



AHRN NEWSLETTER

AHRN: The Asian Harm Reduction Network – Targeting HIV/AIDS and Drug Use in Asia

AHRN is a project supported by UNAIDS, the Royal Netherlands Government and the Drug Policy Foundation (DPF) Washington, DC.

From the Editor

Humane responses to harm reduction and (injecting) drug use

The first year of the millennium has quickly passed for AHRN but not without wrapping-up with significant and clearly humane responses that address harm reduction and injecting drug use which cover this issue.

Most recent for World AIDS Day, AHRN called for drug addiction to be considered as a chronic relapsing illness, as a personal and public health problem and not a public security issue. This is essential foremost in a conservative region, where, as history tells us, social and economic forces drive the narcotics industry (that now pretty much supply the rest of the world), and where dramatic changes in drug-use pattern have been recently observed (i.e., smoking to injecting) coupled with rising prevalence in drug use. The interaction of HIV and drug use has long been established and it is inevitable that where unsafe needle and syringe use is common, the virus find conducive alleys to spread. Here in Asia, the alarming rise of HIV epidemics among injecting drug users (IDU) is a reality that risks spreading the infection to the general population.

April saw the International Conference on the Reduction of Drug-related Harm take place for the first time in Asia and hosted by India, where it was acknowledged that coverage on interventions to prevent the spread of HIV is limited, drug users' remain stigmatized and that harm reduction is being diluted in some Western countries.

The UNAIDS Case Study in Best Practice, "The Asian Harm Reduction Network, Supporting Responses to HIV and Drug Use in Asia" was published in May and it defined the unprecedented mechanism set up by the organization that supported pioneering programs addressing drug-related harm in Asia. More heartwarming for us was the unified and clear voice that the UN system position paper on 'Preventing HIV Infection among Drug Users' gave about the issue. Not long after came the commitment from the United Nations General Assembly Special Seating (UNGASS) where we and our partners painstakingly moved to include some of our recommendations.

In November, the Brussels' consultation meeting among NGOs and networks in all regions, strengthened participation of communities and people, particularly those living with HIV/AIDS – one way by which NGOs can contribute to the development of the Global Fund against AIDS, Tuberculosis and Malaria (GFATM).

With humane responses still up our sleeves, this issue also features briefs by the AHRN Secretariat from selected sessions at the 6th ICAAP in Melbourne which scaled up and scaled out harm reduction among IDUs. "The need to focus on emotional and psychological care among people infected and affected with/by HIV," tops the advocacies in our feature on the 5th International Conference on Home and Community Care for People Living with HIV/AIDS.

Finally, we are happy for the continuing support to AHRN by the Royal Dutch Government. Renewal of our funding for the next five years, confirms our lead role in this advocacy and in our recognition that solidarity with donor countries struggling with the issues is critical.

We close 2001 expectant that drug use will soon cease to be seen as an ill of the society and in the long-term, eradicate the stigma attached to drug users; and that in Asia, HIV and injecting drug use will be headlined alongside supportive national policies and programming that focus on humane efforts in reducing widespread harm from resulting to pandemic proportions. We urge you to be our partners in advocacy by participating in our on-line discussions that will be initiated by the AHRN Clearing House starting next year.

5TH International Conference on Home and Community Care for Persons Living with HIV/AIDS

Taking Thailand's example

"Even if we have enough hospital capacity, (the) home is still the best place. It is where we are loved and cared for."

Dr. Usa Duongsaa, who oversees the Empowering Visits Program, captures the essence of this year's international gathering on home and community care for persons living with HIV/AIDS (PHA). "And that is for anybody who is unwell, not only those who are HIV positive," she adds.

The conference will be held for the first time in a developing country, with Chiang Mai as the host.

"We have the problems, but we also have the responses," stresses Dr. Duongsaa, referring to the once widescale prevalence of HIV/AIDS infection in the (northern) region compared to the rest of Thailand.

The country, which experienced a surge in HIV/AIDS cases ahead of the rest of Asia, gave a multi-sectoral and multi-level response that involves the Ministry of Public Health, non-governmental organizations, civil society movements, community-based organizations (CBOs) and religious bodies. "We have a kind of readiness that gives us an advantage. We have good example of what has been done and what is being done, And being in the heart of the responses we can show to people what can be done in terms of home and community care," she explains.

Holistic and multi-faceted

Most persons with HIV whether in Asia or anywhere in the world, prefer to be cared for at home (provided that they are accepted).

Fuelled in part by the stigma that remains attached to the disease, and by a lack of understanding, acceptance of a person with HIV/AIDS has been slow and painful worldwide. It is even more difficult amongst closely-knit, traditional families and communities in Asia, who are

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5TH International Conference on Home and Community Care for Persons Living with HIV/AIDS

inherently conservative and where issues like sex and sexuality remain a taboo.

Despite this, it is the Asian's 'nature to nurture' that provides a fertile ground to home and community care for people infected with the disease.

The term 'care' does not limit to the physical and health aspects. It is care and support in the home and community that is holistic yet multi-faceted, hence, also including the emotional, psychological, social and economic needs of the positive person.

"If people understand HIV/AIDS - how difficult it is to contract the disease - and THEN understand that they can live together, fears are alleviated," explains Dr. Duongsaa. "This provides emotional and psychological support to the person with HIV/AIDS. And because they live as part of family, the social care already exists."

In Thailand, where pockets of non-acceptance, fear and misunderstanding still exist, government institutions, NGOs and PHA have successfully educated and prepared family and

tals where facilities are presently inadequate as the case is in Thailand. Hospices, usually run by religious groups, are the last resort when the person with HIV/AIDS has no other next of kin.

Working within the local culture

Although interventions against the spread of the disease have been keen, "AIDS has not been looked at adequately," admits Dr. Duongsaa, "and this is reflected in some of the gaps in terms of home and community care despite the fact that the programs here (in Chiang Mai) is one of the best in the country, if not the best itself."

The rural and lowland areas proved to be more conducive to organizing the community because social infrastructures are already in place, and local cultures and traditions are similar. Despite the successes in these places, efforts made among the urban slums have not been adequate (relative to the scale of the problem).

In these areas, community ties have been lost and little room is left to develop social relationships among the people. "Existing social organization is very loose and very weak since people come from various places, and local politics cause even more division."

According to Dr. Duongsaa, "Efforts are difficult in terms of home and community care because there's little sense of 'community'. Family members are hardly at home so persons with HIV/AIDS depend on hospices and hospitals or stay home alone. There is access to information but the psychological and social response is lacking."

Community organizers also struggle to find a common ground with the hilltribes since they have their own culture, tradition and a different social and belief system. Since health issues involving bacteria or viruses such as HIV/AIDS are foreign to many, hence, the difficulty to introduce interventions like harm reduction or condom use when basic concepts are not even understood.

Despite this, NGOs who have worked effectively in the long-term find that binding cultural ties make it easy to introduce home and community care programs, and positive persons have been instrumental in educating members of the family and the community.

"It takes time but we have made a good start," she adds.

Expectations

The conference would be a good learning opportunity for Thailand to learn from others,



The Clear Skies Project of Doi Saket District, Chiang Mai, established and run by a group of people living with HIV/AIDS, provides holistic care training for PLWHAs such as meditation.

especially Africa, which faced and learned to cope with the impacts of the epidemic before this country started to.

Government, NGO, PHA and host group representatives tailored the conference's Empowering Visits Program for delegates to see from Thailand's example that it is possible to promote home and community care, and encourage it to reach people who are more vulnerable, particularly those with HIV/AIDS. Local experiences show that persons with HIV/AIDS can be partners and play more effective roles.

"Many countries still do not understand the kind of roles that people with HIV/AIDS play, and what roles other people can play to support them so that they (the infected persons) can take more active roles in responding to the disease," explains Dr. Duongsaa. She also advocates looking more seriously at issues of emotional and psychological care and support for those who are infected and affected, especially the orphans of persons with AIDS. At present, only their physical and social needs are being addressed and because families and communities are not well aware of their emotional and psychological needs, they cannot respond to it effectively or adequately.

The possibility looms that if these needs are not dealt with, the children may grow up to engage in risk behaviors and become vulnerable to HIV/AIDS themselves. Or, grow up with emotional scars and will be unable to function effectively.

"Do we understand enough? Are we doing enough to respond to these needs?," she challenges. "We need to do more."



The Christian Church of Thailand AIDS Ministry (CAM) based in Chiang Mai is known for its Home-Visit Model, and provides home-based care training for volunteers and relatives of HIV patients.



The Access Foundation, Chiang Rai Networking of People Living with HIV/AIDS and Sai Samphan Association organize camps and provide counseling, alternative care, care and support for affected children, PHA groups and networks.

community members in the basic nursing and clinical care of infected persons. Thus, ensuring that simple, physical needs are taken care of. This is supported by home visits and counseling that supplement existing psychological, social and emotional care already provided by the family.

Economic support from the government is provided through the Department of Welfare via a stipend for people with HIV/AIDS and some funds for family members to initiate income-generating activities. These are encouraged to empower the positive person and their families by making them active partners in fund-raising initiatives. It also facilitates a mixed effort among 'positive and negative' people while ensuring that no discrimination occurs amongst them.

The Thai government also supports NGOs and CBOs but these are limited and are usually directed to actual interventions.

In addition, home and community care also alleviates the burden from nurses and doctors, and provides an alternative to hospi-

Scaling Up & Scaling Out of Harm Reduction for Drug Users in the Region

Is an intensified and wide scale harm reduction among drug users the answer to the growing and changing landscape of HIV/AIDS infection in Asia?

Countries reporting Injecting Drug Use (IDU) have increased globally from 80 in 1992 to 134 in 1999, and countries reporting HIV infection among IDUs have doubled from 52 in 1992 to 103 in 1999. Opium production in Asia has also increased steadily from 2,727 metric tons (1988) to 4,452 metric tons (1995) and 4,691 in (2000)¹. In fact, opium production in Asia doubled within the last 10 years.

The dynamics of drug trafficking and drug laws has added to the increasing number of drug users, drugs, drug use countries/state/provinces and modes of use. Injection which has always been a cost effective way of using drugs, has also seen an increased in incidences.

The health risks related with sharing syringes and needles (includes HIV, Hepatitis, abscess, overdose etc), has been a concern for few countries. Another long-term impact will be on the overall development of the country as HIV can affect all aspects, i.e., like economy, social structure, culture, traditions.

Of the 9.18 million² heroin users globally, 5.74 million come from Asia. In 2000, nearly 50% of the illicit opium cultivation was traced to Myanmar, 36% in Afghanistan, and 10% in other Asian countries like Laos, Thailand and Pakistan.

These rates give us an idea of the extent of risks among new drug users, increased supply and vulnerability of both individual and the general population. In addition, amphetamine users in Asia now comprise 2.1 million out of 24.2 million worldwide, and the figure is rising.

Myanmar, Thailand, India, Nepal, Pakistan, Vietnam, Indonesia and China have reported cases of HIV infection that are related to IDUs³. Prevalence is either in the whole country or is endemic to a particular region only. For instance, in Myanmar, drug use has been reported in Yangon, Mandalay, Sagaing and

the Shan and Kachin states, while in India it is concentrated mainly in the north east and four major cities. The spread of HIV from the IDU community to the general population is highly possible and may do so if no appropriate response is taken up to prevent further transmission of HIV.

Indonesia is an example. After 10 long years of silence (but with recorded widespread 'risk behavior'), there is now a sudden emergence of HIV with a marked increase among sex workers and IDUs. Blood donor data also show indications that HIV is filtering outwards into society⁴.

