



AHRN NEWSLETTER



Issue No. 27, March 2002

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

Supported by UNAIDS, the Royal Netherlands Government and the Drug Policy Alliance (DPA) Washington, D.C.

Drug use and HIV/AIDS

What's happening in Asia and the Pacific?

Changing trends in opium availability and production, and the emergence of amphetamine type substances (ATS) are changing drug taking practices throughout Asia, creating new risks once considered negligible and now fast becoming primary drivers of HIV/AIDS infection

New drugs, new trends

Between 1998 and 2000, Asia produced 96% (average) of the world's opium supply (*Illicit Drug Use Trend 2001 by the UNDCP*), with 72% coming from Afghanistan up until the Taliban imposed a complete ban on opium cultivation in 2000. The recently-concluded US-led military attacks on the country has caused the price of opium to drop, yet the opium industry in Southeast Asia's Golden Triangle – with Myanmar as its epicenter

and Laos following third place in global production – remains unabated, and has even diversified to include the production of amphetamine type stimulants (ATS). Annual prevalence estimates of opiate and heroin use in Asia in the late 1990s is rated at 64% and 63%, respectively.

Revisiting The Hidden Epidemic, 2001 (see Resources & publications section for more information) reports that the popularity of methamphetamines has soared in the last four years in countries such as Thailand, South Korea, Philippines, Taiwan, Japan,

Cambodia, Laos, China and Indonesia with ecstasy becoming the drug of choice in a burgeoning party scene in most urban centers.

Also popular is the illicit ingestion of pharmaceuticals – codeine-containing cough mixtures, analgesics and tranquilizers – and the use of buprenorphine (a synthetic opioid) which is widespread in India, Bangladesh, Pakistan and Nepal.

The use of solvents and glue remains common especially among street children in India, Laos, Cambodia, Indonesia,

Continued on page 2

In this issue

Drug use and HIV/AIDS: What's happening in Asia and the Pacific? 1

Programs and interventions
Breaking the chain Bangladesh – a success story in preventing HIV among injecting drug users Operation G21 5 7 8

Feature
14th International Conference on the Reduction of Drug Related Harm 2003 9

Sections
From the Editor 1
Resources and Publications 10
Conferences 11
Letters: NEIHRA 12

From the Editor

Breaking down barriers, breaking the silence

Welcome to the March 2002 issue of the AHRN Newsletter, the first for the New Year so I'd like to take this opportunity to wish you all a Safe and Happy New Year.

In this issue we have a review of 'Revisiting the Hidden Epidemic' a just released regional assessment of drug use and HIV/AIDS, the twin epidemics spreading rapidly throughout Southeast and South Asia. The report looks closely at drug use and HIV vulnerability in the region and what is most

evident is the lack of leadership and evidence based decision making at the national policy level. There are still far too few harm reduction based programs in place whilst we have increasingly seen 'social order' style campaigns being implemented when it is clear that such campaigns have negative public health outcomes, making HIV prevention work with the most vulnerable populations even more difficult.

Still there is some light and we report on three projects, from

India, Bangladesh and Indonesia that illustrate harm reduction for drug users at work. And working, even in very difficult situations, such as in Manipur, India. As these projects demonstrate, religion and culture do not have to be barriers to success when there's a willingness to meet the challenges.

AHRN is committed to facilitating the momentum generated by the 6th ICAAP and by UNGASS. This issue contains invitations from Jimmy Dorabjee, the Chair-

man of AHRN, and Dr. Suchart from the Ministry of Public Health Thailand, for all of you to join us here in Chiang Mai next year, when we host the 14th International Conference on the Reduction of Drug Related Harm (14th IHRC), 6-10 April 2003.

We hope you appreciate and find much of interest in this newsletter which has been produced by our new Clearing House Team: Irene Lorete, Thirawat Songsawan
Continued on page 10



Mongolia, Vietnam, the Philippines and Thailand, while cannabis and hashish consumption is common throughout the region.

Amidst increased frequencies of intercepted trafficking of methamphetamine tablets from Myanmar through Thailand, China, Cambodia, India and Vietnam, which find new routes through new local roads and highways and via the (Andaman) sea, coordinated efforts by these border countries (except India) is set to battle mushrooming domestic supply points and more devious trafficking routes (*Bangkok Post*, 10 Feb. 2002).

Risky drug using behaviors and HIV

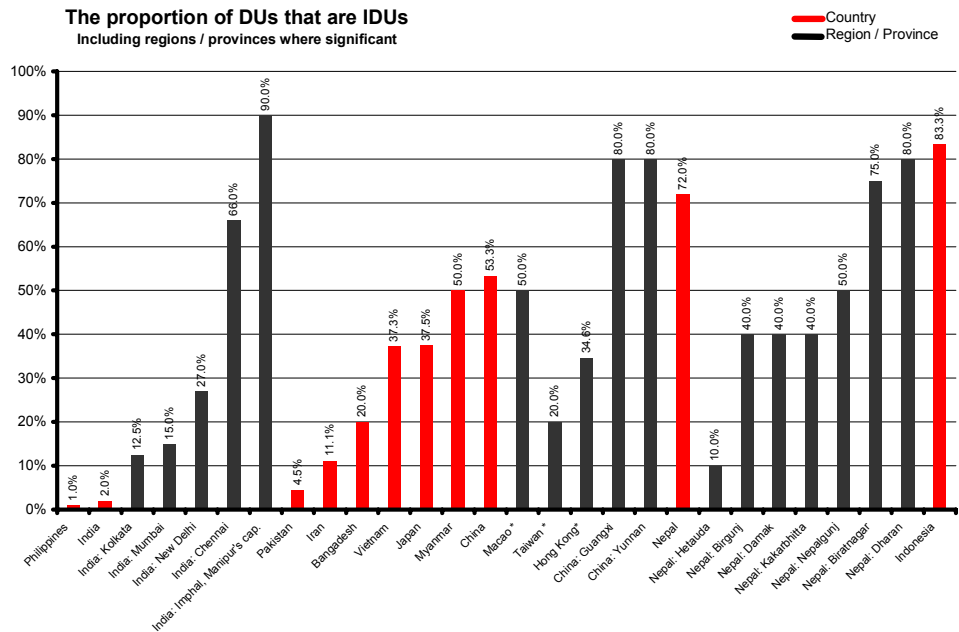
Asia (and the rest of the world) paints a somber picture where HIV/AIDS and injecting drug use are concerned.

