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Proceedings of a Satellite Session on HIV prevention interventions for injecting drug users: Lessons learned from Asia

Organised by
the United Nations Regional Task Force on Injecting Drug Use
and HIV/AIDS for Asia and the Pacific

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11 May 2008
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This document is being made available in the form in which it was received. The observations and recommendations of this document reflect the outcomes of the Satellite Session on HIV prevention interventions for injecting drug users: Lessons learned from Asia at the IHRAs 19th International Conference in May 2008, in Barcelona, Spain. The designations employed and present of the material in this document do not imply the expression of any opinion whatsoever on the part of UNODC and UNAIDS concerning the legal status of any country, territory, city or its authorities, or concerning the delimitation of their frontiers and boundaries.

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Note by the Co-Chairs

The goal of the United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific (UN RTF) is to contribute to the reduction of HIV infection among and from injecting drug users in the Asia Pacific region by significantly increasing coverage of comprehensive HIV interventions through regional and country level advocacy, coordination, and use of strategic information for advocacy and policy dialogue.

The UN RTF also serves as a platform for exchange of information and lessons learned on successful programmes that have advanced the harm reduction agenda in the region.

Given the rapidly changing programme environment in Asia, the UN RTF organised a Satellite Session "Lessons learned from Asia" at the 19th International Conference organised by the International Harm Reduction Association (IHRA), 11-15 May 2008, in Barcelona, Spain.

As the Co-Chairs of the UN RTF, we are pleased to share with you the proceedings of the UN RTF Satellite Session. We sincerely hope that these Asian case studies will be of interest to all countries engaged in scaling-up comprehensive HIV prevention, treatment and care programmes for people who inject drugs and thus help to move towards achieving the national targets of the 2010 Universal Access Initiative.

Mr Gary Lewis
Representative
UNODC Regional Centre
for East Asia and the Pacific

Mr JVR Prasada Rao
Director
UNAIDS Regional Support Team,
Asia and the Pacific

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Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
AIMS	All India Institute of Medical Sciences
ARV	Antiretroviral Therapy
AusAID	The Australian Agency for International Development
DIC	Drop-in centre
DFID	Department for International Development
GFATM	The Global Fund To Fight AIDS, Tuberculosis and Malaria
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HRI	Harm Reduction intervention
IDU	Injecting Drug Use
IHRA	International Harm Reduction Association
LCCS	Low Cost Community Based Care and Support
M&E	Monitoring and Evaluation
MMT	Methandone Maintenance Treatment
MOLISA	Ministry of Labor, Invalids and Social Affairs
NAC	National AIDS Commission
NACO	National AIDS Control Organisation
NCAIDS	National Center for AIDS/STD Control and Prevention
NDDTC	National Drug Dependence Treatment Centre
NGO	Non-governmental organisation
NSP	Needle and Syringe Programme
OST	Opioid Substitution Therapy
PLI	Peer Led Intervention
PVLP	Peer Volunteer Lession Plan
RSRA	Rapid Situation and Response Analysis
SHARAN	Society for Service to Urban Poverty
SHG	Self Help Group
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS RST	Joint United Nations Programme on HIV/AIDS Regional Support Team for Asia and the Pacific
UNODC RCEAP	United Nations Office on Drugs and Crime Regional Centre for East Asia and the Pacific
UNODC ROSA	United Nations Office on Drugs and Crime Regional Office for South Asia
UN RTF	United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific
USAID	United States Agency for International Development
VAAC	Vietnam Administration of HIV/AIDS Control
VCT	Voluntary Counselling and Testing for HIV
WHO	World Health Organization
WHO WPRO	World Health Organization Western Pacific Regional Office

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Thanks are due to the UNAIDS Regional Support Team, Asia and the Pacific (UNAIDS RST) and in particular to the Director, Mr JVR Prasada Rao, who is also Co-chair of the United Nations Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific (UN RTF), in securing funding for the Satellite Session.

Technical expert member of the UN RTF, Dr Suresh Kumar drafted the conference abstract submission. UNAIDS, UNODC, WHO staff and Professor Adeeba Kamarulzaman were involved in identification of speakers from the countries.

The Satellite Session was chaired by Mr Christian Kroll, Global Coordinator, UNODC. Dr Fabio Mesquita, Technical Officer, Harm Reduction, World Health Organization Weatern Pacific Regional Office (WHO WPRO), summarised the key challenges and lessons learned as the Discussant at the end of the session.

The UNODC Regional Centre for East Asia and the Pacific (UNODC RCEAP) staff responsible for overall coordination of the Satellite Session was Dr Anne Bergenstrom, Coordinator of the UN RTF.

Finally, thanks to Mr Gary Lewis, Representative, Mr Gray Sattler, Regional Adviser (HIV/AIDS), of the UNODC RCEAP and Mr Cho Kah Sin, Regional Programme Adviser, UNAIDS RST, for their review of the document, and Ms Rattana Duangrapruen for coordinating the printing of the document.

Brief overview of the region

Over half of the world's 16.5 million opiate users (9.3 million) live in Asia[1], including an estimated 4.5 million people who inject drugs.[2] Unsafe injecting drug use, of mostly opiates, is a significant factor in determining the course of HIV epidemics of several Asian countries, particularly early on in the epidemic. Despite overall low rates of national HIV prevalence, several countries in the Asia region report high HIV prevalence among people who inject drugs. For example, HIV prevalence exceeding 40% has been reported among people who inject drugs in Indonesia, Myanmar and Nepal. In Cambodia, China, India, Malaysia, Pakistan, Thailand and Viet Nam, there are reports of overall HIV prevalence ranging from 5% to 35% among people who inject drugs, with large variation in sub-national HIV prevalence.[3] The Philippines, Bangladesh and Afghanistan report emerging epidemics among people who inject drugs, with prevalence of 1.0%, 1.4% and 3.4%, respectively.[4] Several countries, including Lao PDR, Maldives, Sri Lanka and Timor-Leste, have not reported HIV in this population.[5] In total, approximately 730,000 people who inject drugs in South, South East and East Asia are estimated to be HIV positive.[6]

Of the comprehensive package of HIV interventions, needle and syringe programmes (NSP), provision of opioid substitution therapy (OST) and other drug dependence treatment, along with voluntary counselling and testing for HIV (VCT) and antiretroviral therapy (ARV) for those who need it, have been found to have the greatest impact on HIV prevention and/or treatment and care in this population. Implementation and scaling up of these interventions, as demonstrated by China, Indonesia, Malaysia, Viet Nam, Bangladesh, India and Pakistan, are feasible in Asian settings. Yet, HIV prevention, as well as treatment and care, services for people who inject drugs remain politically controversial in some countries and use of services, such as needle-exchanges, carries the risk of exposing people who inject drugs to police harassment or arrest in a number of settings.