The WHO reported in "HIV/AIDS in Asia and Pacific region 2001" that in Myanmar, Thailand, Nepal, China's Yunnan province and Manipur in northeast India, about 50% – or more – of injecting drug users are infected with HIV, the virus that causes AIDS. The report also calls for countries to "aggressively implement" HIV prevention programs for drug users, including the provision of needles to ensure safe injection practices.

In Manipur, the HIV infection rate among IDUs is more than 60% and the infection rate in antenatal attendants is 3%⁵. Due to lack of proper interventions (with quality, quantity, area and timing) HIV infection has now spread to the general population since its detection in 1989-90. This is a good argument for those who believe that HIV amongst IDU is self-containing.

A different trend has emerged in Iran, China and Indonesia where higher HIV infection surfaced among injectors in prison (than among injectors in treatment). This takes into consideration that highest risk injectors are more likely to get arrested but without discounting the fact that HIV transmission is also taking place in jails.⁶ Because of this, public health officials have taken efforts to extend prevention programs for drug users in prison.

Vietnam, with its long history of injecting drug use, has also recorded a recent jump in HIV infection in several areas (Haiphong, Binh Dinh and Ho Chi Minh City).⁷

There are good examples of effective harm reduction interventions within the Asian setting but they are mostly small-scale and therefore may have limited impact on effectively reducing HIV/AIDS and other drug-related harm.

Responses

In India, 400 NGOs are funded by the Ministry of Social Justice and Empowerment and can treat about 40,000-80,000 patients yearly. The country has 500,000⁸ opiate users and each NGO admits 100-200 patients per year. Except for north eastern India, majority of the people coming for treatment are alcohol dependants, including those that relapsed which accounted 60-70%. Harm reduction programs involving Buprenorphine that were conducted in five cities are too small and needs to be quickly scaled up.



The Lifegiving and Lifesaving Society (LALS) in Kathmandu, Nepal which started a needle exchange program in 1991 had a successful report of harm reduction (< 1% HIV prevalence among IDU) until 1998 when surveillance showed HIV prevalence of fifty percent among IDU. The LALS success story was limited to a small area and for a short period in Kathmandu, hence was too small to control the HIV epidemic in Nepal. It would require more NGO and more funds to spread the work over all the affected areas.

Since it started methadone treatment in 1976, Thailand now treats 2,000 patients daily in Bangkok alone. There are 247 treatment centers, half of which are concentrated in Bangkok where 60,000-70,000 drug user are treated yearly. The country has more than 1 million drug users and 60% of these are injectors with 30-40% HIV prevalence⁹. Thailand has shown positive results in reducing HIV infection and in reducing the risk among sex workers but has failed to control the spread of HIV among IDU because of lack of proper policies and programs that address changing trends of transmission.

In addition, for intervention programs to be effective, they must be focused, comprehensive (and sustained with routine surveillance systems, i.e., BSS), and must be targeted.

In Asia, where majority of the population do not engage in high-risk behavior, focusing interventions on those who do will be affordable and effective. An integrated condom promotion and STI control accompanied by behavioral surveillance system (BSS) monitors can be successful as seen in Nepal. Tracking BSS trends, as exemplified in Tamil Nadu state, India, can identify plateaus and reversals necessary in assessing a program's sustenance and expansion.

Lastly, targeting interventions will ensure that the program reaches intended clients, i.e., IDUs, so that they can appropriately respond. This also requires continuous re-evaluation so that interventions reflect (HIV) dynamisms (e.g., changing transmission trends), and remain appropriate especially in Asia where HIV epidemic situations vary from country to country and new trends are continually emerging.¹⁰

With IDU as main mode of transmission for HIV/AIDS in many Asian countries and the grim projections for the region in the near future, urgent action will be required. This means scaling up and scaling out harm reduction via effective interventions that respond to the changing landscape of HIV infection (among IDUs).



Dr. Peter Piot, Executive Director of the Joint United Nations Programme on HIV/AIDS delivers a keynote address at the opening of the conference.

6th ICAAP Highlights



Also opening the conference were (l - R) Dr. Roy Chan, from the AIDS Society of Asia and the Pacific, and the Hon. Steve Bracks, Australian Premier. Mr. Jimmy Dorabjee, AHRN Executive Committee Chairman, co-chair of several sessions on harm reduction among and injecting drug use at the conference.

HIV prevention efforts in DUs are most effective if:

- Coverage (both target and area) is adequate
- Interventions start early before HIV prevalence rates among IDUs exceeds 5%
- Supportive policies are in place
- Adequate funds are allocated
- Ownership and partnership with target group is ensured

KEY POINTS:

Scenarios for scaling up

- Scenario 1 – No intervention
- Scenario 2 – Some interventions / prevention
- Scenario 3 – Adequate coverage

Critical issues for HIV in DUs are:

- Lack of political commitment and action
- Limited resources (financial and human)
- Limited program coverage
- Lack of information/knowledge
- Lack of interagency collaboration
- Stigmatization both on HIV and DU status – lack of community acceptance
- Punishment paradigm prevails
- Need for comprehensive approaches with cross-cutting components
- Limited capacity of existing programs to deliver adequate and effective services
- Safe disposal of used/return syringes
- Lack of participation and ownership of people and communities at risk

¹ UNDCP World drug report 2000

² UNDCP World drug report 2000

³ HIV/AIDS in Asia and Pacific, WHO 2001

⁴ MAP Report, October 2001

⁵ Report -sero surveillance ...Manipur State AIDS Control Society 2001 March

⁶ MAP Report, October 2001

⁷ MAP Report, October 2001

⁸ Oppenheimer, 2001

⁹ Dug use and HIV vulnerability

¹⁰ MAP Report, October 2001

Recommendations by AHRN on scaling up harm reduction for drug users in Asia:

- Implementation of UNGASS Commitments for drug users.
- Policy and financial support for the establishment of countrywide comprehensive programs for IDUs including needle and syringe availability programs; and drug substitution programs.
- Minimum program reach of 80% (for all programs), within four years.
- High-level advocacy missions to countries affected.
- Social marketing of harm reduction strategies.
- Inter-sectoral collaboration: integration of harm reduction for drug users into health and other sector programs, particularly education, police, military, social security.
- Surveillance on drug use and HIV/AIDS-DU policy environment.
- Research / studies on:
 - Program documentation
 - Current interventions on DU (1st, 2nd, 3rd Prevention)
 - Legal and environmental impediments
 - Social research and surveillance on DU and impact
- Review of existing educational programs for health/police professionals for incorporation of harm reduction elements.
- Development of country specific training/advocacy materials.



Session Briefs (Selected)

1. Effective Interventions on Drug Use and HIV

Session Chair: Nick Croft and Alex Wodak
Presenters: Dr. Syed I Ahmed (India), Dr. Zunyou Wu (China), Yen Ngoc Le (Vietnam), and Debashish Das (India)

Background

INDIA, Five harm reduction projects were implemented, constraints observed were:

- denial by family of drug use problem
- denial by family of drug use problem
- denial in the family
- lack of support from the family
- stigma attached with drug use in the community
- no health seeking behavior, and
- lack of awareness and support system (drug treatment, care and rehabilitation)

INDIA, Whenever there is a crisis in the supply of 'brown sugar' or money due to strict vigilance by law enforcers, non-injectors switched to injection en masse. Most preferred were Buprenorphine or in combination with Diazepam and/or Phenergan or Avil, and also Pentazocine. Being inexperienced in safe injection, abscesses and swelling of limbs were common

CHINA, Needle social marketing strategy was implemented to reduce drug injecting sharing behaviors among IDUs. The study involved pharmacies and clinics in Tiandong County in Guangxi who extended their business hours, outreach teams composed of former drug users tasked to sell needles to IDUs (evening and other occasions), and education counseling services.

VIETNAM, Harm reduction programs were carried out among IDUs in five northern provinces since 1998. Effects were demonstrated in results from assessment surveys conducted for two consecutive years in all prevention aspects.

Interventions

Major constraints in harm reduction for injecting drug users can be addressed by:

- Sensitising the community from where the drug users come (India) – In sensitisation sessions, problems of injecting drug users were discussed with community (influential womenfolk) and family members, and the problem was gradually accepted. Support for harm reduction came from peer educators, and from 'Meira Prabi', a women's organization, which provided community development support that sustained harm reduction activities.
- Safe injecting awareness for non-injectors (India, 2nd case) – Harm reduction programs among non-injectors should be given importance in counseling, outreach programs, and education programs on harm reduction and safer injecting practices.
- Needle social marketing strategy to reduce drug injecting sharing behaviors among IDUs (China) – Prevalence

of drug injecting sharing behaviors before and after the program showed that needle social marketing reduces the practice but not sexual behaviors. Showed that education on harm reduction is necessary to encourage safer injecting practices

○ Harm reduction program among IDUs (Vietnam) – Its implementation was effective, appropriate and convenient.

Suggestions to effectively implement these interventions, include:

- 1) Providing education on harm reduction to increase awareness
- 2) Providing treatment and care for IDU, HIV/AIDS and STDs
- 3) Linkage with government, law enforcement and NGOs
- 4) Counseling

The issue of 'return syringes' was also raised.

There is a slow but increasing acceptance of Harm Reduction but the response is far too small to have an impact on spreading HIV infection among IDUs.

2. The Way Forward: HIV/AIDS Strategic Planning in the Asia Pacific Region

Presenters: Andrew Peteru (New Caledonia), Demma (Tibet), Niramark (Laos), Peter D.

AusAID, through the Macfarlane Burnet Centre for Medical Research (MBC), funds many countries in Asia in its formulation and implementation of a strategic plan. This approach to planning responses to HIV/AIDS is flexible, thus, can be adapted to the culture and environment.

The processes involved in national strategic planning include:

- Situation analysis in workshops
- Development of strategic plans
- Access to funding
- Implementation of activities

Strategic planning in the region

The Pakistan government is moving ahead in the development of a strategic plan with support from UNAIDS and MBC.

In Laos, reports indicated a low prevalence surrounded by high prevalence and concentrated epidemics. HIV infection was considered a heterosexual epidemic. There was a strong emphasis on prevention. Findings showed that a sectoral strategic plan is quite effective in addressing the needs of the youth. The national strategic plan involved all sectors from the government and NGOs which cooperated to analyze plans for 2002-2005. The UNGASS declaration was also material in implementing the national strategic plan. The speaker considered planning skills to be exportable.

Tibet, like Laos, reported very few cases of injecting drug use, if none at all.

China had a problem in terms of language. However, they started introducing the strategic plan alongside support by UNAIDS. In Suva, after conducting a situation & response analysis (SRA), strategic planning was made possible through their religion as the people belonged all to a church. "If you want to involve religious institution, go to church," stated the speaker. This was an effective way of introducing the plan.

Key points:

- Donor involvement, i.e., AusAid, is the process and this increases ownership confidence
- Strategic planning is feasible, achievable and proposable.
- Emphasis: the importance of NOW in low prevalence places

3. Emerging Drug Use Trends and Local HIV Transmission

Presenters: Nick Crofts, Paul Griffith

The session was classified according to situations by country.

In China, there is an increasing incidence of HIV infection among Drug Users (DU) despite having prevention as the official response.

Heroin and drug use have been reported in Indonesia since 1997. This year, the police reported 130,000 cases of illicit drug use. The government decided to use strategic planning as an intervention after finding 1,887,354 (19%) IDUs infected with HIV (April 2001). In addition, 89 NGOs are working with DUs in Jakarta, focusing on treatment.

In Malaysia, it is estimated that there are 200,000 IDUs. The government is considering creating a strategic plan for a 13-year period.

Myanmar remains as the world's second largest producer of opium and heroin. This year, amphetamine production has increased, and in some states, HIV prevalence and IDU rates now rank among the highest in the world at 96%. The government has been aware of the link between HIV infection and IDU since 1996.



