

High Coverage Sites

HIV Prevention among Injecting Drug Users
in Transitional and Developing Countries

Case Studies

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Table of Contents

Tables	5
Abbreviations and Terms	6
Executive Summary	7
1. Introduction and Methods	15
Definitions	16
2. Case Studies: Eastern Europe	19
2.1 Soligorsk, Belarus	19
2.1.1 Summary	19
2.1.2 Drug use and HIV situation	19
2.1.3 History	20
2.1.4 Features of services	20
2.1.5 Coverage	22
2.1.6 Maintaining and expanding coverage	24
2.1.7 Further reading	24
2.2 Pskov, Russian Federation	25
2.2.1 Summary	25
2.2.2 Drug use and HIV situation	25
2.2.3 History	26
2.2.4 Features of services	27
2.2.5 Coverage	28
2.2.6 Maintaining and expanding coverage	29
2.2.7 Further reading	30
2.3 Sumy, Ukraine	31
2.3.1 Summary	31
2.3.2 Drug use and HIV situation	31
2.3.3 History	32
2.3.4 Features of services	33
2.3.5 Coverage	35
2.3.6 Maintaining and expanding coverage	36
2.3.7 Further reading	37

3. Case Studies: Asia	39
3.1 Dhaka, People’s Republic of Bangladesh	39
3.1.1 Summary	39
3.1.2 Drug use and HIV situation	39
3.1.3 History	39
3.1.4 Features of services	40
3.1.5 Coverage	43
3.1.6 Maintaining and expanding coverage	43
3.1.7 Further reading	43
3.2 Rajshahi, People’s Republic of Bangladesh	44
3.2.1 Summary	44
3.2.2 Drug use and HIV situation	44
3.2.3 History	44
3.2.4 Features of services	46
3.2.5 Coverage	48
3.2.6 Maintaining and expanding coverage	49
3.2.7 Further reading	50
3.3 Hong Kong Special Administrative Region (Hong Kong SAR), People’s Republic of China	51
3.3.1 Summary	51
3.3.2 Drug use and HIV situation	51
3.3.3 History	52
3.3.4 Features of services	53
3.3.5 Coverage	55
3.3.6 Maintaining and expanding coverage	56
3.3.7 Further reading	56
4. Case Studies: Latin America	57
4.1 Salvador, Brazil	57
4.1.1 Summary	57
4.1.2 Drug use and HIV situation	57
4.1.3 History	59
4.1.4 Features of services	61
4.1.5 Coverage	64
4.1.6 Maintaining and expanding coverage	64
4.1.7 Further reading	65
5. Lessons learnt: High-coverage sites	67
5.1 Common features of high-coverage programmes	67
5.2 Challenges for comprehensive HIV-related programmes	71
5.3 Minimal coverage monitoring and estimation	72
5.4 Recommendations for further research	75

List of Tables

Table 1: Soligorsk, services and products provided	21
Table 2: Soligorsk needle-syringe programme January 2000–December 2002	21
Table 3: Soligorsk, regular reach	22
Table 4: Soligorsk, needles distributed per month per client	22
Table 5: Pskov services and products provided	28
Table 6: Pskov needle-syringe programme, 1999–2002	28
Table 7: Pskov, regular reach	29
Table 8: Sumy services and products provided	34
Table 9: Sumy needle-syringe programme, May 2000–December 2002	35
Table 10: Age Distribution of needle-syringe programme clients, Sumy	35
Table 11: Sumy, regular reach	35
Table 12: HIV-positive injecting drug users in Dhaka	39
Table 13: Dhaka, services and products provided	42
Table 14: Dhaka needle-syringe programme, May 1998–December 2002	47
Table 15: Rajshahi, services and products provided	48
Table 16: Rajshahi needle-syringe programme July 1999–December 2002	48
Table 17: APOSH Programme, 1999–2002	48
Table 18: Rajshahi, regular reach	48
Table 19: Hong Kong SAR, services and products provided	54
Table 20: Hong Kong SAR, coverage	55
Table 21: Salvador, HIV counselling and testing	58
Table 22: Salvador, services and products provided	63
Table 23: CETAD Programme 2002	63

Abbreviations and Terms

ABAREDA	Bahia Harm Reduction Association, Salvador, Brazil
AIDS	Acquired immunodeficiency syndrome
AMS	Auxiliary medical services
BODAR	Self-help group for former drug users, Dhaka, Bangladesh
CETAD	Centro de Estudos e Terapia do Abuse de Drogas, Salvador, Brazil
CRDA	Central Registry of Drug Abuse, HK, PR China
CREAIDS	Centro de Referência Estadual de AIDS
DATC	Drug Addiction Treatment Centres, HK, PR China
DFID	Department for International Development of the Government of the United Kingdom
GUIN	Prisons Department (of former Soviet Union countries)
HIV	Human immunodeficiency virus
HTLV	Human T-cell Lymphotropic Viruses
IBCM	Instituição Beneficente Conceição Macedo
Oblast	Province (of former Soviet Union countries)
OBNON	Drugs police (countries of the former Soviet Union)
PROCHESTA	Self-help group for drug users, Dhaka, Bangladesh
Rayon	Sector (former Soviet Union countries)
RRC	Red Ribbon Centre, HK, PR China
SARDA	Society for the Aid and Rehabilitation of Drug Abusers, Hong Kong SAR, the People's Republic of China
SHAKTI Project	SHAKTI Injecting Drug User Project, Bangladesh
UIC	Unique identification code
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session (on HIV/AIDS)
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development

Executive Summary

UNAIDS commissioned this report to investigate programmes and sites in developing and transitional countries which were regarded by international authorities as “high coverage sites” i.e. where more than 50% of injecting drug users had been reached by one or more HIV-prevention programmes. In all, seven sites were examined, including Soligorsk, Belarus; Pskov, Russian Federation; Sumy, Ukraine; Dhaka, Bangladesh; Rajshahi, Bangladesh; Hong Kong Special Administrative Region (Hong Kong SAR), People’s Republic of China; and Salvador, Brazil.

Each case study includes a description of the development of the programme and features of the services provided, an estimation of programme coverage, factors that led to high coverage, and a discussion of ways to maintain and expand coverage.

The most significant finding is that high level coverage can be attained by programmes addressing HIV among injecting drug users in developing and transitional countries. For example, needle and syringe exchange and methadone programmes reached more than 50% of injecting drug users in the sites studied, and HIV treatment, care and support for HIV-positive injecting drug users have achieved high level coverage in Brazil and Hong Kong SAR and may soon do so in Bangladesh. In Dhaka, Pskov, Sumy and Hong Kong, the coverage achieved has resulted in potential HIV epidemics among injecting drug users being averted or delayed.

Common features of high level coverage programmes include:

Harm reduction principles were used to develop local programmes

The case studies come from a diverse range of countries and the features of the programmes are unique to the social, political and cultural settings in which they were implemented. Rather than replicate models developed by other countries, programme planners and implementers studied the principles underlying effective programmes and designed initiatives appropriate for their sites.

The general community, government, faith-based organizations and other opinion leaders need to support programmes

This was generally achieved through advocacy at many levels.

Advocacy efforts needs to be prioritized, adequately staffed and funded

In each site, careful thought and substantial work was devoted to overcoming community fears and government concerns about the proposed programmes.

The role of law enforcement services is crucial for success

In most countries, addressing HIV among injecting drug users is done within the context of criminalized drug use; yet programmes need to work where drug users are located, and with drug dealers and shooting gallery owners to ensure the maximum number of injecting drug users participate. While law enforcement services do not have to support every initiative they must allow programmes to operate without hindrance.

Funding is important for scaling-up

All programmes (with the exception of Hong Kong SAR) were begun with external donor funding. External donors need to take a flexible approach with regard to the level of funding provided for each site, the specific programme elements and implementation.

Sustained funding

Not one of the programmes described achieved high level coverage in the first year of operation; yet this is often the length of external funding. In most cases, it took more than three years to achieve high-level coverage.

Differences in each setting result in different services and approaches to attract injecting drug users to a programme

All the programmes offered a range of services as well as needle-syringe exchange or methadone substitution. In many cases, such a broad range of services was achieved through close links and partnerships with other organizations. Providing a broad range of services is likely to attract a diverse range of injecting drug users, which requires programme funding to be flexible enough to allow development of programmes tailored to address these diverse groups.

A single programme can be replicated to address the needs of injecting drug users in other districts, cities and provinces

Successful HIV-prevention programmes among injecting drug users can commence at one site, be taken to scale and then replicated in other parts of the country.

Convenience of access

In each of the case studies, injecting drug users were able to access services in a variety of ways and at various times.

Involvement of injecting drug users

Regular interactions based on respect and friendliness between injecting drug users and programme staff is a factor in achieving high coverage. Greater involvement of injecting drug users in appropriate structures (such as advisory bodies, injecting drug user groups or as programme staff) is likely to result in sustainable programmes.

Management issues

Technical assistance and training for managers, and on-going training or retraining of staff, especially those working face-to-face with injecting drug users, is crucial. Also of importance are effective supervision, an ability to deal with problems and regular team meetings.

Learning from experience

Due to the variety of settings in which programmes addressing HIV among injecting drug users are implemented; a process of trial and error is needed to develop a local balance of programme elements, staffing and other features that will result in high level coverage.

Challenges for comprehensive HIV programming include:

High-level coverage is needed for a comprehensive programme

None of the sites offered a comprehensive range of injecting drug use related services, including drug substitution treatment, other forms of drug treatment, outreach, needle and syringe exchange programmes, and HIV treatment, care and support. In many countries, essential elements of a comprehensive approach are missing, including access to affordable treatment for sexually transmitted infections (STIs), HIV-related health care, including antiretroviral therapy, and voluntary (confidential) HIV counselling and testing.

The relationship between programmes and law enforcement services remains difficult

Regular and ad hoc advocacy with law enforcement services and other community sectors at many levels needs to be integrated in all programmes. Additionally, staff members of law enforcement services and other sectors need to be trained about the need for comprehensive programmes and their role in addressing HIV among injecting drug users.

The balance between HIV prevention and treatment expenditure is likely to be an important issue in sustainability

Provision of antiretroviral therapy can result in reduced funding for HIV-prevention activities. While the provision of antiretroviral therapy is an important component of a comprehensive response to HIV, reducing funding for prevention will result in increased numbers of people living with HIV and subsequently the corresponding treatment costs.

Gender and sexual transmission issues remain unresolved

There were low levels of participation by female injecting drug users in most programmes. Furthermore, the sexual transmission of HIV is accorded a lesser priority in programmes than HIV transmission related to drug use.

Lack of standardized monitoring and reporting

A standardized monitoring methodology would simplify measuring coverage and enhance comparisons between programmes.

The number of injecting drug users reached on a regular basis in each site tended to be a small percentage of the total population of injecting drug users in the city or province.

Recommendations for minimal coverage monitoring and estimation

The case studies revealed a very wide range of monitoring processes, which made comparability difficult and, in some cases, made it virtually impossible to determine the number of ever reached and regularly reached clients. For these reasons, a standardized minimal package for estimating and monitoring is recommended, following the model for:

- estimating the number of injecting drug users in a specified geographic area¹; and
- recording the number of individual injecting drug users who access specific services².

Programmes are encouraged to increase monitoring to meet their specific needs but this should be undertaken using a standardized estimation and monitoring system.

The recommended method to estimate injecting drug users in a specified geographic area is to use multiplier and benchmark calculations. These calculations make use of existing data for behaviours or events that are common among injecting drug users, for example, police arrest data for drug use or possession, as well as drug treatment, accident and emergency ward, or drug-related deaths data. This pre-existing information, which is the sum of key behaviours or events over a fixed time period, is called the benchmark information. For all these benchmarks and for survey data (below), disaggregating data by sex is important.

Along with this data set, an estimate of the proportion of the target population, who have experienced this event is required, for example, the proportion of injecting drug users that have been arrested, died, etc; the inverse of this proportion is called the multiplier. Estimating the associated multiplier usually requires small, separate sub-studies and anonymous records are sufficient.

To illustrate the above, if it is known that during 2002, a total of 7000 injecting drug users went to treatment in a given place, and it is also known from surveys that approximately 20% of all injecting drug users underwent treatment in 2002, the estimated number of injecting drug users would be 35 000.

The proportion of the target population in the benchmark may be obtained separately and independently by interviews or questioning, or by specific studies. A common way to carry out this step is to ask specific questions, depending on the benchmarks used, related to arrest, treatment, overdose, etc. in Rapid Assessment and Response surveys or other surveys of HIV risk behaviours among injecting drug users.

It is recommended to use as many benchmark and multipliers as possible, and to use, if possible, other methods of population size estimation. The results of such calculations should be compared to decide on the best estimate. As well as the estimate for the number of injecting drug users, an estimate of the HIV prevalence among injecting drug users is useful.

¹ UNODC (2003). Global Assessment Programme on Drug Abuse Toolkit Module 2. Estimating Prevalence: Indirect Methods for Estimating the Size of the Drug Problem. Vienna, Austria. Retrieved on November 30, 2005 from http://www.unodc.org/pdf/gap_toolkit_module2.pdf

² USAID, UNAIDS, WHO, UNICEF and the Policy Project (2004). Coverage of selected services for HIV/AIDS Prevention, Care and Support in Low and Middle Income countries in 2003. Washington, DC, Policy Project. Retrieved on December 1, 2005 from <http://www.policyproject.com/pubs/generalreport/CoverageSurveyReport.pdf>

Results of this estimation technique should be sufficient to use as the basis for the other calculations described below. However, experience from high coverage sites suggests that such estimates suffer from many inaccuracies when the estimation is made before HIV-prevention programmes among injecting drug users are implemented, or when such services are small. In addition, injecting drug user populations are dynamic, changing in size through the effects of drug policy and larger environmental changes; through attrition such as drug users stopping drug use, leaving the district, or dying; and through new injectors entering the population from non-injecting groups or from other districts.

In several of the case studies, the injecting drug user population size in the area serviced by a programme was re-estimated, using the resources of the programme to extend the reach of surveys or other processes across all social networks, ages, gender, ethnicities and subpopulations of injecting drug users. Re-estimation processes of this type have revealed substantial differences from original estimates, for example, in Rajshahi and Pskov. This re-estimation process is recommended for all programmes.

The second step is to record the total number of injecting drug users (disaggregating by sex) who, during the past month, were:

- reached through outreach, including needle-syringe programmes;
- in abstinence-oriented treatment; and
- in drug substitution treatment, for example, methadone maintenance, buprenorphine, etc.

From the point of view of HIV-prevention programmes, this means that a monitoring system must be in place to record how many injecting drug users are reached by a specific service. For inpatient and residential drug treatment, excluding drug substitution treatment programmes, this task is easily done as the number of persons in residence is normally recorded.

For all programmes providing services to injecting drug users, recording is generally done through the use of a unique identification code (UIC). There are various ways of generating such a code, but all result in each programme client receiving a unique code. These codes should be recorded, together with the date that the client first used a service, on a master list to which other monitoring and reporting systems can refer. The master list should simply contain a number, starting at 1 with the first client, the UIC and the date on which the UIC was issued, which should be the date of the client's first service access visit. To avoid possible later confusion, these three numbers should each be separated by a dash.

If HIV-prevention programmes among injecting drug users are coordinated for a continuum of services, the same UIC can be used for all services. This is done by simply asking each client if they have ever received a UIC from any other service. If not, a UIC can be assigned and added to the master list. If yes, the UIC information is recorded and the client's visit is assigned to that client's UIC. If the client does not recall the UIC it can be generated using the standard method adopted by all the services in an area.

A monitoring form, containing space for the date, the client's UIC and the service provided, is also needed to record each client's access visit. In the case of product-oriented services such as needle-syringe programmes, the form should also provide space for the numbers of needles and syringes, condoms etc, distributed, and other services or referrals provided. Additional questions can be added to this form for greater understanding of how to increase coverage.

An important distinction must be made between the *number of clients* and the *number of client visits*. The former is vital to many processes detailed here, whereas the latter, in the absence of client numbers, is difficult to interpret. If possible, both figures should be recorded but, if this is not possible, the number of clients accessing each service must be recorded.

Using this system, information can be kept and reported on, including:

- the number of injecting drug users ever reached;
- the number of injecting drug users accessing all services in the past month for United Nations General Assembly Special Session (UNGASS) on HIV/AIDS indicator calculations;
- regularity of reach (*see 5.4 Recommendations for further research*); and
- comprehensiveness of services.

The master list itself provides an on-going record of the number of clients ever reached. This can be read at any time by looking at the last number on the list. Where programmes are already being implemented, institutionalization of this system will create a picture of the number of clients ever reached over two to three years, and some adjustment can be made for clients reached before the system was implemented and who do not appear in the records.

Similarly, because the date of access to services is recorded, the number of clients accessing services during a specific month can be easily monitored. If the type of service is also recorded, then comprehensiveness of services can be reported as number and percentage of overall clients accessing each type of service. Depending on the specific characteristics of drug use and HIV among injecting drug users in a locality; this information can assist prevention programmers knowing whether prevention targets are being met.

Recommendations for further research

We still do not know the answer to the question “how much is enough?”; however, we are getting closer to the answer. Future effectiveness studies should track the real increases and decreases in HIV prevalence among injecting drug users in sites where funding and commitment is provided to achieving high coverage. Studies using scaled-up programmes currently planned or being implemented would assist us learn from real-world examples and give clearer guidance about the level and mix of services needed to prevent or reduce AIDS epidemics among injecting drug users.

In addition, work is needed on the development of quality indicators for HIV prevention and care services among injecting drug users. From this report and other studies, it is clear that quality of services is an important factor in achieving high coverage. From the case studies, the following areas require quality indicators:

- convenience of access to services;
- breadth of services to attract subpopulations of injecting drug users, including male and female, younger and older, users of different drugs, and a range of ethnicities;
- involvement of injecting drug users, and the extent to which injecting drug users influence or implement changes to services, including measures for ‘friendliness’ or the relationship between clients and staff;
- management processes, which are flexible, responsive to client needs, to changes in drug use patterns and to political environments; and
- effectiveness of advocacy activities with measures for relationships between programmes and key stakeholders such as law enforcement services, government at various levels and neighbours.

1. Introduction and Methods

The twin epidemics of injecting drug use and HIV transmission through contaminated injecting equipment have already had major impact on the health, social and economic well-being of many countries and regions. By mid 2003, these twin epidemics had taken hold in North and Latin America, Western, Central and Eastern Europe, Southeast and South Asia, and were beginning in the Middle East and Africa.

While rapidly expanding AIDS epidemics have been occurring among injecting drug users in many countries and regions, there is evidence that AIDS epidemics among injecting drug users can be prevented, slowed, stopped and even reversed. For example, all Australian cities, London (United Kingdom), and Dhaka (Bangladesh) have maintained HIV prevalence among injecting drug users at less than 5%. The AIDS epidemic among injecting drug users in Nepal appears to have been delayed by several years; and HIV prevalence among injecting drug users in New York City (USA), Edinburgh (United Kingdom) and several Brazilian cities has fallen. This appears to be the result of a range of specific programmes, which are an effective approach, to address HIV among injecting drug users.