The overriding problem is simple. For people who inject drugs, the coverage of prevention, treatment and care services remains limited.[7] This indicates that the public health rights of majority of the people who inject drugs remain unmet in the Asia region.

At the same time, it is possible to show that some progress is being made in a number of countries in the region in recent years. Though most countries in the region have not yet developed a comprehensive prevention, treatment and care

[1] UNODC. 2008. World Drug Report.

[2] Mathers B, Degenhardt L, Phillips B, Wiessing L, Hickman M, Strathdee S, Wodak A, Panda S, Tyndall M, Toufik A, Mattick RP for the 2007 Reference Group to the UN on HIV and Injecting Drug Use. Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review. The Lancet, 372, 1-15.

[3] Ibid

[4] Ibid

[5] Ibid

[6] Ibid

[7] WHO, UNAIDS, UNICEF. Towards Universal Access. Scaling up priority HIV/AIDS interventions in the health sector. Progress Report. WHO 2008.

package for people who use drugs, some countries have addressed essential elements of a comprehensive national response to injecting drug use and HIV. Examples include the need for high level political commitment, supportive HIV law and policy, the scaling up of OST with methadone, and buprenorphine in South Asia, providing HIV interventions for people who inject drugs at multiple levels, prison interventions and reaching out to the sexual partners of people who inject drugs.

Since there are successful programmes in several countries in the Asia region, the UN RTF organised a Satellite Session on HIV prevention interventions for injecting drug users: Lessons learned from Asia at IHRAs 19th International Conference, in May 2008, in Barcelona, Spain to advance the cause of harm reduction in the region by highlighting key successes and to build consensus among the key decision makers towards a comprehensive and scaled up HIV response to HIV epidemics associated with injecting drug use.

Objectives of the satellite session

1. Showcase models that are successful, with positive outcomes, in scaling up of evidence informed harm reduction responses,
2. Highlight critical factors for effective implementation of harm reduction interventions for drug users and to,
3. Share challenges and barriers in scaling up and ways of overcoming those to achieve coverage.

Summary of the presentations

Dr Wenyuan Yin and Dr Zunyou Wu[8]

Scaling-up methadone maintenance treatment (MMT) in China

According to the Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China (2007), by 2007, 230,643 HIV/AIDS cases, including 66,392 AIDS cases, had been reported in China and it has been estimated that 700,000 (550,000-850,000) people are living with HIV/AIDS as of 2007. The HIV infection rate is 0.05% (0.04-0.07%). A total of 50,000 (40,000-60,000) persons were estimated to have become infected in 2007 and injecting drug use (IDU) is associated with some 42% of the new HIV cases. The main mode of transmission of cumulative HIV infections, as of August 2007, has been injecting drug use (39.1%) while sexual transmission accounted for 40.9% of new reported cases in 2007.

The number of current registered drug users is about 957,000 in China by the end of 2007. The Annual Report on Drug Control in China (2008) indicates that about 746,760 are heroin users and 72.5% inject drugs. The predominant choice of drug is heroin with some 78% of all drug users. The second most common type of drug used is "new type drugs", e.g., ecstasy (MDMA), Methamphetamine, Ketamine.

HIV infection among IDUs spread rapidly since 1995. Though the overall rate of HIV infection in IDUs was not high, but in some areas HIV rate among IDUs reached as high as over 80%, such as in Yining City, Xinjiang in 1999. The prevalence of HIV among IDUs remained high in areas where epidemic started early, such as in Yunnan, Guangxi and Xinjiang. There is a great variation in terms of HIV rate geographically.

The methadone maintenance treatment (MMT) programme in China has evolved from pilot to national scale. Prior to 2001 policy advocacy and development was the main focus. The Implementation Protocol was formulated in 2003 and has since evolved over time. The July 2006 Implementation Protocol has reduced the entry criteria, so that clients no longer needed a history of detoxification for entry, and a transfer system has been set up to meet the needs of those who are relocating either permanently or temporarily. The additional services provided include counselling, peer education, testing for Hepatitis C, referral to ARV treatment, Tuberculosis (TB) treatment, and psychosocial support.

Years 2004-2005 saw piloting of the MMT and since 2006 the programme has moved from piloting to rapid scale up resulting in a large scale national programme. From an initial eight MMT clinics in five provinces in 2004, there were 503 MMT clinics in 23 provinces as of December 2007. The number of clients has increased from 1,209 in 2004 to 97,554 in 2007.

[8] National Center for AIDS/STD Control and Prevention, Chinese Center for Disease Control and Prevention.

The evaluation of the MMT programme found that an estimated 255 new HIV infections were averted due to 204 MMT clinics having opened 90 days ahead of the planned schedule. The follow-up survey of 128 clinics also found a significant reduction in reported injecting drug use in the previous month, a decrease in drug related criminal offences in the previous three months, an increase in employment among the clients, a reported improvement in family relations, and overall high levels of satisfaction with the treatment.

Law enforcement sector has played a supportive role in the scale up of the MMT programme. The Article 27 of the HIV/AIDS Regulation, effective since 1 March 2006, states that *the departments of Health, Public Security and Food and Drug Administration of the people's governments in Provinces, Autonomous Regions, and Municipalities shall jointly, based on their local situation of drug use and HIV/AIDS epidemic, implement community-based drug-maintenance treatment as well as other effective intervention programme for drug users*.

