-based" programmes (such as syringe exchange and condom distribution) with "evidence-informed" policies; and remove language supporting the crucial role of "vulnerable groups" in responding to HIV/AIDS. Clear concluded by calling on UNGASS delegates to strengthen the draft political declaration by 1) ensuring that drug users and other marginalized populations have equitable access to HIV prevention, care, and antiretroviral treatment, and 2) scaling up access to sterile injection equipment, condoms, and methadone and buprenorphine substitution therapies for opiate addiction.

For the full text version of Allan Clear's remarks visit www.pepfarwatch.org/pubs/AllanClearRemarks.doc or www.usnewsire.com/ or releases. www.usnewsire.com/GetRelease.asp?id=66695. Contact Allan Clear of the Harm Reduction Coalition at clear@harmreduction.org.

UNGASS + 5 - Failure to Learn Will Be the Harshest Judgment of All

Originally published on May 22, 2006

Tim France, HDN

The five-year day of reckoning for the most significant political promises and commitments on HIV/AIDS is upon us. At a special session of the UN General Assembly later this week, Member States can either come clean by admitting collective failure to deliver adequate HIV/AIDS programmes in the most affected counties, or they can simply move the goalposts. True to form, the Joint UN Programme on HIV/AIDS (UNAIDS) and its eight UN agency co-sponsors seem to favour the second option and are moving us headfirst towards a new goal of 'universal access'. One of the potential risks of moving so hastily is that the opportunity for genuine evaluation of the past five years, and the invaluable lessons that must be extracted, will be lost.

According to the five-year AIDS report card published recently by UN Secretary-General Kofi Annan, a 2001 special session of the UN General Assembly on HIV/AIDS (UNGASS) was a "landmark in global efforts to respond to the AIDS crisis." For the first time in the history of the pandemic, a series of time-bound targets were adopted, and set out in a 'Declaration of Commitment on HIV/AIDS', signed up to by leaders from 189 countries.

In the five years since then, Annan asserts, the Declaration of Commitment has "galvanized global action, strengthened advocacy by civil society and helped guide national decision-making."

Buoyant talk, given just how badly we have actually done over the past five years – or perhaps the past 25 years – to address a global AIDS pandemic that has already claimed 25 million lives.

Later this week, all UN Member States meet in New York for a five-year progress review of the promises they made in that Declaration. Despite some progress in expanding access to HIV prevention and treatment, Annan is expected to dryly advise most governments that they are being outpaced by the epidemic in most places because HIV programmes are still failing to reach the very people and communities most vulnerable to HIV.

According to Annan's report, for example, a mere 9 per cent of men who have sex with men received any type of HIV prevention service in 2005. Among people who inject drugs, fewer than one in five receives HIV prevention services. A condom was used on average, the report estimates, in only 9 per cent of "risky" sex in the past year.

Less than 10% of pregnant women with HIV have access to the relatively simple drug treatments that prevent mother-to-child transmission: the main reason three million children were born with HIV in the past five years.



On 30 May, on the eve of the High-Level Meeting on AIDS, UN staff members hold open red umbrellas to form the AIDS ribbon in the North Garden at UNHQ. The red ribbon is the universal symbol of AIDS awareness.

Credit: © UNICEF/HQ06-0605/Susan Markisz.

Care and support reaches fewer than one-in-ten of the 15 million children orphaned by AIDS and millions more children made vulnerable by the epidemic.

One of the few global targets that was achieved is the amount of money that governments, international agencies and other partners said they would need to tackle AIDS. In 2005, approximately \$8.3 billion was spent on AIDS programmes in low- and middle-income countries, reaching the Declaration of Commitment financing target of between \$7 billion and \$10 billion per year.

One inescapable conclusion is that while the money is available, the end results are not. But, rather than insisting on a frank analysis of why we have all failed so terribly to make a difference, the UN agencies tackling HIV/AIDS (UNAIDS and its cosponsors) is claiming: "...the foundation for an extraordinarily stronger and sustained response is largely in place."

How can such disappointing performance be hailed as a foundation for anything? Exhaustive learning from the past five years would be more appropriate.

Instead, 'universal access' – the goal of providing a comprehensive package of HIV/AIDS treatment, care, support and prevention – is now being promoted heavily by the UN. This is a new and untried strategy based on what is – at best – a confusing and ambiguous statement of intent by governments.