In 2000, the United Nations agencies agreed that action was urgently needed to implement the following programmes to address HIV among injecting drug users³.

- **Drug abuse treatment**, in particular drug substitution treatment such as methadone maintenance, therapeutic communities and outpatient drug-free programmes, assist injecting drug users to decrease their drug consumption significantly.
- **Outreach activities** have been successful in accessing, motivating and supporting injecting drug users who are not in treatment to reduce their illicit drug use risk behaviours and sexual risk behaviours as well as reducing HIV incidence. Findings from research indicate that outreach activities that take place outside the conventional health and social care environments reach out-of-treatment drug injectors and increase drug treatment referrals.
- **Syringe and needle exchange programmes** have shown reductions in needle risk behaviours and HIV transmission and no evidence of increase into injecting drug use or other public health dangers in the communities served. Such programmes also serve as points of contact between injecting drug users and service providers, including drug treatment programmes. The benefits of such programmes increase considerably, if they go beyond syringe exchange alone to include AIDS education, counselling and referral to a variety of treatment options.

In order to prevent, or have an impact on, an injecting drug use-related AIDS epidemic, these programmes need to be implemented on a sufficiently large scale to reach sufficient numbers of drug users, who then change their drug use- and sex-related risk behaviours. This has been achieved in many cities in North America, Oceania and Western Europe and in countries, including Australia, Germany, Netherlands and the United Kingdom.

³ ACC Subcommittee on Drug Control (2000). *Preventing the Transmission of HIV among Drug Abusers: A position paper of the United Nations System*. Annex to the Report of 8th Session of ACC Subcommittee on Drug Control, 28-29 September, 2000. [Electronic version] http://www.unaids.org/html/pub/publications/irc-pub03/hraids_en_doc.htm

Increasingly, the importance of programmes coverage to prevent HIV transmission among injecting drug users is being discussed in developing and transitional countries. For example, in 1999, at the first Eastern European Regional HIV Strategy Meeting⁴, a coverage target of 60% was accepted by a range of organizations, including WHO and UNAIDS, working on HIV prevention among injecting drug users, but little work has been done to operationalize it.

In 2002, UNAIDS commissioned an investigation of sites in developing and transitional countries, which were regarded by international authorities as “high coverage sites”. Six sites were chosen, including Soligorsk, Belarus; Pskov, Russian Federation; Sumy, Ukraine; Dhaka, Bangladesh; and Salvador and Porto Alegre, Brazil. In the course of the study, Rajshahi, Bangladesh, and Hong Kong Special Administrative Region (Hong Kong SAR), People’s Republic of China were added, the latter due to the high coverage of its methadone maintenance treatment programme. Due to problems with data collection, Porto Alegre was excluded from this report. It should be noted that the list of sites is not an exhaustive list of high-level coverage sites.

Definitions

Primary clients (or contacts or exchange) are those people who a service provider comes into face-to-face contact.

Secondary clients (or contacts or exchange) are people reached by primary clients but without face-to-face contact with the service provider.

Coverage: the three sets of measures that provide information about coverage of injecting drug users by HIV-prevention services are:

1. number of injecting drug users ever contacted by a service;
2. regularity of service access; and
3. the number of sterile syringes provided to injecting drug users divided by the estimated number of injecting events during a specified time frame.

Each measure uses as a base the estimated size of the injecting drug user population in a given locality. Due to the hidden nature of injecting drug use in most cultures, an accurate estimate is difficult to make. In each case study, the methodologies used for estimating the population size are described.

For the first two measures, the concept of reach is important.

Reach refers to those injecting drug users contacted by any agency with HIV-prevention materials for injecting drug users, including sterile needles and syringes, methadone or other drug substitution treatments, or abstinence-based drug treatment and rehabilitation, excluding detoxification which is not regarded as an effective treatment by itself. Programmes providing these services are referred to respectively as needle and syringe programmes, drug substitution treatment programmes and drug rehabilitation programmes.

‘Ever reached’ figure is the number of injecting drug users ever contacted by a service. This figure is cumulative and continues for as long as the service operates so in theory

⁴ Second Strategy Meeting to Better Coordinate Regional Support to National Responses to HIV/AIDS in Central and Eastern Europe and Central Asia (2000). UNAIDS Copenhagen, Denmark, 4-5 December 2000.

a service can achieve a 100% ever reached figure by contacting every individual injecting drug user in a specified geographic area. In practice, figures of 100% are rarely, if ever, achieved due to changes in modes of drug use, new injecting drug users etc. In order to calculate this figure, services need to develop ways of identifying each injecting drug user. For ease of comparison, a figure of ‘**reached last year**’ is also used.

Regular reach is the regularity of service access, which is difficult to measure as there are many different ways of measuring “regularity”. In this report, the monitoring results provided by each service or set of services are analysed to determine a “regular reach” figure. Due to the diversity of monitoring methods employed, comparability is difficult between sites so a figure of ‘**reached in a sample month**’ has also been used.

The number of sterile syringes provided to injecting drug users divided by the estimated number of injecting events during a specified time frame, is a complex measure with many possible sources of error. For example, in calculating the number of injecting drug users, the number of injecting instances per injecting drug user, the number of syringes available from a variety of sources etc. As a result, this measure generally has not been used in this report.

2. Case Studies: Eastern Europe

2.1 Soligorsk, Belarus

2.1.1 Summary

Soligorsk, which was founded 40 years ago, has a population of 100 000 and 150 000 in the Soligorsk Rayon (sector). Soligorsk lies 140 km south of Minsk in Minsk Oblast, and its main industry is mining for fertiliser components, with 20 000 people working for a single enterprise.

The estimated number of injecting drug users is between 1260 and 1480. The ever reached figure is more than 1200 injecting drug users, equalling almost 100% of injecting drug users. In 2002, 1127 injecting drug users were reached by needle-syringe programmes. There are no drug substitution treatment or drug rehabilitation programmes.

In terms of regular reach, in the five-month period from August to December 2002, of 276 clients registered in that period, only 1% (2) attended more than four times per month. Injecting drug users reached in a sample month were 140 (9.5–11.1% of the estimated number of injecting drug users).

2.1.2 Drug use and HIV situation

In recent years, Belarus has experienced a rapid increase in injecting drug use and related HIV transmission. As of end 2003, the estimated number of people living with HIV in Belarus was between 12 000 and 42 000⁵. In 2001, a rapid situation assessment undertaken suggested that the actual number of drug users, of whom almost all are injecting drug users, is five to seven times higher than the officially registered number of 6363⁶.

Soligorsk is estimated to have 1260–1480 injecting drug users⁷. These figures are derived using a set of multipliers, derived from the results of several surveys for all Oblasts. These include the use of survey results to determine the ratio of injecting drug users registered by drug treatment services, and the percentages of who experienced overdose, and who were arrested for drug-related crimes.

Soligorsk has the second highest number of injecting drug users in Minsk Oblast after Minsk. The rapid situation assessment which found that 16–25% of injecting drug users were female, made no specific statements about the male to female ratio in Minsk Oblast or Soligorsk. Similarly, the assessment found that, nationally, 67% of injecting drug users were 20–30 years old. The most commonly used drugs for injecting are home-produced liquid opiates, known as poppy straw. Syringes are sold in pharmacies without prescriptions. As of 1 October 2003, the number of people living with HIV in Soligorsk was 343, of whom 269 (74.4%) were injecting drug users⁸.

⁵ UNAIDS (2004 July). *Report on the global HIV/AIDS epidemic*. Geneva, Switzerland. Retrieved on April 6, 2005 from <http://www.unaids.org/bangkok2004/report.html>

⁶ National AIDS Centre (2001). *Situation with the Spread of Injection Drug Use and HIV in the Republic of Belarus: Report on the Rapid Assessment Results* Minsk.

⁷ Ibid.

⁸ Ministry of Health of the Republic of Belarus National Center for AIDS Prevention (2001). *AIDS in Figures as of 01.07.2001* Informational bulletin N° 30. Minsk.

2.1.3 History

In Soligorsk, the process of establishing a needle-syringe programme began after visits by the current Programme Manager and other city medical staff to Svetlogorsk to study the local HIV epidemic among injecting drug users in 1996 and 1997. This was followed by the discovery of several injecting drug users in a district hospital during a hepatitis B outbreak in 1996-1997 and a rapid situation assessment undertaken by the Republican AIDS Centre in Soligorsk in 1998⁹. The results of the assessment were distributed to representatives of many sectors of society and subsequently the Republican AIDS Centre offered to write a project proposal for a local needle-syringe programme.

After some attempts to collaborate with a local nongovernmental organization, it was decided to seek the City Administration's approval for a needle-syringe programme within the then Soligorsk Centre for Hygiene and Epidemiology. Approval was received in December 1999 and a funding application was approved by UNAIDS in January 2000. In 2000, members of the multisectoral HIV Committee travelled to Svetlogorsk to assess the local HIV situation among injecting drug users and the response, including needle-syringe programmes.

The Programme commenced in February 2000, staffed by a psychologist, a doctor specialized in sexually transmitted infections and another specialized in drug dependence. In 2001, the doctor specialized in drug dependence was replaced with an infectious diseases doctor in order to attract more people living with HIV to the services. A lawyer was also employed for some months to provide free legal advice.

Between January and August 2002, UNAIDS funding for the Programme ceased. The Soligorsk City Administration provided funds for syringes, information materials and vitamins for people living with HIV, and a local mining company, Belaruskaly, provided some syringes. In August 2002, external funding resumed, though this together with the City Administration's funding was less than that available during 2001. In 2002, the city authorities responsible for AIDS and drugs also visited Svetlogorsk.

By 2003, several services available in 2001 were no longer available (*see Table 1: Soligorsk services and products provided*), leading to reductions in the number of client visits and needles and syringes distributed.

2.1.4 Features of services

Only two services, both Government-funded and -operated, specifically target injecting drug users, a needle-syringe programme at the Soligorsk District Centre for Hygiene and Epidemiology, and drug dependence services at the City Drug Dependency Dispensary. Funding for the drug dependence services is provided by the Soligorsk City, Oblast and National Governments. Funding for the needle-syringe programme comes from the Soligorsk City Government and UNAIDS.

Five people, including a programme manager, who is also the Deputy Head of the Centre for Hygiene and Epidemiology, a nurse and counsellor at the fixed site, and two outreach volunteers, are employed by the needle-syringe programme. The Programme is housed in the building of the Soligorsk Centre for Hygiene and Epidemiology, which is located near the city centre though the police headquarters are nearby, and access is simple. The Programme is open from 14.00 to 17.00 Monday to Friday. The services at the City Drug Dependency Dispensary

⁹ National AIDS Centre (2001). op.cit.

commenced in November 2002; however, there is no full time staff and access is difficult as it is located on the fourth floor and down several corridors.

Only two outreach volunteers, active injecting drug users, hold paid positions. However, it is evident from client statistics (see **2.1.5 Coverage**) that many other people access secondary distribution and exchange. Paid volunteers receive certificates related to their work in case they are stopped by police. The two paid volunteer positions were vacant at the time of visiting; one volunteer was in prison and the other had stopped using drugs. Volunteers, including unpaid volunteers, service 30–40 sites around the city, covering 30–100 injecting drug users per site daily.

Table 1: Soligorsk services and products provided

Services and Products	Centre of Hygiene and Epidemiology NSEP	City Drug Dependency Dispensary Drug dependency services	Outreach
Needles and syringes distributed	X	X	X
Needles and syringes returned	X	X	X
Needles and syringes disposal	X	X	–
Water for injecting	X	–	–
Alcohol swabs	X	–	–
Disinfectant for syringe cleaning	–	–	–
Vitamins	X	–	–
Filters and cotton balls	–	–	–
Hepatitis treatment	X	–	–
Treatment for HIV and AIDS	*	–	Referral
Drug detoxification	Referral	Referral	Referral
Other medications	–	–	–
Condoms distributed	X	X	X
Information, education and communication materials distributed	X	X	X
Face-to-face individual education and advice	X	–	–
Group education	–	–	–
Sexually transmitted infection services	*	–	–
Counselling (general)	X	–	–
Counselling on drugs	X	X	X
Counselling on HIV and AIDS	X	–	–
Legal assistance	*	–	–
Housing and welfare assistance	–	–	–
Drug user support groups	*	–	–
Former drug user support groups	X	–	–
People living with HIV support groups	–	–	–

* Denotes services that were available in 2001.

Table 2: Soligorsk Needle-Syringe Programme, January 2000 – December 2002

	2000	2001	2002	TOTAL
Syringes distributed	22 245	103 774	61 254	187 273
Syringes returned	19 024	94 458	56 527	170 009
Percentage returned	85.5	91	92.3	90.8
Total client visits	1 657	4 716	1 822	8 195
Calls to hotline	302	342	*	644
Counselling	955	561	117	1 623

* Service ceased due to reduced funding

The only detoxification or other drug treatment services in Soligorsk are provided by the City Drug Dependence Dispensary. Here, clients are either provided outpatient or day inpatient care or referred to the Minsk Oblast Drug Dependence Hospital for men or the Oblast Psychiatric Hospital for women. There are 40 beds for detoxification in the Minsk Oblast Drug Dependence Hospital, which is the total for the entire oblast and there are no beds specifically assigned to women. Inpatient medicated detoxification lasts from 10 to 30 days. Outpatient assistance at the City Drug Dependence Dispensary involves counselling and medications to assist detoxification.

There are no drug rehabilitation services, drug substitution treatment or other drug treatment services in Soligorsk.

2.1.5 Coverage

The ever reached figure, since February 2000, is more than 1200 injecting drug users. Statistics recorded 1190 clients registered with the needle-syringe programme from May 2000 until July 2002 and recommenced in August 2002, with 276 new clients registered by 31 December 2002. Some of these new clients were also previously registered, though at least 1200 individuals were registered at the Programme between January 2000 and December 2002. The Programme estimates that it reached 1127 injecting drug users in 2002.

Of the 276 clients who were registered between August and December 2002, 16% were female (44), which is in the mid-range of estimates for female injecting drug users in Belarus. All but 10 clients were aged between 16 and 30 years of age, which correlates with the general profile of injecting drug users in Belarus.

With regard to regular reach; in the five months from August to December 2002, of 276 clients registered, only 1% (2) attended the Programme more than four times per month; but 73% (202) took sufficient needles and syringes on average per month to meet their injecting needs, which is estimated at least 13 syringes per client per month. Reduced funding curtailed regular reach in 2002.

Table 3: Soligorsk, regular reach

Attendance	Percentage of clients (number)
Less often than monthly	53% (149)
Attended Monthly	19% (53)
Monthly to Fortnightly	10% (26)
Fortnightly	10% (28)
Fortnightly to Weekly	7% (18)
Weekly or more	1% (2)

Table 4: Soligorsk, needles distributed per month per client

Needles distributed per month per client	Percentage of clients (number)
Fewer than 13 syringes per month	27% (74)
13–40 syringes per month	42% (116)
41–80 syringes per month	19% (53)
81–120 syringes per month	6% (17)
More than 120 syringes per month	6% (16)

Secondary exchange was high with 31% of clients (86) taking more needles and syringes than they were likely to need in a month, taking on average more than 40 syringes per client per month; and 12% (33) taking on average more than 80 syringes per client per month.

The friendliness of the Programme staff at the Soligorsk Centre for Hygiene and Epidemiology was noted by many clients. Illustrated by statements such as:

'We get such a warm reception here. It's very unusual to get such a warm reception' (young female client).

'I come here to share my soul. Even my mother doesn't understand me as well as they do here' (older male client).

Support by the City Administration and the police were important. An HIV and AIDS Multisectoral Council was established with the needle-syringe programme manager as its Secretary. The manager believed that this and other ways of increasing collaboration between the various agencies had led to the programme's success, highlighting the need for cooperation between police, Programme staff and medical institutions. Written agreements, including one between the police and health units as well as a resolution by the City Administration approving the Programme were important. Relations with police are excellent, for example, the regular patrol route was altered so that police vehicles were less likely to pass the Programme at the Centre for Hygiene and Epidemiology during its opening hours. Individual work and the commitment of people, including the programme manager were seen as important by several interviewees.

Another commonly cited factor was the wide publicity by newspaper, television and radio given to the programme's work, which is a result of the administrative support received by the programme. The programme manager, Head of the City Administration and Chief of Militia have appeared twice on television talking about HIV transmission prevention among injecting drug users. A two-day information campaign in which information officers visited every workplace, distributing information about drugs, HIV and AIDS, and the role of the Programme was undertaken in 2002. The Women's Council, an organization with links to every workplace, also provides information about the programme to its members. Through these processes, the programme manager believes that everyone in the city is informed about the programme's purpose and location.

In 2000-2001, according to both clients and programme staff, the presence of other medical professionals attracted injecting drug users, particularly people living with HIV or people unsure of their HIV status, to the programme. This, linked with clients' anonymity (*"real anonymity, not just claimed"* said a programme worker) and confidentiality of clients' HIV status and other information facilitated HIV testing and treatment. One client stated:

'Free HIV testing is available elsewhere in the city but "everyone would know (the HIV test results) in a day'.

2.1.6 Maintaining and expanding coverage

The economic, social and political situation in Belarus is such that local or State funding will not be soon forthcoming to respond to issues related to HIV and drugs in cities such as Soligorsk. External assistance is likely to be needed for the programme to return to the high coverage levels achieved in mid-2001. At the time of writing, this assistance seemed most likely to come through a World Bank loan under negotiation. In order to restore high-level coverage, funding would need to increase beyond the purchase of needles and syringes to ensure that the products such as water, vitamins and medications as well as services such as treatment for sexually transmitted infections and visits by infectious diseases doctors and lawyers, which attracted injecting drug users, were also restored. Antiretroviral therapy and other HIV-related health care would also attract HIV-positive clients.

Several interviewees spoke of the need to ‘complete the chain’ of needle-syringe programmes, drug dependence detoxification, counselling, long-term drug treatment, drug substitution treatment and rehabilitation. Drug substitution treatment would facilitate adherence to antiretroviral therapy as well as enhance HIV transmission prevention among injecting drug users.

2.1.7 Further reading

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2.2 Pskov, Russian Federation

2.2.1 Summary

Pskov, located in the northwest of the Russian Federation, is the centre of an agricultural region, has a population of 206 000 and is the capital of Pskov Oblast, which has a population of 827 000.

The estimated number of injecting drug users is between 1200 and 1300. The ever reached figure was 1153 by 31 December 2002, equalling 88–96% of the estimated number of injecting drug users. In 2002, 268 injecting drug users were reached by needle-syringe programmes, equalling 20.6–22.3% of the estimated number of injecting drug users. There is no drug substitution treatment available and a drug rehabilitation service was established in Pskov in August 2002.

In terms of regular reach, of the 808 primary clients registered in 2002, only 3% (22) attended the Programme's fixed site exchange more than once a month, 97% (786) attended less than monthly with 14% (114) attending six to ten times, 50% (404) attending two to five times, and 33% (268) attending once. The number of injecting drug users reached in a sample month was 98, equalling 7.5–8.1% of the estimated number of injecting drug users.