China's Action Plan for Controlling HIV/AIDS (2006-2010) has set a target of >70% of urban areas being covered with MMT sites, and >50% of rural areas having needle and syringe programme (NSP) set up, by year 2010.

Lessons learned in scaling up MMT programme from pilot to national scale highlighted the critical role of political commitment of the government, multi-sectoral cooperation, capacity of clinical staff required to deliver quality services and importance of involvement of family members and peers in the promotion and improvement of MMT services. The lessons learned also unearthed a need to expand access to MMT service through mobile service delivery to those people who inject drugs with limited access to existing MMT services and the need to establish incentive mechanisms at clinics to reduce drop-out rates. Furthermore, the need for a web-based managements system to enable temporary migration and need to integrate technical support to monitoring and evaluation (M&E) and use of information collected during site visits to improve services was highlighted as a lessons learned. International cooperation was also reported as key during the scale up of the programme.

Key challenges ahead were reported to range from the need to enhance capacity of the staff involved, expand MMT service to large scale to achieve expected impact, increase retention rate to prevent relapse, addressing co-infection with HIV, TB and Hepatitis C Virus (HCV), and building the MMT clinics into platforms for comprehensive service delivery, including social support.

Dr Nafsiah Mboi[9]

HIV interventions for drug users at multiple levels: A case study from Indonesia

As the world's largest archipelago, Indonesia has over 17,000 islands and, with the population of 230 million people, is the world's fourth most populous nation after China, India and the US.

The first case of AIDS was diagnosed in 1987. As of March 2008 a cumulative total of 11,868 AIDS cases has been reported. The HIV epidemic in Indonesia is diverse. By 2008, several provinces had a concentrated epidemic, with over 5% most at risk populations infected with HIV, while the 2 provinces of Tanah Papua reported a low level generalized epidemic. The national prevalence is low, but masks high HIV prevalence in some sub populations, for example 48% of people who inject drugs in East Java, 22% of sex workers in Sorong, West Papua, and 25% of prisoners in Jakarta.

According to national estimates, between 190,000 and 247,000 persons are injecting drugs. The first harm reduction programme was initiated by a non-governmental organisation (NGO) in Bali in 1998.

In 2007, Indonesia updated its National Strategy 2007-2010, including development of a costed action plan. The approach adopted is one of an integrated system with distinct actions to be implemented at multiple levels. For example, the HIV prevention programme consist of comprehensive interventions, ranging from NSP, MMT, condom promotion on one hand, behaviour change interventions on the other hand, and primary health care, VCT, sexually transmitted infection (STI) management and addiction treatment for those who need them. Creation of an enabling environment forms the backdrop for implementation of these interventions aimed at reaching people who inject drugs, their sexual partners, and prisoners.

The stakeholders involved at district and city levels include district/city AIDS Commissions, local authorities, police, Narcotics Board, prison authorities, local hospitals, community health centres, NGOs working with people who use drugs and, networks of people who used drugs. These key players are engaged in provision of harm reduction services in health care settings and in prisons, outreach activities and collaboration on creation of an enabling environment for harm reduction programmes.

The stakeholders engaged at provincial and national levels include government authorities, law, health and harm reduction services, Narcotics Board, local hospitals and networks of people who used drugs (The National Network of Drug Victims) and NGOs working with people who use drugs. The national and provincial level activities range from provision of guidance, technical assistance, setting regulations, creation of an enabling environment, resource mobilization and development and strengthening of systems for a longer term response.

[9] Secretary, Indonesian National AIDS Commission.

People who used drugs are actively engaged in policy making (e.g. Input on National Strategy regarding drug use, anti discrimination bill and amendment to narcotics and psychotropic bill). People who used drugs also participate in the Working Group of Harm reduction in the National AIDS Commission (NAC) Secretariat and they have organised to respond to violation of their human rights.

Achievements to date include an increase in the number of NSPs from four in 2002 to 119 in March 2008 and increase of number of methadone clinics from two in 2003 to 24 in seven provinces in 2007. By March 2008, 1,805 people were receiving methadone maintenance treatment. The plan is to have 120 operational methadone clinics, located in a hospital setting, community health centre and in prisons/detention centres, by 2010.

There are at least 78 NGOs with specific harm reduction activities and 274 peer support groups for people living with HIV across 31 provinces and 86 cities or districts. Many of these support groups have been started by people who used drugs.

Funding for harm reduction interventions, in addition to that allocated by national and local governments, has been received from Global Fund To Fight AIDS, Tuberculosis and Malaria (GFATM), Indonesian Partnership Fund with an initial grant from the Department for International Development (DFID), The Australian Agency for International Development (AusAID) and United States Agency for International Development (USAID).

Pressing challenges include rapid spread of HIV, in particular among people who inject drugs, calling for an emergency response in terms of the need to scale up interventions while building systems for a longer term response. Yet, resources available are uneven. Effectiveness and quality of services and programmes is another challenge and finally, the need to increase political commitment of the national and local government to mobilise domestic resources and gradually decrease over-reliance on donor partners.

In conclusion, strong collaboration between government and civil society is crucial and both national and local governments commitment is needed to ensure ownership and sustainability of the harm reduction programme. Furthermore, people who used drugs can and do play a critical role in policy making, planning and implementation, and civil servants, including police, and prison officials can learn to work to respect the rights of people who use drugs. International support, other than financial, is also important.

Mr Wan Mohamad Nazarie Wan Mahmood[10]

Harm Reduction: Initiating Methadone Maintenance Therapy (MMT) in Prisons in Malaysia

The Government of Malaysia is concerned about the extent of drug use, with estimated 250,000 drugs users, and considering drug use as a national threat aims to achieve a drug free society by 2015. According to a WHO estimate, some 118,000 persons inject drugs.

The number of reported HIV/AIDS cases has increased from 3,000 in 1993 to over 64,000 in 2004, to 80,000 in 2007. Up to 75% of these HIV infections have been due to injecting drug use while the mode of transmission for the remaining HIV infections has predominantly been heterosexual transmission.

