“Strengthening Partnerships for a Safer Future”

The 14th International Conference on the Reduction of Drug Related Harm

6th–10th April 2003
Chiang Mai, Thailand

Organised by:
International Harm Reduction Association

In partnership with:
Asian Harm Reduction Network

Hosted by:
Ministry of Public Health, Thailand
Office of the Narcotics Control Board, Thailand

Co-sponsored by:
Family Health International
USAID
The Centre for Harm Reduction
UNAIDS
World Health Organization
International Harm Reduction Development
International Federation of the Red Cross & Red Crescent Societies
UNICEF
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Acknowledgements

The organizers, International Harm Reduction Association (IHRA) and Asian Harm Reduction Network (AHRN), would like to acknowledge the following individuals and organizations for their invaluable contributions to this conference.

Our co-hosts
Thailand’s Ministry of Public Health
Office of the Narcotics Control Board

Our sponsors
Centre for Harm Reduction
Family Health International
International Harm Reduction Development
International Federation of Red Cross and Red Crescent Societies
USAID
UNAIDS
World Health Organization
UNICEF

Interpreting support
For their support of simultaneous interpreting in three languages:
UK Government Department of International Development
Open Society Institute
Ministry of Public Health Thailand

Health and Development Networks (HDN)
Our sincere gratitude also goes to HDN and their dedicated Key Correspondents who worked tirelessly to document the conference and produce the On Track Newsdaily newsletter.

HDN Key Correspondents
Amporn Boontan (Thailand)  Lucy Reynolds (China)
Anong Boonchuey (Vietnam)  Monthatip Suksopha (Thailand)
Chitra Ahanthem (India)  Ruan (Kitty) Jingping (Thailand)
Dan Allman (Canada)  Shona Schonning (Russia)
Greg Manning (India)  Stephen Wye (Australia)
Jessica Silver (Thailand)  Suchada Taweewit (Thailand)
Joe Selvaretnam (Malaysia)  Sutthida Malikaew (Thailand)
Khuat Thi Hai Oanh (Vietnam)  U Than Htut (Burma/Thailand)

On-site HDN management and editorial team
Chakatip Kiatduriyakul (Thailand)  Manju Chatani (India/Ghana)
Cheryl Nelson (Canada/Thailand)  Monruedee Laphimon (Thailand)
Hinda Abbou (Germany/Thailand)  Nadine France (Ireland/Thailand)
John Kromodimedjo (Suriname/Thailand)  Susie Hopkins (Australia/Thailand)
Jordi Baroja (Spain/Thailand)  Tim France (UK/Thailand)
Madeleine Lynch (Ireland/Thailand)  Warunee Kuthithamee (Thailand)

Special contributions were also made by the Youth Rapporteur Team at the conference. We are also grateful to Catherine Hesse-Swain for her impeccable editing of this report.

Thanks also to AHRN staff, IHRA colleagues, Asia Congress, Diethelm, and other colleagues, friends, and volunteers who helped make the conference a reality.

Lastly, we would like to extend our heartfelt thanks to the Ministry of Foreign Affairs of the Royal Netherlands Government, which, in its ongoing support for AHRN, confirms our determination to make a difference in Asia where drug use and HIV/AIDS are concerned.
Harm reduction is proving to be a pragmatic and cost-effective way to reach out to marginalized groups by offering them services that focus on reducing the negative consequences of drug use for the individual, the community and society as a whole. Harm reduction assists in the control of illicit drug use and supports the reintegration of recovering drug users into the community. The past decade has shown that a major achievement of harm reduction programmes is the prevention of HIV/AIDS and Hepatitis C.

Our achievements globally and regionally compel us to move forward to face new challenges by reinforcing established partnerships and forging new ones. We must now weave our local, regional and international networks together – enriching each other’s work through a multi-sectoral approach to collaboration and the sharing of experience, expertise and knowledge.

It was in the spirit of this belief that the key organizers of the conference were honoured to host the 14th International Conference on the Reduction of Drug Related Harm (14th ICRDHR) held in Chiang Mai, Thailand on April 6-10, 2003. The conference brought together 909 delegates, with significant numbers from all continents, particularly from across Asia. Held over four days, the conference was a hive of activity with plenary and major sessions, symposia, roundtables, skills building, and thematic poster sessions. In all there were about 70 sessions with 350 speakers. The conference theme, “Strengthening Partnerships for a Safer Future”, captured areas of activity where major advances need to be made.

This report summarizes the highlights of the 14th ICRDHR beginning with the conference’s history and moves on to coverage of the sub-themes and objectives. We are presented with the main issues emerging from the conference through the eyes of the rapporteur teams, key correspondents and selected participants. The focus then shifts to a brief description of the on-site newspaper On-Track and the training and skills sessions, and finally, the rapporteur’s presentation.

By documenting the proceedings of the 14th ICRDHR we hope to continue to realise the goals of harm reduction. Long-term solutions to the challenges of HIV/AIDS and drug use will be elusive if we do not approach them from the harm reduction perspective. We hope that holding the harm reduction conference in Asia for the second time will not be the last reminder.

Ton Smits
Conference Director, 14th IHRC
Executive Director, Asian Harm Reduction Network
The conference theme, “Strengthening Partnerships For A Safer Future”, was intended to bring to the fore the many challenges of reducing drug related harm in the context of rapid social change and competition for scarce resources. The 14th ICRDRH’s diversity of sub-themes, articulated through a range of presentation mediums, had one main objective at heart – to stimulate a multi-sectoral approach to harm reduction policy development and implementation by promoting partnerships between national, local and community leaders, law enforcement agencies, drug treatment providers, drug users, agencies working with young people, people living with AIDS and the private sector.

More specific objectives of the conference were to:
- provide a forum for taking stock and exchanging ideas, experiences and lessons learned in harm reduction among stakeholders in the region and globally;
- to share information on the HIV and drug use profile in participants’ countries;
- to address HIV among injecting drug users (IDUs) in participants’ countries;
- to examine how funding issues can limit or expand harm reduction responses, and how to enhance advocacy;
- to examine areas of information and expertise that could be usefully exchanged in the future;
- promote gender equity in harm reduction strategies;
- promote greater understanding of the social justice perspective of harm reduction principles, particularly in relation to the poor, excluded, and marginalized;
- address the changing socio-cultural, political, and economic contexts affecting harm reduction programmes in the region and globally;
- to identify practical ways to build collaborative partnerships for research, policy, and action; and,
- the development of a post-conference advocacy document.

Presentations covered science and research in harm reduction, policy and practice of harm reduction, and critical viewpoints or commentaries in harm reduction issues, and were communicated via plenary sessions, symposia, roundtables, forums, skills sharing sessions, training workshops, thematic poster presentations and special sessions. For the purposes of this report, four key sub-themes have been developed as a way of coherently presenting the volume and diversity of the conference topics and outcomes.

1. Changing context of harm reduction locally, regionally & globally

Current developments and dynamics were explored, such as changing international, political and economic situations and their effect on drug use and harm reduction policy and practice at a local, national, regional and international level. Many speakers took the opportunity to frame harm reduction within its current political, social and/or economic context. The world is a changing and changed place and those involved in harm reduction policy development and implementation must keep abreast of the climate they are working within – the constraints and the possibilities. The opening plenary sessions addressed these very issues, specifically in relation to the Asia region. Under the title “Update on Asia”, the speakers examined two major topics: “Injecting drug use and blood-borne viruses in the Asian region”; and, “From policy to quality: Responding to HIV epidemics in the Asian region”. More specifically, sessions looked at the following issues.

Assessing drug use in the context of HIV/AIDS

Speakers presented papers profiling their own country, mainly focusing on drug use and HIV infection. The countries covered were Australia, China, Indonesia, Nepal, Thailand, and Vietnam. Social turmoil and HIV epidemics were explored in papers on the Russian Federation (Russia), Nepal, Tajikistan, and Central Asia. Two-part thematic poster presentations entitled “HIV epidemics” included case studies on communities in Brazil’s Bahia State, Cambodia, Nepal, Pakistan, and Thailand. As hosts to this conference there was a major session on “Thailand: Current situation, perspectives and response”.

Assessing drug use and harm reduction in Central and Eastern Europe (CEE) and the Former Soviet Union (FSU)

Issues covered included: the current state of methadone maintenance and harm reduction programmes; capacity-building; drug user involvement; people trade, drugs and HIV/AIDS; and, drug policies and practices in EU candidate countries.

The Impact of economic and social change on the younger generation, vulnerability and their own experiences of IDU

A facilitated session and a forum were used to bring together young people from across the Asia Pacific region with experiences related to drug and substance use, to: share and analyse findings from their respective country consultations; evolve a plan of action; analyse, from a rights perspective, mechanisms currently used in targeting young people in harm reduction/substance use prevention programming; and, contribute their findings to a post-conference advocacy document. In other sessions case studies were presented on the current state of youth and drug use in Thailand and Canada.

Impacts on drug use and harm reduction of increasing mobility and cross-border movement of people

Papers explored the complex issues surrounding cross-border movement, drug use, HIV/AIDS and the role of harm reduction across Asia, including studies of Afghan refugee women in Pakistan, women in Central Asia, and adolescent girls in India.
Vulnerable minorities
Speakers examined the current IDU/HIV situation for a number of vulnerable minority populations, including the Akha in northern Thailand and the indigenous peoples of Australia and Canada.

2. Taking stock

Research findings
This conference was an opportunity to reveal the latest scientific and medical research data on drug use, treatment and HIV/IDU, and its possible implications for harm reduction strategies. Speakers presented a wide range of research data on:

- substitution treatment and substance dependence (opiate dependence and pharmacotherapies);
- the use of naloxone in overdose prevention;
- methadone prescription;
- buprenorphine injecting;
- free detoxification;
- mainstreaming addiction treatment;
- advances in and limitations of modelling secondary transmissions of HIV;
- needle and syringe exchange programmes (NSEP) – national coverage and quality; and,
- heroin and cocaine use in the context of IDU transition.

A number of speakers also assessed the feasibility of certain research methodologies, including peer research and ethnography.

Review and assessment of harm reduction policy
There was an effort to address some of the pressing legal reform issues in countries around the world, as well as a more general sharing of experiences in defining and developing effective harm reduction policy. Policy was primarily addressed in a major session on “Drug policy: Change and evaluation”, which included papers on cannabis policy changes in Queensland and the Netherlands, the promotion of drug law reform in Argentina, and the impact of new drug legislation in the Czech Republic.

In other sessions, several speakers addressed: global shifts in drug policy reform; harm reduction in the context of child rights; harm reduction and law enforcement approaches via experiences in Argentina, Bangladesh, Brazil, Canada, China, Manipur State in India, Russia, the United Kingdom (UK), and Vietnam; and, the policy implications of treating teenagers for alcohol and drug abuse. The thematic poster session on “Policy issues” presented studies on defining effective drug policy, comparative analysis of HIV and drug use laws in Russia and the Ukraine, and the national campaign to decriminalize drugs in Argentina. One session focused exclusively on the economic analysis of policy and intervention.

Review and assessment of harm reduction implementation
Review and assessment papers traversed a number of significant areas, including:

- HIV prevention and care – programmes in the treatment and care of IDUs with HIV/AIDS, and access to antiretroviral (ARV) treatment across the globe, including Brazil, India, Iraq and countries of Central and Eastern Europe and Central Asia, as well as studies from Brazil, China, the United States of America (USA), and Vietnam;
- epidemiology and overdose prevention – issues ranged from drug combinations, police attendance, transient behaviour change, injecting centre experiences, overdose management and victim care, to the epidemic of drug overdose deaths in British Colombia, Canada;
- HIV prevention in high prevalence drug user epidemics – the experiences of communities in New York, Nepal, Portugal, Russia, and Thailand in the use of harm reduction strategies to bring HIV epidemics among IDUs under control;
- harm reduction impact and cost-effectiveness, including new studies from the Ukraine and Bangladesh, and assessment of programmes run by needle exchange programmes (NEP) in Odessa and CARE-SHAHTI in Bangladesh;
- assessment of female drug user access to services – gender and vulnerability, including that of pregnant IDUs, and HIV and women in India;
- rapid assessments of drug injecting – studies from Argentina, Belarus, Colombia, Malaysia, Mongolia and Iran, and even a cross-cultural rapid situation assessment on the Internet;
- feasibility of needle and syringe distribution in Vietnam;
- Thai HIV vaccine efficacy trials; and,
- Hepatitis vaccination campaigns.

3. Emerging trends in drug use and issues of service delivery
There were many presentations addressing emerging trends in drug use and the implications for harm reduction service delivery. Under the title “Emerging trends”, plenary speakers examined two major trends: “Methamphetamine abuse in the young: Harms and hopes”; and, “Creating harm - The local consequences of Afghanistan’s opium economy”.

Trends
- Youth and drug use risk behaviours - Issues included new drugs, the interconnections between nightife, drug use and risk behaviours, alcohol harm reduction among university students, and the alarming increase in meta-amphetamine usage among young people in the Asia-Pacific region (studies on substance abuse among secondary school students in China, street children in Chiang Mai, and young people in Manipur state, India);
- Amphetamines - Trends in amphetamine use in Australia, San Diego, and Thailand and other countries of the Asia Pacific region.
- Drug preparation and use - Trends in and IDUs understandings of the risks of home drug manufacturing, syringe sharing, and introduction of new substances (ie Subutex and Ritalin tablets);
- HIV incidence and risk behaviour among IDUs – Studies on syringe acquisition and disposal, and female IDUs as a bridging population for HIV transmission, as well as community studies among female crack users in Bahai State, Brazil; prisoners in Bangkok; heroin users in Pakistan; and, IDUs in Thailand and Cambodia;
- Prison inmate risk behaviour – Trends in risk behaviour among IDUs, including HIV epidemics, Hepatitis C transmission, as well as individual studies from prisons in Australia, Canada, Lithuania, Russia, and the Ukraine;
- Harm reduction and sex work - Interconnections between sex work and IDU, and the increasing significance of gender-sensitive and holistic harm reduction strategies, with studies from Sao Paulo, Brazil, the Ukraine, UK, and Vietnam;
- Drug-injection in big cities – Data from the WHO Drug Injecting Study – studies on risk behaviours in Great Rosari (Argentina), Minsk (Belarus), Nairobi (Kenya), St Petersburg (Russia), and Tehran (Iran);
- Public injecting environments and street-based users – Studies from Australia and Chennai, India;
- Hepatitis C epidemiology and prevention - Issues of risk and increased prevalence of HCV among IDUs in Australia (young injectors), southern India, London, USA, and UK prisons.

Service delivery
- Progress in estimating the size of IDU populations – Papers examined a number of methods, including a multi-site behavioural surveillance system used to monitor IDU trends in the US, as well as
specific examples from Indonesia and Kathmandu, Nepal.

- Treatment and care - A diverse range of presentations on service delivery strategies and programmes from all over the globe, including: access to pharmacotherapy in prisons; effectiveness of buprenorphine maintenance on high risk behaviour in India and Iran; simple and effective interventions for needle and syringe programmes; de-escalating angry clients; integrating primary care; building cultural competence for dealing with clients with drug and alcohol problems; and, access and adherence to ARV therapy among HIV-infected IDUs.
- New developments in rapid assessment methods - Successful stories from: Brazil where rapid assessment projects were directed at understanding the risks and context for HIV transmission for IDUs in multiple locations throughout the country, and to evaluate HIV/AIDS risks in vulnerable populations; Bangladesh where CARE adopted a collaborative approach to rapid assessment across eight districts; and, Buenos Aires where rapid assessment was employed for cocaine use and sexual risk behaviour.
- Expanding harm reduction services - Innovative developments in: the provision of primary health care to drug users in Australia and the UK, drop-in-centres as forums to strengthen rapport with IDUs in Nepal, and development of a complex needs approach to address problems around substance abuse, employment and social functioning in deprived areas of London and a multi-centre trial in Utrecht, Holland.
- Need for low-threshold, youth friendly harm reduction services - low threshold centres for preventing HIV transmission among IDU street children.

4. Scaling-up and re-orienting services for harm reduction

Sustainability

Many presentations fell into line with the main theme of “Strengthening Partnerships for a Safer Future”, focusing on policy development and service delivery strategies that seek to reinforce harm reduction’s achievements and ensure its future sustainability in reducing drug-related harm and preventing the spread of HIV/AIDS. Speakers shared their experiences and knowledge of the theory and application of scaling-up strategies, capacity building in funding and advocacy, building partnerships, and self-empowerment through IDU social networks and peer-driven initiatives.

Funding

Speakers addressed the following funding-related issues:

- the HIV vaccine research agenda and IDUs;
- volunteers versus paid workers in harm reduction (stories from Australia, Brazil, India, Nepal, and Russia);
- donor viewpoints on giving and getting funds for harm reduction and the funding relationships between international donor agencies and governments and their recipients; and,
- the current programmes and resource allocation of international organizations, such as the Slovenian Red Cross, AIDS Foundation East-West (AFEW), and Open Society Institute (OSI) - Russia.

Advocacy

Issues included:

- experiences of harm reduction advocacy - training to conferences - from Indonesia, Argentina, Brazil, and Lithuania;
- the role of education programmes in harm reduction capacity building - studies on harm reduction as an undergraduate subject at universities and colleges in Brazil, professional development training packages for frontline human service workers in Australia (Directions in Substance Education in Queensland), and professional development training for HIV prevention in the Russian Federation;
- advocacy and human rights, with specific studies on the rights situation of HIV positive IDUs in Thailand, India, Argentina, and Poland, Lithuania and Germany (three-country study);
- “Humanitarian principles in action” presentation/skills sharing session aimed at exploring the link between humanitarian values (such as the “Fundamental Principles” of the Red Cross and Red Crescent) and advocacy to create a supportive climate for harm reduction programming.

Building partnerships

Building partnerships was the overarching theme of the conference, addressed to a degree in many of the papers mentioned above. There were, however, presentations where the primary conceptual focus was on forging and nurturing partnerships. The two plenary sessions under the title “Partnerships” were: “Toward a partnership of modern day healers”, where the relationship between public health providers and law enforcement agencies was considered crucial; and, “Providing methadone effectively through a partnership of doctors and patients”. One forum focused on “From segregation to integration: Encouraging new regional and national partnerships that respond to drug abuse-related HIV vulnerability”. There was a roundtable session dedicated to exploring “Networks for better partnerships” with experiences from the Asian Harm Reduction Network (AHRN), the North East India Harm Reduction Network (NEIHRN) and the Latin American Harm Reduction Network (RELARD). One interesting example of innovative partnership in practice was the paper on a cross-border HIV prevention project for IDUs in China and Vietnam.

Self-empowerment and IDU social networks

While there has been a proliferation of harm reduction non-government organisations (NGOs) and government organisations (GOs) working within developing societies, often there remains resistance to harm reduction strategies within local communities. Speakers examined innovative social support mechanisms revolving around self-empowerment through IDU social networks and peer-driven programmes. Studies explored the concept of peer-driven intervention (PDI) where drug users can play an important role in the management of their drug dependence, including the social network approach, peer leader training, and flexibility in outreach interventions. Examples include:

- the democratisation of drug user organizations in Bangladesh;
- professional injectors (PIs) helping to reduce sharing among IDUs (CARE Bangladesh);
- community partnerships and involvement of IDUs in harm reduction programmes in Cambodia, Chiang Mai (Thailand), India, Kachin State (Myanmar), the Philippines, and the Ukraine;
- evolving IDU community networks and self-help groups for harm reduction in Eastern Europe;
- peer education approach in Yunnan Province, China
- peer support project in Amsterdam aimed at reducing the use of club and party drugs;
- realistic peer approaches to supporting friends with speed psychosis - a project targeting inner city gay ‘tribes’ who inject amphetamines in Sydney; and,
- IDU peer training and participation in outreach programmes in Nepal, the Ukraine, and Vietnam.
The annual International Conference on the Reduction of Drug Related Harm (ICRDR) is now entering its 15th year and is the major international conference on reducing harms from all drugs – including alcohol and tobacco.

The 14th ICRDRH in 2003 placed special emphasis on working across organisational and national boundaries under the theme “Strengthening Partnerships for a Safer Future”. Under the umbrella of this main theme there was also emphasis on young people, harm reduction advocacy, implementation and scaling up. This conference followed the success of the 13th conference in Slovenia, which focused on social change, inclusion and exclusion, and the 12th conference in India where community development for harm reduction was the key theme.

Conference organizers commented that abstract submission quality had steadily been improving with the number of abstracts submitted for 2003 rising by 50 per cent from the previous year.

The 15th ICRDRH is being held in Melbourne, Australia on 20-24th April 2004.

Young people are growing up in a very different context from that of previous generations. In 2003 many countries, including those in Asia, the world’s most populous region, were going through major social and economic upheaval. Development has been hampered by the downturn in the world economy and the uncertain threat of global terrorism. Further, Asia has a large number of people who are mobile or displaced. There are huge demands on existing resources in order to tackle a wide range of health and social issues. There are new challenges to meet, because in some countries the response to rapid social change has been to launch campaigns against so-called social evils. These campaigns will further stigmatise and criminalize those groups most at risk and make effective prevention of HIV and other blood-borne diseases even more difficult.

The 14th International Conference on the Reduction of Drug Related Harm (14th ICRDRH) focused on confronting these ongoing challenges. The four-day conference drew some 900 participants from 67 countries to Chiang Mai in Thailand. Delegates examined the most pertinent issues currently surrounding harm reduction at the local, national, regional and global levels – reviewing progress of harm reduction initiatives and proposing creative solutions to unmet needs and problems. This conference was unique, attracting people working in many different fields – policy makers and politicians, scientists and researchers, advocates, and people working in health, criminal justice, social welfare, and education. One of the conference’s single great achievements was to involve and closely collaborate with drug users themselves.

The presentations covered science and research on harm reduction, policy and practice of harm reduction, and critical viewpoints or commentaries on harm reduction issues, via a diverse range of conference formats, including plenary presentations, symposia, roundtables, skills sharing and problem solving, and training workshops.

