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Agenda item 11

Thematic segment: Halving HIV transmission among people who inject drugs

Country submissions

CONTENTS

INTRODUCTION

A total of 37 submissions were received from all the geographical regions of UNAIDS: six from Africa, eleven from Asia and the Pacific, fourteen from Europe, two from Latin America and the Caribbean, one from North Africa and three representing multi country submissions. The submissions detail a wide variety of effective harm reduction programmes at national, city, district and other local levels and in various settings, including closed settings.

> "Not only is there an ethical imperative to make harm reduction programmes universally available, but in stark contrast to compulsory detention, these approaches are globally effective, represent good value for money and are often cost-saving, indicating their value to improving the health outcomes for people who inject drugs and the broader population."

The collection of submissions give concrete examples of the evidence that harm reduction works for reducing HIV transmission among people who inject drugs and increasing access to and impact of HIV prevention, treatment, care and support. They also show how many of the most successful programmes are those that are 'low-threshold' interventions that involve people who inject drugs and people living with HIV at all levels from initiation to service delivery.

I. Africa

1. Mauritius

Title of programme: National Harm Reduction programme, Mauritius
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Implemented by: Government, Civil Society
Areas of focus of the programme: Policy and legal environment; the financial crisis and its impact on people who inject drugs programmes
Programme is being implemented since: 2006
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Mauritius is a small island developing state and a functioning upper-middle income democracy, with a population of 1.3 million inhabitants who come from a variety of ethnic groups. It is a welfare state with long standing political and social stability.
Serial IBBS, conducted every 2 years since 2009, indicate an estimated population size of 10,000 people who inject drugs (PWID), 10% of whom are women, and showed a 44.3% prevalence of HIV in 2013.

In 2005, it was observed from programme data that 92% of detected cases of HIV were PWID, thus prompting Government to react urgently to introduce the Harm Reduction Programme. This required setting the stage legally, politically, and socially, which was done by passing the HIV/AIDS Act 2006, and Regulations of 2007, accompanied by a strong advocacy campaign using the media, as well as advocacy meetings with stakeholders such as religious leaders, parliamentarians and opinion leaders in villages.

Approach:
The Harm Reduction programme, comprising Methadone Substitution Therapy (MST) and Needle Exchange Programme(NEP), was designed to be HIV specific and HIV sensitive. In fact the programme emanated from the HIV programme, within a context where a holistic approach was needed to stop needle sharing practices that was driving the HIV epidemic. On one hand MST was aimed at decreasing injecting behaviour, and on the other, the NEP provided access to sterile equipment.

For HIV sensitivity, other services were integrated into the two programmes, namely: HCT, condom distribution, referral to ART services, STI & TB diagnosis, IEC/BCC.

Both NEP and MST are free Government programmes implemented with the partnership of NGOs that receive financial support from the Ministry of Health to do so. All medical products are procured and supplied by Government. Out of 47 Needle Exchange sites, 36 are operated by the Government and 11 by NGOs. MST is only provided by MOH, however NGOs refer clients to the programme and provide psychosocial support. Programme

leadership and coordination for both NEP and MST are centralized at MOH, while M&E are at the NAS.

MST, NEP, ART, PMTCT are all linked to each other through a referral system.

Reach of the intervention:
Out of the estimated 10000 PWID, 6303 had been induced to Methadone as of Dec 2013, and 5692 were still on maintenance. There are 18 Methadone dispensing sites scattered over the island, including the prisons. NEP provides for 2300 clients, serviced through 47 sites that are spread geographically. Delivery models vary from fixed and mobile to outreach and peer distribution.

The progression of the epidemic among PWID has slowed down. Likely decrease in transmission among PWID can be demonstrated by the following:

- The percentage of PWID among new cases of HIV has dropped from 92% in 2005 to 38% in 2013,
- The percentage of prison inmates tested positive at entry – the majority being PWID - has decreased from 40% in 2009 to 18.5% in 2013, and
- The percentage of clients tested positive at entry of MST Centres has declined from 20% in 2010 to 8% in 2013,

Overall the number of new cases of HIV per year has declined from 921 in 2005 to 260 in 2013, in spite of scaling up of HIV testing.
Around 80% of the estimated PWID population is reached with services; this regular contact between the population and service providers provides a valuable opportunity to deliver health education and HIV prevention messages, which has resulted in behaviour change over the years. The percentage of PWID reporting the use of a condom at last sexual act has increased from 28.1% in 2009 to 38.2% in 2013, and the percentage of PWID reporting the use of sterile equipment at last injection has increased from 71.7% in 2009 83.8% in 2013. It is also noted that **the level of petty crime has fallen significantly**, as methadone removes the need to resort to larceny to provide the means of procuring drugs.(Statistics Mauritius: Digest of Crime, Justice and Security Statistics-2012).

Financing and management:
Both the NEP and MST programmes are coordinated and managed by the Harm Reduction Unit of the Ministry of Health. 70% of the national HIV response is funded by the Government, the rest being from the Global Fund, the only external source of funding in the HIV programme so far.

Government remains the major source of financing of the Harm Reduction programme, and thus its financial sustainability is ensured, as evidenced by the substantial increase in the budget allocated under the programme based budget. Government spending on HR was 1.4 Million USD in 2010, and this has increased to 1.8 Million USD in 2013.

Mauritius being a welfare state, and having an Upper Middle Income level, relies primarily on domestic funds. Under the Corporate Responsibility Scheme, the Private Sector is obliged to contribute 2 % of its profits to Civil Society Organizations working in certain designated areas. Thus, the private sector remains a valuable potential partner to the Government.

Lessons learnt and recommendations:
The chief element that helped in the success of the intervention was commitment at the highest level in the country. This was the result of advocacy by the Ministry of Health experts as well as CSOs. The advocates used the scientific evidence that international organizations such as UNAIDS, WHO and UNODC published in order to convince politicians as well as the public, that there was urgency and that the cost of inaction would be very high. Once the political will was acquired, putting up the institutional structure, passing the necessary laws and regulations, and resource mobilization were relatively easy.

The main challenge was community resistance. People do not want the PWID community to be visible in their locality. An advocacy programme has been carried out throughout the country by 50 Family Support Officers with 130,000 people in 124 Village Council Areas and Municipal Council Areas during the period from January 2010 to December 2013, to reduce stigma and promote acceptance of the harm reduction programme in Mauritius.

In view of the great demand for induction on Methadone, Government had to scale up the programme very fast. Thus it was difficult to maintain a good quality of services, especially during the rapid scale up phase. Psychosocial support was the main weakness, and the NGOs who were responsible for its provision had insufficient capacity to deliver.

The harm reduction programme has been evaluated annually by experts from various organizations such as WHO, UNODC, and international consultants from APMG. Recommendations from these evaluations have informed improvement actions taken.

Lessons learnt:

- Political Commitment at highest level is critical for successful implementation.
- Scientific evidence and guidance from International Organizations (WHO, UNAIDS, UNODC) enhance advocacy.
- Strong Civil Society Advocacy is a determinant for policy decisions
- Enabling laws have to be enacted and existing ones have to be reviewed, as necessary.
- Private Public Partnership works best for programme roll out.
- Synergy between NEP and MST bring comprehensiveness to the programme and help show impact faster.
- Integration of and linkages to HIV services have helped to detect new cases and also treat new clients.
- Implementation and scaling up of a Harm Reduction programme adds considerable load to health systems as well as Community systems in terms of capacity and human resource.
- Community Engagement is key for programme acceptance and support in the community for smooth implementation.
- Continuous advocacy is required, including publications of statistics to demonstrate to decision makers and the general public the benefits of the programme

Annexes:
1. WHO Geneva. Situational analysis of harm reduction strategies in Mauritius and suggestions for scaling up methadone maintenance therapy and needle and syringe programs. August 2008.
2. AIDS Project Management Group (APMG). The Right Service at the Right Place at the Right Time; An evaluation of the national Harm Reduction Programme in Mauritius

2. MOROCCO

Title of programme: OST National Programme
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Implemented by: Government, Civil Society, United Nations or other intergovernmental organization
Areas of focus of the programme: Policy and legal environment; the role of the community of people who inject drugs in service delivery
Programme is being implemented since: 2010
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
In the 2000s' Morocco got clues of a rising HIV epidemic among people who inject drugs (PWID) where HIV prevalence ranks from 7% to 38%. Awareness of Moroccan government has risen when health professionals and community communicated situations of injected drug use in particular in the northern region of Morocco. The first response was to urge an early designed national programme in response to HIV spread. Hence, Harm Reduction comprehensive plan 2008-2011 was launched to address this challenge. Since 2010, the Opioid Substitution Therapy (OST) programme has been implemented as a pilot experience and as an essential component of comprehensive Harm Reduction interventions targeting PWHID in Morocco. Currently, and according to UN orientations, the 2012-2016 plan is a consensual strategic plan which translates objective vision toward 50 % reduction of HIV infection in PWID as a challenge, with specific management of optimizing resources, in an international context of scarcity of financial resources.

Approach:
According to international orientations and best practices experiences worldwide, OST programme in Morocco has been launched in 2010 as a pilot experience in 4 sites, based on evidence.
The main axes of the national plan were:

- Creating a national committee which constitutes a basic platform for making consensual decisions and policy management.
- Implementing OST Programme in a consensual process and as an essential component of a comprehensive plan to dealing with HIV and Hepatitis infections in PWID.
- Advocacy and reinforcement of involvement of several actors in supporting interventions: professionals, NGOs, stakeholders, media, UN agencies and other partners.
- Starting gradually with a first option of a "low level of eligibility", based on community support and targeting drug users' self-support.
- Supporting NGOs and professionals capacity building and encouraging networks.

- Choosing the evidence based condition to implement actions, in response to field situation, by conducting quantitative and qualitative studies as an essential first step to providing adequate responses.
- Evaluating the process to measure achievements of the programme plan before a scale up of the programme at national level.

Reach of the intervention:
OST programme concerns national level. It focuses on sub population of opiates users. It offers a global response including HIV and hepatitis prevention, care and rehabilitation.

Impact of the intervention:
Since 2010, Harm reduction plan and OST in particular, have been benefiting from a high political level support. A financial support has been allocated specifically, which enabled extension of facilities in close adaptation to targeted population. Rapid assessments studies and RDS surveys conducted as first steps before implementing interventions had an impact on optimization of resources. Hence, in a frame time of 4 years, the number of facilities reached 10 centers, with a national number of 5 OST settings. Interventions of OST has impacted in a positive way targeted populations, and proved efficiency and efficacy of the programme toward targeted objectives, as shown from the first evaluation of the programme in 2011. Current data show that the objective of 500 persons in June 2014, included in OST has been reached. Results of switch from injection behavior have been noticed in some sub populations of PWID (e.g. in Tangiers).
In another part, awareness at the national level and implemented interventions raised demand of care and higher social support needs.

Funding and management:
Moroccan experience is of a high interest to advocate for acceptability, efficacy and efficiency of HR concept in general and of OST design for similar countries in MENA region. Actions, as enhancing advocacy for the national plan, promoting international partnership, encouraging professionals and communality, optimizing human resources and building capacities, are main aspects of success.

Several aspects for management and optimizing resources have been taken into account including an integration of the programme in the whole and comprehensive plan in control of HIV transmissions, involvement of NGOs and professionals as partners, and enforcement of advocacy at national and international levels in order to invest more resources.

Lessons learned and recommendations:
Morocco gives a successful experience as a model of intervention in an early epidemic stage, and on evidence based programmes. Success factors include a combination of the holistic approach to risk reduction policy in Morocco, membership of users and strengthening the community sector for development of user behavior and to change attitudes within society.

In the current plan, Morocco adopted the UN comprehensive package of HR interventions, taking into account the scarcity of resources and of specialized human resources. Process of implementing OST programme raised importance of human resources optimization, advocacy in supporting interventions, and also the pertinence of focusing on field factual data. In the near future, and in a context of scarcity of international financial resources,

actions should enhance user involvement in social and community life and continuous adaptation of intervention methods.

The OST national programme is now challenged by enhancing accessibility to treatment by better integrated services in community, strengthening the comprehensive prevention package design, and scaling up actions for specific populations as prisoners in order to ensure continuity of care.

Strengthening advocacy, reinforcement of local and regional networks for capacity building and exchange on developed local technical skills, and developing research and knowledge exchange at regional and international level will lead to greater time and expense gains that will benefit the efficiency of the programme.

3. MAROC

Intitulé du programme : Appui a la mise en place de la stratégie mobile de la réduction des risqué du VIH et les hépatites auprès des usager(e)s de drogue dans la région de Tanger.
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Maitre (s) d'œuvre: Société civile
Le programme couvre le (s) sujet (s) suivant (s): Politiques et environnement légal, Le rôle de la communauté des consommateurs de drogues injectables dans la prestation de services
Programme mis en œuvre depuis : 2007
Le programme a-t-il été évalué/analysé ? Oui
Le programme s'inscrit-il dans la mise en œuvre de la stratégie nationale de lutte contre le SIDA? Oui
Le programme s'inscrit-il dans la mise en œuvre du programme national sur les drogues? Oui

Contexte:
Le nord du Maroc, principalement dans la ville de Tanger, la ville côtière la plus proche de la bordure méditerranéenne, se concentrent à la fois la consommation de l'héroïne et la pratique d'injection intraveineuse. La mobilité des usagers de drogues entre l'Europe (notamment du Sud) et le Nord du Maroc est, sans doute, un élément important pour comprendre la diffusion de l'héroïne, de la cocaïne, de l'injection, du VIH et du VHC dans cette partie du Royaume.

Selon l'évaluation rapide de la situation sur le risque d'infection à VIH en relation avec l'usage des drogues injectées et injectables et à problème au Maroc réalisé par le Ministère de la Santé, Programme National de Lutte contre les Toxicomanies en 2006, dont l'échantillon est constitué de 347 hommes usagers (84.14%) et 77 femmes usagères (15.59%), l'héroïne et la cocaïne sont les deux substances les plus injectés, ainsi que presque une personne sur deux déclare avoir partagé une seringue avec un autre usager, 50% des hommes et 70% des femmes ont des partenaires sexuels multiples et utilisent rarement le préservatif.

La politique marocaine de réduction de risques s'est fixée comme objectif principal d'« Assurer aux usagers de drogues un accès à des services de prévention, dépistage du VIH, de traitement et de prise en charge de qualité ». Cet objectif est traduit sur le terrain par le renforcement des activités de prévention répondant aux besoins des UDI exposés aux risques d'infection au VIH et VHC, assurer aux UDI identifiés un accès au dépistage, au traitement et à la prise en charge adéquats, stimuler les réponses communautaires des usagers de drogues dans la lutte contre le VIH/sida et VHC et, enfin, afin de garantir la complémentarité et la cohérence de l'ensemble, instaurer un pilotage national du dispositif de réduction de risques. Pour y parvenir, trois axes prioritaires de travail ont été définis. Il s'agit du ciblage systématique des populations difficiles à atteindre (travail de proximité et programmes d'échange de seringues) ; de la mise en place des programmes de maintenance aux produits de substitution, essentiellement la méthadone et, enfin, de l'encouragement à la formation et au soutien de groupe d'auto-support d'usagers de drogues.

Démarche:
Nos actions dans le cadre de réduction des risques cible à réduire les risques sanitaires liés à l'usage de drogues :

- Les risques sanitaires infectieux VIH et hépatites virales ;
- Les autres risques infectieux non viraux (exemple : abcès) et les autres risques liés à l'injection et aux autres modes de consommation sont pris en compte à travers des pratiques de consommation à moindre risque de transmission du VIH et du VHC ;
- Le risque des overdoses ;
- Les risques sociaux liés à la discrimination et la stigmatisation dont les usagers de drogues font l'objet.

Portée de l'intervention:

- L'intervention s'inscrit dans la mise en œuvre des objectifs de la déclaration Politique sur le VIH/Sida
- Pour atteindre l'objectif principal, notre intervention s'articule sur trois axes.
- Permettre aux UDI un accès aux activités de prévention combinée régulières et de qualité par le biais des équipes de proximité par les deux unites a bas seuil fixe et mobile(distribution des kits d'injection et préservatifs, récupération des seringues utilisées, information, sensibilisation des UDI sur les risques liés à l'usage des produits psycho actifs, l'orientation des UDI vers les structure de soins, dépistage VIH sur les sites de consommation
- L'orientation des UDI vers le centre médico-psychologique pour le traitement de substitution aux opiacés;
- Accompagnement psycho-social et professionnels des personnes sous traitement de substitution (TSO) et les usagers actifs.
- Le programme touche la région Tanger/Tétouan, et cible 1700 usagers et usagères de drogues dont les 600 sont des consommateurs par voie intraveineuse.

Impact de l'intervention:

- Depuis le démarrage du programme en 2007, les résultats satisfaisants ont été marqués à savoir :
- La couverture du maximum des usagers dans la ville de Tanger ;
- le taux de VIH chez les usagers à Tanger est de 0.4% selon l'enquête RDS 2010, chose qui a été prouvé par le dépistage périodique du VIH ;

- l'introduction de traitement de substitution aux Maroc depuis Juin 2010, 380usager(e) s actuellement à Tanger bénéficient du TSO ;
- L'accès des UDI aux services d'appui psychosocial et d'insertion professionnel.

Financement et gestion:
Le programme RDR a été mis en place par l'association Hasnouna de soutien aux usager(e)s à Tanger en partenariat avec le ministère de la santé, le fons mondial de lutte contre le Sida La tuberculose et le paludisme, L'ONUSIDA et la GIZ.

Pour pérenniser ces actions, l'AHSUD a développé son portefeuille de partenariat nationaux et internationaux, en 2013 l'AHSUD a mis en place un centre de ressources et formation avec l'appui de la fondation Drosos, ce centre a pour objectif de Contribuer au développement d'une approche de Réduction de risques liée à la consommation de drogues au Maroc, dans la région Maghreb et en Afrique Francophone.

Enseignements tirés et recommandations:

Les facteurs ayant contribués au succès de l'intervention sont les suivants :
- La volonté des instances politiques au niveau local et national (ministère de la santé, ministère de l'intérieur ...) pour une meilleure réponse nationale pour faire face à l'usage de drogues ;
- L'implication de différents partenaires financièrement et techniquement (Fond Mondial de Lutte contre le Sida, la Tuberculose et le Paludisme, l'ONUSIDA, La fondation Drosos, L'ONUDC, ESTHER, ALCS, GIZ, L'agence Catalan, Fondation la CAIXA, Association Casal Del infants ;
- la mobilisation de différentes parties prenantes au niveau local (la police, les riverains, les pharmaciens, les médias,
- L'implication du personnel de l'association

Annexes e pièces jointes :
1. Revu du programme national de RdR VIH chez les UDI au Maroc
2. Rapport d'Elaboration et consolidation du travail en réseau d'acteurs hétérogènes pour la prévention du VIH et une prise en charge globale des Utilisateurs de Drogues Injectables

4. TANZANIA

Title of programme: Harm Reduction service delivery, training and national advocacy to increase access to adequate HIV and viral hepatitis prevention services, treatment and care for people who use drugs in Tanzania
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Implemented by: Civil Society
Areas of focus of the programme: Policy and legal environment; the role of the community of people who inject drugs in service delivery

Programme is being implemented since: 2010
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Tanzania's position as a trafficking point for heroin between Asia and North America and to a lesser extent cocaine between South America and Europe has led to a local market for drug consumption since the mid-1980s. Initially heroin was only smoked, sniffed, or inhaled (chased), but changes in the market – namely a shift from brown to white heroin availability – introduced the practice of injecting heroin between 1998 and 1999. There are currently an estimated 30,000 people who inject drugs (PWID) in Tanzania. Heroin tends to be the sole drug injected, although in a sample of MSM PWID based in Zanzibar one third used cocaine the last time they injected. It is suggested that a third of PWID in Tanzania are aged 25 or under. It is common for PWID in Tanzania to begin using heroin when they are young, often being introduced to the drug through marijuana or tobacco cigarettes laced with heroin.

A small number of studies documenting injecting drug use in mainland Tanzania have found that PWID routinely engage in high risk injecting and sexual risk behaviours. Sharing needles and other works has been commonly reported among a significant proportion of PWID in Tanzania. Among a sample of young PWID in Dar es Salaam, 31% had injected with used needles at least once in the previous month, although the majority reported using a new needle the last time they injected. It has also been reported that PWID who inject reuse needles they had left hidden, without knowing if the needle has been used in their absence. Another reported risk practice is vipoint, whereby injectors share the contents of a syringe by only injecting a measured amount of heroin before passing on the syringe to the next injector. Many female drug users are also involved in transactional sex work.

HIV in mainland Tanzania being characterized as a generalized epidemic, there is evidence that injecting drug use is contributing to high rates of HIV transmission among drug using groups, with growing concerns of the potential for onward transmission of HIV to non- drug using populations. Evidence estimates that HIV prevalence is around 36% in PWID in Tanzania, compared to 5.8% in the general population. Gender disparities in population HIV prevalence are also evident within groups of PWID, reaching as high as 67% among female PWID. Data from MdM Rapid Assessment and Response (RAR-2011) showed that 28% of all people who use drugs (PWUD) tested HCV antibody positive. Concurrent HIV and HCV seropositivity was detected in 17% of PWID.

Drug use is highly stigmatized both within the general community and by health care workers, further marginalizing people with drug dependence problems. Thus, this group has been denied access to basic health services and moreover had no access to adapted service to their specific needs. For example women who use drugs who have been reached through MdM harm reduction services had never attended antenatal care and the great majority had never tested for HIV.

The Tanzania context is favourable to dissemination of successful HR interventions and national policy authorises harm reduction. But even if NSP and OST have been accepted, increased advocacy on the needs of PWIDs and benefits of harm reduction strategies is still needed. Till today national capacities to implement harm reduction services are very limited.

Approach:
The overall objective of the MdM program is to contribute to the mitigation of HIV (and viral hepatitis) transmission and HIV/AIDS-associated morbidity and mortality among PWUD in association with Tanzanian stakeholders. This is to be reached through the scale-up of quality, comprehensive, low threshold harm reduction services for people who use drugs in Dar es Salaam along with promotion of harm reduction policies and programs countrywide in Tanzania.

MdM signed a Memorandum of Cooperation (MoC) with the Ministry of Health and Social Welfare (MoHSW) and Temeke Municipal Council in November 2010 to start a comprehensive harm reduction program with governmental and civil society partners. The program includes all interventions recommended by international bodies, as well as extra activities:

- NSP through outreach work and at the MdM drop-in centre (DIC)
- Accompanied referral to OST (as well as OST adherence support)
- Testing & counselling for HIV, HBV, HCV, TB and syphilis
- Accompanied referral to HIV & TB treatment and care (as well as adherence support)
- Symptomatic treatment of STIs & accompanied referral to SRH clinics
- Male & female condom distribution (outreach & DIC) and safer sex counselling
- Information, education & communication; individual counselling, workshops, theatre, brochures, films and songs
- Basic medical care & accompanied referral to general health clinics
- Alphabetisation & basic mathematic classes
- Psychosocial counselling (individual, couple, family counselling)
- Legal advice & support and human rights education
- Overdose prevention & management classes, including use of Naloxone
- Income generating training & coaching as well as financial support for small cooperative business start-up

The goal of MdM is not just to serve PWUD, but to be a model for others to follow. Therefore MdM provides technical assistance & capacity building to Tanzanian NGOs (through training, internships, on the job coaching and management coordination meetings) as well as continuous sensitisation/training meetings for medical workers, police officers, administrative & religious leaders, journalists and other stakeholders. The MdM Training & Resource Centre (TRC), reaching 2,500-3,000 stakeholders per year has been officially recognised by MoHSW.

MdM also successfully works with Temeke municipal government on M&E and resource mobilization for HR interventions as well as on national and international advocacy for HR – aiming on one hand to create a more conducive environment for PWUD and on the other hand on mobilizing resources for HR programming. Specific point of attention in MdM advocacy strategy is the availability of HCV diagnostics, care & treatment.
Since the start of the program MdM has always included former and active PWUD as staff (outreach workers, testing counsellors, trainers). Besides, MdM supports the empowerment of PWUD through hosting self-support groups for HIV+ PWUD and PWUD on OST; providing peer education training and employing peer educators as volunteers (so far 25; 25 more graduating and starting this December); supporting loan & saving groups of PWUD; supporting the creation of small businesses by PWUD. Finally MdM has motivated and supported PWUD to create the Tanzanian Network of People who Use Drugs (TaNPUD)

and continues supporting the network with funds, coaching, training and introducing its members to national and international fora in order for them to advocate for scale up of quality HR services and rights-based drug policies as well as assessing quality of existing services.

Reach of the intervention
MdM service delivery takes place in Temeke Municipality, reaching on average 1,000 PWUD per month of whom roughly half are PWID. The total number of PWID served so far exceeds 6,000 (plus 5,000 non-injecting PWUD). MdM's main national partner, the NGO MUKIKUTE, has established DICs & outreach services in the whole of Dar es Salaam. Together with partnering clinic PASADA we tested more than 1,000 PWUD between February and July 2014.

Through training & sensitization meetings MdM reaches medical staff in Dar es Salaam and NGOs/CBOs and police officers throughout the country; in 2013 alone over 200 NGO/CBO members, 260 medical workers, 1,750 police officers and 250 other stakeholders were reached by MdM TRC. The advocacy component reaches regional authorities throughout Tanzania as well as national government bodies (MoHSW, Ministries of Interior, Education, Gender & Community Development, Parliament, National Aids Control Program NACP, TZ Aids Commission TACAIDS, and Drug Control Commission DCC).

Impact of the intervention:
PWUD practice less risky behaviour; are more assertive (claiming rights); have improved knowledge; increased self-esteem; improved relationships with relatives; improved living conditions; better access to health care; thanks to MdM many PWUD who had never tested before, now know their HIV status and those needing treatment are starting ART with (adherence) support from MdM; continuous sensitization and training of medical staff has improved attitude of these people towards PWUD, moving towards friendly services. Introduction of 'true' HR programming in the country, including NSP; MdM implements NSP and sub-grants MUKIKUTE, who already reached more than 5,000 PWID; MdM strongly contributed to the national Key Populations Guideline, which mentions NSP.

Financing and management:
Three expatriate coordinators work with 32 Tanzanian employees, over 30 volunteers (most of whom PWUD) and a number of interns. Main donors are Agence Française de Développement (AFD) and Elton John AIDS Foundation (EJAF); other donors are Open Society Foundation (OSF), UNAIDS, ILO, UNODC, PSI and private contributors.

Lessoned learned and recommendations:
By far most important is to have (create) a motivated team that is close to PWUD (partly composed of PWUD), that understands PWUD, doesn't judge PWUD and is willing to take an extra step (in terms of working outside office hours, carrying out tasks that are not foreseen, improvising in problem solving). Secondly support from all layers of community is indispensable; from relatives and neighbours to medical, social and law enforcement professionals and local and national authorities. For this reason consultation, sensitization and advocacy are utterly important and an integrated part of our program. Thirdly thinking out of the box, being creative and open to unplanned actions helps to reach unexpected but important results. For example MdM trained beneficiaries in video making, leading to the creation of VAMA (Video for Health and Development), an independent group consisting of PWUD who produce songs and videos to educate their peers and raise awareness on drug use in society.

5. TANZANIA

Title of programme: Origins, evolution and future status of the high-volume low-threshold Medication Assisted Treatment for HIV prevention among People Who Inject Drugs (PWID) in Dar es Salaam, Tanzania
Implemented by: Government**,** Civil Society, UN or other inter-governmental organization
Areas of focus of the programme: Policy and legal environment, the role of the community of people who inject drugs in service delivery
Programme is being implemented since: PWID Programme- 2008; MAT programme- 2011
Has the programme been evaluated /assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
The United Republic of Tanzania (TZ), in addition to facing the enormous burden of heterosexually transmitted HIV as most countries in sub-Saharan Africa, has been experiencing changes in patterns of drug use, increased injection and the spread of HIV and other blood-borne diseases. Currently there are 1.4 million persons living with HIV in TZ, 666,876 enrolled in care and treatment, of which 567,892 are on antiretroviral treatment (ART). Though the burden of HIV remains high and the increasing demand for antiretroviral treatment for persons living with HIV/AIDS challenging, HIV sexual transmission appears to be stabilizing in Tanzania while the burden of HIV among PWID is increasing. It is estimated that among PWID HIV prevalence ranges from 42%–50%. HIV prevalence among the general population in the Dar es Salaam is 6.9%.

The globalization of the drug trade and resulting increases in the availability of drugs – particularly heroin –due to trafficking along the Southern route from source countries of Afghanistan and Pakistan to and through TZ has resulted in an increase in demand, a shift from smoking to injecting heroin, high-risk injection practices and high HIV prevalence among PWID. East Africa has become a hub for drug trafficking. Drug control seizure of heroin is extremely limited; therefore, reducing the demand for heroin is imperative to prevent the further spread of HIV and other blood borne diseases. The introduction and scale up of Medication Assisted Treatment (MAT) with methadone has been shown to effectively achieve these objectives. It is estimated that there are 30,000 PWID in TZ with the majority living in Dar es Salaam. Approximately 60% of PWID in Dar es Salaam reported injecting 3 times per day, with 41% reporting needle sharing in the preceding 30 days. Both male and more so among female injection drug users engage in high risk sexual practices. Tanzania is the first country in Africa, other than Mauritius, to establish MAT, with support from the Tanzanian government and Ministry of Health (MoH), as one of the core intervention program as part of its comprehensive HIV prevention response for PWID. In February 2011, the first public MAT clinic offering methadone was launched at Muhimbili National Hospital in Dar es Salaam. Several years earlier community-based outreach was introduced to reach hidden hard-to-reach PWID populations, engaging them in risk reduction, providing the means for behavior change and link and refer them to other prevention and ART treatment services. In a relatively short period of time TZ created an overall strategic framework in October 2010 to guide the provision of comprehensive HIV prevention and risk reduction interventions, including MAT for PWID as part of an overall prevention, care and treatment program. TZ has implemented drug policies reflecting a

multi-sectoral consensus, across government and community, that recognizes the importance of a public health harm-reduction approach and at the same time supports supply reduction interventions.

Approach:
Tanzania has implemented a comprehensive HIV prevention, care and treatment program for PWID, including core interventions of community-based outreach, HIV testing and counselling, MAT and access to antiretroviral therapy. Community-based outreach was implemented starting in 2009. Outreach workers are often most trusted by PWID. They reach PWID in their social circles, provide risk reduction information and supplies to enable them to reduce their risks. This critical core intervention also links and refers PWID to more formalized, particularly government services, about which they may be unaware, or uncertain that they can receive services respectful of their everyday lives. Outreach is an intervention that starts the process of helping PWID engage in a cascade of prevention, care and drug, and HIV treatment services. MAT is a core intervention in a comprehensive HIV prevention, care and treatment program for PWID. PWID enrolled in MAT services in Dar es Salaam receive services in a conducive and safe environment and have opportunities to access other services including- HIV testing, care and treatment, STI screening and treatment, hepatitis screening, TB diagnosis and treatment, and a range of other health care services. These services are evidence-based and have been highlighted as part of a comprehensive package of services by WHO, UNAIDS and UNODC. Currently Needle and Syringe Programs (NSP) are provided by an international non-governmental organization though there is a great need for these programs to be scaled-up. The MAT program is supported by an enabling environment of laws, policies, and regulations that can prevent the further spread of the HIV epidemic among persons who inject drugs (PWID). The Second National Multi-sectoral Strategic Framework (NMSF) on HIV and AIDS (2008-2012) guided in development by the Office of the Prime Minister brought together sectors of the government and the community to create policies and documents including but not limited to - Policy Guidelines for Medically Assisted Treatment of Opioid Dependence in Tanzania; Minimum Standards for Medically Assisted Treatment of Opioid Dependence in Tanzania and Clinical Guidelines for Medically Assisted Treatment of Opioid Dependence (see Annex 1).

The Strategic Framework details the country's HIV prevention approach for PWID for the period of 2012-2016. Medically Assisted Treatment (MAT) for opioid dependence is recognized in this document as the most effective treatment modality for opiate addiction and a prevention strategy that reduces HIV transmission among drug users. MAT is also an effective modality for linking, enrolling and maintaining HIV-positive PWID in HIV Care and Treatment services and it contributes to retaining those on ART. Methadone is currently available at three public Hospitals in Dar es Salaam. The MAT clinics provide linkages to a range of allied support services including psychosocial support, community reintegration and livelihood development offered by civil society organizations and local government departments.

All clients enrolled in MAT are linked to a collaborating community-based organization (CBO) that has trained outreach workers and social workers providing ongoing psychosocial support. This is the avenue for continuous engagement between the facility providing MAT and the community-based activities. Among the critical roles for the community groups are facilitating family sessions and community reintegration activities, hosting and mentoring peer support groups, tracing clients who may have been lost to follow-up, and playing a liaison role between the community and the facility. The CBOs and community outreach

workers are regularly share local community opinions, concerns and identify areas for support of the MAT services.

The evolution of the MAT program approach reflects: 1) expansion in the number of clinics since 2011; 2) locating clinics in high HIV prevalence geographic areas where PWID congregate and other services such as needle and syringe exchange programs; 3) a shift over time focusing on strategies to recruit for higher-volume/ greater coverage and reducing barriers to help reach out and recruit more female PWID, 4) a commitment to an implementation science approach to test innovative, practical public health strategies for improving the organization and delivery and coverage of MAT (e.g., more dispensing windows at clinics and take-away doses and reducing the burden of assessments for PWID) and providing integrated services for PWID.

Reach of the intervention:
As mentioned earlier, in February 2011, the first public MAT clinic offering methadone was launched at Muhimbili National Hospital in Dar es Salaam. A second public MAT clinic began enrolling PWID in 2012 in Mwananymala (Dar es Salaam) and most recently a MAT clinic began enrolling PWID in the Temeke District of Dar es Salaam. A MAT clinic is currently being planned for Zanzibar.

As of June 2014, more than 1,600 PWID have been enrolled in the three MAT sites in Dar es Salaam (see Annex 2). Initially PWID were referred to MAT clinic through community outreach workers and five sessions were required before enrolment. Based on a review and evaluation of the early work at the pilot site, it was determined there were difficulties reaching and engaging female PWID in MAT. A change in strategy was implemented to permit peer and self-referral to the MAT program reducing a barrier to reaching and enrolling more female PWID. The percentage of female PWID increased greatly. In the initial program out of 782 clients enrolled only 57 were female PWID. In the Mwananymala program the clinic enrolled 147 female PWID out of a total of 583 PWID.

Overall 26% of those enrolled in MAT were HIV positive with the HIV prevalence among females (54%) twice as high. Those HIV positive PWID enrolled in MAT are enrolled in HIV care and treatment accordingly. Forty-seven percent were positive for antibodies for hepatitis C with female higher (60%) than males. Twenty-nine percent are positive for Hepatitis B surface antibodies with higher prevalence among females (43%) than males (see Annex 3). As the second and third clinics opened there was a shift from recruiting only through CSOs and slow enrolment procedures, reducing paper work and opening clinics with more dispensing windows to provide more optimal, higher coverage and efficient service provision. The shifts can be characterized as moving from higher threshold to lower threshold programs. The relatively low HIV prevalence among MAT clients compared to community PWID population samples may also be a result of the higher threshold approach initially established for MAT enrolment.

Reach of the intervention is increasing. The shift to lower threshold services distinguishes the MAT program in TZ. As each new MAT clinic has become operational there has been a planned effort to increase the number of methadone dispensing windows: the more dispensing windows that a program has, the more patients can be served, helping to reach coverage targets that can impact the HIV epidemic.

Furthermore, Tanzania is one of the only countries that are now preparing to test an additional new strategy allowing some PWID take-home methadone doses and resulting in

further lowering the threshold for MAT access. This is the basis of a key population implementation science project supported by PEPFAR. It is expected that take-home doses will reduce burden on staff and enrolled PWID, increase volume significantly and perhaps increase retention in MAT as well as potentially lower the costs. The evidence is that the longer you retain PWID in treatment the greater the likelihood of prevention of HIV transmission.

Impact of the intervention:
Since 2011, a pilot study has been conducted and results of the evaluation have been published by Lambdin et al (2013) revealing 57% of those enrolled remained in MAT treatment at 12 months (see Annex 3). Patient retention in methadone maintenance is comparable to estimates from programs in North America, Europe, and Asia. In 2012 and 2013 additional MAT sites were opened. Methodologically this first evaluation was conducted as a retrospective cohort study of methadone-naive patients enrolling into methadone maintenance treatment. Overall, 629 PWID enrolled into methadone treatment during the study. At 12 months, the proportion of clients retained in care was 57% (95% confidence interval [CI], 53%–62%). PWID receiving higher doses had a lower likelihood of attrition. It was concluded from this evaluation that future implementation strategies should focus on higher doses and flexible dosing strategies to optimize program retention and strengthened efforts for clients at higher risk of attrition.

A study is now underway to examine take-away doses for some PWID. It is anticipated that reaching more PWID and reducing staff burden should result in lower costs, potentially allowing thousands more PWID to enroll in MAT. The implications from the TZ take away methadone study will be of global importance and of great significance for the organization and delivery of MAT for the treatment of opioid addiction and the prevention of HIV and other blood-borne diseases.

Few (if any) middle- to low-income countries with PWID epidemics provide take away methadone dosing. Take-away dosing is an innovation that could be a useful approach in countries with high HIV burden and low MAT coverage and retention rates. Increasing retention rates for MAT has major public health implications; the longer a person remains in MAT the lower the risk for HIV transmission. The take home strategy in TZ will provide an opportunity to evaluate this lower threshold strategy. It is a proof of concept study about the feasibility and effectiveness of a take away methadone component in an overall program that also includes international best standards for all other critical elements. It should be noted that prescribing for ART is monthly or every two months and directly observed treatment is not a practiced strategy.

The Tanzania PWID program and particularly the MAT core intervention has already informed PWID programming elsewhere in Africa, in particular Kenya, but other countries like Mozambique and Uganda have already started study tours to Tanzania and some from staff from TZ MAT program have done TA in Kenya. Ghana too is looking at the Tanzania experience. Just wondering if this can be expanded. Tanzania MAT take away strategy will be a of proof of concept for similar programs worldwide.

Financing and management:
MAT services in Tanzania are currently implemented in public health facilities by existing human resources with support through PEPFAR to facilitate infrastructure renovations, supplement supplies and equipment, and provide technical assistance as needed. The MAT program is part of a comprehensive set of HIV prevention and risk reduction interventions,

which receive financial support from a variety of other sources. The vision for sustainability is for the services to be absorbed into the routine services provided at the respective services. The Ministry of Health and Social Welfare has already begun budgeting for methadone procurement through the public system and the involved Council Health Management Teams have integrated costs for running the MAT clinics in their upcoming Comprehensive Council Health Plans.

Lessons learned and recommendations:
Political will at the highest level of government, and inter-ministerial, multi–sectoral response accounts in large part for introducing and scaling up of effective, lower threshold MAT services for the treatment of opioid addiction, and the prevention of HIV and other blood-borne diseases among PWID. It also helps account for avoiding the all too common occurrence of anti-methadone propaganda that characterizes many countries (see Annex 4 where we at PEPFAR highlighted this program in a publication in 2012).
The United Republic of Tanzania created an enabling environment with supportive legislation, policies and regulations that facilitated the introduction and expansion of services for PWID.
Formalized guidance documents combined with technical assistance has ensured the implementation of high quality, evidence-based implementation science approach to better understanding and implementing lower threshold services that has resulted in reaching larger number of PWID, most vulnerable of PWID including female PWID, retaining them in MAT and referring and linking them to other services.
More than 1600 PWID have been reached since 2011 in the three public clinics and with the shift to lower-threshold and new innovative service delivery systems such as methadone take-home doses it can be anticipated that TZ will contribute to reducing the demand for drugs and preventing the further spread of HIV among PWID.
Sustaining the MAT program as a core component of a comprehensive HIV prevention program has the potential for halving the new HIV infections among PWID.
With heroin as easily available as it is in TZ, the public health response of making MAT and other services as easy available and accessible as heroin will contribute to the countries reducing the demand for drugs, thus impacting supply and reducing the harms associated with use of heroin. This remains a challenge.