At the end of 2001, 7.1 million adults and children

New trends in drug user profiles

- Declining age of initiation into drug use throughout the region
- High levels of unemployment and involvement in unskilled work among drug user populations
- A tendency to be poorly educated
- Sexually active but infrequent users of condoms
- High percentages have experienced incarceration
- Many are in poor health that worsens with length of drug use

The proportion of DUs that are IDUs
Including regions / provinces where significant



in the Asia Pacific region are expected to be living with HIV/AIDS, according to the Population Reference Bureau 2000 World Population Data Sheet. Of that total, 6.1 million are in South and Southeast Asia and 1 million in East Asia and the Pacific. *AsiaSource* (December 2001), quoted Peter Piot, Executive Director of UNAIDS, in warning that "with 60 percent of the world's population, Asia is showing the steepest infection curve and could fast become the region with the most HIV infections."

The on-line publication further noted that with this increasing rate of infection, Asian governments, NGOs, and activists confront HIV epidemics in Asia that are diverse, localized and have varying characteristics. In their efforts to educate the public and research ways for prevention, there are several issues particular to Asia that are being addressed.

Topping this list is the escalating incidence of injecting drug use, and recent reports from WHO and WPRO indicate that most new HIV infections are due to injecting.

Injecting as a mode of administration is often favored when drug availability is limited, hence a need for greater efficiency. When prices soar, injection can compensate by giving a more rapid and powerful effect that results in minimal wastage.

"Estimates of the number of drug users and injectors have generally increased over the 1998 figures, and in some countries the rise is substantial," states *Revisiting The Hidden Epidemic, 2001* with reference to the first report *The Hidden Epidemic, 1998*.

Injecting of heroin is a practice that has caught on in the recent years (the drug is commonly smoked in cigarettes or inhaled by 'chasing the dragon'). Amphetamines, whose addiction is harder to treat than heroin, are also being injected in countries such as South Korea and Japan, and among pockets of populations in Thailand, Laos, Indonesia, Philippines and China.

Cocktails of pharmaceuticals are also reportedly injected in India, Pakistan and Bangladesh.

Drug injectors have also become more apparent in Cambodia, Laos and Mongolia, although estimated numbers are still relatively small.

Sharing equipment – a very efficient way of spreading HIV – is common among injecting drug users (IDU) in the region, and methods of cleaning injecting equipment (i.e., use of cold water instead of boiling water or bleach) are often inadequate, hence promoting transmission of blood borne viruses (BBVs). More than 50% of injecting drug users in Myanmar, Nepal, Thailand, China's Yunnan Province and Manipur in India have acquired the HIV virus in this manner. In Vietnam, a third of users admitted sharing needles, while 55% of male users in Northern Bangladesh and 75% in the central region reported sharing equipment at least once in the week prior to being questioned, according to recent surveys (*AIDS Epidemic Update 2001*).

The existence of 'shooting galleries' in Pakistan, India, Bangladesh, Nepal, Vietnam, Myanmar and Malaysia, where equipment is

What's happening in Asia and the Pacific?

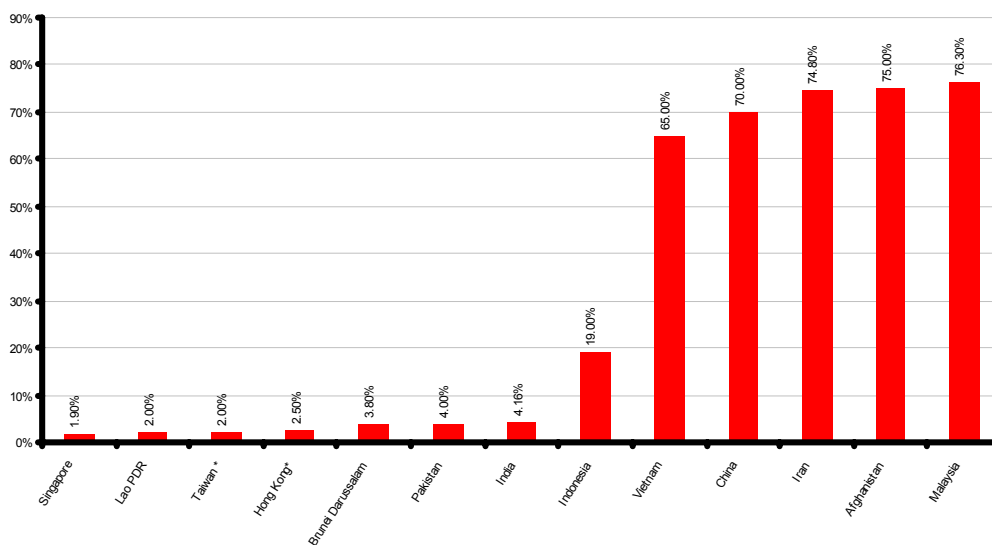
shared by many people, are also inevitable sources of BBV infections.

Although the majority of drug users in Asia are male, female drug users are to be found in all countries and the numbers are increasing. In Yunnan and Guangxi, China, 16-25% of drug users in treatment are female. In Vietnam, Nepal, the Philippines, India, Bangladesh, Indonesia, Sri Lanka, Hong Kong, China and Pakistan, female IDUs are increasingly becoming involved in commercial sex work (CSW). There is also increasing evidence of female sex workers taking up injecting drug use in Vietnam. (But information is little and needs to be researched further.)

This intonation is hardly comforting considering that the "behaviors that bring the highest risk of infection in Asia and the Pacific are unprotected sex between clients and sex workers, needle sharing and unprotected sex between men," states the *AIDS Epidemic Update 2001*, a report by the UNAIDS and WHO. "Commercial sex provides the virus with considerable scope for growth," the report highlighted.

It also noted how only few countries are acting vigorously to protect sex workers and their clients from HIV despite indications that it is

IDU as mode transmission in cumulative HIV total per country (2001)



from this relatively small pool (of sex workers) that HIV finds its way into the wider community via the male clients of sex workers. It is they who may unknowingly transmit the virus to their wives, partners or and to their children.

Government responses

"Social evils is all the rage now in Southeast Asia," said Jamie Uhrig, an AIDS consultant based in Vietnam. "The problem is, it doesn't work. Imprisoning people with addictions or those involved in sex work does not seem to help public health," reported the *South China Morning Post* (10 Jan 2002).

Most countries in the region impose harsh penalties on people convicted of trafficking, production and import-

ing and exporting drugs. The death penalty is applied for trafficking in China, Singapore, India, Indonesia, Iran, Malaysia, Brunei Darussalam, Myanmar, the Philippines, Sri Lanka, Thailand and Vietnam.

