

USERS' PERSPECTIVE

Hi Friends! My name is Shivakumar. I am a 37 year old recovering drug user. My addiction story is very thrilling and very sad. It starts when I was young and I wanted to become a police officer, but I got diverted to drugs.

When I was 19, my friend and I had a road accident in which I broke my left hand. I was hospitalized at the same hospital where I was working. The pain was unbearable so the doctor gave me an intramuscular injection of Tidigesic – a powerful pharmaceutical analgesic. For three hours, there was no pain and the drug was giving me some high – which I was enjoying! When the drug wore off, I started feeling pain again, the high was gone, and my addictive personality was calling for me to take one more shot without the doctor's knowledge. So I raided the hospital storeroom and took another injection of Tidigesic. Within hours, I was addicted to drugs.

For three years following my accident, I kept taking drug injections at a rate of more than 15 ampoules per day. One of the doctors became suspicious because of my behavior on while I was on duty. It was understandable since I was high while I was at work most of the time. Sometimes, my hands swelled up because of a bad fix. I became very afraid that the doctor might come to notice my drug use and would have me arrested, so I confessed to doctor that I had become drug dependent. I thought that he would surely fire me or have me arrested but, instead, he understood my problem and tried to help me. My fear was gone, so I

Breaking the Downward Spiral
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kept using and working at the hospital for a year. As time went on, my physical condition deteriorated to the point where I couldn't perform my duties. So one day I decided to give up drugs but I just couldn't. Being around drugs at the hospital on a daily basis didn't help, I came to realize, so I decided to move on.

Once out of work, I started to mingle with brown sugar users and very soon, I got hooked to it and cannabis. It was hard for me to support my drug use because my family knew what I was doing. I couldn't face my family. I left home, but I had no idea where to live. I ended up in a graveyard where I lived for a couple of months. Earlier, my family and close friends were there to help quit drugs but I could never accept what people told me.

My drug use landed me in a local jail three times. It was there that I really felt the pain of isolation and I must admit that it went to my heart and touched me. I wasn't happy with the way I was,

the life I was leading; I felt ashamed of myself. I wanted to commit suicide. I wanted it all to end. So I loaded a barrel full of drugs hoping for a last dying trip...

When I came to, I was in a hospital. After a few days, I was released and I started using again. I injected for six months but, this time, my family came to help me. They took me to TT Ranganathan Clinical Research Foundation Hospital (TTK Hospital) where I enrolled in a three-month treatment programme. There, I learned a lot of helpful tips to really give up drugs. After getting discharged, I failed follow what I had just learned and started hanging out with my old drug using friends. It didn't take long for me to relapse. Again, the downward spiral which led to my second suicide attempt. With the grace of God, I survived but my body was heavily damaged because of excessive drug intake. I was in a coma for three days. Even after waking up, I realized that my obsession for had drugs never left me

for a single second – and would never leave – ‘where can I get my next fix?’ was my next thought ... but I couldn’t use because my physical condition.

So there I was, in the worse condition of my life, being pulled back into this hospital bed. It became unavoidable to notice that my drug use was the reason I kept ending up in the hospital. I thought to myself ‘this time, why don’t I try not using and see where that leads!’ After that, I went back to TTK and cleaned up my act, went to self-help group meetings where I got strength and hope and I went wherever help was available. With God’s grace and the precious help I found at TTK, I am recovering from drug dependence, staying away from all drugs for more than ten and a half years

now and still attending the self-help meetings in Chennai on a daily basis.