5. TANZANIA
Title of programme: Spreading the Word to Spread the Work
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Implemented by: Civil Society
Areas of focus of the programme: The role of the community of people who inject drugs in service delivery
Programme is being implemented since: January 2013
Has the programme been evaluated /assessed? No
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:

The emerging drug use among the youths during the last decade in Tanzania like many countries in the world is an alarming issue. A ball park figure of between 25 000 and 50 000 PWID is frequently cited according to various sources. A large number of drug users are concentrated in three districts of Dar es Salaam alone. Heroin is the most common drug found to be used amongst the people who use drugs. In the recent years, however, cocaine also started to be smoked among this population. Despite the limited studies conducted among key populations in Mainland Tanzania, the HIV epidemic is disproportionately having an affect among these vulnerable people as reflected by the high HIV prevalence as follows: PWID (51%), female sex workers (31.4%), MSM (42%), and among women who inject drugs ranges ranging from 55% to 68%.The moralistic perception of drug users, stigma and discrimination in various manners, violation of basic human rights, deprivation of social safety and livelihood support, criminalization, lack of access to quality health care services and treatment still continue to play havoc in the lives of PWUD. Thus it has become extremely important for the PWUD community to come together as one to address these issues which are affecting their daily lives in many ways, and ensure that the voice of PWUD are heard and they are meaningfully involved in making the decisions that affect their lives.

Approach:
The Tanzanian Network of People who Use Drugs (TaNPUD) was established in January 2013 in Dar Es Salaam, Tanzania. TANPUD is a strong and growing network of PWUD in Africa with committed leaders and networks with other networks of key populations not only in the country but in the region like with Uganda HR network, KeNPUD, network of people who use drugs Mauritius, also internationally with CoNe and soon visiting VOCAL. Our network is clearly innovative in the region and has been heard and recognized by our national and local governments. We work hard to have a strong basis, second line leaders, so that many of us are able to go to fora and speak for our community. We are strongly convinced we can play a role to influence UNGASS 2016!

Reach of the intervention:
Tanzania Network of People Who Use Drugs (TaNPUD) is envisioned as a national level network whose mission is to empower people who use drugs to participate in community development and be involved in planning and decision making that affects PUD and also to have equal rights and access to health care services. TaNPUD has identified key issues that affect the lives of PUD and advocate for change: advocate for the implementation of scientific and evidence based drug policy in Tanzania; and advocate for evidence based quality harm reduction services across the country with inclusion of Opioid Substitution Therapy (OST).

TANPUD has been speaking at various international fora including IHRC in 2013 in Vilnius. The network was presented at the East Africa Harm reduction conference in Mombasa in 2013; and was the only African network of PWUD present at ICASA in Cape Town in 2013 where its vice chair Very Kunambi spoke at all sessions addressing key populations as well as satellites events. TANPUD was of course present at the 1st KP African conference in Dar es Salaam in 2013 and its coordinator was invited to speak at the HIV conference in Addis Ababa in 2014. TaNPUD presented the progress of the network and scope of work at the Cross Learning Workshop on Harm Reduction for PWIDs (India and Africa) in August 2014 in Zanzibar. Its coordinator has received full scholarship to attend the Harm reduction conference in Baltimore, USA, in October 2014. Furthermore, COACT requested a video to be shot for UNAIDS for the Vienna conference in 2014, presenting TANPUD as a case study and broadcasting TANPUD coordinator speaking for rights of PWUD in Tanzania.

Impact of the intervention:
TaNPUD believes that improving the socio economic situations of PWUD is critical to leading a dignified life. It is now seeking avenues for income generating activities. TANPUD has set a crisis response (including legal aid with hotline). The network organizes referrals of PWUD to harm reduction services. Its education and communication unit engages students in schools in Dar es Salaam.

For World Drug Day (2013 and 2014) TANPUD has organized mass education campaigns and a symposium (150 attended including politicians, donors, medical personnel, police, and members). The network has visited the Parliament and continues to work with the Parliament's HIV and drug use committee. The network sensitizes general public and key stakeholders (political leaders, religious leaders, police, and health workers) on drug use issue during public hearings and training. The advocacy work includes research of the consequences of the current drug law on health seeking behaviour of drug users, by interviewing stakeholders such as police, drug users and politicians. TaNPUD writes an advocacy brief on drug policy. TaNPUD engages the government at various levels: Drug control commission, TACAIDS, NACP and actively contributes to task force and technical working groups. TaNPUD and partners organize massive action and press coverage on all major international days (World AIDS Day, Hepatitis Day, Overdose Day, etc., and on the first international Drug Users Day on November 1st). The coming festival in November 2014 is to create a positive image of drug users and fight stigma and discrimination. TaNPUD and other partners will organise again a symposium (December 1st 2014- World AIDS Day) on drug policy (to build on the one organized on World Drug Day).

Financing and management:
Membership growth and involvement of more and more number of members is key to the network, to remain a vibrant and strong organization. Membership thus is the primary pillar of the network. TaNPUD secretariat is crucial for the strengthening of the network as a whole with robust communication mechanism, adequate management systems and procedures in place, and the capacity to deal with other external stakeholders. The secretariat functions as the coordinating unit to coordinate all the activities of the network. The network has weekly meetings for Dar es Salaam members, with capacity building workshop of PWUD at hot spots locations; as well as weekly board meetings. Selected members visit and conduct outreach to other cities at least twice a year (for example for World Drug Day). TANPUD set up structure of local coordinators in Mbeya, Morogoro, Tanga, Zanzibar. A crucial event is the annual general meeting.

Main partners are Médecins du Monde (MdM) in Tanzania (hosting TaNPUD office, providing technical assistance & capacity building as well as sub-grants) and ORCHID in India (visiting Tanzania three times per year for training, coaching, and strengthening the network). The network is also working as closely as possible with INPUD in the United Kingdom for international networking and exposure.

Lessoned learned and recommendations:
Support (technical, financial, organizational) in establishing and strengthening the network by MdM has been indispensable, as well as intense contacts with INPUD and ORCHID. MdM also assured acceptance of TaNPUD by national government bodies (TACAIDS, NACP, DCC) and credibility towards donors.

Challenges are lack of organizational experience and lack of trust between PWUD (from different districts as well as between smokers, injectors, PWUD on methadone and former users).

II. Asia

1. AFGHANISTAN

Title of programme: HIV and AIDS in Afghanistan: What do we know?
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Implemented by: Government, UN or other inter-governmental organization
Areas of focus of the programme: The role of the community of people who inject drugs in service delivery, the financial crisis and its impact on people who inject drugs programmes
Programme is being implemented since: 2013
Has the programme been evaluated /assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
The Islamic Republic of Afghanistan faces a high risk of HIV epidemic. Three decades of armed conflict, millions of displaced, poor socio-economic indicators and wide availability of opium made the country face a growing HIV epidemic among people who inject drugs (PWID). As a low prevalence but high risk country, national authorities recognize HIV control as a major priority.
Furthermore, Afghanistan is one of the war- torn countries .After more than three decades of war, health, social and economic conditions have declined markedly. The literacy rate in the general population is very low (36%) and even lower among women (21%)
Only recently has Afghanistan had to face the problem of HIV. The Ministry of Public Heath reported a total of 1529 HIV infections in Afghanistan, based on data from the Kabul blood bank, DICs, HMIS and VCT.
Afghanistan entered towards the HIV concentrated epidemics, driven by PWID .IBBS conducted in 2012 demonstrated prevalence among PWIDs reaching an average of 4.4 % in 5 provinces central cities.

Approach:
HIV prevalence was documented at the National AIDS Control Program (NACP) of the Ministry of Public Health Afghanistan. Data is received from the Kabul blood bank, HMIS and VCT. HIV prevalence among high risk groups was researched through IBBS study, conducted in 2012.

It is a specific HIV prevention harm reduction intervention for People Who Inject Drugs.

Reach of the intervention:
A comprehensive harm reduction services, including needle and syringes program, HIV testing and counselling, HIV awareness session, STI management, Condom promotion, primary health care and social services. The safe place was initially initiated in Kabul province and then scaled up to two other provinces i.e. in Herat and Balkh. There are around 5000 PWID covered under the harm reduction intervention, through DIC , outreach and safe places.

Impact of the intervention:
- PWID remained the population with the highest prevalence for HIV and HCV infection among all of the at-risk populations.
- The PWID population living in Herat continued to have the highest disease prevalence in the country.
- The HIV and HCV prevalence in Herat were significantly higher than any of the other cities.
- Illiteracy is high (55.2%) and HIV knowledge is low (40% or lower across all cities).
- Risk behaviors are high, with the Herat having the highest risk behaviors with corresponding highest HIV and HCV prevalence rates.

    - 38.4% reported buying sex from a female at least once in their life,
    - 44.0% participants reported ever being in prison
    - 12.2% reported having sex with a boy at least once
    - Use of RRS are low (58%) and ever received HIV testing (29%).

PWID remained to be the principal driver for HIV infection in Afghanistan. These results also showed the intersection and potential transmission of HIV from PWID to other at-risk populations (FSW, MSM, prisoners and RW) in Heart.

Financing and management:
The intervention is managed by NACP, which is financially supported by the World Bank.

Lessoned learned and recommendations:
- PWID are driving the HIV epidemic in Afghanistan.
- Prisoners are probably the second highest prevalence and second top priority
- Data demonstrates levels of risk behavior and overlapping among various sub-populations.
- It is time to effectively respond to further increase in HIV prevalence among PWID and potential spread to other sub-populations in Afghanistan.

Recommendations:
- Extend surveillance activities to other regions, utilizing same surveillance protocols.
- Continue to conduct regular surveillance activities among PWID to monitor behavior and HIV/STIs.
- Continue to conduct regular surveillance activities among the female sex workers (FSW), men who have sex with men (MSM), and prisoner population to monitor behavior and HIV/STIs patterns.
- Conduct IBBS every 2 years.
- Scale up targeted prevention programmes to address high-risk behaviors among the PWID, FSW, MSM, RTW, and prison populations.

- Share findings and recommendations with other government agencies and stakeholders.
- Implement programmes to monitor and evaluate the efficacy and effectiveness of risk reduction services and HIV/STI prevention, treatment and care services.
- Share findings and recommendations with other government agencies and stakeholders.
- Strengthen collaboration within the government ministries as well as with non-governmental organizations to address HIV/STI prevention and care in Afghanistan.
- Implement strategies to fight stigma and discrimination.
- Further research is needed to understand the disparity of significant risk patterns but low HIV and BBI among FSWs, MSM, Prisoners, and RTWs.

2. CAMBODIA

Title of programme: "Creating a Police Community Partnership Initiative for effective HIV programming in Cambodia
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Implemented by: Government
Areas of focus of the programme: Policy and legal environment
Programme is being implemented since: August 2012
Has the programme been evaluated /assessed? No
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Although Cambodia's concentrated epidemic requires reaching those at-risk of HIV transmission, some existing policies hinder HIV service delivery. Recognizing this, the National AIDS Authority (NAA), Ministry of Interior (MOI), FHI 360, and UNAIDS developed the Police Community Partnership Initiative (PCPI). PCPI strengthens partnerships among MOI, provincial officials, local authorities, police, health workers, NGOs, and members of Key Populations (KPs) to ensure KPs' are able to access HIV services. The PCPI concept was adapted from the MOI's Strategic Plan (2008-2013), which outlines the role of police as enablers and facilitators of KPs' service use at the community level.

PCPI was implemented in Banteay Meanchey province from November 2010 to October 2011 and found to be useful:

"We used to work in isolation… We were afraid of each other actually, but since we've started meeting together and sharing information when we meet, we've grown to understand each other and no longer fear each other [laugh]. It's so much better than working separately!"
– Deputy Provincial Police Commissariat

"Since PCPI, cooperation [with the police] has been restored. Today, the police inform us if they're going to have a crackdown, if they arrest someone, where and why… We are more effective in our outreach and target support."
– NGO worker

"Entertainment Workers (EWs) aren't afraid of us like they were before. The NGOs have passed on the information we gave them, so EWs know that we don't mean to harass them."
– Deputy Provincial Police Commissariat

"Once I was arrested because of drugs. They [the police] asked if I could stop using and I agreed. I have been coming to the MStyle Club's drug use program (support group of men who have sex with men – MSM) and have been using drugs less."
– MSM

Based on this experience, the HIV Secretariat of MOI, with technical support from FHI 360 and financial support from DFAT/HAARP, expanded PCPI and sought to make it a core component of the Royal Government response to HIV.

Approach:
Starting in 2012, with DFAT/HAARP support, PCPI has been implemented in 5 of the 9 khans of Phnom Penh, Cambodia. As in other parts of the country, PCPI aims to **create an enabling environment** in which KPs are able to access health, HIV, and social services. It also aims to **strengthen collaboration** among ministries, local authorities, police, health care providers, development partners, non-government organizations and members of key populations.

PCPI entails a series of meetings at different levels from the municipality to the commune. At the commune level, a Rapid Response Team (RRT) comprising post police, outreach workers/peers, NGO staff, KPs and Mekas (entertainment establishment managers) coordinate and facilitate events, such as mapping/updating hotspots. The RRT also identifies and addresses immediately any incident (e.g. arrest of a KP) that occurs.

Reach of the intervention:
To date, in Phnom Penh, a sensitization session was held with 169 government and police officials from national and local levels, UN partners, entertainment establishment owners, and representatives of KPs. Approximately 245 police and NGO workers were trained on the role of police in Harm Reduction (HR). There were 1155 police & authorities, members of KPs, and NGO stakeholders who participated in Sangkat level meetings, 282 who participated in Khan level meetings and 211 who participated in the Municipality meeting. Notwithstanding the above achievements, there were some challenges faced in the implementation of PCPI activities during two major national events in the country, the ASEAN Summit 2012 and the General National Election in 2013, in which all police officers were on heavy duty on social security issues. Limited availability of treatment and rehabilitation services for drug use in Cambodia has also been considered as a major challenge to limiting referral options of drug users by police.

Impact of the intervention:
Preliminary results in Phnom Penh are similar to the Banteay Meanchey experience – police are reporting that they refer drug users to services rather than arrest them. Through PCPI, cooperation between police and NGOs and networks (e.g., the Women's Network Union)

has been improved, as has police referral rather than arrest of KPs (see case studies below for examples). The baseline survey before implementing this initiative was carried out in 2012. Impact of the PCPI has not yet been evaluated; it is planned at the end of 2015.

Financing and management:
The PCPI process has been integrated into existing Khan/Sangkat monthly meetings.Topics regularly discussed relate to balancing the Village Commune Safety policy and women anti-trafficking with harm reduction. The results of NGO hotspot and service mapping are shared, facilitating the cooperation between NGO staff and police to support KPs. Once HAARP funding ends in December 2014, it is anticipated that European Union funds will be used to sustain these efforts until a more long-term sustainability plan is in place for the full integration of PCPI into existing police structures.

Lessons learned and recommendations:
Recognizing the importance of creating an enabling environment, PCPI was incorporated into the Ministry of Health's standard operating procedure (SOP) for HIV service delivery for KPs. This SOP redefined a rapid response team composed of police, local authority, NGOs, and KPs to address/prevent arrests, threats, and violence, all of which can interfere with HIV service provision. Through national implementation, PCPI will help Cambodia achieve its HIV elimination goal by 2020.

Annexes:
Case Study #1: On 7 February 2014 Tumnop Toeuk Police (khan Mean Chey) arrested an injecting drug user (around 33 years old) who stole a bicycle. The arrested drug user reported that he was an NGO client and on methadone from the Ministry of Health's Methadone clinic. Knowing that, the police contacted FHI 360 to get the contact for the NGO. After that, the police contacted the NGO to ensure the client was able to get his services. Fortunately, the person from whom the bicycle was stolen did not press charges, so the thief was released to the NGO staff.

Case Study #2: On 26 May 2014, police referred a 20-year-old drug user who was beaten by her friends to an NGO. When the NGO's staff arrived, the drug user was out of control and reported to be having a psychological problem. The NGO's staff brought her to their drop-in center and sent her to the Khmer-Soviet Friendship hospital for treatment. After treatment at the hospital, she was sent back to her home. The NGO's staff routinely visits her, reporting that she has been better and is back at work.

3. CHINA

Title of programme: From Science to Policy: the evolution of China's National Methadone Maintenance Treatment Programme
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Implemented by: Government
Areas of focus of the programme: Policy and legal environment
Programme is being implemented since: 2004

Has the programme been evaluated /assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Illicit drug use reemerged when China implemented the “Opening Up and Reform” policy in the late 1970s. The number of registered drug users in China has increased rapidly from 70,000 in 1990 to 2.47 million in 2013. China reported the first Acquired Immune Deficiency Syndrome (AIDS) case in Beijing in 1985. Four years later, in 1989, more than 100 drug users infected with Human Immunodeficiency Virus (HIV) through needle and syringe sharing behaviors were identified in Yunnan Province bordering Myanmar. Since then, HIV epidemic has spread from Yunnan province to other neighboring provinces though drug-trafficking routes at an alarming rate because of high-risk behaviors among drug users. As of 2002, all 31 provinces in mainland China have reported cases of HIV infection due to injecting drug use.

By the end of 2011, approximately 780,000 people were estimated to be living with HIV/AIDS nationwide, with 28.4% of infections attributed to injecting drug use. Among the 48,000 estimated new infections during 2011, transmission through injecting drug use accounted for 18%. It is estimated that HIV prevalence among the general population in China is 0.058% in 2011, but much higher among drug users (DUs) overall. HIV sentinel surveillance data indicated HIV prevalence among DUs was 5-8% nationally and HIV prevalence among DUs is over 50% in some regions, such as Yunnan and Xinjiang.

Approach:
In an attempt to combat the growing drug use and HIV epidemic, with the coordination of different departments, China initiated a community-based methadone maintenance treatment (MMT) programme for opiate addicts. China’s MMT programme follows an outpatient model. Clients attend clinics daily to obtain their methadone dose, under the direct observation of clinic staff. There is no option for take-home doses, nor any legal way to obtain methadone outside the clinics.

The daily dosage recommended by the national protocol is 80-120mg. Clients are charged a maximum of CN¥10 (roughly 1.5 USD) per day for treatment (irrespective of dose). A baseline survey is conducted within one month after enrollment to collect data on drug use, sexual and criminal history, and social functioning. A blood sample is taken to assess HIV, HCV and syphilis status. A follow-up survey is scheduled for 6 months post-enrollment at which time this information is collected again and clients’ satisfaction with the service is measured.

A web-based system, the National MMT Data Management System, was set up in 2008, which simplified the data management and data analysis process for users at all levels and facilitated the monitoring and evaluation of the programme.

Reach of the intervention:
Under the governance of the Ministry of Health, the Ministry of Public Security and the State Food and Drug Administration, 8 pilot MMT clinics were first established in 2004 in five provinces, which had a high prevalence of drug use and HIV epidemic. With the success of pilot clinics, China’s MMT programme began expanding nationally since 2006. As of August 2014, 765 MMT clinics, including 29 MMT vans, had been established and were operating in

28 provinces, autonomous regions and municipalities. In addition, to enhance the coverage of MMT programmes and to enable more opiate users in the community to benefit from methadone treatment, more than 300 small MMT extension sites based on community healthcare centers in urban areas and township hospitals in rural areas were set up nationwide. Currently, China's MMT programme is the largest single MMT programme in the world, serving more than 410,000 opiate users cumulatively since the first clinic opened in March 2004.

Impact of the intervention:
A substantial decline in HIV epidemic among drug users has been documented. Since the introduction of MMT programme, HIV incidence among MMT clients has dramatically decreased. Assessment data indicate that HIV incidence has been reduced by over 80% from 2006 to 2013. A conservative estimate suggests that about 13000 heroin addicts were prevented from becoming infected with HIV after implementing the MMT programme. Additionally, the MMT programme has a significant impact on the overall HIV epidemic among drug users in China. Among newly diagnosed HIV cases, the proportion of HIV infections due to injecting drug use has decreased from 43.9% in 2003 to 7.7% in 2013 in China.The national average HIV prevalence among drug users in sentinel surveillance declined by 50%, from 7.5% in 2005 to 3.6% in 2013.

Financing and management:
China's national MMT programme has been funded by the Chinese Central Government via the National Family Planning and Health Commission (formerly the Ministry of Health) in collaboration with the Ministry of Public Security and the State Food and Drug Administration. Central government has allocated 740 million RMB to MMT programme since 2004, and annual budget from central government has increased dramatically, from 20 million in 2004 to 79 million in 2014. Local provincial governments allocate funds for the establishment of clinics. Clinics use this revenue for the transportation and storage of methadone, the routine operation of MMT programme clinics, and to provide ancillary services.

China's MMT programme is managed at different levels of government. MMT working groups were established at the national and provincial level. The National MMT Working Group, consisting of the National Health and Family Planning Commission, the Ministry of Public Security, the State Food and Drug Administration, are responsible for examining and approving the eligibility of medical agencies, ensuring the manufacture and supply of methadone, training key MMT service providers, and supervising and evaluating the programme. The role of Provincial MMT Working Groups, consisting of the agencies listed previously at the provincial level, includes organizing, administering, supervising and providing MMT programme services in their province. With approval by the national MMT Working Group, the National MMT Training Centre was set up in 2005 to offer a 10-day training course covering addiction theory, clinical practice and administrative skills for the delivery of MMT services prior to the opening of clinic and to provide ongoing capacity-building training for MMT service providers.

Lessons learned and recommendations:
The rapid nationwide scale-up of the MMT programme is the cornerstone of the response to the HIV epidemic among people who inject drugs. Key factors for the success of China's MMT programme include:1) political and financial commitment from the central government; 2) multi-sectoral collaboration among the three government sectors; 3) a strong technical support team provided on-going support for scaling-up, continuing evaluation, and problem

solving ; and 4) robust support from families and communities, as well as positive interactions between providers and clients.
Nonetheless, there are still many challenges, which include low overall programme coverage, low retention rates, and need for improved staff capacity. In order to maintain its successes in controlling the HIV epidemic among drug users, China's MMT programme should be strengthened to fill service gaps and meet the evolving needs of clients. Future efforts must address low programme coverage and retention, staff capacity, and uneven service quality. In addition, research on preventing mortality among drug users who entered the MMT programme is necessary to better understand the effectiveness of MMT programme. Government commitment to this programme and to preventing HIV among injecting drug users must continue.

4. CHINA

Title of programme: Universal access of harm reduction service for vulnerable drug users at China/Myanmar border area
Contact: Luo Zhi
Title: Mr
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Implemented by: Civil society
Areas of focus of the programme: The role of the community of people who inject drugs in service delivery
Programme is being implemented since: 2009
Has the programme been evaluated /assessed? No
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Located in the southwest of China, Yunnan province has a 4,060 km long shared border with Myanmar, Laos and Vietnam and is located near the "golden triangle". The specific geographic location of Yunnan, with many cross-border farms, results in inter-marriage among the border populations. Along with the development of border economic corridors and booming infrastructure and tourism business, significant numbers of migrant drug-users have been observed in the border areas. Cross-border areas, such as northern Vietnam, Yunnan, and Kachin State, Wa special region and Shan State in Myanmar offer unique but challenging opportunities for addressing HIV epidemics. The HIV epidemic situation is accelerating along these border areas.

Drug trafficking, drug use and drug related harm, such as HIV infection, has been a serious problem in Yunnan. The earliest cases of HIV infection found in Yunnan in 1989 were Myanmar cross-border people who inject drugs (PWID). The PWID HIV epidemic then started to spread gradually from the border areas into the inland and from the countryside to cities.

It is estimated that there are around 10 million person-time border crossings between China and Myanmar every year. Reports show that both Yunnan and Myanmar, particularly the

northern region, have been hit by the HIV epidemic with the Chinese PWID HIV infection rate reported as about 31.7% in Yunnan.

The challenges remain as lacking substantial cross border cooperation mechanism on HIV control and meaningful engagement across sectors and with PWID. Mobility of the population as well as homelessness of drug users adds to the complexity of the HIV response in the border areas.

Approach:
Funded by the Government of Australia, the intervention was HIV specific focusing on harm reduction for PWID groups and affected communities. The project was implemented by Yundi, a local NGO in Yunnan under the supervision of the Yunnan Provincial AIDS Bureau with oversight provided by UNAIDS China.

The project helped to build supportive environments for PWID to receive harm reduction services along the border areas. It supported the build-up of cross-border cooperation and mechanisms between local authorities in both China and Myanmar. The project promoted and advocated policies and practices for equal access to public health services by both Chinese and Myanmar drug users through providing training to management staff, peer education, distribution of clean needles and condoms, promotion of safer sex and safer injection behaviour, peer led naloxone rescue, referral to Voluntary Counselling and Testing (VCT), methadone clinics and anti-virus treatment. Positive and long term cooperation has been built up among health, public security, academic institutions, civil affairs and NGOs in policy dialogues, training and project supervision and evaluation.

Reach of the intervention:
The project supported the drug user's organizations in activity planning, implementation, management, capacity building, monitoring and evaluation, at three cross-border sites between China and Myanmar (Longchuan-Lwejie, Ruli-Muse, and Zhenkang-Laukai).

Impact of the intervention:
Impressive coverage of services has been achieved among PWID in the project areas with funding support from the HAARP project, Yunnan Provincial AIDS Bureau and other sources. The total number of PWID (Chinese and Myanmar) who received harm reduction services in the border areas was 1346 as off 31 May 2014. Among them, 237 PWID received referral services for MMT, ART and STD treatment. In addition, with support from the government, the local drug user's organizations established a replicable livelihood model for local communities to provide food, shelter and skills training to 204 Chinese and Myanmar homeless drug users.

Two surveys were conducted in the border sites including a baseline survey in 2008, before HAARP started, and another in 2011. During this period it was reported that 174 Myanmar drug users were referred to Methadone clinics on the China side of the border for services. The surveys showed that needle sharing with others decreased from baseline 28.2% in 2008 to 10.6% in 2011. Condom use in last time sexual contact increased from 42.7% in 2008 to 61.9% in 2011. 350 heroin overdose PWID also received peer led field lifesaving Naloxone services. PWID satisfaction rates (with the project services) reached 83.0%. In addition, Yundi followed HAARP data collection requirements focusing on input and output data collection and reporting (through submission of the minimum data sets), no surveys have been conducted in border sites since 2011.

The project supported policy and practice changes in relation to services provided for PWID. “A Report on the Feasibility of ex-Drug Users withdrawal from the Dynamic Controlling System”, published by the Yundi Harm-reduction Network informed the development of an official drug policy document. As a result of the new policy, around 68,000 drug users not taking drugs for more than three years were removed from the public security dynamic control system. It has improved the lives of these former PWHID by reducing stigma and harassment and has helped the project gain trust from PWID and their families. In addition, the project supported Yundi Harm Reduction Network to identify policy barriers to universal access to service for Myanmar drug users who live in the China side of the border.

Clean needle distribution as part of harm reduction approaches has been officially acknowledged as Yunnan provincial government policy on HIV control and prevention. Yundi Harm Reduction Network supported Myanmar PWID to access HIV services including HIV testing, methadone replacement and anti-virus treatment in the border.

Financing and management:
There were two phases of the project implementation with Phase 1 implemented by National Centre for HIV Control and Prevention and Yunnan Provincial AIDS Bureau with participation of Yundi Harm Reduction Network and Phase 2 implemented by Yundi Harm Reduction Network with oversight provided by Yunnan Provincial AIDS Bureau and UNAIDS China.

In Phase 2, Yundi received funding from the provincial bureau of health and Government of Australia through UNAIDS. The Yunnan Provincial AIDS Bureau was responsible for overseeing the performance of Yundi and approving overall financial application. The Provincial AIDS Bureau facilitated coordination and inputs from local multi-sectorial agencies and experts in order to ensure the quality of the project implementation. In addition, the Bureau took charge of supervision of the project and endorsement of the activity completion report before it was submitted to UNAIDS.

Yundi Harm Reduction Network was responsible for financial management and implementation if activities at the project site level. With support of the project in particular long term support from the Government of Australia through HAARP, the capacity of Yundi Harm Reduction Network has been greatly improved both in harm reduction service provision and project management. The achievements made by Yundi in provision of harm reduction services have been well acknowledged by the government and the communities. This ensures the sustainability of the services, including attracting funding support from other sources.

Lessons learned and recommendations:

- Support provided to drug user’s organizations, such as Yunnan Yundi Harm Reduction Network, from national, provincial and county levels through multi-sector cooperation can foster trust as well as build capacity of NGOs and support strong enabling environments (policy and cooperation mechanism). This forms a basis for successful implementation of harm reduction services in border areas. Donor funding support to cross border activities could assist with piloting interventions by removing policy barriers and implementation difficulties.

- With funding support, drug user organizations can be equipped with adequate skills in the provision of harm reduction services and play a critical role in accessing hard-to-reach communities like drug users, homeless and cross border PWID. They can deliver

harm reduction services and referrals of NSP to VCT/Methadone/anti-virus therapy in border areas.

- With support from the government, drug user organizations can facilitate universal access to harm reduction services for vulnerable drug users, including those living on the Chinese side of the border. With evidence gained and achievements made from the project implementation, NGOs can work jointly with government and others to advocate for resources and lobby for policy changes. It is anticipated that Methadone and ART services may be accessible for Myanmar drug users who work and live on the Chinese side of the border.

- Challenges remain such as the lack of long term, systematic and sustainable funding mechanisms in interventions among PWID in the cross-border areas, in particular for services provided by NGOs. The established capacity of NGOs could collapse without continued funding support in order maintaining the same level and quality of services.

Annexes:

1. Policy influence example "The Report of Dynamic Surveillance System Influence on Former Injecting Drug User" access by http://www.ynaidsxm.com/index/ywcl/ywcl.htm
2. Border area heroin overdose rescue report "Feasibility Studies of Providing Naloxone Treatment for Heroin Overdose by Outreach Workers" can be downloaded http://www.ynaidsxm.com/index/ywcl/ywcl.htm
3. Community based drug user's organization harm reduction service film "light of border" available by http://www.tudou.com/programs/view/aH5dHD9iavM/
4. XUE Hao-ming, DUO Lin, YANG Li-hua, etc. Evaluation and analysis to clean needle syringe comprehensive intervention of mainline drug addicts in HAARP counties of Yunnan province. [J]. Soft Science of Health, 2011 25(12): 845-848.
5. LUO Zhi, DUO Lin, LIN Yun, etc. Investigation about feasibility of Naloxone first aid carried out by outreach workers. [J]. Soft Science of Health, 2011 25(12): 845-848. Chin J Drug Depend, 2013，22 (2): 134-136.
6. DUO Lin, LUO Yan, YUAN Pin, etc. The comprehensive intervention result analysis among Myanmar cross border injection drug user. [J]. Chronic Pathemathol J, September 2013, 14(9): 704-705.

5. INDIA

Title of programme: To improve access to HIV prevention and treatment, sexual and reproductive health and other services for PWID-both male and female – as well as their spouses/partners and children
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Implemented by: Civil Society
Areas of focus of the programme: Policy and legal environment
Programme is being implemented since: 2012
Has the programme been evaluated /assessed? No

Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
The burden of HIV disease among people who inject drugs (PWID) in India is expanding along with other blood-borne infections such as hepatitis B (HBV) and hepatitis C (HCV) primarily through sharing of contaminated needles and syringes. PWID are not only at risk for acquiring and transmitting HIV through the sharing of needles/syringes, but also through unprotected sex, unsafe sex under the influence of drugs/alcohol and sex for exchange of drugs. An epidemic, initially started by the sharing of contaminated injecting equipment, is spread through sexual transmission from PWID to others including regular and other sexual partners; the interface between drug use and sex work additionally is fueling the HIV epidemic. Even though regional differences exist relating to the type of drugs injected (for example, heroin/brown sugar vs. pharmaceutical injecting), size of PWID population and the HIV prevalence amongst them, high-risk behavior of needle sharing and low condom use makes PWID a critical sub-population for HIV prevention interventions.
In some of the states with emerging PWID-HIV epidemics, it is perceived that the capacity to implement effective harm reduction programmes is lacking and there is insufficient understanding of drug use issues among service providers and programme managers. Hridaya aims to fill in the capacity and implementation gaps through its approach in the states of Bihar, Haryana, Jammu, Manipur and Uttarakhand as suggested by the National AIDS Control Organization (NACO), Ministry of Health & Family Welfare, Government of India.

It is not uncommon for women in India, in particular from low income groups to be subjected to verbal/physical violence for suggesting condom use during sexual intercourse with a primary partner. Spousal violence - verbal, physical and sexual violence is reported by spouses of PWID in Chennai (Solomon et al, 2011). As a result, women are acquiring HIV through their male partners and thus vertical transmission is also taking place in low resource poor settings.

Approach:
The basic guiding principle for Hridaya activities has been provision and enhanced uptake of evidence-based services that are reflected in the recommendations of the Technical working group strategy document for NACP IV. The Government of India under the Ministry of Health & Family Welfare, National AIDS control Organization (NACO) works with the States AIDS Control Societies (SACS) who are implementing Targeted Intervention (TI) programme for PWID. These TI programmes are implemented by community based non-governmental organizations providing a set of Harm Reduction services as per the universal UNAIDS/UNODC/WHO guidelines. The major focus remains on providing harm reduction services to PWID and their spouses. Sexual partners and families are missed in the process. Hridaya project aims to supplement this programme by providing a complimentary package of services that aims at increased quality of life of PWID, their spouses, sexual partner and families. To achieve these services, the Hridaya project has constituted a team of community workers mainly female outreach workers and female peer educators. Additionally, the project has included PWID in the workforce, working as Peer Counsellors at each site. There have been three-layers of services: i. Direct support; ii. Education; iii. Referrals:

Direct support focuses on monetary support services for PWID and their families such as:

drug treatment, PLHIV emergency support; skill building; vocational training

Education services primarily focus on increasing the levels of awareness of spouses, sexual partners and families on Harm Reduction, Positive living, Positive prevention, home based care, HIV, HBV, HCV, SRH, Tuberculosis and overdose management.

Referral services aims at linking individuals and families with social entitlement schemes and avail services for HIV, ART, HBV, HCV, SRH, Tuberculosis testing and treatment etc.

The peer educators are carefully identified as those affected by drug use especially wives, sisters, mothers of PWID and their prime responsibility is to create a doorway to the broader community in understanding harm reduction for PWID, enable access to essential services such as SRH that includes HIV testing, Tuberculosis treatment, Non SRH, legal rights, skills building through facilitating access to vocational training, forming support groups/self-help groups, positive prevention, counselling etc.

Reach of the intervention:
Hridaya works at a total of 34 sites in five states in India namely: Bihar (12 sites), Haryana (13), Jammu & Kashmir (01 site), Manipur (02 sites) and Uttarakhand (06 sites). It works with the grass root level organizations that are already providing the national harm reduction services which include NSP, ART, OST, IEC, BCC, STI to the male PWID. Hridaya has successfully reached out to approximately 11000 PWID and has also provided services to a total of 6928 spouses and approximately 51000 close contacts of these PWID who have been provided with one or more of the three layered Hridaya services. A total of 2252 spouses of PWID have been referred and tested for HIV at the ICTC and 18 spouses have so far been tested positive to HIV. 26 individuals have initiated ART through Hridaya services.

Impact of the intervention:
Hridaya approach has been evidence based and hence a baseline and endline evaluation was conducted. This exercise was helpful in revealing evidences that Hridaya has been successful in involving communities that have been able to increase service uptake of harm reduction services. The importance of involving spouses and families of PWID has ensured retention to treatment such as OST, ART, consistent condom use and positive prevention. It has also successfully formed state level Drug Users' Forum in the states of Bihar, Haryana and Uttarakhand.

The Hridaya project has been able to persuade the policy makers to include female outreach workers into the programme design. The national programme has accepted the importance of reaching out to female partners of male PWID and hence has included this position into the recent NACP IV project framework. Additionally, the Hridaya project conducted a Drug Use Pattern Assessment (DUPA) across four states namely Bihar, Haryana, Jammu region of Jammu & Kashmir and Uttarakhand. The inferences drawn from the findings recommend certain changes in the overall approach in the programme design and these recommendations have been shared with NACO and constant follow-up is being done.

Financing and management:
The project is managed at two levels: state level and national level. The state level team consists of a Coordinator and a Compliance officer. Both of these are responsible for providing mentoring, supervision, on-site training, following legal and financial compliances, managing records and documentation. At the site level there are 5 staff namely: Project

officer; female outreach worker; female peer educators (02) and a peer counsellor. These people are mainly responsible for implementing Hridaya services at the grassroots directly to PWID and their spouses, partners and families. Efforts are being put in to link these families with the social entitlement schemes to continue receiving benefits provided by the government.

The national level team is mainly responsible for liaison between all the agencies working with the drug using population that includes NACO, SACS, TSU, DAPCU. This team is responsible to conduct stakeholder consultations and sensitisation programmes with the health care departments, law enforcement agencies and other stakeholders. This team also looks into building capacities of not only the state based staff but thematic trainings are also conducted for all the implementing partners on an ongoing basis.

Lessons learned and recommendations:
Most of the team members at the national and state level are members from the drug using community that have their own unique experience of implementing various programmes and understand the changing dynamics of the drug using community. The states that Hridaya works in were new states for PWID harm reduction and thus had been difficult in implementing the programme at the onset. The implementing partner sites at Manipur has served as a technical partner for demonstrating best practice in community mobilisation, reaching out to female partners and families of drug users.

6. INDONESIA

Title of programme: Community based treatment in delivering services
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Email: office@rumahpeka.org
Implemented by: Civil society
Areas of focus of the programme: The role of the community of people who inject drugs in service delivery
Programme is being implemented since: 2011
Has the programme been evaluated /assessed? No
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
The situation of people who use drugs in Indonesia is at a level of high concern. According to National Narcotics Board of Indonesia, in 2013 people who use drugs were estimated around 4, 5 million. While in Bogor city, the District AIDS Commission has done a mapping amongst people who inject drugs, the mapping resulted in an estimation of 463 people by 2013. Not to mention the prevalence of 55% people living with HIV amongst the people who inject drugs in Indonesia.

Health service providers and drug dependency treatment providers so far have ineffective approaches towards people who use drugs, caused by social stigmatization that still encapsulates the country. Many service providers use a moral approach to the people they

are supposed to serve. These sorts of approaches have fuelled the reluctance from people who use drugs to access the necessary services for their issues. No real peer to peer approach has been used so far especially in the area of drug dependency treatment. The government, with its policies regarding narcotics has been addressing people who use drugs as subjects imposable to criminal punishment rather than treating them from their drug dependency disease. Even though the most recent half-hearted policies have acknowledged drug dependency as a disease, the government bodies have yet to acknowledge, let alone utilize the community based service provider in tackling drug dependency issues.

The vast amounts of drug users in Bogor are not proportional with the rehabilitation centres that existed in the area. In the early years of 2000 there were several rehabilitation centres and NGO's that focuses their work on helping drug users, but many of those places are no longer open. On the other hand, the remaining facilities that are still open have the same method which is behaviour shaping. This situation has left drug users with little options of treatments that suited their needs.

According to the fifth edition of *Diagnostic and Statistical Manual for Mental Disorder V (DSM V),* drug dependency is categorized in substance dependency, where mind and behaviour change is possible but requires a comprehensive approach, along with highly dedicated and professionally trained human resources

The treatment paradigm on People Who Use Drugs is still aimed at total abstinence, thus neglecting the key aspect in treating any person, which is the improvement in the quality of life.

Approach:
PEKA is a community led service provider, starting from the top management down to the staff members; most have the same background of people who use drugs. Realizing the common background between us as the servant and the people we serve that is manifested in our approach, have created the key element of trust, thus enabling us to do our job more effectively since all clients are comfortable in stating their respective issues in the spirit of openness. The principles of human rights have also paved our foundation as an organization, where we respect everybody's free will.

Reach of the intervention:
People Who Inject Drugs (PWID) are still at higher risk of transmitting HIV. By this fact, PEKA provides a continuum of care for people who use drugs, starting from our education programme that educates the community about Drug Dependency, life-skills and HIV prevention, care and stigma. Our outreach programme to key populations consists of sterile injecting equipment distribution and VCT testing, ARV distribution assistance and referral, HIV and AIDS medical referral and consultation assistance, general medical referral and consultation assistance, PWID peer support group that disseminates various information on current situations related to HIV and drugs usage, paralegal assistance that advocates for special needs and other legal needs for our clients in detention, and on top of that we provide counselling as our fundamental service. All the services provided are well documented and managed under the programme division of PEKA Halfway House

Our geographic coverage includes Jakarta, Bogor City and district level, Depok City and district level.

Impact of the intervention:

We have achieved sterile needle and syringe distribution among all our reached people who use drugs specifically PWID. The significant number of people who maintain to use sterile injecting equipment is outstanding. The level of peer motivation is high looking at the admission of each clients has reached 95% by their own will to adhere on ART. Care and support are the key points of successful intervention on this community led services. The impact is measured by several tools such as Addiction severity index, WHO- Quality of life, and BBCTRAQ. (Tables attached in annexes)

Financing and management:
In implementing the programmes PEKA is still backed by donors majorly from Global Fund that also appoints PEKA as the SSR (Sub Sub Recipient) for the City of Bogor. Financial audits have also been carried out yearly. So far we have achieved the highest score in the financial audit report by an independent auditor.

