



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

Yunnan cradles reponses to drug use like a newborn

The province is among five regions in southwestern China where drug users are 'at risk' of an IDU-led HIV/AIDS epidemic. Fifty-eight to eighty percent of IDUs are infected with HIV in Yunnan, in Xinjiang 39-84%, Jiangxi 17%, Guangdong 5-20%, and Guangxi 12-40%.

Drug use has a long history in China and as late as 1949 5% of the population were addicted to opium. Whilst this declined afterwards the drugs trade remained important and China continued as a primary transit country for products of the golden triangle, opium and heroin. Added to this scenario is the more recent emergence of ATS production and trafficking from the triangle and most recently reports of opium growing amongst impoverished Chinese farmers, partly it would appear as a

result of the dramatic shift in the social order in China.

And increasingly drug use is again becoming a wide-spread problem, including injecting drug use. Needle sharing is common practice and cleaning inadequate. The result being that drug users figure largely in the HIV infection figures: 70% of infections are amongst drug users. HIV infection amongst users had been reported in 27 provinces by 2001 and continues to spread. Several provinces have serious epidemics, whilst these have traditionally been the opioids,

ATS production and trafficking has been increasing.

Whilst HIV infection rates overall are still low in China, the numbers are large: UNAIDS believes that by 2005 there will be five million people with HIV in China, and this could increase to 20 million if no countermeasures are implemented successfully.

Yunnan, China's most southern province shares a long border with Myanmar and to a lesser extent with Lao PDR and Viet Nam. It should not be surprising then

Continued on Page 2

In this issue

Drug use and HIV/AIDS Yunnan cradles responses to drug use like a newborn	1
Programs Nai Zindagi	4
Advocacy ASEAN Work Program on HIV/AIDS II	5
User's insight Heroin overdose	6
Network bulletin Asian Youth Congress of Drug Abuse Prevention Task Force on Drugs & HIV Vulnerability	10
Features Harm reduction gets recognized at the World AIDS 2002	12
Inside AHRN The new Executive Committee led by Tariq Zafar	17

This was Carol Jenkins' gentle but firm reminder at the 14th World AIDS Conference in Barcelona where the tireless voices of harm reduction advocates were finally heard as our issues 'sat at the same table' as those of mainstream HIV/AIDS prevention, treatment and care. It's a small but tangible step in the long struggle ahead of us.

Harm reduction is about comprehensive services for drug users, however, what works for one person does not necessarily work for another. While conventional strategies struggle to keep users off drugs as 90% of

them relapse, the broad range of services structured by harm reduction provide other options for the majority. So AHRN takes you to southwestern China from where an IDU-lead HIV epidemic continues to grow, where little is still known about the disease and where the beginnings of a range of treatment options for drug users other than compulsory detoxification are in sight. On to Pakistan, Nai Zindagi's

non-drug oriented services that are cored on vocational skills training and jobs is a model and inspiration. Its self-supporting socio-economic project has motivated drug users to access treatment and care, also subsidizing free services for them. While we feel uncomfortable with vows to 'fight' drugs, especially one that enjoins the youth, we will support voices that prevent initiation to drug use. At the

Asian Youth Congress on Drug Abuse, the youth urged, among others, for messages that balances the dangers and real effects of illicit drug use.

User's insight also kicks-off in this issue with heroin overdose. This section will be your window into a drug user's life, to understand its complexities and better-fit your services to them.

Continued on Page 5

From the Editor

"Harm reduction should not be disturbing policies but giving it medical cognizance ..."



Drug use and HIV/AIDS



that it has a long history of reported and significant levels of drug use. And given the documented relationship between drug trafficking and the spread of HIV, it is also not surprising that it was one of the first to report HIV infection in China and amongst drug users.

Inevitably the two epidemics have overlapped to create the situation we have today: unofficially the number of drug users in Yunnan is estimated to be 150,000. Amongst these it is reported that 80% or 90% inject and that needle sharing is common (despite equipment being relatively easy to obtain and not expensive, although this must be regarded as a relative statement when everything depends on how much money you have to buy the drugs). HIV infection rates are reportedly 13% amongst those in the Municipal Compulsory Detoxification Centre, however this is almost certainly an understatement. Hepatitis B & C rates were reported to be between 70% and 80%. It is important to note that there is a lack of any real understanding of the nature of using in Kunming, much of what was related was impressionistic and not based on any study. There is a clear need for ethnographic studies into drug using and its contexts in order to better understand the situation and to



Top left and above: The garage and carwash which has now expanded to bodywork and painting is the economic rehabilitation stage of the pilot therapeutic community project in Kunming run by YIDA with Daytop support. The 'graduates' can work here as a part of their process or reintegration. Top right, Residents in the rehab centre doing their regular exercise.

develop appropriate responses in prevention, education, treatment and care.

Current situation

Following discussions with Billy Stewart, DFID Technical Advisor to the China-UK HIV prevention and control programme it was agreed that a meeting would take place in Kunming. This visit was meant to assess and report on the problems of drug use and HIV, and the current responses. The trip was arranged with and supported by YIDA, the Yunnan Institute of Drug Abuse and its Director, Dr Li Jianhua. Interpretation for meetings in agencies that did not have English speakers was given by Liou Jian, Deputy Director of Prevention and Education and a researcher at the Institute.

Drugs. The earliest reports we have of drug use for Yunnan are anecdotal, from the early 1980s, when

injecting was reported from the area around Dali Lake. This was confirmed in discussions with people now involved in the YIDA/Daytop project who say they knew of using prior to 1985 but that it was not widespread. Then as now the main drugs are the historical ones, opium and since that time, heroin. The extent of using grew they say until only a few years ago but it has levelled of the last few years. Heroin and opium remain the drugs of choice, and almost all those entering treatment report using them. There is however emerging evidence of ATS and party drugs (referred to as MAMD by one informant). Drug users come from all social strata and across all age groups, many come from amongst the displaced rural population, which is increasingly moving into the city.

Drug users. Kunming officially has some 45,000 drug users, however

unofficially, informants suggested that the number is over three times that, 150,000. Most of them are injecting. The age range in treatment at the Kunming Municipality Mandatory Drug Addiction Dropping Centre (KMCDC) is from 12 to 69 years old. About 25% of patients at Centre are women, a relatively high number but also true of the YIDA/Daytop project.

Reportedly 60% are from rural areas although it is not clear if they moved first moved to the city. A number of conflicting accounts were given of the education levels of users, however it would appear that most have at least "middle level" schooling, that is partly completed high school.

Drug using. Injection is the most common practice, equipment sharing seems to be the norm and cleaning is inadequate to prevent the transmission of blood borne diseases. Needles and syringes are available and not expensive but of course this is a relative statement, given the need for money to first buy drugs.

Discussions with the Director of the KMCDC about the circumstances under which many users live and use confirmed that sharing is the common practice, however there has been little research

done in this area. A priority would be to undertake ethnographic studies into using behaviour.

Responses

Since the government decreed that all drug users should be put into compulsory detoxification, centres have been established and run by the PSB across the province. The one visited, the Kunming Municipality Mandatory Drug Addiction Dropping Centre (KMCDC), is the largest with some 3,500 patients. They undergo a 3-stage treatment programme (detoxification, treatment and rehabilitation) reportedly followed by a social re-integration programme that is supposed to help them get work and reunite with family and society.

There are similar centres all over the province, although not as large, numbers ranging from 60 to 100. Treatment is not free, theoretically patients pay for their food, but many cannot and so work during their rehabilitation phase on products that can be sold. We were told that the relapse rate is high, the manage-

ment suggested over 80% however patients have reportedly and of course jokingly, said it is 150%.

In discussions with the PSB Director, there were indications of an increasing willingness to look at additional activity and review of the services offered. He stated that he agreed that the current approaches were not working and that a new approach was needed. He acknowledged the importance of HIV and the need to take a harm reduction approach. And there is support for this in their collaboration with YIDA and having HIV prevention education teams come into the centres on a regular basis.

The other treatment service seen, that run by YIDA and Daytop is also a user pays service. This one is quite expensive, at least for the first phase (of five) because of the cost of the drugs used in detoxification (including methadone). It has some advantages however, it is voluntary, has what appears to be a more substantial programme, grounded in the work of Daytop, an experienced residential treatment agency from the USA.¹ This program includes a final economic re-integration



The outreach team at the TC (therapeutic community). This and an old MDM project are now supported by DFID, good to give DFID some credit. Its the only one of its kind in China.

phase, where people are working and living off site. Altogether this program is getting a lot of attention and the government has requested that Beijing University evaluate the project or programme (further information on this should be sought from UNDCP, since it came out at the taskforce meeting). It is a labour intensive project, with over 25 staff.

The other services available, but not seen are the clinics, reportedly providing counselling, methadone and some providing an NSEP. These are part of the YIDA programme, which is mostly short-term, pilot work, so the

issue of sustainability and scaling up are prominent in everyone's minds. There are already the beginnings of a range of treatment options in Kunming that could easily be expanded with an increasing likelihood of engagement with the public sector services.

There is also a clear need for training around what harm reduction means in its application, for IEC materials and training packages that can be used in different treatment and related interventions. And of course, a massive scaling up of the

Continued on Page 5

Country updates

Pakistan – Programs in the non-profit sector have demonstrated the need and impact for harm reduction projects. There is scaling up but indiscriminate efforts have caused more harm than good. World Bank has approved a loan that will initiate and implement projects for the prevention of HIV among injecting drug users. This will be the Enhanced HIV/AIDS control programme which will be run by the National AIDS Control Program of the Ministry of Health.

India – The National AIDS Control Organization (NACO) policy oversees the harm reduction components as important HIV interventions for drug

users. But in reality there are very few projects addressing the needs of drugs within the context of harm reduction. The coverage is inadequate. Few state AIDS Society are covering drug users as risk groups in HIV prevention programs. (Funded by the World Bank through NACO, each state in India AIDS Societies are found in every state and is headed by a government officer – Ed.) We are currently engaged in developing, implementing and evaluating HIV intervention for drug users in Chennai.

Nepal – Harm reduction, so far, has been limited to few harm reduction centers where injecting drug users stay from two to six months. Needle and

syringe exchange is still illegal although the Lifegiving and Lifesaving Society (LALS) has been doing it for almost 12 years. There is a plan for the Nepal Initiative to provide the service in wider areas. How smoothly it will go, remains to be seen. A law liberalizing these measures is being reviewed and we expect parliament to pass it in a year's time. A high level council chaired by the Right Honorable Prime Minister is expected to be instrumental in harm reduction and other aspects of the country's STI and HIV/AIDS program.

(from the AHRN Executive Committee)

Programs and interventions



Nai Zindagi leads holistic harm reduction services in Pakistan's five major cities

Drug use is a major social problem in Pakistan. At half a million, it has one of the largest number of heroin users in the world, 90% of whom chase heroin; and among the injectors, 90% are infected with hepatitis C. Pakistan's heroin comes from neighboring Afghanistan and the current war on terrorism has resulted in sporadic supplies and raised the price and lowered the quality of street heroin. This has meant shifting from smoking heroin to injecting heroin and pharmaceuticals. In Quetta injecting went up by 20% in just two months. Considering that over 65% share syringes and needles, this may well trigger an HIV epidemic.