6th ICAAP Highlights

In Thailand, prevalence of HIV among IDUs is reported at 54 %. Harm reduction programs exist, i.e., a methadone program that was launched for hill tribes. The Asian Harm Reduction Network, with an office based in Chiang Mai, also provides materials on harm reduction for the region.

In Vietnam, incidences of IDU and HIV infection are increasing in the north – 25% occur among sex workers, and 65% among IDUs.

It was concluded that:

1. The continuing dynamics of IDU epidemics across Asia has resulted from a massive rise in ATS availability and use.
2. There is a continuing explosion of the HIV epidemic which is now endemic in many places.
3. There is an increasing cross-over of IDU/CSW in some places.
4. There is a slow but increasing acceptance of Harm Reduction but the response is far too small to have an impact on spreading HIV infection among IDUs.

4. WHO Injecting Drug Use Study Phase II: From Assessment to Prevention Development
Presenters: Maristela Monteiro (Switzerland), Vladimir Poznyak (Switzerland)

This drug injecting study looks into the assessment and then development of prevention interventions among developed and developing countries. In the Phase II of the study, the WHO focused on developing countries in Africa (Nigeria) and Asia where HIV infection is continuously spreading. The study looked into personal issues that lead to HIV infection, the local environment, and the culture in a particular area. It took 2-3 months to collect primary information through questionnaires given to IDUs under a treatment program.

The assessment has been completed and was being analysed (at the time of the conference). The study will be concluded in 2002.

A separate study following this will look into the syringe exchange program of a local area and the risk behavior of people in the city (towards syringe exchange).

5. Policy to Enhance HIV Prevention Among Drug Users

Presenters: Shamin Rabbani (Bangladesh), Dave Burrows (Australia), Robert Broadhead

From presentations of low, middle and high income countries, it appeared that we can move faster with harm reduction for drug users.

But, despite evidence that harm reduction works, it remains controversial in the USA. Australian examples were given on the negative impact on CB programs due to lack of community support. The Dacca program by CARE showed how comprehensive these programs are.

All presentations made clear that programs need to start early and then move on. Tasks on social advocacy and for establishing enabling policies never end.

Key points:

- Social marketing of harm reduction is key to getting different sectors onboard
- Community owners are essential for successful interventions.
- Advocacy and political support are essential.
- CARE Bangladesh's HIV/AIDS program deserves to be looked at as model for duplication in Asia (BP documentation <draft> was recently completed). Research on economic impact of DLL and HIV was urged.

Alliances among and with legitimate mainstream institutions, i.e., immunization campaigns, hospitals and primary health care is encouraged to address the barriers.

6. Breaking down barriers to harm reduction and drug use in the region

Chair: Aninya Chatterjee
Presenters: Rajiv Kafle (Nepal)

Barriers of harm reduction:

- Non-availability
- Drug users are seen as criminals and not as people with health problems
- Government policies
- Belief that it promotes drug use
- Non-acceptance
- Lack of information and education
- Lack of support from donors

Focus was made on the lack of policy support for harm reduction in Nepal with mention on AHRN's activities in the region.

7. Barriers to Scaling Up Harm Reduction in Asia

Presenters: Nick Croft (Australia), Jimmy Dorabjee (India) – Chair

Issues raised revolved around the principle that 'harm reduction is about human rights'.

- Human Rights of injecting drug users (IDU) – status as 'human beings' are low and non-existent, hence the inaccessibility to harm reduction programs (i.e., needle exchange and disposal of used injecting equip-

ment) in order to protect themselves from blood-borne diseases; and drug use is seen as a criminal and social aberration, and not as a health problem.

- Disposal of returned needles and syringes – incineration, the most satisfactory disposal method is expensive and not available to all. Alliances among and with legitimate mainstream institutions, i.e., immunization campaigns, hospitals and primary health care, is encouraged to address the issue.

- US influence on policy of prohibition changed the whole attitude – relies on the repression of drug users, and uses demonization as one of its major weapons.

- No focus on a single holistic harm reduction method.
- We are still learning.
- One of the worst in scenarios in HIV/AIDS infection is the concurrent prevalence of both IDU and HIV.

8. Scaling-up Harm Reduction in Asia

Chairs: Jimmy Dorabjee and Gundo Weiler
Presenters: Dr. Alex Wodak, Tariq, Dr. Wu, Daisy Tachinta, Suresh Kumar

Main points:

1. Mechanisms of scaling-up:
 - a) Education of drug users and others
 - b) Change syringes more often
 - c) Drug treatment
 - d) Community development
2. Issues: misconception, over indulgence, financial imbalance, exit policy from harm reduction, and strict laws
3. Lessons: quality data, advocate harm reduction, coverage and access to treatment
4. Challenges: children refugee; CSW-IDU; influencing factors more than injection, e.g., terrorism, capacity, non-injecting drug users, female drug users
5. Advocacy tools: use of estimation on rates of HIV infection among IDUs (total figure containing no. of injections/day); meeting and conference delegates
6. Regional database

Regional highlights:

- UNAIDS - Strategy/Policy 90% of IDU coverage and 60% behavior change
- China - Policy has been created but there is concern about the funding in light of the large population: 27 provinces have reported HIV infection among IDUs (except four provinces), Yunnan, 90%, Guangxi, 70%, Guangdong, 70%.
- Pakistan - Every RSA (rapid situation assessment) was followed by intervention
- Indonesia - Harm Reduction Network Foundation has been created by Yayasan Hati Hati

10. Political Leadership Amongst Parliamentarians

Presenters: Chris Publick (Australia), Dr. Baramuli (Indonesia), Meechai (Thailand) - Chair



Main points:

- Publick – the Australian experience
- Baramuli (Indonesia) – Legislation budget; Advocacy action required at every level of government
- Philippines – They have a registered awareness visibility for persons living with HIV/AIDS patients (PLWHA).

There was limited information that would guide others wishing to make developing leadership amongst parliamentarians a strategy.

11. Substitution Program for Injecting Drug Users in India: Lessons Learned

Presenter: Suresh Kumar (India)

With injecting drug use (IDU) escalating in India, metropolitan cities and big towns now report of opiate use. Yet, HIV interventions among IDUs are limited.

In 1993, buprenorphine sublingual intervention was initiated in Delhi. Six years later, in 1999, five cities – Mumbai, Chennai, Calcutta, Delhi and Imphal – started substitution treatment with the drug. About 2,000 injecting drug users in the country are presently being maintained, and in Mumbai and Emphal, 50% come regularly. However, reports show that condom use remains the same, as well as visits to CSW.

Emphasis was given on the need for significant impact of the buprenorphine program in the five cities.

Challenges:

- 1) Maintenance of sublingual buprenorphine substitution treatment
- 2) Sustainability (cost of the drug)
- 3) Government support needed
- 4) Improve delivery mechanism
- 5) Alternative drug options for substitution, i.e., methadone, must be available
- 6) Increase coverage (need scaling up)

12. Creating an Enabling Environment for Prevention

Presenters: Ruthy Libatique (Philippines), Ashok Pillai (India), Matur Rahman (India), Susan Paxton (Australia), Ton Kim (Cambodia)

Philippines: Striving for an Effective HIV/AIDS Prevention at the Community Level: Popularizing the Philippine AIDS Control Act of 1998

This law has been cited as being a Best Practice initiative on HIV/AIDS prevention and control. Three years after, however, the law has yet to be articulated. Hence, the Philippine HIV/AIDS NGO Support Program (PHANSuP) with the assistance of the Philippine National AIDS Council (PNAC) initiated its popularization through a series of workshops.

Local governments, civil societies and communities are slowly learning why it is beneficial to know and implement this law. With unity and concerted effort, PHANSuP and PNAC hope to reach key areas, sectors and locales in the country in the next two years.

India: Living with HIV, Finding the Purpose in Life and Striving to Establish "A Strong People Living with HIV/AIDS Movement in India": A Personal Experience

A personal account of how the speaker, as a 20-year-old, and after two years in the Indian navy found out he was HIV positive and was simply told he will die. But still living after 10 years, he, along with 12 other people, founded the national network of people living with HIV.

At the dawn of the PLWHA movement in India, he demonstrated by leading from the front and from doing task that living with a person with HIV/AIDS could be a lot easier with a positive mind frame, while improving the PWH/A's quality of life.

By facing AIDS-related stigma, psychological release, and liberation from the burden of secrecy and shame is gained.

Bangladesh: Prevention in the Armed Forces of Bangladesh Particularly with Peacekeeping Force

HIV positivity in the Armed Forces of Bangladesh is negligible in spite of their deployment in high risk areas abroad. Risk behavior (in this sector) is also very low compared to the general population due to better compliance of universal health precautions. This stems from following a multi-level, multi-sectoral approach to all HIV/AIDS related issues with strong political support and the Armed Forces' full commitment to their own as well as their nation's activities in the prevention and control of HIV/AIDS.

Australia: Paradox of Public (HIV) Disclosure

The presentation had a positive and significant impact on the audiences. By facing AIDS-related stigma, psychological release, and liberation from the burden of secrecy and shame is gained. It increases benefits to health but counselling is necessary in the event of family disclosure

Also, adequate emotional and optimal organization support is needed from governments and AIDS organizations. Those putting a human face to AIDS need skills and confidence through training, accreditation and financial support.

Cambodia: The Development of Enabling Environments for HIV Prevention in the Provinces

"People from the community know their own community." This was stressed after post-basic education workshops were conducted in several villages by the Cambodian HIV/AIDS Education and Care (CHEC). Presenters explained the ways in which they dealt with the problems and the lessons learned from selecting the participants (inclusion of women especially traditional birth attendants, the literate and illiterate), choosing venues (considering Buddhists and Muslims), using Western adult education methods and resources, dealing with sexually-explicit topics, and coping with logistics in a rural set-up.

13. Strategies for HIV Prevention in Low Prevalence Settings

Presenters: Gita Werosit, Dr. Tobi Saidel (Thailand), Dr. Timothy Brown (East-West Center, UNAIDS), Steve Mills (UK), Dr. Raquero (Philippines), Dr. Choncy (Laos), Gita (Bangladesh), Michael (Nepal)

Many countries in Asia still register low population prevalence of HIV. In Thailand there is a low to high concentration, a situation that is very different from Africa.

Interventions, however, need to be implemented to avoid an epidemic. On discussing the reasons why a country may be considered as having a 'low prevalence', Dr. Timothy Brown of the East-West Center/UNAIDS cited Indonesia which is now going from low to high prevalence and where high risk groups are reported. The latter considered as a fluid environment.

In the UK, risk behavior is cited but there are no risk groups. The focus is now on the youth, the population with the highest risk.

In Laos, reports cite 'no risk groups, no risk behaviors and low prevalence'. The reason being, that they took steps very early. A surveillance system has been in place since the early stages and high degree of mobility was observed.

In Bangladesh, where sex workers average at least 67%, it is considered that inadequate coverage doesn't work (45% is not enough).

HIV prevalence in Nepal varies from low to concentrated, and global coverage is greater than 80%. Hence, they recommend that advocacy must be constant, resources must be mobilized, and that 'Champions of Change' be found.



Following the scent of blood

The 6th International Congress on AIDS in Asia and the Pacific (6th ICAAP) highlighted drug injecting as a multiplier of new HIV infections and illustrated the growth of harm reduction responses in the region. The meeting also underlined the importance of drug users as key stakeholders in efforts to address the twin problems of injecting drug use and HIV/AIDS in Asia. ICAAP was followed by *The 4th annual meeting of the Global Research Network (GRN) on HIV Prevention in Drug Using Populations*. This smaller meeting provided a more thorough examination of role played by drug injecting in expanding the global AIDS pandemic. This report looks at both meetings, discussing the implications of injecting drug use for AIDS in Asia and future actions to consider.