In the financial sustainability aspect, we are still working by contract from donors but so far efforts to be a self-sustaining community have also been carried out through our start-ups empowerment ventures such as fried chicken, angkot (form of public transportation) and t-shirt printing

Lessoned learned:

Community led services is still not getting the needed acknowledgement and invitation by the government in tackling the drug dependency issues in the country, yet so far the services carried out by the community are found to be more affective in our area in a sense of repeated demands by the client in accessing the necessary services.

Having common ground especially in the area of drug dependency is the driving factor in the effectiveness of service delivery, since it indulges the preconceived point of view on who understands us best other than one of us (People Who Use Drugs) and also using true peer to peer approach have helped the client to adhere to treatment that they choose.

Financial sustainability is still the biggest obstacle in delivering services since programme implementation is majorly dependent on contract by donors while at the same time the necessity of service in the community is impossible to be postponed.

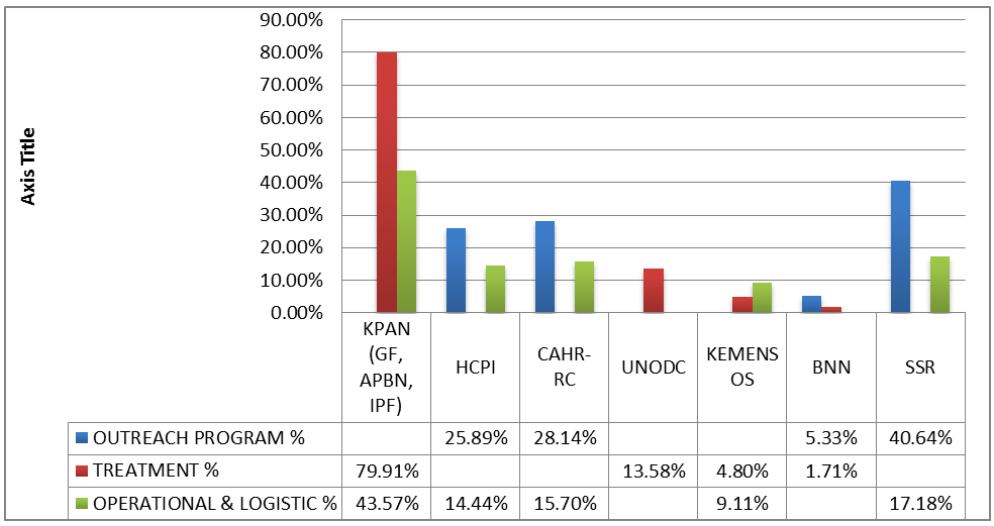
Recommendations:

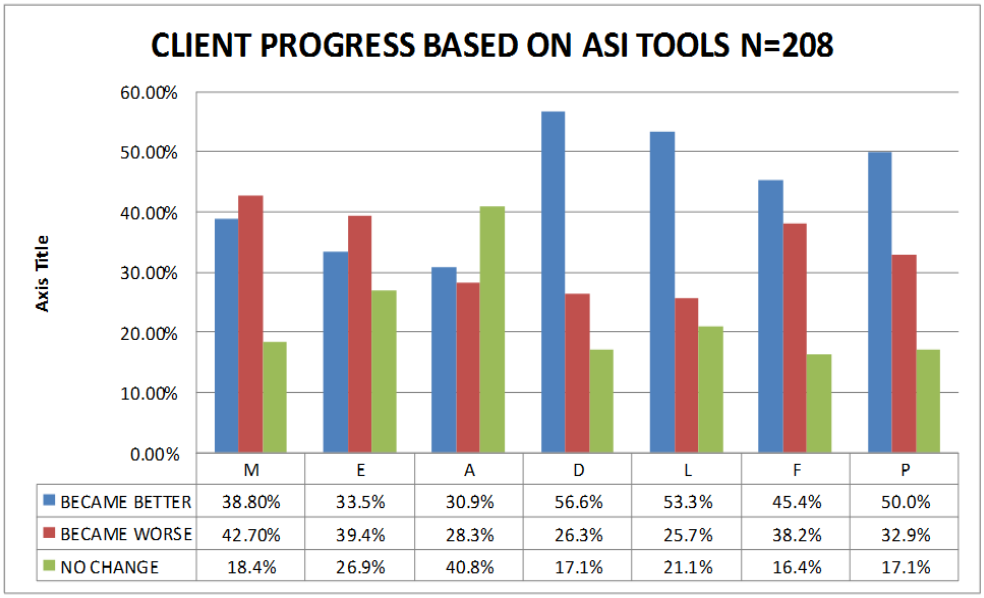
Government acknowledgement and invitation for participation towards community of People Who Use drugs that delivers services will increase the effectiveness of alleviation initiatives on Drug Use, HIV/AIDS, TB and Hepatitis C Virus in the country. The focus on Harm Reduction and knowledge and that total abstinence is not the only indicator of success should be accepted by every sector.

Annexes:

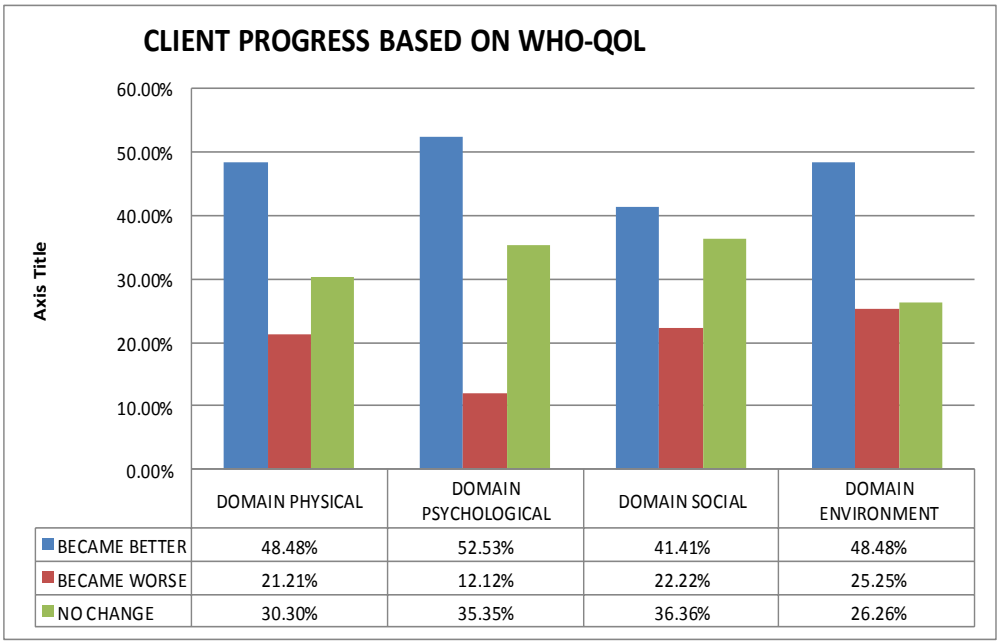
YEAR	SOURCE	PROGRAMME COST	MANAGEMEN & OPERATIONAL COST	TOTAL AMOUNT
2010 - 2014	GLOBAL FUND (COMMUNITY BASED TREATMENT)	IDR 789,645,083.00	IDR 374,613,893.00	IDR 1,164,258,976.00
2011	GLOBAL FUND (VOCATIONAL)	IDR 84,454,000.00	IDR -	IDR 84,454,000.00
2012	IPF	IDR -	IDR 36,000,000.00	IDR 36,000,000.00
2012	UNODC	IDR 159,046,400.00	IDR 39,761,000.00	IDR 198,807,400.00
2012 - 2013	THE MINISTRY OF COORDINATOR PEOPLE WEALTH	IDR 325,042,500.00	IDR 216,695,000.00	IDR 541,737,500.00
2011 - 2014	COMMUNITY ACTION FOR HARM REDUCTION (CAHR) OUTREACH	IDR 208,564,366.00	IDR 312,846,550.00	IDR 521,410,916.00
2011 - 2014	HIV COOIDRERATATE PROGRAMME FOR INDONESIA (HCPI - AUS AIDS) OUTREACH	IDR 195,526,670.00	IDR 293,289,990.00	IDR 488,816,660.00
2013 - 2014	THE MINISTRY OF SOCIAL	IDR 118,837,500.00	IDR 38,687,500.00	IDR 157,525,000.00
2013 - 2014	BNN	IDR -	IDR 64,220,000.00	IDR 64,220,000.00
2013 - 2014	PKBI - SSR	IDR 721,528,500.00	IDR 590,341,500.00	IDR 1,311,870,000.00
	TOTAL	**IDR 2,602,645,019.00**	**IDR 1,966,455,433.00**	**IDR 4,569,100,452.00**

USD 1 = IDR 10,000





	M	E	A	D	L	F	P
BECAME BETTER	38.80%	33.5%	30.9%	56.6%	53.3%	45.4%	50.0%
BECAME WORSE	42.70%	39.4%	28.3%	26.3%	25.7%	38.2%	32.9%
NO CHANGE	18.4%	26.9%	40.8%	17.1%	21.1%	16.4%	17.1%



	DOMAIN PHYSICAL	DOMAIN PSYCHOLOGICAL	DOMAIN SOCIAL	DOMAIN ENVIRONMENT
BECAME BETTER	48.48%	52.53%	41.41%	48.48%
BECAME WORSE	21.21%	12.12%	22.22%	25.25%
NO CHANGE	30.30%	35.35%	36.36%	26.26%

NOOR SALIM, NURSEHAN & SINARAHARDJA

Laporan Auditor Independen

Laporan No. 003-GA/NNS/IV/2013

PERKUMPULAN PEMULIHAN KOMUNITAS ADIKSI

Kami telah mengaudit laporan realisasi anggaran Dana Bantuan KFAN untuk Perkumpulan Komunitas Pemulihan Adiksi (PEKA), untuk periode Oktober 2010 sampai dengan Desember 2012, yang dinyatakan dalam mata uang Rupiah Indonesia. Laporan keuangan tersebut adalah tanggungjawab manajemen. Tanggungjawab kami terletak pada pernyataan pendapat atas laporan keuangan berdasarkan audit kami.

Kami melaksanakan audit berdasarkan standar auditing yang ditetapkan Institut Akuntan Publik Indonesia. Standar tersebut menghendaki kami merencanakan dan melaksanakan audit agar kami memperoleh keyakinan memadai bahwa laporan keuangan bebas dari salah saji material. Suatu audit meliputi pemeriksaan, atas dasar pengujian, bukti-bukti yang mendukung jumlah-jumlah dan pengungkapan dalam laporan keuangan. Audit juga meliputi penilaian atas prinsip akuntansi yang digunakan dan estimasi signifikan yang dibuat oleh manajemen, serta penilaian terhadap penyajian laporan keuangan secara keseluruhan. Kami yakin bahwa audit kami memberikan dasar memadai untuk menyatakan pendapat.

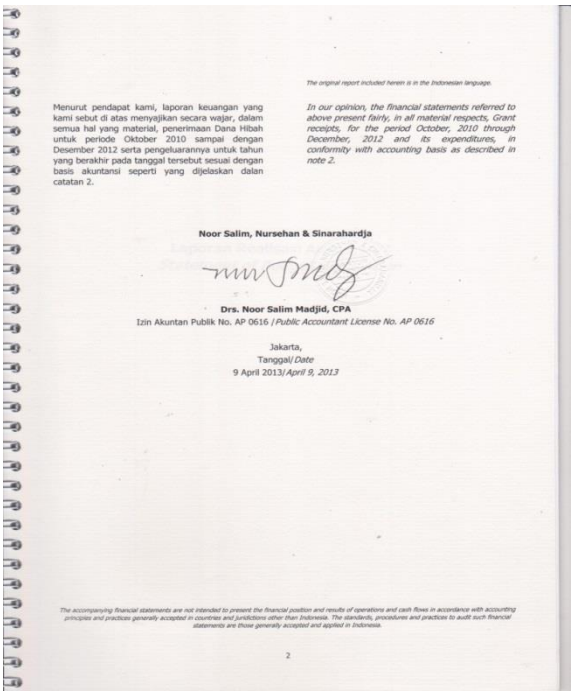
Independent Auditors' Report

Report No. 003-GA/NNS/IV/2013

ADDICTION RECOVERY COMMUNITY ASSOCIATIONS

We have audited the Statement of budget realization of KFAN Grant for Addiction Recovery Community Associations for period of October, 2010 through December, 2012, which are expressed in Indonesian Rupiah Currency. These financial statements are the responsibility of the management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards established by the Indonesian Institute of Certified Public Accountants. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimate made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis of our opinion.



The original report included herein is in the Indonesian language.

Menurut pendapat kami, laporan keuangan yang kami sebut di atas menyajikan secara wajar, dalam semua hal yang material, penerimaan Dana Hibah untuk periode Oktober 2010 sampai dengan Desember 2012 serta pengeluarannya untuk tahun yang berakhir pada tanggal tersebut sesuai dengan basis akuntansi seperti yang dijelaskan dalam catatan 2.

In our opinion, the financial statements referred to above present fairly, in all material respects, Grant receipts, for the period October, 2010 through December, 2012 and its expenditures, in conformity with accounting basis as described in note 2.

Noor Salim, Nursehan & Sinarahardja

Drs. Noor Salim Madjid, CPA
Izin Akuntan Publik No. AP 0616 / *Public Accountant License No. AP 0616*

Jakarta,
Tanggal/*Date*
9 April 2013/*April 9, 2013*

7. INDONESIA

Title of programme: Meaningful involvement of people who use drugs in montiroing the quality of the harm reduction programme in Indonesia
Contact person: Edo Agustian
Title: National Coordinator
Organization: Indonesian Drug Users Network/Persaudaraan Korban Napza Indonesia (PKNI)
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Implemented by: Government**,** Civil Society
Areas of focus of the programme: Policy and legal environment, the role of the community of people who inject drugs in service delivery
Programme is being implemented since: 1st April 2013 – 31st January 2014
Has the programme been evaluated /assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? No

Background:
There are an estimated 74, 326 (61,901-88,320) people who inject drugs (PWID) in Indonesia, one third to one half of whom are living with HIV (National AIDS Commission 2012). Despite a decrease in the number of HIV cases via injecting drug use in recent years, people who inject drugs remain one of the key populations affected. The latest Ministry of

Health data indicates that 14% of new HIV cases are among PWID, while HIV prevalence in this population ranges between 25% and 56% (Ministry of Health 2012).

Whilst Indonesia has steadily increased its commitment to expanding the scale of harm reduction programmes, the coverage and quality of key harm reduction interventions is still too limited to have a major impact on the HIV and viral hepatitis epidemics. For instance, although the number of sites distributing sterile needles and syringes has increased, coverage varies widely across different geographic areas. Figures for 2011 indicated that national-level coverage equated to only seven needles and syringes per year per person injecting drugs (GAPR 2012). Similarly, the availability and scope of opioid substitution therapy (OST) are limited by a lack of coverage, and where services exist, poor programme quality, including lack of proper follow-up among those who drop out and inappropriate dosing levels (GAPR 2012).

The policy response to drugs in Indonesia has been dominated by punitive law enforcement measures. In 2009, Indonesia launched a new law on narcotic drugs (Narcotics Law no. 35), which introduced mechanisms for diverting people who use drugs away from prison and towards drug treatment programmes. The new regulations provide judges with discretionary powers to impose drug dependence treatment as an alternative to imprisonment. However, despite provisions to divert people into drug treatment, the ongoing criminalisation of drug use has resulted in high rates of imprisonment of people who use drugs and severe overcrowding in existing facilities. In practice, the content of Indonesia's Narcotics Law no. 35 (2009) is not implemented and applied uniformly, and law enforcement officers and courts continue to prosecute people who use drugs.

Although Indonesia has a strong national drug user network, people who use drugs remain largely excluded from local programming decisions and high-level policy-making.

Approach:
In response to the sub-standard quality of existing services for PWID, including harm reduction services such as methadone maintenance therapy and needle-syringe programmes, as well as STI/HIV testing and management, ARV management and condom promotion, in late 2012 PKNI began advocating for a systematic evaluation of existing services with a solid and meaningful role for the drug user community. PKNI felt that this situation can be overcome by providing more comprehensive health services and improving the quality of harm reduction programs in line with international standards set by UNAIDS, WHO and UNODC in the latest 2013 target-setting guide.

As a result of extensive advocacy efforts, a collaboration among PKNI, Indonesia's National AIDS Commission and the Directorate-General of Prisons was forged in 2013 with the aim of monitoring the quality of harm reduction services in prisons and in the community. The three pronged approach to monitoring harm reduction service quality included joint development of the monitoring and evaluation tools, and a clear division of roles whereby:
(1) the National AIDS Commission assessed service quality from the perspective of harm reduction service providers such as government-run community health centres (*puskesmas*);
(2) the Directorate-General of Prisons monitored the provision of harm reduction services in prisons and other closed settings; and
(3) PKNI assessed the quality of services within the community from the beneficiary perspective.

Reach of the intervention:
The harm reduction service quality monitoring activity was carried out twice (baseline and follow up) across 9 provinces between April and December 2013 in order to reach a range of locations and services across Indonesia. PKNI community members were trained in conducting key informant interviews, and interviewed people who had used harm reduction services in the target areas. The assessment utilised mixed quantitative and qualitative survey methods. These included focus group discussions (FGDs) and quantitative survey instruments. From the beneficiary perspective, a total of 270 people, approximately 30 people from each of the 9 provinces, provided comprehensive information on their experience of service quality. The assessment instrument jointly developed by PKNI and the National AIDS Commission included sections on level of understanding about HIV and its effects, and understanding of services related to HIV prevention, treatment, care and support. This included sections on the quality of needle syringe programs, methadone maintenance therapy, HIV testing and treatment access, HIV and Hepatitis C co-infection and treatment, overdose awareness and prevention, and sexually transmitted infection prevention, testing and treatment.

Impact of intervention:
The assessment and monitoring exercise established a baseline for the quality of HIV prevention, treatment and case services among PWID in Indonesia by and among the community itself. It also increased understanding of where services needed to improve to achieve a basic level of quality. The evaluation conducted by PKNI was combined with those of the NAC and Directorate General of Prisons to form an overall picture of service gaps in Indonesia.

The initial baseline results from the community perspective were utilised to inform improvements to harm reduction and HIV prevention service delivery. A follow-up monitoring exercise was conducted 6 months later using the same mixed methods methodology across the same 9 provinces. This follow up exercise provided an opportunity to assess progress on programme and service quality. Analysis is currently being conducted on the follow up data, with results expected by the end of 2014.

PKNI continues to engage in advocacy around using this assessment exercise in order to improve service quality in particularly affected areas.

Financing and management:
The intervention was jointly managed and coordinated by the two government institutions listed above, in collaboration with the Indonesian Drug Users Network. PKNI is an independent network of drug user organizations which was established in 2006 to address stigma, violence, discrimination and violations of human rights towards people who use drugs, representing the common priorities of 25 self-organised drug user groups across 19 provinces in Indonesia. The network played an active role in project design, development, and implementation, including the development of assessment tools and analysis of findings.

While the assessment itself was completed according to the initial agreement between the community government partners, a lack of commitment to follow up assessment results directly with service providers is lacking on the part of the government institutions involved.

The funding for this intervention was provided separately by each participating partner. For its own portion of the assessment, the National AIDS Commission financed the assessment as part of its national strategic plan budget. PKNI financed its portion of the assessment from the community perspective using funds from the Robert Carr Civil Society Fund via the Asian Network of People who Use Drugs (ANPUD). The project could not be continued into 2014 due to a lack of funding. PKNI is actively searching for additional funding to continue monitoring harm reduction service quality in Indonesia.

Lessons learned and recommendations:
A key aspect of this intervention's success was political willingness on behalf of the government to allow for more space for the meaningful involvement of the drug user community in harm reduction service quality assessment and evaluation. The success of this project demonstrated that genuine collaboration between policy makers and the drug user community is not only possible, but is necessary to the delivery of effective, evidence based services that accommodate the needs and concerns of the community, and thus work toward halving HIV infections among people who inject drugs.

An ongoing challenge remains the need for continued advocacy from the community to secure a meaningful role in the delivery and evaluation of HIV services.

Annexes:
1. Powerpoint presentation on the programme described above presented as an oral abstract at the IAS Conference 2014 in Melbourne, Australia.

8. IRAN

Title of programme: Harm Reduction programmes (Methadone Maintenance Therapy and NSP) among people who inject drugs in Iran
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Tel: +98 21 8145 5001
Email: mgouya57@gmail.com
Implemented by: Government, Civil Society, Private Sector, UN or other intergovernmental organizations
Areas of focus of the programme: The role of the community of people who inject drugs in service delivery
Programme is being implemented since: 2002
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Total estimated number of drug users in Iran is 1,300,000, out of which approximately 200,000 are injecting drug users. The first case of HIV in Iran was reported in 1986. The first case of HIV transmission through injecting drug use (needle sharing) was reported in 1989, and the number of such cases increased by only 5-10 cases per year until 1995. In 1996, due to an HIV epidemic among drug users in one prison, there was 23 times increase in number of HIV positive identified cases as compared to previous year, however, the

epidemic among people who inject drug (PWID) took off and the number of cases reported annually began to increase dramatically. Since then, injecting drug use has been the most prevalent route of HIV transmission in Iran. Prevalence of HIV among PWID is 13-15%. According to data from the HIV case registry, the number of people known to be living with HIV in Iran was 27888 as of March 2014, of whom 88.7 per cent were men and 11.3 per cent women. Of all the cases recorded since 1986 in the country, the most common route of transmission has been needle sharing among PWID, accounting for 67.6 per cent of recorded cases. However, in the last year, 45.7% of registered new HIV cases were PWID.

Approach:
The approach is a mix of all. Since all PWID are most at risk for HIV, these services are provided for all PWID including HIV positive or negative.The 3rd National Strategic Plan (2010-14) was developed to respond to the HIV epidemic in Iran. This programme is the result of close, multi-sectoral collaboration between all the relevant stakeholder institutions and organizations. Harm reduction is one of the most important strategies under the National Strategic Plan for HIV. The CSOs are the implementers of harm reduction programme through establishment and running of Drop-in Centers in which the clients receive harm reduction services (IEC, condom promotion, Needle Syringe distribution, Methadone Maintenance Treatment, outreach services), along with other support services (mental counselling, primary health care, food and tea serving).

The Harm Reduction programme is implemented through collaboration of various organizations including Ministry of Health (MOH), the State Welfare Organization (SWO), Drug Control Headquarters, Medical universities, and NGOs. Iran's harm reduction programmes have been documented by the World Health Organization and UNAIDS as "role models" and "good practices" in the Middle East and North Africa (Eastern Mediterranean) region.

Reach of the intervention:
Since PWID are usually hard to reach, Iran has established Drop In Centers (DICs) in high risk regions throughout the country for more access to these populations. The programme is gender-sensitive, non-discriminatory and user-friendly. In this regard, special DICs for women have been established in different provinces. Furthermore, the criteria for registration in DICs are simplistic and clients do not need to show any identification card to get services. By the end of 2013, there have been 238 DICs and 400 outreach teams. Together, these services provided harm reduction facilities to almost 200,000 clients in 2013. Primary focus of the programme is HIV prevention. As of September 2012, free needle-syringes were being distributed by more than 559 service outlets. In addition, some support services e.g. shelter for PWID is also provided.

According to 2010 bio-behavioural survey of PWID, the proportion of PWID who report receiving free needles/syringes during the year preceding the survey was 69.7%. The number of syringes distributed per person who injects drugs per year by NSP was between 26 to 35 syringes for every person who inject drugs in 2011 and between 55 to 77 syringes in 2013. As of March 2014, the number of outlets providing methadone maintenance treatment (MMT) stood at 5292, which had catered for close to half a million drug users. MMT coverage trends increased steadily between 2001 and 2011.

In order to provide psychosocial support for people living with HIV and their families including those who use drugs, approximately 30 "Positive Clubs" have been established throughout the country. As a result of the above initiative and with support of the national

Social Protection Task Force free medical insurance for all PLHIV and their families is being provided. The Task Force and the Positive Clubs have also instituted efforts to reduce HIV-related stigma and discrimination. In Iran, Voluntary Counselling and Testing (VCT) services are easily accessible to the entire population and all the services on offer through VCT Centers, and counselling posts are free of charge. Although VCT sites play an important role in access to HIV testing, however target groups may attend different settings. In order to increase access of PWID to test, country has developed a plan for introduction of HIV testing by using rapid methods in HIV testing protocol. DICs, MMTs, TB clinics, ANC clinics and also private sectors are included in this approach. Rapid tests are also provided by outreach programmes to find HIV positive people who are not able to attend the available centres. HIV treatment and care services are provided in accordance with standard national guidelines, which are based on the guidelines proposed by the WHO. The Antiretroviral medication is available across the country and is dispensed free-of-charge to patients.

Impact of the intervention:
HIV prevalence among people who inject drugs averaged 15% nationwide in 2010, which shows a gradual decrease from the figure of 15.3% reported in the 2008 national bio-behavioural survey. Successive rounds of IBBS have shown that the proportion of nationally-representative samples of PWID who report using a sterile Needle/Syringe in their last injection has increased from 84.3% in 2008 to 88.8% in 2010.

Total number of HIV tests has increased during the past year, meanwhile number and proportion of newly diagnosed HIV patient injection has decreased significantly. Based on the latest estimation and projection exercise conducted in 2014 using the UNAIDS model, Iran's HIV population is estimated to be around 76000 (55000 men and 21000 women). These numbers are projected to increase by 2019 to 86000. Based on modelling studies conducted in 2014, PWID still account for the largest number of new cases but the proportion of this route of transmission has been decreased as 4508 out of 6810 total new HIV infection in 2008 (66%) to 4043 out of 7330 in 2014 (55%). This figure is estimated to be as 3410 out of 6830 in 2010 (50%).

Financing and management:
The main coordination of the programme is with the Drug Control Headquarters, who regularly meets all the stakeholders, including CSOs, and distributes the budget of the harm reduction among the Ministry of Health (MOH), the State Welfare Organization (SWO), and the Iranian Prisons' Organization. MOH and SWO distribute the budget among NGOs and DICs. Harm reduction activities is mainly supported financially by government. Meanwhile, some international organizations as well as charities also support the harm reduction programme.

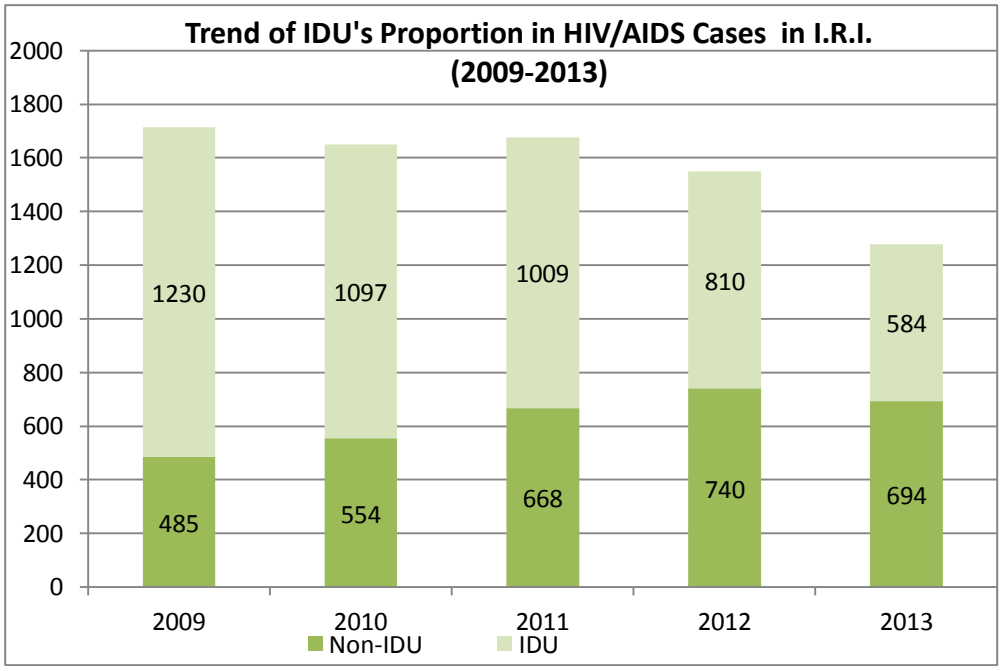
Lessoned learned and recommendations:
The programme was geared up after issuance of a Directive by the Head of Judiciary in 2005 to support harm reduction activities. As a result, the judges and the police were obliged to cooperate with all the harm reduction centres. During these years, the CSOs have been successful in advocacy with the local mosques, local councils, and society for continuing their activities.

Challenges: Further inter-sectoral coordination and collaboration is needed for a more effective referral system. In addition, due to annual inflation, a bigger budget is needed for smooth continuation and expansion of services. For effective control of HIV among PWID, a more comprehensive harm reduction package needs to be provided to clients. Some

elements such as TB diagnosis, care and treatment, HBV and HCV related services, STI management, etc., have to be added to the existing package through a robust referral system.

Annexes:

1. Iran Drug Control annual report, 2013
2. Estimation-Projection report, 2014
3. WHO Best practice on HIV/AIDS prevention and care for injecting drug abusers
4. Outcome evaluation of the opioid agonist maintenance treatment in Iran



9. MYANMAR

Title of programme: Comprehensive prevention, treatment and care through a collaborative “one-stop service” model in Myanmar.
Contact person: Linda O’Brien
Title: Senior Programme Manager
Organization: DFAT
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Implemented by: Government, Civil Society
Areas of focus of the programme: The financial crisis and its impact on people who inject drugs programmes
Programme is being implemented since: September 2014
Has the programme been evaluated/ assessed? No
Is the programme part of the implementation of the national AIDS strategy? Yes

Is the programme part of the implementation of the national programme on drugs?
Yes

Background:
Myanmar is one of the least densely populated countries in Asia, with over three quarters of the population living in rural areas. Many years of ethnic conflicts, civil wars and displacement have led to large scale socioeconomic hardship, and absence of state structures - including health. Years of limited public spending on health and isolation have also left the health care system incapable of responding effectively to endemic infectious diseases.

For more than a century the production and trafficking of opiates has been endemic in upper Myanmar, especially in upper Shan and Kachin states. Opium cultivation is once again on the increase and according to the latest report from the UN Office on Drugs and Crime (UNODC)[1], drug cultivation, production and use is now rising at the steepest rate in years. Historically large populations of people who inject drugs (PWID) have lived in these traditional drug production areas, often working as transient economic migrants and regularly changing location to work in mining, timber and construction industries. All of these factors need to be taken into consideration when designing and implementing services for PWIs in Myanmar.

In 2010 the prevalence of HIV amongst PWID was 28.1%[2] and in 2013 it was reported at 18.7%, ranging from 5.4% to 35.5% across various survey sites[3]. This decrease in prevalence can largely be explained due to deaths of large numbers of PWID due to lack of availability and access to essential services, such as ART. Almost 28.1% of all reported HIV infections in Myanmar occur through injecting drug use[4] and epidemiological modelling suggests that by 2015 the largest percentage of new infections will be among PWID (35--40%)[5].

The changing political climate in Myanmar has enabled discussions, planning and implementation of a new model of working; where for the first time a range of partners from Government agencies, civil society and the donor community have developed a 'one-stop service' for PWID.

Removing the requirement for PWID to attend several appointments at different clinics was essential to improve accessibility and increase overall adherence. The ethos behind the 'one-stop service' is to provide a comprehensive package of prevention, treatment and care in one compound to as many individuals as possible. The core principles are as follows:

- Reach **maximum number of individuals in targeted areas of high PWID and HIV prevalence,** and have the **greatest impact** while also being **cost effective;**
- **Holistic approach -** where comprehensive prevention, treatment and care provided, including diversified pharmacological and psychosocial interventions **under one roof;**

[1] UNODC, Southeast Asia Opium Survey, Lao PDR and Myanmar. 2013
[2] Nap Progress Report 2010.
[3] National Strategic Plan and Operational Plan 2011 - 2015. National Aids Programme.
[4] Myanmar Ministry of Health.*HIV Sentinel Sero-surveillance Survey Report, 2012*
[5] Myanmar Technical and Strategy Group on AIDS. *HIV estimated and projections. Asian Epidemiological Model 2010-2015.* 2010

Improvement in adherence and overall attrition rates where there is **reduction in 'drop-out'** as individuals have fewer appointments at different locations.

Approach:
The intervention is HIV specific as it provides a range of services under the minimum package of care for PWID (as under international guidelines); is HIV sensitive as it provides universal access to PWID in one Government health compound, and is PWID sensitive in that it addresses their needs based on individual assessments and care plans.
The model is based on the Public Private Partnership (PPP) approach where there is synergy between Government Agencies – Drug Treatment Centre (DTC), Central Committee for Drug Abuse Control (CCDAC), National AIDS Programme (NAP), National TB Programme (NTB) -and I/NGOs working in the field. The 'one-stop services' are located in Government health compounds and technical assistance/support is provided by I/NGOs. All I/NGOs working in 'one-stop services' work together in a collaborative manner under the minimum package of care for PWIDs as identified in the model.

Reach of the intervention:
The 'one-stop services' are located in various geographical locations, identified as having the greatest need due to prevalence of PWID, while expansion to more locations is currently being discussed.
Programmatically, the model follows three different stages, which has allowed for the development of a national tiered structured system – please see figure 1 & 2 in annex. All PWID enter the system at stage 1, generally through outreach, DIC, CCDAC referral etc., they are then referred to stage 2 which is the 'one-stop service' where they receive all services, and finally they access stage 3. All 'one-stop services' require a minimum package, which consists of the following interventions[6]: Opioid substitution therapy (MMT), HIV testing and counselling (HTC), Antiretroviral therapy (ART), Condom programme for PWID and their sexual partners, Targeted information, education and communication (IEC) for PWID for their sexual partners, Testing and Vaccination of Hepatitis B, STI screening and treatment, TB screening and treatment, Prevention of overdose (Naloxone).

Impact of the intervention:
While it is too early in the project cycle to provide data on impact, it will be measured through outcomes based on essential packages of evidence based interventions – i.e. number on MMT, adherence to MMT, number on ART etc. Overall attrition rates and adherence, risk behaviour, and HIV prevalence will be recorded for each 'one-stop service'.

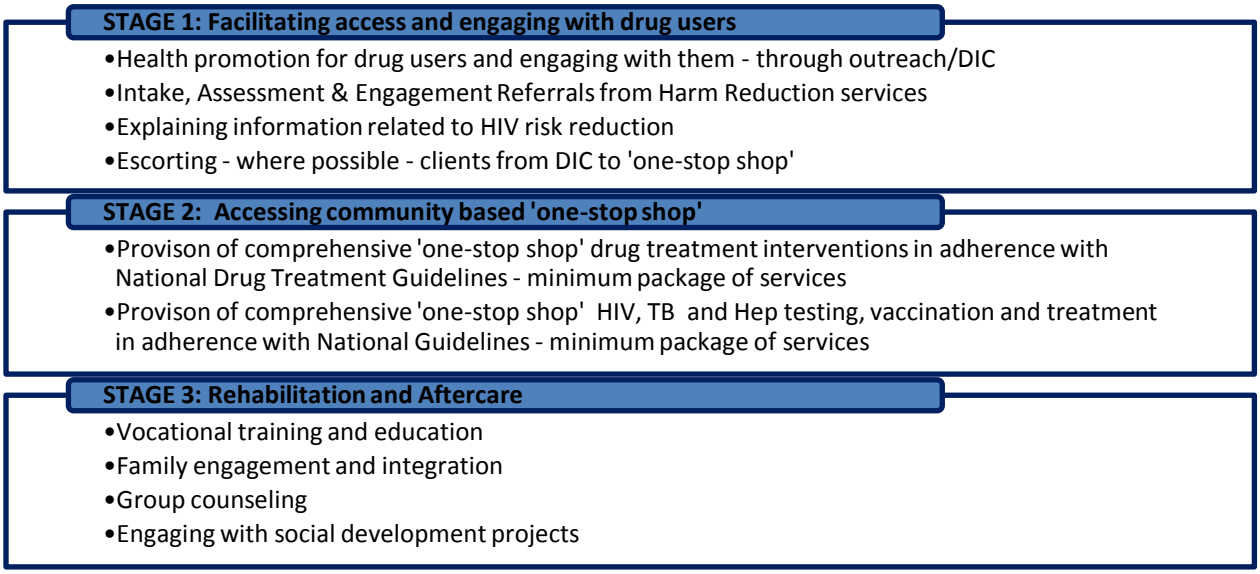
Financing and management:
The project is coordinated at the local level by the Drug Treatment Centres from the Ministry of Health (MOH) who act as the focal point with other relevant sections from the MOH i.e. National AIDS Programme etc. A central role is also played by Central Committee for Drug Abuse Control (CCDAC) who has a coordination role and also can refer PWID to stage 1 of the 'one-stop service'.
Currently 'one-stop services' are funded by 3MDG in Myanmar to which Australia is a major donor. Financial sustainability is essential and one of the benefits of a 'one-stop service' is its cost effectiveness, in terms of resource sharing, staffing, reduced costs for clients etc.

[6]It is understood that some compounds cannot provide all interventions, therefore the recommendation in the guidelines is to offer these services as a satellite at allocated times i.e. STI screening is made available three times a week etc.

Lessoned learned and recommendations:
Creating a platform for open dialogue amongst all partners (Government agencies, National and International NGOs and Donor Fund Manager) was essential in planning and instrumental in overall project design and implementation. Once the foundation of open dialogue was developed all partners worked together to develop the model, TOR and minimum package of care. Services were developed based on needs of individual areas but the core principles of all one-stop services is the same, which has provided a standardisation in approach on the national level.
A key recommendation when developing 'one-stop service' is to have early discussions and coordination around the design of the project, minimum package of care etc. This will ensure that all stakeholders are involved from initiation, and allow for standardisation in approach. Advocacy from an early stage at both central and local level is also key when developing a multi stakeholder approach to addressing the needs of PWID.
A challenge with this and other harm reduction projects has been the capacity of staff to deliver evidence based services. As services scale up, it is essential to have a qualified and trained workforce to deliver these interventions with the capacity to sustain the programmes over many years to come. To address this challenge a learning resource centre will be developed and the aim of the centre is to *build national capacity to deliver evidence-based interventions, within a comprehensive continuum of care*. Those who attend the resource centre will participate in an on-going cycle of professional learning and development through a newly developed national training curriculum.

Annexes: -

Figure 1:*Stages of 'one-stop shop' model**



**The agreed model in Myanmar allows for a series of steps where individuals will start their treatment journey at stage 1, and continue to stage 3 (please refer to figure 2 below). This will ensure there is a tiered treatment system available in the country, and a national standardization in prevention, treatment and care approaches.*

Figure 2: ***'One-stop shop' Community based referral pathway***

10. PHILIPPINES

Title of programme: Local Harm Reduction Programme of Cebu City Health Department
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Email: ilya91663@yahoo.com
Implemented by: Government, Civil Society
Areas of focus of the programme: Policy and legal environment; the role of the community of people who inject drugs in service delivery
Programme is being implemented since: Mid-year 2012
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? No

Background:
The Philippines is currently one of nine countries where more than 25% increase in new HIV infections are reported in 2011 than in 2001 (Global AIDS Report 2012). The rapid spread of HIV infections is primarily due to the sharing of contaminated needles and syringes among people who inject drugs (PWID) and unprotected sex among men who have sex with men (MSM).

An explosive HIV epidemic among PWID exists in Cebu City. In 2008 HIV transmission was primarily due to sexual contact (90%), but by 2012 it was injecting drug use (77%). The 2011 biological and behavioural surveillance in Cebu City reported HIV prevalence among PWID to be 54%, with Hepatitis C prevalence reaching 94%. The same study found 15% of freelance female sex workers had injected drugs and among male injectors 24% reported same sex behaviors. There are an estimated 6000 PWID in metro Cebu, with 2000 - 2500 PWID in Cebu City, of which the majority share their injecting equipment; many are sexually active, resulting in spread of HIV to their non-injecting wives/partners and then possibly to their babies. Provider-initiated counseling and testing done in antenatal clinics, identified 30 pregnant women with HIV infection from 2010 – Aug 2014.

Collaborative efforts among key stakeholders have proven instrumental in making Needle and Syringe Programs (NSP) a part of a comprehensive HIV programme for PWID, despite daunting legal challenges. Legal prohibitions on needle distribution are stipulated under the Law on Comprehensive Dangerous Drug Act (2002). Collaborative efforts initiated by the local health department led to the implementation of a facility-based NSP in response to HIV among PWID. Needles and syringes are distributed regularly to PWID but only at a health facility, thus limiting coverage. Various services are provided to PWID to match their needs.