For drug users, the penalties are variable and depend on the type and amount possessed. It is common, however, for those caught violating the law either to be coerced into treatment or incarcerated. Treatment and rehabilitation centers are available in most countries but there is not enough of them at a limited range. The 70 to 90% relapse rates are frustrating some governments such as Singapore, Vietnam, China and Malaysia, who are opting for longer detention for repeat offenders in chronic relapsing conditions.

In the article "The Scent of Blood" (*AHRN Newsletter* 25-26, Dec. 2001), it was mentioned that despite the dramatic escalation in injecting drug use, there has been no commensurate response which also fails to reflect the scale of the HIV epidemic. Within only 2% of government national spending is directed to this population. Perhaps this will change soon since 2002-2003 have been designated the "ASEAN Drugs Awareness Years" by the 34th ASEAN Foreign Ministers meeting (July 2001, Hanoi) to help raise awareness of the dangers of illicit drugs and narcotics trafficking, as well as to mobilize people's support in further strengthening the region's efforts in the fight against drugs.

Non-government organizations such as the International Federation of Non-Government Organisations (IFNGO) have been approached by the ASEAN Secretariat for ideas and suggestions on how ASEAN could implement the drug awareness campaign.

So far, implementation of HIV/AIDS prevention and control

Where needle and syringe exchange programs (NSPs) are operational but small in scale and numbers Vietnam, China, Nepal, India, Iran, Bangladesh, Pakistan, Thailand and the Philippines.

Where methadone maintenance programs (MMP) are in existence but small in scale and numbers China, Thailand, Iran, Nepal and Indonesia. Hong Kong is the only country in mainland Asia which has completely embraced MMP, with 21 clinics operational.

Where buprenorphine substitution therapy is in use Indian cities but only in New Delhi, Calcutta, Mumbai, Chennai and Imphal

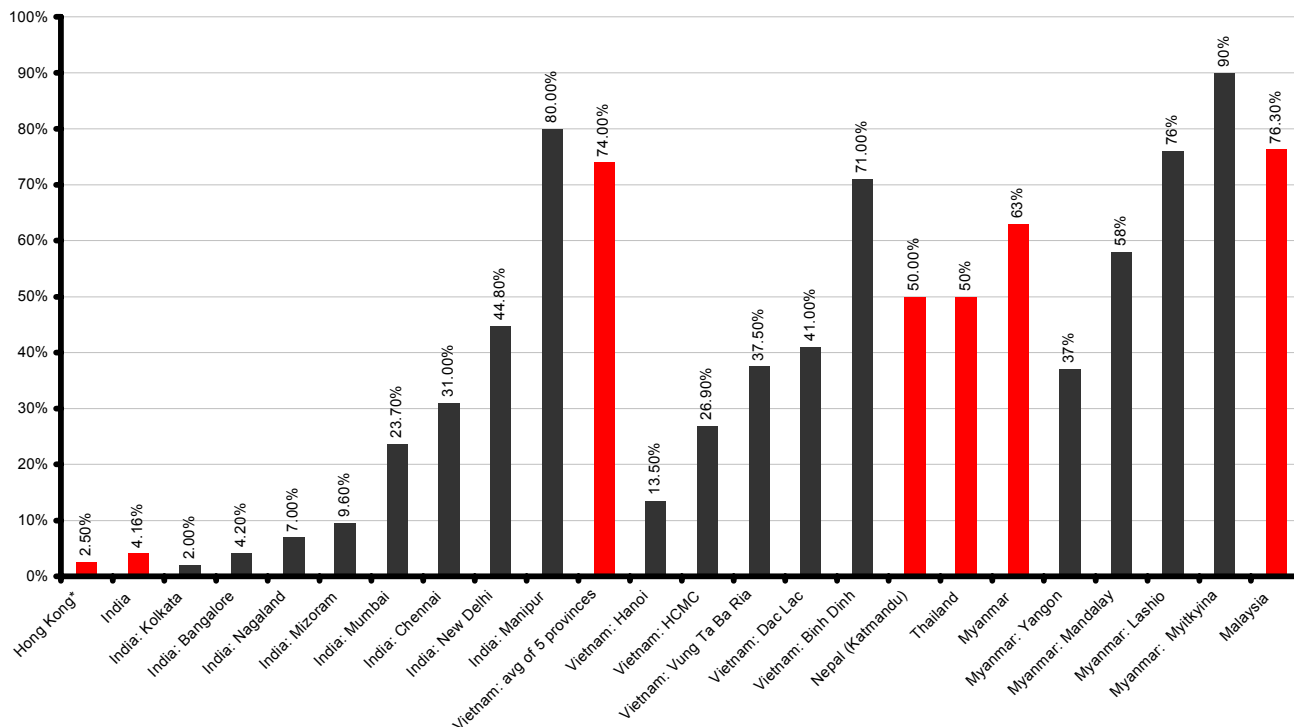


Drug use and HIV/AIDS

Estimated prevalence of HIV infections among IDUs (2001)

Including regions / provinces where significant

Country (Red bar)
Region / Province (Black bar)



measures for IDUs have been slow, if not inappropriate.

It is apparent from recent policy developments that Asian countries are still more concerned with a legal response to drug use than the health implications of HIV/AIDS. Information dissemination does not focus

on IDUs, is lacking in detail and is not explicit or far-reaching enough to impact on drug users. It is a similar story for other prevention approaches, which are mostly implemented by government sanctioned NGOs and whose programs are usually small in number while

attempting to serve a large demand.

Harm reduction works

Prompt, focused prevention is key according to the AIDS Epidemic Update 2001 report. "Countries that still have low levels of HIV infection should avert the epidemic's potential spread, rather than take comfort in low prevalence rates."

Low prevalence presents special challenges and at the same time offer opportunities. Indonesia, who, after 10 years of negligible rates recently found itself with rapidly increasing infection rates among injection drug users and sex workers, unfortunately failed to see its opportunity (in the last 10 years).

Where HIV is not yet established at risk in the wider population, the key is to enable the most vulnerable groups to adopt safer sexual and drug-injecting behaviors,

minimizing virus' spread within the communities whilst addressing the most difficult challenge of bolstering the wider communities' ability to protect itself against the virus.

"Extensive harm reduction programs can and do work," stated the 2001 report by UNAIDS and WHO, citing Australia's success in the late 1980s and isolated initiatives such as the SHAKTI Project in Dhaka, Bangladesh (see related article in this issue) and IKHLAS in Kuala Lumpur, Malaysia.

