

**Third Biregional Partners Meeting on  
Harm Reduction among Injecting Drug Users**

**Melbourne, Australia  
19-20 April 2004**



**WORLD HEALTH ORGANIZATION**  
Regional Office for the Western Pacific  
Regional Office for South-East Asia

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## **REPORT**

### **Third Biregional Partners Meeting on Harm Reduction among Injecting Drug Users Melbourne, Australia**

**19-20 April 2004**

Convened by:

**WORLD HEALTH ORGANIZATION  
REGIONAL OFFICE FOR THE WESTERN PACIFIC  
and  
REGIONAL OFFICE FOR SOUTH-EAST ASIA**

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## NOTE

The views expressed in this report are those of the participants in the *Third Biregional Partners Meeting on Harm Reduction among Injecting Drug Users* and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of *Member States* in the Region and for those who participated in the *Third Biregional Partners Meeting on Harm Reduction among Injecting Drug Users*, 19-20 April 2004, Melbourne, Australia.

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## ABBREVIATIONS

AHRN	Asian Harm Reduction Network
AIDS	Acquired immunodeficiency syndrome
ANCD	Australian National Council on Drugs
ART	Antiretroviral treatment
AusAID	Australian Agency for International Development
CDC	United States Centre for Disease Control and Prevention
CHR	Centre for Harm Reduction (Melbourne, Australia)
CND	Commission on Narcotics Drugs
DFID	UK Department for International Development
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
FHI	Family Health International
HIV	Human immunodeficiency virus
IDU	Injecting drug use
MAC	Malaysian AIDS Council
NGO	Nongovernmental organization
STI	Sexually transmitted infections
TDN	Thai Drug Users' Network
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNAIDS-SEAPICT	UNAIDS South East Asia and Pacific Inter-country Team
UNODC	United Nations Office on Drugs and Crime
UNRTF	United Nations Regional Task Force on Drug Use and HIV/AIDS Vulnerability
USAID	United States Agency for International Development

## 1. INTRODUCTION

The Third Biregional Partners Meeting on Harm Reduction among Injecting Drug Users was held in Melbourne, Australia from 19 to 20 April 2004. The meeting was organized by the World Health Organization Regional Offices for the Western Pacific and South-East Asia.

### 1.1 Objectives

- (1) To provide and review the latest epidemiological and surveillance information on HIV and drug use in the two Regions.
- (2) To review progress and proposals for a biregional approach to harm reduction-based responses to HIV and drug use.
- (3) To consider and make recommendations on responses to HIV and drug use in closed settings (e.g. prisons, compulsory drug treatment and rehabilitation centres, juvenile detention centres).

The meeting's programme of activities is attached at Annex 1.

### 1.2 Participants

Thirty-four participants attended the meeting, including country participants from Cambodia, China, Indonesia, Malaysia, Myanmar, Nepal, Thailand and Viet Nam; and partner organizations including Asian Harm Reduction Network (AHRN), Australian Agency for International Development (AusAID), the Centre for Harm Reduction (CHR), Family Health International (FHI), Malaysian AIDS Council (MAC), POLICY Project, United Nations Office on Drugs and Crime (UNODC) Regional Centre for East Asia and the Pacific. During the joint sitting with the United Nations Regional Task Force on Drug Use and HIV/AIDS Vulnerability (UNRTF), representatives of additional agencies on the Task Force joined the meeting. Representatives of the World Health Organization came from Headquarters; Regional Offices for South-East Asia, the Western Pacific and Europe; and country offices in China, Indonesia, Myanmar and Viet Nam. Temporary advisers for the meeting were drawn from affected and vulnerable communities, i.e. drug users and people with HIV.

A full list of participants, temporary advisers, observers and the secretariat is attached as Annex 2.

### 1.3 Organization of the meeting

The meeting was held in the Melbourne Convention Centre, Melbourne, Australia from 19 to 20 April 2004. Methods used in this meeting included plenary sessions, presentations and small group discussions.

Considering that the meeting was planned in conjunction with the 15<sup>th</sup> International Conference on the Reduction of Drug Related Harm, formal presentations by participants and observers on the country situation and developments were not included in the agenda. Participants and observers were, however, invited to present posters for display during the

meeting. Posters and all presentations made during the meeting were collected and placed on a compact disk for distribution.

The meeting also included a joint sitting with UNRTF, which was also meeting in conjunction with the 15<sup>th</sup> International Conference on the Reduction of Drug Related Harm.

## 2. PROCEEDINGS

### 2.1 Opening ceremony

The meeting was formally opened by Dr Bernard Fabre-Teste, Regional Adviser for HIV and STI, World Health Organization, Western Pacific Region, on behalf of Dr Shigeru Omi, Regional Director, World Health Organization, Regional Office for the Western Pacific, and Dr Samlee Plianbangchang, Regional Director, World Health Organization, Regional Office for South-East Asia. The Regional Directors' opening remarks are in Annex 3. Additional opening remarks and a welcome note were given by Dr Alex Wodak, President of the International Harm Reduction Association (IHRA).

Following the opening ceremony, Dr Ying-Ru Lo, Medical Officer, World Health Organization, South-East Asia Region, presented the meeting objectives and programme for agreement.