The upbeat UNAIDS position has its roots in a single sentence from the Gleneagles G8 meeting

last year and the subsequent World Summit declaration:

“We commit to ... developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010 for all who need it....”

According to UNAIDS: “These ambitious commitments have brought the AIDS response to another historic juncture.”

Alongside the other 177 paragraphs of the World Summit document this one sadly does not stand out as particularly striking. Similarly, the G8 is good at making ambitious commitments, and this one is not especially “historic” when placed alongside the endless HIV/AIDS promises they have made – and then promptly broken - over the past five years.

The UN position on universal access is an immens leap of faith, and one that currently trumps the one obvious fact that should actually be bringing the AIDS response to an historic juncture ; We are failing to address the epidemic effectively.

Despite popular rhetoric about “knowing what to do about AIDS” we clearly need to learn a lot more before AIDS programmes will reliably provide basic prevention and treatment services to the people who need them.

But even as the ink dried on a late-2005 UN resolution requesting UNAIDS to find out what was preventing ‘universal access’ from being achieved, the agency’s most efficient operation ever was unveiled. Almost overnight, plans were in motion to coordinate over a hundred national consultations, set up seven regional consultations and establish a global steering committee.

UNAIDS has since claimed: “Thousands of people from all walks of life have mobilized to seize this extraordinary opportunity.” The UNAIDS- and UK government-led universal access ‘initiative’ did take a large number of people along with it – unfortunately not in a common understanding, but in a collective misunderstanding. Why? Because the terms ‘access’, ‘utilization’, ‘availability’ and ‘coverage’ are often used interchangeably to stand for the general idea that most people thought they meant when talking about ‘universal access’: That people in need of essential AIDS services and commodities to protect their health are actually going to get them. Many people take the ‘promise’ of universal access literally.

There is also a widespread misconception that ‘universal access’ applies solely to the goal of increasing access to antiretroviral drugs, rather than to the intended one of improving access to a comprehensive range of HIV prevention, care, support and treatment services.

Universal access offers an easy enticement, especially given the disappointing outcome of the recent World Health Organisation (WHO)-led AIDS treatment initiative – 3by5 – that promised



On 30 May, on the eve of the 2006 High-Level Meeting on AIDS, UNAIDS Executive Director Peter Piot addresses attendees at the launch of the UNAIDS 2006 Report on the global AIDS epidemic, at UNHQ. The report, a special edition marking UNAIDS’ 10th anniversary, contains the most comprehensive data on the AIDS response to date, based on progress reports from 126 countries.
Credit: © UNICEF/HQ06-0601/Susan Markisz.

to provide antiretroviral (ARV) drugs to three million people with HIV in poor countries by the end of 2005, but only delivered them to less than half of that number.

When the UN system moves with the speed and efficiency that it has shown around universal access, and goes to such lengths to make the process appear inclusive and country-driven, it’s generally a sure sign that a major policy shift is brewing.

Underlying the universal access strategy are recent debates – also largely led by UNAIDS and the UK government – about how donor support for AIDS can be more harmonized and aligned.

A UNAIDS document reveals that “Scaling up towards Universal Access is a partnership between the country and its external development partners facilitated by UNAIDS.... It is aimed to better link increased financial support to agreed-on policy and programme goals.”

A significant shift to re-build the AIDS response on individual ational AID Splans risks consigning thepast five years of accountability against the UNGASS Declaration of Commitment (DoC) to a moment in history. Placing universal access centre stage dilutes the most significant and specific political promises on HIV/AIDS overnight.

Adopting individual universal access road-maps would also turn the strategic clock back about ten years to when support for national AIDS programmes was channelled by donors to individual national

governments through WHO's Global Programme on AIDS (GPA). Back then, aid was less tied to international frameworks – with more cash provided directly for government - managed country priorities.

At a recent meeting on AIDS in London, the head of UNAIDS, Dr. Peter Piot, commented that he hoped the UNGASS+5 review later this week will not be: "One of those summits where we say: 'We've failed, we've failed, and we have no results and we need more money,' and then we go home."