In recognition of the need to address the injecting drug use related HIV epidemic, the Ministry of Health in 2005 responded by distribution of condoms and clean injecting equipment to 30,000 drug users.

The MMT programme was launched in Malaysia in 2005. Since then, the programme has extended from an initial of four project sites to 18 sites. The Ministry of Health plans to have 15,000 individuals on the MMT programme by 2010 and it is widely recognised that the MMT programme will have a positive impact on the overall harm reduction programme in Malaysia.

There are 36,937 prisoners in Malaysian prisons, 94% of whom are male and 36% of whom are foreigners, respectively. Drug related offences account for 33% and drug related crimes to 60%. Of the prisoners, 1,477 (4%) are living with HIV/AIDS.

In 2006, the Prisons Department showed leadership in deciding to implement the MMT programme in prisons. The general objective of the MMT programme in prisons is to reduce drug dependency among the prisoners following the release. The specific objectives of the programme are to reduce relapse and recidivism, stabilise the lives of prisoners who are dependent on heroin or addicted to drugs, to reduce harms associated with drug use and to reduce transmission of HIV. The MMT programme also has the objective of increasing self-confidence and productivity of the prisoners and to create a safe environment when the prisoners return back to society.

The MMT programme in prisons began with a pilot, involving 50 prisoners, in Pengkalan Chepa Prison on April 2008. The MMT programme is accredited by the Ministry of Health of Malaysia with the support of Malaysian AIDS Council. The treatment consists of Methadone dosing and individual counselling sessions. In addition, participants in the programme received a group briefing, group counselling and a briefing by a pharmacist before taking Methadone.

The criteria for entry in the MMT programme are: at least two years of opiate addiction before imprisonment, a minimum of 3-6 months of incarceration before

[10] Deputy Director General, Prison Department, Malaysia.

release, and support from family. Priority is given to inmates living with HIV/AIDS. The standard operating procedure involves an initial interview, assessments, a physical examination, TB screening and enrolment in the MMT programme.

The initial dose of Methadone is 5 mg in liquid form for a period of 3-4 days, after which the dosage is increased to 5 mg gradually. Once the individual is stabilised with the dose they will receive 60-80 mg per day. The hours of operation of the MMT programme are from 9.00 am to 11.00 pm every day and the service is managed by medical offer or pharmacist. A week prior to release, the inmates will attend to treatment at government hospitals and clinics. Following release, the individuals may continue MMT at any government hospital or clinic where the service is available.

In conclusion, the success of the programme is due to strong collaboration and cooperation among related agencies, the society and the families of the inmates. The MMT programme in prisons will benefit not only the prisoners but the community and society as a whole.

Mr Salman ul Hasan Qureshi[11]

"The Hidden Truth" – Findings of a study of HIV vulnerability, risk factors and prevalence among men injecting drugs and their wives – Pakistan

The objective of the study was to assess HIV vulnerability, risk factors and prevalence among men who inject drugs and their wives. Specifically, the study aimed to examine vulnerability of wives because of injecting behaviours of their husbands, assess vulnerability and risk of HIV infections among wives of men who inject drugs, assess the financial and social burden of drug use and HIV on households of people who inject drugs, explore the nature of the sexual and injecting contacts between the husbands and their wives and study the current prevalence of HIV among wives of men who inject drugs in Sargodha, Faisalabad and Lahore.

Participation criteria were married men, aged 18 or above, currently injecting drugs, who consented to participate in the study and agreed that the study team could approach their wives for the purposes of the study and wives of currently injecting IDUs who consented to participate in the study.

There are an estimated 125,000 street-based people who inject drugs in Pakistan of whom 50% are currently married. The number of registered people who inject drugs in the three cities included in the study is 3,245 in Sargodha, 4,976 in Faisalabad and 2,790 in Lahore, respectively. HIV prevalence among people who inject drugs in these three cities ranges from less than 10% in Lahore to 50% in Sargodha.

Among wives of HIV positive husbands HIV prevalence was 5% in Sargodha, 15% in Faisalabad and 10% in Lahore, respectively.

In view of the low level of education of the men and women the study recommends provision of simple, practical and easy-to-understand verbal or visual information and knowledge to the wives to enable themselves to protect themselves from HIV. The study findings indicate that extreme poverty, no education and no access to information or health care services makes families more vulnerable and puts individual family members at risk of contracting HIV.

Interviews on sexual behaviour of the couples found that most drug users are sexually active despite chronic drug use, which is presumed to lead to reduced frequency of sex. The risk of HIV transmission due to unprotected sex between husbands and their wives is clearly evident.

Among study participants, over eighty per cent (80-90%) of the husbands and over forty per cent (43-61%) of their wives claimed to have heard about HIV or AIDS. However, knowledge of transmission and ways to prevent transmission was weak.

Over 70% of the wives reported that condom was not used in most recent sex with husband and the study therefore suggests that wives of husbands who inject drugs are at risk of acquiring STIs and HIV due to unprotected sex with their husbands.

[11] Deputy Program Manager, Nai Zindagi, Pakistan.

Between twenty to thirty five per cent of all (men and their wives) reported symptoms of STIs in the last 6 months. There was also evidence of extra marital sex, as reported by study respondents. The number of respondents engaged in extramarital sex was very low, however, transmission of HIV to the general population through sex cannot be ruled out. The study recommends for condom education and distribution to be conducted with both members of the couple together and that prevention of HIV transmission among men who inject drugs must include a range of measures that minimise the adverse consequences of poverty, drug use and HIV on affected children.

The study concluded the following. There is evidence of sexual transmission of HIV from married men who inject drugs to their wives, an estimated 60,000 wives and 240,000 children are vulnerable and at risk of HIV transmission and drug use related harms in Pakistan. These numbers could drastically increase if the remaining 250,000 non injecting drug users shift to injecting drugs. Wives of men who inject drugs are the second most-at-risk group known to date in Pakistan followed by men who have sex with men, female, male and transgender sex workers and adolescents engaging in drug use. There are currently no services for wives and children of men who inject drugs in Pakistan. The study concludes that established service delivery packages to prevent HIV among street-based male injecting drug users must include essential services for wives and children as a matter of urgent priority.

