

Inter-country Consultation on Preventing HIV among IDUs: From Evidence to Action

Kolkata, India
10-13 April 2007

Background

Injecting drug use is one of the main drivers of HIV transmission in the South Asia Region (SAR). The countries in the region share common challenges in scaling up and sustaining efforts to reduce HIV among IDUs. Although overall HIV prevalence in SAR is relatively low, data show rapidly rising HIV prevalence among clusters of IDUs, and most countries are experiencing dual epidemics of drug use (both injecting and non-injecting) and HIV.

In response to demand from countries, an inter-country consultation was organized to bring together teams from neighboring countries that share common cross border issues to review experiences and discuss how to scale up efforts to tackle HIV among injecting drug users. Country teams from Afghanistan, Bangladesh, India, Nepal, Pakistan and Myanmar shared experiences related to drug use, HIV transmission, and responses to date. The consultation provided a forum for participants to learn from each other and from international experts on how to improve responses to IDU fueled HIV transmission and remove obstacles to scaling up with a view to strengthening country-level capacity and surveillance and evidence based programming.

The consultation was hosted by the Indian National AIDS Control Organization and cosponsored by the World Bank, Sida, UNODC, DfID and AusAID.

Objectives

The overall focus of the consultation was on program effectiveness and not on technical issues which have been covered in other recent meetings. The consultation was organized around the key obstacles to scaling up comprehensive harm reduction interventions and how to overcome the barriers to scaling up.

The overall objectives of the consultation were to:

- i. **Scale up interventions:** support participating country teams in their efforts to contain the spread of HIV in high-risk groups (IDU and their sexual partners) by tackling obstacles to the scaling-up of targeted interventions.
- ii. **Create an enabling environment for harm reduction interventions** and increase program effectiveness by building capacity of policy-makers and NGOs/CBOs, sensitizing government officials, and facilitating the sharing of best practices through open discussion of key issues. The central role that the drug using community must play in designing, implementing and monitoring interventions was emphasized.

- iii. **Collaborate cross borders:** Due to the cross border nature of HIV and drug trafficking/use, the consultation encouraged cross border collaboration by governments, implementing organizations, police, etc. in addressing and implementing HIV prevention interventions. In addition, the critical role of multi-sector collaboration among key ministries and departments dealing with HIV and drug use/drug users at all levels (national, provincial/state, site) was encouraged.

Key outputs of the consultation were critical actions to take forward in participating countries and ideas for cross border collaboration.

Summary

The three and a half day consultation was held in Kolkata, India from 10-13 April, 2007 and brought together more than 70 participants including country teams from Afghanistan, Bangladesh, India, Nepal, Pakistan and Myanmar, regional and international experts (US, Australia, Iran, UK, and Vietnam). The consultation was organized around the following themes: key issues and gaps to scaling up HIV prevention among IDUs, oral substitution therapy, legal frameworks in the region, overcoming stigma and gender barriers, the socioeconomic determinants to drug use, strengthening surveillance, and cross border collaboration. The consultation was opened by the Honorable Minister In-charge Dr. S.K. Mishra, Health & Family Welfare, West Bengal and attended by the Director General of India's National AIDS Control Program, Ms. Sujatha Rao.

One day was devoted to learning from the West Bengal HIV prevention program by visiting sites in and around Kolkata implementing targeted interventions for injecting drug users (including oral substitution) and sex workers. On the final day, each country team presented concrete and strategic actions that they will undertake in order to strengthen the harm reduction programs in their respective countries.

UNODC's Regional Office for South Asia launched an important report by the Lawyers Collective HIV/AIDS Unit on Legal and Policy concerns related to IDU harm reduction in SAARC countries. The launch was attended by the Honorable Mr. Oscar Fernandes, Convener of the Parliamentary Forum on AIDS, India.

Recurring themes and some key recommendations that were brought up in plenary presentations, discussions and country team presentations included:

- Scaling up oral substitution therapy. In general, coverage of opioid substitution therapy is low across the region and **needs to be scaled up**. In some countries scale-up is hampered by issues surrounding the legality of substitution therapy.
- Coordination. There is a general lack of a coordinated response to drug use related problems. This is true among donors, within governments (various ministerial mandates), and the NGO community. **Coordination needs to be improved**. In addition, HIV and harm reduction interventions need to be coordinated not segmented e.g. where IDUs are

targeted only with clean needles and substitution therapy and sex workers are targeted only with condoms.