Given the Secretary-General's five-year AIDS report, how could we possibly claim anything other than a collective failure? The current status of the AIDS pandemic – and the appalling track record of providing essential HIV-related services to the people and communities who need them – demands that the UNGASS+5 review meeting be truthful and authentic by going further than

even Dr. Piot fears, by concluding: "We've failed, we've failed, and we need to candidly ask why, before we set ourselves new targets or frameworks on AIDS."

Each and every UN Member State has an unmistakable choice before it at the UN General Assembly later this week: Either strongly reaffirm the UNGASS DoC of 2001 and ask candidly why we are addressing AIDS so slowly; or move on with platitudes and blind faith that we are succeeding against the worst pandemic in history.

The first option calls for political nerve and pragmatism in order to learn fully from our failures. The second requires a disregard for the lessons and warnings of the past five years, and for the needs of the 40 million people living with HIV.

Source: <http://aidscrewatch.blogspot.com/2006/06/ungass5-failure-to-earn-will-be.html>; <http://aidsunsaid.blogspot.com/2006/05/ungass5-failure-to-learn-will-be.html> For additional information on the process and outcomes of UNGASS, please visit www.ahrn.net/index.php?option=content&task=view&id=2496&Itemid=2#top.



When avoiding the key questions and ignoring the tough lessons of the past, too much remains unsaid...

UNGASS Political Declarations

In 2001, the signatories of the UNGASS Declaration agreed to:

By 2005, ensure: that a wide range of prevention programmes which take account of local circumstances, ethics and cultural values, is available in all countries, particularly the most affected countries, including information, education and communication, in languages most understood by communities and respectful of cultures, aimed at reducing risk-taking behaviour and encouraging responsible sexual behaviour, including abstinence and fidelity; expanded access to essential commodities, including male and female condoms and sterile injecting equipment; harm reduction efforts related to drug use; expanded access to voluntary and confidential counselling and testing; safe blood supplies; and early and effective treatment of sexually transmittable infections (Paragraph 52).

In 2006, the UN Member States agreed to: Commit ourselves to remove, where needed, legal, regulatory or other barriers that block access to effective HIV prevention interventions, commodities and services such as condoms, harm reduction and other prevention measures (Paragraph 9). It is with concern that AHRN notes the lack of explicit references to services for people who use drugs except in the reaffirmation of prior commitment yet with exceptional dilution of the language - 'needles' and 'syringes' as well as 'methadone', 'buprenorphine' and 'pharmacotherapy' have been completely omitted from the draft document, representing a significant disappointment for service providers and people using drugs when compared with the original 2001 Declaration of Commitment.

For full copies of the 2001 and 2006 Declarations of Commitment, visit www.un.org/ga/aids/coverage/ and www.un.org/ga/aidsmeeting2006/.

PROGRAMME

Drug Demand and Harm Reduction in the Islamic Republic of Iran This article is a reprint of GTZ's Project Sheet

The project aimed at strengthening the ability and technical capacity of NGOs in Teheran to plan, implement and monitor drug demand and harm reduction measures. The project supported NGOs working directly with substance dependents (i.e. focusing on Afghan refugees) and drug users who engage in high-risk behaviour. The project was funded by the German Federal Republic, additional funding being provided by UNODC for one of the project's components. Given Iran's long border with Afghanistan and Pakistan, its Eastern provinces are situated on major "Golden Crescent" drug smuggling routes. Opium and heroin are both easily available and relatively inexpensive. The largest concentration of drug users is found in Teheran.

One partner organisation chosen for this particular project, Persepolis, was identified by GTZ together with the Iranian Ministry of Health to carry out the project in two districts (Ghar and Bagh-eh-Azari) in South Teheran, where a very high and concentrated prevalence of drug use exists.

The harm reduction approach was chosen due to GTZ having gained positive experiences with this approach in various other countries and due to the absence of such efforts in Iran so far. Harm reduction aims at preventing the transmission of HIV/AIDS and other infectious diseases as well as death from drug injection (through overdose).

The project was also destined to improve awareness of the drug-use problem and to focus on various methods (e.g. syringe exchange, condoms, etc.) as first steps to harm reduction versus severe prosecution.



The services offered by Persepolis address a growing need in Teheran, so much so that drug users line-up in the morning outside the drop-in centres.