Since I beat my addiction, I have been working at TTK’s Outreach Centre for six and a half years as the buprenorphine project coordinator. The work I do is part of harm reduction even though TTK’s ultimate goal is total abstinence. The people working at TTK understand that beating drug addiction doesn’t work on a one-size-fits-all programme; some treatment options will work for some, while other will need other interventions to leave drugs behind them. TTK currently offers capacity building, awareness raising programmes, detoxification, rehabilitation, as well a buprenorphine pharmacotherapy. So, I can see how providing pharmacotherapy

drugs like buprenorphine will eliminate all physical withdrawal symptoms and the need to fix and thus enable people using drugs to live longer, more productive lives, free from blood borne infections like HIV/AIDS and hepatitis C which are easily transmitted through shared needles and syringes. Whatever people might say, I know that providing people using drugs with pharmacotherapy can’t be bad since it allows them to get jobs, enjoy their family lives and maintain decent social relationships.



To find out more about TTK hospital, contact me at TTK outreach centre, S3 Jawaharlal Nehru Salai, 15th Avenue, Ashok Nagar, Chennai 600 078, Tamil Nadu, India.



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The Seven Sisters Strategic Plan 2006 - 2010

By Shiba Phurailatpam, APN+ Regional Coordinator

As the Coalition of Asia Pacific Regional Networks on HIV/AIDS (also known as the Seven Sisters) has developed and grown since its inception in February 2001, a need was identified to be clear about the direction of its growth over the next period, and to reaffirm what the Coalition is, what it stands for and what are its priority activities. After performing an internal and an external evaluation, the Coalition set out to develop a strategic plan to guide its work over the next few years. The strategic planning meetings would not have been feasible without the support from UNAIDS Regional Support Team (RST) and AusAID.

The strategic plan process started with intense consultation by email in 2005 with Seven Sisters' member networks and other relevant stakeholders. The first strategic planning meeting was organised in February 2006 in Kuala Lumpur, Malaysia, and included discussions about the Coalition's past, present and particularly what its future might look like. The participants at the meeting also identified future strategic goals and directions.

As a follow-up to the previous meeting, a final strategic planning meeting was held in Bangkok between 13 and 15 June 2006. The three day meeting was very intense and exhausting, but for most, the achievements were very rewarding. The Coalition

representatives looked at the strategic directions and activities that emerged from the previous meeting and consultation, and examined some of the cross-cutting issues such as GIPA, Universal Access, capacity development and gender.

Participants at the strategic planning meeting were divided into four groups to work on identifying the activities, indicators and outcomes associated with a single strategic direction. The second meeting provided network representatives a chance to finalise the mission, vision, activities, outputs, timelines and some indicators. Participants left the second meeting with some minor details to iron out before the completion of the Coalition's strategic plan.

The final steps ahead include obtaining approval on the final draft of the strategic plan from the Coalition's newly formed Management Committee as well as designing, printing and disseminating to members, partners and relevant stakeholders in the Asia Pacific region. Deployment of the strategic plan will incorporate and integrate many of the recommendations formulated during the external evaluation.



After all the hard work, the Coalition representatives invited colleagues based in Bangkok to join the evening reception by the pool. Colleagues wish Susan Chong of APCASO good luck with her new projects in Australia.

The Coalition of Asia-Pacific Regional Networks on HIV/AIDS is a broad based alliance between seven regional networks: the Asia Pacific Network of People Living with HIV/AIDS [APN+], AIDS Society of Asia Pacific [ASAP], Asian Harm Reduction Network [AHRN], Asia Pacific Network of Sex Workers [APNSW], Co-ordination of Action Research on AIDS and Mobility in Asia [CARAM Asia], Asia Pacific Network of Lesbians, Gays, Bisexuals and Transgenders [AP-Rainbow] and the Asia Pacific Council of AIDS Service Organisations [APCASO].



Representatives from all seven networks work together to finalise the Coalition's strategic plan.



For more information about the members of the Seven Sisters Coalition or for information related to the strategic plan, please contact the author at shiba@apnplus.org or info@apnplus.org.

A look at the Service Gaps for IDUs in Central Asia

By M&E and Research Department
AIDS Foundation East-West

Background

In the AHRNews #40, an overview of a recent research project conducted by AIDS Foundation East-West (AFEW) in Central Asia was provided. This research was conducted as AFEW set out to implement a HIV prevention and care and support project in four Central Asian republics in 2005.