Participants, observers and secretariat members were introduced, and the opening ceremony concluded with a group photo.

### 2.2 Joint sitting with UNRTF on HIV in closed settings

A joint sitting with UNRTF was convened in recognition of the importance of a multisectoral response to HIV. The session was co-chaired by Mr Gray Sattler (WHO/Western Pacific Region) and Mr Wayne Bazant (UNODC Regional Centre for East Asia and the Pacific). The joint sitting considered issues related to HIV transmission prevention, treatment, care, and drug dependence treatment in closed settings.<sup>1</sup>

Mr Bazant welcomed the joint collaboration between UNODC and the World Health Organization, noting that the Commission on Narcotic Drugs (CND) recommended such collaboration during its 2004 meeting. In this regard, there appeared to be strong support for UNAIDS, UNODC, the World Health Organization and other relevant organizations to join forces to pursue the study of the effectiveness of drug-related HIV prevention programmes. He noted that the CND also called for UNAIDS, UNODC and the World Health Organization to convene an intergovernmental expert group meeting, in Vienna, to put together a programme on HIV/AIDS and drug abuse with specific focus on prevention, injecting drug use and risk-taking behaviour. Mr Bazant further noted that suggestions on how to embrace the above recommendations were welcome.

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<sup>1</sup> Closed settings encompass a range of custodial institutions including compulsory drug treatment and rehabilitation centres, prisons, lock-ups and remand centres.

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### 2.2.1 Compulsory treatment issues, definitions and responsibilities

Dr Robert Ali, Australian National Council on Drugs (ANCD), made a presentation on compulsory treatment issues, definitions and responsibilities. World Health Organization studies have shown that 60% of police custodies have lifetime diagnoses of substance abuse; however, the prevalence of drug problems in prisons is even higher: 68%–83% of inmates have an alcohol or other drug problem related to their incarceration; 20%–25% of inmates use heroin; 64%–69% of inmates share needles; and 33%–66% are hepatitis C carriers. Dr Ali presented the overall principles of drug dependence treatment in compulsory drug treatment settings, noting that they should be responsive to individual needs, comprehensive and multidimensional, continually assessed, and integrated into a programme that is also available in the community.

Dr Ali discussed treatment modalities, including the “therapeutic community” and substitution treatment. Therapeutic communities should include social, psychological, behavioural and physiological dimensions. They should rely on self-help and mutual support as the principal means of recovery. They should foster community spirit and a sense of belonging. Residents should participate in management and operation procedures, and should live in a safe environment. Finally, treatment should be of an adequate duration in order to minimize the risk of relapse. Drug substitution treatment, e.g. methadone, which may be more contentious, has been shown to work in compulsory settings, reducing injecting, bloodborne virus transmission, violence and recidivism. It is important, Dr Ali noted, that treatment is adequate and that there is continuity of service for those returning to their communities.

### 2.2.2 Prisons, HIV and drugs: international review

Mr Gino Vumbaca, Executive Officer, ANCD, provided an overview of the extent of the interface between injecting drug use, prisons and HIV. Research estimates indicate that 50% to 75% of prisoners have injected drugs before being locked up, and many injecting drug users have been in prison. Mr Vumbaca further indicated the interaction between drug use, particularly injecting drug use, sex work, availing of commercial sex and HIV transmission. Through what is referred to as ‘mixing’—drug use, violence, tattooing, sex and rape—HIV can spread rapidly in the prison system or any other closed settings such as lock-ups and compulsory drug treatment centres. In prisons, 50% to 75% of inmates will have injected drugs before incarceration, up to 50% will continue to inject in prison, and although injecting decreases in prison, sharing increases. Mr Vumbaca suggested that such settings could play key roles in the spread of HIV, between those incarcerated, with staff and the communities that they come from and return to. He presented evidence that drug dependence treatment in prison can substantially reduce re-incarceration rates and argued that while there are certainly challenges in doing so, prison management can meet the challenge of HIV. It was noted that a range of responses have been implemented worldwide: 18 centres have implemented condom distributions, 14 have made bleach available, eight have initiated methadone programmes, and four have already implemented needle and syringe programmes. The need to ensure that closed settings provide services that are equal to and integrated with other parts of the health care system was stressed.

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### 2.2.3 Harm reduction and prison health services for drug users

Dr Parviz Afshar, Iranian Prisons Chief Medical Officer, presented the evolution of the Iranian prison system and how it came to embrace harm reduction. Dr Afshar noted that the re-incarceration rate among drug users was almost 30% and about 8000 injecting drug users were locked up. Dr Afshar referred to the evolution of harm reduction in Iran as a 'revolution in collaboration'. For example, a memorandum of understanding was drafted between the Ministry of Public Health and that of Public Security. 'Triangular' clinics were established and harm reduction programmes, including bleach distribution, methadone maintenance, and condom distribution, started in prisons. In terms of lessons learnt from such experiences, Mr Afshar noted: (1) collaboration between health care services in and out of prisons is of foremost importance; (2) peer education is an integral part of success; (3) a guarantee of the programme's sustainability is vital to prevent relapse and to assist the community adequately.