It was identified as important for the project to primarily support younger adults and teenagers with drug and HIV/AIDS prevention measures, and adults (with special emphasis on women) with drug treatment and harm reduction measures. The main objective of the project was to establish outreach activities for high-risk populations in the districts Ghar and Bar-eh-Azari to reduce risk behaviour among street injecting drug users and sex workers. Secondary objectives were to gain access to highly excluded vulnerable people, to encourage drug users to seek treatment and to carry out research into drug use prevalence and patterns of consumption and criminal behaviour in this area.

The main components of the project were:

- Capacity building/training of staff
- Establishment of a drop-in centre
- Needle and syringe exchange (NSE)
- Outreach activities
- Basic health education
- Data collection on HIV prevalence among injecting drug users (IDUs)

Drug situation in Iran

- Iran is the world's largest consumer of opiates (especially opium and heroin)
- Officially, two million people are using opiates regularly; experts estimate that the prevalence is twice as high
- Drug treatment options and services are inadequate
- Iran is currently facing a remarkable growth in the number of HIV/AIDS cases, transmission through injecting drug use accounts for almost 75% of all HIV cases.

Impact

The main achievements of the project were the successful establishment of a drop-in centre and the initiation of outreach work in the streets of the two districts. In addition, Methadone Maintenance Treatment (MMT) was offered and supervised by two nurses and one doctor.

Outreach

Newly hired outreach personnel were trained in basic knowledge on HIV/AIDS and drug-related issues. The outreach work was conducted through



Injecting drug use in Iran represents the most important mode of HIV transmission. In an effort to curb the spread of the epidemic, the Iranian government has released a legislative decree to ensure a response to drug dependence that is founded on public health approaches and based on accumulated evidence.

a peer-based approach, meaning that the outreach staff mainly consisted of former drug users or drug users on MMT. The staff was trained in conducting outreach activities, collecting data on IDUs and in carrying out a rapid situation analysis based on ethnographic observation and in-depth interviews to collect information about the level and patterns of drug use among the target group. The actual outreach work consisted of contacting and registering mainly homeless drug users in parks, on the street and other deserted places, providing harm reduction and HIV/AIDS counselling, needle/syringe exchange, condom distribution and wound dressing. The peer-led approach succeeded in increasing the contact time of the outreach personnel with a usually highly marginalised target group.

Community-based drop-in centre
One of the aims was to establish community-based drop-in centres (DIC) in the south of Teheran near the target groups to provide counselling, and necessary treatment (i.e. HIV-tests) free of charge. It was crucial for the project to gently gain acceptance by the communities and to show the benefits especially in this area of town, where refugees mainly gather. The drop-in centre was set up to provide voluntary medical examinations, information on risky behaviour, needle/syringe exchange, access to the MMT programme or referral to local treatment clinics, condom distribution, HIV/AIDS and Hepatitis B/C counselling and testing, as well as provision of food, clothes and washing facilities.

During the project, demographic data of clients was gathered which showed a high HIV prevalence rate (31% in 2003). This showed the importance and relevance of intervening quickly and on a long-term basis.

Due to their lifestyle and dependence, drug users often face barriers in accessing social and health services or avoid seeking such services because they fear stigmatisation. Reaching out to drug users by employing outreach workers who enter drug users' communities, was a novel strategy in Iran. The project was very successful, which was partially demonstrated by the target group showing a high interest in the measures offered, demonstrating a clear need for this type of services. A large number of clients came forward to get sterile syringes/needles and condoms, which can be traced back to a higher awareness of HIV/AIDS risks.

The NGO Persepolis has received considerably positive feedback from international experts and media highlighting the project's unique contribution to promoting the health



There is a great need to deliver honest education about drug use and its related hazards to young people in Iran in order to prevent HIV transmission.

of an otherwise highly excluded and vulnerable population in Iran.

In January 2005, the success and importance of harm reduction was officially recognised by the Iranian Head of Judiciary stating that all judicial authorities should abstain from charging those who are active in this field with the criminal offence of facilitating drug taking. The international community and drug organisations in Iran have highly welcomed this statement.