The 6th ICAAP

Mixing message of compassion and hope with those of frankness and fear, ICAAP featured voices from affected communities, researchers, activists and other key stakeholders. At the congress opening ceremony, Indian film actor and activist, Shabani Azmi spoke about a virus 'following the scent of blood, eating away civilizations from within'. Suzana Murni, a positive woman from Indonesia spoke on how we see people living with HIV and AIDS as a target group, something to be studied or counted.

There was also greater inclusion of current and ex-drug users at ICAAP. Rajiv Kalvi of Nepal spoke about the daily needs of drug users. In particular, he highlighted the limited availability of needles and syringes; lack of IEC relevant to drug users; and the reluctance of donor agencies to support harm reduction programs.

The Asian Harm Reduction Network (AHRN) was well represented, they co-chaired as well as co-hosted the session on "The Scaling Up of Harm Reduction in Asia" with the World Health Organization, a first for both organizations and significant because of the acknowledgement by WHO of the importance of injecting drug use in the spread of HIV in Asia. This session was widely regarded as one of the more interactive and stimulating at the conference.

It was significant for AHRN too. AHRN has come a long way in promoting the issue of harm reduction and in advocating for the inclusion of users and the spread of HIV amongst users in the regional agenda. Many of its members presented findings in selected sessions relevant to harm reduction and IDU at the ICAAP. Briefs from said sessions are included in this issue.

New epidemics

ICAAP confirmed that there has been a dramatic escalation in injecting drug use globally and in much of Asia. The response however has not been commensurate with the scale



Suzana Murni, Indonesian AIDS Activist from the Spiritita Foundation



Shabani Azmi, MP, New Delhi

of the epidemic at all. Recent reports from WHO and WPRO amongst others indicated that most new infections in Asia are due to injecting. In some countries injecting makes up two in three HIV infections, but only 2% of government spending is directed to this population. Asia is particularly vulnerable because of its large population and the large number of people who inject drugs.

Presentations from across the region illustrated that IDUs are one group where HIV prevalence rates are still rising, especially with new trends towards the injection of amphetamines. Increases in HIV infection through injecting reflect the lack of programs targeting HIV risk among drug users in Asia. There are also significant social and political resistance to harm reduction, with needle exchange and other proven approaches being illegal or unpopular, and strong preference for anti-narcotic and abstinence based approaches. Political advocacy, ongoing surveillance, capacity building and, above all, more harm reduction programs on the ground are needed urgently if countries in the region wish to counter rising HIV rates.

Other sessions on injecting drug use (IDU) reiterated the need to view drug users as human beings rather than demonizing them. Harm reduction expert, Dr Nick Crofts explained how "existing conditions which criminalize drug users make it virtually impossible for HIV prevention to happen". Police harassment, social ostracism and government policies, which prevent harm reduction, further compound this situation. He went on to explain how people get involved in problematic drug use due to the lack of employment options and how women gravitate towards sex work because "the only other options are so restrictive".

Scaling up Harm Reduction in Asia

A lot of attention was given to scaling up at this congress and it would be fair to say 'scaling up' became a catch phrase at this ICAAP. Scaling up prevention strategies usu-

ally means increasing coverage. Besides the fact that increased coverage is usually only directed toward targeted 'risk groups,' it also has implications on how we conceptualize our responses to the epidemic. For prevention programs, scaling up translates into more staff, more resources, more supplies and automatically implies capacity building of those who are in the business of prevention. What gets left out of the picture is the capacity building of the communities in which interventions take place – the capacity of communities to respond, rather than to receive.

To build this requires a certain quality of engagement, consistency of presence and commitment to scale down and scale out in order to facilitate community response to go to scale. Scaling up also means involving more sectors in finding solutions to the problem of drug use. Police and Public Security figures need to be brought into the equation as do church leaders and governments at all levels and sectors. We also need to urge donors to support projects large and small to tackle this problem at the policy level and on the ground. If we do not, the scenario for the next two years is frightening, with more people at risk than ever before.

The 4th Global Research Network Meeting

The 6th ICAAP dovetailed neatly with the 4th GRN a Global Research Meeting on HIV prevention among drug using populations. Speaking before the meeting, renowned US researcher, Dr Don Des Jarlais, stated, "For many years, HIV epidemics among IDUs have been ignored, there has been a misconception that such epidemics among injecting drug users are self-contained and will not spread to the general community. However, recent research in Asia has demonstrated that changing sexual norms, high risk sexual practices and mixing of sexual networks risks the rapid spread of HIV from IDUs to the general population.

In many countries there is a significant overlap between IDUs and sex workers. In a



2000 study by Family Health International, 20% of female street-based sex workers in Hanoi, Viet Nam, had injected drugs. Over a third of IDUs in Jakarta, Indonesia, had paid for sex in the previous year, and condom use among IDUs is universally very low. Along with Heroin, pharmaceuticals and other injectables, another drug is also sweeping across the region – Amphetamine-type stimulants or ATS. Amphetamines are increasingly replacing heroin and other opioids in Asia. And ATS dependence is more difficult to treat than heroin dependence.”

To this end, the Global Research Network (GRN) met for two days to catalyze research and responses to HIV and injecting drug use. Formed in 1998, the GRN has met in Europe, North America and Africa. GRN and the many people at ICAAP involved in the struggle to reduce drug-related harm helped moved us forward with the urgency, evidence and conviction needed to scale-up harm reduction responses in Asia.

The GRN was chaired by Dr. Alex Wodak of St. Vincent’s Hospital and Dr. Nick Crofts from the Center for Harm Reduction, Burnet Institute, who also hosted the meeting. The meeting was supported by a wide range of co-sponsors including Health Canada; the joint United Nations Program on HIV/AIDS; the World Health Organization; the United Nations Drug Control and Crime Prevention Program; the National Institute on Drug

Abuse; the Office of AIDS Research and the Fogarty Institute.

Deliberating on implications of IDUs as major multipliers of HIV to the general population, the GRN covered topics including:

- HIV-1 subtypes in IDUs and other populations
- Country and regional reports on HIV and IDU trends around the world
- Discussion on how regional research and advocacy networks can help to scale-up harm reduction responses.

The report on last year’s (3rd) GRN meeting is available at: <http://www.chr.asn.au/oceania/GV.Durban2000.html>

Conclusion

Overall, the ICAAP conference and the GRN meeting both pointed to the fact that we still have a long way to go before HIV epidemics cause by drug use have been controlled or even contained. Until such time, more work is needed by researchers, governments, harm reduction programs and communities as a whole to make drug use and drug users into a more manageable problem.

With drug injecting fuelling the overall AIDS epidemic in Asia, HIV prevention among injecting drug users must become a priority and a reality urgently. If not, many of the hard fought gains in slowing AIDS will be negated. Not one country is safe until all countries are.

Looking back at the past two years, it feels like we have come 2 steps forward but 3-4 steps back in the battle against HIV and IDU. Responses have grown markedly, but as much as the problem. So we need to move quickly from demonizing drug users, to seeing them as an important part of the solution. We also need to move from tokenism and rhetoric in responding to the IDU issue. Saying that a program or agency targets IDU without actually providing lasting and meaningful interventions on the ground is no longer enough. We need to see drug treatment and needle-exchange programs replacing prisons as an option for treatment. Donor agencies and implementers must ensure projects activities and funds reach affected communities.

Above all, we need to move fast before the gap between the epidemic and response becomes any wider. We need to respond with action, more action, humanity, inclusion and, above all, love. Finally, when we go home today, we should think not only about the many people already living with HIV/AIDS but also about those yet to be infected. – Paul Deany

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Indonesia takes concrete steps against HIV infection among drug users

A meeting took place between AHRN, the Indonesian Minister of Public Health H.E. Dr. Achmad Sujudi, and representatives of drug treatment and HIV-related services in Indonesia and members of its NGO community during the 6th International Conference on AIDS in Asia and the Pacific. The meeting was encouraged after AHRN, together with representatives of the Family Health International Project for Indonesia (ASA), participated at the Rapat Kerja Evaluasi Kegiatan Komite Penanggulangan Penyalahgunaan Napzaa Workshop this September in Jakarta.

Mr. Ton Smits, AHRN Executive Director, thanked the Minister for supporting the prevention of HIV infection among drug users, citing his foreword in the recently completed Bahasa Indonesia version of the Manual for Reducing Drug Related Harm in Asia.

Indonesia is now experiencing a surge in HIV cases after 10 years of dormancy and the Minister has expressed concerns over the sharp increase in incidence amongst drug users as well as the observed rise in injecting behaviour since 1999 (with 80% of users now injecting).

Well aware of the positive outcomes at the UNGASS, he stated prevention as the Ministry's primary goal, citing efforts by the National AIDS Committee, community outreach activities and a drug dependence hospital in Jakarta.

For its part, Dr. Jaroon Jittiwutigarn, member of the AHRN Foundation and Director of the Northern Drug Dependence Treatment Centre here in Chiang Mai, discussed the range of services available in Thailand, including methadone maintenance treatment. At present, the country does not have needle and syringe availability programs for drug users but a comprehensive pilot study is likely to be implemented next year. The ultimate goal is to interrupt/intercede in the client's drug using behavior, stressing awareness of its limitations and called for 'pragmatism'.

Dr. Sujudi concurred difficulty in changing people's behaviour, mentioning that punishments meted out to drug users in Indonesia would be light and 'are not likely to change and go the way of Malaysia'. Harm reduction is still a sensitive issue in the country, hence, 'one would have to work around its limitations', the Minister explained, and drew analogies

with the maternal and infant mortality rates, and illegal abortions. He also admitted that harm reduction is evidently an issue in Indonesia and that amending existing policies are needed. Laws associated with the implementation of harm reduction-based strategies need to be revisited and are at present under study.

The Minister complimented NGOs in their capacity to reach users and stressed the importance of these efforts particularly when the policy environment is yet to undergo amendments.

Indonesia has also developed a strategic plan to address HIV/AIDS infection. While government funding is available, Dr. Sujudi mentioned support from the UNAIDS for an upcoming Methadone Maintenance Pilot study.

World AIDS Day 2001: "I care ... do you?"

Who Cares About The Asian Pandemic?

Asia at risk of "major, generalized epidemics" of AIDS, driven by intravenous drug use, unsafe sex, and tainted blood transfusions.

Asia is home to 53% of the world's population where the threat of "major, generalized epidemics" of AIDS, driven by intravenous drug use, unsafe sex, and tainted blood transfusions is very real. This year, 1.07 million adults and children were newly infected with HIV in Asia and the Pacific, bringing to 7.1 million the total number of people living with HIV/AIDS in this region alone. Of particular concern are the marked increases registered in some of the world's most heavily populated countries.

For example in China, with prevalence rates higher than 70% among injecting drug users in a number of areas, such as Yili Prefecture in Xinjiang and Ruili County in Yunnan, some other provinces are possibly on the brink of HIV epidemics among injecting drug users because of very high rates of needle sharing. At the same time heterosexually transmitted HIV epidemics are on the rise in at least some of the Southern Provinces with HIV rates reaching 4.6%-10.7% among sentinel sex worker populations in 2000. Another example is Indonesia, the world's fourth most populous country, where HIV infection in injecting drug users was not considered worth measuring until 1999/2000. Indonesia, is experiencing a surge in infection rates among injecting drug users and sex workers and, in some places, an "exponential" rise in infection among blood donors. As the World AIDS Report indicates 40% of injectors in treatment in Jakarta are already infected. In Bogor, in West Java Province, 25% of injecting drug users tested were HIV-infected, while among drug-using prisoners tested in Bali, prevalence was 53%.