Dr Afshar stated that further advocacy, meetings and sessions were needed to produce a change of attitude and perception with regard to preventing HIV among drug users in Iran. Dr Afshar is sharing Iran's success story with audiences around the globe. He indicated that success was due, in part, to the advocacy efforts and continuous support of UNODC in Iran.

### 2.2.4 Harm reduction and policing

Inspector General Made Mangku Pastika, Police Chief, Bali, Indonesia, expressed his support for the harm reduction approach, calling it a "common sense" approach, especially when it comes to the role of the police in the community. Indeed, Gen Pastika considers the police as the ultimate protectors of society, which includes the victims of drug abuse. Mr Pastika argued that police have a tremendous responsibility in regard to the HIV epidemic among injecting drug users as the police have the most contact with them. This is because 'drug use' is as criminalized as 'drug trafficking'; hence drug users are arrested as a normal practice in most countries.

### 2.2.5 Peer-based harm reduction issues (Australia and Viet Nam)

Ms Annie Madden from the Australian Injecting and Illicit Drug Users' League was scheduled to present. She was unable to attend and sent her apologies.

Mr Phan Thanh Van, Temporary Adviser, World Health Organization, provided a perspective on HIV prevention, treatment and care and closed settings and recent experiences in Viet Nam. Mr Phan told the meeting that the response to drug use has been to isolate drug users from their communities by placing them in treatment and rehabilitation centres for one to five years. Mr Phan acknowledged that some benefits may be found in this approach, e.g. illiterate people had an opportunity to study and vocational training could be offered; however, there is no evidence that this approach was effective in treating drug dependence. Rather, relapse rates ranged from 80%–95% and HIV infection was higher in the centres, with rates estimated to be 75% in Ho Chi Minh City.

Mr Phan also spoke of the situation in these centres: heroin is smuggled in, single syringes are used by many people, unsafe sex occurs, and unsafe tattooing is also done. The power relationships in such centres, where 'prisoners dominate prisoners' create an unhealthy environment that can result in violence and sexual abuse.

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While the large numbers of people in the centres make education difficult, the centres presented HIV education opportunities, as one international nongovernmental organization has demonstrated, providing information and education to staff. The centres could also be a source of information and education for drug users, providing accurate knowledge on harm reduction based HIV/AIDS prevention, care and treatment.

Mr Phan announced that in March 2004 a new national strategy for HIV/AIDS control, effective to 2010, with a vision to 2020, was approved. This strategy includes harm reduction for all vulnerable groups, creating the positive environment necessary to resolve the dilemma that this area has faced for many years.

#### 2.2.6 Discussions

A panel discussion with speakers followed the presentations.

- With the reported global increase in drug use and injecting drug use, countries face serious questions in how to respond to drug use and the harms that can ensue, particularly HIV/AIDS.
- The proportion of HIV positive cases in closed settings can be higher than in the general population. The movement of people through such settings increases the possibilities for HIV (and other transmissible disease) transmission while making it difficult to prevent such transmission.
- It is evident that HIV transmission occurs in closed settings. It occurs through injecting drug use (non-sterile needles and syringes commonly used), tattooing (*non-sterile equipment commonly used*) and *unprotected sexual activity*.
- At the individual level, a majority of those in closed settings are likely to be there in relation to drug use, yet drug dependence is a health issue that requires treatment. A number of approaches to drug dependence treatment, which can be provided in a range of settings, including closed settings, were discussed. Placing people into closed settings represents one approach that has been widely employed, however the challenges this presents have been noted. One way to address these would be to reduce the number of injecting drug users in such settings; thus, consideration should be given to an expanded range of responses to the detection of illicit drug use, involving a continuum of service provision involving closed settings and community based services. With the development of community-based, non-custodial treatment options, drug treatment could be *diverted or released into such programmes*. Where people are placed into custodial care, drug dependence treatment and other services that will reduce injecting drug use and the risk of HIV transmission, should be made available.

Country-based, small group discussions followed. The objective was to identify lessons learnt, future commitments and country goals. It was clear from the reports that, overall, harm reduction services in closed settings were minimal and that relevant programmes in all countries needed to be initiated or, where present, significantly scaled up, in line with international best practices.

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- Research into specific institutional closed settings needs to be carried out to improve our understanding of the situation and risks with regard to HIV infection. With this knowledge, recommendations can be made to governments on how best to employ resources in responding to the need for these and other health services.
- Harm reduction needs to be implemented in closed settings or existing efforts need to be scaled up.
- Mapping of health services in closed settings is required to determine: how best to provide such services, who is responsible, and what action should be undertaken.
- Fostering of intersectoral collaboration should continue as it is fundamental for taking actions at the country level.
- Coordination among UN agencies and other international agencies should be encouraged as fragmentation of actions can reduce effectiveness. To this end there should be regular communication between the World Health Organization Inter-country Contact Group, the UN Regional Task Force, World Health Organization Regional Offices and the UNODC Regional Office for Asia/Pacific regarding HIV prevention and care and drug dependence in closed settings.

### 2.3 Biregional Strategic Plan

The session was chaired by Mr Chad Hughes of World Health Organization, South-East Asia Region/Myanmar, and co-chaired by Mr Lok Man Singh Karki, Health Secretary of Nepal, and Mr Nguyen Duc Thu, Senior Officer from Department for Social Affairs, Viet Nam.