Lessons learned:

- Harm reduction is an effective method of preventing HIV/AIDS among injecting drug users (IDU)
- Harm reduction is often the only way to reach the vulnerable and marginalised group of drug users
- Pilot measures at local level can be an effective tool in advocacy for adopting harm reduction measures at national level

For more information about GTZ, its publications and its projects, contact Eva Schildbach Drug abuse prevention expert, Development-Oriented Drug Control Programme (DDC) at the Division of Health, Education, Social Protection: eva.schildbach@gtz.de or visit www.gtz.de/en/themen/uebergreifende-themen/drogen/5501.htm for more of GTZ's publications.

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Note: Persepolis was featured most recently in the DrugLink Newsletter volume 21, issue 2 (March/April 2006), pp. 20-23; "Iran opens up to opium reality." You may be able to obtain a copy of this article by contacting DrugScope at info@drugscope.org.uk.

PROGRAMME

Multi-Agency Cooperation to Enhance Services to Drug Users in Delhi

This article is a reprint of GTZ's Project Sheet

The GTZ financed project “Multi-agency cooperation to enhance services to drug users in Delhi” aims to develop an integrated approach to preventing and reducing substance dependence through enhancing services and their accessibility for drug users in Delhi. The long-term objective of the project is to create healthier communities. It was initiated and is being carried out by three local NGOs: Navjyoti Delhi Police Foundation, Sharan and Sahara. GTZ supports these experienced NGOs in innovative drug dependence treatment and training measures. Prior to the project, Navjyoti Delhi Police Foundation, Sharan and Sahara had already been providing a wide range of services to drug users, from homeopathy and yoga to outreach and harm reduction.

Multi-stakeholder round table on drug related issues

One objective of the project is to establish a round table for enhancing multi-agency cooperation at city level, bringing together and improving coordination among stakeholders from various sectors that are addressing the drug problem in the community.

To achieve this objective, the project makes use of the GTZ method “Integrated local drug policy”. As no single organisation or agency on its own can meet all the demands in a community, a regular forum was established to bring together politicians, members of the administration and judiciary institutions, law enforcement agencies, NGOs, medical personnel and user-groups. These stakeholders meet regularly to learn from each other and tackle the problem according to the needs, capacity and resources available in Delhi.

This multi-disciplinary and intersectoral approach assembles all relevant actors and allows them to harmonise and coordinate their efforts in a joint community-based response. Together with the Indian partners, GTZ established the Delhi Round Table on drug-related issues as the first pilot initiative of its kind in Asia.

Training in prevention, treatment and harm reduction

The second objective is to support training in prevention, treatment and harm reduction to demonstrate the effectiveness of different methods and enhance capacity building. Activities supported under this objective are:

- training courses in homeopathy and yoga to service providers (Navjyoti)
- awareness-raising courses for the police (Navjyoti)
- vocational training for drug users (Sahara / Sharan)
- establishment of a “job-shop” database for ex drug users (Sahara)
- trial with sublingual buprenorphine substitution (Sharan)
- outreach project for extremely marginalised eunuchs and transgender “hijras” who are drug users (Sahara)

Impact

The multi-stakeholder round table on drug-related issues is the first of its kind in South Asia, and its meetings focus alternately on political and technical issues. The Delhi Round Table has been very well accepted by the relevant stakeholders, including the international community. The first results clearly confirm the necessity of such a forum. The close collaboration with the three partner NGOs has proven to be very fruitful also in identifying key figures for participation in the network.



“Does being human refer only to a man or a woman?”



“I like this picture because I look so good. I like the way I have worn the sari. Since my childhood, I wanted to wear female clothes. This picture gives me a sense of fulfilment and I feel like a beautiful woman.” – Neha

One of the major outcomes has been the commitment to develop a City Action Plan on Drugs, which could become the forerunner for an innovative approach to managing drug-related issues in cities in Asia and other regions.

Transgender/hijra project (Sahara)
The Sahara transgender outreach project aims at reducing the impact of HIV/AIDS and at creating a more accepting environment for this highly marginalised group. It provides primary health care, treatment of STIs (sexually transmitted infections), peer educator training in HIV/AIDS and STI awareness, and activities to enhance access to health and social services for transgender persons.

In one initiative, people from the transgender community took photos of their daily lives. These photos have been put together for an exhibition accompanied by a publication to be shown in Delhi and Germany to raise awareness about their lives and needs in India.