The AFEW project is financed by the Dutch Government and is aimed at establishing a network of client-focused HIV prevention, care and support services for sex workers, IDUs and former prison inmates within one region in each of the target countries; Bishkek in Kyrgyzstan, Almaty in Kazakhstan, Navoi in Uzbekistan and Khojand in Tajikistan. In this context, the purpose of the research was to identify the needs of the target groups as well as assess the capacity of the existing service providers in each region to meet these needs.

To gain this information, AFEW partnered with and provided training and support to local organisations to conduct a survey amongst service providers and three target groups in each of the selected regions.

As was outlined in the earlier article, the study objectives were:

1. To describe the service needs of SWs, IDUs and recently released Prisoners in relation to HIV/AIDS within the selected oblasts/regions;
2. To assess the capacities of existing service providers to meet these needs through the use of a Client Management Unit model; and
3. Provide recommendations regarding future capacity building activities.

The following table provides a breakdown of the survey sample.

Table 1: Survey Sample

	IDUs	Sex workers	Inmates	Service Providers	Total
Kazakhstan	293	337	301	105	1036
Kyrgyzstan	416	400	300	34	1150
Uzbekistan	318	300	300	33	951
Tajikistan	301	306	285	76	968
Total	1328	1343	1186	248	4105

IDU Responses

Below are the key findings that arose from the surveys of IDUs in the four countries.

1. Approximately 27% of respondents in Kazakhstan said that they needed drug dependence assistance but only 60% of them indicated that they were able to get it. In the other countries these figures were 60% and 49.1% in Tajikistan, 41% and 47% in Kyrgyzstan and 50% and 66% in Uzbekistan. This suggests that few IDUs are either seeking or receiving this assistance. Consequently, there is an urgent need to increase coverage of drug dependence services by introducing free-of-charge detoxification and treatment programs. In particular it is felt that trainings for specialists as well as informational materials may decrease barriers for IDUs to enter these facilities.

2. The poor availability and accessibility of employment and social support and care services, self-support groups and crisis counseling in each of the countries is particularly concerning. For example, approximately a quarter of respondents in Tajikistan (25%) and Uzbekistan (23%) said that self-support group were needed but 80% in Tajikistan and 70% in Uzbekistan said that this service is not available. Based on this, it is recommended that there be significant improvement of social care services and involvement of credible and trusted workers (peers) in service delivery such as outreach and mobile services.

3. In all the studied countries it was found that improved access to harm reduction services is needed, including making them more closely located and accessible to the target groups. In this, it appears that special attention should be paid to making the range of services wider. In particular, beyond needle/syringe exchange and education, there

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should be an effective referral system developed to assist IDUs in navigating their way through the system.

4. Only 16% of respondents in Kazakhstan knew that HIV treatment (HAART) exists at all, with similar figures in Uzbekistan (13%), Kyrgyzstan (14%) and Tajikistan (17.8%). Thus, an information campaign could be delivered through various communication channels (booklets, leaflets, posters, seminars) and aimed at increasing knowledge on HIV treatment.

5. The respondents reported quite a low rate of coverage by medical care in each of the countries. The main reported obstacles mentioned were expensive medical service, limited availability, judgmental or negative attitudes of staff and high costs. Provision of free/cheap specialised as well as general medical care with minimal barriers created by stigma is therefore required. In particular, the services available should include voluntary counseling and testing for HIV and STI.

6. In many places, stigma and conservative social and cultural traditions severely limit the ease and apparent practicality of programme and policy development. Therefore, it is important to raise awareness among governments, law enforcement structures and other civil society groups about the value and necessity of investing in locally appropriate ways of preventing HIV and STIs among IDUs.