Retrospectively, a number of sub-themes can be identified, flowing out of the main theme of “Strengthening Partnerships for a Safer Future”. Many presentations and discussions focused on updating our contextual sense of where harm reduction sits in the world, and the
economic and social changes that are influencing its progress. In the past decade, Asia has witnessed major changes in the use of drugs, alcohol and tobacco. There has been a rise in the use of amphetamine type drugs, the spread of drug injecting, new and high levels of alcohol use, and rising health problems caused by tobacco. There are no simple answers to the looming development crisis as a consequence of HIV/AIDS, Hepatitis B and C, tuberculosis and deaths related to alcohol and tobacco in Asia, as in other parts of the world.

Predictably, delegates were also keenly involved in taking stock of harm reduction’s role through recent research findings and the review and assessment of harm reduction programmes and IDU treatment at the coalface. Other key sub-themes were: emerging trends in drug use; issues in service delivery, such as HIV prevention and care among drug users, youth, drug use and harm reduction, and risk behaviours; and, scaling-up and re-orienting services for harm reduction sustainability, including funding, advocacy, partnerships and IDU social networks. Delegates actively worked to identify opportunities for re-orienting services to meet the challenges of harm reduction’s changing context. The potential for harm reduction to reinforce abstinence-oriented programmes and law enforcement strategies is no longer in question in much of the developed world. However, harm reduction continues to fight hard to get a hearing in developing country settings and to challenge the new social order campaigns. In Asia and elsewhere, there are many excellent examples of good harm reduction practice. But these efforts need to be scaled up and new initiatives developed. Advocacy with national and local leaders is crucial, as too is the need to improve the evidence base - in order to identify best practice and promote evidence-based policy making.

The setting for the conference - Chiang Mai in northern Thailand - was very appropriate. Chiang Mai is situated in the Golden Triangle, which produces much of the world’s opium and heroin. Thailand is estimated to have between two and three million drug users. Methamphetamine is now overwhelmingly the drug of choice and there are also an estimated 40,000 opiate drug users of whom about 90 per cent inject. Several countries in the region have serious HIV epidemics among injecting drug users. This has certainly triggered the HIV epidemics in the general populations in Thailand, Myanmar and Manipur State in northeast India.

The harm reduction concept is becoming accepted in more and more countries. The quicker this is translated into policies and programmes, the quicker we can alter the course of the HIV/AIDS epidemics in this part of the world. But this conference was not just about this region or even just about HIV and injecting drug use. It was also about other health problems and also the social and economic costs of drugs.

A sign of the growing strength of harm reduction worldwide is the fact that the first regional harm reduction network, the Asian Harm Reduction Network, is situated in Thailand. The IHRA / AHRN partnership in promoting this conference was a living testimony to how collaboration can play a significant role in the dissemination of knowledge and the building of networks. Indeed new partnerships were already being forged in the lead up to the conference. In addition to traditional sponsors of the yearly harm reduction conferences such as UNAIDS, we welcomed for the first time as sponsors the World Health Organization, UNICEF, Family Health International, the International Federation of Red Cross and Red Crescent Societies, and the Centre for Harm Reduction.

In addition to the many presentations and cultural activities held during the conference there was a comprehensive skills sharing and training workshop programme, offering some 15 sessions designed to give participants the opportunity to build on their practical skills in the area of harm reduction. Issues, concepts and case studies were further captured in the 19 thematic poster presentations and more than 250 poster exhibits. The outcomes of the conference proceedings were vividly documented by the Health and Development Networks (HDN) team, which worked energetically to produce the daily On Track News. This report is a reflection of the on-going close partnership between AHRN and HDN.

It is clear that reducing the negative consequences of drug use cannot be achieved by repressive measures, or by the health sector alone. This conference spelled out more than ever the urgency of a multi-sectoral approach to harm reduction policy and implementation. There is a pressing need to establish and expand partnerships. National, local and community leaders, law enforcement agencies, drug treatment providers, drug users, agencies working with young people, people living with HIV/AIDS and the private sector, must share a common goal: reducing drug-related harm.
Main Issues Emerging from the Conference

Asian IDU and HIV at crisis proportions
A preoccupation of conference delegates was coming to terms with the devastating size and impact of the drug use and HIV/AIDS situation across the Asian region. Overall, there are seven million people with HIV in Asia, one per cent of the women in the general population of Southeast Asia is HIV positive, and in the year 2002 alone 490,000 people died of AIDS-related conditions. Drug injecting and HIV continues to spread throughout the region and several new outbreaks of HIV among drug injectors are taking place – in certain areas the prevalence of HIV ranges between 40 and 60 per cent. The IDU sexual transmission of HIV, Hepatitis B and C, and other blood-borne diseases is taking place at an ever-increasing rate. From the range of data presented at the conference it is clear that harm reduction needs to be urgently expanded to address these issues.

Youth and drug use
The conference programme also addressed the alarming growth in injecting drug use among young people globally, but particularly within Asia and in Russia and the former Eastern bloc countries, where street children are injecting from a very young age. The increasing usage of speed drugs like methamphetamine in Southeast Asia was captured in a number of sobering studies where IDU youth were seen to be engaging in various risk-related behaviours, involving: sexual HIV transmission; new drugs; syringe sharing and risky preparation; and, nightlife club and party scenes. Several studies examined alcohol use among university students in the US. The development and implementation of peer intervention strategies, like peer support networks, were seen as crucial to working with youth in the future. To this end, a facilitated session and forum were used to bring together young people from across the Asia Pacific region with experiences related to drug and substance use to share and analyse findings from their respective country consultations, and help develop appropriate harm reduction policy and strategies.

Debate on the impact of HIV/IDU epidemics in generalised HIV epidemics and the role of modelling
Discussion took place about whether IDU can and do accelerate and enhance the start of a heterosexual spread of the HIV epidemic and whether the existence of a large sector of commercial sex work would play an important role in driving the HIV epidemic. The limitations of modelling were also discussed, with particular reference to two models presented for the same country but with different conclusions. Different modelling groups, including groups of researchers, need to discuss and agree on their conclusions and the harmonization of data sets in order to prevent giving conflicting suggestions to policy-makers. There is a need for interventions to address both drug injectors and their sexual behaviour.

IDUs access to antiretroviral (ARV) therapy
The World Health Organization has set the goal for three million people living with HIV/AIDS in the developing world to access ARV therapy by 2005. There are estimated to be two to three million drug injectors with HIV globally, but that in many countries access to ARV therapy is extremely limited, especially for drug users. Barriers to equitable access to ARV therapy, particularly in Eastern Europe, are not only due to stigma or discrimination, but also to poverty, repressive legal and regulatory frameworks, and lack of experience. Stigma and discrimination are often the consequence of these barriers.

Adherence to ARV therapy, however, is seen as a challenge affecting the whole HIV/AIDS population, not particularly drug users. Brazil showed itself as a role model for access to ARV therapy. In 1996, universal and free access to ARV treatment was established by a presidential decree. In the period 1997-2000, there was a 52 per cent reduction in mortality due to HIV/AIDS and the average costs of treatment were reduced by 58 per cent, due to agreements with pharmaceutical companies and the production of several medications in Brazil.

Vaccine trial results
The results of the first phase three trial of vaccines for HIV in the USA were presented two months ago. This VaxGen trial 04 was directed to over 5000 men who have sex with men (MSM) and around 300 women at risk. The results highlighted that, for some unexplained reasons, Asian and African-American participants responded better to the vaccine, although their absolute number in this study was very small. In Thailand, another trial has been conducted (VaxGen 03) amongst 2500 drug injectors recruited from treatment centres and tracked for the last three years. The results will be presented in a few months, but because this trial is conducted amongst Asian participants expectations are high.

Naloxone in overdose prevention
The long-running academic debate on merits of naloxone distribution to opiate users in order to prevent fatal overdose continued during this conference, with arguments on both sides. The general conclusion was, that although the particular situation and the context will influence the need for naloxone, there should be a role for naloxone as part of a
broader and comprehensive overdose strategy, which definitely should include training and education of drug users and workers. We were also reminded of the relative impact of overdose on mortality amongst drug injectors, which in many places exceeds the mortality rate due to HIV/AIDS.

**Other drugs, new drugs**

Several papers addressed the prevalence of use of substances other than opiates, as well as poly drug use. In particular, stimulant use was reported, including crack and cocaine, in Western Europe and methamphetamine use in Southeast Asia, Australia and New Zealand. Emerging trends were reported, such as the use and injection of Ritalin in New Zealand and the smoking of scorpions mixed with opiates, hashish and other ingredients in Afghanistan. There is a need to address these issues and even in the case of large-scale problematic use, such as in the case of methamphetamine, crack and cocaine, treatment options are still limited and unexplored.

**Importance of Inter and multi-disciplinary research**

The importance of combined research methods was stressed, as well as calls for inter and multi-disciplinary approaches. We need to identify what the problem is, as well as understand the underlying context of that problem in order to develop effective interventions. Interventions need to address structural factors and devise effective strategies.

**Ethnography**

There was confirmation of the importance of ethnographic studies and qualitative research to inform drug and harm reduction policies. Qualitative research methodology is particularly informing of the underlying contexts for why people still engage in risk behaviours despite their knowledge of the possible negative outcomes. Suggestions were made to think in terms of risk associated behaviours and situations instead of risk groups. The concept of relative risk was discussed, as well as the misfit in perceptions of risk between drug users, researchers and service providers.

**The growing importance of Rapid Assessment and Response (RAR)**

RAR seeks to both understand a situation and effect change to that situation. Several reports mentioned that RARs are being increasingly funded and conducted in many countries across the world using the recent WHO guide. RAR utilises a wide range of sources and their application across the world is important because they will contribute to harmonized data sets. Evaluations demonstrate that RAR has positive outcomes, although more training on the conduct and quality of RAR is recommended.

**Lack of research on vulnerable groups**

The specific context and risk situations of diverse groups of people were discussed:

- vulnerable minorities;
- migrants and refugees;
- young people;
- prisoners (IDU/HIV epidemics); and,
- clubbers or nightlife drug users.

People in these specific groups are highly vulnerable to problematic drug use and HIV infection. Exciting new strategies for working with these communities are currently being devised and explored, particularly where drug use and HIV are denied in order to avoid further stigmatisation of marginalized groups. However more research on these issues and groups is clearly required so that effective interventions can be developed.

**Harm reduction sustainability**

Policy development and service delivery strategies that seek to reinforce harm reduction’s achievements and ensure its future sustainability in reducing drug-related harm and preventing the spread of HIV/AIDS were a major focus. Delegates discussed their experiences and knowledge of the theory and application of scaling-up strategies, capacity building in funding and advocacy, building partnerships, and self-empowerment through IDU social networks and peer-driven initiatives.

**Coverage and scaling-up**

Coverage established itself as a complex issue, with the setting of targets and needs too often based on assumptions. People are working towards a greater clarification on the relationship between coverage and scaling-up responses and to workable definitions. Issues addressed included: the need for a more united approach to bridge different policies and programming; the need for a horizontal exchange of good practices between countries rather than reinventing the wheel; the often-frAGMENTED nature of policies and interventions; and, the need to focus on how quality, high-coverage programmes can be delivered, particularly in resource-constrained and politically volatile settings. Scaling-up is closely tied to institutional reform because using existing services to provide a network and educational system was essential to significantly scaling up prevention activities.

**Empowerment through user-driven intervention**

The presence and involvement of a considerable number of IDU delegates underlined the logic of and growing faith in user-driven initiatives, such as IDU community networks and democratisation, peer support groups, and, peer training and education for outreach programmes. Drug users have shown to be: constructive partners in a dialogue to improve their own quality of life and that of their society; equals on government and medical boards and task forces; effective health educators of other drug users; and, powerful advocates for each other and for improved treatment facilities that respect their rights. The continuing challenge is to break down barriers of stigma, discrimination and resistance to disclosure among the IDU/HIV populations in more traditional and developing communities – so that IDUs are free to access their own inner resources for self-help and peer support.

**Building partnerships and regional networks**

This conference demonstrated the bringing together of many partners from diverse sectors and professional backgrounds, and from different parts of the world. The future challenge is to keep building and nurturing multi-sectoral and cross-organisational partnerships. Of particular interest is the evolution of regional networks like Asian Harm Reduction Network (AHRN), North East India Harm Reduction Network (NEIHRN) and Latin American Harm Reduction Network (RELARD). These networks set the pace for the generation of new regional networks across the globe.

**Gaps**

- Some drug user delegates felt their presence was symbolic, and that the harm reduction movement is getting off-track.
- Lack of participation at the conference of drug dealers.
- Paucity of systematic data available on other adverse consequences of drug injecting, aside from consequences of blood-borne diseases.
- Research on special risk associated behaviours and situations.
- Treatment options for drug use other than opiates (crack, cocaine and methamphetamines) and new injecting drugs (Ritalin).
- HIV/AIDS stigma and drug use, and implications for harm reduction not adequately addressed.
- Some delegates believed that children and drug use was not adequately addressed.
- The essential role of women, either as drug users or affected by drug use, as community stakeholders was not adequately addressed.
Conference Coverage

Speaking the world of harm reduction: HDN Key Correspondents in action at THE 14th ICRDRH

A team of Health and Development Network (HDN) Key Correspondents (KCs) were on-site throughout the event to capture information, debate and discussion as they happened and to extend the conference beyond session halls. HDN regularly brings together KC teams at international, regional and national health and development-related events. The idea is to share information from the conference with those who cannot attend, through the unique perspective of the Key Correspondent’s own experience.

The KC concept was evolved by HDN to improve the availability and quality of information and reporting on HIV/AIDS, TB and other development-related issues. From diverse cultural and professional backgrounds, these country-based writers are skilled, creative and dynamic. KCs help document local experience, provide independent reporting and monitor some of the commitments, declarations and other plans issued at international and national levels. They are a barometer to the complex and constantly evolving health and development landscape.

As conference delegates presented papers and posters, listened and discussed at sessions and meetings, and debated in the corridors – some of their experiences were being captured in the daily on-site newsletter.

On Track News. At the same time, thousands of virtual delegates throughout the world were able to follow the highlights of the deliberation through various forums such as SEA-AIDS, via the conference website and the HDN website.

A team of 28 HDN Key Correspondents and staff made sure that the lessons learned and perspectives gained in Chiang Mai, were not lost but were instead shared with those unable to attend. The KCs at the 14th ICRDRH came from many countries throughout Asia and beyond. They are community activists, researchers, students, project coordinators, media – working in harm reduction and HIV/AIDS.

One Key Correspondent commented: “I have attended conferences as an organizer, as a delegate and now as a KC. As an organizer, I was too busy with logistics and I had no clue about the content; as a delegate I listened passively; and now as a KC, I am more actively engaged in really understanding what we are talking about.”

For further information on HDN, the KC Team, or to join an eforum please visit http://www.hdnet.org or write to correspondents@hdnet.org

HDN Key Correspondents provided comprehensive and incisive coverage of the conference. They compiled the following articles, which have been organised under the same sub-themes introduced in the section of “Conference themes and objectives”.

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Section 1 Changing context of harm reduction locally, regionally & globally

Turmoil

Scientific research and programme planning is going ahead based on an assumption of a stable operating environment. Very often, drug use and harm reduction interventions are not practiced in a stable environment.

At least one third of the population of Afghanistan is displaced. The government in Nepal has changed 14 times since democracy began in 1990. The Thai government is pursuing its war on drug users. Manipur has 11 insurgency groups with influential military capacity. We have disproportionate prison populations due to the number of inmates incarcerated on drug-related charges. Globalised military manoeuvres are introducing unfamiliar drugs into newer regions.

When we enter turbulent contexts through the eyes of the delegates of the 14th ICRDRH, whom do we meet? We meet gatherings of refugee women from Afghanistan who are using a variety of drugs. We meet Russian volunteers who are operating extensive networks of needle exchanges. We meet the wives and children of the so-called at risk or targeted group. We meet the newly appointed Minister for Health. We meet the new Secretary of the positive people’s group following the death of the previous Secretary.

Programme structures may need to make allocations for able negotiators at whatever level is necessary. This role may reduce the disruption caused by potentially violent or repressive sectors and create space within existing networks of allies for previously excluded stakeholders. Despite a turbulent political context, one needle and syringe exchange programme grew to 20 per cent client coverage in the space of six months. The programme was committed to cultivating an enabling environment, by targeting the point of disruption. Similarly, practitioners in Manipur have repeatedly described the importance of not only gaining the support of the government, but also the support of insurgency groups.

When we enter tumultuous contexts through the eyes of the delegates of the 14th ICRDRH, whom do we meet?
The 14th ICRDRH has highlighted some of the new partnerships that need to be established. It is becoming increasingly obvious that law enforcement officials are stakeholders and partners in harm reduction. One group that remains on the margins so far are women. Regardless of whether or not they use drugs themselves, women in communities affected by drug use are crucial stakeholders and must become partners.

Amphetamine use today in the Asia Pacific region

Thirty years ago in the west, amphetamines were prescription medicine, used by many people as diet drugs. Today in Thailand they are front-page news as yaa baa, (the crazy drug), a menace to society.

Rebecca McKetin’s team presented evidence during the conference that right across the region amphetamine use is increasing. In Japan, the Philippines, Indonesia and Eastern China, most is in the form of the smokeable crystal meth (‘ice’), while the Golden Triangle area has seen a huge influx of yaa baa pills. Law enforcement agencies in Thailand were seizing one million yaa baa tablets every day until the crackdown started in February 2003. Annual hauls of ice in China are reported to be in the tens of tonnes. A household survey reports that 1.8 million Filipinos smoke ice. In Australia and New Zealand too, ice dominates the market. Crushing pills and injecting them generates particular problems. Stephen Farquhar presented a New Zealand study of the potentially fatal consequences of injecting crushed amphetamine pills that have not been adequately filtered to remove particles.

The crazy drug

A research team from Chiang Mai University presented ethnographic data on Thai amphetamine users. They found that half of users are in the 15 to 18 year age group, with use often starting at 13 years old. Other data on Thai amphetamine users. They found that half of users are in the

It is clear that it is not only injecting amphetamine users who are at higher risk of HIV infection

According to young Thai users, sex on speed is more fun, lasts longer and may be rougher. Mixed groups may take yaa baa together, and often the result is unprotected sex. The people involved may know about the risks of HIV transmission but subscribe to the common fallacy that people they know well cannot be infected. These teenagers also report that they become involved in “illegal activities” and fights.

The same picture is seen elsewhere in the region and indeed in the world. Fights and domestic violence are common. Heavy users may become psychotic. A psychiatrist who works with this group said that amphetamine psychosis and hallucinations show up often among his patients. Most spontaneously recover once the drug is out of their system.

Views were mixed about the effects on sexual behaviour, and thus on HIV risks, of using amphetamines. While libido may increase, Myatt Htoo Razak, who also works in this area, commented that many users are too agitated by the drug to have sex. Other users in Australia are using ice with Viagra as a cocktail to enhance sex. Information from local infectious disease control experts indicates that 90 per cent of amphetamine users in the Chiang Mai provincial jail have some form of sexually transmitted infection.

It is clear that it is not only injecting amphetamine users who are at higher risk of HIV infection. Harm reduction responses to the increase in amphetamine use are needed urgently before it results in a boom in HIV infections through both blood-to-blood and sexual transmission.

Government’s dreams give youth nightmares

“Stop forced treatment.” “We still have value.” “Stop killing people.” “Stop selling us dreams.” These were words on some of the placards that a group of young people displayed at the end of Tuesday’s Young People’s Forum, organized by UNICEF. Many of the speakers at the Forum spoke about the futility and danger of forced treatment, and the need to rethink attitudes to drug users.

“Please stop forcing people into treatment. It doesn’t work. Better still, give some real follow-up support to those who volunteer for it.”

Rojana Kingdonnok, representing Thailand at the Forum, said that the methods currently used in working with young people on drug issues were largely unsuccessful. She said that to date the Government appeared to have used three approaches: prevention, treatment and suppression. Media prevention messages saying “Don’t use drugs” and “Drugs are bad” have not been effective, she said, because they fail to provide useful information. They don’t say why drugs may be “bad.” More to the point, they failed to explain the likely effects of taking a drug.

Users had very few options for appropriate treatment and detoxification, she said, and for the greater part, most were forced into treatment. Worse still, many treatment centres had no professionals with relevant experience and no real “treatments” for widely used drugs.

Suppression, said Ms Kingdonnok, was the least successful approach. “It doesn’t help solve the problem at all. Many people have been killed, and the fact that drugs are more difficult to find and more expensive more only creates more crime.

Nanthaphon Chuechuklin, a former drug user, spoke about another needed change.

“Adults need to change their attitude and think about how drug users can contribute to society rather than dismissing them as junkies and useless people. They should also try to understand individuals’ circumstances before judging them “good and bad”, he said.

Nanthaphon went on to say that students need training in life skills in order to effectively deal with the problems they face, and that rather than making the situation worse by expelling drug-using students, schools should open channels of communication with students and parents. Expelling students, he emphasised, didn’t help anyone.
“Lastly, I want to send this message to the government,” he said. “Please stop forcing people into treatment. It doesn’t work. Better still, give some real follow-up support to those who volunteer for it.”

30 baht scheme must cover methadone

Thai drug users gathered for a protest one hour before the Minister of Public Health arrived for the opening ceremony. The protest aimed to draw the attention of the Thai government to the problems faced by drug users, and asked for participation in government policies addressing drug use.

“We demand involvement in addressing the problems of drug users. When policies and programmes affect our lives we need to know about them and to participate in their development in order to solve our own problems”, shouted Paisan Tan-Ud, Coordinator of Thai AIDS Treatment Action Group through his loud hailer.

We don’t need any privileges but just equal rights in health

The Thai Drug Users’ Network produced a list of demands and submitted it to Sudarat Keyuraphan, the Thai Minister of Public Health as soon as she had finished her opening speech.

Two of the eight demands included: immediate involvement of drug users (active and former) in the development of all policies and programmes that affect drug users’ lives; and the demand to cover the cost of drug treatment, including substitution, antiretroviral and other relevant therapies, under the National Health Plan (commonly known as the 30 Baht Health Scheme).