Although less than 1% of drug users have HIV, only 4% claim to know how the virus can be transmitted. Drug using Afghan refugees, who are more likely to inject and share needles than Pakistani drug users, are also taking toll on an already overburdened and under-resourced drug harm and demand reduction programmes.

Only a handful of the 86 NGOs currently working on HIV/AIDS prevention in the country target drug users. With few and ineffective drug treatment services provided by the government, Nai Zindagi (or new life) lists among the few programs that recognize the urgent needs of urban, street-based drug users. The program started in

Lahore and was designed in a collaborative effort with UNDCP and the UNAIDS using best practices from the Region, particularly in India, Nepal and Bangladesh.

During its pilot phase, much progress was made by Nai Zindagi. Today it provides holistic services in five major cities that vary from peer-based outreach to service provision at drop-in centers that include counseling, primary health care services, treatment of STIs and needle and syringe exchange. Nai Zindagi's program extends to integrated services in drug treatment and on to socio-economic rehabilitation, by

Nai Zindagi's strength lies in the fact that vocational skills training and jobs motivate drug users to access treatment and care with a specific non-drug oriented aim.

providing clients market oriented vocational skills and job opportunities.

Nai Zindagi's philosophy is based on the fact that most drug users who seek services find themselves in such situation as a consequence of lack of opportunities and their poor socio-economic situation. Economic rehabilitation stands at the fore-

ground of Nai Zindagi's focus. Its strength lies in the fact that vocational skills training and jobs motivate drug users to access treatment and care with a specific non-drug oriented aim. It also enables them to maximize gains achieved in the process of treatment and care and sustain post treatment efforts by being gainfully employed and return to society normalized, rather than ex-drug users only.

The socio-economic project is 100% self-supportive and income from it subsidizes NZ's non-income generating activities, mainly the free drug services for drug users. It has been made a model by various funding agencies and considered for replication at larger scale elsewhere. An example is the recently initiated UNDCP harm reduction projects in Karachi which were modeled on the Lahore pilot and NZ planned, designed, trained and assisted 2 NGOs in

program start-up activities.

Nai Zindagi has proven its efficacy through comprehensive services where nearly half of its clients opted for detoxification, most of whom have left the street sub culture and have remained 'clean'. Its needle and syringe availability service has recorded a return rate of almost 95% and a coverage of over 65%. Further, over 60% of its clients were employed and became economically sustainable. Overall health improved significantly, while STI prevalence was reduced from 34 to 8 percent.

With a HIV prevalence estimate among IDUs that is below 1%, there is still a window of opportunity to prevent expansion of the epidemic among this highly vulnerable group in Pakistan. Consistent computerized data collection ensures adequate monitoring of trends that can facilitate design and implementation of need-based programs to prevent HIV transmission, as well as support the reduction of drug demand and the harms related to its use. (*Nai Zindagi's programs will be detailed in the UNAIDS Best Practice report which will be out in December. Email them at recovery@isb.compol.com*)



Users in Quetta huddle for the shot of the day. Above, Nai Zindagi's rehab in Angoori, near Islamabad up in the foothills of the Himalayas. Photos by Tariq Zafar.

ASEAN Work Program on HIV/AIDS II (2002-2005)

Embraces harm reduction and identifies AHRN as a collaborating partner

3.7 HIV Prevention, Treatment and Care Among Drug Users

Drug use is a regional problem. An increase in IDUs and Amphetamine Type Stimulants (ATS) users has been observed in many countries. HIV transmission through the sharing of injecting equipment by intravenous drug users is a main cause of the HIV epidemic in many parts of the world. In some ASEAN countries like Thailand, Myanmar and Vietnam there is documented evidence of HIV epidemic among injecting drug users (IDUs) due to sharing injecting equipment.

In other countries such as Indonesia, HIV infection among IDUs is rapidly increasing. The use of Amphetamine Type Stimulants (ATS) is also on the rise and there may also be an increased risk of sexual transmission among ATS users.

Although the problems of HIV transmission among drug users are well documented, HIV prevention and care interventions for this group remain relatively weak. This is due to the dominating policies on supply reduction, the illegal status of drug users; stigmatization and discriminatory attitudes and practices toward users and inadequate skills of personnel involved with the: issue of drug use. Such practices make it more difficult for drug users to access drug treatment and HIV prevention information. At the 7th AFTOA Meeting held in

Brunei Darussalam in November 1999, one of the priority intervention areas identified was the promotion of harm reduction amongst drug users.

Specific Objectives

- To reduce HIV incidence among drug users
- To provide care for drug users
- To build capacity on rapid assessment and surveillance on HIV/AIDS prevention among drug users
- To establish an ASEAN surveillance and monitoring system on HIV/AIDS prevalence among drug users
- To advocate for proactive policies and legislation to ensure effective HIV/AIDS prevention strategies

Activities

- Lead countries: Indonesia, Malaysia, Myanmar and Vietnam
- Conduct in-country reviews and consultations on laws, regulations, policies and programmes to ensure effective HIV/AIDS prevention strategies for drug users.
 - Source financial and technical support to initiate and/or scale up HIV/AIDS prevention activities, harm reduction interventions, standardise drug treatment services and care for IDUs.
 - Collaborate with international organisations, the UN Task Force on Drug Use and HIV Vulnerability and regional networks (such as Asian Harm Reduction Network) to mobilise resources for advocacy and
 - Capacity building (training workshops, sharing experience and expertise, study visits or attachment) for HIV/AIDS prevention, treatment

care, support, harm reduction, rapid assessment and HIV/AIDS surveillance amongst drug users.

- Conduct training workshops to standardise the surveillance and monitoring system and establish an annual reporting procedure to AFTOA.
- Encourage the development of and study the feasibility of establishing pilot projects to reduce HIV vulnerability among IDUs.
- Develop strategies to scale up existing harm reduction projects.

Success criteria

- Governments address the issue of HIV infection among drug users in national policies (harm reduction approach or health approach).
- Positive enabling environment to facilitate the implementation of projects/ activities on HIV prevention and treatment for drug users.
- Drug users have access to standard drug treatment, HIV prevention and care services.
- Collaborative actions in the region regarding HIV prevention, treatment and care for drug users.
- Surveillance system on epidemic of drug use and HIV and manual report to AFTOA.
- Pilot and scaling up projects on harm reduction in the region and consider formation of regional expert group on harm reduction.
- ASEAN member Countries are capable of assessing and managing the problems of HIV related to drug use.
- Availability of regional mechanism for surveillance and monitoring HIV prevention among drug users.
- Capacity building and training workshops activities. *(This section of the program can be found in pages 57-58. The publication is available at www.ahrn.net.)*

From Page 3: Yunnan cradles responses ...

response is essential – it is very small at this stage.

Response to HIV and drug use nationally

Several items of note nationally emerged through discussions with people and agencies in Kunming. UNDCP very recently convened a Taskforce on HIV and drug use in Beijing. Last year in November the first Chinese national conference on HIV and AIDS was held which is likely to be a bi-annual event, so the next one would be in late 2003. Discussions with Regional and Provincial representatives of ARC suggest that the situation in Xinjiang is very similar to that in Yunnan, with high ethnic minority populations, historical drug use and trafficking and new or renewed problems with drug use and HIV. This is another of China's most southern provinces and within the context of a regional strategy it was suggested that an exploratory visit to Xinjiang should be considered. *(AHRN extends its thanks to Dr Li Jianhua of YIDA, Save the Children Fund UK China Programme and the Australian Red Cross for making this trip to Kunming possible.)* ¹ See <http://www.daytop.org/international.html>

From Page 1: From the Editor

Through Tariq Zafar and the new members of the AHRN Executive Committee, we have recognized that only through partnership with programs and service providers can we look ahead. Our consultant database online which we launch here will gather experts in the community for this reason. Lastly, because we have filled our glass to the brim, our series on amphetamines in Asia will continue next time.



From this issue onwards, AHRN would like to write more from a drug user's perspective. This will cover the user's views, issues and day-to-day difficulties they encounter such as overdose. The *User's insight* will serve as an eye opener to policy makers, law enforcers, NGOs and health personnel who are unable to deal with these situations due to a lack of understanding. We would like to invite and encourage the community to submit information and personal experiences to this newsletter on a regular basis. This will enable our non-using readers to understand more the drug user and in return, improve their services. Given the current policies in this region about illicit drug use, we will not disclose sources and keep identities strictly confidential.

Heroin use continues in many Asian countries like India, Myanmar, China, Indonesia and Vietnam where an IDU-

led generalized HIV epidemic is already prevalent or imminent. And as long as there is heroin use, overdose is inevitable. In providing comprehensive harm reduction services, it is necessary to give information about overdose to the injecting drug user to be able to avoid it, or to enable them to cope when it happens. Like the misprioritization of services such as NSEPs and substitution due to the lack of support from local and national policies, overdose information and services are relegated in a similar light by NGOs already working in harm reduction.

Hence as a starter, this issue's *User's insight* will be heroin overdose with a re-print of an article by the Harm Reduction Coalition (HRC) combined with a real life overdose experience from India. The article which was originally published in the "Harm Reduction Communication" newsletter, Fall 1999 No 9 issue has been slightly altered to suit the local scene.

MR. M HAS BEEN A USER OF SP (POPPER: SPASMO proxyvon/Dextopropoxyphene) since 1998 but switched to heroin in September 2001, injecting occasionally with a friend. He had an overdose two months later on the 12th of November while injecting with friends in his room. His parents noticed that he looked drowsy and was unable to open his eyes and talk. They contacted me at home at around 9.30pm and I advised them to take the patient immediately to the Regional Institute of Medical Sciences (RIMS) hospital. They managed to admit him without much difficulty. When I reached the hospital the patient was not being attended to by the doctor, his breathing was shallow, his complexion had 'darkened' (face and lips). I approached the doctor for help but they said they could not prescribe any medicine until the patient is confirmed of heroin overdose. In the meantime the patient's condition deteriorated. After discussing this with the parents, they disclosed a friend's name and address. I went to see the friend who initially denied taking heroin with him but later confirmed it after explaining the situation. I immediately confirmed to the doctor that it was a heroin overdose. Only after the news did the doctor attend to the patient and prescribed overdose medicine (i.e., Lethridine injection). However, it was not easily available at the nearby pharmacy; we found it at another hospital, the Jawaharlal Nehru (JN), but purchased it only from the black market at Rs. 3500 (US\$73) per ampoule (2 ampoule was prescribed), it costs only Rs. 36 (US\$0.75).

After injecting the medicine, the patient started shivering and vomiting, and after sometime his condition improved and returned to normal. He was lucky that no file (FIR) was made but only after giving some bribe (Rs. 200/US\$4), or he could've ended in trouble and locked up jail. The patient was discharged from the hospital on the same night at around 1.00am. The next day he was admitted to a rehab center and today he is maintaining a 'clean life' with the help of NA fellowship. (NOTE: Overdose medicines are often only available, even with prescription, at blackmarket prices, sometimes right outside pharmacies of major hospitals. There is a need to make them available and accessible in all hospitals or drop-in centers (DIC). The writer is K. Birjit Singh, a counselor and social worker for drug users in Saso, Manipur.