Trial with sublingual buprenorphine substitution (Sharan)

A sublingual buprenorphine substitution project was set up to assess clients for behaviour change and to reduce the harm directly or indirectly connected with drug use, especially the spread of HIV/AIDS and other blood-borne infections among drug users and their partners. The drug is given as a substitute enabling people to move away from injecting drugs.

The buprenorphine trial proved to be very successful: of the 150 clients only 2 experienced a relapse. The others either stabilised and drastically reduced their drug consumption or became abstinent. The Johns Hopkins School of Medicine (USA) subsequently funded the continuation and expansion of this project.



“As in general society, in the transgender community, a mother-in-law blesses her daughter-in-law.”

Navjyoti Delhi Police Foundation – Training Centre

In 2003, Navjyoti built a new “Drug Demand Reduction Training Institute” in Delhi with funding from the Japanese Embassy and KK Shah Charitable Trust. At the new premises, detoxification and treatment as well as training (funded by GTZ) and research activities are combined under one roof. The participants of the training workshops and seminars are mostly social workers, doctors and other people working with drug users.

Lessons learned:

- integrated local drug policy is an effective and useful approach at community or city level and makes decision-making more transparent
- the Round Table is an effective method to facilitate the development of an integrated local strategy through all relevant stakeholders
- local policy development that is based on consensus at community level can have a positive impact on national policy.



“Like all women, we love to sit and chat in our free time. Normally, we get together and talk, gossip, laugh and play ludo. Through these moments, we come to know each other better and share our secrets.”

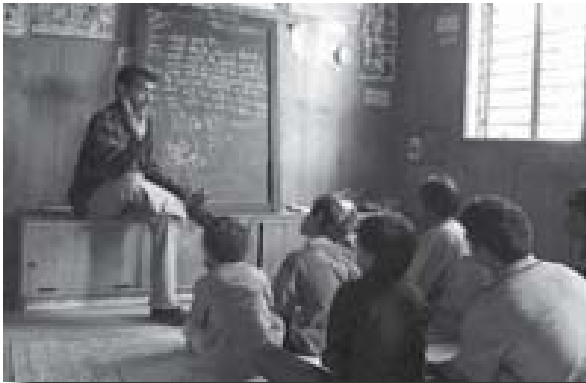
For more information about GTZ, its publications and its projects, contact Eva Schildbach Drug abuse prevention expert, Development-Oriented Drug Control Programme (DDC) at the Division of Health, Education, Social Protection: eva.schildbach@gtz.de or visit www.gtz.de/en/themen/uebergreifende-themen/drogen/5501.htm for more of GTZ's publications.
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Outreach services in Delhi are providing clean injecting equipment and education and information about drug use to street-based users in order to minimise the health and social risks commonly associated with drug use.



Drop in centres are safe spaces for vulnerable and marginalised communities to meet and exchange with people who are in similar situations, get social and medical support, rest and recover from the hardships of the street.



Delivering honest evidence-based information and communication is crucial to halting the spread of HIV in Asia. Fear-based messages that exaggerate and distort the facts only fuel stigma, discrimination, marginalisation, and criminalisation which then hamper the deployment of an effective response among vulnerable communities.

Drug situation in Delhi

- 140,000 people officially use drugs illicitly (unofficial numbers are likely to be higher)
- More than 30% of people living on the streets use illicit drugs
- Injecting drug use (IDU) has in recent years become increasingly prevalent and led to an alarming rise in the number of HIV infections
- The main substance injected is not heroin but a cocktail of buprenorphine, a synthetic opiate, benzodiazepam, and avil (an anti-histamine)

Although GTZ has been providing financial assistance to the Sahara transgender project in Delhi, India, as well as to Persepolis in Teheran, Iran, the support from GTZ was discontinued after a certain period of operations without them having developed mechanisms for alternative sources of funding and without regards for the consequences of the lives of those groups at high risk for HIV transmission. These temporary investments demonstrate a lack of commitment in the response to drug use and HIV and AIDS in Asia, and have the tendency to lead to more problems rather than actually and effectively resolving anything.