“The government has announced that drug users are patients, so why do we still have to pay more for Methadone. It is a kind of treatment. We don’t need any privileges but just equal rights in health,” said Piyabutre Nakapew, Coordinator of the Thai Drug Users’ Network.

Before leaving the conference, the Minister of Public Health responded to one of the demands and said she would be more than happy to have involvement of drug users in helping government address the problem. She assigned Dr Boonrueng Triireungworrawat, the Director of Thanyarak Institute (the National Rehabilitation Centre) the task of making sure this happens – a swift response that time will judge.

Latin America: so far, yet so close

Latin America is roughly 15,000 km away from this conference and its central focus – Southeast Asia. Latin American delegates, however, feel that there are similarities between the regions, and many lessons to be learned from each other. “One comes to the other side of the world to realize that the activities done are similar in Nepal, Brazil or France... and even the results are similar,” stated Miguel Conconce from Argentina. Despite the similarities, however, the Latin American situation displays some trends that seem particular to that region.

Firstly, the primary illegal drug used is cocaine. Opiates are quite rare, although a continuous increase in the use of this family of drugs has been observed. The second noticeable characteristic of drug use in Latin America is the mechanism of consumption, which is normally smoking, sniffing or inhaling, as opposed to injection. It is interesting to note here that according to some delegates from the region, the issue of inhalation has not been covered by the conference, although it is very much a part of daily life for many streets kids in the region (generally glue sniffing).

Finally, the number of injecting drug users in Latin America is still relatively low in comparison with other regions.

“The governments have begun to react about harm reduction issues only two years ago. Before that, civil society had to manage it by itself”

According to Silvia Inchaurraga, President of the Latin American Network for Harm Reduction (RELARD), there is another interesting and unusual aspect of the region: harm reduction has been promoted primarily from universities. “The governments have begun to react about harm reduction issues only two years ago. Before that, civil society had to manage it by itself”. We have seen some interesting examples of civil society at work presented in Chiang Mai this week, such as advocacy in Argentina through judges, or the approaches to IDUs in some Brazilian cities, she added.

When delegates were asked if coming to Thailand was worth the effort, the answer was an overwhelming yes. This in spite of the unfortunate linguistic barrier some delegates still face to receiving the full benefit of what this conference is offering. For Osvaldo Juncos, former drug user and now community instructor to poor communities in Rosario, Argentina, his presence in Chiang Mai has provided him with a very positive dose of energy: “I have been so glad to see that we are not alone in this fight – that this fight in the defence of drug users rights is not so unequal as I thought”.

Regional focus: Harm reduction in the Middle East

Harm reduction programmes have not been the norm in Middle Eastern countries, but the recent remarkable growth of harm reduction programmes in Iran could serve as a model for the whole region. Conference delegates who attended the special session titled “HIV/AIDS and drug use in the Middle East and North Africa: Harm reduction as part of an effective response” learned about the fledgling success of such programmes, and about Lebanese efforts to establish outreach programmes and create networks.

If these drug users start to inject heroin (as the minority already does) there will be a sizable new group at risk for HIV in the region.

In Iran, it is estimated that one to two per cent (800,000 to 1.5 million in a population of 65 million) of the population have serious health problems caused by drug use. After the Iranian revolution of 1979, the official government response was to focus on supply reduction and opium production was completely uprooted. Over the last eight to 10 years this policy has been shifting to demand reduction, with an emphasis on the rehabilitation of drug users, not their imprisonment.
As a result of this shift to demand reduction, many new harm reduction programmes have been established. Government and non-governmental programming includes prevention, treatment, harm reduction and supply reduction. There are programmes in the country’s schools and jails. This new commitment to harm reduction programmes is creating tremendous growth in the options available to drug users in Iran. Despite the Iranian public’s strong preference for abstinence programmes, a methadone maintenance programme (MPM) has been available since September 2002, and has more than 40 patients.

What will Iran’s fast-growing success mean to the rest of the region? At the end of 2002 there were reportedly 640,000 people living with HIV/AIDS in 21 Middle Eastern and North African countries. While prevalence is low in comparison to other regions, there is an upward trend. The traditional drug preference of the region is to smoke opium, but if these drug users start to inject heroin (as the minority already does) there will be a sizable new group at risk for HIV in the region.

A major issue that harm reduction programmes in the Arab world will need to address is the intense stigma faced by drug users. Mustafa El Nahib told delegates that drug use goes against social and religious norms of Lebanon. In Lebanon, methadone treatment is not allowed. Only detoxification programmes are accepted. This results in the marginalization and oppression of Lebanese drug users, and the denial of the problem by their communities.

Bijan Nassirimanesh, director of an Iranian non-governmental organization and founder of the Middle Eastern Harm Reduction Network, says government must not be blamed for the slow development of harm reduction programmes in the region. “It is our problem and our fault,” says Nassirimanesh. “It is always the fault of non-governmental organizations and civil society.” Nassirimanesh hopes that the newly formed network can increase harm reduction activity and stresses that law enforcement, harm reduction programmes, and prevention programmes must work in harmony.

Although Nassirimanesh has invited non-governmental organizations from Arab countries to join the network, so far he has no takers. Most of the 17 member organizations are from Iran, Pakistan, and Afghanistan, and he has had offers of assistance from around the world. When asked why no Arab organizations had shown interest in joining the network, Nassirimanesh suggested that they might not agree with the use of the words “Middle East” in the network title, due to the sensitive implications of the name. Nassirimanesh assured this writer that the name of the network can be changed and that he welcomes participation from his Arab colleagues.

With the Iranian delegation to this year’s conference numbering an impressive 25, it can only be hoped that at next year’s conference more of Iran’s neighbours will also show up in force.

**Harm follows market trends, says Crofts**

During the last few decades, illicit drug use has been dramatically internationalised. Globalisation has afforded the illegal drug industry the same benefits as other kinds of commerce: new markets, new distribution routes, and easier methods of communication. Economic crises, especially those during the 90s, have helped rather than hindered expansion. Central and Eastern Europe in the mid-90s and Asia following the 1997 economic crisis are two very good examples.

“We are seeing every sign of an increased vulnerability, increased drug production, increased diversification, better infrastructures to manage drug trade, and as a consequence a growing HIV epidemic among IDU populations,” said Centre of Harm Reduction (Melbourne, Australia) director Professor Nick Crofts. Perhaps the most enabling of all these infrastructures is systemic corruption, he added.

Crofts compared the illegal drug trafficking, the second most profitable illegal international trade, to the most profitable, illegal arms. Drug trade provides the income to purchase illegal arms. As with Bosnia, Serbia, Myanmar, and Sri Lanka, in almost any region where there are ethnic struggles, the two industries exist side by side.

With the move from agricultural towards laboratory production of illegal drugs markets have diversified. “With chemical production, unlike having to tend poppy fields for heroin, you can set-up a production plant up in hours, tear it down, and move it in as few as eight hours. It’s a very mobile production.”

The availability of amphetamines in Asia “… has been little short of a flood since 1997.” They were used occupationally for decades “… as stay-aways for truckers, fishermen, etc.,” but since 1997 their production in the Golden Triangle has increased dramatically. Mobile production makes supply sustainable, easily moved, and easily replicated.

“The thing about injecting drug use is that you have to look for it or you won’t find it,” Professor Crofts noted. However, as shown in both Myanmar and Indonesia, a willingness to recognise and deal with injecting drug use may also stir up political will to make war against injectors as well as open up channels for good harm reduction interventions.

“When you have a war, you need an enemy to war against, and in this case, the drug user becomes a proxy for the drug trafficker that the war is waged against. … It is wrong because it violates basic human rights, it is not pragmatic because it does not work, and because it is not within a public health framework, it does not reduce harm.”

Globally, there are probably at least 10 billion injections related to illegal drug injection each year. Professor Crofts said that the real challenge to addressing harm related to injecting drug use, and especially HIV, is to make people realise that “… injecting drug users are people first.”

**How SARS is affecting the conference programme**

Anyone who walks through the second floor, just in front of the conference registration desk, will have seen dozens of small stickers on the big conference programme poster. Most of them with the same message: Mr A cancellation, Ms B replacement… To what extent is Severe Acute Respiratory Syndrome (SARS) the cause of so many cancellations and is the quality of the programme or the debate being weakened because of that?

**Those who are attending the conference are a highly motivated group, because despite all obstacles, they have decided to come and share their experiences**
The question is how effective are all these strategies? Strategies to cope with negative influence from the USA drug policy trying to advocate for law change, promote user’s rights and find enforcement structure. Colleagues from Russia, Vietnam, Myanmar, have been successful in making harm reduction a part of the formal law enforcement. Following an enabling strategy, colleagues from the UK and Australia have been successful in making harm reduction a part of the formal law enforcement structure.

The most affected countries in terms of cancellations have been the United States and Canada. Some entities, like John Hopkins University, have recommended that their staff not travel to Thailand due to SARS. Nick Thomson, a John Hopkins team member based in Chiang Mai, is attending the conference. He regrets the absence of some colleagues with a lot of experience who could have contributed significantly to the quality of the debate. However he has a positive perception of what he sees around: “There are a lot of good people around with good contributions to make”. Even though WHO cancelled the Second Bi-regional Partners Meeting on Harm Reduction Among IDUs, scheduled to precede the conference, many WHO staff are attending the conference and the organizers have commented that they have not received any official cancellation from the international body.

China, despite being one of the main epicentres of SARS, has sent an extensive delegation to the conference as most of them come from non-affected areas. On the other hand, only about 10 Vietnamese delegates have been able to attend, from an expected number of 65. “It is a big chance lost for Vietnam”, said a Vietnamese delegate, “… because this conference is an excellent opportunity for our country, and neither members of Vietnam WHO delegation, the National Assembly nor the Ministry of Health have shown up in Chiang Mai”.

Section 2  Taking stock: Research findings, review & assessment of policy & implementation

Working with law enforcement - what to expect at 14th ICRDRH

The importance of working with law enforcers in initiating harm reduction projects cannot be overemphasized. Innovative strategies have been developed in many countries and the 14th ICRDRH has paid special attention to a number of these. At least 12 abstracts in the conference will present various perspectives on this topic. In addition, there are law enforcement representatives attending the conference as delegates.

Although the common goal of all these strategies is to obtain a safe environment for harm reduction practices, approaches can be different. These strategies can be persuasive or enabling. A short review of the abstracts shows that both strategies will be reflected this week in Chiang Mai.

Following an enabling strategy, colleagues from the UK and Australia have been successful in making harm reduction a part of the formal law enforcement structure. Colleagues from Russia, Vietnam, Myanmar, China and Bangladesh find educating police and local power brokers, as well as advocacy efforts, effective.

Using persuasive strategies, groups in Argentina and the USA have been trying to advocate for law change, promote user’s rights and find strategies to cope with negative influence from the USA drug policy toward other countries.

The question is how effective are all these strategies?

Spotlighting the Netherlands’ winning strategy to working with cops

The key message in the presentation of Dutch police detective, Ton Snip at a Monday training session was that regardless what legal environment you work in, if you can work to create a “win-win” situation, you have a much better chance to improve partnership in harm reduction. The Netherlands example he described gives us hope for our own work.

The Netherlands experience is an interesting situation where drug users, the community, public health and the police – all win. After the passing of the Opium Act in 1976, the Dutch police moved from a position of strict law enforcement to a more integrated public health approach. This change in the law came after both social workers and police officers on the ground advocated reforming the ineffective drug policy.

This new approach, on one hand, was to reduce risks for users, their immediate circle of family and friends and society at large, and on the other hand about going after drug importers and exporters and local dealers of hard drugs.

The trick, so to speak, was to create a legal/policy environment that benefits both the drug users and the law enforcers. How so?

The drug user who is arrested has rights, which require the police to inform a lawyer, the re-socialisation worker (social worker) and a doctor. The drug user, according to Snip, is less aggressive when arrested because they know their rights will be respected including being given, under medical supervision, drugs they need whilst in the detention centre. This includes antiretroviral drugs for those who are HIV positive.
The police, according to Detective Snip, have benefits from the Act as well as they do not have to interrogate users when they are sick and this often results in a grateful drug user who in turn is more supportive to police work. Further, he says the police have more time to concentrate on drug suppliers. The community is happier as they have less drug-related crime and hence are more tolerant towards drug users.

In advising those of us advocating for partnerships with law enforcers in our own countries, Snip believes that the police would be more agreeable to policies which help make their work that much easier. That, in essence is the key in partnership – make the work of your partner easier and then you have a willing partner. It may be a long or very long process but what is the alternative?

Harm reduction: Police getting into the act

Law enforcement has often been viewed as having a minimal role to play in HIV/AIDS prevention and harm reduction. Drew Morgan, in his presentation “The Role of Law Enforcement in IDU Related Harm Reduction” sought to redress the imbalance by showcasing some of the successes of the Asia Regional HIV/AIDS Project. The project, based in Vietnam, Myanmar and China, is an AusAID funded initiative, focused on the institutional capacity development of both the government law enforcement and health sectors.

Everyone has heard of the horror stories, however looking at law enforcement and law enforcers from a positive slant takes a little more effort

Mr Morgan observed that law enforcement officers could have either a good or devastating role in harm reduction. Everyone has heard of the horror stories, however looking at law enforcement and law enforcers from a positive slant takes a little more effort. Changing the established culture of the law enforcement community takes time and perseverance. Such work is not a pill of immediate relief but a process, which is often slow.

Drew points out that the adoption of an overly critical standpoint on the law enforcement community is unfair, since in some situations their actions are determined and constrained by pre-existing policies. He suggested examining the training and operational procedures in place. For example, some police stations measure performance by the number of arrests. One strategy might revolve that performance to include how many drug user referrals they make to the health facility or to rehab-focused NGOs. Another is to provide a health course on HIV prevention to police officers.

It is important to remember and highlight that law enforcement agencies are supposedly the protector of people and communities, and that includes drug users. The challenge is to work to get the law enforcement officers to look at the issue in a new way. Peer education – using police officers to educate other police officers, is one of the most effective ways of doing this. But Drew was quick to warn that the choice of peer educator must be appropriate. They need to be able to understand the ground reality and conceptualise the examples. If you want to engage officers on the ground then the peer educator must be an operational officer who has credibility with the other officers. Drew makes the important point that “...often police officers grow to hate drug users, and that is part of their culture”. We need to be able to understand that culture to be able change it, just as we need to understand the culture of drug users.

The results of such work can be surprisingly rewarding, as demonstrated by findings presented by Ton Snip, a police detective living and working in the Netherlands. His paper “Partnerships of law enforcement and public health in harm reduction policy development and implementation – experiences within the European context” presented some encouraging results. In the Netherlands, crime figures among drug users have declined. As a result, drug users have increasingly been perceived as less of a threat and the community has become less condemnatory in their opinion of drug users.

Access to treatment for HIV-positive injecting drug users: Needs and constraints

A major session entitled “Caring for HIV-positive injecting users: principles, models, strategies” was organized by the World Health Organization (WHO). The session covered presentations on experiences, strategies and needs for implementing and scaling-up HIV treatment services for injecting drug users (IDUs). Srdan Matic from the WHO Regional Office for Europe spoke of how new classes of combined antiretroviral drugs can lower death rates, reduce AIDS-related opportunistic infections, improve people’s quality of life and transform people’s perceptions of HIV. He concluded by saying, “Obstacles to access to treatment are often due to poverty, legal / regulation policy exercises and lack of experience.”

Dr Ingrid Van Beek, Director of Kiroton Road Centre, Sydney (Australia) outlined the opportunities and challenges in the management of HIV among IDUs. Antiretroviral treatment outcomes in IDUs can be as effective as in other affected populations, provided that IDUs can comply with and adhere to the treatment regimes, she asserted. To facilitate this compliance, the specific needs of IDUs first have to be addressed. Psychosocial issues such as emotional stability, living conditions and income situation, as well as patterns of drug use and levels of drug dependence all need to be taken into account. However, she noted that the high costs of antiretroviral therapy put the option of treatment out of the reach of many IDUs in developing countries. She went on to comment that existing resources and infrastructure in many developing countries limited even the availability of information and basic treatments of opportunistic infections, abscess management or overdose.

“We need to think of what happens after there is access to ARV. There is a crying need for them, no doubt, but it also involves strengthening existing capacity of health systems especially in developing countries”

In his presentation entitled “Treatment and care for HIV-positive IDUs in India: How to scale up good practice?” Samiran Panda spoke about the Indian Government’s limitations in providing support for detoxification services for IDUs. In such a setting NGOs can effectively act as bridges by providing community-based services. Elaborating, he said “There should be package delivery of needle exchange, peer health education, access to primary health care, wider range of treatment and management of abscess, sexually transmissible diseases/infections, tuberculosis, condom promotion, [and] referral to health services.”
Kambar Alaie, who spoke on counselling and care initiatives for HIV-positive IDUs in Kermanshahr, Iran, emphasized the need to include partners, family, and the broader community in the provision of effective services for IDUs. “It is hard to reach IDUs and their partners, but if confidentiality is ensured along with a comprehensive range of services, it can be accomplished.” He went on to add that, as a result of fear of stigma and discrimination, there was a high incidence of suicide among IDUs within their first year of their HIV-positive diagnosis. Replying to a question from the audience, he said, “Drug use is acceptable to some but there is still a lot of stigma attached to HIV, since it has been perceived to be related entirely with homosexual behaviour. This attitude has been slowly changing due to involvement of community members”.

Fabio Mesquita of the Sao Paulo Health Department, Brazil, probably gave the best example of how political commitment can positively influence access to antiretroviral therapy for HIV-positive IDUs. The Brazilian policy of universal access to medication is applied to every citizen including IDUs, and a study conducted by the University of Sao Paulo showed that IDUs’ adherence to treatment regimes is the same as other clients. The programme includes distribution of needles, syringes and other injecting equipment, provision of male and female condoms, antiretroviral drugs and other medical treatment. The government is now turning its attention to new challenges that address female IDUs, build partnerships with law enforcers, focus on harm reduction policies and initiate innovative programmes among transsexuals.

Commenting on the session Dr Getachew Gizaw, Senior Health Officer with the International Federation of Red Cross and Red Crescent Societies (Switzerland) said, “We need to think of what happens after there is access to ARV. There is a crying need for them, no doubt, but it also involves strengthening existing capacity of health systems especially in developing countries. ARV’s are about clinical management, is there enough infrastructure and skilled personnel to monitor them?”

**Asian drug policy-making not based on evidence: Community voices still not seen as relevant**

The first plenary of the 14th ICRDRH confirmed many delegates’ perceptions of the grim picture of harm reduction efforts in the region in general, and especially as it relates to existing policies. The silences in the presentation amplified the missing partner in all these discussions of effective change policy – users and affected communities.

Mukta Sharma from London School of Economics, her wedding henna not yet faded on her hands, reviewed policies in 11 Asian countries from a literature review and key informant interviews. The many requests for clarification from the floor showed the necessity of an accurate regional mapping project and stock-take ahead of this type of event, but also the dynamic nature of harm reduction efforts – the realities changing even as they are put to paper.

In her presentation, she pointed to unclear mechanisms for drug policy development, dominated by personal opinions, beliefs and morals rather than evidence. With no overarching HIV/AIDS prevention policy framework to guide policy development, a punitive paradigm as a response, little dialogue between relevant agencies, and little knowledge of research by decision-makers, there are few existing national strategies to limit HIV/AIDS infection among IDUs.

Two dichotomies present themselves here – the first in programming, between IDU-related programmes and HIV-related programmes. And the second at the policy level between health and public security agencies.

Often, Sharma said, public health agencies (and/or related counter-parts) may understand and advocate for harm reduction strategies, but public security agencies, with more control over drug policy formation, negate their efforts.

**Often, public health agencies may understand and advocate for harm reduction strategies, but public security agencies, with more control over drug policy formation, negate their efforts**

Following the session, Nick Crofts of the Centre of Harm Reduction in Australia, described the scenario well in a response given to him by a Malaysian bureaucrat a few years ago who said: “HIV and IDU will solve each other.”

There are few Asian countries with large enough NGO sectors to affect policy through more integrated programming efforts. In an interview after her plenary, Sharma said that although policy and programming influence each other in a cyclical manner, more coordination at the policy level (through government sectors) should become the priority.

In reviewing policy movement in the last five years, Vietnam and Malaysia were seen as countries where the situation has worsened. In Vietnam, for example, effective programming has been obstructed due to the Social Evils campaign that seeks to eradicate IDU and sex work.

Sharma said that the fragmented nature of contemporary policies and programmes did not lend themselves to an effective way forward.

She did however mention countries where there was the beginning of more coordinated efforts within government such as India, Indonesia and China. In India, she attributed these changes to time – “the epidemic is old enough” – to advocacy efforts by NGOs and activists, to litigation efforts and pressure from the World Bank.

What is missing, however, in this discussion of more coordination and integration – in essence stronger partnerships – is the partnership of people who use illicit drugs. None of the criteria that Mukta presented as markers for policy development, success or failure, nor the factors related to poor programme outcomes included the involvement of users as a relevant component to consider.

It seems improbable that we can continue to describe or evaluate harm reduction efforts without considering the community input that can readily provide a real sense of how these efforts translate on the ground.

**The need for subsidised antiretroviral therapy**

An ongoing issue for the conference participants was the call for the low cost antiretroviral drugs. While the price of antiretrovirals has come down, they remain out of reach for many people. The need for subsidized antiretrovirals is particularly strongly felt in developing countries where government health ministries have been unable to provide these drugs for people living with HIV/AIDS.
Manipur, located in the North Eastern region of India, has seen a rapid rise in the number of HIV infections. The average income of a government employee in the state is anything between US$150-300 per month. Khumanthem Jayanta Kumar of Manipur Network of People Living with HIV (MNP+) has been living with HIV for the past 13 years.

“It is good that ART drugs have come along for those who can afford it, but what of those unable to access them? It is like rubbing salt into existing wounds.”

Khumanthem started to take antiretroviral three years ago, when his condition became critical.

“For the first six months, it involved spending around US$650 per month, digging into the savings of my father. Seeing that there were other household expenses to take into account, I had to opt for ART drugs of another manufacturing company. These were cheaper but not as effective as the others I had been using.”

