

HIV and drug use: Community responses to injecting drug use and HIV

**GOOD
PRACTICE
GUIDE**



Good Practice Guide series

This guide is one in a series of *Good Practice Guides* produced by the International HIV/AIDS Alliance (the Alliance). This series brings together expertise from our global community-level HIV programming to define and guide good practice in a range of technical areas, including:

- Human rights and GIPA
- Research, evaluation and documentation
- HIV prevention
- Integration of sexual and reproductive health, HIV and rights
- HIV and tuberculosis
- HIV programming for children
- HIV and drug use
- Programme cycle management

Alliance Good Practice Guides are:

- user-friendly 'how to' guides
- targeting HIV programmers working in community settings in developing and transitional countries
- helping to define what is good practice for community-level HIV programmes.

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Alliance good practice HIV programming standards – HIV and drug use

ALLIANCE GOOD PRACTICE HIV PROGRAMMING STANDARDS FOR HIV AND DRUG USE	
Good practice standard 1	Our organisation uses a harm reduction approach to drug use and HIV
Good practice standard 2	Our organisation promotes and/or provides access to clean injecting equipment, condoms, and information about safe injecting and safe sex for people who use drugs and their sexual partners
Good practice standard 3	Our organisation promotes and/or provides access to antiretroviral treatment, opportunistic infection prevention, tuberculosis prevention and treatment, opiate substitution therapy, and hepatitis C treatment for people who use drugs and their sexual partners
Good practice standard 4	Our organisation promotes and/or provides access to psychosocial support services to meet the priority needs of people who use drugs and their sexual partners
Good practice standard 5	People who use drugs participate in our programming and decision-making
Good practice standard 6	Our programmes targeting people who use drugs are gender-sensitive, and including interventions for the sexual partners of people who use drugs
Good practice standard 7	Our programmes targeting people who use drugs are part of a local network of services and programmes
Good practice standard 8	Our programmes address stigma and discrimination related to HIV and drug use

Each guide in the Alliance good practice series is accompanied by a set of programming standards. Implementing these is one of the ways that the Alliance, our partners and other organisations can define and promote a unified and quality-driven approach to HIV programming.

This *Good Practice Guide* contains information, strategies and resources to help programme officers meet the good practice standards of our HIV and drug use programmes

The full programming standards for HIV and drug use can be found in Appendix 2 at the back of this guide.



KEY RESOURCES

For the full list of Alliance good practice programming standards, see: www.aidsalliance.org/Publicationsdetails.aspx?Id=451

French version
www.aidsalliance.org/Publicationsdetails.aspx?Id=452

Spanish version
www.aidsalliance.org/Publicationsdetails.aspx?Id=453

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ABBREVIATIONS AND ACRONYMS

ART	Anti-retroviral therapy
ATS	Amphetimine-type substances
BBV	Blood-borne virus
BCC	Behaviour change communication
CBO	Community-based organisation
GIPA	Greater involvement of people living with HIV
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HCV	Hepatitis C virus
NSP	Needle and syringe programme
OST	Opioid substitution therapy
MAC	Malaysian AIDS Council
MMT	Methadone maintenance therapy
PMTCT	Prevention of mother-to-child transmission
SRH	Sexual and reproductive health
SASO	Social Awareness Service Organization
STI	Sexually transmitted infection
TB	Tuberculosis
VCT	Voluntary counselling and testing
WHO	World Health Organization

Introduction

KEY TO ICONS USED IN THIS GUIDE



Key resources



Example



Strategy



Remember!



Good practice
standard

What is this guide for?

Injecting drug use is one of the major drivers of the global HIV epidemic. In many parts of Asia and Eastern Europe, the sharing of injecting equipment by injecting drug users is a leading cause of HIV transmission.¹ The sharing of injecting equipment also fuels the spread of hepatitis C (HCV), and many people who inject drugs are particularly vulnerable to tuberculosis (TB). In many parts of Africa and Latin America, unsafe injecting drug use is increasingly impacting on HIV transmission.²

Approximately 80% of people who inject drugs live in developing and transitional countries,³ yet much of the research and documentation of practice in response to HIV and injecting drug use exists in developed or resource-rich countries. This is changing as HIV and harm reduction research and practice develops globally.

This guide aims to support the scale up of community-based HIV and harm reduction programmes in developing and transitional countries. It looks at practice and research in developing and transitional countries and the principles underlying practice and research in resource-rich countries. It also sets out an approach to programming at the community level, where communities are fighting poverty, rapid social change, inequality and sometimes restrictive political cultures.

People who use drugs – especially those living with HIV and their families, friends, neighbours and communities – are most affected by drug use and HIV. This is why they need to be involved in their local response. To participate in the response, local people need skills and resources. They also need opportunities to have their say and to share their ideas and experiences – be part of the solution when drug use and HIV is the problem.

Support for a harm reduction approach to drug use and HIV is building around the world.⁴ New guides and reference manuals are appearing all the time. Many of these are intended for national government programme managers, primary care physicians or national public health planners. Very few guides or tools exist to

1. UNAIDS (2008), '2008 report on the global AIDS epidemic'. Available at: www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp

2. International Harm Reduction Association (2008), 'Global state of harm reduction 2008: mapping the response to drug-related HIV and hepatitis C epidemics'. Available at: www.ihra.net/GlobalState2008

3. Aceijas, C. et al. (2006), 'Estimates of injecting drug users at the national and local level in developing and transitional countries, and gender and age distribution', *Sexually Transmitted Infections*, 82: 10–17.

4. See note 2.

support action at a grassroots or community level. As a starting point, this guide aims to assist local community organisations who are responding to drug use and HIV.

Who is this guide for?

This good practice guide is aimed at people who are developing and delivering HIV and harm reduction programmes or services at a community level in resource-poor settings, or settings where there are low levels of capacity or political support for harm reduction programmes.

The guide is for:

- **people with limited experience of HIV and harm reduction programming in a community setting.** It is not a comprehensive manual containing everything that is known about successful HIV and harm reduction programming. Instead, it aims to be an accessible and user-friendly guide to thinking through what “good practice” means for community organisations working with people who use drugs. It refers the reader to many other in-depth and technical tools
- **people working in resource-poor settings.** HIV and harm reduction programmes and services are well established in Canada, Australia and parts of Europe. But in many developing and transitional countries where HIV and harm reduction programming is urgently needed, there are added challenges of fewer resources and fewer “safety nets” or state welfare systems for people who use drugs. This affects our definitions of what are key services and programmes.

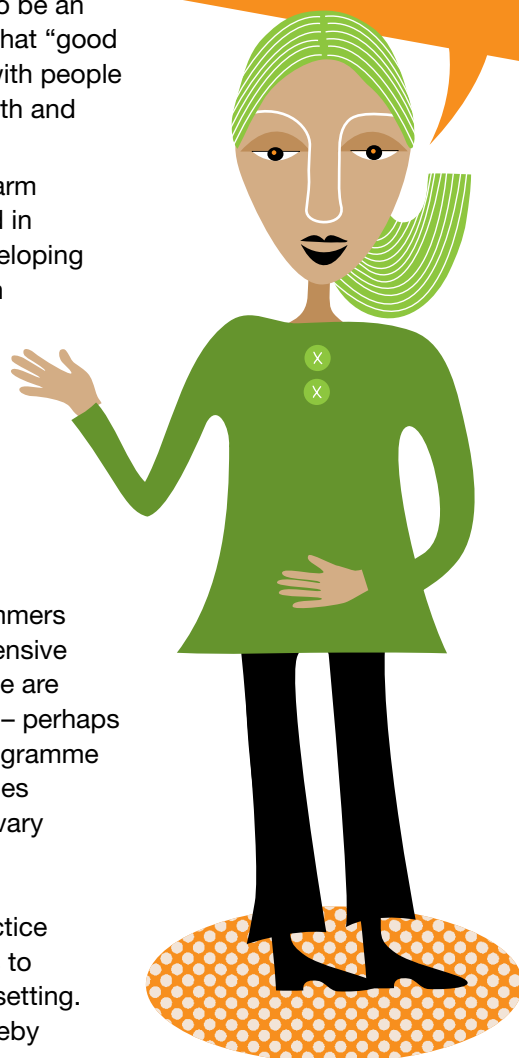
Making it work “on the ground”

Very few of us start out as HIV and harm reduction programmers with the resources or the opportunity to design a comprehensive programme of interventions or services. More commonly we are funded or motivated to do one or a small number of things – perhaps set up a drop-in service or design a needle and syringe programme (NSP) – in order to have an impact on HIV in our communities of concern. Moreover, the environments in which we work vary enormously.

This guide aims to distil some of the elements of good practice in different settings. It also aims to assist HIV programmers to think through these elements and apply them to their own setting. It encourages a “combination prevention approach”,⁵ whereby

This guide is for people who are setting out to:

- prevent HIV transmission among people who use drugs
- provide treatment, care or support to people who use drugs, including people living with HIV and their partners and families
- advocate for HIV and harm reduction programmes and services, and for policy change to support harm reduction programming.



5. UNAIDS and The Lancet (2008), 'The Lancet: series on HIV prevention.' Available at: www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080806_Lancet.asp



KEY RESOURCES

There are a number of more comprehensive and technical manuals available in the field of HIV and harm reduction programming, notably the many technical guides provided by the World Health Organization (WHO). We will suggest and refer to many of these guides for a more in-depth focus on a particular topic.

programmers think not only about service delivery but also about the structural and social drivers that impact on behaviour, access to services and HIV needs. We aim to provide a tool that is adaptable to many different environments and conditions.

Who developed this guide?

This guide was developed in five stages:

- We reviewed existing tools and resources on drug use, harm reduction and HIV.
- The first draft was developed by people working in civil society organisations from the Alliance “family” of organisations in Asia and Eastern Europe during a workshop held in Chiang Mai in July 2008. This guide is shaped by their ideas, knowledge and experiences.
- The draft guide was reviewed by international technical experts.
- The draft guide was field tested by HIV programmers working in civil society organisations, including people working in grassroots community organisations and people who use drugs.
- Learning-from-the-field testing and external expert review was then used to revise and finalise the guide.

Language matters! People who use drugs

Throughout this guide we mostly use the term “people who use drugs” to describe the group of people our work concerns. When we use that term we mean both women and men, and young people who use drugs. We use this term, influenced by the term “people living with HIV”, to assert that people who use drugs are more than just a “risk group”. They are people first and foremost.

Sometimes we use “injecting drug user”, a commonly used term to refer to the particular subset of people who inject drugs. Injecting is the behaviour that is the focus, and so sometimes “injecting drug user” is more specifically relevant. Sometimes, for brevity, we simply use “drug user”. We avoid terms like “drug addict”, “drug abuser” or “junkie” as they are stigmatising and have negative values attached to them.

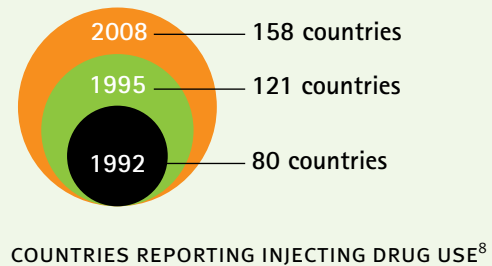
1 Drug use, HIV and health – what are the issues?

In this chapter:

- Injecting drug use and HIV
- Drugs and their effects
- Why do people take drugs?
- How drugs are taken
- What is dependency?
- Why is drug use a health issue?
- How do drugs affect peoples' lives?
- Drugs, crime and the police
- Co-infections – hepatitis C and tuberculosis
- Other health issues for HIV-positive drug users
- Drugs and sex

Patterns of illegal drug use

The Reference Group to the United Nations on HIV and Injecting Drug Use estimates that 15.9 million people inject drugs.⁶ Approximately 200 million people use illegal drugs,⁷ but because of the particular risks associated with injecting drugs, the figure of 15.9 million is important for global, national and local efforts to prevent HIV transmission.



The International Harm Reduction Association describes some important trends in injecting drug use:

- Injecting as a practice can spread rapidly – it can take only a few years to develop.
- Drug trade routes influence local markets for drugs. When police and drug control officials close down a drug trafficking route in one country it can move to a neighbouring country.
- Drug use patterns are influenced by political, cultural, economic and legal conditions; for example, increased drug use can be linked to rapid social change or increasing inequality, as in former Soviet Union countries.⁹

KEY MESSAGE

In this guide we focus mainly on illegal drugs that are linked to HIV transmission. These are drugs that are injected (opiates and amphetamines) or that influence sexual practice and therefore sexual transmission of HIV (amphetamines). Both opiates and amphetamines are widely used. Alcohol is also linked to increased sexual transmission risk, but not dealt with in detail in this guide.

Injecting drug use and HIV

Sharing injecting equipment is a very efficient way to transmit the HIV virus, along with other blood-borne viruses (BBVs) such as HCV. When we share injecting equipment we dramatically increase our risk of acquiring and passing on HIV. Sharing injecting equipment has been associated with the rapid expansion of HIV epidemics in Asia and Eastern Europe.

Approximately 10% of all HIV infections occur through sharing injecting equipment.¹⁰ Injecting drug use is the main driver of HIV transmission in Asia, Eastern Europe, Central Asia, the Middle East and North Africa. It is also a factor in regional transmission trends in Latin America and sub-Saharan Africa.¹¹

The Reference Group to the United Nations on HIV and Injecting Drug Use estimates that 3 million people who inject drugs might be HIV positive worldwide.¹² Many of them do not know their HIV

6. Mathers, B. et al. (2008), 'Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review', *The Lancet*, 372. Available at: www.idurefgroup.unsw.edu.au/idurgweb.nsf/page/Publications

7. United Nations Office on Drugs and Crime (2007), '2007 world drug report'. Available at: www.unodc.org/pdf/research/wdr07/WDR_2007.pdf

8. See note 2

9. See note 2

10. Aceijas, C. et al. (2004), 'Global overview of injecting drug use and HIV infection among injecting drug users', *AIDS*, 18: 2295–2303. Available at: www.ihra.net/

11. See note 1

12. See note 6

status. In many countries, including China, India, Kenya, Myanmar, Nepal, Thailand and Vietnam, the prevalence of HIV among people who inject is 50% or higher.¹³ In many cities a large number of people share injecting equipment; for example, 58% in Delhi, India, 55% in Dhaka, Bangladesh, and 32% in Yangon, Myanmar.¹⁴

Access to services for people who inject drugs is very poor. In 2003 UNAIDS estimated only 5% coverage of basic HIV treatment, care and prevention services for people who use drugs. Ban Ki-moon, the United Nations Secretary-General, reported in 2007 that 92% of people who use drugs have no access to basic HIV services.¹⁵

A review of coverage of prevention and treatment services for injecting drug users published in 2010 described that coverage as “low”.¹⁶

In 2009 the World Health Organization estimated that fewer than 5% of people who need substitution treatment had access in many parts of South and South-East Asia (3.5% in India, 1.5% in Indonesia, 0.7% in Nepal).¹⁷

All of these factors – large numbers of people injecting, high rates of HIV among people who inject, high rates of sharing injecting equipment, low access to services, including HIV prevention services – create the conditions for the rapid spread of HIV and for reduced quality of life for drug users living with HIV.

200 million people use illegal drugs

Nearly 16 million people inject drugs

3 million injecting drug users may be HIV positive

92% of people who use illegal drugs have no access to HIV services

50% of injecting drug users are HIV positive in China, India, Kenya, Myanmar, Nepal, Thailand and Vietnam

58% of injecting drug users in Delhi share injecting equipment

13. See note 2

14. Sharma, M. et al. (2009), ‘A situation update on HIV epidemics among people who inject drugs and national responses in South-East Asia region’, *AIDS*, 23(00). Available at: www.searo.who.int/LinkFiles/HIV-AIDS_PWID_in_SEA.pdf

15. ‘Declaration of commitment on HIV/AIDS and political declaration: focus on progress over the past 12 months’, United Nations General Assembly, 20 March 2007. Available at: http://data.unaids.org/pub/Report/2007/20070418_sg_%20progress_report__en.pdf

16. Mathers, B. et al. (2010), ‘HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage’, *The Lancet*, 375(9719). Available at: www.idrefgroup.unsw.edu.au/idurgweb.nsf/page/Publications

17. See note 14

CATEGORIES OF DRUGS¹⁸

STIMULANTS

Ecstasy
Speed
Base
Ice
Methamphetamine
Amphetamine
Dexamphetamine
Phentermine
Methylamphetamine
Crystal methylamphetamine
Paramethoxyamphetamine
Cocaine
Crack cocaine

DEPRESSANTS

Cannabis
GHB
Inhalants
Heroin
Morphine
Codeine
Methadone
Buprenorphine
Pethidine
Dilaudid
Kapanol
MS Contin

HALLUCINOGENS

LSD
Magic mushrooms
(psilocybin)
PCP (phencyclidine)
Ketamine
Mescaline

Drugs and their effects

It is important if we are working in drug user and community organisations that we have a basic scientific understanding of drugs, how they can affect different people, and how and why they are taken.

A drug is any substance that alters our function physical or psychological functioning. There are three main categories: depressants, stimulants and hallucinogens.

Depressants are drugs that slow down the activity of the brain and other body functions. They are often used to relieve pain, reduce anxiety and help us relax or sleep. They include opioids, cannabis, benzodiazepines and alcohol.

Stimulants are drugs that speed up the impulses going to and from the brain. The use of stimulants increases heart rate and body metabolism, and delays sleep. Some people who use stimulants experience increased alertness, energy and a feeling of power. Stimulants include amphetamines and amphetamine-type substances (ATS) (such as methamphetamine, dexamphetamine and crystal methylamphetamine), ecstasy, cocaine, crack cocaine, tobacco, coffee and some inhalants like amyl or butyl nitrites.

Hallucinogens are both natural and synthetic drugs that mix up impulses going to and from the brain, causing changes in our perception of reality. Hallucinogens include LSD, cactus plants containing mescaline, mushrooms containing psilocybin, PCP (phencyclidine) and ketamine.

Lists of the potential effects of different drugs can be both long and misleading in that they may not be experienced by all users in the same way. The Zinberg model¹⁹ provides a helpful framework for understanding the drug experience by examining the interactions between the drug, the “set” (or the person using drugs) and setting in which the drugs are used:

- **Drug** – the type of drug and its source, form, quality, quantity and strength.
- **Set** – our current mental and physical health, and level of experience of and tolerance to the drug (some people react badly to drugs that cause few problems for others).
- **Setting in which drugs are used** – for example, the experience of smoking cannabis with friends at home will be very different if repeated in public near a police station.

18. Ceida: 'The three main categories of drugs': Available at: www.ceida.net.au/drugs.asp

19. Zinberg, N. (1984), 'Drug, set, and setting: the basis for controlled intoxicant use', Yale University Press.

By examining the drug, set and setting in combination, the experience of the drug and the degree of potential harm can be better understood. Similarly, strategies to address harms associated with drug use should examine these three factors together.

Our focus is mainly on opiates and amphetamines, so we will examine their potential effects in more detail below.

Opiates and opioids

Opiates are a group of drugs derived from opium, an extract of the poppy plant. Opiates include morphine and its synthetic derivatives, such as heroin, morphine and codeine. There are also synthetic opioids such as methadone and pethidine. Collectively, opiates and opioids can be termed “opioids”.

The effects of opioids can include:

- depressing the central nervous system so our functions (including breathing and bowel movement) are slowed down
- a feeling of euphoria and a subsequent sense of profound wellbeing
- pain relief
- drowsiness and lethargy.

Opiates can be injected, snorted, swallowed or smoked. Heroin is “active” in the body for around five hours. This means that a sustained effect requires around four doses a day.

Amphetamines

Amphetamine-type substances (ATS) are central nervous system stimulants that quicken the heartbeat, breathing rate and brain activity. ATS can induce feelings of confidence, energy and alertness. Sometimes they can stimulate libido and sexual activity. We can become more outgoing and talkative, but we may also feel tense and anxious. The effect usually lasts for three to six hours, after which withdrawal can lead to tiredness, irritability and depression.

Withdrawal symptoms for both opiates and amphetamines are intense when we are dependent on drugs (see page 15).

Benzodiazepines

Benzodiazepines are legal drugs usually prescribed to relieve anxiety and insomnia, and they have varied “active” duration in the body. They include diazepam (Valium), nitrazepam (Mogadon), oxazepam (Serepax), flunitrazepam (Rohypnol), temazepam (Normison).

Benzodiazepines are also important for us to consider as they are sometimes diverted to the black market and injected. They play a significant role in overdose risk, particularly when we consume additional depressants such as alcohol or heroin.



For more detail on drugs and their effects, see The Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research and Asian Harm Reduction Network (2003), ‘Manual for reducing drug related harm in Asia’. Available at: www.burnet.edu.au/freestyler/gui/files//Manual.pdf

KEY MESSAGE

Sharing injecting equipment is a high-risk practice

Injecting is a very high-risk activity in terms of HIV and HCV transmission because BBVs can spread when injecting equipment is shared. If people find it difficult to access sterile injecting equipment, or if they do not know about preventing HIV and HCV transmission, they often end up sharing with their friends.

KEY MESSAGE

Only when we understand the context and practices – injecting and sexual – that put us at risk of HIV transmission do we really know how best to intervene and act.

Why do people take drugs?

People take drugs for many reasons, some personal and others related to the culture and values of the communities we live in. These can include:

- to experience a high
- to prevent withdrawal symptoms
- to escape daily realities
- to alleviate pain – mental and/or physical pain
- peer pressure or to belong to a group or friendship network
- because of setbacks or disappointment
- to “medicate” against depression
- to temporarily escape family problems
- as a reaction to a sense of hopelessness, particularly about economic and social conditions
- to celebrate at special occasions and festivals
- to feel relaxed
- to experiment
- out of curiosity
- to experience reality in a different way
- to improve creativity
- to enhance sex
- to sleep
- to stay awake
- to lose weight
- for fun.

Although this is not an exhaustive list, it does highlight that the reasons why people take drugs are many and varied.

The reasons for taking drugs, the types of drugs and ways of taking them are usually specific to our contexts and social conditions. Understanding the reasons why people take drugs, which drugs they use, what methods they use to take them and the setting in which drugs are used is all essential for the HIV programmer.



How drugs are taken

Drugs can be injected, swallowed, snorted or smoked. Some people prefer to inject as the effect is intense and almost immediate. Unlike smoking, where some of the substance may “blow away”, injecting may be seen as a more “economical” use of sometimes expensive drugs. For example, a person might start out snorting amphetamines, but because of a police crackdown supplies might become scarce. So, in an attempt to get a strong effect from a smaller amount of amphetamines, they might try injecting. Snorting can also result in a direct and powerful impact. When a drug is swallowed, the effects are not as direct and take longer to experience.

Sometimes people inject substances that are not made to be soluble for injection. For example, some benzodiazepines, available in tablet form, are crushed, mixed with water and injected. Because the particles don’t break down well, this practice can put extra strain on the blood vessels and lead to blood vessel damage.