H.I.V. is also on the rise in the central Asian republics of Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan. This rise can be attributed to such factors as widespread unemployment, economic insecurity, changing social mores, the use of injected drugs and the disintegration of public health institutions. In other Asian countries such as Vietnam, Thailand, Malaysia, Nepal, India, Pakistan and Iran the HIV virus has been causing havoc among injecting drug users for many years.

But do we really care about drug users?

Arguably this is the most disenfranchised and marginalised group in society today, the subject of vilification and the victims of confused policy making. It is about time that drug addiction is considered a chronic relapsing illness, and as such should be addressed as a personal and public health problem, not

a public security issue. Moreover, recent reports from Monitoring the AIDS Pandemic (MAP) Network supported by UNAIDS and USAid reconfirm clearly that the theory of a "self-contained epidemic" among drug injectors does not hold true for Asia.

In many Western countries it has been recognised that investing in the prevention of HIV among (injecting) drug users is most worthwhile. Yet we have seen very limited support and solidarity from these countries to overcome challenges in this area elsewhere in the world. The Dutch and Australian Government are one of the few exceptions to this rule.

The Dutch have just demonstrated that they are concerned about both issues. Not just at the home front but also elsewhere in the world.

"Today, it was announced that The Royal Dutch Government will continue supporting the Asian Harm Reduction Network for programmes targeting HIV/AIDS and drug use for at least five more years."

AHRN Executive Director Mr Ton Smits said: "This is great news, they have provided support for our core programme activities throughout Asia for the next five years."

"It is only this year that politicians and policy makers have accepted that they must address the double issue, the double problems of HIV and injecting drug use, if they are to prevent a pandemic that will make the African situation seem small in comparison," he continued.

What else is needed? If we are really going to prevent a public health disaster in Asia, then several things must happen now," he added.

Political commitment is urgently required

First, there must be visible political commitment and action from governments that signed the UNGASS Declaration in June of this year. Last year's World AIDS Day slogan was "Men make a difference?". With a majority of politicians and leaders in the Asia Pacific Region being male, this is certainly an area where they can make a difference in whether we are going to win this battle or face a further spread of HIV of unknown proportions.

Behavioral research must be undertaken now

There must be a concerted effort to understand the twin epidemics (drug use and HIV) so that good public health policy can be developed. Behavioural surveillance must become standard practice if we want to understand the size of these problems and behavioural factors involved and target our interventions effectively.

Treatment for drug addiction

In most Asian countries there are few treatment options for drug users who want to cease their drug use. The mainstream is still "the lock them up policy" which is certain to result in pushing the issue further underground. A broad variety of quality drug treatment services inclusive of needle and syringe availability programs and long-term drug methadone or buprenorphine therapy programs, need to be made widely available and accessible if we want to win this battle.

Make (ex-) drug users part of the solution

In numerous cases it has been shown that former drug users are a vital partner in developing and implementing interventions. They have a good understanding of drug users' needs and ways of communicating with them and therefore need to be given a much more prominent role in addressing the twin epidemics.

Financial support to large-scale programming

In large parts of Asia and the Pacific, prevention programs are poorly funded and resourced. Typically, small projects are scattered across countries and do not acquire the scale or coherence that is needed to halt the epidemic's spread.

National budget allocations need to emphasize much more on preventing HIV among so-called "vulnerable groups" such as drug users, sex workers and men having sex with men. Increased financial support and solidarity from Western countries will be equally crucial.



Understanding the epidemic amongst injectors

Injecting drug use and resultant HIV epidemics pose new and sustained threats to communities across South and South East Asia. Drug injecting exposes new populations to HIV risk. It challenges communities and governments alike to find new strategies to deal with the entrenched problem of illicit drug use and the reality of new and increasingly explosive HIV/AIDS epidemics.

The twin problems of drug use and HIV are closely linked to poverty, population mobility and livelihoods, often occurring when people are away from their normal supports, looking for a new life and work in cities and towns. Drug use and needle sharing also occurs in the absence of sustainable livelihoods, placing people in a vicious cycle of drug use, unemployment, crime and increased HIV risk. Drug users often have to undertake difficult, demeaning and dangerous work to sustain their habit. When they are women their vulnerability is even greater, particularly if they are involved in sex work.

Importantly, it must be stressed that HIV epidemics among injecting drug users do not stay confined to this group, but rather lead to widespread epidemics among the broader community. Paradoxically, injecting drug users are one group that we know how to successfully reduce HIV through education, counseling, drug treatment, substitution programs, needle exchange and other measures that have been proven to reduce the harmful consequences of drug use.

But these proven measures are still far too few, meaning that rapidly expanding HIV epidemics, fuelled by drug injecting, are now undermining many of the gains made so far on HIV and development. *What then can be done to empower communities to turn fear, denial and lethargy about the HIV and drug problem into community action?*

What can be done?

Firstly harm reduction programs and other measures to target HIV among drug users need be mainstreamed into current development initiatives such as poverty alleviation programs, pre and post departure briefings for migrants and programs targeting governance, mobility, gender, livelihoods and sustainable human development.

Secondly communities need to be empowered and mobilized to discuss, debate and better understand the challenges posed by drug use and HIV. This increased understanding in-turn needs to be translated into strengthened community capacity to respond to current and new HIV epidemics caused by drug injecting.

Finally, we need to drastically scale up proven harm reduction responses to a level commensurate with HIV epidemics now occurring among drug using communities in South and South East Asia. If we do not, our failure to respond to the drug use problem will be a glaring and costly omission in attempts to respond to HIV and development in Asia.

Source: UNDP 2001, *Drug Related HIV Risk, Livelihoods and Communities in Asia*. UNDP South & South West Asia in collaboration with UNDP South East Asia HIV & Development Project, New Delhi, India. <http://aidsouthasia.undp.org.in>



World AIDS Day 2001: "I care ... do you?"

Inaugural speech of H.E. Lt. General Khin Nyunt, Secretary-1 of the State Peace and Development Council, and Chairman of the National Health Committee on World Aids Day International Business Centre, December, 2001

Every year, World AIDS Day is commemorated throughout the globe on the first of December to remind the people of the menace of the dreadful disease AIDS, which has become a global public health problem. This year's theme is "I care ... do you?" and it is indeed most appropriate.

This slogan is in fact a continuation of the year 2000 campaign "Men make a difference", which was chosen to discuss the central role of men in the fight against HIV/AIDS. But the slogan also has a broader underlying message that includes issues relevant to prevention and care, to both men and women, and to different age groups and populations. The campaign also aims to involve men, particularly young men, in the national responses to HIV/AIDS. This campaign calls upon men as leaders, heads of families and responsible care-givers to actively respond to the AIDS epidemic.

All this does not mean that women and girls are less involved in the prevention and care programmes. We must work in a way that programmes enhance gender equity and focus on the needs of both sexes. We must design our own programmes that meet the needs of the national and local priorities.

Myanmar is committed to fighting HIV/AIDS as a national cause. Towards this end,

the multi-sectoral National AIDS Committee comprising of high-level officials from various sectors was formed in 1989. Since then the committee has laid down policy guidelines, strategies and activities on AIDS prevention and control. Moreover, Myanmar is in the process of laying down a four-year Master Strategic Plan (2002-2005) for expansion and enhancing HIV/AIDS prevention, control and care activities. For the implementation of the Master Strategic Plan, the Ministries of Health, Social Welfare and Home Affairs will serve as focal points in partnership with other government sectors, NGOs and the international community.

The social behaviour in the society can also have a strong impact on the spread of the disease. In Myanmar, the social and cultural values, particularly the Buddhist teachings play a very significant role in preventing the spread of AIDS in the society. Moreover, Myanmar people are by nature gentle and kind hearted, being guided by loving-kindness and compassion. To look after and care for less fortunate individuals is imbued in our family and community spirit. Therefore the slogan "I care" is no stranger to Myanmar people.

In speaking about our efforts in this field, it will not be complete without mentioning the valuable contribution made by NGOs like Myanmar Maternal and Child Welfare Association, Myanmar Red Cross Society, and Myanmar Medical and Dental Associations. I wish to commend the NGOs for their noble work, which is largely implemented at the grassroots level.

HIV/AIDS is a trans-border issue. Myanmar is therefore actively participating in bilateral, regional and international programmes. Therefore Myanmar has at-

tended HIV/AIDS fora such as Southeast Asia regional meetings, ASEAN Meetings on AIDS, ESCAP preparatory meetings, UN General Assembly Special Session on HIV/AIDS held in New York as well as the First Asia and Pacific Ministerial Meeting on HIV/AIDS in Melbourne, Australia. Moreover, in September Myanmar hosted the meeting of the 9th ASEAN Task Force on AIDS. Realizing the threat of the disease to the region, ASEAN countries including Myanmar adopted the ASEAN Declaration on HIV/AIDS on 5 November 2001 at the 7th ASEAN Summit held in Brunei Darussalam.

In addition, Myanmar has also invited many missions like the European Commission, Second Generation Surveillance Group, UNAIDS Headquarters Deputy Executive Director, International Organization for Migration, Asian Harm Reduction Network, JICA Missions, AusAID Mission and many other International NGOs and UN Missions so that they can witness effective and sustainable HIV/AIDS prevention and control activities being implemented in Myanmar. All of the missions acknowledge that the Myanmar Government is doing its utmost to combat HIV/AIDS. I am happy to note that these Agencies have now become our coordinating partners and are advocating for us. At the moment, we are relying mostly on our resource. However, I am confident that with the support and assistance from our foreign partners, our capacity to tackle the issue will be much more enhanced. I also would like to thank and take this opportunity to express our appreciation to all the local as well as international partners including international NGOs who are working together with us in this noble task.

Speech delivered by Pol. Maj. Gen. SOE WIN, Secretary of CCDAC and Director General of Myanmar Police Force at the UN Regional Task Force Meeting on Drug Use and HIV Vulnerability Yangon 3-4 Dec 2001

Distinguished guests from UNAIDS, UNDCP, AusAID, USAID, EU/SEAPICT, UNICEF, United Nations, Asian Harm Reduction Network, McFarlane Burnet Centre, Population Services International, participants from Ministries and Departments and Ladies and gentlemen.

On behalf of the Central Committee for Drug Abuse Control, may I take this opportunity to extend to you all a warm welcome to Myanmar. I am deeply honored to be given

this opportunity to give a speech on behalf of the CCDAC at this very important meeting of the UN Regional Task Force on Drug use and HIV vulnerability.

At the outset, allow me to say a few words about the CCDAC, its organizational structure and its functions in general. The CCDAC is the Myanmar Government's focal point for all matters pertaining to drug abuse control areas that are being conducted within Myanmar. It has two broad components, namely, Demand Elimination and Supply Elimination.

Under these two broad components, a wide range of Ministries take part in implementing the functions of the various work committees that have been formed. Among these sub-committees, the Ministry of Health implements the functions of the Treatment Sub-committee, while the Ministry of Social Welfare implements the functions of the Rehabilitation Sub-committee. Sub-committees are chaired by the

Deputy Ministers of the respective Ministries, which reflect the importance attached to the functions by the Myanmar Government.

Since HIV infection is one of the common dire consequences of drug use among IDUs, the CCDAC is fully aware of this and has taken this issue seriously and has been conducting an all-out effort to control this very dangerous disease. In this regard, it has taken the initiative to control the spread of HIV among IDUs in addition to its efforts to control drug abuse.

HIV was introduced among the drug users in Myanmar during the late 1980s and reached high levels by the 1990s. This prompted the CCDAC to introduce HIV prevention measures among IDUs through various ways in a collaborative effort with relevant Ministries. Health education regarding



The following is a letter from Mr. Rian van de Braak, General Director of AIDS Foundation East-West (AFEW) and Head of Mission, AIDS programs MSF-H/Moscow



Dear Partners and Colleagues,
 These have been busy months for Medecins Sans Frontieres-Holland (MSF-H) operations in the Newly Independent States (NIS) of the former Soviet Union. We have continued our missions in Russia and the Ukraine, concluded our work in the neighboring country of Mongolia, and are currently planning to establish a new base of operations in Kazakhstan.