"The need to expand such programs nationally is patent if these concentrated epidemics are to be brought under control before they spill into the wider population," mentions the report. Many IDUs are sexually active young men, with steady partners but those who buy sex create a striking overlap between the using a commercial sex worker community that can accelerate the wider spread of the virus.

Continued on page 10

Misconceptions and barriers to addressing HIV/AIDS among IDUs

- The view of some that policies and programs focusing on drug use and HIV are not necessary because an epidemic of HIV has yet to occur among (their) IDUs
- Narcotics legislation that hold back risk reduction and prevention activities (i.e., Thailand, China, Vietnam, Nepal, Iran, Malaysia, and Indonesia where there is high prevalence of HIV among IDUs)
- Poor operational links between drug control policy, HIV prevention and intervention policies
- Disquiet and reluctance among professionals in HIV prevention (India)
- Poor understanding among senior level drug and health policy makers (India)



Programs and interventions

Breaking the chain

By Yachintha Disembriartista

Yayasan Hatihati's harm reduction program for drug users in Indonesia attempts to break the chain that spreads blood-borne viruses

The number of reported HIV cases among IDUs in Indonesia is increasing rapidly. Data from the Ministry of Public Health showed that in September 2001 the number of IDUs who contracted HIV/AIDS had reached 449 out of the total 2313 HIV/AIDS cases recorded in that month, while only 36 IDUs who contracted HIV/AIDS were reported out of 1146 cases recorded in February 2000.

Moreover, HIV anti-body testing in some drug rehabilitation centers in Bali and Java had showed a 10-50% range.

A 1998 survey, which involved 34 respondents, conducted in Bali showed that 73.3 percent of IDUs always shared needles and syringes. Even though 83.3 percent of IDUs claimed that they knew how to clean needles properly after being used, the fact was only 30 percent stated that they cleaned their needles with alcohol while the others merely used water, if they cleaned the needles at all. None of the respondents used new needles every time they injected drugs (Setiawan et al., 1999).

Yayasan Hatihati was established in 10 December 1998 based on the results of this survey. It is a non-profit, non-governmental organization dedicated to reducing the harm associated with drug use (particularly blood borne viruses) and assisting drug users who would like to cease their use.

The organization made its first step by implementing a harm reduction program at Denpasar and Kuta in March 1999 with funding from the Australian government aid program, AusAID. It started with a manager, a financial and administration staff, and four outreach workers, two of which were users while the other two were ex-drug users. Yayasan Hatihati has now grown as an institution in terms of human resources and program and presently employs a manager, a field coordinator, four outreach workers (no more current users), a counselor, three detoxification program staff, a financial organizer and an administrative staff. In addition, there are 92 volunteers assisting with a variety of tasks.

While harm reduction is still its core program, in response

to the community's perception that Yayasan Hatihati condones drug using activities, and in order to meet the needs of an accessible and affordable recovery program, a peer support group was started in July 2000. It was supported by individual patrons and was aimed at supporting and encouraging drug users who wish to overcome and end their addiction. This program is ran and managed by groups of peers (drug users) who have succeeded in stopping their drug using habit.

Yayasan Hatihati's harm reduction program emphasizes on effective efforts to break the chain that spread HIV/AIDS in the community through activities that include information dissemination and education about harm reduction, field work, outreach, and providing peer education and trainings. Ex-drug users are involved in its planning and implementation.

As of December 2001, Yayasan Hatihati has established contact with 993 individual drug users: 454 male IDUs, 39 female IDUs, 429 male non-IDUs, and 71 female non-IDUs.

Regular field visits are made in at least 136 locations commonly frequented by drug users, usually in and around the mayoralty of Denpasar, and the regencies of Badung (including Kuta and

Abiansema) and Gianyar. In recent months, there have been visits to all other regencies in Bali (Tabanan, Singaraja, Negara, Bangli, Klungkung and Karangasem). Education activities also targeted junior and senior high schools students, teachers, traditional communal institutions of banjars, prisoners, and local government officials.

A program evaluation survey in May to August 2000 of 34 IDUs showed that the program has succeeded in bringing about behavior change. The proportion of IDUs who use sterile needles had increased from 30% in the preliminary study to 67.9%, the quality of syringe and needle cleaning practices had improved where 28.6% had indicated using bleach, and the proportion that used condoms also increased from 10% to 25%.

However, many IDUs are still reported to be involved in highly risky behavior such as needle sharing. Among the reasons cited for such behaviors include the steep price of one needle and syringe (about 5000rp-6000rp). Not many pharmacies are willing to sell needles and syringes freely and because of the possibility of being arrested by the police, IDUs are not wont to bring their own needles and syringes for they can be used as proof that they are drug users.



(L - R) Training on on-site overdose handling, January 2002; and a condom exercise in a volunteers' training in December 2000.

Programs and interventions

Yayasan Hatihati has been running a trial-based needle exchange program since December 2000; however, the number of needles and syringes provision is very limited due to minimal funding. So far, 1450 needles and syringes have been

distributed to 307 IDUs through an outreach program. Outreach workers usually approach the IDUs, give them a fresh needle and syringe in exchange for used injecting paraphernalia. Nowadays however, it has become common for some IDUs to come to the Yayasan Hatihati office and ask for new needles and syringes.

Many of the drug users have viewed these meetings as a type of safe haven. They can come along, listen to a variety of health issues directly related to their lifestyle. We do not feel threatened. The police understand what we do. They tell us: 'These people (drug users) will not stop drug taking, even if threatened with prison. (They thought) its better drug users get some health information'.

- Outreach worker

Data collected during the trial showed that IDUs do not want to share the needles they get from the outreach worker with other IDUs, however, once these are ruined or lost; they start to share (needles and syringes) again.

The absence of national legal policies that clearly support needle exchange program (NEP), the limited supply of needles and syringes, and the fear of the legal consequences that prevents IDUs from carrying their needles and syringes everywhere they go, have become obstacles in conducting NEPs.

From its inception in July 2000 up to December 2001, the peer support group program (PSG) has provided services to 23 IDUs, 11 of

them have succeeded in completely stopping drug use after a 3-month program. Of these successful participants, nine have become staff and/or volunteers who are actively involved in program planning and implementation.