Drug use patterns – what drugs are used and how they are taken – vary according to what drugs are available, trends and norms among peers in different drug-using communities, and changes in what people want or need. All of this information is vitally important to the HIV programmer. For example, in some communities mixing heroin into a solution using blood in the syringe is common, but in other communities the practice does not occur. This has implications for BBV transmission, so it is important information.

What is dependency?

Opiate dependency

When we use opiates consistently and over time, adaptation occurs in our body in order to “normalise” to our usual opiate levels. The brain stops producing its own opiates (called “endorphins”) to regain the usual balance. The pleasure or reward systems in the brain adapt to higher concentrations of endorphins from opiates, and we need more in order to feel “normal”. This is called “neuro-adaption”. Neuro-adaption explains why opiate users report needing to take increasing doses to achieve the same effect. This is known as “tolerance”. If a dependent person suddenly stops taking opiates, it takes their body a few days to return to normal endorphine production. In the meantime, with no opiates or endorphins in the body, the person will experience an uncomfortable period of withdrawal. The degree of discomfort correlates with the degree of dependency, or the size and frequency of a person’s usual dose.

Opiates are a central nervous system depressant, so they slow down our metabolic rate and unconscious muscle movements like breathing and intestine contractions. An opiate overdose is sometimes

Description of opiate dependence from the World Health Organization

“Opioid dependence develops after a period of regular use of opioids. The time required for dependence to occur in a person varies according to the quantity, frequency and route of administration, as well as factors such as individual vulnerability and the context in which drug use occurs.

Opioid dependence is not just a heavy use of opioids, but a complex health condition that has social, psychological and biological determinants and consequences. It is not a weakness of character or will.”

World Health Organization, United Nations Office on Drugs and Crime, Joint United Nations Programme on HIV/AIDS (2004), ‘WHO/UNODC/UNAIDS position paper: substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention’.

described as “forgetting to breathe” – the dose has been larger than we can tolerate and the system has slowed down to the point where breathing has ceased. This is why first aid for overdose involves mouth-to-mouth resuscitation. Contrary to popular belief, if opiates are taken in pure form and measured doses, the only potential negative physical effects are constipation, tooth decay (due to decreased saliva production) and dependence.

The key elements of opiate dependence are:

- a strong desire or sense of compulsion to take opiates
- difficulties in controlling opiate-taking behaviour
- a withdrawal state when opiate use has stopped or been reduced
- evidence of tolerance – increased doses are required to achieve effects similar to those originally produced.

Treatment

Opiate dependency is a chronic and relapsing condition typically involving cycles of dependence, withdrawal and relapse.²⁰ Treatment is important when communities are faced with an HIV epidemic among people who inject opiates. When people who have an opiate dependence are ready to receive effective treatment, they stop injecting or reduce the amount of injecting, and this has a powerful effect on preventing HIV transmission.

There is no one drug dependence treatment that works for everyone, and some treatments are more effective than others. However, opioid substitution therapy (OST) (methadone or buprenorphine) has been proven to be highly successful²¹ in terms of HIV prevention, as well as cost-effectiveness, supporting anti-retroviral treatment (ART) adherence, reducing crime, health and lifestyle improvements, and overdose prevention.

OST can be very effective at:

- reducing transmission of HIV and HCV
- helping people to manage opiate dependency
- improving the health and quality of life of people dependent on opiates
- supporting adherence for people living with HIV who use drugs and who need ART.

20. World Health Organization/United Nations Office on Drugs and Crime (2008), ‘HIV/AIDS care and treatment for people who inject drugs in Asia and the Pacific: an essential practice guide’. Available at: www.wpro.who.int/publications/PUB_9789290613206.htm

21. World Health Organization (2005), ‘Evidence for action: effectiveness of drug dependence treatment in preventing HIV among injecting drug users’. Available at: www.who.int/hiv/pub/advocacy/idupolicybriefs/en/

Amphetamine dependency

Amphetamine dependency is different to opiate dependency. Although amphetamines have significant physical effects, the way they act on the physical chemistry of the brain makes them less physically addictive than opiates. However, people can experience strong psychological dependency. Frequency of daily use is greater than that of heroin because they act in the body for shorter periods. If they are also injecting, this can mean they are injecting more regularly than a person who is dependent on opiates, and therefore at higher risk of HIV/HCV transmission because of the frequency of their injecting.

Amphetamines can either be illegal substances made privately in unregulated conditions, or can also be pharmaceutical drugs. They can also be mixed with other pharmaceutical drugs, although mixing in this way can be risky.

Treatment

There are very few effective treatments for amphetamine dependency, although different interventions are currently being tested. This is discussed in a review by the Cochrane Collaboration.²²

Why is drug use a health issue?

Drug use can be a health and HIV issue for five main reasons:

1. Sharing injecting equipment dramatically increases our risk of acquiring HIV and HCV. People living with a BBV and who share injecting equipment are likely to transmit infection. To prevent this we need to promote safe injecting and offer sterile injecting equipment. Providing people with education about safe injecting and making it easy for them to get new injecting equipment is a priority intervention, proven to prevent BBV transmission effectively.²³
2. When we take drugs our ability to make rational and sensible judgments about our health and the health of others can be compromised. When we are drunk or “high” we might take more risks, including sexual risks. Sexual risk-taking can increase our vulnerability to HIV or the likelihood of us passing on HIV sexually.
3. When we take drugs, and in particular when we mix different types of drugs or when we take drugs and drink alcohol, we risk overdosing. Overdose rates can be very high among people

22. Srisurapanont, M., Jarusuraisin, N., Kittirattanapaiboon, P. (2001), 'Treatment for amphetamine dependence and abuse', *Cochrane Database of Systematic Reviews* 2001, Issue 4. Art. No. CD003022. DOI:10.1002/14651858.CD003022. Available at: www.cochrane.org/reviews/en/ab003022.html

23. World Health Organization (2005), 'Evidence for action: effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users'. Available at: www.who.int/hiv/pub/advocacy/ridupolicybriefs/en/

HIV infections in communities of injecting drug users

HIV epidemics among injecting drug users tend to present themselves very differently from epidemics in which sexual transmission is the main risk factor. Sexually transmitted HIV may remain undetected for several years while associated health problems worsen. However, drug-related epidemics spread more rapidly because sharing injection equipment is a much more efficient mode of transmission. Once the virus is introduced into a community of injecting drug users, tens of thousands of HIV infections may occur within a short period. Infection levels among injecting drug users may rise from zero to 50–60% within one to two years, as we have seen in cities as different as St Petersburg (Russian Federation), Imphal (Manipur, India) or Ruili (Yunnan Province, China).

WHO, UNODC, UNAIDS (2004), 'Advocacy guide: HIV/AIDS prevention among injecting drug users'.

who use heroin.²⁴ Overdose is particularly linked to leaving drug treatment or prison.²⁵ If a person who has been drug free or having irregular access to opiates in prison or in treatment takes the same dose of heroin when they leave treatment as they were used to before they went in, the body can no longer tolerate that amount, resulting in overdose.

4. When we take illegal drugs supplied in an unregulated market, quality cannot be guaranteed. So over the long term our general health can be affected. Added to this, the cost of illegal drugs can be high, leaving little money for food, rent and clothing. Injecting drug users are often forced to use drugs quickly, sometimes in unsanitary conditions, in order to escape the notice of police. They can be malnourished, more vulnerable to TB or have problems with veins, skin, mental health or reproductive health. If they are also HCV positive, these general health problems can become more serious. If co-infected with HIV and HCV, maintaining general health is important.
5. When we take illegal drugs we are more likely to be marginalised or treated badly by authorities, families, neighbours, police and health care staff. This can lead to people who use drugs being excluded from health care services, such as primary health care services, pharmacies, hospital services, family planning or mental health services. When we are excluded from health services we are more vulnerable to ill health. If we are living with HIV we can be further marginalised or treated badly.

How do drugs affect peoples' lives?

When a person's drug use intensifies, the problems associated with drugs intensify too. If they are poor, their poverty is usually intensified by the expense of buying illegal drugs. For those who have become dependent, their thoughts and actions for most of the day may be related to ensuring the next dose. The other parts of life – family, work, study – may become less of a priority. This can lead to increased social isolation, family and health problems.

Many of these problems arise because drugs are illegal and therefore expensive and unregulated. Unregulated production leads to unknown purity and potential contaminants, with overdose and other health implications. Problems with the police can become a dominant part of drug users' lives, as can the pressures that may

24. Coffin, P. (2008), 'Overdose: a major cause of preventable death in Central and Eastern Europe and Central Asia. Recommendations and overview of the situation in Latvia, Kyrgistan, Romania, Russia and Tajikistan', Eurasian Harm Reduction Network. Available at: www.harm-reduction.org/images/stories/library/od_report_2008_en.pdf

25. Curtis, M. and Guterma, L. (2009), 'Overdose prevention and response: a guide for people who use drugs and harm reduction staff in Eastern Europe and Central Asia', Open Society Institute. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/overdose_20090604/overdose_20090604.pdf

result if they are desperate for money to buy drugs. This can lead to risky behaviour and increased HIV vulnerability, and the stigma that accompanies injecting drug use can lead to social exclusion, discrimination and incarceration.

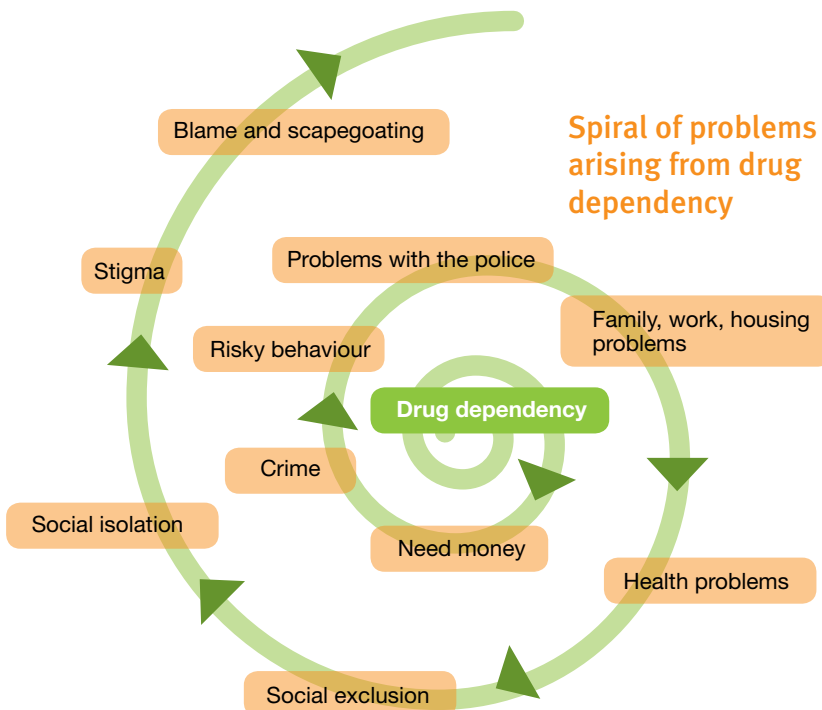
Some people in the general community can be afraid of people who use drugs. Their fears may derive from prejudice or they may be anxious about HIV infection. This is known as “scapegoating” of drug users. Therefore, educating the general public – especially those who most come into most contact with people who use drugs, such as police, drug treatment workers and other service providers – about drug use and drug dependency is an important part of a comprehensive response.

Not all of the effects of drugs are bad. A person can experience euphoria, relief from pain, creative inspiration, colourful dreams and other pleasurable effects from opiates. People who use drugs often become part of a close-knit community and value some of the social aspects of being with other people who use drugs. With the help of peer education programmes, people who use drugs can support and care for each other, and educate each other about health, HIV prevention, preventing and managing overdose and how to use drugs safely.

Drug user scapegoating

In his article ‘The political economy of drug-user scapegoating and the philosophy and politics of resistance’ Sam Friedman describes how drug users become “scapegoats”; that is, they function as a symbol of the many problems in society. Friedman argues that the function of drug users as scapegoats is to distract attention away from some of society’s biggest problems – globalisation, economic difficulties, inequality, lack of social cohesiveness – and to blame society’s problems on young, poor individuals.

Friedman, S. (1998), ‘The political economy of drug user scapegoating and the philosophy and politics of resistance’, *Drugs: education, prevention and policy*, 5(1).



KEY RESOURCE

Open Society Institute (2009), 'At what cost? HIV and human rights consequences of the global "war on drugs"', describes a range of human rights problems associated with the criminalisation of drug use and drug users. One of the main problems they evidence is the increase in HIV vulnerability because of the "war on drugs" approach to drug use. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/atwhatcost_20090302

KEY MESSAGE

We can extend the impact and relevance of our programming by integrating HCV prevention efforts and by working to improve access to HCV treatment.

Drugs, crime and the police

In most countries drug use is illegal. Many of us would argue that keeping drugs illegal and underground makes managing the negative consequences of drug use and dependency more difficult.

Because of the illegal nature of drug use, people who use drugs are often incarcerated, taken away from their communities and families, and encounter high-risk injecting-related and sexual exposure to HIV in prisons. In some countries they are beaten, denied treatment and forced to pay bribes to local police or other officials.^{26,27} People who use drugs are also forced to undergo urine tests carried out by the police, and are stopped and searched more than other people. Experiencing fear, harassment and corruption makes people take more risks with their drug use. They may inject in a rush, and they are more likely to share injecting equipment and inject in unsafe, unhygienic conditions.

The illegal nature of drug use creates challenges for HIV prevention.²⁸ Fearing arrest, many people who use drugs are reluctant to carry new or used syringes in case they are seen as evidence of drug use.²⁹ Similarly, they may be reluctant to attend health services or to disclose their drug use to health professionals, fearing that health care workers will report them to the police. As a result, many people who use drugs have no access to information about HIV prevention, treatment or care because their drug use is secret.

Co-infections – hepatitis C and tuberculosis

Injecting drug users are at risk of two important related infections: HCV and TB.

Hepatitis C

HCV is a BBV and can be transmitted by shared injecting equipment. Many injecting drug users are HCV positive, leading in many cases to debilitating symptoms arising from poor liver function. HCV is more infectious than HIV and so is very common among people who use drugs.³⁰ As with other BBVs, HCV can be transmitted not only by sharing needles and syringes but also by sharing injecting equipment such as cotton swabs, water and spoons, or cookers. Unlike HIV, it is

26. Open Society Institute (2009), 'At what cost? HIV and human rights consequences of the global "war on drugs"'. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/atwhatcost_20090302

27. Human Rights Watch (2006), 'Rhetoric and risk: human rights abuses impeding Ukraine's fight against HIV/AIDS'. Available at: www.hrw.org/en/reports/2006/03/01/rhetoric-and-risk

28. Rhodes, T., Singer, M., Bourgois, P., Friedman, S., Strathdee, S. (2005), 'The social structural production of HIV risk among injecting drug users', *Social Science and Medicine*, 61.

29. Human Rights Watch (2008), 'An unbreakable cycle: drug dependency treatment, mandatory confinement, and HIV/AIDS in China's Guangxi province'. Available at: www.hrw.org/en/node/76256/section/1

30. European Monitoring Centre for Drugs and Drug Addiction, *Hepatitis and Injecting Drug Use*

unusual for HCV to be transmitted sexually. For more information on HCV symptoms, prognosis, management and treatment see www.hepatitisaustralia.com/about_hepatitis/hep_c.html and <http://digestive.niddk.nih.gov/ddiseases/pubs/chronichepc/>

Many people who inject are co-infected with both HIV and HCV. Co-infection can exacerbate health problems; for example, HCV disease progression is accelerated and HIV treatment is compromised or complicated.³¹ There is very poor access to HCV testing and treatment in most developing and transitional countries, so most people with HCV are unaware of their status. HCV can lead to liver disease, and in many countries is a major cause of death among people with HIV/HCV co-infection.³²

Tuberculosis

In addition to high rates of HIV and HCV, people in developing and transitional countries who use drugs also have high rates of TB. If they are also living with HIV, this greatly increases the risk of the TB infection becoming TB disease. Other factors, such as poverty, homelessness and incarceration, also increase drug users' vulnerability to TB disease. Countries with the highest rates of injecting-driven HIV epidemics also have the highest rates of multi-drug resistant TB.

People with HIV and TB, particularly those who use drugs, often get very poor or no treatment for their infections because of stigma against drug users or because of a lack of capacity in health care systems. Often, TB doctors do not know how to treat HIV and TB together, or HIV doctors do not recognise or test for TB, and HIV and TB services are often not integrated.

Other health issues for HIV-positive drug users

People who use drugs often have a range of other health concerns besides HIV and other BBVs. WHO have developed a list of common health problems (not including overdose) associated with injecting drug use (see page 20).

People who use drugs may have limited access to primary health care because:

- there is a lack of health services in a district or region
- health services are not free and people who use drugs are often poor



KEY MESSAGE

Health problems associated with drug use are more common in those who are most isolated and socially excluded.

31. Collins, S. and Swan, T. (2007), 'Hepatitis C for people living with HIV: testing, coinfection, treatment, support', HIV i-Base. Available at: www.i-base.info/guides/hepc/index.html

32. World Health Organization, 'Management of hepatitis C and HIV co infection: clinical protocol for the WHO European region'. Available at: www.euro.who.int/__data/assets/pdf_file/0007/91924/E90840_Chapter_6.pdf



REMEMBER

Community organisations can build capacity among other service providers, including those providing HIV, hepatitis, TB and sexually transmitted infection (STI) testing and treatment, to improve access for drug users to these essential health services.

All these health problems underline the need to provide access to primary health care services for people who use drugs, especially for people living with HIV.



- health services discriminate against people who use drugs and treat them badly, if at all; for example, they may withhold medical treatment until the person stops using drugs
- health services might report drug use to the authorities, or people who use drugs might fear that they will
- health services may require people to have official papers and residency rights – many people who use drugs will not have these
- people who use drugs might be young, and health services will require parental consent in order to treat them
- people who use drugs might be pregnant women or mothers and fear having their children taken away from them by health officials.

Improving access to primary care services for people who use drugs is important, along with health information and education, home care services and counselling and other mental health services.

HEALTH PROBLEMS ASSOCIATED WITH DRUG USE

INJECTION-RELATED INJURIES AND INFECTIONS

Injection-related injuries

- Bruising
- Scarring
- Swelling and inflammation, including urticaria
- Venous injury
- Arterial injury

Injection-related infections

- Cellulitis and abscess
- Thrombophlebitis

Complications of injection-related infections

- Bacteraemia and septicaemia
- Musculoskeletal infections
- Endovascular complications
- Tetanus

INFECTIOUS DISEASES

- Sexually transmitted infections
- Hepatitis B and C
- Respiratory tract infections
- Tuberculosis

NON-INFECTIOUS DISORDERS

- Psychiatric disorders
- Substance dependence

OTHER COMMON HEALTH PROBLEMS

- Pain
- Constipation
- Poor dental conditions

World Health Organization Regional Office for South-East Asia (2009), 'Management of common health problems of drug users'. Available at: www.searo.who.int/LinkFiles/HIV-AIDS_Primary_care_guidelines.pdf

Remember!

People who use drugs have sex. Wives and other sexual partners of men who inject are particularly vulnerable.



Drugs and sex

Sometimes when our focus is primarily on injecting practice there is a tendency to overlook the sexual transmission of HIV among people who use drugs. It is important to remember that people who use drugs, including people living with HIV, have sex too. Some studies show that people who use drugs have very low rates of condom use, especially adolescents and those living and working on the street.³³ Therefore, the need to prevent sexual transmission of HIV always applies.

Strategies include:

- condom (male and female) promotion
- information, education, skills-building and counselling, as part of a behaviour change communication (BCC) strategy
- diagnosis and treatment of STIs
- diagnosis and treatment of HIV and referrals to psycho-social care and support services
- increasing access to sexual and reproductive health (SRH) services
- provision of outreach and low threshold services offering psycho-social support, information, education, counselling and skills-building, referrals and advocacy.³⁴

Using such strategies to minimise the risk of sexual transmission is a feature of good HIV programming with people who use drugs. Underpinning these different strategies is an understanding that the people we work with will be HIV positive, HIV negative and untested.

Drugs and sexual risk-taking

Amphetamine use

Amphetamine use is associated with increased sexual risk-taking. Most of the research on this focuses on studies with men who have sex with men in Europe and the USA. This work clearly needs to expand to focus on the many amphetamine users in Asia and Eastern Europe, but in the meantime programmers need to be aware of the greater likelihood of sexual and HIV risk-taking when people use amphetamines.

The overlap between injecting drug use and sex work

In our work with women and men who are injecting drugs we often see the overlap between drug use and sex work. Many people who use drugs – mainly women but also men – report engaging in sex work to get money to buy drugs, or selling sex in direct payment for

33. UNAIDS Inter-agency Task Team on HIV and Young People: www.unfpa.org/public/iattyp/

34. See note 33

drugs.³⁵ In addition, we know that some people are coerced into sex in return for drugs. When people are dependent on drugs, the conditions for unsafe sex, including coerced sex, increase.

UNAIDS report a significant overlap between injecting drug use and sex work in Asia, Eastern Europe, Central Asia, the Middle East and North Africa. Many studies report that significant numbers of sex workers who are injecting drugs, and that many injecting drug users are paying for sex and not using condoms.³⁶

Alcohol use

Alcohol use, sex and HIV risk are linked. Although alcohol and sexual practice could be the focus of an entire and separate guide, it is worth thinking about alcohol as another drug that has an effect on sexual practice (as well as injecting practices).

Light to moderate consumption of alcohol can lead to behavioral and physical changes that may play an important role in sexual transmission, susceptibility to infection and progression of HIV disease. There is growing evidence that alcohol consumption and dependence may have a significant impact on the occurrence and progression of co-infection with HCV and TB, adherence to medications, and service provider and patient attitudes towards treatment. Alcohol use has also been shown to be associated with drug risk-taking behavior among people who inject drugs.³⁷

35. Burns, K. (2009), 'Women, harm reduction and HIV: key findings from Azerbaijan, Georgia, Kyrgyzstan, Russia, and Ukraine', Open Society Institute. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/wmhardred20091001

36. See note 1

37. Stein, M. et al. (2002), 'Alcohol and HIV risk taking among intravenous drug users', *Addictive Behaviors*, 27(5).

2 The needs of specific groups

In this chapter:

- Women
- Children and young people
- People in prison or detention

Women

Women are affected by drug use in many ways. Some of these effects are similar or the same for men, but some are very different. When we speak about women's needs in relation to drug use and HIV we include:

- women who use drugs
- women who are partners of drug users, including wives and widows
- women who use drugs and sell sex
- pregnant women who are using drugs, and mothers who are using drugs
- women living with HIV who are using drugs
- young women and girls.