But perhaps most importantly, we have continued to move forward in the creation of AIDS Foundation East-West (AFEW), the first international NGO dedicated to addressing the pending HIV/AIDS epidemic in the NIS.

AFEW, which is being created with the support of MSF-H, The Open Society Institute and the Dutch government, was officially estab-

lished in The Netherlands on 4 January 2001. On 16 June 2001, the AFEW Executive Board gave final approval for plans to effect the transfer of MSF-H HIV/AIDS operations to AFEW starting 1 December 2001 - World AIDS Day. There is little time to lose. Each month, the data show HIV/AIDS rapidly spreading throughout the NIS. During the last year, the NIS showed the world's steepest HIV infection rate curve, with the number of people infected with the disease more than doubling over the past two years. Ukraine, Belarus, Russia and Kazakhstan have been the hardest hit so far, with increasing numbers of HIV/AIDS patients beginning to overwhelm the existing health care structures.

AFEW is specifically designed to be the first international NGO to address these issues head-on. This new Dutch organization will draw upon the knowledge, resources, experience, and expertise generated by the international and national staff of MSF-H/Moscow to continue to develop and implement effective HIV/AIDS prevention, care and support interventions in the NIS.

With headquarters in Moscow and operational offices in Kiev and Almaty, AFEW will coordinate an array of activities, including an on-going series of successful mass media campaigns, effective training and outreach programs, and the world's most comprehensive research of the HIV/AIDS epidemic

in the Russian prison system. AFEW will continue to expand to new countries in the NIS region and to duplicate our proven prevention, care and support activities, while at the same time developing new approaches and methodologies to combat this growing epidemic.

There is much work to be done, but together with our colleagues, counterparts, and our international network of experts and supporters, there is a real chance to make a difference before it's too late. Through swift and concrete action, we will be able to maximize the current window of opportunity and to begin to make real changes in the national policy, the lives, and the health of the citizens of the NIS.



AFEW will officially begin operations on 1 Dec. 2001 with inaugural events planned for Moscow, Kiev, Amsterdam and New York. If you have any questions, comments or ideas, please feel free to contact me at info@msfholru.org.

Continued From Page 12

the consequences of drug use was given to the students of Myanmar through inclusion in the curricula from Primary to the High School level. Furthermore, HIV/AIDS health education using the mass media is being conducted regularly. Youths of the hill tribes in the highland areas were also given HIV/AIDS prevention education for three years commencing 1996, as part of a multi-national project.

The CCDAC has also conducted collaborative efforts with International NGOs to control HIV among drug users. The Injecting Drug Use Prevention Education Project which was implemented in the Kachin State from early 1999 to December 2000 by World Concern is an example. This project had as one of its objectives, the reduction of HIV/AIDS among drug users and high-risk individuals.

Another collaborative effort with an international NGO, CARE Myanmar, is currently underway. This project aims to enhance multi-agency coordination to improve interventions in drug use and HIV/AIDS prevention in Myanmar. This project has the following broad objectives:

- (1) to create a forum to discuss issues related to HIV transmission and drug use,
- (2) to develop an appropriate and effective mechanism for coordination.

The CCDAC has also made collaborative efforts with National NGOs, one of which is the Myanmar Anti-Narcotic Association (MANA). Training of outreach workers to prevent HIV/AIDS transmission among IDUs who are outside of treatment programmes, was conducted by MANA in collaboration with CCDAC.

The CCDAC is now in the process of drawing up plans for collaborative efforts with UNAIDS and UNDCP in the future. These are several examples of the commitment of the CCDAC to control drug use and the spread of HIV among drug users, and from them to the general population.

With the aim of gaining experience and exposure in HIV control measures among drug users, the CCDAC has also sent delegations to attend relevant conferences, seminars and meetings in the region as well as in the sub-region. The experiences and understandings gained were brought back and assessed based on its feasibility and applicability in the context of Myanmar culture and traditions.

The CCDAC fully recognizes the gravity of the HIV infection among drug users and the importance of conducting effective and timely interventions and above all, the importance

of implementing HIV prevention projects along with drug control activities in collaboration with our neighbouring countries. We are also fully aware of the need to strengthen our capabilities in all aspects and would like to say that we welcome warmly any assistance of goodwill in our fight against the scourge of drug abuse and its consequences.

Myanmar has been implementing the National HIV/AIDS Programme as a national concern after the establishment of the National AIDS Committee.

It was learned that a range of strategies for working with partners in the region to fight the HIV/AIDS epidemic was outlined at the 6th International Congress on HIV/AIDS in Asia and the Pacific (ICAAP) held on 10 October this year in Australia.

I believe that the outcomes of this meeting would be beneficial to participating countries and to be supported by regional programmes that fight against HIV/AIDS.



7th ASEAN Summit Declaration on HIV/AIDS

5 November 2001, Brunei Darussalam

[1] WE the Heads of State and Government of the Association of South East Asian Nations (hereinafter referred to as ASEAN):

[2] RECALLING that the ASEAN Vision 2020, adopted by the 2nd ASEAN Informal Summit held in Kuala Lumpur in December 1997, envisioned ASEAN as a concert of South East Asian nations, outward looking, living in peace, stability and prosperity, bonded together in partnership in dynamic development and in a community of caring societies;

[3] RECALLING the UN Declaration of Commitment on HIV/AIDS adopted at the 26th Special Session of the General Assembly in June 2001 that secured a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat HIV/AIDS in a comprehensive manner;

[4] DEEPLY CONCERNED that the HIV/AIDS pandemic is a threat to human security and a formidable challenge to the right to life and dignity that affects all levels of society without distinction of age, gender or race and which undermines social and economic development;

[5] RECOGNISING that at least 1.6 million people are living with HIV/AIDS in the ASEAN region, and that the number is increasing rapidly through risk behaviors exacerbated by economic, social, political, financial and legal obstacles as well as harmful attitudes and customary practices which also hamper awareness, education, prevention, care, support and treatment efforts, particularly to vulnerable groups;

[6] REITERATING the call of the Ha Noi Declaration adopted by the Sixth ASEAN Summit in December 1998 that we shall make sure our people are assured of adequate medical care and access to essential medicines and that cooperation shall be stepped up in the control and prevention of communicable diseases, including HIV/AIDS;

[7] NOTING the Joint Declaration for a Socially Cohesive and Caring ASEAN adopted at the 33rd ASEAN Ministerial Meeting held in Bangkok in July 2000, to strengthen people-centered policies that will promote a positive environment for the disadvantaged, including those who are in ill health;

[8] COMMITTED to realizing a drug-free ASEAN, as called for by the Joint Declaration for a Drug-Free ASEAN adopted by the 33rd ASEAN Ministerial Meeting held in July 2000 and the Bangkok Political Declaration in pursuit of a Drug-Free ASEAN 2015 adopted by the International Congress "In Pursuit of a Drug Free ASEAN" held in October 2000;

[9] ENCOURAGED by the notable progress of the ASEAN Task Force on AIDS in responding to the call by the Fourth ASEAN Summit held in Singapore in February 1992, to implement regional activities on health and HIV/AIDS aimed at curbing and monitoring the spread of HIV by exchanging information on HIV/AIDS, particularly in the formulation and implementation of joint policies and programs against the deadly disease;

[10] REALISING that prevention is the mainstay of the response to HIV infection and that there are opportunities for the ASEAN region to prevent the wide-scale spread of HIV/AIDS by learning from the experiences of some ASEAN Member Countries, which have invested in prevention programs that have reduced HIV prevalence or maintained a low prevalence;

[11] ACKNOWLEDGING that prevention, treatment, care and support for those infected and affected by HIV/AIDS are mutually reinforcing elements that must be integrated in a comprehensive approach to combat the epidemic;

[12] STRESSING that gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS, and that youth are especially vulnerable to the spread of the pandemic and account for over fifty percent of new infections;

[13] AFFIRMING that a multisectoral response has resulted in a number of effective actions for HIV prevention, treatment, care and support and minimization of the impact of HIV/AIDS;

[14] AWARE that resources commensurate with the extent of the problem have to be allocated for prevention, treatment, care and support;

[15] EMPHASISING that the epidemic can be prevented, halted and reversed with strong leadership, political commitment, multi-sectoral collaboration and partnerships at the national and regional levels;

Hereby DECLARE TO:

LEADERSHIP

[16] LEAD AND GUIDE the national responses to the HIV/AIDS epidemic as a national priority to prevent the spread of HIV infection and reduce the impact of the epidemic by integrating HIV/AIDS prevention, care, treatment and support and impact mitigation priorities into the mainstream of national development planning, including poverty eradication strategies and sectoral development plans;

[17] PROMOTE the creation of a positive environment in confronting stigma, silence and denial; elimination of discrimination; addressing the prevention, treatment, care and support needs of those in vulnerable groups and people at risk, particularly young people and women; and strengthening the capacity of the health, education and legal systems;

[18] INTENSIFY and STRENGTHEN multisectoral collaboration involving all development ministries and mobilising for full and active participation a wide range of non governmental organisations, the business sector, media, community based organisations, religious leaders, families, citizens as well as people infected and affected by HIV/AIDS in the planning, implementation and evaluation of national responses to HIV/AIDS including efforts to promote mutual self help;

[19] INTENSIFY inter-ministerial collaboration at the national and international levels to implement HIV/AIDS programmes;

[20] SUPPORT strongly the mobilization of technical, financial and human resources to adequately advocate for and implement national and regional programs and policies to combat HIV/AIDS, including efforts to promote mutual self-help;

REGIONAL ACTIVITIES IN SUPPORT OF NATIONAL PROGRAMMES

[21] CONTINUE collaboration in regional activities that support national programs particularly in the area of education and life skills training for youths; effective prevention of sexual transmission of HIV; monitoring HIV, STDs and risk behaviors; treatment, care and support for people living with and affected by HIV; prevention of mother to child transmission; creating a positive environment for prevention, treatment, care and support; HIV prevention and care for drug users and strengthening regional coordination among agencies working with youths;



JOINT REGIONAL ACTIONS

[22] STRENGTHEN regional mechanisms and INCREASE and OPTIMISE the utilisation of resources to support joint regional actions to increase access to affordable drugs and testing re-agents; reduce the vulnerability of mobile populations to HIV infection and provide access to information, care and treatment; adopt and promote innovative inter-sectoral collaboration to effectively reduce socioeconomic vulnerability and impact, expand prevention strategies and provide care, treatment and support;

[23] MONITOR and EVALUATE the activities at all levels and systematically conduct periodic reviews and information sharing with the full and active participation of non-governmental organisations, community-based organisations, people living with HIV/AIDS, vulnerable groups and caregivers;

INTERNATIONAL COLLABORATION

[24] URGE ASEAN Dialogue Partners, the UN system organisations, donor agencies and other international organisations to support greater action and coordination, including their full participation in the development and implementation of the actions contained in this Declaration, and also to support the establishment of the Global HIV/AIDS and health fund to ensure that countries in the region would have equal opportunity to access the fund;

ASEAN WORK PROGRAMME ON HIV/AIDS

[25] ADOPT the ASEAN Work Programme on HIV/AIDS and work together towards accomplishing the regional activities in support of national programs and joint regional actions.

ADOPTED on this Fifth Day of November 2001 in Bandar Seri Begawan, Brunei Darussalam.

Key Recommendations from the NGO GFATM Consultation Meeting Brussels 12 - 13 November 2001

This document presents the conclusions of a consultation meeting among 70 individuals from non-government organizations and networks working in all regions, held in Brussels on 12-13th November, 2001.