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Service Providers Responses

In addition to the target groups surveyed, the service providers point to the following barriers to providing effective services to IDUs:

- Limited access to and coverage of the target groups;
- No practical assistance in dealing with the target groups;
- A lack of motivation and professionalism among specialists;
- A sense that non-governmental organisations are not serious and capable organisations and partners;
- Programmes activities are non-systematic with no clear driving principle or structure;
- The absence of anonymity for clients;
- Absence of documents and registration (propiska) for people from target groups;
- Weak financial and logistical support for service providers;
- Charging for services limits access by vulnerable groups;
- The treatments available in many cases are limited in supply and ineffective;
- The target groups themselves often don't appeal for assistance, are not eager to access services and/or don't appreciate it;
- Often the target groups fail to attempt to change behaviour;
- A lack of adherence to treatment programmes;
- The absence of testing systems; and
- Frequent change of managers/directors in organisations.

A particular issue identified by the

service providers was a lack of any connection between the target groups and the social services available. This was attributed to such things as:

- Fear for personal safety;
- A fear of HIV;
- Other people being afraid of these groups;
- A fear of law enforcement action;
- A belief that the services will not be able to solve their problems; and
- Religious beliefs.

As a result of this research, the AFEW project aims to respond to the overall recommendation that a significant capacity building programme is to be put in place:

- To reduce the stigma and fear surrounding the target groups and HIV;
- Build the skills, resources and knowledge of the service providers to adequately meet the needs of the target groups; and
- Develop a mechanism and system for supporting these vulnerable groups in planning and managing their service utilization, including integrating the various social and health services into a functioning network with an effective referral system.



A medical doctor from Almaty oblast (regional) AIDS centre is interviewing a drug user in Taldykogan city as part of the RAR. Photo by A. Backer.



A box of used syringes in the needle exchange point in Bishkek city. Photo by A. Backer.

For more information about this study, please contact Mr. Nicolas Cantau, Regional Director, Central Asian Republics, AIDS Foundation East-West (AFEW) at nicolas_cantau@afew.org.

Combating Substance Dependence in Northeast India

By M. Amarjeet Singh

Recognising the seriousness of the multi-faceted implications of the incidence of alcoholism and substance dependence in India, the Ministry of Social Justice and Empowerment (MSJ&E) of the Government of India launched "Scheme for Prohibition and Drug Abuse Prevention" in 1985-86. Since then the Ministry has been promoting a community-based approach towards the identification, treatment and rehabilitation of substance dependents. The Scheme was subsequently reviewed in 1999 and restructured as "Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse". The Scheme is being implemented through registered societies or organisations fully funded or managed by a State government or a local body.

By 2000, there were altogether 54 such Centres that comprised 26 Counselling Centres (CCs) and 28 De-addiction Centres (DCs) being assisted by the Ministry for the aforesaid Scheme in the Northeast region. Out of the eight states of the region, our study covered the States of Assam, Meghalaya, Mizoram, Manipur and Nagaland. Considering the spread of these States on difficult communication network, one-third of the Centres were selected for the study. Hence, one-third of the total Centres formed the part of the sample, where ten substance dependents from each selected Centres were interviewed to ascertain the efficacy of the Scheme. Besides fifteen opinion leaders representing various segments of social interest groups from each of the Centre were identified for their assessment of the Scheme.

Altogether 10 of these Centres were located in the five capital cities of the respective States. Five others were located in the small district towns, one each in the industrial area and tourist place, and last one was placed in a rural surrounding. Ironically, only

a few of them were equipped with sufficient medicines and medical equipment. Counseling was provided in all the Centres. It was also identified that individual and group therapies were commonly practiced. They were also engaged in community services like public awareness campaigns, home visits and village meetings.

The monthly attendance of drug users in these Centres ranges in between 10 to 90. Most of the Centres had 10 beds available for the patients requiring detoxification. Some Centres claimed to have facilities of training the inmates in carpentry, tailoring, embroidery, typewriting, poultry and piggyery.

The steps taken up by these Centres to increased community participation as well public cooperation are: awareness programmes like workshops, seminars, religious meetings; youth leadership training and the involvement of other NGOs.