2.2.2 Drug use and the HIV situation

The AIDS epidemic in the Russian Federation is one of the fastest growing globally. As of end 2003, the estimated number of people living with HIV in the Russian Federation was 860 000¹⁰. AIDS epidemics among injecting drug users in various parts of the country, particularly in Moscow and Irkutsk, have driven the epidemic over the past five years. In 1999, a rapid situation assessment in Pskov estimated the number of injecting drug users to be between 400 and 700¹¹.

After a five city study of needle-syringe programmes, which included Pskov, in 1999–2000¹², a further situation assessment study was undertaken in 2000, contacting injecting drug users who had accessed the Programme over the previous year¹³. The methodology included the use of benchmarks such as the number of overdoses, using data on overdose taken from militia and forensic expertise, and data on specific outreach clients, as well as the number of injecting drug users registered at the Oblast Drug Dependency Dispensary with each data set compared to the results of a survey of more than 200 Programme clients. This study estimated the number of injecting drug users to be between 1200 and 1300, which is the estimate currently used.

In Pskov Oblast, the most commonly injected drugs are home-produced ephedrine-based stimulants and liquid opiates (chernaya), and heroin. Syringes are sold in pharmacies without prescription. In addition to Pskov, there are other areas of drug use and HIV infection in Pskov Oblast, including Velikie Luki, a city, and OPOCHKA, a town. As of August 2002, there were 143 registered people living with HIV in Pskov Oblast, of whom 28, including eight

¹⁰UNAIDS (2004 July). Report on the global HIV/AIDS epidemic. Geneva, Switzerland. Retrieved on April 6, 2005 from <http://www.unaids.org/bangkok2004/report.html>

¹¹Rhodes T and Sarang A (2002). HIV transmission and HIV prevention associated with injecting drug use in the Russian Federation. DFID, London (Unpublished).

¹²Grund J-P, Kobzev D, Melnikov V, Zadoretzky C, Zemlianova E, Titus S, Perlis T, Paone D, Bodrova V and Des Jarlais DC. (2001). Drug use patterns and HIV risk behaviours of Russian syringe exchange participants. Paper presented at 12th International Conference on the Reduction of Drug-Related Harm Delhi.

¹³Sivatcheva I, Trofimov V, Gonchar E, Igorodetskaya I and Lukicheva T (2002). Some results of work of Pskov prevention programme among intravenous drug users on limiting the spread of HIV infection. Materials of II Russian Scientific-Practical Conference on HIV and blood borne viral hepatitis Suzdal Oct 1-3.

injecting drug users, are registered in Pskov. HIV prevalence in Pskov is among the lowest in Russian Federation, and the percentage of injecting drug users among people living with HIV (28%) is lower than the national average of approximately 70%. The Pskov needle-syringe programme is one of more than 80 programmes established in the Russian Federation.

2.2.3 History

The first attempts to start HIV-prevention activities among injecting drug users began in Pskov in 1996 after the chief doctor of the Oblast AIDS Centre, who is now also the Project Director of the harm reduction project, returned from an HIV conference in Kaliningrad, at which HIV infection among injecting drug users had been discussed. Subsequently, the internet was used to learn about HIV transmission prevention among injecting drug users and harm reduction. In May 1997, staff attended a conference on AIDS and related diseases in St. Petersburg at which initial harm reduction work in St. Petersburg and Lithuania was discussed. Later in the year, the Health Committee in Pskov Oblast provided initial funding for the AIDS Centre, which was used to purchase needles and syringes.

The needle-syringe programme was established in August 1998 and was advertised on local television. In September 1998, the first peer outreach worker, a female active injecting drug user, married to a Roma man, who was also an active injecting drug user (at that time in prison), started to work. The new outreach worker serviced clients but also attracted new outreach workers and volunteers. For the first six months, these were mainly Roma. It should be noted that from the beginning the project worked extensively with drug users from the Roma community. Also in 1998, training was provided in Rapid Assessment and Response for carrying out a rapid HIV and drug use situation assessment in Pskov and a visit was undertaken to the needle exchange bus in St Petersburg. Gaining knowledge of international and Russian-based experience assisted the project managers to reflect on their work and improve it.

In March 1999, the project received its first external funding from the Open Society Institute (OSI), Russia. Since 1999, each year the programme has expanded its services geographically or the range of services offered or both, striving to reach high coverage levels of injecting drug users and others at highest risk of HIV infection. Initially, the project achieved high coverage of needle exchange among injecting drug users in Pskov, and then attempted to provide similar services throughout the Oblast, particularly in Velikie Lukie and OPOCHKA. It then expanded its services to address sex workers and prisoners, many of whom were also injecting drug users. By 2002-2003, the programme had reduced its dependence on external funding, with 56% of funding being provided by the Oblast and National Governments as well as local corporate donors.

The programme's work was evaluated at an early stage when Pskov participated in the five-city study of needle-syringe programmes¹⁴, which investigated behavioural changes among injecting drug users by comparing levels of reported risk behaviours in the one month prior to participation in a programme against the previous month during participation in a programme. Of 201 injecting drug users surveyed in Pskov, reductions following participation in the needle-syringe programme included:

- from 26% to 4% of respondents using non-sterile injecting equipment;
- from 47% to 36% of respondents sharing drugs from syringes; and
- from 25% to 9% of respondents injecting in an anonymous injecting location.

¹⁴Grund et al. (2001). op.cit.

In 2002, another study¹⁵ of HIV prevalence among 741 clients participating in the needle-syringe programme found less than 1% were HIV-positive.

2.2.4 Features of services

The harm reduction project of the Pskov Oblast AIDS Centre comprises 22 staff, including the project director; project coordinator; outreach manager; driver; six outreach workers (including three former injecting drug users) and one active injecting drug user, and eight unpaid volunteers in Pskov. An additional 12 outreach workers operate in Velikie Luki. In Pskov, the programme targets injecting drug users, sex workers and prisoners; actively cooperates with sexually transmitted infection treatment services, OBNON (drugs police), the Oblast Vice-Governor and local nongovernmental organizations; and has referral agreements with all medical facilities.

The needle exchange services comprise a fixed site exchange in Pskov, a mobile unit, which operates in Pskov and OPOCHKA, and outreach. The fixed site is situated in the Pskov AIDS Centre, operates from 8.00 to 19.00 Monday to Friday, and reaches on average 50–60 clients and exchanges up to 1300 needles and syringes per week, as well as offering additional medical services through the AIDS Centre polyclinic, including access to infectious diseases doctors, therapists and dentists. The programme provides a wide range of materials (*see Table 5: Pskov services and products provided*).

Outreach work in Pskov comprises street-based work, including at the railway station, and in drug users' apartments. The bulk of needles and syringes are distributed and exchanged through secondary distribution in some 50 apartments. The programme provides social assistance to outreach workers, including assistance with finding work, as well as the possibility of working part time. Outreach work takes place between 9.00 and 19.00 Monday to Friday and the outreach team meets to provide daily reports. A significant achievement has been access to the Roma community.

¹⁵Sivatcheva et al. (2002). op.cit.

Table 5: Pskov services and products provided

Services and Products	Fixed site NSEP	Mobile NSEP	Outreach
Needles and syringes distributed	X	X	X
Needles and syringes returned	X	X	X
Needles and syringes disposal	X	–	–
Water for injection	X	–	–
Alcohol swabs	X	X	X
Disinfectant for syringe cleaning	X	X	X
Filters and cotton balls	–	–	–
Vitamins	X	–	–
Medications for hepatitis		–	–
Treatment for HIV and AIDS	X	Referral	Referral
Drug detoxification	Referral	Referral	Referral
Other medications	–	–	–
Condoms distributed	X	X	X
information, education and communication materials distributed	X	X	X
Face-to-face individual education and advice	X	X	X
Group education	–	–	–
Sexually transmitted infection services	Referral	Referral	Referral
Counselling (general)	X	–	–
Counselling on drugs	Referral	Referral	Referral
Counselling on HIV and AIDS	X	–	–
Legal assistance	–	–	–
Housing and welfare assistance	–	–	–
Drug user support groups	–	–	–
Former drug user support groups	–	–	–
People living with HIV support groups	–	–	–

Table 6: Pskov needle-syringe programme, 1999–2002

	January– December 1999	May 2000– March 2001	June 2001– May 2002	Total
Syringes distributed	24 667	36 660	64 570	125 897
Percentage returned	85.5	91	92.3	89.6
Total client contacts	*	6 662	5 130	11 792
Condoms distributed	5 894	11 007	17 374	34 275

* Denotes “not recorded”

Detoxification in Pskov is carried out by drug dependence services and there is no drug substitution treatment services provided in the Pskov Oblast. In August 2002, a rehabilitation centre “Kamen” was established, which cooperates with the harm reduction programme. The centre is supported by different sources, including churches, though fewer than 20 people have attended the programme.

2.2.5 Coverage

The ever reached figures for the Programme were 575 clients in 1999, 793 in 2000, 857 in 2001, and 1153 by the end of 2002. The drug rehabilitation service, Kamen, also reached 20 clients but it is unknown whether these clients were also Programme clients.

With regard to regular reach, 3% (22) of the 808 primary clients registered at the Programme in 2002 attended the fixed site exchange monthly or more often; while 97% (786) attended less often than monthly.

Table 7: Pskov, regular reach

Attendance at fixed site exchange	Percentage of clients (number)
Attended 12 times or more in 12 months	3% (22)
Attended 6–10 times in 12 months	14% (114)
Attended 2–5 times in 12 months	50% (404)
Attended once in 12 months	33% (268)

Attendance at the fixed site exchange is low. However, the use of mobile services, outreach workers, volunteers and a sophisticated secondary exchange system allow needles and syringes to be distributed to a large network of injecting drug users. It is likely that fears of police surveillance (*see 2.2.6 Maintaining and expanding coverage*) are a cause of the low attendance rates at the fixed site, with most clients preferring to obtain needles and syringes from friends. It is impossible to estimate the coverage by secondary exchange; however, the Project Director stated that many of the city's injecting drug users received their needles and syringes regularly through secondary exchange.

An important factor in the initial growth of the programme was hiring an active injecting drug user as an outreach worker. Without their involvement, it would have been impossible to establish relations with the injecting drug user community. Several previous attempts had been made by the AIDS Centre staff with no results. Establishing strong and trusting relations with drug users was key to accessing injecting drug user networks.

Establishing an effective system of outreach management and supervision was crucial to increasing outreach and needle exchange coverage. As all outreach workers were injecting drug users, it was important to establish a strong management system which maintained discipline and ensured adherence to rules such as not using drugs during work hours. Outreach workers were encouraged to seek new clients and not to remain with those clients that they knew well. The Project Director was closely involved with outreach workers from the beginning and personally knew many clients.

To ensure efficient and transparent management, weekly team meetings were held. Outreach workers had clear goals set for each week and contact norms, for example, at one time, each outreach worker had to make at least 10 new contacts per week of whom three had to be female. Access to young female drug users was seen as an important priority. Moreover, there was a rule that all new clients should either come to the fixed site exchange or be introduced to the Project Coordinator. Work requirements and rules were reflected in job descriptions and other official documents signed by the employees.

Building understanding and partnerships with key city officials, including the heads of the Oblast Health Department, OBNON and GUIN (Prisons Department) were important for increasing coverage, as was the resolution of the Vice-Governor to implement harm reduction programmes in OPOCHKA and Velikie Luki.

2.2.6 Maintaining and expanding coverage

The major barriers to continued and expanded coverage are certain people and institutions in some areas, and the lack of national, supportive policies and laws. For example, the slow introduction of a needle-syringe programme in OPOCHKA is the result of resistance by some local police officials, despite the support of the Oblast Vice-Governor. At the national level, there is a lack of a regulatory framework for the operation of harm-reduction projects. For example, a position for a social worker within the state public health institutions has not been

defined. As a result, the AIDS Centre cannot hire a drug user or any other person, who does not have the appropriate education, to work with the target groups, except through creative means, for example, through external funding. The lack of a supportive national government legal framework means that on-going problems with police, particularly those from St Petersburg, who carry out periodic raids in Pskov, prevent some injecting drug users from accessing fixed and mobile services.

In December 2002, Pskov Oblast was ranked 62 out of 88 Russian Federation territories in terms of HIV prevalence. As HIV prevalence is low the AIDS Centre has been able to supply care for most HIV-positive people, including some experimental access to antiretroviral therapy. Increased access to effective treatments would increase the Programme's ability to attract HIV-positive people to its services on a more regular basis. Drug substitution treatment would also assist this process as well as leading to enhanced HIV prevention among injecting drug users.

Sustainability of the project is difficult to predict. With new external funding from the Department for International Development (DFID) of the United Kingdom, and a World Bank loan, sufficient funding may be found to keep the programme operating.

2.2.7 Further reading

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2.3 Sumy, Ukraine

2.3.1 Summary

Sumy, located about 500 km northeast of Kiev with a population of 297 000, is the centre of an industrial region bordering the Russian Federation, and is the capital of Sumy Oblast, population 1.35 million.

The estimated number of injecting drug users in Sumy is 1500. The ever reached figure of injecting drug users reached by the needle-syringe programme is 1100 by 31 January 2002, equalling 73% of the estimated number of injecting drug users. There are no drug substitution treatment or drug rehabilitation programmes.

With regard to regular reach, of the 341 clients, who attended the Programme in a sample month in 2002, 14% attended between six and ten times, 50% attended between two and five times and 33% attended once. Injecting drug users reached in a sample month were 341, equalling 22.7% of the estimated number of injecting drug users.

2.3.2 Drug use and the HIV situation

Ukraine has experienced the largest increase in injecting drug-use-related HIV infections in Eastern Europe. As of end 2003, the estimated number of people living with HIV in Ukraine was 360 000¹⁶. In 2002, it was estimated there were more than 300 000 injecting drug users.

The National HIV and AIDS Prevention Programme is being implemented in Sumy Oblast through the HIV and AIDS Prevention Programme, 2001–2003, signed by the Head of the Oblast State Administration which:

‘...ensures operation of needle exchange programmes for the injecting drug users and trust cabinets for the representatives of other vulnerable groups (including mobile units) in all cities of the oblast in order to provide a wide range of medical, psychological, legal and social services’.

A similar statement was included in the previous Prevention Plan, 1999-2000.

According to Clause 4 of the Ukrainian law *On prevention of Acquired Immune Deficiency Syndrome (AIDS) and social protection of population* (1998), the State guarantees:

‘HIV prevention among persons, using injecting drugs, in particular to arrange conditions for exchange of used injecting needles and syringes for sterile needles and syringes’.

The number of injecting drug users in Sumy is estimated at 1500. This figure was calculated by using a multiplier technique with the number of injecting drug users registered as a benchmark, and the percentage of needle-syringe programme clients who are registered as a multiplier. The resulting figure was compared to an estimate from injecting drug users interviewed by Programme staff and another estimate by a local journalist. At the end of 2002, the number of registered people living with HIV in Sumy was 75, of whom 35 were injecting drug users. This percentage of injecting drug users among people living with HIV is lower than the

¹⁶UNAIDS (2004 July). *Report on the global HIV/AIDS epidemic*. Geneva, Switzerland. Retrieved on April 6, 2005 from <http://www.unaids.org/bangkok2004/report.html>

national average of 57%¹⁷. In Sumy Oblast, there were 489 registered people living with HIV, of whom 301 were injecting drug users. The Sumy Programme is one of more than 20 established in Ukraine.

2.3.3 History

In mid-1998, the Chief Epidemiologist of Sumy Oblast received a new AIDS law, which contained the clause referring to needle exchange quoted in **2.3.2 Drug use and the HIV situation**. Prior to this, the Chief Epidemiologist had never heard of needle exchange. A similar clause was included in the Sumy Oblast's HIV and AIDS Prevention Plan, 1999-2000. As needle-syringe programmes were mentioned in the Oblast Prevention Plan, areas of the Oblast began to implement programmes, firstly in Shostka, the second largest city, then in the towns of Romni, Esbudar and Ochtir.

In August 1999, the Chief Epidemiologist became Chief Doctor of the Sumy Oblast HIV and AIDS Prevention Centre and sought assistance from UNAIDS and the International Renaissance Foundation for establishing a needle-syringe programme. The application was supported by the Oblast Administration, particularly the Health Department. OBNON, the drugs police, was also supportive from an early stage. A senior OBNON officer together with the First Deputy Head of the Health Department and the Chief Doctor of the Oblast AIDS Centre had attended a meeting on the Harm Reduction Strategies in Kiev in January 2000.

In May 2000, a needle-syringe programme was established at the Sumy Oblast's HIV and AIDS Prevention Centre, initially operated by the AIDS Centre; the charitable foundation, 'Pace Forward to Meeting', took over the programme in September 2002. Technical assistance was provided by the needle-syringe programmes in Poltava and Nikolaev.

A former injecting drug user, recently released from prison, became the Programme's first outreach worker and attended a training workshop on outreach in Kiev. The outreach worker knew many injecting drug users and began distributing syringes among friends and acquaintances, as well as at drug selling points, explaining the aims and tasks of the programme. As a result, many injecting drug users visited the fixed site exchange at the AIDS Centre.

From September 2000 to January 2001, three mobile exchange points operated in different parts of the city to access as many injecting drug users as possible and inform them about the work of the programme. Through this process, and by engaging knowledgeable injecting drug users in various parts of the city, the field sites and operating hours were fixed. These sites were established between June 2000 and July 2001. The Programme was staffed by a project manager, senior outreach worker, five social workers, a psychologist and a bookkeeper. Consultations with the AIDS Centre's infectious diseases doctor and a lawyer were organized for Programme clients.

By December 2000, two stationary and four field exchange sites were functioning; when, the head outreach worker visited a drug dealer to encourage him to become involved in the Programme. The dealer was both suspicious and aggressive; however, the outreach worker kept returning, providing educational materials and syringes, while explaining the Programme. Finally a friendship was established, three other dealers were introduced and the four dealers became secondary exchangers for the programme.

¹⁷Dr. Arielle Braye. 3 by 5 Country Programme Officer, WHO Country Office in Ukraine. (personal communication, April 2005).

In October 2002, the charitable foundation, ‘Pace Forward to Meeting’, began HIV-prevention activities among sex workers, including providing HIV-related information and education; distributing HIV and other sexually transmitted infection prevention materials, condoms, disinfectants and other materials; referring sex workers to services such as the AIDS centre, sexually transmitted infection clinic or the needle-syringe programme; and organizing self-support groups for sex workers, as well as press conferences, seminars, round table events etc.

2.3.4 Features of services

Needle and syringe exchange and other services for injecting drug users are provided through two fixed sites at the Oblast AIDS Centre and the Sumy Oblast Drug Dependency Clinic where clients are served by a staff nurse, as well as four field units operated by social workers, and a psychologist on a rotating basis. Operating hours are:

- Sumy Oblast AIDS Centre, Monday to Friday 9.00–16.00;
- Sumy Oblast Drug Dependency Clinic, 24 hours a day, seven days a week;
- Field units:
 - Prokofiev St: Monday and Friday, 15.00–17.00;
 - SKD St: Tuesday and Thursday, 15.00–17.00;
 - Sumskaya St: Tuesday, Thursday and Saturday, 13.00–15.00; and
 - Parkovaya St: Wednesday 15.00–17.00.