These different (and not mutually exclusive) social roles, behaviours and factors can lead to multiple vulnerabilities, needs and risk practices.

Many drugs services fail to address the needs of women. Also, men who have sex with men and transgender people are poorly served.

Large numbers of women are married to or in a sexual relationship with men who use drugs, yet they do not use drugs themselves. Because of high rates of HIV among men who use drugs, these women and their babies and children are very vulnerable to the sexual transmission of HIV. Many of them be unaware of their vulnerability.³⁸

Lack of “women-friendly” services

Most services for people who use drugs are directed towards the needs of men. This can mean that women feel like outsiders and that their needs are not met. For example, many drugs services, do not offer pregnancy or maternal health services or programmes for women with children. Support groups or peer education groups run by men who use drugs can exclude or intimidate women, or simply not meet their needs. Alongside this, services targeting women, such as SRH services or micro-financing programmes, often lack the skills and experience to work effectively with women who use drugs.



38. Kumar, M.S. and Sharma, M. (2008), 'Women and substance use in India and Bangladesh', *Substance Use and Misuse*, 43(8 & 9): 1062–77.

Gender and vulnerability

Gender is an important factor in vulnerability to HIV:

- Women have particular vulnerabilities to HIV related to injecting drug use.
- Drug use, including injecting drug use, is influenced by gender norms in different cultures or sub-cultures.
- Men who have sex with men, and transgender people who use drugs often experience multiple vulnerabilities in terms of HIV – sex work, marginalisation and increased exposure to violence and abuse.

Women and injecting – risks and vulnerabilities

Studies in nine European countries show that the average HIV prevalence among women who inject is 50% higher than among men who inject.³⁹ Studies in China and Kenya also demonstrate higher HIV prevalence amongst women who inject.⁴⁰

Many women begin injecting drugs in the context of sexual relationships,⁴¹ and they often borrow or share injecting equipment from their male partners. Gender inequality in many developing and transitional countries is also reflected in social patterns that can affect injecting practices. For example, women:

- are more likely to be injected by their male partners – being injected by another person or being helped to inject is a predictor of HIV infection
- are more likely to be the last person to use shared injecting equipment
- who inject drugs are often dependent on their sexual partners to obtain drugs, which compromises their ability to negotiate safer sex or safe injecting practices.

Women who inject drugs have lower access to services than men who inject drugs. There is evidence of this among HIV prevention programmes in Central and Eastern Europe and South-East Asia, and among drug dependence treatment programmes in South Asia.⁴²

39.,40. Pinkham, S. and Malinowska-Sempruch, K. (2007), 'Women, harm reduction, and HIV', International Harm Reduction Development Program of the Open Society Institute. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/women_20070920 See also Pinkham, S. et al. (2008), 'Women, harm reduction and HIV', *Reproductive Health Matters*, 16(31).

41. See note 40

42. United Nations Office on Drugs and Crime (2005), '2005 world drug report'. Available at: www.unodc.org/unodc/en/data-and-analysis/WDR-2005.html

Women, sex work and drug use

Many women engage in commercial sex or transactional sex to deal with drug dependency, poverty and homelessness. Commercial sex is generally the exchange of sex for money, whereas transactional sex can be more informal and involve the exchange of sex for drugs, a place to stay or food. For example, women who use drugs in Imphal, Manipur, exchange sex for drugs and for a place to sleep.⁴³

Women who use drugs are more likely to take risks in sex work because of their drug habits or those of their partners, and are less likely to work in brothels.⁴⁴ They are less likely to have access to or use condoms. A study in China showed that drug-using sex workers were likely to have more clients and use condoms less often than non-drug-using sex workers.⁴⁵

Pregnancy and motherhood

Women who use drugs and are pregnant need extra support. Often the reverse happens and they are marginalised as health care workers, families, partners and the women themselves assume that their drugs will be causing substantial harm to their unborn babies. In fact, drug-using pregnant women and their unborn babies are more likely to experience problems relating to malnutrition, lack of sleep, lack of medical care and tobacco and alcohol use than from illicit drug use itself.⁴⁶ Because women who use drugs sometimes stop menstruating, pregnancies can go undetected. When pregnant women who use drugs are HIV positive as well, the need for supportive medical care intensifies, in particular ensuring access to prevention of mother-to-child transmission (PMTCT) programmes.

Women who use drugs in maternity wards rarely have access to OST. This means they give birth in states of withdrawal, and need to leave hospital immediately after giving birth in order to buy drugs.⁴⁷

When women who use drugs discover they are pregnant, it can be a good opportunity to reassess their drug use and seek treatment for drug dependency and HIV, and promote maternal health.

Mothers who use drugs may fear losing custody of their children. This means they become reluctant to use services, including HIV and drug dependency services, for fear that their children will be taken away by the authorities.

43. Reports from staff at SASO

44. See note 40

45. See note 40

46. Reported in Pinkham, S. and Malinowska-Sempruch, K. (2007).

47. See note 35

Children and young people


Children or young people who use drugs are particularly vulnerable to HIV. Young people have less access to information about HIV prevention, both preventing injecting-related infection as well as sexually transmitted infection. They are less skilled at negotiating safer sex and in practising safe injecting, and they have lower access to condoms and new injecting equipment. Poverty and homelessness also intensify the problems of drug use and HIV for many young people.⁴⁸ Many services will require parental or guardian consent, effectively excluding many young people who use drugs who are cut off from families, or whose families do not know about their drug use. As a result, many services are reluctant to provide for children or young people who use drugs because of child protection concerns and requirements.

People in prison or detention

Injecting drug use is a reality in many prisons, and most incarcerated drug users share injecting equipment because they have no access to clean equipment. HIV prevalence is high among prisoners, along with HCV and TB. In addition, prisons in developing and transitional countries are frequently overcrowded and often have very small health budgets. These factors combine to mean that HIV and HCV transmission occurs in prison as a result of drug use, also intensifying drug users' vulnerability to TB. Evidence from Europe, Russia, Canada, Brazil, Iran and Thailand demonstrates a link between HIV and HCV infection and imprisonment, including among women prisoners.⁴⁹

People in prison who are HIV positive and who use drugs have very poor access to health services, particularly drug dependence treatment, ART, TB and HCV treatment. They are often tested for HIV and HCV without counselling or consent.

Some prison authorities have struggled to act to prevent HIV and HCV transmission in prisons out of a concern that providing HIV/HCV prevention interventions means acknowledging that drug use does occur in prison. The reality is that just as it has proved impossible to create a drug-free society, so it is impossible to create drug-free prisons. Consequently, countries are increasingly recognising the need to address prisoner vulnerability to HIV, HCV and TB.

**KEY RESOURCE**

WHO (2009), 'HIV testing and counselling in prisons and other closed settings'. Available at: www.who.int/hiv/pub/idu/tc_prisons/en/index.html

48. Interagency task team on HIV and young people, 'Global guidance briefs: HIV interventions for most-at-risk young people'. Available at: www.unfpa.org/hiv/iatt

49. Jurgens, R. et al. (2009), 'Interventions to reduce HIV transmission related to injecting drug use in prison', *The Lancet*, 9.

3 What needs to change?

In this chapter:

- The change framework – developing interventions at different levels
- Risk and vulnerability
- Behaviour change, health promotion and the Ottawa Charter
- Building social capital for health

In **Chapter 1** we discussed some of the common issues around drug use and its link with HIV and health. Thankfully there is a wealth of global experience about how we can improve the situation, and we have learned important lessons from drug users and from HIV and drugs services over the past 25 years. What is clear is that the most successful approaches are those where civil society organisations work in close collaboration with health service providers, and where communities help to shape policy environments so that they support and enable health for everyone, including people who use drugs.

The change framework – developing interventions at different levels

In order for change to happen it is important to try to work at multiple levels. Based on learning from behaviour change and health promotion theory and practice, it is helpful to think about what needs to change by organising our ideas and plans around four different levels: individual and family; social, environmental and community; structural or policy; health and support services.

Effecting change at each level may require different types of interventions. The change framework builds on the principles of the Ottawa Charter (see page 33) in that it acknowledges that the ability of an individual, family or community to change is not always fully in our hands but is often influenced by context and dependent on laws, policies and economics. Therefore we need to reflect on the challenges that pose a threat to health at different levels and then decide what best mix of interventions, preferably chosen from those proven to be most effective, will help lessen or remove those threats and improve health.

1. Individual and family level

This is the level where we support and help individuals and their families or households to make the changes necessary to improve their health. We help people who use drugs to understand their health risks, and we support healthy behaviours such as safe injecting, educating and skills-building to protect and improve health and wellbeing. We also make sure that people have knowledge of relevant health services; for example, HIV testing, treatment and care services, family planning, counselling, STI treatment and drug dependence treatment.

At the individual and family level, activities need to address:

- **Literacy** Can the person read? Is the HIV information conveyed in a way that leads to increased understanding of personal risk and ways to prevent transmission?

KEY MESSAGE

We need to effect change in order to:

- reduce the number of people who use drugs who become infected with HIV
- increase access of drug users to effective and supportive services
- reduce the negative impact of stigma and discrimination towards drug users.

Doing nothing is not an option!

- **Socio-economic status** Does the person have the funds and other service provider criteria, such as identity papers or age restrictions, to enable them to access health and HIV prevention services?
- **Basic needs** Are the person's basic needs for food, shelter and clothing being met? Can they focus on HIV prevention if these basic needs are not being met?
- **Information on HIV, sex and drugs** Does credible, relevant information and education reach the people it targets?
- **Agency** Does the person live in circumstances that prevent them from acting on HIV prevention? For example, are they free to make changes or are they coerced into behaving in a certain way?
- **Community connection** Is the person or family connected to the community or do they live inside a community but are shunned by it?
- **Health-seeking behaviour** Does the person want to participate in health services or do they wish to be hidden?
- **Individual behaviour** How does the person use, or in which situations do they use, the means of prevention such as injecting equipment and condoms?

2. Social, environmental and community level

This is the level where we address the values and social factors influencing the communities where individuals live and where their families and households are based. It is at this level where hostility to drug users operates, along with police harassment, stigma and discrimination, harmful gender norms, racism and fear of outsiders. This is also the level where risk and vulnerability arise from the social spaces and the environments where drug use takes place.

This is where we provide safe spaces for people who use drugs and where we educate groups of drug users about safer drug use, in particular by developing peer education programmes. It is where we educate local communities, police and officials about responding to drug use humanely and in order to protect public health. We challenge stigma and discrimination through campaigns and community education, and we mobilise communities to plan and act together to prevent HIV and care for people with HIV who use drugs.

At the community level, activities need to address:

- **Power** Who has the power to obtain and regularly use clean injecting equipment, condoms and health services? Who has the power to stop that happening?
- **Values** How are people who use drugs treated by the community? How will this affect access to and use of clean injecting equipment, condoms and health services?

- **Social networks** How are drug users connected to each other? Are there social networks? What effects do these networks have on injecting and sexual practices?
- **Social capital** To what extent are people who use drugs offered assistance by the community? To what extent can community mobilisation among people who use drugs and their families happen? Are drug users even visible in the community?
- **Resources** What services and social spaces are used by injecting drug users?

3. Structural or policy level

Our lives are influenced by the public policies and laws that govern us. These relate to how health resources are funded and oriented, and whether social support structures such as housing and welfare systems exist or not. They also relate to whether laws support and promote human rights and dignity, or marginalise and criminalise groups of people such as men who have sex with men, sex workers or people who use drugs. This is where we advocate for laws and policies that support HIV prevention, treatment and care, and that protect people who use drugs from harassment and abuse.

At this level activities need to address:

- **Policy** How is HIV dealt with? What policies and guidelines shape how HIV is addressed among people who use drugs?
- **Legal issues related to drug use, drug trafficking and sex work** What laws affect people who use drugs most? What laws protect them, such as anti-discrimination laws? What laws are overlooked and what laws are applied?
- **Gender** What does it mean in terms of HIV risk and HIV vulnerability to be a man or a woman?
- **Marginalisation as a drug user, sex worker, person living with HIV or member of a particular race or ethnicity** In what ways does marginalisation affect people who use drugs?

4. Health and support services level

We all need health and other social support services. When we use them we hope we will be treated with respect, that our health and other problems will be understood and addressed, and that service providers will not discriminate against us because of prejudice or ignorance. However, people who use drugs frequently experience prejudice and poor service because of the judgemental attitudes of health care workers. In order for change to happen, we must work with health care workers to help them overcome these barriers and

make services more welcoming and responsive to people who use drugs and their needs.

At the services level, activities need to address:

- **Access** Are HIV prevention programmes and commodities, and HIV treatment and other health services accessible to people who use drugs?
- **Advocacy** Are the rights to health of people who use drugs being protected?
- **Building capacity** Do health care workers need to know about drug use and the most effective ways to respond to drug use and HIV? Do health services need to change the way they deliver services in order to meet the needs of people who use drugs?

Risk and vulnerability

When we work at these different levels we are able to influence both HIV risk and HIV vulnerability.

KEY MESSAGE

Risk and vulnerability are key concepts in HIV prevention.

Risk is the likelihood that a person will become infected with HIV.

Risk refers to the probability or likelihood that we will become infected with HIV. Particular behaviours, such as sharing injecting equipment and unprotected sex, increase risk. The degree of risk depends on many factors, such as the HIV status of our sexual partners and whether injecting equipment contains traces of blood from an HIV-infected person.

Vulnerability refers to the range of factors outside the control of an individual or community that reduce our ability to avoid risk. For example, lack of access to information about safe injecting, lack of access to services or commodities, such as peer education or new injecting equipment, or human rights violations all increase our vulnerability to HIV. Stigma, discrimination and other human rights violations increase our vulnerability to HIV by making us more likely to be poor, criminalised, excluded from society or secretive about the sex we have or the drugs we use.

When we are poor we are more likely to exchange sex for money, food or shelter, and we are more likely to be dependent on drugs. When we are criminalised because of the drugs we use or the sex we have, we become more vulnerable to HIV because we use drugs and have sex in secret, in a hurry or without protection, and with a reduced ability to negotiate safer sex and safe injecting. We might end up in prison where our HIV transmission risk increases.

Vulnerability reduces a person's ability to reduce this risk.

Behaviour change, health promotion and the Ottawa Charter

The Ottawa Charter⁵⁰ is an internationally recognised approach to health which acknowledges that health is not just the absence of disease. It also acknowledges that our ability to achieve our own health goals is affected by the context in which we live. Importantly, it implies that drug use need not be a cause for health problems. The Charter points towards supportive environments, community action, building personal capacity and expanding health services as the means by which organisations can promote health among drug users. It uses a health promotion approach to behaviour change and healthy living, and acknowledges the social and structural prerequisites for health. This approach was endorsed by WHO in 1986.

The Ottawa Charter sets out five key areas for action in order to promote health:

1. Healthy public policy
2. Creating supportive environments
3. Strengthening community actions
4. Developing personal skills
5. Reorienting health services towards health promotion and illness prevention.

Underpinning this change framework are theories and principles that have been developed over time, based on programme learning and on the application of theories from social science and medicine. When we work with communities affected by HIV, research has shown that building the collective capacity of people that share common characteristics – for example, sex workers, men who have sex with men, or drug users – enhances and builds on efforts made at the individual level.⁵¹ This is known as building social capital.

50. The Ottawa Charter for Health Promotion. Available at: www.who.int/healthpromotion/conferences/previous/ottawa/en/

51. Gupta, G.R., Parkhurst, J.O., Ogden, J.A., Aggleton, P., Mahal, A. (2008), 'Structural approaches to HIV prevention', *The Lancet*, 372(9640): 764–75. Available at: [www.thelancet.com/journals/lancet/article/PIIS0140-6736\(08\)60887-9/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)60887-9/fulltext)

Interventions to bring about change at different levels

Here are some examples of the kinds of interventions we can implement to bring about change at different levels. These categories are not fixed. Some actions can effect change at multiple levels. To effect the change that we most want to achieve, we need to choose the actions that are most likely to have that effect. Importantly, to achieve the most change we need to create (or motivate others to create) actions at all these levels.⁵² When we select actions for ourselves (or for others), we need to co-ordinate and work in partnership with the other main actors. In **Chapter 5** we discuss interventions in more detail.

INDIVIDUAL INTERVENTIONS – ADDRESSING BEHAVIOURS AND INDIVIDUAL HEALTH

- Health information and education
- Improving risk perception and increasing health-seeking behaviour
- Peer education
- Outreach
- HIV and HCV testing
- Counselling – mental health, safer drug use or ending drug use, sex and relationships, preventing relapse, family problems
- STI testing and treatment
- Family support
- Provision of new injecting equipment
- Drug dependency treatment (including OST)
- ART
- Improving nutrition
- Overdose prevention and management
- Treatment adherence support/improving treatment literacy.

COMMUNITY ACTION INTERVENTIONS – ADDRESSING SOCIAL VALUES AND RISK ENVIRONMENTS

- Community mobilisation to educate and inform communities/neighbourhoods about drug use
- Community education about HIV, harm reduction and HIV prevention
- Local advocacy with police and other officials to improve relations between police, law enforcement officials and drug users
- Creation of safe community spaces for people who use drugs, such as drop-in centres
- Establishment and support of networks of drug users
- Education sessions on health, rights and safer drug use with networks of drug users.

POLICY AND STRUCTURAL INTERVENTIONS – CHANGING LAWS AND POLICIES

- Advocacy for laws and policies that promote access to health services for people who use drugs
- Advocacy to protect the human rights of people who use drugs
- Advocacy for appropriate health spending to meet the needs of drug users for HIV prevention and care
- Ensuring that the prevention, care and treatment needs of drugs users are included in national HIV strategic plans
- Drafting model HIV, public health and drug laws
- Documenting and publishing human rights violations towards drug users.

SERVICE LEVEL – IMPROVING SERVICES

- Educating health care workers, police and prison staff about drug use and the rights to health of people who use drugs
- Educating health care workers, police and prison staff about a harm reduction and health-based approach to drug use
- Multi-sectoral co-ordination and co-operation to promote a continuum of care for people who use drugs, to avoid duplication of services and to identify gaps in services for people who use drugs.

52. Rhodes, T. et al. (2005), 'The social structural production of HIV risk among injecting drug users', *Social Science and Medicine*, 61.

Building social capital for health

Social capital is a key social science concept that is useful when thinking about theories of change. Social capital is the skills, structures and beliefs we have in order to form social networks, or the “glue” that helps social networks or communities work together. Social capital helps to create community action.

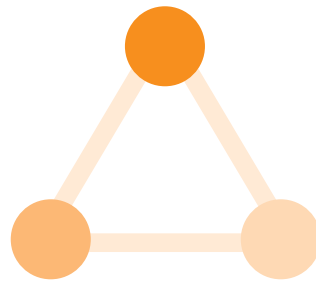
There are three types of social capital that are relevant to community action on drugs and HIV:

- **Bonding social capital** between people who are similar and have a shared common purpose; for example, a group of young drug users living on the street.
- **Bridging social capital**, which involves ties between people who are different from each other across the community; for example, a village development group made up of leaders, service providers and drug users.
- **Linking social capital**, which involves ties to those with more power and resources, in or outside the community; for example, ties to local police or local government, to national government or national drug control agencies, or to national, regional and international networks of drug users.

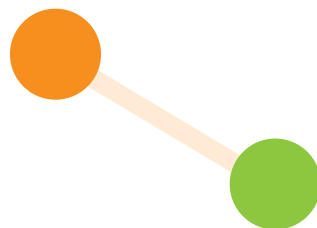
To apply this theory to drug use and HIV, we could describe the networks that exist between a group of drug users as bonding social capital. When those people who use drugs work together with a local women’s group to ensure that used syringes are not discarded near a children’s playground, they use bridging social capital – they form bridges between different types of networks to advance each other’s needs. And when the drug user group, working with the local women’s group, want the police to know about and support their syringe disposal plan, they build linking social capital to make the plan sustainable, endorsed by the wider community and more effective.

We build social capital among people who use drugs when we rely on them to educate each other about how to inject safely or how methadone works. We also build social capital when people who use drugs work together with health care workers to provide new injecting equipment to drug users on the street.

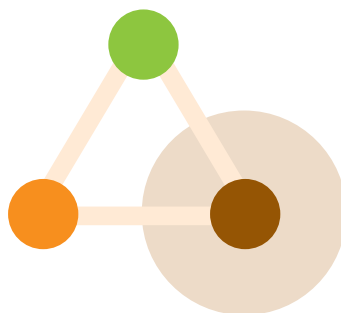
When we plan for interventions to prevent HIV or to provide treatment, care and support to HIV-positive drug users, we need to factor in interventions or strategies that help build social capital. Social capital builds confidence and helps people to work together for change.



A network of drug users – bonding social capital.



The network of drug users work with a local women's group – bridging social capital.



The network of drug users and local women's group involve the police in their project – linking social capital.

KEY RESOURCES

Australian Injecting and Illicit Drug Users League (2006), 'A framework for peer education by drug-user organisations'. Available at: www.aivl.org.au/files/FrameworkforPeerEducation.pdf

Toronto Harm Reduction Task Force (2003), 'Peer manual: a guide for peer educators and agencies'. Available at: www.canadianharmreduction.com/readmore/ichip_peerManual.pdf

Peer education and social capital

Peer education is an education method used to provide information and support for each other in an equal, non-judgmental and non-coercive manner. UNAIDS has identified peer education as part of a comprehensive, integrated and effective system of measures to prevent HIV transmission.⁵³ It is an effective means of reaching people who may not otherwise be reached. Evidence shows that outreach using peers has been effective in reaching drug users and providing means for effective adoption of safer practices.⁵⁴

Peer educators are people who have common social characteristics and have been trained in the required knowledge and skills. They meet with members of the same group to provide knowledge, skills and advice, and support them to reduce their risk-taking behaviour and access related services such as counselling and health care.

Elements to consider when implementing a peer education programme include:

- selecting the right people to be peer educators
- training and support
- assigning tasks to peer educators
- supervision and support for peer educators
- appropriate use of educational materials
- preparedness/response when peer educators drop-out.

The Australian Injecting and Illicit Drug Users' League – the main body for drug user organisations in Australia – lists the following principles for peer education by drug user organisations:

- **Equality** – where we talk to each other as equals, offering encouragement and empowerment.
- **Self-determination and ownership** – acknowledging our inherent rights to control and improve our own health, and providing opportunities for ownership over processes and outcomes.
- **Pragmatic learning** – applying adult learning principles.
- **Developing community** – empowering drug user community members to tackle problems collectively.
- **Harm reduction** – applying pragmatism and humanistic values, focusing on reducing harms, balancing costs and benefits, and prioritising the most pressing needs.
- **Upholding privacy and confidentiality.**

53. Joint United Nations Programme on HIV/AIDS (2005), 'UNAIDS policy position paper: intensifying HIV prevention'. Available at: http://data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf

54. World Health Organization (2004), 'Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users'. Available at: www.who.int/hiv/pub/idu/idu/en/

4 Approaches

In this chapter:

- How human rights, public health and development shape our work
- Demand reduction, supply reduction and harm reduction
- Why harm reduction programming?
- Low threshold services
- Community mobilisation
- Gender-sensitive programming

“ There will be no equitable progress in HIV prevention so long as some parts of the population are marginalised and denied basic health and human rights – people living with HIV, sex workers, men who have sex with men, and injecting drug users.