#### 2.3.1 Finalization of the Biregional Strategic Plan

Progress made since the 'Second Biregional Partners Meeting' towards the 'WHO Biregional Strategic Plan for Harm Reduction in the South-East Asia and Western Pacific Regions' was presented by Mr Gray Sattler, World Health Organization, Western Pacific Region. Following comments from the Second Biregional Partners Meeting in 2002, the Strategic Framework document was revised and submitted to the Technical Working Group (TWG) for technical revision. The Framework has subsequently been used to draft a Biregional Strategic Plan. An overview of the plan, including guiding principles, objectives and core interventions, was presented.

#### ***Guiding principles***

- ✓ Respect the fundamental human right of all individuals to health.
  - ✓ An evidence-based and cost-effective programme: harm reduction.
  - ✓ Enable individuals and communities to take control of their health and well-being.
  - ✓ Involve representatives of the affected and vulnerable communities.
  - ✓ A multisectoral response, involving other ministries that contribute to the response to illicit drug use, the private and nongovernment sectors, is required.
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- ✓ An integrated HIV/AIDS strategy that is incorporated into broader health policy and programming is needed.
- ✓ Focus on situations that place people at risk, rather than individuals or groups of people who are at risk.

### ***Objectives***

- ✓ To decrease HIV transmission among injecting drug users and their partners.
- ✓ To ensure access to treatment, care and support services for injecting drug users.
- ✓ To create an enabling environment for harm reduction interventions.

### ***Core harm reduction interventions***

- ✓ Information and education
- ✓ Needle and syringe programmes
- ✓ Drug dependence treatment
- ✓ An enabling environment

To achieve this, strategies to provide surveillance and research, monitoring and evaluation will also be included.

A question was raised on the period of time that the Biregional Strategic Plan would address. It was agreed that the Biregional Strategic Plan should be a five-year strategic document.

Following discussion, it was proposed that the Biregional Strategic Plan be finalized by:

- revision based on comment from the meeting;
- referral to the TWG for technical comment and review;
- circulation to all Inter-country Contact Group members; and
- submission to the regional bodies.

This was supported by the meeting. It was also agreed that a revised draft should go to the TWG by September 2004.

### **2.3.2 Involvement of the vulnerable communities**

The importance of involving the vulnerable and affected community was recognized at the meeting. Their role in the development and implementation of the Biregional Strategic Plan was represented through comment by a community representative organization, Thai Drug Users' Network (TDN).

Mr Paisan Tun Ud presented on the establishment of TDN and the activities conducted by TDN in Thailand. The presentation included information and lessons learnt

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on establishment of user groups, advocacy and stigma/discrimination reducing activities, and fund mobilization for drug user networks with reference to the success of TDN's application to the GFATM. The presentation concluded with a call for the establishment of such groups in other countries in the two Regions and for regional collaboration and support networks between user groups.

Discussion ensued on issues that the TDN are currently facing with clarification on certain points provided by the participants from Thailand. There was a request for increased support from the World Health Organization to TDN and other drug user networks.

The meeting acknowledged the critical role and importance of the contribution that the affected and vulnerable communities can make to the response to HIV among drug users. The recommendation that the vulnerable and affected communities be extended an invitation to continue their participation in Biregional Partners Meetings and to join the TWG was supported.

#### 2.4 Treatment of HIV infection for drug users

The session was co-chaired by Dr Ying-Ru Lo of World Health Organization, South-East Asia Region/Myanmar and Mr Lok Man Singh Karki, Health Secretary of Nepal.

##### 2.4.1 Dual treatment needs

Dr Ingrid van Beek made a presentation on *dual treatment needs for people with HIV* who are drug dependent. The presentation covered several issues including interactions between pharmacotherapies and antiretroviral treatment (ART) *in vivo*, increased concerns of hepato-toxicity and other medical complications when dealing with HIV/hepatitis co-infection, adherence to ART concerns for active drug users. The presenter also raised some issues regarding the provision of ART in developing and transitional countries.

##### 2.4.2 Integrating prevention and treatment programmes ("3 by 5")

Dr Andrew Ball from the World Health Organization presented the mandate and strategic plan for the 3 by 5 Initiative through which drug users in both Regions will shortly have increased access to antiretroviral treatment. Progress to date on rolling out the 3 by 5 Initiative was also presented.

##### 2.4.3 HIV prevention, care and ART for drug users: community perspective

Coming back to the guiding principle of the involvement of the vulnerable and affected community, Mr Ronnie Waikhom from Manipur, India presented on the lessons learnt from providing HIV treatment and care to injecting drug users through the CARE Foundation. The presentation showcased the feasibility of rolling out ART to injecting drug users in resource poor settings, provided lessons learnt and obstacles encountered. Mr Waikhom's presentation most importantly highlighted: the success of the vulnerable and affected community in having the capacity to establish and maintain a comprehensive and successful service delivery model, and the importance of the successful integration of treatment and care with HIV prevention/harm reduction services within one community-level service provider.

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The meeting was joined at this time by His Excellency Dr Achmad Sujudi, Minister for Health, Indonesia. The Minister's statement is attached as Annex 4.