Fortunately, the AHRN initiative From Margins to Mainstream, in partnership with Mainline and with support from the Dutch Ministry of Foreign Affairs, has been providing financial and technical assistance to both Persepolis and Sahara in the wake of the funding shortages they faced after GTZ's support was terminated.

In this light, AHRN calls on GTZ to deliver sustainable support for development projects seeking to improve the environment for the delivery of comprehensive services targeting drug use and HIV/AIDS. In short, AHRN encourages GTZ and other donors to continue supporting harm reduction as an essential, effective and safe set of services that significantly reduce the transmission of HIV, while maintaining support for successful pilot projects. In that sense, AHRN is eager to see sustainable financial and technical support being delivered with a focus on organisational development.

Mr. Ton Smits,
Executive Director, AHRN

Dr. Bijan Nassirimanesh, Executive
Director, Persepolis

Mr. Luke Samson,
Executive Director, Sahara House

Editors' note : All pictures and captions were originally published in Kaaya: Beyond Gender – A Window into the Lives of a Transgender Community, by the Centre for Media and Alternative Communication (CMAC) in collaboration with GTZ and Sahara House.

INSIDE AHRN

From Margins to Mainstream Project Update

By Patrick O'Gorman,

AHRN Project Manager (Technical), From Margins to Mainstream

The “From Margins to Mainstream” project represents a unique collaboration between the Asian Harm Reduction Network (AHRN), Thailand and Mainline Foundation, the Netherlands. For a number of years, AHRN has sought to bring the expertise and knowledge possessed by Mainline to the Asian region. In 2004, this was realised through a joint and collaborative bid to the Dutch Ministry of Foreign Affairs (MOFA) to finance an Asian regional programme. The programme concentrated on the triple nexus that exists between poverty, injecting drug use and HIV& AIDS. AHRN’s local experience was invaluable in generating a strategy to respond to the challenges in the region by developing replicable impact-based models of intervention which support the continuum of care for drug users. The project is being implemented in seven countries. In Iran (Teheran), Persepolis is developing outreach support to drug users and enhancing its drop-in centre where pharmacotherapy support is delivered. In Pakistan (Islamabad), Nai Zindagi is developing a vineyard on 25 hectares of land which will employ up to 400 drug users (many of whom are living with HIV and AIDS). In India (New Delhi), SHARAN is improving residential detoxification component and pioneering home-based detoxification; Sahara House is providing comprehensive health and social care services to transgender groups. In Nepal (Kathmandu), Youth Vision has developed an outreach programme to current users in the valley. As part of

this programme, it is hoped that buprenorphine pharmacotherapy will be implemented in the country. In Cambodia (Phnom Penh), Friends International and Mith Samlanh are providing technical assistance to government departments and other actors to enlarge the capacity of outreach to young people (street children) who are increasingly drawn into drug use. In addition, a small business – Creative Design Studios – is focussed on teaching design concepts and unleashing the creative potential and entrepreneurial ability of young people completing rehabilitation. In Malaysia (Terengganu), Pelangi is developing a hospice care model for homeless drug users who are living with HIV and AIDS and developing an organic dragon fruit business. In Indonesia (East Kalimantan), LARAS is pioneering outreach services to drug users in Samarinda and health and social care services to sex workers in villages outside Samarinda and Bontang. Activities in the first year of the programme concentrated on developing the specific design of projects; its structure, establishing principles of how outcomes would be delivered and building the implementation network. Contracts which include the details regarding deliverables and objectives have been signed with all partners. The partnership with the Ministry of Foreign Affairs (MOFA) in the Netherlands was established productively. MOFA has proved to be a flexible and supportive partner and demonstrates an excellent understanding of development dynamics. Furthermore, MOFA has been extremely supportive of measures aimed at improving the debilitating nexus of drug use, HIV and AIDS and poverty.



Pelangi Community Foundation in Malaysia provides hospice and palliative care to homeless people living with HIV/AIDS.

Iran – Persepolis

Persepolis currently provides pharmacotherapy (administering methadone) to 350 patients daily. The location of the drop-in centre was changed in April. The new location is more secure and has added some benefits to the service. Various government departments have been supportive of the initiative during the past few months and staff morale is high. The outreach programme has been enhanced through the purchase of six bicycles which have been adapted to carry supplies and outreach support is provided to 250 people monthly. The plan of introducing a mobile clinic is on hold awaiting the delivery of mobile vans which should take place in the next months. The project has enabled Persepolis to become increasingly linked both regionally and internationally and this has reduced their isolation and provided access to international protocols.