Lilabanta Singh is an India Country Representative of Asia Pacific Network of People Living with HIV/AIDS.

“**It is good that ART drugs have come along for those who can afford it, but what of those unable to access them? It is like rubbing salt into existing wounds**”

“The current price of antiretroviral will increase once international patent laws are enforced at the end of December 2004. Manufacturing companies will have full control of the price. I was part of a team representing Indian Network for People Living with HIV/AIDS in handing a memorandum to the President of India stating the need for ready availability and access to ARV drugs. He has promised to look into it - but for the Government to respond, there is an urgent need for various stakeholders of the community to support us to get there.”

**What harms more - drug use or stigma?**

Stigma functions as a powerful tool of social control by excluding and marginalizing groups and individuals. People whose behaviour is considered deviant or immoral by society have always been imbued with stigma, and arguably no more so for injecting drug users.

**Social Evil campaigns can be seen as ‘harm-maximization’ policies that purposely instil fear and hate of IDUs in the community**

The onset of the HIV/AIDS epidemic has served to further exclude these already marginalized groups, as they have faced recrimination and reproach as potential vectors of the virus. HIV-infected drug users face a double dose of stigma, with HIV-related stigma layered onto pre-existing drug-related attitudes. In the last few years, the significance of HIV-related stigma has begun to be explored and addressed. Here at the conference, the damaging effects of the stigma society attaches to drug users has already received some attention. But is this enough?

Looking through the conference session listings, there is little direct mention of stigma. There is more reference to discrimination and human rights. But if the stigma that causes discrimination and the abuse of human rights isn’t addressed how can we bring about real changes in discriminatory or abusive behaviour or policies?

Global campaigns to combat HIV/AIDS-related stigma are currently being implemented by two of the co-sponsors of the conference – UNAIDS and the International Federation of the Red Cross (IFRC).

“Harm reduction is entirely consistent with the humanitarian principles of the IFRC,” according to Bernard Gardiner, head of the International Federation’s HIV/AIDS unit.

On the eve of the conference, the IFRC condemned Social Evil policies that “fuel HIV/AIDS” pointing to the evidence that when leaders and policy-makers define social problems as evil, drug use and drug users are driven underground. This makes drug users more difficult to reach and hampers efforts to instigate safe practices, thus contributing to the transmission of HIV/AIDS. Social Evil campaigns can be seen as ‘harm-maximization’ policies that purposely instil fear and hate of IDUs in the community.

Support for many demand reduction activities in these countries relies on the existence of the societal view that drug users are undeserving and a menace to society. The current ‘war on drugs’ being implemented by the Thai government, for example, would not succeed were it not accompanied by high levels of stigma against drug-users in the community.

The stigma associated with HIV/AIDS and that associated with drug use are not the same thing, although they may have many similarities and at times may be closely related. To explore how we might overcome drug-related stigma, it must be looked at systematically, in much the same way as it has been and continues to be in relation to HIV/AIDS.

If there is to be success in reducing drug-related harm we need to explore our own attitudes and prejudices, and accept that we all play a part in the stigmatisation of drug users. Stigma can only be addressed head-on by mainstreaming this critical issue into all harm reduction strategies, as well as designing and implementing strategies specifically to address drug-use related stigma in its own right.

**Abstinence and harm reduction: Can opposites attract?**

“Abstinence and harm reduction – is it possible to do both?” That’s what was on the note slipped to me. Not long afterwards, Bill Nelles, from the UK Methadone Alliance, was giving a qualified “Yes!” to the same question. “Yes,” he said, “providing people from both persuasions are prepared to acknowledge the other, but people must not be coerced. They have the right to actively participate in decisions which affect their lives.”

The fact remains that there are two points of view: some think of abstinence as the bride of harm reduction, while others consider it an avenging angel. To complicate matters further, policies in some countries take for granted that the goal of harm reduction is to turn users into former users. Some would say this is unrealistic. Others, especially some drug users, would go further and characterise it as an abomination.
Likewise, when it comes to designing harm reduction programmes and interventions, there appear to be two approaches. Some, usually designed and developed with extensive input and review by users, take for granted that drug users are individuals, not expressions of a great alpha god of addiction, and recognise that not all users will be able, let alone want, to stop using their drug of choice (or other illicit drugs, for that matter). They also recognise that some who may want to stop using will need encouragement and assistance rather than bullying to achieve their goal. The second approach addresses the issue from quite a different point of view - it reflects the desire and will of various states, the churches/mosques/temples, the UNODC, the International Narcotics Control Board (INCB), over the reality of an individual's desire and abilities.

To be realistic, the choice of whether or not people use a harm reduction service (e.g., a substitution treatment, needle exchange), abstinence programmes should be a matter of choice, not coercion. After all, experience would indicate that forcing people to do anything about a matter as personal as drugs will usually fail to achieve the desired goal.

Some think of abstinence as the bride of harm reduction, while others consider it an avenging angel

To be practical, we must acknowledge that experience in both the East and West indicates that harm reduction services of any kind will not succeed without at least a modicum of support from the non-using community. Take Manipur, India as an example where attempts to introduce outreach needle exchange services have failed, despite the government’s development of a harm reduction policy. Eight years after the enabling legislation to establish these services, needle provision is dead in the water because of widespread community opposition. Malaysia has experienced similar difficulties.

Recently in Sydney, Australia, in a pre-election climate, the New South Wales government directed that a long-established government-funded drug user magazine be withdrawn from circulation because the publicity given to the magazine on a local radio station could have become an electoral issue. No doubt there are many other variations along the same theme.

Those who support harm reduction, especially where such concepts are new and feared, assert that a harm reduction approach can be successful only with extensive advocacy, be it lobbying government officials, law enforcement, and other powers, or extensive education efforts with the population as a whole.

Users may facetiously declare, “Abstinence is OK with me.” What we need to hear at the same time is the voice of their community affirming that “Harm reduction is OK with us.”

Overdose: Naloxone, non-fatality, and the need for skills training

Overdose and the role of naloxone in its treatment have been discussed in several conference sessions this week. Though naloxone is generally accepted as an appropriate treatment for overdose when administered by paramedics or in a hospital setting, there is substantial debate surrounding the idea of giving drug users supplies of naloxone to be used without medical supervision if need be.

Naloxone, an antagonist that reverses the effect of the opiate (generally heroin) in the body is given to someone after they have overdosed. The most common application of naloxone is through injection, though application through a nasal inhaler is also possible. Dr Ingrid Van Beek, medical director of the Sydney Medically Supervised Injecting Centre (MSIC) – the only injecting centre in the world that administers naloxone – pointed out in her presentation on overdoses in a supervised injecting room setting that in an overdose situation, the first thing a person needs is oxygen. This is due to the raised carbon dioxide levels and lowered oxygen in the blood after heroin use, which affects the body’s ability to breath.

This primary need for oxygen, rather than naloxone, is central to the argument against giving drug users their own supplies of naloxone. There is a concern that if drug users are given naloxone, they will use it initially instead of performing resuscitation or calling an ambulance, which would be the more appropriate course of action. Drug users often hesitate in calling an ambulance out of fear that this will result in police being called to the scene.

Annette Verster, an independent researcher, explained that many people are against giving naloxone supplies to users because it creates a false sense of security. Naloxone only works in the case of a heroin overdose, but has no effect with cocaine and other drug overdoses. In the common situation where an overdose is the result of more than one drug being taken in combination, naloxone would not solve the problem. If a drug user overdoses and requires intervention, their friends may not know exactly which drugs have been taken, making naloxone a questionable choice.

“I think it should be available, but on the other hand, it’s not a panacea. There are easier methods”, explained Verster.

Other concerns are legal ones. Naloxone is not available over the counter in most countries (though it is in Italy and Russia) and requires a prescription. Since prescriptions are generally intended to be for the person who gets them filled, a grey area is created in the case of naloxone, which might be prescribed for use on others.

Although naloxone use is an important part of the overdose discussion, many other issues surrounding non-fatal overdose also need to be addressed

Still other concerns involve risk-taking. One theory is that the availability of naloxone might encourage injecting drug users to increase their dose to more dangerous levels in the belief that if they overdose, the naloxone will be there waiting. But some in the field strongly disagree. “I absolutely think injecting drug users should be able to carry their own naloxone. I don’t believe that it will encourage anyone to increase their dosage”, explained Nicole Wiggins of Canberra Alliance for Harm Minimisation and Advocacy. “There is nothing fun about an overdose.” Wiggins supports a trial which would include users in the planning, and like Verster and Dr Van Beek, she emphasized that training and education for injecting drug users about how to use naloxone must accompany it.
Dr Van Beek suggested that in remote regions where ambulance services are not available or emergency response is slow, the benefits of injecting drug users carrying their own naloxone outweigh the drawbacks, but that in areas where there is rapid response and ambulance service it would be better to call for help.

Another point to consider in the debate is the relatively short half-life of naloxone compared to opiates. When naloxone is injected it stops the effects of the opiate in the body therefore forcing the user into immediate withdrawal. Despite this withdrawal, the opiate is still present in the system and another overdose can occur from the original dose of the opiate. The immediate forced push into withdrawal can make the user aggressive, and can often make him or her want an additional opiate dose soon after the naloxone application. A second dose of an opiate would further increase the chance of a subsequent overdose once the naloxone wears off.

The debate is particularly pertinent to Australia, where there has been interest in developing a trial in three key states: Western Australia, Victoria and Queensland. Paul Dietze of Turning Point Alcohol and Drug Centre explained in a conference presentation that naloxone would be one component of a peer first aid response. The first aid package would include education and training in overdose prevention and risk factors; signs of overdose; the importance of airway support, breathing support and monitoring; when, why and how to call an ambulance; how to decide if naloxone is warranted and routes of administration; and the importance of continued support until the ambulance arrives.

John-Peter Kools hammered the relevance of the overdose discussion home in his presentation on the question of naloxone in the broader context of overdose prevention and treatment. Kools told conference delegates that overdose was the main factor of death among drug users and that drug users have a mortality rate 15 times higher than the general population. This information in itself is reason enough to make the question of overdose treatment central. But Kools went on to frame the overdose question as being on the cutting edge of several complex issues, most notably private versus public responsibility and the line between medical support and law enforcement.

While the issues surrounding a potential trial of naloxone for drug users is frequently discussed, there is often “not enough emphasis placed on the harms associated with non-fatal overdose,” says Dr Van Beek. Most overdoses are indeed not fatal. Of 3,872 clients that completed a drug overdose history at the Sydney MSIC, 44 per cent had experienced an overdose in their lives, with 12 per cent having experienced an overdose in the previous twelve months. Similarly, Anya Sarang of the AIDS Foundation East-West (AFEW) reports that of 763 injecting drug users surveyed in 16 Russian cities in 2001, 59 per cent had experienced an overdose, 15 per cent had witnessed a fatal overdose, and 81 per cent had seen others overdose.

Although naloxone use is an important part of the overdose discussion, many other issues surrounding non-fatal overdose also need to be addressed. Dietze identified the following risk factors for non-fatal overdose: other drug use, demographics (age, sex, etc.), location of heroin use, changes in tolerance due to imprisonment or treatment, and heroin purity levels.

An aim of the Sydney MSIC is “... reduced morbidity and mortality associated with drug overdoses”. Reduction of morbidity would include brain damage, muscle damage and other potential harms that can result from a non-fatal overdose. To reduce such harms, clients at the Sydney MSIC are monitored during the entire time they are there. If signs of overdose occur, registered nurses are present to intervene from the beginning. Dr Van Beek points out that “If you overdose in a back street, maybe people will find you and maybe they won’t, but you will be treated much later and therefore suffer increased morbidity.” In the MSIC setting, Van Beek believes that mortality and morbidity have been reduced due to supervision.

In response to the need for additional skills to properly handle overdoses, conference delegates were offered a training and skills session on the topic that included a resuscitation lesson taught by nurses from Chiang Mai University’s School of Nursing.

Sharing experiences with methadone treatment

On Track listened in on a conversation between Bill Nelies (BN) and Chokchai Thaptavee (CT), one of the core group of the Thai Drug Users Network.

BN: What are the main obstacles to methadone services in Thailand?

CT: Certainly there is a problem of methadone services here. When they start giving a certain dose, they reduce it quite fast.

BN: This has been a problem in England too. There is very little effectiveness in giving reducing methadone like that. When the methadone goes below a certain point, people start to relapse and they start to use heroin again. And then people say that users are breaking the rules. If they had the proper dose they wouldn’t do that.

CT: Yes. And because of that reduction, some users have to run around to different clinics to get more. They force us to be a difficulty.

BN: Exactly, because the system is so rigid that the whole benefit of methadone doesn’t follow. The benefit from methadone is that it frees you from reliance to the black market. And we also have to keep in mind that some people cannot stop opiates. We’ve been telling people for years “everyone who wants to, can stop using opiates”. This isn’t true. And furthermore, people who are methadone stable are just like normal people. I’ve been methadone dependent for 25 years and that let me go to college, hold down a job, work as a manager at the health service.

CT: Coming back to the obstacles we face in Thailand, one of the most important is that we need the government to listen to us. And we have no place to get information. When you go to the clinic they just see you badly and say: “stay quiet”, “don’t speak about it”, “go home”... we have no place for us to learn and understand what methadone is about.

BN: Now, I know that if you give people enough methadone and you give it with a support structure – this is a strong drug so it needs to be giving safely – then we really get benefits back from it. But when we give it in a way that is very unfriendly we don’t get the benefit we could get from methadone. And I think the first step for users is to gather information, and to hear from each other the things that we know work and the things that we know are not successful. What kind of information do you need?

CT: The basic one. When you go to a methadone clinic they just give the methadone to you and then send you home. We want to get information

When you go to the clinic they just see you badly and say: “stay quiet”, “don’t speak about it”, “go home”... we have no place for us to learn and understand what methadone is about
from them on how to clean needles, for example. The doctors and the nurses won’t say a word on that. And it is about health!!!! This is why the Thai drug users need to organize ourselves. But we need allies, people to listen... This can be supported by the conference and people are certainly listening to us now. I am scared myself to speak it out like this.

BN: In the UK, we built an alliance of powerful people and drug users and this is the first step that you have to do. To find the people who want to help you: the doctors, the nurses, the politicians... and they do exist.

CT: That would be great. The first objective is to get more people who want to be part of the network. Secondly we want to work with the government together, I know it is hard, but we need their support, and also from doctors, nurses... and, of course, from other countries.

BN: I will commit my organization to stay in touch with the Thai drug users and try to fund another visit over to Thailand to work with the Thai users. With a right treatment we are not a threat to anybody... that's what we have to get people to understand.

### Innovative harm reduction: an Indonesian experience

Implementing a harm reduction programme in a country where drug users are still strongly stigmatised and marginalized is challenging. The challenges are twice as great when drug users themselves are those who do the outreach work.

In a session on innovative harm reduction services, Dr Irwanto of Indonesia, shared with delegates the experiences of a bleach project among IDUs in Indonesia. The programme presented by Dr Irwanto focused on the training of 10 drug users, and equipping them with outreach skills. This group of IDU outreach workers, who are now programme staff, carry out activities in crowded communities of 13 sub-districts of Jakarta.

Stigma is the most challenging aspect of the project, having to deal with the destructive prejudices that people in the community often have towards outreach workers who are drug users themselves. Dr Irwanto shared with delegates that the strength of the approach is that the project carries a lot of credibility among drug users.

Unfortunately, outreach workers still face a great deal of prejudice from people in the community as they do their work. According to Dr Irwanto, some see outreach workers as setting a bad example within the community, encouraging or teaching others to use drugs, particularly when they are seen giving demonstrations on needle bleaching. In addition, people feel that they do not deserve the right to educate or help others.

Lessons learned in Indonesia highlight that as long as negative attitudes towards drug users remain intact, and as long as drug users are not treated with respect, it is not possible to successfully introduce innovative interventions that aim to reduce drug-related harm.

Therefore, the first task at hand for harm reduction advocates is to alter people’s ways of thinking about drug users before they commence harm reduction programmes. This effort will require community involve-ment, and an alteration of public discourses that revolve around governments’ policies on drug issues.

### Social reintegration programme for young ex-drug users

At one of the display booths at the conference, you may have noticed the lovely white T-shirts with a small blue screened-graphic. If you stop there you will be able to see the black letters on the T-shirts read Ruam Mit Bakery. You will see also leaflets, bakery products including cookies, bread, cakes, some Thai sweets and two young adolescents, boy and girl who tend the booth.

The booth presents the Ruam Mit Foundation for Youth and its activities. The foundation was established in August 2000 in Chiang Mai. It primary focuses are the activities that offer vocational skills of making bread, cookies and cakes to youth who are ex-drug users and are at risk of using drugs or sex trades. It also teaches youth to market their products. The foundation set up the business ventures, Ruam Mit Bakery and Ruam Mit Café in order to provide a training venue for youth participating in the programme. The foundation also aims to generate income for its activities on drug prevention by relying on its own businesses. Youth who join in the programme come from different backgrounds. Some are ex-street children and some were transferred from treatment centres or other non-governmental organizations working with youth. There are some youth who come from migrant displaced communities located along Thailand’s northern borders.

According to its leaflet, the foundation took its name from the term ruam mit, a kind of Thai pudding that combines various ingredients to create a delectable delicacy. The term also denotes social cohesion among diverse elements bringing about enjoyable moments of friendship. This name implies the ambitious goal of this small Thai NGO to reintegrate young ex-drug users into society.

### Section 3 Emerging trends in drug use and issues of service delivery

#### When an injecting sex worker is not a sex working injector

Not all sex workers do drugs and not all drug users sell sex, yet for those who do sell sex and use drugs, a fine distinction should be made between those that sell sex and do drugs and those who use drugs and sell sex in order to support drug habits.

For drug-using sex workers, HIV prevention and education can represent special challenges, asserts Cambodia-based Carol Jenkins whose work for USAID was highlighted in one of two symposium sessions focusing on harm reduction and sex work.

In her paper entitled “Sex Work and Injecting: Approaching the Whole Person”, Jenkins stated that these special challenges are due to the dual risks imposed by possible sexual activity and possible drug use. Yet, a line can be drawn between sex workers who support drug habits or who do drugs and injection drug users who sell sex in order to buy drugs.
While on the surface the distinction between these two groups of people may seem trivial, in reality the seemingly minor differences may be anything but.

First, you are either an IDU, then you may start exchanging sex for drugs or money, or first you are a sex worker, then you may take up drugs and injecting.

Jenkins, a long-time sex work activist and researcher, whose current work is largely based in Asia, says that while there are “... increasing numbers of sex workers who do drugs... there are many more injection drug users who sell sex”.

**Not all sex workers do drugs and not all drug users sell sex, yet for those who do sell sex and use drugs, a fine distinction should be made between those that sell sex and do drugs and those who use drugs and sell sex in order to support drug habits.**

Thus, interventions for individual groups need to be tailored to meet specific needs.

Jenkins’ hypothesis of the assessed needs of sex workers versus those of injection drug users was also used to illustrate this point, for example studies have found that female injection drug users place health and child care, housing, legal aid, partner violence, drug treatment and mental health and psychological support as service priorities in that order, whereas female sex workers give priority to services addressing police violence, manager abuse, partner violence, health and child care, legal aid, and alternate incomes.

While there are overlaps in stated needs, sex workers and drug users prioritise differently.