Dr Nguyen Dac Vinh[12] and Dr Nguyen Thi Huynh[13]

High level political commitment and enacting HIV laws for effective implementation of harm reduction interventions in Viet Nam[14]

In Viet Nam, the first case of HIV was detected in 1990, and by December 2007, 121,734 people have been diagnosed with HIV. Cumulative number of deaths due to AIDS is 34,476. The majority of HIV cases are identified among the age group 20-39, accounting for 80% of all HIV infections and increasingly new infections are being identified among young persons. Injecting drug use has been associated as the main mode of HIV transmission in 50% of the cases. HIV prevalence among people who inject drugs increased from 18.3% in 1994 to 29.4% in 2001 and 2002, and has since reduced to 23.2% in 2006. Some provinces and cities report very high prevalence at 54.5% in Quang Ninh, 47.6% in Ho Chi Minh City, 46.3% in Hai Phong, 45% in Can Tho, 40.8% in Thai Nguyen and 36.83% in Đien Bien, respectively.

On 29 June 2006, the National Assembly enacted a Law on HIV/AIDS Prevention and Control No. 64/2006. The Law on HIV/AIDS Prevention and Control.

The HIV law consists of six chapters and 50 articles. Article 2, Item No. 15 which states that *harm reduction intervention measures in the prevention of HIV transmission include: propaganda, mobilisation and encouragement of the use of condoms, clean syringes and needles, treatment of addiction to opium-related substances with substitute substances and other harm reduction measures in order to facilitate safe behaviours to prevent HIV transmission*.

Article 21 gives recognition to the role of harm reduction intervention measures to prevent HIV transmission and states that harm reduction intervention measures to prevent HIV/AIDS transmission shall be implemented among target groups with risky behaviours through programmes and projects suitable to socio-economic conditions and that the Government shall provide for the organisation of implementation of harm reduction intervention measures to prevent HIV.

On 26 June the Government's Decree No. 108/2007/ND-CP was passed detailing the implementation of a number of articles of the Law on HIV/AIDS prevention and control. The Decree includes: 6 chapters with 23 articles, including Artilcle 4: Harm reduction intervention measures in the prevention of HIV transmission, such as provision of condoms and guidance on condom use provision of clean needles and syringes and guidance and treatment of opiate addiction with substitution drugs.

Activities on harm reduction intervention in the prevention of HIV transmission in Viet Nam to date have included distribution of over 5 million syringes and needles, distribution of over 70 million condoms, over 165.954 medical examination for individuals at high risk and treatment for over 68,000 persons.

[12] Chief of Scientific Research and International Cooperation Department, The Vietnam Administration of HIV/AIDS Control (VAAC).

[13] Chief of Harm Reduction Department of the Vietnam Administration of HIV/AIDS Control, Ministry of Health of Viet Nam.

[14] This proceeding is a resource from Vietnam Administration of HIV/AIDS Control (VAAC).

The pilot project of treatment of opioid substance dependence by Methadone substitution therapy has been approved by the Ministry of Health in December, 2007. The programme has been carried out at six different sites of Hai Phong and Ho Chi Minh cities and it is estimated that approximately 1,500 heroin dependent persons will benefit from the pilot programme. By 2010 it is expected that the methadone programme will be expanded to other eight provinces.

Challenges in the country include absence of harm reduction programmes in 20 provinces, limited coverage rate of the harm reduction programme, such as 10-15% of people who inject drugs having been reached with a NSP. It is recognised that the inter-sector collaboration is not sufficiently strong and there is lack of consensus and coordination among Ministries of Health, Public Security and Labor-Invalids-Social Affairs. Other challenges include lack of size estimations of number of people who inject drugs, shortage of staff working in harm reduction interventions (HRI), regular rotation and changes of staff have affected organisation of HRI deployment, limited availability of resources available for harm reduction programmes. High level of stigma and discrimination towards people who inject drugs further hamper programme implementation.

Lessons learned include critical role of local authorities in successful implementation of the harm reduction interventions, need for inter-sectoral collaboration and the need for support and involvement by the public security and Ministry of Labor, Invalids and Social Affairs (MOLISA). In addition, expansion of intervention activities is extremely crucial in order to increase the coverage of the programme and increasing the proportion of people who inject drugs being reached by the programme.

The plan of action by the Government of Viet Nam on the national HIV programme consists of strengthening the condom programme, maintaining and expanding the NSP programme, including education on safe injecting, diversification of forms of syringe and needle distribution to improve reach of the programme and which best facilitating the injecting drug users to reach the programme, and, based on the success of pilot MMT programme, expansion of the programme to eight additional provinces/cities.

Ms Ashita Mittal[15]

Diffusion of pharmaceutical injecting in South Asia: Challenges in containing the dual epidemic

In South Asia, injecting of pharmaceutical drugs, such as heroin and buprenorphine, has been increasingly reported and unsafe injecting practices remain one of the key factors in the spread of HIV in India, Nepal, Pakistan and Bangladesh. The estimated number of people who inject drugs in South Asia is as follows: 20,000-40,000 in Bangladesh, 96,000-190,000 in India, 1,600 in Maldives, 16,500-23,200 in Nepal, 125,000 Pakistan and Sri Lanka, respectively. No estimate is available in Bhutan.

Commonly abused pharmaceuticals in South Asia include Buprenorphine, Dextro-propoxyphene, Codeine-based cough syrups, Diazepam, Nitrazepam, injectable opiates like Morphine, Pethidine and Pentazocine (Fortwin*), Promethazine (Phenargan*) and Chlorpheniramine (Avil[16]).

India produces some 10% of world's pharmaceuticals are mainly abused in India, Bangladesh, Pakistan and Nepal due to widespread over the counter availability. Though their production and sale is regulated by law and there is a greater need for monitoring compliance with law. Internet-based pharmacies are a growing menace. Counterfeiting of brand products is becoming a major source of supply for illicit trade and it is estimated that 25-50% medicines consumed in developing countries are fake.