We are encouraged by the underlying principle of the Fund to strengthen the participation of communities and people, particularly those infected and directly affected by the three diseases, in the development of proposals. This is particularly important with regard to the involvement of people living with HIV/AIDS, whose experience in representing affected communities may be usefully transferred to the other conditions covered by the Fund.

The deliberations of this group are just one of the ways whereby NGOs are contributing to the development of the Global Fund against AIDS, Tuberculosis and Malaria (GFATM). These comments were compiled with reference to NGO inputs previously shared through the Break-the-Silence email discussion forum, but are not intended to reflect or pre-empt any other NGO contributions, past or future, received directly by the Transitional Working Group (TWG) or through other means. They reflect areas in which agreement and unity were reached during the meeting.

We must also qualify this contribution to the GFATM process by acknowledging the limited information made available to NGOs prior to this meeting. While we appreciate that these circumstances are shared by other consultations and the Fund process in general, this has crucially restricted the depth and scope of this consultation, and the extent to which fully informed debate could take place.

Despite these limitations, the NGO consultation engaged NGO organizations in animated and constructive deliberations, which resulted in a meaningful outcome.

We have intentionally limited our discussions and conclusions to those specific decision-making areas that we understand will be the focus of the forthcoming TWG meeting on November 22-24, 2001. The conclusions and recommendations are therefore not intended to be comprehensive, and do not preclude NGOs from making contributions on these or any other priority areas in due course.

These comments and recommendations are provided in an effort to improve the Fund and its impact. We strongly urge the TWG/TSS to respect basic principles of effective consultation by providing, as agreed, a written summary of what the TWG has heard from this consultation, including a list of the recommendations the TWG accepts and those it rejects – giving relevant reasons.

The TWG should also ensure that regular progress updates, including conclusions of

other Fund-related consultations taking place this week, are communicated to NGOs in a timely way.

We recognise that our participation in these meetings as representatives of the NGO sector carries with it a responsibility to communicate back to our communities the proceedings and decisions, and in turn to reflect accurately their perspectives at any future meetings.

Governance

1. Any conditions for donation/earmarking of resources to the fund should not support, promote or tolerate stigma and/or discrimination on the basis of race, gender, health status or specific behaviours.

2. NGO participation must be ensured in Fund decision-making and activities at all levels.

3. Within the governance structure, there should be a channel for appeal and arbitration to address civil society concerns and complaints.

Board

1. Considerations for NGO participation on the Board should include: regional representation on rotational basis; gender balance; and representation of PLWHAs.

2. The Head of Board and/or Head of Secretariat should be selected from NGO/CSO candidates - to ensure that at least one key position is held by the NGO community.

3. The composition of the GFATM Board should reflect the following proportions and status:

- NGO participants with full voting status (not less than 30%);
- UN/multilateral organization participants have observer status;
- There should not be pharmaceutical industry participants;
- Donors and recipient nations should have equal representation in Board participation;
- Nomination of NGO participants should be conducted through an open, and NGO-led, process (not within TWG mandate).

4. The Board should be responsible for ensuring and overseeing a thorough organisational and procedural review of the GFATM, and report on its findings to the Global Partnership Forum before the end of 2003 for the purpose of appropriate restructuring.

Secretariat

1. Due consideration should be given to diversity and gender balance during recruitment for all Secretariat positions. Every effort should be made to recruit individuals from the NGO community including PLWHAs for the Secretariat.

2. The Secretariat must recognise and fully accomplish its outreach and communications responsibilities, in order to ensure transparency in all processes and decisions related to the fund.

3. There should be a dedicated position on the Secretariat with responsibility for NGO liaison and outreach.



Technical Advisory Panels/ Global Partnership Forum

1. Technical advisory panels should include people infected and affected by the three diseases, as well as NGOs.

2. NGO should be fully represented at the Partnership Fora. As with other delegates, this requires financial and communications support. Also, to facilitate communication between NGO representatives and to help them prepare for full participation in the meetings, a full-day preparatory meeting should be held immediately preceding the formal Partnership Forum.

Accountability & Eligibility

1. The fund application process should be a two stage proposal process. Firstly, an eligibility note should be submitted which. If they are eligible, they can submit a more detailed proposal.

2. NGOs agree that strong accountability and monitoring mechanisms should be built into the fund. However, current proposed indicators for program accountability are insufficient and focused on national program indicators. They should include indicators of added value of the Fund, and issues such as leveraging national resources, sustainability and specific program outcomes.

3. Reports on implementation of funded programs should be signed off by all partners, including NGOs and civil society partners.

4. In order to ensure maximum transparency in GFATM activities, all fund proposals, interim and final reports, as well as other supporting/review documentation, and working documents of the GFATM Board, Secretariat and Global Partnership Forum should be available publicly and for comment in a timely way.

5. Current proposals should be posted and open for comment on the internet. The comments should be made available to the Technical Review Panel (TRP) within the established proposal review time frame. This is to ensure transparency, to allow sharing of ideas between countries and to contribute to capacity building. It is in keeping in with the environmental impact assessment precedent requiring public hearings.

6. In circumstances where NGOs or vulnerable groups are not recognized by national governments, mechanisms must be in place to allow them to have access to the Fund.

7. In some countries there may not be sufficient capacity to effectively apply for funds and this will need technical and financial support in order to prepare and submit a Fund proposal. The Fund should provide for this type of support and related capacity-building.

8. The Fund should obtain commitments of resources from national, regional, and international sources (including the UN system, national governments, foundations and private sector) to support regional and national NGO networks and build their capacity to fully participate in country-level processes.

Country Processes: Country Coordination

1. The key roles of the Country Coordinating Committee (CCC) should be to bring together all key stakeholders, including NGO, civil society and representatives of people living with and affected by the three diseases covered by the Fund; set country priorities; and monitor programs supported by the Fund.

2. The CCC should build on existing structures. However, it must be recognized that, currently, these are rarely truly participative and action must be taken to ensure that all stakeholders can participate effectively.

3. The Fund must set clear criteria for participation on the CCC. If criteria are not met by a given CCC, then the Fund should not consider proposals from it. Participation must include affected and vulnerable populations, particularly the disenfranchised.

4. Interim principles and contingency guidelines should be set so that proposals can be approved in the first year.

5. Participants in the CCC should have equal status.

6. The most appropriate person should chair the CCC and it should not be assumed that this person shall be from the Ministry of Health or from a government. They should be nominated by the CCC.

Country Processes: Country Proposal

1. The Fund should include consideration of regional, sub-regional and multi-country proposals in addition to country-specific proposals. This is because countries can often work better collectively. This will also increase cost effectiveness, adapt to economies of scale and facilitate south-south collaboration and technical assistance.

2. The Fund should support: inter-sectoral activities, public health approaches, health system development, operational research, innovative and scaling up approaches.

3. In addition to the CCC option, the Fund must provide a contingency for national NGOs and civil society organizations to access the Fund directly.

4. A two-stage proposal process should be developed to include, in the first stage, a Concept Note incorporating objectives, a framework for a consultative process, and a clearly explanation who is involved in the consortium and how they will work together, and may also include a request for pre-proposal funding, technical assistance and resources to support the consultation process. This will be followed by the submission of a final proposal.

5. The Fund should NOT accept any proposals that have not been developed through a participatory mechanism including NGOs, private sector and affected communities.

6. The Fund should develop standard proposal review guidelines that are widely communicated to all potential grantees including – but not limited to – submission deadlines, review periods, response turnaround and funding disbursement timelines.

7. Country proposals with a commodity component must use best value procurement such as bulk purchasing and least cost/best quality products through use of safeguards foreseen in trade agreements as appropriate.

Country Processes: Monitoring and Evaluation

1. The core requirements to be monitored through existing and new monitoring and evaluation mechanisms include:

- The involvement of NGO and civil society in proposal development and program implementation
- Program benefits reach PLWHA and marginalized groups including children, women, drug users, men who have sex with men, sex workers, youth and mobile populations
- Evidence of added value
- Increase in absorptive capacity of the grantee
- Increase in efficiency
- That funds are allocated and spent according to the proposal
- Increase in provision and quality of treatment, care and support services for people affected by HIV/AIDS, malaria and tuberculosis
- Success in scaling-up
- Outcome indicators which are not limited to health, but include health and social indicators including poverty, access to IEC materials, coverage and sustainability

2. Innovative reporting mechanisms should be developed including regional and national reports to regional and national evaluation panels, the Board, the Secretariat and civil society.

Country Processes: Finance

1. The fund should be proactive in leveraging in-country finance and policy and process objectives.

2. It is preferable that funds to be used by NGOs as part of a coordinated proposal should be dispersed directly to NGOs rather through any intermediary.

The coalition of HIV/AIDS Regional Network (7-Sisters) Gets Commitment from AusAid

At the 6th ICAAP, the Australian Foreign Minister, Alex Downer, announced AusAid's commitment to support the 7-Sisters Secretariat for the next three years. It's a positive highlight for the organization who will hold its second meeting for the year on 14 December 2001. Agenda will cover assessment of the 6th ICAAP (from the 7-Sisters perspective) and of the organization's activities; and the 7th ICAAP to be held in Kobe, Japan in 2003.



S.O.S. from SASO in Manipur

The state of Manipur (India) is known for its high HIV infection rate since its first detection from a cluster of IDUs in 1989. Ten years later, HIV transmission related to IDUs constituted 76%. The sero-surveillance rate for IDUs in Dec. 2000 was 65.24%. In Imphal, capital of Manipur and where drug injection has long been established, the estimated drug user population is approximately 14000, 92% of which are IDUs (UNESCO-RSA Imphal 1999-2000). Existing drug treatment or demand reduction programs worked but with the high relapse rate (80%), high cost of treatment, longer duration of treatment and restricted treatment modalities, drug users are in constraints. HIV/AIDS intervention programs do exist but is too short for adequate coverage.

In December 1990, the Social Awareness Service Organization (SASO) was established by a group of ex-drug users aspiring to address in their own way issues that have already affected their own lives. They are people who have experienced the pain, agony and chaotic life of drug use. Their families and society were also affected to a large extent, thus, the need for collective effort to prevent further damage.

One focus of the organization is to "payback" the economic and social damages brought on by the epidemic of drug use and its implication – HIV/AIDS – on Manipur. SASO felt the need to uplift their society through initiatives and brandishing the motto: "Humility, Courage and Wisdom."

Supported only by limited contributions from its members, SASO quietly worked among IDUs and communities amidst constraints from lack of human, financial and technical resources. Today it has expanded and intensified its activities thanks to the supporters and well wishers.

But in "moving forward," SASO realizes along the way that more and more issues need to be addressed, and that it has a long way to go. SASO is determined but needs support and guidance.

SASO's Objective:

- To attain social and general upliftment among its members, and the general public to the best of advantages.
- To maintain discipline and politeness among members by imparting the best and by giving satisfaction to the public.
- To provide assistance during natural calamities, i.e., flood, famine, drought, etc., through volunteers and financial contribution.
- To share in the grievance of members in cases of misfortune, i.e., calamities, death, sickness and accidents.
- To promote culture, education, science, sports and others social activities.
- To raise funds through donations and contributions from members and non-members alike, i.e., public and other financial assistance from government and civic bodies.
- To work in the field of drugs and HIV/AIDS to the best of our capabilities, through awareness programs, care giving and medical support systems, counseling, etc.