## 2.5 Closing session

The closing session was co-chaired by Mr Lok Man Singh Karki, Health Secretary of Nepal, and Mr Nguyen Duc Thu, Senior Officer from Department for Social Affairs, Viet Nam.

The meeting considered and adopted the concluding statement (see item 3.2. below).

The meeting was formally closed following final remarks from Professor Nick Crofts, Conference Director for the 15<sup>th</sup> International Conference on the Reduction of Drug Related Harm. Professor Crofts commended the meeting for its work and welcomed participants and others to the conference.

## 3. CONCLUSIONS AND RECOMMENDATIONS

### 3.1 Summary of recommendations supported by the meeting

- (1) The Meeting adopted the Provisional Agenda and Objectives for the meeting.
  - (2) Following country-based, small group discussions, it was evident that harm reduction services in closed settings were minimal and that relevant programmes are needed in all countries, including:
    - the implementation of harm reduction based services or where already in place, their expansion;
    - research to improve our understanding of the situation and risks with regard to HIV infection in closed settings;
    - mapping of health services in closed settings to determine how best to provide services, who is responsible and what should be provided;
    - fostering of intersectoral collaboration; and
    - coordination among UN agencies and other international agencies.
  - (3) The Biregional Strategic Plan will be for five years, 2005–2010.
  - (4) The draft Plan is to be finalized and circulated for comment by the Technical Working Group (TWG) established for this purpose at the last meeting (Yangon 2003). This technical review should be completed no later than August 2004.
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(5) Following the technical review, the document should be circulated to the WHO Inter-Country Contact Group and countries in both Regions for comment in preparation for its presentation to Regional Committee Meetings in the two Regions.

(6) The meeting recommended that the next meeting should be held in June 2005 and accepted an invitation for the meeting to be held in Indonesia.

### 3.2 Meeting statement

During its closing session the meeting adopted the following statement:

"The meeting:

- ✓ acknowledged and recognized the significant work done by agencies across different sectors in working for HIV prevention and care among drug users;
- ✓ considered issues related to HIV and drug use in closed settings in joint session with the UN Regional Taskforce on drugs and HIV vulnerability;<sup>2</sup>
- ✓ reviewed and commented on the World Health Organization's Biregional Strategic Plan for a harm reduction approach to HIV prevention and care among drug users in Asia; and
- ✓ recommended several action points to the concerned parties.

#### *Action points by the World Health Organization*

The World Health Organization, in collaboration with UNAIDS co-sponsors and other partners, will:

- assist countries to enhance effective intersectoral cooperation between health, correction and public security agencies for a comprehensive national workplan with regard to HIV prevention, care and drug dependence treatment for populations in closed settings (partners include the UN Regional Taskforce on drugs and HIV Vulnerability and the UNODC Regional Centre for East Asia and the Pacific);
- advocate for enhanced national strategic plans for HIV prevention, care and support to address populations in closed settings equally to that which exists in the non-incarcerated community;
- advocate for and provide support for the greater involvement of people who inject drugs and with HIV/AIDS in designing and implementing prevention, care and treatment programmes at all levels. In this regard representatives of people who inject drugs and with HIV/AIDS will be invited to join the World Health Organization Technical Working Group on harm reduction;

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<sup>2</sup> Closed settings encompass a range of custodial institutions including compulsory drug treatment and rehabilitation centres, prisons, lock-ups and remand centres.

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- build capacity in countries for the management of drug dependence treatment and antiretroviral therapy that address the specific needs of drug dependent people (in this regard, the World Health Organization will develop and adapt for countries, in collaboration with UNODC and other partners, a toolkit addressing treatment needs for those who require drug dependence treatment and/or HIV prevention education and treatment in closed settings, by April 2005); and
- gather experiences from different countries of HIV/AIDS treatment and care for injecting drug users as possible models of good practice for countries to scale up services.

*Action points by Member States*

Recognizing progress made, Member States should:

- further strengthen effective intersectoral cooperation between health, correction and public security agencies, NGOs and civil societies with regard to HIV prevention, care and drug dependence for populations, including those in closed settings;
- ensure national strategic plans for HIV prevention, care, support and treatment address populations in closed settings equally to what exists in the non-incarcerated community;
- increase the involvement of people who inject drugs and with HIV/AIDS in designing and implementing prevention, care and treatment programmes; and
- advocate for and develop supportive policies and implementation strategies for the management of drug dependence treatment and antiretroviral therapy that address the specific needs of drug dependent people.”<sup>3</sup>

### 3.3 Next meeting

The meeting proposed to reconvene in June 2005. An invitation to convene the next meeting in Indonesia was extended by the Indonesian representatives.

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<sup>3</sup> Note that the goal of the statement is to be inclusive rather than exclusive, thus: "HIV prevention, care" is an inclusive term; it has been used to simplify the statement, rather than having to repeatedly say HIV/AIDS education, prevention, treatment and care and drug dependence; and "people who inject drugs and with HIV/AIDS", refers to people who use drugs, people with HIV/AIDS, and/or both.