Evidence of diffusion of pharmaceutical drug is available from four recent studies; Rapid Situation and Response Analysis (UNODC, 2007), Knowledge Attitude and Practices of drug users in India, SPYM (2006), Substance Use Amongst Women and HIV/AIDS risk (SWAHA) (2007) and a study of HIV in partners of drug users (Panda, 2005).

The Rapid Situation and Response Analysis (RSRA) involved a survey of 9,465 people who inject drugs, including 8,819 men and 646 women in five countries in South Asia, namely India, Bangladesh, Nepal, Bhutan and Sri Lanka. Respondents from all countries in South Asia reported ever injecting including heroin, buprenorphine and propoxyphene. The study highlights that in Nepal nearly 76.6% of respondents reported ever injecting buprenorphine and 11.3% reported ever injecting propoxyphene. Similarly, in India in sample of 5,800 drug users over 25% reported ever injecting buprenorphine and over 29% propoxyphene. Similar trends were observed in Bangladesh. The study also reported cocktailing of a combination of pharmaceuticals by injecting drug users. High risk injecting practices and risky sexual behaviour was reported by injecting users that can have a significant impact on the spread of the HIV epidemic in the countries.

The study on Knowledge Attitude and Practices of drug users in India commissioned by SPYM involved 3,059 people who inject drugs through data collected in 144 sites in India. Most common drugs injected were buprenorphine and cocktail of

[15] Senior National Programme Officer, UNODC Regional Office for South Asia (ROSA), India.

[16] The trade names mentioned do not imply a pejorative connotation.

pharmaceuticals. Reported sharing (ever) was 40% and 33% reported not having cleaned injection equipment before sharing. On last occasion 76% had shared injecting equipment.

The study on Knowledge Attitude and Practices of drug users in India, SPYM, assessed the situation in eight states (Arunachal, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura) in North East India in 2006. Total sample size was 4,157 people who inject drugs and data were collected from 93 sites. The most common drugs injected were reported to be Heroin (64%) and Spasmoproxyvon (42%). Some 80% of drug users reported having ever shared injecting equipment and 28% reported not having cleaned injection equipment before sharing: 28%.

Substance Use Amongst Women and HIV/AIDS risk (SWAHA) study commissioned by UNODC ROSA involved 110 NGOs throughout India and covered 4,401 women partners of male substance users (non substance using partners) and 1,865 women substance users. Drugs used included dextropropoxyphene 341 (18.3%), Cough syrup 154 (8.3%), buprenorphine 79 (4.2%), sleeping pills 292 (15.7%). Of 587 injectors majority injected heroin or dextropropoxyphene, followed by buprenorphine. Mean age at first use of pharmaceutical drugs ranged from 19.3 year (cough syrup) to 22.5 years (buprenorphine).

Prescription opiates and other drugs are common drugs of misuse by women throughout the country yet women substance users have very little knowledge of harm minimization and women partners and women substance users are unable to negotiate safe sex. There seems to be a rapid progress to injecting and in some cases, initiate with injecting drug use and unsafe injecting practices are common.

A study of HIV in partners of drug users (Panda et al., 2005[17]) explored sexual transmission of HIV from and among men who inject drugs and their sex partners, India. The study found a 16% HIV prevalence among the regular sex partners of HIV positive men who inject drugs (heroin or buprenorphine injectors).

The impact of pharmaceutical drugs includes harms similar to other illicit drugs, if non-injectable, when injected, abscesses and increased risk of HIV transmission. Challenges in terms of injecting pharmaceutical use include: increasing hidden population of people who use drugs, denial in a community increases as home based population increases, possible changing profile of drug users, smaller cohorts resulting in a need to rethink programme models for dispersed population for prevention and care services and tracking the spurious market and diversions from licit into illicit.

Programmatic measure that need to be taken include understanding the range and extent of the problem, including extent of "cocktailing", determining prevalence of injection related injury and disease, assessing treatment options available, including substitution interventions are needed for cocktail injectors and determining ways to minimise the medical consequences of unsafe injecting.

[17] Panda, Kumar et al. (2005). Acquired Immune Deficiency Syndrome, Volume 39(1), May 1.

Furthermore, there is a need to act by using existing infrastructure and to reach out with oral substitution programmes to people who inject pharmaceutical drugs, reduce diversions and prevent abuse, improve public health system to reduce self medication, provide public information on services, build capacities of service providers to deal with pharmaceutical abuse related health complications and to establish lateral linkages with ARV, TB, Hepatitis programmes. Reaching out with programmes for Pharmaceutical IDUs is critical in the overall response to HIV in South Asia.

Ms Harsheth Virk[18]

Reaching and providing harm reduction services for drug users and their sexual partners: South Asian experience

In South Asia the HIV epidemic is driven by HIV transmission among vulnerable groups, including people who inject drugs, sex workers and men who have sex with men. In Bangladesh, Nepal and North East India, HIV transmission associated with injecting drug use ignites sexual transmission, which is maintained by HIV transmission among sex workers and their clients. In other parts of India HIV epidemics are mostly associated with heterosexual transmission, and it is understood that HIV prevention programmes aimed at people who inject drugs play a role in curtailing sexual epidemics.

Main obstacles for scaling up HIV prevention, treatment and care programmes for people who inject drugs in South Asia include lack of a conducive legal and policy enabling environment for service providers, limited availability of comprehensive services (including oral substitution with methadone or buprenorphine and referral services for treatment), insufficient coverage of people who inject drugs with HIV programmes (ranges 5-40%) and poor quality of needles/syringe exchange programmes (often less than 1 needle per person per week, accompanied with inadequate health education).

Opportunities in South Asia include the following: HIV is preventable and 99.6% of people in South Asia are uninfected, HIV epidemics are containable with better use of existing knowledge, focus, implementation and coverage, epidemic are concentrated locally, opportunity for early action to prevent new infections with targeted interventions for individuals at high risk of infection.

The goal of the "H13" regional project, implemented by UNODC ROSA is to reduce the spread of HIV among drug using populations in SAARC countries. The Phase I of the regional project has consisted of a preparatory phase (2003-04), programme phase (2004-06), extended phase (2006-07), leading to Phase II from 2007 onwards. Phase I lays the base for comprehensive intervention and was carried forward in Phase I extension.