To assess these fresh insights into the similarities and differences between sex workers who do drugs and drug users who sell sex, a diverse range of conference delegates of both genders were polled on their beliefs and the debates around the similarities versus differences:

**Similarities**

“They are the same to me. I don’t know much about this stuff but it seems like they are the same to me”. (Male, Thailand)

“I think they are one and the same thing. Well, it depends if the dealer’s is selling or pimping, well then that is a different thing, but if it is someone who is a sex worker and just happens to be using drugs whether it is funding their... you know, or they are having the sex to fund their drug habit, I think it is the same, I think it is one and the same thing”. (Female, Australia)

“In a way yes, and in a way no. Yes, Being different because the actions and the consequences are totally different. For the primary you have a sex worker who is using drugs is perhaps for different circumstances or situations altogether or even different reasons, but a drug user selling sex could be in a different state of mind altogether which leads to a different state of mind altogether, which leads to another consequence”. (Male, India)

“I can’t personally see any difference between the two. Is it a riddle? Well I guess it depends on the definition of sex worker, but apart from that they seem like the same thing to me”. (Female, Australia)

“I don’t understand the position. I don’t understand the point. Probably the question is what was first, sex work or drugs, but the final result is that they are vulnerable because of the two reasons. Yeah, I don’t see the point from the perspective of taking care, giving care, approaching them. I don’t see the difference”. (Male, Spain)

“Yes it is the same. It is just two things in a different place. It is the same”. (Female, India)

“But they are the same person. I mean they are doing the same behaviour. I mean they might be the same kind of people. Or not? Because the activities they do are to sell sex and taking drugs. The sex worker who takes drugs might be a stereotype of a female but an injection drug user who sells sex might be anyone”. (Female, Vietnam)

“Different. I don’t know. May be different because every people is different. I think that sex workers are very different because people from society may not agree, and that we have to help them from harm. We have too much discrimination about sex workers. They have to test for HIV, sometimes every month, sometimes every two months. I think drug users and sex workers are not treated different but that people think about them different, but I don’t have experience with sex workers. I have never talked to them before”. (Female, Thailand)

**Differences**

“Because drug users in order to get their supply would do almost anything, because sex work is a solution to their problem. Sex workers just use drugs as any one else could use drugs. Doesn’t mean that drugs are important to sex work.” (Female, United States)

“Yes, they are different. You can say that sex work is inevitable. It is almost in every society. It is not allowed but it is tolerated by many. As long as you practice safe sex it does not really harm you that much if you do it in the proper way, but if you do sex and drugs together, it is really devastating. Yeah it is different, because for one sex is the main profession and in the other one drug is what they are going for and then they sell sex, so I think it is different”. (Male, Thailand)

“I think that there is a difference between those because there might be someone who is a sex worker just because that’s what they like to do and

It seems to me there is a continuum from survival sex to more lucrative forms of commercial sex and it is probably not easy to divide people into two categories
that’s how they get their income, and they just happen to be a drug user that’s different than the person who becomes a drug addict and then has to sell sex to fund their habit. Yeah, I think that not all sex workers are drug addicts”. (Female, Australia)

“Women who consciously decide to be a sex worker are different than women who are constrained to become a sex worker to earn their money for their drugs. The first group tend to be more professional about their profession, the second group may be more prone to risk behaviour, risky situations, but would the interventions then have to be different? If you had a series of doors with the name of the intervention, which door would the person who is the drug user or sex worker or how they would identify themselves, and it is not just about what is behind the doors but which one they would choose to go through”. (Male, United States)

“I remember going to brothels in Amsterdam about 15 years ago in order to see if we could convince the management of providing condoms and education to women working there, and talking to some of the women of who were professional sex workers of Dutch origin who had decided to become sex workers and kind of also used drugs in order to… and they couldn’t really be interested in HIV risk because even they couldn’t care because their life was all about risk, they kind of defined their lives consisting of risk - shorter term risk and so longer term risk was of minor importance”. (Female, Holland)

“So let me get the situation straight. One is a prostitute who involves drugs in their daily lives and another one is a drug user who doesn’t have any money and probably has to sell sex to exchange for drugs. Yes there is a difference. It is totally different one group has one problem and the other group is another. I personally know a person who is a drug user and sells sex for drugs. She is not a prostitute but it is because of drugs that she sells sex. To harass her as a prostitute involved in drugs, I don’t think that is fair, because she would not have to sell sex if she was rich and had a lot of money in the first place”. (Male, Thailand)

“It seems to me there is a continuum from survival sex to more lucrative forms of commercial sex and it is probably not easy to divide people into two categories, I mean it doesn’t make it any easier to identify how you would intervene even if it is a more realistic assessment of the situation. The difficulty is always how to come up with the proper interventions for the people who are more at risk, who may lean more to the survival sex end of the sex but not just for diseases but also for violence, so for those people the interventions are much more complex and much more directive, so then there would be some truth that the interventions have to be tailored separately”. (Female, United Kingdom)

“A lot of sex workers use drugs but don’t have a drug dependency. They are like the rest of the population. They are occasional users. In contrast, there are a lot of drug dependent people who do sex work to support their habit, whereas their are sex workers who don’t have a habit who are out buying houses, etc. and occasionally dabble, so that is how I would take it. More about drug dependency and the need to support a habit as opposed to working for a different purpose and just being a casual drug user. Definitely, yes, because if you are working purely to support a habit, all your money is going there, it is not a profession as such, but some people are sex workers to travel the world, to support their families and use drugs casually, so there is a big distinction. It is important because a sex worker who does not have a problem is not interested in drug interventions. Often they are the ones who do things safely because their priorities are elsewhere. They are not desperate” (Female, Australia)

“Yes, yes, because sex workers use sex, I mean not use but because sex is their career. It is like their livelihood, but drug users on some occasions have to use sex to be able to get money so that they can get drugs. It is not normal day-to-day activity. It is just incidental”. (Female, Thailand)

“I think for the sex worker, they want more money, and for the drug user, because they want to have… there is a difference. I don’t think they have everything exactly different but some differences. I think we need to know what they sell and what they want the money for. We have to group what they sell and what they want to sell sex for. We have to look group by group but not everything is different”. (Female, Thailand)

“I think we have to be really careful that we don’t reinforce the stereotypes that we all think of when you use those names and I think there are people who sell sex and there are people who use drugs and some of them are the same people but I think it is impossible to generalize… I mean there are people who sell sex and work in banks. There are people who use drugs and work in banks. You wouldn’t be confused about it. It is only because we make value judgments about sex workers and drug users that you actually need to ask that question”. (Male, England)

“I would agree with that”. (Female, Vietnam)

“Yes, I think so, because drug users who sell sex may have some problems because after they use drugs for a while may have no money, and they have to find some money by selling sex, but sex worker who uses drugs maybe they don’t want to be a sex worker and they have to use drugs because they want to be not in the real works, they want to be in a dream or something like this so that they can do a job as a sex worker, so the attention should be different”. (Female, Thailand)

“Yes, for me there is no strong association about that. Drug users may try to have sex to get some drugs but it doesn’t mean that every drug user is doing that, and another way is that there might be sex workers who are doing commercial sex”. (Female, Thailand)

“To quote Alfred Kinsey, ‘the world cannot be divided into sheep and goats’. I think there are similarities and differences, overlaps and individualities. There is no one model of behaviour or experience”. (Male, Canada)

Indeed, as Jenkins concluded, for any individual “… there is a historical trajectory. Surely the conditions of life start to overlap, but addressing a human being whose has a primary identity may be useful in the development of certain kinds of interventions, and I think that in each case, whether you are talking about male sex workers, females, transgenders, whether they are working in brothels – for brothel based sex workers you can’t be anything else… the primary identity is as a brothel based sex worker. So, addressing almost ‘hidden’ injecting needs… if I had to design an intervention, I would have to deal with it differently, so all I am pleading for is the possibility of a difference having an influence on the way you design services. It has to be thought about, but clearly there are many overlapping needs”.

**Adopting strategies - What works in the East?**

About 25 Thai drug users marched into the conference, quietly holding placards advocating for drug users’ rights. One delegate asked curiously about the protest during the speech of the Thai Minister of Public Health, “Is this Thai way of doing things?”

Reactions of non-Thai participants towards the Thai drugs users’ advocacy style are interesting to note. “I really like the way they’re protesting… quiet and not disturbing, attractive and powerful in itself,” one delegate from Australia said. “Quite dignified,” an English participant added.

It has been an ongoing theme this week – the cultural appropriateness of
models from the West applied to the East. We may have seen an example of appropriate advocacy, but what of other issues?

At a training session on school-based prevention strategies before the conference, participants looked at European models and considered their adaptation to the Asian context.

“This living in Chiang Mai, most of us make a huge effort to find out how we can make the world a better place. Yet when we want to talk about drugs in school, it becomes a big deal to do more than say, “Don’t do drugs,” Monaphit Suksopha told us.

Dutch school-based drug prevention has become a model for other European countries, and as described in the workshop, the harmony between school curriculum, parents, communities and police seem like a dream come true.

The broad range of delegates at the workshop – from South Africa, Malaysia, Thailand, Laos and India and Canada – is evidence that many are looking for new approaches. And although, what works in one place may not necessarily work in another, grassroots workers and school teachers want to know what works, how and why – so that they can apply it to their own culture to find practical tools.

We need to compare Western and Eastern models so there can be exchange of ideas. But although there is some good drug education happening in Asia, most of it is informal, rarely documented and evaluated, let alone publicized. It then becomes hard to compare when we are not really sure what we have...

According to a workshop participant, strong family bonds, typical of many Asian countries, can be strengthened to respond to the drug problems in the school context.

Like all interventions we adapt, they have to be contextually appropriate. For example, Thai school-based interventions are often done as sex education, and harm reduction in Laos is often embedded in sex worker outreach programmes.

It’s interesting to note what strategies Asian countries are adapting, using and rejecting, and what the West is learning from these approaches.

**Volunteers may be priceless, but does that mean they shouldn’t get paid?**

The session on volunteers versus paid workers sparked a very animated discussion about the exploitation of drug users in their use as volunteers in harm reduction strategies.

Presenters spanned a myriad of issues. The themes included whether it is reasonable to expect people who live in poverty to work as volunteers; the imaginative design of programme delivery through the use of multi-sectoral teams; the exploitation of already marginalized people; the pros and cons of international volunteers and unrealistic donor expectations.

The views put forward varied significantly. Two south Asian presenters said that it is impossible to expect people to do volunteer work when they themselves need to earn a living. The presenters from Russia and Brazil found successful and imaginative ways to include volunteers in their programmes although reported that problems such as volunteer safety and the harmony between school curriculum, parents, communities and police seem like a dream come true.

An important point was made in this context that donors often have unrealistic expectations of volunteer contributions to projects. A member of the audience then contributed that the International Federation of Red Cross and Red Crescent National Societies reported has a staggering 79,000,000 volunteers providing services world-wide.

Section 4  **Scaling-up and re-orienting services for harm reduction sustainability (funding, advocacy, partner-ships, & empowerment / idu peer initiatives)**

**Users are the solution, not the problem**

Until drug users are treated with dignity and respect, and are seen as part of the solution rather than part of the problem, harm reduction programmes will never succeed. This was the resounding central theme of the conference opening ceremony.

Speaking on behalf of people who have used or are using drugs, 31 year-old Wassawut Yimchaem from Thailand, himself a user for more than 10 years, set the tone for the conference with a first-hand account of the stigma and discrimination that users face.

Injecting drug users (IDUs) are often blamed for social disorder, violence, crime, promiscuous behaviour and the spread of HIV/AIDS and other sexually transmitted diseases. Different power groups – including health care providers, the media and society elites – perpetuate the stigma and discrimination faced by users. Unbalanced government policies also play a role in these judgemental attitudes.

“No matter what our methodology or background, the starting point for all our efforts must be to ensure the basic human rights of those we wish to help,” said Wassawut. “People who use drugs are almost never seen as people with dignity. They are viewed as dangerous, untrustworthy, irresponsible people; people to be feared,” he continued. “As the Thai Prime Minister’s recent programme to eliminate drugs has demonstrated, drug users and dealers are viewed as people whose very lives are of no concern or value.”

International agencies taking part in the conference are also keen to emphasise that injecting drug users are human beings and, as such, they occupy multiple identities as fathers, mothers, brothers, sisters, sons or daughters.

“We need greater global recognition of the fact that ostracising and marginalizing groups of people makes them especially vulnerable to harm and disease. Singling out injecting drug users as people deserving of punishment drives drug use and drug users underground. This encourages the sort of unsafe practices that can result in public health
“The only way to reverse this trend is for governments to implement policies that bring about a deliberate shift from social exclusion to social inclusion of injecting drug users. Strategies to reach out to them and make their practices safe are essential. The provision of clean needles is just a start,” added Barra.

Thailand’s Minister of Health, Sudarat Keyuraphan, stressed the urgency of the situation in her address.

“We can no longer afford to limit responses to supply and demand reduction measures alone. Therefore the region urgently needs to enable harm reduction policies, strategies and programmes for both licit and illicit drug use. In their absence Thailand and Asia may face an epidemic that can threaten both the economy and society.” Appealing for a more compassionate and equitable approach to injecting drug users she continued:

We need greater global recognition of the fact that ostracising and marginalizing groups of people makes them especially vulnerable to harm and disease.

“Lessons learned from many places in the world show that a successful way of addressing these issues is to ensure access to our target group – those individuals who use drugs. Once this relationship is established we can start working with clients on other issues, bearing in mind that they are important actors in solutions we provide.”

Where is Kyrgyzstan? On the cutting-edge!

Kyrgyzstan, a country which, until recently few people even knew existed, is likely to become the first of the former Soviet countries to scale-up a variety of harm reduction services including methadone maintenance treatment (MMT) and needle exchange. Given that 99 per cent of the 389 registered cases of HIV infection are among IDUs their need to urgently scale-up harm reduction is clear.

Kyrgyzstan may become one of the few countries in the world to have made harm reduction part of national policy early enough in its epidemic to keep HIV prevalence low. “I don’t know if she realizes how exciting her presentation was,” said a Russian delegate after hearing Roushan Abdiladze’s presentation on the needle exchange in Kyrgyz prisons. Kyrgyzstan’s approach may soon become a model, not only for other former Soviet countries, but for other countries throughout the world.

While many other countries in the region have faced strong legal and political barriers to piloting needle exchange or substitution therapy programmes, Kyrgyzstan has successfully piloted both. There are needle exchange and MMT programmes in two out of seven provinces. The dynamics of networking

The conference lived up to its theme of “Strengthening partnerships for a safer future”. The conference was organized by an impressive coalition of international and regional stakeholders - the International Harm Association (IHRA) in collaboration with various other agencies - Asian Harm Reduction Network (AHRN), Ministry of Public Health, Thailand, Office of the Narcotics Control Board Thailand and co-sponsored by Family Health International (FHI), International Harm Reduction Development (IHRD), Center for Harm Reduction (CHR), World Health Organization (WHO), USAID, International Federation of Red Cross and Red Crescent Societies, United Nations International Children’s Fund (UNICEF) and United Nations Joint Programme on HIV/AIDS (UNAIDS).
The presence and participation of various non-government organisations and experts in harm reduction not only gave scope for expanding personal informal networks but also gave inspiration for regional and inter-country regional networks. “Networking is the backbone of enabling harm reduction”, says Irene Lorete, Information Officer, AHRN. She adds further, “Networks at any level can keep track of programmes, activities and experiences of harm reduction in different settings which can then be relayed on to be learnt from, modified upon or adapted to suit a particular context.”

Amporn Boontan of the Thai Youth AIDS Prevention Project, a member of the Northern Child and Youth Network, Thailand says, “Networking helps. We had a Youth Lounge during the conference facilitated by UNICEF and we have been able to link up with our network and the Thai Users Network besides generating considerable interest from other delegates and the media. Our network came into existence because we feel the need to advocate for our participation in issues related to us - health for one. It makes a difference when young people are involved in something, which is meant for them.”

Various delegates attending the conference approached the youth network; some taking inspiration from them while others shared information on how to strengthen it.

Our network came into existence because we feel the need to advocate for our participation in issues related to us

Dr SI Ahmed a member of the North East India Harm Reduction Network (NEIHRN) says, “Our network is in its infancy. We came here to learn from others and in the process enhance our capacity by learning from others. It is easy to form networks, maintaining it is hard but sustaining it even harder for various reasons: lack of funds and the conflicts that arise because of that. We want to involve more people”.

NEIHRN has 11 non-government partners from five different states in the North Eastern region of India. Most of the states in the region share a long and porous international boundary with Myanmar making it one of the main transit points for heroin. Poor resource settings in health care, lack of information, infrastructure and capacity has fuelled twin epidemics of injecting drug use and HIV/AIDS in the region. The network has ex drug users, people living with HIV/AIDS and is backed by the Manipur State AIDS Control Society.

L. Birendrajit Singh of Social Awareness Service Organization (SASO) who is also a member of the network says, “Networking is not just about organizational set ups but having a link up of services and activities. Before being a member of NEIHRN we had informal networks within our set up: linkages with injecting drug users (IDUs), people living with HIV/AIDS, self-help groups for widows of IDUs, members of Narcotics Anonymous, community based organizations etc. Being with NEIHRN in the formal sense gives us an opportunity to strengthen ourselves as we have our own limitations. We lack resources to provide mobile health services, we want to be able to provide medicine support for opportunistic infections and antiretroviral therapy drugs and we can always advocate our need for them through this network.”

According to Diane Riley, one of IHRA’s founding members, “The theme of this conference is central to our aim. The best way to increase harm reduction is to link people at the grassroots level. Networks can help each other to move governments, share resources, exchange skills, training etc. Various Network groups have approached us to get feedback on what they have been doing. This conference has strengthened our resolve to link up with AIDS networks besides tapping the various youth networks. That is where the energy and the drive are and also the risks to drugs and drug-related harm. UNICEF’s interest in harm reduction is a new endeavour and it looks exciting.” IHRA will be moving towards providing routes for funding to networks and to help in developing skills and capacity.

If the response to the conference was anything to go by when it came to networking, it probably means it succeeded in that various networks now know of each other. It also gave ground for deliberations and discussions on how best to link up with one another.

Thai drug users protest

In a protest staged just before the conference opening ceremony, demonstrators demanded involvement of drug users in the development of all policies and programmes and the creation of a supportive social, political and legal environment for the implementation of harm reduction programmes, including the provision of clean needles.

Placards read – “30 Baht must cover drug treatment and methadone”; “Protect the rights of drug users”; “Stop AIDS among drug users, their families and friends”; “Access to treatment, the right to life”; and “Harm Reduction in Thailand - 10 years too late”.

Donor policy and reality on the ground: Does it match?

Many in the audience did not appear happy with the policy and funding plans presented by five bilateral donors and foundations on Monday morning. Although most of these donors aimed for international and bilateral collaboration, NGOs did not seem to enter the equation for two of the five donors.

Three of the donors spoke of their individual plans and funding criteria, and stated they will limit their funding to international, regional and national level programmes. This means local NGOs who are working at the ground, and therefore directly with the target groups, will receive even less than the currently limited support that they receive now. Fortunately, there are donors like Tides Foundation and Ford Foundation that will still provide financial support to NGOs, and directly support programme/project implementation. The Ministry of Foreign Affairs from the Netherlands also made it clear that NGOs can receive support if their activities are implemented in partnerships with IDUs and/or people living with HIV/AIDS, saying " NGOs are in a better position to know the needs of target groups."

Although there is a difference between policy and reality on the ground, it appears we had better start now to work together in partnerships at global, regional, national, and local levels, and with all parties concerned so that those who we are seeking to help can be part of the solution. This might even including working together on mobilisation of resources.

As was stated by Els Klinkert, from the Netherlands Ministry of Foreign Affairs, “… no single organization is able to fight the epidemic successfully.”

Partnership – It can be too late to wait for everyone on board

Partnership is considered an important condition for the success of any programme in general, and for harm reduction efforts in particular. The ideal partnership for harm reduction, as acknowledged at the 14th
ICRDRH in Chiang Mai, is having drug control, public health, community and drug users all on board. However, is the ideal partnership a pre-condition for the success of harm reduction?

At the global level, we can observe the partnership between WHO and UNODC – the largest health organization and the largest drug control organization. The UNGASS Declaration is probably the document at the highest level, addressing issues of IDU and HIV as well as drug use. It encourages Member States to “…implement measures that reduce or eliminate the need for sharing non-sterile injecting equipment”. It also states the need for comprehensive prevention and treatment programmes for people living with HIV/AIDS and those who are using drugs. It obtained signatories from all countries almost two years ago.

But not everyone practices what they preach.

The theme of the 14th ICRDRH itself shows the common need for a stronger partnership.

The ideal

Brazil is one of the very few countries that could offer an example of drug control, public health, community and drug users working together.

In Brazil, as described by Regina Bueno, Director of the City of Sao Paulo Harm Reduction Project, the personal use of drugs has been legal in Sao Paulo since 1998 and in Brazil since 2001. The needle and syringe exchange programme is strongly supported by the government. Public health agencies and NGOs can request supplies of syringes, needles and condoms from the government to provide to drug users. Police who are informed about the programme will support the group by identifying drug users or simply stay away to avoid drug users getting frightened. Community and church support the programme by not rejecting needle and condoms or even offer their premises as meeting places. Outreach groups are drug users whose responsibility is to reach their peers and provide services.

The reality

It had not been like that all the time. “Before it is very difficult”, said Bueno. The “before” she mentioned was when drug use was illegal, when harm reduction had not been supported by the government. In those days, Bueno and her colleagues “had to hide the services” for the sake of the drug users. “When we saw a drug user and we wanted to stop to provide service to him but he gave us the sign that police around, we had to keep driving”, Bueno said.

The before of Brazil is probably the today of many countries.

The drug wars in Thailand and Argentina are obvious examples of insufficient communication and partnership between drug users and law enforcement officials. Frustration burst out into the demonstration of the Thai Drug Users Network right before the opening ceremony of the conference. We all know more than 2,000 Thais lost their lives during the Thai drug war in early 2003. Silvia Inchaurraga of the Argentinean Harm Reduction Association presented the figure of nearly 12,000 Argentineans arrested in Argentina’s drug war in 2000.

A Swiss doctor, who has been providing substitution treatment for more than 10 years, admitted that he was not able to involve drug user groups into his programme. “If we could involve such a group, it is great. But I could not find a group like that in Switzerland”.

From China, Lucy Reynolds explained why her project does not involve the community. “In China everything is decided by the authority on the top. They decide everything. Community has no role”.

Speaking at one of the conference plenary sessions, Chokchai Thaptaavee of the Thai Drug Users Network told his own story “I have been injecting drugs for five years. I have... relapsed many, many times. Doctors have taken my blood (for testing) many, many times but there was just one time a doctor spoke to me”.

Law enforcement or health provider, drug user or community may not be on board at the same time, as they should. But does it help if we just wait for everyone?

Act now, partners will join.

Nigel Fyles of the Criminal Justice Team of Manchester Drug Service, in a one year period, was able to support 17 drug users who sleep on the street. He calls it “individual partnership”. He provides information, discusses and refers drug users for the treatment of their choice, supports them in re-housing or other needs. He believes his work will be expanded.

Voluntarily and without any charge, Kamiar Alaei and his brother in Kermanshah, implemented a community-based project on counselling, care and treatment for drug users and people with HIV in their home province in Iran. Their project turned out to be a very successful model, which has been replicated in five other provinces in Iran.

Australia is always spotted as the country that is successful in preventing HIV epidemics within drug user populations. But as pointed out by Stephen Wye, law enforcement agencies should not be acknowledged for this success. The Aussies must feel lucky that health professionals and drug user groups did not wait around until law enforcement came on board to start working on harm reduction.

All the successful stories presented in the conference have a similar feature - there must be somebody to start and on the way more partners will join.

Contrary to this, the Vietnam Drug Law states that personal drug use is not illegal. But this is not taken as an advantage for harm reduction activities. One delegate from Vietnam pointed out “It is nothing about law. Our problem is that nobody takes action. Nobody does the work”. As the result, except for a few small-scale needle exchange projects, there is no effort at the national level towards harm reduction. The consequences of this inaction were pointed out by Carol Jenkins, in her presentation at the last plenary session of the conference - “HIV infection rate among IDUs in Hai Phong” (the third biggest city of the country) increased from one per cent in 1997 to 72 per cent in 2001. By the end of 2002, HIV prevalence among IDUs in some provinces was as high as 90 per cent.

The lesson is obvious: start now and even if you have to start alone, partners will find you.


The second edition of the Manual for Reducing Drug Related Harm in Asia was enthusiastically received by UNAIDS Associate Director, Anindya Chatterjee, who said that this Manual represented “…a very necessary tool to scale up and quickly move things along.”