Current services:

- Information on HIV/AIDS
- Counseling/behavioral therapies
- Orientation programs
- Home-based care services/ Free clinic
- Telephone help-line service
- Free STD & T.B. treatments
- Participation in schools/colleges and community programs
- Needle and syringe exchange program/Abscess management
- Referral network - drugs & HIV/AIDS
- Home detoxification
- Drug substitution therapy
- Condom promotion
- Outreach and peer education

The Buprenorphine substitution program: (from 25th Jan 2000 to October, 2001):

Participants	441 (433 males, 8 females; 20 SP injectors)
Clean	11
Expired	21
Jailed	5
Voluntary phasing out	148
Drop out	191 (20% Joined NSEP at SASO)
Continuing program	45
Untraceable	20

Note: Since the project is in its winding up stage (March, 2002), clients are recommended for phasing out with detoxification or referral.

Supporting Activities	
STD treatment	16
HIV testing	16 (11 positive)
Abscess management	36
TB medication government program	36
Referral to drug treatment	38
No. of clients provided with free medical support /treatment	250
Home detoxification and out patient detoxification	267
(30% later joined NSEP)	
NSEP Clients registered	660
Syringes and needles distributed	17,597
Return Syringes & needles	10,750
Return rate	61%
No. of condom distributed (sold)	5863
No. of condom distributed (free)	4062
No. of community programs	48 nos
Focus group discussion (Client & spouse)	93 nos
Training	16
Sessions on safe behavior (per month)	8

According to the report in Feb. 2001, 140 (31.7%) clients receiving adequate doses were found not injecting at all and 159 (36%) clients have reduced their injecting significantly

Problems

- A great number of IDUs referred by the community cannot be accommodated to the program as they are already above the target of 250 persons
- Inadequate dosing leads to craving for heroin and results to mixing
- Abscess & HIV-related opportunistic infections create stumbling blocks in the continuation of adequate dosage
- Take home doses leads to misuse
- Lack of family participation

"Practical" lessons learned

Buprenorphine substitution therapy can:

- Effectively address both issues of drug abuse and the spread of HIV/AIDS
- Reduce injecting incidence significantly
- Address relapses with a wider perspective
- Be an effective alternative for IDUs who don't have the resources to abstain from drugs
- Help drug users live cleaner lives
- Stabilize IDUs by setting them free from drug craving, crime and unproductivity
- Help retaining drug users within a continuum of treatments.
- is attractive to IDUs
- Be a consistent rehabilitation or caring process by itself to bring out a positive lifestyle
- Be a rehabilitation process done before or without detox
- Empower drug users to stop risky behaviors
- Maneuver IDUs towards abstinence

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RESOURCES AND PUBLICATIONS

Drug Use and HIV/AIDS in Thailand in the Year 2000

Commissioned by Family Health International, this report by Aaron Peak updates on the drug use and HIV/AIDS scenario in Thailand.

DRUG USE AND HIV/AIDS IN THAILAND IN THE YEAR 2000



Aaron Peak
Asian Harm Reduction Network
Submitted to

Family Health International
Asia Regional Office

Edited and with commentary by Carol Jenkins

This study covered key areas of western, northern, northeastern, and southern Thailand, and Bangkok, where it appears that approximately half of the living IDUs in the country are already infected with HIV and the remaining half, except among Akha hill tribes and heroin users in the southern portion of the nation, are rapidly switching to 'chasing' (inhaling the smoke through a tube) or ingesting methamphetamines, known locally as *yabaa*.

From an estimated 984,000 persons infected with HIV since 1988, approximately 289,000 have died of AIDS, and over 695,000 persons are now living with HIV. By the end of

1999, national HIV sentinel surveillance showed that prevalence had declined among Army conscripts, female direct/indirect sex workers, and pregnant women, but had increased among injecting drug users, from 39% in 1989 to 54.1% by June 1999.

The Office of Narcotics Control Board (ONCB) reports that *yabaa* comprises 75% of the drugs in use, heroin 10%, and others, 15%. Similarly, the proportion of new heroin users (1993 to 1999) has declined steadily with a consistent increase of methamphetamine use during the same period. Other drugs such as ecstasy, opium, marijuana, glue and solvents are available and usage has remained stable over the same period. There has also been a decline in heroin injecting and snorting and an increase in *yabaa* ingesting and 'chasing'. Harm reduction for drug users has been a notable gap in AIDS initiatives. Notably, only one program exists among Akha villages in Chiang Rai province. A link between use of methamphetamine or ATS and HIV risk has yet to be clarified, yet a dramatic increase in ATS use has been seen which can create serious health consequences. Research is critical to examine the mechanisms by which ATS use or ATS and alcohol use combined could lead to HIV infection.

The study suggests that, "Where injecting is rampant, harm reduction measures are needed, complemented by adequate treatment regimes. Current opiate treatment consisting of detoxification (often with methadone for 45 days), has low efficacy and with high relapse rates. Improved treatment modes are required, and where they have been implemented, need documentation with

long-term follow-up. To impact reduction of the spread of HIV from already infected IDUs, voluntary counseling and testing (VCT) programs are needed to identify them and bring them under treatment if possible, with adequate counseling for them, their partners and families."

Yabaa use (chasing and ingesting) is now dominant but, of itself, does not constitute a risk of HIV acquisition or spread, unless the drug facilitates increased sexual risk taking. Proper qualitative sexual research is needed to validate the latter followed up with behavioral surveillance surveys (BSS). This is necessary especially for sex workers and youth.

On the area of comprehensive package to care, many small NGOs and CBOs have requested help with supporting people living with HIV and AIDS (PLHA), and where home and community-based care is the most cost-effective option. Programs of this nature conducted in communities where infections were largely acquired through drug injecting, would reach a group avoided by others due to strong stigmatization of IDUs.

"As the current drug and HIV situation in Thailand is complex," the report concludes, "drug use pattern monitoring is a high priority."

Drug use patterns are likely to change again, and Thailand, along with several nations globally, must invest in readying itself for dealing with the phenomenon for a long time to come.

The publication can be viewed online at <http://www.ahrn.net/Thai2000.pdf> and can be downloaded in .pdf format.

In the next issue: Expect a copy of the Nepal Assessment, a report commissioned to AHRN by Family Health International Asia Regional Office.



Monitoring the AIDS Pandemic (MAP)

The Status and Trends of HIV/AIDS/STI epidemics in Asia and the Pacific October 4, 2001 Melbourne, Australia

This report draws upon detailed presentations made by MAP network members at the Melbourne MAP Symposium, September 30 to October 2, 2001, which preceded the 6th International Congress on AIDS in Asia and the Pacific.

Since the last report in 1999, where many countries recorded relatively low infection rates even with high-risk behavior, new variations of the epidemic between and within the countries in the region has been observed.

Drug injectors – whose domain was long-established in Manipur, Yunnan and Myitkyina

– have now emerged as flashpoints for infections in countries like Nepal, Indonesia, Iran and Vietnam.

A major threat in HIV infection is likewise seen among population of MSMs (men who have sex with men), and among men who buy sex and the women who sell it to them. The men inevitably pass the fatal virus to their wives and regular girlfriends.

In Indonesia, where HIV infection has remained low in the last 10 years despite evidences of risk behavior, emergence of the infection has been alarming. Steep rises are seen among drug injectors and sex workers, as well as blood donors, the latter indicating a filtering outwards into society.

Where there are low levels of HIV, signs of risk exist, especially among sex workers in countries such as Bangladesh and the Philippines where there is low level of condom use. Coupled with extensive overseas migrations, the scenario also creates a fertile ground for HIV infection in the Philippines.

The report also identifies 'bridges' – sexual linkages between populations – that determine whether or not an HIV epidemic spreads outside the groups of people with highest risk behavior. Discussed were: the interface between sex and drugs, men who have sex with men and

women, and molecular epidemiology (linkages through HIV subtypes).

Rather than concentrating on national averages, the report suggests combining local data, with an understanding of how HIV epidemics evolve to provide a more realistic basis for assessing the future course of the region's epidemics.

And for Asia, where majority of the population does not engage in high-risk behavior, focused interventions can keep infection rates low in specific groups and reduce the risk of extensive HIV spread to the larger population.

MAP reports are available through the following websites:

Asian Harm Reduction Network
<http://www.ahrn.net/map2001.pdf>

Family Health International
<http://www.fhi.org>

FXB Center for Health and Human Rights
<http://www.hri.ca/partners/fxbcenter>

UNAIDS
<http://www.unaids.org>

US Census Bureau
<http://www.census.gov/ipc>

Workshops & Conferences

13th International Conference on the Reduction of Drug-Related Harm 03-07 March, 2002

On the 3rd of March 2002 will commence the 13th International Conference on the Reduction of Drug-Related Harm in Ljubljana, Slovenia. Concurrent to this five-day event will be the 2nd International Harm Reduction Congress on Women and Drugs, a one-day conference to be held on the first day.

IHRA (International Harm Reduction Association), the event's main organizer, will be supported by The Sound of Reflection Foundation and several of the most prominent governmental and non-governmental Slovene organizations in this field.

This five-day interdisciplinary conference will present practice, drug policy, research and evaluation in all areas of drug use, with clear focus on the reduction of drug-related harm of legal and illegal drugs. Special emphasis will be placed on promoting harm reduction in prevention and abstinence-oriented programs.

Expected attendees include distinguished world experts, clinicians, researchers and other professionals, members of users' organizations, and others involved in the field have already agreed to engage in debates, plenary and major meetings, small-scale workshops, and round table and forum discussions.

"The strength of the conference rests on its ability to attract people working in many different fields – policy makers and politicians, scientists and researchers, advocates, and people working in health, criminal justice, social welfare, and education," notes Gerry Stimson, Conference Program Director.

The 13th conference in this series will be held in Slovenia, between Europe's east and west.

"Each year the conference has grown in stature, credibility, scientific quality," states Pat O'Hare, Executive Director of IHRA. "The development of the Central and Eastern European Harm Reduction Network is mirrored in similar developments in other regions of the developing world where the Networks are playing an important role in advocacy for harm reduction with notable success in changing the way people think about tackling the problems caused by the use of drugs, legal and illegal."

Following the success of this year's conference in Delhi whose theme was community development for harm reduction, the 2002 conference on the Reduction of Drug-Related Harm will have a special emphasis on social change, transitions and the impacts on drugs and health.

It carries the theme "Social Changes: Lines of exclusion and diversity" and will be a ma-

ior global arena for science and research, discussion, education, training and networking to reduce the health, social and economic harms associated with drugs (including alcohol and tobacco).

In addition, it raises public awareness, influence in policy, legislation, reducing harm of illicit drug use, reduction in criminality, in infectious diseases, hepatitis, AIDS and overdoses.

Andrej Kastelic and Tatja Kostnapfel Rihtar, President and Director of the conference, respectively, jointly assure that, "We have done our best to make sure that the very latest ideas and research findings are presented and published in the proceedings."

2nd International Harm Reduction Congress on Women and Drugs

Hosted by the 13th International Conference on the Reduction of Drug-Related Harm and held concurrent on the first day, Sunday March 3, 2002 from 9:00 to 5:00, this one-day event will be organized by The International Harm Reduction Network on Women and Drugs.

While harm reduction movement remains a male-oriented domain, traditional women's rights organizations continue to exclude issues that address the needs of drug using women. In addition, the mental health field still has not adopted harm reduction principles to deal with female drug use. Hence, the need to give women a voice within the international dialogue about drugs (and alcohol).

The International Harm Reduction Network on Women and Drugs is working to develop allies with organizations in the fields of mental health and women's rights. This congress will be an opportunity to begin the process of building bridges with these constituencies to inform them about harm reduction and issues addressing the needs of drug using women. It will also address the need to raise a stronger voice for women within the harm reduction and drug policy movements.

Keynote speakers include Pirkko Lahti (invited), elected President of the World Federation of Mental Health and a representative of the women's movement.

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Asian Harm Reduction Network

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Members will receive AHRN's bi-monthly newsletter (free) and have access to its extensive on-line database of articles on HIV/AIDS and drug use in Asia.



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