Phase I commenced with a Rapid Situation and Response Analysis (RSRA), involving a baseline of 250-300 current users and 150-200 regular sex partners. Other components included Peer Led Interventions (PLI) of 250-300 current users and 150-200 regular sex partners, Low Cost Community Based Care and Support (LCCS) with 75 current users, with three camps held annually, setting up drop-in centres attended by 250 current drug users receiving abscess treatment and Self Help Groups (SHG) were formed for partners of drug users, and piloting opioid substitution treatment with 45 drug users.

The total number of drug users surveyed in five countries (Bangladesh, Bhutan, India, Nepal, Sri Lanka) is 9,465 and the number of regular sex partners surveyed in the five countries was 4,612. Reported injecting drug use ranged from four per cent

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in Sri Lanka to 61% in India and 80% in Nepal. Of those who reported injecting drug use, between 10%, in Sri Lanka, and 51%, in India, reported having lent their injecting equipment, and between three per cent, in Sri Lanka, and 51%, in India, reported having shared other paraphernalia. In India, the reported extent of injecting of drugs had increased from 43%, as per findings of the RAS in 2002, to 61%, as per the findings of the H13 RSRA, in 2005.

Another component of Phase I was a focus on enabling men who inject drugs and their regular sex partners to discuss issues in "non-threatening" environment which was aimed at increasing safer practices among injecting drug users and their sex partners. The process involves building capacity among outreach staff to address the following areas: how to do PLI, Positive Living, RSRA, Peer Volunteer Lesson Plan (PVLP), OST, LCCS, basic health, drugs and HIV, IEC, services, drug users rights, harm reduction, overdose management etc. So far, over 13,000 men who inject drugs and their sex partners have been reached and a total of 30 regional/national trainings have been conducted, and 500 staff trained.

By April 2007, 25 Drop-in centres (DICs) had been established and during November 2006 and April 2007, a total of 7,155 referrals had been made, 5,369 abscesses treated and 173 support groups convened.

In Nepal, in term so of the Safer Practices component of the project, the focus is on scaling up NSP, assisting in the procurements of a harm reduction package, training on PVLP, and Methadone Maintenance Treatment (MMT) which is explained subsequently.

In India, the project established collaboration with a Regional Learning Centre, AIIMS, New Delhi, and five participating centres (NDDTC, AIIMS, SHARAN, Calcutta Samaritans, SASO and Presbyterian Hospital) for scaling up OST. Inclusion criteria for the project supported OST programme include: age >18 years, opiate dependent for at least 5 years, having failed at least two abstinence attempts, not currently on medication. Women and those on ARV were also included during the January – December 2006 pilot. The 9 month findings of the pilot OST programme found a significant reduction in reported drug use (from 28% at baseline to less than two per cent at 9 month follow-up), reported injecting drug use (from 52% at baseline to 14 per cent at follow-up), reported sharing of injecting equipment (from 42% to 15%) and an increase in reported condom use with casual partners (from 77% to 96%).

The project aims to facilitate a transfer of the OST pilot to make it part of the Indian Government's national programme, the National AIDS Control Organisation (NACO) asked UNODC to carry out an evaluation of 48 OST sites in India. This was conducted based on criteria set by Expert Group, and it was completed over a 3 weeks period. 33 of the 48 sites were taken over by NACO as part of their programme. In Nepal, UNODC has been supporting an Emergency Response with MMT being delivered through an institutional model with a social support unit for 100 clients.

In summary, the Phase I is characterized by government buy-in in all countries, a gender-driven response, institutionalization of capacity-building, finalization and

field testing of toolkits and use of findings from demo sites to advocate for a scaled up response.

The Phase II consists of a preparatory phase (2007-08), programme phase (2008-2010), mid term evaluation (in 2009), realigned programme phase (2009-2012) and final evaluation in 2012. The scale up will be achieved by ongoing advocacy to support scaled up and comprehensive responses, focus on comprehensive risk reduction approaches for men who inject drugs and their regular sex partners, scaled up risk reduction interventions implemented by national governments, efficient and effective management and coordination of Project.

While advocating for a comprehensive programme, Phase II of the project will operate in different countries with varying intensity depending on the status of the epidemic in that country, so that more intensive involvement in catalysing scaled up responses will be the focus in Bangladesh, Nepal, Pakistan and India while a lower threshold approach will be adopted to pursue certain intervention elements in Sri Lanka, Maldives and Bhutan.

Increasing technical capacity will be a key focus area, and training will be implemented through institutional mechanisms established or strengthened by the project. Another focus area will be OST and the project plans to advocate and influence decision makers and community leaders to accept pragmatic and evidence-based approaches to deal with injecting drug use related HIV. Increasingly, the national partners will become more autonomous.

The project is being implemented with recognition to the evidence that HIV prevalence among people who inject drugs does not decline as swiftly as it rises and that it takes 7-10 years before a substantial drop in prevalence is observed. The recommendations therefore include the following: need for programmes that reduce drug injecting, promotion of use of sterile equipment when injecting occurs and encouraging safe sex among people who inject drugs and their partners. Furthermore it is recognised that as risk of HIV transmission in closed settings is particularly high there is a need to scale up HIV interventions in prison settings, interventions should be of sufficient scale and effective interventions irrespective of cost should be prioritised and funded from AIDS budgets.

Future plans of the project include collaboration with stakeholders to work on costing of interventions to achieve universal access, obtain additional funds to meet the universal access targets, strengthen procurement systems, build capacity for scaled up response, advocate for Methadone/Buprenorphine to be included in essential list of medicines and to develop country level OST policies.

Conclusions

It is evident from the information presented during the meeting that scaling up national HIV prevention programmes for drug users is feasible in a relatively short time frame in Asian settings. The rapid scale up of the national MMT programme in China, from eight sites in 2004 to 503 sites in 2007, demonstrates that significant progress is being made in terms of increasing geographic and programmatic coverage of essential harm reduction interventions in the Asia region.