Most of the Centres claimed that the Scheme had a positive impact on the drug use scenario. The impact of the Scheme was felt in the following ways: 'it has brought awareness of the problem to the common people', 'it is helpful in changing the attitude of the people' and the 'citizens have been made aware of it as a serious social problem'.

The study covered 180 substance dependents inclusive of 12 recovering drug users; ten clients randomly selected from each of the Centres and the information from them were solicited through a questionnaire. It was found that 93.33% of the beneficiaries were male and the rest were women. More than a half of them were aged between 21-30 years and were mostly unmarried. The largest social group of the sample was unemployed youth, followed by students. The deficiencies of these Centres, according to them were: water scarcity, irregular power supply, insufficient staffs, inadequate recreational facilities and insufficient built in space.

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More importantly, in their day-to-day affairs, these Centres faced the following difficulties:

- Lack of sufficient and trained staff;
- Insufficient honorarium given to the staff;
- Financial difficulties;
- Poor building infrastructure; and
- Lack of people interest on the issue.

Based on the study, there are certain areas of operation, which need urgent attention with the view to making the Scheme a success:

- Lack of contact between the beneficiaries and the Centres once the recovering drug users leave the Centre after care;
- Lack of vocational training and rehabilitation package;
- Lack of emphasis on games and sports;
- Lack of reliable, regular and easy availability of medical facilities in the Centres: It should be considered whether a full-time medical doctor is to be employed especially in the distant frontier and rural areas, where the Centres are located;
- Insufficient, irregular and erratic provision of financial support: financial issues need urgent attention;
- Institutions involved with the Scheme must work along with local schools, youth association and women fora, and
- One of the weakest points has been lack of monitoring of the awareness programmes undertaken by these Centres. It is advisable that the number of awareness programmes be increased and when they are conducted, they should be implemented in association with local voluntary bodies such as women, youth and students associations. It will also be ideal that involved Centres in the region organise their camps, occasionally disseminate their positive achievements and share experiences with each others.

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Bridging HIV/AIDS and Education: The Positive Learning Working Group

By Sumedha Sharma, Programme Officer, ASPBAE

The Asia-Pacific region is facing an uphill battle against the HIV/AIDS epidemic. 2,685 new HIV infections are recorded everyday (111 per hour) while 1,192 people living with HIV/AIDS die each day in Asia-Pacific. The current prevalence may not be as alarming as elsewhere but taking into account the socioeconomic context of the region, including population density, widespread poverty, low levels of education, and a host of other factors, it is clear that the risks for HIV/AIDS transmission accumulate and vulnerabilities overlap for those in disadvantaged situations. Education – both formal and non-formal plays a very important role to prevent the spread of HIV. A new analysis by the Global Campaign for Education suggests that if all children received a complete primary education, the economic impact of HIV/AIDS could be greatly reduced and around 700,000 cases of HIV in young adults could be prevented each year – 7 million in a decade¹. The challenge is big in the Asia-Pacific region where three-fourths of world's illiterates live. Today, almost one billion adults – equal to the total population of Africa – are denied their basic right to literacy. Out of these, 61.3% of adult illiterates – more than 472 million persons – live in only five countries of Asia: India, China, Bangladesh, Pakistan and Indonesia. In South Asia alone, 42 million children are reportedly out of school².

The Asia-Pacific region has strong and active networks – both in the field of Education and HIV/AIDS. Unfortunately, a gap persists amongst the two fields and is reflected in the region's educational programming on HIV/AIDS. With an aim to bring the two fields together and explore the inter-linkages and facilitate and strengthen the intersections, the Asian South Pacific Bureau of Adult Education (ASPBAE) and the AIDS Education Programme (AEP) took the initiative to collect strategic input from various expert organisations based in the region. The consultation resulted in the formation of the Positive Learning Working Group (PLWG).