Ban Ki-Moon, United Nations Secretary General

Remarks at the launch of the Report of the Commission on AIDS in Asia. UN Headquarters (New York), 26 March 2008.

When we have problems in our community relating to drug use, health and HIV, we acknowledge that change needs to happen. The way we go about making change is influenced by a range of ideas, values, principles and methods – our approach. In this section we investigate the approaches that shape the way we respond.

How human rights, public health and development shape our work

Our work in the area of drug use and HIV is informed by human rights, public health and development approaches.

Rights-based approach

Human rights principles and practice help shape our beliefs and values, as well as our sense of what to do. The following human rights apply especially to our work with people who use drugs:


- The right to life
- The right to health
- The right to privacy
- The right to non-discrimination
- The right to freedom from torture and cruel, inhuman and degrading treatment.

These rights listed here are enshrined by the Universal Declaration of Human Rights, and the International Covenant on Economic, Social and Cultural Rights. They apply to all human beings, including people who use drugs.

Often, governments, police or other authorities will deny people who use drugs their basic human rights because of the illegal nature of drug use. This is not only a human rights violation, it also presents problems in terms of our HIV responses because people who use drugs do not access services or are denied services.

In a human rights approach, when faced with human rights abuses against people who use drugs, we advocate to defend their rights, in particular their right to health. A human rights-based approach to programming differs from a basic needs approach in that it recognises the existence of rights. It also reinforces the capacity of duty bearers (usually governments) to respect, protect and guarantee these rights.

In the programmes and services we provide, we do not discriminate against people who use drugs, despite the fact that drug use is illegal. We ensure the meaningful participation of people who use drugs in the way we plan, deliver and evaluate our programmes and services. This is called a rights-based approach.

 **KEY RESOURCES**

Open Society Institute and Equitas (2007), 'Health and human rights: a resource guide'. Available at: www.soros.org/initiatives/health/focus/law/articles_publications/publications/guide_20070630

The United Nations Population Fund (UNFPA) information on human rights and SRH: www.unfpa.org/rights/approaches.htm

Public health approach

Public health principles are also central to our approach. As well as addressing our individual health needs, public health addresses the determinants of ill health and prioritises approaches that help improve the health of communities. It is concerned with interventions that reduce our vulnerability to infection and disease, and promote healthy public policy. From the field of public health we have learned to focus on pragmatic interventions that rely on science and research, and have been proven to be effective. For example, NSPs and opiate substitution programmes are based on good public health as they are proven to be effective at reducing the risk of infection and improving the lives of drug users.

Development approach

Development principles and practice inform our work because we are working with people who are living in poverty and because our work is undertaken in resource-poor settings. Informed by human development practice, we use participatory methods, we are concerned with sustainable programmes and organisations, and we focus on those most in need or most vulnerable to HIV. Addressing poverty and inequality, and developing and adapting programmes so that they are culturally and socially appropriate, are central to our policy and practice in order to build capacity.

Demand reduction, supply reduction and harm reduction

What is demand reduction?

Demand reduction refers to interventions that reduce the demand for drugs through education or treatment. There are two main approaches to demand reduction: drug prevention education and drug dependence treatment.

Drug prevention education

This is education to prevent drug use, targeting the general community – particularly young people through school-based education programmes – and people who use drugs so they can make informed decisions about drugs.

Education for young people to prevent drug use can provide some basic information about drugs and their effects. However, evaluations of drug education programmes show they are ineffective at reducing or stopping drug use. The complex social, economic and personal factors that shape drug use are not addressed through education programmes.

Evidence also suggests that the effectiveness of large-scale campaigns targeting general populations is limited. These approaches

KEY RESOURCES



International Harm Reduction Association on harm reduction and human rights: [www.ihra.net/GlobalResponse](http://www.ihra.net/)

Kaplan, K. (2009), 'Human rights documentation and advocacy: a guide for organizations of people who use drugs', Open Society Institute. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/hrdoc_20090218

World Health Organization Regional Office for South-East Asia (2008), 'Public health approach to combating HIV/AIDS'. Available at: www.searo.who.int/LinkFiles/RC61_12-pa_Item-14.pdf

can provide some basic information to a population about drugs and their effects, but they are unlikely to have a serious impact on behaviour. When campaigns depict drugs as a “social evil” they can end up portraying drug users themselves as “evil” and intensify the stigma and discrimination that many drug users report. This can make it harder to reach them with essential HIV-related services.

Drug prevention education and reintegration programmes for people who use drugs teach about the problems associated with dependency, with mixing drugs and ART interactions, and with long-term drug use. Pragmatic drug prevention education will also educate drug users about how to use drugs safely, the health benefits of avoiding injecting, the importance of nutrition and safer sex, and how to access health services. Again, the evidence base for such approaches is weak, with few achieving sustained abstinence and little impact on HIV rates.

Drug dependence treatment

Opiate substitution therapy

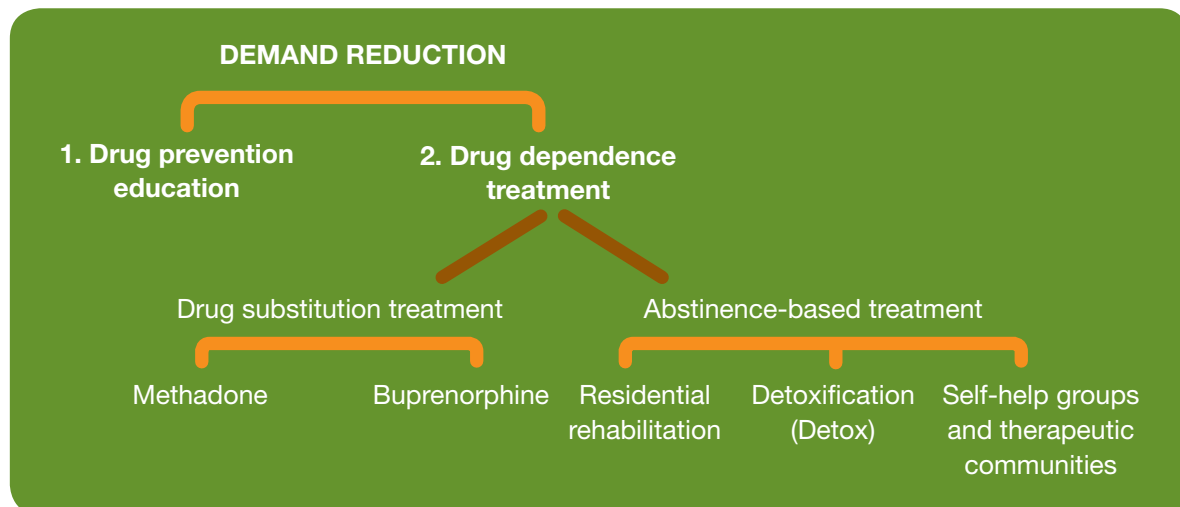
OST is medication that treats opiate dependency. The two main types of OST medicines are methadone and buprenorphine. Methadone and buprenorphine were classified as “essential medicines” by WHO in 2005.⁵⁵ WHO sets out the evidence base for the effectiveness of OST in their document ‘Effectiveness of drug dependence treatment in preventing HIV among injecting drug users’.⁵⁶

OST works in three main ways:

- **Physiologically** it acts on the neurotransmitters in the brain that are affected by opiates, preventing withdrawal symptoms and therefore helping the user feel normal and well.
- It **reduces risk practices** by taking away or reducing the need to inject. HIV transmission rates drop significantly among people who have access to OST because they inject less or stop injecting altogether.
- **Socially**, OST allows opiate-dependent people to study or work, to care for children or other family members, and to get involved in their community. This is because when we are on a stable dose of methadone or buprenorphine we are not in pain or distress from withdrawal, and do not have to spend our days in a cycle of raising money, buying drugs, injecting and hiding from police.

55. World Health Organization (2007), ‘WHO model list of essential medicines’. Available at: www.who.int/medicines/publications/EssMedList15.pdf

56. See note 21



OST is also an important intervention to support ART.⁵⁷ When the chaotic daily patterns associated with the need to find money to buy and use heroin are changed, making peoples’ lives more stable, the ART adherence rates of drug users become the same as everyone else’s. However, enrolment in OST should never be a prerequisite for access to ART.

Abstinence-based treatment

Abstinence-based treatment includes residential rehabilitation programmes, detoxification services (including community detoxification), self-help groups and therapeutic communities based on the Narcotics Anonymous “12 step” approach. While the evidence for these types of treatment is not compelling in terms of effective HIV prevention, they are recommended for countries where non-opioid drugs such as ATS and benzodiazepines are commonly used.

Abstinence-based approaches to drug dependency have a wide appeal to policymakers, parents, governments, medical professionals and some former and current drug users. However, these programmes have only a modest success rate, as many people start using or injecting drugs again once they have been through a detoxification process.⁵⁸ Relapse is common for most people going through detoxification, and often they have to go through repeated relapse before they are able to stop using drugs. Relapse rates are particularly high in programmes that compel people to stop using drugs. These high relapse rates suggest that it is only when we reach a point in our lives where we are ready and able to

57. World Health Organization (2005–6), ‘Evidence for action on HIV/AIDS and injecting drug use. Policy brief: antiretroviral therapy and injecting drug users’. Available at: www.wpro.who.int/NR/rdonlyres/539F9FB1-0801-49B9-BAFF-B6FF88EF6583/0/antiretroviraltherapy.pdf

58. World Health Organization (2005), ‘WHO bi-regional strategy for harm reduction 2005–2009: HIV and injecting drug use’. Available at: www.wpro.who.int/NR/rdonlyres/984BABB1-BCBA-4F27-BAA5-B090961DE0A1/0/BiregionalStrategyPlan.pdf

stop using illegal drugs that abstinence-based programmes can succeed. Some people will stop using drugs without the support of abstinence-based programmes, while others will continue to use drugs all their lives.

Success in residential rehabilitation treatment is linked to how long we are able to remain there. Longer stays have greater success.⁵⁹ However, “successes” are only moderate and relapse rates remain high. Residential rehabilitation can also be costly. In many countries the number of people seeking residential rehabilitation far outweighs the number of places available. For example, in Manipur, north-east India, there are around 35–50,000 people who use drugs. The residential treatment centre has a capacity of 20 beds and the treatment period is three months. This means that most drug users in Manipur will never access this service.

Compulsory drug treatment is a very common response to injecting drug use in many Asian countries. In reality, many of these compulsory treatment centres are more like prisons, and are widely referred to as “boot camps”. In these compulsory settings, drug users report widespread human rights violations, including torture, lack of access to health care, lack of access to education about drugs or health, compulsory labour, and “re-education” programmes teaching drug users about the “evils” of drug use.⁶⁰ Not surprisingly, drug users leaving these compulsory treatment centres have very high levels of relapse.⁶¹

What is supply reduction?

Supply reduction refers to interventions to reduce the supply of drugs. This approach is also sometimes called “drug control”. Supply reduction efforts include interventions to eradicate drug cultivation, such as crop spraying or crop substitution, to curb the processing of drugs and to stop the transportation, distribution and sale of drugs. These efforts are usually carried out by drug control officials and police.

Despite vast resources being spent on drug control measures, drugs are increasingly available for use.⁶² When one drug transportation route is tightened up by drug control authorities, an alternative route is found. Crop eradication programmes are undermined by poor prices on alternative crops for farmers. As trade barriers are lifted and as globalisation leads to more trade and travel, raw materials

59. World Health Organization Western Pacific Region (2006), ‘Integration of harm reduction into abstinence-based therapeutic communities’. Available at: www.wpro.who.int/NR/rdonlyres/0424577C-C624-49EE-A7B4-906145D26364/0/WHOSCaseStudy.pdf

60. See note 29

61. See note 59

62. Transnational Institute (2009), ‘Withdrawal symptoms in the golden triangle: a drugs market in disarray’. Available at: www.tni.org/report/withdrawal-symptoms-golden-triangle-4

for processing drugs become increasingly available, along with opportunities for the distribution and sale of drugs.

Drug control measures can also create unintended consequences. For example, police crackdowns on the supply of drugs often become a crackdown on drug users themselves. This can lead to people taking more risks when they inject – they might be more likely to inject in a hurry, or in unfamiliar and unhygienic settings. When drug supplies are suddenly interrupted, people are more likely to switch to injecting to optimise the effect from a reduced amount of the drug.

What is harm reduction?

Harm reduction aims to reduce the harms associated with drug use and HIV. It is a pragmatic approach to health comprised of interventions that address harms like HIV transmission, HCV transmission, overdose and unsafe injecting.

Harm reduction is shaped by both public health and human rights principal. It relies heavily on evidence of the effectiveness of its key interventions. Demand and supply reduction approaches to drug use do not address the rapid transmission of HIV among injecting drug users. Harm reduction is the only proven successful approach to HIV programming for people who inject, offering interventions that can reduce the risk of HIV transmission and build a culture of care and support for HIV-positive drug users.

A harm reduction approach uses the concept of a “hierarchy of risk” to categorise HIV infection risk related to injecting drug use:

Never use drugs or stop using drugs.

This is the most effective way to avoid HIV infection related to drug use.



If you use drugs, do not inject them.

This is a very effective way to avoid HIV infection related to drug use.



If you inject drugs, always use sterile injection equipment.

This is the only effective way to avoid HIV infection related to drug use.



If you cannot always use sterile injection equipment, re-use your own injecting equipment.

HIV infection related to drug use can be avoided if you re-use your own injecting equipment (so long as no one else has used the equipment).



KEY MESSAGE

Harm reduction is the main influence on our programming to prevent HIV and HCV transmission, and to provide treatment, care and support to people with HIV who inject drugs.

The International Harm Reduction Association refers

“to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community.”

www.ihra.net

The World Health Organization defines harm reduction as:

“Interventions that reduce the adverse health, social and economic consequences of psychoactive substance use for individual drug users, their families and their communities. Comprehensive harm reduction programmes can reduce new HIV infections among people who inject drugs.”

World Health Organization South-East Asia and Western Pacific Regions (2008), ‘HIV/AIDS care and treatment for people who inject drugs in Asia and the Pacific: an essential practice guide’.

Similar hierarchies of risk can be established for other viral infections such as HCV, and for particular drugs or drug types. Harm reduction measures are used to assist us to move up the hierarchy from most risky to least risky behaviour, depending on our individual life circumstances and personal choices.

The harm reduction approach does not set out to stop people taking drugs, acknowledging that those who are currently unwilling or unable to become abstinent remain at risk of HIV and other preventable harms. Abstinence-based programmes do not have effective HIV prevention outcomes,⁶³ and some approaches that set out to stop people using drugs have also severely restricted their human rights. Harm reduction, based on public health principles, has a client-driven approach, aiming for improved health at a speed that is acceptable and realistic for the client.

Harm reduction is pragmatic and focused on short-term, achievable goals. This focus is driven by the urgent need to prevent HIV and HCV transmission, and to get services to people with HIV and/or HCV who inject drugs. Many commentators would argue that a drug-free world is a long-term or even unattainable goal, and that in the meantime HIV needs to be prevented and people need health services, education, care and support.

Harm reduction programmes that are shaped by development principles take the approach beyond its public health and human rights roots to include a focus on family and partner support, income support and improved livelihoods. This makes harm reduction more meaningful and relevant in developing and transitional countries where poverty is deeply entrenched and where the social safety nets available to drug users in resource-rich countries, such as welfare systems and free health care, do not exist.

Essential harm reduction interventions include NSPs, peer outreach and OST. These and other key interventions are listed in **Chapter 5**.



KEY RESOURCE

The Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research and Asian Harm Reduction Network (2003), ‘Manual for reducing drug related harm in Asia’. Available at: www.hivpolicy.org/Library/HPP000683.pdf

63. Farrell, M. et al. (2005), ‘Effectiveness of drug dependence treatment in HIV prevention’, *International Journal of Drug Policy*, 16: S67–S75. Kumar, S. M. (1998), ‘A study of factors contributing to relapse in alcohol/drug dependants’, in V. Navaratnam and A. Abu Baker (eds) *International Monograph Series*, 12, Pulau Penang: Centre for Drug Research USM.

Why harm reduction programming?

- **Effective** Harm reduction provides the only approach currently known to be effective in preventing HIV among people who inject drugs.
- **Evidence-based** WHO's Evidence for Action ⁶⁴ reports and manuals set out the scientific evidence base for the effectiveness of a harm reduction approach to reducing HIV and HCV transmission, and to providing treatment, care and support to people living with HIV and HCV who inject drugs.
- **Pragmatic and based on short-term achievable goals** Ending drug use and stopping the supply of drugs are long-term goals that are unachievable. The urgency of preventing HIV and HCV transmission means us accepting that drug use happens and seeking to reduce the harms associated with it, particularly the transmission of HIV and HCV by sharing injecting equipment.
- **Rights-based** People who use drugs and others affected participate in decision-making and implementation. Rights-based responses to drug use seek to improve access to services; provide structures for meaningful involvement of drug users; provide protections against discrimination and harassment; and favour health and social care interventions to drug use over law and order interventions that generally lead to the widespread incarceration of people who use drugs.

We can respond to drug use using a combination of harm, demand and supply reduction approaches. A balanced approach would be one that focuses on reducing supply by targeting the large-scale drug suppliers, while educating communities, including people who use drugs, about preventing HIV and promoting health. It would also provide drug treatment while attending to the health and social care needs of dependent drug users.

64. World Health Organization 'Evidence for action series', available at: www.who.int/hiv/pub/idu/idupolicybriefs/en/

OVERVIEW OF DEMAND, SUPPLY AND HARM REDUCTION APPROACHES

APPROACH	AIM	CHARACTERISTICS	KEY INTERVENTIONS
Demand reduction	To reduce the demand for drugs through education and treatment	<ul style="list-style-type: none"> ■ Educational approaches are varied and can target general community or specific groups ■ Treatment approaches include OST ■ Abstinence-based treatment is included as a treatment approach, but relapse is common 	Includes school-based educational programmes, pragmatic drug user education, drug substitution and abstinence-based programmes
Supply reduction	To reduce the supply of drugs using drug controls	<ul style="list-style-type: none"> ■ Involves border officials and police. Targets growers, manufacturers and traffickers ■ illegal drugs are increasingly available, affordable and potent 	Crop spraying or substitution, efforts to curb the processing of drugs, efforts to stop the transportation, distribution and sale of drugs (including arrest and punishment of drug users)
Harm reduction	To reduce harms associated with drug use, such as HIV transmission	<ul style="list-style-type: none"> ■ Pragmatic and shaped by public health, human rights and development ■ Evidence-based ■ Effective in reducing harm and preventing HIV/HCV infection 	Includes NSPs, peer outreach and OST

KEY MESSAGE

Innovation and experimentation are important when developing and improving low threshold services. Knowing what attracts drug users to services, what women, men, young people and children need, and what is possible when resources are scarce, requires constant questioning and testing of new ideas.

Low threshold services

Mainstream services are often not geared towards taking a holistic and sensitive approach to the needs of drug users. Some people who use drugs can also experience them as hostile and discriminatory, or not responsive to their lifestyle. Because of the illegality of drug use, many drug users believe that it is unsafe to access services or that in order to use services they will be asked to stop using drugs.

When we are providing services for people who inject drugs, we should address these fears and expectations in order to create a service that drug users will trust and value. Our services must be non-judgmental, confidential, client driven and with structures for the meaningful involvement of drug users. In these circumstances, low threshold services – commonly drop-in centres – can offer drug users a “safe place” to learn about HIV, get support after an HIV diagnosis, get new injecting equipment and condoms in a friendly environment, and be referred to other services. Primary health care services provided by a visiting doctor or nurse through drop-in centres can be very successful.

Good practice NSPs and drop-in services are low threshold services. They are often located where drug users live or spend time, and discretely positioned so that drug users can come and go without being noticed by the general public or the police.

In addition to offering basic services, such as food and a place to rest, low threshold services can incorporate other services such as NSPs, overdose prevention and management education, primary health care, support groups, peer education, referral, counselling, and HIV and HCV testing and treatment.

Different types of low threshold services might be needed for different drug users. For example, women who are selling sex might prefer to contact the service through peer outreach workers rather than attend a drop-in centre, while young men who inject drugs may find a drop-in centre more relevant and approachable.

Low threshold services are:

- open for longer than office hours – they are responsive to their main client “flow” hours and client consultation
- located in or near areas where people who use drugs congregate, ideally with a discrete entrance and exit
- run by people who use drugs, or those who can relate easily to people who use drugs – or a mix of both
- confidential and do not require people who use drugs to provide identification or detailed personal information
- do not impose too many rules or too much paperwork on clients
- free
- able to offer short waiting times
- able to offer food, a place to rest, bath or wash clothes.

Outreach

Outreach as an approach to health promotion with drug users has been described and endorsed by WHO as an effective approach to HIV prevention.

Because people who use drugs are marginalised and criminalised, it can be difficult for us to reach them for health promotion and health services. Outreach is an important approach in service provision to a range of marginalised populations, and has a particularly important role and history in HIV prevention among people who use drugs. It involves current and/or former drug users, or people with close links to drug user networks, “reaching out” to drug users for health education, peer support, distribution of new injecting equipment, collection of used injecting equipment, condom distribution, referral and consultation.

KEY RESOURCES



World Health Organization (2004), ‘Evidence for action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users’. Available at: www.who.int/hiv/pub/advocacy/idupolicybriefs/en/

Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute (2008), “Nothing about us without us”. Greater, meaningful involvement of people who use illegal drugs: a public health, ethical, and human rights imperative’. Available at: www.aidsalliance.org/publicationsdetails.aspx?id=310

Remember! All kinds of low threshold services can be offered that will respond to the needs of people who use drugs in a non-judgemental environment. These can reach people who will not or cannot attend large hospitals or mainstream services.



A fundamental principle of outreach is providing health and social support where drug users live, where they spend time with other drug users, and where they take drugs. Peer outreach programmes are particularly effective at accessing hard-to-reach drug users and providing relevant, credible HIV-related information and commodities.

When access to health services is limited, outreach is an important way of delivering essential HIV prevention services and support to drug users who may otherwise have no contact with health services. We can provide services directly using outreach workers, and more specialised services, such as STI testing and treatment or ART, can also be promoted by making sure that there are good referral systems to health services that will treat drug users with respect and dignity.



EXAMPLE – OUTREACH IN PHNOM PENH

Korsang, a community-based harm reduction organisation in Phnom Penh, Cambodia, runs a community outreach programme as part of their harm reduction activities. Four teams go out into the community every day in vans or on motorbikes, traveling to places where they know drug users are living or using drugs. Each team includes a health worker, an HIV advisor, a peer educator and a specialist from the women's health team.