National responses to HIV epidemics associated to injecting drug use, as highlighted by the presenters, included a number of key components.

First, as reported by the Government of Viet Nam, a supportive HIV law and an enabling policy environment, inter-sectoral collaboration and support of the public security sector, were reported as critical to successful scaling up of the national harm reduction response.

The second essential element, reported by the Government of Indonesia, was strong collaboration between the national and local government with civil society and that engagement of drug users is essential in the policy making, planning and implementation of harm reduction responses.

Thirdly, the presentations from India and Pakistan highlighted the high HIV risk and vulnerability of the sexual partners of men who inject drugs. This is evidenced by the high level of sexual risk behaviour among couples. The result is a high rate of HIV prevalence among non-injecting wives and sexual partners of men who inject drugs. It is important to note that the presentation drew attention to the current situation where HIV prevention services for female partners of male drug users were either completely absent, or limited in scale. Existing services therefore need to ensure that sexual partners and children of drugs users are reached with required services.

Fourth, diffusion of pharmaceutical injecting was reported as an entrenched challenge in countries in South Asia. It was evident that harm reduction programmes need to adapt to changing and emerging patterns of injecting drug use. There is a need to understand the extent and range of pharmaceutical injecting and well as how to use the existing infrastructure to address this phenomenon.

Finally, it is critical to make essential harm reduction services available for people who live in custodial settings. This was reported by the Government of Malaysia in the presentation on scaling up MMT programme in prisons. The presentation concluded that MMT programme in prisons will benefit not only the prisoners, but the entire community.

Satellite Session abstract submission (October, 2007)

Satellite Session

Theme: HIV prevention interventions for Injecting Drug Users: Lessons learned from Asia

Organised by the UN Regional Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific

Date: Sunday, 11 May 2008

Venue: Room 12

Time: 10:00-15:00
[Morning session: 10:00-12:10; Lunch: 12:10-13:10; Afternoon session: 13:10-15:00]

Background:

Unsafe injecting drug use is a significant driving factor in the HIV epidemics of several Asian countries. Reducing the sharing of injecting equipment and providing substitutes for injected drugs are the most effective ways to reduce new infections among IDUs. These approaches can be effective in Asian settings, as examples from China, Viet Nam and Bangladesh, among others, show. However, HIV prevention (as well as treatment and care) services remain politically controversial, and using services (such as needle-exchange projects) often carries the risk of exposing persons to police harassment or arrest in some settings. Though many countries in the region are yet to develop a comprehensive prevention, treatment and care package for drug users, some countries have addressed critical issues like high level political commitment, law, scaling up of opioid substitution therapy with methadone, providing HIV interventions for IDUs at multiple levels, prison interventions and reaching out to the sexual partners of IDUs. Since there are successful programmes in some countries, countries in the region as well as other parts of the world can benefit from the successful experiences in Asia.

Some key questions for this session:

1. Discuss different factors that are critical for effective implementation of harm reduction interventions for drug users
2. Discuss challenges and barriers in scaling up and ways of achieving coverage
3. Showcase models that are successful, with positive outcomes.

Further, the following will be discussed:

1. What should be the main elements of a comprehensive prevention, treatment and care package for injecting drug users?
2. Which key stakeholders must be won over to such an approach, and how can that be achieved?

3. What environmental interventions (e.g. relating to law enforcement strategies and practices etc.) must be put in place to ensure higher coverage and maximum impact? Is this feasible in Asia? What kind of legal approach will support and facilitate effective large scale programmes?
4. Is it possible to identify, and does it make sense to try and target prevention efforts at populations at risk like the sexual partners of drug users?
5. Should methadone maintenance therapy for injecting drug users be a standard part of HIV prevention strategies in countries where injecting drug use features in the epidemic? If so, what steps should be taken to ensure that this forms part of harm reduction programmes?

Format:

Invited speakers would be presenting on the successful case studies from different countries in the region. Each presentation will be followed by discussion from an invited discussant and from the floor.

Speakers:

Moderator: **Mr Christian Kroll**, Global Coordinator, UNODC

1) Scaling up methadone maintenance treatment (MMT) in China.
Speaker: **Dr Wenyuan Yin**, Department of Health Education and Behavior Intervention, National Center for AIDS/STD Prevention and Control (NCAIDS), Chinese Center for Disease Control and Prevention (China CDC)

2) HIV interventions for drug users at multiple levels: A case study from Indonesia.
Speaker: **Dr Nafsiah Mboi**, Secretary of the National AIDS Commission, Indonesia

3) Initiating methadone maintenance treatment (MMT) in the prisons, Malaysia
Speaker: **Mr Wan Mohamad Nazarie Wan Mahmood**, Deputy Director General, Deputy Director General, Prisons Department, Malaysia

4) High level political commitment and enacting HIV laws for effective implementation of harm reduction interventions in Viet Nam.
Speaker: **Dr Nguyen Dac Vinh**, Chief of Scientific Research & International Cooperation Department, The Vietnam Administration of HIV/AIDS Control (VAAC) **and Dr Nguyen Thi Huynh**, Chief of Harm Reduction Department of the Vietnam Administration of HIV/AIDS Control, Ministry of Health of Viet Nam

5) "The Hidden Truth" – Findings of a study of HIV vulnerability, risk factors and prevalence among men injecting drugs and their wives"
Speaker: **Mr Salman ul Hasan Qureshi**, Deputy Program Manager, Nai Zindagi, Pakistan

6) Reaching and providing harm reduction services for drug users and their sexual partners: South Asian experience
Speaker: **Ms Harsheth Virk**, Project Coordinator, H13, UNODC Regional Office for South Asia (ROSA), India

7) "Diffusion of pharmaceutical injecting in South Asia: Challenges in containing the dual epidemic"
Speaker: **Ms Ashita Mittal**, Senior National Programme Officer, UNODC Regional Office for South Asia (ROSA), India

Discussant: **Dr Fabio Mesquita**, Technical Officer, Harm Reduction HIV/AIDS and STI, WHO Regional Office for the Western Pacific World Health Organization (WHO), Western Pacific Regional Office (WPRO), the Philippines

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