The before of Brazil is probably the today of many countries.
drug users and HIV-positive drug users in Kuala Lumpur. He found the manual is immense because it represents the single most comprehensive practices in programme design, implementation and maintenance and includes useful appendices relating to blood-borne viruses, drugs and their actions and sexually transmitted diseases.

An Indonesian language version of the manual will also be published. Coordinator Yacintha Dany said the value of the bahasa Indonesian manual is immense because it represents the single most comprehensive body of knowledge on the issue in Indonesia. Elisha Tan works with drug users and HIV-positive drug users in Kuala Lumpur. He found the manual to be “...a life saver in its simplicity” and because it “...explains technical stuff in detail with a minimum of jargon.”

For manual availability go to: www.ahrn.net

New partnerships: IHRA practices what it preaches

Twelve months and many, many kilometres later, the 14th International Conference on the Reduction of Drug Related Harm arrived in Chiang Mai.

Over the past year, conference organisers and local committees have worked hard to bring last year’s theme of “Social changes: lines of inclusion and diversity” to this year’s theme: “Strengthening partnerships for a safer future”.

And not in words alone.

This year’s conference extends this focus to the importance of working together in the reduction of drug-related harm — locally, nationally, and internationally

The International Harm Reduction Association has put this year’s theme into practice by partnering with the Asian Harm Reduction Network, Thailand’s Ministry of Public Health and Office of the Narcotics Control Board, Family Health International, USAID, Center for Harm Reduction, UNAIDS, The World Health Organization, International Harm Reduction Development, International Federation of Red Cross and Red Crescent Societies, and this year’s new sponsor - UNICEF.

Together, working in partnership, for a safer future.

Ljubljana’s 2002 conference had as its focus the social changes brought on by transitions, wars, migration, and changing values and a focus on lines of orientation, inclusion, and diversity — and the ability of drug use and drug-related harm reduction to transcend wars, violence, marginalization, exclusion, and abandonment.

This year’s conference in Chiang Mai extends this focus to the importance of working together in the reduction of drug-related harm — locally, nationally, and internationally — to develop safer futures for ourselves, our families, our friends, and our fellow citizens.

Every harm reduction conference is unique, and the current event promises to offer special challenges and special rewards for those attending and for those watching from afar.

In Slovenia, we said, “Harm reduction is an inclusive paradigm. It has the capacity to include other approaches and there is the need and opportunity to view the issue of drug use from various angles.”

In Thailand, it is said this year’s conference “... will allow us to strengthen partnerships with communities involved or affected, with law enforcement agencies and drug treatment providers, religious leaders, and youth representatives”.

Partnerships can develop into leadership. Leadership can develop into new and stronger partnerships.

And all in the pursuit of a common goal: Safer, healthier futures and the reduction of drug-related harm.

East-East exchange: The first “China Plus Meeting”

Prior to the commencement of the conference, key stakeholders from China, Central Asia and Eastern Europe gathered for the first “China Plus Meeting”. The meeting was jointly organized and funded by The Centre for Harm Reduction of the MacFarlane Burnet Institute for Medical Research and Public Health and the UK Department of International Development (DFID).

Given the demographic, epidemiological and political connections and similarities between countries in this region, the meeting’s objective was to promote information sharing and explore continued means of exchanging experiences. Country overviews and descriptions of model programmes were presented, followed by discussions of the kinds of activities that could promote further inter-country cooperation and collaboration.

The HIV epidemics in most countries in this region have been characterized by relatively low HIV prevalence, with rapid prevalence increases among injecting drug users recently noted. As well as similar epidemic profiles, many of the countries share a common political and ideological communist heritage with centralized, vertical institutional structures for managing public health issues. As a result, organizations promoting harm reduction in these countries often experience similar opportunities and constraints.

These opportunities and constraints have been handled in differing ways. For example, methadone maintenance programmes have been successfully piloted in China, whereas Russian law strictly prohibits such initiatives. Similarly, in Russia, while needle exchange programmes have been effectively implemented in several regions, in China such programmes are forbidden. Participants agreed that activities such as study tours, Internet exchange, and follow-up meetings could be instrumental in promoting fruitful exchange. The organisers expressed interest in supporting such efforts at inter-country
dialogue. Follow up meetings are planned for upcoming international HIV/AIDS and harm reduction conferences.

**Voice of the dealer?**

Here’s a voice we rarely hear, but that is present in almost all transactions of illicit drugs – the vendor.

The purchaser of any substance, legal or otherwise, may never come into contact with a service provider, physician or a harm reduction practitioner, yet may be in daily, even hourly contact with their dealer or pimp or their peers and comrades in illicit and illegal behaviours. These renegade underlords – the first and sole contact that some users may have with other drug professionals – may offer potentially invaluable and unique first lines of defence in providing harm reduction services.

Yet we don’t see them here in any presentations. Will we ever?

Regardless of their legal or illegal status, regardless of whether we consider them to be a drug user’s best friend or pariahs of society, regardless of their culturally universal vilification as purveyors of evil – we cannot deny their central role in illicit drug trade.

One of the anecdotes from Australia at a conference symposium was of a pusher, when arrested by the police, was found with clean needles in his bag. He told the police he gave them out because his father, a senior sergeant, often talked about harm reduction! Maybe he just wanted his clients using drugs for a longer time, but that’s another issue...

Question is – is targeting dealers another harm reduction strategy? Will it save lives?

Yes and yes.

**Helping Buddhist monks reduce harm**

“We are sons of Buddha, so we have a duty to help people from suffering. Monks should willingly participate when society is suffering,” said Phra Wanchai Jantawanno, monk and chairman of the Child-Watch Network in Chiang Mai.

At the Thai Youth Forum, on Monday evening, monks, young people, drug users and youth workers came together to share their experiences with HIV. Drug users were able to tell their own stories.

Many Asian cultures, like that of Thailand, have a strong spiritual belief and faith. Where other parts of the world have churches or mosques, Thailand has its temples. Many temples in Thailand have become refuges for people with HIV, and monks have become like nurses, attending to spiritual as well as physical suffering.

“If we want to talk about drug users, we must accept that they have their own way to finding happiness. They may be satisfied with the happiness they have chosen. They have the right to be happy...” Amphorn, from the Thai Youth Network project, said. “We need to let these drug users know how to enjoy their happiness with safety.”

Drug users at the forum shared what they have learned about pursuing their happiness “safely.” It seemed clear that the community has a lot of learn about the realities and practice of using drugs from drug users themselves.

In Thailand’s small towns and villages, temples and monks can play crucial roles in bridging the gap between users and their communities. Monks are often community leaders who have come from poor families themselves and received education and assistance from their communities. They are, increasingly, willing to be the social conscience of their communities, and affect change through activism as well as ‘good work.’

“It’s time we repaid society,” said one monk at the forum.

Programmes conducted by monks have received moral and financial support from their communities. Unfortunately, the government seems reluctant to provide monetary support and few monks have experience or skills in fundraising.

How long can the Thai government continue to ignore monks and their communities who are so obviously ready and willing to act?

**Numb-ers**

I stare at the numbers on the electronic screen
numbers whispering their truths, page on page,
not the fables of political orators
but a matter of rage
in my aging body,
numbered injustice exposing
the numbering lies,
showing that inequality kills,
spreads drugs,
spreads injecting,
spreads AIDS,
spreads murder,
spreads hate.

The numbers enumerate the guilt of the powerful,
not of the junkies or of the poor,
but of the wealthy,
and as I stare at these numbers
I muse upon century-old truths:
That the point is to change the world,
not just to understand it,
not to inject drugs of solace
nor of joy
with points of steel,
but to change the world,
a task for billions enraged
seizing numberless offices, factories and streets
from within,
winning the allegiance of soldiers and even scattered cops
from the snarlers who gave them Agent Orange
and stonewalled medications and research for those so-exposed.

For a moment, I despair at my life spent
in research and philosophy
but then I rally in realization that thought and anger
are best friends,
that both feed the rebellion,
that the seizing of the world from its killers
needs the best anger, the best thought,
the best action
that the sneered-at billions can feel,
can think,
can do
so the barbarians who play as statesmen
can be ousted by the rule of us all.

Sam Friedman
**YOUTH RAPPORTEUR COMMENTARIES**

**Young spectators become participants at the Youth Lounge**

Young people have an important role to play in responding to the challenges posed by drugs. After all, young people are one of the groups most vulnerable to drugs and drug-related harm. Policies or programmes targeting the issue of drugs must consider their views.

In order to give young people a voice at the conference, UNICEF, in partnership with the Thai Youth AIDS Prevention Project and the Northern Youth Networks, hosted a Youth Lounge. A variety of services and activities were available including: open forum discussions, advocacy training, and other participatory events. The Youth Lounge also offered free internet and computer access, movie screening, and a cafeteria.

Of particular interest for young people who wanted to be more deeply involved in this conference was the partnership between youth rapporteurs and the Key Correspondents (KCs) who report the events of the conference and produce On Track News. Youth rapporteurs partnered with a KC to interview personalities and write articles.

The Youth Lounge also received exposure through daily updates to the Internet and evening radio programmes in both Thai and English. The content for these media spots was provided by the youth rapporteurs, and in the case of the radio programmes, young people were invited as guest speakers.

The Youth Lounge was an effective channel of communicating the important opinions of young people.

**The young speak, the not-so-young listen**

During the Tuesday Morning Countdown, the debate focused on the role of young people. Among some of the most significant comments made were, “Youth must be brought into the mainstream and not just be left at the sidelines” and “We should not just talk about youth but we must talk to youth.”

**Most parents were seen as ill equipped to assist their children in negotiating the difficult world of drugs**

During the conference there were several events, including the Youth Lounge, that targeted young people specifically, and there is one event that gave young delegates a chance to speak out about their experiences. But is it enough? It has been acknowledged that young people are central to the creation of any youth-targeted efforts but how often do they get a chance to be included not as an audience but as designers and implementers?

Two events on Tuesday provided chances for young people to vocalise their concerns. At one session - “Young People’s Experiences” - over 80 young people and close to 60 not-so-young delegates gathered to hear first-hand accounts of young ex-drug users from Thailand and Indonesia, and a report from Vietnam read out. While there were some statistics presented, it was the personal stories that truly catalysed the session and brought forth important discussion.

Two points became especially relevant during the proceedings: appropriate information and the role of parents in the lives of their children.

With regards to information, the gap between what is provided and that which young people actually need was seen as an obstacle to achieving positive results. Most parents were seen as ill equipped to assist their children in negotiating the difficult world of drugs, and are often not there when their children need them most. The not-so-young delegates did not actively participate in this session but rather held their opinions till the afternoon session.

At the later forum “Responses to Young People’s Vulnerability”, not-so-young delegates got a chance to respond to the young people’s opinions and to ask specific questions. The dialogue from the morning continued and the two main issues of information and parents also featured highly in the discussions.

Undoubtedly, it was the not-so-young delegates who gained the most from this session by being exposed to views that they may have not taken into consideration before. Something must also be said of the welcoming atmosphere that they created for the young people by encouraging them to speak out.

Let us hope that this dynamic will continue throughout all inter-generational cooperation.

**Power to the people – the young people**

The Wednesday morning Countdown kept its promise to young people and chose to not only talk about them but to talk with them. Paul, a 21 year old ex-drug user from Indonesia and Wee, a current drug user from Thailand, shared the stage and kicked-off the third day of the conference. They talked confidently and openly about these issues that affect them so directly.

“Rehabilitation is a not a one-dimensional process – it involves mental, psychological, social and spiritual aspects,” said Paul. Wee declared, “Drugs users are viewed as lower than second class citizens by society.” They may not be academic experts, but they have first-hand knowledge that puts them at the forefront of finding solutions to the central issues of the conference.

It was surprising how much you can achieve by simply holding hands, looking into others’ eyes and standing side-by-side.

The most relevant youth event for Wednesday was the UNICEF training session titled “Do It Yourself.” It was a continuation of two previous youth sessions. The objective of this training was to take previous lessons learnt, analyse positive elements from that session and develop ways to
continue the momentum built during the conference. It is essential that input into the conference by young people is not lost, that it is used to ensure that progress is made and that it directs change in dealing with drug-related issues and young people.

The first half of the training was facilitated by Dave and Joyce Gordon of Yayasan Kita, a rehabilitation centre in Jakarta. The activities encouraged communication and support.

The 60 people present were from different countries, genders and ages, but due to the nature of the training, everyone got to know each other on a deeper level than anyone one would have thought possible in only 45 minutes. It was surprising how much you can achieve by simply holding hands, looking into others’ eyes and standing side-by-side.

After completely “breaking the ice”, the training moved into the second half of the session which concentrated on building problem-solving skills. Animated discussions by young people powered a variety of ideas and suggestions, with the main focus placed on the rights of young people to access the right kind of information, and the right to make choices based on that information. Also discussed, was the need for advocacy by young people to open channels of access to decision-makers.

The training session was closed by an exercise in which young people developed post-conference plans. These plans focused on partnerships with decision-makers, as well as the applicability and access to communication mediums. The training continued 30 minutes over the scheduled time and would have continued for longer if subsequent sessions had allowed. This is just the type of thing that young people need – a chance to show that youth can share valuable experience and that that is synonymous with answers and progress.

**GENERAL CONFERENCE COMMENTARY**

**Q&A with the conference organizers**

HDN asked some of the key people involved in organizing the IHRC for their perspectives as the conference kicks off.

**Question: Why is the ICRDRH theme important?**

**Tariq Zafar:** There are plenty of good practices and expertise in harm reduction in this region. Why should we reinvent the wheel? Instead, we should be working in partnership with others so that their successful approaches can be replicated.

**What are your expectations for the ICRDRH?**

**Tariq Zafar:** I hope that this conference will provide sufficient sources of knowledge so that people can learn and consequently improve the services to their clients on the street. Ultimately, the conference must benefit the drug user community.

**Pat O Hare:** I am looking forward to hearing what is happening in the world and of the progress that has been made in the field of harm reduction. The whole debate about naloxone and overdose interests me. Also I would like that governments in this region can come to learn that harm reduction is not threatening, but can in fact help them to deal with the consequences of illicit and licit drug use. They can see the evidence and see that this has happened elsewhere. Any little movement forward is a great success.

**Question: In recent years, the ICRDRH was held in Switzerland, India, Slovenia and now Thailand. Why was it important to hold the conference here?**

**Pat O Hare:** Holding the conference here will give a boost to the people who are working in harm reduction in Thailand and the Southeast Asian region. It is also important because to hold this conference in this region because 60 per cent of the world’s population live in Asia. Consequently, Asia will have a large population of people who are injecting drug users and who are infected with HIV.

**Holding the conference here will give a boost to the people who are working in harm reduction in Thailand and the Southeast Asian region.**

**Gerry Stimpson:** It is hugely important to hold the conference in Thailand, because it raises the profile of drug-related issues. There is an awful lot to be done and Thailand is at the epicentre of countries where injecting drug use is common, including countries like Myanmar and China.

**Question: If you had to three priorities for harm reduction, what would they be?**

**Pat O Hare:** More emphasis placed on enabling strategies rather than persuasive strategies. Advocacy – the evidence is there that a combination of substance prescription and clean equipment would stop HIV. What we have to do is be able to present evidence and be able to persuade. Thirdly, we need to realize that there is more to this issue than injection drugs... the global use of MDMA-type drugs and alcohol is massive.

**Ton Smits:** I would like to see the emergence of responses to HIV/AIDS, such as needle exchange, outreach, drop-in centres and pharmacotherapy programmes, a supportive policy environment and strategies that address underlying issues and reduce vulnerability.

**Question: What about the Thai war on drugs?**

**Tariq Zafar:** No government has succeeded in eliminating drug use through repressive measures. A war on drugs is a war on drug users. Such measures drive people underground and you can’t reach them.

**What do delegates expect from the conference?**

At the opening ceremony, HDN Key Correspondents asked delegates what they expected from the 14th ICRDRH this week:

“*I want to see a policy of treating drug users with more humanity.*”  
— Kru Nam, Street Child Project, Thailand (F)

“*To learn about illicit drug use in Asia, particularly in Southeast Asia.*”  
— Anonymous, Cambodia (M)

“I want to know more about harm reduction in particular and HIV in general because we want to scale-up HIV/AIDS activities in Russia.”  
— Elena Tanskova, Russian Federation Red Cross National Society (F)

“The first thing is to learn from the experience of others at this meeting – so I can take that to my community.”
Language-related harm - conference participants beware

Delegates, speakers and organizers are responsible in different ways for an inclusive conference.

The conference is providing simultaneous interpreting for people who prefer Mandarin, Thai or Russian. While this is essential to enable broader attendance and participation in the conference, it does not ensure that the expertise of the participants and speakers can be fully shared. For example, a delegate from Russia commented that the interpreters at the 13th ICRDRH in Slovenia struggled to communicate technical concepts that were being presented. Because of this, he was not able to make sense of many presentations.

Moments after arriving in Chiang Mai, conference programme director Gerry Stimson expressed the hope that people from developed countries would learn from people from developing and transitional countries. It is a hope shared by many at this conference, however its realization may depend upon how we use language.

Delegates, speakers and organizers are responsible in different ways for an inclusive conference. Delegates are responsible for creating a demand for interpreting. Wearing headsets is a clear sign that people are ready to listen to and learn from people who speak a foreign language, particularly during the spontaneous question periods.

Speakers are responsible for addressing the entire audience, appreciating that the speed of their speech and the technicality of their language may overwhelm the translators.

And organizers are not only responsible for providing appropriate technological interpreting support, but for appointing conference interpreters who are skilled at understanding and interpreting technical language and jargon. Otherwise, the interpreting will not make sense, and expertise may sound like nonsense.

If language is only descriptive of what is, the status quo will be maintained. Drug users in Thailand do not have this luxury. It is important that the language of this conference be clear and creative, to help form new partnerships and possibilities that do not yet exist.

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Left out in the cold? Drug user delegates dissatisfied with conference’s interpretation of harm reduction

Have you ever been in a crowded room where everyone was talking about you, but you yourself were forced to remain silent? Have you ever sat gaping at a PowerPoint presentation while your life was dissected on screen? Have you ever been the recipient of indulgent smiles and fawning nods of agreement as you explained how you go about your life? Have you ever been told that you and your life were not “normal”? Have you ever been forced to listen to twaddle and crap for an hour and a half and...
when you've raised your hand in dissent, been told that “I'm sorry, you can't speak because our time has run out.” No? Perhaps you haven't been a drug user at a harm reduction conference. Or perhaps you missed out on the 14th ICRDRH.

The word around the corridors on the last day of the conference was that drug users were uniformly dissatisfied with the current direction of the harm reduction movement. They said that harm reduction should be a goal in itself rather than merely a vehicle to abstinence, and that much of what they'd heard at Chiang Mai seemed to assume that drug users used drugs not out of choice but because their lives were governed by exigencies that set them quite apart from “normal people.”

“I heard so much from people who had no idea why people used drugs and little or no interest in finding out,” said an Australian user. “What they wanted most was not to understand drug use but to control drug users. I can’t remember anyone actually mentioning the pleasure of various drugs. It seems they want to go no further than “Drugs are Bad,” and really, if that’s the message that the harm reduction movement wants to endorse, even by default, it will surely lose credibility with users.”

“Drug use is a normal expression of what it means to be human,” said another, “and until the harm reduction movement embraces this, it will fail to prevent harm. Drugs do not of themselves cause harm. What causes harm? The laws, the policies, moral attitudes, and belief systems entrenched in practically every country represented here at this conference.”

Harm reduction during this conference, she said, focused primarily on prevention, treatment, and control, and we should understand what these phrases really mean.

Although many will acknowledge the futility of official drug prevention efforts (e.g., DARE, and the just Say No programmes), we rarely heard about initiatives that accepted that people want to use drugs and focused on how they can use their drugs safely. “Perhaps once or twice I heard someone talk about the desirability of involving users in the conceptualisation, development and dissemination of information or resources about how to use drugs and just as rarely I heard about programmes that do this. The session on nightlife drugs was outstanding. I wish we'd heard similar approaches about heroin, amphetamines, and the rest.”

Treatment received an ongoing focus at the conference. But too often, as most notably in Thailand at present, it referred to forced treatment. “Some, but not all users want treatment,” one user commented, “but I know of so many stories about punitive, overly directive, unfriendly treatment protocols and services that ultimately dilute the dignity of clients and cause more harm than they prevent.”

Drug control is the third element of the troika. The consensus at the close of the conference seemed to be that few presenters acknowledged the fact that attempts to restrict supply, while they may satisfy the demands of puritans and fanatics, have never succeeded and will never succeed in stopping people from using drugs. "Drug law enforcement," one delegate said, "... inflicts harm more serious than any that comes from using the substances in question." She said that many users were and remained suspicious of any conference co-organised by an organisation such as the Office of the Narcotics Control Board, Thailand. No doubt such an arrangement may have been accompanied by some progress achieved in the past, but in making that shift, users fear that the strong human rights basis that had previously characterised the harm reduction movement could be seriously diluted.

Perhaps it was merely an aberration of Chiang Mai. At the close of the conference, human rights, which appeared to have gone into hiding through much of the public pronouncements during the conference, was the phrase on almost every speaker’s lips.

IHRA president Dr Alex Wodak declared in his address to the Thai Users Network, “The HIV virus has taught us that if we’re to control HIV, we must protect human rights, and if we are to protect human rights, we must protect the rule of law.” Yet how can one commit to protecting the rule of law when the drug laws so flagrantly ignore human rights?

Several speakers said the expected niceties about the presence of the Thai User’s Network at the conference. Although its leaders in public appeared gracious, in private the rank and file felt isolated and unsupported. Some users with more experience in attending these conferences felt that this was the real metaphor of the conference. Sure, the presence of drug users at IHRA conferences makes everyone feel good. But given the emerging philosophical differences between the user movement and the harm reduction movement, is it worth returning?

Delegate opinions

Indian official supports Thai drug users

The government of Manipur, in the North East of India tried to control HIV amongst drug users through a ‘Police Model’. They rejected the strategy because it didn’t work.

Dr I. Ibhabi Singh, from the Manipur State AIDS Control Society, says, “We must not blame anyone. You cannot impose any compulsory methods and approaches. Participation must be voluntary.”