The teams provide information to people who use drugs about HIV and safe injecting. They offer clean syringes and other injecting equipment, blood tests, condoms and women's health information. The health worker attends to any minor cuts, bruises or infections, and helps drug users to access other services such as hospital treatment, blood testing or other referrals. Women who use drugs are offered access to programmes that target their particular needs, such as reproductive health advice, and these services are delivered by women.

Outreach is particularly important in Phnom Penh as many drug users are unaware of the services available to them. Many of them are unwilling to come to the drop-in centre, fearing that the police will follow them and they will face prosecution. Through outreach, Korsang can provide services to drug users in their own environments and on their own terms.

Korsang also works with local authorities and communities to reduce discrimination against people who use drugs. They have built good relationships with local communities, who appreciate their efforts to reduce the numbers of discarded needles in public places.

Korsang attributes their success to their peer approach. Staff, peer educators and volunteers are mostly drug users or have used drugs in the past. This helps service users to identify with them and trust them. The outreach team dress casually and relate to service users on equal terms, building trust and lasting relationships.

See www.khana.org.kh

Community mobilisation

What is a community?

A community is a group of people who feel that they have something in common. They might live in the same village, work together, have the same problems or share the same interests.

People usually belong to more than one community at the same time. For example, a drug user might identify herself as part of the wider community where she lives, a member of the CBO she works with and as a part of the neighbourhood women's community. People living with HIV might form a community group to respond to their challenges or to socialise and spend time together. We need to understand how people identify themselves, rather than how others identify them, and how different sectors of community overlap and interact. We can support communities to develop CBOs that can play a role in HIV prevention, treatment and care. They can provide new injecting equipment and home care, educate young people about HIV transmission, build partnerships with others and access resources for advocacy.

What is community mobilisation?

Community mobilisation is a process through which individuals, groups and organisations assess, plan, carry out and evaluate the activities that target them on a participatory and sustained basis in order to improve their own health and lives.

It implies that the people most affected by drug use issues, including those living with HIV, can play an active and influential role in shaping an effective response. It also means that community members take responsibility for addressing the problems of drug use and HIV themselves.

Community members and others use a series of participatory activities to identify causes of vulnerability and those most vulnerable. They identify resources available to meet the gaps in response to their needs, develop a plan and create a sense of ownership, commitment and support for the plan in the community.

Capacity-building is a key concept in community mobilisation. To increase the engagement of people who use drugs in community mobilisation, we need to provide supportive structures and processes, such as training, career development and financial remuneration.

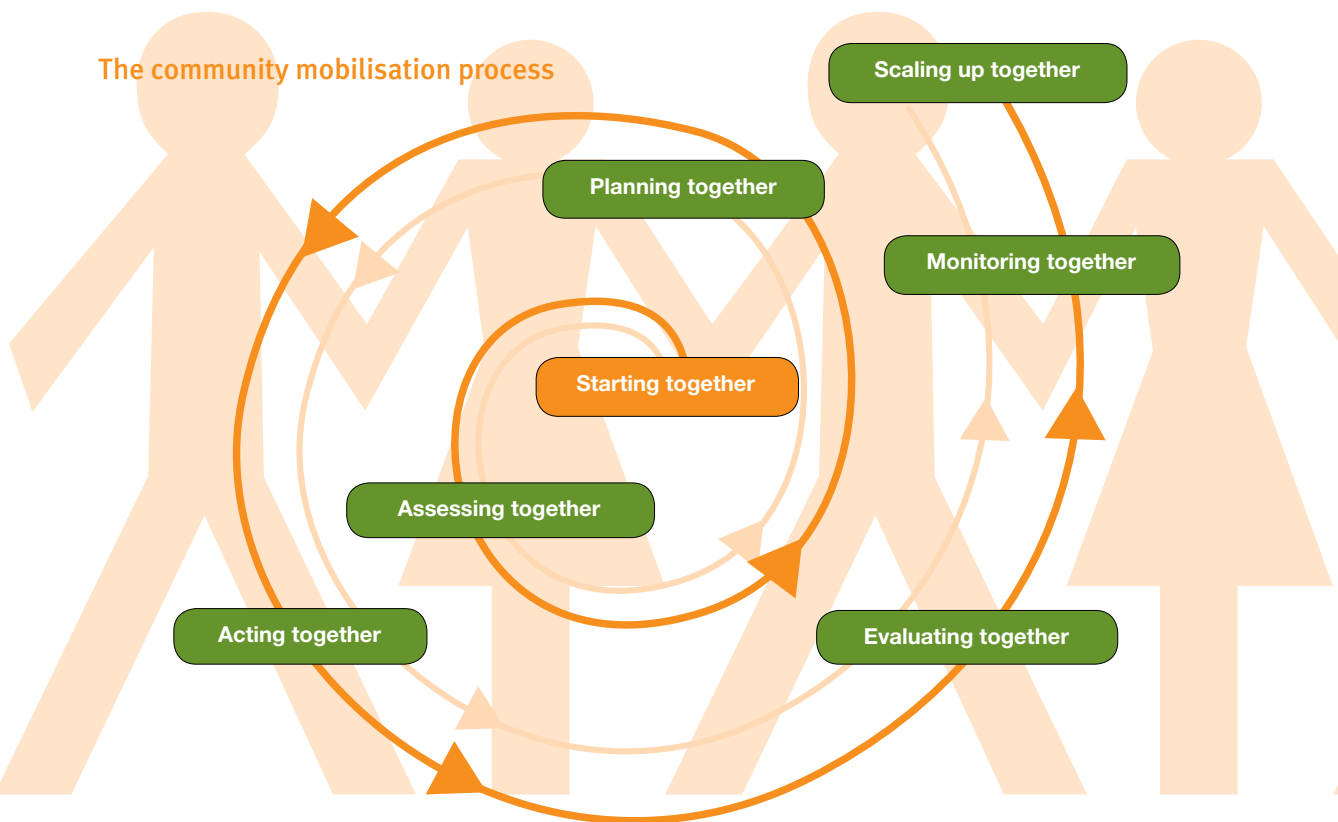
The process of training and engaging people who use drugs in assessment, planning, carrying out activities and evaluating builds capacity. As more people participate in these processes, more capacity is built and programmes become more sustainable and effective.

KEY RESOURCES

International HIV/AIDS Alliance (2006), 'All together now! Community mobilisation for HIV/AIDS'. Available at: www.aidsalliance.org/publicationsdetails.aspx?id=228



The community mobilisation process



Gender-sensitive programming

When services or programmes are intended for everyone who uses drugs but really only meet the needs of men, we can say they are “gender blind”. This means that they lack insight into the ways in which women or transgender people are excluded from services. Gender-sensitive programming responds to these problems by being active and aware of gender in the way it operates. This awareness and action can take many forms, including:

- measures to ensure the participation of both women and men in decision-making
- employment of both men and women in outreach work
- training for staff, volunteers and HIV-related service providers on the special needs of women who inject drugs
- keeping gender-aggregated service data
- providing specific services and programmes to meet the needs of both women and men
- programmes that challenge gender norms
- programmes that respond to the needs of transgender people.

Challenging gender norms benefits both for women can mean information and skills to promote empowerment and to challenge gender-based violence or inequities in injecting practices. For men this can mean opening up opportunities to talk about masculinity and drug use, condom use and sexual risk.

Priority services for women who use drugs and women partners of men who use drugs:

- Provide women-friendly drop-in centres that offer childcare and other forms of parenting support.
- Set up women-specific peer support and peer education groups.
- Promote HIV testing and counselling for women who use drugs and women partners of men who use drugs.
- Ensure access to OST for women who use drugs, in particular for pregnant women using drugs.
- Ensure access to PMTCT services for pregnant women who use drugs, and for women partners of men who use drugs.
- Establish strong links with family planning services, such as contraception and safe abortion services, and sexual health services, for women who use drugs.
- Establish strong links with maternal health services.
- Ensure access to OST for women drug users who are incarcerated.
- Establish strong links with domestic violence crisis centres.
- Provide legal services.



EXAMPLE – SERVICES FOR WOMEN IN INDIA

SASO is an HIV and harm reduction non-governmental organisation, created in 1991 by former drug users in Manipur, north-east India. It provides a wide range of HIV and harm reduction services to drug users, their partners and families, and people living with HIV. These include home care, HIV prevention programmes, care and support programmes for children affected by HIV, and community drug detoxification services.

SASO also implements a small-scale, innovative programme for women who inject drugs. This group is highly marginalised in Manipur, and many have experienced police violence and harassment. A lot of the women are involved in sex work, and many of them are rejected by their families because of the stigma associated with drug use and sex work.

The programme provides them with free basic health care from a female doctor, counselling services, overdose prevention and management, support groups, and referrals to other essential services. It also runs a drop-in centre and a night shelter for homeless women who inject drugs – the only service of its kind in India.

SASO is also developing vocational training and micro-credit programmes that will increase the economic security of women who use drugs, as poverty and exploitation can make them more vulnerable to HIV and worsen their isolation and marginalisation.

www.aidsalliance.org/linkingorganisationdetails.aspx?id=43

5 Harm reduction interventions

In this chapter:

- Key harm reduction interventions
- Selecting and planning for interventions

Key harm reduction interventions

A harm reduction approach to HIV programming identifies a range of key interventions:

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counselling
4. Antiretroviral therapy (ART)
5. SRH services, including STI services and PMTCT
6. Behaviour change communication
7. Vaccination, diagnosis and treatment of viral hepatitis
8. Prevention, diagnosis and treatment of tuberculosis (TB)
9. Basic health services, including overdose prevention and management
10. Services for people who are drug dependent or using drugs in prison or detention
11. Advocacy
12. Psychosocial support
13. Access to justice/legal services
14. Children and youth programmes
15. Livelihood development/economic strengthening.

WHO have also produced a list of key harm reduction interventions that is shorter and more focused on clinical interventions.⁶⁵ We have added some community-oriented interventions to this list, such as psychosocial support and children and youth programmes. We have also expanded the range of clinical services to include SRH and PMTCT services.

In some countries planners pick and choose from these lists at the expense of high-coverage implementation of essential interventions. We need our programming to be comprehensive and extensive enough to offer many of these interventions, or to be co-ordinated as part of an overall plan for comprehensive service delivery by a range of providers for people who use drugs. Rarely do individual interventions work on their own.

65. WHO, UNODC,UNAIDS (2009), 'Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users'. Available at: www.who.int/hiv/pub/idu/targetsetting/en/

KEY RESOURCES

For guidance on participatory assessment with people who use drugs, see: International HIV/AIDS Alliance (2003), 'Developing HIV/AIDS work with drug users: a guide to participatory assessment and response'. Available at: www.aidsalliance.org/publicationsdetails.aspx?id=88

For guidance on acting on the findings from an assessment see our Good Practice Guide on the project cycle (forthcoming).

For more detailed guidance on planning and implementing the specific interventions listed in this chapter, see the key references sections under each heading.

Selecting and planning for interventions

When we are planning a programme to meet the HIV (and other) needs of people who use drugs, we need to select interventions from this list. But before we do this we need to be clear about our objectives. What are we trying to achieve? What are the needs – HIV and otherwise – of people who use drugs and their partners in our community? Reflecting on the concept of working at individual, community, structural and service levels (see page 29), what range of interventions are required to make the most important changes at each level?



1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ The provision of sterile injecting equipment and the safe disposal of contaminated equipment. ■ Information and education on safe injecting. 	<ul style="list-style-type: none"> ■ To reduce the risk of HIV and HCV transmission through the provision of sterile injecting equipment (plus condoms and targeted information and education). ■ To link injecting drug users to other health services. 	<ol style="list-style-type: none"> 1. Community-based needle and syringe programmes 2. Pharmacy-based programmes 3. Safe disposal of used injecting equipment <ul style="list-style-type: none"> ■ NSPs can be provided from a fixed site, a mobile service (such as a van) and/or through outreach. The location of the NSP is important because drug users need to access it easily and without fear of being noticed or arrested. ■ In addition to sterile injecting equipment, NSPs also provide other commodities and services, including condoms, information and education on safer sex negotiation skills, information and education on safe injecting, overdose prevention and management, and referral to other agencies, particularly primary health care, ART, SRH services, drug dependency treatment and TB services. ■ Pharmacy-based schemes are an additional approach to the distribution of sterile injecting equipment. Needles and syringes are available through pharmacies for free or at a minimal cost. These schemes can be very popular with drug users as they increase the number of services available to them, often dramatically. Pharmacy staff often require training in harm reduction and non-judgmental attitudes to drug use and drug users. One drawback of this approach is that they rarely have the capacity to provide referral or peer education and support etc. ■ Local residents or local businesses may resist having a NSP in their neighbourhood, so local advocacy is often required to establish an NSP and to ensure its work is understood and accepted by local residents and businesses, local police and other authorities, and local health service providers. ■ The safe disposal of used injecting equipment is important for two main reasons: <ul style="list-style-type: none"> ■ infection control and public safety ■ community acceptance of NSP programmes. Often local community members reject proposals for an NSP out of fear of inadequate disposal of used needles. Attention to safe disposal can build local support for NSPs.

KEY REFERENCES

- WHO (2007), 'Guide to starting and managing needle and syringe programmes'. Available at: www.who.int/hiv/pub/idu/needleprogram/en/index.html
- WHO (2004), 'Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users'. Available at: www.who.int/hiv/pub/idu/pubidu/en/
- Strike, C., Leonard, L., Millson, M., Anstice, S., Berkeley, N., Medd, E. (2006), 'Ontario needle exchange programs: best practice recommendations', Ontario Needle Exchange Coordinating Committee. Available at: www.health.gov.on.ca/english/providers/pub/aids/reports/ontario_needle_exchange_programs_best_practices_report.pdf



EXAMPLE – MALAYSIA’S NEEDLE AND SYRINGE PROGRAMME

A national NSP was introduced in Malaysia in 2006 after the Malaysian AIDS Council (MAC) successfully advocated for needle and syringe programming as an effective intervention for reducing the spread of HIV among injecting drug users. Injecting drug use is the main driver of the HIV epidemic in Malaysia – 71.2% of people living with HIV from 1986 to 2008 were injecting drug users. By the end of 2008 MAC had reached over 13,000 people who use drugs across Malaysia.

The NSPs are based in drop-in centres, where clients are able to rest, eat, bathe, wash their clothes and receive basic medical attention. Drugs and drug use are not allowed on the premises, and detailed operating procedures guide each NSP. Activities include:

- exchanging used needles for sterile ones
- safe disposal of used injecting material
- HIV education – preventing HIV transmission, HIV and health, managing drug dependency
- referrals to drug treatment and other health and welfare agencies
- safer sex counselling and distribution of condoms
- liaising with local agencies such as the police and local government.

Scaling up is now underway, with a target of reaching at least 60% of drug users through new NSP outlets and outreach programmes in rural areas and fishing villages.

See www.mac.org.my/index.htm

2

OPIOID SUBSTITUTION THERAPY (OST) AND OTHER DRUG DEPENDENCE TREATMENT

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ Provision of OST – commonly methadone or buprenorphine – to people who are dependent on opiates. OST is an important HIV prevention intervention because it reduces injecting and therefore also reduces HIV risk. ■ Drug substitution treatment is currently limited to OST. Substitution treatment for ATS use is not currently available. ■ Research on the use of drug dependence treatment as an HIV prevention strategy has shown that OST is the most effective drug treatment for opiate-dependent people. Other approaches to drug treatment such as residential or outpatient drug-free treatment are less successful due to high relapse and drop-out rates. ■ However, there is no one model of drug treatment that fits all, so establishment of a range of evidence-based, voluntary drug dependence treatment services, including OST, is necessary. 	<ul style="list-style-type: none"> ■ To support HIV prevention by reducing or stopping injecting. ■ To improve the health and wellbeing of people who use drugs by treating the effects of withdrawal from opiates. ■ To support drug users who are taking ART. It helps with adherence to ART. ■ Drug dependence treatment has generally been under-resourced and has often had the effect of taking those caught using illicit drugs out of their communities, without providing any credible treatment or therapy. In most countries a range of evidence-based, voluntary drug dependence treatment is not widely available. There are reports of growing private sector entry into this area, yet few countries have standards or service accreditation mechanisms in place. 	<ul style="list-style-type: none"> ■ Provision of OST through drug treatment services that are easy to access, low threshold and protected from police harassment and coercion. ■ Psycho-social interventions, including peer support, family support and counselling, can help to optimise the benefits of drug treatment programmes. ■ Information and education, including peer education, for people who use drugs and their families about drug dependence treatments, along with other treatments such as ART and TB treatment, is important to promote treatment uptake and retention. ■ Provision of residential and/or outpatient drug-free treatment in community or health service programmes. Non-coercive, evidence-informed, accessible to women and men who use drugs. ■ Advocacy may be required to expand the range and quality of drug treatment, and to re-orient existing treatment services to introduce evidence-based interventions such as OST. ■ Linkages and referral pathways are important: SRH services, (including services for pregnant women), HIV and TB services, and micro-financing or job training services.

2 OPIOID SUBSTITUTION THERAPY (OST) AND OTHER DRUG DEPENDENCE TREATMENT

KEY REFERENCES

- WHO (2009), 'Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence', World Health Organisation. Available at: www.who.int/hiv/pub/idu/opioid/en/index.html
- WHO/UNODC UNAIDS (2004), 'WHO/UNODC UNAIDS position paper: substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention'. Available at: www.unodc.org/docs/treatment/Brochure_E.pdf
- WHO (2006), 'Effectiveness of drug dependence treatment in preventing HIV among injecting drug users'. Available at: www.who.int/hiv/pub/idu/idupub/en/
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- UNODC/WHO (2008), 'Discussion paper: principles of drug dependence treatment'. Available at: www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf
- WHO Regional Office for the Western Pacific (2009), 'Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: application of selected human rights principles'. Available at: www.wpro.who.int/publications/PUB_9789290614173.htm

For drug treatment implementation:

- WHO SEARO (2008), 'Operational guidelines for the management of opioid dependence in the South-East Asia region'. Available at: www.who.int/hiv/pub/idu/op_guide_opioid_depend/en/index.html
- O'Brien, S. (2004), 'Treatment options for heroin and other opioid dependence guidelines: a guide for frontline workers', Commonwealth Department of Health and Ageing for National Drug Strategy. Available at: www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/opioid-workers
- Jenner, L. and Lee, N. (2008), 'Treatment approaches for users of methamphetamine: a practical guide for frontline workers', Australian Government Department of Health and Ageing. Available at: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/id-tremeth
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- WHO (2006), 'Treatment of injecting drug users with HIV/AIDS: promoting access and optimizing service delivery'. Available at: www.who.int/substance_abuse/publications/treatment_idus_hiv_aids.pdf
- Keeney, E. and Saucier, R. (2010), 'Lowering the threshold: models of accessible methadone and buprenorphine treatment', Open Society Institute. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/lowering-the-threshold-20100311

Information for drug users about drug treatments:

- Australian Drug Foundation (2006), 'The methadone handbook'.
- O'Brien, S. (2004), 'Treatment options for heroin and other opioid dependence guidelines: a guide for frontline workers', Commonwealth Department of Health and Ageing for National Drug Strategy. Available at: www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/opioid-workers
- The Methadone Alliance, a UK-based organisation of methadone users: www.m-alliance.org.uk



EXAMPLE – SUPPORTING PEOPLE ON METHADONE

The Chinese government introduced methadone maintenance therapy (MMT) in 2004 in order to control HIV transmission, improve health and welfare outcomes, and reduce crime among opiate-dependent people. By 2008 there were nearly 600 methadone clinics, and 178,600 heroin users were registered at clinics across 22 provinces of China.

However, the retention rate was poor. Too many people were dropping out of the programme, and Alliance China wanted to know why. So they conducted a needs assessment with the Guangxi AIDS Office, China Centers for Disease Control, and MMT clinicians and clients. They discovered that people were dropping out of the MMT programme because of the financial burden (both MMT service fees and transport costs), lack of public and family support, insufficient information about methadone and the programme, mobility and employment constraints, and police arrests.

Based on these findings, Alliance China developed a peer-led MMT psychosocial support project at four government-led MMT clinics in Nanning, Guangxi province, in 2009. These offer individual peer support, peer support group activities and family support group activities, implemented by teams of trained peers. Alliance China also supplemented its harm reduction project in Emei, Sichuan province, by adding peer-led MMT adherence support services to the existing NSP programme, which operates largely through outreach and small group activities. The MMT support programme offers individual peer support, small group activities and family group activities. Together, both types of services are leading to a more comprehensive approach to harm reduction services for injecting drug users. In 2009 Emei's MMT retention rate was the highest in Sichuan province.

The peer-led services are acknowledged by many clinicians, MMT clients and their families to be important in supporting people to stay involved in the programme. They are improving their understanding of HIV prevention and the benefits of MMT, and offering a place for drug users and their families to get support.

However, some challenges remain, including improving clinicians understanding of the psychosocial support needs of people on the MMT programme, managing the turnover of peer educators, and improving support from local public security officials.

See www.alliancechina.org

3

HIV TESTING AND COUNSELLING

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ Testing for HIV antibodies to enable people who use drugs and their sexual partners to know their HIV status. ■ Pre- and post-test counselling to discuss sexual and injecting risk, the meaning of an HIV-positive result, HIV prevention, and HIV treatment, care and support. 	<ul style="list-style-type: none"> ■ Knowledge of HIV status is important for two main reasons: <ul style="list-style-type: none"> ■ so that we can manage our health, including seeking HIV treatment if necessary; and ■ so we can understand our role in preventing HIV transmission or acquisition. ■ Good-quality HIV testing gives us the knowledge we need to manage our health, our sexual and reproductive lives, and our injecting practices. 	<ul style="list-style-type: none"> ■ Key principles to guide HIV testing and counselling: <ul style="list-style-type: none"> ■ HIV testing and counselling must be voluntary. The person being tested makes their own decision about whether to take the test or go for counselling. ■ HIV testing and counselling must be confidential. Information should not be shared with anyone else without the permission of the person who takes the test. ■ HIV testing services must ensure informed consent. The person being tested must explicitly agree to the test, based on knowledge of what the test is, and what the implications of being tested are. ■ There are a number of methods to test for HIV, but the most common way is to take a blood sample and test for antibodies to the HIV virus. Testing can be carried out by a doctor, nurse or community health worker. Rapid tests are available in some places, giving instant results. When a positive result is indicated by a rapid test, a confirmatory laboratory-based blood test is recommended. ■ Counselling is a critical component of HIV testing. There are two types of counselling in this context: pre- and post-test HIV counselling. <ul style="list-style-type: none"> ■ Pre-test HIV counselling provides an opportunity to: <ul style="list-style-type: none"> ■ discuss possible exposure to HIV ■ provide clear information about how HIV is transmitted ■ explain the HIV test ■ discuss the implications of knowing your HIV status, leading to informed decision-making. ■ Post-test HIV counselling provides an opportunity to: <ul style="list-style-type: none"> ■ discuss the HIV test result ■ provide information, support and referral ■ promote risk reduction strategies such as safe injecting, safe sex, drug treatment, STI treatment, behaviour change to reduce the risk of becoming infected if the test is negative, or to reduce the risk of HIV transmission and of re-infection if the test is positive ■ where the test result is positive, strategies to cope with the result and its consequences for both the individual, their partner/s and families. ■ For people who use drugs, HIV testing and counselling should be provided at a site where drug users feel safe, and where knowledge of HIV status and drug use is confidential.