Scaling-up harm reduction in Indonesia

Since 1999, there has been efforts to address drug abuse in Indonesia, especially injecting drug use, from a public health perspective (rather than punitive/criminal perspective). In September of that year, a national workshop on illicit drug use was held in Cipanas, West Java by KerlipNAZA in collaboration with Project Concern International (PCI), UNAIDS, HAPP and AusAID. One of the major recommendations of this workshop was the undertaking of Rapid Assessment and Response (RAR) projects that will look closely at HIV among IDUs in Indonesia. The recommendation was then carried out from January to June 2000 in the cities of Jakarta, Bandung, Jogjakarta, Surabaya, Denpasar, Manado, Makassar, and Medan.

In July/August 2001, a harm reduction study tour for representatives of Indonesian NGOs (i.e., Yayasan Hatihati), government and law enforcement agencies

was arranged in collaboration with the Center for Harm Reduction, The MacFarlane Burnet, Australia. Participants traveled to Sydney to learn about and observe harm reduction programs under the sponsorship of AusAID and USAID.

Taking into account the reports of the participants, the study tour was considered a success and contributed to: (1) a major shift in attitudes/perceptions among the participants, particularly those from government and law enforcement institutions, towards harm reduction strategies, (2) better communication and, (3) the emergence of collaboration between members of these groups.

One of the major recommendations by the study tour participants was to undertake NEP pilot projects in Bali and Jakarta. Initiating and establishing an Indonesia harm reduction network was also discussed where Yayasan Hatihati was appointed as the secretariat.

Planning for a NEP pilot project in Jakarta and Bali in August 2001-January 2002

was soon underway, as well as a methadone maintenance pilot study with the support of the UNAIDS.

Another sign of growing government support was the Minister of Public Health's approval for the publication of the Indonesian version of Manual for Reducing Drug Related Harm in Asia, which was launched in November 2001 by the Ministry of Health and Social Welfare in Jakarta, and with the involvement of local AIDS commissions in several provinces such as Bali, East Nusa Tenggara, and Sulawesi. In addition, local governments have included harm reduction in the strategic planning of the Bali Local AIDS Commission for 2002-2005.

Despite all these positive efforts, the implementation of harm reduction programs in Indonesia remains a difficult task. Critical obstacles need to be addressed such as the prejudice by religious and traditional groups, who, for some biased reasons, believe that the time is not yet ripe for the implementation of harm reduction in Indonesia. There is also opposition from the police force against NEPs, raising concerns that the program may undermine social order, and interfere with (police) efforts to uphold the law.



Beach clean-up and flyer/condom/safe sex package distribution at Kuta beach in December 2000 for World AIDS Day.

Bangladesh – a success story in preventing HIV among injecting drug users

By Jimmy Dorabjee

Bangladesh is a remarkable example of a success story in the prevention of HIV among injecting drug users. It is one of the few countries in Asian that has responded to the prevention of HIV and other harms among injecting drug users (IDUs) in a timely and competent manner. Surrounding this tiny country are others who have seen the growth and spread of injecting epidemics and the resultant spread of HIV amongst injecting drug users but have failed to provide sufficient responses on the necessary scale to have impacted on the twin problems of IDU and HIV. Unfortunately, this situation continues all across the region today and that is why the story of Bangladesh needs to be told..

There is much similarity in the profile of IDUs in Bangladesh with those in the Indian subcontinent. In the late 1980s, Delhi, among other Indian cities, had a large population of Bangladeshi refugees living in slum and resettlement colonies. Every so often, they would be deported back to Bangladesh by the Indian authorities but invariably, economic hardships and better employment opportunities saw them return to other Indian cities. With an abundance of cheap, good quality brown heroin entering India from the western borders, many of these refugees became addicted to chasing heroin and, over time, unable to afford the drug due to rising prices, began to injecting pharmaceutical products including buprenorphine, diazepam,

promethazine and chlorpheniramine, often in cocktails.

It was entirely predictable that these Bangladeshi citizens 'immigrants' would take their newly acquired injecting habits back to Bangladesh, where reports of large scale injecting drug use began to appear. Like so many of its neighboring countries in the region, the country witnessed a rapid shift from non-injectable drug use to injecting, along with a surge of risk-related behaviors among the drug users. In 1998, Dr. Monica Beg from the CARE program reported that "the spread of drug injecting has become an epidemic in Bangladesh".

In 1997, a study conducted in Dhaka by CARE found an estimated 5000 IDUs and 11000 heroin inhalers. The majority of IDUs were male, and more than 90% of the street-based injectors had previously smoked heroin, a pattern very similar to other South Asian countries surrounding Bangladesh. In 2000, a rapid assessment study was also conducted by CARE in six other major cities and estimated 10,000 injecting drug users throughout the country.

In November 2001, I travelled to Dhaka and Rajshahi, where, under a program called SHAKTI, CARE Bangladesh provides HIV prevention services to IDUs.

I was amazed at the immense coverage of the SHAKTI program, from the interventions among IDUs to the remarkable outputs it has managed to achieve. Along

with the staff of SHAKTI and outreach workers, we went around the streets and visited drop-in centers to see the work of the outreach teams.

Earlier studies have shown the effectiveness of SHAKTI's approaches in changing the needle-sharing behaviors of both street-based IDUs and those using professional injectors. Where men inject in groups or inside shooting galleries, the intervention strategy has essentially turned these locations into safe injecting rooms, enabling extensive changes in sharing behavior to occur very quickly.

Rehabilitation and drug treatment facilities, however, are woefully lacking in Bangladesh. In the capital city Dhaka, there are only 40 beds at the Government Drug Treatment Hospital. Apart from this, a few non-government and private drug treatment programs exist, but they are expensive and have a limited capacity. Around 200 treatment slots are available in the country at any given time and they provide residential treatment, ranging from 14 days to 6 months duration. Most follow the 12-step Narcotics Anonymous (NA) approach while others provide medical

detoxification. As usual, relapse rates are high.

When viewed from the perspective that there are approximately 10000 IDUs and another estimated 12000 heroin inhalers in Bangladesh, it is easy to see the urgent need for more drug treatment facilities and for options that move beyond the detoxification and rehabilitation services currently available. With a total of 22000 opiate users and only 200 treatment slots available, alternative measures to engage drug users in some form of treatment urgently needs to be created.

Until Bangladesh develops easily accessible, widely available, user-friendly and effective drug treatment services, saving lives and preventing the harms related to injecting drug use is the main options. Needle and syringe distributions systems, including the exchanges set up by SHAKTI, are currently the first line of defence. Preventing current heroin smokers from switching to injecting is another. This is exactly where the SHAKTI interventions have made a remarkably significant impact – reaching 74% of the known 6750 IDUs in

Continued on page 8



The SHAKTI injecting drug users peer educator graduating class of 1999, at a ceremony on World AIDS Day in Dhaka.