At the 14th ICRDRH, he expressed his support for the Thai network of drug users by wearing their T-shirt, which says: “Protect the rights of drug users. Thai government drug policy = drop dead”.

Delegate opinions and quotes of the week

“Methadone saved my life - and I am very grateful to it for that.” — Bill Nelles, The Alliance, UK

“Drug use must be seen as one way of coping with complex effects of stigma, marginalization and loss of land/territory.” — Patricia Spittal, the VIDUS Project, British Columbia

“When drugs of choice are not available, opium users also switch to alcohol and other drugs, and people who used to be calm, etc., can become violent. People will not stop using drugs. Without understanding and putting ourselves in their shoes, we are not going to be able to...
“The guiding principle of much of what I’ve heard appears to be politics rather than reality. We need empowerment and freedom to talk about the reality of drug use.”
— Delegate, Red Cross, Thailand (M)

“Basicbally, pretty boring ... there’s been very little about what’s happening in Europe and Australia, which are much more advanced than elsewhere. It seems more like an HIV/AIDS conference than a harm control conference.”
— Delegate, Switzerland (M)

“I went to an excellent session about nightlife drugs, but otherwise it was same-old, same-old without advancing the discussion. The conference programme might in future focus more closely on the needs of all delegates. You have to wonder what’s going on when a conference like this gets no publicity in Thailand. Who’s been handling the media?”
— Delegate, United Kingdom (F)

“The IHRA conferences at present represent one of the few opportunities for international drug activists to get together, but it seems that in future we need to be organising our own rather than spinning around as satellites for public health, HIV, or harm reduction for that matter. What passes as harm reduction at this conference should be more accurately described as treatment, substitution therapy, law enforcement, etc. The focus has been on long-term harm rather than stopping the various world wars against drug users. Clean syringes are of little use to someone in a coffin.”
— Delegate, Australia (M)

“Too many self-important egos living in the clouds, where, we all know, there is very little oxygen.”
— Delegate, Australia (M)

“Most of the presentations we have heard are based on what one lot of people would like another lot to do. Most entirely overlook the pleasures of using drugs. As long as harm reduction programmes are really about protecting innocents, it will be a vessel commanded by arrogant fools carrying unwilling passengers towards a destination that does not appear on any map of human contentment.”
— Delegate, Australia (M)

“The conference? Personally, I enjoyed the lobby. There was nothing new in any of the presentations. I learned a lot more talking to people informally.”
— Delegate, India (M)

“We think we are 20 years in front of almost every person here. For us there has been nothing new.”
— Delegate, Denmark (M)

“Bad. We have had neither good accommodation nor any translators. I would go to another IHRC conference, but only with the help of a sponsor and lot more support than we have been given here.”
— Delegate, Thailand (M)

“The networking is invaluable and in talking to users I’ve now got a much better perspective on the enormity of the situation. Other than that there was very little of use to me at home.”
— Delegate, New Zealand (M)

“This conference is more about encouraging people to be abstinent than empowering drug users. For example, there’s been a lot of talk about peer education, but very little has been peer driven. We know that that’s the kind of education that works best.”
— Delegate, The Netherlands (M)

“Harm reduction is not a vehicle to make people abstinent. It should be a goal in itself. The former point of view was pervasive at this conference, and if it continues as the underlying assumption of the harm reduction movement, nothing will change. As long as the harm reductionists remain focused on applying Band-Aids like methadone and NSEP, their client population will lose their limbs and their lives.”
— Delegate, Australia (F)

“Harm reduction continues to be the poor cousin of law enforcement, supply reduction, and demand reduction. Do we need to come here to learn that?”
— Delegate, US (M)

“So many ideas, new contacts and possibilities.”
— Elisha Tan, Malaysia (F)

“So much to learn but so little time. The contacts I have made will help me so much.”
— Fauziah Ismail, Malaysia (F)

“Nine hundred knowledge data bases in my areas of interest was truly a buzz.”
— Joe Selvaretanam, Malaysia (M)

“My first harm reduction conference and as a police officer it was a little overwhelming but I survived.”
— Idris, Malaysia (M)

“Disappointed with some of the presentations that were so poorly prepared – narrative not analytical.”
— Doctor from Bangladesh

“A great opportunity to network and pick up ideas for projects.”
— Kartini Slamah, Malaysia (F)

“It has been excellent, exceeding my expectations. There are so many people from so many places in the world. If I didn’t go to this conference, I would never know anything about Kysgyzstan. I would never have a night like last night (the party)”
— Nick Walsh, Harm Reduction Center, Australia (M)

“Very nice. Meet nice people, learn a lot”.
— Bijnas Nasirimanash, Iran (M)

“It was good. I have never been in a country in this region. When I was in my country, I felt as our human rights were not respected but when I come here and see what is happening here, I feel better”.
— Balazs Denes, Hungary (M)

“Nice conference, a lot of people I don’t know, not as a lot of conferences. There are many new people in this conference”.
— Robert Heammmig, Switzerland (M)

“It is the very, very first time I have attended a conference in this region and I have learnt so much. It is a wonderful opportunity to share, to learn - so many people from so many places. You know, it is boring to see the same people all the time. It is pity that many of my colleagues from the
US could not come”.
— Barry Zack, USA (M)

“It is a great opportunity to network”
— Pedro Suarez Baltodano, Costa Rica (M)

“It is amazing. They organize such a big conference so well. I have learnt a lot of new things, also about the way the conference is organized”.
— Nguyen Quang Hai, Vietnam (M)

“The organization is really good but I am disappointed about presenta-
tion skills of many presenters”.
— Anon, Vietnam (F)

“I learn[ed] many things from this conference for example; how to do project activities and how to speak to large audience.”
— Monir Hoosirin, Bangladesh (M)

“People from Southeast Asia are very generous to share their experience and I could learn many things from them.”
— Craig Carmichael, Australia (M)

“As far as this conference is concerned, I have to say two answers: No. 1 is Yes, good to be in this conference. I learn a lot and No. 2 is No, Thailand is not doing well enough for Harm Reduction.”
— Nigoon Jitthai, Thailand (F)

“This conference is a place, where we can exchange information and also it is a good place for networking.”
— Bigen Nassirimanesh, Iran (M)

“It is very impressive. This is my first time to participate in this kind of conference. It covers huge amount of topics.”
— Anthony Roy Tongue, United Kingdom (M)

“Too big, but not enough involvement of IDUs in this conference. It should have more rooms for IDUs to take part in such kind of conference.”
— Uncle Ken Kampe, Thailand (M)

“Have a chance to meet experts from many countries and some government officers. It is a good place for networking.”
— Hu Jia, China (M)

“Good sharing, good meeting, good networking.”
— Nguyen Quang Hai (male), Vietnam

“It is very interesting. It is a place for sharing experience. Rich and poor countries meet together to work for the same goal.”
— Ly Po, Cambodia (M)

“Provide opportunity for people to work for harm reduction networks, update the strategy and implementation activities.”
— Aranya Ngamwong, Thailand (F)

“We need to work much more toward needle exchange programmes.”
— Anon, Australia (M)

“Advocacy, advocacy, advocacy !!!”
— an, India (F)

“Work more on demand reduction as well as supply reduction”
— an, Iran (F)

“HIV is taken on hold in Asia”
— an, NL (F)

“We have not fought enough the HIV battle. We have to include HIV much more into the HR programmes.”
— an, India (F)

“Ideally less research data presentation and more practical information to take home.”
— an, USA (M)

“We need more skills building capacity in our country.”
— an, Thailand (F)

“The situation is very, very, very bad in Asia.”
— an, France (F)

“Great lack of support from donor organisations.”
— an, Myanmar (F)

“Are we actually progressing or regressing in terms of policies and programmes in Asia?”
— an, Ukraine (M)

“It is clear that there is lack of political understanding and political support of the HR and HIV issue.”
— an, UK, (F)

“Yes, I have a lot of experience in harm reduction and I wanted to complete my training in HIV/AIDS. And I guess I did.”
— Dr Aung Kyaw Oo, India

“I am a lawyer and it has been very interesting to keep a complete view into this issue. I got a deeper view. It was excellent”
— Petr Zeman, Czech Republic

“Well... I've been in four conferences, and this is the poorest one I've had attended because many key people couldn’t come”
— Larissa Badrieva, Russia

“Absolutely, I got a lot of feedback. It's nice seeing people interested in your work”
— Peter Vickerman, UK

“The update of Asia was really helpful and also the coverage interventions”
— Anna Foss, UK

“The conference was great. I have learnt so many things, which I will take back to my country. I will share it with my student friends and we will campaign the government for the adoption of harm reduction strategies.”
— an, Indonesia (F)

“I don’t think that things related to women were featured enough in the programme”
— Shakuntala Mudaliar, India (F)

“I am coming away from this meeting with the intention of including police and women in our networks in a greater way.”
— Greg Manning, India (M)

Did the conference live up to your expectations?

“Yes – in a very positive way, which was not a lot to do with the programme. If I didn’t know more about it I would have thought it was a conference about AIDS.”
— an, UK (F)

“Yes, but because of the opportunity to connect with people. There was very little on treatment and not enough on drugs other than opiates.”
— an, UK (M)

“It was the first time for the Thai Drug User Network to come and it has been very helpful.”
— Pipat Chansolop, Thai Drug Users Network, Thailand (M)
"More than. Every year it gets better than the last."
— Gerry Stimson, Conference Programme Director, UK (M)

"Yes. Because it's a good bunch, it's good to interact, make new contacts, collaborate."
— Nick Thomson, Centre for Harm Reduction, Thailand (M)

"Yes. It showed how far China has to go."
— Michelle Rudolph, (F)

"Yes it did. It is always particularly fantastic to catch up with like-minded people in troubling political times and to have the opportunity to give each other support."
— Dr Ingrid van Beek, Australia (F)

"Yes because we were here to learn about harm reduction - me and the staff and some of the target group - the kids we work with, and we were given a booth which helped us to raise our profile and network and to meet people in the field who are a wealth of knowledge."
— Zarina Mulla, Thailand, (F)

"I believe delegates at this conference got a bit of something. We at AHRN have been able to link up with networks on Harm Reduction in the Middle East."
— Sidharth Singh, Training Officer AHRN

"Relief!" — anon

"It gave validation to all the tough times we go through when implementing harm reduction. It is comforting to know that we are not alone."
— Shalini Singh, India

"Not really satisfying in context of involving more drug users. There were no grass roots people here."
— Tai Kien, Malaysia

"It was a tough job!"
— Warinda A, Registration staff

"It was a major experience - putting our Network forward, learning from others, sharing our experiences, getting new ideas from people implementing harm reduction."
— H. Raghunani Singh, India

"The International community got to know about the Thai Drug Users Network through this Conference but I wish that more people here in Thailand will speak out for them."
— Bunsanong Thangyndee, Thailand

"It was a chance to meet a lot of people. I met a lot of people who can help us to do our work better."
— Charan Sharma (India)

"Great for meeting people" — anon

"Everything I have been in has been intelligent discussion and thoughtful questions. It has been enjoyable meeting people. It has raised the profile on the attack on local drug users here in Thailand."
— Campbell Aitken (Australia)

"I have enjoyed the discussions outside the formal forums the most, when we are talking about the sessions."
— Peter Higgs (Australia)

"I would like to hear more praxis oriented work. I already know harm reduction is good, but I would like to know the details about practicing it. Secondly, the Asian people did not get to discuss their opinions. The programme could have supported more substantial dialogue. For this I would welcome skilled facilitators who know how to maintain continuity and use time well, rather than chair persons."
— Gelaresh Mostashari (Iran)

"This has been a learning experience, and now I need to put it back into practice."
— S.Suresh Kumar (India)

"The conference was good, except we did not address the needs of children."
— Mini Varghese (India)

"I got to realize that drugs are a major problem on health too. I thought drug users were bad but learnt during the conference that it is not so. I hope other people will also realize that."
— Worangool Keawlawa, Youth participant, Thailand

"I wonder how much money was spent and recovered!"
— anon

"If treatment professionals really want to understand what it's like to be a drug user, I suggest that they first do a little research and take the drug in question themselves."
— Anonymous user, Sydney, Australia

"My experience of conferences like this is that although some presentations and sessions are beneficial, the most beneficial part is the work that you do outside the sessions. Talking to people about the work they do and the experience of it. It was an excellent opportunity to network."
— Carol Finneghan, Northern Ireland (F)

"This is my first conference experience. I come from Myanmar, and work for a French NGO there. I gained a lot of knowledge and experience from this conference."
— Gam Aung, Myanmar (M)

"Yes and No. It was a shame that a lot of people didn't come, but nonetheless some of the presentations were very interesting and also quite surprising. The grassroots versus government is loosening up. There is more working together. It is very good how people are presenting themselves here; people aren't shoved in a corner. It is very family-like. But it is sad that the conference isn't covered in the media here, and we are very separate from the Thai situation. There is hardly anything we can do from this conference. We are all very helpless about it and I think we should admit that."
— Susanne Schardt, Germany (F)

"It is a very organized conference. All the management is up to the mark. There could be a more spacious area for the panels, but all is going in a very structured way, so I do appreciate the organizers."
— Shamim Rabbani, Bangladesh (M)

"I was a bit disappointed that there wasn't a lot of grassroots reporting back. It's good to see research, but we need to see more projects on the ground."
— Polly Williams, Australia (F)

"I thought that it was good. A lot of the stuff from the first couple of days, which was focused on HIV in the region, was a bit repetitive for me because I have attended many conferences on the topic. But the subsequent days were great. Very informative."
— David Voon, Australia (M)

"No. The political situation here is complex, but I feel I haven't learnt anything about the situation here from the professionals. The most I learnt was from the Thai drug users. There are too many UN and WHO guys in suits spouting statistics that are useless. I learnt more from a woman describing her life as a Thai drug user in 15 minutes than from anything else I've seen here. And I'm going to head butt the next person who shows me a bar chart. The venue is bad also. There are not enough
areas to meet and sit down in. People are sitting on the stairs. You end up feeling guilty for being here. There is a drug war, people are dying, and I bought a t-shirt.”

— Michael Linnell, UK (M)

“While there was a good range of countries and projects described, there wasn’t much discussion or analysis. In addition, I feel that some of the hard political issues around drugs, politics, and morality were not seriously discussed.”

— Piergiorgio Moro, Australia (M)

“I expected more young people would be here as delegates. The youth were mainly from Thailand and I was expecting to hear the voice of international youth. Also, the party was great – great food and great entertainment, but I thought the conference would be about solving problems, not about enjoying ourselves. We discuss the problems of drug users who are always searching for money, and the NGOs are always searching for money, and then we have a fancy party that throws money out the window. It was a good party, but I thought it was inappropriate.”

— Manuel Loosli, Thailand (M)

“I was staff at the youth lounge, and I was very pleased that many people came to the youth lounge – youth and adults. Our volunteers made strong connections with delegates, and some will take the delegates to tour around Chiang Mai tomorrow. Then they can practice their English.”

— Kaewta Sangsuk, Thailand (F)

The challenge for young people – What now?

On the final day of the conference the young people attending are faced with the pressing question – what now? Much information was disseminated, youth-advocacy has been encouraged and most importantly, young people have had the opportunity to speak their minds. As young people return to their home countries and communities some may have a chance to continue the high level of interaction they have enjoyed at the conference and some may not. So what do they plan to do in order to advocate their needs? Following are some responses.

Olie (M) — Indonesia

Olie and his team will disseminate the information they have gained during the conference through any means possible, including their website. He said he would also seek to increase the influence of young people over the decisions of policy-makers. “Young people have ideas that must be considered by decision makers,” he concluded.

Rumi (M) — Bangladesh

Rumi will share the skills and the many positive examples he has seen with his colleagues at the rehabilitation centre he belongs to. “The concrete programmes we saw here can be implemented back home,” he said before continuing, “I hope the next conference will also feature youth as important participants”.

Urairat (F) — Thailand

“Information about not only the dangers of drugs but also about the ways to deal with these dangers is very important for youth”. Urairat also said that young people need support but she went on to say, “In the future you will see youth solving their own problems”.

Manu (M) — Swiss exchange student living in Chiang Mai

“I will use the knowledge I have gained to improve the activities of the organization I work with”. He believed that his conference was a good beginning to greater advocacy by youth. “Never the less, I would like to see young people involved to a greater degree at the next conference in Melbourne” he concluded.

These are just some of the ideas raised by the young delegates of the 14th ICRDRH. One can only wait to see the results of this enthusiasm at the 15th ICRDRH

“In the future you will see youth solving their own problems”.

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On-site Newsletter

About *On Track News*

*On Track News* succinctly and incisively documented the daily conference events, outcomes and personalities, a high pressure task that was achieved through reporting by the Health and Development Networks (HDN) Key Correspondent (KC) team and production by the HDN editorial team. Many of the articles included in the “Conference coverage” section of this report were published in *On Track News*.

Without the newsletter there would have been no accessible forum for delegates to garner what was covered during each day of the conference. Due to overlapping times, it was not possible for delegates to attend all the sessions they were interested in, so *On Track News* filled that gap by providing an excellent news format summary of what they might have missed. *On Track News* also provided a voice for young delegates at the conference who formed their own Youth Rapporteur Team, and for other delegates whose opinions about the conference were published each day in “Quote of the day”. 
No conference would be complete without skills-sharing sessions and training workshops, where delegates get to share skills developed at the coalface, as well as receive practical training in specific areas. Delegates had the opportunity to attend 15 different sessions.

Skills sharing sessions
These sessions promoted the transfer of skills and practical solutions to common problems. Each session addressed a key problem for policy or practice, identified in advance (e.g. “How to influence politicians”). Presenters spoke for seven minutes each, discussing how that problem has been solved in different settings and the audience was encouraged to participate.

Topics
- Working with cocaine and crack users
- Needle and syringe programmes: National coverage and quality
- Harm reduction for youth
- Harm reduction services: Sharing skills
- Innovative harm reduction services
- Advocacy workshop - “Do it yourself”

Training workshops
These workshops enabled specific skills and knowledge to be learned. Trainers prepared the programme and resource materials, and structured the training to maximise learning.

Topics
- School-based drug prevention in a global perspective (AHRN)
- Partnership of law enforcement and public health in HR policy development and implementation – experiences within the European context
- HR: From science to practice: Field experiences of implementing HR in India, Pakistan, Bangladesh and Malaysia
- Outreach work modules
- Overdose
- Communication skills for outreach workers and peer educators
- Policy advocacy: “Convince them or be convinced”
- Islam and harm reduction
Complementing the plenary presentations, symposia, roundtables, forums, skills sharing sessions and training workshops, was an excellent programme and display of poster presentations, with a particularly strong representation of grassroots and peer-based activities. These poster exhibits were diverse, visually thought provoking and sometimes controversial.

**Thematic poster sessions**

These presentations were assisted by poster displays. Selected posters dealing with similar topics were displayed together. Participants read the poster either before or after the session, and made five-minute presentations highlighting key points from their poster. The chairperson encouraged debate and discussion with the presenters and audience drawing out major findings, important areas of disagreement and possible areas for future work.