KEY REFERENCES

- WHO and UNODC (2009), 'Guidance on testing and counselling for HIV in settings attended by people who inject drugs: improving access to treatment, care and prevention'. Available at: www.wpro.who.int/publications/PUB_9789290613985.htm
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- WHO (2007), 'Guidance on provider-initiated HIV testing and counselling in health facilities'. Available at: www.who.int/hiv/pub/vct/pitc2007/en/
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- WHO (2009), 'HIV testing and counselling in prisons and other closed settings', World Health Organisation. Available at: www.who.int/hiv/pub/idu/tc_prisons/en/index.

4 ANTI-RETROVIRAL THERAPY (ART)

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ ART is a combination of drugs that can suppress the HIV virus and stop the progression of HIV disease. ■ This results in a reduced (often called “undetectable”) viral load. The very reduced levels of virus mean that the immune system is no longer under attack and can result in CD4 count (a measure of immune system functioning) increase. Treatment is most effective if started before CD4 counts drop below 200–350 cells/mm. 	<ul style="list-style-type: none"> ■ ART can allow people living with HIV to lead a normal life and HIV therefore becomes a chronic manageable illness. However, ART is not a cure and requires very high levels of adherence. Medications must be taken continuously and at regular intervals. ■ Increasingly, countries are looking to ART as a major strategy in HIV prevention among injecting drug users. Providing ART to significant numbers of HIV-positive injecting drug users can play an important role in limiting overall HIV prevalence. 	<ul style="list-style-type: none"> ■ ART provision for drug users should address the following factors: <ul style="list-style-type: none"> ■ Drug users are often unable to access services because of personal circumstances, inappropriate location and type of services, and/or discrimination from other service users or service providers. ■ Starting ART early enough for greatest benefit is complicated by limited availability in some countries, and the lack of access to regular monitoring or other services for drug users. ■ Some service providers make assumptions about the ability of drug users to adhere to treatment and may decide not to offer ART to users. The demands of adherence may be made more complex by other factors such as homelessness, poor nutrition, limited income and lack of social support. However, with adequate support, drug users are able to adhere to treatments as well as other groups of people living with HIV. ■ Co-infection with hepatitis can make managing HIV treatment more challenging and requires skilled medical staff who understand treatment and co-infection.

KEY REFERENCES

- OSI (2004), ‘Breaking down barriers: lessons on providing HIV treatment to injection drug users’. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/arv_idus_20040715
- WHO (2006), ‘Treatment of injecting drug users with HIV/AIDS: promoting access and optimizing service delivery’. Available at: www.who.int/substance_abuse/publications/treatment_idus_hiv_aids.pdf
- WHO (2006), ‘Basic principles for treatment and psychosocial support of drug dependent people living with HIV/AIDS’. Available at: www.who.int/hiv/pub/idu/basic_principle_drug_hiv/en/index.html
- WHO (2008), ‘HIV/AIDS care and treatment for people who inject drugs in Asia and the Pacific: an essential practice guide’. Available at: www.who.int/hiv/pub/idu/searo_wpro_essential/en/index.html
- WHO SEARO (2007), ‘Treatment and care for HIV-positive injecting drug users’. Available at: www.searo.who.int/en/Section10/Section18/Section356_14247.htm
- International HIV/AIDS Alliance (2007), ‘Positive prevention: HIV prevention with people living with HIV. A guide for NGOs and service providers’. Available at: www.aidsalliance.org/Publicationsdetails.aspx?Id=90
- Urban Health Research Initiative (2009), ‘HIV treatment may be a powerful tool for HIV prevention among drug users’. Available at: <http://uhri.cfenet.ubc.ca/images/Documents/haart-prevention.pdf>
- WHO (2007), ‘HIV treatment and care. Clinical protocols for the WHO European region’. See chapter 5, “HIV/AIDS treatment and care for injecting drug users”. Available at: www.who.int/hiv/pub/idu/euro_treatment/en/index.html

5 SRH SERVICES, INCLUDING STI SERVICES AND PREVENTION OF MOTHER-TO-CHILD TRANSMISSION

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ A range of services to address sexual health, reproductive health and maternal health services for people who use drugs and their partners. ■ Key services: <ul style="list-style-type: none"> ■ STI testing, counselling and treatment ■ Condom promotion – male and female ■ Drug user-friendly contraception, family planning and safe abortion services, for people who use drugs and their partners. ■ Access to PMTCT services for HIV-positive women who use drugs and the partners of men who use drugs. ■ Access to drug–user friendly maternal health services such as pre and post natal care and safe delivery services for women who use drugs. 	<ul style="list-style-type: none"> ■ People who use drugs and their sexual partners need to prevent the sexual transmission of HIV. They also need services to meet their reproductive and sexual health needs when they need contraception and family planning advice, when they are pregnant or when they have an STI. ■ It is important to provide interventions to reduce the sexual risk practice of people who use drugs, including providing male and female condoms, improving access to SRH services, and prevention and treatment of STIs, particularly among women who inject drugs, and especially those who engage in sex work. 	<ul style="list-style-type: none"> ■ Foster drug user-friendly SRH services that are linked to drugs services. ■ Provide STI diagnosis and treatment services alongside drug services. ■ Foster drug user-friendly PMTCT services. ■ Foster drug user-friendly pregnancy and maternal health services for women who use drugs, including safe abortion and family planning services. ■ Contraception and family planning advice for women who use drugs and partners of people who use drugs.

KEY REFERENCES

- UNFPA, WHO, PATH (2005), 'Condom programming for HIV prevention: an operations manual for programme managers'. Available at: www.unfpa.org/public/global/pid/1292
- International HIV/AIDS Alliance (2010), 'Good practice guide: integration of sexual and reproductive health, HIV and rights' (forthcoming).
- International HIV/AIDS Alliance (2008), 'Sexuality and life-skills: participatory activities on sexual and reproductive health with young people'. www.aidsalliance.org/includes/Publication/Sexuality_and_lifeskills.pdf

6 BEHAVIOUR CHANGE COMMUNICATION

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ BCC is health information, education and skills development to promote healthy behaviour. ■ It involves a range of different types of interventions to promote health. ■ BCC in the context of HIV and drug use means interventions to support individuals to practice safe injecting or safer sex. ■ Peer education and peer outreach have been shown to be the most effective ways to reach otherwise hidden populations with BCC. 	<ul style="list-style-type: none"> ■ BCC principles are based on the understanding that information alone will not necessarily change behaviour. ■ A BCC approach also addresses skills, and involves dialogue and discussion as well as the provision of information. ■ Good BCC practice responds to the environment in which people's behaviour occurs, and how people learn and adapt. For example, BCC for sex workers who have low levels of literacy would choose video, dialogue or role play over printed materials, and would use language and concepts that would be familiar and relevant. The place where sex work was occurring would be a factor in the design of the communication materials, as would issues such as the amount of time available to pay attention to health communication messages. 	<ul style="list-style-type: none"> ■ BCC uses local languages, traditions and expressions to convey health messages. A range of methods are used, including: <ul style="list-style-type: none"> ■ Peer education groups and one-to-one education for and by people who use drugs on a range of health topics. Drug users learn from and trust other drug users to provide health information that is relevant and accurate. ■ Outreach is a BCC method to reach people who use drugs who do not access mainstream services. Outreach workers make contact with people who use drugs where they are – often on the streets and in neighbourhoods where drug users live – providing health information, new injecting equipment, condoms, and advice and referral to services. Sometimes outreach workers are also peers; that is, other drug users or former drug users. This is known as peer outreach. ■ Condom promotion and marketing. ■ Information and education materials on HIV and safe injecting, safer sex, safe drug use, drug treatment, and overdose prevention and management. Peer outreach is particularly effective at getting materials to people who need them. Materials can be printed or electronic. Workshops, meetings and role play can also be used. Sometimes organisations put health messages on the wrappings of injecting equipment or on related paraphernalia such as lighters or condoms. ■ Health communication campaigns for health promotion normally use mass media or local media, community radio, billboards, flyers, public service announcements, celebrity endorsements, websites, blogs and e-forums. These risk being stigmatising for drug users. Understanding what communication tools and channels drug users use (such as mobile phones, fanzines, social networking) will help identify how best to do health communication campaigning with/for people who use drugs. ■ Counselling/inter-personal communication to provide information and education on health. Can be face-to-face or via telephone services. Instruction and dialogue on healthy behaviours. ■ Personal skills development to support behaviour change; for example, assertiveness training to practice safer sex, safe injecting skills, overdose prevention and management skills, and relapse prevention skills.

KEY REFERENCES

- WHO (2004), 'Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users'. Available at: www.who.int/hiv/pub/idu/idu/en/
- Toronto Harm Reduction Task Force (2003), 'Peer manual: a guide for peer workers and agencies'. Available at: www.canadianharmreduction.com/readmore/ichip_peerManual.pdf
- Johns Hopkins Bloomberg School of Public Health (2008), 'Population reports: communication for better health'. Available at: www.infoforhealth.org/pr/j56/j56.pdf
- WHO (2004), 'Training guide for HIV prevention outreach to injecting drug users'. Available at: www.who.int/hiv/pub/idu/hivpubidu/en/
- International HIV/AIDS Alliance (2005), 'Guide to participatory production of resources for HIV prevention among vulnerable populations'. Available at: www.aidsalliance.org/Publicationsdetails.aspx?Id=194



EXAMPLE – PEER-LED INTERVENTIONS IN UKRAINE

Alliance Ukraine has developed an innovative approach to the difficulties of reaching large numbers of marginalised drug users with HIV and harm reduction programmes. Their model is peer driven, and focuses on getting HIV prevention education to people who use drugs and their peers, and raising awareness of services.

Individual drug users pass HIV prevention information to three or four of their personal contacts, and through a voucher system encourage them to access services. When their peers make contact with services and show they understand the basics about HIV prevention, they receive a reward, and the peer recruiter also gets an incentive.

The results of this model have been significant, with a large increase in the number of people reached in a short space of time. Beginning with only six “seeds” (individual drug users), the project reached 900 new drug users in six months. The model was then scaled up to increase the number of sites, and in seven months 17 projects reached 16,920 drug users who had been unaware of services.

Drug users who are part of the programme receive information about HIV prevention and peer education. This means that they are discussing prevention a number of times – when they are recruited into the programme and during the outreach work. This is a more intensive form of BCC than reading HIV prevention information on a poster or in a leaflet.

The approach is particularly suitable for under-resourced environments, as each project requires only three or four staff. Using this model it is also possible to target particular populations, such as young people who use drugs or stimulant users, by selecting “seeds” who have access to these specific populations.

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7

VACCINATION, DIAGNOSIS AND TREATMENT OF VIRAL HEPATITIS

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ Hepatitis literally means “swollen liver”. It is caused by over-consumption of substances that are toxic to the liver (such as alcohol) and/or by viruses named a,b,c,d,e...as new types emerge and are identified. To date, the hepatitis virus types most affecting injecting drug users are HBV and, increasingly, HCV. HBV is the most common form of hepatitis in the world, and HCV is the most common form affecting drug users. 	<ul style="list-style-type: none"> ■ HCV has a range of effects to do with poor liver function, including (in a minority of cases) liver cancer and liver failure. ■ Chronic HCV can also limit the effectiveness of ART and make HIV management challenging. ■ Treatment for HCV and HBV can be successful but they are rarely available because of their cost. However, there are effective vaccines available for HAV and HBV, and methods to prevent transmission of HBV and HCV. 	<ul style="list-style-type: none"> ■ Vaccination for HAV and HBV should be routinely offered to drug users (as well as staff and volunteers) through integrated HIV/SRH or primary health care services. ■ Hepatitis prevention can be incorporated into existing HIV prevention programmes and services targeting drug users through promotion of vaccination for HAV and HBV, by expanding NSP coverage and by providing accurate and credible information about hepatitis transmission to drug users. In particular, drug users should know how HBV and HCV are transmitted, how to prevent transmission and where to access testing and counselling services. ■ NSPs can be effective in preventing a range of BBV transmission, such as HIV, HCV and HBV. HCV and HBV can survive outside the body for much longer than HIV, and education programmes must stress the importance of trying to keep all injecting equipment (including tourniquets and preparation surfaces) clean. ■ Counselling and testing for HBV and HCV should be offered as part of integrated harm reduction programmes. ■ Hepatitis treatment programmes, where they exist, should be responsive to the needs of former and current drug users. ■ Advocacy is required to expand access to HCV treatment. Treatment for hepatitis co-infection should be integrated into HIV treatment programmes. ■ Support for people who have hepatitis to make healthy changes to their lives, such as reducing alcohol intake, maintaining a well-balanced diet that is low in fat and considering overall health maintenance.

KEY REFERENCES

- HIV i-Base (2009), ‘Hepatitis C for people living with HIV: testing, co-infection, treatment, support’. Available at: www.i-base.info/guides/hepc/index.html
- OSI (2006), ‘Delivering HIV care and treatment for people who use drugs: lessons from research and practice’. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/delivering_20060801
- WHO, ‘Management of hepatitis C and HIV co-infection’. Available at: www.euro.who.int/en/what-we-do/health-topics/diseases-and-conditions/hepatitis/publications/pre2009/management-of-hepatitis-c-and-hiv-coinfection
- Hepatitis Australia: a website with a wide range of information and resources on hepatitis A, B and C. www.hepatitisaustralia.com/

8 PREVENTION, DIAGNOSIS AND TREATMENT OF TUBERCULOSIS (TB)

WHAT?	WHY?	HOW?
<ul style="list-style-type: none">■ TB testing and treatment services for people who use drugs, their partners and families.	<ul style="list-style-type: none">■ Injecting drug users may have increased vulnerability to TB and as a co-infection with HIV. It is important to provide services for prevention, diagnosis and treatment of TB for injecting drug users.	<ul style="list-style-type: none">■ TB testing and treatment services linked to HIV treatment services.■ Integration and clear roles and responsibilities between providers of HIV, TB and drug treatment services.■ Foster drug user-friendly TB services.

KEY REFERENCES

- WHO, UNODC, UNAIDS (2008), 'Policy guidelines for collaborative TB and HIV services for injecting and other drug users: an integrated approach'. Available at: www.who.int/tb/publications/2008/tbhiv_policy_guidelines_injecting_drugusers/en/index.html
- International HIV/AIDS Alliance (2010), 'Good practice guide: TB and HIV programming' (forthcoming).

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ Primary care health services to meet the basic health care needs of people who use drugs, beyond those related to HIV. These include STI, hepatitis and TB testing and treatment; infections that relate to injecting practices; and the negative health implications of being poor and socially excluded. ■ Overdose prevention and management are important features of basic health care for people who use drugs to address high rates of overdose. 	<ul style="list-style-type: none"> ■ To address the health needs of people who use drugs who are not in contact with mainstream health services. ■ By addressing these primary needs, the relevance of HIV-related services is improved. 	<ul style="list-style-type: none"> ■ Providing drug user-friendly health services. ■ This can mean health services provided by health care workers (including trained peer workers) with specific understanding of the health needs of drug users, and/or reorientation of existing primary health care services through cross-training, meetings/relationship-building, cross-referral etc. ■ Basic health services can be provided at drop-in centres, NSPs or as mobile services; for example, mobile health clinics that visit sites where drug users are. Some drug user services make arrangements to employ doctors or nurses for a day a week or according to demand to address more complex cases. It is also important to develop referral networks with other health service providers. ■ Overdose prevention services include educating people who use drugs about overdose risk and risk reduction strategies. Overdose management may require emergency resuscitation and administering of naloxone, an antidote to opiate overdose. People who use drugs can be trained in mouth-to-mouth resuscitation, and efforts should be made to equip drug users with naloxone and knowledge on its use in the event of opiate overdose. At a minimum, health facilities, NSPs and drop-in centres should stock naloxone and train staff to use it.

KEY REFERENCES

- WHO SEARO (2008), 'Management of common health problems of drug users'. Available at: www.searo.who.int/LinkFiles/HIV-AIDS_Primary_care_guidelines.pdf
- Curtis, M. and Guterman, L. (2009), 'Overdose prevention and response: a guide for people who use drugs and harm reduction staff in Eastern Europe and Central Asia', Open Society Institute. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/overdose_20090604

10 SERVICES FOR PEOPLE WHO ARE DRUG DEPENDENT OR USING DRUGS IN PRISON OR DETENTION

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ Drug users are particularly vulnerable to HIV in prisons as transmission through unprotected sex and sharing of injecting equipment is well documented. Risky practices are often exaggerated because of the need to hide and because of lack of prevention commodities. 	<ul style="list-style-type: none"> ■ Prisoners have the same rights as other citizens to receive health services comparable to that of the general community. ■ We need to ensure equal provision of treatment services and BBV prevention programmes between prisons and communities, and continuity of care. 	<ul style="list-style-type: none"> ■ Promote access to: <ul style="list-style-type: none"> ■ Voluntary counselling and testing (VCT) ■ ART ■ OST ■ NSPs ■ Condoms ■ Information and education programmes – BBV prevention. ■ Continuity of treatment post-release ■ Community linkages, including links to HIV and drug treatment services.

KEY REFERENCES

- WHO Regional Office for the Western Pacific (2007), 'Inside out: HIV harm reduction education for closed settings'. Available at: www.wpro.who.int/publications/PUB_978+92+9061+221+6.htm
- WHO (2007), 'WHO guidelines on HIV infection and AIDS in prison'. Available at: http://data.unaids.org/publications/IRC-pub01/jc277-who-guidel-prisons_en.pdf
- WHO, UNODC, UNAIDS (2004), 'Evidence for action policy brief: reduction of HIV transmission in prisons'. Available at: www.wpro.who.int/sites/hsi/documents/policy_brief_04_05.htm
- WHO, UNODC, UNAIDS (2007), 'Effectiveness of interventions to address HIV in prisons'. Available at: http://whqlibdoc.who.int/publications/2007/9789241596190_eng.pdf

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ People who use drugs experience stigma and discrimination, and are routinely marginalised in the community, health care settings and the criminal justice system. There is usually very little political or public support for their rights, in particular their right to access health services. In addition, policies and laws can undermine HIV prevention. ■ Advocacy is critical to persuade influential individuals, groups and organisations to defend the rights of people who use drugs; to improve access to services both within and outside closed settings; to promote harm reduction approaches to drug use; and to create an enabling environment for effective HIV prevention. 	<ul style="list-style-type: none"> ■ To increase access to essential services for people who use drugs by removing or reducing policy, legal and structural barriers. ■ To advocate for laws and policies that support a harm reduction approach to drug use and HIV. ■ To promote effective approaches to HIV and drug use. ■ To address stigma and discrimination against drug users and ensure that their rights are not violated. 	<ul style="list-style-type: none"> ■ Advocacy needs vary according to different social, political and cultural contexts. The general principle is to influence key decision-makers, opinion leaders, community leaders and the media of the importance of increasing access to services for drug users and to create an enabling environment for HIV and HCV prevention by promoting a harm reduction approach to drug use and HIV. ■ Advocacy strategies include: <ul style="list-style-type: none"> ■ Supporting drug user networks. ■ Forming coalitions with wider civil society movements to increase the political capital of drug users. ■ Working with health service providers to create drug user-friendly health services. ■ Working with health service providers to improve access to treatment – HIV, HCV, TB and drug dependence treatment – for people who use drugs. ■ Documenting and reporting human rights violations. ■ Developing draft laws and policies that support harm reduction and that protect the rights of people who use drugs. ■ Educating politicians and other decision-makers about the harm reduction approach to drug use and HIV. ■ Working with the media to educate journalists about drug use and human rights issues, and to inform the public about evidence based approaches. ■ Working with the wider community to increase understanding of the value, safety and effectiveness of interventions such as NSPs. ■ Working with law enforcement agencies to reach agreement on policing practices that support public health interventions.

KEY REFERENCES

- WHO (2004), ‘Advocacy guide: HIV/AIDS prevention among injecting drug users’. Available at: www.who.int/hiv/pub/idu/iduadvocacyguide/en/index.html
- Kaplan, K. (2009), ‘Human rights documentation and advocacy: a guide for organizations of people who use drugs’, Open Society Institute. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/hrdoc_20090218
- HIV/AIDS Regional Program (HAARP), ‘Law enforcement and harm reduction’. Available at: www.haarp-online.org/resources/document/Law%20Enforcement%20and%20Harm%20Reduction%20Manual%20%28pdf%29%20%281.44mb%29.pdf
- International HIV/AIDS Alliance (2002), ‘Advocacy in action: a toolkit to support NGOs and CBOs responding to HIV/AIDS’. Available at: www.aidsalliance.org/publicationsdetails.aspx?id=142



EXAMPLE – ADVOCACY FOR SUBSTITUTION TREATMENT IN UKRAINE

OST, specifically methadone, was identified by Alliance Ukraine as an essential part of ART scale-up for people who use drugs in Ukraine. Many HIV-positive drug users were struggling to access ART, and were calling for methadone to help them manage their opiate dependency, as well as assist them with ART adherence.

However, OST was proving extremely challenging for many government agencies to accept. Although it formed part of the public health strategy, few people outside of the international HIV community in Ukraine were committed to it. Moreover, the narcologists (doctors who deal with drug and alcohol dependence) who were nominated to provide OST were reluctant to take on an additional workload, and were also concerned about the impact of OST on existing treatment for drug dependence.

In response, Alliance Ukraine led an advocacy campaign to improve access to OST. The first step was to introduce OST to demonstrate its effectiveness. Initial pilot OST programmes used buprenorphine, as this was already a registered drug and Ukrainian drug treatment specialists were familiar with it. Following this, a series of meetings and national conferences introduced officials to the international experience of implementing OST, culminating in a special meeting called by the President of Ukraine, where he strongly criticised the government for not implementing methadone-based OST.

Following recommendations from Alliance Ukraine and other civil society representatives, a presidential decree was issued in 2007 requiring the elimination of barriers to the scale-up of methadone-based OST. The Alliance and its partners worked with government agencies at the highest levels to secure this commitment. Finally, in 2008 methadone-based OST was introduced.

However, sustained opposition in the state sector slowed down implementation, until the Minister of Health intervened to scale up OST programmes to most regions of Ukraine, with a target of 6,000 people. Government commitment was confirmed in 2009, when parliament approved a national programme for 2009–2013 that includes OST with methadone. As a result, OST availability has increased from six to 26 regions across Ukraine.