Five social workers, a senior social worker, a psychologist, a bookkeeper, a harm-reduction project manager and assistant are funded through the programme’s budget. Salaries for the workers of the fixed site exchanges and nurses at the AIDS Centre and Drug Dependency Clinic are funded through their respective budgets. The psychologist counsels briefly at the field sites; for longer or more private counselling, clients are asked to visit the AIDS Centre where counselling is provided in a private room.

In addition, three trained injecting drug user volunteers provide secondary exchange and information and education to other injecting drug users, who do not attend exchange points. About 100 injecting drug users, including teenagers, access this secondary exchange system.

Access to fixed and field sites is simple and quick. A separate entrance is used by Programme clients at the AIDS Centre, and needle exchange is provided in a separate room. In the field, social workers provide needles and syringes, alcohol swabs, condoms, disinfectant, some minor medications (such as headache pills), counselling, and referral for HIV testing, and HIV and drug treatment. Field site clients stated that the Programme provided them with the materials that they needed, though condoms were sometimes in short supply. Syringes and swabs were viewed as the most important provisions.

Some interviewees were concerned that police could be watching, perhaps even videotaping the field sites or the AIDS Centre. Others laughed and one respondent said that visiting the site was “*like going to the shop—routine*”. Other interviewees said they felt safe coming to the site, “*Police know about this place but they don’t hassle us here*”. This lack of police activity around field sites was confirmed by OBNON.

Needles and syringes are collected by programme workers and placed in puncture proof containers, which are stored when full at the AIDS Centre. Every three months, the containers are transported to a local metal factory and burnt.

All needle-syringe programme sites keep records of visits by clients and services provided. A simple, unique numerical identification code is used and all new clients are issued with an identification card with their number. This card is needed for all visits to the Programme. Data on needles and syringes distributed and returned, and a range of other information is collated. Each new client is required to fill out a questionnaire on their age, sex, etc. and their sex- and drug-use-related behaviours. The first 600 questionnaires have recently been analysed. Other questionnaires to track changes in clients' behaviour are provided to a sample group of 100 clients over a one to two week period every six months. In May-June 2001, the Programme undertook qualitative research, using in-depth interviews, a questionnaire and focus groups to gain a deeper understanding of clients' needs.

Table 8: Sumy services and products provided

Services and Products	AIDS Centre NSEP	Drug Dependency Dispensary NSEP	Field sites
Needles and syringes distributed	X	X	X
Needles and syringes returned	X	X	X
Needles and syringes disposal	X	–	X
Water for injection	–	–	–
Alcohol swabs	X	X	X
Disinfectant for syringe cleaning	X	–	X
Filters and cotton balls	X	–	X
Vitamins	X	–	X
Hepatitis treatment	X	–	X
Treatment for HIV and AIDS	X	Referral	Referral
Drug detoxification	Referral	X	Referral
Other medications	X	–	X
Condoms distributed	X	X	X
Information, education and communication materials distributed	X	X	X
Face-to-face individual education/ advice	X	–	X
Group education	X	–	X
Sexually transmitted infection services	Referral	Referral	Referral
Counselling (general)	X	–	X
Counselling on drugs	Referral	X	Referral
Counselling on HIV and AIDS	X	Referral	Referral
Legal assistance	–	–	–
Primary medical assistance	X	–	X
Voluntary HIV testing with pre- and post-testing counselling	X	X	X
Housing and welfare assistance	–	–	–
Drug user support groups	–	–	–
Former drug user support groups	–	–	–
People living with HIV support groups	–	–	–

Table 9: Sumy needle-syringe programme, May 2000–December 2002

	May – December 2000	2001	2002	Total
Syringes distributed	22 967	109 972	141 282	274 221
Syringes returned	20 845	106 028	133 158	260 031
Percentage returned	90.7	96.4	94.2	94.8
Total client contacts	3 699	14 368	18 550	36 617

Detoxification is carried out by drug dependence services. No drug rehabilitation services, drug substitution treatment or other drug treatment are available in Sumy Oblast.

2.3.5 Coverage

The ever reached figure for injecting drug users accessing the needle-syringe programmes was 382 in 2000, 825 in 2001, 1047 by the end of 2002 and 1100 by 31 January 2003. The table below outlines the age distribution of the 1100 clients.

Table 10: Age Distribution of needle-syringe programme clients, Sumy

Age	Percentage
Under 19	10%
20–25	44%
26–29	20%
30–35	16%
36–39	6%
Over 39	4%

Of 600 client registration forms which have been analysed, 13% were female.

With regard to regular reach, client statistics were analysed and averaged for two random sample months in 2002. The table below outlines the attendance of the 341 primary clients who accessed the needle-syringe programme.

Table 11: Sumy, regular reach

Attendance	Percentage of clients (number)
1–5 times per month	69% (229)
6–10 times per month	21% (73)
11–15 times per month	7% (27)
16–20 times per month	1.4% (6)
21–25 times per month	0.6% (2)
26–30 times per month	1% (4)

Programme staff estimated that 10% of all needles and syringes distributed were to secondary exchangers, who passed them on to about 100 other injecting drug users.

The main factors in achieving high coverage among injecting drug users were:

- national policy. The Ukrainian law, *On AIDS prevention and the social public protection* (1998), which introduced needle-syringe programmes as part of HIV-prevention programmes nationally and the National HIV and AIDS Prevention Plans that emphasized needle-syringe programmes;
- good working relationships between the project manager and Oblast Administration, OBNON and the Oblast's Health Administration;
- stability of donor funding over three years, as well as donors providing training, information and technical assistance;
- convenience of the field sites for injecting drug users to access services close to their homes and/or to drug selling points;
- snowballing i.e. the provision of small incentives to clients who brought a new client to the Programme. As this continued, groups of injecting drug users, who injected drugs together, began to arrive at the Programme. Sometimes they later disappeared in groups, either leaving the city or being incarcerated, though they usually eventually returned to the Programme;
- the stability of the field sites with schedules being adhered to irrespective of weather or other adverse conditions;
- regular monitoring of the project;
- involvement on a paid basis of former and active injecting drug users as outreach workers, and the assistance of leaders among injecting drug users. Trust was built gradually with injecting drug users, and staff have been careful to remain polite, tolerant, have a positive attitude and make clients feel comfortable at fixed and field sites;
- retention of programme personnel, which was felt to be a result of the personal motivation of programme officials, regular meetings to discuss problems and issues, regular training, legal security and the support by the local authorities for the needle-syringe programmes;
- regular work with journalists, including a competition for regional media on the best reporting of the work of the harm reduction project, and assisting two local journalists to attend training sessions on HIV reporting; and
- combining the strengths of the charitable foundation, 'Pace Forward to Meeting', and the Government organization, AIDS Centre, for programme implementation.

2.3.6 Maintaining and expanding coverage

The charitable foundation, 'Pace Forward to Meeting', plans to expand its work to the three largest prisons and has applied for international funding for a project to provide HIV and AIDS education to prisoners and staff, condoms and access to needles and syringes.

At needle-syringe programmes, social workers often meet the mothers, wives and other family members of injecting drug users. In late 2002, two meetings were held with groups of mothers of injecting drug users, who wanted family support to assist their children to stop their drug use. This led to discussion of the need for a drug rehabilitation programme but to date this has not been implemented.

Drug substitution treatment would assist in the provision of antiretroviral therapy and other treatment for HIV-positive injecting drug users as well as leading to enhanced HIV prevention among injecting drug users. 'Pace Forward to Meeting' is planning to apply to the International Renaissance Foundation and Open Society Institute to implement methadone substitution treatment in Ukraine, but this has not yet occurred.

Current activities by the Ukrainian Government under a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria and a loan from the World Bank may provide the necessary support to increase Sumy's and the Sumy Oblast's funding for maintaining and expanding the work of the needle-syringe programmes.

2.3.7 Further reading

Balakireva O, Galustian Y, Yaremenko O, Scherbynskya A, Kruglov Y, Levchuk N, Onikienko V, Andruschak L, Barnett T and Whiteside A. *The social and economic impact of HIV and AIDS in Ukraine: A re-study*. British Council/ Ukrainian Institute for Social Research. Kiev, Ukraine. 2001.

Ukraine Ministry of Health. *HIV/AIDS Epidemiology Bulletin*. July 1, 2003.

UNAIDS. *Join the fight against AIDS in Ukraine*. Kiev, Ukraine. June 2002.

3. Case Studies: Asia

3.1 Dhaka, People's Republic of Bangladesh¹⁸

3.1.1 Summary

Dhaka, with a population of 12 million is the capital of Bangladesh. The estimated number of injecting drug users is 7650. The ever reached figure is 9630 injecting drug users after six years at the end December 2002. With regard to regular reach; a sample month in 2001 was analysed, in which some 4000 clients attended drop-in centres or were reached by other services, equalling 52% of injecting drug users in Dhaka.

3.1.2 Drug use and the HIV situation

Bangladesh has much lower HIV prevalence than several other countries in South Asia. As of end 2003, the estimated number of people living with HIV in Bangladesh was between 2500 and 15 000¹⁹. The number of drug users has been estimated at between 100 000 and 1.7 million, with 20 000–25 000 of these being injecting drug users²⁰. There are three needle-syringe programmes and related projects in Bangladesh, all established and funded by CARE Bangladesh, as well as a small number of drug treatment programmes.

The number of injecting drug users in Dhaka is estimated to be 7650. This figure was calculated through a rapid situation assessment for HIV and drug use undertaken by CARE Bangladesh in 1998²¹. Regular behavioural surveillance surveys have identified few HIV-positive injecting drug users.

Table 12: HIV-positive injecting drug users in Dhaka

HIV-positive injecting drug users in Dhaka	1998-1999	1999-2000	2000-2001	2001-2002
Number injecting drug users tested	402	418	400	400
Number (%) HIV-positive	11 (2.7)	6 (1.4)	7 (1.7)	16 (4)

3.1.3 History

CARE Bangladesh's SHAKTI Injecting Drug User Project (SHAKTI Project) commenced in Dhaka in May 1998. Prior to establishing the project, a rapid situation assessment was carried out, from which it was estimated that there were some 7650 injecting drug users and at least 11 000 heroin smokers in Dhaka. Other results included:

- for injecting drug users, the drug of choice was injectable buprenorphine and other prescription drugs such as diazepam, promethazine, and pheniramine, which is used together with buprenorphine;

¹⁸Some of the information from this section is drawn from Panda S, Chapter IV: Outreach in Dhaka, Bangladesh, in UNAIDS/AHRN/UNODC (2002). *Preventing HIV/AIDS among drug users: case studies from Asia*. Geneva, Switzerland. http://www.unaids.org/html/pub/Publications/IRC-pub03/AsiaDrugUsers_en_pdf.pdf

¹⁹UNAIDS (2004 July). *Report on the global HIV/AIDS epidemic*. Geneva, Switzerland. Retrieved on April 6, 2005 from <http://www.unaids.org/bangkok2004/report.html>

²⁰NASROB (National Assessment of Situation and Responses to Opioid/ Opiate Use in Bangladesh) (2002 June). *What will happen to us? Country highlights and recommendations* Family Health International/ CARE/ HASAB. Dhaka.

²¹Beg M. (1999). *Injecting drug user Intervention, SHAKTI Project, CARE Bangladesh. Activity Report March 1998 to June 1999*. CARE Dhaka.

- more than 90% of injecting drug users have previously smoked heroin; as such, the 11 000 heroin smokers could be viewed as potential injecting drug users; and
- over 80% of injecting drug users had shared needles and syringes, 90% had shared other injecting equipment, 30% were homeless, 46% had no education, 84% were ever arrested and 66% were ever jailed.

SHAKTI Project staff, with the assistance of guides, who were active injecting drug users, and other key informants, mapped the city through field visits and observations, identifying 42 drug injecting sites, some of which were also drug selling points. The project began by training 12 active injecting drug users as peer outreach workers. The five-day training covered a range of topics, including educating other injecting drug users on sexually transmitted infections, HIV, and drug-related issues; and offering health services for abscesses and sexually transmitted infections, needle and syringe exchange, and distribution of condoms. During the training, working hours were set and rules for staff behaviour were agreed, including no injecting drug use and no carrying of drugs during work hours, and avoiding involvement in criminal activities.

The first drop-in centre was set up in April-May 1998 with drug selling points being avoided. The Ward Commissioner provided space in his own office building, the community centre, free of charge and by June 1998, peer outreach workers had reached 150 injecting drug users and distributed 1753 needles and syringes.

By June 1999, the average number of injecting drug users reached daily was 1945 and more than 2200 on some days. A further six drop-in centres had opened, there were 26 peer outreach workers and 20 medicine shop sellers trained, and 160 volunteer peer educators. The programme eventually expanded to 11 drop-in centres and 50 peer outreach workers. From the Dhaka experience, CARE Bangladesh went on to open similar injecting drug user programmes in the northwest Bangladesh in Rajshahi in May 1999, Chapai Nawabganj in March 2001 and Char Narendrar in February 2002 (*see 3.2 Rajshahi, People's Republic of Bangladesh*).

3.1.4 Features of services

In Dhaka, there are 11 drop-in centres, which provide injecting drug users with HIV prevention, diagnosis and treatment services for sexually transmitted infections, and primary health care, mostly treatment of abscesses. Weekly diagnosis and treatment services for sexually transmitted infections are provided by a doctor, partly funded by the Marie Stopes International Clinics, an international nongovernmental organization, and other weekly medical treatment is provided by a Government doctor. SHAKTI Project staff said that the programme's links to CARE, the Government and international nongovernmental organizations assisted in shielding drop-in centres from neighbourhood opposition.

The drop-in centres operate from 8.00–15.00 Saturday to Thursday and some 1570 injecting drug users visit the drop-in centres monthly. Drop-in centres are also used as venues for training peer outreach workers and educators, and for group education of injecting drug users; provide referral to other services such as clinics for more serious medical problems, HIV testing and drug treatment; and provide a safe space for injecting drug users to spend time. Each drop-in centre has a person in charge and another person, usually an active or former injecting drug user, who dresses and provides abscesses management.

Needle-syringe programmes were not based in drop-in centres after community consultations found that neighbours worried that programmes would turn drop-in centres into shooting galleries. Instead these services were provided by peer outreach workers, who use the

drop-in centre as a base for collecting outreach supplies, holding outreach meetings, completing monitoring and other forms, and storing used equipment. Used equipment, some 25 000–30 000 needles and syringes, is collected from all drop-in centres once a month and transported to a medical research facility where it is burnt in a medical waste incinerator.

In addition to the 42 sites originally found, some 30 other injecting drug use and selling areas have been identified through mapping the city and interviews with injecting drug users; all these sites are covered by outreach. Outreach work is conducted for 26 days each month, with workers alternating between two outreach areas, spending 13 days per month on alternate days in each site. More than 50 paid peer outreach workers, mostly active drug users, provide education, needle and syringe exchange, condom distribution and referrals. All peer outreach workers and educators are men, which may explain the low ratio of female to male injecting drug users accessing project services (see **3.1.5 Coverage**).

Each injecting drug user receives, on alternate days, two needles and two 1 ml syringes during outreach visit but can have extra needles if needed. Strict one-for-one exchange is practised with few exceptions, and the corners of packs are torn to prevent resale. Four needles and syringes are provided on Thursday as the service does not operate on Fridays. If extra injecting equipment is required, clients are advised to clean and re-use their own injecting equipment.

The SHAKTI Project also employs a technical coordinator, one administrator, and four programme officers who each concentrate on one of the following issues: enhancing outreach effectiveness, mobilization of current and former drug users to form self-help groups, and advocacy; there are also eight field trainers all of whom work from the CARE Bangladesh Dhaka office. All staff members, including peer outreach workers, attend a monthly team meeting to discuss programme statistics and problems, discuss specific issues such as research work or planning World AIDS Day activities, and the formation of two self-help groups: PROCHESTA, for drug users and BODAR, for former drug users. CARE plans for these two groups to eventually take over some of the injecting drug user services. BODAR already assists in the running of the weekly Narcotics Anonymous meetings held in five drop-in centres.

The field trainers supervise the work of peer outreach workers and drop-in centre staff and provide them with on-the-job training; assist peer outreach workers undertake group education; and regularly monitor injecting drug users' behaviours and needs through six-monthly interviews with random samples of clients. Field trainers ensure that drop-in centres are properly run and each trainer works with one peer outreach worker daily, ensuring that outreach education and monitoring tasks are being completed correctly. Field trainers also carry out neighbourhood advocacy, asking the advocacy programme officer for assistance when needed. Harassment of peer outreach workers by police or hoodlums are also dealt with by field trainers and programme officers.

The SHAKTI Project organizes in partnership with the Central (Government) Drug Treatment Hospital in Tejgaon, Dhaka, community-based detoxification camps in spaces donated or rented at discount rates from the community. Each camp lasts 14 days and injecting drug users donate US\$ 3 each, which goes into BODAR's trust fund. The costs of medications, housing, food and medical assistance are paid by SHAKTI. No drug rehabilitation services, drug substitution treatment or other drug treatment services are provided in Dhaka, though BODAR hopes to start a drug rehabilitation programme, if sufficient funding is sourced. Drug substitution treatment is illegal in Bangladesh.

Table 13: Dhaka, services and products provided

Services and Products	Drop In Centres	Outreach
Needles and syringes distributed	–	X
Needles and syringes returned	–	X
Needles and syringes disposal	X	–
Water for injecting	–	–
Alcohol swabs	X	X
Disinfectant for syringe cleaning	–	–
Filters and cotton balls	X	X
Vitamins	–	–
Medications for hepatitis	–	–
Treatment for HIV and AIDS	–	–
Drug detoxification	X	Referral
Other medications	–	–
Condoms distributed	X	X
Information, education and communication materials distributed	X	X
Face-to-face individual education/ advice	X	X
Group education	X	X
Sexually transmitted infection services	X	Referral
Counselling (general)	X	–
Counselling on drugs	X	X
Counselling on HIV and AIDS	X	X
Legal assistance	–	–
Housing and welfare assistance	–	–
Drug user support groups	X	Referral
Former drug user support groups	X	Referral
People living with HIV support groups	Referral	Referral

Table 14: Dhaka needle-syringe programme, May 1998–December 2002

	May–December 1998	1999	2000	2001	2002	Total
Syringes distributed	145 682	597 712	810 66	1 125 549	742 818	3 422 727
Syringes returned	96 385	483 701	675 666	833 833	541 052	2 632 637
Percentage returned	66%	81%	83%	74.1%	72.8%	76.9%
Condoms distributed	41 249	165 950	148 001	62 688	68 285	486 173
Injecting drug users with abscesses treated	494	4550	3894	3 682	4 039	16 659
Injecting drug users treated for sexually transmitted infections*	NA	430	426	372	310	1 538

*Sexually transmitted infection services started in March 1999

3.1.5 Coverage

The ever reached figure for the needle-syringe programme was some 3000 injecting drug users in 1998, 8000 in 1999, and 9630 in 2000 with little increase in the figure since. About 70 of the injecting drug users are women (0.8%). It is not known if this reflects the ratio of male to female injecting drug users in the city. The number of clients reached is greater than the number of estimated injecting drug users due to the movement of large sectors of the opiate using population between injecting drug use and heroin smoking.