Collected data show a rise in the number of PWID accessing services: 43 (1 female) in January 2013 to 650 (80 females) in November 2013. The progress of this initiative and support of local key stakeholders has resulted in approval for a pilot of community-based NSP in Cebu, which is a much-needed policy breakthrough on harm reduction in the country.

Approach:
The interventions conducted are HIV specific that seeks to address the upsurge of HIV cases among PWID in Cebu City. The local HIV response in this country is actually anchored in Social Hygiene Clinic (SHC) under the health department of local government unit (LGU). These clinics are the forefront of STI and HIV control, and are mandated to provide mandatory STI education and routine case detection, prevention and care services particularly to entertainment establishment workers (EEW) or registered female sex workers as supported by various national and local laws and policies. With the recent changing scenario in HIV situation affecting PWID, the Cebu City Health Department (CHD) SHC is now expanding its services to PWID by providing a somewhat comprehensive package of services that addresses not just prevention intervention but also in providing them STI/ HIV treatment, care and support.

The recently released 2012 revised Technical Guide for Countries to Set Target for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users endorsed by WHO, UNODC and UNAIDS and the recommendations from the international consultant on harm reduction contracted by DOH and WHO in 2013 sets guidance in expanding and strengthening the HIV interventions and package of essential services for PWID in Cebu City as implemented by the City health department through its SHC.

Reach of the intervention:
The programme is intended for PWID in Cebu City, however other PWID from nearby cities are also accessing the programme. There are an estimated 6,000 PWID in Metro Cebu, of which about 2000 PWID are in Cebu City (PAHI 2012). Currently in CCHD SHC database as of June 2014, a total of about 800 PWID have already accessed the NSP facility-based services in CCHD SHC.

Table 1 showed the profile of PWID in Metro Cebu whereby majority of them (98%) are injecting Nalbuphine).

Table 1. Profile of PWID in Metro Cebu

Median age of respondents (n = 767)*	**30 years (15-56)**
Age of first drug use (median)	**16 years**
Age of first injection (median)	**19 years**
% injecting nalbuphine	**98%**
Average number of injectins per day	**3 (1-12)**
% PWID tested and knew thei HIV status in last 12 months	**6%**

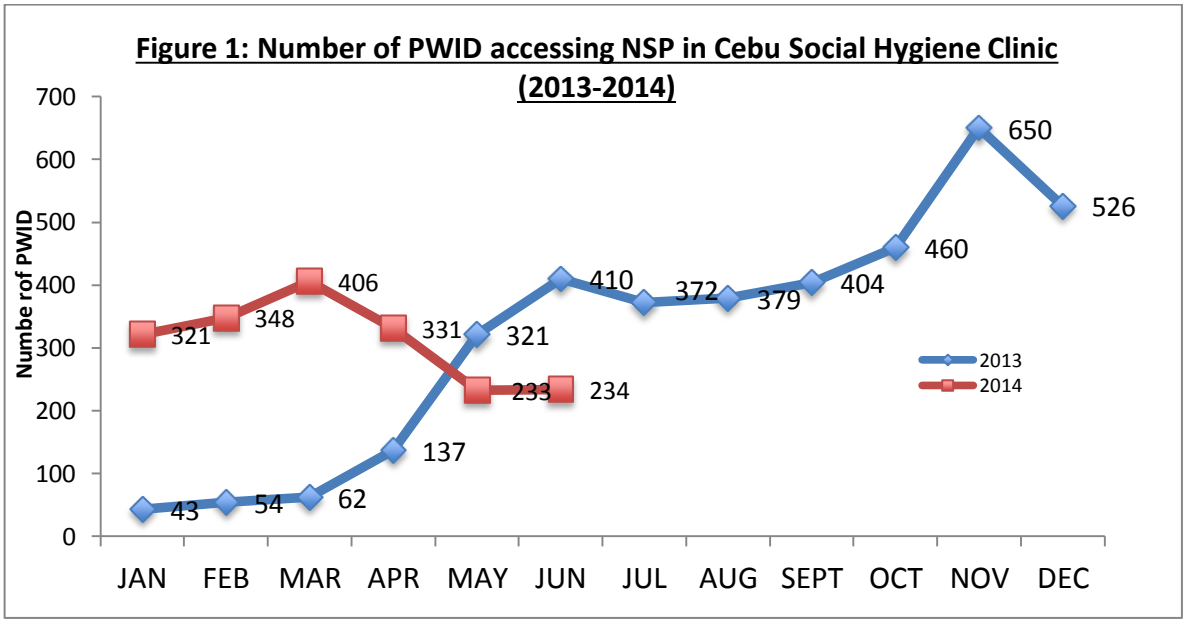
*** data source: IHBSS survey 2013**

Services for PWID have also reached those in Cebu City detention center. With 34 PWID reported to be positive out of 161 tested between 2010 to 2012, advocacy to jail officers led to the implementation of ART programme in this detention center.

CCHC-SHC became a satellite treatment hub mid- 2013. As of now 38 PWID PLHIV are enrolled in anti-retroviral therapy.

Impact of the intervention:
The Harm Reduction programme that provides comprehensive package of services for PWID in Cebu city based in a health facility (CCHD SHC) has been implemented for almost 2 years now and includes needle and syringe program (free needles and syringes), HIV counseling and testing, antiretroviral therapy, management of sexually transmitted infections, condom programme for PWID and their partners, targeted information, education, communication through community outreach and peer education and psychosocial services for PWID and their partners, vaccinations, diagnosis and treatment of Viral Hepatitis, prevention, diagnosis and treatment of TB , and referral for voluntary rehabilitation and obstetric care.

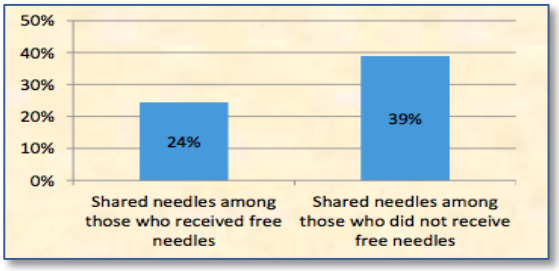
Despite daunting challenges, the implementation of NSP resulted in more PWID accessing the services with an average of 300 PWID accessing the services per month (figure 1). This number could be easily increased once the restriction on distribution of needles and syringes per visit is lifted, free needles/syringes has been demonstrated a powerful incentive for PWID.



To monitor the serological and behavior of the key populations in the country, the National Epidemiology Center conducted this surveillance study every 2 years. In late 2013 the, Integrated HIV Behavioral and Serological Surveillance (IHBSS) showed a reduction in prevalence of HIV among PWID from 53.2% in 2011 to 48%. Furthermore, the risky practices of sharing needles were also reduced for those who are accessing the services

(figure 2).

Figure 2. Sharing of needles among PWID by access to free needles from SHC/ Peer educator, IHBSS, 2013



Financing and management:
The harm reduction programme of CCHD SHC is a result of collaborative efforts of different partners and key stakeholders. The effort is an example of a local problem that requires a local solution. The CCHD recognizing the need to urgently respond to a public health crisis in Cebu city allowed the implementation of NSP within its facilities despite legal challenges. Such effort allows the pouring in of support from partners such that WHO, the lead UN agency for Metro Cebu provides technical assistance from active advocacy to local politicians, key stakeholders and law enforcement agencies to active assistance in the implementation of its programme. The department of health through its National AIDS STI Prevention and Control programme and Global Fund projects provides the logistics from STI and HIV medicines and test kits to the hiring of peer educators, NSP coordinators and TCS implementation officers. The USAID FHI 360 supported also the facility- based peer education and the formation of support groups. The ADB/ WB just recently implemented the operations research on the community-based comprehensive package of service for PWID. Active NGO partners such as Cebu Plus Association, inc (CPAI) also actively participated as they also provide manpower and assistance as they are the projects implementers. The PWID community and its peer educators actively assist the programme in not just educating fellow PWID on safe injecting, regular access/ referrals to services for medical needs but also in motivating some to start ART.

With the intervention implemented and supported by local government unit, sustainability can be ensured in the future especially when any legal barriers can addressed.

Lessoned learned and recommendations:
Despite international evidence supporting best practices, implementing HIV responses for PWID has many challenges. A first step to any response is to recognize the need to act by developing a proactive alliance of various local and national stakeholders including leadership and advocacy propelled by Social Hygiene Clinic and City Health Office, coupled with technical and logistical support from the Department of Health and its partners, particularly WHO. Consultations with and meaningful involvement of PWID greatly assisted in the process.

Lessons Learned:
- Social hygiene clinic based NSP - a model fits well the Philippines
- Dedicated manager/staff essential, and more trained staff in demand to ensure quality of
- services and use of data

- Strong support from DoH, PWID community, NGOs from HIV-positive groups and faith-
- based organizations
- WHO local consultant provides direct support and facilitates additional assistance in time
- Working with police possible! Increased police understanding of public health solution
- to HIV crisis as public security

Way forward:
- Continue advocacy to enforcement agencies (including city lawyers) to sustain the local
- enabling environment, with a vision to reform the drug policy/laws
- Strengthen and monitor current programme to ensuring the quality of services and use of data
- Extend and monitor the current facility-based services to community-based
- Replicate Cebu model to other cities which have HIV among PWID (e.g. under the GF new funding model)

Annexes:

Attachments:
1. Local key stakeholder's letter of support to DDB
2. Advocacy Briefing paper
3.IHBSS 2013 Briefer from NEC
4. Abstract on Policy Breakthrough on NSP (Needle and Syringe Program) for People who
5.Inject Drugs in Cebu City Philippines

11. THAILAND

Title of programme: The Comprehensive HIV Prevention Among Most-At-Risk Populations by Promoting Integrated Outreach and Networking (CHAMPION) IDU
Contact person: Katri Kivioja
Title: Programme Director
Organization: PSI Thailand
Address: 38 Convent Rd, Bangkok
Tel: +662 234 911 5-9
Email: katri@psithailand.org
Implemented by: Government, Civil Society
Areas of focus of the programme: Policy and legal environment; the role of the community of people who inject drugs in service delivery; the financial crisis and its impact on people who inject drugs programmes
Programme is being implemented since: 1 July 2009
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? No

Background:
Thailand has long been considered a leader in the response to HIV for its successful interventions to reduce HIV transmission among sex workers in the early 1990s, and for the provision of generic antiretroviral treatment (ART) to over 80% of people who need it. However, for more than two decades, HIV prevalence among people who inject drugs

(PWID) has remained alarmingly high – between 25% and 50% since 1989.[7] Recent studies indicate that as many as 90% of PWID are living with hepatitis C virus (HCV).[8]

The focus on law enforcement and public security in addressing drug-related issues in Thailand has led to:

- **Mass incarcerations**: with over 60% of the prison population being incarcerated for drug-related crimes,[9] Thailand's prisons are overcrowded – operating at double the maximum capacity[10] – and offer little in the way of health services to address HIV and drug dependence besides ARV.[11]

- **Forced detention**: hundreds of thousands of individuals are detained in the name of drug treatment. For example, between 1 October 2011 and 30 September 2012, the Thai government recorded over 500,000 people entering so-called drug treatment centers,[12] more than three times the number sent to such centers during the 2003-2004 war on drugs[13]. Across Thailand, the government records over 1,200 such centers[14] with the vast majority being operated by military personnel who have little or no medical training or certification[15]. People sent to drug treatment centers do not have access to due process, legal support or an appeal system. [16]

- **Human rights violations:** physical, sexual and psychological abuse has been documented at the hands of law enforcement, in community[17] and closed[18] settings. Far too common to be ignored, the testimonies of people who use drugs indicate that routine bribery, drug planting, and exchange of sexual favours with law enforcement with comparably few opportunities to hold law enforcement accountable.

- **Public health barriers:** law enforcement focused approaches are now widely acknowledged to drive people who use drugs underground, further away from essential health services, while fuelling stigma and discrimination as well as the transmission of HIV and other blood-borne infections like hepatitis C. Clients of the CHAMPION-IDU have been recorded saying that "I would prefer to get HIV than be (re) arrested", testifying to the significant amount of violence from law enforcement against PWID.

The passing of the National Harm Reduction Policy in February 2014 is an encouraging step towards government buy-in and support for interventions to improve the health and well-

[7] Canadian HIV/AIDS Legal Network. 2009. *Drug use and HIV/AIDS in Thailand*.
[8] Hayashi, K. 2011. "Low Uptake of Hepatitis C Testing and High Prevalence of Risk Behavior Among HIV Positive Injection Drug Users in Bangkok, Thailand" in *J Acquir Immune Defic Syndr*, 56:5.
[9] UNODC. 2006. *HIV/AIDS and Custodial Settings in South East Asia: An Exploratory Review into the Issue of HIV/AIDS and Custodial Settings in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam*.
[10] International Center for Prison Studies: www.prisonstudies.org/info/worldbrief/wpb_country.php?country=114.
[11] Kaplan, K. 2011. "HIV and Prison in Thailand", in *HIV Australia*, 8:4.
[12] Office of the Narcotics Control Board. 12 September 2012*. Press Release.*
[13] Kaplan, K. and Tanguay, P. 2013. "One Step Forward, Two Steps Back: Consequences of Thailand's Failure to Adopt Evidence-based Drug Policy*"* in "*Drug Law Reform in East and Southeast Asia.* (In print).
[14] 17 August 2012. "Govt war on drugs hailed a success" in *Bangkok Post*.
[15] Canadian HIV/AIDS Legal Network. 2009. *Compulsory Drug Treatment in Thailand: Observations on the Narcotic Addict Rehabilitation Act B.E. 2545 (2002)*.
[16] Ibid.
[17] Thai AIDS Treatment Action Group. 2012. *Reducing Drug-Related Harm in Thailand: Evidence and Recommendations from the Mitsampan Community Research Project.*
[18] Open Society Institute. 2010. *Detention as Treatment: Detention of Methamphetamine Users in Cambodia, Laos, and Thailand*.

being of PWID in Thailand. However, despite efforts to foster an enabling environment for harm reduction service delivery, elements within the Thai government and society at large remain sceptical, even opposed, to harm reduction. In particular, the harmonization and synchronization of public health imperatives with law enforcement practices continues to pose important challenges to effective roll out of HIV prevention services for PWID as well as other populations. Indeed, the self-elected National Committee on Peace and Order has just re-launched yet a new wave of war on drugs in September 2014.[19]

See additional information in the IDPC Drug policy brief on Thailand and CHAMPION-IDU narrative PUDR reports.

Approach:
CHAMPION-IDU is designed as an HIV prevention project but operated for the past five years to improve the quality of life of PWID. CHAMPION-IDU is a community-based, peer-led project almost exclusively implemented by civil society. This strategy has been very successful in recruiting PWID and facilitating access to health services because of the innate trust that exists between peers – government drug treatment centers have seen up to a fourfold increase in in- and out-patient admissions since the initiation of the CHAMPION-IDU project. In fact, approximately 80% of the 350 CHAMPION-IDU workers hired over the past five years have been active and/or recovering from drug use, giving a real employment opportunity to PWID and building their capacity to become productive members of society. Peers operate drop-in center based and outreach-based activities, including behaviour change communication to reduce risks, education, sterile injecting equipment, condoms, overdose prevention with naloxone, and referrals to HTC, MMT, ART and STI.

Unfortunately, because of the hostile operating environment, retention of peers and staff has been a crippling challenge to the project; CHAMPION-IDU workers and staff are routinely arrested, detained, abused and stigmatized by law enforcement and health service providers across Thailand (at least one worker arrested every month). In turn, these impact on capacity and willingness of workers to stay on – outreach workers can't distribute condoms or sterile injecting equipment when they are in prison. To address the high turnover of workers, PSI Thailand deployed a range of measures detailed in the attached programmatic narrative report.

To increase demand for HIV services, PSI initiated additional service components to complement the CHAMPION-IDU package supported by GFATM and combat significant HIV-messaging fatigue among Thai PWID. In January 2013, an overdose prevention and management project – called SCOOP – was initiated and generated massive success (see attached SCOOP report). In addition, CHAMPION-IDU partners, particularly PSI and Thai Red Cross, worked in Thai prisons to provide education, training and behaviour change support to hundreds of inmates over the programme term as well as sensitization of dozens of prison guards – the prison component was so successful that PSI was invited by the Department of Corrections to formally include the CHAMPION-IDU training curriculum on life skills, drugs, HIV and sexual health in the regular yearly prison programme. In addition, expanded support was negotiated with the Thai CCM and GFATM to use the CHAMPION-IDU infrastructure to reach out to vulnerable PWID and provide them with HCV testing and access to treatment, with support from the private sector. Unfortunately, the NFM envelope to Thailand was significantly reduced and the funding for PWID reduced dramatically (though

[19] Tibke, P. 15 September 2014. "Thailand steps up its dubious war on drugs" in *Asian Correspondent*.

negotiations are not final), and agreements to expand service delivery to include HCV are regretfully being cancelled.

Additional synergies have been established despite the lack of support from the Thai government, in particular with national agencies responsible for provision of methadone in Thailand – the Bangkok Metropolitan Administration (BMA) and the Princess Mother Institute for Treatment of Drug Abuse (formerly known as the Thanyarak Institute). Here, synergies were generated between national opioid substitution systems, CHAMPION-IDU and SCOOP projects where naloxone is now in the official national guidelines on methadone and is kept at all methadone access points. In addition, all trainings on opioid substitution are now conducted in partnership between the Princess Mother Institute, BMA and PSI due to PSI's efforts over the past five years. Note that prior to CHAMPION-IDU, all methadone related trainings were delivered by the Princess Mother Institute with extremely poor results (see World Bank, 2011, *Harm reduction policies and interventions for injection drug users in Thailand*).

To address law enforcement barriers, PSI hired a senior Thai police officer to act as an advisor to CHAMPION-IDU with the mandate to establish effective working relationships with local law enforcement agencies and bodies at all CHAMPION-IDU sites; build capacity of CHAMPION-IDU programme and field teams in terms of interacting with law enforcement agencies, officials and officers; identify strategic opportunities to raise the profile of harm reduction at policy level with law enforcement agencies, officials and officers; and facilitate access to the Royal Thai Police Academy to sensitize and train Thai law enforcement.

Reach of the intervention:
Over the project life cycles (2009-2014), over 13,000 of the estimated 40,300 PWID were reached by CHAMPION-IDU project services across 19 of the Kingdom's 76 provinces. The CHAMPION-IDU project is the ONLY national scope intervention to prevent HIV and improve the quality of life of PWID. CHAMPION-IDU recruited more than 20 private sector pharmacists who support the provision of health services, including distribution of health commodities, and referrals to additional services. No other civil society or government agency has ever reached as many PWID as CHAMPION-IDU.

Impact of the intervention:
The CHAMPION-IDU project was rated B2 by the GFATM performance measurement framework. Unfortunately, target setting was based on outdated data and evidence that drove targets beyond realistic expectations (see Global State of Harm Reduction 2012 section 3.5).

The CHAMPION-IDU project provided skills, salaries and support to over 350 PWID over 5 years. PWID in Thailand, after a first arrest, are prevented from working in many sectors, including government and most private sector businesses. As a result of regular work and social support, many of the CHAMPION-IDU workers have reduced their drug use.

Ozone, PSI Thailand's branded network of drop-in centers, will become independent and fully localized. The transition, required by the CCM as a condition for continued funding, was initiated in June 2014 and should be completed by 1 January 2015. Though this was part of the PSI Thailand plan – to localize Ozone – the timelines forced unto PSI are unreasonable and against best practice and push the majority of operating the national response to HIV among PWID onto a nascent NGO. That said, Ozone will be the largest provider of health services to PWID at national scale once the transition is complete.

In the context of the Support Don't Punish campaign, CHAMPION-IDU partners lobbied the Office of the Narcotics Control Board in June 2013 to ensure deployment of a national harm reduction policy which had been pending for years. Less than 12 months later, the Deputy Prime Minister of Thailand signed the official policy.

Financing and management:
GFATM provided PR-PSI with $16.6 million under Round 8 to implement CHAMPION-IDU; additional funding for overdose prevention was provided by OSF. Major partners included Raks Thai Foundation, Thai Drug Users' Network, Thai Red Cross, and Foundation for AIDS Rights and 12D.

As noted above, the sustainability of GFATM's investment is under significant threat as Thailand moves towards the NFM. Localization of Ozone, changes in PR and management systems, closure of at least 7 of 19 provinces, increase in programmatic targets with concomitant ~60% reduction in budgets threatens to topple the entire investment to prevent HIV transmission among PWID in Thailand. Despite calls for discussion about those risks, UN agencies, donors and Thai government agencies have not responded with support, pushing the responsibility for ensuring sustainability to a nascent local organization.

Lessons learned and recommendations:
CHAMPION-IDU received little support from Thai national government agencies over the past 5 years. On the contrary, many Thai government agencies, particularly law enforcement, have diametrically opposed objectives to those assigned to CHAMPION-IDU by the CCM.

The IPSR evaluation noted that significant barriers to scaling up CHAMPION-IDU had to do with total lack of coordination with Thai government agencies – from Ministries of Health and Justice, including ONCB, BMA, PR-DDC, Thanyarak, and police. However, local collaboration has been very successful, especially in the deep south of Thailand where religious leaders were leveraged to mobilize high level government support, resulting in the official endorsement of needle and syringe distribution by the National Islamic Committee. Despite local successes, high level support for harm reduction is still close to nonexistent in Thailand, even though an official policy endorses the services and strategies that are currently in place.

Annexes:
1. IPSR External evaluation report
2. Latest narrative Programme Update reports sent to the donor (for internal use only)
3. Overdose prevention report (unpublished, embargoed)
4. IDPC drug policy paper
5. OIG recommendations
6. WB assessment of harm reduction programmes and policies

III. Europe

1. ESTONIA

Title of programme: Harm reduction component of the national HIV and drug policy
Contact person: Aljona Kurbatova
Title: Head of Department of Infectious Disease and Drug Prevention
Organization: National Institute of Health
Email: aljona.kurbatova@tai.ee
Implemented by: Government, Civil Society
Areas of focus of the programme: Policy and legal environment; the financial crisis and its impact on people who inject drugs programmes
Programme is being implemented since: 2004
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Since the 1990s, Estonia faces a major HIV epidemic among people who inject drugs (PWID). According to the UNAIDS Report on the Global AIDS Epidemic 2013, 52,4% of PWID in Estonia lived with HIV in 2012. However, the estimated number of PWID has decreased over recent years, but is still at a high level. The number of PWID among 15-44 year-olds fell from 15,675 (2.7% of the given population) in 2005 to 5,362 in 2009 (0.9% of 15-44 year-olds) (Uusküla *et al.*, 2013). However, many experts have questioned the results from the 2009 study estimating that the number of PWID is 8 000 – 10 000.

The data of the Health Board of Estonia (1988-2013) shows that new cases of HIV has been dramatically increasing from 1988 until 2001 and from 2001 a steady decline of new HIV cases could be observed. At the peak of HIV epidemic in 2001, 1474 new HIV cases were registered whereas 325 new HIV cases were registered in 2013 (Annex1). New HIV infections among PWID have been also steadily declining (from 980, 3 per 1 million population in 2001 to 51, 5 per 1 million population in 2011, AIDSinfo/EMCDDA).

Responding to the sharply increasing numbers of new HIV cases in the beginning of 2000-s, especially among PWID, and a high prevalence of drug use in a small society (app. 1, 5 million population at the time) Estonia reassessed its policy on drug use and HIV prevention and adopted new multidisciplinary national strategies on HIV prevention (from 2006) and drug use (from 2004). Despite increased efforts to respond to the growing HIV and drug use epidemic, interventions and services remained fragmented. In order to better integrate the national response on the strategic/programmatic level planning and budgeting, all public health programmes were merged into the National Health Plan.

Implementation of harm reduction interventions started in Estonia in the late 1990s. However, the volume of the interventions was extremely modest, geographically scattered and financed on a project-to-project basis. Although the policy reassessments concluded that harm reduction was a strategic intervention needed, the need for reassessing funding for harm reduction – its sufficiency and sustainability - remained. By 2000, harm reduction interventions (OST and NSP) were supported by the national government and local municipalities, on an unsystematic and project-based manner. One of the major changes occurred in 2003 with the launch of the Global Fund HIV programme in Estonia. It allowed establishing a more systematic harm reduction approach between 2003-2007 (introduction of tendering, service purchasing model, monitoring and evaluation framework). In 2004, the

European Commission's PHARE programme allowed to establish three new low threshold centres in cooperation with the local municipalities and led to introduction of the joint national and local government financing model. In 2007, the Global Fund stopped financing harm reduction programmes, but the joint national and local government financing model that was put in place ensured that the country is ready to transition smoothly from international to national funding of harm reduction. Since 2007 Estonia fully (100%) finances harm reduction programmes from domestic sources. In 2010, Estonia spent US$ 2,086,135 on HIV prevention programmes for PWID and 100% of it came from domestic public sources (GARPR 2013).

Approach:
In recent years Estonia has been moving away from disease specific policies towards health and social determinants-based integrated policy and health systems approach. Thus, the HIV response became not only HIV-specific and HIV-sensitive, but also HIV-relevant, and harm reduction interventions, previously viewed only as HIV-specific or sometimes HIV-sensitive, became also HIV-relevant interventions. Separate strategies (including HIV and drug strategies) have been integrated into the National Health Plan that is currently serving as a unified basis for intervention planning and budgeting.

Contrary to often the case, Estonia adopted a holistic approach – its HIV response is also aligned to its drug policy. The recently adopted White Paper on Drug Policy (2014), which emerged from the first multidisciplinary National Drug Dependence Prevention Strategy (2005-2012), embeds 3 major principles of which harm reduction is one of the 3 key pillars: (1) Decrease availability of drugs and drug-related crime (Supply reduction); (2) Avert and postpone initiation of drug use (Demand reduction); (3) Reduce harms and offer treatment and recovery services to persons with drug addiction (Harm Reduction). The White Paper rejects repressive drug policy approaches and instead adopts that treatment and evidence-based approaches are favoured compared to criminal punishment of people who use drugs. It states that if it was impossible to prevent the start of drug use, harms of drug use must be limited for those who have already started using.

The practical application of these principles involves HIV-sensitive and HIV-relevant interventions: (1) Supply reduction system; (2) Universal prevention system; (3) Early detection and referral system; (4) Harm reduction system; (5) Treatment and recovery system; (6) Social Reintegration system; (7) Monitoring and Evaluation. Such an approach requires also an inter-sector and inter-ministerial cooperation. Therefore, the drug prevention policy is coordinated at the level of the Government Committee on Drug Prevention in order to ensure consistent cooperation between the areas and levels of government. Four Ministries - Interior, Justice, Social Affairs, and Education and Research - are represented at the highest level. Substantive coordination of drug policy is undertaken by the working groups dedicated to each subsystem, where service providers, representatives of the involved Ministries and the drug coordinators of implementing agencies meet. The working groups discuss common priorities for planning the national budget, solving ongoing problems in cooperation, and the feedback from the working groups are submitted to the ministers as an input for making executive decisions.

Since the main shortcoming in the previous strategy period was insufficient coordination, it is considered important to ensure sufficient communication, sharing of the common vision, and tracking the same performance indicators among the working groups. Each working group has an appointed leader and the leader of each group has his own task force. This body

discusses overlapping and cooperation between the systems and makes suggestions to the government committee on concrete needs for stewardship and investment.

Reach of the intervention:
National harm reduction efforts aim to increase both, regional coverage and quality of the services. They focus on providing primary health and social aid and counselling, including needle and syringe exchange programmes, take-home naloxone programme to reduce the number of fatal overdoses, referral to HIV, STI, TB testing, referral to drug addiction, HIV and TB treatment.

Needle and syringe exchange programs in Estonia were launched in 1997. The number of service provision sites has increased from 13 in 2002 to 37 in 2013 (in 17 cities/settlements by 10 organizations (mostly NGOs)). Services are mostly provided in Tallinn and its surrounding areas and in North-Eastern Estonia. A high percentage of PWID report having visited NSPs or having been in contact with outreach workers. In 2013, about 7,000 clients visited NSPs. NSPs distributed almost 2.2 million free syringes and needles (approximately 230 syringes per PWID per year) and close to 460,000 free condoms in 2013. HIV testing is not routinely offered in NSPs, clients are referred to anonymous HCT sites. Opioid substitution therapy (OST) is also offered to PWID. OST services were first initiated in 1999. In 2013, the number of OST clients was 1,166.

In September 2013 Estonia launched a national pilot programme on overdose prevention (take-home naloxone). During September 2013 - June 2014, 554 persons were trained on the use of naloxone and given the kits containing prefilled syringes with naloxone. The trained were active drug users and their relatives and outreach workers. During this period, the trained persons reported 72 cases of the naloxone use, which most likely saved 72 lives (if 72 were different persons).

Impact of the intervention:
As referred above, new HIV infections among PWID have been steadily declining. Studies on HIV prevalence among PWID show that harm reduction is effective in HIV prevention. For example, in the city of Kohtla-Järve (North-Eastern Estonia) HIV prevalence among PWID decreased from 70% to 62% and in 2012 84% of respondents were aware that they were infected, whereas in 2007 only 49% were aware of being HIV-infected. Uusküla *et al.* (2011) found that increase in NSPs led to decrease in the number of new HIV cases among PWID (Annex 3 and 4). Also, according to the available data the age and injecting period of PWID is increasing - the population seems to have stabilized.

Financing and management:
Harm reduction interventions are funded entirely from the national budget in the framework of the National Health Plan that serves as the main planning and budgeting tool, while the current National HIV and AIDS strategy and White Paper on Drug Policy provide wider political/strategic directions. The Ministry of Social Affairs is responsible for funding harm reduction programmes. It has, however, delegated the responsibility for coordinating, managing and funding the interventions and services to the National Institute for Health Development (NIHD) that is working directly under the Ministry. The National Health Plan (2009-2020) defines long-term objectives, detailed long-term and yearly implementation plan, describes the volume of services targeted at PWID planned for the whole country and resources budgeted. Based on the yearly plan, funds are allocated to NIHD for implementation of harm reduction. NIHD contracts organizations (NGOs mainly) to provide harm reduction services based on jointly agreed service description (guidance) through a

simplified procurement process. Depending on the type of organization and service, yearly or 3-year contracts are rewarded and funds allocated (for NIHD tasks and service provider tasks, refer to Annex5). Apart from harm reduction coordination, management, and funding, NIHD feeds the data and feedback from the grass-root service level back to the planning and budgeting process of the National Health Plan, proposes changes in funding, when needed. NIHD also prepares situation overviews for the Government Committee on HIV (coordinated by Ministry of Social Affairs) and the Government Committee on Drug Prevention (coordinated by the Ministry of the Interior).

Lessoned learned and recommendations:
Estonia faced a serious HIV epidemic, which drove the country to look for the best solutions. As a result, effective and evidence-based approaches and programmes were adopted with an accompanying strong commitment to their funding. The key factors to today's good policy and legal framework practice and sustainable national funding were:

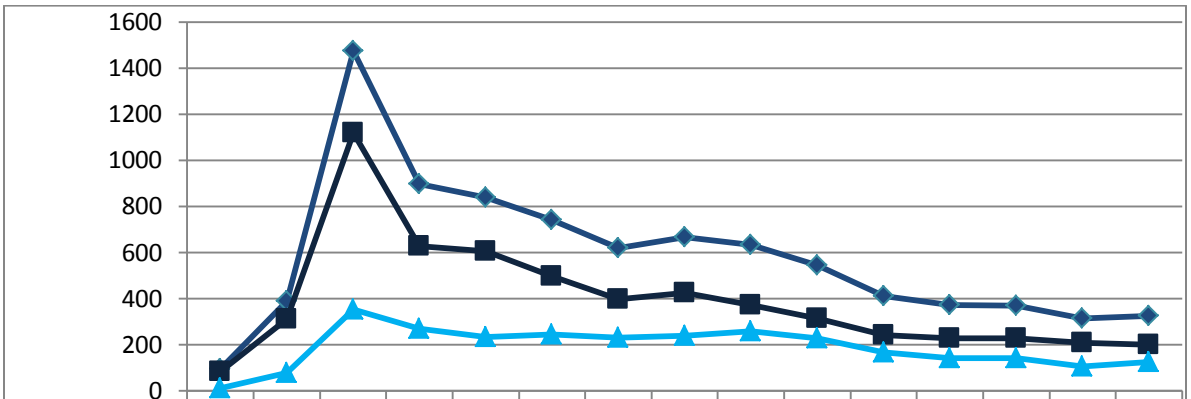
- A holistic approach that incorporates harm reduction and decriminalizes the individual drug use;

- Successful inter-sector and inter-ministerial cooperation for an effective HIV response as well as a team approach and flexible/innovative cooperation among different organizations and yet united under the same goal;

- Strong commitment to harm reduction in the HIV response and response to the drug use, which led to the smooth transition from international funding to national funding for harm reduction that is not temporary or project-dependent, but rather sustainable funding for these strategic-evidence-based interventions.

Annexes:
1. Newly diagnosed HIV-cases according to gender, all age-groups, 1988–2013
2. White Paper on Drug Policy (attached separately)
3. Number of syringes distributed in Tallinn in 2003-2009 (NIHD)
4. HIV incidence among new PWID in Tallinn in 2005-2009 (Uusküla et al, 2011)
5. NIHD and service provider tasks
6. Evaluation of National HIV and AIDS Strategy until 2015 and National Drug Dependence Prevention Strategy 2012

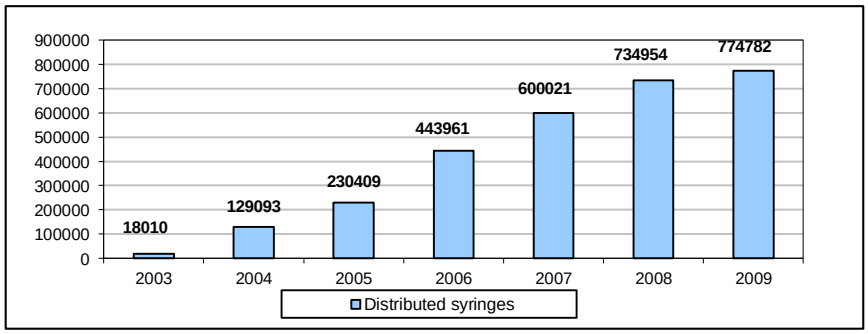
Annex 1: Newly diagnosed HIV-cases according to gender, all age-groups, 1988–2013



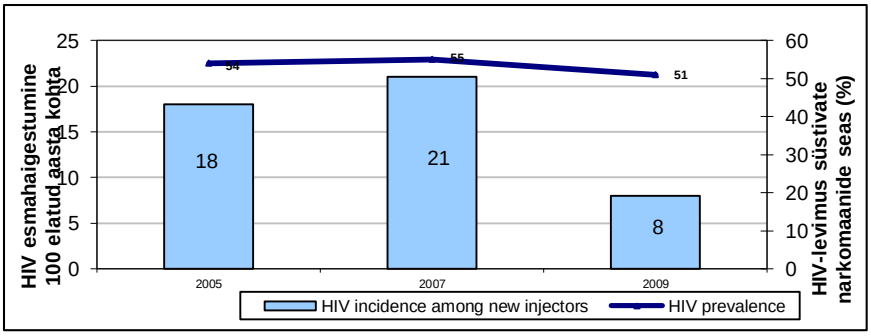
	1988 – 1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
TOTAL	96	390	1474	899	840	743	621	668	633	545	411	372	370	315	325
Male	84	312	1120	629	605	497	398	427	373	315	243	228	228	209	200
Female	12	78	353	270	235	245	232	241	260	230	168	144	142	106	125

Annex 2. White Paper on Drug Policy

Annex 3: Number of syringes distributed in Tallinn in 2003-2009 (NIHD)



Annex 4: HIV incidence among new PWID in Tallinn in 2005-2009 (Uusküla et al, 2011).



Annex5: NIHD and service provider tasks

Tasks of the NIHD on national level:

- coordinating the general development of the service
- planning the budget and the service need for the country

- conducting centralised public procurements (syringes, needles, condoms etc)
- contracting services (yearly call for proposals)
- organising staff trainings
- monitoring and evaluation

Tasks of the harm reduction organisations (Service providers):

- planning the service and the budget in their organisation
- preparing funding proposal to NIHD (capacity plan including opening hours and staff, budget, narrative on how service provision is planned)
- delivering service to the target group
- participating in monitoring and evaluation, development of services

Annex6: Evaluation of National HIV and AIDS Strategy until 2015 and National Drug Dependence Prevention Strategy 2012
National harm reduction programme originates from National HIV and AIDS Strategy until 2015 and National Drug Dependence Prevention Strategy 2012. Both strategies have been evaluated – National HIV and AIDS Strategy has been evaluated both externally (WHO evaluation missions) and internally, National Drug Dependence Prevention Strategy has been evaluated internally.Internal reports are available only in Estonian language online:
Final report/evaluation on the old drug strategy is http://www.sm.ee/sites/default/files/content-editors/eesmargid_ja_tegevused/Tervis/Tervislik_eluviis/ners_l6pparuanne.pdf

Internal evaluation of nationall HIV strategy, period 2009-2012:
http://www.sm.ee/sites/default/files/contenteditors/eesmargid_ja_tegevused/Tervis/Tervislik_eluviis/hiv_aids_strateegia_2009_2012_hindamine_loplik.pdf

WHO reports:
https://intra.tai.ee/images/prints/documents/132732174112_WHO_UNODC_Estonian_mid_term_Evaluation_2011.pdf

2. GERMANY

Title of programme: TEST IT -Community-based rapid HIV testing for drug users in low-threshold services
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National representativ MoH:
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Head of Unit
German Ministry for Health
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Implemented by: Civil Society
Areas of focus of the programme: The role of the community of people who inject drugs in service delivery

Programme is being implemented since: 2010
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Despite the fact that the number of newly-diagnosed HIV infections among people who inject drugs in Germany has stabilised at a relatively low level[20], this group is at particular risk of HIV. The majority of drug users on the open drugs scene only have limited access to HIV and HCV Tests. In addition to that studies carried out with people in opiate substitution treatment showed that users' knowledge of their own infection status is insufficient and HIV tests are not taken up to the necessary extent or hard to reach.

"TEST IT" offered PWID as a pilot project in three cities community based access to HIV counselling and HIV rapid tests in low threshold services as drug consumption rooms. The task was to check whether rapid HIV/HCV testing can be used in low-threshold drug services, and whether the barriers to having an HIV/HCV test could be lowered.

Approach:
The project strengthened the levels of cooperation between AIDS-Organizations and drug service centers

Reach of the intervention:
TEST IT were offered in 3 cities (Dortmund 01-12.2010, Berlin 01-12.2011; Wuppertal 03-12.2012,).
The project's goal was to determine the level of interest and willingness of drug users to participate in a low-threshold test offer.

- Provide low-threshold access to professional test counselling and testing.
- Evaluate project participants' awareness regarding their individual risk.

Impact of the intervention:
Low-threshold service centres can provide an adequate setting to offer community-based HIV/ HCV rapid testing.

The fact that rapid HIV testing is "straightforward" largely contributes to the good rate of take-up (quick, no venous blood, uncomplicated).

Confidence in the center respectively the counsellors, plays an important role – only 2 % of the users would get tested elsewhere.

The individual risk situations underlying the wish for testing result both from drug use (unsafe use) and from sexual intercourse (unsafe sex). Remarkable is the high percentage of risk situations during sex (50% of all participants with a known risk situation).

[20] Among the estimated 3,400new HIV infections in Germany in 2012, 210 (95% CI[160–270]) were transmitted by injection drug use, corresponding to 6.2% of new infections - Epidemiologial Bulletin-Robert Koch Institute 2013, 45:1–12.

Use of Alcohol was one of the main indicators for an increased readiness to assume risks during sex.

Financing and management:
The pilot project in Dortmund has been funded by the Federal Ministry of Health. The 2nd and 3rd Cites in Berlin and Wuppertal have been paid by Mac AIDS Fund. The projects were managed and coordinated by Deutsche AIDS-Hilfe) (national umbrella NGO) in close cooper*ation with the local AIDS Organiz*ation.

All projects have been sustained until now. Although local initiatives try to convince the responsible regional authorities to implement these added tasks into the regional budget plans.

Lessoned learned and recommendations:
- Low-threshold drug service centres can provide an adequate setting to offer community-based HIV/ HCV rapid testing.
- Drug users definitely have a very high level of health awareness.
- They want regular HIV & Hepatitis C Tests.
- A project like "Test it" stands at the interface between AIDS- Service and Drug service organizations. It increases the essential level of cooperation between these organizations and the willingness to have an HIV and/or HCV test of longterm drug users.