Understanding heroin overdose

By Kristen Ochoa, Heather Edney-Meschery and Andrew Moss

Overdosing is probably the most immediate life-threatening health issue facing injection drug users today. It is a major cause of excess mortality among heroin users in the United States¹, and in many countries, deaths attributed to overdose are equal to or greater than deaths attributed to HIV.² Despite the number of persons who overdose, the issue has received little attention. In the U.S., very few studies on overdosing exist and few programs are focused on overdose prevention. The issue is only just beginning to emerge. Perhaps the advent of better treatments for HIV has allowed us the space to consider the risks of overdose more carefully, or perhaps the deaths among our peers and coworkers have become far too common.

For heroin injectors, overdosing is an occupational hazard. It's hard to avoid – the fact is that heroin overdose will continue to happen as long as heroin users continue to use. What can be done? While we may not be able to completely prevent overdoses, we can prevent overdose fatalities. No one should ever have to die from a heroin overdose – we have rescue breathing (CPR) and we have the antidote (Naloxone). However, there are many barriers that stand between users and these lifesaving measures. Understanding the barriers may be the first step towards breaking them down.

Dispelling myths about who overdoses and why

Contrary to widespread views, we found in our recent study of San Francisco injectors that overdosing is just as common for the seasoned injector as it is for the new initiate.³ Just because someone has a long-time habit does not mean they are safe from overdosing. It's also just as common for women to overdose as it is men. Another misconception is that heroin overdoses are often suicide attempts. This is actually very rare. Few injectors intend to kill themselves when they overdose; more often they attribute the cause to just wanting to take too much. Intention falls into a gray area, where there are no plans to OD, but there is a kind of ambivalence about the

possibility. The most concise explanation comes from a participant in our study:

"Tolerances go up and down, some drugs are more cut than others, someone accidentally can do more ... From what I've seen of people who overdose, they don't have intentions of doing it; their intentions are just getting really high."

Obstacles to seeking help in the event of an overdose

The primary barrier to seeking help during an overdose is fear of police involvement.⁴ For this reason injectors are usually apprehensive about calling emergency medical services, i.e., 911. Most, in fact, will try several things to bring the person back before contacting them. Real or perceived, the threat of arrest greatly impacts decision-making at the overdose. According to our participants, using with others, which is common among young injectors in particular, is not necessarily protective, given this fear:

"A lot of people freak out and just run away. I've made so many friends in the park by finding them blue and bringing them back because everybody just flips out, 'Man, I can't call the cops because I'm holding and I don't want to get caught.' It's really stupid because you can call from somewhere way across the scene, but if you did survive it's because somebody called 911."

According to our study, 71 % of injectors have witnessed at least one overdose, so there is great opportunity for intervention because others are often present and can take action to keep the person alive. People need skills to effectively intervene, including CPR training. It is also important for people to know location-specific details about how to make an emergency call. What you say to the dispatcher (in case of an emergency call), depending on the city and county, will sometimes elicit a police response in addition to an emergency medical response; other times it will not.

(In most Asian countries where 911 emergency services are not always available, maybe users can make sure that the overdosed person is immediately reached by any available health services or personnel.)

Policy and the police

Though education about calling for emergency services is needed, it is not enough. Since we began our study, we have learned of injectors being arrested in different cities as a consequence of their overdose or someone else's overdose. In Santa Cruz, officers issue citations to program participants at the hospital where they are recovering from an overdose. The problem of police involvement in overdoses is probably the largest barrier to preventing fatal overdose.

Many needle exchanges have come to agreements with law enforcement, keeping the police from arresting people in and around their exchange sites. Similarly, we must work collaboratively with the police to insure that they will not arrest, search or charge drug users who have made a 911 call. If this can be accomplished, programs should spread the message to injectors that punitive actions will not be taken if

Make a plan



Photo by Tariq Zafar

Talk with your partners to work out a plan in case one of you overdoses. Obviously, the time to talk is when all of you can talk. Among the questions to consider for yourself and your partner(s) are:

- When should someone take action? (How slow should the person's breathing be? If which part of them is turning blue?)
- What's preferred regarding calling emergency help (immediately, or should resuscitation be tried first?), the use of CPR (if t's not working, at what

point is an emergency service called or Narcan used?) and trying Narcan (where/how administered? how much – 1 cc or less, multiple doses?)

- What should be done after the person resumes breathing? (What kind of support is desired? Will the person go to the ER?)
- What's the plan when the naloxone wears off?(Do you go to the ER? Who will stay with the person? What's to be done if the person's really dopesick afterwards?)
- Last, but not least, discuss whether it's ok to remove an overdosing individual's I.D. – just in case they have any warrants. Some people have medical conditions, and an ID bracelet or information could save such a person's life.

If you're going to use naloxone or Narcan, make sure you have a kit made up, and put it in a place where everyone can find it. It's a good idea to have a short instruction sheet, especially something written that gives the proper dosage info. (Narcan/naloxone comes in different strengths and container sizes, and syringes also differ in capacity. It can sometimes get pretty confusing)

If you have a CPR cheat sheet, that's even better, too.

REMEMBER, THE MORE YOU PLAN OUT IN ADVANCE, THE LESS ROOM THERE IS FOR ERROR AND PANIC IN THE EVENT OF AN ACTUAL OD!

they do call for help. The cost-benefit analysis of minimizing police involvement at drug overdoses saves both officer time and court costs. If we don't work with the police, we continue to limit injectors' access to paramedics and the emergency room, and we continue to lose lives.

Though there is still much work to be done in San Francisco, the police generally do not seek prosecution of those present at an overdose. Unfortunately, because users have had bad experiences in other cities, many still do not have faith that it is safe to call 911 here. A participant in our study explains what goes on in San Francisco:

"We've all experienced when a friend goes out and they don't want you to call 911, but the police aren't there to arrest you. The only time they will arrest you for a drug overdose is if you refuse to go with them to the hospital, and they only do that so you will seek medical care. If you have



User's insight

a problem with the cops coming, let the paramedics know and they will listen to you."

Recognizing and defining the problem

In the U.S., one of the major barriers to solving the overdose problem is recognition. Even when programs and researchers acknowledge and work on overdose, it is usually due to their own interest and initiative. Government and private funding set aside specifically for overdose scarcely exists, if at all. As a result, overdose and ways to prevent overdose are not as well understood in the United States as they are in Europe and Australia. Heroin, the heroin epidemic, the relationship between drug users and the police, and between drug users and health care providers are all very different in the U.S. For this reason it is hasty to conclude that findings in other countries accurately reflect the overdose epidemic here. We must work to better understand our own epidemic in order to create effective prevention strategies at home.

In Asia, the initial problem faced during an overdose is the availability of medicine. When it does become available, prices double. Similarly, there is fear of law enforcers which when contacted will mean filing of the first information report (FIR). Poor health services and the lack of basic skills, i.e., CPR, among the health and NGO personnel also compound the problem.

Preventing overdose

A comprehensive overdose intervention would include direct service organizations, hospitals, emergency services, police and research. Educational campaigns, CPR and basic life-saving courses as well as grief and loss support should be major components. The distribution of naloxone (the opiate antagonist, a.k.a. Narcan) to drug users as part of a larger prevention program should also be explored. Since opiates usually stay on board after naloxone has been administered, more than one dose may be required. Following up with a call to emergency services or a visit to the emergency room may therefore still be necessary in order to completely bring the person out of danger. Naloxone may buy time for some, but it will not solve the problem for people who inject alone – only an educational program can do that.

Outreach and education can also offer tools for dealing with less severe overdoses that do not require naloxone, as many people are revived simply with rescue breathing or by their friends keeping them awake.

One of harm reduction's strengths is its pragmatism and realism. Harm reductionists are generally aware of the need for integrative approaches and are wary of single solutions. If naloxone alone were provided to injectors, would it prevent people from accessing emergency services? More work must be done before we understand the complexities of naloxone distribution.

Only one Australian study has evaluated the acceptability of naloxone among drug users, but there is no published study of naloxone use itself. It is a more difficult task to raise consciousness and create change among drug users and emergency authorities than it is to simply give out vials of

naloxone. Programs that can do both are likely to provide a longer lasting, more fail-safe method of curbing the overdose problem.

Kristen Ochoa (kochoa@itsa.ucsf.edu) is Project Director and Andrew Moss is Principal Investigator for the University of California, San Francisco's UFO Study. Heather Edney-Meschery (scnep@gotnet) is Executive Director of the Santa Cruz Needle Exchange Program. The UFO Study is a collaboration between UCSF, the Haight Ashbury Youth Outreach Team and the Santa Cruz Needle Exchange. The Santa Cruz Needle Exchange routinely provides overdose prevention trainings to participants and high school students in Santa Cruz County. The UCSF Department of Epidemiology and Biostatistics has been studying overdose in young injection drug users for three years. (See on-line version of the article at www.harmreduction.org for the references.)

Naloxone/Narcan

Naloxone/Narcan is an opioid antagonist drug that is used to treat overdose. Its availability over the counter is very essential to lessen the extent of an overdose. Narcan does not cure heroin overdoses. It is an important tool, one useful part of an organised approach to resuscitating overdosed patients. In most cases, friends try to keep the overdosed awake and breathing as primary response. In the developing world, the availability of the medicine over the counter is a problem as traders try to monopolize its sale by increasing its price. For example in Manipur, India the overdose medicine is marked up as much as 100 times than normal.

Some people advocate that Naloxone/Narcan be made available as a take away medicine to ensure safety or have it available from NGOs. Administration can be as difficult as handling an overdose if done by an untrained person.

Effects:

1. It interrupts the effects of opiates like heroin, morphine and the like. If the subject has used a non-opiate drug, then it is of no use.
2. It has been found to cause sharp increases in blood pressure, allergic reaction, cardiac arrhythmias and other peculiar side effects including death.
3. As the effects of opiates last longer than Narcan, it needs to be administered repeatedly in order to get people through an overdose.



For more information on **overdose, its signs and treatment**, see: www.harmreduction.org/idu/chapter4.html
On **CPR**: <http://depts.washington.edu/learncpr/quickcpr.html>
<http://www.amherst.edu/~jaloduca/cpradult.html>
On **recovery**: <http://firstaid.eire.org/Recover.htm>,
<http://www.drugsinfile.com/emergency.html> and <http://www.health.harvard.edu/fhg/firstaid/recovery.shtml> where images for 'Reviving an overdosed person' were taken.

HEROIN: No. 4, putaw, Harry, Brown scag, brown sugar, H, horse, scag, smack, junk

Signs	What to do	Treatment	Don't
blue lips, toenails and fingernails (caused by lack of oxygen); very slow and shallow breathing or no breathing at all; snoring or gurgling breathing in someone who is asleep; no response to shaking, calling their names or pain; very slow, faint or no pulse; abnormal behaviour; and confusion	stay calm; clear the airway; squeeze earlobe, press on fingernails; If they respond, try to walk them around; if no response, check breathing and pulse; if no breathing, start rescue breathing; if no pulse, start (CPR Cardio-Pulmonary Resuscitation); if unconscious, place in coma position; send for immediate medical help / ambulance	Naloxone (the opiate antagonist – a.k.a. Narcan) NOTE: As the effect of the opiate wears off due the interruption of Naloxone, beware of the withdrawal effects that follow.	do not put the person into bath as they could drown, it is unwise to make an unconscious person vomit – they may inhale the vomit and suffocate, do not attempt chest compression (i.e., CPR) if there is pulse; tea, coffee or alcohol will not wake up someone who has overdosed and may make them vomit; do not inject amphetamine or other stimulants to counteract the effects of heroin; do not give injection of salt water (saline solution), this will not wake someone who has overdosed; and do not feed by mouth.