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**PROVISIONAL TIMETABLE**  
**Third WHO Bi-Regional Partners meeting on harm reduction among injecting drug users**  
**Melbourne, Australia 19– 20 April 2004**

<b>Time</b>	<b>Monday, 19 April</b>	<b>Time</b>	<b>Tuesday, 20 April</b>
0800	Plenary session	0800	Plenary, discussion
0830	Registration of participants Opening Ceremony <ul style="list-style-type: none"> <li>▪ IHRA</li> <li>▪ WHO (RA/WPRO on behalf of RD)</li> </ul>		Treatment of HIV infection for drug users. <ul style="list-style-type: none"> <li>▪ Dual treatment needs</li> <li>▪ Integrating prevention and treatment programmes (3x5)</li> <li>▪ HIV prevention, care and ART services for drug users in Manipur and Thailand</li> </ul>
0900	Overview of the meeting <ul style="list-style-type: none"> <li>▪ Agenda</li> <li>▪ Objectives</li> </ul>	0945	Discussion and adoption of resolution covering this session
0945	Introduction of participants Group photo		
<b>1000</b>	<b>Coffee Break (30 m)</b>	<b>1000</b>	<b>Coffee Break (30 m)</b>
1030	Plenary Welcome & Opening Addresses by UN & WHO Chairs Compulsory Treatment Issues, Definitions & Responsibilities. <ul style="list-style-type: none"> <li>▪ Prisons, HIV &amp; Drugs International Review.</li> <li>▪ Harm reduction and prison health services for drug users.</li> <li>▪ Harm Reduction and Policing.</li> <li>▪ Peer based harm reduction issues.</li> </ul>	1030	Plenary Session Closing matters: Next Meeting, date and location?
		1115	Discussion and adoption of Meeting Statement.
		1145	Closing ceremony
<b>1250</b>	<b>Working Lunch (60 m)</b> <b>Panel Discussion (Q&amp;A) with speakers</b> <b>Chairs: Mr Gray Sattler (WHO) &amp; Mr Wayne Bazant (UNODC)</b>		
1350	Working group session Small Group Discussions (exact number to be determined) on the Lessons to be Learnt & Future Commitments and Goals in Home Country  Small Group Reports to Meeting (Country by Country)  Conclusions, Recommendations & Joint Statement (5-6 minutes per rapporteur)  Closing Addresses by UN & WHO Chairs  Adoption of joint statement on HIV prevention and care and drug dependence in closed settings.		
<b>1600</b>	<b>Coffee Break (30 m)</b>		
1630	Plenary, discussion session Bi-Regional Strategic Plan. <ul style="list-style-type: none"> <li>▪ Presentation, discussion and comment on the Strategic Plan (WHO)</li> <li>▪ Involvement and participation of the vulnerable community (TDN).</li> </ul>		
1730	Discussion and adoption of resolution covering this session		
1740	End of day 1		

PROGRAMME

ANNEX 1

ANNEX 2

**LIST OF PARTICIPANTS, TEMPORARY ADVISERS  
OBSERVERS AND SECRETARIAT**

1. PARTICIPANTS

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ANNEX 3

ADDRESS BY  
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OFFICE FOR SOUTH-EAST ASIA  
AND  
DR SHIGERU OMI, REGIONAL DIRECTOR, WHO REGIONAL OFFICE FOR THE  
WESTERN PACIFIC

THIRD BIREGIONAL PARTNERS MEETING ON HARM REDUCTION AMONG  
INJECTING DRUG USERS

19-20 April 2004, Melbourne, Australia  
(read by Dr Bernard Fabre-Teste, Regional Adviser, WPRO)

Distinguished Participants, Ladies And Gentlemen,

I have the honour to convey to you all warm greetings from Dr Uton Samlee Plianbangchang, Regional Director of the WHO South-East Asia Region, and Dr Shigeru Omi, Regional Director of the WHO Western Pacific Region. Both would very much have liked to be present here today at this very important meeting. Due to other commitments, however, they are unable to do so. I have, therefore, the privilege of delivering their address to you. I quote:

Around 9.5 million people are living with HIV/AIDS in the South-East Asia and Western Pacific Regions of WHO. Injecting drug use (IDU) has been identified as a major mode of transmission, second only to sexual transmission of HIV/AIDS. Serious HIV epidemics among injecting drug users have been reported in China, India, Indonesia, Malaysia, Myanmar, Nepal, Thailand and Viet Nam. HIV prevalence rates of more than 50% among injecting drug users have been reported in some of these countries. Obviously, these have serious implications for the spread of the HIV/AIDS epidemic. It has also been demonstrated that the HIV epidemic can spread from injecting drug users via bridging populations to the general population.

We also know that there are efficient, cost-effective, pragmatic interventions for the prevention of HIV transmission among injecting drug users. However, there are formidable challenges and barriers which we must overcome in order to scale up services and thus have an impact on the epidemic.

The United Nations agencies have called for a comprehensive HIV/AIDS prevention programme, including a harm reduction approach targeting injecting drug users, in response to the spread of HIV through sharing injecting equipment. A strategy based on harm reduction means a comprehensive package of interventions that collectively reduce the negative consequences of injecting drug use for both the individual and the community. These interventions in no way undermine other efforts addressing drug use, such as programmes to decrease the demand for, and supply of, drugs.