With regard to regular reach, a sample month was analysed in 2002²²; the results showing that some 4000 injecting drug users were 'enlisted' i.e. they regularly attend outreach or drop-in services. Some 58% of enlisted clients accessed outreach services on 10–13 days, 22% between seven and nine days, and 20% fewer than six days in the month. Of those who lived near drop-in centres, 99% accessed outreach services on 10–13 days in the month. Lower regular reach and higher mobility was found in those areas such as slums from which injecting drug users were routinely forcibly evicted.

According to BODAR, around 120 injecting drug users had undergone treatment in detoxification camps between January 2000 and November 2002. The Drug Treatment Hospital can treat a further 1020 people per year; however, the hospital caters to all dependent people, including heroin smokers and alcoholics. The number of injecting drug users treated at the hospital is unknown.

For a discussion of the factors in achieving coverage see **3.2.5 Coverage**

3.1.6 Maintaining and expanding coverage

See **3.2.6 Maintaining and expanding coverage**

3.1.7 Further reading

See **3.2.7 Further reading**

²²UNAIDS/AHRN/UNODC (2002). *Preventing HIV/AIDS among drug users: case studies from Asia*. Geneva, Switzerland. [Electronic version] http://www.unaids.org/html/pub/Publications/IRC-pub03/AsiaDrugUsers_en_pdf.pdf

3.2 Rajshahi, People's Republic of Bangladesh²³

3.2.1 Summary

Rajshahi with a population of 300 000 lies 270 km northwest of Dhaka and is separated from West Bengal, India, by the Padma River. Rajshahi is a university city, and the centre of an agricultural district, with trade and travel between Rajshahi and West Bengal on-going.

The estimated number of injecting drug users is between 770 and 1000. The ever reached figure since May 1999 is 500, equalling 50–70% of the injecting drug users in Rajshahi.

With regard to regular reach, in a sample month in 2002, 436 clients attended harm reduction or drug treatment services, equalling 44–57% of the injecting drug users in Rajshahi.

3.2.2 Drug use and the HIV situation

For the national situation in Bangladesh, see **3.1.2 Drug use and the HIV situation**

The number of injecting drug users in Rajshahi is estimated to be between 770 and 1000. An early rapid assessment of six cities in Bangladesh²⁴ suggested that there could be between 12 000 and 15 000 injecting drug users in the northwest of the country, mostly in Rajshahi and the neighbouring town, Chapai Nawabganj. However, in 2000, a team from CARE Bangladesh's SHAKTI Injecting Drug User Project used a mixture of mapping and identification of drug using areas as well as other methods to estimate that there were 1000 injecting drug users in Rajshahi²⁵. In late 2001, a further assessment, as part of a large study by several international and national organizations, estimated there were 770 injecting drug users and 1475 heroin smokers²⁶.

Regular behavioural surveillance surveys have not identified any HIV-positive injecting drug users in the northwest of Bangladesh. The 1998-1999 survey did not include Rajshahi, and the 1999-2000 survey found no people living with HIV among the 416 injecting drug users interviewed, nor in the 2000-2001 and 2001-2002 surveys^{27, 28, 29, 30}.

3.2.3 History

In May 1999, CARE Bangladesh started the SHAKTI Injecting Drug User Project in Rajshahi. Technical support was provided through visits by programme staff from Dhaka until Dhaka staff transferred to Rajshahi to take up positions as technical coordinators. At an early stage, it was decided to work with a group of former drug users, who had formed APOSH, a nongovernmental organization, assisting them to start a detoxification and drug rehabilitation centre.

²³ Some of the information from this section is drawn from Panda S, Chapter IV: Outreach in Dhaka, Bangladesh, in UNAIDS/AHRN/UNODC (2002). *Preventing HIV/AIDS among drug users: case studies from Asia*. Geneva, Switzerland. http://www.unaids.org/html/pub/Publications/IRC-pub03/AsiaDrugUsers_en_pdf.pdf

²⁴ Bangladesh AIDS/STD Control Programme (2000 June). *Report on the Sero-Surveillance and Behavioural Surveillance on STD and AIDS in Bangladesh, 1998-1999, Bangladesh*. Dhaka.

²⁵ Rabbani S and Mallick PS (2000). *Re-estimation of injecting drug user population in Rajshahi*. Health and Population Sector, CARE Bangladesh. Dhaka (Unpublished).

²⁶ NASROB (2002). *op.cit.*

²⁷ Bangladesh AIDS/STD Control Programme (2000 June). *Report on the Sero-Surveillance and Behavioural Surveillance on STD and AIDS in Bangladesh, 1998-1999, Bangladesh*. Dhaka.

²⁸ Bangladesh AIDS/STD Control Programme (2000b September). *Report on the Second National Expanded HIV Surveillance, 1999-2000, Bangladesh*. Dhaka.

²⁹ Bangladesh AIDS/STD Control Programme (2001 November). *HIV in Bangladesh: Where is it going?* Dhaka.

³⁰ Bangladesh AIDS/STD Control Programme (2002). *National Sentinel Sero-surveillance Report*. Dhaka.

One staff member commented:

'In this way, CARE could say we are not only doing needle exchange, we are also helping people to get off drugs'.

There was resistance to the project by owners of shooting galleries in the city. In Rajshahi and Chapai Nawabganj, most injecting drug use is based in shooting galleries where a person sells drugs, which injecting drug users can either inject themselves with, or be injected by the drug dealer. As Rajshahi is close to the Indian border, smuggling of various items, including drugs, occurs and is controlled by drug lords. Shooting gallery owners were afraid of the drug lords and their possible reactions to the programme. Also, hooligans employed by the drug lords harassed peer outreach workers and tried to extort money during the initial phase of the programme. Furthermore, any political changes or a new police chief sent panic through the injecting drug user community, and police or army activity could result in shooting galleries closing down or injecting drug users leaving town, all of which made outreach work difficult.

Advocacy was carried out with the main stakeholders both prior to starting the programme and on an on-going basis. Programme staff explained to employees of the drug lords the programme's activities and purpose, that the programme was not providing information to the police, and showed that the programme's activities were not directed against the drug lords' business interests. To the hooligans, who had harassed peer outreach workers, it was explained that CARE was a social humanitarian organization that had the support of the Government and working arrangements with law enforcement services. As a result, the harassment eventually ceased.

After a rapid situation assessment carried out by staff from Dhaka and Rajshahi, the programme expanded to Chapai Nawabganj, with a population of 60 000, 60 km from Rajshahi in March 2001. Following the assessment, a meeting was held between the assessment team, district commissioners and important community leaders to discuss the results and gain the leaders' support for a programme. This meeting resulted in the imam of the mosque closest to the drop-in centre site deciding to join the drop-in centre committee, which meets bimonthly and works with the community to reduce neighbourhood concerns.

The replication process involved the field officer, who had worked in the Dhaka programme then in Rajshahi before working in Chapai Nawabganj. Since February 2002, the programme manager and field trainer also cover Char Narendrapur, 14 km from Chapai Nawabganj, which can only be reached by boat.

In 2002, increased activities by the army in Rajshahi and Chapai Nawabganj caused problems, including shooting galleries shutting down and re-opening in different sites every few days, and eviction and scattering of injecting drug users, making both shooting galleries and injecting drug users harder to access. Anti-drug activists have harassed peer outreach workers, taken their outreach bags, needles and syringes and, in the worst case, beaten them. As a result, in Rajshahi, needle and syringe distribution and collection dropped by some 30% and condom distribution dropped by some 25%.

The drop-in centres are aware of their limited attractiveness to other people at risk of drug use-related HIV transmission. Heroin smokers, who may switch to injecting drug use if the drug supply patterns change, and female sexual partners of injecting drug users were interviewed by programme staff. They view the drop-in centre as a place for injecting drug users but not for them.

Female injecting drug users are also reluctant to come to the drop-in centre. It was suggested that in Rajshahi, at least, there needs to be a separate service for female injecting drug users. Such a project could be connected to sex worker outreach as most female injecting drug users are also involved in sex work.

In Rajshahi, a self-help organization is being established to try to decrease the stigmatization and assist in the social rehabilitation of drug users.

3.2.4 Features of services

The SHAKTI Injecting Drug User Project in Rajshahi is a replication of the Dhaka SHAKTI Project, on a smaller scale and with several modifications, taking into account the local drug injecting context. Paid peer outreach workers are stationed at each shooting gallery, providing a new needle and syringe for each drug injecting event, retrieving each used needle and syringe, providing other materials and education to injecting drug users, and noting these tasks on a monitoring form. Peer educators also do some limited outreach work in areas where injecting drug users live. When a shooting gallery closes, the peer educator takes used injecting equipment and completed forms to the drop-in centre. Shooting gallery owners are also encouraged to become unpaid peer educators and undergo training in HIV and abscess prevention.

Project staff members are two programme managers, two field trainers, eight paid peer outreach workers, one of whom is female, as well as a person in charge at the drop-in centre and a person who dresses abscesses. Peer outreach workers work in two shifts from the morning until 14.00 and from 14.00–20.00. As in Dhaka, needles and syringes are exchanged on a strict one-for-one basis. The greatest challenge faced by peer outreach workers is police harassment, most of whom have been detained at least once, and, to a lesser extent, ‘religious people’, who believe that needle-syringe programmes facilitate drug use. This can result in burnout among staff as they are often accused of ‘evil’ activities.

Several groups of injecting drug users were interviewed during visits to the Rajshahi and Chapai Nawabganj drop-in centres, on the streets of Rajshahi and at a shooting gallery in Chapai Nawabganj. From these interviews, the services most important to clients were the provision of abscess care, access to needles and syringes, and assistance with entering drug treatment. Several injecting drug users mentioned that an important feature of the service was friendliness. As one female injecting drug user stated:

‘There is warmth and love here (in the drop-in centre), recognition that you are not alone, things I can’t get normally. Here I can be free and open.’

Housing, particularly at the time of the visit, was of great concern as the army had undertaken mass evictions in the slum areas so that they could be demolished. Employment was another urgent need of injecting drug users. Fear of the police and army were common. The army’s actions were said to have made drugs harder to find and to have doubled the cost of some drugs.

CARE Bangladesh also works with APOSH, a local nongovernmental organization, which provides detoxification and rehabilitation services. Drug treatment services began in 1999, though APOSH had begun as an anti-drugs group in 1980. In 2000, five injecting drug users were offered drug treatment. By 2002, with increased support from CARE, APOSH had moved to a larger, 15-bed facility with four paid staff and four volunteers, all former drug users, most of whom had been treated in Dhaka and were trained there by CARE. Two staff members

are outreach workers, visiting injecting drug users in their homes, encouraging their entry into treatment and providing family counselling.

The treatment programme is a residential, one month drug-free programme with a daily routine, including classes on drugs, addiction, life skills, and controlling frustration and emotions, as well as sport and cultural activities. Treatment is provided for drug users from Chapai Nawabganj, Char Narendrapur and Rajshahi. At the time of visiting, APOSH had a waiting list of about 25.

After treatment, participants are encouraged to attend Narcotics Anonymous meetings at APOSH twice weekly. APOSH representatives also visit a drug user's family post-treatment and provide family counselling. All people treated to date have been male; however, APOSH plans to provide treatment for women, if another residence can be funded. No Government drug detoxification or treatment services are available in the Rajshahi area.

In Chapai Nawabganj, there is one drop-in centre staffed by a person in charge, a programme manager, a field trainer, a person who dresses abscesses and three peer educators, reaching about 260 injecting drug users, about 200 on a regular basis, of the estimated 400 injecting drug users.

Char Narendrapur has one drop-in centre staffed by a person in charge and two peer educators, serving some 20 injecting drug users.

Drug substitution treatment is illegal in Bangladesh.

Table 15: Rajshahi, services and products provided

Service and Products	Drop In Centres	Outreach	APOSH
Needles and syringes distributed	–	X	–
Needles and syringes returned	–	X	–
Needles and syringes disposal	X	–	–
Water for injecting	–	–	–
Alcohol swabs	X	X	–
Disinfectant for syringe cleaning	–	–	–
Filters and cotton balls	X	X	–
Vitamins	–	–	–
Medications for hepatitis	–	–	–
Treatment for HIV and AIDS	–	–	–
Drug detoxification	Referral	Referral	X
Drug treatment	Referral	Referral	X
Other medications	–	–	–
Condoms distributed	X	X	–
Information, education and communication materials distributed	X	X	–
Face-to-face individual education and advice	X	X	X
Group education	X	X	X
Sexually transmitted infection services	X	Referral	Referral
Counselling (general)	X	–	–
Counselling on drugs	X	Referral	X
Counselling on HIV and AIDS	X	X	X
Legal assistance	–	–	–
Housing and welfare assistance	–	–	–
Drug user support groups	X	–	–
Former drug user support groups	X	–	X
People living with HIV support groups	–	–	–

Table 16: Rajshahi needle-syringe programme July 1999–December 2002

	July– December 1999	2000	2001	2002	Total
Syringes and needles distributed*	128 740	292 870	295 388	202 793	919 791
Syringes and needles returned*	128 325	274 054	280 987	193 436	876 802
Percentage returned	99.7%	93.6%	95.1%	95.4%	95.3%
Condoms distributed	4 428	29 419	17 364	12 901	64 112
Injecting drug users with abscesses treated	388	421	166	403	1 378
Injecting drug users treated for sexually transmitted infections	**	89**	62	146	297

* Includes both needles and syringes as single units as well as extra needles.

** Sexually transmitted infection treatment did not begin until May 2000

Table 17: APOSH Programme, 1999–2002

APOSH Programme	1999	2000	2001	2002	Total
People undergoing drug treatment	48	94	143	102	387

3.2.5 Coverage

The ever reached figure for the SHAKTI Project was 515 clients and APOSH had reached 387 clients by November 2002. It is likely that most, if not all, of APOSH's clients have also been reached by CARE.

Some 3% (16) of injecting drug users reached by CARE are female. It is not known if this reflects the male-to-female ratio of injecting drug users in the city; however, increased numbers of female injecting drug users may be attracted to the project's services by the female outreach worker. No female injecting drug users had been identified in Chapai Nawabganj or Char Narendrapur and none of APOSH clients are female, though a centre is being considered for women to undergo drug rehabilitation treatment in Rajshahi.

With regard to regular reach, a sample month from late 2002 was analysed. Of the 515 clients registered prior to this month, 79 were not reached by needle syringe or drop-in services during the month, which corresponds with a reduction in the numbers of needle and syringe distributed and collected, and condoms distributed, due to the army's activities at the time. The table below outlines the attendance of the 436 clients, who accessed drop-in or outreach services.

Table 18: Rajshahi, regular reach

Attendance	Percentage of clients (number)
1–5 times	31% (134)
6–10 times	19% (82)
11–15 times	16% (67)
16–20 times	17% (76)
21–26 times	17% (77)

Senior programme managers and staff of CARE Bangladesh agreed there were several important factors in achieving high coverage in Dhaka and Rajshahi. A holistic approach was taken addressing community concerns about drug use and drug users by combining harm

reduction programmes with drug treatment and sexually transmitted infection services, and providing significant resources for on-going advocacy in the neighbourhoods surrounding drop-in centres and outreach sites. Advocacy with key Government, faith-organization and community leaders was also carried out prior to, and during implementation of, each project in Dhaka, Chapai Nawabganj, Char Narendrar and Rajshahi, using a non-confrontational approach to find ways to work with law enforcement services to develop local solutions, which would allow programmes to operate effectively. Advocacy with donors was also vital so that a flexible approach could be taken to programme development.

The role of drug users and former drug users in programme activities has been of great benefit in expanding services. At all four sites, active injecting drug users assisted in mapping, provided on-going advice about where to open drop-in centres and conduct outreach, worked as paid outreach and drop-in centre staff, and also as volunteers. Formation of PROCHESTA, a self-help group for active drug users in Dhaka is a rare achievement and its planned role in taking over some outreach services is unprecedented in developing and transitional countries. These developments are most likely the result of CARE's policy of controlled responsibility, whereby injecting drug users are employed to carry out tasks after substantial training and with on-going support.

The breadth of services offered through formal and informal partnerships with agencies providing drug treatment and other services has been crucial to the SHAKTI Projects' success. Key partners included the Drug Treatment Hospital in Dhaka, which gave priority to referrals from CARE for detoxification at very low cost and now provides assistance with detoxification camps, and APOSH, which provides drug treatment in Rajshahi. Other important partnerships included those with the Marie Stopes International Clinic; the local community, particularly the provision of some drop-in centres rent free; and a support network of influential people, who provided on-going advocacy support.

It should also be noted that the SHAKTI Projects are only part of the work of CARE Bangladesh on HIV, which includes projects addressing HIV transmission prevention among sex workers, transgendered people, men who have sex with men, ground transport workers such as truck drivers and rickshaw pullers, and port and dock workers. CARE has also supported the formation of a HIV-positive support network. Such a wide range of activities within the one organization allows for shared learning on outreach methods, managing focused programmes and involvement of marginalized communities. Also CARE's network of offices allowed the rapid replication of the Dhaka Injecting Drug User Project in other cities.

3.2.6 Maintaining and expanding coverage

Scaling-up of a range of targeted actions, including HIV transmission prevention among injecting drug users, is a feature of a World Bank loan which has been negotiated by the Government of Bangladesh. The loan activities are currently being implemented and it is hoped that lessons learned from CARE's Injecting Drug User Project's implementation will be used in all sites covered by these activities.

Legalisation of, and access to, substitution drugs such as methadone and buprenorphine would assist the Dhaka and Rajshahi services to attract injecting drug users and heroin smokers to drug treatment, enhance HIV prevention and assist in building drug user self-help groups. For those few HIV-positive injecting drug users living in Dhaka, drug-substitution treatment would also provide a link with HIV treatment, counselling and other services. In order

to make prevention more effective, quality HIV testing and counselling services, addressing issues of confidentiality, stigma and discrimination, and access to antiretroviral therapy and health care services should be established so that injecting drug users feel safe, are encouraged to access services and motivated to adopt safer injecting and sexual behaviours.

CARE Bangladesh plans to achieve sustainability by an increased use of partnerships with Government, nongovernmental organizations and community-based organizations. The plans to hand over some activities to self-help groups are good examples of what partnerships can achieve. CARE's investment in empowering injecting drug users and former drug users is perhaps the best guarantee of long term success for injecting drug user programmes in Bangladesh.

3.2.7 Further reading

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3.3 Hong Kong Special Administrative Region (Hong Kong SAR), People's Republic of China³¹

3.3.1 Summary

Hong Kong SAR with a population of 6.8 million is a financial and business centre.

The estimated number of injecting drug users is 6547, equalling 56% of the 11 691 registered heroin users. The ever reached figure after 30 years of operation is 53 800 at end June 2003. The 'effective registration' i.e. heroin users accessing methadone services at least once in the past 28 days, was 10 127 in December 2002, equalling 87% of registered heroin users.