Tips to avoid HEROIN OVERDOSE

- Do not inject in isolation. Always use with someone else, or have someone on the telephone when you use.
- If you are in doubt of the purity or you have bought the heroin from a near someone, try a small amount first before taking your regular dose
- Do not inject large quantities at one go- if frequent use keep a gap between each fix.
- Do not mix with alcohol or barbiturates.
- If you haven't use for a while (days), do not start with the last dose that you took.

Reviving an overdosed person

Recovery position

In an unconscious patient with intact breathing and pulse, the recovery position keeps the tongue from falling back and blocking the airway.



1. Make the patient lie down on his back.
2. Remove clothes and shoes
3. Lift the chin to ensure that his airway is open.
4. Patient's arm on your side should be positioned so as to make a right angle with his body, with elbow bent and palm facing out.
5. Patient's other arm on opposite side should be placed across the chest, with back of their hand against the cheek on your side of the patient.
6. Pull up the patient's knee joint (side away from you) as it bends with the foot flat on the ground.
7. Roll over the patient in this position towards your side.

8. As shown in the diagram the uppermost leg should be adjusted in such a way that the hip and knee are at right angles.

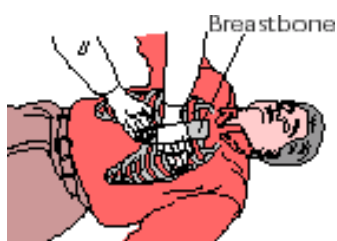
9. Seek immediate medical help.

10. Do not move the patient if head/spinal injury suspected.

Cardio-Pulmonary Resuscitation (CPR)

This is a life saving technique which when done properly and early, can revive the patient back into life. If patient stops breathing and no pulse is felt, CPR has to be started immediately, preferably by two people alternating as it can be a very tiring procedure.

1. Call for medical help/ambulance immediately and meanwhile start with CPR.
2. Make the patient lie flat on his back on a firm surface.
3. Ensure that the airway is unobstructed .
4. Get down on your knees.
5. Start with five artificial ventilations, mouth-to-mouth.



6. Locate the bottom of the middle part of the breastbone

and measure three fingers upward.

7. Place the heel of one hand on top of the other over this area and firmly interlock the fingers.



8. Keeping your arms straight at the elbow, lean over the patient and firmly depress your interlocked hands on the patient's breastbone (sternum) , pressing down vertically and firmly. Depress it to about two inches, firmly and evenly – 15 times in 10 seconds.

9. Then give two full, mouth-to-mouth ventilations.

10. The ratio is one breath to every five compressions.

11. Continue until pulse/ breathing returns.

Do not

1. Use jerky movements.
2. Use too much pressure (May break bones, can cause more harm.)
3. Blow too hard and too fast.

Artificial ventilation/respiration

If there is pulse but there is no breathing, artificial respiration must be given. If done appro-

priately and without delay it can be lifesaving.

1. Ensure that the patient's airway is clear by checking the mouth for any obstruction. If obstruction present, dislodge by slapping patient's back firmly and gently, or by kneeling on top of the patient with one hand on top of the other, give abdominal thrust, sharply and gently at the solar plexus.



2. Pinch the patient's nostrils with your index finger and thumb.

3. Take a deep breath and place your mouth over the patient's mouth.

4. Blow steadily for about two seconds and watch the patient's chest rise and fall. If it does not, repeat the above.

Due to the lung's elasticity, blowing air into it displaces the air inside causing an 'exhalation' which can be confirmed by the falling of the chest, breathing sounds and breathing felt with the hand.

5. Repeat until the patient starts breathing on his own.

“Give us messages that warn on the dangers and real effects of illicit drugs” – Youth Congress

They pledge to treat drug users not as criminals but as human beings and support those who want to be free from these substances

The media must not display mixed messages that warn of the dangers of drugs, both legal and illegal, while at the same time glorifying and not showing their real effects – this was one of the recommendations at the Asian Youth Congress on Drug Abuse Prevention held in Bali, Indonesia 26 to 29 August 2002.

One hundred and fifty youth representatives from over 20 countries within and outside of Asia actively participated in four days of workshops, brainstorming sessions, training, performances and outdoor activities that made this congress a youth-powered gathering. New friendships were formed, new prevention methods were shared and the impetus for youth-led prevention was invigorated.

Following are the recommendations of the congress as well as the action plans, which the participants developed and pledged to implement in their countries and communities.

Four specific topics were presented and discussed in sub-groups where a chairperson and a rapporteur was elected.

1. School-based programs

Recommendations:

- * Principals and teachers must be trained in drug prevention education and they should be drug and tobacco free
- * There should be drug prevention counselling centres in every school

* Information should be available to all schools not just those in the capital

Action plan:

- * To participate actively in the formulation and design of school based-programs
- * To volunteer in regional areas to provide information and counselling to students who don't have access to drug prevention information

2. What can the youth do?

Recommendations:

- * There should be a balance and cooperation between the school, the community, homes, etc.
- * The youth must be backed-up by people of influence for moral support, financing and provision of facilities. Nevertheless, the youth should also be active in the gathering of funds and resources.
- * The youth must be taken seriously and included as competent stakeholders in the fight against drugs.

Action plan:

To use music, movies, computers and other means to increase the impact of prevention efforts and make prevention an activity that the youth would want to be a part of.

3. The community and youth

Recommendations:

- * Schools are part of the community and as such, must provide drug prevention information to safeguard the community.
- * The youth must be engaged and motivated in suitable activities geared for them. These include sports, youth meetings, street shows and peer education programs.

Action plan:

To support community efforts and take an active part in their formulation and implementation.

4. Media literacy

Recommendations:

* Media makers must not display mixed messages that warn of the dangers of drugs, both legal and illegal, while at the same time glorifying and not showing their real effects.

* Education that helps youth to interpret the meanings of media 'messages', must be included in youth-targeted prevention efforts.

Action plan:

To view media not simply as consumers but as discerning individuals who can understand the intentions of both advertisers and other media-makers and thus protect ourselves against pro drug abuse tendencies.

A pledge created by the youth was recited at the closing ceremony. The Asian Youth Congress on Drug Abuse Prevention was organized by the Yayasan Cinta Anak Bangsa (YCAB) Indonesia, and was hosted by the National Narcotics Board (BNN) of Indonesia, The Colombo Plan – Drug Advisory Programme. It was supported by the Bureau for International Narcotics & Law Enforcement Affairs, US Department of State (INL).

(This preliminary report was courtesy of Mr. Gerson Bergeth of YCAB. A copy of the youth pledge and a more detailed congress report will be available at the YCAB website: www.ycab.net).

'Talking it out' remains a part of conventional treatment strategies

used in most rehab centers. Setting them as examples has its pluses, but complementing them with holistic harm reduction strategies maximizes their benefits especially for those who cannot afford in-house treatment or are not (yet) ready for this kind of intervention.

I'm Tara, and I was 14 years old when I smoked my first pot with friends. I was 16 years old when I started using putaw (heroin). A few months later I was caught chasing the dragon in the school bathroom and was expelled from high school. That was also the first time my parents learned that I was using drugs. "I come from a very religious family and my parents never talked to me about drugs or sex. I was never in trouble before, and my parents always thought I was a normal and quiet girl, so it was painfully shocking for them when they received the letter from my school telling them that I was involved in narcotics." I was then taken to a hospital in Jakarta for detox. The doctors in the hospital never did any form of counseling whatsoever with me. His only conversation was, "How long have you been using?" and "Do you chase the dragon or inject?" Then he would write prescriptions for medication, and that would be the end of the session. They never talked to me about my problems, or about how to stay away from drugs. This, of course, did not help me, and I was back using putaw shortly. Then I found out one of my brothers was addicted too, and we started using



Some of the youth at Yayasan Kita enacting a play at the 2001 World AIDS Day.

drugs together. He was the one who taught me how to inject, so I started using needles and started sharing needles with other people." My parents took me to see other doctors, but after a few weeks of medication, I'd be back using drugs again. I didn't know anything about recovery or harm reduction then. The doctors never told me about the risks of sharing needles with other people, or about the risks of having unprotected sex. It wasn't until later, when I was admitted to a treatment center in Bogor, that I learned I was hepatitis C positive. "At Yayasan Kita I had pre-test counseling, before I got tested for HIV and hep C, and post test counseling afterwards, so I knew what I would be facing. Before that I didn't know anything about these viruses and how they spread. I know much more now, and I know how to protect myself, and other people around me also."

Psychiatrists and other service points here tend to neglect the importance of counseling for addicts. Nowadays most of the psychiatrists and doctors around Jakarta only seem to care about how to make as much money as possible from the addicts and their families. Their main function seems to be prescribing medications for addicts. "I was in the hospital for two

weeks, but the doctor only saw me a few times during my stay, and that was only to ask me how my body felt, and asked me if I needed more medications. The hospital was supposed to be the leading drug dependency hospital but it lacked the programs addicts needed most — a recovery and a harm reduction program." I think hospitals with detoxification programs should also provide counseling especially harm reduction counseling, given the present condition of HIV/AIDS and hepatitis C that is spreading so rapidly, especially within the IDU community. If drug abusers can't stop, at least they would learn about the risks they're facing and how to better protect themselves.

Recovery from drug addiction is not an easy process. It's a lifelong process. Narcotics Anonymous is a 12-Step Program designed by addicts, for addicts, and that is now part of my recovery program. NA has been proven to be a very successful recovery program, which has saved the lives of millions of addicts around the world. Mine too. NA is run by the members themselves — each group is self-governing, does not have rules and regulations that must be followed, is self-supporting and free of

charges. In many ways we think NA is a wonderful harm reduction program. NA plays a very important role in our recovery process, and there are meetings for our family also. Around Jakarta, there are more meetings people can go to. Support groups such as this help addicts find the strength to stop using and stay clean.

Here at the treatment center, we don't just learn about drugs, its effects, and recovery from addiction to it, but also about psychology, communication, and harm reduction techniques. "Before we came into treatment, most of us did not know anything about harm reduction. But now we've learned so much! We learned about the viruses, what they were and how they spread, how to protect ourselves and protect others (if we are already infected with HIV or hep C) by minimizing the risks of our behavior, like using condoms instead of having unprotected sex. Even if we do relapse after treatment, we know not to share needles, and how to clean the needles properly if we don't have our own needles."