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### Annex 3

Scaling up HIV/AIDS/STI prevention efforts are part of WHO's comprehensive strategic response to prevent and contain the spread of the HIV epidemic among and from vulnerable populations at an early stage. WHO is committed to assist governments, organizations and affected communities to rapidly scale up HIV/AIDS/STI prevention efforts, with particular emphasis on injecting drug users. WHO has taken the initiative to develop and implement tools for effectively scaling up harm reduction activities and to facilitate partnerships. We must now identify and mobilize the necessary resources for this task.

In addition to scaling up HIV/AIDS prevention activities for injecting drug users, WHO is committed to *the important task of providing antiretroviral treatment to those already infected with HIV*. The '3 by 5' Initiative of WHO and UNAIDS aims to provide antiretroviral therapy to at least half of the HIV/AIDS patients in need, in developing countries, by the end of 2005. With a high percentage of new HIV cases in the Asia-Pacific region being among injecting drug users, many people who seek access to treatment through "3 by 5" will be drug users. We must ensure that, throughout the process, drug users have equal access to quality treatment and are not discriminated against, and that treatment regimes and delivery modalities are designed to ensure accessibility and suitability to this target population.

The involvement of the vulnerable and affected communities in all stages of planning and implementation of both prevention and treatment activities is a key to the success of our efforts. We can learn many lessons from already established drug user groups, associations and networks and they have a vital role in planning and implementing harm reduction interventions at every level. We should identify ways to support the establishment and development of such groups elsewhere.

In the fight against the epidemic of HIV/AIDS linked to the use of injecting drugs, WHO works alongside other partners within the UN system, the donor community, governments, non-governmental organizations and affected communities. In this spirit of collaboration, a *joint session with the United Nations Regional Task Force will be a part of this meeting's agenda*. This joint session will look at the important issue of harm reduction in closed settings like prisons, drug treatment and rehabilitation facilities and detention centres.

At the Second Biregional Partners Meeting on Harm Reduction among Injecting Drug Users, in August 2003, in Yangon, participants continued collaboration on the development of a biregional strategic framework for a harm reduction approach to HIV prevention and care among injecting drug users in Asia. We are now here to garner consensus for this strategic document and subsequent action at country and regional levels.

You all have a very important task ahead of you. We are confident that you will not only make valuable contributions at the meeting, but also strengthen the collaboration, which is so necessary to success, and extend this effort to include more partners in the process. It is *clear that we need a broad partnership across different sectors to effectively scale up interventions to reduce harm among injecting drug users*. This meeting provides opportunity to exchange experiences on international good practices of relevance to both Regions. The focus for this 2004 meeting will be to develop strategies that will contribute to improved national and regional responses to the drug-related elements of the HIV epidemic, in

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Annex 3

particular, addressing involvement of affected communities, linking prevention programmes with care and treatment, and addressing the important issue of service provision in closed settings.

We hope this important meeting will provide a platform for shared learning and generate valuable outputs.

Unquote

I will, of course, convey the outcome of this meeting to the two Regional Directors. I would conclude by wishing you all fruitful deliberations and a very pleasant stay in Melbourne.

Thank you.

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## ANNEX 4

Opening address by Dr Alex Wodak, President, International Harm Reduction Association

HIV/AIDS, injecting drug use and Asia in 2004: the band still plays on.

It is now clear during the last two decades that even pessimists underestimated the seriousness of the HIV/AIDS epidemic. AIDS is now a more serious health problem than the epidemic of Black Death which originated in Asia in the 1340s and then spread to Europe resulting in the death of about a quarter of the population. It is still less than a quarter century since the AIDS pandemic was first recognised. So these are still early days in the history of an evolving pandemic. How will AIDS affect the world a generation or two from now? It is frightening to think about the world our children and grandchildren will inherit.

During the course of this decade, the epicentre of the AIDS epidemic will move from sub-Saharan Africa to Asia - home to half the world's population. The epidemic is poised to shift from a region where drug injecting plays a minor role to a region where drug injecting plays a critical role. But if even the pessimists underestimated the seriousness of the HIV/AIDS epidemic, it is also true that even harm reduction supporters underestimated two decades ago just how right they were.

For almost two decades we have known that HIV has sometimes spread with alarming speed among injecting drug users. In some countries, HIV has then spread rapidly from drug users to the general population. We do not yet know how to predict the speed of spread of HIV between injecting drug users or the rapidity of spread from injecting drug users to the general population. For the last decade and a half we have known how to effectively control the spread of HIV infection among injecting drug users. Slowing the spread of HIV among injecting drug users is one of the most effective interventions in the entire AIDS prevention and treatment repertoire. Needle syringe programmes and substitution treatments are effective in reducing HIV spread. They are safe and are also cost effective. Harm reduction measures are now supported by abundant and incontrovertible evidence. Yet we still find political roadblocks at the national, regional and international level to the adoption in time and implementation on sufficient scale of these life saving prevention measures. Why?