- Fund flow. Sustainable, predictable financing is a challenge across the region and there is an **urgent need for an uninterrupted flow of funds for comprehensive harm reduction and HIV prevention services for drug users**. Linkages exist with coordination issues as there have been instances where lack of coordination has led to interrupted fund flow even when funds have been available.
- Capacity constraints. To varying degrees across the region there is limited in-country technical capacity for implementing harm reduction programs - including in NGOs. **Opportunities to strengthen capacity should be increased**.
- Women. The consultation highlighted the nexus of poverty, sex work and drug use. Women who use drugs are often engaged in sex work to support their habit and may also sell drugs. Furthermore, regional studies have shown that female sex workers inject drugs (BSS, 2001 Manipur, India; Bangladesh). **There is an urgent need to address obstacles to women seeking drug treatment and other comprehensive harm reduction and HIV prevention services**.
- Non-injectors. The importance of **including non-injecting drug users in harm reduction packages** was a main theme throughout the consultation. Non-injecting drug users need to be targeted and covered by interventions since they may switch to injecting – often due to structural reasons not personal choice.
- Common definitions/standardizing language. There was a **call for standardized language and common definitions** as they relate to harm reduction. For example, what do we mean by “comprehensive services”? What do we mean by “coverage” e.g. coverage with what? Needles and syringes? Condoms?
- Government commitment. A recurring question was how to foster and sustain government commitment to a comprehensive harm reduction package and how to encourage and ensure action on the part of policy makers. **The power of local data should not be underestimated in its ability to influence policy makers**. Both rapid assessments and modeling economic impact can serve as powerful, evidence-based tools.
- Stigma. Stigma (both HIV and drug related) is an overarching issue that affects all countries in the South Asia region and impedes access to services. Stigma is complex and multi-faceted: there is social stigma against sex work and drug use and gender-based stigma (e.g. female injecting and males selling sex). Stigma and fear are interrelated: e.g. fear of HIV infection and/or being perceived as being HIV positive. Stigma can be extremely destructive – the heavier the stigma, the more difficult it can be to have a supportive policy environment and the more stigmatized certain groups or behaviors are, the more hidden they become, thus making outreach more difficult and services more difficult to provide yet highlighting the **vital role of peer-based education and services**. **Stigma must be addressed and countered**.

- Legal framework. Currently, harm reduction measures in South Asia operate on the basis of policy directives that respond to concerns about drug use and its role in HIV epidemics. **The effective implementation of harm reduction strategies requires the amendment of some existing laws.** In the meantime, harm reduction programs are being implemented throughout the region. One progressive and successful example is the case of West Bengal where the police work closely together with NGOs and government.
- Sexual partners. The importance of **including the sex partners of drug users in comprehensive harm reduction interventions** was emphasized.

Annex I: Country Actions

The following 'next steps' were identified by individual country teams as follow-up actions to the consultation.

Afghanistan:

- Provide referral to drug treatment options; substitution therapy such as methadone maintenance therapy (MMT) need to be explored.
- Ensure sterile needle and syringe access and disposal programs.
- Provide primary healthcare for IDUs e.g. hepatitis B vaccination, abscess and vein care.
- Prevent sexual transmission of HIV among drug users and their partners by providing access to condoms; provide information, advice and education about HIV, other diseases, and sexual and reproductive health; prevent and treat STIs.
- Provide voluntary confidential counseling and testing and access to AIDS treatment for IDUs who need it.
- Provide access to affordable clinical and home-based care, essential legal and social services, psychosocial support and counseling services.

Bangladesh:

- Scale up IDU interventions nationally by December, 2007.
- Provide oral substitution for IDUs in Central Dhaka by December, 2007.

India:

- Establish a core group at the national level (e.g. thematic reference group) to focus on the issue.
- Identify the needs, what can be addressed and the remaining gap.
- Prepare a proposal to the Global Fund (and/or others) to fund the gap.

Myanmar:

- Activate the harm reduction group under the AIDS TSG by late 2007.
- Visit successful sites in other countries by late 2007.
- Document success stories from the model townships by late 2007.
- Mobilize additional resources by NAP, the UN and others since the current Global Fund financing is not adequate.
- Expand the network of services available and linked to harm reduction activities, 2007.
- Improve the technical capacity of stakeholders – particularly local NGOs and CBOs, 2007.
- Improve the management capacity of NGOs and CBOs, 2007.
- Develop a human resource development plan in line with the NSP and its OP.

Nepal:

- Start and expand oral substitution to cover 15% by 2008 and 75% coverage by the end of 2011.
- Expand the needle syringe program to cover 15% by 2008 and 75% coverage by the end of 2011.

- Scale-up rehabilitation services for male and female IDUs.
- Provide condoms and STI services for drug users and their sexual partners.
- Provide ARVs to drug users.
- Enhance partnerships and collaboration!

Pakistan:

- Scale up existing services
 - Mapping; new sites included; 80% coverage
- Include oral substitution therapy
- Government initiative