Most of what we do here in the treatment center is harm

I think hospitals with detoxification programs should also provide counseling especially harm reduction counseling, given the present condition of HIV/AIDS and hepatitis C that is spreading so rapidly ...

reduction. Not only do we have IEC programs, we also have an outreach and risk reduction. We give seminars in schools, universities, churches, work places, hospitals and even government offices. In seminars we talk about the facts concerning drug abuse and addiction, the viruses, and spread of the viruses. When we talk to people, we share our experience, we let them know that drugs aren't only about fun. Drugs are a serious matter and we let them know the risks they're facing if they use it, and the real truth about addiction, and getting infected with HIV/AIDS or hepatitis C. We also give out literature about drugs, feelings and emotions, relationships, parents, religion and spirituality, what to do when someone overdoses, and more. We also have handbooks for teachers and parents, and a lot of printed materials. We want people to know the truth, to really understand how serious this condition is, and hope they learn something from what we share, which will help to make a difference in their lives.

Yayasan Harapan Permata Hati Kita is based in Indonesia. Contact: David & Joyce Gordon at Tel. (62) (251) 243 069 / 243 077, Email: info@yakita.or.id <http://www.yakita.or.id>



Task Force on Drugs and HIV Vulnerability

Malaysia does not see IDU and HIV/AIDS as interconnected, and other regional issues. Kuala Lumpur, 15-16 July 2002

Drug abuse (including injecting drug use) and HIV/AIDS in Malaysia are perceived as two separate issues, and not as interconnected issues. This came out of the presentations by the National Drug Agency, the Health Ministry, the Royal Malaysian Police, the Malaysian AIDS Council (MAC) and the Kuala Lumpur City Hall. Further efforts are needed to address the two problems jointly in a comprehensive public health policy guided by a sense of urgency. The Malaysian AIDS Council suggested that a group of NGOs, government agencies and UN office present a joint briefing on the HIV/AIDS epidemic and drug abuse to the cabinet, in order to provide top leaders with accurate information and policy options.

The UNAIDS and UNDCP joint presentation highlighted the need for effective responses on a large scale in order to curb the course of the epidemic. They observed that interventions found in most countries include legal approaches, information only, and detoxification. The most effective interventions, such as promotion of clean injecting behaviors, needle distribution, substitution therapies, peer education and outreach services, are least practiced in the region. Countries implement such strategies on a very limited scale that cannot impact on the epidemic.

To overcome this situation improving the flow of funds, formulation of scaling up plans, capacity building for governments, communities

and NGOs, and establishing monitoring and evaluation systems, were identified as the main steps to be taken.

New opportunities that exist with the Global Fund to fight AIDS Tuberculosis and Malaria was also given. The Task Force recommended that three countries from the region submit application for GFATM, namely Indonesia, Myanmar and Malaysia. Including specific interventions for IDU in GFATM proposals is a responsibility of each CCM and should they decide to do so direct support can be obtained through the Task Force for the formulation process.

The essential elements of evidence-based intervention to control the epidemic among IDUs are:

- Availability of: needles and syringe exchange programmes; and treatment and rehab programs, including substitution maintenance
- Outreach with strong involvement of the drug user community
- Intervention with near to 100% coverage of the IDU population for effective behaviour change

Syringe disposal, the new Ausaid project, status of the ASEAN work programme, and the harm reduction conference in Chiang Mai were also taken up. AHRN is a regular member of the task force which includes donors, UN and government agencies, and national and international NGOs involved in drug abuse, HIV prevention among drug users or drug control. For full report, see: www.undcp.un.or.th

Harm reduction gets long overdue recognition at the World AIDS Conference 2002

It's not old news as some harm reduction advocates are starting to think

Covering sessions on drug use at the AIDS Conference in Barcelona back in July was an experience better described as a 'step out of the box'. You will agree that as advocates of harm reduction, we face drug use issues over and over again each day that facts concerning the effectiveness of needle and syringe exchange or drug substitution has become common knowledge and at times rhetoric for us all. That drug use (and sex) does not stop behind bars, where injection becomes riskier and HIV infection rates are often higher than outside of it. Yet at Barcelona, these were trumpeted all over again, the bigger difference was that harm reduction/drug use was given much interest unlike in previous conferences, with many more people attending related sessions. One respected advocate couldn't help but remark 'Old news'. But are they? What to us are 'old news' were new information to most especially in a conference of nearly 15,000 participants where at least six speakers spoke in every two-hour session. Here are some of the burning issues we gathered.

HIV/AIDS and drug use – the global situation

While harm reduction seeks the same amount of attention given to AIDS treatment, prevention and care in order to effectively address HIV transmission from drug users to other drug users, to vulnerable populations such as sex workers, and onto the

general population, key issues still remain under wraps.

A balance has yet to be achieved between supply, demand and harm reduction. "Drug use (and sex work) are heavily structured by police work and lawmakers," reiterated Scott Birth from the U.S. "It is already known that they influence access to prevention and treatment yet there is not enough data on how they structure these two populations (commercial sex work and injecting drug users)."

"It has been apparent that the level of analysis from the injecting drug users to the community remains low and law makers still need to realise the risk to the general community," acknowledged Nicholas Grassly in reply.

"The institution of incarceration is a third extremely critical element," added Dr. Alex Wodak. "It is directly under the control of lawmakers and puts communities at risk. In Iran, more HIV infection occur among injecting drug users in prison and very little outside of it."

Injecting drug use, is already a primary, if not, a secondary course of HIV transmission in most countries in Asia.

The balance has also tipped badly against the favour of drug user programs in Pakistan due to the war on terrorism. More than three million heroin users live in the country – the highest number of users in the world – but after the 9/11 incident in the



U.S., access to drug users has become limited. "Budget allotted for development and social issues has been cut because national security is in danger," explained Tariq Zafar who runs Nay Zindagi, the largest successful harm programme now derailed by this recent development. Locking up drug users has pushed them to go 'underground' once again, cutting off access to treatment and services. The disruption in the supply of heroin has also raised the number of drug users from 9% to 23%, the incidence of injecting to an average of twice or thrice per day, and the sharing of injecting equipment has gone up to 79%.

Eighty-nine percent of drug users are infected with Hepatitis C due to syringe sharing, and with all modalities in place, the war on terrorism will trigger an HIV epidemic. Although less than 1% of drug users has HIV, only 4% claim to know how the virus can be transmitted. Drug using Afghan refugees, who are more likely to inject and share needles than Pakistani drug users, are also taking toll on an already overburdened and under-resourced drug harm and demand reduction programmes.

"Damage has again been done. We need to admit the severity of the damage and we need to know how to respond quickly to these changing needs," emphasises Tariq. "We already know the good examples in the region and we should act."

"Given the intention of the U.S. to expand the war on terrorism in Peru, Bolivia and some areas in the Philippines, what set of intervention package can you suggest to

mitigate the spread of HIV?," asked Sam Friedman. Tariq's reply: "To grind flour, we need to keep on moving a stone in circular motion against a fixed stone and keep on adding seeds in between (the two stones). It cannot be that the two stones are moving in the same direction."

In the joint: Prisons and prisoners

Is it possible to do HIV prevention work in prisons without dehumanizing people? Can you honestly get freely-given informed consent in this setting? How does one keep a balance between confidentiality and security yet promote mandatory (HIV) screening on entry? These questions loomed as realities were disclosed in five U.S. prisons, at a juvenile detention in Australia, and in Zambia and Nepal.

While sex and drug use occur behind bars they do so opportunistically and inmates would rather feign knowledge of their existence. While norms dictate that sex behind bars must be ignored, prisoners say that it is difficult to abstain from it. Sex is an important tool for trading scarce resources, this type of exchange often occurring between inmates and prison officials. There are also hierarchial 'sexual exchanges' between older and a younger men.

According to David Seals who surveyed five U.S. prisons, most inmates doubt that anything can be done about substance abuse and sex inside correctional facilities. Injecting drug use is denied yet information about it remains pervasive. North-west Tanzania finds itself in a similar situation noted a listener, commending the follow-up that Seals' group

has been doing after (the inmate's) release. The follow-up concerns behavior 'outside' and following the harm reduction model, reintegration and re-employment of the ex-inmates. There are plans for better in-prison programs for long-term incarceration.

AIDS is the challenge behind bars in Zambia. Despite WHO's guidelines on HIV/AIDS management inside prisons that mandate the inmates' right to healthcare and where policies of health programs should apply, they continue to receive little protection against the disease. Poor living conditions, inferior health services, lack of appropriate information, and a greater focus on safety and security than on public health has put many at risk, encouraged risk behavior, and has increased infection rates for TB, HIV and other STIs. Eighty-six percent of the recorded HIV infection in 1999 were among inmates yet none was attributed to sex between men or to drug injecting, hinting instead that it may have come from 'outside'.

Nepal and Zambia share moral as well as legal concerns that declare sex between the same sex as a punishable offence, therefore preventing condom access. Its slightest mention is a barrier in Botswana, said a participant. This has limited to advocacy Zambia's 'In but Free' project that offers HIV prevention, care and support services to prisoners.

In a region east of Nepal, it is therefore no surprise that HIV infection among incarcerated individuals has been



"A sentence to prison must not be a sentence to HIV/AIDS," maintains Oscar Semolya (Zambia)

consistently higher than in the general population, and where 75% share needles, a high prevalence of hepatitis B and C among injecting drug users is common. A similar number of inmates do not perceive the risk of HIV infection or are unaware of the signs and symptoms of STIs and HIV or AIDS, with a handful even believing that condom is a treatment. Access is also restricted by political prisoners.

Twenty to twenty-five percent of the juveniles detained in Victoria, Australia have histories of injecting drug use and one out of five are infected with hepatitis C. Methadone substitution reduces the frequency of injection in custody and post-release overdose, however, once released, access to them becomes a problem. Concerns also arise in some staff on the training on safety and equipment use on one hand and labelling them as contrabands on the other.

These scenarios paint the need for political and community will towards the healthcare needs of juvenile and adult inmates who come from and will go back to the

Capturing Barcelona

community. They have a right to health, quality and dignity. For years, we have seen prisons become breeding grounds for infectious diseases like TB, Hepatitis B/C and recently in greater numbers, AIDS. Prevention must become an inimical part not only of the community but more importantly, within prison walls. More mandatory screening on entry is essential yet balancing confidentiality and security remains a concern.

Due to the lack of classification of inmates, Semolya suggests non-custodial sentences to women and juveniles, and where there is barrier to condom use focus must be made on more at-risk situations with consideration to release on medical terms. Peer education has worked to some extent within the prison confines of Nepal despite restricted access, shared Chitra Paul (Nepal). "Education in safety as an intervention in detention and its continuity outside of it is important," says Mary O'Brien (Australia), "while detention is often viewed as a high-risk environment, the failure of the services in the community can be equally damaging." Seals (USA) recommends further research on understanding of stigmatized, taboo behavior; balancing public health concerns; societal stigma; and on correctional settings in general.

Have epidemics in IDU led to self-sustaining epidemics in heterosexuals?