Operation G21

Responsible clean-up keeps harm reduction viable

A clean-up drive of used needle and syringes discarded along riverbanks in Imphal India took place in September 2001 through Operation G21 (G for Gun, the local slang for syringe; 2 = 2 ml syringe; 1 = 1 ml syringe). Spear-headed by SASO, the objective was to get rid of contaminated injecting equipment dumped along three marshy riverbanks areas in Imphal – North A.O.C, K.R. Lane (New Checkon) and Mahabali. Four NGOs are presently working on needle and syringe exchange programs (NSEP) in these areas.

Prohibition, stigmatization and strict implementation of laws on injecting paraphernalia have turned these marshy riverbanks near main drug peddling areas in Imphal into major injecting areas. Drug users also prefer to get their 'fix' right where they 'score' to avoid hassles with the law or from pressure groups unlike when mobile. As a result, these prominent peddling and injecting sites are fast becoming dumping

grounds for blood-stained contaminated "sharps", putting residents, who depend on the river for their daily water requirements, at high risk of becoming infected by blood-borne pathogens. Other drug users are also at risk from reuse of the hastily discarded needles and syringes. SASO, who has been implementing various harm reduction programs in Imphal, is convinced that hidden injecting sites do exist in the city and the possibility of sharing injecting paraphernalia is high.

Operation G-21 was needed because of the growing negative sentiment of the community towards NSEPs as reported by service providers and drug users. The general public felt that the place has become a dumping ground for contaminated "sharps" disbursed by agencies and pharmacies located nearby. "If you are all are giving out needles/syringes which are irresponsibly disposed around me after being used by drug users, I don't like your work out here,"



Drug users and ex-users participate in other needle and syringe clean-up programs SASO not only those along the riverbanks.

voiced an alarmed resident. Field visits confirmed the report.

With already high incidences of HIV and other blood-borne diseases among IDUs, the situation has muted effective responses from the community, posing a threat to harm reduction approaches.

Operation G21 took place on the 10th of September 2001, two days after a big flood that washed down these riverbanks. Volunteers and IDU clients of SASO incinerated the 1,500 needles and syringes collected, paraphernalias estimated to have been used only for two days of injecting incidences. And because the IDU population is still increasing despite claims and efforts, it is certain that injecting is happening beyond the estimated rate.

Lessons learned

Proper incineration of the returned and used syringes is another issue, which continues to be taken lightly by the NGOs. Public health responses such as NEP must be friendly to the environment and to the public, where equal focus must be given to both target group and the area in which they move around. The situation in Imphal is an example of how used, and possibly contaminated, needles and syringes left astray in a public domain pose a risk to the general population. When incidents like this happen, support and participation from the public diminishes. The retrieval and disposal of these strayed contaminated sharps is paramount and frequency of retrieval should correspond to the frequency of drug injecting incidences.

Bangladesh – a success...
Continued from page 7

Dhaka, Rajshahi and three other towns through needles availability, HIV education and primary health care. This would not have been possible without the active involvement of PROCHES-TA, a recently-formed current group of IDUs group who function as outreach workers and peer educators in Dhaka. Plans are underway to form similar drug user groups in the other cities.

Also, SHAKTI's behavioural surveillance data also reveals that in the last year, 58% of sex contacts involving by IDUs were protected through consistent condom use and an 83% return rate of needles has been achieved. This may be one of the main reasons why the HIV infection trends among IDUs in Bangladesh remain low (less than 2.5% since 1998).

However, the issue of drug substitution seems to have generated some resistance from policy makers here. India had the same experi-

ence but, on seeing how NGO-run substitution programs have impacted quality of life and other health indicators, the Ministry for Social Justice and Empowerment, nodal funder for more than 400 drug treatment centres in the country, showed during the 2001 International Harm Reduction Conference in Delhi that it was very much in favor of harm reduction strategies.

SHAKTI program managers recognize the urgent immense need for substitution

programs and are lobbying the Government of Bangladesh to permit piloting them. One can only hope that donors and government decision-makers would realize the need to continue investing in needle/syringe distribution and a range of other harm reduction education strategies for the country.

To date, the HIV epidemic seems under control, but any drop in coverage would change the dynamics and snowball into a potential disaster, one that so far has been averted.



14th International Conference on the Reduction of Drug Related Harm 2003

In 2003, the city of Chiang Mai in Thailand will host the 14th International Conference on Drug-related Harm. This is the leading international conference on reducing harms from all drugs – including alcohol and tobacco. Organized annually by the International Harm Reduction Association, the 14th conference in this series will be conducted in partnership with the Asian Harm Reduction Network (AHRN).

Co-hosting this important event locally and supporting AHRN are Thailand's Ministry of Public Health (MOPH) and the Office of the Narcotics Control Board (ONCB).

Mr. Jimmy Dorabjee, Executive Committee Chairman of AHRN, and Dr. Suchart Laobhriptr, Director of the Division for Coordination of Drug Abuse Treatment, Ministry of Public Health Thailand invite you to the 14th IHRC.

Contact our conference secretariat for more details: IHRC2003@asiacongress.com

ASIA IS THE WORLD'S MAIN supplier of heroin; a region where a rapid growth in drug use continues to occur despite concerted efforts to control the cultivation and production of illicit drugs. With the increase in injecting drug use – a more effective delivery system – Asia is also witnessing an unabated spurt in HIV infections and other related harms.

In fact, South Asia is now recognized as the epicentre of the HIV epidemic and the devastation that will occur through the massive transmission rates would be staggering, destabilizing the economies of many developing countries. Despite evidence of increased drug use, there is

still a strong denial of the existence of IDU in many Asian countries and a failure to recognize the importance of IDU as a contributing factor for HIV infection in the region.

Effective and well-planned interventions in this situation can only occur if up-to-date information and adequate resources are available in order to design appropriate programmatic responses. In this region, changes in trends of drug use and other factors which influence the spread of the epidemic are scantily documented and even less understood. A dearth of such information is evident in the lack of large scale harm reduction initiatives in the region as well as the continuation of largely ineffective drug treatment programs based on an abstinence philosophy.

HIV and drug use both require a comprehensive range of responses and long-term planning. No single strategy suffices to cover the various nuances brought about by injecting drug use and HIV. Strategic alliances and partnerships need to be forged so as to effectively respond to these issues on a large enough scale so as to impact on the progress of the epidemic.