Annexes:
1. TEST IT- BERLIN. HIV Counselling and Rapid Testing for drug users in Berlin. Final Report.
2. Poster of TEST IT.

3. GREECE

Title of programme: A Seek-Test-Treat-Retain (STTR) intervention to decrease HIV/AIDS transmission among people who inject drugs in Athens Metropolitan Area (ARISTOTLE programme)
Contact person: Angelos Hatzakis
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Implemented by: Government, Civil Society
Areas of focus of the programme: The role of the community of people who inject drugs in service delivery; the financial crisis and its impact on people who inject drugs programmes
Programme is being implemented since: 2012
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
For many years, Greece has experienced a low-level, stable HIV epidemic concentrated

mainly in men who have sex with men. In 2011, a 16-fold increase in the number of reported HIV cases in people who inject drugs (PWID), as compared to 2010, was observed in Athens. Molecular analysis of HIV-1 sequences from PWID sampled in 2011 confirmed the recency of this outbreak and the presence of phylogenetic clusters which indicated transmission through injecting drug use and sharing of injection equipment. Prior to 2011, prevention and harm-reduction services such as opioid substitution treatment (OST) and needle and syringe programs (NSP) were available but coverage was low. More specifically, in early 2010, more than 5,500 opioid dependent individuals were waiting to receive OST for on average of 7.6 years in Athens and NSP distributed an estimate of approximately seven syringes per PWID per year. The emergence of the HIV outbreak in IDUs coincided with the economic recession and a possible causal role of the economic recession has been proposed. Estimates of HIV prevalence among PWID in Athens before the outbreak are available through sentinel data on PWID entering drug treatment or accessing low-threshold services. According to the 2010 data, HIV prevalence was 0.8%. In 2013, based on the data collected by ARISTOTLE programme, HIV prevalence was 16.4%.

Approach:
ARISTOTLE was a peer-driven intervention that employed respondent-driven sampling to reach the target population of PWID. Its main objective was to rapidly identify as many PWID residing in Athens as possible, test them for HIV infection, inform them about how they could prevent HIV infection and transmission, and link those found HIV-positive to OST and antiretroviral treatment. During August 2012-December 2013, 5 sampling rounds were conducted with a recruitment target of approximately 1,400 PWID per round. Blood samples were collected for HIV testing and personal interviews were performed using a questionnaire that included sections on injecting drug use and sexual behaviour. The participation of non-Greek nationals was encouraged through cultural mediators and interviewing in multiple languages. Apart from HIV testing and linkage to care, the programme provided to all PWID, independently of their HIV status, various services and incentives (monetary incentives for participating and collecting their HIV test result, counselling, condoms, a kit of 25 low dead-space syringes and injecting paraphernalia, leaflets in multiple languages). Thus, ARISTOTLE intervention was both HIV sensitive and HIV specific.

The programme was implemented by the University of Athens and the Greek Organisation Against Drugs (OKANA). There was collaboration with two NGOs; an experienced volunteer from the NGO "Positive Voice" was located in the programme site to assist the counselling of seropositive PWID and seropositive migrants without documents were referred to NGO "Praxis".

The intervention part of ARISTOTLE was implemented during August 2012-December 2013. Analysis of behavioural and laboratory data and dissemination of results is currently performed.

Reach of the intervention:
The primary focus of the programme was HIV prevention though testing, counselling and linkage to care and OST. It aimed to test 1,400 PWID in each round. This target was reached in 12 weeks on average per round. Within a total period of 16 months, **7,113** questionnaires and blood samples were collected from **3,320** unique PWID in Athens with injecting drug use in the past 12 months. Out of these 3,320 participants**, 2,689** reported having injected drugs in the last month. According to the Greek REITOX Focal Point of the European Monitoring Centre for Drugs and Drug Addiction, the estimate for the number of

active PWID (i.e. who had injected drugs in the past 30 days) living in Athens was **2,803** in 2011. Thus, the coverage of the target population was very high.

Furthermore, we evaluated the geographical coverage of the programme by assessing the reported place of residence of the recruits. These data suggest that the programme covered the entire Athens Metropolitan Area.

We estimated HIV-1 incidence among PWID during the programme by assessing seroconversions among participants with multiple samples and by testing HIV(+) samples with LAg-Avidity EIA to identify recent infections. According to both approaches, HIV-1 incidence declined by 78%-80% during the programme, i.e. from August 2012 to December 2013. In addition to that, HIV prevalence in the 5 rounds of the programme was stable.

We also compared self-reported risk behaviors among PWID who participated in both the first and the last round of ARISTOTLE. This comparison revealed the adoption of safer injecting practices by participants, independently of their HIV test result, and of safer sexual practices among HIV (+) PWID. Furthermore, the number of new HIV diagnoses among PWID as reported to the Hellenic Centre for Diseases Control and Prevention has decreased considerably during 2014.

Financing and management:
The ARISTOTLE programme was managed and coordinated by the University of Athens in collaboration with the Greek Organisation Against Drugs. It was implemented under the National Strategic Reference Framework (NSRF 2007-2013) and was co-funded by the European Social Fund and national resources. Additional financial support was provided by the Hellenic Scientific Society for the study of AIDS and STDs and the grant "Preventing HIV Transmission by Recently-Infected Drug Users" (NIH National Institute of Drug Abuse grant DP1 DA034989). Support was also provided by NGO "Positive Voice" and NGO "Praxis". At the time, there is no funding available to continue the intervention.

Lessons learned and recommendations:
The success of the intervention can be attributed to the following factors:
1. Design: the fact that it was a peer-driven intervention with monetary incentives allowed to reach rapidly a large part of this hard-to-reach population. To our knowledge, it is the largest RDS programme ever performed in one city. Due to its design, ARISTOTLE may have functioned as an “induction” type of network intervention that stimulates peer-to-peer interaction to create cascades in information and behavioral diffusion.
2. Services: the programme provided multiple services apart from monetary incentives and HIV testing (linkage to care, linkage to OST, counselling with the programme's psychologist, doctor and social workers, syringes, condoms, light snack in the waiting room, leaflets with information, linkage to the Addicts Care Facility of OKANA where PWIDs could have access to meals, coffee, juice, shower, laundry etc)
3. Synergies: Experienced staff from the Greek Organization Against Drugs and two NGOs were involved in the programme
4. Repeated visits: The programme was implemented in a building in the centre of Athens and PWID could participate multiple times which allowed building trust between the participants and the investigators
4. External experts: The Advisory Board of the programme included experts in the field from Europe and USA who provided valuable experience to the design and implementation of the programme (S. Friedman, NDRI/New York, D. Des Jarlais, Beth Israel/New York, M. van de Laar, ECDC/Stockholm, A. Pharris, ECDC/Stockholm, L. Wiessing, EMCDDA/Lisbon, M.

Donoghoe, WHO-Europe/Copenhagen, K. Gazgalidis, OKANA/Thessaloniki, Greece)

Annexes:
1. Evaluation/assessment report of the Advisory Board
2. Published results from the 1st round of the programme (Sypsa et al, Am J Public Health, 2014)
3a-3d. Four abstracts submitted to the 20th International AIDS Conference (1 oral and 3 poster presentations) reporting results from the 5 rounds of the programme
4. A paper discussing this outbreak in the context of economic crisis in Greece

4. KYRGYZ REPUBLIC

Title of programme: **Law enforcement and public health in the Kyrgyz Republic**
Contact person: Natalia Shumskaia
Title: Chairperson
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Implemented by: Civil Society
Areas of focus of the programme: Policy and legal environment
Programme is being implemented since: 2008
Has the programme been evaluated/ assessed? No
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
HIV transmission in Central Asia is driven by intravenous drug use in urban centers and along drug transport corridors from Afghanistan. There are 5 492 HIV-cases registered in the Kyrgyz Republic as of August 1, 2014 and more than half of them are injecting drug users. According to the 2013 IBSS HIV-prevalence among drug users is 12.4%.
There is a variety of harm reduction (HR) programmes available in Kyrgyzstan, including MAT and syringes exchange points. But the access to the programmes was impeded by police officers who groundlessly detained the clients right at the points of the HR programmes implementation, making them afraid to come. Outreach workers were also constantly brought to police stations because of carrying boxes with used syringes.

The work with police to explain basic principles of the harm reduction programmes and develop tolerant attitude to drug users, sex workers, former prisoners and other most-at-risk populations was started in 2008 by developing official Guidelines on HIV prevention among vulnerable groups of population and police officers. The Guidelines were officially approved by the MIA order #417 in 2008. The most important provisions were as follows:

1. Basic information on HIV and ways of its' transmission
2. HIV prevention and post-exposure prophylaxis in case of accidents at work

Prohibition to carry out operative and investigative activities in the areas where harm needles/syringes exchange points and methadone substitution treatment points are located

Approach:

The chosen approach was a mix of all listed above definitions. It intended to create a legislative basis for police support of the harm reduction programmes in the form of the official Guidelines (mentioned above) and to create a continuous consistent system for instructing police officers on harm reduction interventions and role of policemen in HIV prevention in the Kyrgyz Republic.
The main steps were as follows:

- To create a team of friendly policemen in 5 regions of the Kyrgyz Republic so that they could be focal points for non-governmental organizations who experience problems with police relationships. The team of 5 policemen (which was further extended to 13 policemen) was appointed by the Minister of Internal Affairs and participated in a thorough training on the Guidelines and HIV/AIDS.

- To arrange mini-seminars for police officers (mostly district police officers) in the project sites. The seminars were delivered by the most active members of the friendly policemen team together with AIDS Center and AIDS-service NGOs representatives under supervision of experienced experts and AFEW staff. The agenda included HIV/AIDS facts, cooperation with AIDS-service NGOs, and detailed information about the Guidelines. Each participant received a copy of the Guidelines in Russian and Kyrgyz languages.

- To introduce HIV/AIDS and harm reduction problems to the curricula of the local MIA Academy. Textbooks “On legal foundation of harm reduction” and “On decreasing vulnerability of sex workers” were published in Russian and Kyrgyz languages. To ensure efficiency of such courses comprehensive lecture modules with presentations alongside with presentation equipment were handed out to the lecturers. Further feedback was provided by the sex workers (SW) and people who inject drugs (PWID) community leaders representatives, who visited several lectures to provide additional on-site coaching. Annual refresh-trainings for instructors from the MIA Academy are delivered with the donor support.

- Regular round tables linking up the MIA officials with the community leaders are held to discuss further cooperation between police officers and AIDS-service NGOs.

- To encourage policemen who cooperate with non-governmental sector awards and honour certificates “For personal contribution to HIV prevention in the Kyrgyz Republic” are given out to the most cooperative law enforcement officers. The candidates were selected based on a survey among NGOs in all the project sites.

- To review the Guidelines and its target groups. On January 21, 2014 new Guidelines on HIV prevention by authorized state agencies of internal affairs, drug traffic control and penalty execution was approved (ref. # 34 – Ministry of Health, ref. # 49 – Ministry of Internal Affairs, ref.#24 – State Service on Penalty Execution, ref.#202 – State Service on Drug Traffic Control) Therefore, the Guidelines intends to provide regulations for all law enforcement agencies which interact with the most-at-risk populations.

- To incorporate the Guidelines trainings to the internal MIA training curricula and to prepare a team of peer trainers among responsible police officers.

- To ensure regular monitoring of the Guidelines implementations through site-visits by representatives of the Ministry of Internal Affairs and NGOs. The results are announced

at meetings of HIV-preventative commission created under the relevant law enforcement agencies.

- Mini-trainings for drug control officers and prison officers on the Guidelines were started in 2014 under support of various donors.

Reach of the intervention:
In the period from 2008 to 2014 the geographic coverage of projects was expanded to 9 cities of the Kyrgyz Republic. These are Bishkek, Tokmok, Balykchy, Cholpon-Ata, Naryn, Osh, Karasuu, Kyzyl-Kiya, Djalal-Abad.

Impact of the intervention:
The intervention created a legislative framework for support of HIV-preventative efforts for police officers. The following extracts from the Section IV “HIV prevention among vulnerable groups” of the Guidelines demonstrate its contribution to creating favourable environment to HIV-preventative programmes:

“Heads of departments shall ensure tolerant and proper attitude to representatives of vulnerable groups, preventing discrimination related to HIV-status”

“Heads of departments shall ensure continuity of care for MAT clients, people living with HIV who receive ART and other vulnerable groups representatives on treatment, who were detained and are kept under custody in pre-trial detention facilities and prisons”

“Law enforcement officers shall refer vulnerable groups’ representatives to HIV-preventative programmes”

“Law enforcement officers shall motivate vulnerable groups’ representatives and victims of rape to receive post-exposure prevention”

“Law enforcement officers shall provide first aid in cases of drug overdose and other life-threatening situations for vulnerable populations”, and etc.

Various trainings, meetings and round tables have created opportunities for representatives of drug users and sex workers groups to meet police outside the frame of enforcement. When the Police Academy curriculum was complete, people who used drugs and sex workers presenting it at the Ministry of Internal Affairs joked that “this was the first time they were coming [to the ministry] un-cuffed.” The “friendly police” report that a major reason for their change in attitude toward marginalized groups has stemmed from in-person interactions during trainings that helped them see sex workers and drug users as human beings—like anyone else in the community. The resulting reduction in stigma has been pivotal in building greater trust.

Not all interactions between police and drug user and sex worker groups have been easy. At the seminars, “Some very heated discussions took place, up to and including accusations that AIDS service organizations supported prostitution and drug use,” says AFEW’s Chairperson Natalia Shumskaia. “However, it was through such discussions, and opportunities to argue one’s position, that many in the law enforcement have come to understand the importance of harm reduction programmes for vulnerable groups.”

No extensive researches were conducted to measure the impact of the intervention. But in 2011 there was a study among police officers to assess whether having undergone HIV trainings was associated with improved legal and public health knowledge, positive attitudes toward public health programmes and policies, occupational safety awareness, and intended practices.

In a 313-officer sample, 38% reported undergoing the training. In a multivariate analysis, training was associated with the officer being significantly more likely to support referring individuals to public health organizations (aOR 2.21; 95%CI 1.33–3.68), expressing no intent to extra judicially confiscate syringes (aOR 1.92; 95%CI 1.09–3.39), and better understanding sex worker detention procedure (aOR 2.23; 95%CI 1.19–4.46), although trainee knowledge of policy on routine identification checks for sex workers was significantly lower (aOR 3.0; 95%CI 1.78–5.05). Training was also associated with improved occupational safety knowledge (aOR 3.85; 95%CI 1.66–8.95).

Financing and management:
These projects have been implemented by the Public Foundation “AIDS Foundation East-West in the Kyrgyz Republic” under the financing of Soros Foundation Kyrgyzstan and co-funding of the “Bridging the gaps: health and rights for key populations” project (MIA of the Netherlands). Consequently, coordination and financial management of the projects is being accomplished by two organizations. The major partners of the projects are: Ministry of internal affairs of the Kyrgyz Republic, local AIDS-service NGOs, Republican AIDS center and its regional departments.

Lessoned learned and recommendations:
Throughout the years of cooperation, AFEW built a comprehensive model of cooperation with police at several levels: legislative and policy level, police authorities’ level, local police departments level. We think that one of the main success factors was building strong ties between law enforcement officers and governmental/non-governmental AIDS-service organizations. Face-to-face contact and regular meetings alongside with the officially approved Guidelines created a strong basis for cooperation.

We also found that arranging trainings for high-level officers and decision-makers is an important success factor to provide understanding and political support of the intervention.

Regular monitoring together with our partners from the civil society, Public Supervisory Board and regular reports to the HIV-preventative commission foster accurate implementation of the Guidelines implementation at all police departments.

5. MOLDOVA

Title of programme: Mechanism for national funding for HIV prevention programmes for people who inject drugs as a bridge from adequate policy and legal framework to the actual funding in reality

Contact person: Ala Iatco
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Implemented by: Government

Areas of focus of the programme: Policy and legal environment; the financial crisis and its impact on people who inject drugs programmes
Programme is being implemented since: 2014
Has the programme been evaluated/ assessed? No
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
It is estimated that 31,562 people who inject drugs (PWID) live in the Republic of Moldova, of which estimated 6,200 in Chisinau and 5,100 in Balti, in which the IBBS reported the highest HIV prevalence in the country – 40%. As of 2011, HIV prevalence among PWID in Chisinau was 16,4%.[21] As of 2012, HIV prevalence among PWID in the country was 7,9% (UNAIDS Report on AIDS Epidemic, 2013). This is much higher than HIV prevalence in the general population (adults, 15-49 years), which in 2012, was estimated at 0,58% (UNAIDS, AIDS info database). The WHO/UNAIDS/UNODC recommended most effective interventions for PWID for HIV prevention – needle and syringe programs (NSP) and opioid substitution therapy (OST) – has been almost fully funded by the Global Fund since 2003. In 2013, harm reduction spending for PWID amounted to $US 400,555, of which domestic spending accounted only 7% (GARPR, 2014). Moldova is a middle-income country, which under the New Funding Model has to meet stricter requirements for the Global Fund funding. According to the Global Fund Investment Guidance for the EECA region (2014), the counterpart co-financing requirement for lower low-middle income countries as Moldova is minimum 20%. As a result, under the new Global Fund grant for Moldova (2015-2017), national funding for harm reduction has to increase – the government must finance at least 2 harm reduction programmes in the amount (1 941 200 MDL), which is twice of the resources allocated in 2014. In the light of the changing donor funding for HIV in middle income countries, there is an urgent need to increase national funding for harm reduction programmes for PWID. In November, 2013, a decision was made to develop a mechanism for the national government's funding for harm reduction.

Approach:
Harm reduction programmes – NSPs and OST – are HIV-sensitive interventions as they target people who are at risk of HIV infection because of sharing of non-sterile injecting equipment. However, the scale of harm reduction programmes and its potential to prevent HIV is very much dependent on funding of harm reduction programmes. Under the risk of decreasing donor funding for harm reduction programmes, having a mechanism for national harm reduction funding is central for sustaining the scale and, therefore, particularly relevant to HIV as it would have an impact on HIV through the level of scale of these programmes provided in the country.

Reach of the intervention:
It is estimated that approximately 8504 PWID are reached by the NSPs and approximately 275 patients by OST (outside of the penitentiary system) that help to prevent HIV by providing sterile injecting equipment or by preventing the risky-behaviour, respectively. It is only one third of the PWID in the country that are covered by NSPs and a very low coverage of OST outside of the penitentiary system. Under the risk of decreasing donor funding, the

[21] Estimating Sizes of Populations of People Who Inject Drugs, Sex Workers, and Men who have Sex with Men, Republic of Moldova, 2011. Available at: www.aids.md

country may not sustain even this coverage if funding for these harm reduction programmes are not overtaken by national funding. Therefore, having a mechanism developed to fund harm reduction programmes, especially through NGOs is a key factor.

Impact of the intervention:
The effectiveness of NSPs and OST in preventing HIV and other harms does not need to be further proved. A number of studies[22] conclude that these harm reduction programmes are effective and cost-effective. A study[23] that was conducted in 2014 reviews 91 other studies on cost-effectiveness of HIV programmes and find that programmes targeting populations at highest risk, such as PWID, SW, and MSM were most cost-effective while programmes targeting the general public were not cost-effective or much less cost-effective than targeted programmes. A study (Wilson, et.al) on effectiveness and cost-effectiveness of NSPs in 8 Eastern Europe and Central Asia countries that includes Moldova revealed that an increase in NSP coverage decreased the number of new HIV infections among PWID. Since 2006 (just 3 years after the Global Fund started funding harm reduction programmes in Moldova) new HIV infections among PWID in Moldova steadily decreased (65,7 per 1 million population in 2006 to 17,1 per 1 million population in 2011; AIDS info database). However, fluctuations and risks in funding for harm reduction programmes may have severe impact on the positive outcomes on HIV prevention achieved thus far.

Financing and management:
The mechanism for national funding of harm reduction programmes is an essential tool to the path of sustainable national financing of harm reduction programmes in the country. To develop this mechanism in Moldova, a working group has been established that is composed of the Deputy Minister of the Ministry of Health; Specialists of public health; economists; coordinators of national programmes, UNAIDS, NGOs. The working group is primarily in charge of the two lines of work:

1. Analysis of the national legal basis and analysis of the regional practice. The working group concluded that there is no need for new laws and that the existing ones would allow financing NGOs – pending an effective mechanism of funding. A Regulation on the NGO Working in the Area of Public Health Funding by the Ministry of Health, however, still needs to be further developed and approved by the government with a special governmental order;

2. Development of appropriate documents that would determine a mechanism for funding of HIV prevention programmes from national resources. The projected mechanism envisions the following structure: The Ministry of Health – contractor of services; NGOs – service delivery (for NSPs, while OST only by medical institutions); the source of funding – government's budget: mid-term budget of the Ministry of Health, under which resources are planned every year for the next 3 years; mechanism for funding – open competition/concourse for project proposals organized by the Ministry of Health or assigned medical institutions. At the moment the regulation for funding of harm reduction programmes from the national budget needs to be further developed and approved. It would include: 1. General definitions and principles; 2. Procedures for funding; 3. Priority areas and types of funded services; 4. Concourse/competition: rules, regulations, requirements, criteria for

[22] Over 10 studies on effectiveness of harm reduction programs are summarized in the study mapping report.
[23] Craig et al (2014) Spending of HIV resources in Asia and Eastern Europe: systematic review reveals the need to shift funding allocations towards priority populations. Journal of the International AIDS Society. For its summary, refer to the study mapping report.

assessments, requirements for project proposals and requirements for participants of the competition; 5. Rules for budgeting and reporting.
Under the current mechanism for harm reduction funding that is primarily funded by the Global Fund, services for the most-at-risk-populations are delivered by: 1. Medical institutions; 2. Social institutions; 3. Departments of penitentiary systems; 4. NGOs. Under the current system, partnerships are maintained between: 1. Local and central authorities; 2. Governmental and non-governmental institutions; 3. Institutions of social protection 4. Police. When approved, the new mechanism of national funding for harm reduction programmes should maintain such structure.

Lessoned learned and recommendations:
The key factors that helped facilitate the development of the mechanism of harm reduction funding from national resources include:

- The necessary policy and legal basis already existed in the country (National HIV/AIDS Plan, Law on Prevention of HIV/AIDS, Standards for harm reduction among PWID, Protocol for OST, Instructions for HIV prevention among most-at-risk-populations).

- There was already experience of extending harm reduction services that were and are still funded primarily by the Global Fund and, as a result of it, certain mechanisms and practices can be easier adopted by applying a mechanism for funding from national resources.

- Concerns about harm reduction services upon risks of reduction of international support.

- Realization of the government that harm reduction services are important and effective in HIV prevention. Advocacy by the NGOs played an important role in this.

- The working group established to develop this mechanism included the key stakeholders necessary for progress in developing such a mechanism.

- The support and expertise of international organizations, such as UNAIDS.

Development of a mechanism for harm reduction funding from national resources is a substantial step; however, approval and implementation of this mechanism is the next key step that is absolutely necessary in sustaining the necessary services for HIV prevention among PWID.

Annexes:
1. Regulation on funding public health NGOs by the Ministry of Health in Moldova
2. Order of the Minister of Health to establish a working group for funding harm reduction programmes in Moldova

6. MOLDOVA

Title of programme: Comprehensive package of services for people who inject drugs (PWID) in Moldovan Prisons
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Implemented by: Government, Civil Society
Areas of focus of the programme: Policy and legal environment; the role of the community of people who inject drugs in service delivery
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Moldovan authorities have demonstrated leadership, and pragmatism, in adopting evidence-based HIV prevention programmes. 15 years later, Moldova remains one of only a few countries in the world where comprehensive harm reduction services are available in prisons. In terms of statistics, the number of annual new cases of HIV infection detected amongst inmates decreased from 32 cases (2003) to 21 cases (2013). The proportion of people living with HIV (PLHIV) under ART increased from 2% (2005) to 62% (2013). Deaths amongst PLHIV in prisons has dropped three times from 23% (2007) to 8.6% in (2013).

Currently, the prison system is implementing 12 out of 15 interventions recommended within the UNODC/ILO/UNDP/WHO/UNAIDS comprehensive package of HIV services in prisons.
Main steps of implementing the Comprehensive package of services in prisons:

1. 1999 - starting needle exchange and distribution of condoms programmes;
2. 2001 - Implementation of DOTS for tuberculosis;
3. 2004 - Implementing antiretroviral therapy and development of the first DPI ordinance for HIV/AIDs control;
4. 2005 - Implementation of pharmacotherapy with methadone and also in 2005 implementation of DOTS (plus) treatment for resistant tuberculosis;
5. 2007 - excluding the mandatory HIV testing of inmates when entering the prison;
6. 2008 – the opening of HIV Voluntary Testing Counselling services and the methodological recommendations on HIV –TB co-infection management in prisons;
7. 2012 (GeneXpert) the method for rapid diagnosis of tuberculosis is implemented;
8. 2013 – VTC through NGO on saliva available for inmates.

The needle and syringe exchange program in the Republic of Moldova was initially piloted in one prison and gradually it was extended to 11 prisons out of 17 in 2014. The average number of syringes distributed annually is about 80,000 syringes per 11 prisons. The actual number of beneficiaries is difficult to estimate due to indirect method of exchange which is prevailing (prisoner do not need to come in person to NS site as the exchange could be done via packet). To regulate the work of medical and non-medical staff, UNODC has provided technical support for the development of Operational Manual/Handbook for NSEP. Methodology of implementing the programme, although in each prison the medical unit is responsible for implementing the programme itself the syringe exchange is carried out through volunteers selected amongst the prisoners, trained as per the principle “peer to peer”, and stimulated by being provided with monthly food packages, whose value is defined in advance. As per beneficiaries of the programme, there are two groups: inmates who continue to use drugs while being in prisons and prison staff as the implementation of the

programme is reducing significantly the risk of accidental puncture with used needles therefore serving as a security at work place response. The syringe exchange programme is unrolled within prisons 24/24 and 7/7days, confidentiality is fully respected. At the NS sites, alcohol swabs, antiseptic and anti-inflammatory items and IEC materials are also distributed. Condoms programme is implemented in all 17 prisons. The condoms are distributed through peer to peer; also condoms are available at the medical units and in the prolonged visits rooms. Approximately 35,000 condoms are distributed annually.
Pharmacotherapy with methadone is implemented in 11 prisons (extended to 4 more prisons in 2014). On 1 April 2014 the cumulative number of beneficiaries of pharmacotherapy was 319 persons (261 men and 58 women). The methadone is distributed at the medical unit of each prison; the prison doctor and the pharmacy are responsible for determining and distributing the necessary dosage of Methadone.
Since 2004 ARV is implemented in prisons. The treatment is done based on the National Clinical Protocol on ARV and treatment is available for all inmates which have medical recommendation. The ARV is indicated by the infectious diseases doctor from the medical hospital. Patients are screened for immunological condition outside of prisons system 2-4 times a year. In order to increase the adherence to the treatment since 2013 follow up method for ARV patients is implemented by the CSOs. As of January 2014 a number of 114 inmates were HIV positive out of which 71 are enrolled in ARV programme.
Prison Hospital is a centre of integrated services for HIV and TB. Since the implementation of TB programme in prisons the incidence of TB amongst inmates has decreased 4 times, from 550 cases in 2006 to 127 cases in 2013. In 2001, 10% (1,100) of all inmates were registered to have TB; the number has dropped to 2% (152 inmates) in 2013. Mandatory screening for TB is undertaken twice a year for those who are imprisoned and one screening for the newly entering the prison. The treatment is indicated by prisons TB specialist according to susceptibility. Out of all diagnosed patients 60% are in DOTS (+), 10% out of all TB patients are with HIV/TB co-infections. 50% of mortality rates are registered amongst HIV/TB co-infections.

Approach:
The prison system is part of the National Programme on HIV 2011-2015 and is also part of the National Drug Control Strategy 2011-2018.

Reach of the intervention:
As of January 2014, Moldovan prison system consists of 17 prisons including 6853 inmates. NSP and OST are implemented in 11 prisons; Condoms, TARV, TB programmes are implemented in all 17 prisons.

Impact of the intervention:
IBSS results amongst inmates (2007, 2010 2012) show a decrease in blood-borne diseases such as HIV and viral Hepatitis. HIV prevalence among inmates declined from 4.2% (2007) to be 1.9% (2012). Prevalence of HCV decreased from 21% (2007) to - 8.6% (2012). Integrated HIV knowledge indicator has increased from 30.8% (2007) to 42.2% (2012).

Financing and management:
Currently, Harm Reduction programmes in prisons are financed by the GFATM. With respect to management, the head of penitentiary institutions is the Programmes Coordinator of NSP and OST and the implementation is undertaken via prison medical service. In 2013, the DPI took over the management over the needle exchange programme while ensuring the maintenance of the two programmes in case of no external financial support. The major partners are: NP (MoH), Narcology/Addiction Treatment Service, Soros Foundation-

Moldova, CSOs: New Life and “AFI”, also UNODC, UNAIDS, LEAHN.

Lessoned learned and recommendations:
Success:

- Since 15 years of implementation the programme has proved that implementation of syringe exchange programme is a necessary and feasible intervention that can be adapted to the prison system conditions.

- Syringe exchange programme in prisons facilitate the access of PWID to treatment programme for drug dependence.

- Syringe exchange programmes in prisons have not led to any incidents related to syringes held for own use; it is worth mentioning that this programme cannot be used as a controlling mechanism of drug use in prisons through blackmailing and harassing the prisoners who benefit from access to sterile injecting devices granted by syringe exchange points/units.

- Syringe exchange programmes in prisons, just like the ones unrolled in the community, determine behavioural changes leading to the reduction of drug use-associated harms.

- The partnership with the community medical service and CSOs has a positive impact over the HIV/AIDs epidemic and HR programs in prisons.

Challenges:

- Continuous information of the inmates and the penitentiary staff about the programme is important within ensuring the access to these services (when designing and implementing the program will be considered the nature of criminal subculture and the rigidity of penitentiary system).

- Extending comprehensive package of services is important (prevention of violence, the treatment of hepatitis and post-exposure prophylaxis) and maintaining current achievements is a challenge for prison system. The need for continuous training for prison staff and inmates information, including through multidisciplinary teams.

Annexes:
1. IBSS 2012 (http://aids.md/aids/index.php?cmd=item&id=293)
2. Evaluation of Opioid Substitution Treatment in Moldova 2012 (http://aids.md/aids/index.php?cmd=item&id=1429)
3. HIV Program Assessment 2012
4. UNOD and DPI Operational Manuals OST in Prisons 2014

7. POLAND

Title of programme: Estimation of HIV and HCV prevalence among people who inject drugs in Warsaw and surrounding area – pilot survey

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Implemented by: Civil Society
Areas of focus of the programme: The role of the community of people who inject drugs in service delivery
Programme is being implemented since: 1.12.2013
Has the programme been evaluated/ assessed? No
Is the programme part of the implementation of the national AIDS strategy? No
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Over the recent years the Polish drugs scene has changed dramatically. The trend of injecting drug use is on the decline. In 2010, half of the patients of drug treatment units had never injected psychoactive substances. In 2012, this share rose to two thirds. Surveys conducted by the National Bureau for Drug Prevention show that injecting drug use is still relatively common and poses a grave threat related to blood borne diseases. Preliminary data available for 2012 indicate that the number of people who inject drugs (PWID) in Poland ranges from 4 307 to 10 304. From 1985 to the end of March 2014, 17 773 HIV infections were registered in Poland, out of which at least 6 026 (33.9%) were related to injecting drug use. The analysis of new HIV infections among PWID reveals a general downward trend and its stabilization in recent years. In 2013, the share of HIV-positive individuals who had got infected through injecting drugs stood at 3.5%. However, it must be stressed that these data refer exclusively to those individuals who reported a likely route of virus transmission. At present, the problem of unknown virus transmission concerns 68.2% of all registered HIV infections. After excluding reports with incomplete information, the percentage of infections related to injecting drug use to 9.0%. Among clients of Consultation and Diagnostic Centres (PKD), the percentage of injecting drug use-related infections gradually decreased. In 2012, only 1% of the survey participants got infected this way. Considering simultaneous injecting drug use and risky sexual behaviour, this rate stood at 10.9%. The study “Estimation of infectious disease prevalence (HCV, HBV and HIV) among PWID in the cities of Gdansk and Krakow” conducted in 2008-2009 concluded that HIV prevalence among PWID stood 10.3%. According to the 2012 PKD data, the HIV-positive rate among PWID stood at 8.1% and is the highest among all analyzed groups. The data do not include the 10% of PKD clients under the category of mixed risks. A relatively high percentage of HIV-positive individuals combined with tendencies to engage in risky behaviours causes that infections among PWID have a dynamic spread potential. What is more, due to the fact that PWID have sexual partners who do not use drug in this manner they might pose a threat to the general population. According to the PKD data, 44.1% of the survey participants share needles and syringes while injecting drugs. Moreover, 63.7% report sexual contacts under the influence of alcohol, 12.6% never use condoms whereas 20.7% use them occasionally. Monitoring new trends in HIV and HCV infections among PWID is an important source of information on serious health consequences of substance use. Access to PWID is very limited though. A percentage of PKD clients who report injecting drug use is relatively low (less than 2%). The latest HIV and HCV epidemiological study among PWID in Warsaw was conducted in 2004. There are no up-to-date data on the prevalence of infectious diseases in this population. As a result, the AIDS Social Committee attempted to estimate the prevalence of HIV and HICV among

people who inject drugs in Warsaw and surrounding area. The specific objective was to create a profile of people who inject drugs, their behaviours related to the high risk of contracting the viruses. Another objective was to identify risk factor for blood borne infections in this population. Moreover, information flow channels among PWID were to be described and measured in terms of effectiveness.

The project was implemented according to cross-sectional design based on anonymous questionnaires containing closed and open-ended questions as well as HIV and HCV lab tests. The questionnaire was created by a team of practitioners and epidemiologists of Warsaw Medical University.

Approach:
Due to the limited access to people who inject drugs it was decided that two separate participant recruitment method would be applied. The respondents were recruited by trained volunteer leaders – active drug users and patients of methadone programmes and through invitations distributed via drug services. The project featured an internal awareness campaign that was designed to motivate and ennoble people who inject drugs circles. 30 individuals were recruited. They represented various sub-groups of the target population and varied in terms of age, sex and frequency of substance use. The volunteers took part in one-day leader workshops in the Warsaw head office of the Harm Reduction Foundation. During the workshop they were provided with the basic knowledge of HIV/AIDS and mastered skills helpful to convince other substance users to have an HIV test. The workshop participants were informed on the framework, course and objectives of the study. They were updated on the current situation in the field of research into the relationship of injecting drug use and HIV/AIDS and planned actions. They were familiarised with the idea of harm reduction and peer work among people who inject drugs. The workshop participant actively engaged in discussions, asked questions and reported doubts. They shared their experiences and observations. They were precisely instructed as regards the survey recruitment process. The volunteer leaders received small pay for recruiting the respondents. The respondents in turn received small presents.

Reach of the intervention:
The survey was a pilot project and covered the city of Warsaw and surrounding area. For the purposes of the campaign, four versions of invitations in four different colours were created. They were distributed in the area of 10 000 square kilometres.

The green version was distributed by volunteer leaders. Each received 15 coupons to hand out among their friends. 25 volunteer leaders came back to pick up more invitations (15 coupons per person). The other colour versions were assigned to the distribution sites. In each site more than 1000 coupons were distributed:

a. Blue – methadone programmes
b. Yellow – harm reduction programmes
c. Orange – Office of Ombudsman for Drug Dependent People and NGOs.

The survey included individuals who at least once in a lifetime had injected drugs, permanently resided (in the last 3 months) in Warsaw area and were aged over 18. In the course of 5 months 96 participants took part in the study. Not all had coupons. 79 coupons were received: 60 green, 14 yellow, 3 orange and 2 blue.

Impact of the intervention:

The prevalence of HIV in the study population stood 14.7% while the rate for HCV reached 71.6%. A great majority of the HIV-positive respondents were also HCV positive. What is significant is that that no HIV infections were observed among respondents aged under 30. An average age of positive respondents was 40.4. As many as 85.7% of HIV infections were detected among males. In the case of HCV infections the values were slightly lower. Among the respondents there were relatively many socially marginalized individuals. Almost one third of the respondents had been in prison in the last 12 months (in the case of HIV this rate reached 42.9%). 23.4% of the inmates served sentences for possessing drugs, 27.7% received homeless-related care while only 28.4% were in paid employment. Higher prevalence of HIV did not correspond to poorer socio-economic status. It must be stressed that over one third of the respondents had not injected psychoactive substances in the last 30 days prior to survey. Among PWID the most popular drugs included heroin (86.9%), stimulants (49.2%) and mephedrone (34.4%). The trends regarding the use of Polish home-made heroin (kompot), methadone, stimulants, mephedrone and methcathinone were of downward nature. Heroin use was on a similar level. Most respondents had previously been patients of inpatient drug rehab clinics (57.4%). However, only 28.3% resided there in the last 12 months prior to survey. Slightly more respondents had been clients of specialist outpatient drug treatment centres (34.4%). HIV-positive individuals seemed to reject this kind of assistance. None had resided in an inpatient drug rehab clinic in the last 12 months prior to survey and only 7.1% had visited an outpatient drug facility in that time. HIV-positive individuals were willing to use NGO services and drop-in centres (71.4% and 58.3% respectively). 70% of the respondents were informed on the risk of infection.

HCV-positive respondents were slightly better informed compared to the HIV-positive group. They frequently found out about infections at various treatment institutions (most respondents stated Harm Reduction Foundation and MONAR Association). An important source of information were friends. The least common were social workers, doctors and therapists. What is significant is that a large number of the respondents benefiting from the institutional support reported that they had not been given information on the risk of HIV and/or HCV. The worst situation in this respect was in hospitals and outpatient clinics where the respondents had undergone detoxification, substitution treatment programme, specialist counselling centres and drug treatment units in general. The best situation was in non-governmental organizations, drop-in centres and harm reduction programmes.

It seems that the most effective channel of information flow among people who inject drugs are NGOs. Nearly all respondents reported that they got supplies of clean injecting equipment. Interestingly enough, HIV and/or HCV-positive survey participants used clean equipment more often than negative. A great majority of respondents did not have problems with getting supplies of injecting equipment at pharmacies. However, in the group of HIV-positive respondents only 35.7% used equipment purchased at pharmacies. A less popular setting was syringe and needle exchange sites – 30.9% of survey participants used this form of assistance. Almost 80% of the respondents reported engaging in risky behaviours (sharing injecting equipment, unsafe sex). What is interesting, the fact of receiving information on the risk of infection did not reduce such behaviours. HIV and/or HCV-positive respondents were more likely, compared to negative survey participants, to share injecting equipment. These groups differed in terms of the frequency of unsafe sex.

The most dangerous risk factor for HVI and/or HCV infection was the total time of injecting drug use. Other factors included the use of heroin, methadone and mephedrone. Paid employment, in turn, seemed to be a protective factor. The period of injecting drug use turned out to be a stronger predictor than the respondent age. It was shown that there was a

relationship between the higher prevalence of HIV and/or HCV and getting supplies of clean injecting equipment at syringe and needle exchange centres. However, it was caused by other variables. The respondents who got needles and syringes at drop-in centres were socially marginalized and particularly deeply dependent on psychoactive substances.

The surveys of the so-called hidden populations pose a great challenge to researchers. Therefore, the fact that within 6 months it was possible to involve the expected sample of respondents can be considered a success. The most effective was the recruitment conducted by volunteer leaders. However, it seems that in order to increase motivation of volunteers among people who inject drugs, an increase in financial reward for recruiting more respondents and their participation should be considered. Distributing invitations at drug services and organizations proved to be relatively effective in recruiting respondents. Among institutions where coupons were handed out, harm reduction programmes were most successful.

Financing and management:
The project was in half co-financed by the National Bureau for Drug Prevention, a governmental agency and Global Drug Policy Programme, Open Society Foundations, a non-governmental organization. The intra-sectoral partnership provided the project implementers with an opportunity to apply innovative harm- reduction based approaches towards people who inject drugs, with a simultaneous legitimacy of a public institution. Consequently, the survey results can be used to develop governmental strategies for people who inject drugs support in Poland.

Lessoned learned and recommendations:
On 24 June 2014, a presentation of the survey results and a meeting of the Round Table of public health experts were held. The event was attended by specialists of the National Bureau for Drug Prevention, National AIDS Centre, National Public Health Institute (PIH), Institute of Psychiatry and Neurology, Warsaw Medical University, Helsinki Foundation for Human Rights, Political Critique, Harm Reduction Foundation, Lambda Society Warsaw and AIDS Social Committee. During the meeting the following conclusions were formulated:

- Drug-dependent individuals are particularly exposed to the risk of HIV and HCV. That is why a comprehensive response based on scientific evidence and harm reduction model should be developed. It refers to reducing risk of substance use i.e. wide access to injecting equipment (needles, syringes, cotton wads, electrolysed water, containers), activities promoting safer injecting and sex (trainings, workshops), widely understood health promotion (educational classes, specialist assistance).