Injecting drug use-associated HIV epidemics can lead to generalized HIV epidemics as we have already seen in Thailand (54%), India (Manipur), Myanmar (42-77%) and Ukraine where

more than 25% of the injecting drug users and more than 1% of the the general population are now infected (a definition by the Monitoring the AIDS Pandemic (MAP) Workshop). The timing of the IDU epidemic is a crucial factor in the AIDS virus' progression. "The bridging of IDU and sex work in an early, uncontrolled heterosexual epidemic can advance the HIV epidemic by a decade or more," says Steffanie Strathdee of the Johns Hopkins University. "By itself, IDU can contribute 20-30% to an established HIV epidemic." Other issues to consider include context of injection drug use, rate of sexual mixing between IDUs and non-IDUs, STDs, incarceration rates, paid blood donations and the role of prevention programs.

Drug users in five regions in southwest China are also 'at risk' with infections rates at: Xinjiang 39-84%, Jiangxi 17%, Guangdong 5-20%, Guangxi 12-40% and Yunnan 58-80%. Other areas where an IDU-led HIV epidemic is imminent include: Belarus, Kazakhstan, Moldova, Russia, Indonesia, Malaysia and Vietnam. In most of these places, HIV infection follows the drug trafficking pattern. In several Eastern European cities, escalating incidences between 17-80% are also revealed among IDU-sex workers.

IDU-associated HIV epidemics have been identified, those 'at risk' have been alerted. We also know what individual-level interventions work: voluntary HIV testing and counseling, interventions focused on migrant IDUs, access to sterile syringes and drug treatment (methadone/buprenorphine maintenance); and what does not work: incarceration and denial to

access to syringes or drug treatment. At the community level, 100% condom campaign has worked (but which needs serious review as it was coercive to sex workers), so does the deregulation of syringe paraphernalia laws and drug decriminalization in Western countries. Interventions that discourage transition to injection along the drug trafficking routes can also be effective and provided that a dramatic upscaling is carried out, 29 million infections could be averted by 2010.

The scenario is grim, for now. The conditions that facilitate and/or prevent IDU-associated epidemics are still not well understood. But we have an ace on our sleeves because we know that we can prevent transitions to inject, we know that we can prevent needle sharing and we know that we can prevent sexual transmission HIV.

Injecting drug users and HIV vaccine trials: What does the science say?

In many parts of the world outside Africa, the epidemiological picture of HIV in 2002 is strikingly different – majority of the reported HIV infections and AIDS cases arose not from sexual transmission but through needle sharing behaviors among injecting drug users. While the number of IDU infections in any one country may not be large on a population basis, i.e. Vietnam, these states have enormous young populations, many with rapidly rising



If an HIV vaccine is to help turn the tides against HIV/AIDS, it must be effective against IDU transmission.

substance abuse rates. Where IDU does not represent the majority of infection, nonetheless they play an important role in spreading HIV, and in Asia (except Cambodia), IDU-related outbreaks were key in the introduction and dissemination of HIV.

Epidemiology of HIV in 2002 therefore tells us that for a vaccine to be truly effective in curbing the global epidemic, it must work both against sexual and IDU transmission. Scientifically however, we do not know if the same set of immune responses will work against both routes, while IDU populations also present their own challenges.

Chris Beyrer of the Johns Hopkins University argues three key issues:

- 1) Scant evidence cannot suggest that vaccines which prevent or reduce HIV transmission will necessarily work as well against IDU spread;
- 2) IDUs do not make for poor participants in HIV vaccine trials as shown by their active enrollment and retention (n=2,500) in Thailand's ongoing AIDSVAX trial in Bangkok's methadone clinics where retention has been

strikingly high and if maintained will give an overall retention well over 90% during the three-year trial, remarkable for any HIV at-risk population. But barriers to their participation do exist, i.e., IDU is a highly criminalized and stigmatized behavior globally, HIV prevention strategies among IDUs (NSEPs, MMTs) are forbidden or restricted by law in most countries; and 3) In addition to Bangkok, cohort in Chiang Mai supported by the National Institute for Drug Abuse (NIDA) led by David Centeno and Vinai Suriyanon can also participate in future vaccine trials in IDU. Several sites are also being built in Guangxi Province, southern China supported by HVTN together with the HIV Prevention Trials Network (HPTN), which also works in Xinjiang (northwest). The same protocol is underway among IDUs in St. Petersburg, Russia. A clinical trial collaborated by SHARAN and Johns Hopkins researchers, with support from NIDA, is testing whether new drug treatments for addiction are useful in HIV prevention as possible vaccine trial platform. Other studies are ongoing in Hanoi, Moscow, Karachi and several Brazilian cities.

If an HIV vaccine is to help turn the tides against HIV/AIDS, it must be effective against IDU transmission. With appropriate commitment and buildup, IDU cohorts suitable for these trials can be available. Engaging them, in turn, requires expanding partnerships with drug users, NGOs and research groups active with IDU, and the vaccine research community. (Excerpt from the IAVI Report Vol. 6, No. 3, May/June 2002, released at Barcelona. Authored by Chris Beyrer.)

Needles and drug use are a spiky affair

Asia has the largest number of injecting drug users in terms of numerical data but how can we convince policy makers to do things? Must treatment remain abstinence-oriented only?

"Needle exchange remains among the cheapest and most-cost effective program available," says Jimmy Dorabjee. "There's a huge body of benefits yet Asian countries remain slow and cautious because of the social and political mindset. In south Asia, excellent drug treatment programs and facilities already exist with a solid grounding, with some programs like Shakti (Bangladesh) covering 75% of the drug user population, yet we seem to be unable to move harm reduction."

Most governments do not address harm reduction in national HIV/AIDS plans. It remains largely unclear how policies are being developed. In terms of vulnerability to the disease, decision-makers remain unaware of the evidences accumulated internationally with respect to drug policies.

"Policies are instrumental in making things happen," says Kasia Malinowski, director of the International Harm Reduction Development (IHRD), an arm of the Open Society Institute supporting extensive harm reduction programs in Central and Eastern Europe. After implementing 200 programs in the region, majority of which are NSEPs, IHRD learned that needle and syringe exchange programs (NSEP) are a lot easier to set up than methadone substitution because it can be operated within 'gray law'. "We also noticed that in the

Bits & pieces

Users must pay to get into rehab in China

"Methadone is not illegal but can be used in (pilot) projects and in hospitals. We have just decided to develop a protocol for a methadone substitution pilot project," confirmed Shen Jie, Director of China's National Center for HIV/AIDS Prevention and Control in a conversation after the closing ceremony of the AIDS conference. The government recently confirmed that nearly a million Chinese is now infected with HIV, an epidemic that was initially traced to injecting drug use recently became widespread due to unsafe blood donations and unsafe sex. "We provide re-education and rehabilitation to drug users," says Shen Jie. "The government believes in running health education programs to stop the use of drugs, to inform users to use clean needles and to educate families." This is made possible through community projects and person-to-person interventions. In June, AHRN visited the Yunnan Institute for Drug Abuse (YIDA) in Kunming and learned about the pay-for-treatment rehabilitation centers. "Drug users who volunteer to go into treatment do not pay," clarifies the Director, "others (who did not enter the program voluntarily) pay only for the food – treatment is free." According to her, 7% of female drug users in China are involved in commercial sex work and the government is pushing for condom promotion to prevent HIV transmission. She did not however elaborate on the treatment of drug users who become infected with HIV, commenting only that, "...



Director Shen Jie with Dr. Jack Whitescarver.

it is difficult to do treatment, there are not enough medicines available and they are expensive (unlike in Thailand)."

Thai government needs to be 'taken out of the box' – Senator Meechai

Leadership and political will were what the Thai government representatives promised at the next AIDS conference in Bangkok in 2004. "Given that over half of the drug users in Thailand have HIV, can we expect the same for harm reduction?," asked AHRN. "The establishment is very conservative," replied Senator Meechai. "We have to convince them with a lot of proof and take them out of the box." He finds these necessary in order to broaden their attitude about needle and syringe exchange, or



Senator Meechai at the press conference of the 2004 World AIDS Conference to be held in Bangkok. Beside him is Thailand's Minister of Public Health Sudarat Keyuraphan who will also head the 14th International harm reduction conference in Chiang Mai, April next year.

Capturing Barcelona



and for commercial sex workers who sell sex to support their drug use – a habit they depend on to ‘medicate’ themselves – are examples.

“... the important is to share the lack of successes... people will learn where the reality is a struggle.”

long-term, they necessarily served all clients,” added Kasia. “Policies are necessary to normalize harm reduction. Most (of our) programs are still pilots and policies are needed to make harm reduction a norm, to include them in National AIDS Programs.”

Kasia was also careful to point out that one cannot just set-up a (needle exchange or drug substitution) program. “We must be careful in setting them up ... they cannot be left alone. Through twinning in the region, we can be more relevant, programs can become cheaper and we can build leadership.”

Future issues Demand for HIV care among drug users has now multiplied several-fold. In newly-independent states like Russia, only 40 programs exist for 900,000 infected injecting drug users - 90% of all the HIV-infected. According to Jimmy, “Developing and developed countries have a lot to learn from each other. Innovation is possible for developing countries but they need more resources. Programs must be based on relationships than be monetary. Because individuals are more important than programs, they need to become user-specific to suit current needs.” Advocating for services in prisons

“Harm reduction should not be disturbing policies but giving it medical cognizance,” says Carol Jenkins. “If there’s a lesson to be learned by Western and Eastern Europe from Asia – like the methadone substitution program that was expanded to cover all 20 Akha hilltribe in northern Thailand to treat opium dependence despite local police’s insistence on becoming 100% drug-free – it is to bring treatment to the community level. It is important to bring harm reduction as close to the people as possible.”

“There will be passive acceptance of harm reduction and funding will continue to be an issue as efforts are channelled to scaling up programs,” adds Kasia. North Africa and the Middle East are following closely where, unfortunately, political efforts against terrorists are driving drug users underground all over again. “What role can Spain play in these regions based on this kind of model?,” she asks. “No matter how extensive a program is, the important is to share not only the successes but also the lack of successes. The reality is people will learn from countries where the reality is a struggle.”

Does drug abuse influence AIDS progression?

IDUs are the largest group of HCV coinfecting individuals.

methadone substitution as a treatment in order to prevent HIV transmission. Thailand’s 100% condom campaign has been touted to be most effective in the government’s initial preventive campaign against the HIV epidemic and Senator Meechai compares: “Harm reduction is similar to the condom, however (with HR) we must educate the government that it is not condoning drug use,” he added. Because harm reduction remains political since it reaches out to drug users (who are often criminalized) through pragmatic programs such as needle and syringe exchange, the Senator continues, “Like having knives in your kitchen, it does not mean that when you have several you will use them to kill.”

Medazolam use among IDUs in Bangkok

During the AIDS VAX B/E trial in Thailand where 2,545 IDUs participated between March 1999 and August 2000, medical injection of medazolam was reported by Dr. Fritz van

Griensven of the country’s Center for Disease Control office. The drug is another version of Dormicum, more popularly known as “Prozac” which induces sleepiness and is used to reduce anxiety. Of the predominantly male IDUs 98.5% of whom were using heroin and 15.8% were under methadone treatment, more than half had injected medazolam, a trend which has increased within six months. Incurred time, age and treatment were associated with increased levels of injection while lower education and frequency were associated with the opposite trend. It did not however impair heroin use as it was often used alone. This finding is significant in reducing injection among IDUs, especially during preventive counseling, says Dr. Griensven, however he stressed that medical injecting is independently associated with needle sharing. They recommend more qualitative studies and the need for education and regulation of medazolam by the government.