With regard to regular reach; 7036 heroin users on average attended clinics daily in June 2003, equalling 60% of all registered heroin users.

3.3.2 Drug use and the HIV situation:

The AIDS epidemic in China has, until recently, been largely confined to injecting drug users. HIV has now been reported in all 31 mainland provinces, autonomous regions and municipalities. UNAIDS estimate that there are 840 000 people living with HIV, 80 000 of whom are living with AIDS, and between 21 000 and 75 000 people have died of AIDS-related causes³². At the end of June 2003, there were 45 092 people registered as living with HIV, including 3532 people living with AIDS and 1800 had died from AIDS-related causes³³.

The number of registered drug users has grown from 70 000 in 1990 to 900 000 in 2001³⁴. The true number of drug users is likely to be between seven and eight million, of whom three to three-and-a-half million are estimated to be injecting drug users. In 2000-2001, national sentinel surveys of injecting drug users found national HIV prevalence among injecting drug users of between 10-12%.

In contrast to other parts of China, Hong Kong SAR is considered to have low HIV prevalence of 0.1% with some 2600 people living with HIV³⁵, of whom 54 were injecting drug users³⁶. In 2001, the number of heroin users registered in Hong Kong by the Central Registry of Drug Abuse (CRDA)³⁷ was 11 691, of whom 56% were injecting drug users³⁸.

³¹UNAIDS/AHRN/UNODC (2002). *Preventing HIV/AIDS among drug users: case studies from Asia*. Chapter VIII. Geneva, Switzerland. [Electronic version] http://www.unaids.org/html/pub/Publications/IRC-pub03/AsiaDrugUsers_en_pdf.pdf

³²UNAIDS (2004 July). *Report on the global HIV/AIDS epidemic*. Geneva, Switzerland. Retrieved on April 6, 2005 from <http://www.unaids.org/bangkok2004/report.html>

³³China Ministry of Health and UN Theme Group on HIV/AIDS in China (2003 December 1). *A Joint Assessment of HIV/AIDS Prevention, Treatment and Care in China*. Beijing: Ministry of Health, P.R. China and UNAIDS China Office.

³⁴Cheng Feng (2003). A Situation Assessment of Drug Use in China in the Context of HIV/AIDS: Overview of HIV/AIDS among injecting drug users in China. In *East To East: First meeting of HIV/AIDS and injecting drug use programme and policy staff from Eastern Europe, Central and East Asia*. Chiang Mai, Thailand 6 April 2003 *Proceedings Part 2*. Centre for Harm Reduction. Melbourne.

³⁵UNAIDS (2004 July). *Report on the global HIV/AIDS epidemic*. Geneva, Switzerland. Retrieved on April 6, 2005 from <http://www.unaids.org/bangkok2004/report.html>

³⁶Hong Kong Department of Health (2003). *STD/AIDS Update 2003*, volume 9, no. 1, statistics for quarter 1. <http://www.info.gov.hk/aids/english/surveillance/index.htm>

³⁷The CRDA is a central registry of drug users established in 1972 and collects reports from a range of law enforcement, treatment and welfare agencies in Hong Kong SAR.

³⁸Narcotics division, Security Division, Hong Kong SAR Government (2003). *Central registry of Drug Abuse Fifty-first report*. Government printer. Hong Kong.

Compulsory Drug Addiction Treatment Centres (DATC), operated by the Correctional Services Department, to which drug users are sentenced by a criminal court, commenced in 1997. Hong Kong SAR also has a wide range of other drug treatment options, including numerous low cost voluntary residential drug-free treatment centres operated by nongovernmental organizations, which offer detoxification, rehabilitation and aftercare. The Hospital Authority in Hong Kong has established six substance abuse clinics which cater primarily to non-opiate users. There are no needle-syringe programmes or outreach programmes in Hong Kong SAR.

3.3.3 History

A general practitioner established the first two methadone clinics in Kowloon and on Hong Kong Island in the early 1970s. At the time, Hong Kong, with a high level of crime, was a poor territory of the United Kingdom; prisons were full and many prisoners were known to be addicted to opiates. In 1972, the Hong Kong Government invited a United States drug treatment specialist to assess the situation and provide advice on responding to drug-related crime. On the specialist's advice, the Health Department took over operation of the first methadone clinics and rapidly expanded their number to some 20 clinics.

Although the Health Department operated the clinics, the methadone policy was established by the Hong Kong's Security Ministry; this arrangement continues today. As a result, the day-to-day operations are carried out by the Health Department, which reports regularly to the Security Ministry. The clinics were a quick success, with the crime rate dropping and pressure on jail space easing within a few years.

In order to minimize controversy about methadone clinics; they operated as other clinics in Hong Kong. In the early 1970s, outpatients at any clinic were asked to pay HK\$ 1 (approximately US\$ 0.13) for each visit. The same practice was used at the methadone clinics and they were quickly integrated into the Government's health care services.

In the mid-1980s, methadone clinics began to work in close cooperation with other HIV and drugs initiatives. The first person living with HIV was diagnosed in 1985 and surveillance of various groups, including methadone clients, commenced. From 1991, the clinics worked with the Red Ribbon Centre, an AIDS education and research facility operated by the Department of Health and since 1998 a UNAIDS collaborating centre. Since 1994, the Red Ribbon Centre has distributed condoms through the clinics as well as provided other forms of assistance. Counselling is provided in the clinics by the Society for the Aid and Rehabilitation of Drug Abusers (SARDA), a nongovernmental organization. In 2001, Phoenix Project, a harm reduction outreach project, which employs former drug users to contact methadone clients and street-based drug users, was established by the Red Ribbon Centre and SARDA (see **3.3.4 Features of services**).

Advocacy has been a regular feature of the methadone programme. Every few years, politicians or the general public debate whether to close the methadone clinics. In 2002, a harm reduction media campaign jointly organized by the Department of Health, the Narcotics Division of the Security Bureau and the Information Services Department of the Hong Kong Special Administrative Region Government was undertaken. Messages about harm reduction, focusing on methadone use, were publicized on television, radio and street advertisements, and through public transport, and a webpage was established to provide further information on harm reduction and copies of campaign materials³⁹.

³⁹www.harmreduction-hk.com

This campaign was carried out to increase public understanding of drugs and HIV-related issues, and the role of methadone, aiming to change public attitudes towards drug users and methadone clients. The campaign was moderately successful in this but achieved unexpected results in other areas, including the number of applications to methadone clinics, which rose, and drug users reported that they felt more comfortable and were glad someone was speaking out on their behalf and offering assistance.

3.3.4 Features of services

The Methadone Treatment Programme in Hong Kong SAR comprises 20 outpatient clinics, four on Hong Kong Island, nine in Kowloon and seven in the New Territories. The clinics have no waiting lists and operate an 'open door' policy, accepting any opiate dependent person regardless of age, sex, nationality or religion, including visitors to Hong Kong. All clinics operate seven days a week including holidays and remain open for long hours, for example, 07.00–22.00, to accommodate the needs of a diverse clientele. Clients, who are Hong Kong residents or are eligible for free public medical services, are required to pay HK\$ 1 (approximately US\$ 0.13) for each visit. Since April 2003, non-eligible persons have to pay HK\$ 23 (approximately US\$ 2.95), which was the expenditure per patient calculated on 2002 figures.

Most clinics share premises with the outpatient clinics of the Department of Health, though often with separate entrances so that methadone clients do not mix with other patients. Each methadone clinic usually has three or four doctors, who mostly work part time in the evenings, prescribing medication, monitoring the physical conditions of clients and administering the methadone programme. Provision of methadone is carried out by auxiliary medical services staff members who are volunteers and are paid an honorarium. Such measures have kept operating costs low.

After assessment, clients are usually offered two options: methadone detoxification or maintenance. Opiate users, who are under 21 years of age or with less than two years of regular opiate use, are usually encouraged to try drug-free treatment first, though they are still admitted to the methadone programme if they refuse drug-free treatment. Opiate users, who are under 18 years of age, are generally asked to provide evidence of parental consent.

Methadone detoxification usually takes between three and five months. The daily dose of methadone provided is reduced over a period of time with regular client monitoring and counselling. If detoxification fails, clients are encouraged to enter drug-free treatment or the methadone maintenance programme. If detoxification is successful, clients are followed-up for 18 months with a quarterly urine test to verify that opiates are not being used.

The methadone maintenance programme usually begins with a daily dose below 30mg with urine tests every two weeks to determine tolerance. If needed, the dose is increased with a maximum daily increase of 10mg, until an optimal dose is reached, which normally does not exceed 60mg. After an optimal dose is reached, urine tests are conducted every four weeks for monitoring. The presence of other drugs in the urine is not a reason for dismissing a client from the programme.

In both types of methadone treatment, the client has to present daily to a methadone clinic together with his or her patient identification card, which is issued upon entry to the programme. Methadone must be consumed in full view of the staff at the clinic.

The methadone clinics work in close cooperation with other HIV and drugs initiatives in Hong Kong. One partner is the Red Ribbon Centre, which undertakes prevention activities targeting the general community, implementing mass media campaigns, and running a website and information exhibitions. The Red Ribbon Centre also provides educational materials such as videos, leaflets, posters for vulnerable groups, including injecting drug users, and provides staff training in methadone clinics. The Centre has assisted clinics to conduct client surveys and has provided training for clinic staff in interviewing. In 1994, the Red Ribbon Centre began condom distribution through the clinics, with some 8400 condoms distributed monthly.

At the 20 clinics counselling is provided by full time, SARDA seconded social workers. Intensive counselling is provided to clients under the age of 21, with counselling for older and re-admitted clients on request.

In 2003, the Phoenix Project had 13 volunteers, who were former drug users, making 400 contacts with methadone clients and street-based drug users per month and distributing around 380 condoms in the vicinity of the methadone clinics per month.

If methadone clients are found to be HIV-positive, they are assisted to access antiretroviral therapy and other health care services. Voluntary HIV counselling and testing was introduced for methadone clients on a trial basis in mid-2003 and, is now offered at all methadone clinics.

Table 19: Hong Kong SAR, services and products provided

Services and Products	Methadone clinics
Vitamins	–
Medications for hepatitis	–
Treatment for HIV and AIDS	Referral
Drug detoxification	X
Substitution drug treatment	X
Drug-free treatment	Referral
Other medications	X (tetanus medication)
Condoms distributed	X
Information, education and communication materials distributed	X
Face-to-face individual education/ advice	X
Group education	X (by SARDA)
Sexually transmitted infection services	Referral
Counselling (general)	X
Counselling on drugs	X
Counselling on HIV and AIDS	X
Legal assistance	Referral
Housing and welfare assistance	X **
Drug user support groups	X #
Former drug user support groups	X
People living with HIV support groups	–

** Provision of half-way house upon discharge from Shek Ku Chau etc.

Separate groups for young drug users, female drug users and families of active users.

3.3.5 Coverage

Coverage of drug substitution programmes is defined slightly differently than for the other programmes described in this report. Due to the differences in methadone detoxification and methadone maintenance programmes, statistics are provided separately in the table below.

Table 20: Hong Kong SAR, coverage

	End of 1980	End of 1990	End of 2000	End of 2002
Methadone Detoxification	NA	176	128	175
Methadone Maintenance	NA	10 775	9 048	9 952
Effective registration*	NA	10 951	9176	10 127

NA = Not Available

* The 'effective registration' figure for a particular date is defined as the number of clients attending methadone clinics at least once in the past 28 days.

Since 1972, the total number of opiate users ever reached by the methadone programme is 53 800. As this figure includes a large number of people, who may now be dead, have left Hong Kong SAR or have stopped drug use, the ever reached figure is much higher than the current estimate of injecting drug users and other opiate users. The cumulative total of injecting drug users reached by all programmes in Hong Kong SAR cannot be estimated as injecting and non-injecting drug users are combined in data collection processes. However, it is likely that a significant majority of injecting drug users are reached by methadone services and other drug rehabilitation programmes.

With regard to regular reach; the average daily attendance at methadone clinics in a sample month in 2003, which equals the number of clients receiving daily dose of methadone, was 7036. About 15% of the clients are women; a figure which has remained stable for several years.

One of the factors in achieving high coverage of methadone substitution treatment in Hong Kong SAR has been its implementation by the Health Department, with policy set by the Ministry of Security. As the programme is operated by the government, often in premises shared with general outpatient clinics, community acceptance is higher than it would probably have been if nongovernmental organizations or private medical practitioners had implemented such a large-scale programme. Government support for the programme has been strong for 30 years and the programme's long history has normalized methadone treatment in a way which has occurred in few developing or transitional countries. Collaboration between law enforcement and health care services was guaranteed by the structure used to set policy and operate the clinics. Individuals were also important in the introduction of the Government's methadone programme, including the Commissioner for Narcotics, who quickly understood the possible benefits of the programme.

Cost-effectiveness has clearly been a key factor in maintaining such a large-scale programme for three decades. It is estimated that each visit to a methadone clinic, on average, costs between HK\$ 20 and HK\$ 30, with HK\$ 1 being paid by the methadone consumer and the remainder by the Government. This is much less expensive than many other health care services in Hong Kong SAR and has the additional benefits of reducing crime and HIV transmission.

Both HIV prevention and methadone provision programmes are closely associated due to the Health Department implementing both. Links to services such as the Red Ribbon Centre and SARDA place the methadone clinics, in the general public's understanding, as part of a spectrum of HIV and drug treatment services. This was assisted by the harm-reduction media campaign in 2002.

3.3.6 Maintaining and expanding coverage

It is difficult to see how coverage could be expanded as there is a limit to the percentage of opiate users who want to detoxify or to enter a drug substitution programme. The Hong Kong Advisory Council on AIDS has noted that there is a need for broader HIV-prevention services among injecting drug users. Although methadone substitution treatment has been very successful in preventing an AIDS epidemic thus far; the rapid HIV transmission among injecting drug users in other parts of China, coupled with the mobility of injecting drug users and a slowly increasing HIV prevalence among injecting drug users in Hong Kong SAR; led the Advisory Council on AIDS to recommend that outreach programmes be started and that needle-syringe programmes be considered⁴⁰.

Most methadone clients in Hong Kong SAR have long histories of opiate use. There is an urgent need to reach younger injecting drug users, who have less experience of opiate use or other drug use, for whom methadone substitution is not always the desired, or most appropriate, treatment option.

In terms of the methadone programme, the Government remains fully committed to its continuation and expansion. On-going advocacy continues to be needed and further harm reduction media campaigns would be useful.

3.3.7 Further reading

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⁴⁰Hong Kong Advisory Council on AIDS (2002). *Recommended HIV/AIDS Strategies for Hong Kong 2002-2006*. Hong Kong.

4. Case Studies: Latin America

4.1 Salvador, Brazil

4.1.1 Summary

Salvador, located on the northeast coast of Brazil, with a population of three million is the capital of Bahia State.

The estimated number of injecting drug users is between 5000 and 14 000, with a further 56 000 crack cocaine smokers⁴¹. In 2002, the ever reached figure was at least 68% of injecting drug users in Salvador⁴².

With regard to regular reach, in 2002, all Centro de Estudos e Terapia do Abuse de Drogas (CETAD) services reached 12 198 new clients, of whom 675 were injecting drug users, including 72 women; and 7211 were crack cocaine users, including 1369 women. Most clients appear to be reached on a monthly basis by CETAD staff, and more often by field agents. Actual regular reach is impossible to calculate due to the monitoring system employed.

4.1.2 Drug use and the HIV situation

The AIDS epidemic in Brazil appears to have stabilized in recent years. As of end 2003, the estimated number of people living with HIV in Brazil was 660 000⁴³, of whom about one third were estimated to be injecting drug users⁴⁴. It has been estimated that about 11% of new HIV infections and people diagnosed with AIDS in 2001 were injecting drug users, a dramatic reduction from 25% in 1991⁴⁵.

It was estimated that at the end of 2001 there were about 800 000 injecting drug users in Brazil⁴⁶. Unlike the populations described in other case studies here, very few injecting drug users in Brazil inject opiates. The main drugs injected are cocaine, and steroids for body-building. HIV transmission among injecting drug users has followed clear patterns in Brazil. From the mid-1980s to the mid-1990s, most HIV infections among injecting drug users were along an area that joins the southern part of the mid-west to the coast of the State of Sao Paulo, coinciding with the principal cocaine trafficking routes. In the mid-1990s two major changes occurred. Firstly, the AIDS epidemic expanded quickly to the southern coast of Brazil and secondly, an epidemic of crack cocaine use occurred, at first in Sao Paulo and then in many other parts of the country.

⁴¹ Andrade T, Lurie P, Medina MG, Anderson K and Dourado I (2001). The opening of South America's first needle exchange programme and an epidemic of crack use in Salvador, Bahia Brazil *AIDS and Behaviour* 5 (1): 51-64.

⁴² UNDCP (2002 November 4). Case study: Salvador, Brazil. Brasilia.

⁴³ UNAIDS (2004 July). *Report on the global HIV/AIDS epidemic*. Geneva, Switzerland. Retrieved on April 6, 2005 from <http://www.unaids.org/bangkok2004/report.html>

⁴⁴ Aceijas C, Stimson GV, Hickman M, Rhodes T. (2004). *Global overview of injecting drug use and HIV infection among injecting drug users*. London: Centre for Research on Drugs and Health Behaviour on behalf of the United Nations Reference Group on HIV/AIDS Prevention and Care among IDU in Developing and Transitional Countries.

⁴⁵ Bastos FI, de Pina MdF and Szwarcwald CL (2002). The social geography of HIV/AIDS among injection drug users in Brazil. *International Journal of Drug Policy* 13: 137-144.

⁴⁶ Aceijas et al. (2004). op.cit.

For Salvador, these changes led to major shifts in drug use patterns. CETAD programme statistics showed that the number of injecting drug users has fallen by about 80% since the mid-1990s, with almost all former injecting drug users converting to smoking crack cocaine. In mid-2003, it was estimated that there were some 14 000 injecting drug users and a further 56 000 crack cocaine smokers. A separate estimate of 5000 injecting drug users was based on calculations using the number of HIV-positive injecting drug users. Drug users changed from cocaine injecting to smoking crack cocaine largely for reasons related to cost, convenience and drug supply. As such, many may switch back to cocaine injecting if changes occur to any of these conditions.

Drug use is generally covered by the Psychoactive Drugs Law 6368/76, which not only prohibits drug use, possession, supply, cultivation, manufacture and trafficking; it also explicitly states that needle and syringe exchange is an activity that facilitates the use of addictive substances and penalizes anyone carrying out such activities with between three to 15 years in jail. In the late 1990s, the sections of this law pertaining to needle and syringe exchange were repealed and replaced by a law legalizing harm reduction, including needle and syringe exchange. The law reform movement began with changes in the laws in the States of Sao Paulo, Rio Grande do Sul, Rio de Janeiro and Santa Catarina. In January 2002, a new National Law on Drugs legalized needle and syringe programmes throughout Brazil⁴⁷.