Harm Reduction is a public health response adopted by many countries and is endorsed by UN agencies responsible for developing programmatic and policy responses to HIV/AIDS among drug users. Internationally, harm reduction based programs have demonstrated their success in attracting and retaining drug users in treatment. In Asia, only a handful of harm reduction based programs have been initiated with limited reach and coverage, nevertheless they have made tremendous gains. A great deal of effort is

required to bring injecting drug use and HIV onto regional agendas, especially where competing priorities filter the scope of responses that could be made available. And in the meantime, HIV continues to infect drug users and their communities. For example, it was recently reported that HIV prevalence among IDUs in Thailand has risen to 50% in 2001, up from 32% in 1997.

It is with this backdrop that I invite you to attend and participate in the 14th International Conference on the Reduction of Drug Related Harm, being held in Chiang Mai, Thailand in April 2003. In the 14 years since the first conference at Liverpool, it is being held in Asia for the 2nd time, the last being in Delhi in 2001.

It is with great pleasure that the Asian Harm Reduction Network (based in Chiang Mai) welcomes participants to this conference. Chiang Mai lies in the middle of the infamous Golden Triangle Region, where, before the recent war in Afghanistan, majority of the world's heroin was produced. The city is well connected to all parts of the globe, and boasts of excellent business and tourist facilities. It is also an inexpensive city to live in and has numerous discotheques, bars, shopping centres, night bazaars, entertainment facilities, excellent internet connections, as well as natural attractions.

The successful promotion of harm reduction around the world depends on sharing our knowledge and creating new networks, which is what this conference does very successfully.

See you in Chiang Mai in 2003.

Jimmy Dorabjee

THAILAND IS AMONG THE developing countries who monitor the HIV/AIDS epidemic, a model to other countries in the region. The modes of HIV transmission are clear without doubt that injecting illicit drugs is one of them. Between November 1987 and August 1998, the rate of infection among injecting drug users (IDUs) in Thailand rose dramatically from 0 to 30 percent, and in a number of Asian countries, needle sharing among IDUs has proven to be a high risk activity that spread HIV/AIDS.

In response, the Thai government, through the Ministry of Public Health, has introduced new policies that include Methadone Programs and Health Education Programs, and an extended Drug Dependence Treatment Centre. This year we also enact new laws that will compel drug users to undergo treatment combined with community participation and extended information and education on sexuality to prevent further transmission of HIV.

We welcome everyone to the 14th International Conference on the Reduction of Drug Related Harm in Chiang Mai, April 2003, hosted by Thailand's Ministry of Public Health and the Office of the Narcotics Control Board. It's an ideal venue to promote the reduction of drug-related harm that translates to needle exchange, drug replacement therapy and peer education programs in order to prevent HIV transmission associated with illegal drug use. We wish for the success of this event in reducing harms associated with all drugs in the region.

Dr. Suchart Laobhriptr



Resources and Publications

Revisiting 'The Hidden Epidemic'

A Situation Assessment of Drug Use in Asia in the context of HIV/AIDS



○ Drug injecting is spreading to all the countries and its popularity is increasing with professional injectors of illicit drugs operating in Pakistan, India, Bangladesh, Nepal, Vietnam, Myanmar and Malaysia

Written by Gary Reid and Genevieve Costigan, the Centre for Harm Reduction, a unit of the Burnet Institute, Melbourne, Australia.

The review found that drug use had become one of the major causes of the HIV epidemic in the Asia region. Massive rise in amphetamine type substances in the eastern Asian region; new populations, especially young people, are fast becoming involved with illicit drugs and with their injection; there is continuing explosive epidemics of HIV among different populations of injecting drug users; and rising numbers of people with AIDS as a result of infection from sharing contaminated injecting equipment; are the startling findings of the world's most comprehensive review of drug use and AIDS in more than 20 countries.

Some other findings:
○ The opium industry of South East Asia's Golden Triangle with Myanmar as its epicentre continues unabated

○ High proportion of drug injectors are infected with HIV in Myanmar (63%), Vietnam (65%), China (70%), Thailand (50%), Indonesia (19%), Nepal (50%) in Kathmandu and Iran (75%)

○ Most Asian governments are more concerned with the legal implications of drug use rather than the public health implications of HIV/AIDS

It was also reported that effective programs for HIV prevention among injecting drug users and scaling-up of the response to meet the scale of the epidemic are urgently required lest Asia becomes home to the worst regional AIDS epidemic on earth.

This assessment report has been made possible with support from AHRN, UNDCP and UNAIDS. *A full report is available on the Internet at <http://www.ahrn.net/rapidassessment.pdf> and also at <http://www.chr.asn.au> (under publications)*

From the Editor

Continued from page 1

and Kessaraporn Sreechurn. They have asked me to stress your importance, and the importance of your work and to continue sharing your stories and experiences through the newsletter.

In the meantime I hope that

those of you who are attending the 13th IHRC in Slovenia, find strength, encouragement and inspiration from the work presented and the people present. For those of you who are unable to attend, be assured that we will have extensive coverage on the conference in our next edition.

HIV AND INJECTING DRUG USE IN SELECTED SITES OF THE TERAI, NEPAL January 2001



By Maitland J Peak, Asian Harm Reduction Network (AHRN) Consultant Sujata Rana, Family Health International (FHI), and Lokendra B Rai, Nepal National Consultant. Submitted to FHI/Nepal.

Between January 7th and 24th, 2001, field visits were carried out in eight sites in Nepal: Biratnagar, Dharan, Birgunj, Nepalgunj, Pokhara, Damak, Kakarbhitta and Hetauda. Two group meetings were conducted at each site, one with current injecting drug users and the other with representatives of key stakeholder organizations (government and non-government sectors).

Representation in each of the groups ranged from 10 to 20 individuals and lasted

Drug Use and HIV/AIDS

Continued from page 4

The sad thing however is that funding for prevention programs in Asia and the Pacific is inadequate. Because many high-risk practices are frowned upon and even criminalized, politics remain a barrier to addressing the issue.

"Harsh crackdowns drive drug use and prostitution further underground," argue experts, "making it difficult to educate people at high risk for AIDS and to conduct 'harm reduction' programs

approximately two to three hours. Local experts were asked to estimate the number of drug users and IDUs present in their areas.

This assessment demonstrated the urgent need in many areas of Nepal for IDU-related HIV prevention services. The acute lack of outreach and peer education reflects the uncertain and often negative legal and policy environment. Effective national HIV prevention among IDUs will require a network of services able to provide easily accessible, free or inexpensive injecting equipment, skills-based education, STD and abscess treatment services, safer sex counseling and opiate dependency treatment.