It has been nine months since PLWG was formed. In these nine months PLWG³ members have met three times and have maintained a regular flow of information amongst the network. The name of the network is based on the popular phrase 'positive living,' on the one hand, and the name Positive Learning Working Group (PLWG) borrows elements from 'meaningful living' that stresses an integrated approach to a person's development based on spiritual, mental and physical health. On the other hand, the term 'positive' in the HIV/AIDS field is a non-discriminatory formulation referring to individuals and/or groups affected by HIV/AIDS. As such, 'positive learning' has roots in the HIV/AIDS field but blossoms through the education field.

The driving principle of PLWG as decided by the members is Life Long Learning (LLL). LLL stresses that education is a process that takes place throughout an individuals' life not withstanding environmental or institutional context. The mission of PLWG is – to strengthen the response to HIV/AIDS through LLL and promote and mainstream the integration

of both fields. The broad principle of the two sectors coming together is to learn from each other's advocacy work and have coordinated complementary responses to bring about significant change. The PLWG's role was explicitly formulated as an advocacy body which would provide technical support and facilitate capacity building in the Asia-Pacific region.

The need to integrate is felt in both the sectors. For the HIV/AIDS sector education is clearly a process not to be bypassed while looking at HIV/AIDS prevention and also to reduce stigma and discrimination. For the education sector, the need to include HIV/AIDS prevention in their curricula is equally important, firstly to prevent the increasing epidemic, and secondly to prevent the exodus of millions of children, teachers and adults who are opting out of education because they are either directly affected by HIV/AIDS or have to take care of people living with HIV/AIDS. In practical terms, this translates in a sharing of expertise, knowledge and methods where education and HIV/AIDS meet.

In September this year, PLWG organised its first capacity building initiative - HIV/AIDS Regional Skill Building workshop on Stigma and Discrimination. Participants from organisations working on HIV/AIDS issues, representatives of education coalitions and member organisations working on formal and non-formal education have been invited to join the workshop. Look for further developments in upcoming editions of AHRNews.

For more information on PLWG, ease write at plwg@eforums.healthdev.org. To learn more about the members, activities and objectives of the Positive Learning Working Group, download the PLWG position paper at www.ahrn.net/library_upload/uploadfile/PW-LABrochure.pdf.

1Global Campaign for Education; Learning to survive – How education for all would save millions of young people from HIV/AIDS; April 2004

2Source: UNESCO

3Members of PLWG - AIDS Education Programme (AEP), AIDS Network Development Foundation (AIDSNet), Asia-Pacific Network of People Living With HIV/AIDS (APN+), Asia-South Pacific Bureau of Adult Education (ASPBAE), Asian Harm Reduction Network (AHRN), Constellation for AIDS Competence, E-NET Philippines, EMPOWER, Health & Development Networks (HDN), Help Age International, MAP Foundation (Migrants Assistance Project), Migrant Forum in Asia (MFA), Remedios AIDS Foundation, UNESCO Institute for Education (UIE).

Committee on the Prevention of HIV Infection among Injecting Drug Users in High Risk Countries

By Alicia R. Gable, MPH, Senior Programme Officer, Institute of Medicine

In September 2005, at the request of UNAIDS and the Bill and Melinda Gates Foundation, the Institute of Medicine convened an international committee to review scientific evidence on the effectiveness of HIV prevention strategies for injecting drug users (IDUs), with a focus on countries where drug use is the primary driver of the HIV/AIDS epidemic. Programmes considered include sterile needle and syringe access programmes, outreach and education, and drug treatment, including pharmacotherapies and psychosocial interventions. The review will include evidence from around the world and will particularly seek out evidence from affected regions such as Eastern Europe, the Russian Federation, the Newly Independent States, Central Asia and South East Asia. Specifically, the review will address the following questions:

1. How effective are these programmes in reducing HIV transmission among injecting drug users?
2. What impact do such programmes have on the extent and frequency of drug injection?
3. To what extent do such programmes also increase use of health and social services and drug treatment?
4. What evidence is there that programmes aimed at reducing the risk of HIV transmission among injecting drug users are more effective in reducing HIV transmission when they are part of a comprehensive array of services which include outreach, HIV prevention education, counseling, and referral to substitution treatment, drug rehabilitation services and medical and psychosocial support?