The issues of drug use, and HIV have been responded to by a partnership between the Drugs and AIDS Units of the National Coordination for STDs and AIDS, Ministry of Health. This has gradually resulted in increased convergence between AIDS and drugs policies. By 2001, the Brazilian Government was providing antiretroviral therapy nationally in 656 hospitals, day clinics, and home care and specialized units. In early 2003, 116 000 people living with HIV had access to antiretroviral therapy, and the mortality rate for AIDS had been reduced by 50% since 1996; while AIDS-related hospitalizations had been reduced by 80%⁴⁸. It was also evident from CETAD programme statistics that in May 2003, 2484 people were accessing antiretroviral therapy in Bahia State, of whom 1910 were in Salvador. No statistics were available on the percentage of people receiving antiretroviral therapy who were injecting drug users.

Recent studies have shown that in Salvador there was a substantial decrease in HIV and Human T-cell Lymphotropic Viruses (HTLV) infection rates among injecting drug users, despite the latter being endemic in the general population and hyper-endemic among injecting drug users. Data from CETAD also show that the number of people living with HIV was estimated at 30 000 in Bahia State in May 2003, of whom 24 000 were in Salvador. People living with AIDS numbered 5600 in Bahia State, with 80% of these in Salvador. The overall reduction in HIV infections in Salvador can be seen in the results from the HIV counselling and testing centre, outlined in the table below.

Table 21: Salvador, HIV counselling and testing

	2000	2001	2002
HIV tests carried out	6 095	6 962	10 096
HIV-positive results	185	207	297
Men/women	95/90	131/76	149/148
Percentage of positive results	3.01%	2.97%	2.94%

⁴⁷Teixeira P (2002). *The role of politicians in promoting policy changes*. Paper presented at the 13th International Conference on the Reduction of Drug Related Harm. Ljubljana 3-7 March.

⁴⁸Bastos FI, Kerrigan D, Malta M, Carneiro-da-Cunha C and Strathdee S (2001 November). Treatment for HIV/AIDS in Brazil: strengths, challenges, and opportunities for operations research. In *AIDS Science* 1 (15).

It has been estimated by CETAD that use of contaminated injecting equipment among injecting drug users in Salvador declined from 60% to 18% during the 1990s; while condom use among injecting drug users increased from 3% to 30%, and the percentage of injecting drug users in contact with health services rose from 28% to 68%. The Salvador needle-syringe programme is one of more than 160 harm reduction projects operating in Brazil.

4.1.3 History

The Salvador needle-syringe programme was the first in Brazil. It was established in 1995 after a ruling in 1994 by the Federal Council on Psychoactive Drugs that needle-syringe programmes could be approved if they were associated with research projects.

Centro de Estudos e Terapia do Abuse de Drogas (CETAD) is a facility operated by the Federal University (Universidade Federal) of Bahia in Salvador that has investigated drug use in the city since 1985. Through communication with researchers and other people implementing HIV-prevention programmes in Europe and the Americas, CETAD staff had learned about needle-syringe programmes but were prevented by legal barriers from starting a programme until 1995.

In March 1995, the Bahia State Government approved the establishment of a needle-syringe programme run by CETAD to address the problems—use of contaminated injecting equipment and high HIV prevalence among injecting drug users discovered during CETAD's surveys of drug users in the city's poor neighbourhoods (bairros)⁴⁹. Financial and technical support was provided by the Bahia State Secretary of Health, and further support was accessed through the participation of a CETAD representative on the State Council on Psychoactive Drugs.

CETAD staff members met with police officials and held seminars for police officers to explain the needle-syringe programme's operations and the principles of harm reduction. Newspapers wrote articles about the opening of the Programme and interviewed health professionals, religious representatives and injecting drug users. For the first six months, CETAD staff answered questions from media representatives, assisted by a media consultant, highlighting that HIV prevalence among injecting drug users was high in Salvador, that needle-syringe programmes had been shown to prevent HIV infection in other countries, and that needle-syringe programmes did not result in increased drug use.

The Programme opened its first site in Pelourinho, the old city centre of Salvador, which was then a poor area frequented by drug users. Between March 1995 and February 1996, only 90 syringes were exchanged, partly due to on-going controversy over the Programme. After an outreach worker was hired, who began exchanging needles and syringes, distributing condoms and providing health referrals from home, the number of clients increased. By 1999, there were four needle-syringe programme sites each with two outreach workers and one supervisor. All sites provided referrals for drug treatment, alcohol wipes, spoons for drug preparation, sterile water, condoms, instructions on safer sex and safer injecting techniques, and medical and social services referral.

⁴⁹ Andrade et al. (2001). op.cit.

During the mid- to late-1990s, injecting drug users began to switch to smoking crack cocaine. This change is reflected in the number of clients attending CETAD's drug treatment for the first time. In 1993, none of the 285 new clients reported crack cocaine use; in 1996, 4% of the 625 new clients used crack cocaine; and in 1997, 14% of the 482 new clients used crack cocaine. In 1998, the percentages climbed rapidly, with 20% of new clients in January using crack cocaine; 33% in May and 40% in June. By late 1998, in some parts of the city more than 80% of former injecting drug users were smoking crack cocaine. When the crack cocaine supply was reduced, prices rose or crack cocaine was adulterated with other substances, these drug users often reverted to injecting cocaine. In the late 1990s, CETAD's research found that anabolic steroids were being used by increasing numbers of young people in poor barrios to increase muscle mass. Consequently, some injecting steroid users also became clients of the CETAD outreach programmes.

In Brazil, new HIV infections associated with crack-cocaine-use-related sexual transmission have increased the number of people living with HIV, especially women. It should be noted that people infected through drug-use-related sexual transmission are generally not included in the figures for HIV infections linked to drug consumption. The transition to crack cocaine use by people, who often revert to injecting drug use when crack cocaine is scarce or of low quality, has created a complex and permanently changing drug trafficking and consumption scene, with major repercussions for the AIDS epidemic. In response, integrated programmes aimed at drug use prevention and programmes aimed at contributing to the social rehabilitation of drug users with an emphasis on treatment of the most serious forms and the most harmful consequences of drug consumption are being implemented.

The CETAD programme in Salvador has become a model programme. In 1997, the CETAD programme began to widen its services to attract other drug users apart from injecting drug users. Mobile services were used to introduce CETAD workers to many parts of the city. After meeting with members of the communities, including drug users and people living in drug-using neighbourhoods, networks of field agents and outreach workers were established.

In 1998, the Information and Resources Section was established to develop a wide range of educational materials, provide information to individuals and groups for advocacy for harm reduction, and provide an evidence base for the Information and Resources Section's activities. In January 2001, CETAD began working with drug users and other people in Bahia State's prisons.

In October 2001, a Pathfinder/United States Agency for International Development (USAID)-funded programme, Comunidad (Community), was established to provide drug education, alternative activities for children, and links to health and social services for people living in drug-using neighbourhoods.

4.1.4 Features of services

CETAD has 30 full time staff, of whom four, including the harm reduction programme manager, are funded by the Federal University of Bahia, with the remainder funded by the Bahia State Government. Funds are also provided by the United Nations Office on Drugs and Crime (UNODC), USAID and the Brazilian Government.

The comprehensive CETAD approach includes the following facilities and activities.

- Outpatient drug treatment centre using psychoanalytic techniques;
- Harm Reduction Division (DRD/CETAD) with a coordinator and an assistant coordinator, nine supervisors, 28 outreach workers and 44 community health agents, who work with the Municipal Government's Family Health Programme, trained by DRD/CETAD to provide care and prevention to drug users in general including active injecting drug users—this division operates 52 needle-syringe programmes in 24 barrios in seven of the 12 districts of the city.
- A prisons project with a coordinator, two supervisors and two peer educators in three prisons for men and one prison for women.
- A community project, which focuses on drug prevention and assisting overall health and social problems in poor areas, with a coordinator, a supervisor, six outreach workers and four trainees, operating in three districts. It also provides drug education in schools and workplaces, and through courses at CETAD's office. Drug prevention activities include soccer matches and craft classes among barrio children.
- Mobile Points of Prevention Project, which concentrates on sexual and drug-related transmission of HIV with an emphasis on female crack cocaine users, distributes male and female condoms and other materials. The project is staffed by a coordinator, a supervisor, five outreach workers and five trainees, operating from a mobile van in five barrios in three districts.
- A library and information centre; and research offices.

The field agent system is innovative as it involves paying a small salary to people—usually active drug users—who live in the heart of poor barrios, to provide needle exchange, condom distribution and education from their homes. This system effectively provides 24 hour access to HIV-prevention materials, education and basic counselling in the areas where drug users live. Both outreach workers and community health agents are referred to as field agents. All field agents receive at least 60 hours of training on drug use and HIV transmission prevention, sexually transmitted infections, HIV, AIDS, tuberculosis and other topics; and all field agents meet about four times a month to discuss their work.

Supervisors work with all the field agents in a district and are in charge of ensuring that services in all the neighbourhoods of a district are meeting the needs of drug users and their associates. Coordinators and assistant coordinators work across the programme, ensuring that services are evidence-based and effective.

The trainee system is also innovative. CETAD is attached to a university and can take up to 10 trainees from undergraduate or postgraduate courses annually. Many trainees are from the medical or nursing faculties but trainees have also come from journalism, law and the social sciences. Students can apply for a traineeship, which is credited towards a degree, or CETAD can advertise for a trainee from a specific discipline, as it did for journalism students

to assist in media work. Most students write papers and a thesis on their work, some of which are used for research reports or information materials, or for funding proposals for expanded or new services.

CETAD attempts to address drug using neighbourhoods rather than just drug users. This approach means that CETAD has established a range of services, which form a comprehensive set of drug and HIV-prevention activities as well as general health and social assistance. While the main object is to provide services to injecting drug users, crack cocaine smokers and other non-injecting drug users, services also try to reach their families, sexual partners, neighbours and other people living in drug-using neighbourhoods. Female specific services are provided, including programmes to reach female crack cocaine and female condom distribution.

By providing services for whole neighbourhoods and by continual advocacy for more services for poor barrios, CETAD has established itself as a 'friend' to tens of thousands of drug users and their associates throughout Salvador. This in turn has resulted in assistance for such work as the field agents providing needle exchange, condom distribution and education from their homes. The services implemented are based on a body of research carried out by CETAD in Salvador and Bahia State, as well as research from other parts of Brazil and other countries, collected and disseminated by CETAD's library and information centre.

CETAD works in partnership with many organizations. CETAD assisted in the establishment of the Bahia Harm Reduction Association (ABAREDA) formed by active drug users in Salvador. ABAREDA's goals are to increase the number of harm reduction programmes in Bahia State, ensure drug users' social rights and their social interaction, defend the rights and freedom of action of harm reduction workers, and establish municipal associations of ABAREDA i.e. local harm reduction or drug users' groups. CETAD and ABAREDA are working on plans for the latter to eventually take over harm reduction activities in at least some parts of the city.

CETAD also works closely with the University Hospital, one of the largest in Salvador, to provide outpatient assistance, including HIV counselling and testing, to clients accessed through the Community Project. HIV treatment, care and support are provided by a network, including the State Government, nongovernmental organizations and CETAD. For example, injecting drug users are provided with HIV treatment at the Centro de Referência Estadual de AIDS (CREAIDS), a State Government facility near the CETAD office. Instituição Beneficente Conceição Macedo (IBCM), a nongovernmental organization working in the bairro of Pernambues, provides care for HIV-positive children or children whose parents are living with HIV, and provides weekly food parcels to HIV-positive injecting drug users and other people living with HIV in need of such assistance. During the food parcel distribution, CETAD staff members provide needles and syringes, and HIV and drug use education.

Table 22: Salvador, services and products provided

Services and Products	CETAD Outreach*	Prisons Programme
Needles and syringes distributed	X	–
Needles and syringes returned	X	–
Needles and syringes disposal	X	–
Water for injecting	X	–
Alcohol swabs	X	–
Disinfectant for syringe cleaning	X	–
Filters and cotton balls	–	–
Caps for mixing drugs	X	–
Materials for safer crack pipes	X	–
Vitamins	–	–
Hepatitis treatment		–
Treatment for HIV and AIDS	Referral	–
Drug prevention activities	X	–
Drug detoxification	Referral	–
Drug treatment	Referral #	–
Other medications	–	–
Condoms distributed	X	X
Information, education and communication materials distributed	X	X
Face-to-face individual education/ advice	X	X
Group education	X	X
Sexually transmitted infection services	Referral	–
Counselling (general)	X	–
Counselling on drugs	X	–
Counselling on HIV and AIDS	X	–
Legal assistance	–	–
Housing and welfare assistance	–	–
Drug user support groups	X	–
Former drug user support groups	–	–
People living with HIV support groups	–	–

* refers to all services, including harm reduction, mobile points and community programmes

Drug treatment is mostly provided by CETAD staff at the CETAD offices.

Table 23: CETAD Programme 2002

	Harm Reduction Programme	Mobile Prevention Points	Community Programme	Prisons Programme	Total
Occasions of service*	27 763	13 807	5 282	2 343	49 163
Syringes and needles distributed	14 049	1 526	12	0	15 587
Male condoms distributed	139 491	90 323	21 925	11 275	263 014
Female condoms distributed	4 086	12 054	714	1 571	18 425
Educational materials out	9 683	5 199	4 010	1 532	20 424

* The CETAD monitoring process records occasions of service and whether a client is new or not. Numbers of new clients can be estimated (see 4.1.5 Coverage); however the total client base and regularity of reach cannot be estimated from these records.

4.1.5 Coverage

UNDCP estimated that CETAD had reached 68% of injecting drug users in Salvador by November 2002⁵⁰. The approach taken by CETAD to coverage is to try to reach as many barrios as possible in which drug use and related HIV infection exist or are likely to occur. As seen above, this approach has resulted in access to many different drug users, their family members and sexual partners throughout the poorer sections of the city.

The number of new clients seen by all services in 2002 was 12 198, of whom 675 were injecting drug users and 2296 were crack cocaine users. Of the 675 injecting drug users, 72 were females, whereas among the 2296 crack cocaine users, 376 were females. The remaining clients were steroid users, who neither injected steroids nor used crack cocaine; marijuana and alcohol users; families or sexual partners of drug users; and other people living in drug-using neighbourhoods. Included in these figures are 1090 new male clients and 23 new female clients reached in prisons. There are only 70 female prisoners in Salvador and the programme in the female prison began in late 2002. Of the new prisoners reached, 27 were injecting drug users and 150 were crack cocaine smokers.

Most clients appear to be reached on a monthly basis by CETAD staff, and more often by field agents. Actual regular reach is impossible to calculate due to the monitoring system employed.

Friendliness and good relationships between CETAD staff and the drug using neighbourhood communities are vital to the programme's success. Advocacy has also been crucial. During the interviews a complex picture emerged of advocacy at the local neighbourhood level by field agents, supported when needed by supervisors, coordinators, manager or specialist assistance from media students; at the larger community or district level by supervisors and coordinators; and at the university and at the State and National Government levels by the manager and ABAREDA. The importance of the involvement of active injecting drug users in these advocacy efforts was stressed, and increasing the role of active drug users in harm reduction programmes in Bahia State is one of the main goals of ABAREDA.

Breadth of services is the key to increased coverage within drug using neighbourhoods. By having a wide range of activities associated with CETAD, from soccer matches to musical instrument-making to needle exchange, to demonstrations and distribution of male and female condoms, most people in poor barrios can access something they need from CETAD. The services and products are also extremely convenient, often distributed from homes within the barrio or from mobile vans or by outreach workers that tour various neighbourhoods.

4.1.6 Maintaining and expanding coverage

With such an ambitious programme, CETAD struggles to continue funding its separate services, most of which have several sources of support. Funding has been reduced since 2001 and further funding cuts occurred in late 2003. The World Bank AIDS and STD Control III Project in Brazil may assist the National and State Governments to increase funding for agencies such as CETAD. Another priority of the World Bank Project is to establish an effective monitoring and evaluation process for all areas of HIV prevention and treatment.

⁵⁰UNDCP (2002). *op.cit.*

In addition, a Harm Reduction Advocacy Campaign has been suggested for five sites in Brazil, including Salvador, which would increase public and Government understanding of the need and usefulness of programmes such as those run by CETAD. Such a campaign would also advocate for greater spending on prevention programmes as part of the Brazilian mix of prevention and treatment activities.

4.1.7 Further reading

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5. Lessons learnt: high-coverage sites

The most important finding is that high level coverage can be attained by programmes addressing HIV among injecting drug users in developing and transitional countries. For example, needle and syringe exchange and methadone programmes reached more than 50% of injecting drug users in the sites studied, and HIV treatment and care, and support for HIV-positive injecting drug users, have achieved high level coverage in Brazil and Hong Kong SAR and may soon do so in Bangladesh. During the course of data collection and writing this report, at least several other sites were identified which may also have high coverage programmes.

In at least some sites, the coverage achieved has led to AIDS epidemics among injecting drug users being averted or delayed. In Bangladesh; Hong Kong SAR; Pskov, Russian Federation; and Sumy, Ukraine, high HIV prevalence among injecting drug users has been avoided despite high prevalence in neighbouring provinces or countries with similar cultures and levels of injecting drug use. In Soligorsk, Belarus, the needle-syringe programme started after high HIV prevalence had been established so the effect is not so clear, and much higher, sustained coverage for several years is likely to be needed to achieve a reduction in prevalence. In Salvador, Brazil, major changes in drug use patterns confuse the HIV prevalence picture; however, it is likely that programmes have stabilized and reduced HIV prevalence among injecting drug users.

5.1 Common features of high coverage programmes

Harm-reduction principles were used to develop local programmes

The sites studied here are located in a wide range of social, political, religious and cultural contexts. In Russian Orthodox cities such as Pskov, Russian Federation, Islamic cities in Bangladesh, and largely Roman Catholic Brazil; in industrial and financial services economies and those based on agriculture; in cities such as Dhaka, Bangladesh, with 12 million people and small towns of 30 000; in transitional countries and long standing democracies; programmes have reached a high coverage among injecting drug users.

The features of the programmes are unique to the social, political and cultural settings in which they were implemented. This has resulted in differences in methods of operation, numbers and types of staff employed, specific services and products provided, links with other services etc. Rather than replicate models developed by other countries, programme planners and implementers studied the principles underlying programmes and designed appropriate HIV programmes for their sites.

Advocacy efforts needs to be prioritized, adequately staffed and funded

Effective approaches to addressing HIV among injecting drug users are controversial in many parts of the world. In each site, careful thought and substantial work was devoted to overcoming community fears and government concerns about the proposed programmes. In several sites, at least part of the work of several salaried workers was devoted to advocacy, and as in Dhaka and Rajshahi specific staff positions were dedicated to advocacy.

In addition, each of the programmes involved at least one person, who could be called a ‘credible proponent’ i.e. a person or organization proposing effective approaches who will be listened to and has authority at least with the government and possibly with the general community. Credible proponents normally have, or can quickly establish, links with senior government officials, both within the health field and in other key sectors such as administration and the law enforcement services.