The organic dragonfruit plantation generates income both to sustain Pelangi Community Foundation’s activities and to support clients.



Persepolis delivers a comprehensive set of harm reduction and primary health care services to injecting drug users in Teheran in order to stem the rapid transmission of HIV.

Pakistan – Nai Zindagi.

Most of the vineyards have been planted. Staff has been recruited directly upon completion of detoxification. To date, the retention of the workforce is about 45-50%. Those who have adapted to the work have become very committed and their outlook on life has been transformed. The current crop of grapes is being harvested and the result is of high quality. The project has concentrated on recruiting those people living with HIV and AIDS completing treatment. This has increased the challenge of implementing the project as many require ongoing medical care. Training modules and certification processes are currently being developed.

(See the Byabani Grapes booklet inserted in this issue for details regarding this project.)

India – SHARAN – Sahara House

Currently, SHARAN is providing residential detoxification on a monthly basis to 40-50 homeless, street-based drug users. Generally, clients are responding well to treatment, with a drop-out rate as low as 28%. SHARAN has linked the detoxification programme to the continuum of care and on average 38% of those completing treatment are referred for rehabilitation to Sahara House; Hospitals Michael Care Home; Teen challenge; Asha Bhavan. Sahara House has enlarged its capacity to provide health and social care to transgender groups by relocating to a larger locale and additional staff. Three transgender staff members are included in the team. The new location is a three-storey building which has the capacity to provide residential treatment and an isolation ward for those who have contracted Tuberculosis.

Currently 19 people are receiving dedicated in-house care and a further ten receive short-term support. Referrals have been made to Michaels Care Home (a hospice supporting people living with HIV and AIDS) and ten clients are accessing antiretroviral treatment (ART) provided by state authorities. Funding has been secured from GTZ to provide operating equipment.

Nepal – Youth Vision.

Youth Vision began its outreach programme to drug users in December 2005. Currently it operates a satellite drop-in centre close to injecting sites. The key component of the programme – pharmacotherapy – is being discussed with the national government and a workshop is planned for early August 2006, where the applicability and value of buprenorphine will be reviewed and discussed.

Cambodia – Friends International and Mith Samlanh

Friends International and Mith Samlanh are providing support to government and other actors to enhance the capacity of service provision to street children in Siem Reap and Kratie provinces. At the beginning of June, Creative Design Studios moved into a prime location on street 240 – one of the most popular streets in Phnom Penh. As the business develops, it is anticipated that its location will be of strategic marketing value. Mith Samlanh’s main operating centre is being threatened as ownership of building complex has changed. Mith Samlanh is currently raising funds to purchase the location outright (considering the strategic value to the place). For further details visit www.streetfriends.org/CONTENT/LIFE/events.html.

Laras has been building capacity of local sex workers and delivering primary health care in Samarinda with great success.



Malaysia – Pelangi Community Foundation, Terengganu.

Pelangi provides hospice care to homeless people who are living with HIV and AIDS in Terengganu, one of the poorest provinces in Malaysia. The hospice currently provides residential care for six clients – five of whom are recovering drug users and three are transgender persons. Attached to the hospice, the organic dragon fruit farm employs two full-time and one part time worker. For details please refer to www.ahrn.net/index.php?option=content&task=view&id=2485#2.

Indonesia – LARAS, East Kalimantan

One of the most significant achievements of the programme so far has been the initiation and development of health and social care interventions by LARAS - an NGO new to the scene. Prior to the initiation of “From Margins to Mainstream”, no services were available in East Kalimantan for drug users. LARAS conducted a needs assessment and has now recruited and trained a young team who are delivering practical care to drug users in Samarinda and sex workers in sex villages in both Bontang and Samarinda. Exceptional progress has been made in a short time. One of the most significant achievements has been established through LARAS’ networking ability – the provision of generic health care services where medical check-ups and interventions have been established through local city authorities in both Bontang and Samarinda.

The following was a brief project update of what is taking place throughout the region. Further details can be provided on request by contacting the author at patrick@patrickogorman.co.uk.