5. What evidence is there on the extent to which these prevention strategies help reduce HIV transmission from injecting drug users to their sex partners and through maternal to child transmission to their offspring?

In December 2005, the committee held an information gathering workshop in Geneva, Switzerland to hear testimonies from experts in the field and officials from highly-affected regions. The agenda and PowerPoint presentations from this meeting can be found at: www.iom.edu/idu.

The Committee further conducted a comprehensive search of the English language peer-reviewed scientific literature, and evaluated previous systematic reviews and reports prepared for UNAIDS, the World Health Organization, and other international organisations. The Committee plans to release its findings and recommendations in a report in August 2006. Please refer to www.iom.edu around that time for the latest information and links to the report upon release.

Established in 1970 under the charter of the United States National Academy of Sciences, the Institute of Medicine is a private, non-governmental, non-profit organisation that provides independent, objective, evidence-based advice on important issues in public health and medicine. The IOM's expert consensus methodology aims to add value through illuminating more extensively the evidentiary basis for selecting among difficult policy options.

For additional information concerning this project, contact Alicia R. Gable, MPH, Senior Programme Officer at the Institute of Medicine at agable@nas.edu.



CONFERENCES

Overview of the 17th International Conference on the Reduction of Drug Related Harm in Vancouver, Canada

(30 April – 4 May 2006)

By Jamie Bridge, IHRA

Last month, the 17th International Conference on the Reduction of Drug Related Harm took place in Vancouver, Canada. The five day event was attended by 1,300 delegates from over 60 countries and included keynote speeches, seven plenary sessions, eight major sessions, 42 concurrent sessions and hundreds of poster presentations.

The conference opened with a formal reception on Sunday 30 April but there had already been several successful satellite sessions (such as the 'Users Congress') earlier that day. On Monday 1 May, a vibrant spectacle of dancing and music from local Aboriginal families was followed by a plenary session on indigenous people, who represent a disproportionate number of local persons experiencing drug-related harms. The personal, moving accounts from this session provided both a global and intimate context for the remainder of the conference.

Over the following four days, there were well received addresses from Vancouver Mayor Sam Sullivan (a pioneer of legislation for people with disabilities in Canada who spoke about the transferable lessons between public attitudes towards disability and those towards drug users) and Stephen Lewis (the UN Special Envoy for AIDS in Africa, who gave an impassioned speech about what has been achieved and the international

challenges that lie ahead). There were also further plenary sessions on HIV/HCV, policing, US and UN drug policies, cannabis, alcohol and young people. Additionally, 'major' sessions covered topics such as human rights, user involvement and amphetamine use while the numerous 'concurrent' sessions covered subjects such as sex work, homelessness, tobacco harm reduction, overdose prevention, advocacy and mental health.

Several general themes emerged from the conference proceedings, such as the overall maturation of the user involvement movement. This was evident in the way the conference was conducted, with people who use drugs taking an active role at every level (including organising committees and presentations). In particular, the emotive final plenary session on 'young people' retold poignant stories from Kyrgyzstan, China, Brazil, Ukraine and Canada and reinforced the need for programmes and safe spaces designed by and for young people (and closed with the announcement of a newly-formed young person's harm reduction network).

Another key conference theme was human rights for people who use drugs (such as access to drug treatment and medical care such as HIV and HCV treatment) and the huge international contrasts in this field. Methadone maintenance is still illegal in Russia and unavailable in many other countries whereas Iran has

become the first Islamic country to have established methadone maintenance in prisons and Switzerland has integrated heroin maintenance into its primary health care system to "give back autonomy to our clients" (Dr. Haemmig presenting on Tuesday 2 May). As Canada demonstrated, however, the contrasts can be on a national level too – with presentations showcasing Vancouver's safer injecting site and heroin maintenance trial while others bemoaned the rest of Canada's "decade of dithering" (Diane Riley, Monday 1 May).