HIV accelerates hepatitis C progression to liver disease while HCV in turn accelerates the natural history of HIV. A coinfection of HCV and injecting drug use results in rapid progression of the disease, according to Dr. Gerald Friedland (Yale University). But there is very little data on the benefits of HCV and HIV treatment among IDUs because they have been restricted to HCV therapeutic trials. HIV infected IDUs face similar issues when it comes to access to care however due to the inexperience of clinicians, they have less access to them. Gender-specific diseases such as cervical cancer are also

common due to the large number of female IDUs. There is also the easy presumption that substance abuse is a predictor to non-adherence, that being an IDU is a barrier to adherence to HAART while the high prevalence of mental illness among drug users contributes to decreased access to and benefit from therapies, complicating provision of care and creating more difficulties with adherence to medications to adversely influence disease progression. Despite these predilections, Dr. Friedland emphasizes on reaching out to out of treatment injecting drug users and bringing them to care.

Strengthening partnerships to develop a common response

By Tariq Zafar

Countries in Asia are at various levels of the HIV epidemic, from countries with a potential risk to fast emerging pandemics. Drug users and particularly injecting drug users are at a high risk and evidence indicates that neither the number of drug users nor the number of infections is reducing.

In fact we need to realize that a majority of the existing drug programs are traditional and costly residential treatment services introduced in the seventies with the hope of reforming 'delinquent' drug users. While successful for some individuals, residential treatment models have fallen short of having a significant impact on both trends and scope of drug use and the overall goal of reducing the demand for drugs.

The other aspect that needs to be taken into account is the fact that opportunities for drug programs are time bound. The moment HIV/AIDS epidemic will move from high-risk groups to the general population, support for high-risk groups will decrease if not all together diminish. In the last 10-15 years, NGOs and individuals have looked for ways to change the drug treatment paradigm from institution-based services to community-based interventions. The underlying concept is to bring services to drug users, reduce the threshold of services and facilitate ownership of the service among its clientele.

The significant shift is to de-focus from the substance and focus on the individual and

his/her environment. The goal is to improve the quality of life of drug users not only when and if abstinence is achieved but also and especially during their drug using careers.

This approach reaches out to drug users rather than waiting for them to hit rock bottom and then (if they still can) approach services for help. With the advent of HIV/AIDS, we recognize that there will be a high price to pay in terms of public health, social and economic well being, if societies do not acknowledge or address the needs of drug users in their environment.

Recognizing that drug users have needs before they ever reach a treatment centre, organizations and individuals involved in the drug field are now increasingly understanding the value of meeting people's needs long before these people are capable or willing to address their drug use.

In spite of the fact that street based harm reduction services for drug users have been effective in Asia, the reality is that on ground the most successful interventions are often the least in number. A majority of drug users have no access to any services and in most cases are not even aware of services. Many have no desire to give up but just want to regain some control over their drug use. Some are critically ill, have no friends or family and so are unable to make contact. Without support, basic information and advice, they remain poor, ignorant, open to disease, ill

health and malnutrition. Many more will die.

There is need that programs in the Region network and exchange information and views to develop a common response based on principles rather than methodologies. However to develop a common response we need to strengthen partnerships. This can happen if we believe and demonstrate that we are all equal and all that we know or don't know is best shared or questioned with a genuine

"The goal is to improve the quality of life of drug users not only when and if abstinence is achieved but also and especially during their drug using careers."

commitment to work together for safer communities.

The aim is to reach out to the drug user, provide a bridge, keep the drug user as healthy as possible, provide basic information and advice, provide a space where the drug user feels safe and become a his/her reliable ally.

AHRN is committed to further strengthen its relationship with programs and service providers in the region and provide a platform for developing partnerships to maximize benefits of lessons learnt. To achieve this, AHRN will work towards rapidly achieving harm reduction

goals at country level through a locally led network response. Networks of programs and service providers will be encouraged and supported for their capacity building and to enable them to network regionally.

In the next two years, AHRN will develop a program for the provision of needs-based services in five to seven countries in the region, in collaboration with local programs. AHRN has over 2400 members of which over 700 are programs and service providers. By the first quarter of next year AHRN will have collected additional information of existing programs and the nature of their services/approaches. This will further assist in mapping for organizational needs which AHRN will respond to with support.

In addition, AHRN will utilize its extensive network and bring on board development agencies and donors to assist



in working towards a common response to HIV/AIDS and drug use in the region.

All said and done, the success or failure of programs to develop a common response to drugs and HIV in the region will mainly depend on the commitment of programs to come forward and play an active role in guiding and helping AHRN.

AHRN welcomes aboard the new Executive Committee ...

AHRN wishes to thank Jimmy Dorabjee (India), Dr. Monica Beg (Bangladesh), Dr. Zhijun Li (China), Dr. Dhurba Man Shrestha (Nepal) and Aaron Peak (Consultant, Thailand) for their important roles in the network during their tenure and their continued dedication so that AHRN lives out its mandate to support and link programs and organizations working for harm reduction. The third wind of the Executive Committee ever since AHRN was established in Australia in 1996 and then moved on to its second base in Chiang Mai in 1998, steps in at a crucial time when many more are being infected (and are dying) of AIDS because of the failure to prevent HIV transmission among drug users, when we already know how. Their combined expertise will ensure that harm reduction 'moves and makes differences' at both the grassroots and the political level. Dr. Jaroon Jitiwuttikarn remains in his dual capacity as Executive Committee member and AHRN Foundation member, as well as Mr. Ton Smits being the Executive Director of the AHRN Secretariat. The committee is also seeking representatives from China, Vietnam and Indonesia.

Tariq Zafar, Pakistan

Our new Executive Committee Chairman is bringing into the network the "say" of programs and clients (drug users) for an improved visibility among programs of AHRN. Assessment, design, planning, implementation and monitoring/evaluation of harm reduction in Pakistan with a special emphasis in the cost-effectiveness of programs and their financial/social sustainability has been Tariq's important role in this community. His knowledge of engineering and experience in business and development as well as human rights advocacy are incentives for one of the many successful projects of *Nai Zindagi* – remodeling and re-selling (exporting) jeeps by users under their program.

I began to work in the harm reduction field in India in 1993, but have always been unconsciously applying the harm reduction philosophy in my life. One of the major influences that motivated me to continue in this often controversial and misunderstood area was a workshop on IDU and harm reduction organised by the St. Vincent's Hospital, Sydney, the Macfarlane Burnet Centre for Medical research and LALS in Kathmandu in 1994. This was where I first met with Nick Crofts, Alex Wodak and Aaron Peak, some of the most renowned names in the harm reduction arena, and from whom I constantly draw inspiration.



The 1st Harm Reduction Conference I ever attended was the one held in Hobart in 1996, after which I attended the Asian Satellite meeting where the concept of an Asian Harm Reduction Network was fleshed out and the organisation born. I have been one of the executive members since then and



Dr. Suresh Kumar, India

Psychology has allowed Dr. Kumar to take active involvement in the treatment of drug users since 1979 and in 1991 started to work in the prevention of HIV transmission in this community. He has conducted rapid assessment studies on IDUs in Kazakhstan and India (Chennai, Trivandrum and Hyderabad). Previously a Professor of Psychiatry at

the Madras Medical College in Chennai and Senior Civil Surgeon at the Institute of Mental Health in India, he has since become an important resource person in harm reduction workshops in the region as well as in international AIDS and harm reduction conferences. Dr. Kumar, who is on his second term in the Committee also belongs to the Abuse Research Network on HIV Prevention among Drug Users, and the Global Reference Group for the Prevention of HIV among IDUs organized by the UNAIDS, WHO and ODCCP.

Dr. Ben Karki, Nepal

Twice the National Programme Manager for HIV/AIDS in Nepal, and at present the Chief of Planning at the Ministry of Health, Dr. Karki made sure that harm reduction tops the list of his agenda. As the Director of National Center for AIDS and STI Control in 1991 and 1992, he directed the first nation-wide RAR survey among drug users, then planned and implemented programs with active community participation in order to make them sustainable. "Injecting drug use, harm reduction and injecting drug user rehabilitation are highly challenging jobs," shares Dr. Karki. "I wanted to learn more about it and with my experience contribute to the cause of AHRN."



... and tips its hat to Jimmy

have recently handed over the Chair to my good friend and colleague Tariq Zafar.

One of the most striking moments at that conference was an act of kindness that I will never forget. After more than 2 1/2 decades as a drug user, I had just quit in 1991 and had just begun to reorganise my life. I was working, earning and saving money, and had just about acquired some furniture and other things for my rented house in Delhi. While I was away in Hobart, my flat was broken into and everything of value, including a TV, money, stereo system, etc, was stolen. I got the news while still at the conference and was shattered. How and when would I ever be able to get these things again? The next day, an announcement was made at the conference and donations of money were made and handed over to me. I remember thinking then that these harm reductionists were people full of compassion and generosity.

Resources/events



AIDS, hepatitis, tuberculosis and other infectious diseases are found more frequently within the walls of a prison than outside. Working in a penitentiary, therefore carries a higher risk of infection. But how big exactly is this risk and what can you do to protect yourself? This book contains the facts about infections and includes tips to prevent infections inside the prison. But also included in this book is specific information on drug use. What are the health risks of drug use. What are the health risk of drug use and how does drug use influence the direct environment? For instance, does drug use encourage aggression? Published by Stichting Mainline, The Netherlands. Email: info@mainline.org

HIV/Aids in Burma

17 - 18 October, 2002
Royal Benja Hotel,
Sukhumvit Soi 5, Bangkok,
Thailand
Organizer: Burma Centrum
Nederland (BCN)
Information: Burma Centrum

And this thought has always stuck to me. What else is Harm Reduction if not a humane and pragmatic response to human problems?

And over the years, from a very few harm reduction programs in Asia, we have witnessed the growth of so many programs, often in very strict and difficult cultures and countries.

When I look back, I can clearly see how we have succeeded in changing the perceptions and views of so

Nederland (BCN) Paulus
Potterstraat 20 1071 DA
Amsterdam The Netherlands
Tel: 31-20-671 6952
Fax: 31-20-671 3513
E-mail: bcn@xs4all.nl
www.burmacentrum.nl

The European Drugs Conference 2002 - Drugs and Society, Implementing the Changing Agenda

24-25 October 2002
Kent, United Kingdom
Information:
Tel: + 44 (0)1273 623 222
Fax: + 44 (0)1273 625 526
E-mail : info@pavpub.com ,
www.pavpub.com/pavpub/conferences/showfull.asp?Section=2&SubSection=0&Conference=171

Alcohol and Drugs Conference APSAD 2002

Incorporating the National Methadone Conference
18-20 November
Adelaide hotel, Australia
Organizer: Australian Professional Society on Alcohol and other Drugs (APSAD)
Information:
www.plevin.com.au/APSAD2002
Registration:
www.plevin.com.au/APSAD2002/registration.htm
Secretariat:
Tel +61 8 8379 8222
Fax +61 8 8379 8177

many from the abstinence field into supporting and endorsing harm reduction. Yes we have come a long way since Kathmandu in 1994. But, as my friend Alex Wodak recently said to me, we probably now have 20 million more AIDS deaths, 30 million more HIV infections, we have IDU related epidemics in many countries, we have lost Keith Kanga and so many others who dedicated their lives to improving the lives of drug users.