- Drug-dependent individuals are particularly at risk of HIV and HCV and they need comprehensive, specialist HIV and HCV testing services adequate to their health status and living conditions. In the case of HIV it is recommended that rapid diagnostic methods eliminating traditional genetic material collection (injecting) be applied. Testing sites should be adequate to the real needs of the clients. Apart from testing, clients should have an opportunity to receive professional help (medical, psychiatric, social, legal, etc.) as well as widely understood psychosocial support. Once testing becomes part of an extensive package, it will be more likely to come into and maintain contact with people who inject drugs.

- HIV-positive drug users are in need of a comprehensive, institutionally guaranteed support offer to start and continue antiretroviral therapy (ARV). It is necessary to develop and

implement action that would make it easy for PWID to navigate the care and treatment system.

- Drug users committing crimes in connection with their disease should be referred to specialist drug treatment centres. Due to the nature of drug dependence disease and risk of contracting HIV and HCV they should not be sent to correctional facilities.

- Programmes targeting drug-dependent individuals should be designed and implemented jointly by governmental institutions, local authorities and non-governmental organizations. Drug users, according to the peer work principle, should be involved in such programmes at every stage, from planning actions through implementation and evaluation.

Annexes:
The whole report is available at http://www.skaids.org/pl/do-pobrania/raport-program-pilotazowy-skierowany-do-osob-przyjmujacych-narkotyki-droga-iniekcji

8. SPAIN
Title of programme: Needle/syringe Exchange Programmes (NEP) and Opioid Substitution Therapy (OST) in Spanish prisons
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Implemented by: Government
Areas of focus of the programme: Policy and legal environment
Programme is being implemented since: 1998
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
HIV infection still represents a serious challenge worldwide, and in recent years, Spain has been at the head of both incidence and prevalence rates in Europe. The most serious problem, however, has without any doubt been in penitentiary centres, where mean incidence and prevalence rates go clearly beyond those for the general community, with HIV infection among inmates in Spanish prisons reaching 30% in 1990.

Approach:
The intervention is a mix of all. The programme is especially for people who inject drugs (PWID), who form a group who, along with the risks inherent in this particular lifestyle, are also stigmatized and discriminated against by society and made more vulnerable as a result.

Reach of the intervention:
The programme covers all Spain Prison System, about 50.000 inmates.

Impact of the intervention:

- The number of prisoners who have never shared injecting material has increased.
- The percentage of individuals who said they used condoms systematically has increased significantly.
- There has been a decrease in the number of individuals who have consumed drugs, and particularly among those who are HIV-positive.
- Individuals with histories of drug consumption presented higher levels of knowledge about HIV infection, with the risk perception variable seeming to be the explanation for this.
- There has been a substantial decrease in HIV prevalence, with infection rates dropping year after year.
- The other diseases addressed by these programmes have followed the same pattern: the hepatitis rate has fallen, TB incidence rates are lower and HIV and HCV seroconversions have both significantly dropped.
- Officials have not observed any increase in conflict nor in intravenous drug use, and most believe that NEP improves hygienic conditions for inmates.

Financing and management:
The intervention is financed and coordinated by the Ministry of Interior

Lessons learned and recommendations:

- *A set of escalating measures*

As part of the public health care service, the prison health system must ensure assistance equivalent to that provided outside prison. According to WHO criteria, in the 1990s a series of health measures was introduced in Spanish prisons which focused on improving health conditions for inmates, and included programmes for illness prevention and control, harm reduction and health promotion. Each programme forms part of a comprehensive response: i.e. an overall plan of escalating measures, beginning with prevention and education, and ending with harm reduction activities, including clinical assistance for infections and behavioural treatment for changing unsafe habits.

- *Contact with community institutions*

In 1993, the World Health Organization and the Council of Europe issued recommendations regarding HIV/AIDS in prisons, stating expressly that "in countries where sterile needles and syringes are available for injecting drug users in the community, the possibility of providing prisoners who so request with sterile injection kits should be considered.....". The degree of application of this guideline had up to then been limited everywhere on the grounds of its alleged illegality and hazards. The first step in starting a programme of these characteristics in prisons must therefore be to establish contact with the institutions in the general community that are already running harm reduction programmes, with the aim of coordinating efforts and exploring the possibility of transferring these kind of programmes into prison.

- *Health care in prison with the same standards of quality*

Drug users, especially people who inject drugs, form a group who, along with the risks inherent in this particular lifestyle, are also stigmatized and discriminated against by society and made more vulnerable as a result. They present more greatly impaired physical and mental health in comparison with the non-drug-using population, suffering principally from mental disorders, the effects of drug abuse itself and infectious disease. In addition, most have seldom or never accessed health care services before imprisonment. Prison services are thus compelled to ensure that inmates are provided health care with the same standards of quality available outside prison, according to the provisions established by the UN and the Council of Europe in the 1960s. Prisons are in fact the first health care resource for that part of society which has difficult access to the public health care system, due either to marginalization or to self-exclusion. Prisons cannot be considered an isolated element of society as a whole, as it is that society from which individuals in prison have come and to which they will return; in the meantime, they must be ensured their right to the coverage of their fundamental needs, among which the right to health care is primary.

- *Each society has its own view*

Each society has its own view, tradition and history regarding the use of illicit drugs and these opinions cannot be ignored in deciding what should be done about it. Taking into account the scope and nature of the problem, and local awareness of legal, social and political factors, lists of possible actions have been created that individual countries can consider, for which considerable evidence is available on their effectiveness and which have the backing of the key international organizations dealing with the challenges of communicable diseases in prisons.

- *Health protection measures, including harm reduction programmes, are effective*

There is evidence that health protection measures, including harm reduction programmes, are indeed effective within the setting of Spanish prisons, despite the well-known tensions in places where secure detention is seen as the primary goal, above the basic requirements for health protection, treatment and prevention.

9. SWITZERLAND

Title of programme: Comprehensive Swiss drug policy
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Implemented by: Government
Areas of focus of the programme: Policy and legal environment
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
According to UNAIDS Global Report on the AIDS epidemic 2013, coverage of HIV prevention services for people who inject drugs has improved but remains low in many countries. Also, according to the contribution of the Executive Director of the United Nations Office on Drugs and Crime to the high-level review in the implementation of the Political

Declaration and Plan of Action on International Cooperation toward an Integrated and Balanced Strategy to Counter the World Drug Problem, conducted by the Commission on Narcotic Drugs in March 2014, several countries that have implemented evidence-based programmes to reduce the adverse consequences of illicit drug use among people who inject drugs appear to have reduced the number of HIV infections among such people. This seems to have been the case, for example, in many countries in Western Europe and Oceania, where needle and syringe programs and opioid substitution therapy, combined with a range of other health and social services, appear to have resulted in a decline in unsafe injection drug use, which is related to the spread of HIV. Despite the encouraging progress observed in such countries, the global HIV epidemic among people who inject drugs is far from being resolved.

So the question of interest is how did Switzerland, that in 1986 officially reported the highest rate of HIV cases in Western Europe, manage to turn the tide?

Approach:

The Swiss drug policy

End of the 1980s the public pressure on the political sphere increased mainly because of the open drug scenes and the high HIV prevalence among drug users. After consulting with the cantons and people working in the field, the Federal Council decided that a shift from maintaining public order to ensuring public health as the main goal of the Swiss drug policy was necessary. The new national drug policy was based on four pillars - prevention, treatment, harm reduction as well as law enforcement and control. The policy's aim is to direct actions in the four pillars in a way that they become mutually reinforcing. Thanks to this approach, focused on pragmatism, effectiveness and efficiency, Switzerland achieved positive results, like the reduction of drug related deaths and the improvement of addicts' health. Its aims are

- Reduction of illicit drug abuse,
- Reduction of negative effects of illicit drug consumption and
- Reduction of the negative effects on the health of the addicts.

It is this four-pillar policy that has led to a decrease in HIV infection prevalence. But it is essential that it was not one measure but the overall balanced and multidisciplinary approach that lead to the reduction and stabilization at a low rate. It is therefore essential to understand what the measures of each pillar are.

Prevention:

This pillar intends to prevent the start of drug use and therefore the development of an addiction. The health of the person is put at the center of reflections which, in a broader sense, contributes to the overall quality of the person's life. Thus, prevention doesn't aim primarily at preventing a first consumption of drugs but is aimed at preventing the negative health outcomes in a more general way. Consequently, prevention is increasingly transformed into health promotion and influences the respective target groups (children, youth) indirectly through structural changes.

Treatment

Therapeutic integration of affected persons, improvement of their physical and mental health, social and socio-professional reintegration as well as the creation of conditions which allow a life free of addiction on a permanent basis are general goals of therapies for persons with addictive behavior. The objectives of a therapy are adapted to the individual's needs and possibilities.

The most important services in addiction treatment are ambulatory and residential psycho-social counselling and therapies, psychiatric therapies, substitution assisted treatment (ambulatory or residential), detoxification units or clinics, abstinence-based residential treatment, follow up care and assisted accommodation. The provision of services lies within the competencies of the Cantons.

Substitution assisted treatment is a medically supervised therapy whereby an illegally consumed opioid (usually heroin) is replaced by a legal medicament and accompanied by additional therapeutic measures. Substitution assisted treatment is nowadays one of the standard therapies in case of opiate addiction in Switzerland.

Harm Reduction
Harm reduction intends to ensure that people who at some point in their life use drugs can overcome this phase with the smallest possible physical, mental or social harm. Specific objectives are lowering risks of infectious diseases, stabilization and improvement of the health conditions of drug users, and improvement of their social reintegration. Further, harm reduction measures aim at leading drug users towards therapeutic services. For society, harm reduction measures intend to reduce social costs of drug addiction and ensure public safety. For instance, measures can include the exchange of syringes (so they are not discarded of in public), provision of sterile injection equipment (in order to stem the transmission of infections) but also offering contact centers or injection rooms (in order to get into contact with the addicts in the first place).

Law enforcement and control
Law enforcement is responsible for reducing the supply to illicit drug markets, especially, but not limited to, large scale supply. According to Swiss Narcotics Law, supply reduction measures should be carried out by cantonal police forces. The Federal Office of Police and the Federal Criminal Police assist cantonal police forces in carrying out such operations upon request and if appropriate. Operationally, a complex set of laws and regulations not necessarily in accordance with national drug policies in all instances governs cantonal police actions on drug matters. This creates the risk that the law enforcement and control pillar is perceived as being separate from the other pillars, acting sometimes in contradiction to the efforts of those pillars concerned with public health issues.

In order to mitigate this risk and reduce contradictory outcomes of law enforcement actions on public health efforts, the Federal Office of Police regularly consults with representatives of all other pillars and at all relevant levels of governance. These consultations aim at better understanding how police action interacts with other – e.g. health-based – interventions into drug markets, identifying shared interests among pillars and creating synergies by acting in together with other actors in the drug field. Furthermore, the Federal Office of Police, together with the Federal Office of Public Health is co-chairing a national working group on the cooperation on police and public health. The working group organizes among others conferences and seminars in which best practices in the cooperation between police and public health professionals are developed, documented and shared as well as training opportunities for police and public health identified.

Reach of the intervention:
Drug policy with national coverage. Comprehensive approach covering 4 areas: prevention, treatment, harm reduction, law enforcement and control (more details, see above).

Impact of the intervention:
The Swiss National Programme on HIV and other STI (NPHS) 2011–2017 groups HIV and STI interventions and measures into three axes. The definition of the three axes of intervention is based on considerations of prevalence and vulnerability. Axis 2 is about individuals who engage in risky behavior or are vulnerable in an environment with an increased prevalence. Axe 2 identifies several groups, one of which is the people who inject drugs (PWID), besides men who have sex with men, sex workers, migrants from high prevalence countries and people in prisons. They require additional, specific measures, since they have a greater risk of infection, such as

- The harm reduction measures are basically maintained, and adapted to their needs,
- Centers for PWID also encourage prevention of HIV and other STI,
- Preventative measures, specific information for PWID working as sex workers and
- Raising awareness about the risk and high prevalence of hepatitis C.

As for the situation in Switzerland today, the general epidemiological situation regarding HIV diagnoses among PWID can be summarized as follows: At the beginning of the HIV epidemic, in Switzerland, needle exchange between PWID was the most common way of infection. By the late 1980s, the proportion of transmission within PWID reached 50% of the new diagnoses, but then it fell rapidly to less than 15% by the late 1990s. Over the last 5 years, this proportion has remained at less than 5%. In 2013, it even fell to less than 3%, with a total of 15 diagnoses (absolute numbers): 12 men and 3 women. Given the small figures, it is difficult to interpret the changes occurring from one year to another and generate any tendency whatsoever. Among PWID diagnosed in 2013, 80% were Swiss nationals and three quarters men, which corresponds to roughly to the proportion of men among all PWID.

Financing and management:
The four pillars of the Swiss policy is anchored in the Federal Law on Narcotic Drugs which ensures the implementation of said pillars and their respective interventions, guaranteeing a certain sustainability. The interventions are managed and coordinated by the cities and the cantons, with coordination bodies ensuring regular exchange. It is the cities, the cantons and the federal government that share the finances according to the respective competences. The total costs of illicit drug consumption are difficult to measure as they imply social and human costs as well and can only be measured with various indices, therefore being merely estimates. With regards to the 4 pillars, the costs can be divided into 60% repression and control, 20% treatment, 10% prevention and 10% harm reduction.

Lessons learned and recommendations:
HIV was only one of the driving forces that led to a fundamental rethinking of the Swiss drug policy, resulting in expansion of evidence-based services. Therefore, Switzerland encourages **deliberations on approaches** that could be more efficient and effective than drug policies focused on enforcement of measures strictly aiming at abstinence and without offering alternatives in therapy or measures to reduce the harm caused by the adverse consequences of drug abuse.

A **health-centered approach** to addressing illicit drug use and drug dependence is still not sufficiently implemented in all countries, even though significant progress in this direction has been made in several parts of the world over the last few decades. Similarly, people who illicitly use drugs and people who are dependent on drugs and living with HIV often experience **stigma, discrimination and human rights violations**, discouraging them from seeking the health and social services they need even if such offers exist. Though the

coverage of services based on scientific evidence has increased in some countries, it is still inadequate in most countries.
Cooperation between the different players such as health and social workers and police are essential in order to understand each other's aims and to support their goals.
The reduction of HIV-incidences does not allow for inactivity, but raises the challenge to keep the **incidence** at such a **low rate**.

Annexes:

1. Open source book "From the Mountaintops: What the World Can Learn from Drug Policy Change in Switzerland", October 2012
   http://www.opensocietyfoundations.org/reports/mountaintops

2. Switzerland's National Drug Policy (2006-2011) that was extended to the year 2016.
   http://www.bag.admin.ch/shop/00035/00204/index.html?lang=en

3. The Swiss National Programme on HIV and other STI (NPHS) 2011–2017
   (http://www.bag.admin.ch/hiv_aids/05464/05465/12491/index.html?lang=en)

10. SUISSE

Intitulé du programme : Campagne Nationale Hepatitis C
Contact: Aline Bernhardt Keller et Peter Menzi
Titre: Collaboratrice Scientifique/ Directeur Adjoint
Organisation: Infodrog, Centrale National de Cooridnation des Addictions Mandatee par l'OFSP
Adresse: Igerplatz 5, 3000 Berne 14
Telephone: **031 3 760 401**
Email: a.bernhardt@infodrog.ch / p.menzi@infodrog.ch
Maitre (s) d'œuvre: Gouvernement
Le programme couvre le (s) sujet (s) suivant (s): Le rôle de la communauté des consommateurs de drogues injectables dans la prestation de services
Programme mis en œuvre depuis : 2007
Le programme a-t-il été évalué/analysé ? Oui
Le programme s'inscrit-il dans la mise en œuvre de la stratégie nationale de lutte contre le SIDA? Non
Oui

Contexte :
Les données épidémiologiques actuelles sur l'hépatite C montrent qu'environ les deux tiers des nouvelles infections apparaissent dans la population des consommateurs de drogue par voie intraveineuse. Les conséquences de ces chiffres ne sont pas seulement les atteintes considérables à la santé des consommateurs de drogues, mais aussi les conséquences au niveau social ainsi que et les charges financières pour les pouvoirs publics. Le besoin d'agir est evident.

Démarche :
Lorsqu'on parle d'hépatite C, on parle également plus généralement des maladies transmissibles et du VIH. Les aspects de safer sex et safer use permettent par exemple de prévenir les deux maladies. Réduire les risques de transmission de l'hépatite C veut

également dire réduire les risques de propagation du VIH. Lors de co-infection, il y a des répercussions sur les traitements envisagées.
La campagne de sensibilisation *hepatitis C* s'adresse aussi bien aux professionnels qu'aux usagers de drogue et poursuit les objectifs suivants:

- Transmettre les dernières connaissances sur l'hépatite C, aux professionnels et aux consommateurs de drogues.
- Améliorer la prévention des risques d'infection par le virus de l'hépatite C.
- Inciter au dépistage systématique du virus de l'hépatite C chez les consommateurs de drogues.
- Améliorer l'accessibilité aux traitements pour les consommateurs de drogues.

Jusqu'à présent, plus de 500 professionnels du domaine des addictions ont été formés grâce à la campagne. Les institutions mènent régulièrement des actions de sensibilisation. Un manuel et une brochure ont été développés pour les professionnels ainsi que du matériel pour les consommateurs de drogue.
(http://www.hepch.ch/fr/4_kampagnematerialien.html)
Un site internet en 4 langues (f/e/a/i) a été développé (www.hepch.ch)

Portée de l'intervention:
Portée nationale sur trois axes :
- Prévention
- Dépistage
- Traitement

Impact de l'intervention:
Il n'y a pas eu suffisamment de fonds pour financer une évaluation externe mais les retours des professionnels du terrain indiquent que le dépistage est plus systématique, que les messages de prévention ont un impact et que davantage de traitements ont été mis sur pied. Les connaissances sur l'hépatite C des professionnels du domaine des addictions sont bien meilleures grâce aux formations et à un effet multiplicateur. Les usagers sont ainsi mieux informés et leurs connaissances sur le sujet sont également meilleures.

Financement et gestion:
Financement de l'Office fédéral de la santé public, section drogue.

Enseignements tirés et recommandations:

- Le développement à un niveau national a permis de toucher toutes les régions et de créer des synergies entre les différentes régions.
- Le besoin de mettre en place une Stratégie Nationale sur la thématique de l'hépatite C demeure**.**

Annexes:

- Analyse de la situation de l'hépatite C chez les usagers de drogue en Suisse. (Institut universitaire de médecine sociale et préventive - IUMSP Unité d'évaluation de programmes de prévention – UEPP, Institut für Sucht- und Gesundheitsforschung, Zürich – ISGF, Service de la Santé Publique, Lausanne – SSP)

11. TAJIKISTAN

Title of programme: Provide improved access to HIV prevention via provision of low-threshold services for people who inject drugs
Contact person: Mavzuna Burkhanova
Title: Deputy Programme Manager, HIV, TB, Malaria ControlProgramme, UNDP
Organization: UNDP
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Email: mavzuna.burkhanova@undp.org
Implemented by: UN or other inter-governmental organization
Areas of focus of the programme: The role of the community of people who inject drugs in service delivery
Programme is being implemented since: 2009
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
The population of Tajikistan is approximately 8 million, of which over 70% live in rural areas and 40% is under the age of 18. The country is faced with challenging geography, as it is 93% mountainous and landlocked, with limited access to other regions. Tajikistan's economy is particularly susceptible to the global economic crisis, due to its reliance on labour migration. In 2012, the current official rate of unemployment was at 11.5% (World Bank, Human Development Indicator). With a Human Development Index (HDI) of 0.622, the country is ranked 125th among 182 countries listed by this indicator in the UNDP Human Development Report 2012[24].

The majority of socio-economic spheres in Tajikistan in the post-Soviet period, in particular the healthcare system, have been severely affected by civil war, economic collapse, and a dramatic decline in health financing. Tajikistan's health sector budget is only 1.6% of GDP, which covers only 16% of total health sector expenditure[25]. The government budget is not sufficient to cover all needs of building capacities. In particular, there is a risk of an exponential increase in HIV and tuberculosis, if this issue is not immediately addressed. In general, these ongoing challenges require the continued support of UNDP in partnership with the government and non-governmental organizations, as well as with other UN and international agencies.

The first HIV case in Tajikistan was recorded in 1991. However, before the early-to-mid 2000s, there was little known about HIV in Tajikistan. By the end of 2006 there had been a cumulative total of 707 people diagnosed with HIV, a number which then increased to 5,550 (of which 4,581 are still alive) at the end of 2013. The main modes of HIV transmission comprised unsterile injection (52.3%), sexual intercourse (39.5%) and MTCT (2.6%), and 5.6% cases were of unknown origin.

Regular behavior sentinel surveillance (BSS) among key populations provides the country with ample opportunity to follow the dynamics of HIV prevalence and, accordingly, take necessary actions to further strengthen the HIV programme. Unsterile injecting practices and unsafe sexual intercourse are referenced as the main driving factors of HIV

[24] http://hdrstats.undp.org/images/explanations/TJK.pdf
[25] Tajikistan Ministry of Health statistics 2008

transmission; consequently, HIV prevalence among key populations must be consistently validated to control the epidemic. Also of note is a steadily decreasing trend seen in HIV prevalence among people who inject drugs (PWID) between 2007-2014 -- 19.4% in 2007, 17.6% in 2008, 17.3% in 2009, 13.5% in 2011 and 12.8% in 2014. Owing to the fact of applying micro-capital grants for civil society organizations the UNDP can be considered to be as a great contributor to such remarkable achievement regarding PWID. It is namely CSO that provide HIV prevention to over 50% of PWID in remote rural areas countrywide.

As of today, UNDP in Tajikistan, as the Principal Recipient of Global Fund grants, provides various harm reduction services to more than 45% of PWID via 3 umbrella/regional public organizations working with PWID, 26 National AIDS Center-coordinated Trust Points in 24 districts, 1 needle/syringe exchange point in a detention facility, 5 anti-retroviral therapy clinics and 6 OST sites to provide low-threshold services and harm reduction interventions countrywide.

One of the local public organizations, “Svon+”, implements a project to provide low-threshold services to PWID within the framework of the GF grant. The organization was established by the initiative of PWID in 2011 to provide this key population with quality harm reduction services and to influence their behaviour for the better. This is the second public organization in the country that has been founded by former (and active) PWID, who wish to support their peers in recuperating a healthy life style and re-cultivating practical skills. The organization was awarded its first grant in 2012 by UNDP aiming to help the NGO to begin implementing HIV prevention services among PWID. The initial proposal of the NGO was not perfect; nonetheless, it was replete with commitment and personal engagement. At the time of the next proposal submission, the NGO had grown into an influential and strong organization with a solid and relevant bank of experience.

Approach:
The project interventions are considered to be a mix of all approaches such as HIV specific, sensitive and relevant. Through the provision of low-threshold HIV services, the NGO has been able to encourage PWID to take up other HIV harm reduction interventions such as adherence to ART and OST. The organization of daily information sessions, group meetings, and the social support of clients via outreach and self-help group prompted the conscious behaviour change and attitude alteration among PWID.

Reach of the intervention:
The programme implemented by Svon+ reaches 300 people through HIV prevention services in and around Kulyab city. The primary focus of the intervention is to improve access to HIV prevention; however, support to people who inject drugs and HIV-positive individuals is also an important component of the intervention. Svon+ focused on providing low-threshold services such as: meals, laundry, recreation, accommodation, daily information sessions, group meetings, counselling, referral to health facilities and social support of clients via outreach and self-help groups.

Impact of the intervention:
The UNDP in Tajikistan seeks to support various initiatives of community-based organizations (CBOs) in the belief that continuous capacity-building of local public organizations yields tangible outcomes and impacts in communities as a whole. The involvement of CBOs, timely harm reduction interventions and improved access to HIV prevention services in the country have resulted in quality coverage of PWID, an increased number of clients who receive ART, stronger adherence to methadone-based therapy and

safer injecting practices. According to national behavior sentinel surveillance conducted in 2014, 90.3% of PWID used sterile injecting equipment the last time they injected as compared to 69% of PWID in 2010.

Financing and management:
The interventions are financed by the GF grants under the management and implementation of the NGO "Svon+". Currently, the organization is one of the active stakeholders in the country contributing to the success of the National HIV strategy. Over the course of a two-month period between 2 projects/grants, the NGO volunteered to continue providing HIV services and social escort to its clients. Furthermore, the organization is a member of Coordinating board of CSO and local governmental bodies in Kulyab city, which considers various agenda to jointly prioritize issues, tackle challenges, coordinate activities. Additionally, the NGO is a grantee of other donor organizations (e.g. AIDS Foundation East-West - AFEW) in Tajikistan, vividly demonstrating the vigour and interest of the organization in playing a key role in the national HIV response.

Lessons learned and recommendations:
A major strength of public, community-based organizations like Svon+ is the engagement of former and active PWID. Project staff has endured addiction and has had similar experiences to beneficiaries, meaning that they know the needs of the community and are able to more successfully interact with the target group. Moreover, non-governmental organizations are willing to work in harm reduction areas, are well-aware of clients' needs and are resourceful in advocating HIV prevention and healthy life style among at-risk population.

Today, UNDP in Tajikistan uses several mechanisms and approaches used to cooperate with NGOs as effective and important links/units with which to collaborate with governmental structures in providing quality prevention services. In particular, much attention is paid to the support initiatives of PWID communities through the provision of micro-capital grants that favorably facilitate the development of such communities. Such kind of grants is of great help to National AIDS Center-coordinated Trust points for PWID that are mainly located in the densely-populated areas (towns, cities) that are not able to extend scope of HIV prevention to hard-to-reach regions. By and large, majority of PWID remain excluded from HIV services and it is PWID communities and co-family members that carry out major interventions within own communities in close collaboration with governmental medical facilities. The network of PWID communities and CBOs constantly encourages experience and knowledge sharing on covering PWID by means of study tours, close interaction about common events, etc. Furthermore, in order to strengthen the role of local NGOs and extend their impact in HIV prevention among PWID, UNDP has applied an umbrella-based approach to empower local NGOs in managing more complex projects at the regional level.

As a result of continuous support and close collaboration with civil society, UNDP has succeeded in laying a favorable foundation for effectively addressing HIV through the interaction of various stakeholders in Tajikistan. Nowadays, representatives of civil society are actively engaged in the work of the Country Coordination Mechanism to fight AIDS, TB and Malaria, productively participate in national decision-making events/activities, effectively implement far-reaching programmes/projects on HIV prevention at regional level vs. the local level and significantly contribute to attaining national targets on HIV by covering hard-to-reach key populations/PWID.

12. UKRAINE

Title of programme: HIV Prevention for people who inject drugs with support of GFATM and USAID (Round 1, 6, 10, SUNRISE)
Contact person: Pavlo Smyrnov
Title: Deputy Executive Director
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Implemented by: Civil Society
Areas of focus of the programme: The role of the community of people who inject drugs in service delivery
Programme is being implemented since: 2004
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Ukraine has experienced one of the worst HIV epidemics in Europe and the Commonwealth of Independent States (CIS) with HIV prevalence in the general adult population estimated at 0.62%, twice the average in the rest of Europe. According to data from January 2014, 139,573 people living with HIV were officially registered in the country; however the actual number of people living with HIV is estimated as high as 238,000. AIDS-related mortality in Ukraine accounts for around 17,000 deaths annually (National HIV/AIDS estimates, the Ukrainian Centre for Socially Dangerous Disease Control (UCSDDC), 2013; "HIV Infection in Ukraine "Bulletin #41, UCSDDC, March 2014).
Ukraine remains a country where the epidemic is driven by most-at-risk populations and their sexual partners. The highest level of HIV prevalence is continuously observed in people who inject drugs (PWID). 20% of the PWID population are currently HIV infected, which is 62,000 people, or half of the total number of all HIV-positive adults registered in Ukraine. HIV cases in PWID have been reported from all 27 regions. The largest total number of cases since 2005 has been in Donetsk, Dnipropetrovsk, Kyiv City, Odesa and Mykolayiv. These top five regions account for 59% of HIV cases among PWID reported since 2005.
The harm reduction programme outlined below has been designed and delivered by the International HIV /AIDS Alliance in Ukraine ('Alliance Ukraine'), a national Ukrainian civil society organisation, that strengthens community systems by providing grants and technical support to 80 community organisations across Ukraine. Alliance Ukraine works alongside and supports government health services, integrating community-based harm reduction services with government health services, and building the capacity of government health service providers to create services responsive to the needs of PWID and other people affected by HIV. The programme has been independently evaluated as effective and has led to decreases in HIV transmission amongst PWID. However this national programme is now under threat due to shifting donor priorities and the unstable national political environment.

Approach:
Alliance Ukraine have developed four models for reaching PWID with HIV services: 1) outreach, 2) mobile clinics, 3) stationary points and 4) pharmacy based services. The

combination of four models maximizes coverage by offering different points of entry for PWID, and provides clean injecting equipment and condoms; HIV risk reduction communication; case detection by screening for HIV, HCV, HBV, STIs and integrated primary TB screening; linkage to care through the community initiated treatment intervention (CITI) – a short-term rapid linkage to care intervention which facilitates early HIV and drug dependence (OST) treatment access for PWID.

At outreach routes, mobile clinics and stationary points community health workers and peer outreach workers assess health and drug use-related needs, provide information on safe injecting and safe sex, overdose prevention, sexual and reproductive health and anti-violence services, information on the importance of HIV, STI testing, reducing harm of drug use, TB awareness and early identification, information about available services at NGOs, health or social facilities. They distribute syringes/needles, condoms, information-educational materials (IEM).

Community health workers work alongside clinical staff to provide screening for HIV, HCV, HBV, and some STIs with help of rapid tests at the four service points: outreach, mobile clinics, drop-in centers and pharmacies. Clients receive a full treatment course if tested positive for syphilis, chlamydia, and gonorrhoea. People who test positive for HIV are referred to the government AIDS clinic for test result confirmation and are connected with a case manager from the CITI (Community Initiated Treatment Intervention). The case manager provides assistance in registering with the AIDS clinic, as many PWID are 'lost' to the system at this crucial point. The CITI intervention links HIV positive clients in community-based harm reduction projects to government HIV treatment services using a case management approach. The CITI intervention is focused on initiating ART and adherence support for PWID. In its first six months of operation in 2014 CITI assisted 787 PWID to start ART.

Opioid Substitution Therapy (OST) began in 2005 and is available free-of-charge at clinics run through a Government / NGO partnership. 156 OST clinics operate throughout the country including at 'narcological and psychoneurologic' dispensaries, at AIDS clinics, at hospitals treating communicable diseases, at TB dispensaries, as well as at local and district general hospitals. Currently 7,784 people receive OST. In close collaboration with the Ministry of Health an integrated care system has been developed in which patients receive both medical and psychosocial support. Psychosocial services increase patient referrals and patient motivation, as well as increases adherence to HIV/TB treatment in OST clients, and decreases in HIV transmission rates.

Alliance Ukraine's community mobilization approach has resulted in a number of interventions successfully driven by PWID. These include Peer Driven Interventions (PDI), an intensive outreach intervention targeting women and young people who use drugs; and secondary syringe exchange for outreach to those clients who don't attend harm reduction programmes; and gender-sensitive services such as couples counselling and family support services. Participatory Site Assessments inform programme planning. NSP programmes rely on outreach work conducted by peers.

Reach of the intervention:

In 2013 the programme reached 196,460 PWID (which constitute 64% of the estimated PWID population size in Ukraine) with HIV services. The programme was implemented by 80 community-based organizations through 1,606 NSP sites, 15 mobile clinics, numerous outreach routes, and 143 pharmacies and covered 302 cities, small towns and villages all over Ukraine.

The programme is designed to maximize coverage of PWID but also to address specific needs of sub-populations including women and young people who use drugs, and both opiates and stimulants users.

Impact of the intervention:

High and consistent levels of programme coverage have led to a significant impact on Ukraine's HIV epidemic amongst PWID. Over the last five years HIV incidence among PWID (HIV prevalence among PWID who recently initiated injecting drug use) fell from 8.2% to 3.5% (national IBBS data, Chart 1). A parallel decrease has been observed by epidemiologists in HIV registration data among PWID (Chart 2).

Equally importantly, the decrease in HIV incidence among PWID has led to HIV epidemic stabilization among the general population. According to the official registration data, HIV incidence stabilized in 2012, when, after continuous growth during the previous years, the number of new cases per 100,000 became equal to the previous year, and in 2013 this indicator started to decrease Chart 2).

Programme impact is measured through studies such as IBBS and AIDS Center statistics on new HIV cases (IBBS among PWID, 2011, 2014; AIDS Center bulletin, 2013).

Financing and management:

The Ukrainian national harm reduction programme has relied heavily in international donor support, in particular from Global Fund and USAID. Alliance Ukraine is a Principal Recipient for the Global Fund programme and provides overall programme management and technical support, develops programme approaches and packages and funds implementation through over 80 regional sub recipients. Programme monitoring is implemented through SyrEx software that allows tracking individual clients and services and commodities provided. All interventions are implemented by community-based organizations that have capacity and experience in working with PWID.

Alliance Ukraine centrally procures commodities to ensure lowest possible price. Overall over 25,000,000 syringes are distributed annually with the average number of 143 syringes per client. The programme works in close collaboration with government health services and supports referral systems between community-based organizations and hospitals. However, due to the allocation restraints of the Global Fund NFM Ukraine is facing funding cuts of up to 50% to its HIV programming, this will severely limit the continued reach of this highly successful programme. The requirement to fit all HIV and TB dire needs into one critically shrinking overall budget led to reduction of annual client cost from $31 to $19 and 53% reduction of overall budget for PWID programmes (Fig.1 and 2).

It was expected that the Ukrainian government would invest around 100,000,000 USD into the national AIDS budget, however due to the war in Eastern Ukraine national currency has devalued meaning that in real terms the total budget has decreased by 71% to 29,000,000 USD (Fig.3).

Lessons learned and recommendations:

All data sources (Ukraine HIV Data Synthesis Project, CDC, UCSF, WHO, 2013) confirm an inverse correlation between increasing coverage of the national harm reduction programme in Ukraine and the number of new HIV cases among PWID. Intensified outreach services, rapid HIV testing in outreach settings, case management aimed at increasing coverage and improving PWID retention in services, case detection and access to care, are key to the success of the national harm reduction programme in Ukraine. Intensifying efforts to address the seek-test-treat-retain cascade is the current programme priority, targeting PWID who have disproportionally low access to HIV treatment and care.

However the effectiveness of these programmes can be easily undermined by decreasing coverage or by limiting the range of services for PWID. The anticipated decline in funding of

services for PWID in Ukraine as result of new funding policies of the Global Fund are a threat to the future of this work. In a context of political and financial crisis in Ukraine, there are low expectations of substantial financial support to this programme by the Ukrainian Government.
It is anticipated that the package of services for PWID will decrease as a result of funding cuts. The following services will not be funded in 2015: STI testing, treatment and counselling, HBV testing and vaccination, involvement of STI doctors, VCT doctors and nurses, outreach to reach new clients, couples interventions, gender specific interventions, interventions for stimulant users, self-help groups, psycho-social and legal services. .
It is critically important that international donors ensure that a responsible transition mechanism is put in place before funding is withdrawn from Ukraine, and that national governments and their "willingness to pay" feature in the decision to withdraw funding for successful national HIV programmes. Withdrawal of funding for harm reduction on the basis of crude measures of country income will undermine this most successful national programme.

Annexes:

1. HIV prevention for People Who Inject Drugs implemented by the International HIV/AIDS Alliance in Ukraine, September 2013, updated April 2014, G. Shaw, unpublished
2. Keeping Women Who Use Drugs Healthy, 2013, http://www.aidsalliance.org/assets/000/000/381/90653-Keeping-women-who-use-drugs-healthy_original.pdf?1405520678
3. Support for Assessment of the Implementation of the National AIDS Programme in Ukraine among IDU, CSW and MSM, UNAIDS, 2013, unpublished
4. **Combination Approaches for Injecting Drug Users**, AIDS-Star One, http://www.aidstar-one.com/focus_areas/prevention/resources/case_study_series/alliance_ukraine
5. From Beyond Boutique to Epidemic Control, Evaluation Report of HIV prevention activities by International HIV/AIDS Alliance Ukraine funded by the Global Fund to Fight AIDS, TB and Malaria. APMG, D. Burrows, 2009, unpublished
6. Ukraine HIV Data Synthesis Project. CDC, UCSF, WHO, 2013
7. Monitoring of the behaviour and HIV prevalence among people who injecting drugs as a component of second generation surveillance: analytic report on the results of the integrated bio-behavioural study of 2013 / O. Balakireva, T. Bondar and others. – K.: ICF "International HIV/AIDS Alliance in Ukraine", 2014. – 181 p. - http://www.aidsalliance.org.ua/ru/library/our/2014/zvit%20IDU_s.pdf (only Ukrainian version is available)
8. Monitoring of the behaviour and HIV prevalence among people who injecting drugs as a component of second generation surveillance: analytic report on the results of the integrated bio-behavioural study of 2011 / O. Balakireva, T. Bondar and others. – K.: ICF "International HIV/AIDS Alliance in Ukraine", 2012. – 128 p. - http://www.aidsalliance.org.ua/ru/library/our/2012/me/idu_en_2011.pdf

9. HIV infection in Ukraine: information bulletin / Ukrainian Centre for Socially Dangerous Diseases Control, Gromashevsky Institute of Epidemiology and Infections – K. 2014. – #43. – 40 p. http://ucdc.gov.ua/attachments/article/586/%D0%92%D0%86%D0%9B-%D1%96%D0%BD%D1%84%D0%B5%D0%BA%D1%86%

D1%96%D1%8F%20%D0%B2%20%D0%A3%D0%BA%D1%80%D0%B0%D1%97%D0%B
D%D1%96.%20%D0%86%D0%BD%D1%84%D0%BE%D1%80%D0%BC%D0%B0%D1%8 6%D1%96%D0%B9%D0%BD%D0%B8%D0%B9%20%D0%B1%D1%8E%D0%BB%D0%B5%D1%82%D0%B5%D0%BD%D1%8C.%20%E2%84%96%2042.pdf (only Ukrainian version is available)

Chart 1. Decrease of HIV incidence among PWID and coverage with prevention programs.
Source: Programmatic monitoring and epidemiological surveillance data.

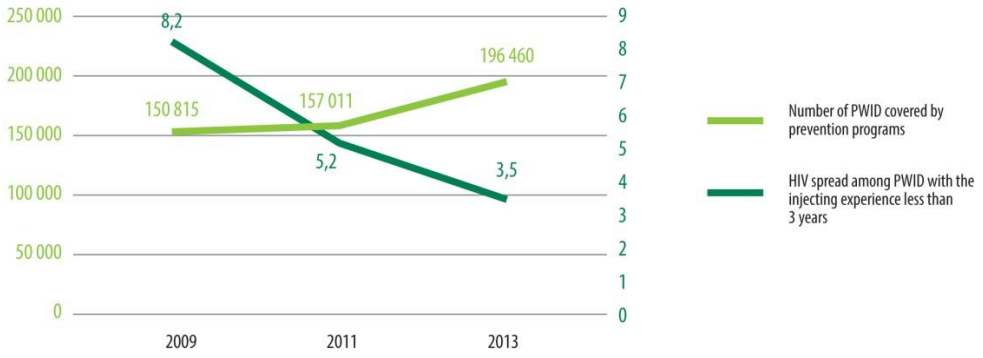


Chart 2. Number of new HIV cases depending on the testing availability.