What works in drug policy is often hard to get supported and what does not work in drug policy is often easy to get supported. This is the nub of the problem. The spread of HIV among and from injecting drug users has been exacerbated by the entrenched and ideological support for global drug prohibition. Many authorities prefer to risk a generalised HIV epidemic by obstructing harm reduction measures lest they ever be criticised for appearing to condone illicit drug use. Progress has been made over the last two decades, but it still falls dreadfully short of what is needed. Supply control still has a stranglehold on the international policy setting apparatus, though this is slowly weakening. Even the International Narcotics Control Board has had to concede this year that 'the ultimate aim of the conventions is to reduce harm'. At the heart of this debate is a very simple question: is the paramount objective of drug policy to reduce the adverse consequences of drug use – as harm reduction supporters argue – or is the ultimate objective the reduction of drug use regardless of drug-related harm – as a dwindling band of drug policy hard liners would claim?

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#### Annex 4

It is gratifying that an increasing number of countries and UN and other major international organisations are now expressing explicit and strong public support for harm reduction policies. More countries are now implementing harm reduction programmes. But in 2004 we still find that HIV continues to spread more rapidly between and from injecting drug users than the implementation of harm reduction programmes. Until that changes and until the epidemic is brought under control among injecting drug users, we cannot rest.

In 1990, a small group gathered in the English city of Liverpool at the first international harm reduction conference. We were at that time quite marginalised. Now a decade and a half later, 14 of these international conferences later, harm reduction is the mainstream in many parts of the world and in many major organisations. The notion of trying to create a drug free world is increasingly regarded as not just impractically utopian, but a dangerous distraction from the urgent and achievable task of controlling HIV/AIDS. We risk aiming for the unachievable and failing at the cost of not accomplishing the achievable.

Helping to turn this around is difficult. There is an important role in this for the International Harm Reduction Association, a very small international non-government organisation with a network of regional organisations, saying and doing things that governments and international governmental organisations cannot say or do. It is clear that revolutionary changes are not required to bring HIV/IDU under control among injecting drug users. This can be achieved, for example, without changing the three major international treaties. Everything we need to do to bring this epidemic under control in this population can be done within the letter and the spirit of the three major drug treaties. But the international community will have to stop pretending that illicit drugs is primarily a law enforcement problem and return to the framework of drugs being accepted as primarily a health and social issue where law enforcement continues to have an important but supportive role. The Single Convention of 1961 begins with the simple phrase 'The parties, concerned with the health and welfare of mankind...'. If we are indeed concerned with the health and welfare of mankind, we cannot adopt harm reduction policies and implement harm reduction programmes soon enough.

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ANNEX 5

STATEMENT

H.E Dr. Achmad Sujudi, Minister of Health Indonesia  
3rd Biregional Partners' Meeting  
on Harm Reduction among Injecting Drug users

Dear Distinguish Participants and Partners,

It gives me great encouragement to see many country representatives, partners and distinguished senior government officials here this morning.

The association between HIV and drug use is dramatic. In Indonesia, parenteral mode of HIV transmission among injecting drug users is increasing rapidly and now, the epidemic is driven primarily by IDUs. Over 80% of the new infections in 2003 nation wide is due to IDU.

While Indonesia is now experiencing major outbreaks of HIV among IDUs, as Health Minister of a large country, I believe we have come a long way in only a few years. We have been fortunate enough to have close technical guidance and financial support from very strong partners in the region as well as in country, such as the AusAID – Indonesian HIV/AIDS Prevention and care project, USAID – Family health International ASA project, the Centre for Harm Reduction, the Asian Harm Reduction Network, the UNAIDS, the WHO and many others.

The most valuable thing, I can share with all of you here now, is our experience to date. While I cannot state with certainty that we have turned the corner in controlling HIV in Indonesia, I do believe that we are on the way to doing so.

The new national strategy (2003 - 2007), puts HR as one of the main activities expressing a common Understanding of the National Aids Committee on HR. Pilot projects such as Methadone Substitution, Needle and syringe programs were initiated with joint technical and financial support from international agencies and local NGOs. National Harm Reduction Networking is ongoing with support from the CHR and AHRN through Bimonthly News Letter and Quarterly Implementing agencies workshops. National reference guidelines and tools for advocacy, policy development, program development and training has been adapted and adopted from WHO guidelines with financial support from the AusAID regional programme.

The Cabinet Meeting - Special Session II on June 2003 – agreed that “ HR “in the certain area / sites under supervision of the health provider, police and local authority should be implemented.

An MoU between the NAC – BNN was signed on 08 December 2003 agreeing that prevention and care activities for HIV and injecting drug use be implemented through a public health approach. 5 working groups were formed to develop: 1) Policy; 2) Advocacy and socialization; 3) Program; 4) Capacity and 5) resource mobilization.

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## Annex 5

*In the effort to ensure that the epidemic does not become more widespread and spread to the general population (generalized epidemic) and become a national threat, in the framework of a Coordinating Meeting of the National AIDS Commission with the six priority provinces for AIDS control in Indonesia, with awareness and responsibility declare agreement to fight HIV/AIDS through a National Movement the "Sentani commitment" on 19 Jan 2004 –a commitment to intensify HIV prevention and care including making treatment available where HR continues to be included as a priority area.*

*I would like to appreciate the efforts of the WHO and Partners in facilitating this very important discussion. I hope that this meeting will further strengthen technical as well as financial resources, still much needed in many of our countries, if we are to truly avert greater epidemics from injecting drug use and HIV.*

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