The tension between investing in demand reduction, drug treatment and harm reduction was evident. Without policy consensus at both the local and national levels, efforts to reduce the spread of HIV among and from IDUs are likely to be small and short-lived as before.

A full report is available for downloading at <http://www.ahrn.net/nepal.pdf>

such as needle exchanges and condom distribution." That could threaten progress achieved in the region in battling AIDS in recent years, United Nations experts say (SCMP, 10 Jan. 2002).

Data for the charts in this article as well as most of the information was courtesy of 'Revisiting The Hidden Epidemic, 2001' by the Centre for Harm Reduction, The Burnet Institute, Australia. Also sourced was the 'AIDS Epidemic Update 2001', a report by UNAIDS and WHO.





Knowledge and Commitment for Action

Many governments have now pledged their support to the fight against HIV/AIDS and have committed funds toward this effort. Moreover, many scientific discoveries, both in prevention and treatment, have been achieved. Barcelona, the first International AIDS Conference of this century, will be a timely conference, occurring just one year after UNGASS, and offering an excellent opportunity for an examination of both progress thus far and next steps.

The theme: 'Knowledge and commitment for action' was selected to reinforce the need that all involved sectors at all levels, including scientists, the community, people working in the field, and the public and private sectors, work together to review the knowledge gained through science and experience, and use this knowledge to commit to action. This action must be focused across all aspects of HIV/AIDS and include all infected and affected groups.

The theme of the XIV International AIDS Conference also reflects a focus on translating the knowledge gained from science and experience from all nations, particularly the most affected areas of the world: sub-Saharan Africa, South and Southeast Asia, Eastern Europe and Latin America, into action at all levels.

Over the years, knowledge gained from the basic and

clinical sciences has been dramatically important, and has contributed greatly to increasing the life expectancy and quality of life of affected persons. Moreover, prevention efforts have succeeded in reducing the rate of new infections in many populations around the world, though there is still much work to be done in this area. The pandemic is expanding in many parts of the world, particularly among the poor and other vulnerable populations, and access to new diagnostic and therapeutic strategies is available to only an extremely small percentage of at-risk and affected people.

On the other hand, at the highest political levels, there is a growing awareness of the magnitude and impact of the HIV/AIDS pandemic. On June 27, 2001, 189 member countries of the United Nations General Assembly Special Session, UNGASS, on HIV/AIDS approved a Declaration of Commitment to address the problem in all its aspects as well as to secure a global commitment to enhancing coordination and intensification of national, regional and international efforts to combat HIV/AIDS in a comprehensive manner.

As a result, it is now clearer than ever that progress in the fight against this pandemic will depend not only on scientific developments, educational programs and support programs, but also on political commitment to act globally.

"It is our hope that this Conference will share important new scientific information and will provide consensus on best practice and joint multisectoral action programs at local, regional and global levels, with commitment of countries and of major international agencies to take these forward and put them into action," declares Dr. Jose Gatell and Dr. Jordi Casabona, conference co-chairman.

They are optimistic that each participant's contribution in the meeting will be crucial to its success, and their personal presence in Barcelona will serve to renew the friendship and solidarity of the international community working against the pandemic and its effects.

Important dates

Standard payment:

before May 1, 2002

Student Registration:

before May 1, 2002

Group Registrations:

contact Congrex Sweden AB, e-mail, Lena Vernersson at aids2002registration@congrex.se

Late Breaker Abstract

Submission:

Opens May 1, 2002

A small number of late breaker abstracts will be accepted, with roughly one half to be presented orally and one half presented as posters. The percentage of abstracts selected for late breakers will depend on the number of submissions, but selection will certainly be more rigorous than for regular abstracts.

Late Breaker Abstracts can only be submitted via the Internet and the deadline is June 1, 2002. All abstracts must be submitted in English. All abstracts that are to be presented as Late Breakers, either orally or as posters will be listed in The Program Supplement. The XIV International AIDS Conference offers two options for abstract submission.

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Montréal 2002



World Forum on Drugs and Dependencies

September 22-27, 2002

Montreal, Canada

For further information, visit their website at www.worldforumdrugs-dependencies.com/ or contact secretariat@worldforumdrugs-dependencies.com

Deadlines

Abstract submission:

01 March 2002

Notification of acceptance:

15 April 2002

Full papers: 15 June 2002

Pre-registration: 21 June 2002

Hotel Reservation: 02

August 2002



Letters

Manipur takes the lead

New year's greeting from all of us here. I would like to inform you that we have just initiated the formation of a harm reduction network for the north-eastern region of India. We have had a meeting in January 18, 2002 here at Imphal (capital of Manipur) with NGOs working on harm reduction-based programs and interested individuals, and it has been decided to form a network under the name North East India Harm Reduction Network (NEIHRN). Eleven NGOs were present in the meeting and we have contacted some others in Manipur as well as in other states in the NE region of India. We are planning to have the next meeting in February to finalize its objectives and strategies. I would like your

feedback and suggestions on this and how AHRN can support us to strengthen this venture.

H. Dineswar Singh
kristyimphal@yahoo.com

AHRN followed-up and these are the developments:

What: North East India Harm Reduction Network NEIHRN, founded in 18 January 2002 by a group of harm 'reductionists' and activists from Imphal, Manipur (India) as a community to promote responses for addressing the dual epidemic of injecting drug use and HIV/AIDS as a public health issue.

Who: Individual activists, service providers/NGO workers, ex-users, medical/

health personnels, user group members/self help group members, and NGOs working in the field of drug use and HIV/AIDS in the North Eastern States of India.

Why: Conceived to scale up, adopt, upgrade and enhance drug treatments and blood-borne disease interventions among drug users, approaching it as an interwoven issue. It will link-up with relevant organizations, officials and persons in the region; seek help, guidance and support from national, regional and international bodies; and will support and cooperate with them to promote harm reduction, locally and globally.

Where: c/o Kripa Society RIMS Road (south), Imphal 795001, Manipur, India; Tel: 91 385 410749, 411408; E-mail: neihrn@yahoo.com

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AHRN is a project supported by the UNAIDS, the Royal Netherlands Government, and the Drug Policy Alliance (DPA, Washington D.C.)



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Opinions expressed by contributing writers herein are not necessarily the views of AHRN. We welcome articles on new harm reduction initiatives, interventions and networks.

Asian Harm Reduction Network

Membership Application Form

Fax to: 66 53 894 113

Please register me as a new member of AHRN's Information Sharing Facility.

Name (First, Middle, Last)

Title

Qualification

Organization

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Phone

Email

Fax

Signature