The perception of OST among specialists and the public has also been transformed, with the Ukrainian media moving from a negative to a more balanced and sympathetic response. There is increasing understanding of drug dependence as a health problem rather than a moral failing.

Following the long struggle to remove obstacles, the intervention has now been scaled up further to meet drug users' health and social needs in a more integrated way. The first integrated services are now being supported by USAID to address simultaneously drug dependence and mental health, HIV, TB, HCV, STIs and reproductive health, general health and psychosocial support.

The advocacy work to introduce OST built important bridges between civil society, government departments, and law enforcement and drug control agencies. It also gave a voice to people who use drugs, who are often marginalised from public life. Current and potential OST patients actively participated in the advocacy campaigns, and have now registered a national organisation for OST clients. Just as the campaign for ART made people living with HIV a visible, vocal, organised force for political and social change, so OST is helping the visibility and advocacy capacity of people who use drugs.

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WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ Counselling and peer support for people who use drugs. ■ Support for the families and partners of people who use drugs to increase their knowledge and understanding of drug use and HIV, and to engage them in HIV prevention and harm reduction strategies. 	<ul style="list-style-type: none"> ■ People who use drugs have support and care needs, including support with mental health problems, family problems, relationship problems and isolation, fears and anxieties. ■ Families and partners need education about drug use, HIV and harm reduction. ■ Families and partners of drug users have support and care needs too. ■ Support and care services can reduce the stigma and discrimination that people who use drugs face within their own families and communities. 	<ul style="list-style-type: none"> ■ Peer support groups, meetings and individual or group counselling. Peer education can be a useful method for information and education with families or partners; for example, parents of drug users educate other parents of drug users about HIV and harm reduction. ■ Home visits from outreach workers. ■ Education programmes for partners, family members and communities about drug use and HIV, including HIV prevention. ■ Home care programmes.

KEY REFERENCES

- International HIV/AIDS Alliance (2008), 'Breaking new ground, setting new signposts: a community-based care and support model for injecting drug users living with HIV'. Available at: www.aidsalliance.org/Publicationsdetails.aspx?Id=290
- 'Drug facts: nine fact sheets for families of drug users', Family Drug Support, Sydney. Available at: www.fds.org.au/substance1.html

13 ACCESS TO JUSTICE/LEGAL SERVICES

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ Interventions to improve access to justice and provide legal protections for people who use drugs. 	<ul style="list-style-type: none"> ■ People who use drugs are often targeted by police and law and order officials in crackdowns and other campaigns to “clean up the streets”. This makes it difficult for people to inject safely, and harder to reach people who use drugs with health services. ■ Human rights violations such as HIV or drug use-related discrimination require legal redress. Legal services can improve access to justice for people who use drugs. 	<ul style="list-style-type: none"> ■ “Know your rights” training on HIV, drugs and legal issues for people who use drugs. ■ Access to free legal advice, street lawyers. ■ Community legal services.

KEY REFERENCES

- OSI (2008), ‘Police, harm reduction and HIV’. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/policeharmreduction_20080401
- ARASA HIV/AIDS and Human Rights Advocacy and Training Resource Manual. Available at: www.arasa.info/trainingmanual

14 CHILDREN AND YOUTH PROGRAMMES

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ Support and services for children and young people affected by drug use and/or HIV, HCV and TB. ■ Support and basic services for young people vulnerable to drug use and HIV. ■ Support and education to young people who use drugs. 	<ul style="list-style-type: none"> ■ To educate young people about HIV and other health problems arising from drug use. ■ To provide youth-friendly HIV and harm reduction services to young people who use drugs. ■ To support children and young people who experience problems associated with their parents' drug use or HIV, HCV, TB-related illness. 	<ul style="list-style-type: none"> ■ The provision of child-friendly and youth-friendly services within drop-in centres for drug users; and/or reorientation of youth-friendly services to improve access for young drug users. ■ Peer education and support programmes for young people who use drugs. ■ Outreach to vulnerable children, in particular street children, and provision of basic services – food, shelter, etc. ■ Education and recreational programmes for young people to prevent drug use or drug injecting.

KEY REFERENCES

- AIATT/YP, 'Guidance brief: HIV interventions for most-at-risk young people', Interagency task team on HIV and young people'. Available at: www.unfpa.org/hiv/iatt
- EHRN (2009), 'Young people and injecting drug use in selected countries of Central and Eastern Europe'. Available at: www.harm-reduction.org/library/1301-young-people-and-injecting-drug-use-in-selected-countries-of-centraland-eastern-europe.html
- Hoffmann, O., Boler, T. and Dick, B. (2006) 'Achieving the global goals on HIV among young people most at risk in developing countries: young sex workers, injecting drug users and men who have sex with men' in Ross, D., Dick, B., Ferguson, J. (eds) 'Preventing HIV/AIDS in young people: a systematic review of the evidence from developing countries', UNAIDS interagency task team on HIV and young people.
- Youth R.I.S.E. – a harm reduction organisation for young people: www.youthrise.org

15 LIVELIHOOD DEVELOPMENT AND ECONOMIC STRENGTHENING

WHAT?	WHY?	HOW?
<ul style="list-style-type: none"> ■ Education, training and financial support for people who use drugs, including those receiving drug dependence treatment, to generate income. 	<ul style="list-style-type: none"> ■ People who use drugs are often poor and socially excluded. This undermines employment opportunities, and many drug users find themselves in a cycle of poverty and drug use. ■ People who use drugs may need livelihoods and income, and means to escape poverty and disadvantage. 	<ul style="list-style-type: none"> ■ Education and training. ■ Vocational support. ■ Micro-financing programmes.

KEY REFERENCES

- Yadhav, D., Dhawan, A., Yadav, S. (2009), 'Occupational rehabilitation of opiate user through micro-credit', Conference presentation, International Harm Reduction Conference, Bangkok, 2009. Available at: www.ihra.net/Assets/1857/1/Presentation_21st_C14_Yadav.pdf
- Deany, P. (2001), 'Drug-related risk, livelihoods and communities in Asia (parts 1 and 2)'. Report on the UNDP sponsored session at the 12th International Conference on the Reduction of Drug Related Harm New Delhi, India, 1–5 April 2001, UNDP Bangkok. Available at: www.hivpolicy.org/Library/HPP000264.pdf and www.hivpolicy.org/Library/HPP001139.pdf

6

Involving people who use drugs and other stakeholders

In this chapter:

- Involving people who use drugs in programming
- Working with stakeholders
- Key characteristics of an effective HIV programme targeting people who use drugs

People who use drugs have the greatest expertise on what drugs people use, how they use them, what the needs of drug users are and what education or care strategies might work best.

Involving people who use drugs in programming

Why involve people who use drugs?

It is important for us to support the meaningful involvement of drug users in planning, programming and decision-making because:

- involvement and participation is a right
- drug users have knowledge and expertise that is different to the knowledge and expertise of non-drug-using service providers
- drug users can reach other people who use drugs and are more likely to be trusted as educators or support providers
- involving people who use drugs in advocacy can put a “human face” to drug use and be an effective tool for diminishing stigma.

Benefits to programmes

- Involving drug users means better needs identification and planning, leading to higher-quality services.
- Involving drug users means better quality assurance and greater relevance and credibility of programmes and services.
- It also means a stronger voice for drug users as consumers of health services, leading to greater influence over health service delivery.
- Within community-based organisations that provide services to people living with HIV, working with a person who uses drugs can help staff who do not use drugs to overcome their prejudices and change their perceptions about people who use drugs.
- Patterns of drug use, types of drugs and drug use practice are often poorly understood by health and other professionals because of the hidden nature of drug use. Drug use patterns are always changing too. So involving people who use drugs in our planning and decision-making helps us to understand changing drug use patterns and practices.

People who use drugs are often treated badly or misunderstood by health professionals. This means that many of them are reluctant to use health services. Indeed, services often require people who use drugs to be drug free in order to access them. For those of us whose job it is to provide programmes and services to people who use drugs, extra efforts are needed to make our programmes accessible. Involving people who use drugs in the design and delivery of services and programmes will improve their access.

Benefits for people who use drugs

When we provide people who use drugs with structures and support to get involved in programming, they can build skills in service delivery or programme design, and can advocate for additional services. Drug users working with their peers in programme design or delivery can find purpose or meaning, and discover that they have

a stake in this type of work. Their involvement can also be a form of peer support.

People who use drugs have a human right to be involved

Beyond the practical benefits of involving people who use drugs, there is an important ethical principle that we are committed to: that everyone should have a right to be involved in decisions affecting their lives. This principle is advanced in the following commitments:

- The Paris Declaration of 1994, where 42 national governments agreed to support a “greater involvement of people living with HIV/AIDS”.
- The Declaration of Commitment on HIV/AIDS adopted in 2001 by the United Nations Special Session on HIV/AIDS, which calls for the greater involvement of people living with HIV and of people from marginalised communities.
- The United Nations International Guidelines on HIV/AIDS and Human Rights, which require that representatives of vulnerable groups, such as people who use drugs, be involved in consultations, and in planning and delivery of services.

What is involvement?

Meaningful involvement means:

- people who use drugs participating in decision-making about programmes and services
- recognising and respecting the expertise of drug users who know about drug-use patterns
- people who use drugs implementing services or programmes as peer educators, evaluators, carers and programmers.

How do we do it?

Social, legal and personal barriers can prevent people who use drugs from being involved in programmes and services. Stigma and discrimination also create barriers, along with laws that prohibit and criminalise drug use. We must address these barriers in order to achieve meaningful participation and involvement.

Some suggestions are provided in the pyramid of involvement on page 81. Underpinning these is the need to build a culture of empowerment in our programmes and services. Support is essential to empowerment, including financial support and capacity-building for drug users to mobilise and advocate for access to services, or to challenge police violence or punitive drug treatment. Support is also part of an effective approach to the prevention of HIV among people who inject drugs.

 **KEY RESOURCE**

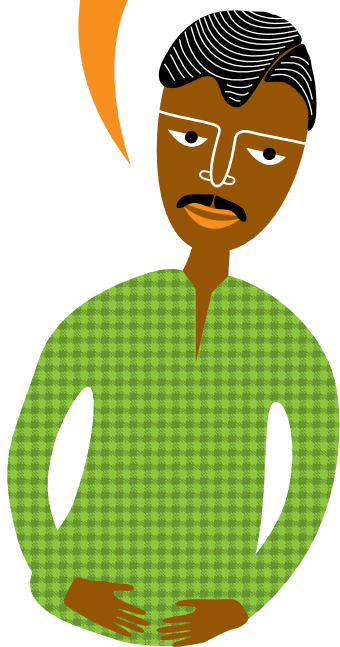
The International Network of People who Use Drugs advocates for the rights of people who use drugs and supports drug user networks around the world: <http://inpu.d.wordpress.com/about/>

Remember!

Address practical barriers to involvement by checking that the following are appropriate:

- opening hours
- location of a service or programme
- attitudes and behaviours of staff
- physical look and feel of a programme or service.

Always seek advice on overcoming practical barriers from people who use drugs.



CBOs can struggle to make the greater involvement of people who use drugs a priority when funding is insufficient to meet many of their needs and they have little time and energy to take up new challenges. So far, very little training has been offered to service providers to enable them to involve people who use drugs, nor to people who use drugs to enable them to participate more effectively. This needs to change.

Challenges include:

- educating board members and staff of organisations about why the involvement of people who use drugs is important, including defining what meaningful involvement is and its value to our organisations
- incorporating involvement into organisational planning, including staff recruitment
- changing the indicators and outcomes we use to evaluate our organisation's work in order to measure the participation of people who use drugs in our activities
- being non-judgemental about drug use
- tackling the stigma that surrounds drug use and people who use drugs
- being prepared to be flexible; for example, by changing work hours
- being prepared to support the development of groups of people who use drugs.

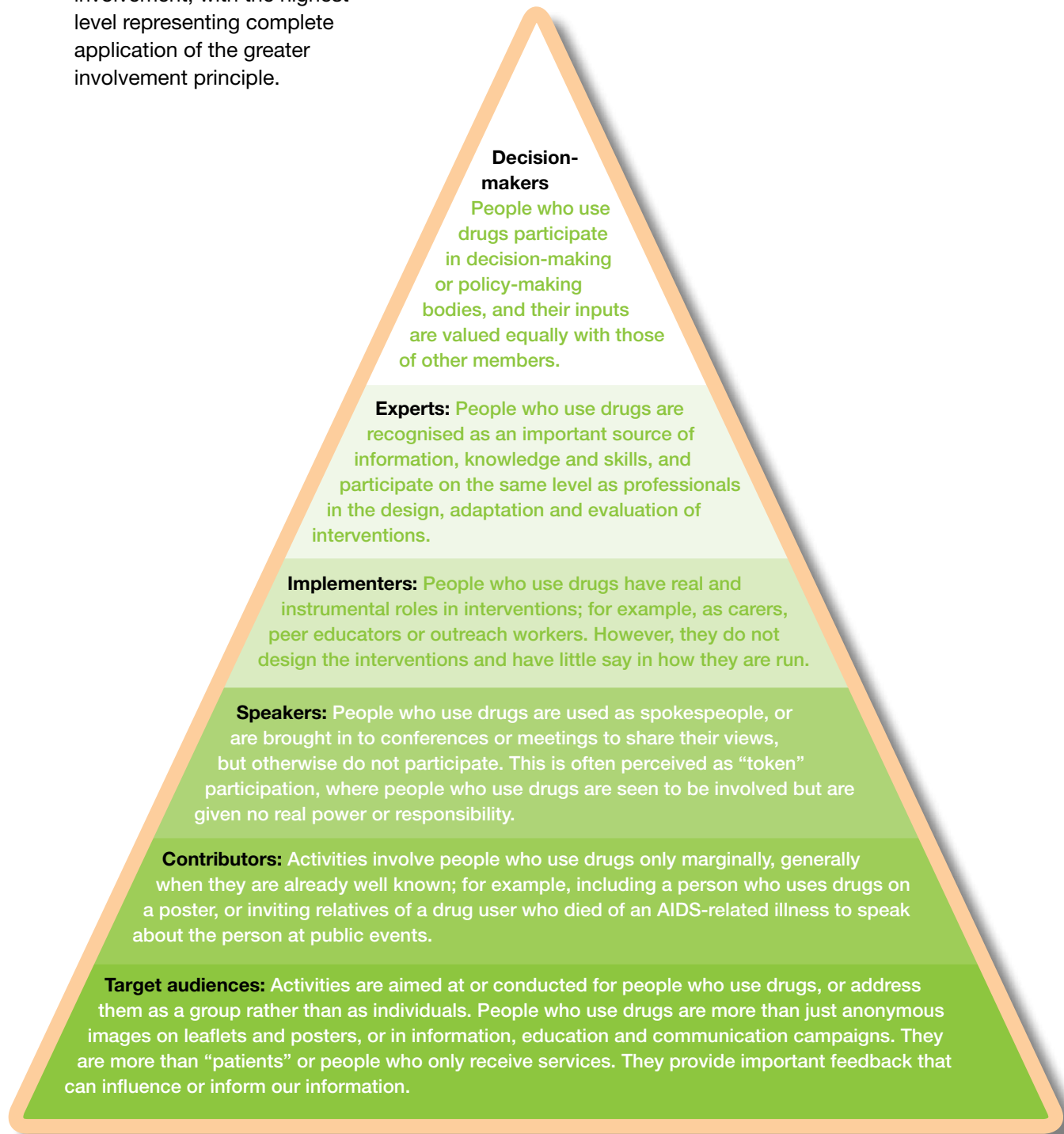


EXAMPLE – SOCIAL AWARENESS SERVICE ORGANIZATION

Social Awareness Service Organization (SASO) is a CBO based in Manipur, India. It was set up and is run by drug users and former drug users who want to care for one another. Services are tailored to the needs of local drug users because SASO's staff and volunteers are part of the same community as those who use their services. The SASO experience is a good example of how drug users can care for and provide comprehensive services to other drug users. It is documented in the International HIV/AIDS Alliance (2007), 'Breaking new ground, setting new signposts: a community-based care and support model for injecting drug users living with HIV'. www.aidsalliance.org/publicationsdetails.aspx?id=290

A pyramid of involvement

This pyramid models increasing levels of drug user involvement, with the highest level representing complete application of the greater involvement principle.



Nothing about us without us: Greater, meaningful involvement of people who use illegal drugs.
www.aidsalliance.org/publicationsdetails.aspx?id=310



KEY RESOURCE

More tips, strategies and examples of good practice in drug user involvement are described in International HIV/AIDS Alliance, Open Society Institute and the Canadian HIV/AIDS Legal Network (2008), “Nothing about us without us”. Greater, meaningful involvement of people who use illegal drugs: A public health, ethical, and human rights imperative’. Available at: www.aidsalliance.org/publicationsdetails.aspx?id=310



STRATEGIES FOR INVOLVING PEOPLE WHO USE DRUGS IN PLANNING, IMPLEMENTATION AND DECISION-MAKING

- Use participatory methods to assess drug use patterns in your site. Participatory approaches to assessment are described in International HIV/AIDS Alliance (2003), ‘Developing HIV/AIDS work with drug users: a guide to participatory assessment and response’. Available at: www.aidsalliance.org/Publicationsdetails.aspx?id=88
- Invite drug users to elect representatives on to programme advisory committees, providing transport and other expenses, training and mentoring, and support to consult with other drug users.
- Support people who use drugs to be spokespeople, but put in place privacy safeguards so they have control over disclosure of their drug use.
- Build capacity – documentation, organisational development, programme management, peer education, evaluation – among people who inject drugs.
- Set up a leadership development programme – identify people who use drugs who are potential leaders and help them build a network and capacity.
- Set up focus groups of drug users to evaluate programmes and services.
- Support drug user groups/networks to provide peer support, advocacy and peer education, and to develop information and education materials.



EXAMPLE – INVOLVING DRUG USERS IN ANALYSIS

Alliance Ukraine believes that involving people who use drugs in analysis is important:

“An important aspect of the participatory assessment process is the involvement of non-governmental organisation staff and community members in the analysis of findings. They find the analysis extremely challenging but very exciting and rewarding as they witness the projects being delivered in front of their eyes. Most of the research and situation assessments they dealt with in the past involved them only at the stage of raw data collection. The analysis was done elsewhere and usually presented in extremely generalised and abstract ways. No concrete and needs-sensitive interventions could be developed from those kinds of analyses.”

Working with stakeholders

Working with stakeholders is important for a number of reasons. HIV and harm reduction programmes are often controversial or poorly understood. So when we involve external stakeholders in HIV and harm reduction programming, we can build “buy-in” or external support and sustainability for the programme.

Sometimes building support is difficult. Stakeholders may be people who need to change what they do or what they believe. For example, the police, who are important stakeholders in HIV and harm reduction programming, can be the best friend or the worst enemy of harm reduction. This is why it is important to keep building a culture of partnership so that local police understand what our programme is trying to achieve, that it is supported by an evidence base and that it will benefit the local community. Often the police are under pressure from other community members to respond to the “problem” of people who use drugs in the community, particularly where they assume that crimes have been committed by drug users. Working with the police to understand the pressures they are under and addressing concerns together can be an effective way of making sure that drug users are not harassed.

The range of stakeholders will vary in each context, and can include:

- people who use drugs
- their sexual partners, partners or spouses
- their parents and other family members
- religious and other local leaders
- local authorities and local government
- police and law enforcement agencies
- the local neighbourhood or community
- anti-drug pressure groups (social and moral observers)
- women’s groups
- youth groups
- health care providers, including pharmacists
- other service providers – social welfare service providers
- local researchers and academic institutions
- donors
- peer leaders.

What are stakeholders and gatekeepers?

Stakeholders are people who have an interest (or stake) in the outcome of a local community-based programme.

Gatekeepers are people who control access to certain individuals, groups of people, places or information. For example, schoolteachers and parents are gatekeepers to children; brothel owners are gatekeepers to sex workers.

Some people may be both a gatekeeper and stakeholder, but many are mainly one or the other.



KEY RESOURCE

HIV/AIDS Asia Regional Program (HAARP), 'Law enforcement and harm reduction'. Available at: [www.haarponline.org/resources/document/Law%20Enforcement%20and%20Harm%20Reduction%20Manual%20\(pdf\)%20\(1.44mb\).pdf](http://www.haarponline.org/resources/document/Law%20Enforcement%20and%20Harm%20Reduction%20Manual%20(pdf)%20(1.44mb).pdf)

Strategies for working with stakeholders (and gatekeepers):

- Have a clear objective about what kind of role stakeholders will play in the programme and why they need to be involved.
- Keep stakeholders informed.
- Plan and budget for stakeholder involvement (resources, time and so on).
- Conduct a stakeholder mapping – who, why, where, how?
- Identify common ground, goals and objectives among different stakeholders.
- Develop a memorandum of understanding as a statement of commitment to co-operation or partnership.
- Educate stakeholders about HIV and harm reduction – sensitisation and educational workshops, study tours and so on.
- Locate the programme within existing local plans and targets so that community stakeholders understand how the programme “fits in”.
- Build relationships and networks with key stakeholders using both informal and formal means.
- Develop relationships with local as well as senior officials, such as local police officers and senior police chiefs. Police harassment or abuse often happens at the ground level, so local street-based police are just as important stakeholders as the senior decision-makers.
- Develop activities to demonstrate that stakeholders are valued and have something important to offer the programme. Build a sense of ownership of the issues and the harm reduction response.
- Keep stakeholders continually informed. Share reports, research or evaluation findings and success stories with them.
- Set up community advisory committees made up of different stakeholders.
- Invite stakeholders to see the programme in action.

Key characteristics of an effective HIV programme targeting people who use drugs

- The needs of people who use drugs are at the centre of the programme design.
- The programme is focused on evidence of need – HIV prevention needs, HIV treatment and care needs.
- HIV prevention programmes focus on where HIV transmission is occurring.
- People who use drugs, community members and other relevant stakeholders are involved in the programme.
- The programme has a budget and workplan that is aligned.
- The programme is integrated into the local infrastructure or the local service plan for a continuum of care. Other services refer people to this programme and it is not duplicating efforts.
- The programme is based on a thorough assessment process and assessment is ongoing to ensure the programme stays relevant.
- The programme is monitored and evaluated regularly and rigorously.
- The programme is accessible to people in cities and rural areas, poor people, women and men, people with diverse sexuality and ethnicity, and young people, including those who live on the streets.
- The programme builds capacity of the target population, the staff and volunteers, and the wider community.
- The programme is sensitive to cultural, racial, ethnic and gender differences and imbalances.
- The programme is sustainable. It has resources and it has a plan for the future that is strategic.
- The programme is achievable at scale – it has a vision for scale from the beginning and is able to be replicated from a single site to many sites. The combined efforts from a number of sites achieve meaningful levels of coverage.
- The programme helps to build political support for an enabling legal and policy environment.
- The programme is accountable to people who use drugs and the wider community.
- The programme is documented, shares knowledge and captures lessons learnt.
- The programme is aligned with national HIV strategies or priorities where these are based on evidence of effectiveness. Where national plans and priorities are insufficient, it is advocating for changes in national plans.