Law enforcement was another central issue, especially timely given the situation in Mexico during the conference week – where their groundbreaking bill to decriminalise small amounts of drugs for personal use succumbed to the United States' relentless interference in international drug policy. Presentations from the USA, Mexico, Canada, Poland and the United Kingdom described how punitive policing strategies could affect the health of people who use drugs, while some police officers also presented on their more positive collaborations and approaches (in Vancouver, police have openly supported the safe injection site and even escorted people to the programme).

Adapted from the 'Conference Report' by Steffanie Strathdee et al. by Jamie Bridge, Communications and Project Development Officer, International Harm Reduction Association. www.ihra.net
www.harmreduction2006.ca

In addition to all of these sessions and debates, there was also room for a 'Drugs and Harm Reduction Film Festival', the International Harm Reduction Association (IHRA) Annual General Meeting, the 2006 IHRA Awards Ceremony and a live performance from the 'Harm Reduction All-Stars' at the closing ceremony in Vancouver's prestigious 'Commodore Ballroom'.

Overall, the conference showcased a lot of the current international success stories, such as the listing of methadone as an essential drug by the World Health Organisation, peer-based harm reduction initiatives in Cambodia, Vietnam and Brazil and drug consumption facilities being established and evaluated across the world (with no reported overdose deaths at any facility to date). However, this was constantly balanced by the acceptance that more needed to be done. At the opening ceremony, Dr. Prasada Rao (Director of UNAIDS Regional Support Team for Asia and the Pacific) pointed out that only US\$200 million is needed to prevent injection-related HIV transmission (compared to the estimated US\$11 billion needed to stop the global HIV pandemic) – what is lacking is not money but political will and this must be the target for the coming year. In the closing words of Conference Co-Chair Sue Currie, "the success of any conference can only be measured by what comes before and what comes after". Plans are already well underway for next year's 18th conference, where the event finally "comes of age" in Warsaw, Poland (13-17 May 2007; www.harmreduction2007.org).



Peers and volunteers made the 17th edition of the Conference an event to remember. Their support and assistance laid the very foundation for its success.



Ms. Caitlin Padgett of Vancouver Coastal Health played a crucial coordination role during the conference as did all peer volunteers.



Conference Co-Chairs Sue Currie (middle) and Patricia Spittal (right) welcomed Conference delegates at the opening ceremony and in the hallways throughout the event.



On 30 April, the Users' Congress was held in the afternoon. This session was held as a follow up to initiatives started in Belfast last year. The aim of the session was to coordinate drug user organisations as well as user activist groups at the international level. A Declaration was released and circulated following the conclusion of the Congress. (*To read the full text of the Declaration, Why the world needs an international network of activists who use drugs, visit www.brugerforeningen.dk/bfny.nsf/Pagesuk/DE15097B28F4D8CFC1257182007BE09A?OpenDocument&S=UK.*) The Congress was part of a massive and unique effort to provide services for users delivered by users during the Conference. For example, a mobile needle and syringe exchange van was parked every evening next to the Conference venue for an hour; methadone and buprenorphine could be obtained even without prescription at the conference venue; emergency services were on call 24 hours a day to respond to overdoses and other health emergencies; a Safe Ride vehicle was made available five times a day to take users to the safe injection site in Vancouver; condoms, syringes and other harm reduction equipment was available throughout the event at the registration desk; a chill out room was open daily. The unprecedented peer support made the event one to remember and also one to establish service baselines for similar events in the future.

The International Rolleston Award was awarded to Dr Robert Newman. The National Rolleston Award went to the Vancouver Conference Drug User Advisory Group. And the Travis Jenkins Award was delivered to Jason Farrell. Read more about the awards and the work of the recipients at www.ihra.net.



The National Rolleston Award highlighted the hard work of the Canadian Drug User Advisory Group which fostered a unique space for a unified voice for Canadian drug users across the country