Figure 1. GF funds: HIV

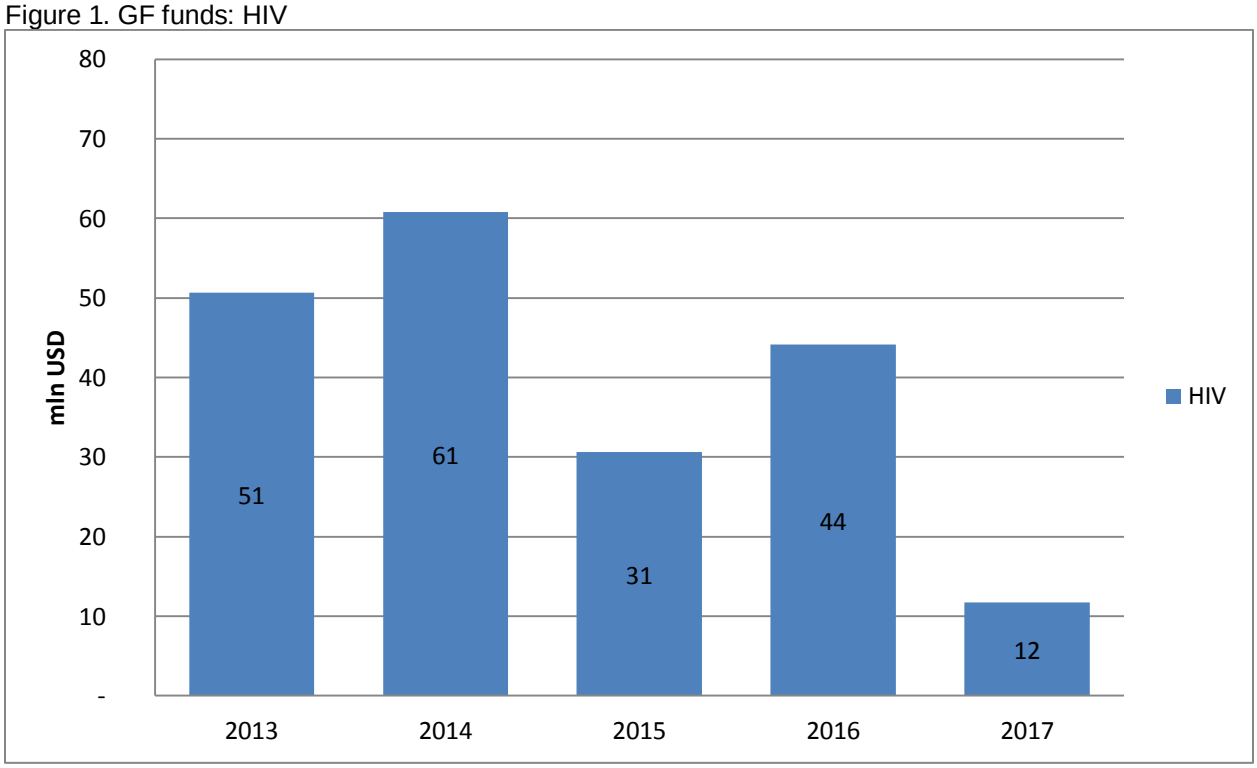


Figure 2. GF Funds allocation (HIV Prevention Ukraine)

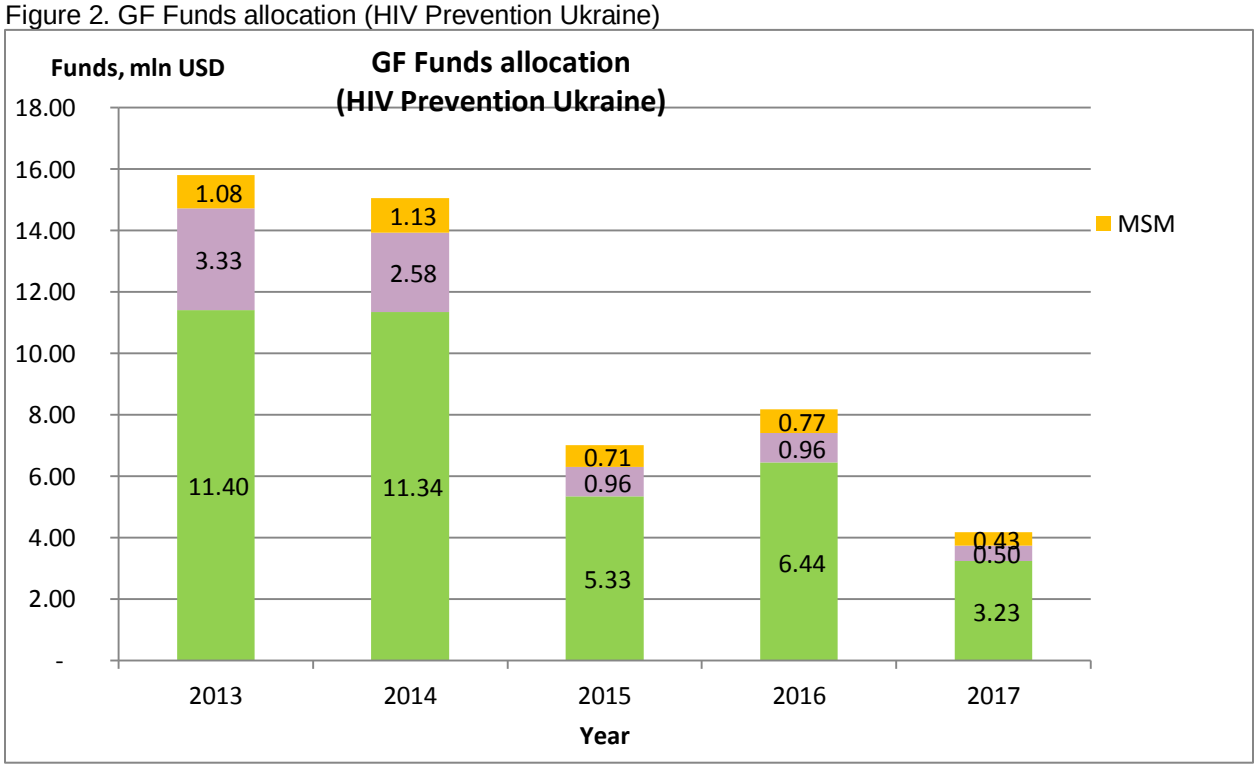
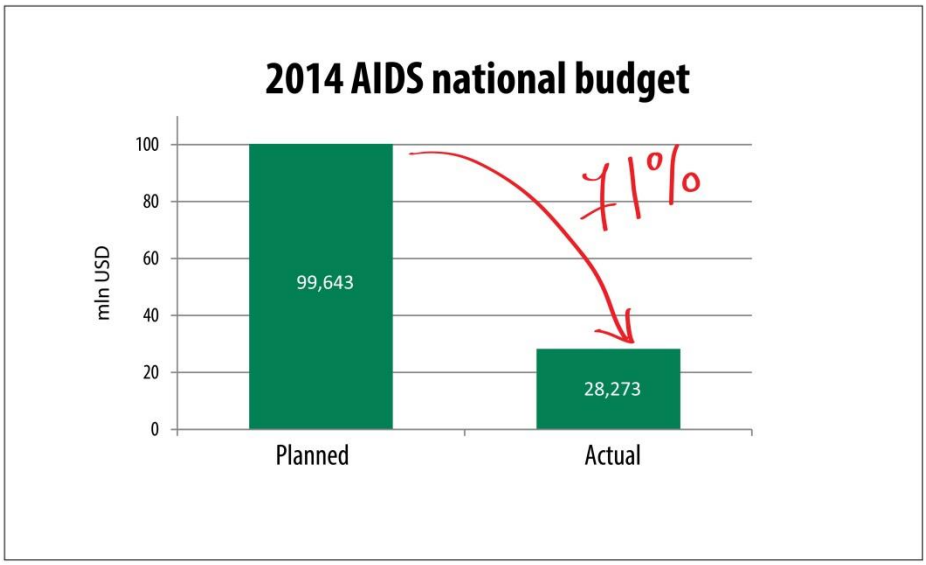


Figure 3. Ukraine National budget for AIDS 2014



13. UKRAINE

Title of programme: PMTCT among HIV positive pregnant women using drugs in Ukraine
Contact person: Professor Natalia Nizova
Title: Director
Organization: Ukrainian Centre for Socially Dangerous Disease Control of the Ministry of Health of Ukraine
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Tel: 044 281 2357
Email: nizova@ukraids.gov.ua
Implemented by: Government, Civil Society
Areas of focus of the programme: Policy and legal environment; the role of the community of people who inject drugs in service delivery
Has the programme been evaluated/ assessed? No
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? No

Background:
Success in implementing PMTCT programme in Ukraine has led to growth and achievement of high levels of key indicators on monitoring PMTCT programmes.
In 2013: 3,898 children taken under supervision; 3,504 children removed from the list due to absence of HIV

Official data on children born by HIV infected mothers in Ukraine

Under medical supervision	2011	2012	2013

Total	9 457	9 828	10 044
HIV infected children	2722	2 929	3 129
Annual increase in the number of children	*+101 children*	*+207 children*	*+200 children*
AIDS patients	752	829	849
Children with to be confirmed HIV status	6 735	6 899	6 915

In 2013 the coverage of HIV testing for pregnant women was 99.3%, ARV prophylaxis for HIV-positive pregnant women - 96.2%, tests of HIV-positive pregnant women to determine the number of CD4 cells - 95.6% and the viral load of HIV in blood plasma - 94.0%, ARV prophylaxis for infants born by HIV-infected women - 98.7% and artificial feeding - 96.7%.

However, official statistics and research results indicate that Ukraine is still facing the challenges in preventing HIV transmission from mother to child:

- Over the last five years in Ukraine the HIV prevalence among pregnant women (the proportion of HIV-infected pregnant women, regardless of the time of diagnosed HIV, total number of pregnant women) has not significantly decreased (1.0% in 2009 and 0.9 % in 2013). In 2013 in 10 regions of Ukraine, the figure was equal or higher than **1.0%**, which marks wide pathogen prevalence among the population of reproductive age and a possibility for HIV epidemic generalization in these areas[26].

- Late referral of HIV-infected pregnant women for antenatal care: For the period 2011-2013 in Ukraine the share of pregnant women taken under medical supervision at the III-IV HIV clinical stages among the number of pregnant women with newly diagnosed HIV infection during pregnancy, gradually increased – **12.8%, 16.9%, 21.7%, respectively.**
- According to special study[27] for **48.0%** HIV infected women who born HIV infected children, the pregnancy was unplanned; **33%** of women were not followed at women consultations, **24.4%** of mothers of HIV infected children before the birth had high level of HIV viral load in plasma blood corresponding to prevailing HIV-infection (30,001-100,000 copies/ml) or AIDS stages (> 100,000 copies/ml); **56.0%** of women had low adherence to ART. Only every fourth women (**25.0%**) among those who needed received social support during pregnancy.

The basic reasons for non-receiving ART for PMTCT among women who give birth to HIV infected children are as follows:
- HIV infected pregnant women are not followed in women's consultations (**28.0%**);
- Women who are active injecting drug users, social behavior (**14.3%**);
- Personal denial of women to use ARV drugs (4.8%)
- Referral of women to obstetric hospital in a pre-birth period (17.5%) and giving birth at home (3,5%);
- Diagnosis of HIV after labors (11.1%);
- A share of pregnant had limited access to services as they lived in villages (1.3%).

[26] Guidelines for second generation HIV surveillance: an update: know your epidemic, WHO/ UNAIDS – 2013.

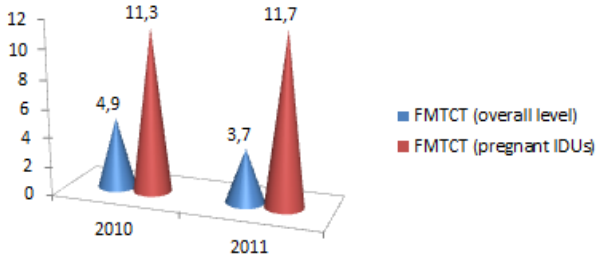
[27] Institutional study "Social, demographic and medical determinants of risks of HIV mother-to-child transfer in Ukraine" Annotated Report - 2013, SI "Ukrainian Centre for Socially Dangerous Disease Control at MoH Ukraine", UNICEF, Institute of Sociology of NAS of Ukraine"

HIV infected pregnant injecting drug users

In Ukraine there is a slow decrease in the intensity of the epidemic process of HIV among people who inject drugs (PWID) according to different data sources. However, based on the biological and behavioural surveillance, there are data that indicate a high degree of risk behaviour among female injecting drug users:

- HIV infection rate among female injecting drug users is higher than among male injecting drug users: **23.6%** and 20.8% (2011) and **22.4%** and 18.8% (2013) respectively;

MTCT frequency among children whose mothers are IDUs, 2011 (based on serology studies)



5 regions: FMTCT-IDU = 12.1% in Dnipropetrovsk region
15.8% in Donetsk region
20.0% in Zaporizhzhia region
75.0% in Kyiv region (3 children)
100.0% in Luhansk region (1 child)

9 regions: FMTCT-IDU = 0%
13 regions: no pregnant active IDUs

- percentage of female injecting tested for HIV in the last 12 months and who know their status was only **40.1%** (2011) and **46.8%** (2013));
- percentage of female injecting drug users who reported using a condom during their last sexual intercourse is only **47%** (2011) and **51.2%** (2013).

A proportion of pregnant women who inject drugs among newly diagnosed HIV pregnant women in Ukraine has gradually reduced - from 7.6% in 2009 to 6.1% in 2013.

In 2013 the number of such pregnant **women** was **131,** including **85 women** who actively inject drugs during pregnancy.

However, according to the study "Evaluation of the number of drug-addicted women of reproductive age and pregnant women drug addicts in Ukraine" (Centre "Social Monitoring", UNICEF) as of 01.01.2014, the estimated number of HIV pregnant women in Ukraine infected as a result of drug use by injection, reached **1,225 women**.

According to official data for the period 2011-2013 in Ukraine, the *"percentage of female IDUs who knew their HIV-positive status during labor"* was **16.8%, 18.0% and 17.5%,** respectively (all HIV infected pregnant - 4.3%, 4.9%, 4.9%, respectively) and the *"percentage of female IDUs who knew their HIV-positive status after childbirth"* was **10.3%, 11.8%, 12.7%,** respectively (all HIV infected pregnant women - 4.5%, 4.2%, 3.8%, respectively)

According to the special study[28] ARV prophylaxis was conducted only for 49% of HIV infected pregnant women who inject drugs.

[28] Institutional study "Social, demographic and medical determinants of risks of HIV mother-to-child transfer in Ukraine" Annotated Report - 2013, SI "Ukrainian Centre for Socially Dangerous Disease Control at MoH Ukraine", UNICEF, Institute of Sociology of NAS of Ukraine"

The frequency of transmission of HIV from mother to child among children (CHPMD) whose mothers were active injecting drug users exceeded threefold the overall rate CHPMD in 2011 (based on serology) - 11.7% vs. 3.7%, respectively.
Pregnant women who inject drugs suffer more from the consequences of HIV infection compared to HIV-positive pregnant women who are not injecting drug users, and have more difficult pregnancy and childbirth, which must be considered while supervising HIV infected pregnant women who inject drugs.

Approach:

The basic strategy - an integrated approach in prenatal care services, obstetric care and postpartum care that shall cooperate with:

- harm reduction services for drug users who refer pregnant women IDUs to prenatal counseling;
- experts on drug treatment (during pregnancy);
- HIV service agencies;
- services of psychological and social assistance;
- specialized obstetric services;
- services of pediatric and neonatal care.

Counseling is a required component of care for HIV-infected women with drug addiction, including a discussion of the following issues:

- danger of drugs to the fetus and a newborn;
- benefits of OST for the mother and fetus;
- risk of fetal stress due to failure of attempts to quit drugs in the absence of medical and psychological care;
- effect of pregnancy on opioid dosing at OST and the possible need to increase the dose;
- interaction between the drugs for OST and ART under PMTCT;
- adherence to OST and ART – administration of medicines once a day.

In case of following HIV-infected female injecting drug users who referred to the hospital during labor, the staff should be prepared to:

- assess the drug level and inform the results to neonatologist;
- offer rapid HIV tests if HIV status is unknown or was negative during pregnancy;
- conduct appropriate treatment of withdrawal syndrome;
- if necessary, start the OST;
- consult a woman about the impact of drugs on pregnancy outcomes, a baby and advise possible treatment.

Lessons learned and recommendations:

The breakthrough towards the MTCT elimination and ending AIDS by 2030 will be possible in Ukraine in case of the full coverage of the HIV positive women from the risk groups, especially HIV positive pregnant women drug users, with high quality PMTCT services.

Next steps

Development of a national strategic plan to combat the challenge of HIV transmission from mother to child in Ukraine, taking into account:

- adapted WHO clinical approaches for the prevention of vertical HIV transmission;
- improve the equipment of laboratory services to increase access to timely testing of HIV infected pregnant women and their new-born children;

- increasing access to diagnosis of HIV children using the method of “dry drop”;
- ensuring uninterrupted supply at the expense of local budgets of rapid tests (for maternity), infant formula, and materials for delivery and cesarean section;
- ensuring functioning of the system to redirect pregnant women among risk groups to AIDS service for VCT, medical care and social support by joint efforts of social services and HIV-service NGOs;
- increasing and improving the knowledge of health workers on PMTCT;
- creating an effective strategy of educational programmes among general population and high-risk groups;
- improving obstetric practices based on the principles of kindness to mother and child - the elimination of stigma and discrimination.

14. UKRAINE

Title of programme: Reaching drug-using pregnant women with integrated PMTCT and addiction care services in Ukraine
Contact person: Nina Ferencic
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Implemented by: Government, Civil Society, UN or other inter-governmental organization
Areas of focus of the programme: Policy and legal environment; the role of the community of people who inject drugs in service delivery
Programme is being implemented since: 2011-2014
Has the programme been evaluated/ assessed? Yes
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? Yes

Background:
Women who use drugs often face a dual challenge: They are more vulnerable to both sexually and injection-transmitted HIV infection than male drug users, and they encounter greater obstacles to accessing the services they need.

In Ukraine a number of issues are influencing drug using women’s vulnerability to HIV and access to services. The capacity of antenatal and maternity clinics to provide adequate care and support services to drug-using pregnant women has been limited.
Despite the success of PMTCT programmes and the substantial reduction in the number of new HIV infections among children in Ukraine, there are still important challenges remaining in relation to the poor access and late entry into antenatal care services among pregnant women using drugs. This represents a challenge not only for their own health but also in relation to the rights of their children to be born HIV free.
In Ukraine 2011 national data indicated injecting drug use was the key route of HIV infection among 19.1% of the HIV-positive reproductive-age women. 3.5% of all pregnant HIV+ women reported active drug use during the latest pregnancy (a substantial underestimate due to the high stigma of admitting drug use, especially in pregnancy) (Martsynovskaya, 2012). Only 7.3% (29 of 395) of HIV+ pregnant women who used drugs received opioid

substitution maintenance therapy and the majority of them continued using street drugs during pregnancy.
Injection of drugs during pregnancy is associated with increased risk of advanced HIV disease, premature deliveries and a high risk of mother-to-child HIV transmission. HIV positive pregnant women using drugs often have poor access to PMTCT services. Pregnant drug-using women frequently missed prenatal care and those who presented to services often presented late, only in the third trimester of pregnancy or even as late as during labour and delivery. Access to obstetricians and gynaecologists who are familiar with the issues of drug use during pregnancy was practically non-existent, and many women reported judgmental or stigmatizing attitudes by providers, as well as prohibitive fees.
Women who use drugs are 3.5 times more likely to be diagnosed with HIV in labour than other women (Thorne, 2012). Moreover, relatively few HIV+ pregnant women who injected drugs received ARV prophylaxis (65% compared with 94.5% overall).
Although Ukraine has been committed to achieving the goals of elimination of mother-to-child transmission of HIV, it is clear that those goals will not be achieved if the needs of drug using pregnant women and their children are not adequately addressed.

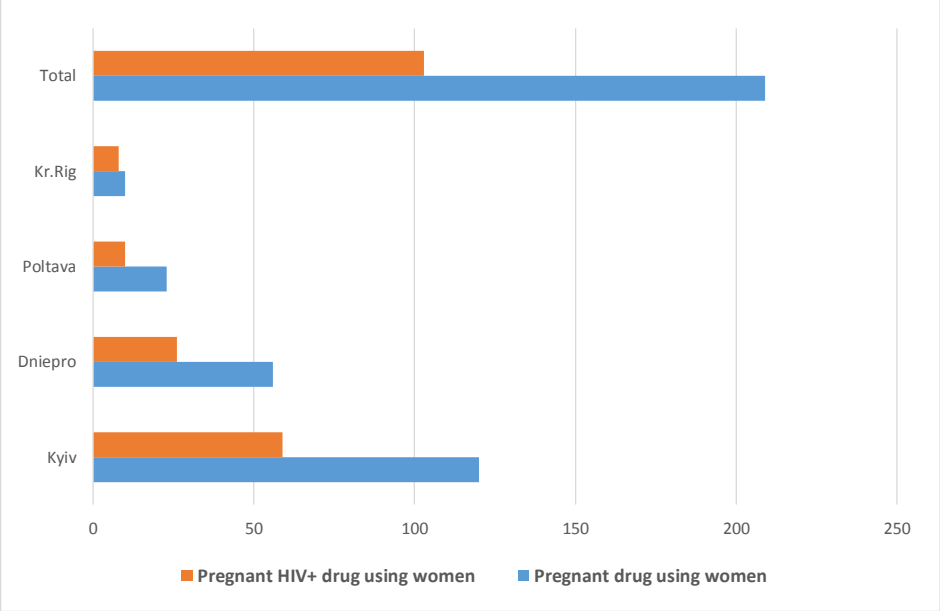
Approach:
Interventions for prevention of MTCT among pregnant women using drugs in Ukraine were based on the following principles and priority actions:

- Integration of services for drug using pregnant women into MCH services with the objective to improve pregnancy outcomes, prevent HIV infection among infants and improve health and wellbeing of mothers;
- Setting up functional linkages between MCH, HIV services and addiction services to prevent MTCT among pregnant drug using women and contribute towards elimination of MTCT in the country.

Strengthening cooperation between government and civil society organizations, particularly those that have been working on prevention and support to drug using populations in order to help build trust and demand for services.

Reach of the intervention:
Interventions have focused on scaling up access to PMTCT, HIV and addiction management services for pregnant women using drugs.
Timeframe: March 2011 – November 2014
Geographic coverage: selected provinces in Ukraine (Dnipropetrovsk, Poltava, Kyiv City and Kriviy Rig)
Direct beneficiaries: 209 drug-dependent (49% were HIV-positive) pregnant women and their infants (Figure 1).
Service providers: 120 healthcare and social workers from governmental and non-governmental facilities.

Figure 1. Project direct beneficiaries



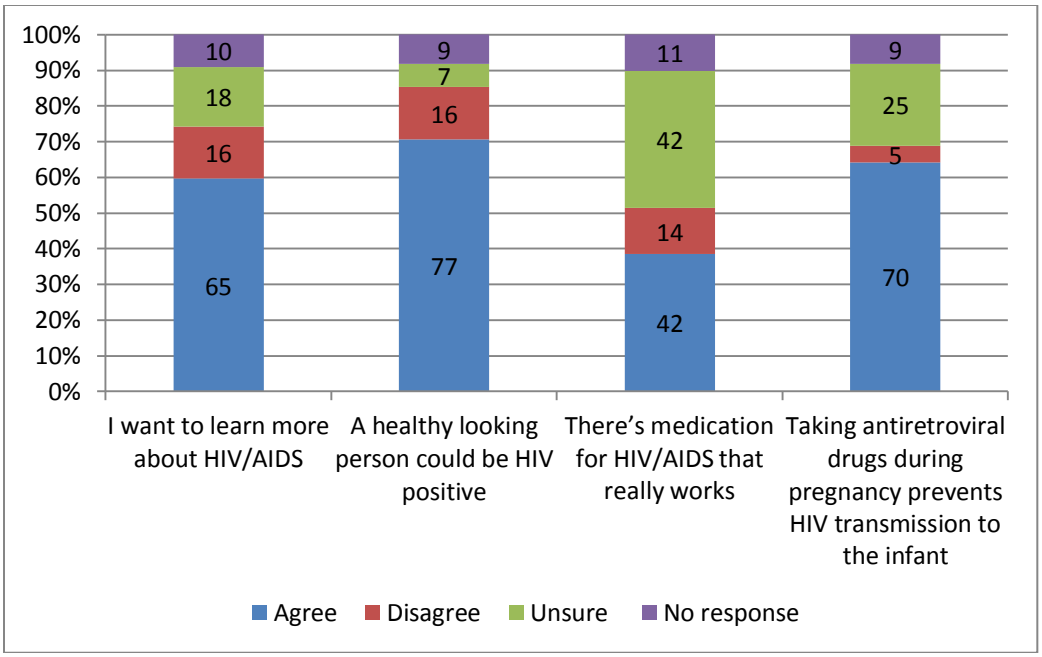
mpact of the intervention:

HIV Prevention Outcomes:

Primary prevention of HIV infection among reproductive age and pregnant women using drugs:

- 50% of women currently pregnant and 40% of postpartum women had accessed harm reduction services during pregnancy
- 43% of postpartum women used condoms
- 50% of pregnant women used condoms

Figure 2 Knowledge and attitude of drug using women towards HIV/AIDS and PMTCT



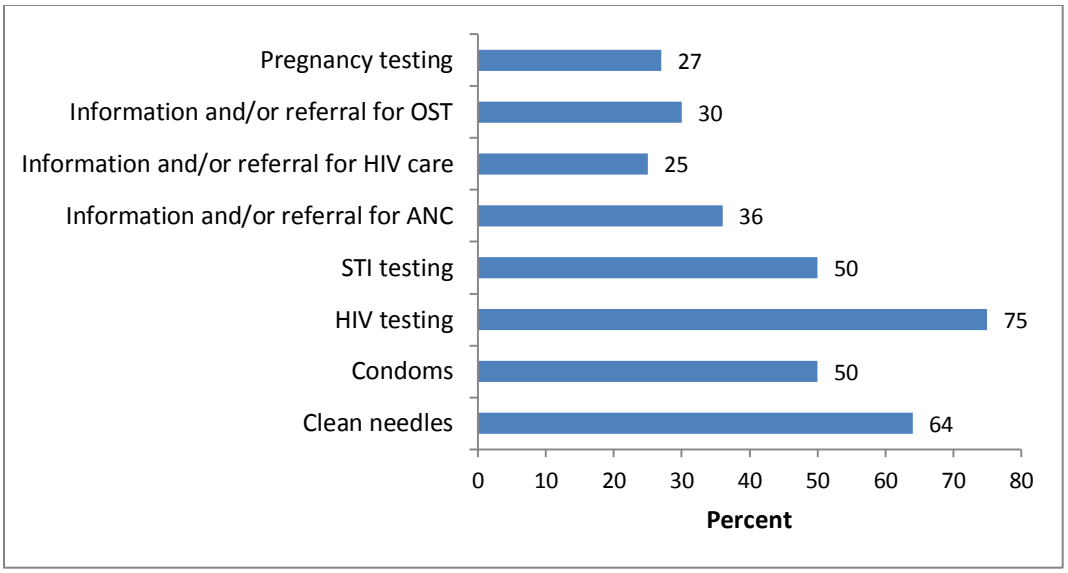
Prevention of unintended pregnancies among drug using women:

- 42% of women had received FP counselling in the maternity, of whom 32% received a free supply of contraceptives
- 13% used oral contraceptives and IUD

Improved access to ob/gyn services (Figure 3):

- 44% of women had been seen by a gynecologist in the past 12 months (excluding ANC)
- 75% of IDU women received HIV testing during pregnancy or delivery

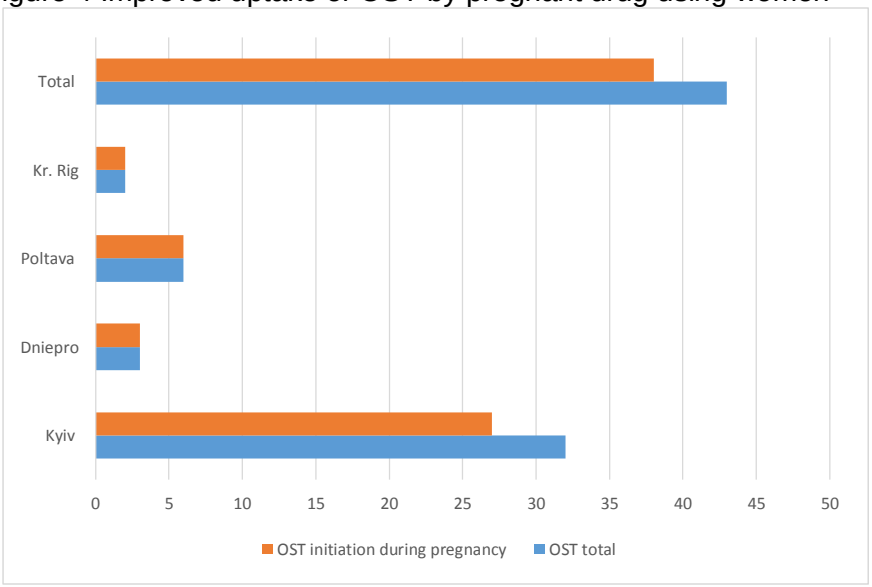
Figure 3. Service coverage for pregnant women using drugs



Impact of the programme: **NOT A SINGLE** case of HIV mother-to-child transmission was identified during the project. Among 79 children born to HIV positive pregnant drug using women all received EID with DNA PCR at 1 month. All women chose to formula feed their children.

Treatment, care and support services: Healthcare workers gained skills and knowledge on the management of drug dependent pregnant women and their infants. This led to significant improvement of uptake of opioid substitution treatment (OST) among drug using pregnant women (Figure 4) as well as to significant improvements in attitudes towards drug using pregnant women.

Figure 4 Improved uptake of OST by pregnant drug using women



The positive enabling environment created in healthcare settings promoted cooperation between staff members and pregnant women using drugs. The impact was measured using focus group interviews and ACASI surveys among direct beneficiaries of the project and healthcare workers (Figure 5).

Figure 5. Women opinion about ANC staff attitude towards pregnant drug using women

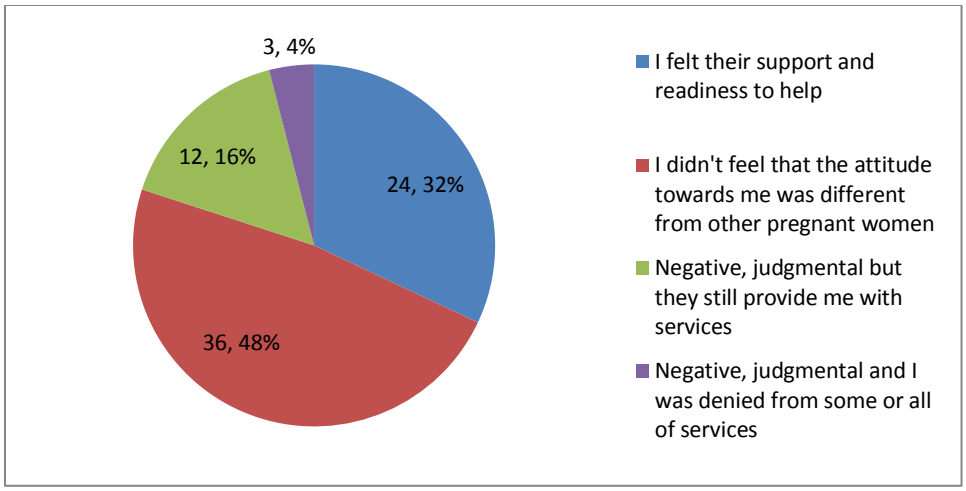
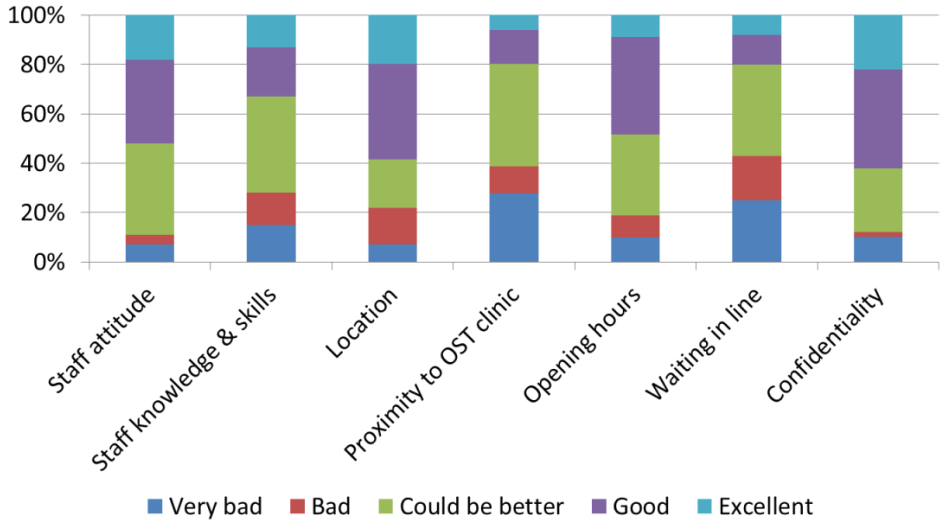


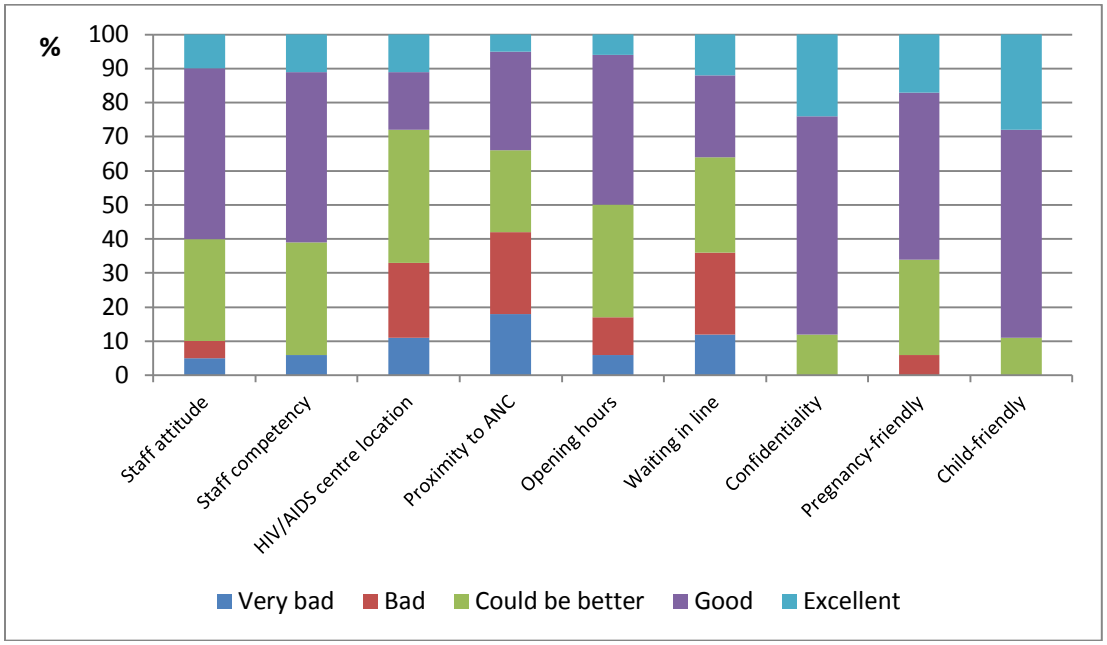
Figure 6 Women's scores for ANC clinic with respect to women who use drugs



"We become close with our patients and built trust towards each other and we now we see them as if they were our daughters." (The Head of maternity in Dnipropetrovsk)
"I like very much the attitudes of the medical staff at this clinic. They are kind and supportive, and they treat us with respect. That makes it very special, much better than anything we could get at any other place" (Natalia from Dnipropetrovsk)

HIV positive women high scored HIV-services provided during pregnancy and postpartum and infant follow up (Figure 7)

Figure 7 Women opinion about quality of HIV services during recent pregnancy and postpartum



Financing and management:
Financial support for this programme was secured within the UNICEF Country Programme for Ukraine, with the special contribution from the Austrian Government. This enabled UNICEF to support Ukraine Ministry of Health in developing and implementing a programme to protect vulnerable women and their children infected/affected by HIV/AIDS.

Strong UNICEF advocacy, technical support and evidence generated through assessments of project sites along with strong partnerships built with key stakeholders, - resulted in Government's recognition of the models of care developed through the programme. The National AIDS Plan 2014 – 2018 and strategy for the elimination of HIV mother-to-child-transmission incorporated the lessons learnt from the programme and plan for National scale up of interventions for pregnant women using drugs.

Partnerships:

- national and local health authorities (Ministry of Health, State AIDS Service, Ukrainian Centre for Disease Control, Ministry of Social Policy)
- civil society partners, specially the key project implementing partner the William J. Clinton Foundation in Ukraine (WJC Foundation), national and international research institutions; national NGOs (All Ukrainian Network of PLWH, International AIDS Alliance in Ukraine and other HIV-services and harm reduction NGOs at project sites) and Eurasian Harm Reduction Network and Coalition of HIV-services organizations in Ukraine, Open Society Foundation
- UN agencies supporting implementation of the pilot project within the UN Joint Programme of Support on HIV/AIDS to the Government of Ukraine for 2012-2016.

Lessons learned and recommendations:

- The project helped bridge the health care and social systems in order to improve the continuity of care and outcomes for HIV positive drug using pregnant women and their children.
- The Project contributed to improvements in access to care and treatment for drug using women using a multidisciplinary team approach
- The project had an impact on staff attitudes and tackling stigma among service providers, and resulted in a recognition by medical personnel that "one-stop shop" approach best serves the needs of pregnant women using drugs
- This project generated important learning and "buy-in" among Ministry of Health and has a potential to reshape Ukrainian health and social sectors towards better provision of services for people using drugs.
- A number of barriers have to be overcome for scaling up of the project, including the ongoing economic crisis and delays in implementation of reforms in health and social sectors, insufficient funding, staffing shortages, policy issues and poor coordination between different sectors.

Experiences of the project have been shared within the CEECIS region. The project results and lessons were presented at the International Harm Reduction Conference in Vilnius on 11th of June 2013 in Lithuania.

IV. Latin America and the Caribbean

1. DOMINICAN REPUBLIC

Title of programme: Building Dominican Republic's capacity to promote HIV/STD/TB prevention and reducing risk among drug users, also know as Proyecto ActitUD
Contact person: Francis Taylor
Title: National AIDS Coordinator
Organization: Centro De Orientación e Investigación Integral (COIN)
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Tel: 809-685-0824 / 809-681-1515 / 1-829-341-4418
Implemented by: Civil Society
Areas of focus of the programme: Policy and legal environment; the role of the community of people who inject drugs in service delivery
Programme is being implemented since: 2012
Has the programme been evaluated/ assessed? No
Is the programme part of the implementation of the national AIDS strategy? No
Is the programme part of the implementation of the national programme on drugs? No

Background:

This intervention was developed amidst a reality characterized by restrictive judicial and political framework of zero tolerance. The current Law of Drugs 50-88 penalizes the possession of drugs, distribution of drug paraphernalia, methadone and buprenorphine, and categorizes as trafficking the possession of any amount of heroin. This creates barriers for the development of harm reduction strategies, limits access to treatment for people who inject drugs and criminalizes drug users, in particular those who use injectable drugs. On the other hand, we have to contend with a forced migration from the United States of individuals who have broken United States' laws and once they complete their sentences are deported to the Dominican Republic. Upon arriving in the island, they are registered with the Justice Department and the

National Police, which creates a record that limits their access to jobs and education, prevents them from exercising their full rights and makes victims of stigma and discrimination.
Many arriving deportees already present problematic use of injectable drugs while others either initiative their use and begin using again when they arrive in the Dominican Republic in part due to the lack of social/institutional supports, opportunities, the stigma and discrimination they face as deportees with a criminal record and the lack of access to programmes targeting deportees and/or people who inject drugs.

The effects of these dire conditions are evident in the prevalence of HIV among this population with an 8% compared to the 0.8% among the general population, and they are responsible for 21% of new infections. Despite the high prevalence of HIV among this population, the Dominican government does not recognize drug use as a public health problem and limits its approach to drug use to repression and persecution. This punitive approach makes people who use drugs vulnerable to persecution, police violence, extortion and social exclusion.

Approach:
This intervention is HIV specific, directed at mitigating the HIV epidemic among the population of drug users. In its development, strategic alliances were created with the government through the Department of Public Health, the National Council on Drugs, General Directorate of Control Sexually Transmitted Diseases and AIDS, and civil society organizations dedicated to the treatment of drug use, prevention of substances use and empowerment of drug using community. These alliances allowed the articulation of a wide support network at different levels for people who use drugs.

Reach of the intervention:
This intervention was carried out in Santo Domingo, Santiago, Higuey, and Barahona, four regions of the country with the highest exposure according to the First Survey of Serological Behavior Surveillance, 2008 (ONUSIDA-COPRESIDA). It is based on a prevention, HIV services, and advocacy approach from a perspective of Human Rights, harm reduction, and the transformation of public policies that benefit people who use drugs. It is targeted to people who use drugs, health workers, justice personnel, education personnel, and people who are decision makers in issues related to drug and HIV policies.