Appendix 1

Resources

These resources are important and related reading for HIV and drug use programming at the community level. They should be read alongside the many more specific references that are listed in the tables of key interventions in **Chapter 5**. Those listed here are more general and wide-ranging in their scope.

- The Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research and Asian Harm Reduction Network (2003), 'Manual for reducing drug related harm in Asia'. Available at: www.who.int/hiv/topics/harm/manual2003.pdf
- Commission on AIDS in Asia (2008), 'Redefining AIDS in Asia: crafting an effective response. Report of the Commission on AIDS in Asia', Oxford University Press. Available at: http://data.unaids.org/pub/Report/2008/20080326_report_commission_aids_en.pdf
- International Federation of Red Cross and Red Crescent Societies (2003), 'Spreading the light of science: guidelines on harm reduction related to injecting drug use'. Available at: www.ifrc.org/what/health/tools/harm_reduction.asp
- International Harm Reduction Association (2008), 'The global state of harm reduction 2008: mapping the response to drug-related HIV and hepatitis C epidemics'. Available at: www.ihra.net/GlobalState2008
- International Harm Reduction Association (2010) Global state of harm reduction 2010: key issues for broadening the response, International Harm Reduction Association. www.ihra.net
- International HIV/AIDS Alliance (2006), 'All together now! Community mobilisation for HIV/AIDS'. Available at: www.aidsalliance.org/Publicationsdetails.aspx?Id=228
- International HIV/AIDS Alliance (2003), 'Developing HIV/AIDS work with drug users: a guide to participatory assessment and response'. Available at: www.aidsalliance.org/publicationsdetails.aspx?id=88
- International HIV/AIDS Alliance (2006), 'Tools together now! 100 participatory tools to mobilise communities for HIV/AIDS'. Available at: www.aidsalliance.org/publicationsdetails.aspx?id=229
- Joint United Nations Programme on HIV/AIDS (2007), 'UNAIDS practical guidelines for intensifying HIV prevention: towards universal access'. Available at: www.unaids.org/en/KnowledgeCentre/Resources/PolicyGuidance/OperationGuidelines/HIV_prev_operational_guidelines.asp
- Jürgens, R. (2008), "Nothing about us without us". Greater, meaningful involvement of people who use illegal drugs: a public health, ethical and human rights imperative', International HIV/AIDS Alliance, Open Society Institute, Canadian HIV/AIDS Legal Network. Available at: www.aidsalliance.org/publicationsdetails.aspx?id=310
- Open Society Institute (2009), 'At what cost? HIV and human rights consequences of the global "war on drugs"'. Available at: www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/atwhatcost_20090302
- World Health Organization Evidence for action series. WHO's Evidence for action series is a highly recommended collection of evidence-based technical manuals and policy on a range of topics in HIV and harm reduction programming. It includes: HIV and TB programming, advocating for harm reduction, community-based outreach, interventions to address HIV in prisons, effectiveness of NSPs and effectiveness of drug dependence treatment. Available at: www.who.int/hiv/pub/advocacy/idupolicybriefs/en/



Appendix 2

Alliance good practice HIV programming standards – HIV and drug use

What are good practice programming standards?

Programme standards define quality and good practice. The standards also define our approach to HIV programming and conducting research. They define what users or beneficiaries of our programmes can expect.

At the intervention level, we refer to tools that define good practice for specific intervention types.


These programme standards do not define reach and scope. Targets for reach and scope are set by people closer to the specific programmes, according to local epidemiology and context.

Why develop programming standards?

- To define and promote good practice in community-based HIV programming. Definitions of good practice and quality are based on evidence and programme learning, and are shaped by the Alliance's values.
- To support assessment and evaluation of programme quality.
- To influence programme design.
- To build an evidence base for quality programming.
- To shape the provision of technical support provided through the Alliance's Technical Support Hubs.


Who is involved?

- Alliance Linking Organisations and their implementing partners (community- and faith-based organisations), and Alliance's Technical Support Hubs, their users and beneficiaries, will use programming standards to design, implement and evaluate HIV programmes.
- Users or beneficiaries of Alliance services and programmes can use programming standards to understand what our programmes are for, and to help evaluate Alliance programmes.
- Alliance programme officers and programme managers will use programming standards to assess, design and evaluate programmes (using a self-assessment tool).
- Alliance resource mobilisation staff will use programming standards to develop high quality proposals.
- Funders of Alliance programmes have an interest in programming standards. Alliance standards illustrate that our programmes are shaped by a culture of quality and good practice, are informed by evidence, and are monitored and evaluated according to a set of standards.
- Other civil society organisations are interested in quality standards for their community level programmes. Alliance programming standards can influence and guide good programming in other civil society organisations.

STANDARD	DESCRIPTION	IMPLEMENTATION ACTIONS	MARKERS OF PROGRESS
<p>A standard is an agreed-upon level or benchmark of quality. It is measurable and evidence-based</p> <p>STANDARD 1</p>  <p>Our organisation uses a harm reduction approach to drug use and HIV</p>	<p>Explanation of the standard and evidence</p> <ul style="list-style-type: none"> ■ A harm reduction approach addresses the harms caused by drug use. Harm reduction refers to policies, programmes and practices that aim to reduce the adverse health, social and economic consequences of legal and illegal psychoactive drug use. Harm reduction does not necessarily reduce drug use itself. A harm reduction approach is based on the premise that many people who use drugs are unable or unwilling to stop using them. Ending drug use is not necessarily the objective of these programmes. Instead, preventing HIV or preventing drug-related harms, and meeting the treatment, care and support needs of people who use drugs are the explicit objectives. ■ Harm reduction interventions are supportive rather than coercive, and acknowledge the measures people who use drugs take, however small, to prevent harm and protect health. ■ There is strong evidence that a harm reduction approach to HIV prevention among injecting drug users is effective. Harm reduction interventions are pragmatic, feasible and effective. [See WHO (2004), 'WHO Advocacy Guide: HIV/AIDS Prevention among injecting drug users'.] ■ A harm reduction approach is shaped by human rights principles and practice. A rights-based approach honours the rights of people who use drugs to services, privacy and confidentiality, self-determination, and freedom from discrimination. (See standard 1.1 on human rights.) ■ A policy stating our organisational commitment to harm reduction acts as a marker of what we believe is the most effective response to drug use and HIV. 	<p>Suggestions for actions to implement the standard</p> <ul style="list-style-type: none"> ■ Develop a harm reduction policy stating the organisation's commitment to a harm reduction approach. ■ Identify the harm reduction features of the work we do with people who use drugs. 	<p>Markers of progress</p> <ul style="list-style-type: none"> ■ An organisational harm reduction policy exists that reflects the Alliance-wide policy on harm reduction. ■ The organisation's harm reduction policy is publicly available, for example on its website.


MATERIALS AND RESOURCES

- Centre for Harm Reduction, Macfarlane Burnet Centre for Medical Research and Asian Harm Reduction Network (2003), 'Manual for reducing drug-related harm in Asia', Centre for Harm Reduction. www.who.int/hiv/topics/harm/manual2003.pdf
- International Harm Reduction Association (2009), 'What is harm reduction?'. www.ihra.net/whatisharmreduction

STANDARD	DESCRIPTION	IMPLEMENTATION ACTIONS	MARKERS OF PROGRESS
<p>STANDARD 2</p>  <p>Our organisation promotes and/or provides access to clean injecting equipment, condoms, and information about safe injecting and safe sex for people who use drugs and their sexual partners</p>	<ul style="list-style-type: none"> ■ Preventing the transmission and acquisition of HIV (and hepatitis C) through sharing injecting equipment and unprotected sex is a priority for our programming. Providing sterile injecting equipment and condoms are highly effective strategies to prevent HIV (and hepatitis C) transmission. ■ Commodities such as injecting equipment and condoms need to be of acceptable quality. Commodities of insufficient quality can lead to increased risky behaviour. ■ Provision of commodities needs to be accompanied by information and education about safe injecting and safe drug use, along with programmes to build skills in practising safe injecting and safe sex. ■ Peer education and peer outreach are useful methods of reaching drug users to provide commodities, along with information and education about safe sex and safe injecting. 	<ul style="list-style-type: none"> ■ Provide sterile injecting equipment through fixed sites, outreach, or community pharmacy programmes. ■ Provide condoms along with injecting equipment. ■ Develop information and education materials on safe injecting and safe sex for people who use drugs and their sexual partners. ■ Develop peer-based behaviour change programmes for people who use drugs and their sexual partners that inform, educate and build skills in safe sex negotiation and safe injecting. ■ Provide safe disposal programmes. ■ Where legal or policing barriers exist to prevent needle and syringe programmes, advocacy and community education campaigns are developed to improve access. ■ Consult with drug users to check for the quality of commodities. Ensure procedures are in place to change commodities if/when they do not meet the needs of users. 	<ul style="list-style-type: none"> ■ Programmes to provide safe injecting equipment and condoms are in place. ■ Programmes to inform, educate and build skills for safe injecting and safe sex are in place. Peer education and peer outreach are the main methods used to educate, inform and build skills. ■ Programmes to ensure the safe disposal of syringes are in place. ■ Strategies to check the quality of commodities are in place.


MATERIALS AND RESOURCES

- Burrows, D. (2004), 'Training guide for HIV prevention outreach to injecting drug users', WHO.
www.who.int/hiv/pub/idu/hivpubidu/en/index.html
- Ministry of Health Malaysia (2006), 'Needle syringe exchange programme: standard operating policy and guidelines',
www.mac.org.my
- Needle, R.H. et al. (2004), 'Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users', WHO.
[www.mac.org.my/v2/wp-content/uploads/attachment/NSEPStdSOP\(R\).pdf](http://www.mac.org.my/v2/wp-content/uploads/attachment/NSEPStdSOP(R).pdf)
- Strike C. et al. (2006), 'Ontario needle exchange programs: best practice recommendations', Toronto: Ontario Needle Exchange Coordinating Committee.
www.toronto.ca/health/cdc/factsheets/pdf/needlex_best_practices.pdf
- WHO (2004), 'Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users'.
www.who.int/hiv/pub/idu/e4a-needle/en/index.html
- WHO (2007), 'Guide to starting and managing needle and syringe programmes'.
www.who.int/hiv/pub/idu/needleprogram/en/index.html

STANDARD	DESCRIPTION	IMPLEMENTATION ACTIONS	MARKERS OF PROGRESS
<p>STANDARD 3</p>  <p>Our organisation promotes and/or provides access to antiretroviral treatment (ART), opportunistic infection prevention, TB prevention and treatment, opiate substitution therapy, and hepatitis C (HCV) treatment for people who use drugs and their sexual partners</p>	<ul style="list-style-type: none"> ■ Many people who use drugs have HIV, TB and/or HCV and need treatment. Our programmes must directly address the HIV, TB and HCV treatment needs of people who use drugs, or must work in partnership with agencies that do. ■ Opiate substitution therapy is the most effective form of treatment for people who are dependent on opiates. Drug substitution treatment also supports HIV, TB and HCV treatment by making the lives of people who use drugs more stable and by supporting drug users to engage with health services. ■ In situations where treatment for HIV, TB, HCV or opiate substitution therapy is not available, activities are in place by our organisation to advocate for access to these services. ■ In situations where treatment is denied to drug users, advocacy and education campaigns are in place to improve access and to develop adherence support programmes specifically targeted at drug users. 	<ul style="list-style-type: none"> ■ Develop drug user-friendly HIV, TB and HCV treatment services that incorporate opiate substitution therapy, in partnership with other providers of health services. ■ Advocate for access to ART, TB prevention and treatment, opiate substitution therapy and HCV treatment for people who use drugs and their sexual partners. 	<ul style="list-style-type: none"> ■ Accessible and affordable HIV, TB, HCV and opiate substitution therapy programmes are in place for people who use drugs. ■ Where treatment services are not in place, or are not accessible to people who use drugs, advocacy plans are in place to improve access.


MATERIALS AND RESOURCES

- Farrell, M. et al. (2005), 'Effectiveness of drug dependence treatment in prevention of HIV among injecting drug users', WHO.
www.who.int/hiv/pub/idu/e4a-drug/en/index.html
- I-Base (2009) Hepatitis C for people living with HIV: testing, co-infection, treatment, support.
www.i-base.info/files/2009/10/hcv-march-2009.pdf
- OSI (2004), 'Breaking down barriers: lessons on providing HIV treatment to injection drug users'.
www.soros.org
- UNODC, WHO (2008), 'Principles of drug dependence treatment: discussion paper'.
www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf
- UNODC, WHO (2008), 'HIV/AIDS care and treatment for people who inject drugs in Asia and the Pacific: an essential practice guide'.
www.who.int/hiv/pub/idu/searo_wpro_essential/en/index.html
- WHO (2006), 'Treatment of injecting drug users with HIV/AIDS: promoting access and optimizing delivery'.
www.who.int/substance_abuse/publications/treatment_idus_hiv_aids.pdf
- WHO, UNAIDS, UNODC (2004), 'Position paper on substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention'.
www.unodc.org/docs/treatment/Brochure_E.pdf
- WHO (2009), 'Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence'.
www.who.int/hiv/pub/idu/opioid/en/index.html
- WHO (2007), 'HIV treatment and care. Clinical protocols for the WHO European region'. See chapter 5, "HIV/AIDS treatment and care for injecting drug users".
www.who.int/hiv/pub/idu/euro_treatment/en/index.html

STANDARD	DESCRIPTION	IMPLEMENTATION ACTIONS	MARKERS OF PROGRESS
<p>STANDARD 4</p>  <p>Our organisation promotes and/or provides access to psychosocial support services to meet the priority needs of people who use drugs and their sexual partners</p>	<ul style="list-style-type: none"> ■ People who use drugs have a range of psychosocial support needs, including the need for advice and support on drug use, sex and relationships, and health (including mental health), and adherence support for HIV, TB, HCV and drug dependence treatment. ■ The wives and widows of men who use drugs, and other sexual partners of people who use drugs, need information, advice and support on their health and the health of their partners, and on sex, relationships and drug use. 	<ul style="list-style-type: none"> ■ Educate and support people who use drugs to adhere to drug dependence treatment, ART, and TB treatment. ■ Provide counselling, support groups and other psychological support services to people who use drugs and their wives or sexual partners. ■ Support people who use drugs to practise safer sex through advice, support and skills building. ■ Support people who want to stop using drugs to access high quality detoxification or drug dependence treatment services. 	<ul style="list-style-type: none"> ■ Psychosocial support programmes and services are in place. ■ Training is provided for staff, volunteers and peers in non-judgemental provision of psychosocial support. ■ Links exist between psychosocial services and ART, TB, HCV and opiate substitution therapy programmes.


MATERIALS AND RESOURCES

- WHO (2006), 'Basic principles for treatment and psychosocial support of drug dependent people living with HIV/AIDS'.
www.who.int/substance_abuse/publications/basic_principles_drug_hiv.pdf

STANDARD	DESCRIPTION	IMPLEMENTATION ACTIONS	MARKERS OF PROGRESS
<p>STANDARD 5</p>  <p>People who use drugs participate in our programming and decision-making</p>	<ul style="list-style-type: none"> ■ The meaningful involvement of people who use drugs in programming and decision-making reflects the Alliance's core values and commitment to rights-based approaches. Involvement means drug users participate in key programming processes such as assessment, planning, implementation and evaluation. ■ Good practice in drug user involvement means more than one or two people. Setting up a drug user programme reference group to act as a regular advisory group to programmers is a potential starting point. 	<ul style="list-style-type: none"> ■ Establish a programme advisory group made up of drug users and their sexual partners. ■ Support the development of a drug user network. ■ Encourage drug user participation in organisation governance structure. ■ Ensure workplace policies allow for support to drug users on staff. 	<ul style="list-style-type: none"> ■ Drug users are present on programme advisory committees. ■ Drug users (ex or current) are on staff. ■ Drug users are present on governing board. ■ Drug users are active participants in assessment, planning, implementation and evaluation processes. ■ Drug user networks are supported.


MATERIALS AND RESOURCES


- International HIV/AIDS Alliance, Canadian HIV/AIDS Legal Network, OSI, International Network of People who Use Drugs (2008), 'Nothing about us without us: greater, meaningful involvement of people who use illegal drugs'.
<http://tiny.cc/1bzjz>

STANDARD	DESCRIPTION	IMPLEMENTATION ACTIONS	MARKERS OF PROGRESS
<p>STANDARD 6</p>  <p>Our programmes targeting people who use drugs are gender-sensitive, and including interventions for the sexual partners of people who use drugs</p>	<ul style="list-style-type: none"> ■ Specific programmes or interventions are required for women, men who have sex with men, and transgenders in most situations. These gender-specific needs should be identified through assessment, and responded to with specific programmes. ■ Women who use drugs (including pregnant women) are generally poorly served by harm reduction services and mainstream health services. HIV and HCV prevention; HIV, TB and HCV treatment; and opiate substitution therapy programmes must be accessible to women who use drugs. Improving access to sexual and reproductive health services for women who use drugs and female partners of men who use drugs is a priority. 	<ul style="list-style-type: none"> ■ Involve women, men who have sex with men, and transgenders in community assessments on drug use. ■ Provide or promote HIV and HCV prevention; HIV, TB and HCV treatment; and opiate substitution therapy programmes that are accessible to women who use drugs. ■ Provide or refer to drug user-friendly sexual and reproductive health services those who need them. ■ Provide support services for pregnant women who use drugs. ■ Provide support services for drug users who are parents, such as child care services at harm reduction programmes. (See standard 6.6 on children.) 	<ul style="list-style-type: none"> ■ Gender-specific programmes or services are in place, including services for pregnant women who use drugs. ■ Women who use drugs and/or female partners of men who use drugs are present on governing boards. ■ Women, men who have sex with men and transgenders participate in community assessments. ■ Specific programmes and interventions exist for women who use drugs, female partners of men who use drugs, men who have sex with men and transgenders, where these needs have been identified.

MATERIALS AND RESOURCES

- Burns, K. (2009), 'Women, harm reduction and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia, and Ukraine'. OSI.
<http://tiny.cc/t3be3>
- Pinkham, S. and Shapoval, A. (2010), 'Making harm reduction work for women: the Ukrainian experience', OSI.
www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/harm-reduction-women-ukraine_20100429

STANDARD	DESCRIPTION	IMPLEMENTATION ACTIONS	MARKERS OF PROGRESS
<p>STANDARD 7</p>  <p>Our programmes targeting people who use drugs are part of a local network of services and programmes</p>	<ul style="list-style-type: none"> ■ Coordination of Alliance HIV and harm reduction programmes with other local agencies is good practice. Positioning the services and programmes that we provide among a range of others that people who use drugs need is an important part of planning for comprehensive service delivery. 	<ul style="list-style-type: none"> ■ Assess drug users needs for a range of services. ■ Map the service network for drug users. ■ Establish or join local multi-stakeholder committees. ■ Build and maintain relationships with local service providers to ensure quality referral systems and to avoid duplication. 	<ul style="list-style-type: none"> ■ A local, multi-agency coordination group exists. ■ A plan of local services for people who use drugs exists. ■ Referral systems are in place.

STANDARD	DESCRIPTION	IMPLEMENTATION ACTIONS	MARKERS OF PROGRESS
<p>STANDARD 8</p>  <p>Our programmes address stigma and discrimination related to HIV and drug use</p>	<ul style="list-style-type: none"> ■ People who use drugs, their partners and families experience high levels of stigma and discrimination related to both HIV and drug use. This undermines the rights of drug users to health services, education and employment. It also leads to drug users' rights being violated by the police and other authorities, and to incarceration and violence. ■ Drug users are often marginalised and live 'outside society'. This marginalisation undermines drug users' rights to participate in community and family life. It also acts as a barrier to HIV services and programmes, notably HIV prevention programmes. 	<ul style="list-style-type: none"> ■ Educate communities about drug use, harm reduction and the human rights of people who use drugs. ■ Advocate for human rights protections for people who use drugs. ■ Advocate for improved access to services for people who use drugs ■ Educate police and other authorities about drug use, harm reduction and the human rights of people who use drugs. ■ Document human rights violations. ■ Support drug users to organise and form networks. ■ Build the capacity of drug user networks to advocate for their rights. 	<ul style="list-style-type: none"> ■ Community education on drug use and harm reduction is planned and implemented. ■ Advocacy for human rights protections, or to improve access to services, is evident in work plans. ■ Education for the police and other authorities about drug use, harm reduction and the human rights of drug users is planned and implemented. ■ Human rights violations are documented and the findings are reported. ■ Drug user networks are supported and capacity-building plans are in place and implemented.

MATERIALS AND RESOURCES

- WHIV/AIDS Asia Regional Program, 'Law enforcement and harm reduction advocacy and action manual'.
<http://beta.tiny.cc/hcdje>
- International HIV/AIDS Alliance, Canadian HIV/AIDS Legal Network, OSI, International Network of People who Use Drugs (2008), 'Nothing about us without us: greater, meaningful involvement of people who use illegal drugs'.
<http://tiny.cc/1bzjz>
- International HIV/AIDS Alliance and ICASO (2002), 'Advocacy in action: a toolkit to support NGOs and CBOs responding to HIV/AIDS'.
<http://tiny.cc/7lrxv>
- International HIV/AIDS Alliance, International Center for Research on Women, Academy for Educational Development, PACT Tanzania (2007), 'Understanding and challenging HIV stigma: toolkit for action (revised edition)'.
<http://tiny.cc/3i626>
- OSI, 'Drug use and human rights advocacy toolkit'.
www.soros.org
- WHO, UNAIDS, UNODC (2004), 'Advocacy guide: HIV/AIDS prevention among injecting drug users'.
www.who.int/hiv/pub/idu/iduadvocacyguide/en/index.html



A global partnership:
International HIV/AIDS Alliance
Supporting community action on AIDS in developing countries

GOOD PRACTICE GUIDE

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Established in 1993, the **International HIV/AIDS Alliance** (the Alliance) is a global alliance of nationally-based organisations working to support community action on AIDS in developing countries. To date we have provided support to organisations from more than 40 developing countries for over 3,000 projects, reaching some of the poorest and most vulnerable communities with HIV prevention, care and support, and improved access to HIV treatment.

The Alliance's national members help local community groups and other NGOs to take action on HIV, and are supported by technical expertise, policy work, knowledge sharing and fundraising carried out across the Alliance. In addition, the Alliance has extensive regional programmes, representative offices in the USA and Brussels, and works on a range of international activities such as support for South-South cooperation, operations research, training and good practice programme development, as well as policy analysis and advocacy.

www.aidsalliance.org