The general community, government, faith-based organizations and other opinion leaders need to support programmes

This was generally achieved through advocacy at many levels, including with the community in the immediate neighbourhood of services, through formal and informal meetings, public information campaigns, involvement by programme managers in multisectoral AIDS and drugs committees and, in most cases, by carefully building relationships with selected representatives from the mass media. In addition, regular evaluations and dissemination of results has assisted in building political and community support. In some cases, political support has resulted in laws and policies, which provide for HIV-specific services, and government funding to ensure programme implementation. Sustainability is most likely in sites where this type of political commitment exists.

The role of law enforcement services is crucial for success

In most countries, addressing HIV among injecting drug users is done within the context of criminalized drug use. Programmes need to work where drug users are and with drug dealers and shooting gallery owners to ensure the maximum number of injecting drug users participate. Outreach workers carrying new and used needles and syringes need to be able to work without supplies being confiscated. Programme clients need to be able to attend needle exchange sites, or methadone or HIV treatment clinics without fear of arrest. While law enforcement services do not have to support every initiative they must allow programmes to operate without hindrance.

At a minimum, in most of the sites studied, law enforcement services entered into flexible and trust-based working relationships with programme staff. At its broadest, law enforcement services participated as a full partner in planning and expanding programmes. In most sites, senior law enforcement officers were consulted at the beginning of the planning process and regularly throughout implementation. A deep and on-going commitment to effective approaches by law enforcement staff is likely to be one of the key factors in determining programme sustainability.

Funding is important for scaling-up

All programmes except that in Hong Kong SAR were started with external donor funding. The most likely reason that most of the sites in Eastern Europe are cities with injecting drug user populations of 1000–1500 is that HIV programmes in such cities are more likely to fit within the usual range of donor funding in that region i.e. between US\$ 20 000 and US\$ 30 000 per year. In settings with larger numbers of injecting drug users such as Dhaka and Hong Kong SAR larger investment is needed. Programme staff members at CARE Bangladesh spoke of the flexibility of the donor’s approach as a factor in achieving high coverage in Dhaka. In Hong Kong SAR, the Government’s commitment to funding methadone treatment for all opiate

users, who need it, resulted in high coverage. In all other sites, funding increased in at least the early years of the programmes to take account of increased use of services. External donors need to take a flexible approach with regard to the level of funding provided for each site, the specific programme elements, and implementation.

Sustained funding

Not one of the programmes described achieved high level coverage in the first year of operation; yet this is often the length of external funding. In most cases, it took more than three years to achieve high level coverage.

Funding should not only be flexible enough to allow for growth in service use; a commitment is also needed for at least two years to ensure that programmes reach sufficient numbers of injecting drug users. With the exception of the Soligorsk, Belarus, and Salvador, Brazil, programmes, funding increased each year. In programmes with reduced funding, the breadth of services has decreased and coverage is likely to suffer as a result.

Differences in each setting result in different services and approaches to attract injecting drug users to a programme

All the programmes offered a range of services as well as needle-syringe exchange or methadone programme. In many cases, such a broad range of services was achieved through close links and partnerships with other organizations. Providing a broad range of services is likely to attract a diverse range of injecting drug users, including users of various drugs, male and female, younger and older, and people from specific ethnicities. In addition, people at risk of drug use-related HIV infection may include people who do not inject drugs. Some programmes have worked with the sexual partners of injecting drug users, with sex workers, who may also inject drugs, with families of drug users, and with non-injecting users, who may switch to injecting drug use at some point. Programme funding needs to be flexible enough to allow programmes to develop to address these diverse groups.

All needle-syringe programmes studied were fairly strict exchange programmes i.e. new needles and syringes were only distributed if used needles and syringes were returned. While this is not common practice in some developed countries; the lack of adequate safe waste management processes in many of the sites means that control and safe disposal of used equipment is an important issue in addressing epidemiological concerns about transmission of infectious diseases and community concerns about the perceived dangers of contaminated equipment on the streets. One-for-one exchange appears to be suitable in these contexts.

A single programme can be replicated to address the needs of injecting drug users in other districts, cities and provinces

As the CARE process in Bangladesh showed, successful HIV-prevention programmes among injecting drug users commenced at one site, were taken to scale, and then replicated in other parts of the country. As the country needle-syringe programme statistics show in Belarus, the Russian Federation, Ukraine and Brazil, high coverage can also be achieved by several HIV-prevention programmes commencing at the same time.

Convenience of access

In every case study, injecting drug users were able to access services in a variety of ways and at various times. Outreach is the most common method for providing convenient access to education, needle and syringe exchange and other services; while easy access to services for injecting drug users in fixed sites, for example, near building entrances or separate entrances for injecting drug users, increases their attractiveness.

For needle-syringe programmes, the use of secondary exchange increases convenience as injecting drug users can acquire injecting equipment through friends, drug dealers or at shooting galleries. For secondary exchange to be successful, good working relationships are needed with the law enforcement services, and monitoring is required to ensure that injecting drug users are receiving appropriate information and education from secondary exchangers or peer educators.

Drug substitution treatment programmes operate from fixed site clinics with a few exceptions such as backpack buprenorphine distribution in India and methadone buses in Germany and the Netherlands. The number and location of clinics is vital to ensure convenience, for example, the Hong Kong SAR programme.

Involvement of injecting drug users

Most programme managers interviewed gave credit to specific injecting drug users as the ‘father or mother’ of the programme, seeing their early involvement in programme operations as vital in reaching injecting drug users. Even with the Hong Kong SAR methadone programme, clients are involved through surveys which lead to changes to services. Regular interactions based on respect and friendliness between injecting drug users and programme staff is a factor in achieving high coverage. Working with groups of active and former users has been undertaken in Salvador, Dhaka and Rajshahi and is being considered in Hong Kong SAR. Greater involvement of injecting drug users in appropriate structures such as advisory bodies, injecting drug user groups or as programme staff is likely to result in sustainable programmes.

Management issues

Technical assistance and training for managers, and on-going training, or retraining of staff, especially those working face-to-face with injecting drug users is crucial. Also of importance are effective supervision, ability to deal with problems, regular team meetings and on-going training opportunities, resulting in staff retention, which in turn attracts regular attendance by injecting drug users.

Also, successful programmes are not ‘top heavy’ i.e. there are only a few management or supervisory positions compared to field staff, or clinic staff in the case of Hong Kong SAR. Even in Dhaka, 11 managers and supervisors work with more than 50 paid peer outreach workers. A balance between control or supervision of outreach or clinical work, and trust of outreach and clinical staff to perform their work is necessary. The CARE Bangladesh system of field trainers and coordinators for programme areas, including advocacy and outreach, may be particularly suitable to South Asia and South-East Asia, where active injecting drug users employed as

outreach workers are likely to have lower levels of education and experience with regular work.

Learning from experience

In Salvador, a Paulo Friere quote is used to describe the CETAD programme, “*We make the road by walking*”. Due to the variety of settings in which programmes addressing HIV among injecting drug users are implemented; a process of trial and error is needed to develop a local balance of programme elements, staffing and other features that will result in high level coverage. New ideas need to be implemented, evaluated, and expanded if they work, or adjusted, or abandoned if they are ineffective. Also, as the Pskov case study shows, starting a programme and then gaining knowledge of international and Russian-based experience assists programme managers reflect on the work they had commenced and improve it.

5.2 Challenges for comprehensive HIV-related programmes

High-level coverage is needed for a comprehensive range of programmes

None of the sites offered a comprehensive range of injecting drug-use-related programmes, including drug-substitution treatment, other forms of drug treatment, outreach, needle and syringe exchange programmes, and HIV treatment, care and support. Only Brazil has come close to a comprehensive approach, but the impact of the approach has been limited by technical problems such as the lack of an appropriate cocaine substitution treatment. In many countries, essential elements of a comprehensive approach are missing, including access to affordable treatment for sexually transmitted infections, HIV-related health care, including antiretroviral therapy, and voluntary (confidential) HIV counselling and testing.

Relationship between programmes and law enforcement or military activities remains difficult

Regular and ad hoc advocacy with both law enforcement services and other community sectors at many levels needs to be integrated in all programmes with funding made available for training staff in advocacy activities and, where the programmes are large enough, the funding of designated advocacy positions. Additionally, people from the law enforcement services and other sectors need to be trained about the need for comprehensive programmes and their role in addressing HIV among injecting drug users.

The balance between HIV prevention and treatment expenditure is likely to be an important issue in sustainability

Provision of antiretroviral therapy can result in reduced funding for HIV prevention. While the provision of antiretroviral therapy is an important component of a comprehensive response to HIV, reducing funding for prevention will result in increased numbers of people living with HIV and the subsequent treatment costs.

Gender and sexual transmission issues remain unresolved

Due to the greater stigma attached to female injecting drug use in many countries, it is difficult to determine the ratio of male to female injecting drug users. There were low levels of participation by female injecting drug users in most programmes. Also, HIV

sexual transmission is accorded a lesser priority by programmes than HIV transmission related to drug use. It is possible that these two issues are linked.

A reverse bias may be required in which programmes establish services oriented towards female drug users and sex workers, who use drugs, in the absence of evidence of drug injecting or links between drug use and sex work. By starting services of this type, female injecting drug users and female sex workers, who are injecting drugs, may emerge, who would otherwise stay hidden to services, research or assessments. It is certain that those sites, which employ at least some female outreach workers, find greater numbers of female injecting drug users than those sites which employ only male outreach workers. A mixed team of male and female outreach workers should be encouraged.

Lack of standardized monitoring and reporting

Much work was required to derive the statistics for this report at almost all sites. A standardized monitoring methodology would simplify measuring coverage and enhance comparisons between programmes. Estimating the number of injecting drug users in each locality was also problematic, particularly in Brazil. This is partly due to injecting drug use being a hidden activity in most societies, and partly, particularly in Brazil, due to the rapid changes in drug use patterns.

The number of injecting drug users reached on a regular basis in each site tended to be a small percentage of the total population of injecting drug users in the city or province

It is possible that secondary exchange and other peer-based methods are ensuring regular contact with a larger group, but programmes need to increase their efforts to bring injecting drug users into regular contact with a wider variety of services.

It should also be noted that none of the sites cover 50 000 or 100 000 injecting drug users, such is the number in some cities in developing and transitional countries. High coverage of such numbers of injecting drug users will require substantially greater investment than has been needed for the programmes described in this report.

5.3 Minimal coverage monitoring and estimation

The case studies revealed a very wide range of monitoring processes, which made comparability difficult and, in some cases, made it near impossible to determine ever reached and regularly reached figures. For these reasons, a standardized minimal package for estimating and monitoring is recommended, following the model for:

- estimating the number of injecting drug users in a specified geographic area⁵¹; and
- recording the number of individual injecting drug users who access specific services⁵².

Programmes are encouraged to increase monitoring to meet their specific needs but this should be undertaken using a standardized estimation and monitoring system.

The recommended method to estimate injecting drug users in a specified geographic area is to use both multiplier and benchmark calculations. These calculations make use of existing data for behaviours or events that are common among injecting drug users, for example, police arrest data for drug use or possession, as well as drug treatment, accident and emergency ward, or drug-related deaths data. This pre-existing information, which is the sum of key behaviours

⁵¹UNODC (2003).op. cit.

⁵²USAID, UNAIDS, WHO, UNICEF and the Policy Project (2004). op.cit.

or events over a fixed time period, is called the benchmark information. For all these benchmarks and for survey data (below), disaggregating data by sex is important.

Along with this data set, an estimate of the proportion of the target population, who have experienced this event is required, for example, the proportion of injecting drug users that have been arrested, died, etc.; the inverse of this proportion is called the multiplier. Estimating the associated multiplier usually requires small, separate sub-studies and anonymous records are sufficient.

To illustrate the above, if it is known that during 2002, a total of 7000 injecting drug users went to treatment in a given place, and it is also known from surveys that approximately 20% of all injecting drug users underwent treatment in 2002, the estimated number of injecting drug users would be 35 000.

The proportion of the target population in the benchmark may be obtained separately and independently by interviews or questioning, or by specific studies. A common way to carry out this step is to ask specific questions, depending on the benchmarks used, related to arrest, treatment, overdose, etc. in Rapid Assessment and Response surveys or other surveys of HIV risk behaviours among injecting drug users.

It is recommended to use as many benchmark and multipliers as possible, and to use, if possible, other methods of population size estimation. The results of such calculations should be compared to decide on the best estimate. As well as the estimate for the number of injecting drug users, an estimate of the HIV prevalence rate among injecting drug users is useful.

Results of this estimation technique should be sufficient to use as the basis for the other calculations described below. However, experience from high-coverage sites suggests that such estimates suffer from many inaccuracies when the estimation is made before HIV-prevention programmes among injecting drug users are implemented, or when such services are of small scale. In addition, injecting drug user populations are dynamic, changing in size through the effects of drug policy and larger environmental changes; through attrition as drug users stopping drug use, leaving the district or dying; and through new injectors entering the population from non-injecting groups or from other districts.

In several of the case studies, the injecting drug user population size in the area serviced by a programme was re-estimated, using the resources of the programme to extend the reach of surveys or other processes across all social networks, ages, gender, ethnicities and subpopulations of injecting drug users. Re-estimation processes of this type have revealed substantial differences from original estimates, for example, in Rajshahi and Pskov. This re-estimation process is recommended for all programmes.

The second step is to record disaggregating by sex and total, the number of injecting drug users:

- reached through outreach, including needle-syringe programmes during the past month;
- in abstinence oriented treatment during the past month; and
- in drug substitution treatment, e.g. methadone maintenance, buprenorphine, etc.

From the point of view of HIV-prevention programmes, this means that a monitoring system must be in place to record how many injecting drug users are reached by a specific service. For inpatient and residential drug treatment, excluding drug substitution treatment programmes, this task is easily done as the number of persons in residence is normally recorded.

For all programmes providing services to injecting drug users, recording is generally done through the use of a unique identification code (UIC). There are various ways of generating such a code, but all result in each programme client receiving a unique code. These codes should be recorded, together with the date that the client first used a service, on a master list to which other monitoring and reporting systems can refer. The master list should simply contain a number, starting at 1 with the first client, the UIC and the date on which the UIC was issued, which should be the date of the client's first service access visit.

If HIV-prevention programmes among injecting drug users are coordinated for a continuum of services, the same UIC can be used for all services. This is done by simply asking each client if they have ever received a UIC from any other service. If not, a UIC can be assigned and added to the master list. If yes, the UIC information is recorded and the client's visit is assigned to that client's UIC.

A monitoring form, containing space for the date, the client's UIC and the service provided, is also needed to record each client's access visit. In the case of product-oriented services such as needle-syringe programmes, the form should also provide space for the numbers of needles and syringes, condoms etc, distributed, and other services or referrals provided. Additional questions can be added to this form for greater understanding of how to increase coverage.

An important distinction must be made between the *number of clients* and the *number of client visits*. The former is vital to many processes detailed here, whereas the latter, in the absence of client numbers, is difficult to interpret. If possible, both figures should be recorded but, if this is not possible, the number of clients accessing each service must be recorded.

Using this system, information can be kept and reported on, including:

- the number of injecting drug users ever reached;
- the number of injecting drug users accessing all services in the past month for United Nations General Assembly Special Session (UNGASS) on HIV/AIDS indicator calculations;
- regularity of reach (*see 5.4 Recommendations for further research*); and
- comprehensiveness of services.

The master list itself provides an on-going record of the number of clients ever reached. This can be read at any time by looking at the last number on the list. Where programmes are already being implemented, institutionalization of this system will create a picture of the number of clients ever reached over two to three years, and some adjustment can be made for clients reached before the system was implemented and who do not appear in the records.

Similarly, because the date of access to services is recorded, the number of clients accessing services during a specific month can be easily monitored. If the type of service is also recorded, then comprehensiveness of services can be reported as number and percentage of overall clients accessing each type of service. Depending on the specific characteristics of drug use and HIV among injecting drug users in a locality; this information can assist prevention programmers knowing whether prevention targets are being met.

5.4 Recommendations for further research

We still do not know the answer to the question “how much is enough?”; however, we are getting closer to the answer. Future effectiveness studies should track the real increases and decreases in HIV prevalence among injecting drug users in sites where funding and commitment is provided to achieving high coverage. Studies using scaled-up programmes currently planned or being implemented would assist us learn from real-world examples and give clearer guidance about the level and mix of services needed to prevent or reduce AIDS epidemics among injecting drug users.

In addition, work is needed on the development of quality indicators for HIV prevention and care services among injecting drug users. From this report and other studies, it is clear that quality of services is an important factor in achieving high coverage. From the case studies, the following areas require quality indicators:

- convenience of access to services;
- breadth of services to attract subpopulations of injecting drug users, including male and female, younger and older, users of different drugs, and a range of ethnicities;
- involvement of injecting drug users, and the extent to which injecting drug users influence or implement changes to services, including measures for ‘friendliness’ or the relationship between clients and staff;
- management processes, which are flexible, responsive to client needs, to changes in drug use patterns and to political environments; and
- effectiveness of advocacy activities with measures for relationships between programmes and key stakeholders such as law enforcement services, government at various levels and neighbours.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) brings together ten UN agencies in a common effort to fight the epidemic: the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations Children's Fund (UNICEF), the World Food Programme (WFP), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime (UNODC), the International Labour Organization (ILO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Health Organization (WHO), and the World Bank.

UNAIDS, as a cosponsored programme, unites the responses to the epidemic of its ten cosponsoring organizations and supplements these efforts with special initiatives. Its purpose is to lead and assist an expansion of the international response to HIV/AIDS on all fronts. UNAIDS works with a broad range of partners – governmental and nongovernmental, business, scientific and lay – to share knowledge, skills and best practices across boundaries.

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- is a series of information materials from UNAIDS that promote learning, share experience and empower people and partners (people living with HIV, affected communities, civil society, governments, the private sector and international organizations) engaged in an expanded response to the AIDS epidemic and its impact;
- provides a voice to those working to combat the epidemic and mitigate its effects;
- provides information about what has worked in specific settings, for the benefit of others facing similar challenges;
- fills a gap in key policy and programmatic areas by providing technical and strategic guidance as well as state-of-the-art knowledge on prevention, care and impact-alleviation in multiple settings;
- aims at stimulating new initiatives in the interest of scaling up the country-level response to the AIDS epidemic; and
- is a UNAIDS interagency effort in partnership with other organizations and parties.

Find out more about the Best Practice Collection and other UNAIDS publications from www.unaids.org. Readers are encouraged to send their comments and suggestions to the UNAIDS Secretariat in care of the Best Practice Manager, UNAIDS, 20 avenue Appia, 1211 Geneva 27, Switzerland.

High Coverage Sites HIV Prevention among Injecting Drug Users in Transitional and Developing Countries - Case Studies

UNAIDS commissioned this report to investigate programmes and sites in low-income and transitional countries which were regarded by international authorities as 'high coverage sites' – that is, where more than 50% of injecting drug users had been reached by one or more HIV-prevention interventions. The most significant finding is that high level coverage can be attained by interventions addressing HIV among injecting drug users in developing and transitional countries. The seven case studies each include a description of the development of the programme and features of the services provided, an estimation of programme coverage, factors that enabled high coverage, and a discussion of ways to maintain and expand coverage.

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