Impact of the intervention:
At the Macro level, this intervention has been achieved interconnection among civil society, government, and international agencies (UN, Collaborators, Funders) at two levels. First, at the advocacy and development of public policies level and second, at the level of provision of services for this population.

At the first level, it created the “Mesa de Usuarios de Drogas” (roundtable of drug users) as a space of conciliation for political advocacy with representation of government organisms implicated in the Health, AIDS and Drugs, cooperating agencies and international founders (United Nations, CDC, USAID, etc), and organizations from civil society that coordinated services in the areas of Drugs and HIV. This roundtable has served to promote actions to transform the legal framework (revising the Law of Drugs, creating a proposal to transform the Law of drugs towards a focus on Health and Human Rights), to provide support for the development of the first Harm Reduction interventions in the country (Syringe exchange and clean paraphernalia, education for drug users about how to reduce risk behaviors), to promote the inclusion of people who use drug in the national health programs and to develop strategies to reduce stigma and discrimination towards people who use drugs.

At the second level (service provision goals for this population), collaboration agreements were developed between the implementing organization (COIN), the Ministry of Public Health, the National Council on Drugs (CND), The General Directory of Control of Sexually Transmitted Diseases and AIDS (DIGECITSS), National Council of HIV and AIDS, UNODC, UNAIDS, "Hogares CREA" y "Fundacion Volver". The objective was to create a network of comprehensive services that could address the diverse health problems of people who use drugs. This allowed the creation of a Center of Comprehensive Services for Drug Dependence (CAID) which is the first center of services for the treatment of drug dependence in the Ministry of Health. It also helped strengthen the Dominican Harm Reduction Foundation (FUNDOREDA), an organization formed by drug users to develop HIV initiatives and advocate in favor of people who use drugs. We were able to provide professional development to health workers at centers for the treatment of drug dependence, primary care units and regional hospitals in strategies for provision services to people who use drugs and people living with HIV. It permitted the creation of a network for referral to HIV friendly services. It also provide support for the implementation of the first pilot project for Medication Assisted Treatment with Buprenorphine for injecting drug users by CIAD, MSP, COIN, CND, DIGECITSS.

At the micro level, it has been able to reach 7, 235 of people with a package of services that includes,

- Outreach services
- HIV, Sifilis, and Hep-C testing with pre and post counseling.
- Harm reduction education
- Case management
- Health services referrals
- Syringe Exchange and clean injection equipment

Financing and management:
This intervention was possible through a **CDC-RFA-GH11-1172** grant: Building the Capacity of the Dominican Republic to Promote HIV/STD/TB Prevention and Harm Reduction among Drug Users under the PEPFAR Plan funded by the Center for Disease Control in the amount of $300,000 a year for a total of 3 years. The project is implemented along with CDC, "Fundacion Volver", and Pangaea Global AIDS Foundation.

Lessoned learned and recommendations:
A fundamental factor in the success of this intervention were the statistics obtained through the First Survey of Serological Behavior Surveillance, 2008 (UNAIDS-COPRESIDA). This survey evidence the delicate situation and vulnerability of this population with respects to HIV, AIDS and other health conditions that helped bring attention to the situation. In addition, the creation of the Roundtable of Drug Users was an important platform from which to promote initiations geared towards prevention and harm reduction, and to advocate the adoption of this focus among political decision makers at the government level. It has also allowed us to begin a process of analysis of national drug policies and a window of opportunity for revising some of them. The inter-agency and institutional agreement signed with sectors of the government in charge of addressing public health responses made viable the development of a sensitizing and professional development of about the service provision for this population, in addition to guaranteeing the sustainability of these actions by having a health personnel adequately trained to provide quality services with empathy when project reaches its conclusion. It is worth noting that this process provided the base for the creation of network of specialized services for drug users. The close collaboration and work towards strengthening the first network of drug users (FUNDOREDA) allowed the community empowerment of target population and strengthen the

debate through social mobilizing that ensued and that guarantees the presence of people who use drugs themselves, previously made invisible, in the sociopolitical processes responsible for the creation of strategic plans for health, drugs and HIV and/r the creation of national policies relevant to this topics.

We recommend:

- To continue strengthening inter-institutional spaces and agreements created by:
  - Roundtable of Drug Users
  - Dominican Harm Reduction Foundation (FUNDOREDA)
  - Collaborative agreements with governmental organisms
- Support and provide follow up to the process of revising the Law of Drugs 50-88 and promote the changes need to provide an adequate response to health and human right issues involved.
- Increase professional development for the health and justice sector.
- Expand the network of referrals with new providers who are adequately trained.
- Promote the implementation of Medication Assisted Treatment for people who inject drugs
- Implement health policies that support interventions based on harm reduction such as syringe exchange and providing clean injection equipment
- Work towards eliminating stigma and discrimination towards people who are deported
- Create mechanism for social inclusion and access to services for people who are deported
- Support the social mobilization of people who use drugs
- Eliminate zero tolerance policies and legislation that criminalizes personal consumption of drugs or that do not approach the issue from a public health and human right perspective

2. PUERTO RICO

Title of programme: "Syringe Exchange Programme" and "Descriminalizacion.org" (Drug Policy Reform Programme)
Contact person: Rafael A. Torruella, Ph.D**.**
Title: Executive Director
Organization: Intercambios Puerto Rico
Address: Calle Round F-26, Fijardo, PR 00738
Tel: 787 678 9008
Email: r.tourruella@housingworks.org
Implemented by: Civil Society
Areas of focus of the programme: Policy and legal environment; the role of the community of people who inject drugs in service delivery
Programme is being implemented since: 2009

Background:

The lack of a coherent drug policy in Puerto Rico has had dire consequences for its civilian population particularly in terms of public health, HIV transmission rates and violence. Puerto

Rico suffers an alarming HIV transmission rate (45.0 per 100,000).[29] Unlike in any jurisdiction in the U.S., HIV transmission in Puerto Rico is fuelled by injection drug use. More than 50% of those living with HIV in Puerto Rico acquired the virus through injection drug use. In 2011, the rate of diagnosis of HIV infection was 28.6 per 100,000 and for people living with HIV (stage 3) was 15.7 per 100,000 for Puerto Rico.[30] In 2011, people who inject drugs represented 25.81% of the total of people diagnosed with HIV between 2005-2011.[31] At least 7,102 people who inject drugs were living with HIV as of December 31, 2011.[32] In 2011, Puerto Rico had an incarceration rate of 311 per 100,000,[33] and a June 2012 report from the Puerto Rico Department of Corrections and Rehabilitation revealed that an alarming 87.71% of Puerto Rico's prisoners were sentenced in cases related to drug use. Nearly half of these prisoners were first-time offenders, and over three-quarters were considered drug users. Moreover, during the last 20 years of the failed 'war on drugs', Puerto Rico has experienced over 15,000 homicides. In 2010, the Puerto Rico Police Department estimated that 60% of all murders were drug-related and in 2011 the United Nations Office on Drugs and Crime reported that Puerto Rico's intentional homicide rate was a staggering 26.6 per 100,000[34], greater than that of war-torn Mexico (23.7 per 100,000) and over five times that of the 50 United States (4.8 per 100,000). Despite the need for services, the Puerto Rican government severely underperforms in terms of drug treatment service provision. A 2009 home survey report by Puerto Rico's Mental Health and Addiction Services Administration, revealed that only 8.5% of individuals meeting drug abuse criteria (not including alcohol) and 24.2% of individuals meeting drug dependence criteria (not including alcohol) accessed specialized services.[35] A lack of treatment alternatives and harm reduction services in the island has contributed to the phenomenon of "turfing" for treatment-seeking injecting drug users. Instead of increasing drug treatment provision and harm reduction services or forming better linkage agreements with existing service providers, local elected officials often choose to send treatment seekers to the continental U.S., many times under false pretences.[36]

Approach:

The SEP programme is a proven HIV specific, sensitive, and relevant intervention to reduce transmission of HIV and increase linkage to care for HIV positive individuals. The Drug Policy Reform Programme, Descriminalizacion.org, is an HIV-relevant and HIV-sensitive intervention, given that repressive drug policies contribute to the stigmatization of people who use drugs,

[29] Centers for Disease Control and Prevention, "Incidence and Diagnoses of HIV Infection – Puerto Rico, 2006", *Morbidity and Mortality Weekly Report 58,* no. 21 (2009): 589-581.
[30] Centers for Disease Control and Prevention. *HIV Surveillance Report, 2011*; vol. 23. http://www.cdc.gov/hiv/topics/surveillance/resources/reports/. Published February 2013. Accessed September 23, 2014.
[31] Departamento de Salud. *Perfil Epidemiológico Integrado para la Prevención del VIH en Puerto Rico, 2005-2011.* (Puerto Rico: Sistema de Vigilancia de VIH/SIDA, Departamento de Salud de Puerto Rico, 2011, p.40).
[32] Departamento de Salud. *Perfil Epidemiológico Integrado para la Prevención del VIH en Puerto Rico, 2005-2011.* (Puerto Rico: Sistema de Vigilancia de VIH/SIDA, Departamento de Salud de Puerto Rico, 2011, p.40).
[33] Roy Walmsley, *World Prison Population List,* 10th ed. (London: International Centre for Prison Studies, 2013), http://www.prisonstudies.org/sites/prisonstudies.org/files/resources/downloads/wppl_10.pdf
[34] United Nations Office on Drugs and Crime (UNODC), *Global Study on Homicide* (Vienna: UNODC, 2011, http://www.unodc.org/unodc/en/data-and-analysis/homicide.html.
[35] Administración de Servicios de Salud Mental y Contra la Adicción (ASSMCA), *Trastornos de Substancias y Uso de Servicios en Puerto Rico* (Puerto Rico: ASSMCA, 2009).
[36] Rafael A. Torruella, "¿Allá en Nueva York Todo es Mejor?: A Qualitative Study on the Relocation of Drug Users from Puerto Rico to the United States" (dissertation, City University of New York – The Graduate Center, 2010), http://www.academia.edu/306628/_Alla_En_Nueva_York_Todo_Es_Mejor_A_Qualitative_Study_On_The_Relocation_Of_Drug_Users_From_Puerto_Rico_to_the_United_States

stimulates HIV risk behaviours, and inhibits opportunities for adequately funding harm reduction HIV interventions and other evidence-based services.[37]

Reach of the intervention:
"Intercambios Puerto Rico" focuses on reducing the harm of drug use and the transmission of HIV and Hepatitis C in Puerto Rico from two angles: 1) provision of HIV prevention/harm reduction services and 2) drug policy reform. Our syringe exchange programme (SEP) provides sterile syringes, clean injection equipment, condoms, harm reduction/HIV and Hepatitis C counselling and education, referrals to detoxification, drug treatment, and medical services to over 635 injecting drug users (mostly males 25-40 years old) in 15 communities across 5 municipalities (Canovanas, Fajardo, Loiza, Luquillo and Naguabo) in the eastern region of the island. Intercambios draws on its experience providing direct services to inform its drug policy change programme "Descriminalizacion.org". As the leading national drug decriminalization campaign in Puerto Rico, this technology-enabled campaign seeks proven alternatives to the criminalization of drugs and drug users in Puerto Rico. It currently has a growing social media reach of over 60,000 and over 29,000 Facebook followers. Understanding that the "War on Drugs" has failed[38] and that it negatively affects our island and fuels the HIV epidemic, we seek to stimulate research based-dialogue, critical analysis, and activism on issues related to drug use, abuse and dependence.

Impact of the intervention:
Our SEP is the largest volume SEP in Puerto Rico distributing over 140,000 syringes in a given year and reaching a syringe exchange rate of up to 94% which helps reduce the transmission of HIV virus and Hepatitis C by reducing risk behaviors such as sharing needles and promoting safe practices and access to condoms, clean syringes and other injection equipment. The SEP employs an outreach worker (staff) and two trained harm reduction peer educators, who are former/current drug users to conduct syringe exchange and condom transactions, collect participant and provision data, provide counselling about HIV prevention, safe-injection techniques, proper vein care, overdose prevention, and active referrals to participants. It utilizes two delivery methods a "regular peer delivery system" where peers do outreach along with an outreach worker and a recently implemented "on their own peer delivery" where the peer educator is not accompanied by the outreach worker (staff). Comparison data was collected from January-May 2014. The "on their own peer delivery" model consistently achieved a higher exchange rate throughout the five month period when compared to the regular peer delivery approach (an average of 92% "on their own model" vs. an average of 81% for the regular model). In one particular month the "on their own model" actually recorded a 128.72% exchange rate without changing the limits of syringes a participant can receive. "On their own", peers were able to exchange syringes and provide HIV and Hep C prevention services in more intimate and marginalized spaces than as part of the SEP route.

Our "Descriminalizacion.org" programme has been successful in promoting a discussion in Puerto Rico about alternative drug policy models and creating public awareness about the negative consequences of the "Drug on Wars" which has driven the unprecedented massive

[37] Global Commission on Drug Policy, *The Negative Impact of the War on Drugs on Public Health: The Hidden Hepatitis C Epidemic* (Brasil: Global Commission on Drug Policy, May 2013)

[38] Global Commission on Drug Policy, *Taking Control: Pathways to Drug Policies That Work* (Brasil: Global Comission on Drug Policy, September 2014)
http://static.squarespace.com/static/53ecb452e4b02047c0779e59/t/540da6ebe4b068678cd46df9/1410180843424/global_commission_EN.pdf

incarceration of drug users and increased the social drivers of HIV transmission among injecting drug users by alienating, criminalizing their behaviours and preventing them from accessing clean injection equipment and adequate care. This technology based social media campaign achieved 17,165 Facebook followers during its first year, 2013 and in the first 9 months of the current year, 2014, it has increased to over 29,000 Facebook followers. In the last year and half, Intercambios Puerto Rico has presented its position about decriminalization of all drugs and drug users in over 20 radio interviews, at least 10 TV shows, over 30 news articles (printed and online) and has been invited to over 15 panel presentations in academic forums on the issue which have been covered by local and international news media. It participated in drafting a joint resolution of government institutions, professional health associations and community-based organizations supporting drug policy reform efforts in Puerto Rico. It also created the first national essay competition for university students “Decriminalize your mind” seeking to promote critical thinking and innovative drug policy alternatives among young university students. Intercambios Puerto Rico is also a member of the International Drug Policy Consortium (IDPC) and the Latin American Network of People who Use Drugs (LANPUD).

Financing and management:
Intercambios Puerto Rico has been able to make a large impact with a small budget (less than $180,000) by keeping operating costs low and maintaining a dedicated team of volunteers. Intercambios Puerto Rico became a Housing Works Inc. affiliate in 2011 and these achievements can be attributed in part to Housing Works’s commitment to Intercambios’ financial and organizational success. It also receives partial funding by private institutions including AIDS United through the Syringe Access Fund for its SEP and Open Society Foundations through the Global Drug Policy Programme for its “Descriminalizacion.org” program. The organization does not receive any federal or local government funds. A ban on syringe exchange programmes is in effect at the federal level (U.S.A.), and local funds for harm reduction efforts are virtually non-existent. Despite public knowledge that HIV incidence on the island is fuelled by sharing contaminated syringes, the government of Puerto Rico has not allocated new funding for syringe exchange efforts in the last four years, and Puerto *Rico’s* Department of Health does not anticipate having available funding for the next few years. Only three of the six SEPs in Puerto Rico receive funding from the local Department of Health.

Lessons learnt and recommendations:

- Intercambios Puerto Rico founded the Puerto Rican Harm Reduction Coalition in 2012 that brings together the existing six syringe exchange programmes on the island to coordinate harm reduction/HIV prevention policies and strategies in order to facilitate advocacy and collaboration. The Coalicion Puertoriqueña de Reducción de Daños (CoPuReDa-Puerto Rican Harm Reduction Coalition) is working to develop a united front and advocate for harm reduction measures as a public health response that the local government should support in order to deal with the HIV crisis and to provide services targeted to injecting drug users.

- The utilization of various methods of peer delivery SEP services allows greater penetration of evidence-based HIV and HEP-C prevention into the networks of people who inject drugs (PWID). Peer educators have greater access to assess and observe risks behaviours PWID engage in and have greater knowledge about how to improve SEP programmes and better tailor HIV and HEP-C prevention messages for drug users.

- Incorporating lessons learned and insights gained from the provision of services to PWID and input from peer educators and drug users themselves into our advocacy and drug policy

change efforts has been essential to formulating a solid campaign that resonates with both drug users and non-users.

- Conducting a benchmarking process allowed us to craft and define the scope and goals of the drug policy change campaign and distinguish it from others. Social media like Facebook and Twitter created more visibility and exposure for the campaign than the campaign's website. Paralleling social media with a likeable, knowledgeable spokesperson with academic credentials allowed us to push the claims of evidence-based approaches within regular media and academic circles and provide a fresh, new, alternative voice that could rally the claims of a public health approach.

V. NORTH AMERICA

1. UNITED STATES

Title of programme: New York State Department of Health AIDS Institute: Comprehensive Harm Reduction Programmes
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Title: Director, Bureau of Special Populations
Organization: New York State Department of Health AIDS Institute
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Implemented by: Government, Civil Society
Areas of focus of the programme: Policy and legal environment; the role of the community of people who inject drugs in service delivery
Programme is being implemented since: 1992
Has the programme been evaluated/ assessed? No
Is the programme part of the implementation of the national AIDS strategy? No
Is the programme part of the implementation of the national programme on drugs? No

Background:

In 1992, 54% of all AIDS cases in New York State (NYS) were in people who inject drugs. To respond to this, the NYS Department of Health (NYSDOH) AIDS Institute took actions to promulgate emergency regulations which allowed individuals to possess syringes without a prescription as a measure to address the HIV epidemic in people who inject drugs (PWID). With the passage of Section 3383 of the Public Health Law, 80.135 the NYS Rules and Regulations, five community based syringe exchange programmes emerged from underground operations into State funded entities.
To become an authorized syringe exchange programme (SEP) an agency was required to submit an application to provide syringe exchange services using a comprehensive harm reduction approach. To be approved, the organization needed to illustrate how syringe exchange would be integrated into a programme which included outreach, sexual and substance use risk reduction education, counselling, condom distribution and demonstration, referrals for medical, mental health and substance use treatment.

Approach:

Syringe Exchange Programmes (SEP) were created to directly address the HIV epidemic people who inject drugs, their sexual partners and children. Community based

organizations, Article 28 healthcare facilities and local health departments are the entities that are eligible to apply to become a syringe exchange programme. Community level support is a required element of opening a SEP. NYSDOH/AIDS Institute convenes meetings with community based organizations, communities of PWID, community/town boards, law enforcement entities (town, city; and county police departments, sheriffs, district attorneys, defence attorneys, judges) to educate about the need for SEP and create appropriate models of service delivery.

To be accessible to PWID, the SEPs are designed to be low threshold programmes; no names or addresses are required or collected for enrolment. Instead, programmes create participant specific unique identifiers and provide clients with NYS issued SEP identification cards.

Various models of SEP were developed based on the needs of the PWID in communities. The models include storefront office sites, mobile van, street side, "walkabout", single room occupancy hotel SEPs, Special Arrangements and Peer Delivered Syringe Exchange (PDSE). The relative importance of each model type varies according to geo-spatial, political, and social considerations.

Agencies use one or multiple models depending on community support or concerns about SEP. The storefront model is conducted at a fixed agency location. This model allows agencies to offer a wide array of ancillary services including HIV/HCV testing, case management, mental health, meals, ear-point acupuncture, behavioural interventions and drop-in center activities including showers, computer access, and support groups. Mobile van and/or street side SEP bring services to locations where PWID are known to frequent and congregate. The mobile vans operate at an approved location for specific days and hours. Mobile vans are configured to have a private enclosed space where counselling and/or HIV/HCV testing can be offered. "Walkabout" SEP gives SEP staff the opportunity to bring services to even more disenfranchised PWID subpopulations that would otherwise not access SEP services or new, sterile syringes. With "walkabout" SEP, staff cover a specific route at preapproved times and days and conduct SEP with PWID who may be homeless and living in encampments under bridges, in parks or abandoned buildings. Single Room Occupancy (SRO) hotels SEP is conducted in SRO hotels where homeless HIV+ clients are temporarily housed. By providing new, sterile syringes to this population, the individuals are able to establish a connection to SEP that may continue after housing placement. Also, these HIV+ individuals are provided with a sufficient amount of syringes so that they do not have to share with friends or family members who may not be HIV infected. Special Arrangements SEP was created for agencies that cover a large geographic area where distance and lack of public transportation act as barriers to service acquisition. PDSE (described under Reach of Intervention).

Core SEP programme services include syringe exchange, HIV prevention education, risk reduction information, condom and bleach kit distribution, and referrals to medical care, substance use treatment and supportive services. Additional services are provided dependent on funding. This includes: HIV counselling and testing; Hepatitis A, B, and C screening, testing and referral; Hepatitis A, B vaccine; mental health; nutrition/food; housing placement; buprenorphine induction, on site medical and psychiatric care; escort to appointments; and HIV treatment adherence counselling, support groups and other supportive services.

NYSDOH/AIDS Institute has also worked with various police departments to develop Operations Orders or Legal Bulletins to instruct their officers on what to do when they encounter a person who inject drugs with a SEP identification card and syringes. This element of our work has proven essential to increasing the use of SEPs in several cities.

Reach of the intervention:
Currently there are 23 programmes with 53 sites located throughout NYS. There is a SEP in each region of NYS. Although all major cities in upstate NY have a syringe exchange programme, it was recognized that there are communities that will not support the development and placement of SEP services in their area. Also, some locations are very isolated therefore it may not be economically feasible to establish and maintain a syringe exchange programme in the area. To address this, in 2000 NYS legislature passed the Expanded Syringe Access Programme (ESAP) which authorized enrolled pharmacies, hospitals and other health care facilities, and licensed physicians, nurse practitioners and physician assistants to furnish syringes to injection drug users without a prescription. The majority of ESAP providers are pharmacies, so the furnishing of syringes is a commercial transaction, at no cost to NYS. All major chain pharmacies have enrolled in the programme, bringing the availability of new, sterile syringes to every county in NYS except for one that is mostly parkland and does not have a pharmacy.

In 2007, the NYSDOH/AIDS Institute created a new model of syringe exchange, Peer Delivered Syringe Exchange (PDSE), to reach disenfranchised, people who inject drugs who do not access new, sterile syringes through SEP or ESAP. Agencies approved to offer PDSE, identify, hire, train and "deputize" programme peers (active users or individuals in recovery) to conduct syringe exchange in their social networks. PDSE clients receive all of the benefits of SEP interactions - a SEP identification card, safer sex and injection practices education and harm reduction supplies - where they are located. The goal is to provide PDSE services until the person who inject drugs feels capable and interested in visiting a SEP for additional service provision. For rural areas of the state, PDSE transactions frequently outnumber regular SEP.

Since 1992, the SEPs have enrolled 177,800 clients. Client demographics show that 41% are Latino/a, 31% are Caucasian, 25% are African American, and 3% are mixed race/ethnicity. Regarding age: <1% are < 20 years of age; 4% are 20-29 years of age; 14% are 30-39 years of age; 23% are 40-49 years of age and 58% are 49+ years of age. The majority of clients (74%) are males; 25 % are females and 1% transgender. SEPs are mandated to offer referrals for supportive services but participants are not required to accept them. Of the 330,535 referrals that were accepted by programme participants, 20% were for substance use treatment; 30% for medical services; 18% for food and the remaining 32% are for supportive services

Impact of the intervention:
New York State has supported SEPs since 1992 and the ESAP since 2000. HIV seroprevalence among people who inject drugs in NYS has fallen from 54% in the early 1990's to less than 4% based on data as of December 2012. Injection related HIV transmission continues to decline in NYS. In fact, PWID (excluding MSM/PWID) comprised just 3.3% of new HIV diagnoses in 2012 (5.1% including MSM/PWID), down from 18 .1% in 2000. PWID comprise a higher percentage of newly diagnosed AIDS cases, however, 203 of NYS' 2,370 new AIDS diagnoses in 2012 were among PWID, representing 8.6% of all cases (11.3% including MSM/PWHID) as of December 31, 2012.

Financing and management:
NYSDOH/AIDS Institute has used State funding since 1992 to support the development and maintenance of syringe exchange programmes. Every programme received start-up and basic programme operating funds. The AIDS Institute used its Federal Centers for Diseases Control and Prevention (CDC) funding to support ancillary services at SEPs, including outreach, education, and behavioural interventions. Similarly, Ryan White Part A funds were awarded to SEPs to provide mental health, harm reduction, recovery readiness and relapse prevention to HIV+ individuals. NYSDOH has remained steadfast in its commitment to SEPs and has not re-procured the pool of funding allocated for these organizations. In 2005, the NYC Department of Health and the New York City Council allocated tax levy funds to NYC based SEPs to expand services. Currently, agencies use these funding streams to operate comprehensive harm reduction programmes. Foundations, such as Robin Hood, Comer, New York City AIDS Fund and other such organizations, fund add-on projects or seed funding for new services.

Lessoned learned and recommendations:
Over several years of providing syringe access services, the NYSDOH/AIDS Institute has learned that SEP services need to be anonymous and low threshold in order to engage the target population. Programme success depends on the availability of various models of SEP in order to reach a wide range of subpopulations of injectors. Peer Delivered Syringe Exchange and Special Arrangements SEP have proven to be cost effective ways to reach PWID in isolated areas of the state.

In addition relationships with law enforcement are integral to the success of SEP. Resources must be consistently and continuously dedicated to the education and training of law enforcement on syringe access programmes. The NYSDOH/AIDS Institute has a staff position dedicated to working on law enforcement issues. Initially, the SEPs existed by virtue of the Public Health Law but police generally know and use the Penal Law when dealing with PWID. Having a staff person whose sole responsibility is to work with law enforcement at all levels to ensure that they are following all applicable laws is essential. In 2010, the Penal Law was changed to reflect the Public Health Law but police still need on-going education to improve their interactions with PWID. Educational materials, including podcasts, video and law enforcement notebooks, were developed to enable police officers to easily access accurate information from the internet and receive educational credit for viewing the materials.

VI. Multiple Countries

1. SOUTH EAST ASIA (Cambodia, China, Vietnam, Indonesia, Malaysia, India)
Title of programme: “Asia Action” Financial tracking of harm reduction investment in Asia
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Implemented by: Civil Society

Areas of focus of the programme: The financial crisis and its impact on people who inject drugs programmes
Has the programme been evaluated/ assessed? No
Is the programme part of the implementation of the national AIDS strategy? No
Is the programme part of the implementation of the national programme on drugs? No

Background:
Harm reduction programmes in many low and middle income countries are overly reliant on international donors for sources of funding. To ensure the sustainability of services, there is an urgent need for increased national government investment in harm reduction approaches. The tracking of international and national investment in harm reduction is essential to inform advocacy for increased resources for harm reduction. This information is challenging to gather as most donors and governments do not record or disaggregate their budgets in a way that is useful for monitoring harm reduction spend.

The strategic investment framework estimated that USD $2.3 billion would be required in 2015 to implement the core package of harm reduction interventions at recommend coverage levels. This amount, invested appropriately would significantly reduce new infections among people who inject drugs. The last global estimation of spend for harm reduction in 2010 placed this figure at USD $160 million, just 7% of what is required. Tracking the current level of investment in harm reduction is challenging for a variety of reasons including poor national reporting uptake to the UNAIDS National Spending Assessment (NASA) and the Global AIDS Progress Reporting systems, poor disaggregation of spend on key population focused interventions by international donor and a lack of standardized methodology for disaggregating harm reduction spending across donors, governments and implementers.

This programme seeks to establish a standardized methodology and track harm reduction spend in India, Indonesia, China, Malaysia, Cambodia and Vietnam to establish the current state of harm reduction funding.

Approach:
An international expert in financial tracking was commissioned to develop a standardized methodology. This methodological framework was developed with input from the Eurasian Harm Reduction Network (EHRN) who are developing similar research to ensure comparable data across regions. This methodology will be deployed across 6 countries in Asia – Cambodia, China, Indonesia, Malaysia, India and Vietnam.

The data gathered includes level of total investment, funding source and, where possible, will make an assessment on how these funds are spent (e.g. which interventions from the UNAIDS/UNODC/WHO are funded, geographical reach of the intervention and if interventions target particular groups such as women or young people).

In addition to assessing harm reduction expenditure, the research seeks to establish whether current spend is proportionate to epidemiological need within the context of national spend on HIV programming. Where possible, it will also assess national spend on punitive drug policy approaches such as incarceration within prisons and other closed settings such as compulsory drug detention centres. The information gathered through this research will inform national and regional advocacy efforts for increased strategic funding (particularly government funds) for rights-based harm reduction programming.

Reach of the intervention:
This data will cover the 6 countries outlined above allowing for informed advocacy at the national, as well as regional levels within Asia. The data will also inform advocacy for securing sustainable funding for harm reduction at the international level.

Impact of the intervention:
The impact of this project will be measured through the adoption of advocacy messages around funding scale up by partner organizations in country, as well as the increased understanding at a national and regional level of the gap faced in terms of financing for harm reduction.

Financing and management:
This project is financed by the European Commission through a project focused on harm reduction advocacy in Asia – entitled "Asia Action". The project is managed by the International HIV/AIDS Alliance, with linking organizations at a national level.

Lessoned learned and recommendations:
Current level of spend on harm reduction at a global level remains difficult to determine due to a lack of data for the methodological reasons outlined above. We would recommend investment in further data analysis in key regions where concentrated epidemics among people who inject drugs are prevalent.

International donors and governments should systematically track disaggregated harm reduction investment and this information should be transparent.

Multilateral agencies such as UNAIDS and UNODC should directly monitor harm reduction spending. A successful system would enable monitoring of fluctuations or gaps and facilitate early recognition of potential funding crises. It should also equip civil society and others with data in order to allow for advocacy for sustainable funding for harm reduction programmes.

2. SOUTH EAST ASIA, SOUTH ASIA, SUB-SAHARAN AFRICA, EASTERN EUROPE AND CARIBBEAN (Vietnam, Philippines, Myanmar, Thailand, India, Kyrgyzstan, Kazakhstan, Tajikistan, Moldova, Ukraine, Tanzania (mainland and Zanzibar), Kenya, South Africa, Brazil)
Title of programme: Enhancing Partnerships between Law Enforcement and Civil Society Organisations in the context of Drug Use and HIV
Contact person: Zhannat KOSMUKHAMEDOVA
Title: Expert
Organization: UNODC,HIV/AIDS Section
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Email: Zhannat.KOSMUKHAMEDOVA @unodc.org
Implemented by: UN or other inter-governmental organization
Areas of focus of the programme: Policy and legal environment
Programme is being implemented since: May 2013
Has the programme been evaluated/ assessed? No

Background:
UNODC, together with partners from civil society organizations, has identified 24 high priority countries for HIV and people who inject drugs (PWID) for 2013-2015. The selection

was based on the epidemiologic situation (high prevalence of PWID and high prevalence of HIV among PWID), the readiness of the country to harm reduction and the level of resources.
In all these countries, stakeholders involved in the development of plans of action identified as a major obstacle for PWID to access harm reduction services. The poor cooperation between LEA and CSO and the lack of support of LEA towards harm reduction activities.

Approach:
A two-day round table facilitated dialogue for both Civil Society Organizations and Law Enforcement Officials in order to examine the opportunities and key ingredients for enhancing partnerships between LE and CSOs in order to increase access to harm reduction services and increase public safety.

A generic guide was developed and in close collaboration with national CSOs adapted to the local situation

The objectives of each workshop are:
1. To sensitise law enforcement officials about harm reduction services in the context of HIV and how law enforcement practices can influence (positively or negatively), the access of people who use drugs to harm reduction services;
2. To build capacity of the CSOs to advocate with LEAs to ensure greater access of people who used drugs to harm reduction services;
3. To create a space for LEAs and CSOs to share respective positions, concerns and ideas for enhancing future collaboration.

These workshops were conducted in partnership individual consultant members of the LEAHN (Law Enforcement and HIV network).

Reach of the intervention:
In 2013, 150 law enforcement officials and 125 representatives from CSOs working with people who use drugs in 8 countries.

Impact of the intervention:
The scope of the pilots does not allow for measuring any impact on the access to services. The evaluations conducted in each country after the workshops indicated:

- It was the first opportunity for CSO and LEA to have a space for dialogue
- The misconception related to people who inject drugs and their needs could be clarified
- LEA got sensitised to the impact of the police attitude and practices on the access for PWID to harm reduction
- All countries were the workshops were conducted requested to replicate the exercise

Financing and management:
- UNODC provides seed funding for conducting the LEA/CSO workshops in the high priority countries.
- The workshops curriculum have been developed to allow for replication
- In each workshop potential national trainers were identified and supported to become trainers
- The activities are conducted in closed collaboration with the police training academies

- A training guidance for police officers to be incorporated in the police academic core training is being developed

Lessons learned and recommendations:
- The activity is responding to a need
- Similar activities should be replicated for CSOs and LE at the level of relevant municipalities

3. ASIA AND EASTERN EUROPE

Title of programme: Assessing the cost-effectiveness of harm reduction strategies
Contact person: Pandu Harimurti
Title: Health Specialist
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Implemented by: Government, Civil Society, UN or other inter-governmental organisation
Areas of focus of the programme: Policy and legal environment; the financial crisis and its impact on people who inject drugs programmes
Programme is being implemented since: 2012
Has the programme been evaluated/ assessed? No
Is the programme part of the implementation of the national AIDS strategy? Yes
Is the programme part of the implementation of the national programme on drugs? No

Background:
Many countries in Asia and Eastern Europe have responded to injecting drug use through law enforcement measures and compulsory detention. There is no evidence to suggest that compulsory detention of people who use drugs is effective in reducing drug dependency or rehabilitative, as most detained people return to drug dependency after release. An alternate approach is harm reduction, which refers to methods of reducing health risks when eliminating them may not be possible. Harm reduction can also reduce social and economic harms that individuals experience as a result of engaging in risky activities. In the context of HIV prevention and injecting drug use, harm reduction generally includes needle-syringe programs (NSPs) and opioid substitution therapy (OST). Provision of antiretroviral therapy is also considered to be within a comprehensive package of HIV-related services for PWID. Harm reduction approaches were first introduced in the Netherlands, United Kingdom and Australia in the mid-1980s in response to AIDS epidemics. We now have three decades of data to assess the evidence of effectiveness and cost-effectiveness of these approaches.

This World Bank programme reviews the effectiveness, cost-effectiveness and return on investment of the packages of harm reduction services, as well as estimate resources required to meet coverage targets. It provides necessary evidence at global, regional or country level to help policy makers improve their priorities and programmes.

Approach:
The intervention is HIV specific and focused on the cost-effectiveness and return on investment of harm reduction strategies. However, it also considers in the analysis the broader social and economic impact of NSPs, OST and ART.

Reach of the intervention:
The World Bank analysis of the cost-effectiveness of harm reduction strategies covers multiple regions. The main results presented stem from the Return on Investment Studies conducted in Malaysia and the Philippines, as well as from a WB/UNSW global research paper summarizing the key conclusions on cost-effectiveness of harm reduction.

- Reach of the intervention in the Philippines: the Philippines is one of nine countries with increasing HIV cases although the epidemics is highly concentrated in major cities. The most alarming trend of HIV infections has been among IDUs, specifically in Cebu province where HIV prevalence among IDUs has increased from 0.59% (n=341) in 2009 to 53.16% (n=301) in 2011. The study, “Return on investment of needle-syringe programs in the Philippines”, aims to assess the potential cost-effectiveness and return on investment of implementing NSPs in Cebu city.
- Reach of the intervention in Malaysia: Malaysia is combating an epidemic of HIV infections transmitted through sharing contaminated needles and syringes. In 2006, the government initiated limited programs of "harm reduction" interventions. The program included the Needle and Syringe Program (NSP), a program where people who inject drugs are offered clean needles and syringes, and Methadone Maintenance Therapy (MMT), a program offering heroin addicts enrolment in rehabilitation therapy where heroin is replaced with synthetic methadone. These harm reduction programs have succeeded, and Malaysia has now expanded them nationwide. The study assesses the cost effectiveness and return on investment of these harm reduction interventions.

Both Malaysia and the Philippine studies support the Global analysis that Harm Reduction interventions are cost effective.

Impact of the intervention:
The programme provides key evidence supporting the cost effectiveness of each of the three interventions (NSPs, OST and ART) across all regions, all being generally cost-effective in the short-term and very cost-effective to cost-saving when long-term and societal benefits are considered (cost-effectiveness ratios in terms of costs per HIV infection averted among PWID are highly favorable, ranging from $100 to $1,000). It also provides additional evidence that implementing combined harm reduction interventions would further improve their effectiveness and cost-effectiveness.

This data has a key impact for national programming. For example in Malaysia, the study concluded that:

- 12,653 HIV infections were successfully averted since 2006 with the implementation of the NSP and MMT harm reduction programmes, targeting people who inject drugs. These averted infections have resulted in savings of RM47.1 million in direct health care costs
- Continuing support for harm reduction would produce even higher returns over the next ten years. The savings in healthcare are expected to increase four-fold which will exceed total investment by RM1.07 for every ringgit spent. It is also expected that harm reduction programmes will continue to be cost-effective and help prevent more than 23,000 new infections.
- A long term benefits projection for the period 2006-2050 indicates savings of approximately RM910 million in healthcare costs and an average return of RM1.13 for every ringgit invested in harm reduction programmes.

This study provides strong evidence that even with the present programme coverage, harm reduction programmes are cost-effective and are expected to produce net cost-savings to the government in the future. It provides a solid basis for continued support for these programs.

In the Philippines, the study provided similar conclusion with all scenarios of NSP implementation leading to savings in health care costs and showing that if they were implemented in the Philippines, they are predicted to be effective and cost-effective, costing around US$500 per infection averted.

Two Impact Evaluation (IE) analysis are currently ongoing in Malaysia to compare Compulsory detention vs Voluntary, and NSP programme in the Philippines; these two studies will provide further evidence to support policy making process.

Financing and management:
The Programme is financed and coordinated by the World Bank with the Kirby Institute, University of South Wales as main global partner and implementer, as well as with local researchers (Malaysia), and in close collaboration with the Governments (both Malaysia and the Philippines).

Lessons learned and recommendations:
The main challenges to overcome lie in the policy environment, which is not currently favorable to harm reduction programs, and the significant investments needed to scale up the approach:

- The coverage of harm reduction programs among PWID populations is currently too low across almost all global regions and the programs have yet to sufficiently scale up to lead to the population impact commensurate with their known effectiveness and cost-effectiveness.
- The total annual costs of scaling up each of the harm reduction strategies from current coverage levels, by region, to meet WHO guideline coverage targets are high with ART greatest, followed by OST and then NSPs.
- The unit costs of harm reduction interventions are relatively low, but can vary by provider type, delivery model and region. NSPs are generally the least expensive harm reduction strategy. OST costs vary the most by delivery mode. The costs of ART are expected to decline by 2020, which will lead to more favourable cost-effectiveness ratios for its use as a harm reduction strategy.

- However, scale-up of all three approaches is essential and these interventions can be cost-effective in the short-term and cost-saving in the long-term.
- There are many historical and very recent examples in diverse settings where the absence of, or reduction in, NSPs have resulted in exploding HIV epidemics compared to controlled epidemics with NSP implementation.
- NSPs are relatively inexpensive to implement and highly cost-effective. There is strong evidence that substitution therapy is effective, reducing the risk of HIV acquisition by 54% on average among PWID. OST is relatively expensive to implement but studies indicate these programs are marginally to reasonably cost-effective; other societal benefits substantially improve the cost-effectiveness ratios. Many studies have shown that ART is cost-effective for keeping people alive and there is growing evidence of the additional effectiveness and cost-effectiveness of ART as prevention among PWID.

- Not only is there an ethical imperative to make harm reduction programs universally available, but in stark contrast to compulsory detention, these approaches are globally effective, represent good value for money and are often cost-saving, indicating their value to improving the health outcomes for PWID and the broader population.

Recommendations: the best way to address the funding crisis is to identify the most cost-effective interventions. National governments may wish to re-examine their approaches to responding to PWID and consider how the strong evidence and rationale for harm reduction programs can influence future funding allocations within national public health programs and help avoid much greater financial and societal costs further down the line. Although the overall costs of scaling up harm reduction programs will be high, it will be a worthwhile action for governments to adopt; not only do the societal benefits of harm reduction programs exceed treatment costs, but they will also present significant returns on investment due to infections and subsequent health costs which are averted.

Annexes:
The cost-effectiveness of harm reduction (Abstract paper); Philippines ROI study; Malaysia ROI study

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