- Rapid assessments of drug injecting (Mongolia, Argentina, Malaysia, Belarus, Spanish-speaking internauts / www.users, Colombia, and Iran)
- Sex workers and services (Hanoi, Sofia, Vilnius, and Belarus)
- Alcohol and drug use (Nigeria, Brazil, US, and Australia)
- Outreach (Ukraine, Brazil, Vietnam, and Nepal)
- Communities and harm reduction (Bangladesh, US, UK, Indonesia, India, and Brazil)
- Blood-borne viruses – HBV, HCV and HIV (Australian prisons, India, US, Albania, and UK)
- Treatment issues Part 1 & 2 (US, India, Australia, France, Canada, and UK)
- HIV epidemics Part 1 & 2 (Brazil, Thailand, US, Pakistan, Nepal, and Cambodia)
- Drug transients Part 1 & 2 (Australia, Netherlands, Iran, Bangladesh, Bogota (Colombia), Kenya, Canada, France, and India)
- Understanding risk: Drug preparation and drug use (New York City, Hungary, Russia, UK, Australia, and Chiang Mai)
- Educational programmes for harm reduction (Brazil, Australia, Slovenia, and Russia)
- Advocacy and harm reduction (Nepal, Russia, Czech Republic, India, Ukraine, and St. Petersburg)
- Policy issues (Ukraine, Russia, and Argentina)
- Treatment and care (US prisons, India, Australia, US, UK, Iran, and Canada)
- A cross-sectional study on AIDS awareness among eligible couples
- Boys to men? Many die in the arms of Morphine – thanks to drugs!
- Substance abuse amongst Kohls, a panacea to gender discrimination
- Strategies for protection from HIV-infection among Thai youth and CSWs
- Developing a mobile resource group from ex and current drug users
- Needle exchange with steroids and anabolics users
- A holistic, client-centred approach for women
- An experience on buprenorphine substitution programme at Imphal
- Educating the policemen the principles of harm reduction
- Harm reduction in prisons in Voronezh region
- Innovative projects on HIV prevention in Russian prisons
- Peer education network for Eastern Europe and Central Asia
- Analysis of the medical, social and demographic factors of drug-using
- Plan for the nurses: Training sessions ‘working with HIV-patients’
- Shifting the euphoric ideas of drug users through adventure
- From intervention to therapy in Croatia – Region net – “Split model”
- Subversives, drug addicts and bandits
- Comparing a standard to a simplified peer-driven model for IDUs in Russia
- Transgender and HR: A new approach to work with transgender in Sao Paulo
- The psychology of care giving in Thailand
- The International Coalition on Alcohol and Harm Reduction (ICAHRE)
- The mysterious case of the missing cop: Law enforcement and HIV
- Harm reduction, users rights and the Argentinean drug users organization Raddud
- HIV risk behaviours through the lens of gender: Female IDU
- Drugs in Italy: Pleasure, illness or crime?
- Intravenous drug use and risk to acquire HIV
- Basic & complementary principles in damage-reduction programmes & policies
- Behavioural characteristics of harm reduction programme participants

**Poster exhibits**

- Indicators of IDU and HIV in developing and transitional countries
- Risk behaviours associated with HIV infection among IDUs in Kathmandu
- IDUs and role of the family
- A holistic approach for HIV/AIDS prevention among IDUs
- Reaching out effectively to injecting drug users in Guwahati City in Assam
- Female controlled methods and harm reduction amongst wives of IDUs
- Hepatitis C virus infection in HIV-positive patients of Kermanshah
- The epidemiological status of HIV infection in addicts of Kermanshah
- Depression and anxiety in HIV infected non-infected IDUs in Kermanshah
- Peer to peer support programme for HIV/AIDS infected drug users in Nepal
- Drop-in centre is a forum to access mobile IDUs in area of affinity
- Evaluation plan of the project HIV Prevention in Central Asia
- Harm reduction in closed drug scenes
- Harm reduction at the beginning - The Open Doors Project
- Pilot project on harm reduction among IDUs in Lahore – A success story
- Pre-intervention and follow-up surveys in an HR project in Lahore
- Negative impact of targeted Intervention (IDUs) in Manipur
- Harm reduction via residential treatment for young drug users
- Drug harm reduction and rehabilitation services for street drug addicts
- Influence of HRP on group norms of HIV risk behaviour of IDUs
- Kazan Training Center: Improvement of effectiveness of Russian HRPs
- Analysis of the medical, social and demographic factors of drug-using
- Plan for the nurses: Training sessions ‘working with HIV-patients’
- Shifting the euphoric ideas of drug users through adventure
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- Intravenous drug use and risk to acquire HIV
- Basic & complementary principles in damage-reduction programmes & policies
- Behavioural characteristics of harm reduction programme participants
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- Conducting focus group discussions (FGD) with yaa baa users in Chiang Mai
- Scheduled STD interventions among addicts, a milestone of HRP
- In preparation for a vaccine trial: Results of the baseline survey
- Re-emerging syphilis in the North West of England
- Collaborating with native-nation alcohol users
- Drug overdose, prevention and education survey study
- Communication politics of the Mendoza government
- Short & sweet – Opportunistic harm reduction interventions
- Promoting a culture of the human body for reducing drug-related harm
- Harm reduction in female prison of Rosario City
- Health and social consequences of drug abuse: The middle way
- Court diversion scheme at Manchester action on street health
- Social characteristics and sexual behaviour of drug users in Russia
- Monitoring trends in psycho-stimulant use, availability and harms
- Harm reduction orientation in drug policies of four EEC countries
- Four years of zero tolerance: Prohibition and harm reduction in Hungary
- Community mobilization and advocacy of cross-border HR programme – Nepal
- Medical professionals? Attitudes to drug substitution programmes in Russia
- Experience of harm reduction intervention in a drug treatment hospital
- Increasing HIV trend amongst IDU in Mumbai, India
- Training cadres in rehab centres to improve harm reduction knowledge
- Before hitting bottom: Helping addicted Australians ‘not wanting help’
- Harm reduction among Roma community
- Drug use harm reduction and behaviour of the target group
- Reduction of damages in consumption of cocaine
- The importance of the integration of interdisciplinary teams
- Evolving strategic partnership with CBO of recovering addicts
- Free One-For-One Exchange improves return of used injection equipment
- Asian drug users in the UK: An analysis of the effects of cultural difference
- Patterns of use: Sociological analysis of social exclusion
- How are we doing providing care to people who use drugs in the UK
- Establishment of drug-user organizations in India
- Correlates of change in treatment availability for USIDUs
- Development of cooperation of NGOs working in prisons of CEE/CIS
- Rare in Brazil: Partnership between Ministry of Health and CDC
- Deteriorated health requires Invigorated Strategy
- Comprehensive community-based harm minimisation programme in Manipur
- Drug information needs among party drug users
- Health services for IDUs through community urban health clinics, Nepal
- Trialling the Brief Treatment Outcome Measure (BTOM) in detoxification counseling and rehabilitation services
- Risk of sexual transmission of HIV infection among IDUs
- Models of safer sex mass media campaigns in Russia 1997-2002
- Three years of peer education and outreach in the Russian penal system
- Protective behaviours in new IDUs in a declining AIDS epidemic in Rio
- Harm reduction: How new is it?
- Risk factors associated with drug overdoses in Montreal street youth
- Harm reduction strategy in Sumy, the Ukraine
- Assessment of blood-borne virus transmission risk in Victorian prisons (Australia)
- Thinking outside the square
- Methadone prescribing in Ontario, Canada
- Study of drug and psychoactive substances abuse among secondary school
- Adolescent drug use during a period of reduced heroin availability
- Collaboration of NGOs with PWHA Networks
- Drugs, poverty & harm reduction: Challenges of programmes among marginal population
- Social press as an innovative approach to HR strategy realisation
- Having the think-tank wide open: Grup Igia 20 years
- Project of syphilis tests as a part of harm reduction project
- GIPA, capacity development for caretakers and rehabilitation staff
- Health and social problems: Polish heroin-addicted persons
- Responding to an explosive HIV epidemic driven by frequent cocaine injection: Is there a role for safe injecting facilities?
- Beyond medical harm reduction
- Human behaviour leads IDUs to be drugs free
- Harm reduction in Dushanbe
- Two years of work of the project “Harm Reduction in Dushanbe”
- Problems of rights protection of drug users and people living with HIV infection
- Harm reduction in the midst of illegal trafficking and punishments
- Blood awareness among ex and current injectors
- Review of the programme of working with adolescents who consume narcotics
- Partnership with prison administration in implementing HR in prison
- Role of volunteers in the project “Harm reduction in Dushanbe”
- The development of social skills of drug users
- Ukrainian Harm Reduction Association as professional union
- Treatment of addicts by applying computer based music psychotherapy
- High-risk sexual behaviours among heroin users
- Drug use and sex risk behaviour in patients with STIs
- Black cobweb
- Thirteen years of the PLUSS Hungary
- Prevalence of HIV amongst IDUs in the Kathmandu Valley, Nepal
- Targeted education campaigns in prisons reduce the stigma
- The relationship between social network factors and overdose
- Harm reduction on HIV among injecting drug users and sex workers in Lang Son Province, Vietnam
- Designer drug analysis for dance drug users at Free Parties
- Drug interactions with methadone: A 700-blood-samples retrospective analysis
- Crack use and drug injection among Montreal street youth
- Newsletter as an instrument for the development of an informal network
- Situational assessment of sexual health including drug use in China
- Genetic toxicology of methamphetamines
- HIV and HCV co-infection in drug users in Pingxiang city, Guangxi
- Risk factors for sharing syringes among IDUs in Guangxi, China
- HIV/AIDS epidemiology in Lithuania
- Effective tools for policy advocacy on harm reduction
- The clinical analysis on co-infections of HIV and pulmonary tuberculosis in preparation for a cross-border needle exchange project
- Smoking cessation services are reducing the inequalities health gap
- Street children: Lifestyle and drug using patterns
- Street children users in central Kolkata – need immediate intervention
- HIV risk perception and risk behaviour in injecting drug users
- Supportive service for HIV control and prevention
- Low dose burenorphine therapy in heroin dependence in Manipur
- Caring community for PWHA – a one-year experience in Manipur State
- Monitoring and supervision of HR project in Baksakov, Russia
- Nutrition support programme for people living with HIV/AIDS (PWHA)
- Community AIDS Care Network – a Web site connecting AIDS Care NGOs
- The evolution of a mobile overdose response service
- Drug injectors’ views on safe injection facilities & prescribed heroin
- Elaboration of tactics of HRP among commercial sex workers in Sakhalin

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• Effectiveness of VCTC for IDUs intervention - an Indian situation
• Strategic advocacy to reduce the vulnerability against drug users
• Sunshine Homeland: Prevention and re-entry project for IDU in Yunnan
• How long do we have to wait for humane drug policies?
• Community radio, power, discrimination and hepatitis C
• Drug use/HIV prevention in children and street youth in FSU
• Need for scaling up STI/AIDS intervention among IDUs of Bangladesh
• Outreach training for young peer IDUs in Chennai, India
• How to destroy an effective harm reduction strategy
• Patterns of illicit drug use among young people in Mendoza, Argentina
• Changes in injecting practices among the clients of the Day Centre
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• Drug users fighting against social exclusion in the City of Sao Paulo, Brazil
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• Focusing of harm reduction strategy on sex workers in Shymkent
• The project of harm reduction among the WWCS
• A qualitative study of familial characteristics of drug use, in Iran
• In search of a fix: Needle exchange and primary health care
• HIV among incarcerated and non-incarcerated drug injectors in Iran
• Club without tobacco
• Harm reduction and HIV prevention, key issues of a regional public policy
• Profile of injecting drug users in the city of Mumbai
• Strengthening the harm reduction movement in Brazil
• What after detoxification? Some issues to consider for poor women users
• A sample intervention as emergency setting on harm reduction in Nepal
• The role of HIV testing in HIV risk reduction among IDUs in Bali
• A sex worker’s paper to reduce intoxication
• Damage control journal prepared by users of modern day drug policies
• HIV/AIDS prevention for IDUs through harm reduction intervention
• Targeted harm reduction programme in Jhapa, Nepal
• Injecting networks of IDUs in Kathmandu – Results of an ethnographic study
• Legislation and municipal policy during HIV/AIDS epidemic in the Ukraine
• Interface between a medical institute and local partners
• Harm reduction – exercise and citizenship learning
• AIDS sexual risky behaviour among street kids in Brazil
• Changing times, changing needs - injecting drug use in CBD Melbourne
• The role of PWHA Networks in harm reduction
• Drugs, HIV/AIDS and programmes in Manipur
• Scaling up of promotion of condoms and other women preventive options
• Observation of Matrix Programme in northern Thailand
• Our experience – holistic approach to harm reduction
• Harm reduction approach: Self-treatment among male drug users, Thailand
• Evaluation of an Internet-based resource for peer education
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• Evaluation of intensity of HIV/AIDS and drug use prevention in Russia
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• An outreach approach to sex work
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• The roles of witness perception and experience during drug overdose
• Enhancement of harm reduction based targeted Intervention project by IDUs
• Coping with IDU-related HIV/AIDS without antiretroviral drugs
• NSPs and the Media: A case of balanced and accurate reporting?
• Prevention of Hepatitis C and HIV among tattoo and piercing makers
• Harm reduction in Argentine prisons – new challenges to reduce related harms
• Severity of addiction and high-risk behaviour among injecting drug users
• Experience of Pskov Preventive Programme on HIV Spreading Restriction
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• Paying drug users in scientific research
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• Still in harm’s ways: Patterns of injecting drug use among IDUs
• Changing patterns and trends of drug use in Manipur
• Complexities of ART on IDUs in resource poor settings
• The MOD SQUAD. A harm reduction approach to overdose prevention
• Evaluation of an unsanctioned peer-run needle exchange programme
• Harm reduction in Bulgaria. The need of governmental support
• Engaging alienated young people in substance use issues
• How you can safeguard yourself against HIV/AIDS
• HIV incidence in drug users in Guangxi, China
• Harm reduction in small communities in Russia
Introduction

I would like to thank the programme committee and organizers of this conference for inviting me to be the rapporteur of this conference, and in particular for their trust in me to be able to do this.

Limitations

The conference programme this year consisted of 139 hours of presentations and discussion and debate. In order to just listen and participate to all this you would need four working weeks. And then I haven’t included the time you’d need to synthesize all the information and summarise the key findings and highlights. You will all understand that the task of the rapporteur is a difficult undertaking.

What I have done is I have adopted a method very much like the Rapid Assessment and Response strategy: I have attended as many sessions as possible and asked my friends and colleagues to act as key informants. Many people have provided me with their impressions and what they considered highlights of this conference. In the next 20 minutes I will try to summarise both their and my personal impressions of this conference programme.

Acknowledgements

I would like to thank everybody who helped me as well as the HDN Key Correspondent team, who provided a nice summary of what is going on during and around this conference in their daily newsletter.

I want to also particularly thank Robert Power, Kate Dolan and most of all Jane Fountain for their extremely helpful and faithful contributions.

What do we know?

Epidemiology of drug use and blood-borne diseases

Several papers provided information on the epidemiology of drug use and blood-borne diseases. Anindya Chatterjee gave an overview in the first plenary on the Asian situation and in particular on the devastating size and impact of the situation with regard to drug use and HIV/AIDS in the region. Overall, there are seven million people with HIV in Asia, one per cent of the women in the general population of Southeast Asia is HIV positive and in the year 2002 alone 490,000 people died of AIDS.

Drug injecting and HIV continues to spread all over the region and several new outbreaks of HIV among drug injectors are taking place, in certain areas the prevalence of HIV ranges between 40 and 60 per cent. HIV sexual transmission via injecting drug users is taking place at an ever-increasing level.

Although there is overall little systematic data available on other adverse consequences of drug injecting, several papers reported on other blood-borne diseases. The continuing spread and staggering prevalence rates for Hepatitis B and C were reported for certain areas (up to 15-60 per cent HbsAg and 40-90 per cent antiHCV).

It is clear from these data that harm reduction needs to address and keep on addressing these issues.

Modelling

Advances of modelling the HIV epidemic were addressed, as well as the importance of the link between injecting drug use and sexual activity in driving epidemics. Discussion took place about whether injecting drug use can accelerate and enhance the start of a heterosexual spread of the HIV epidemic and whether the existence of a large sector of commercial sex work would play an important role in driving the HIV epidemic. The limitations of modelling were also discussed, with particular reference to two models presented for the same country but with different conclusions.

The importance and implications for harm reduction can be summarized in two points:

- Different modelling groups, and of course this goes for any group of researchers, need to discuss and agree on their conclusions and the harmonization of data sets in order to prevent giving conflicting suggestions to policy makers, and,
- Interventions need to address both drug injectors and their sexual behaviour.
Ethnography

In the session on ethnography it was important to see confirmed the importance of ethnographic studies and qualitative research to inform drug and harm reduction policies, in particular on the underlying reasons why people still engage in risk despite their knowledge. The presentation of several case histories clearly showed again that it is about context, about setting and setting. It was suggested to think in terms of risky situations instead of risk groups. The concept of relative risk was discussed and the misfit of researchers’ and service providers’ perceptions of risk and the users’ one for some heroin is the solution and not the problem.

Rapid Assessment and Response (RAR)

The aim of RAR is not only to understand the situation (RA) but also to change it (R). There have been several reports of RARS being increasingly funded and conducted in many countries across the world using the recently published WHO guide. One of the main advantages of RAR is the fact that a wide range of sources is being used. The fact that RARS are conducted across the world is important because they will contribute to harmonized data sets. Evaluations show that RAR has positive outcomes, although in some cases more training on the conduct and quality of the RAR is needed.

Conclusion

Again these examples underline the importance of a combination of research methods and call for an inter and multi-disciplinary approach. We need to know what the problem is as well as understand the underlying reasons for the problem in order to develop effective interventions. Interventions need to address both structural factors and come up with enabling strategies.

What do we do?

Coverage and scaling-up

Clearly, coverage is a complex issue, which refers to targets and needs, which are mostly based on assumptions. It is therefore good to know that many people are working towards a greater clarification on the relationship between coverage and scaling-up responses and to workable definitions. Issues have been addressed, including: the need for a more unified approach to bridge different policies and programming; the need for a horizontal exchange of good practices between countries rather than reinventing the wheel; and, the often-fragmented nature of policies and interventions. And it has been stated that there is a need to focus on how good quality and high coverage programmes can be delivered, in particular in resource-constrained and politically volatile settings. Working together with stakeholders and different partners was stressed at several points. In particular international donors need to work together and although in the initial pilot phase it is often easier to by-pass existing institutions, it was stressed that in order to dramatically scale up preventive activities, the use of existing services is required to provide a network and educational system. This means that scaling-up is closely tied to institutional reform.

Substitution treatment

The sessions on substitution treatment included some excellent presentations describing the latest thinking and research on programme delivery and implementation.

Robert Ali demonstrated in his concise overview of the various opioid agonist and antagonist medications, the importance of evaluating and monitoring treatment. Even though maintenance treatment for opioid dependence in particular has repeatedly proven effective, it still is important to demonstrate this because “nothing works better than to show the community that their projects work!”

Today, Garth Poppel described the pioneering work of the organization We Help Ourselves in showing how harm reduction has an important place within residential and abstinence based treatment as well.

ARV – antiretroviral therapy

The session on “Caring for HIV-positive injecting drug users: Principles, models and strategies”, was organised by the WHO. The WHO has set the goal to get three million HIV-positive people on ARV therapy by 2005.

The issue is that there are around two to three million drug injectors with HIV across the world but that in many countries there is extremely limited access to ARV, in particular for drug users. Obstacles to equitable access to ARV therapy in particular in Eastern Europe is not necessarily due to stigma or discrimination, but to poverty, legal/regulatory factors, and lack of experience. Stigma and discrimination are often the consequence of these obstacles.

Regarding adherence it was stressed that adherence is a challenge to the whole affected population and not particularly to drug users (CDC reports an overall 35 per cent non-adherence rate). Fabio Mestasquita reported the extremely interesting situation in Brazil. In 1996, universal and free-of-charge access to ARV treatment was established by a presidential decree. A study in Sao Paolo was presented with 22,000 people on ARV therapy, of whom 22 per cent are drug injectors. In the period 1997-2000, there was a 52 per cent reduction in mortality due to HIV and AIDS and the average costs of treatment were reduced by 58 per cent, due to agreements with pharmaceutical companies and the production of several medications in Brazil.

A major finding of the study, however, was that adherence to treatment amongst drug injectors was found to be affected not by drug use but by other factors, including poverty and the quality of the services.

Vaccines

In the session on Thai vaccine trials, Kachit Choopanya reported that the results of the first trial on phase three of vaccines for HIV in the USA were presented two months ago. This VaxGen trial 04 was directed to over 5000 MSM and around 300 women at risk. The results pointed out that for some unexplained reasons Asian and African American participants responded better to the vaccine. However their absolute number in this study was very small.

In Thailand, another trial has been conducted (VaxGen 03) amongst 2500 drug injectors recruited from treatment centres and followed for the last three years. The results will be presented in a few months, but because this trial is conducted amongst Asian participants the expectations are high.

By the way, the difference between the two trials also concerns different sub-types of HIV: Vax Gen 03 is a BIE and VaxGen 04 is a BB.

Overdose prevention

One session focused on the long running academic debate around the pros and cons of naloxone distribution to opiate users in order to prevent fatal overdose. Paul Dietze gave insight in the design of the planned trial in Melbourne, Australia. Robert Haemgg and John-Peter Kools both showed that in the context of both Switzerland and the Netherlands, where there are comprehensive drug policies and the availability of treatment, ambulance services and considerate police, the need for naloxone distribution is lower and the focus lies much more on resuscitation and training of the correct way of doing this. Robert Heimer presented data from Chicago, where naloxone distribution together with extensive training and education of both staff and users were successful and resulted in an overall reduction of fatal overdoses of 20 per cent.
The implication is that there is a need to address these issues and even in Afghanistan. Opiates, hashish, and other ingredients are used with Ritalin injection in New Zealand and the smoking of scorpions mixed with other substances as well as poly drug use. In particular, stimulant use was stressed in order that appropriate responses can be developed. The need to confront these problems was addressed, and especially catching was his statement that even if there wouldn’t be an opiate cultivation and an opiate problem, Afghanistan would still face an enormous drug problem, as so many different drugs, chemicals and medication are currently being used. He also clearly explained that drug use is not the problem, but a symptom of the problem. The need is for appropriate responses can be developed.

Dave McDonald gave an excellent insight on the situation of Afghanistan, of the double-edged sword of the poppy cultivation both from the perspective of cultivators and of consumers. In fact, he demonstrated after assessing the situation for risk factors and situations, that the whole Afghan population was actually at risk for problem drug use and the consequences that go with that.

He also described the transition from hashish to heroin smoking amongst the Afghan population as an example of decreasing the risk of being caught, with heroin having less pungent fumes than hashish, while obviously increasing the potential harm for their health.

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Other drugs

This brings me to the other drugs. Again, there has been much focus on opiate use. However, several papers addressed the prevalence of use of other substances as well as poly drug use. In particular, stimulant use was reported in several papers, including crack and cocaine in Western Europe and methamphetamine use in Southeast Asia, Australia and New Zealand.

Also some emerging new trends were reported, such as the use and injection of Ritalin in New Zealand and the smoking of scorpions mixed with opiates, hashish and other ingredients in Afghanistan. The implication is that there is a need to address these issues and even in the case of large-scale problematic use, such as in the case of methamphetamines, crack and cocaine, treatment options are still limited and unexplored.

Partnership

I would like to conclude with the theme of this conference “Strengthening Partnerships for a Safer Future” as was also pointed out by Carol Jenkins in today’s plenary. She showed, using examples from her work in Asia, how important it is for the success and the sustainability of harm reduction to bring together partners from different sectors.

This conference has succeeded in bringing together many partners of different sectors. People from different parts of the world, 63 countries I believe, and from a wide range of professional backgrounds:

- international institutions;
- all relevant UN agencies;
- government departments;
- the community; and,
- NGO’s.

But also:

- health professionals;
- researchers;
- law enforcement; and,
- last but not least, drug users.

Bill Nelles reminded us that this conference is one of the few if not the only one to involve and closely collaborate with drug users themselves and I consider this a great achievement.

And all of you (and me) have not only attended the programme and learned new things, but you have also engaged in networking, in making new contacts and in formal and more informal meetings.

Bill Nelles gave the great example of user-driven methadone provision in the UK and their impact on policy and practice. The UK alliance has shown that drug users:

- can be constructive partners in a dialogue to improve their own quality of life and that of their society.

And that they:

- can sit as equals on government and medical boards and task forces;
- can be most effective health educators of other drug users; and,
- be powerful advocates for each other and for improved treatment facilities that respect their rights.

If we need more proof of this, the wonderful speech of Wassawut Yimchaen at the opening ceremony was proof enough.

Beyond the differences, there is a common goal to ensure the welfare, peace and tranquility of affected communities. But partnership implies equality and working in partnership is more effective than working in confrontation and this conference has taken great strides in demonstrating this.

Thank you.