But there are also some pluses.

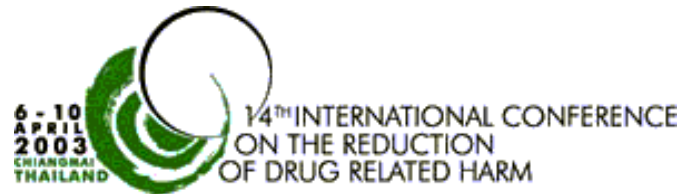
Email: events@plevin.com.au
www.plevin.com.au/plevin

Canadian National Harm Reduction Conference

22-24 November 2002
Toronto, Canada.
Registration: <http://206.108.4.21/registration/>
Information: CHRC c/o CASPER 1251 Jarvis Street Vancouver, BC V6E2E1
Tel : 250.704.2990 , Fax : 250.920.4221
E-mail : info@harmreduction2002.ca
<http://harmreduction2002.ca/>

European Conference: Search for quality in school based drug prevention

27-19 November 2002,
Hamburg, Germany
Information: www.school-and-drugs.org
Secretariat: Trimbos Institute - Unit International Affairs -
Tel: + 31.(0)30.297.1100 -
Fax: + 31.(0)30.297.1111 -
Email: ehsd@trimbos.nl.



On-line abstract submission is now ongoing at www.ihrc2003.net/abstract. Deadline is on 31 October, 2002. Details on the program, registration, scholarship and hotel booking are also available.

People realise now that we were right in our approaches, and that our opponents were wrong. IHRA and AHRN have grown to be respected organisations. The Centre for Harm Reduction is well acknowledged as leaders in providing technical assistance and support for harm reduction. The movement has grown from a handful to a large pool of harm reductionists, and we are still growing.

The International Conference on the Reduction of Drug

4th National Harm Reduction Conference: Taking Drug Users Seriously

1-4 December, 2002
Sheraton Seattle
Seattle, Washington
Organizer: The Harm Reduction Coalition (HRC)
Registration:
www.harmreduction.org/conference/confreg1.htm
Contact: Paula Santiago, at 212 213 6376, ext. 15
conference@harmreduction.org

Second international conference on substance abuse & HIV

3 December 2002
Mumbai , India
Organizer: The Hope 2002 International Conference on Substance Abuse and HIV
Information:
yusufmerchant@sanskritindia.com
www.hopeconference.org/Topicsofabstract.html
Registration:
www.hopeconference.org/registration.asp

Related Harm occurs each year and attracts more and more people. The next one, the 14th will be held in Chiang Mai in 2003, and we can expect to see new faces that have been attracted to the concept and philosophy of harm reduction.

Finally, as I step down from the Chair, I am not leaving AHRN but am giving way to newer and more competent colleagues who will take the harm reduction movement forward to even greater heights. *Viva la Harm Reduction.* Salaam.



AHRN Consultant Database

As an information and support network that links programs working on drug use and the prevention of HIV/AIDS from and within this community in Asia, AHRN is constantly approached to recommend experts in this field, locals in particular, for long-term or short-term appointments. It has also become increasingly focused on network-based solutions for scaling up harm reduction via training program and technical assistance through partnerships with other bodies, local and international.

This database will help us identify the right person(s) for the right assignments in:

- Advocacy
- Community development
- Crop substitution
- Drop-in center
- Drug education
- Drug substitution
- Drug treatment
- Education and training
- Information sharing
- Law enforcement
- Needle & syringe availability program
- Outreach program

- Peer education
- Training
- Research

Practitioners with extensive experience in harm reduction, especially those from the community, or a related field in a developing country, and an expertise in harm reduction supported by either a post-graduate or graduate qualifications are invited to register.

How to register

Fill-up the registration form in the next page and fax to +6653 894113. Or you can also register on-line at <http://www.ahrn.net/consultant.html>

Important

1. Keep your username and password. You will need them in updating your details on-line.
2. Update your details regularly.
3. This database is not for public use.
4. AHRN reserves the right to verify references provided and refuse those whose details are found void.

AHRN's privacy policy on the Consultant Database is available on-line.

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)

Job Title

Department

Organization

Postal Address

Phone

Email

Fax

Signature

AHRN Executive Committee

Tariq Zarfar
Chairman

Dr. Ben Karki
Dr. M. Suresh Kumar
Dr. Jaroon Jittiwutikarn
Ton Smits

Editorial Team

Ton Smits
Executive Director
Umesh Sharma
Training Officer
Irene Lorete
Information Officer and Editor
Thirawat Soisangwan
Management & Information Services Officer
Ekkachit Krekkiawan
Clearinghouse Assistant

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

P.O. Box 235
Phrasingha Post Office,
Chiangmai 50200,
Thailand
Tel: +66 53 223 624
+66 53 894 112
Fax: 66 53 894 113
Email: ahrn@loxinfo.co.th
Website: www.ahrn.net
ISBN: 1440-138X

For information and membership, send an e-mail to: clearinghouse@ahrn.net

Opinions expressed by contributing writers herein are not necessarily the views of AHRN. We welcome articles on new harm reduction initiatives, interventions and networks. Announcements and inquiries are most welcome. We may not have what you need sometimes, but we can direct you to those who can help.

AHRN Consultant Database Registration Form

Section 1. Please give us your details

PLEASE FAX TO +66 53 894 113

Title: _____
First Name: _____ Middle Name: _____ Last Name: _____ Sex: Male Female
Date Of Birth: _____ Country of Birth: _____ Nationality: _____
Address: _____ Suburb/City: _____
State/Province: _____ Country: _____ Post Code: _____
Contact Number: _____ Fax: _____ Mobile: _____
E-mail: _____ Alternative E-mail: _____
Web URL: _____ AHRN member: Yes No
Participate in AHRN E-Group: Yes No

Section 2. Education

	Year	Degree/diploma	Major/discipline	University/institute
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Section 3. Professional

1. Date from _____ to _____ Position _____
Employer Name _____ Organisation _____

Organisation Type (Please select one)

- Academic/research institute Donor Agency Government Health Care Organisation
 International NGO International Organisation Local NGO Multilateral Agency
 Private/business organisation Professional Organisation Religious Organisation Others, please specify

Brief Description of your duties _____

2. Date from _____ to _____ Position _____
Employer Name _____ Organisation _____

Organisation Type (Please select one)

- Academic/research institute Donor Agency Government Health Care Organisation
 International NGO International Organisation Local NGO Multilateral Agency
 Private/business organisation Professional Organisation Religious Organisation Others, please specify

Brief Description of your duties _____

3. Date from _____ to _____ Position _____
Employer Name _____ Organisation _____

Organisation Type (Please select one)

- Academic/research institute Donor Agency Government Health Care Organisation
 International NGO International Organisation Local NGO Multilateral Agency
 Private/business organisation Professional Organisation Religious Organisation Others, please specify

Brief Description of your duties _____

Section 4. Professional expertise

1. Expertise in:

- Community development Crop substitution Advocacy Drop in centre
 Drugs education Drug substitution Drugs treatment Education & training
 Information sharing Law enforcement Needle & syringe availability program
 Out reach program Peer education Training

in (country) and/or (region), please select one below:

- Africa Caribbean Central Asia East Asia
 Eastern Europe Latin America Middle East Oceania
 Pacific Commonwealth of Independent States (CIS) South Asia
 USA and Canada Western Europe



2. Expertise in:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Community development | <input type="checkbox"/> Crop substitution | <input type="checkbox"/> Advocacy | <input type="checkbox"/> Drop in centre |
| <input type="checkbox"/> Drugs education | <input type="checkbox"/> Drug substitution | <input type="checkbox"/> Drugs treatment | <input type="checkbox"/> Education & training |
| <input type="checkbox"/> Information sharing | <input type="checkbox"/> Law enforcement | <input type="checkbox"/> Needle & syringe | <input type="checkbox"/> availability program |
| <input type="checkbox"/> Out reach program | <input type="checkbox"/> Peer education Training | | |

In (country) and /or region, please select one below:

- | | | | |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> Africa | <input type="checkbox"/> Caribbean | <input type="checkbox"/> Central Asia East | <input type="checkbox"/> Asia |
| <input type="checkbox"/> Eastern Europe | <input type="checkbox"/> Latin America | <input type="checkbox"/> Middle East | <input type="checkbox"/> Oceania |
| <input type="checkbox"/> Pacific | <input type="checkbox"/> Commonwealth of Independent States (CIS) | | <input type="checkbox"/> South Asia |
| <input type="checkbox"/> USA and Canada | <input type="checkbox"/> Western Europe | | |

3. Expertise in:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Community development | <input type="checkbox"/> Crop substitution | <input type="checkbox"/> Advocacy | <input type="checkbox"/> Drop in centre |
| <input type="checkbox"/> Drugs education | <input type="checkbox"/> Drug substitution | <input type="checkbox"/> Drugs treatment | <input type="checkbox"/> Education & training |
| <input type="checkbox"/> Information sharing | <input type="checkbox"/> Law enforcement | <input type="checkbox"/> Needle & syringe | <input type="checkbox"/> availability program |
| <input type="checkbox"/> Out reach program | <input type="checkbox"/> Peer education Training | | |

In (country) and /or region, please select one below:

- | | | | |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> Africa | <input type="checkbox"/> Caribbean | <input type="checkbox"/> Central Asia East | <input type="checkbox"/> Asia |
| <input type="checkbox"/> Eastern Europe | <input type="checkbox"/> Latin America | <input type="checkbox"/> Middle East | <input type="checkbox"/> Oceania |
| <input type="checkbox"/> Pacific | <input type="checkbox"/> Commonwealth of Independent States (CIS) | | <input type="checkbox"/> South Asia |
| <input type="checkbox"/> USA and Canada | <input type="checkbox"/> Western Europe | | |

What kind of work would you be especially interested in doing ?

Preferred length of assignment

- Less than 1 month 1-3 months 3-6 months over 6 months

Section 5. Publication

	Title	Journal	Year	Co-author
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Level of Languages Proficiency

1. _____	Speaking & Listening	<input type="checkbox"/> Basic	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Fluent
	Writing	<input type="checkbox"/> Basic	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Fluent
	Reading	<input type="checkbox"/> Basic	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Fluent
2. _____	Speaking & Listening	<input type="checkbox"/> Basic	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Fluent
	Writing	<input type="checkbox"/> Basic	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Fluent
	Reading	<input type="checkbox"/> Basic	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Fluent
3. _____	Speaking & Listening	<input type="checkbox"/> Basic	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Fluent
	Writing	<input type="checkbox"/> Basic	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Fluent
	Reading	<input type="checkbox"/> Basic	<input type="checkbox"/> Intermediate	<input type="checkbox"/> Fluent

Section 6. List 3 referees (Not working in the same organisation)

	Name	Position	Organisation	Email or contact number
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Do you object to us contacting the referees ? Yes No

Additional Comments

Please identify your

User Name : _____ Password: _____

